The Elbow - Ref 79RD - Draft Transcript

with Rupen Dattani

20th July 2020

TRANSCRIPT

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Steven:

I'm joined once again by Mr Rupen Dattani consultant, orthopaedic surgeon. Rupen - great to have you with us. Thanks for having me on. And most time we talked about shoulder replacement largely, but this time we're turning our attention more to the elbow, but we might over the shoulder later on, quite useful for us. I mean, obviously physical therapists, osteopaths, chiropractors, physios, you know, we see a lot of, golfer's elbow tennis elbow. And of course, our, our approach to that is going to be largely soft tissue. How does it present to you and what do you do about?

Rupen Dattani:

So very similar? So, two groups of patients we tend to see with, with some tennis and golf solvers, either people that are doing a lot of manual work, a lot of rotation movements or then you also get the, sort of the amateur sportsman you know, rarely do, you know, you rarely see tennis elbow and professional tennis players. And similarly, with golfers in professional coffers it tends to be, you know, usually problems with riff tend to be more of an overuse injury. So, the patients who tend to come to my clinic you know, people who have sort of had several months of pain, you know, this tennis level and the, on the lateral aspect of the elbow with the golf sub on the medial aspect. And he sorts of reached a point where it's, you know, rather than being activity. I well exacerbated activities, so more of a constant age and constant, you know, just activities of daily living such as holding a cup of coffees, becoming quite difficult. And that's the usual presentation when people come to mind,

Steven:

Are they usually coming to you after they've had a series of appointments with you know, physical therapist or using them straight off?

Rupen Dattani:

Well, a combination of the two. So, there's some people who've just literally had onset of symptoms for the last few weeks and wanted to get that checked out before they continue with this boards. Often, they've already seen a therapist and, you know, I've had sort of several sessions of therapy and feel they're not getting better. Oral therapist is recommended to come and see me about it.

Steven:

So, I suppose one of the interesting things for us would be what, what would be your clinical approach to this? How do you assess them physically Rob a bit, we, of course, don't have sort of read such ready access to MRIs and x-rays as you do? Presumably you go through that clinical scanning before you send off for imagery.

Rupen Dattani:

Yeah. So, I mean, it's, it's all based on the history. So, the history be quite classical, you know, patients who are sick is tennis, elbow pain, predominantly over the lateral aspect, which then goes into the extensor compartment. And then with the golfers, the other way around and the pain on the medial side of the elbow with sort of rotation on to the photo aspect of the forearm and you know, quite often, you know, it's now at that point, it's probably become more constant ache, quite often, disturbing sleep, which is interesting. And also, then, you know, it has to be exacerbated sort of movements of the elbow. And at that point, what we tend to do is so that's sort of somewhat competed decided to you can still hear me all right. So, the convenience and started to have some

kind of an update, but yeah, at that point, you know, it's based on the clinical examination. So, the clinical examination with a tennis Alvarez tends to be focal tenderness over the lateral. Epicondyle with me, you know pain with wrist extension, and quite often with middle finger extension because the CCRB tendon is quite often the one that's affected and the CCRB is the one that's attached to the middle finger. So, it's quite often pain there with the golfer's elbow, it's sort of pain on the medial aspect and then pain with pro nation because it's quite after the print ex terrorist, a tendon, which attaches on the medial side, it can be painful and pain with resisted elbow flection, my preferred sort of way of treating these is, you know, initial I always tend to get imaging on these patients, but rather than MRI, I tend to go for ultrasound. And the reason for the ultrasound is because the ultrasound a is a dynamic examination and B it tells you about vascularity Copleston, there's increased vascularity at this particular sort of tendons and with a Doppler scan that you have attached to the ultrasound will tell you increase flow to that particular area. So that's sort of two-pronged approach in terms of, I find the ultrasounds a lot more informative. Right. And would you say that it is it's reliable and it's not going to give you any false positives, which you might get with other imagery? No. I think if, if it's, if you've got the clinical diagnosis and you've got the ultrasound findings, I think it's almost very, very reliable because the increased blood flow, the near neurovascular is really quite indicative on that particular injury. And sometimes you may also see a small tear within the tendon insertion and that sign that you've come across, which could be mistaken for golfers, which were a bit more serious. Yeah. So, with the tennis elbow, there's a, you know, if you've got a patient who, you know, in diagnosis 10, I haven't improved with other modalities of treatment, then you can get something called radial tunnel syndrome, which is basically entrapment of the posterior interosseous nerve just, just around sort of the just proximal to the radial head, sort of just the radio head. And sometimes if that's entrapped, it can give you very similar kinds of symptoms. And conversely, on the other side, and the golfers up aside is all the no problems. So, when you go on there being very close proximity to that area sometimes you get on the nerve problems can manifest as symptoms, similar to finding ways of excluding those that don't involve. So, it's based on literally on the, on the clinical diagnosis, I think most therapists, you know, rarely do you get sort of referrals where the diagnosis is it's in doubt, I think quite often, it's, it's a very classical history and examination findings, which cost and will clinch the diagnosis is only though those cases where they've had multiple sorts of treatments with any form of injections. So for them not improved or occasionally with surgery, haven't improved, then you have to sort of go back and reinvestigate as to whether you've got diagnosis, correct approach to these injuries. So, you know, I think my first approach is a reassurance for the patients. You need to let them know what the diagnosis is. And also, to advise patients that this isn't a quick, there, isn't a quick fix solution to this. And I think, you know, and therapists and assertions, we struggled together point across the patient saying if once you've got tennis or golfer's elbow, this is an overuse injury. So, you have to cut back on whichever activities is aggravating you since then, if it means few months off sports, that's what it means. Cause there's no quick fix solution to this. And I think that is the key, you know, if you look at all the literature surrounding tendinopathies around the elbow, rest is as good as doing nothing else. Yeah. And then if they've, you know, if they've come to my clinic and they said, well, I've, you know, I've given up my tennis and there's, despite there continues to be painful. I quite like, you know, study controversial. So quite like, there's this Casper's that way you need your coffee and you've seen the tennis club. People will wear these sorts of tennis elbow braces. Absolutely. And the reason is I'm talking about from experience. Cause I haven't had tend to start with myself. I was at it's like anything. Right. You know, I used to, I used to tell people about these straps having never worn one. And then when I had the symptoms, I put that on. I find it helped. Now it's the only holes for as long as you got to strap on. But I think one is the reminder and secondary, it also allows that particular aspect of the tendon to heal. And you know, some quotes

