From the Editors’ Desk:

Exploring Hand Therapy, Inc (EHT) continues to provide you with excellence in education at affordable prices. The winter months are upon us and we have some great courses you can watch, snuggled by the fire, hot cocoa in hand, while in your P.J.'s.

EHT recently updated a few of our most popular courses. Don’t delay go to www.treatment2go.com and order: *Lateral Epicondylitis, The Therapist Approach to Conquering Pain; *A Royal Pain in the... Thumb; and *No More Aching Arms: A Comprehensive approach to soft tissue and neurological pathologies, treatment and surgical intervention.

Watch our web listings to order additional popular courses coming soon: *Cervical Exam, *Myofascial Therapy and *Neural-tension Approach to Treatment.

EHT’s magazine is for informational purposes only and is not intended to be a substitute for professional medical advice, diagnosis or treatment. Always consult your supervisor before implementing ideas.

Order our courses at: www.exploringhandtherapy.com or www.treatment2go.com

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**MCP Arthroplasty - A Delicate Balancing Act**

When a patient decides to undergo an MCP arthroplasty it is vital that the therapist/physician/patient team come together so an understanding of goals is accomplished. Pre-operative visits are crucial for a successful outcome. Some patients may desire reconstruction for vanity, others for functional purposes and some are concerned about both. It is our job as therapists to inform these patients of the commitment they make when they decide to undergo this "project". I say that word project because that is what it is. This is not a quick fix procedure but a carefully planned out and guided path for the patient which will take great volumes of effort on the part of the patient, therapist as well as the physician. I tell all my patients before surgery, especially those whose primary reason is for cosmetic improvement, that if they don't follow the program properly immediately and long term post-operatively that they will end up with very expensive FLY-SWATTERS!

I will now go over a brief discussion of the pathomechanics that occur in the rheumatoid hand. As the ligaments and cartilage of the wrist are destroyed the wrist collapses in radial deviation and the MCP's then reciprocates by collapsing into ulnar deviation. The extensor mechanism becomes stretched out and is no longer centralized over the MP but falls between the between the metacarpal heads. (Figure 1). The extrinsic extensors pull the fingers more in ulnar deviation and the intrinsic muscles of the hand become contracted contributing to intrinsic tightness which will pull the MP’s into flexion while extending the IP joints. Was that brief enough? Confused yet? I am...

An important thing to know is that the wrist will be treated before the MP’s are treated as the wrist is where the pathology is initiated. The wrist may be treated with an implant, partial fusion or total fusion. Once the wrist procedure is complete the MCP’s can be addressed. On occasion a gutsy physician will do the wrist and MCP’s together.

The concept of MCP joint replacement was first... continue page 3
THE HAND

27 Bones
12 Muscles
22 Joints
25 Tendons

1 Pain Reliever

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described in 1959. In 1972 Swanson introduced the silicone MP implant. Many others have been developed and presented since that time. Some MPJ implants may be especially designed to place the MCP's in flexion when they are at rest, some designed with mesh covering and others are metallo-plastic prostheses. Some are one piece, two pieces, constrained by screws or unconstrained and cemented or non-cemented to name a few. The Swanson implants were improved in 1986 but they still fail over time by fracturing and fragmenting.

The MCPJ arthroplasty is a fantastic surgical procedure to view and I would recommend it to any therapist practicing in hands. It is a great way to review your anatomy and see how the extensors function. This is a very complicated procedure and requires the physician to do a LOT of rebalancing and fine tuning. This procedure requires a skilled hand surgeon to perform the surgery due to the fine tuning required.

A summary of what is performed surgically includes: The ulnar intrinsics are released, dorsal capsule is opened, synovectomy is performed and the metacarpal head is then removed with a saw. The metacarpal shaft and the proximal phalanx are reamed with an awl to allow for the prosthesis to fit. The prosthesis is then fit and a grommet may or may not be used as an interface between the silicone and the bone to protect the implant and add stability. The collateral ligaments are then reattached if possible and the dorsal apparatus is relocated over the MP joint. After that the sagittal fibers are stabilized on the radial side. Dorsal and palmer based splints hold the digits in extension are usually applied post-operatively the patients are often hospitalized for a day or two. Although one day surgery is also common.

