



Golfer's elbow has a misleading name. Many of the people who develop it have never picked up a club. I see it most often in golfers, racquet sport players, tradespeople, weight lifters, office workers who grip a mouse too hard for too many hours, and parents who spend months lifting a toddler with one arm. The common thread is not the sport. It is repeated loading through the tendons on the inner side of the elbow, usually without enough recovery.

When the condition lingers, it becomes frustrating in a very specific way. The pain is not always dramatic, but it interferes with ordinary tasks. A handshake stings. Carrying grocery bags becomes irritating. Pulling open a heavy door hurts more than it should. Even holding a coffee mug can remind you that something is off. That is often the point where people start looking beyond rest, braces, and anti-inflammatory medication, and where Shockwave Therapy enters the conversation.

Done well, shockwave can be a useful treatment for stubborn golfer's elbow. Done at the wrong time, for the wrong diagnosis, or with poor rehab around it, it can disappoint. The details matter.

What golfer's elbow actually is

Golfer's elbow, or medial epicondylalgia, involves pain at the tendon attachment on the inner side of the elbow. The wrist flexor and forearm pronator muscles anchor there. These tissues help you grip, flex the wrist, and rotate the forearm. When they are overloaded again and again, the tendon can develop a degenerative pattern rather than a purely inflamed one.

That distinction matters. A lot of people still talk about tendon pain as if it is simply inflammation that needs to be calmed down. In reality, chronic tendon problems often reflect a failed healing response, microscopic tissue disorganization, sensitivity in the local nerves, and a tendon that does not tolerate load well anymore. This is one reason why quick fixes often fall flat. The tendon needs help, but it also needs the right kind of mechanical stimulus.

Symptoms usually include tenderness at the bony prominence on the inside of the elbow, pain with gripping, discomfort during resisted wrist flexion or forearm pronation, and morning stiffness or soreness after activity.

Some people also report a spreading ache into the forearm. If numbness or tingling enters the picture, especially into the ring and little finger, the ulnar nerve may be involved too, which changes management.

Where Shockwave Therapy fits

Shockwave Therapy uses acoustic pressure waves delivered into tissue through a handheld device. It sounds dramatic, but in practice it is a short in-clinic procedure. The goal is not to break tissue apart. The goal is to stimulate a healing response in a tendon that has stalled.

There are two common forms. Focused shockwave concentrates energy at a specific depth and is often used for deeper or more precise targets. Radial shockwave spreads energy more broadly and is frequently used in sports medicine and musculoskeletal clinics. Both are used for tendon conditions, though clinics differ in preference and equipment.

For golfer's elbow, shockwave is usually considered when symptoms have been present for several weeks to several months, especially after basic care has not been enough. It is rarely my first move for a brand-new flare-up that started two weeks ago after an unusually hard weekend of golf. In that early phase, load modification, technique review, and a simple exercise plan often work well. Shockwave becomes more attractive when pain keeps returning, grip strength drops, and the tendon remains irritable despite sensible rehab.

How shockwave is thought to help

[Shockwave Therapy](#)

The exact mechanisms are still being studied, but the clinical reasoning is fairly consistent. Shockwave appears to create a controlled mechanical stimulus that nudges tissue toward repair. It may improve local blood flow, influence pain signaling, and stimulate cellular activity involved in tendon remodeling. Some patients also seem to get an analgesic effect that makes it easier to start or progress strengthening work.

That last point is often overlooked. Shockwave should not be treated as a stand-alone magic wand. Tendons generally recover best when a symptom-guided loading program follows. In real practice, the best results usually happen when shockwave reduces irritability enough for the patient to rebuild capacity through exercise.

This is why results can look uneven online. One person has three sessions, keeps overloading the arm between visits, does no rehab, and says it failed. Another person combines treatment with changes in grip mechanics, reduces aggravating volume for a few weeks, and gradually restores strength, and they call it a turning point. Both experiences are believable.

What a treatment course usually looks like

Most clinics provide shockwave once a week for three to five sessions, though some extend to six depending on severity, chronicity, and response. The treatment itself is brief. The area is identified by symptoms, palpation, and functional testing, then the device is applied over the tender tendon region and sometimes into the involved muscle-tendon junction in the forearm.

Intensity is adjusted based on the device, the target tissue, and patient tolerance. It should feel uncomfortable, sometimes sharply so, but usually not intolerable. People often describe it as a rapid tapping or snapping sensation over a bruised area. That description is not elegant, but it is accurate.

