## Cubital fossa syndrome treated with dry needling: a case report

### INTRODUCTION

Cubital tunnel syndrome is a common nerve entrapment syndrome, second only to carpal tunnel

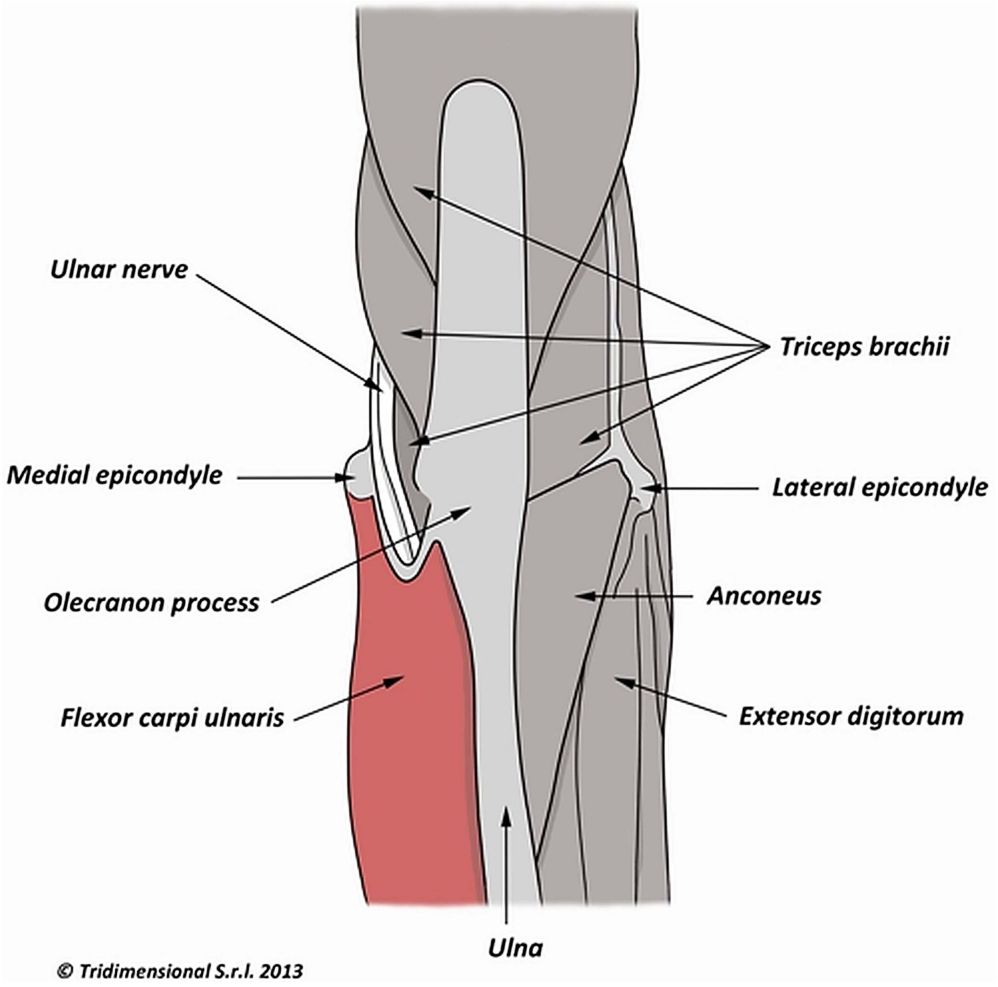


**Figure 1** Ulna nerve entering cubital tunnel between the two heads of flexor carpi ulnaris. Figure copyright: Tridimensional and reproduced with permission.

syndrome.[1] The tunnel starts where the ulnar nerve enters the space between the two heads of the flexor carpi ulnaris. The roof of the tunnel is an aponeurotic arch that bridges the two heads (see figure 1).

The main complaints are numbness and tingling along the little finger and ulnar half of the ring finger. The grip may be weak. Rarely, with severe prolonged compression, muscle wasting and clawing or abduction of the little finger may occur.

## THE PATIENT

The patient, a 54-year-old Malay man who works as a supervisor in a local building management company, presented on 5 June 2013, complaining of numbness over his left little and ring fingers, which had started 1 month previously. He had no weakness or pain. For a few weeks before the symptoms, he had had to visit many more work sites than usual, reaching the sites by motorbike. He consulted a rheumatologist for his symptoms shortly after their onset and received three local injections on separate occasions in his left hand, but to no avail. He was unsure about the injection sites and the type of drugs used.

Clinical examination showed numbness over his entire left ring and little fingers up to the level of the metacarpophalangeal joint. His sensation was tested and showed intact prick and temperature sensation but diminished vibration sensation. Significantly, there was a tender trigger point over the anterior aspect of the forearm, 2 cm distal from the medial epicondyle. Pressure at this point produced an ache over his two affected fingers.

Dry needling was carried out at the trigger point and at HT3. Needling to the trigger point was to the depth of the tender band, where a resistance was felt and the patient perceived a twitch and ache down the forearm to his affected fingers. Fanning dry needling was carried out around the trigger point band. As for HT3, the needle was inserted to a depth of about 1.5 cm, when an ache was felt down the forearm. Both needles remained in place until the sensation of ache or twitch disappeared. Seirin's 3 cm J needles were used. The patient's sensation of vibration immediately improved. He was taught home stretching techniques for his

forearm muscles and no further treatment was given. A few months after his treatment, his fingers were completely symptom-free and have remained so up to 26 December 2013 (about 6 months later).

It is interesting to note that the sensory nerve fibres that conduct vibration (Aβ fibre) differ from those that conduct prick (pain) and temperature (Aδ and C fibres) in that the Aβ fibre seems to be more susceptible to pressure.

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