

### Supplementary Material 3. Included studies demographics, sample sizes, interventions, outcome measures and results

Study (year)	Country	Total sample size n* and age**	Interventions	Length of follow-up	Outcome measures	Results
<b>Bisset et al, 2006</b>	Australia	198 total PT n=66 (47.9±7.2) (3 lost at 1y follow-up) CI n=65 (47.8±8.2) (0 lost at 1y follow-up) WSP n=67 (47.3±8.1) (5 lost at 1y follow-up)	PT: 8 treatments of 30 min over 6 weeks, consisting of a previously described program of elbow manipulation and therapeutic exercise CI: 1 ml quantity of 1% lidocaine with 10 mg of triaminolone acetone in 1 ml WSP: Instructions on modifying daily activities to avoid aggravating pain, stay as active as possible and to use analgesic drugs, heat, cold, or braces as needed	3, 6, 12, 26, and 52 weeks	Global scale of improvement on a 6-point Likert scale PFGS Assessor's rating of severity on VAS (0-100) Secondary: Pain 7-day period on VAS (0-100) PFFQ	CI showed significantly better effects at 6 weeks (p<.05). PT had better outcomes than CI in the long-term. PT was superior to WSP in the short-term (p<.05). No difference between PT and WSP was seen at 52 weeks, when most participants in both groups reported a successful outcome.
<b>Cherry et al, 2012</b>	USA	71 total (48.5±10.8y) Ex n=9 (3 lost at 6w follow-up) Ex+ICE n=21 (5 lost at 6w follow-up) Ex+Cryo n=22 (5 lost at 6w follow-up) Cryo n=19 (9 lost at 6w follow-up)	Ex: Resistance exercise band forearm supination and wrist extension (3x10), straight arm wrist extensor stretching (3x20secs) (HEP twice/day 4/week) EX+ICE: Same three exercises described for the Ex group with a gel cold pack application (20m on- 10 min off – 20 min on) Ex+Cryo: Same as Ex+ICE with the use of Cryo-MAX (20m on- 10 min off – 20 min on) Cryo: Cryo-MAX (20m on- 10 min off – 20 min on)	6 weeks	PFGS Pain intensity VAS (0-10) single arm chair pick up DASH questionnaire	Within-group improvement was found between pre- and post-treatment values for DASH, pain level, and grip strength for all subject groups receiving treatment (p<0.05) No between-group differences were found at 6-week follow-up.
<b>Coombes et al, 2013</b>	Australia	165 total (47.9±7.2y) CI n=43 (49.3±8.9) (5 lost at 52w follow-up) CI+PT n=40 (50.8±8.5) (7 lost at 52w follow-up) PlacCI n=41 (49.9±7.4) (4 lost at 52w follow-up) PlacCI+PT n=41 (49.7±8.1) (2 lost at 52w follow-up)	CI: Corticosteroid and local anesthetic medication (10 mg/mL of triamcinolone acetone in a 1 mL injection plus 1 mL of 1% lignocaine) CI+PT: Eight 30-minute sessions over 8w and HEP (2/day) including elbow manipulation (MWM) techniques, sensorimotor retraining of gripping, and concentric and eccentric exercise to progressively load the wrist extensors using resistive elastic latex bands PlacCI: Placebo (0.5 mL of 0.9% isotonic saline) PlacCI+PT: Placebo plus same exercise program as other group	4, 8, 12, 26 and 52 weeks	Global scale of improvement on a 6-point Likert scale Worst pain over the preceding week on VAS (0-100) PRTEE score EuroQol EQ-5D	Lower complete recovery or much improvement at 1 year for CI compared to PlacCI. (p=.01) PT or no PT groups did not differ on 1-year ratings of complete recovery or much improvement. Similar patterns were found at 26 weeks. At 4 weeks, patients receiving the PlacCI+PT had greater complete recovery or much improvement compared to no physiotherapy. (p<.001) No difference between patients receiving the CI+PT compared to CI alone.
<b>Dale et al, 2016</b>	USA	17 total PT n=9 (mean 48y) PilatesBI n=8 (mean 45y)	PT: Therapeutic exercise (lengthening and eccentric strengthening of wrist extensors), modification of daily task performance, use of PAM, ASTYM, friction massage, and	3 months	PRTEE score NPRS (0-10) PFGS	Significant within-groups differences were found for both groups in pain and grip strength (p<.05). No between-group differences.

