CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

EVIDENCE SUMMARY

Tennis Elbow Release

title: “Tennis Elbow Release” slug: tennis-elbow-release region: elbow audience: patient mesh_terms: [] article_count: 0 model_used: qwen3.5-35b-a3b-q8 generated_at: ‘2026-05-18T13:34:14+00:00’ key_articles: [] synthesis_version: “v2” verifier_status: skipped

Anatomy & Pathophysiology

- The pathologic tissue in tennis elbow involves the undersurface of the extensor carpi radialis brevis tendon [1].
- The origin of the extensor carpi radialis brevis is visualized during arthroscopic tennis elbow release [1].
- Decortication of the lateral epicondyle and lateral epicondylar ridge is performed to address pathologic tendinous attachment [1].
- Undersurface tears of the extensor carpi radialis brevis are a finding in tennis elbow release procedures [1].
- Medial capsular injury may occur and allow excessive fluid extravasation during arthroscopic elbow procedures [1].
- A 30-degree arthroscope is adequate to view around the corner for most of the arthroscopic tennis elbow release procedure [1].
- A 70-degree arthroscope may be required in rare instances during arthroscopic tennis elbow release [1].
- The proximal medial or superomedial portal is located approximately 2 cm proximal to the medial epicondyle and 1 cm anterior to the intermuscular septum [1].
- The trocar and sheath for the proximal medial or superomedial portal are introduced anterior to the intermuscular septum [1].
- The trocar is directed toward the radial head while maintaining contact with the anterior aspect of the humerus [1].
- The superolateral portal is established with an 18-gauge needle through the lesion [1].
- Debridement of the capsule and pathologic tendinous attachment of the extensor carpi radialis brevis is performed using a curet and motorized shaver [1].

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

- Decortication of the lateral epicondyle can be done with an arthroscopic burr, handheld instruments, or electrocautery [1].

Treatment

- Arthroscopic tennis elbow release is described as technique 52.39 [1].
- The patient is placed prone on the operating table after intubation [1].
- Two rolled towels are placed longitudinally under the patient's thorax [1].
- All bony prominences are padded well [1].
- The affected extremity is positioned with the ipsilateral shoulder abducted to 90 degrees [1].
- The arm is supported with a precut foam holder [1].
- Anatomic landmarks and portal sites are marked prior to the procedure [1].
- The joint is distended with 20 to 30 mL of saline through an 18-gauge needle introduced through the direct lateral portal [1].
- The proximal medial or superomedial portal is established approximately 2 cm proximal to the medial epicondyle and 1 cm anterior to the intermuscular septum [1].
- The trocar and sheath are introduced anterior to the intermuscular septum [1].
- Contact with the anterior aspect of the humerus is maintained at all times as the trocar is directed toward the radial head [1].
- A 2.7-mm, 30-degree arthroscope is inserted into the joint to perform the diagnostic portion of the procedure [1].
- The superolateral portal is established with an 18-gauge needle through the lesion after pathologic tissue is identified [1].
- A full-radius resector is used to excise the capsule to identify the undersurface of the extensor carpi radialis brevis tendon [1].
- The origin of the extensor carpi radialis brevis is viewed [1].
- A curet and motorized shaver are used to debride the capsule and the pathologic tendinous attachment of the extensor carpi radialis brevis [1].
- The lateral epicondyle is decorticated [1].
- Decortication of the lateral epicondyle and lateral epicondylar ridge can be performed with an arthroscopic burr, handheld instruments, or electrocautery [1].
- A 30-degree arthroscope is adequate to view around the corner for most of the procedure [1].
- A 70-degree arthroscope may be required in rare instances [1].
- Limited internal fixation can be accomplished with cannulated screws when medial capsular injury has not occurred [1].

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

- The benefit of arthroscopy is outweighed by associated risks in more extensive fractures involving significant soft-tissue injuries [1].
- One should be fully prepared to abort the procedure when visualization is poor or fluid extravasation is significant [1].

Key Evidence

References

[1] Campbell S Operative Orthopaedics 4 Volume Set. ARTHROSCOPIC REPAIR OF POSTERIOR HUMERAL AVULSION OF THE GLENOHUMERAL LIGAMENT > ARTHROSCOPIC TENNIS ELBOW RELEASE.

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au