Rotherham Elbow Pathway

Secondary Care

Patient presents with elbow symptoms

Confirm diagnosis (see attached notes)

Primary Care

Please refer the following directly to Secondary Care

History of or suspected malignance, investigate and refer as appropriate. Consider red flags of unexplained weight loss, night pain and high inflammatory markers.

Suspected fracture, dislocation or infection, refer to A&E

Suspected inflammatory condition, investigate and refer to Rheumatology

Acute Distal Biceps rupture: Urgent referral to Orthopaedic Surgeon WITHIN 2 WEEKS OF INJURY

Severe OA or nerve entrapment with marked limitation of function: Refer to Orthopaedic Surgeon.

Tennis or golfer's elbow

Investigations
NOT indicated

Management
Consider analgesia and NSAIDs.

Advise joint care, ice treatment, elbow clasp.

Injection
NOT indicated

Referral
Refer to Physiotherapy

www.shoulderdoc.co.uk

OA

Investigations
X-ray A-P and lateral elbow views. If x-ray shows gross OA changes with gross limitation of function, refer directly to Orthopaedic Surgeon

Management
Consider analgesia and NSAIDs

Injection
Consider x1 as an adjunct to Physiotherapy.
DO NOT inject if surgical intervention is to be considered

Referral
If no improvement with 6 weeks of conservative management, refer to Physiotherapy + /or Occupational Therapy for aids and splinting.

www.cks.nhs.uk
www.shoulderdoc.co.uk

Loose Body

Investigations
X –ray AP and lateral elbow views

Injection
Not indicated

Referral
If loose body evident on x-ray and patient has pain and locking refer on to MSK CATS

www.shoulderdoc.co.uk

Nerve entrapment at the elbow

Investigations
NOT indicated

Management
Consider analgesia and NSAIDS

Injection
NOT indicated

Referral
If mild symptoms refer to MSK CATS

If subluxing ulna nerve or severe intrinsic wasting please refer directly to Orthopaedic Surgeon

www.patient.co.uk

Unstable elbow

Investigations
X-ray AP and lateral elbow views

Management
Consider analgesia and NSAIDS

Injection
NOT indicated

Referral
If obviously unstable: Refer to Orthopaedic Surgeon.

If mild signs or symptoms: Refer to Physiotherapy

www.shoulderdoc.co.uk

Rotherham Elbow Pathway Supporting Information.

Distal Biceps Tendon Rupture

Patient presents with

- A history of forceful contraction involving the biceps resulting in pain and bruising over the anterior aspect of the forearm
- Localised swelling in the area and if the tendon has retracted a lump may be seen in the upper arm.
- Patient may have a very manual job or lift heavy weights.
- More common in males than females.
- Only management is **urgent referral** to Orthopaedics for consideration of repair.

Tennis Elbow

Patient presents with

- Pain described as a dull ache and / or sharp shooting pain over the lateral epicondyle +/- radiation into the forearm
- Pain on gripping activity or when making a "fist"
- Onset of symptoms after repeated activity involving wrist extension e.g. backhand in tennis, using computer keyboard
- No pins and needles are reported
- Tenderness and pain on palpation of the soft tissue mass over the lateral epicondyle rather than the bony epicondyle.
- Increased pain on resisted wrist and middle finger extension
- Reduced and painful wrist flexion as a result of the stretch on the extensor muscles and their attachment
- Elbow and shoulder ROM are usually unaffected.
- Advice regarding rest and avoidance of aggravating activities, especially palm down lifting. Therefore advise palm up when lifting. Advise to apply ice to the painful area.
- Please exclude cervical origin
- Please exclude radio-capitellar OA with pain on pronation and supination, and pain on compression with pro and supination

Golfer's Elbow

Patient presents with

- Pain described as a dull ache and / or sharp shooting pain over the medial epicondyle +/- radiation into the forearm
- Pain on activities that involve flexing the wrist or gripping
- Onset of symptoms after repeated activity involving wrist flexion e.g. playing golf, using screwdriver

- No pins and needles may be reported in the Ulna Nerve distribution of the hand
- Tenderness and pain on palpation of the soft tissue mass over the medial epicondyle rather than the bony epicondyle.
- Increased pain on resisted wrist flexion and passive extension due to the stretch on the flexor muscles and their attachments
- Elbow and shoulder ROM are usually unaffected.
- Advice regarding relative rest and avoidance of aggravating activities especially palm up lifting. Advise to apply ice to the painful area.

- Please exclude cervical origin and in older patients rule out OA of the elbow with A-P and lateral elbow x-rays

Osteoarthritis

Patient presents with

- Gross pain over the elbow joint with associated swelling primarily at end of range flexion and extension
- Some stiffness in the joint after periods of immobility
- History of strenuous manual work and /or previous trauma to the elbow joint that that disrupted the joint surfaces
- May report locking if osteophytes are present on x-ray
- Clinically reduced Active Range of Movement especially terminal extension
- Crepitus is often felt through range of movement
- Effusion may be present over the lateral aspect of the joint
- Management depends on the patient's ability to cope with symptoms and their effect on their quality of life

Loose Bodies

Patient presents with

- Clicking and locking of the elbow which may be painful
- Possible swelling of the elbow joint
- Common in people who undertake sports or occupations that involve repeated overhead activity or heavy lifting (forced elbow extension)
- May have a block to full extension of the elbow

Ulna Nerve Entrapment at the Cubital Tunnel

Patient presents with

- Pain around the medial epicondyle

- Pins and needles or loss of sensation in the Ulna Nerve distribution of the affected hand (Little finger and ulna border of the ring finger)
- Aggravated by prolonged periods of elbow flexion, or direct pressure over the olecranon e.g. Resting elbows on a desk
- Usually worse throughout the night especially if sleeps with elbows flexed.
- Increased symptoms and tenderness on palpation of the ulna groove at the elbow
- Wasting of the intrinsic muscles of the hand
- Positive Froment's sign and positive passive elbow flexion test.
- In severe cases involuntary abduction of the little finger and clawing of the little and ring fingers may be evident
- Positive Tinel's sign at the elbow
- In the case of subluxing Ulna Nerve you may feel a "pop" or "click" over the ulna groove as the elbow is moved. This will be associated with pain and distal symptoms.
- Please exclude cervical and radicular symptoms (C8 nerve root)

Radial nerve entrapment (posterior interosseous branch)

Patient presents with

- Weakness or paralysis of the wrist and digital extensors.
- Pain may be present, but it usually is not a primary symptom.
- Attempts at active wrist extension often result in weak dorsoradial deviation. These patients do not have a sensory deficit.

Management:

- Conservative treatment for 6-12 weeks: refer to physiotherapy for cock-up splint and activity modification help limit repetitive elbow extension, forearm pronation, and wrist flexion. Anti-inflammatory drugs
- Surgery is indicated if no improvement occurs or paralysis increases.

Elbow instability

Patient presents with

- History of previous elbow dislocation or previous surgery
- Patient feels as though elbow is giving way
- Unable to do press-ups or push up off chair
- Varus +/or valgus stress tests may be positive

Management:

- X-ray elbow AP and lateral
- Refer to orthopaedic surgeon