Editorial

The Healing Power of Time: The Case of Lateral Epicondylitis

Lateral epicondylitis can be most distressing. I say this not from years of being interested in this condition, but from my own experience 3 nights ago when my car hit a pothole and I instinctively clasped the steering wheel. A minor ache present for a couple of weeks on my right lateral elbow suddenly became unbearable. Pain extended along the “wad of three” muscles in the lateral forearm. Any attempt to hold something is now cause for excruciating pain; and that sharp tenderness described at the epicondylar enthesis of extensor carpi radialis brevis (ECRB, I have). And if I resist dorsiflexion of the wrist or hyperextension of the middle finger, pain increases acutely. Only today, being right-handed, was I able to inflate the blood-pressure cuff, and this with a lot of pain, which highlights the antagonistic action of ECRB upon grasping.

Thus, no personal setting could be more agreeable than mine to comment on the article by Smidt, et al in this issue of The Journal\(^1\). Their study, which is based on the merging of 2 prospective randomized trials\(^2,3\), clearly confirms that lateral epicondylitis is a self-limited condition in most patients. As it turns out, severe pain, long duration of symptoms, and presence of concomitant neck pain at baseline are associated with higher pain scores at 12 months. Severe pain I have; however, my condition is recent and my neck doesn’t hurt: one bad and 2 good signs that should reassure me for the long term.

Is lateral epicondylitis the sole example of the healing power of time in soft tissue rheumatology? Not at all. Let us take, as an example, plantar heel pain. Many a treatment has been used for this condition, including insoles, heel pads, stretching exercises, night splints, corticosteroid infiltrations, laser therapy, ultrasound therapy, shock-wave therapy, and surgery — with no convincing results\(^4\). Fortunately, regardless of treatment, as in lateral epicondylitis, pain in most cases gradually fades within 4 years\(^5,6\). In idiopathic olecranon bursitis, a steroid injection with the proper precautions is both effective and safe\(^7\). However, although data are limited, if continuing trauma is avoided, most effusions subside within 3 months\(^8\). In frozen shoulder, although steroid injections plus physiotherapy provide early benefit\(^9\), not only does pain disappear, but much of the lost motion is restored within one to 3 years\(^10\). One further example may be chronic shoulder tendinitis, an entity that in most instances is believed to result from subacromial impingement. However, since debridement appears to give the same results as acromioplasty, one cannot help but wonder about the very pathogenetic tenet of this condition\(^11\). To further fuel skepticism, in one trial, supervised exercises led to the same excellent result as arthroscopic decompression\(^12\). Finally, popliteal cysts in children, which by being primary (without knee pathology) differ from the adult form of the disease, regress with time\(^13\). There are, of course, syndromes that are clearly helped by our therapies. Of these, trigger finger, de Quervain’s tenosynovitis, carpal tunnel syndrome, and iliotibial band syndrome are often relieved by corticosteroid infiltrations. Non-insertional Achilles tendinopathy is helped by eccentric exercises\(^14\). And there are conditions, such as trochanteric syndrome, anserine syndrome, retrocalcaneal bursitis, Morton’s neuroma, and myofascial pain, that are benefitted by our therapies in the short term, but their long-term course is largely unknown. Some of the uncertainties surrounding corticosteroid injections in these entities, in particular hard to reach structures such as the shoulder, the retrocalcaneal bursa, the plantar fascia, and Morton’s neuroma, may reflect inaccuracies in needle placement. As shown by Naredo, et al, ultrasound-guided injections in the shoulder\(^15\) may be more effective than blind injections. Ultrasound-based corticosteroid injection trials are definitely needed.