Now it is up to you! Over the next 8-12 weeks you will help the patient's MCP's form a pseudocapsule around the implant. Your clinical goal is to have an end range of motion of around 50 degrees for MP flexion on the index and middle fingers, and 70 degrees at the ring and little fingers (table 1). This goal is set as the first and second fingers need less motion as this is where power pinch will come from while the 4th

<table>
<thead>
<tr>
<th>MPJ</th>
<th>Index</th>
<th>Middle</th>
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<tr>
<td>degree</td>
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Continued page 4
and fifth digits need to have more motion for grasp. Now let’s review the postoperative treatment regime. This regime varies significantly from clinic to clinic. The “standard” protocol involves immediate postoperative splinting with a dorsal extension outrigger splint to be worn during the day (fig. 2) and a resting splint to be worn at night (Fig 3).

Clinical treatment includes AROM/gentle PROM, wound care and edema control. The home program includes AROM of the MP’s in the splint and elevation to control edema. Other authors have proposed leaving the MP’s in extension in a static splint for 3 weeks after surgery to facilitate stability over mobility (fig. 3). This is more likely to be chosen if the joints are unstable after the surgical intervention. Some studies have looked at having the patient use a CPM beginning at day 3-7 post-operatively that moves the MP’s in a 70 degrees arc of flexion while wearing digit extension splints to be used all day (7 hrs a day). Still other programs have suggested wearing two static splints one with the MCP’s at zero and one with the MCP’s at 60 degrees of flexion.

Let’s talk a bit more about the postoperative splinting regime. The dynamic splint is a valuable part of the postoperative management as it is designed to control the position and alignment of the new joints. This splint can be made high or low profile and has been designed with many types of outriggers (figure 2 & 4). Some therapists have reported the high profile as more effective as they need less force to initiate ROM of the MPJ’s. The supported position (resting position) of the MP joints should be at zero degrees while allowing movement of the MP to around 70 degrees. The dynamic splint also holds the wrist at neutral to 20 degrees of extension with slight ulnar deviation. This splint is worn for 6-8 weeks depending on the surgeon. The static night splint that has been fabricated is often worn for 3-6 months or longer.

A few pitfalls to avoid are as follows: One thing you really need to watch out for, with these patients, to ensure they actually flex the MPJ’s continued on page 9
Introducing
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Wear comfortable clothes to the exam, and pace yourself during the exam to make sure that you have time to complete the entire exam and have time to check your answers.

**EHT:** *What do you do when you are not busy in your hand clinic?*

**Marlisa:** My husband Earl and I have a Yorkshire Terrier named Scarlett and a cat named Sugar that provide a lot of company. I enjoy working out, playing tennis, snow skiing (although I’m not very good at this), traveling (I worked as a traveling OT for 5 years and absolutely loved seeing the country—I think that is where I got the travel bug from). Would love to visit Australia and New Zealand one of these years!!!

**EHT:** *What is your favorite diagnosis that you treat and why?*

**Marlisa:** I don’t really have a favorite, however I find tendon repairs challenging.

**EHT:** *Do you have an area of clinical expertise that you can share with us, or a tip or trick?*

**Marlisa:** The one activity that I tend to use frequently is an idea from the “Activities Made Simple” DVD by EHT. The patient tries to remove marbles/coins from putty, with one hand only, not allowing the putty to touch the table or any surface. I have found this works with about every diagnosis and patients just seem to have fun with it!

Marlisa Nolan, OTR/L, CHT

**EHT** would like to thank Marlisa for being our first featured reader! We, Also congratulate her on all her accomplishments.