we'll say to patients and if they've got a manual job and they do still need to do the screaming action that maybe what you wear the brace nice during the daytime, whilst you're working to give you some relief. And why tend to do is that quite often in clinic I'll assess whether that that brace is going to be effective or not. So, I will quite often clasp the hand just, just below the elbow grease and then I'll try to do the provocative movements. And if they feel better with my hand, there is likely that the brace is going to it doesn't always work in everyone. But I think it's a simple solution in, is harmless and that cost. And we'll go down that route initially.

Steven:

Yeah. How important is sizing for those breasts?

Rupen Dattani:

Yeah, I think the sizing is important and also the location, because quite often they'll have a little foam area or a gel pad and that it's gotta be justice again. I'll also educate patients to say, look, you have to play around with that. And then I tend to just get them to do that simple test with the wrist extension or the middle finger extension. If they find that's improved with adjustment strap, and I'll tell them to Mark it there and then to wear it in a particular place. But I think it's a quite effective, simple solution to do these.

Steven:

Probably one of the hardest things is patient compliance. When you say to somebody and again, they're not elite athletes probably, but they actually want to get on with their sport. And you say, I bet you've got to take a month off sport, which may or may not be enough. Usually, they're going to try and get back as soon as the pain appears to be diminishing. And that does all the good work.

Rupen Dattani:

Absolutely. And I think that's, that's the absolute key now, you know, if, you know, if you look at elite athletes, elite football players, when they have an injury, the question, if you take time off and they only go back once their physical or their therapist has said, look, it's time to go back. And they, they don't rush back in into sport knowing that, you know, a secondary injury could mean that they're out of action for it.

Steven:

That's elite sports men. He's probably getting ultrasound therapy and some sort of physical intervention every day and is also being stuck in the gym and being told, do these alternative exercises while we wait for that one to heal. So, they keep their minds being kept off it. Or what do you think about the role of ultrasound therapy? I mean, I mean ultrasound treatment before these injuries go for the tennis elbow.

Rupen Dattani:

Yeah. I think there is some, I think if it, if it tends to work for certain patient groups, I think he's fine. You know, there's other things like shockwave therapy that people have tried a shockwave, you know, if you look at the literature again, having had shockwave myself and the reason that I had it for the elbow, so I find it enough developed. I was one of the few pipe people who've actually developed playing tennis, but pretty badly. I remember it was, it was an acute event where I, I somehow decided to just change my grip one day we're serving. And he was that changing the grip

led to acute tennis elbow. And you know, later that evening I was in absolute agony and a day later literally could not move my elbow. And then that's when I first realized how painful that tennis elbow could be. And this was, you know, over a decade ago and the therapist where I was doing my fellowship just said, well, why don't we try some shockwave therapy? And it sorts of, you know, are they, I don't know whether there was a shockwave that helped or the combination of that, the rest wearing the brace, but it worked. But shockwave there is, you know, if you look at the evidence behind it, it's equivocal in terms of whether it helps them not, you know, there is lots of anecdotal evidence that people found it works. And it's, it's very sort of noninvasive way of trying to treat it. The evidence is poor against it, but you know, some people have had sort of a cost and have people said, Oh, I had shockwave for my plantar fasciitis. Can I work really well? Can I have, if my tennis elbow absolutely. There's no, there's no harm in it. And a lot of therapists are doing shockwave therapy.