			orthosis wear. Some received US during session and/or heat and others ice (2 sessions/week total 10 sessions plus HEP). PilatesBI: breathing techniques, lower extremity exercise using abdominal muscles, postural training to strengthen scapular retractors using resistive band and lengthen anterior shoulder girdle musculature, and lengthening of head/neck musculature (2 sessions/week total 10 sessions, plus HEP).			NOTE: Insufficient data for PFGS and PRTEE at 3-month follow-up.
<b>Drechsler et al., 1997</b>	UK	18 total NT n= 8 (mean age 46.4y) PT n= 10 (mean age 45.5y)	NT: ULTT IIb and Anterior/posterior mobilizations of the radial head. Neural tension exercises 10 reps once a day as home exercise PT: Continuous U/S (1.0-1.5 w/cm2 x 5 min), transverse friction massage 3min. Stretching and strengthening of the wrist extensors 5-10 repetitions, holding each stretch for 30 s. Dumbbells were used for strengthening program (3x 15 repetitions) and as a home exercise program. Twice weekly for 6 weeks	6 and 12 weeks	self-report questionnaire of recreational and occupational activities, level of competition, and chronicity of symptoms MGS Pain (yes/no) during isometric resistance in middle finger extension Radial head mobility manual test ULNT2b ROM elbow extension	There was no statistically significant difference between the NT and PT at discharge or at follow-up for any of the measured variables. A statistically significant improvement in recreational status and ULNT2b for the NT group at discharge and at follow-up (p<.05).
<b>Koch et al, 2015</b>	India	60 total PT+LLLT n=30 Ex+LLLT n=30	PT+LLLT: Cyriax Physiotherapy - DTF and Mill's manipulation. Low level laser (wavelength 632.8 nm) at continuous mode with energy density 2-3 joule/point (3/week for 4 weeks). Ex+LLLT: Eccentric strengthening for wrist extensors (load based on patients 10 RM – 3x10reps) and static stretching of extensor carpi radialis Brevis (30-45secsX3 before and after eccentric strengthening, total of 6 reps). Same LLLT as other group (3/week for 4 weeks).	4 weeks	Pain on VAS (0-10) PFGS PRTEE score	Significant within-group improvements in all outcome measures at 4-week follow-up (p<.05). No significant between-group differences in all outcome measures at 4-week follow-up.
<b>Luginbühl et al, 2008</b>	Switzerland	36 total (47.0±9.0y) CI+FSB n=10 (6 lost at 1y follow-up) CI+Ex n=10 (5 lost at 1y follow-up) CI+FSB+Ex n=9 (one bilateral) (5 lost at 1y follow-up)	CI+FSB: Recommended to wear the band for the whole day, and not at night during sleep; for at least the first 3 months. CI+Ex: HEP=Isometric grip strength exercise using a tennis ball (20secsX20reps, 2/day) for at least 3 months and isometric resisted wrist extension exercise (20secsX20reps, 2/day) for at least 21/2 months. CI+FSB+Ex	6 weeks, 3 months, and 1 year	Grip strength (% of the strength of the contralateral side) Modified Nirschl/ Petrone score Global scale of improvement on a 4-point Likert scale No of patients undergone surgery	All groups were improved in Modified Nirschl/ Petrone score at 6 weeks (p<.05). Subjectively, 63% of all patients rated as better or much better their condition at 1-year follow-up. No between-group significant differences in all outcome measures were found at 1-year follow-up.

<b>Martinez-Silvestrini et al, 2005</b>	USA	94 total (45.5±7.7y)  Stretch n=33 (mean 43.1) (5 lost at 6w follow-up) ConEx+Stretch n=30 (mean 47) (4 lost at 6w follow-up) EccEx+Stretch n=31 (mean 46.6) (4 lost at 6w follow-up)	Stretch: Stretching of the wrist extensors 3x30 secs, with 30-second rest between sets (2/day). Con+Stretch: Progressive purely concentric strengthening HEP by using elastic resistance band 3x10reps, with 2-5min rest between sets. Ecc+Stretch: Progressive purely concentric strengthening HEP by using elastic resistance band 3x10reps, with 2-5min rest between sets.	6 weeks	PFGS PRFEQ DASH SF-36 Pain on VAS (0-10) Global scale of improvement (5-point Likert scale)	Significant within-group improvement in all outcome measures in all three groups at 6 weeks (p<.05).. No significant between-group differences in outcome measures were evident.