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<th>Full 9/5X7.5 (w)</th>
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<td>1.0/10</td>
<td>$219</td>
<td>Finger Fractures: A Detailed Look</td>
<td>.25/2.5</td>
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<td>Difficult Cases in Hand Therapy</td>
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<td>I Too Can Mobilize Edema</td>
<td>.125/1.25</td>
<td>$42</td>
<td>Evaluation &amp; TX of OA and RA</td>
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<td>Understanding The Mysterious Intrinsic</td>
<td>.175/1.75</td>
<td>$52</td>
<td>Treatment of the Distal Wrist and Forearm After Fracture</td>
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<td>Clinical Activities Made Simple</td>
<td>.175/1.75</td>
<td>$52</td>
<td>RSD/CRPS</td>
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Prices vary depending on Media (CD, DVD, Internet) -- above list is not complete-- only a sample of our course variety
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**JAS STATIC PROGRESSIVE STRETCH VS. DYNAMIC SPLINTING**

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<tr>
<th>JAS SPS Therapy</th>
<th>Dynamic Splint Therapy</th>
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<tr>
<td>Manually adjustable constant positioning provides stress relaxation loading</td>
<td>Constant tension system provides creep based loading</td>
</tr>
<tr>
<td>Fulcrum positioned to prevent joint surface loading</td>
<td>Fulcrum positioned across joint, creates joint surface loading</td>
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<tr>
<td>1.5 hours daily treatment time</td>
<td>8-12 hours daily treatment time</td>
</tr>
<tr>
<td>7-10 weeks average total treatment time</td>
<td>12-26 weeks average total treatment time</td>
</tr>
<tr>
<td>Devices work bi-directionally</td>
<td>Most models work in one direction only</td>
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<tr>
<td>Custom fabricated devices</td>
<td>Off-the-shelf devices</td>
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**Splinting Tips and Tricks**

X-lite has a great material for fabricating lightweight durable splints. Patients’ love that they don’t perspire and stick to the material. Also, they feel the support is great for as lightweight & ventilated the material is. This is a fantastic splint material for new therapists & students as it can be thrown back in the pan over and over without losing its properties. Excellent for the seasoned splint maker because of its versatility. Fasteners are easy as you can get rid of your solvents and rivets and have an aggressive & attractive finishing bond with the finishing tape. Go to: [www.runliteusa.com](http://www.runliteusa.com) for more info.

NEWS FLASH: Splinting the CMCJ with an out-of-the-box type splint is preferred by patients with first CMCJ O.A. over a custom made thermoplastic splint and these patients get adequate support with this. Please see the newest release in the JHT for complete article. Journal of Hand Therapy Oct/Dec. 2004 p. 401-406 primary author is our very own... Susan Weiss.

Shrinkant Chinchalkar OTR, CHT and Sean AH Yong OTR, MSc (OT) have developed a double reverse Kleinert Extension splint for zone 6-8 extensor tendon repairs. This splint allows the wrist to glide in a protected fashion to prevent dorsal adhesions that occur in this zone. It allows for a gradual increase in wrist flexion each week with an adjustable hinge. It is critical that the patient understand that they can’t do simultaneous wrist and digit flexion. The JHT has complete instructions on splint fabrication and splint photos if you interested in learning more about this great new splint idea. JHT Oct/Nov 2004.