Steven:

Yeah. We did a session sometime ago with Tim Watson who retired recently from the university of [inaudible] where he was the, I think the UK is needing experts on ultrasound and similar therapies. And he was, he made it quite clear. You have to be very specific about the type of shockwave that you're getting, because there's radial enlist, plural crest, isn't there. And if it's done properly for the right, like most things, if you do the right sorts of therapy for the right sorts of injury, then you'll get a good outcome. If you use it Willy nilly, then your outcome will be a little bit more haphazard.

Rupen Dattani:

Absolutely. And I think that that's, that's the reason why some of the, you know, if you look at this, the literature you get to tend to get mixed results. Cause you've got, you know, a combination of you know, you've got different stages of tennis elbow. You've got different means of applying this different therapy sessions with you need three sessions, six sessions, seven sessions. So, you're not, you haven't really got a uniform group of patients that your, your addressing, and that's why sometimes the results haven't been favorable. But so, you know, shockwave therapy is quite often, you know, is know, I know a lot of therapists do that. And for me, I think it's a completely harmless way of trying to treat this. And then if it works, absolutely. Why not?

Steven:

Yeah. Nick burns of sensing that sort of combined observation and question that you said that he was trying to explain to a consultant dermatologist who is a patient who was also a weekend warrior sportsman that you need. And presumably means that you need to rest in order to heal these things. And he said it's a, it was a real problem. And do you, have you got any tips for getting patients to comply with that advice?

Rupen Dattani:

I think that that's one of the hardest things we do try to get across is, you know, I think in sort of the modern era that we live in, people want a quick fix solution. They want to carry on doing their gym work. They want to carry on playing sports. And, you know, thoughts are taking, you know, six to eight weeks off sport. You know, them,

Steven:

I've always been signed to concerned about those at the slash straps because they do certainly relieve the symptoms for the patient. But I wonder how much, if they carry on doing their work or their sport, that it actually impedes the healing process because there's going to be some strain getting beyond that artificial origin for the muscle. Isn't it?

Rupen Dattani:

Yeah. So, think, you know, as the mechanism, as to how they work is still under debate, you know, what's one thought process is that you just you're diverting the forces more to the medial side of your elbow. And hence allowing that to you. I think that's certainly the case with steroid injections and the Serra injections were the preferred method of treating these, you know, a decade ago. And they fell out of favor purely because this isn't an inflammatory condition and the stereo is an anti-inflammatory drug. And what it tends to do is it gives you that sort of false sense of security, that things are fine and gives you a temporary pain relief and you go and then continue with your sports. And you're just doing more damage to that tendon. If you, if the lot that histology that's been done on tennis show quite clearly shows there are no inflammatory cells around that particular area. It's more degeneration of that tendon. So, what you trying to do, whether it's with shockwave therapy or with PRP therapy or dry needling, is trying to stimulate that particular area to heal. And that's why steroids are really not advisable for this condition. And I, I will, I definitely recommend against steroid, but it's interesting. I still have patients who come in saying look well, you know, I had a steroid 20 years ago for my tennis elbow and can I have the same thing again? So, I presume that if you will, professional advice is that you shouldn't have steroids and you don't want to comply just because the patient says that's a good thing. No, no, exactly. So, the last patient, I remember doing a sterile injection on a lady who had classical tennis though, but she was, I mean, this is just a pre COVID. She had a hiking tour where she was going. I can't remember it was the Alps or somewhere where she'd had this trip a year in advance was going with some friends. It was quite expensive and cheap. So, she said, I don't think I'll be able to go without this. And she and I, she said, can I have a steroid injection just for that temporary pain? And I, you know, I sort of gave her the whole spiel about, you know, the fact that know your pain will come back worse than it was. And she took that risk. And so, she was able to continue with that holiday, but she did come back to me about three months later to say, you're right. And then the paints couldn't pack. Wasn't a, we started off and then that's often the problem. So that's the only, that's the last time I actually physically remember administering a steroid injection for that condition because of that particular circumstance related to our business, using steroids, if patient has responded to conservative care, what's your onward management for them then? So, my preferred option treatment is with PRP injections. Now, you know, PRPs have had sort of mixed reviews and there's been lots written about PRP for various conditions. You know, you got elite sports athletes having for various conditions. There's things when knee arthritis, there are two, there are only two conditions really for which there is some scientific evidence to show that PRB can work. And one is tennis elbow. And the other one is arthritis of the knee. Now, you know, there are with PRP. I, you know, I, I feel that it's, it's a more natural way to trying to get that tendon to heal it. It depends on how it's done. I tend to do them in, in, in either the outpatient clinic when theater settings is by no means a quick fix. Again, you know, quite often people have flare pain, whether it's quite painful having it done. And, but I have, you know, we've had some very good positive results and I probably see, I'd say 40 to 50 cases of tennis elbow a year, both privately and through the NHS. And I, haven't done a tennis elbow really surgically for about 18 months. So, and it's not because, you know, it's not it's because, you know, I tend to sort of advise patients, look, this is a chronic condition. You're going to have several months

of pain. You've got to have a combination of treatment, others rest, possibly shockwave if they want to shockwave, but with PRP, and we've had some really positive results with PRP injections.

