



Golfers elbow has a misleading name. Plenty of people who develop it have never picked up a club. I see it in golfers, yes, but just as often in carpenters, mechanics, weight lifters, racquet sport players, office workers who grip a mouse all day, and parents who spend months carrying a growing child on one side. The common thread is not the sport. It is repetitive load through the inside of the elbow, usually where the wrist flexor tendons attach to the medial epicondyle.

When that area becomes persistently irritated, simple tasks start to feel surprisingly difficult. Shaking hands can sting. Opening a jar becomes a negotiation. A firm backswing, a heavy deadlift, even turning a screwdriver can send a sharp ache through the inner elbow. For some people the pain settles with rest and a few weeks of sensible rehab. For others it lingers for months, sometimes longer, and begins to shape daily life around what the arm cannot comfortably do.

That is where Shockwave Therapy often enters the conversation. Not as a miracle cure, and not as a replacement for good rehabilitation, but as a practical non-surgical option when standard measures have stalled. Used well, it can help reduce pain, stimulate healing in a stubborn tendon, and create a window where progressive loading becomes possible again.

## **What golfers elbow actually is**

Golfers elbow, or medial epicondylalgia, involves irritation and degeneration at the common flexor tendon on the inner side of the elbow. The tissue is usually not inflamed in the classic short-term sense, especially once symptoms have been present for several weeks or months. More often, the tendon has become overloaded and disorganized. Tiny failures in the collagen structure accumulate faster than the body can repair them.

That distinction matters because it changes the treatment mindset. A true short-lived inflammatory flare may calm down with temporary unloading and symptom control. A chronic tendon problem usually needs something more deliberate. Tendons respond to the right amount of mechanical stress. Too little, and they become deconditioned. Too much, and they stay aggravated. The challenge is finding the sweet spot.

People are often told to rest completely, wear a strap, or ice the area and hope for the best. Those approaches can help briefly, especially during a painful flare, but they rarely solve the whole problem if the tendon has been irritated for months. The tissue usually needs a combination of symptom relief, improved circulation, and a graded return to loading. Shockwave Therapy fits into that broader plan.

## **Why persistent cases are so frustrating**

The inner elbow sits at the crossroads of grip strength, wrist control, and forearm rotation. That means even basic activity can keep poking at the problem. Someone with lateral elbow pain, the classic tennis elbow pattern, can sometimes avoid irritating movements more easily. Medial elbow pain is harder to sidestep because gripping is so constant in work and sport.

Golf adds its own complications. Many recreational players try to “play through” low-level pain because the discomfort feels manageable during the round. Then the arm throbs later that evening or the next morning. I have seen this pattern in players who changed nothing except the number of balls they hit at the range. They went from one bucket a week to three, added a few heavy gym sessions, and within a month the inner elbow started talking back. The tendon was not suddenly fragile. It was simply asked to do more than it had adapted to handle.

By the time someone seeks help, the problem has often become layered. There is tendon sensitivity at the elbow, reduced forearm strength, stiffness through the wrist, poor load management, and sometimes nerve irritation in nearby tissue. That is why treatment works best when it is not framed as a single magic intervention.

## **Where Shockwave Therapy fits**

Shockwave Therapy uses acoustic waves delivered to injured tissue through a handheld device. In clinical practice, two main forms are used: focused shockwave and radial shockwave. Both aim to stimulate a healing response in stubborn soft tissue problems, though they deliver energy differently and penetrate tissue in different ways.

For golfers elbow, the goal is not to “break up scar tissue” in the simplistic way people often describe it. The more defensible explanation is that shockwave creates a controlled mechanical stimulus. That stimulus may help with pain modulation, local blood flow, tissue remodeling, and cellular signaling related to repair. Research on tendinopathies suggests it can be helpful, particularly in chronic cases that have not responded to rest, activity modification, manual therapy, or exercise alone.

This is the key point I stress with patients: Shockwave Therapy is usually most useful when symptoms have been present for a while and the tendon has become stubborn. It is less often the first thing I reach for in a brand-new case that only started last week after one overzealous practice session. Early cases often settle with load reduction, targeted exercise, and time. Chronic cases are the ones that make you start asking whether the tissue needs a stronger nudge.

## **What a treatment session feels like**

The first question most people ask is simple: “Does it hurt?” Honest answer, it can be uncomfortable. The device is applied over the tender region, and pulses are delivered over a few minutes. The sensation ranges from mildly sharp tapping to a deeper ache, depending on the machine settings, the exact tissue involved, and how irritable the elbow is that day.

A typical session is short. In many clinics it lasts roughly five to ten minutes for the shockwave portion itself, though the full appointment takes longer because assessment and exercise progression matter. Most treatment plans involve a series of sessions rather than one-off care. A common range is three to six treatments spaced about a week apart, though protocols vary.

I usually tell people to expect one of three responses. Some feel immediate post-treatment soreness that settles within a day or two. Some notice little change after the first session but gradual improvement after the second or third. A smaller group finds the area flares enough that the settings need to be adjusted or the overall plan reconsidered. That last point is important. More intensity is not always better. Tendons respond to the right dose, not the maximum dose.

