CONDITION

Medial epicondylitis - golfer's elbow

Medial epicondylitis is tendon pain on the inner side of the elbow caused by repeated or forceful use.

WHAT IT IS
Overuse-related tendon pain on the inner elbow

BODY SYSTEM
Muscles, tendons and joints

MAIN SYMPTOMS
Inner elbow pain, tenderness, weak grip, forearm aching

WHAT CAUSES IT
Repeated loading of wrist and forearm tendons

HOW IT IS DIAGNOSED
History and examination; imaging when another problem is suspected

MAIN TREATMENT
Activity changes, rehabilitation exercises and pain relief

CAN IT BE CURED?
Sometimes - symptoms often resolve over time

IS IT AN EMERGENCY?
No, unless injury leaves the hand cold or deformed

LONG-TERM OUTLOOK
Most improve, but recovery can take several months

Overview

Medial epicondylitis is pain where several forearm tendons attach to the bony bump on the inside of your elbow. It is commonly called golfer's elbow, although most people who develop it do not play golf.

These tendons help you bend your wrist, turn your palm downward and grip objects. Repeated or forceful use can place more strain on the tendon than it can recover from. Over time, the tendon may become painful and less able to handle load.

Despite the ending "-itis," long-lasting medial epicondylitis is not usually caused mainly by inflammation. It is better understood as tendinopathy, meaning changes and irritation within an overloaded tendon.

The condition can affect work, exercise and everyday tasks such as lifting a bag or opening a jar. It is usually managed without surgery, but improvement may be gradual.

Symptoms

The main symptom is pain or tenderness around the bony point on the inside of the elbow, called the medial epicondyle. Pain may spread a short distance down the inner forearm.

Symptoms are often brought on by:

Your grip may feel weaker because gripping hurts. The elbow can also feel stiff, especially after rest, although complete loss of movement is not typical.

Symptoms may begin gradually after repeated activity. Less often, they start after one unusually forceful movement.

Numbness or tingling in the ring and little fingers is not a typical tendon symptom. It may mean that the nearby ulnar nerve is irritated. This nerve passes behind the inner elbow and is sometimes called the "funny bone" nerve.

- Gripping, squeezing or carrying
- Bending the wrist toward the palm
- Turning the forearm, such as using a screwdriver
- Throwing, swinging a club or lifting weights
- Shaking hands or opening a tight lid

Causes and risk factors

Medial epicondylitis develops when the muscles and tendons on the inner forearm are repeatedly loaded beyond their current capacity. Small areas of tendon damage can build up if there is not enough time for recovery.

Golf can cause this problem when a person repeatedly grips the club tightly or strikes the ground during a swing. However, similar strain can come from many other activities, including:

Risk may increase after a sudden rise in training or workload. Poor technique, equipment that is difficult to grip, and weak or poorly conditioned forearm muscles may also contribute.

Not every case has a clear cause. Normal age-related tendon changes can reduce how quickly a tendon adapts to new demands.

Medial elbow pain can have other causes. These include arthritis, an injured elbow ligament,

pressure on the ulnar nerve, a tendon tear or pain referred from the neck. An assessment can help distinguish between them.

- Throwing sports, racquet sports, climbing and weight training
- Repeated use of hand tools
- Gardening, construction or assembly work
- Frequent lifting with the palm facing upward
- Any activity involving forceful gripping and wrist movement

Diagnosis

Medial epicondylitis is usually diagnosed from your symptoms and a physical examination. There is no single blood test or scan that is required to confirm every case.

During an examination, a healthcare professional may press around the inner elbow and check movement, strength and sensation. Pain when you bend the wrist or turn the palm downward against resistance supports the diagnosis.

They may also examine your neck, shoulder and nerves. If you play a throwing sport, they may assess the ligament that stabilises the inner elbow.

Imaging is not routinely needed when the symptoms and examination are typical. It may be considered if there was a significant injury, symptoms are unusual, or treatment has not helped as expected.

An X-ray can look for a fracture, arthritis or calcium deposits. Ultrasound or MRI can show tendon damage and other soft-tissue problems, although scan findings do not always match how much pain someone has. Nerve tests may be used when persistent tingling, numbness or weakness suggests ulnar nerve involvement.

Treatment and management

Early management usually focuses on reducing the activities that provoke pain. Complete rest is rarely necessary. Instead, you may need to shorten, lighten or temporarily stop forceful gripping, throwing or wrist exercises.

An ice pack wrapped in a towel may ease pain after activity. Some people prefer warmth before movement. Avoid placing ice directly on your skin.

Pain medicines may provide short-term relief. Options can include paracetamol or

non-steroidal anti-inflammatory drugs, such as ibuprofen. These medicines are not suitable for everyone, and anti-inflammatory medicines do not repair the tendon itself. A pharmacist or healthcare professional can help you check whether a medicine is appropriate for you.

A physiotherapist may guide a gradual exercise programme. This commonly includes stretching and controlled strengthening of the wrist and forearm. Exercises are usually progressed over time so that the tendon becomes better able to tolerate gripping, lifting and sport-specific movements.

Some discomfort during rehabilitation can occur, but exercises should not cause a major or lasting increase in symptoms. Recovery often stalls when loading is increased too quickly or when all activity is avoided for too long.