Steven:

Does the NHS so far about shockwave and PLP?

Rupen Dattani:

Yes, yes. Yes. So, the NHS where I work Chelsea was Mr. Shockwave is available for rider conditions, cost, and the foot and ankle guys use the plantar fasciitis, and we tend to use it for tennis elbow. And so, as PRP is available through the NHS,

Steven:

Would you care to talk us through the mechanism of action for PLP?

Rupen Dattani:

Yeah. So, you know, there are, so the PRP, the platelet rich plasma, and what tends to happen is, you know, when you have an injury of any kind, they're the first sort of cells that arrive at your, or your platelets, they form a clot and then various sort of chemicals are secreted by what's called the alpha granules within the, within the platelets. And they've got the growth factors, then start the inflammatory response and the healing response. And the way PRP tends to work is that you were giving them a concentrated form of plasma. Now it depends on which system you use. You're giving them anything from three to eight times, the normal plasma platelet concentration at that particular site. And the mechanism is thought to be by injecting those platelets, you then starting the whole healing response with the growth factors, which then can differentiate into sort of tend themselves and so forth

Steven:

Any contraindications. So that for let's say athletes who are subject to random drug testing and on, because in fiddling with the blood, it has become a common way of cheating and elite sports. Isn't it?

Rupen Dattani:

Yeah. So not, not with this, because obviously with, you know, if you think about the Lance Armstrong case, that was more about, you know, he was having blood taken out and then reinjected, so he had a higher volume here where we're taking some, anything from 10 to 15 mils of blood, but we only we're actually injecting less back. Cause the amount of plasma you get varies from three to five mils back. So, and not from that point would be no. I don't think there's any, any concerns at all.

Steven:

Yeah. We had an anonymous question earlier. I'm getting back specifically to the tennis and golf was elbow, but whether you see problems of the elbow, which actually ended up being shoulder related or, or perhaps even neck related.

Rupen Dattani:

Yeah, absolutely. So, you know, the examination, you know what I think the bit I skipped was I always tend to examine the neck, whether it's a shoulder related problem or elbow related problem to see if it is a I don't know if it's a shoulder C five C, six nerve roots, you know, elbows, [inaudible] kind of nerve root. So, you, that you saw in the hip surgery, whether they have that sort of neuropathic symptoms, but absolutely. And if, if, if five of patients who've been treated either with, you know conservative treatment or with the PRP and they come back to clinic and they're not improving, you have to go reassess and we examine the patient to see whether you've missed something. Yeah.

Steven:

Yeah. If you, if you've got a patient, whether the problem is stemming from the neck, surely your epicondylitis strap is not going to have any effect

Rupen Dattani:

And they won't have that focal tenderness over the lateral epicondyle. And the provocative signs, I think with tennis elbow is one of the few things where I think the diagnosis is fairly clear from the history and the examination findings. And then the strap, like you said, will not have any benefits or,

Steven:

Yeah. Okay. So there's some good clues. Neil has asked about shockwave and said that isn't laser therapy thoughts would be just as effective these days, lasers come on quite a long way in the last year,

Rupen Dattani:

Quite low. I mean, I, I've gotta be honest. I don't know much about the evidence between laser and tennis elbow and whether that works or not, but you know, it's something, maybe I'll go and find that, but not, I don't know what the other laser therapy for tennis, but a lot's been written about tennis lab where people have injected whole blood that have injected lots of very, very subtle things. Some people have injected glucose around the image try. Yeah. And it's called prolotherapy to try and try and again, it causes an inflammatory response. What you want to do is start the healing process from scratch. People have injected the hyaluronic acid around the area. Some people have thought that it's the, the blood vessels to that particular area. So, they've tried to, embolize some of the tiny blood vessels to see if that causes,

Steven:

I think it was gentleman, we were talking about hyaluronic acid and I think his opinion was that it certainly doesn't work in the knee with general knee problems. Has it got any evidence behind it for elbow problems?

Rupen Dattani:

So there, there, there has been a lot written about it. Again, mixed, you know, the people haven't sort of done randomized trials where they've just looked at one versus the other, but there have been some, the articles I've come across have had, have shown some promising results with hyaluronic acid. But as I said, whenever you, whenever you find multiple therapies for one condition, it makes you wonder whether any one superior to the other. And you know, for me, it's

still going back to the basics and it's about that period of rest. I don't think I can emphasize that enough.

