

Tennis Elbow — What Are My Options?

Patient information from Mendip Hand Clinic

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This leaflet sets out the treatments available for tennis elbow so that you can weigh them up before your consultation. It is designed to support, not replace, your conversation with Miss Edwards.

Written by Miss Alison Edwards, Consultant Hand Surgeon. Published: September 2026.
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A note on the numbers in this leaflet

You will notice that this leaflet describes how well each treatment works in words rather than percentages. That is deliberate. The published evidence for most tennis elbow treatments is mixed, the trials are often small, and single success rates quoted out of context give a false impression of certainty. Where a national body has reached a formal position, it is quoted and referenced. Where the honest answer is that we do not know, this leaflet says so.

What tennis elbow is

Tennis elbow, or lateral epicondylitis, is pain on the outer side of the elbow. It comes from the tendons that join the forearm muscles to the bone there — particularly a muscle called extensor carpi radialis brevis.

Despite the name it is usually not caused by tennis. It follows repetitive use of the wrist and forearm, and often there is no single event that started it.

It is also not really inflammation, which matters for treatment. What happens in the tendon is a failure of the normal healing response, with disorganised tissue rather than an inflamed one. This is why anti-inflammatory treatment gives short-term relief but does not resolve the underlying problem, and why loading the tendon does.

Typical symptoms are pain and tenderness on the outer elbow, a weak grip, and pain when gripping, lifting with the palm down, or twisting.

What happens if you do nothing

This is worth knowing before you consider anything else: tennis elbow usually settles on its own, but it takes a long time — often many months, and sometimes more than a year.

That has two consequences. It means doing nothing, while modifying the activities that provoke it, is a legitimate choice. It also means any treatment can appear to work simply because time has passed, which is why comparisons against placebo matter more here than in most conditions.

Physiotherapy and exercise

This is the first-line treatment and the one with the strongest case behind it.

The core of it is progressive loading of the tendon, particularly eccentric exercise — slowly lowering a weight, which lengthens the muscle under control. Alongside this comes activity modification, so the tendon is not repeatedly re-irritated, and advice on technique and equipment.

What to expect. Improvement is gradual, over weeks to months rather than days. It requires consistent daily effort over a sustained period. Ten minutes daily achieves more than an hour once a week.

Why it is recommended first. It addresses the tendon itself rather than masking the pain, it teaches you how to avoid a recurrence, and it is available on the NHS. There is a separate leaflet setting out the exercise programme in detail.

Corticosteroid injection

What it does. It reduces pain, often substantially and quickly.

The catch, and it is a significant one. The relief is short-lived, and the evidence indicates that people who have a steroid injection do worse in the longer term than those who do not — with higher recurrence rates. There is also concern that repeated injections can weaken the tendon.

Where it fits. It can be useful for a severe flare-up, or where pain is preventing you from starting the exercise programme at all. It is not a treatment for the underlying problem, and repeated injections are avoided.

Extracorporeal shockwave therapy (ESWT)

What it is. Targeted sound-wave pulses applied to the tendon, delivered by the physiotherapy team over a course of sessions, usually four to six. It is non-invasive and requires no anaesthetic.

What NICE says, and why you are being told this. NICE has reviewed shockwave therapy for tennis elbow that has not responded to other treatment (Interventional Procedures Guidance IPG313, 2009, now published within NICE's HealthTech guidance). NICE found no major safety concerns. However, it concluded that the evidence on how well the treatment works is inconsistent, and it makes it a condition of offering the treatment that patients are told clearly that its effectiveness is uncertain.

So this leaflet tells you plainly: shockwave therapy may help you and it may not, and the published trials do not agree with one another. It has not been shown to work better, or to last longer, than a steroid injection.

Where it fits. It is worth considering when a proper course of physiotherapy has not been enough, particularly alongside continued exercise rather than instead of it. Availability on the NHS varies by area.

Platelet-rich plasma (PRP) injection

What it is. A small amount of your own blood is taken and spun in a centrifuge to concentrate the platelets, which contain growth factors. The concentrate is then injected into the tendon, with the aim of stimulating repair.

What the evidence shows. This is an area of genuine uncertainty. Some trials report benefit over a steroid injection in the longer term; others find no advantage over placebo. Preparation methods differ between studies, which makes them difficult to compare. It is reasonable to describe PRP as promising and unproven rather than established.

Practicalities. It is not available on the NHS, it is not always covered by private insurers, and it costs more than the alternatives. There is a separate leaflet on PRP injections.

Radiotherapy (low-dose)

Low-dose radiation is occasionally used for long-standing tennis elbow that has not responded to anything else. It is slow to act, taking months for full effect, and it is rarely used. It is not usually available on the NHS.

Given how uncommonly it is used and how limited the published evidence is, it is best regarded as a last resort to discuss individually rather than a standard option.

Surgery

Surgery is rarely needed for tennis elbow. It is considered only after a sustained period — generally six to twelve months — of proper non-surgical treatment has failed, and where the pain is genuinely limiting your life.

The operation releases and debrides the damaged part of the tendon origin. It is not a quick fix: recovery involves a further period of rehabilitation, and it does not help everyone.

Putting it together

Start with exercise and give it a proper go. Most of what follows is only worth considering once a genuine, sustained loading programme has not worked. Three months is a fair trial; three weeks is not.

Be wary of anything offering fast relief. Steroid injection is the clearest example: excellent in the short term, worse in the long term.

Time is on your side. Most tennis elbow resolves eventually. The aim of treatment is to shorten that and to stop it coming back, not to rescue you from something dangerous.

Questions you may want to ask

- How long have I actually been doing the exercises properly, and is it fair to say they have failed?
- What would you expect to happen if I did nothing for another three months?
- Is there anything about my job or my hobbies that is keeping this going?
- If I try shockwave and it does not help, what have I lost?
- Am I a candidate for surgery, and what would that involve for me?

Costs

Shockwave therapy, PRP and surgery are private treatments at this clinic and are priced individually. Current prices are on the costs page of mendiphandclinic.com.

Contact details

Mendip Hand Clinic, Practice Plus Group Hospital, Old Wells Road, Shepton Mallet, Somerset BA4 4LP. Bookings: 0330 818 8981.

If you think anything in this leaflet is unclear or needs updating, please tell us using the contact details above.

A final note

This leaflet is general information and does not replace individual advice. Your own risks, alternatives and expected recovery should be discussed personally with Miss Edwards, in line with GMC guidance on decision making and consent.

References

National Institute for Health and Care Excellence. Extracorporeal shockwave therapy for refractory tennis elbow. Interventional Procedures Guidance IPG313, 2009.