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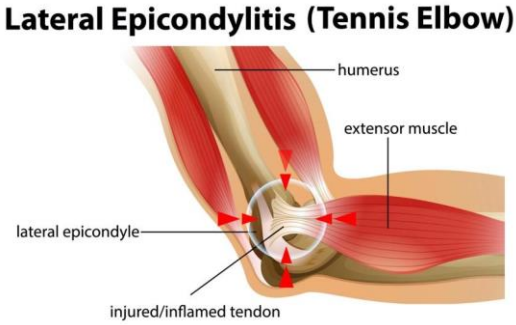
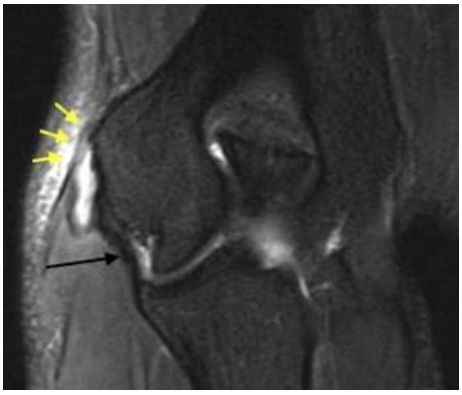
TENNIS / GOLFER'S ELBOW SURGERY

This leaflet provides general information to help you understand the surgical options for tennis and golfer's elbow, to improve pain and function.

Surgery is usually only considered when symptoms have not improved after prolonged non-surgical treatment, and is normally a day case.

At the heart of my practice is **Shared Decision-Making**. Whether we pursue conservative management (Plan A) or surgical intervention (Plan B), the goal is to create a tailored treatment plan that aligns with your lifestyle, values, and functional goals.





This leaflet provides general information and does not replace individual medical advice.

Private Consulting Rooms

- **LIPS Healthcare London**
- **Spire Alexandra Chatham**
- **Practice Plus Gillingham**

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More Info

Scan to visit our website

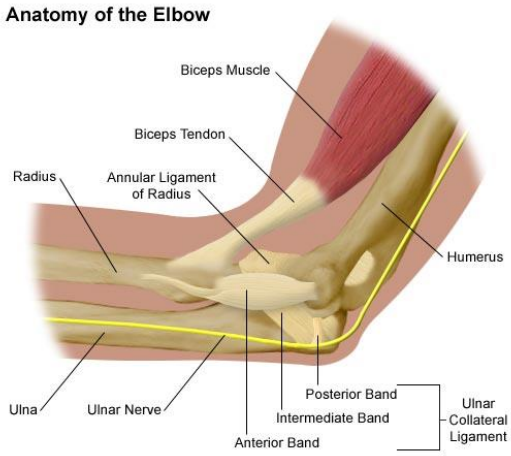
The Anatomy of the Elbow

The elbow is a hinged joint connecting the upper arm to the forearm, relying on several structures for stability and movement:

How the Elbow Works

The joint connects:

- Humerus (upper arm bone)
- Radius and Ulna (forearm bones)
- Extensor tendons (attach forearm muscles to the bone)



What Is Tennis / Golfer's Elbow?

Pain and tenderness from tiny tears where the forearm tendons attach to the elbow — on the outer side (tennis elbow) or inner side (golfer's elbow).

The Affected Tendons

The tendons that control your wrist and grip attach at the elbow:

- Extensor Carpi Radialis Brevis (ECRB)
- Common extensor origin (tennis elbow)
- Common flexor origin (golfer's elbow)
- Nearby: the radial nerve

Common Symptoms

- Pain over the bony bump at the elbow
- Pain radiating down the forearm
- Weak or painful grip
- Pain on lifting, gripping or twisting

When Surgery Is Considered

Surgery is the "next step" when physiotherapy, steroid injections or PRP have not given enough relief after prolonged treatment.

About the Operation

Surgery removes the damaged, degenerated tendon tissue and stimulates healing. There are two approaches — open surgery (most common) and arthroscopic (keyhole) — and the right option for you is discussed and tailored to your individual symptoms and needs.

Open Surgery

The most common approach, usually a day case:

- A small incision over the affected side of the elbow
- The degenerated tendon portion is removed and the bone freshened
- The tendon is repaired, often with a suture anchor, and closed with absorbable sutures

Arthroscopic (Keyhole) Surgery

Used in selected cases:

- Performed as a day case under general anaesthesia
- Uses small incisions and fine instruments
- Allows inspection of the joint to identify and treat additional problems
- The choice of procedure is discussed with you

Before, During & After Surgery

Before Surgery

- Fasting: no food for 6 hours, no drinks for 2 hours before (if under general anaesthetic)
- Smoking: avoid for at least 12 hours before, to aid healing
- Medications: continue as advised; no need to stop blood thinners

On the Day

- Admission: check in at main reception, then to your room
- Consultation: meet your surgeon and anaesthetist
- Preparation: timing and instructions are reviewed

Anaesthesia

- General anaesthetic combined with a local anaesthetic
- In selected patients, awake using a nerve block alone

Recovery & Results

Recovery is a partnership. The timeline below is a guide — your physiotherapist and I will adapt it to you — **this shared decision-making process ensures you are fully informed and involved in your care.**

Recovery Milestones

- Sling: usually worn for 4–5 days
- Gentle hand use: begin as comfort allows
- Avoid heavy activity: for at least 4 weeks
- Recovery: most do well by a few months

Results

Most patients get good relief of pain and improved grip. A small number have ongoing symptoms and may need further assessment; recurrence is uncommon.

After Surgery

The first weeks

Sling: worn for 4–5 days, or longer if needed; elevate the hand on pillows

Pain Relief: a nerve block lasts 8–12 hours; start painkillers before it wears off, for the first 3–4 days

Wound Care: a splash-proof dressing and bulky bandage are applied; the bandage can usually come off after 24–48 hours

Physiotherapy: essential to regain strength and mobility; exercises must be done regularly to prevent stiffness

Risks & Complications

Uncommon, but possible

Stiffness: firmness and tenderness can last 2–3 months; massaging with a moisturising cream once healed can help

Infection: rare (fewer than 1 in 200); treated with antibiotics, and occasionally further surgery

Persistent Pain: a small number of patients have ongoing discomfort after surgery

Nerve Irritation: surgery is near the radial nerve; numbness or tingling is usually temporary and settles over a few months

CRPS: CRPS is a rare (around 1%) reaction causing prolonged swelling, pain and stiffness; managed with physiotherapy and pain management

Return to Work & Everyday Activities

Return-to-work timelines vary by role

- **Managerial / supervisory roles:** 2–3 weeks
- **Light manual labour (e.g. clerical):** 6–8 weeks
- **Heavy manual labour:** 12–16 weeks
- **Driving:** once the wound has healed and pain is controlled; practise short trips first
- **Lifestyle:** avoid heavy lifting for at least 6–8 weeks; stopping smoking aids healing

Red Flags — When to Seek Urgent Help

Increasing redness, swelling or discharge from the wound, a fever, or pain that keeps worsening despite painkillers — seek urgent assessment.
If you experience any of the above, contact the practice, your GP, NHS 111, or attend your nearest Emergency Department.

Key Points to Remember

- **Usually a day-case operation**
- **Most people get good pain relief and improved grip**
- **Considered only after non-surgical treatment**
- **Physiotherapy is essential to recovery**

Questions You May Wish to Ask

- **How soon can I return to work?**
- **When can I drive again?**
- **How much improvement can I expect?**
- **What happens if I choose not to have surgery?**

Book or Enquire Directly at Each Site

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