<b>Murtezani et al, 2015</b>	Kosovo	49 total (51.3±6.4y)  Ex+US n=25 (51.6±6.7) (5 lost at 3m follow-up) CI n=24 (51.0±6.2) (6 lost at 3m follow-up)	Ex+US: Progressive, slow, repetitive wrist and forearm stretching, muscle conditioning, and occupational exercise administered in four steps of increasing intensity (2/day, 3/week for 6 weeks). In addition to US in a pulsed mode with a 20% duty cycle, intensity of 1.5 w/cm <sup>2</sup> , frequency of 1MHz, for 5 to 7 minutes (3/week for 6 weeks). CI: local infiltration of 1mL triamcinolone acetonide (10mg/mL) and 1mL lidocaine 2%.	6 and 12 weeks	Pain on VAS (0-10) PFGS PRTEE score	CI group was significantly better than the Ex+US in VAS, PRTEE pain, PRTEE function and grip strength at 6-week follow-up (p<0.001). The scores of VAS, PRTEE pain, PRTEE function, and PFGS improved significantly in both groups at the 6, and 12-week follow-up (p<0.001). Better outcomes in VAS, PRTEE pain, PRTEE function, and PFGS for the EX+US compared to CI group at 12-week follow-up (p<0.001).
<b>Nargale et al, 2009</b>	India	60 total (mean 38.6y)  PT n=30 (38.0±6.2) (non-lost at 8w follow-up) Ex+Phono (32.0±5.2) (non-lost at 8w follow-up)	PT: Cyriax Physiotherapy - DTF and Mill's manipulation (3/week for 4 weeks). Ex+Phono: Supervised exercise program included static stretching of the extensor carpi radialis brevis (30-45secsX3 before and after eccentric strengthening, total of 6 reps) followed by eccentric strengthening of the wrist extensors (load based on patients 10 RM – 3x10reps). Phonophoresis with diclofenac sodium 1%. US with 100% duty cycle, at 1 MHz, delivered at an intensity of 0.8 W/cm <sup>2</sup> for 5 minutes.	2, 4, and 8 weeks	Pain on VAS (0-10) PFGS TEFS score	Both treatment groups experienced significant improvements in all outcome measures from baseline to discharge at 4 weeks (p<0.05). Despite the patients' worsening post-intervention between 4 and 8 weeks, all outcome measures for both groups remained significantly improved compared to baseline at 8 weeks (p<0.05). Between-group analysis indicated that the Cyriax physiotherapy group had significantly better outcome scores at all follow-up periods compared to those receiving Ex+Phono (p<0.05).

<b>Ollausen et al, 2015</b>	Norway	177 total (46.9±9.7y) CI+PT n=59 (47.9±9.6) (7 lost at 1y follow-up) PlacCI+PT n=58 (48.8±9.4) (5 lost at 1y follow-up) WSP n=60 (44.0±9.7) (8 lost at 1y follow-up)	All groups received naproxen 500 mg twice daily for two weeks. CI+PT: 2 Injections (start and 3 weeks) with 10 mg triamcinolone acetonide (1 ml of 10 mg/ml) and 0.5 ml of 2 % lidocaine. Cyriax Physiotherapy - DTF and Mill's manipulation and soft tissue treatment with stretching of the radial wrist extensors (2/week, 6 weeks) HEP consisting of eccentric exercise (3x30 reps) and stretching of radial wrist extensors (3/ day for 40secs). PlacCI+PT: 2 Injections (start and 3 weeks) with placebo (1 ml of 0.9 % isotonic saline). Same exercise program as the CI+PT group. WSP: Only naproxen.	6, 12, 26, and 52 weeks	Global scale of improvement on a 6-point Likert scale Pain on VAS (0-100) PFGS MGS Pain on resisted dorsiflexion of wrist and 3 <sup>rd</sup> finger on 3-point scale PFFQ	PlacCI+PT showed no significant difference compared to wait and see or to CI+PT at any follow-up. CI+PT had 10.6 times larger odds for success at six weeks ( $p < .01$ ). At 12 weeks there was no significant difference between these groups, but at 26 weeks the odds for success were 91% lower compared to wait and see, showing a large negative effect. At 52 weeks there was no significant difference. Both Wait and see and PlacCI+PT showed a gradual increase in success.