## **Who tends to benefit most**

The best candidates usually share a few features. Their pain has been present long enough to be considered persistent, often beyond six to twelve weeks. The diagnosis is reasonably clear, meaning the tenderness and provocation tests fit golfers elbow rather than a different source of medial elbow pain. They have already tried at least some conservative care, such as modifying activity, changing training volume, or doing basic strengthening, but the symptoms have plateaued.

Shockwave Therapy tends to make more sense when the person also commits to rehabilitation. If someone wants a passive treatment while continuing the exact same overload pattern that caused the problem, the odds of lasting success drop. Tendons are practical tissues. They respond to what you repeatedly ask them to do.

A few examples make this clearer. A golfer in his 50s with four months of inner elbow pain, tenderness at the flexor origin, pain with resisted wrist flexion, and reduced grip strength is often a reasonable candidate if rest alone has failed. So is a tradesperson whose symptoms return every time lifting demands increase. On the other hand, a person with neck pain, tingling into the hand, and diffuse forearm symptoms may need a different workup first because not all inner elbow pain is tendon pain.

## **When it may not be the right choice**

Shockwave Therapy is not appropriate for everyone. Good screening matters, especially around the elbow, where tendon pain can overlap with nerve issues, ligament injury, and referred pain from elsewhere.

Here are the common situations where I would pause or reconsider:

- pain that appears to come from the neck, ulnar nerve, or another non-tendon source
- a recent significant trauma, especially if fracture or ligament injury is possible
- certain medical situations where the clinician advises against shockwave, such as treatment directly over a clotting problem or local infection
- someone who cannot tolerate even mild treatment pressure due to extreme irritability
- a patient looking for a stand-alone fix without any willingness to adjust load or do rehab

That list is not exhaustive, but it captures the principle. The right diagnosis comes first.

## **What the evidence suggests, and what it does not**

The evidence for shockwave in tendinopathy is encouraging but not flawless. Studies on elbow tendinopathies, plantar fasciopathy, calcific shoulder pain, and Achilles or patellar tendon issues suggest it can improve pain and

function in selected chronic cases. Outcomes vary based on the condition being treated, the type of device used, the energy settings, and whether the therapy is paired with exercise.

For golfers elbow specifically, the research base is smaller than it is for tennis elbow or plantar fasciitis. That means anyone promising guaranteed results is overselling it. Still, clinical experience and the broader tendon literature support its use as a reasonable non-surgical option when standard care has stalled.

The most grounded way to describe the evidence is this: Shockwave Therapy can help a meaningful number of people with chronic tendon pain, but it is not universally effective, and it is rarely enough on its own. It is one tool, not the whole toolbox.

## Why surgery is usually not the first answer

Surgery for golfers elbow is generally reserved for a minority of cases, usually when symptoms are severe, prolonged, and resistant to well-executed non-surgical treatment. Most people understandably want **focused shockwave therapy sessions** to avoid that route if possible. Even when surgery is appropriate, it comes with downtime, rehabilitation, and no absolute guarantee of full symptom resolution.

That is why non-surgical options matter. If the pain has lasted months and is interfering with work, training, or sport, there is a big difference between “just wait longer” and “let’s actively improve the tissue environment while rebuilding capacity.” Shockwave Therapy often sits in that middle ground. It gives clinicians a way to target a stubborn tendon without injections or surgery, while still keeping the larger rehab plan moving.

I have seen people who were close to asking for an orthopedic consult regain function once the treatment plan became more coherent. Not because shockwave performed some dramatic rescue, but because it reduced symptoms enough to let the strengthening finally progress. That distinction matters. Pain often blocks loading, and loading is what tendons ultimately need.

## The role of exercise, which matters as much as the machine

This is the part patients do not always want to hear. If your elbow has been painful for three months, no device is likely to solve it while strength, mobility, and load tolerance stay exactly as they are. Shockwave Therapy can improve the environment. Exercise changes the capacity of the tissue.

For golfers elbow, rehab usually starts with tolerable isometric work or light controlled strengthening for wrist flexion, pronation, and grip, then builds gradually. The forearm flexors are only part of the picture. Shoulder strength, thoracic position, swing mechanics, and overall training volume often influence what the elbow has to absorb.

A simple example is the golfer who returns to full practice because daily pain dropped from a six out of ten to a two. The elbow feels better, but the tendon is not automatically ready for two large buckets at the range plus eighteen holes on the weekend. Symptoms often bounce back not because treatment failed, but because the return to load outpaced tissue adaptation.

The most durable recoveries usually follow a few principles:

- reduce the loads that clearly spike pain, without shutting down all use of the arm
- build forearm strength progressively, especially grip tolerance and wrist flexor endurance
- watch the 24-hour response after activity, because tendon irritation often shows up later
- address contributing factors such as technique, equipment, or work ergonomics

- progress back to sport in stages rather than jumping from rest to full volume

Those ideas sound basic, but they are where the real gains are made.