Using a CPM for a stiff hand is a great way to increase ROM. A neat feature of the JACE CPM is that you can interface electrical stimulation and therefore incorporate an active tendon glide with your passive mobilization program. If you want to learn how to do this with your patients call for a local rep. from JACE to come out and give you an inservice. We have used this technique on stiff fingers, that have greater passive than active ROM, that also have limited tendon glide. Visit [www.jacesystems.com](http://www.jacesystems.com) or see the ad on page 12.
and not the PIPJ's. Often, patient's will simply flex the IP's and avoid the MP's completely. You may need to add finger gutters under each finger sling to help them avoid flexing the PIP's vs. the MP's. This problem MUST be addressed early on as encapsulation begins at week one and is completed around week three. Another thing to watch out for is the index finger wanting to medial rotate or pronate. If this occurs an additional outrigger may be added to create a force couple and produce a torque in the direction of supination on the finger while not interfering with digit flexion and extension. Sound tough? O.K - you are right, IT IS, but it can be done! Next, watch the 5th digit closely or the patient may end up looking like he/she is drinking tea. This finger often has had chronic subluxation and will need additional help to get it flex along with the others. You may need to initiate PROM earlier with the 5th digit. Don't forget to instruct your patient on performing PROM for H.E.P. to ensure good outcomes. Also, make sure the outrigger is not too tight and that it allows the patient to move in the appropriate range. Finally, watch out... if the fingers are looking like a fly-swatter (fingers extended with little flexion) you may want to add a dynamic or static progressive flexion component(s) to your splint to work on MP flexion while the capsule is still being formed. Most books will tell you to start this procedure around 3 weeks. I will admit I have applied it as early as week 2 if I see the person heading down the wrong path to get to Grandma's house. But...as usual... don't try this unless you get approval from your Dr. or supervisor!

Now that you know some of the potential pitfalls lets get back to the program. Most of the time the day splint is discharged at 6 weeks and they will continue the night brace for 6 months or longer (figure 3). Some patients may want a small hand-based splint during functional activities but I don't know of any on the market that work that good. Do you? Let us know.

Now your patient is 6-8 weeks post-operative, what should your patient report? Studies have shown that most patients are satisfied with the outcome of their surgery. They report extension and less ulnar drift as a positive improvement. They are generally satisfied with the appearance of their hands. They often report that they do NOT have an increase in grip or prehension skills. A study done in the JHT Oct-Dec issue 2003 was specific to the... CONTINUED ON PAGE 13
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Problem: Pain in the neck and shoulders when talking on the phone and working on the computer.

Solution: Do not hold the phone between your head and shoulder. Placing the receiver on your shoulder will tighten the muscles of the neck and shoulder and cause tension in neck and shoulders. Instead, use the speakerphone (if you don’t have a headset) or purchase a headset. It is recommended to stop typing, while on the phone, and use this time to rest your hands and stretch.

Problem: Tingling in the fingers, aching upper back, and pain in the cervical region and wrists when working on the notebook (laptop).

Solution: You should apply your computer desk ergonomics to your notebook (laptop). Another thing you can do is purchase an ergo lap top desk. (www.ergopro.com)

Problem: Working all morning without a break resulting in fatigue, eye strain, and muscle soreness.

Solution: Implement the 20*20*20 Rule. Which means... every 20 minutes of typing/working, look away 20 feet, and stretch for 20 seconds.

Problem: Are you feeling tired, and having computer workstation overload?

Solution: Have an UPLIFT:

Computer users try this:
* Breathe for more Energy
* Drink water for more Energy
* Move for more Energy
* Hum, sing, whistle or chant

TIP to feel better: When you leave at the end of the day, if you cannot move the clutter from your desk (workspace) or car—straighten the piles. Returning to ‘tidy stacks’ feels much better than finding a big mess; you will begin the next morning feeling much more “in charge” and better organized. It reduces the rubble to “bite-sized pieces”.

Recommendations from www.holisticmatters.net
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Patient’s perspective. This study indicated most patients had increased hand function, some pain, and felt the hand looked "more normal". This study also indicated that grip strength was no better and in many times was worse.

Despite the functional outcomes that we can assess, as hand therapists, we, do not have any evidence of what is the most effective postoperative protocol for an MCP arthroplasty. This is a difficult topic to research due to limited population of patients that undergo this procedure in order to create a randomized controlled trial for study. Anybody up for the challenge? It would be nice if we had more research to justify what we do and what works best with MCP arthroplasty procedures. I think part of the reason limited research has been done as to what clinical methods work best for this procedure is because they are so much better after surgery as far as cosmesis (Figs 5 & 6) and functional outcome that the need to evaluate a "specific" post-operative outcomes has not been stressed.