A typical appointment may include reassessment of pain with grip or wrist loading, the shockwave treatment, then progression of a home program. If a clinic simply applies the device for a few minutes and sends you out

with no guidance, that is a missed opportunity.

What patients often notice after a session

Responses vary, but a common pattern looks like this:

1. The area feels sore for a day or two, similar to a deep bruise.
2. Pain may briefly spike before settling.
3. Daily tasks sometimes feel a little easier within one to two weeks.
4. Grip-related pain often improves before heavier lifting does.
5. Meaningful change usually unfolds over several weeks, not overnight.

That gradual timeline matters. Tendons are slow responders. If someone expects complete relief after one visit, disappointment is almost guaranteed.

What the evidence suggests, without overselling it

The research base for shockwave in elbow tendon pain is stronger for tennis elbow than golfer's elbow, simply because lateral elbow pain has been studied more. Even so, clinical use for medial elbow tendinopathy is fairly common, and the rationale is similar. Studies across tendon disorders suggest shockwave can reduce pain and improve function in selected patients, particularly those with chronic symptoms who have not improved with simpler measures.

The key phrase is selected patients. Shockwave is not a universal answer for every sore elbow. It tends to perform best in chronic tendinopathy rather than acute inflammatory pain, obvious nerve irritation, or pain coming from the neck, shoulder, or joint itself. It also tends to work better when combined with a structured strengthening plan.

In practice, I would describe the expected results this way: many patients notice moderate improvement, some notice substantial improvement, and a minority notice little change. That is not marketing language, but it is honest. If an elbow problem has been simmering for six months, there are no guarantees. Still, shockwave is often worth considering because the downsides are relatively limited compared with injections or surgery.

Who is most likely to benefit

The patients who tend to do well usually share a few features. Their pain is localized to the medial epicondyle or nearby tendon tissue. It is provoked by gripping, wrist flexion, or pronation under load. Symptoms have persisted long enough that simple rest has clearly failed. There is no major tear, fracture, or nerve problem driving the picture. Most important, they are willing to pair treatment with exercise and temporary load modification.

A common example is the recreational golfer in their forties or fifties who developed gradual pain over a season, kept playing through it, rested for two weeks, felt a little better, then relapsed immediately on return. Another is the strength trainee who can bench press but cannot tolerate chin-ups, rows, or heavy carries without sharp medial elbow pain. These are often good shockwave candidates if the diagnosis is solid.

When shockwave is the wrong tool

Not every inner elbow pain problem is golfer's elbow. That sounds obvious, but misdiagnosis is one of the biggest reasons treatments fail.

Inner elbow pain can also come from ulnar nerve irritation, cervical referral, ligament injury in overhead athletes, joint pathology, or pain generated by the flexor-pronator muscles more than the tendon itself. A baseball pitcher with medial elbow instability is a very different case from an office worker with chronic tendon overload. Applying shockwave without sorting that out first is poor care.

There are also standard precautions and contraindications. Pregnancy, local infection, malignancy in the treatment area, active bleeding issues, and certain implanted devices may require avoidance or extra caution, depending on the device and clinic protocol. This is why a proper assessment matters before the first treatment.

The role of exercise, and why it cannot be skipped

If I had to choose between shockwave without rehab and rehab without shockwave, I would usually choose rehab. That is not because shockwave lacks value. It is because tendons need load tolerance rebuilt. Pain relief alone does not restore capacity.

For golfer's elbow, that usually starts with controlled loading of the wrist flexors and forearm pronators. Early on, isometrics can help calm pain. Then the program typically progresses to slow resistance work, grip strengthening, forearm endurance, and eventually the specific demands that caused the problem in the first place. For a golfer, that may include return-to-swing progressions and grip modifications. For a tradesperson, it may involve hammering, carrying, or tool use tolerances.

The dosage matters. Too little load and the tendon does not adapt. Too much load and it flares. The sweet spot is often "challenging but tolerable," with discomfort during exercise allowed within reason as long as pain settles afterward and the next day is not significantly worse. That kind of judgment is more valuable than any gadget.

What recovery really looks like

Recovery from golfer's elbow is often uneven. People want a straight line. Tendons rarely offer one. A patient may feel 30 percent better after two weeks, then aggravate it lifting a suitcase, then improve again over the next month. That does not necessarily mean the treatment failed. It means the tissue is regaining resilience gradually.

