The Electrodiagnosis of Ulnar Nerve Entrapment at the Elbow

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ABSTRACT: Entrapment of the ulnar nerve at the elbow is the second most common focal peripheral neuropathy. Recent advances have facilitated the electrodiagnosis of this common nerve entrapment. The goals of electrodiagnosis are to localize ulnar nerve dysfunction, confirm that the disturbance is confined to the ulnar nerve, and assess the severity of ulnar nerve dysfunction. The goal of this review is to highlight the important advances in anatomy, neurophysiology and methodology that impact upon the electrodiagnosis of entrapment of the ulnar nerve at the elbow, illustrate the limits of electrodiagnosis, and discuss methodological issues that may be the subject of further study. Careful attention to elbow position, temperature, and conservative estimates of conduction block should be part of common practice. Awareness of anatomical variations in structural anatomy, anomalous innervation and fascicular arrangement of ulnar nerve fibers are required to interpret electrodiagnostic studies accurately. The most reliable finding is slowing of the ulnar across-elbow motor nerve conduction velocity to less than 50 m/sec while recording from the abductor digiti minimi muscle, and should be carefully interpreted in the presence of a polyneuropathy or other neurogenic process. Alternative techniques such as relative ulnar slowing in different ulnar nerve segments, use of alternative muscles, sensory and mixed nerve techniques provide complementary information, and like all nerve conduction studies are highly operator-dependent and should be used on a case by case basis. Recent studies have focused the electromyographer’s attention on the use of shorter across-elbow segments (2-5 cm). This may offer a reasonable trade-off between sensitivity and measurement error and may result in improved electrodiagnosis.

Methods

A literature search was undertaken of computerized databases (PREMEDLINE and MEDLINE 1966-2002; Embase 1980-2002; HealthSTAR/Ovid Healthstar 1975-2002; and CINAHL 1982-2002), using the medical subject headings “ulnar neuropathy” and “diagnosis”. Hand searches of “Muscle & Nerve”, “Neurology”, “Annals of Neurology”, “Journal of Neurology Neurosurgery and Psychiatry”, as well as relevant review articles and textbooks yielded additional articles. In total, 395 references were identified and 67/395 that specifically addressed UN-E were selected for this review.

Anatomic considerations

A clear understanding of ulnar nerve anatomy and the various known anomalous innervation patterns are necessary to accurately diagnose UN-E. The selection of appropriate nerve stimulation sites, ‘across elbow’ nerve segment length and interpretation of needle electromyography (EMG) findings depends on awareness of the normal anatomic relationships of the ulnar nerve and upper extremity structures. In the upper arm, the ulnar nerve travels through the medial intermuscular septum (arcade of Struthers) and passes into the posterior compartment of the arm. It then travels adjacent to the medial head of the triceps before passing into the ulnar groove between the medial epicondyle and olecranon. As many as 10% of individuals possess an anomalous epitrochleoanconeus muscle or fibrous epicondyle and olecranon. As many as 10% of individuals possess an anomalous epitrochleoanconeus muscle or fibrous band spanning between the medial epicondyle and olecranon. 9

The ulnar nerve then passes beneath the humeroulnar arcade formed by the aponeurotic arch of the flexor carpi ulnaris muscle and enters the cubital tunnel – there is considerable variability in the anatomic arrangement of this flexor retinaculum 9 (Figure).

After traveling through the cubital tunnel, 10 the ulnar nerve pierces the flexor carpi ulnaris muscle approximately 4 centimeters distal to the medial epicondyne (a potential site of entrapment 11) – this establishes a distal limit to below-elbow stimulation in across-elbow motor nerve conduction studies due to the deep location of the ulnar nerve. At the wrist, the ulnar nerve then passes through Guyon’s canal (between the pisiform bone and the hook of the hamate) and divides into superficial and deep branches.

The ulnar nerve innervates two forearm muscles and most of the intrinsic hand muscles. Ulnar branches to flexor carpi ulnaris and the flexor digitorum profundus muscles usually arise at or below the elbow. Infrequently, the flexor carpi ulnaris branch arises proximal to the elbow and is spared in UN-E. 12 The deep ulnar branch at the wrist supplies the hypothenar muscles, all the interossei, the third and fourth lumbricals, and the adductor pollicis muscle. The palmar and dorsal ulnar cutaneous sensory branches arise proximal to the wrist and supply sensation to the proximal ulnar border of the palm and dorsal ulnar sensory territories. The superficial terminal branch supplies the distal ulnar border of the palm and the palmar digital nerves that supply the fourth and fifth digits.

