





Tendons fail slowly. That is one of the hardest truths for patients to accept, especially active adults who are used to thinking of injury as a single event with a clean start and finish. Degenerative tendon conditions usually do not begin with a dramatic tear or a memorable twist. They begin with a gradual loss of tendon quality, an accumulation of load the tissue can no longer adapt to, and a pattern of pain that becomes stubborn, familiar, and disruptive.

That is the setting in which Shockwave Therapy often enters the discussion. It is rarely the first thing tried. Most people arrive at it after weeks or months of stretching, rest, topical creams, anti inflammatories, massage, and well meant advice from friends or training partners. Some have improved a little, then plateaued. Others have become less active to avoid pain, only to discover that deconditioning makes the problem worse.

Used well, Shockwave Therapy can be a valuable tool for degenerative tendon problems. Used casually or offered as a cure all, it disappoints. The difference lies in diagnosis, tissue stage, load management, and patient expectations. In practice, it works best when it is part of a broader tendon rehabilitation plan rather than a stand alone procedure.

What “degenerative” really means in tendon care

When clinicians talk about a degenerative tendon condition, they are usually describing a tendon that has changed structurally over time. The collagen fibers are less well organized, the tendon may be thickened, the matrix may contain more ground substance, and there may be areas of poor healing rather than classic inflammation. This matters because a degenerative tendon does not behave like a fresh sprain.

That distinction is often missed. A patient with Achilles pain for eight months may still be told they have “tendonitis,” a term that suggests ongoing inflammation as the main problem. In reality, many chronic tendon complaints fit better under the umbrella of tendinopathy, with degeneration and failed healing playing a major role. That is why treatments aimed only at reducing inflammation often produce short lived results.

Common examples include mid portion Achilles tendinopathy, plantar fasciopathy, patellar tendinopathy, gluteal tendinopathy, and some chronic lateral elbow tendon problems. These tissues can remain painful for a long time

because the tendon is biologically sluggish. Blood supply is limited compared with muscle, adaptation takes time, and the tissue responds better to carefully dosed mechanical loading than to prolonged rest.

Where Shockwave Therapy fits

Shockwave Therapy delivers acoustic energy into the affected tissue. The details vary by machine and protocol, but the broad clinical aim is similar: stimulate a local biological response, influence pain, and support a stalled healing process in tissue that has not recovered with simpler measures alone.

There are two main forms in [Shockwave Therapy](#) routine musculoskeletal practice, focused and radial. Focused systems deliver energy that can be targeted deeper and more precisely. Radial systems disperse energy more broadly and are often used for more superficial or larger treatment regions. Patients often assume one is universally better. In real practice, the answer depends on the tendon involved, the machine quality, the clinician's experience, and how the treatment is integrated into the overall rehab plan.

The mechanism is still discussed with some nuance in the literature, but several effects are commonly proposed. Shockwave Therapy may promote neovascular changes, stimulate cellular activity involved in repair, alter pain signaling, and disrupt chronic pain patterns around the tendon. It is not magic, and it does not rebuild a diseased tendon in a single session. What it can do is create a more favorable environment for recovery, particularly when the tendon has become chronically irritable and non responsive.

This is where patients need honest framing. Shockwave Therapy is usually not about instant pain relief on the treatment table. Some patients feel looser quickly, but the more typical pattern is gradual improvement over several weeks. A person who expects to walk in limping and walk out cured is likely to be disappointed.

The tendon problems that respond best

The strongest day to day clinical use tends to cluster around chronic, load related tendon conditions that have failed first line care. Plantar fasciopathy is a classic [Shockwave Therapy](#) example. Many patients with heel pain have already tried shoe inserts, stretching, night splints, and reduced activity. When symptoms have dragged on for months, Shockwave Therapy often becomes a reasonable next step.

Achilles tendinopathy is another common indication, especially mid portion cases. These patients often describe morning stiffness, pain that eases once they warm up, and a loss of spring during running or jumping. Patellar tendon pain in jumping athletes can also respond, though results depend heavily on whether landing loads, training volume, and quadriceps strength deficits are being addressed. Chronic lateral elbow pain can improve as well, especially when the extensor tendon origin has become persistently degenerative rather than acutely inflamed.

Gluteal tendinopathy deserves a separate mention because it is frequently mismanaged. People are often told to "stretch the hip" or sit cross legged to open it up, when compression of an already irritated gluteal tendon can make matters worse. Shockwave Therapy can be useful here, but only when paired with changes in sleeping position, sitting habits, and hip loading exercises. Treating the tendon while ignoring the daily compressive aggravators is like bailing water without patching the leak.

Why some people improve and others do not

One of the more interesting aspects of Shockwave Therapy is how strongly the outcome depends on context. The machine matters, but the tendon story matters more.