In summary, MCP arthroplasties are fun to treat and a great surgery to watch if you can. Have fun and look out for our fantastic course on the MCP arthroplasty to be released soon. Visit www.liveconferences.com to see it upon its release.

Have a wonderful holiday season and we will see you all soon!

Susan Weiss CEO Exploring Hand Therapy

**Northern Exposure News! Heading outside in the cold? These mittens will keep you warm. Just heat the pacs in the microwave before heading out for a fitness walk, shoveling or a cold drive. Great for Raynaud’s, CRPS & poor circulation pathologies. These mittens are enjoyed by anyone with cold hands and a warm heart... learn more.. [http://www.bestofnewengland.com](http://www.bestofnewengland.com)

**www.HTCC.org has a fantastic internet directory that includes all Certified Hand Therapists. This is a great way to find fellow hand therapists when patients move and need continued treatment or for new therapists to find seasoned therapists to call on!

HTCC also shares information about job listings for hand therapists. A good thing to know if you are looking for a job or looking to find staff!

**The American Hand Therapy Foundation (AHTF) established in 1989, enhances the specialty of hand therapy through AHTF projects, organizational engines, and activity highlights. Visit AHTF’s new image map at [www.ahtf.org](http://www.ahtf.org).

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Congratulations Nancy & Mike

Nancy is ENGAGED!!

We send our warmest congratulations to Nancy and Mike....

May your lives be filled with happiness and Love
1. Wrist deformity in R.A. occurs in what direction?
2. Can intrinsic tightness occur with R.A?
3. MCP arthroplasty is always done before any wrist surgery is performed. True or False
4. The concept of MCP replacement was first described when?
5. What Dr. introduced a silicone implant in 1972?
6. When a MCP arthroplasty is performed what is done with the ulnar intrinsics?
7. You are treating a patient after MCP arthroplasty and she has 20-30 degrees at each MCP as her final measurement and very limited hand grasp. How would you classify her outcome?
8. What is the arc of motion allowed after surgery in the very early stages to help form a pseudocapsule?
9. It is mandatory that a dynamic splint is used for all MCP arthroplasty patients. True or False
10. List some of the pitfalls that may occur with this procedure:
11. When is the dynamic splint usually discharged?
12. Are patients generally pleased with the outcomes of MCP arthroplasties?

Answers on page 16
EHT has several new courses to earn CEU's, including:
*Moving on Up: Examination of the Shoulder;*  
*Moving on Up: Treatment of the Shoulder;*  
*The Stiff Hand;*  
*Lateral Epicondylitis;*  
*A Royal Pain in the … Thumb; &  
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*** READ ALL ABOUT IT!! ***

Did you see the second edition of Susan and Nancy's book?  
"Hand Rehabilitation a Quick Reference Guide and Review"

Excellent study and reference Guide!!! We use it all the time... Go to www.treatment2go.com to see it and order it now.

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The Philadelphia Hand Center awards 2 therapists per 6 months a FREE fellowship to learn all about hand therapy. They even give you a stipend! All I can say is … Why didn’t they have this when I first started? Trust me - if I didn’t have a 2 year old - I would still apply because I am sure I would learn a TON from the therapists and physicians team in Philly! (Susan Weiss). See page 18 for more information and on how to apply now.

** By the way… anybody going to the Philly hand meeting? We (EHT) are!!! So, if you have a book and want it signed bring it with you and we will gladly sign it. Hope to see a bunch of you at the meeting. It is a fantastic meeting to attend and a great way to learn from a variety of amazing physicians and therapists! See page 10 to register now.