With our training in medicine, we strive to heal based on sound therapies that should completely or partially reverse the processes of disease. However, the efficacy of our therapies in many of the soft tissue syndromes is limited. Thus, our apparent success (or failure) may largely depend on when in the regressive course of the condition we happen to treat a patient. Following this line of thought, and in contrast to other areas of rheumatology, early detection may not portend a better result, but rather the opposite! It should not be surprising, given this scenario, that disappointed patients often turn to alternative therapies. These, by a happy combination of receiving these patients late in their disease course (and there-

See Lateral epicondylitis in general practice: Course and prognostic indicators of outcome, page 2053

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1. The Journal of Rheumatology 2006; 33:10
2. Their study, which is based on the merging of 2 prospective randomized trials
3. Clearly confirms that lateral epicondylitis is a self-limited condition in most patients.
4. With no convincing results
5. Gradually fades within 4 years
6. Idiopathic olecranon bursitis
7. Both effective and safe
8. Avoided, most effusions subside within 3 months
9. Early benefit
10. Chronic shoulder tendinitis
11. Pathogenetic tenet
12. Arthroscopic decompression
13. Popliteal cysts in children
14. Eccentric exercises
15. Ultrasound-guided injections in the shoulder
fore closer to spontaneous resolution), plus their clever protracted nature, are assured of success.

Returning to the article by Smidt, *et al.*, a long duration of elbow complaints at baseline is an indicator of poor prognosis. While this appears to clash with the self-limited model mentioned above, these patients probably represent long-term failures from previous cohorts. Severe symptoms and concomitant neck pain at baseline, the 2 remaining indicators, raise the possibility that some of these patients, and perhaps some of the patients with long-standing pain as well, had fibromyalgia. This amplifying and perpetuating condition was not excluded in the original studies. It should be mentioned that in fibromyalgia, unless there is concomitant lateral epicondylitis, resisted wrist extension does not cause epicondylar pain (Table 1; personal observations). Finally, I am also distressed by the lack of definition of “concomitant shoulder pain” and “concomitant neck pain.” Although radiculopathy was an exclusion criterion, as a clinician I would like to know whether the shoulder pain had a tendinous or capsular pattern and whether the neck pain was ipsilateral or contralateral to bending or rotation. Clearly, the presence of upstream tendinopathies at baseline could give clues to the underlying factor(s) leading to a poor outcome in lateral epicondylitis.

Given the above, after an anatomically-minded assessment including a search for fibromyalgia, what should a rheumatologist tell patients with lateral epicondylitis? (A) That their condition, left on its own, sooner or later will improve. (B) To modify or cut down on any identified offending activities (a forearm support band may decrease the damaging forces involved). (C) From common sense rather than demonstration, to initiate exercises promptly (shoulder pendular, elbow and wrist active motion, deep transverse friction massage, then stretching and gentle resisted motion) to maintain arcs of motion, avoid muscle atrophy, and perhaps improve long-term outcome. (D) Some patients may request a corticosteroid infiltration. Let them know that these injections, which improve many patients in the short term, may have untoward effects. One is additional pain prior to improvement16. I have seen serious postinjection pain including features of sympathetic dystrophy. The second concern is that injected patients may fare worse in the long term than those not injected3. (E) Patients may inquire about alternative treatments. They should be encouraged to have these treatments first and, should they fail, come back to you. (F) Beware of prolonged and/or expensive unproven treatment methods such as ultrasound therapy, laser therapy, and shock-wave therapy8. (G) If someone has raised the possibility of a surgical procedure let the patient know the results of a survey of physicians who attended postgraduate courses in orthopedic medicine from 1984 to 1992. Of a total of 338 attendees 72 had a history of lateral epicondylitis, and in all but 2 the process had resolved within 2 years. Few took nonsteroidal antiinflammatory drugs or had a corticosteroid injection. Finally, none of these physicians (they should know better) underwent surgery for their condition19.

**Epilogue**

Two weeks have gone by since I wrote the initial paragraph and I am 95% better without any treatment.

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**REFERENCES**


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**Table 1. Physical findings in patients with fibromyalgia and lateral epicondylitis.**

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<thead>
<tr>
<th>Fibromyalgia</th>
<th>Lateral Epicondylitis</th>
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<tr>
<td>Resisted wrist extension*</td>
<td>Dorsal hand pain</td>
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<tr>
<td>Epicondylar tenderness</td>
<td>Yes</td>
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* Palm down, hand resisted from above.