Physio Advice Sheet. Epicondylar Release.

DIARMUID MOLONY
ORTHOPAEDICS

Thank you for looking after this patient's rehabilitation following tennis elbow release. The following is for guidance only and should not replace your own clinical assessment and experience. All patients are different and post op inflammation, pain or complications of surgery may slow progress in some. What follows can also be used as a guide to progress rehab following injection. The goal is to achieve progression in eccentric loading and work hardening with maximal range at the wrist and elbow. The goal of all treatments of epicondylitis is control rather than eradication of symptoms. Where the patient does not maintain their HEP or pre sport routine return of symptoms is common Following surgery recovery to tolerance of ADL may take several months. We typically perform lateral epicondylar release arthroscopically. Access to the joint to identify any other causes of recalcitrant lateral epicondylitis is therefore seen. This will be included in the post op information sheet. Medial epicondylar releases are performed open and include ulnar nerve release and rarely transposition. For medial releases, read flexion/pronation for extension and pronation for supination positions noted below. Progression is otherwise the same.

Phase 1: Days 1-7

- Sling for comfort only. This should be removed at every opportunity.
- Control oedema and inflammation through compression and frequent cryotherapy.
- Allow gentle active hand, wrist, and elbow range of motion (ROM) exercises as tolerated.
- Allow gentle isometrics for wrist and hand flexion and extension.
- Activate proximal limb ROM and Scapular control.
- Minimize the frequency of any activities of daily living (ADLs) that stress the extensor tendon mechanism such as lifting, and combined joint movements (i.e. full elbow extension with wrist flexion). Perform ADL's/light loads with the surgical limb in forearm supination to minimize work load of extensor tendons.
- If pain control is difficult, a futura splint or similar wrist immobiliser can be considered for rest periods but should be weaned early. Tubigrip for swelling is sometimes required.

Phase 2: Weeks 2-4

- Discontinue sling and splint.
- Progress ROM. Passive motion should be continued and combined with active motion within end-range of patient's pain tolerance
- Continue sub maximal isometric extension. Commence grip rehab in 90 deg elbow flexion
- Continue to cryotherapy and tubigrip as needed.

Phase 3: Weeks 5-7

- Patient has full AROM and tolerating passive stretch into end range. Good isometric tolerance
- Advanced strengthening as tolerated to include weights or theraband. Focus should be on endurance training of wrist extensors (i.e. light weights, higher repetitions per set). Progress to eccentric loads as tolerated.
- Modified activities in preparation for beginning functional training. • Gentle massage along and against fibre orientation.

Phase 4: Weeks 8-12

- Counterforce bracing if needed for patient to complete ADLs and/or strengthening activity pain-free.
- Begin task-specific functional training.
- Return to higher-level work / recreational activities.