If the diagnosis is wrong, the treatment can look ineffective when it was simply misapplied. A patient with posterior heel pain from a bursitis, insertional Achilles pathology, lumbar referred pain, or a partial tendon tear may not respond the same way as someone with straightforward chronic mid portion Achilles tendinopathy. The same is true in the elbow, where cervical referral, radial tunnel irritation, or joint driven pain can mimic tendon symptoms.

Duration also matters. A mildly irritated tendon that has only been painful for three weeks may improve with load modification and exercise alone. A tendon that has been painful for a year, thickened on imaging, and repeatedly flared by sport often needs a more layered strategy. Shockwave Therapy can help in the latter group, but recovery will still be slower than most patients want.

Then there is the loading issue. Tendons need load to recover, but not the wrong amount at the wrong time. I have seen runners pay for a course of Shockwave Therapy while continuing the exact same hill sessions that triggered the problem. I have also seen patients stop all activity for weeks, lose calf strength, then wonder why their Achilles still hurts walking downstairs. Neither extreme helps much. The sweet spot is usually modified loading, enough to maintain tendon stimulus and strength, but controlled enough to avoid constant flare ups.

What treatment actually feels like

Patients usually want practical detail before anything else. The treatment itself is brief. Depending on the area and protocol, a session may last only a few minutes once the region is identified. Gel is applied to help transmit the waves, the applicator is placed over the target area, and pulses are delivered. Sensation varies. Some describe it as sharp tapping. Others say it feels like rapid percussion or a deep zinging discomfort over tender spots.

Pain during treatment is not a badge of success. There is an old habit in some settings of turning the intensity up until the patient can barely tolerate it, as if more suffering must mean better healing. That approach is crude. A treatment should be tolerable and purposeful. There may be discomfort, especially over a chronically sensitive tendon, but the goal is not to overwhelm the tissue or the patient.

A typical course might involve several sessions spaced about a week apart, often three to five, though practice patterns vary. Improvement may begin after the second or third session, but it can also take a month or more to declare itself. It is common for symptoms to feel temporarily stirred up for a day or two, especially if the tendon was already irritable.

Most patients can continue daily activities. Athletes may need some modification in training volume, intensity, or explosive work around the treatment period. That decision should not be generic. A recreational runner with Achilles pain is not managed the same way as a volleyball player with patellar tendinopathy in season.

Why exercise still does the heavy lifting

Shockwave Therapy gets attention because it is a procedure. Procedures feel tangible. They are scheduled, billed, and often discussed as if they are the main event. Yet in many degenerative tendon cases, the longer term progress still hinges on exercise.

A tendon adapts to load. It becomes more tolerant when forces are introduced progressively and consistently. For the Achilles, that may mean calf strength work and graded return to running. For the patellar tendon, heavy slow resistance and jump load management often matter. For gluteal tendinopathy, hip abductor strength, control of pelvic mechanics, and avoidance of compressive positions are central. For the lateral elbow, wrist extensor loading and grip capacity are usually part of the plan.

Shockwave Therapy can reduce pain enough to make exercise more tolerable. It can also provide momentum in cases that have stalled. But if the tendon has not regained capacity, symptoms often return as soon as the person resumes the activities that mattered to them in the first place.

This is where clinical judgment counts. Some patients need a clear strengthening plan from day one. Others arrive too flared to tolerate much load and need a short settling period before loading can progress. A rigid formula misses both groups.

Situations where caution is warranted

Shockwave Therapy is generally well tolerated, but it is not appropriate for every painful tendon. Fresh tendon tears, suspected complete ruptures, and conditions where the pain source is not actually tendinous need a different approach. The same is true near areas where other pathology is suspected, such as significant bone stress injury or inflammatory disease.

There are also practical contraindications and precautions that responsible clinics review before treatment. These vary somewhat by device and region treated, but the general themes are straightforward:

1. Avoid treating over known malignancy, active infection, or certain unstable local pathologies.
2. Use caution or avoid treatment in patients with bleeding disorders or relevant anticoagulant use.
3. Do not apply over areas with impaired sensation where feedback is unreliable.
4. Pregnancy may be a contraindication depending on treatment location and clinic policy.
5. Suspected acute rupture or major structural failure needs imaging and specialist assessment, not a routine shockwave booking.

That list sounds obvious on paper, yet shortcuts happen in busy settings. A five minute screening can save a patient from the wrong treatment.

The role of imaging, and its limits

Ultrasound and MRI can be helpful, but neither should be treated as a simple yes or no answer to whether Shockwave Therapy is indicated. Tendons often look abnormal on imaging even when symptoms are mild, and some painful tendons do not appear dramatically damaged. Imaging findings need to match the story and the examination.