The dynamic anatomy of the ulnar nerve at the elbow is an important consideration in choosing elbow position in across-elbow motor nerve conduction study (MNCS). When the elbow is flexed, the ulnar nerve may be compromised as the flexor carpi ulnaris aponeurosis tightens and decreases cubital tunnel volume, as the concave condylar groove flattens and as the medial head of the triceps pushes against the nerve posteriorly. 13-15 Ultimately, the nerve may be stretched tightly around the median epicondyle 16 and may slide up to 1.4 cm distally or completely sublux out of its groove in many normal individuals. 17 The nerve may be compressed at the edge of the humeroulnar arcade or within the cubital tunnel due to a rise in pressure with elbow flexion. 18 In cubitus varus deformities the medial triceps muscle may displace the ulnar nerve over the median epicondyle 19 and this may contribute to UN-E. 20,21

Anomalous innervation must be considered in the interpretation of ulnar MNCS and needle EMG. The Martin-Gruber anastomosis occurs in approximately 17% of the population 22 and consists of motor axons that travel with the median nerve at the elbow and cross to the ulnar nerve below the elbow to innervate the first dorsal interosseous and other ulnar innervated hand muscles. Occasionally the crossover will occur proximal to the site of below elbow stimulation and simulate conduction block. 23 The Riches-Cannieu anastomosis is a rare anomaly in which anomalous motor responses may be recorded from the abductor pollicis brevis muscle following ulnar nerve stimulation at the wrist and elbow. 24 In the presence of this anomalous innervation, the MNCS and needle EMG findings in UN-E would require careful interpretation.

Fascicular involvement in ulnar neuropathy is a well-recognized phenomenon. 12,25 It explains the reported relative sparing of the flexor carpi ulnaris and dorsal ulnar cutaneous sensory fibers and preferential involvement of the first dorsal intersosseous muscle in UN-E. Sunderland 26 observed that the flexor carpi ulnaris and flexor digitorum profundus fibers occupied a deeper intraneural location than those innervating the intrinsic hand muscles. Appreciation of the selective vulnerability of ulnar nerve fascicles assists in the interpretation of UN-E diagnostic studies.
Table: Summary of AAEM Practice Parameter Statement.

<table>
<thead>
<tr>
<th>Technical Issues</th>
<th>Electrodiagnostic guidelines</th>
<th>Practice options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Monitor limb temperature</td>
<td>• Normal above elbow-below elbow MNCV ≥ 50 m/sec</td>
<td>• First dorsal interosseous MNCS</td>
</tr>
<tr>
<td>• Test other nerves if ulnar abnormal</td>
<td>• Normal across elbow-below elbow and below elbow-wrist MNCV difference ≤10 m/sec</td>
<td>• Flexor Carpi Ulnaris or Flexor Digitorum Profundus MNCS</td>
</tr>
<tr>
<td>• Specify elbow position (70-90 degrees)</td>
<td>• Normal below elbow-above elbow CMAP amplitude reduction ≤20%</td>
<td>• Short segment stimulation (‘inching’) study</td>
</tr>
<tr>
<td>• Avoid stimulation &gt; 3 cm distal to medial epicondyle</td>
<td>• Temporal dispersion (no recommendation)</td>
<td>• CNAP Study</td>
</tr>
<tr>
<td>• Exclude Martin-Gruber anastomosis</td>
<td>• Axilla-above elbow and above elbow-below elbow MNCV difference (no recommendation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Needle EMG should include study of first dorsal interosseous muscle</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: MNCV - motor nerve conduction velocity; MNCS - motor nerve conduction study; CNAP - compound nerve action potential; CMAP - compound motor action potential.

Practice parameter standards

The AAEM and AAN practice parameter statements27,28 were jointly developed by the AAEM Quality Assurance Committee and the AAN Quality Standards Subcommittee in 1999. The recommendations are outlined in the Table.

