



UPDATE

NEWS & EVENTS

CHT Clinical Coordinator Speaking at ASSH/ASHT Meeting

Colorado Hand Therapy's Clinical Coordinator, Bobbi Owsley, OTR/CHT has been invited by John Seiler, III, MD of Atlanta to speak on hand therapy for salvage procedures of the arthritic wrist at the Joint Annual Meeting of ASSH & ASHT in San Antonio in September of this year.

Utilization Management -

Colorado Hand Therapy has instituted a Utilization Management Program designed to ensure the cost effective delivery of therapy services. Program objectives are to meet professionally recognized standards in the delivery of hand therapy services and provide therapists with an avenue to seek direction on difficult to manage cases.

For a complete list of participating insurances call 303-777-2393

HAND THERAPY CLINICAL UPDATE:

LATERAL EPICONDYLITIS

LYN HEATHERSHAW, OTR, CHT

Although called "tennis elbow", this tendonitis is seen more commonly in non-athletes and in people between the ages of 30 to 50. Overuse activities that may lead to onset of pain include repeated grasping, elbow straightening, twisting, or lifting objects with palms down. Specific activities might include over reaching for a computer mouse, pulling weeds, or picking up a brief case. Conservative treatment is successful in 90 to 95% of these patients. Rest, ice, therapy, anti-inflammatory medication or cortisone injection may be recommended. Rarely is surgery indicated.

Lateral epicondylitis is characterized by symptoms of pain along the anterior aspect of the lateral epicondyle or the extensor mass of the

forearm. The pathology is inflammation or micro tears within the fibrous origin of the extensors, including the extensor carpi radialis brevis (predominately), the extensor carpi radialis longus, and the extensor digitorum communis. Nirschl describes the following stages:

- STAGE 1: Inflammatory changes that are reversible.
- STAGE 2: Non-reversible changes to the origin of the ECRB.
- STAGE 3: Rupture of the ECRB origin.
- STAGE 4: Secondary changes such as fibrosis or calcification.

Differential diagnoses includes arthritis, radial tunnel syndrome and referred pain from a proximal trigger point.

THERAPY: 0 TO 3 WEEKS Early therapy focuses on reduction of pain and inflammation and healing of the soft tissue structures. Decreasing tension of the tendinous attachment can be done by splinting and optimizing ergonomic positioning. A wrist immobilization splint and/or a counterforce tennis elbow band may be used initially.

Modalities for pain relief and promotion of healing include moist heat, iontophoresis with dexamethasone, phonophoresis, contrast baths, and icing. Manual massage along the length of

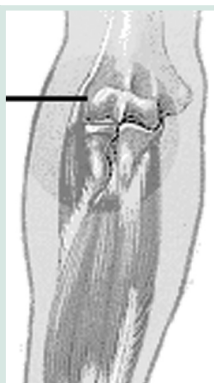
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TENNIS ELBOW

(lateral epicondylitis)

Outside of Elbow Cause & Symptoms

The onset of pain, on the outside (lateral) of the elbow, is usually gradual with tenderness felt on or below the joint's bony prominence.



TENNIS ELBOW/LATERAL EPICONDYLITIS

PHILIP HEYMAN, M.D.

The above terms apply to a wide spectrum of pain patterns about the lateral elbow emanating from the origins of wrist and/or digital extensors. The term "lawn tennis elbow" dates from the British Medical Journal, 1883. This term is a misnomer, as most of the patients we see with this affliction are non-athletes. Thus the term "lateral epicondylitis" is frequently used. This term has its limitations as well. The lateral epicondyle is bone, and "lateral epicondylitis" is an affliction of tendon. Furthermore, histologic analysis of involved soft tissues may reveal degenerative micro or macro tears and no inflammation at

all (Cyriax, JBJS, 1936). Thus, there may be no "itis" in "Lateral Epicondylitis". It's really a "tendinosis". So much for semantics.

The surgeon's role is to accurately diagnose, ruling out arthritis, radial tunnel syndrome, cervical spine disease, and other conditions. X-rays are usually normal. MRI frequently can show abnormalities in age matched asymptomatic patients, and the thoughtful surgeon takes an abnormal MRI with a grain of salt. In the vast majority of patients, activity modification, therapy, steroid injection, and patience cures the affliction.

Surgery involves excision of pathologic tissue at the extensor origin, followed by repair of the remaining defect. Elbow and forearm immobilization for 4-6 weeks ensues, with therapy continuing until 3 months post-op. Reports in the literature are generally positive. However, in no condition is the phrase "Primum, non nocere" more applicable than to this frustrating, though usually self limited condition. "First, do no harm".

Dr. Philip Heyman is a board Certified Hand surgeon with Hand Surgery Associates, P.C., Denver, Colorado.

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MEET OUR THERAPIST Carol Schroeder, OTR, CHT

Carol has worked in hand and upper extremity rehabilitation for 23 years. She received her certification in hand therapy from the Hand Therapy Certification Commission in 1991. Carol is an active member of the American Society of Hand Therapists, Rocky Mountain Hand Surgery Society and Denver Hand Special Interest Group. Carol has lectured on shoulder tendonitis, traumatic work injuries, carpal tunnel syndrome,

epicondylitis, DeQuervain's and Trigger Finger. In addition to her extensive experience treating traumatic injuries and cumulative trauma of the upper extremity, Carol has expertise in ergonomic education, consultation, and work site evaluation. She has provided ergonomic consultation to Kraft, IBM and Honeywell corporations. Carol believes patients need to understand the purpose of each aspect of their home program to encourage full participation and to achieve optimal outcomes.

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LATERAL EPICONDYLITIS

the muscle and perpendicular to the tendon is recommended (cross-friction or transverse fiber massage). A general conditioning program with emphasis on the shoulder and trunk muscles (which are often weak in these patients) is initiated. Active stretching exercises of the extensor and flexor muscles are emphasized at 3 weeks.

4 TO 6 WEEKS: Passive stretch and strengthening exercises are incorporated into the patient's home exercise program. Strengthening generally begins with 1 pound wrist extension and flexion exercises for both eccentric and concentric phases to increase the tensile strength of the involved tendons. This reduces the risk of re-occurrence of symptoms. The strengthening exercises are progressed by an additional pound a week. Progressive exercise must be pain free!

6 TO 12 WEEKS: Progressive, pain free strengthening with elbow extension continues to be an objective. Patients may gradually return to sports at approximately 10 weeks. The use of the counterforce brace during sports may be recommended.

Education is a primary focus throughout patient treatment. Each program is tailored to meet specific needs. A comprehensive ergonomic evaluation of the work place or at home can be performed to identify activities that may aggravate symptoms.

Lyn obtained her master's degree in Occupational Therapy from Texas Women's University. She received her Certification in Hand Therapy in 1994. Lyn is the Team Leader at Colorado Hand Therapy's Littleton clinic.

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