## What golfers should change while recovering

For golfers, the biggest mistake is often volume, not one bad swing. Practice habits matter. A player may feel fine during the first twenty balls, start guarding unconsciously by ball forty, and irritate the tendon by ball seventy. Mats can be harsher than turf for some players, especially if contact is heavy and steep. Gripping the club too tightly can also increase forearm load more than most players realize.

Equipment occasionally contributes. Grips that are too small may encourage excessive squeezing. Very stiff shafts or a setup that forces awkward hand position can aggravate a sensitized elbow. This does not mean everyone with golfers elbow needs a club fitting, but when symptoms repeatedly return despite good treatment, it is worth looking at the [Shockwave Therapy](#) details.

I remember one recreational player who kept flaring up after every lesson block. His exercises were solid and his strength had improved, but his weekly routine told the real story: range session on Tuesday, gym pull work on Wednesday, another range session Thursday, and a full round Saturday. We cut the range volume in half, moved the heavy pulling work away from practice days, and kept shockwave alongside rehab. Within several weeks, the pattern changed. The important intervention was not any one piece. It was finally respecting cumulative load.

## How long improvement usually takes

People want timelines, and fair enough. Most chronic tendon cases do not turn around overnight. If Shockwave Therapy is going to help, changes often emerge over several weeks rather than after one dramatic session. Pain during daily tasks may settle first. Grip strength and tolerance for sport-specific activity usually lag behind.

A reasonable expectation is gradual improvement across a month or two, especially when treatment is combined with progressive loading. Some people feel enough relief within two to three weeks to notice a real difference at work or in the gym. Others need a longer runway, especially if symptoms have been present for many months or if they continue to face unavoidable hand-intensive work.

The longer the problem has lingered, the more patience tends to be required. That is not pessimism. It is just how tendons behave.

## Questions worth asking before you start

Not every clinic uses shockwave the same way, and the quality of the assessment matters as much as access to the machine. If you are considering treatment, ask how the diagnosis is being confirmed, whether the provider also prescribes rehabilitation, what type of shockwave is used, and what sort of response they expect after each session.

If the plan is simply “come in for the machine and see what happens,” that is usually too thin. Better care sounds more like, “We believe this is a chronic medial elbow tendon problem, here is why, here is how we will dose treatment, here is what to do between sessions, and here is how we will judge progress.” That level of clarity tends to produce better outcomes than passive treatment alone.

## Side effects, costs, and practical trade-offs

Shockwave Therapy is generally well tolerated, but it is not free of downsides. Temporary soreness is common. Some people get mild redness or local tenderness afterward. Rarely, the discomfort during treatment is the main barrier, especially when the elbow is highly irritable.

Cost can also influence the decision. Depending on the clinic and region, a course of treatment may be a meaningful out-of-pocket expense. That does not make it a poor option, but it should be weighed honestly against the likelihood of benefit and the quality of the broader rehab program. A strong exercise-based plan with clear load management is often the foundation. Shockwave adds value when it helps stubborn pain move again.

There is also the question of timing. For a fresh case that just started, I would usually invest first in diagnosis, activity modification, and targeted rehab. For a case that has lingered despite doing those things well, Shockwave Therapy becomes more attractive.

## **Relief without surgery, but not without a plan**

The best argument for Shockwave Therapy in golfers elbow is not hype. It is practicality. Many persistent tendon problems live in the grey zone between “rest will fix it” and “surgery is the next step.” That grey zone is exactly where a well-chosen non-surgical intervention can matter.

For the right patient, shockwave can reduce pain, improve function, and make rehabilitation more productive. It can help the office worker get through a day without constant aching, the tradesperson return to heavier tools, and the golfer swing without dreading the next morning’s stiffness. But the machine is only one part of the story. The lasting change usually comes from pairing symptom relief with progressive loading, sensible scheduling, and enough patience to let tendon tissue adapt.

If your inner elbow pain has become a recurring problem rather than a passing annoyance, it is worth treating it like a real tendon issue and not just a nuisance to be ignored. That shift alone often changes the outcome. Surgery is sometimes necessary, but for many people it is not the first, or best, answer. A careful diagnosis, a smart rehab plan, and Shockwave Therapy when appropriate can offer a very credible path back.

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## **FAQ About Shockwave Therapy**

### **What does shockwave therapy actually do?**

Shockwave therapy delivers high-energy acoustic sound waves through the skin to an injured area. This process "wakes up" stubborn, chronic soft-tissue injuries by increasing local blood flow, breaking down calcifications, and triggering the body's natural cellular repair and tissue regeneration mechanisms.

### **What are the drawbacks of shockwave therapy?**

Shockwave therapy can cause temporary pain, skin redness, bruising, swelling, or numbness at the treatment site. It may require multiple sessions, can be costly out-of-pocket because insurance often does not cover it, and is unsafe for pregnant individuals or those with blood-clotting disorders.

### **Does shock wave therapy really work?**

Yes, shock wave therapy (extracorporeal shockwave therapy, or ESWT) works well for specific chronic soft-tissue and bone conditions, showing success rates around 60% to 80% for stubborn issues like plantar fasciitis and tennis elbow when other conservative treatments fail.