Methodological issues

a. Elbow position

The AAEM standards recommend a 70-90 degree elbow position to provide the greatest correlation between surface skin measurement and true nerve length.29 The extended elbow position produces slower across elbow motor nerve conduction velocity (MNCV)10 and in the evaluation of UN-E has been shown to result in a lower30 or equivalent31 diagnostic sensitivity compared to the elbow flexed position. Kincaid et al32 suggested that the elbow flexed position produced less segment-to-segment MNCV variation than the elbow extended position.

b. Length of across elbow segment

The optimal across elbow segment length is a tradeoff between experimental error (specificity) and dilution of the abnormal 2-4 cm nerve segment33,34 by normal nerve (sensitivity). Straight forearm measurement distances of less than 10 cm may be associated with a 25% error in NCV estimates,35 which has been attributed in large part to latency error (using outdated nonelectronic latency identification methods). For an ulnar MNCV of 55 m/sec, Landau et al36 estimated errors for the below elbow-wrist and below elbow-above elbow segments of 3.6 m/sec and 11.6 m/sec respectively. Therefore the recommended above elbow-below elbow and below elbow-wrist MNCV difference of 10 m/sec may result in a high false positive rate. Gert van Dijk et al37 used computer simulations to compare the 50mm and 100mm across elbow distances and calculated sensitivity and specificity estimates using receiver operator curve analysis. They found that area under the receiver operator curve was higher over the 50mm distance despite a widening of the MNCV distribution. Furthermore, experimental error is magnified at higher MNCV values. In a previous study, Pridgeon and Campbell38 suggested a 40mm across elbow segment length. Unfortunately, compression of the ulnar nerve as it exits the flexor carpi ulnaris muscle in the forearm may fall within the below elbow-wrist MNCV estimate in most cases. Based on anatomical considerations the region of interest spans approximately 80 mm, longer than the optimal length of 50 mm and shorter than the recommended length of 100 mm.

c. Measurement of conduction block and short-segment incremental study

Short-segment incremental studies are used in the electrodiagnosis of UN-E to identify the 1-2 cm segments where maximal conduction slowing and/or conduction block occurs.39-42 These studies rely on conduction block (in which measurement error is less important) or focal slowing to detect abnormalities. Azielli et al43 have recently suggested that the measurement of latency change using 2 cm short-segment incremental study is more sensitive than measurement of conduction block or the use of routine across-elbow studies in the identification of UN-E. A minority of studies suggest that conduction block is more sensitive than focal slowing in the diagnosis of UN-E44 and that it may be further improved through the use of regression equations.45 The definition of what constitutes an abnormal decline in compound motor action potentials (CMAP) amplitude or area remains controversial,46-49 with estimates as high as 50% in studies using computer simulations.50 The identification of conduction block in the ulnar nerve requires an appreciation of the effects of temperature,51 the double-hump configuration of...
the abductor digiti minimi CMAP,\textsuperscript{52} anomalous innervation,\textsuperscript{23} and an awareness that conditions other than nerve compression may produce similar changes.\textsuperscript{53} It has been suggested by some authors,\textsuperscript{41,42} but not others,\textsuperscript{53} that conduction block is more likely to be seen in the first dorsal interosseous muscle. When using this muscle to record the ulnar CMAP, efforts should be made to eliminate an initial positive deflection in the first dorsal interosseous CMAP to avoid the effects of phase cancellation which may simulate conduction block.

Short-segment incremental studies may provide important clues to the site of compression in UN-E. A recent study by Hermann et al\textsuperscript{64} demonstrated the presence of conduction block proximal to the medial epicondyle in acute UN-E, contrary to the putative distal site of compression suggested in anatomic studies.\textsuperscript{55} A study by Campbell et al\textsuperscript{66} using intraoperative electroneurography also suggested that most compression occurred proximal to the ME. Therefore, short-segment incremental studies appear to play an important role in the evaluation of UN-E,\textsuperscript{57} despite important methodological concerns,\textsuperscript{58} although the AAEM practice parameter statement lists this technique as optional.

d. MNCV of different proximal and distal muscles

Using needle EMG findings, Stewart et al\textsuperscript{25} suggested that the first dorsal interosseous is preferentially affected in UN-E. Ulnar MNCS recorded from the first dorsal interosseous muscle may have a higher sensitivity than traditional studies involving the abductor digiti minimi muscle,\textsuperscript{59} although other studies have not confirmed this observation.\textsuperscript{42,60} Other investigators have suggested that ulnar MNCS may be recorded from the flexor carpi ulnaris\textsuperscript{61} or flexor digitorum profundus\textsuperscript{62} muscles and used to localize abnormalities in UN-E. The sensitivity of these alternative techniques in UN-E has been studied by Tackmann and co-workers.\textsuperscript{60} Using the flexed elbow position and recording MNCV from the abductor digiti minimi, first dorsal interosseous and flexor carpi ulnaris muscles, they found equal involvement of fibers innervating the first dorsal interosseous and abductor digiti minimi muscles, and found flexor carpi ulnaris MNCS superior to the MNCV recorded from the flexor digitorum profundus muscle.