<b>Park et al, 2010</b>	South Korea	31 total (5 lost at 1y follow-up)  Ex n=16 [50.3 (34-63)] NSAID+Ex n=15 [50.0 (41-58)]	Ex: Patients were instructed to perform as a HEP isometric muscle strengthening exercises immediately following the first visit to the physician (4x50reps/day, 10 seconds hold). NSAID+Ex: Patients performed as a HEP isometric muscle strengthening exercises after 4 weeks of oral NSAID (4x50reps/day, 10 seconds hold).	1, 3, 6, and 12 months	Pain on VAS (0-100) MEPS Modified Nirschl/Pettrone score	Significant better results for Ex group compared to NSAID+Ex in VAS, MEPS, and Modified Nirschl/Pettrone score at 1-month follow-up ( $p < .01$ ). No significant between-group differences at 3,6, and 12-month follow-up in all outcomes. Significant within-group improvement for both groups at 1-year follow-up ( $p < .05$ ).
<b>Peterson et al, 2011</b>	Sweeden	81 total (mean 48y)  Ex n=40 (49.1±8.1) (2 lost at 3m follow-up) WSP n=41 (47.4±8.6) (1 lost at 3m follow-up)	Ex: 3-month daily HEP consisting of forearm extensors progressive strengthening (3x15reps per day). WSP: Patients were informed that the condition was painful but harmless, that the arm should be used in ordinary daily activities.	1,2, and 3 months	Pain on VAS (0-100): a) at MVC and b) at maximum muscle elongation Extensor muscles strength DASH GQL	Significantly greater pain reduction for the Ex group at 3 months follow-up ( $p < 0.0016$ ). No significant differences between groups in DASH scores or quality of life measures. Both groups were improved at 3-month follow-up ( $p < .05$ ).
<b>Peterson et al, 2014</b>	Sweeden	120 total  EccEx n=60 (48.8±6.7) (6 lost at 12m follow-up) ConEx n=60 (47.0±9.4) (8 lost at 12m follow-up)	EccEx: 3-month daily HEP consisting of forearm extensors progressive eccentric strengthening (3x15reps per day). ConEx: 3-month daily HEP consisting of forearm extensors progressive concentric strengthening (3x15reps per day).	1,2 3, 6, and 12 months	Pain on VAS (0-100): a) at MVC and b) at maximum muscle elongation Extensor muscles strength DASH GQL	Significantly greater pain reduction for the EccEx group at the 2-month follow-up ( $p < .006$ ). There were no significant differences between the groups regarding function or quality of life measures at all follow-up time points. Both groups were improved at all follow-up points ( $p < .05$ ).

<b>Pienimaki et al, 1996</b>	Finland	39 total (42.3±5.4y) Ex n=20 [43 (33-53)] (0 lost at 1y follow-up) US n=19 [41 (31-53)] (0 lost at 1y follow-up)	Ex: 6-8 weeks of progressive slow, repetitive wrist and forearm stretching, muscle conditioning and occupational exercises, which were intensified in four steps, instructed by PT and performed as HEP 4-6 times/day. US: Pulsed ultrasound 0.3-0.7 W/cm <sup>2</sup> , pulse ratio 1:5, pulse duration 2 ms, frequency 1 MHz, (10-15 min) 2-3 times/week (up to 15 visits).	8 weeks	Pain on VAS (0-10): a) at rest and b) pain under strain Pain and disability questionnaire MGS Isokinetic muscle performance (wrist and forearm)	Pain in Ex group was significantly more decreased than the US group (p<.05). The isokinetic torque of wrist flexion increased by 45% in the Ex group and declined by 4% in the US group (p=.0002). MGS increased 12 % in the Ex group and remained unchanged in the US group (p=.05).
<b>Pienimaki et al, 1998</b>	Finland	30 total Ex n=16 [45 (36-54)] (4 lost at 36m follow-up) US n=14 [44 (38-57)] (3 lost at 36m follow-up)	Long-term follow-up of a previous study assessing differences in treatment effects between Ex compared to US (Pienimaki et al, 1996).	36 months	Pain on VAS (0-10): a) at rest and b) pain under strain Pain and disability questionnaire	Ex showed beneficial long-term effects compared to US in pain, working ability, and the overall functional condition (p<.05).
