This case presents the management of an elbow joint sprain, which was followed by a shoulder injury and its subsequent surgery. A 19-year old college baseball catcher presented with elbow discomfort during his sophomore year. With conservative management he was able to participate on a limited basis during that year. After being diagnosed with a grade II ulnar collateral sprain and a subluxing ulnar nerve later that year, elbow reconstructive surgery with a nerve transposition was scheduled for that summer. The athlete continued rehabilitation including a progressive throwing program that emphasized throwing with increased shoulder abduction. During the summer his elbow pain decreased, surgery was canceled, and he progressed with his throwing program intending to return to full game participation. As throwing intensity increased, he described a pop and pain in his shoulder. After several weeks of rehabilitation without substantial improvement arthroscopic surgery was performed. The diagnosis consisted of internal rotator cuff impingement with undersurface tearing, marked synovitis and hemorrhaging, and anterior capsular redundancy. Capsular plication and rotator cuff debridement was performed and the patient was immobilized for 4 weeks. Treatment and rehabilitation for the next 3 months consisted of standard modalities, ROM and strengthening exercises, followed by a carefully monitored progressive return to throwing. The athlete did return to participation with occasional biceps discomfort but without significant disability in his shoulder or elbow for spring 2004 season. Differential diagnoses for the initial elbow injury included medial elbow epicondylitis, tendonitis, and/or flexor tendon tear. For the shoulder injury potential diagnoses included glenohumeral subluxation, bicipital tendonitis, or SLAP lesion. What makes this case particularly interesting was the fact that the initial elbow pathology resolved shortly after elbow joint reconstruction was scheduled. The subject’s pain decreased and he was able to begin throwing without limitation. However, shortly after he began using different throwing mechanics, the patient injured his shoulder resulting in surgical management. This may have been due to a conscious change in throwing mechanics where he was attempting to utilize more shoulder musculature to decrease the strain on his elbow. This case demonstrates that with appropriate early conservative treatment, surgical intervention may not be indicated for a grade II elbow sprain. With appropriate follow-up treatment and management, athletes may still successfully return to full participation in a few months. However, when throwing mechanics are altered, other complications may result after this type of injury. Key Words: Elbow joint injury, Throwing mechanics, Shoulder capsular repair