A wrist support or forearm strap may reduce strain during selected activities. It should not be so tight that it causes tingling, numbness, swelling or colour changes in the hand.

A corticosteroid injection may give short-term pain relief for some people, but symptoms can return. Repeated injections can damage tissue, and injections around the inner elbow require care because important nerves and blood vessels are nearby.

Evidence for treatments such as platelet-rich plasma injections, dry needling and shockwave therapy is limited or mixed, particularly for medial rather than lateral elbow tendinopathy. Their possible costs, risks and uncertain benefits should be discussed before treatment.

Surgery is uncommon. It may be considered when substantial symptoms continue despite prolonged, structured nonsurgical treatment. An operation may remove damaged tendon tissue and repair the tendon attachment. Recovery still requires rehabilitation and takes time.

Complications

Some people develop persistent pain that limits work, sport or daily tasks. Ongoing pain can lead to reduced use of the arm, loss of strength and difficulty returning to previous activity levels.

The nearby ulnar nerve may also become irritated. This can cause tingling or numbness in the ring and little fingers, reduced hand coordination or, in more advanced cases, weakness.

A sudden forceful injury can occasionally cause a partial or complete tendon tear rather than simple tendinopathy. This may produce bruising, swelling and a marked loss of strength.

Treatment can also have complications. Injections may cause temporary increased pain, skin colour changes, loss of fatty tissue under the skin, infection or tendon injury. Surgery carries risks such as infection, stiffness, nerve injury and continuing symptoms.

Prevention

Medial epicondylitis cannot always be prevented. Tendons respond differently to repeated work, sport and age-related change.

You may lower the chance of developing symptoms or having them return by increasing new activities gradually. Allow time for recovery after heavy gripping, throwing or forearm exercise.

Useful measures include:

A coach, physiotherapist or workplace ergonomics adviser may help identify movements or equipment that repeatedly overload the tendon.

- Building forearm strength before increasing workload
- Using equipment with a comfortable grip size
- Avoiding an unnecessarily tight grip
- Taking regular breaks from repeated forceful movements
- Reviewing lifting, throwing or golf technique
- Responding early to recurring inner-elbow pain

Living with it and what to expect

Medial epicondylitis often improves with activity changes and gradual rehabilitation, but tendon recovery is usually measured in months rather than days. Symptoms may fluctuate during this period.

You may be able to continue many daily activities while recovering. The aim is usually to find a manageable level of use rather than keep the arm completely still. Tasks can be adapted by using two hands, reducing the weight being carried or changing how an object is gripped.

A brief increase in soreness after unfamiliar activity does not always mean that new damage has occurred. However, pain that remains clearly worse into the following days may mean that the activity level was increased too quickly.

Returning to sport or heavy work is usually gradual. Strength, movement and confidence should be rebuilt before full-speed throwing, heavy lifting or repeated swings. Protective straps may help some people, but they do not replace rehabilitation or workload changes.

Symptoms can return if the same load is resumed suddenly. Keeping up some strengthening and increasing activity step by step may reduce this risk. A small group of people have longer-lasting symptoms or need further investigation and treatment.

When to get medical help

Arrange a routine appointment if inner-elbow pain lasts for several weeks, keeps returning or interferes with sleep, work or usual activities. Assessment is also appropriate if you are unsure whether the pain began with a significant injury.

Seek prompt medical advice if you develop:

Go to an emergency service after a major injury if the elbow looks deformed, bone is visible, bleeding will not stop, or the hand becomes cold, pale or blue. These signs are not typical of uncomplicated golfer's elbow.

- Increasing numbness or tingling in the ring and little fingers
- New hand weakness or difficulty controlling your fingers
- Marked swelling, bruising or loss of strength after an injury
- A hot, red or very swollen elbow, especially with fever
- An elbow that locks or cannot move normally

Common questions

Is golfer's elbow the same as tennis elbow?

No. Golfer's elbow affects the tendon attachment on the inside of the elbow. Tennis elbow affects the outside. Both are usually related to tendon overload, and either condition can occur without playing the sport in its name.

Will golfer's elbow go away on its own?

It may settle, especially when the provoking activity is reduced. However, recovery can take several months. Gradual strengthening and changes to the activity that caused the problem may improve recovery and reduce recurrence.

Should I keep exercising with golfer's elbow?

Complete rest is not usually needed. Activities that cause strong or lasting pain may need to be reduced, while controlled rehabilitation exercises are introduced gradually. The suitable level of exercise is different for each person.

Should I wear a brace all day?

A wrist brace or forearm strap may help during specific painful tasks. Wearing one continuously is not usually necessary and may become uncomfortable. Remove it if it causes numbness, tingling, swelling or changes in hand colour.

Can golfer's elbow cause tingling in my fingers?

The tendon problem itself usually causes pain rather than tingling. Tingling in the ring and little fingers may come from irritation of the ulnar nerve near the elbow and should be assessed if it persists or is accompanied by weakness.

How do I know if I have torn the tendon?

A tear is more likely after a sudden forceful event followed by sharp pain, bruising, swelling or a clear loss of strength. Symptoms alone cannot confirm a tear. Ultrasound or MRI may be considered after an examination.

Sources

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