<b>Sethi et al., 2018</b>	India	26 total SMS+PT n=13 (44.92 ± 10.84) PT n=13 (47.77 ± 9.44)	SMS+PT: Strengthening exercises for lower and middle trapezius and serratus anterior (3/week for 6w) + PT PT: pulsed ultrasound + stretching+ eccentric for wrist extensors (3/week for 6w)	6 weeks	PFGS Pain on VAS (0-10) PRTEE EMG Scapular Position Scapular Muscles Strength	Statistically significant difference in time effect for pain, pain free grip strength, PRTEE, scapular muscles strength, scapular positioning and EMG changes (p<.05). Significant difference for group effect, in EMG activity of LT and ECRB (p<.05).
<b>Smidt et al, 2002</b>	Netherlands	185 total CI n=62 [47 (41-54)] (2 lost at 1y follow-up) PT n=64 [48 (41-52)] (0 lost at 1y follow-up) WSP n=59 [46 (42-54)] (0 lost at 1y follow-up)	CI: Local infiltration of 1 mL triamcinoloneacetonide (10 mg /mL) and 1 mL lidocaine 2%. During the 6-week period, a maximum of three injections was recommended. PT: 9 sessions of deep friction massage and pulsed US (20% duty cycle), intensity of 2 W/cm <sup>2</sup> for 7.5m/session. 6 weeks of progressive slow, repetitive wrist and forearm stretching, muscle conditioning and occupational exercises, which were intensified in four steps, instructed by PT and performed as HEP 4-6 times/day. WSP: Instructions on modifying daily activities to avoid aggravating pain, to use analgesic drugs, NSAID, or naproxen as needed.	3, 6, 12, 26, and 52 weeks	Global scale of improvement (6-point Likert scale) Pain on VAS (0-10): a) main complaint, and pain during the day Modified pain-free function Questionnaire Overall severity of the elbow complaints (0-10) PFGS MGS Pressure pain threshold Satisfaction with the intervention (11-point Likert scale)	At 6 weeks, significant differences in favor of CI were seen for all outcomes. Recurrence rate in the injection group was high after 6 weeks (p<.0001). At 26 and 52 weeks, significant differences for nearly all outcome measures were noted in favor of PT compared with CI (p<.0001). At 26 and 52 weeks, PT showed better but non-significant results compared with the wait-and-see policy. The long-term outcome of the wait-and-see was also better, but non-significant than CI for most outcome measures.
<b>Soderberg et al, 2012</b>	Sweeden	42 total Ex+FBS n=20 (48.0±12.4) (2 lost at 6w follow-up) FBS n=22 (50.0±10.8)	EccEx+Forearm support band: FBS during all daily activities and to perform warm-up exercises for the wrist extensors. Daily eccentric contractions of the forearm extensors as HEP (2x8-12reps/day for 1	3 and 6 weeks	PFGS Pain-free isometric extensor strength Pain on VAS (0-100): during the previous	No significant differences between groups in PFGS and pain-free isometric extensor strength at 3-week follow-up. At 6-week follow-up EccEx group had

		(3 lost at 6w follow-up)	week, for the following 2 weeks progress to 2/day, and in week 3 progress to 3x8–12 2/day). FSB: during all daily activities and to perform warm-up exercises for the wrist extensors.		week	significantly higher pain-free hand-grip strength and higher pain-free hand-extensor strength ( $p=.025$ ). Pain was improved significantly in both groups, but no significant between-group differences were found at 3- and 6-weeks follow-up.
<b>Stasinopoulos et al, 2017</b>	Greece	34 total (mean 43y)  EccEx n=11 (43.6±3.4) (0 lost at 1y follow-up) EccEx+ConEx n=12 (44.7±4.8) (0 lost at 1y follow-up) EccEx+ConEx+Isometric n=11 (42.8±5.6) (0 lost at 1y follow-up)	EccEx: Eccentric exercises as HEP of the wrist extensors (3x15reps) performed slowly (30secs) EccEx+ConEx: Eccentric and concentric exercises as HEP of the wrist extensors performed slowly only eccentric phase (30secs) EccEx+ConEx+Isometric: The patients performed as HEP an isometric contraction of wrist extensors for 45 seconds followed by the eccentric-concentric contraction All groups performed static stretching exercises of the wrist extensors (3 before and 3 after exercises, 30-45secs)	4 and 8 weeks	Pain on VAS (0-10): worst pain over the previous 24 hours Overall elbow function (0-10) PFGS	Significant within-group differences with time were found for all 3 groups at all outcome measures ( $p<.05$ ). EccEx+ConEx+Isometric group had the largest effect in the reduction of pain and improvement of function at all follow-up time-points. There was no significant difference between EccEx and EccEx+ConEx in the reduction of pain and improvement of function at all follow-up time-points. EccEx+ConEx+Isometric group had the largest effect in grip strength at all follow-up time-points. There was no significant difference between EccEx and EccEx+ConEx at grip strength at all follow-up time-points.
