Physiotherapy or a wait and see policy were the best options for lateral epicondylitis at 1 year


QUESTION: In patients with lateral epicondylitis, what is the effectiveness of a wait and see policy, physiotherapy, or corticosteroid injections?

Design
Randomised (allocation concealed*), blinded (outcome assessors),* controlled trial with 1 year of follow up.

Setting
Practices of 85 family doctors in the Netherlands.

Patients
185 patients who were 18 to 70 years of age (median age 47 y) with pain at the lateral side of the elbow that increased with pressure on the lateral epicondyle and with resisted dorsiflexion of the wrist. Exclusion criteria included physiotherapy or corticosteroid injections for elbow pain in the previous 6 months; bilateral elbow symptoms; duration of pain for < 6 weeks; dislocation, tendon ruptures, or fractures near the elbow in the preceding year; and systemic musculoskeletal or neurological disorders. Follow up was 99%.

Main outcome measures
Change from baseline in self reported success rates (6 point scale ranging from completely recovered to much worse; complete recovery and much improved were considered successes), severity of the main symptom, pain during the day, inconvenience, overall severity of elbow symptoms, pain-free grip strength, maximum grip strength, and elbow disability.

Main results
Analysis was by intention to treat. At 6 weeks, more patients in the injection group than in the physiotherapy and wait and see groups reported success (table). Other outcomes were also more improved in the injection group. However, at 1 year, more patients who received physiotherapy rather than corticosteroids reported success. The physiotherapy and wait and see groups did not differ (table).

Conclusion
In patients with lateral epicondylitis, physiotherapy or a wait and see policy were the best long term treatment options.

Success rates for corticosteroid injections (Cort), physiotherapy (Phys), and a wait and see policy (WS) for lateral epicondylitis†

<table>
<thead>
<tr>
<th>Follow up</th>
<th>Cort (95% CI)</th>
<th>Phys (95% CI)</th>
<th>WS (95% CI)</th>
<th>RBI (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 weeks</td>
<td>92% —</td>
<td>32% —</td>
<td>185% (102 to 326)</td>
<td>2 (2 to 3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— 47% —</td>
<td>32% —</td>
<td>46% (–6.4 to 131)</td>
<td>Not significant</td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>69% —</td>
<td>83% —</td>
<td>16.5% (–2.1 to 33)</td>
<td>Not significant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— 91% —</td>
<td>83% —</td>
<td>9.1% (–5.2 to 28)</td>
<td>Not significant</td>
<td></td>
</tr>
</tbody>
</table>

Success = patient self report of completely recovered or much improved; RBI, RBR, NNT, NNH, and CI calculated from data in article.

COMMENTARY
Lateral epicondylitis (tennis elbow) is commonly treated with activity modification, physiotherapy, non-steroidal anti-inflammatory drugs (NSAIDs), and steroid injections. Acupuncture, orthotic devices, and surgery have also been used, albeit without much evidence to support them. The benefit associated with steroid injection is only short term, and long term detrimental effects may exist.1

In this study by Smidt et al, more than 50% of patients treated with physiotherapy or injections reported such adverse effects as temporary increase in pain, pain radiating into the forearm, and swelling. Topical and oral NSAIDs have been shown to provide short term symptom relief for lateral epicondylitis.2 Several patients in the physiotherapy and the wait and see groups in the study by Smidt et al received NSAIDs, which may have influenced the results.

Activity modification to minimise repetitive stress is generally the first step in treating lateral epicondylitis. Better evidence is required before definitive statements can be made about additional treatment. However, a simple wait and see approach combined with NSAIDs as required is probably the most cost effective long term strategy with the fewest adverse effects, although physiotherapy may also be useful.

Hans J Kreeder, MD, MPH
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