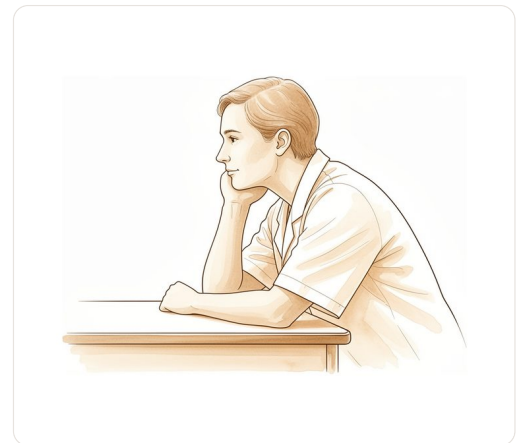


Olecranon Bursitis

Olecranon bursitis: the fluid-filled cushion (bursa) over the bony tip of the elbow swells, producing the characteristic 'goose egg' lump seen here.

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What you're feeling

You may notice a swollen lump at the tip of your elbow. This swelling is caused by fluid building up in the bursa, a small sac that cushions your bone. The area often feels tender to the touch. You might feel pain when you lean on your elbow or bend it fully.

The discomfort can change throughout the day. Many people find their elbow hurts more at night, especially if they sleep on that side. It may also ache after you have been using your arms for a while, such as during housework or gardening. On waking, the joint can feel stiff and tight until you start to move it gently.

Daily tasks become difficult because of the swelling and pain. You might struggle to rest your forearm on a table while working at a desk. Pushing up from a chair or lifting a light bag can be uncomfortable. You may also find it hard to wear long-sleeved shirts or jackets that rub against the swollen area.

In some cases, the skin over the elbow can become red or warm. If the swelling does not go away, or if it keeps coming back, it is important to check for other causes. Rarely, a persistent lump could be linked to a slow-growing infection or other skin conditions. Your surgeon will look closely at the lump to decide if it is simple fluid or something else.

If you have had this swelling for a long time, you might notice a firm cord-like structure under the skin. People with this cord often report less satisfaction after surgery compared to those without it. This is because the tissue changes can affect how the elbow feels after treatment.

Most of the time, the pain is manageable with rest and avoiding pressure on the elbow. However, if the swelling is severe or painful, it can limit your movement. You might avoid using your arm for simple activities like washing your hair or reaching for items on a high shelf. Understanding these symptoms helps you explain your experience clearly to your care team.

What's actually happening

At the tip of your elbow sits a small, fluid-filled sac called the bursa. Think of it as a natural shock absorber or a tiny water balloon. Its job is to let your skin slide smoothly over the bony point of your elbow when you bend your arm.

When this sac becomes irritated, it fills with extra fluid. This causes the noticeable swelling you see and feel. The pressure from this fluid can make the area tender and limit how fully you can straighten or bend your arm.

This swelling can happen for several reasons. Sometimes it is caused by repeated pressure, such as leaning on hard surfaces. It can also follow a direct injury, like a bump or fall. In some cases, an infection enters the sac, causing it to become red, warm, and painful. Less commonly, a slow-growing bacteria may cause a long-lasting swelling that does not respond to standard treatments.

If the swelling persists, the tissue around the bursa can change. In chronic cases, the body may form thickened cords of tissue around the area. These cords can make the elbow feel stiff or lumpy. Patients with these cords often report less satisfaction after surgical removal compared to those without them.

Your surgeon will look at the cause of your swelling to decide the best path forward. For simple cases, rest and compression are often enough. If the fluid is infected, antibiotics are used first. If the swelling keeps coming back or does not settle with basic care, we may discuss other options. These range from minimally invasive procedures to remove the fluid sac entirely, to techniques that tighten the area with sutures to prevent re-accumulation. The goal is always to reduce the swelling and restore your comfort and movement.

What we can do about it

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. We begin with self-care and physiotherapy for uncomplicated cases. You can manage symptoms at home by resting your elbow and avoiding pressure on the tip. Physiotherapy aims to reduce swelling and restore movement. For septic bursitis (infection), evidence shows that empirical management without needle aspiration is effective, with no patients in one study requiring surgery. Deferring aspiration is a reasonable option for uncomplicated infections. We advise giving non-operative care a fair trial before considering more invasive steps.

Medical management focuses on controlling pain and inflammation. We may prescribe pain medication or anti-inflammatories to help you stay comfortable. While some clinicians use injections, recent literature highlights adverse effects of intrabursal injections and surgery compared with noninvasive management for initial treatment of non-septic bursitis. Therefore, we generally reserve injections for specific cases where conservative care has not provided enough relief. If you have recurrent bursitis that does not respond to standard care, we may discuss minimally invasive options. These include sclerotherapy, which uses a medication to shrink the bursa, or hydrothermal ablation using controlled heat. These approaches offer fewer complications than open surgery and have comparable efficacy.

Surgery is considered when conservative care has reached its limit or if the bursitis is severe and persistent. We assess whether surgical excision is needed whenever recurrence or failure of conservative treatment occurs. This leads to good clinical and functional outcomes for many patients. For recalcitrant cases, endoscopic debridement offers minimal invasiveness and rapid recovery. The revision rate after bursectomy is 11.5%. We present these options as a shared decision, ensuring you understand the benefits and risks.

Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. A clinic assessment (history, examination, and imaging where needed) establishes the diagnosis. For degenerative or long-standing problems we usually try non-operative care – activity change, physiotherapy or hand therapy, splinting, and injections – and consider surgery when that has not given enough improvement. For structural or acute problems, surgery may be recommended straight away, without a preceding non-operative trial.

What to expect

Your outlook depends largely on whether the swelling is caused by infection or simple wear and tear. For uncomplicated infections, your surgeon may recommend empirical management without draining the fluid. In these cases, no patients required further surgery. However, if traditional aspiration is used instead, 8 of 11 patients required a bursectomy to resolve the issue. Deferring aspiration in uncomplicated septic cases is a reasonable option that avoids unnecessary procedures.

If your bursitis is not infected, noninvasive management is often preferred over injections or surgery for initial treatment. Older approaches favoured injections, but recent evidence shows they can cause more adverse effects than conservative care. For recurrent or chronic cases, newer options like hydrothermal ablation offer a safe path. This treatment uses heat between 50°C and 52°C. It has fewer complications than open surgery and works just as well.

Surgical options are reserved for persistent cases. Endoscopic bursectomy involves small incisions and minimal invasiveness. Patients reported high satisfaction with this method. There were no recurrences or wound-healing issues that required a return to the operating room. The revision rate after bursectomy is 11.5%. This means most people do not need a second operation.

Recovery feels different depending on the approach. Endoscopic debridement allows for rapid recovery and minimal postoperative pain. Bursal suture repair is another viable alternative for chronic traumatic cases, offering both functional and cosmetic benefits. However, some factors can affect your satisfaction. Patients with olecranon cords were less satisfied after surgical excision compared to those without them.

In rare instances, symptoms may persist due to unusual causes like mycobacterial infection or protothecal bursitis. These conditions can mimic standard bursitis but require specific testing. Atrial spontaneous avascular necrosis is also a rare finding that may accompany pain. Your surgeon will distinguish between septic and aseptic causes through careful examination.

Overall, the typical course settles with appropriate care. Most patients achieve acceptable short- to mid-term outcomes. While 20% of patients may remain dissatisfied with their results, the majority find relief. Your journey involves patience and following your surgeon's guidance to ensure the best possible outcome.

When to see someone

See your GP if you have a swollen elbow that does not improve with rest. Seek urgent care if the skin becomes red, hot, or painful, as this may signal an infection. Ask for a specialist review if symptoms persist for weeks or keep coming back. You should also seek help if you experience weakness, locking, or instability in the elbow. Sudden worsening of pain or swelling warrants prompt assessment. It can be difficult to tell the difference between infected and non-infected swelling without proper testing. Early evaluation helps avoid complications and ensures you receive the right treatment for your specific condition.

In more depth

This section goes further than you need for your own treatment decisions. Olecranon bursitis is worth the extra reading because two of the things most instinctively done about it – draining the swelling with a needle, and injecting steroid into it – have evidence against them.

DRAINING IT CAN BE THE THING THAT CAUSES THE PROBLEM

The intuition is strong: there is fluid, so remove the fluid. The trial data point the other way. In a comparison of management strategies for **uncomplicated septic** olecranon bursitis, empirical treatment **without aspiration** was effective, with **no patients requiring bursectomy** – while in the traditional aspiration group, **8 of 11 patients** went on to need surgical removal of the bursa [1].

That is a striking difference from a small series, and it should be read with that caution. But the mechanism is not mysterious. The bursa sits directly under thin skin over a bony point that takes every knock and every lean on a desk. Putting a needle through that skin creates a tract, and a tract over a pressure point is slow to seal and can keep discharging.

The general reviews agree on direction. Based primarily on level IV evidence, **non-surgical management is significantly more effective and safer than surgical management** [2].

STEROID INJECTION CARRIES RISK WITHOUT IMPROVING THE OUTCOME

This one is stated unusually plainly in the literature. For aseptic bursitis, **corticosteroid injection is associated with significant risks without improving the outcome** [2].

The risks are specific to the site: skin atrophy and depigmentation over a subcutaneous bony prominence, and infection introduced into a space that is difficult to clear. Elsewhere in the upper limb a steroid injection is a reasonable step when simpler measures fail. Here the evidence does not support it, and that difference is worth knowing if it is offered.

SURGERY IS A GENUINE LAST RESORT, WITH A MEASURABLE FAILURE RATE

Where bursectomy is performed, it does not reliably end the story. The **revision rate after bursectomy was 11.5%**, and revision was more frequent in patients with **rheumatoid arthritis, diabetes**, a history of bursitis on either elbow, and in women [3].

Those risk factors describe the situations in which the bursa is likely to reform: an inflammatory or metabolic driver that surgery does not remove, or a demonstrated tendency of that individual's tissue to produce the problem. For recurrent cases, intrabursal doxycycline sclerotherapy – deliberately scarring the space closed rather than excising it – has been described as an alternative in a series of **45** elbows [4].

WHAT ACTUALLY SETTLES IT

The unglamorous answer is protection and time. Because the bursa is irritated mechanically by pressure on the point of the elbow, the treatment that addresses the cause is removing that pressure: padding, and changing the habit of resting on the elbow, sustained for longer than feels necessary. Most cases settle [5], and the interventions above are largely attempts to shorten a course that resolves anyway – which is precisely why an intervention carrying its own risk needs to clear a high bar here.

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