<b>Struijs et al., 2003</b>	Netherlands	31 total  Manipulation n=15 (46.3±8.4) (2 lost at 3 weeks follow-up) PT n=16 (46.0±11.0) (1 lost at 3 weeks follow-up)	Manipulation: thrust techniques in wrist extension (15-20 times per session) x 9 sessions  PT: US (pulsed x 5min), friction massage, and muscle stretching and strengthening exercises with instructions to perform the exercises at home twice daily (resistance, rotational, and occupational exercises) x 9 sessions.	3, 6 weeks	Global scale of improvement (6-point Likert scale) Pain on VAS (0-10) of main complaint Inconvenience during daily activities (0-10) PFGS MGS Pressure pain threshold ROM elbow extension	Statistical differences between groups were found for global improvement after 3 weeks of intervention (62% in group 1 versus 20% in group 2) and for pain during the day after 6 weeks of intervention indicating manipulation was more effective than PT ( $p<.05$ ). No longer statistically significant differences were found between groups at 6 weeks or in other outcome measures between groups.
<b>Struijs et al, 2004</b>	Netherlands	180 total  FSB n=68 (46.0±11.0) (5 lost at 1y follow-up) PT n=56 (43.0±8.0) (3 lost at 1y follow-up) PT+FSB n=56 (47.0±9.0) (2 lost at 1y follow-up)	FSB: Patients were advised to wear the brace continuously during daytime for a 6-week period. PT: 9 sessions over 6 weeks, 7.5 minutes pulsed US, friction massage (5-10 minutes), and structured slow progressive strengthening (2-3x10reps) and stretching protocol as HEP (2/day or 4-6/day) PT+FSB: Combination of the above interventions	6, 26, and 52 weeks	Global scale of improvement (6-point Likert scale) Pain on VAS (0-10) of main complaint PFFQ Inconvenience during daily activities (0-10) PFGS MGS	PT was superior to FSB only at 6 weeks for pain, disability, and satisfaction. Contrarily, FSB treatment was superior on ability of daily activities ( $p<.05$ ). Combination treatment was superior to FSB on severity of complaints, disability, and satisfaction. A statistically significant difference was identified only for increase in

					Pressure pain threshold Patient satisfaction (0-10)	pressure pain thresholds, in favor of combination therapy compared to PT (p<.05). At 26 weeks and 52 weeks, no significant differences were identified between groups.
<b>Svernlöv et al, 2001</b>	Sweeden	38 total  Stretch n=20 [43 (23-54)] (5 lost at 6w follow-up) EccEx+Stretch n=18 [42.1 (29-57)] (3 lost at 6w follow-up)	Stretch: Patients were advised to perform contract-relax-stretching according to the applicable proprioceptive facilitation (PNF) model (3-4 times/day) as HEP for 12 weeks. EccEx+Stretch: Patients underwent a treatment regime as a HEP for 12 weeks including static stretching (15-30secs performed 3-5/day) and eccentric exercise of the forearm extensor muscles (3x5reps/day)	3, 6, and 12 months	Pain on VAS (0-10): a) pain at rest, b) at palpation, c) pain during resisted wrist extension, d) at middle finger test, and e) during strength testing Global scale of improvement on a 4-point Likert scale MGS	No significant between-group differences at 3, 6, and 12 months follow-up in pain evaluation. No significant between-group differences at 3, 6, and 12 months follow-up in subjective improvement. Grip strength increased significantly in both groups after 3 months. At 6 months follow-up the increase was significantly larger in the EccEx group (p<.05).