In practice, imaging is most useful when the presentation is unclear, when rupture or partial tear is suspected, when symptoms are severe or unusual, or when a patient has failed a reasonable course of well directed treatment. An ultrasound can show thickening, neovascularity, and focal tendon changes. MRI offers a broader view of surrounding structures. Still, the image is one piece of the puzzle, not the whole diagnosis.

Patients sometimes fixate on words in the report, especially "degeneration" or "tear." A degenerative report does not automatically mean the tendon is doomed, and a small partial thickness change does not always explain severe pain. Tendons are stubborn, but they are also adaptable.

A realistic timeline for recovery

This is where honesty matters most. Chronic tendon pain often improves in months, not days. Shockwave Therapy may accelerate progress or help break a plateau, but it does not erase the biological pace of tendon remodeling.

For many patients, the early goal is reduced pain with first steps in the morning, less soreness after activity, or a better ability to tolerate rehabilitation exercises. Sport specific confidence comes later. A runner who can walk without limping is not automatically ready for speed work. A tennis player whose elbow hurts less at rest is not necessarily ready for a full serving session.

A pattern I often see is this: the first changes are subtle, then function begins to improve, then the patient gets impatient and overtests the tendon. They do a long hike, a tournament, or a return to sprint intervals because things feel “mostly fine.” The tendon flares, morale drops, and they assume the treatment failed. More often, the tissue was simply challenged beyond its current capacity.

The best outcomes usually come from people who understand that pain reduction and load tolerance must rise together.

What a sensible treatment plan tends to include

There is no single perfect protocol, but the strongest tendon plans usually combine a few consistent elements rather than relying on one intervention alone.

1. A precise diagnosis that distinguishes degenerative tendon pain from tears, bursitis, referral, or joint pathology.
2. A load strategy that keeps the tendon active without repeatedly provoking it.
3. Progressive strengthening matched to the tendon involved and the person’s actual goals.
4. Shockwave Therapy when symptoms are chronic, progress has stalled, or pain is limiting rehab.
5. Clear milestones for return to sport, work, or higher level function.

That structure sounds simple, but execution matters. A warehouse worker with insertional Achilles pain, for example, may need a different program than a distance runner with mid portion symptoms, even if both are told they have “Achilles tendinitis.” Job demands, footwear, stair exposure, body mass, and recovery time all influence the plan.

Cost, value, and the importance of asking the right questions

Shockwave Therapy is often paid out of pocket, so patients are right to ask whether it is worth it. The answer depends less on the marketing and more on the quality of the clinical reasoning behind it.

A worthwhile clinic should be able to explain why your tendon problem fits the treatment, what outcomes are realistic, how many sessions are typically recommended, what type of machine is used, and how your exercise program will be adjusted around the treatment. If the pitch sounds like a universal solution for every painful soft tissue problem, skepticism is healthy.

It is also fair to ask what happens if you do not improve. Good care includes a next step. That may be a different loading strategy, further imaging, a sports medicine review, or consideration of another intervention. Chronic tendons can be challenging, and no ethical clinician should promise certainty.

The common mistakes that derail good results

The biggest mistakes are not usually technical. They are strategic.

The first is treating pain without treating capacity. If the tendon hurts less but remains weak and underprepared, recurrence is likely.

The second is ignoring aggravating mechanics or habits. A gluteal tendon will keep complaining if someone continues sleeping on the sore side with the hip adducted every night. A plantar fascia case may stall if footwear remains unsupportive during long work shifts. An elbow tendon may relapse if workstation strain and repetitive gripping demands never change.

The third is overreliance on imaging language. A tendon does not need to look perfect on a scan for a patient to function well. Chasing image normalization is usually the wrong target.

The fourth is abandoning the plan too early. Because Shockwave Therapy is often sold as a short series, some patients assume progress should be complete by the final session. In reality, the treatment window and the adaptation window are not the same thing. The tissue often continues to change after the sessions end, especially if loading is progressed intelligently.

What patients should expect from a good explanation

A good explanation of Shockwave Therapy is calm, specific, and free of hype. It should sound something like this: your tendon shows features of chronic overload and failed healing, simpler measures have not been enough, Shockwave Therapy may help reduce pain and stimulate recovery, but you will still need a rehabilitation plan and your improvement will likely be gradual.

That style of explanation builds trust because it respects both the potential and the limits of the treatment.

For degenerative tendon conditions, that balance is everything. Shockwave Therapy can be very useful, sometimes decisively so, particularly in chronic plantar fascia pain, Achilles tendinopathy, patellar tendon problems, lateral elbow tendinopathy, and selected gluteal cases. But its real value appears when it is chosen for the right patient, delivered thoughtfully, and paired with the slower work that tendons actually require.

The tendon does not care about slogans. It responds to load, time, biology, and judgment. When Shockwave Therapy is used with that reality in mind, it earns its place.

Injury Recovery Center

Address: 730 W Hampden Ave Ste. 250, Englewood, CO 80110

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.