Steven:

Yeah. Yeah. So, what's your standard recipe then? How long do you tell patients that they've got called to rest? And I guess it depends how severe the problem is, but do you deliberately overemphasize or overstate the need to rescue them more time off than otherwise because otherwise I'll get back to you soon.

Rupen Dattani:

Yeah. So, if, if it's, if it's sporty, I think sometimes if it's tennis, then it'd be anything from eight to 12 weeks, you can't be as long. And you know, the patients often don't like getting that particular bit of advice, but I think that's the harsh reality. That's what it is. But it's also basic things like, you know, which I alluded to earlier is just checking their grip and, you know, if they've got a coach to just make sure they've got the right grip and white side, and there's just some basic advice such as that,

Steven:

Well sort of long-term damage will they do if they trying to work through this or they go, they continue to go back to training too early and then rest a bit longer and then go back to training again, because it is, as you said, that degenerative conditions.

Rupen Dattani:

Yeah. So then, then, then they start getting a tear in the tendon insertion, a lateral epicondyle. So, the more overused you get a more transcendent degeneration, less time the tendency to view. And then, you know, those group of patients sometimes do then end up having surgery whether its office got pickle, open debridement, but you know, even, even after when you've had an arthroscopic go open, debridement is still two, three months before you can start getting back to normality.

Steven:

It was almost the only one, whether you see many of ocean injuries of the elbow, when you say what you do, others

Rupen Dattani:

Motion injuries, we tend to see more sort of with tumor soon. And when people have had an injury and have lost a bit of the coronoid process, the clock often is either part of a through an elbow dislocation kind of injury or where they've had some terrible tried injury where they've branched the radio head and fracture the coronoid and the lateral collateral. It tends to, they tend to occur more as part of that. The other emotion fracture that you see is meaning children that they have locomotion of the lateral and medial epicondyle, it's quite rare to see that in adults

Steven:

Purely because of the bedroom having failed to

Rupen Dattani:

Yeah. How long you would keep people on conservative treatment before you would recommend PLP. If they've had symptoms for me, PRP I've start run three months. If they've had, you know, they've not improved to conservative measures at three months, rather than rushing in really, really early on. I don't rush into a PRP because I think the other thing is, you know, that three months is also trying to reeducate them to say, look, you need that period of rest. And if they've come back at three months, they look off, give it up. All my sports are despite there continues to be painful. Then, then I go onto the PRP injections and know that there's again different sort of multiple companies I've got PRPs in the market and this they're all slightly different in terms of finish their work. Some of them have white cells within the PRP. Some have no white cells, and then there's different theories just in which one, superior to the other and get the questions, how many PRPs to do. Right? And so, when I initially started doing them, I was doing three PRP sort of fortnightly. I've sort of moved away from that. Now I'm sort of tending to do one and then reassessing it four to six weeks. And if at four weeks patients I've noticed some improvement, I get them to just continue. If they've had no improvement, I tend to do a second. And occasionally a third sometimes, you know, people got very severe tennis elbow, both, you know, clinical findings or from ultrasound findings that I made it to sort of two weeks ago. And one of the other questions that came in quite early on was whether you see many bony anomalies of the elbow and how relevant they are to injury only a normal is it's quite rare. Actually. We don't see them very often and quite often yet people who have in fact, we've just got a patient on GTC next week, who's got something called the congenital dislocation of the radial head. So, they've had, they were born with a radio head just dissipated. And what happens is they've got reduced rotation, but in this, in this particular patient had ongoing problems. So, in sort of chart, he's only 18 now is a semiprofessional footballer and he's had a radial head excision. So, he's had that excised as a child, but the proximal aspect of the radial head is overgrown. So now every time he rotates, you can actually see the shaft of the radial head moving and that's catching and causing problems. And so, he's been referred to my clinic. So, I'm due to see him next week, but again, anomalies more like usually tend to be congenital or sometimes people have where there's fusion of both for on bones and as a result of had reduced rotation. But it's amazing how people adapt movements of the shoulder. You cancel the rotator over and that it goes up.

Steven:

What are your, what are your options with your footballer patients? So, this congenital dissertation bum.

Rupen Dattani:

Yeah. So that, that's a tricky one because he's had the radial headache sized, we can't just go and exercise any more of well, the question is whether we can excise any more of a radial head or the radio shop. And the problem is the nerve foster interosseous nerve is in very close proximity. So, he's going to need some further imaging to see where that is. The other thing is, you know, the forearm, the radius, the moment you can think of that as one George has got process membrane. So, it's essentially one joint. So, if you start excising more of the radial head, they can start getting problems with the wrist because you can get proximal migration. Yeah, definitely. You had to then start getting radiometry. And so, it's not a, it's not that straightforward. It can do a condition to treat. So, in this case, you can need some further imaging for us to assess

Steven:

Well, out of curiosity, again, what's he complaining of? Is, is it actually hurting him or was it just unsightly?