<b>Tonks et al, 2007</b>	UK	48 total  WSP n=12 (43.4±7.1) (5 lost at 7w follow-up) CI n=12 (48.2±6.5) (0 lost at 7w follow-up) Ex n=12 (43.8±7.5) (4 lost at 7w follow-up) CI+Ex n=12 (41.9±7.4) (5 lost at 7w follow-up)	WSP: No treatment, observation only CI: A single injection of 10 mg of triamcinolone acetonide and of 2% lignocaine hydrochloride made up to a volume of 1 ml Ex: Progressive slow, repetitive wrist and forearm stretching, muscle conditioning and occupational exercises, which were intensified in four steps, instructed by PT and performed as HEP 4-6 times/day. CI+PT: A combination of CI and progressive slow, repetitive wrist and forearm stretching and muscle conditioning, intensified into four steps (as above)	7 weeks	PFGS Wrist extensors strength PRFEQ	Patients who received CI were statistically significantly better than all the other groups for all outcome measures at follow up (p<.05). No statistically significant effect of physiotherapy nor interaction between physiotherapy and injection was found.
<b>Tonks et al, 2012</b>	UK	64 total (mean 45y)  CI n=21 [45.6 (30-61)] (10 lost at 6m follow-up) US n=21 [45.2 (37-56)] (20 lost at 6m follow-up) Ex n=22 [45.6 (23-64)] (15 lost at 6m follow-up)	CI: A single injection of 10mg Adcortyl US: 6 treatments of US during the first 2 to 3 weeks of treatment (2/week), continuous 3 MHz ultrasound therapy using a 0.5 transducer at 2W/cm <sup>2</sup> for 5 minutes Ex: Progressive slow, repetitive wrist and forearm stretching, muscle conditioning and occupational exercises, which were intensified in four steps, instructed by PT and performed as HEP 4-6 times/day	10 days, 6 weeks and 6 months	PFGS PRFEQ Thermography	A statistically significant difference was found for pain-free grip strength change between the CI group and both the Ex and US groups at 10 days and at the 6-week endpoint (p<.05). A statistically significant difference was found for PRTEE change between the CI and both the Ex and US groups at 10 days and at the 6-week endpoint (p<.05). No statistically significant differences for thermal difference between groups were found at 10-day follow-up.
<b>Tyler et al, 2010</b>	USA	21 total  PT+Ex n=11 (47.0±2.0)	Patients in both groups received wrist extensor stretching, ultrasound, cross-friction massage, heat, and ice during their PT visits	7 weeks	DASH Pain on VAS (0-10): primary provocative	Significant between-group differences were found at 7-week follow-up in favor of PT+EccEx group in DASH

		(6 lost at 7w follow-up) PT+EccEx n=10 (51.0±4.0) (8 lost at 7w follow-up)	PT+Ex: Isotonic wrist extensor strengthening as HEP, PT+EccEx: Isolated progressive eccentric wrist extensor strengthening as HEP by using a rubber bar (3x15reps/day)		activity Wrist extensors strength Middle finger extension strength Tenderness	(p=.01) scores, pain (p=.002), and tenderness (p=.003). Significant within-group improvements in wrist extension and middle finger strength were found at 10 weeks (p<.05) but not significant between-group differences.
<b>Viswas et al, 2012</b>	India	20 total PT+EccEx n=10 (37.4±4.9) (0 lost at 4w follow-up) PT n=10 (38.2±4.3) (0 lost at 4w follow-up)	PT+EccEx: Supervised exercise program (3/week for 4 weeks) included static stretching of the extensor carpi radialis brevis (30-45secsX3 before and after eccentric strengthening, total of 6 reps) followed by eccentric strengthening of the wrist extensors (load based on patients 10 RM – 3x10reps) PT: Cyriax Physiotherapy (3/week for 4 weeks) – DTF (10 minutes) and Mill's manipulation	4 weeks	Pain on VAS (0-10) TEFS	Significant within-group improvements were found for both groups in pain at 4-week follow-up. Significant within-group improvements were found for both groups in functional status (TEFS) at 4-week follow-up. Significant between-group differences were found at 4-week follow-up in favor of PT+EccEx group in TEFS scores and pain.