** THE IDEA House-Senate Conference Committee met on Wednesday, November 17 to finalize the bill to reauthorize the Individuals With Disabilities Education Act(IDEA). AOTA has worked with key House and Senate staff throughout the reauthorization process in order to secure language in bills passed by the House and Senate which support the following areas:

**use of qualified occupational therapists and occupational therapy assistants (as defined by state law);  
**the full scope of occupational therapy practice (including psychosocial and mental health issues);  
**access to occupational therapy services, as a proactive measure, to address broader learning and behavioral needs;  
**inclusion of occupational therapy practitioners in state and local professional development efforts; and  
**inclusion of occupational therapy and related services in U.S. Department of Education funded research and personnel training initiatives.

For a complete listing of who will be serving on the PAOC on DME, here is a link to the CMS web site and specifically a press release on this issue: http://www.cms.hhs.gov/media/press/release.asp?Counter=1208

Note: None of the ASHT, AOTA or APTA representatives were picked to serve on the committee.

**The State of California - supervision parameters for Occupational Therapists. The Occupational Therapy Board of California proposes to amend regulations to interpret and make specific the supervision parameters for occupational therapists in the process of completing on-the-job training.**

**Recertification Section Revised**

CHTs seeking information on recertification will find the new information clear and easy to follow. Take a look!

**Recertification dates for 2005**

If you are due to recertify in 2005, all of your professional development hours must be obtained by May 31, 2005. Your application is due on July 1st.

**A CHT must accumulate a minimum of 80 contact hours of professional development activities, with a minimum of 36 hours in clinical hand therapy courses (Category A) during their five-year accrual period.**

*Category A Formal Courses in Upper Quarter Therapy  
*Category B Informal Courses in Upper Quarter Therapy  
*Category C Formal Courses with General OT or PT Content  
*Category D Hand Therapy Publications  
*Category E Hand Therapy Presentations  
*Category F Activities Related to Organizing and Managing Services  
*Category G Activities That Promote Professional Practice
Answers to Test Your Knowledge

1. Radial deviation  
2. Yes  
3. False  
4. 1959  
5. Swanson  
6. They are released  
7. A very expensive fly-swatter & overall NOT too good!  
8. 70 degrees arc  
9. False  
10. *The patient only moves the IP’s  *The index finger pronates  *MP flexion is poor  
11. Week 6  
12. Yes  

Pssst! Did you Know...........

***Did you know that the ASSH has fantastic patient education programs available free on their website? Pretty cool! [http://www.assh.org/Content/NavigationMenu/Patients_and_Public/Patients_and_Public.html](http://www.assh.org/Content/NavigationMenu/Patients_and_Public/Patients_and_Public.html)

***Did you know Biofreeze combined with ultrasound is a great additional pain management technique? Use about 20% Biofreeze and 80% u/s gel.

***Did you know that JACE offers a CPM for the thumb?

***Did you know that www.eatonhand.com has great clip art for hand therapy and is a great patient education site.

***Did you know Exploring Hand Therapy (EHT) is looking for educators? If interested contact [www.exploringhandtherapy.com](http://www.exploringhandtherapy.com)

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QUALITY FOR LIFE
Evelyn J. Mackin
Fellowship in Hand Therapy
Hand Rehabilitation Foundation
North Coast Medical, Inc.
The Philadelphia Hand Center, P.C.
College of Health Professions at
Thomas Jefferson University

Applications are now being accepted for a funded fellowship position in the
Hand Therapy Department of The Philadelphia Hand Center, P.C., starting in
July 1, 2005 and January 2, 2006. A six-month fellowship is offered in hand
management and patient care, including pre- and postoperative assessment,
treatment planning, splinting, return-to-work programs, and outcomes.
Applicants must be a graduate of an accredited occupational therapy or
physical therapy program (bachelor’s or master’s degree), be licensed, and
have a minimum of one year’s clinical experience, preferably in the area of
upper extremity rehabilitation. Applicants will be selected on the basis of
their demonstrated interest in the specialty of hand rehabilitation and their
desire to advance their therapeutic skills in hand management. Preference
will be given to applicants who evidence financial need and will practice in an
underserved area. The deadline for submission is March 1, 2005 for the July
1, 2005 fellowship, and September 1, 2005 for the January 1, 2006 fellowship.