Rupen Dattani:

No, it's, it's, it's, it's an it's pain. It's so he's you said he was okay, and then he had this sort of surgery in sort of childhood. I think he was about 11, 12, and then he was fine. And now is as, is being semiprofessional football. And there's some of the training regimens he's doing, especially doing press ups and pushups. He's having pain, as soon as he's loading user, his wrist, you see it, just see that clicking sensation. So, and that, you know, it's when he first looked at him, you think, Oh, that's going be straight forward. I'll just take a bit more of the radial head off. Then you realize he's already had quite a lot more taken off. So, it's not going to be that simple. The solution.

Steven:

Yeah. Yeah. I mean, is there an artificial head that you can insert or is that not possible of his stage of degeneration or

Rupen Dattani:

So radial head replacement CA can cost them, do them for an arthritic sort of Radiohead radio capitellar joint cough, and tend to deny trauma where the region has been fractured, but in his case, the problem is the Regal head is also not articulating with a capital M it's actually pointing posteriorly. So, a regular Henry working cause we won't be able to realign that with a capitellar posted. I think we'll do is next time when I come on, I'll try and put these images up to be quite interested to see 'em.

Steven:

Hmm. I was going to set up a fascinating, yeah, it was almost as how you handled patients depending on age. Apparently hick bell has either a 60-year-old patient who gets tennis elbow every year, almost the rest of it. And then it flares up again. Yeah. So

Rupen Dattani:

I think, you know, again, you've got to ask in terms of what what's triggering is sort of tennis, are there particular activities is doing, you know, which tends to exacerbate it and these resting in a coming by far, I think with tennis elbow that, you know, coffin, it is a chronic condition. Cause it's what we know is that the blood supply to these tendons, whether it's your rotator cuff tendons diminishes as we age. So, the vascularity is really poor and hence the heating potential is really poor and cough and people sort of have some get into this cycle where they're there, they've improved for a while. They do something that aggravates it, the resting position. So, I'll try and find out from that particular patient, what, what activities is doing well, that tends to exacerbate that. And specifically, that can be modified in the way I wonder myself, whether it's actually doing nothing for a long period of time, then going straight back to what he remembers as his normal activity levels and that bit in the middle where he's doing nothing, as you say, is leading to that reduced vascularity. Maybe if I can, the problem will be up to you to find out, which is the case in that particular patient's case. And what about elderly patients? You can't fully flex or fully extend their Albers? Maybe arthritis. What if you carry out over replacement? Yeah. So, what we tended to see was a lot of the elbow replacements were done predominantly for rheumatoid arthritis. So traditionally, if you look at all

the literature on elbow replacements is mainly for rheumatoid arthritis. But as the medical treatment of rheumatoid arthritis has improved so much over the last 10 to 20 years, we don't see them in your rooms with elbows anymore because the disease modifying agents have sort of helped them to condition. So, the elbow replacement that tends to occur now is predominantly for arthritic Elvis osteoarthritis elbow, which in itself is quite a rare condition or for trauma where people have had after the distal humerus to such a point where it's not reconstructible and we tend to do an elbow replacement for that group of patients. In fact, the trauma wants is probably the, that people tend to deal with customers for now. Yeah. And then with the arthritic elbow, there are other options before we rushed into sort of a replacement quite often, they can do well with an arthroscopic debridement. They're open debriding to try and, and what's called an OK. Procedure, try and just release some of the scar tissue around the oval, which may also be constructing range of motion. So, you can buy them a lot of time by doing these kinds of obstacles before they're going into an elbow replacement. If you've got age limitations on us as well, because I'm one of the patients that came up in the, the questions that have been coming is clearly

Steven:

Elderly and there's reduced flection in the elbows. And that of course has an effect on quality of life because you know, the patient called, which is hair to wash your car, which is faced to shave properly and has pain in the elbows would do bribe at work that you think,

Rupen Dattani:

Yeah, I mean, what we tend to do is tend to image them first, just get an extra, to see how severe that arthritis is. And maybe also a CT scan to see if there are any osteophytes that could be impinging on that. And there are some osteophytes you can quite often get them arthroscopy. And it's quite a satisfying operation because you can get people the relevance of reflection that they need. So, if you look, if you look at, you know the traditional data that we sort of grew up on in terms of orthopedic training was your functional range of motion had to be between 3,230 degrees, right? Most things, but these were studies that were done in the eighties, pre mobile phone data or mobile phones. You have to, yeah, you need about 140 245 degrees. Somebody with pro nation, you need about sensitive whose apprentice to be able to tie all these studies were done sort of in the eighties where, I mean, a lot of the jobs were not desk based, but now our demands have changed, not just for just fact into daily living and also for work, but so no age limit. No, I don't think it's a fit to undergo some form of surgery now. Yeah.