<b>Vuvan et al., 2019</b>	Australia	40 total Isom n=21 (48.0 +/-7.9) (1 lost at 8w follow-up) WSP n=19 (49.0+/-10.2) (0 lost at 8w follow-up)	Isom: daily isometric wrist extension exercise, performed using a container of water with a handle as resistance. The starting load was equivalent to 20% MVC of the unaffected side and increased to 35% by week 7. WSP: All participants received a 20-minute individualized session and provided written and verbal general advice regarding self-management and ergonomics.	0, 8 weeks	PRTEE, Patient satisfaction (6-point Likert scale) PFGS Pressure and Thermal pain thresholds Pain on VAS (worst and resting)	Significant changes between exercise group compared to the wait-and-see group for PRTEE (p<.05). No difference was found between the exercise and wait-and-see group for rate of success on general perceived improvement. No difference was observed between groups for PFGS, Pain reduction, pressure, cold or heat pain threshold
<b>Wen et al, 2011</b>	USA	28 total EccEx n=14 (48.0±9.0) (non-reported loses at follow-up) PT n=14 (43.9±4.7) (non-reported loses at follow-up)	EccEx: Eccentric exercises as HEP of the wrist extensors (3x15reps/day) performed slowly (6-8secs) PT: Iontophoresis (2 mL of 4% dexamethasone with a 40-mA/min) as well as other modalities at the therapist's discretion. Participants who had more tenderness received US using 1.0 MHz frequency, 100% duty cycle, and 1.0 W/cm <sup>2</sup> (8 min). Stretching of the wrist extensors (3/day)	4, 8, 12, 16, and 20 weeks	Pain on VAS (0-100) PFGS Patient satisfaction (4-point Likert scale)	Significant within-group improvements were found for both groups in pain at 4-week follow-up (p<.05). No significant between-group differences were found at all follow-up time-points. At 8 weeks, the EccEx group had statistically significantly greater pain relief than the PT group (p<.05). No significant differences were found between the groups for grip strength at any time point.
<b>Yelland et al., 2019</b>	Australia	120 total PT n=40 (51.0 ± 9.0) Prolotherapy n=40 (49.2±7.2) Combined n=40 (47.8 ±7.0)	Prolotherapy: Each tender point was injected with 0.5 to 1.0 ml of solution containing 20% glucose and 0.4% lignocaine using a peppering technique with a 25-gauge needle. The injections were repeated at 4, 8 and 12 weeks after the initial treatment session. PT: education, manual therapy (MWM) and	6, 12, 26 and 52 weeks	Global Impression of Change Pain on NPRS (0-10) PRTEE PFGS EuroQol	In the short term, reduction in PRTEE scores was significantly greater at 12 weeks (p = 0.01) for physiotherapy compared to prolotherapy No significant difference in all outcomes between groups over time. PRTEE, Self-reported worst pain (p<0.001), PFG (p<0.001) and

			therapeutic exercise, was used in conjunction with a home exercise program. Four 30 minutes sessions for 5 weeks. Combined: prolotherapy and PT			EuroQol (p = 0.002) significantly improved over time in all three groups
--	--	--	---	--	--	--

\*n= number of individuals in each group.

\*\*Age in mean±SD or mean (range) as reported for the total sample and/or each group in the study.

Abbreviations: PT, Physiotherapy; CI, Cortisone Injection; Wait and See Policy, WSP; VAS, Visual Analogue Scale; PFGS, Pain Free Grip Strength; PFFQ, Pain Free Function Questionnaire; Ex, Exercise; Cryo, Cryotherapy; MAX, HEP, Home Exercise Program; DASH, Disabilities of the Arm, Shoulder and Hand questionnaire; PlacCI, Placebo Cortisone injection; MWM, Mobilization With Movement; PRTEE, Patient-Rate Tennis Elbow Evaluation; PilatesBI, Pilates Based Intervention; PAM, Physical Agent Modalities; ASTYM, Augmented Soft Tissue Mobilization; US, Ultrasound; NPRS, Numeric Pain Rating Scale; NT, Neural Tension; MGS, Maximum Grip Strength; ULNT, Upper Limb Neurodynamic Test; LLLT, Low Level laser therapy; DTF, Deep Transverse Friction; RM, Repetition Maximum; Phono, Phonophoresis; TEFS, Tennis Elbow Function Scale; FSB, Forearm Support Band; NSAID, Non-Steroid Anti-Inflammatory Drugs; MEPS, Mayo Elbow Performance Score; MVC, Maximum Voluntary Contraction; GQL, Gothenburg Quality of Life Instrument; EccEx, Eccentric Exercise; ConEx, Concentric Exercise; Stretch, Stretching; PRFEQ, Patient-rated Forearm Evaluation Questionnaire; PNF, Proprioceptive Neuromuscular Facilitation; SMS, Scapular Muscles Strengthening; EMG: Electromyography; LT, Lower Trapezius; ECRB, Extensor Carpi Radialis Brevis; USA, United States of America; UK, United Kingdom