From the Editors’ Desk:

Exploring Hand Therapy, Inc (EHT) continues to provide you with excellence in education at affordable prices. As we enter the fall and winter months we know how important it is to continue our hand therapy growth via education while maintaining our busy schedules. EHT knows the demands today and EHT has answered your pleas to bring you quality education. EHT offers DVD’s, CD-ROM’s, internet streaming, and VHS educational formats. EHT is an AOTA approved provider and most courses are category A for HTCC renewal.

EHT is honored to present at at the ASHT annual meeting in NC. Susan and Nancy are discussing CRPS/RSD. We hope to see you at our course and at our booth # 517.

This newsletter 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.

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Three’s Company
The Physician’s Perspective
Dale Bramlett

The physician/hand therapist/patient relationship is critical to optimizing clinical results in hand surgery. With the advent of moderate hand surgery under the tutelage of H. Sterling Bunnell, it is apparent that busy trauma surgeons (in particular those specializing in surgery of the hand) represented a unique specialty. Optimizing clinical outcome following severe injuries required an intensive relationship between the physician and patient, as the reputation of surgeons trained in treatment of the hand grew, from a practical matter it was difficult for physicians to spend countless hours with their patients in order to give optimum results. Hand therapy was a natural evolution of the discipline of occupational and physical therapy with specialization in the discipline of hand and upper extremity therapy. As hand surgery evolved, so did the field of hand therapy.

The relationship between the hand therapist and the physician is paramount to obtaining a satisfactory result. Successful clinical outcomes can arise only from the triad of a well motivated patient working in close cooperation with the therapist receiving direct input from the physician who has performed the surgery on the patient. Unless the therapist is physically present in the operating room, communication with the surgeon as to the intricacies of the procedure, the strength of the repair, or the severity of the wound are critical to obtaining maximal improved function following reconstructive surgery of the hand. This is very apparent in the treatment of Dupuytren’s contracture. In our office, if patients refuse to undergo hand therapy post-op, we refuse to offer them surgery of the hand for Dupuytren’s.

Clinical results obtained by a well motivated patient with a competent surgeon and a well trained hand therapist are superior to those obtained in the absence of any of these three essential elements. One should seriously contemplate whether or not surgery is indicated if the patient refuses to undergo a course of hand therapy in the post-operative period. Identification of patients who are at risk preoperatively can help to avoid complications such as recurrence of the Dupuytren’s, reflex sympathetic dystrophy and the possible need for prolonged and sometimes painful thera-
The triad of physician, therapist and patient is critical to getting excellent outcomes after hand surgery. I can’t tell you the number of times I have gotten a script that says flexor tendon repair or wrist strain and nothing else. Of course you can fumble through a visit or two until you have the details but a short chat with the physician will greatly improve your ability to treat your patient. Knowing the suture technique, the tension on the repair and any other details of the surgery makes treating the patient so much easier. If you can’t talk to the Dr. at the very least get a post-op note to assist you with your treatment regime.

Good communication with your physicians will enable you to reduce lost days between surgery and therapy. Often times in our clinical setting we will see patients before surgery and can communicate to them the importance of hand rehab and some of the details of the post-op recovery period so they can plan when the surgery would be best for them. This is the case with patients who have thumb reconstruction, MCP arthroplasty, Dupuytren’s disease, CTS and any other elective procedure.

I have had the pleasure of working under skilled physicians since 1990. The ability to view surgery, tag along in clinic, make emergency splints, do clinical research and spend countless hours reading the physicians surgical books have molded me into the therapist I am today. I LOVE having the physicians in the same office to bring over a patient when I have a question about the possibility of an infection or if I want them to take a quick...
The physicians’ have challenged me on many occasions by quizzing me in the O.R. or in clinical setting and this enhances my clinical problem solving skills and drives me to read and learn more. The obvious benefits of working closely with a physician(s) include getting scripts signed quickly, adding other treatments to the patients programs, as well as contacting them if something is not going right. But don’t dismay if you are NOT in a physician based setting you can still benefit from all the goodies I just mentioned. Get close to a referring physician and ask to shadow him/her in clinic and surgery and tell them you want to be quizzed and challenged and hold on for a great ride. It is exhilarating and challenging to have your minds taxed to pull up basic anatomy and content that you may have put on your back burners. You will become a better therapist by doing this, I promise you. This applies to new therapists as well as seasoned certified hand therapists. I learn something new every time I hang out in the O.R. or do clinical rounds. So challenge yourselves to a day with the doc and see what you don’t know as well as what you do know!

Bonus Featured Article:
Lateral Epicondylitis
Dale Bramlet

Lateral epicondylitis remains one of the most difficult and challenging clinical conditions. Lateral epicondylitis or tennis elbow can cause debilitating pain on the lateral elbow and is, now, frequently treated with steroid injections, occupational/physical therapy as well as splinting. A number of modalities have been shown to be effective and in various treatment regimens are utilized in therapy centers throughout the United States.