For more information, visit our web site at
www.handrehabfoundation.org, or contact:
Terri Skirven, OTR/L, CHT, Director of Hand Therapy,
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**What’s Up DOC?**

This month’s featured doctor... Richard Herrick, M.D.

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**Question:** What is the most effective implant for MCP arthroplasty in your clinical opinion?

**Dr. Herrick:** If the patient is relatively young and has good bone stock, I like the pyrocarbon implants by Ascension—-if the patient is older, physically and mentally, not necessarily chronologically, I think they are best served by one of the newer generation Silastic implants.

**Question:** What type of wrist procedures do you use on your patients before performing their MCP arthroplasties?

**Dr. Herrick:** Extensor tenolysis, ulnar head resection, centralizing the wrist extensor tendons, or even wrist fusion/replacement if the wrist is too far gone. Rarely, finger extensor tendon repair/transfers.

**Question:** Do you ever combine your MCP arthroplasty surgery with the stabilization procedures that are used for the patients wrist?

**Dr. Herrick:** Only if the wrist deformity is minor/minimal.

**Question:** How long do you find your MCP arthroplasties’ implants last before the patients come in for revision?

**Dr. Herrick:** There is a broad range of this. I have revised some after only 8-10 years and some after 20!

**Question:** Do you think that one way of fitting the arthroplasties or one type of implant helps the patient end up with a better outcome than another?

**Dr. Herrick:** Each patient has to be treated individually. One cannot “cookie-cutter” patients, problems or diagnoses! You need to determine what are their problems, expectations, and ability to fully participate in therapy.

**Question:** How long do you immobilize your patients before you send them to therapy?

**Dr. Herrick:** Only for a few days to minimize swelling and allow early soft tissue healing.

**Question:** What type of splint do you think works best for postoperative management and why?

**Dr. Herrick:** A combination of a wrist stabilization splint with dynamic finger extension components, plus a resting hand splint for night. Splint fabrication depends upon the skill, experience and ability of the therapist, as well as the patients commitment to therapy. The splint must be comfortable, gentle, yet unyielding... like a good hand therapist!

**Question:** How long do you have your patients in the post-operative splinting regime?

**Dr. Herrick:** A minimum of 5-6 weeks -- sometimes for several months. The looser the joints and the more immunosuppressed the patient, the longer they will have to be splinted.

**Question:** What do you think is the most critical part of getting a good outcome with these challenging cases both surgically and therapeutically?

**Dr. Herrick:** The patient MUST understand the importance of the therapist/therapy and be willing to actively participate and dedicate themselves to reaching the goal of their expectations (the joint, agreed-upon expectations of the patient, the therapist and the surgeon).

**Question:** When do you think it is best to operate on patients with R.A.? In other words... is it better to operate before the deformity has gone to a complete collapse or do you feel that intervention should come when a patient first starts to notice a deformity and why?

**Dr. Herrick:** If I see an early case of persistent synovitis/tenosynovitis that has been adequately treated by the rheumatologist and therapist, and he/she is not really responding as expected, I can often do some simpler procedures that will minimize, if not prevent, and, at least delay, deterioration, and the need for more complicated procedures.

Thank you Dr. Herrick for your invaluable input. (EHT)

Richard T. Herrick, M.D., was born in New Martinsville, West Virginia, and was educated at the University of Notre Dame and West Virginia University School of Medicine. Dr. Herrick is a fellowship-trained hand surgeon. He has published numerous articles in medical journals, and has made many national and international presentations, relating to hand and upper extremity surgery. To learn more about Dr. Herrick visit www.tampabayortho.com