e. Absolute vs. relative MNCV slowing across the elbow

Most studies have demonstrated that an absolute reduction in ulnar MNCS across the elbow \(\leq 50\) m/sec is more sensitive than a relative reduction of \(\geq 10\) m/sec, compared to the below elbow-wrist segment.\textsuperscript{31,36,37,63} This may relate to a compounding of measurement error, operator-dependent technical difficulties, or axonal dysfunction distal to the site of entrapment. Due to significant measurement error and high variation, comparison of the axilla-above elbow and above elbow-below elbow segments is of lesser utility.

f. Sensory studies

Segmental compound nerve action potentials have been recorded in a small number of subjects with UN-E\textsuperscript{64,65} and a comparison to conventional ulnar techniques has not been reported. The use of near-nerve recording of ulnar sensory nerve action potentials has been reported to effectively differentiate epicondylar from cubital tunnel compression.\textsuperscript{66} However, the studies are invasive, lengthy and have not been compared to conventional methods. It has been suggested that conventional ulnar sensory studies may be more sensitive than motor studies in early UN-E in which only sensory fibers are involved,\textsuperscript{42} however recent studies suggest that MNCS are more likely to be abnormal.\textsuperscript{53} Sensory abnormalities are much more prevalent (73\% vs. 11\%) in the presence of ulnar MNCS slowing.\textsuperscript{67} In general, sensory conduction abnormalities in UN-E do not localize the lesion to the elbow segment and may not differentiate UN-E from other conditions such as thoracic outlet syndrome.\textsuperscript{60} The presence of dorsal ulnar cutaneous sensory abnormalities does help localize the abnormality proximal to the wrist and may assist in excluding ulnar nerve compression in Guyon’s canal. Therefore, the use of these methods may complement conventional MNCS and should be viewed as optional techniques, as they are highly operator dependent.

g. Needle EMG

Needle EMG studies are important to exclude more proximal disturbances such as thoracic outlet syndrome, brachial plexopathies and cervical radiculopathies. The EMG may show greater involvement of the first dorsal interosseous muscle, and abnormalities in the flexor carpi ulnaris and flexor digitorum profundus muscles support ulnar nerve dysfunction proximal to the mid forearm. The motor Tinel’s sign (EMG activity provoked by ulnar nerve percussion) has been the subject of a recent report.\textsuperscript{68} Motor nerve conduction study may be technically difficult in patients who have severe axonal dysfunction – in this context EMG evaluation of ulnar innervated muscles may be the only source of information about the affected distal hand muscles. As is the case with sensory studies, EMG evidence is of limited value in localizing ulnar nerve disturbances to the elbow segment.

CONCLUSIONS AND RECOMMENDATIONS

Entrapment of the ulnar nerve at the elbow is common and electrodiagnosis may successfully localize the electrophysiological abnormality to the elbow segment. The most reliable finding is slowing of the ulnar across-elbow MNCS to less than 50 m/sec while recording from the abductor digiti minimi muscle, and should be carefully interpreted in the presence of a polyneuropathy or other neurogenic process. Alternative techniques such as relative ulnar slowing in different ulnar nerve segments, use of alternative muscles, sensory and mixed nerve techniques provide complementary information, and like all nerve conduction studies are highly operator-dependent and should be used on a case by case basis. Recent studies have focused the electromyographer’s attention on the use of shorter across-elbow segments (2-5 cm). This may offer a reasonable tradeoff between sensitivity and measurement error and may result in higher diagnostic yields.

Careful attention to elbow position, temperature, and conservative estimates of conduction block should be part of common practice. Awareness of anatomical variations in structural anatomy, anomalous innervation and fascicular arrangement of ulnar nerve fibers are required to interpret electrodiagnostic studies accurately.

Electrodiagnosis should always be an extension of the clinical examination and interpreted in light of the observed clinical phenomena. Used appropriately in this fashion, electrodiagnosis

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is an essential tool in the diagnosis of UN-E. Future clinical studies should examine the relationship between electrophysiological findings and clinical outcomes in UN-E.

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**References**