For mild to moderate chronic cases, a realistic time frame for clear improvement is often four to eight weeks. More stubborn cases may take two to three months, sometimes longer. Full return to high-load activity depends on symptom duration, job demands, age, total training volume, sleep, metabolic health, and whether the aggravating mechanics were corrected.

One pattern shows up repeatedly. Patients who respect the recovery window usually progress faster than those who "test" the elbow every day with max grip efforts, heavy curls, or a full round of golf after the second session because it felt a bit better. Tendons do not reward impatience.

Comparing shockwave with other common treatments

There is no single best treatment for every case, but it helps to understand where shockwave sits among the usual options.

Treatment	What it may help with	Limitations	--- --- ---	Activity modification	Reduces irritation quickly
Does not rebuild tendon capacity by itself		Bracing or straps	Can reduce pain during tasks	Often temporary symptom control	
Exercise therapy	Best long-term foundation	Requires consistency and progression		Corticosteroid injection	Short-term pain relief in some cases
Relapse is common, tendon quality may be a concern		Shockwave Therapy	Useful for chronic, stubborn tendon pain	Not instant, works best with rehab	

Platelet-rich plasma is another option people ask about often. It may help in some chronic tendinopathies, but the cost is usually higher, protocols vary, and results are mixed enough that I would not call it an automatic next step. Surgery remains a later option for a small subset of patients who fail prolonged conservative care, typically after many ***You can find out more*** months.

What shockwave feels like, honestly

Most patients want a plain answer to this, not a polished one. Yes, it can hurt during the session. The inner elbow is a sensitive area, and tendons that have been painful for months are rarely delighted to be treated. That said, the discomfort is brief, controllable, and usually manageable when the clinician adjusts energy levels sensibly.

I have seen a wide range of reactions. Some people barely flinch. Others grip the edge of the table and need short pauses. Pain tolerance, tissue sensitivity, and device settings all influence the experience. Good clinicians communicate throughout the session and avoid turning treatment into an endurance contest.

Afterward, mild soreness is common. Significant bruising is less common. Most people can return to normal light use the same day, but I usually advise against heavy gripping or intense forearm work for a short period after treatment, depending on the overall plan.

Practical advice if you are considering it

Choose the clinic as carefully as the treatment. Shockwave is easy to market and easy to oversimplify. What you want is not just a machine. You want someone who can confirm the diagnosis, explain why shockwave is or is not appropriate, and integrate it into a larger recovery strategy.

Look for a clinician who assesses neck, shoulder, wrist, and nerve contribution if needed, tests grip or resisted movements, asks about work and training demands, and gives you a progression plan rather than vague instructions to “take it easy.” That level of care matters more than flashy branding.

Here are a few useful questions to ask before starting:

1. Do you think this is truly golfer’s elbow, or could it be something else?
2. How many sessions do you usually recommend for cases like mine?
3. What kind of exercise program should I do alongside treatment?
4. What activities should I reduce temporarily, and for how long?
5. When would you expect to see progress, and what if I do not?

Those questions tend to reveal very quickly whether the clinic has a thoughtful process or a one-size-fits-all sales script.

Realistic expectations for results

The best way to think about shockwave is as a catalyst, not a miracle. In the right patient, it can reduce pain, improve function, and help restart progress when the elbow has been stuck. It can be especially valuable for people who have plateaued with rest alone and are not ready to consider injections or surgery.

But “results” should be defined carefully. For some patients, success means they can work a full day without constant aching. For others, it means returning to golf, pull-ups, climbing, or racquet sports. Sometimes the first win is simple: pain while opening jars drops from a seven out of ten to a three, and grip confidence starts to come back. Those small functional gains often arrive before complete pain resolution.

The patients who are happiest with shockwave are usually the ones who understand that recovery is a process. They know the treatment may irritate the area briefly, that strength work still needs to happen, and that a tendon irritated for six months is unlikely to normalize in six days.

The bottom line for chronic medial elbow pain

Shockwave Therapy has a legitimate place in treating golfer's elbow, particularly when symptoms are chronic, localized, and resistant to basic care. It is not the first tool for every sore elbow, and it is not a substitute for thoughtful rehab. Still, when used for the right problem and paired with progressive loading, it can be one of the more useful non-surgical options available.

If your inner elbow pain has become a stubborn companion, the most important step is not chasing the latest device. It is getting the diagnosis right, understanding what keeps the tendon irritated, and choosing treatment that matches the stage of the condition. Shockwave can be part of that plan, and sometimes a very effective part, but the best results usually come from the combination of precise treatment, patient timing, and disciplined follow-through.

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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.