Steven:

Nick has asked a question about whether you talk to coaches particularly about, you know, serious young tennis players to discuss how their tennis elbow could be a sign of poor technique or faulty racket grip sizes.

Rupen Dattani:

Yeah, no, absolutely. So, they're, you know, occasionally we do get sort of the, a very good sort of up and coming some players and quite often the coaches will come with them and we'll just sort of give them my advice. And if the coaches haven't come all, I'll say to them, please speak to your coach, just get your racket size, assessed your grip, assessed just someone to have a look at that. But that goes for all players, you know, and you know, for me, just from my experience, it was that change the grip, which I, I don't know, someone, you know, someone on the court said, well, why

don't you just change your grip of it? And I just did, and it was the wrong advice I'd been given. And it was, it was excruciating pain for, for, for yeah, absolutely. I think it's definitely worth talking to the coach.

Steven:

I do remember talking to a spinal consultant. I don't know if you know, Nick Birch who's he's up in Northamptonshire and he was saying that actually talking to the coaches is often, often more difficult than talking to the patients because they are desperately keen to get their athlete back onto the court or the track or wherever it might be. And they certainly don't want to hear anything that says rest them for a month or eight weeks or 12.

Rupen Dattani:

Yeah, exactly. Cause obviously people have got different pressures. The coach has got pressures together, a particular, a teenager or a particular child back to come competition child, that individuals got a precious to try and compete. But you know, I've got friend of mine. His son is a sort of elite tennis player, so he's only 11 years old. Now we're digressive from, from, you know, but he's had various, still knee injuries and it's purely because of that. Cause the rest is potentially, you know, the next up and coming player, but you're gonna want to speak to his dad. He said that's been the hardest thing to try to get into especially when academies have taken the particular kids on there's a lot of pressure to compete. And I know some of these are competing to 70 to 80 competitions a year, so you're almost playing one, one and a half competitions a week, which is a lot for an 11-year-old. Right.

Rupen Dattani:

Absolutely. Yeah. So sometimes that rest, it may sound very basic, but that's, you know, that's yeah. Final question prompts. One elbow, if you find that elbow problems generally present with elbow pain, or do you see lots of referred pain buttons as well? Most all of the pains, you know, like we, we limited neck pain discount that, but the, the, the history will tell you when we're going to neuropathic pain, shoulder pain rarely goes below the elbow unless things like a frozen shoulder, if you're a frozen shoulder, frozen shoulder can go below the elbow. And occasionally people, people will get sort of, even with pain into the hand and occasional intermittent tingling, but it's, I think it's more to do with tightness around the trapezius. And the other thing is that they've got to make sure there's nothing wrong with the wrist not referred off, but quite often elbow pain will, will manifest as you know, it will be an elbow pathology of the, yeah, I'm glad you mentioned frozen shoulder because a little while ago we talked about releasing a frozen shoulder and you said you might share a video with us. Yeah, I'll see. I'll try and share my screen. Actually, I can, I'm gonna show a couple of videos. One is this thing called a hydro distension, which there are two ways of doing the hydrogen potential, which will be either with ultrasound or with extra guidance. So, this was done in sort of theaters under x-ray, although we've now moving always towards oxide. What we tend to do is you can see sort of the dye is injected into the shot to make sure that we're actually in the shoulders. You can see that the needle here and then what we're just doing is volume standing. So, trying to inject predominantly a very small dose of steroid, but predominantly local anesthetic. And say like now the other one would be an arthroscopic release, which I'll try and see, bear with me. Sorry. Can you see that video now? I can still see your mix more. That one. Yeah. The videos aren't running now. No, we're still on the file directory. Sorry, try that one does a modern technology. So just start from scratch. This is looking at their shoulder for a posture reporter. We're looking at the front of the shoulder and you can see how sort of angry looking this sort of bit of tissue is. And this is what's

