PREVALENCE OF TENNIS ELBOW AMONG PATIENTS PRESENTING IN ORTHOPEDICS OUTDOOR DEPARTMENT

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ABSTRACT:
Tennis elbow, also known as lateral epicondylitis, is a condition in which the outer part of the elbow becomes painful and tender. The pain may also extend into the back of the forearm and grip strength may be weak. Onset of symptoms is generally gradual. Golfer’s elbow is a similar condition that affects the inside of the elbow. This cross-sectional study was conducted among the patients presenting in orthopedics outdoor department of different hospitals. Name, age, gender, history of disease and disease duration were noted on a predefined proforma. All the data was entered and analyzed with SPSS Ver. 23.0. There were 120 patients included in this study i.e., 60 males (50%) and 60 females (50%). The mean age of the patients was 28.34±5.31 years. The minimum age was 22 years and maximum age was 42 years. Out of 120 patients only five patients presented with tennis elbow.

KEYWORDS: TENNIS ELBOW
INTRODUCTION:
Tennis elbow, also known as lateral epicondylitis, is a condition in which the outer part of the elbow becomes painful and tender. The pain may also extend into the back of the forearm and grip strength may be weak. Onset of symptoms is generally gradual. Golfer’s elbow is a similar condition that affects the inside of the elbow. It is due to excessive use of the muscles of the back of the forearm. Typically this occurs as a result of work or sports, classically racquet sports. The diagnosis is typically based on the symptoms with medical imaging used to rule out other potential causes. It is more likely if pain increases when a subject tries to bend back the wrist when the wrist is held in a neutral position. A powered screwdriver can cause this injury if overused one-handed. It is classified as a chronic tendinosis, not a tendinitis. Treatment involves decreasing activities that bring on the symptoms together with physical therapy or other treatment gradually increasing loads. Pain medications such as NSAIDS or acetaminophen (paracetamol) may be used. A brace over the upper forearm may also be helpful. If the condition does not improve corticosteroid injections or surgery may be recommended although some experts recommend avoiding cortisone injections due to poor long-term results in high-quality trials. Many people get better within one month to two years. About 2% of people are affected. Those 30 to 50 years old are most commonly affected. The condition was initially described in 1873. The name "lawn tennis elbow" first came into use for the condition in 1882. Early experiments suggested that tennis elbow was primarily caused by overexertion. However, studies show that trauma such as direct blows to the epicondyle, a sudden forceful pull, or forceful extension cause more than half of these injuries. Repeatedly mis-hitting a tennis ball in the early stages of learning the sport causes shock to the elbow joint and may contribute to contracting the condition.
There are multiple aspects of tennis that may cause a player to develop “tennis elbow”. From a technical perspective, leading a backhand with your elbow, excessive pronation of the forearm when putting topspin on a forehand, and
excessive flexion of the wrist on a serve can all greatly lead to tennis elbow. Other things that can be improved are: racquet type, grip size, string tension, type of court surface, and ball weight (1-3). The objective of this study was to see the prevalence of tennis elbow among the patients presenting in orthopedics outdoor department.

**MATERIAL AND METHODS:**
This cross-sectional study was conducted among the patients presenting in orthopedics outdoor department of different hospitals. Name, age, gender, history of disease and disease duration were noted on a predefined proforma. All the data was entered and analyzed with SPSS Ver. 23.0. The quantitative variables were presented as mean and standard deviation. The qualitative variables were presented as frequency and percentages.

**RESULTS:**
There were 120 patients included in this study i.e., 60 males (50%) and 60 females (50%). The mean age of the patients was 28.34±5.31 years. The minimum age was 22 years and maximum age was 42 years. Out of 120 patients only five patients presented with tennis elbow.

**DISCUSSION:**
In tennis players, about 39.7% have reported current or previous problems with their elbow. Less than one quarter (24%) of these athletes under the age of 50 reported that the tennis elbow symptoms were "severe" and "disabling," while 42% over the age of 50 did. More women (36%) than men (24%) considered their symptoms severe and disabling. Tennis elbow is more prevalent in individuals over 40, where there is about a four-fold increase among men and two-fold increase among women. Tennis elbow equally affects both sexes and, although men have a marginally higher overall prevalence rate as compared to women, this is not consistent within each age group, nor is it a statistically significant difference. Playing time is a significant factor in
tennis elbow occurrence, with increased incidence with increased playing time being greater for respondents under 40. Individuals over 40 who played over two hours doubled their chance of injury. Those under 40 increased it 3.5 fold compared to those who played less than two hours per day.

Although anti-inflammatories are a commonly prescribed treatment for tennis elbow, the evidence for their effect is usually anecdotal with only limited studies showing a benefit. A systematic review found that topical non-steroidal anti-inflammatory drugs (NSAIDs) may improve pain in the short term (up to 4 weeks) but was unable to draw firm conclusions due to methodological issues. Evidence for oral NSAIDs is mixed. Evidence is poor for long term improvement from injections of any type, whether corticosteroids, botulinum toxin, prolotherapy or other substances. Corticosteroid injection may be effective in the short term however are of little benefit after a year, compared to a wait-and-see approach. A recent randomized control trial comparing the effect of corticosteroid injection, physiotherapy, or a combination of corticosteroid injection and physiotherapy found that patients treated with corticosteroid injection versus placebo had lower complete recovery or improvement at 1 year (Relative risk 0.86). Patients that received corticosteroid injection also had a higher recurrence rate at 1 year versus placebo (54% versus 12%, relative risk 0.23). Complications from repeated steroid injections include skin problems such as hypopigmentation and fat atrophy leading to indentation of the skin around the injection site.

Steroid injections against appear to be more effective than shock wave therapy. Botulinum toxin type A to paralyze the forearm extensor muscles in those with chronic tennis elbow that has not improved with conservative measures may be viable (4-6).

REFERENCES:


