

Magnetic Resonance Imaging (MRI) of Patients with Lateral Epicondylitis

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Abstract

Background:Aim: The aim of the study is to evaluate the role of magnetic resonance imaging (MRI) in determining radiological severity of chronic lateral epicondylitis in comparison with patient clinical symptoms. **Material and Methods:** A randomized study was conducted in the Department of radiology at Aaruppadaiveedu medical college & hospital, India. The study group comprised 100 consecutive patients (70 men and 30 women) with a clinical diagnosis of chronic lateral epicondylitis, which were examined on Philips Achieva 1.5 T MR System. An MRI scoring system was used to grade the degree of tendinopathy. Clinical symptoms were assessed using the Patient Rated Tennis Elbow Evaluation (PRTEE). **Results:** 100 elbows had MRI assessed tendinopathy, that includes 42(42%) with grade 1, 31 (31%) with grade 2, and 27(27%) with grade 3. The average intra-observer agreement for grading the severity of tendinopathy was 80.17%. Weighted kappa values for intra-observer reliability were 0.79, 0.74, and 0.89 ($P < 0.001$) for radiologists, respectively. An overall weighted kappa value of 0.72 indicates good inter-observer reliability. The median PRTEE score of all patients was 77 (range 8– 96), the median PRTEE score of tendinopathy score 1 was 18, the median PRTEE score of tendinopathy score 2 was 22, and the median PRTEE score of tendinopathy score 3 was 60. The PRTEE scores were gradually increased with the tendinopathy scores. Spearman's test showed a significantly positive correlation between tendinopathy scores and PRTEE scores (correlation coefficient $r = 0.95$, $P < 0.01$). **Conclusion:** MRI is a reliable tool in determining radiological severity of chronic lateral epicondylitis. The severity of MR signal changes positively correlate with the patient's clinical symptom.

Keywords: Magnetic resonance imaging, lateral epicondylitis.

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Introduction

Lateral epicondylitis is caused by repetitive stress of the wrist/ forearm extensor and supinator muscles. It involves the common extensor tendon (CET), and its origin of extensor carpi radialis brevis, longus; extensor digitorum, extensor digiti minimi and extensor carpi ulnaris tendons. Histopathologically the affected tendon shows microtear, progressive mucoid degeneration, immature repair, and angiofibroblastic tendinosis.^[1-3] The term "epicondylitis" actually is a misnomer, because the condition does not exactly feature acute or chronic inflammatory cells thereby suggesting "lateral elbow tendinopathy" as a more appropriate term. Histological studies have shown mucinous degeneration and angiofibroblastic hyperplasia within the tendon leading to partial or complete tear.^[4-6] The diagnostic gold standard of lateral epicondylitis is essentially clinical examination. Radiographic film image and ultrasound are also helpful to clinical diagnosis, and MR imaging is not needed initially. However, when some symptoms are resistant to medical management,^[6] it is necessary to investigate with MRI, which can provide additional information about other abnormalities.

The gold standard diagnosis of lateral epicondylitis is essentially the clinical history and examination. Patients complain of pain in the lateral elbow that is typically exacerbated by digital resisting and wrist extension. At physical examination, patients demonstrate localized tenderness at the CET.^[7] Magnetic resonance imaging (MRI) has an excellent contrast resolution of soft tissue and have demonstrated acceptable levels of sensitivity, specificity, and accuracy in the diagnosis of lateral epicondylitis.^[8-10]

Material and Methods

A randomized study was conducted in the Department of radiology at Aarupadaiveedu medical college & hospital, Pondicherry, India after taking the approval of the protocol review committee and institutional ethics committee. 100 consecutive patients with a clinical diagnosis of chronic lateral epicondylitis were evaluated. There were 70 men and 30 women with a mean age of 45.7 years (range, 20–55 years). The average total duration of symptoms was 1.6 years. None of the patients underwent corticosteroid injection within 4 months of MR examination. No patients had received surgical treatment before MRI assessment. Plain radiography of the elbow had been performed to exclude the possibility of bony pathology such as osteoarthritis or intra-articular loose bodies. All subjects had an MRI assessment of the affected arms using a 1.5-Tesla MR system with a dedicated surface coil employed. Examination was performed in supine position with the affected elbow extended and the palms in supination. In order to obtain high-quality images, the affected arms were placed as close as possible to the center of the MR scanner. Parameters of MRI sequences are provided in [Table 3]. All MR images were interpreted separately by 3 radiologists, who were blinded to all clinical information and were not aware of the severity of disease. Each reader reviewed the images on 3 separate occasions at least 3 weeks apart. A scoring system was devised to grade the severity of tendinopathy at the lateral epicondyle [Table 4]; this system was a modified system devised by Walz et al.^[11] All individuals had a standardized clinical assessment with a validate instrument called Patient-Rated Tennis Elbow Evaluation (PRTEE),^[12] the questionnaire include 2 parts: Part 1 deal with pain (5 questions graded 0 to 10) and part 2 deal with functional disability (10 questions graded 0 to 10). Part 2 is subdivided into specific (eg, turning a doorknob) and usual (dressing, washing) activities. Functional scores are then halved and added to pains scores. The minimum obtainable score is 0 (no pain or disability) and the maximum is 100 (severe pain and disability).

Overall agreement for MRI score was calculated. An inter- and intra-observer reliability analysis, using a linear-weighted Fleiss' kappa statistic, was performed to determine consistency of the 3 radiologists. Kappa value of 0.41 to 0.60 was considered to represent fair agreement: 0.61 to 0.80 good and 0.81 to 1.00 excellent agreements. In the second step, following the kappa test, the MR score for each observation from 3 experts were averaged, and the obtained value was correlated with the standardized clinical assessment measure by using Spearman's rank correlation test. And the correlation was considered significant at $P < 0.05$.

Results

A total of 100 elbows (68 right, 32 left) in 100 patients were included in this study, of all the patients, 100 elbows had MRI assessed tendinopathy, that includes 42(42%) with grade 1, 31 (31%) with grade 2, and 27(27%) with grade 3. The average intra-observer agreement for grading the severity of tendinopathy was 80.17%. Weighted kappa values for intra-observer reliability were 0.79, 0.74, and 0.89 ($P < 0.001$) for radiologists, respectively. An overall weighted kappa value of 0.72 indicates good inter-observer reliability¹³. The median PRTEE score of all patients was 77 (range 8– 96), the median PRTEE score of tendinopathy score 1 was 18, the median PRTEE score of tendinopathy score 2 was 22, and the median PRTEE

score of tendinopathy score 3 was 60. The PRTEE scores were gradually increased with the tendinopathy scores. Spearman's test showed a significantly positive correlation between tendinopathy scores and PRTEE scores (correlation coefficient $r = 0.95$, $P < 0.01$).

Table 1: Demographic Profile of Patients

Gender	N=100	Percentage
Male	67	67
Female	33	33
Age (years)		
Below 20 years	2	2
20-30	28	28
30-40	43	43
40-50	21	21
Above 50	6	6

Table 2: MRI assessed tendinopathy

Parameter	N=100	Percentage
Grade 1	42	42%
Grade 2	31	31%
Grade 3	27	27%

Table 3: Parameters of MRI Sequences

Plane	Sequence	TR (ms)	TE (ms)	ETL	Matrix	BW (Hz)	FOV mm	Thickness (mm)	Gap (mm)
Coronal	T1 FSE	800	24	4	310 × 256	17	160	2.5	0.25
Coronal	T2 FS FRFSE	2000	51	10	310 × 256	33	160	2.5	0.25
Axial	T1 FSE	800	17	5	310 × 256	17	180	2.5	0.25
Axial	T2 FS FRFSE	2380	46	12	310 × 256	33	180	2.5	0.25
Sagittal	T1 FSE	800	26	5	310 × 256	17	160	2.5	0.25
Sagittal	T2 FS FRFSE	2000	46	14	310 × 256	33	160	2.5	0.25

BW ¼ bandwidth, ETL ¼ echo train length, FOV ¼ field of view, FRFSE ¼ fast recovery fast spin echo, FS ¼ fat saturated, FSE ¼ fast spin echo, TE ¼ echo time, TR ¼ repetition time.

Table 4: The Classification of the CET

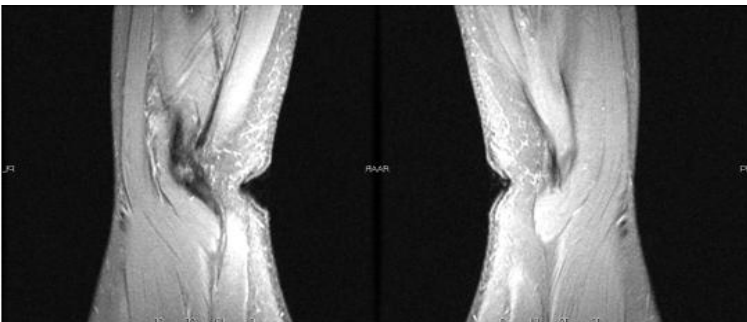
Tendinopathy Score	MR Findings of CET
Normal/mild	Complete homogenous low intensity or mild focal increase in the tendon signal on fat- suppressed T2 images not equal to that of fluid
Moderate	Moderate focal increase in the tendon signal not equal to that of fluid
Severe	Marked a generalized focal increase in the tendon signal with or without frank fluid signal intensity

CET ¼ common extensor tendon

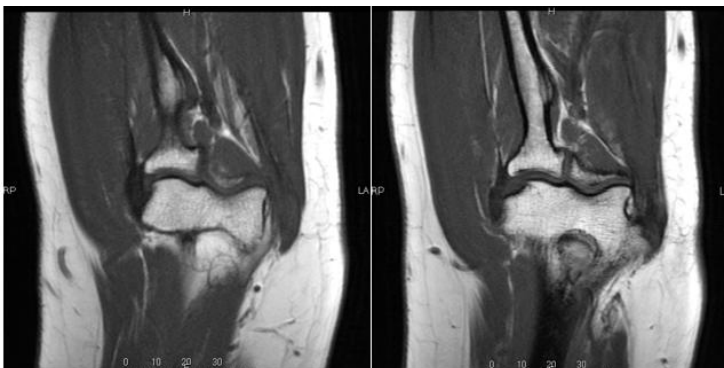
Grade 1 Injury of CET and associated injury of LUCL Complex



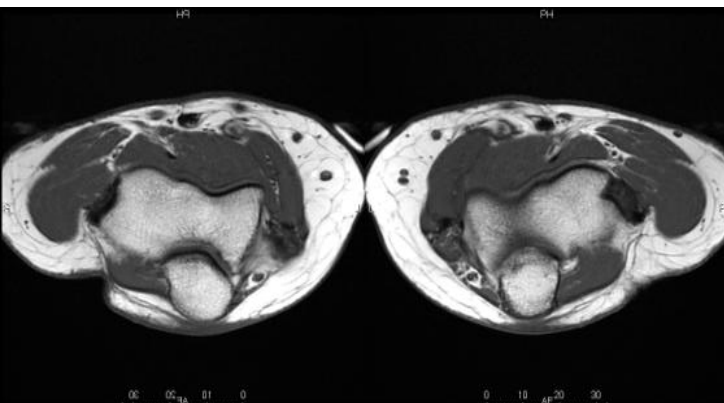
CORONAL STIR



SAGITTAL STIR

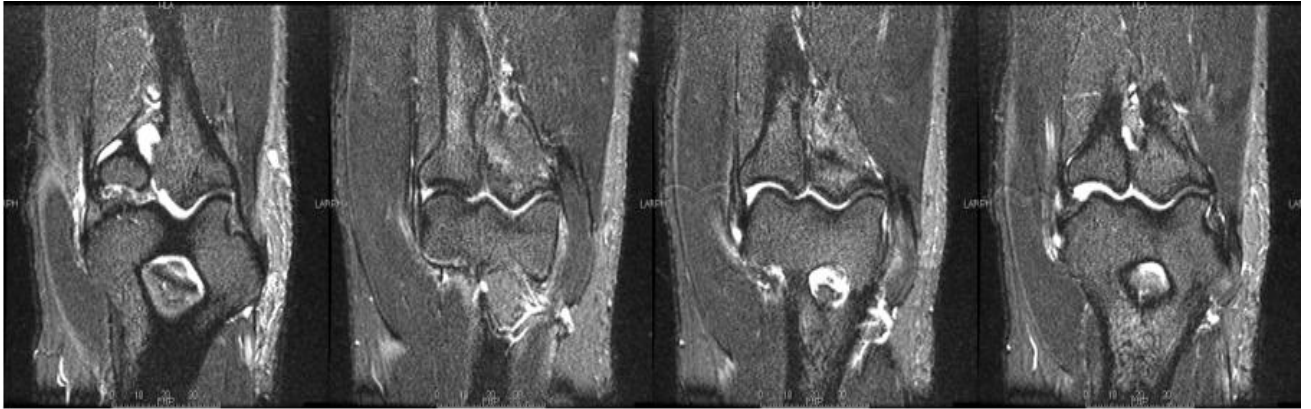


CORONAL T1

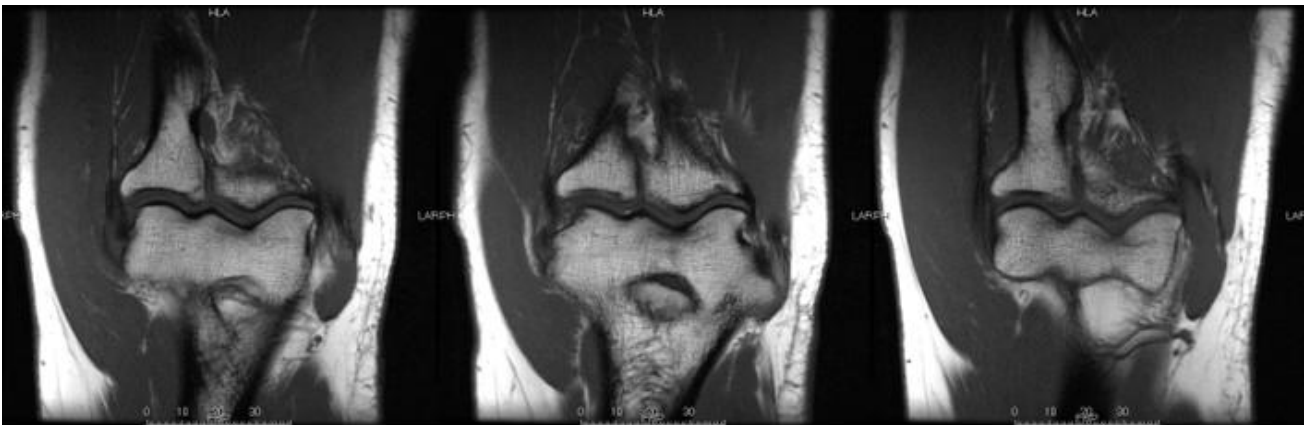


AXIAL T2

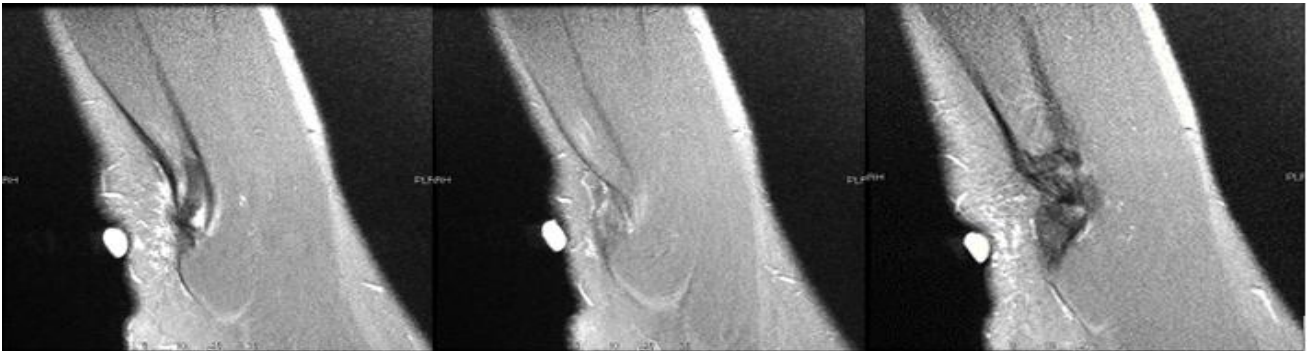
Grade 2 Injury of CET and Associated Injury to LUCL Complex



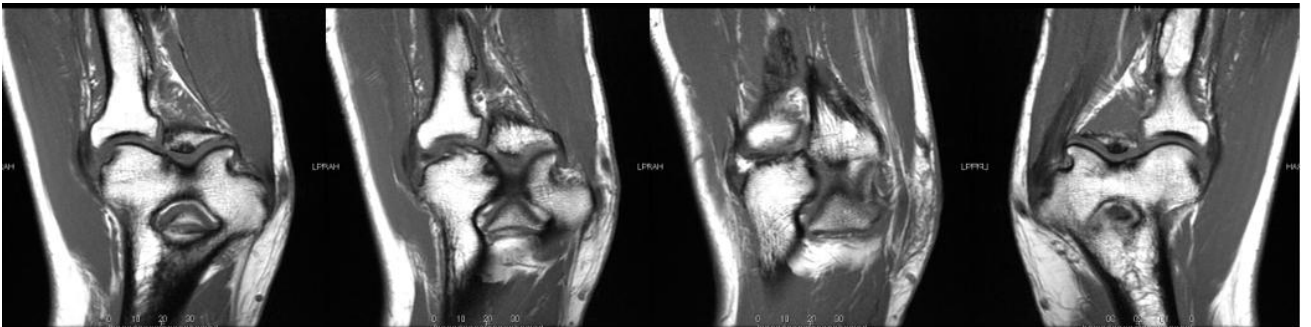
CORONAL STIR



CORONAL PD



SAGITTAL STIR

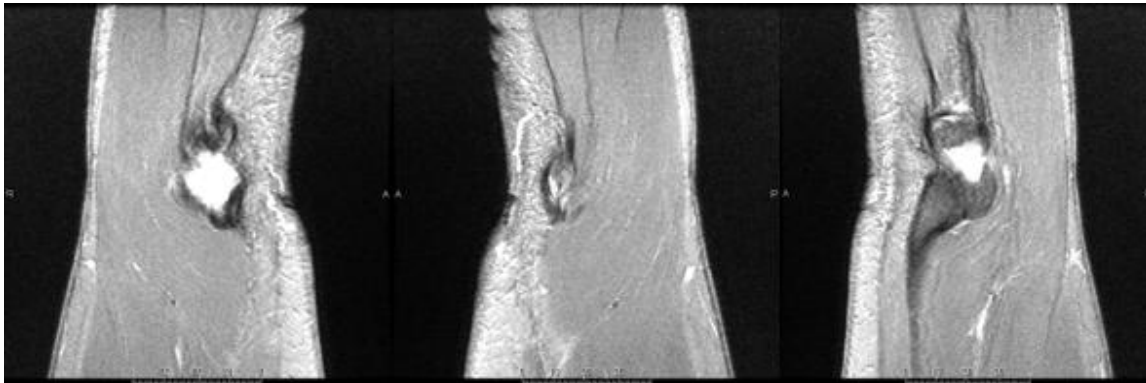


CORONAL T1

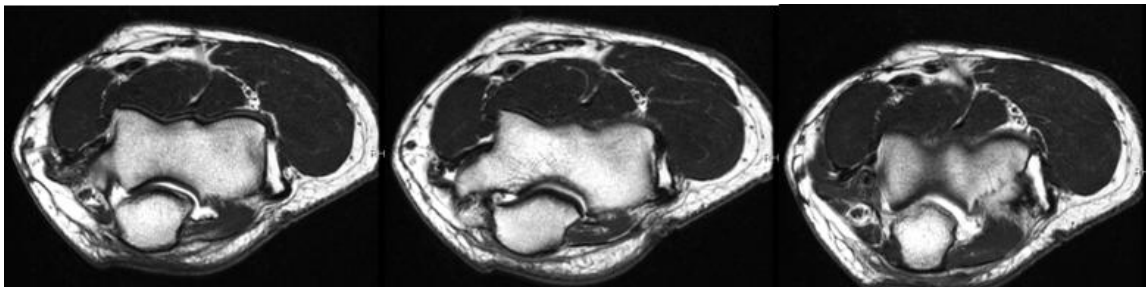
Grade 3 Injury of CET and Associated Injury of LUCL Complex



CORONAL STIR



SAG STIR



AXIAL T2



CORONAL T1

Discussion

Lateral epicondylitis or tennis elbow is a pathologic condition of the CET.^[14] The accepted cause is tendon injury often secondary to repetitive contractions of the forearm extensor muscles.^[15] This lead to disruption of the internal structure of the tendon and degeneration of the cells and matrix, which ultimately leads to macroscopic tear and tendon failure.^[16] Diagnosis of lateral epicondylitis is often made clinically; patients exhibit a continuum of symptoms that range relatively mild, yet persistent, annoyances during daily activities to severe and significantly limiting symptoms in all most facets of life. There have been many outcome measures to stratify patients according to their symptoms such as the visual analog scale (VAS),^[17] the Disabilities of Arm, Shoulder and Hand (DASH) Questionnaire,^[18] and the Upper Extremity Function Scale (UEFS).^[19] However, these measures may not accurately assess the symptoms and functions of an individual joint. They are lengthy and contain questions irrelevant to a specific problem or procedure.^[17] The Patient-rated Tennis Elbow Evaluation (PRTEE) questionnaire was developed by MacDermid and colleagues focusing exclusively on patients with lateral epicondylitis.^[20] In Romper's study,^[12] it demonstrated that the PRTEE was a reliable, reproducible, and sensitive instrument to evaluate lateral epicondylitis, and had a higher standardized response means (SRM) than the other outcome measures. Thus, in our study, we chose the PRTEE as the clinical assessment for patients with lateral epicondylitis. The appearance of tendinopathy in lateral epicondylitis on MRI includes an increased signal within or around the CET, tendon thickening, and a discrete collection of fluid between the lateral collateral ligament.^[21,22] The series by Potter et al and Steinborn et al reported that MR assessment of lateral epicondylitis correlated well with surgical and histologic findings.^[23] Some previous studies have demonstrated that individuals with diagnosis of lateral epicondylitis are statistically more likely to have signal changes on MRI than that of controls.^[24,25] This is also confirmed by a meta-analysis study showing that 90% of patients with lateral epicondylitis had abnormal signal in CET of affected elbows compared with 14% of controls.^[26] We have confirmed in this study, in accordance with previous studies,^[21,24-26] that the majority of patients with clinical diagnosis of chronic lateral epicondylitis have signal changes on MR. The studies by Walton et al,^[27] and Martin et al,^[21] reported that there was a good MRI inter- and intraobserver reliability in the assessment of tendinopathy; we have also confirmed that the severity of MRI signal changes can be reliably interpreted by different radiologists and at multiple views. So far, the relationship between MRI findings in CET and the clinical symptom of lateral epicondylitis is still much less clear. The study by Savnik et al,^[25] commented that there was no difference in the pain level in patients with and without MR signal changes. However, in our study, we find that there is a positive correlation between the degree of MRI signal changes and the PRTEE. The discrepant results might be due to the different methods of clinical assessments of lateral epicondylitis. In Savnik's study, the clinical assessment did not include any other functional deficits. The study Clarke AWet al ultrasound also demonstrated that the changes of CET positively correlates with clinical symptoms of patients with lateral epicondylitis.^[28] Therefore, for the patients with mild lateral epicondylitis evaluated by PRTEE, the CET often shows mild focal increased signal intensity on MR T2WI images, which suggests the presence of mild injury, the treatment initially is conservative and consists of rest and activity modification, if the clinical symptoms progress, an MR examination should be recommended; for the patients with moderate lateral epicondylitis evaluated by PRTEE, CET often portrays moderate focal increased intensity reflecting the moderate injury of CET whereas severe lateral epicondylitis evaluated by PRTEE, CET often depicts generalized focal increased signal intensity on MR T2WI images, suggesting severe injury of CET. Previous studies^[29-31] indicate that these patients may also accompany with other

abnormalities, such as lateral ligament injury, bone injury and edema of the wrist extensors muscles. Conclusively for the better clinical treatment including physiotherapy strengthening exercises, corticosteroid injection, and surgery, a total and a comprehensive assessment of elbow is needed which can be well acquired with the help of MRI. This study has some weaknesses. Few patients for whom the diagnosis of chronic lateral epicondylitis was confirmed surgically. Some patients in this study had received some therapy such as wrist or forearm strap; physiotherapy strengthening exercises which may influence the results of MR or clinical assessment.

Conclusion

MRI is a reliable tool in determining radiological severity of chronic lateral epicondylitis. The severity of MR signal changes positively correlate with the patient's clinical symptom.

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