causing the construction of the movement, cause this is your subscapularis tendon. And this is what's this area here is what's known as the rotates interval. And that's where you've got majority of the sort of scarred inflamed, ugly looking tissue, which is hindering the movement. So, music, radio frequency, probe to try and just release that scar tissue. So, this is looking at it from, from the releasing it from the front and they've got the middle glenohumeral ligament, which is one of the constraints of the shoulder, but in this case it's sort of thick. And so, we've partially released that along with the anterior capsule. And that was done will improve your sort of your external rotation. Then we get to the back of the shoulder and Lisa that, the tissue in the back to try and improve the remainder of the sort of tissue that may be hindering movement, especially internal rotation and then have a quick look around the shoulder and then we do a gentle manipulation. So, you could quite clearly seeing that particular video. How so, how are we thinking? Looking at a bit of tissue was before we started all this sort of issue here, which is, which is the culprit and that's why it always amazes me how you know, shoulders can be, could become so, so stiff, but it's a self-limiting condition. Some, some are this sort of results of repair at a time. But it's one of the most sort of satisfying operations we tend to do. Cause it's, it's almost got a quick instant sort of, you know, in the patient's range of motion. I think it was a radio head. Yes. So, there's a slot probe. What would that, that tends to do is its sort of a burst of a cellular tissue to try and excise that tissue. So, we have two main devices. One is that radio frequency, which uses radio frequency waves to try and release the tissue or the other ones are sort of a shaver. The thing about the shamers is cause bleeding to that tissue. So, we tend to use one that doesn't improve the visualization. So, when you use the radio frequency and presumably there is nothing for you to suck out at that point, its changes are within the tissue rather than it does create smoke. So, we do have attached to it, which you can't see from outside the body. There is a sort of suction device, which sucks that tissue is otherwise. And it's also creates a lot of heat within the body. So, it's got an alarm sort of detection on there which will set off as noise if it gets too hot in there causing damage to the con Congress folks. Yeah. And what's the success rate, very high it's really high. And we, we, we did a study where we did, we looked a hundred of these consecutive patients and those only one patient who needed to go back through rerelease pain can still continue. So, you know, I don't say to patients that you'll have this operation and you'll be absolutely pain free, you can take up to 12 weeks for the pain to diminish. And it's really important that, you know, we work quite closely with our sort of therapists. We, with this particular condition for my mantra with this kind of thing, is have really strong Bankless post-surgery. So, the surgery is done under indicating nerve block. And so, you know, wake up daddy pain free. Then we give them 30 sorts of strong painkillers to go home with and they start the therapy within 48 hours. Cause we wanted to try and maintain what they have and also want the pains and the control, but the pain persists for about 12 weeks or so. And occasionally, some patients need a further injection in about, say five to 7% just for pain. So, it's usually a steroid injection. And when you're setting up procedures quite successful in, in the study is what was it measured against, measured against no treatment manipulation under anesthetic. So now what, what we, what we looked at was actually quality of life improvement. So, there's something called a quality of life, just so whenever you look at any procedure as to how effective is in terms of how much it costs. So, if you look at probably the most, one of the most cost-effective procedures you can have as a hip replacement. So, what they tend to do is they measure your positive life is do you know if you've got arthritis as a 60 and you live up to 80, you'd have 20 years' worth of pain. And then, you know, if you do a hip replacement, that's 10,000 pounds, for example, 10,000 divided by 20. So it's 500 pounds roughly per year. So, you, but you got to compare that to how many times a patient may go to the GP, you know, with pain. And so, yeah, so we looked at that. So nice basically recommended if any procedures less than 30,000 pounds a year adjusted life for you, then it's worth doing that. So we, we measured against that and that capsular release was something about two and

a half thousand pounds. So, it's a vast improvement and what we, what we, the way we measured, it was, it was said basically, if you had a frozen shoulder and he lost three years, arguments sakes that, you know, at three years out. So, we just calculated it from the moment it was diagnosed to when it would have been three years divided the cost of the procedure by that time period. So, it's a very cost-effective procedure in that sense. And we also had sort of, you know, patient related outcome measures where patients subjectively scored their shoulder pre- and post-surgery. And again, vast improvements. I think that's one particular procedure where I think people have a, you know, dramatic improvements in range of motion with a lot of the other stuff we do with shoulders, they rotator cuff repairs and so forth. It's a more long-term sort of investment in terms of their time and effort. And before we can see the results over time. And if I may, can I ask one final question from TNF about elbows? She says, she's just answering some advice for a patient who has bony osteophytes on the anterior aspect. So, the owner bilaterally, any concerns with joining limitations or related or presented like this, is its common causes it they've been doing pullups weeks before elbow flection is difficult, be getting compensated the back and shoulder pain from workouts. You see cases, no lamps, how long to continue managing conservatively before referring for surgery and so on. So, a quick thought from you. Yes, absolutely. So, I think that that's quite common. So, you quite often we do see from the coronoid, which is part of the element we start seeing osteophytes there. So, the anterior compartment, and eventually if they're big enough, they will start in, in the range of motion and he may be because of overuse or they've trained very hard, or may, may have had an injury in the past, which has in reacted to this. If you find that all conservative measures have failed and the patient is starting to struggle, then I would probably say, refer them on. So, we can just have a look, get some basic imaging, maybe an extra, and sometimes a CT scan or three, three-dimensional CT scan is really invaluable in this. Cause you can of have a look at where the osteophytes are and quality can be addressed arthroscopically and, and with sort of very good results.

Steven:

Right? Thank you so much for that. Rubin is very concrete to come back on. Again, we look forward to getting you back on, as you promised for the third time, when we see the results of your footballer's elder elbow procedure, but for now, that's it for you? Thank you. Bringing much in big.