However, some patients do not seem to respond to traditional treatments of splinting, exercises, steroid injections, periods of rest, activity modifications, and/or anti-inflammatory medications.

When conservative measures, including steroid injections, have failed surgery can, many times, be indicated. Surgery

continued on page 9
### Splinting Tips and Tricks

**Fabricating Splints: Hints and Tricks**
- Use gravity to assist for better drape and fit.
- Incorporate arches of the hand for comfort and compliance.
- Evenly distribute pressure while molding... one trick you can try is to smooth cream on the splint or sprinkle some water on the splint and remember STROKE don’t POKE.
- You can use your fingernails to mark the splint for easy trimming.
- Know your material... as some will “shrink” after you remove them from the patient and may be a bit constricting along the sides.
- Pad potential pressure areas before you mold to minimize pressure points. (Remember to remove the padding after molding)

**Adjusting Prefabricating Splints**

To ensure splints do not irritate the soft tissue, reduce circulation, or cause paresthesias you many need to adjust prefabricated splints.
- Flare the ends of the splint
- Cut some of the loop strap and add padding to the cut out area.
- Bubble out pressure areas
- Adjust metal inserts to achieve the appropriate position and comfort
- You may need to add components to splints such as putty-elasticomer inserts for finger separators

**Splint Problems and Solutions**

*Problem: When fabricating thumb splints - the splint is hard to remove because the IPJ is larger than the proximal phalanx.

*SOLUTION: Use a layer or two of coban around the proximal phalanx of the thumb before you fabricate the splint; This will enlarge the proximal phalanx.

*Problem: Proximal end of splint is digging into patient’s forearm.

*SOLUTION: Flare the end of the splint. Round edges of the material. You can do this by dipping about 2-3 mm of the material edge into the hot water, then flare and round using the table or your hand.

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1. What is the primary muscle/tendon injured in lateral epicondylitis?

2. What diagnosis co-exists 20% of the time with lateral epicondylitis?

3. Why would a therapist opt to immobilize the wrist when treating lateral epicondylitis?

4. In regards to reaching and lifting with lateral epicondylitis:
   a. What is a causative motion?
   b. How would you teach your patient to reach and lift to minimize stress on the pathological structures?

5. When rehabilitating a patient post OssaTron (Extracorporeal Shockwave treatment (ESWT)) for lateral epicondylitis when can he resume normal activities?

6. Early post OssaTron rehab should consist of what?

7. The FDA approved ESWT for lateral epicondylitis. T/F

8. Stretching is an integral part of rehabilitation when treating lateral epicondylitis? T/F

9. The one downfall with the OssaTron treatment is using a general anesthesia. T/F

10. What is the success rate, per Dr. Bramlet, when using OssaTron to treat lateral epicondylitis? answers on pg. 10

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Authors:
Nancy Falkenstein, OTR/L, CHT, CEES
Susan Weiss, OTR/L, CHT

“Thanks a lot for your online hand therapy course! I used it as a study aide for the Hand Therapy Certification Exam in November and I am happy to say I am now a CHT! Thanks again!”
Jim Wagner OTR/L, CHT, CSCS

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traditionally has been in the form of lateral epicondylar release with or without a stripping of the extensor aponeurosis. In more extensive cases and/or refractory cases, exploration of the elbow joint with incision of the orbicular ligament may be indicated. In refractory cases of lateral epicondylitis, an anconeus muscle flap has been advocated.

More recently, many surgeons have advocated percutaneous techniques for initial surgical treatment of chronic lateral epicondylitis that have been refractory to conservative measures. A new breakthrough that is gaining more prominence and has now received FDA approval involves Orthotripsy. The OssaTron admits shock waves (similar to those used to treat kidney stones) to, in theory, increase blood flow and stimulate healing of the affected elbow.

Patients who are candidates for OssaTron treatment typically undergo a light general anesthetic, frequently supplemented with a local anesthetic at the end of the procedure. Most patients are taken off anti-inflammatory drugs in the pre-operative and postoperative period. The treatment can be performed at an outpatient ambulatory surgical center and typically takes less than 30 minutes. Generally one treatment suffices, and success rates as high as 65% have been reported in the orthopedic literature. OssaTron treatment may be an excellent non-invasive technique and should be included in the armamentarium of physicians who treat lateral epicondylitis and in particular for patients who have been refractory to other modes of treatment.

What is Extracorporeal Shockwave Treatment?

OssaTron

Extracorporeal Shockwave Treatment is a non-invasive (no incision) treatment that involves the delivery of high energy sound waves, or acoustical energy, to affected areas of the body to trigger the body’s own natural repair mechanisms and stimulate healing. Extracorporeal Shockwave Treatment (‘extracorporeal’ meaning ‘outside the body’) is a safe and effective treatment option. The recovery period is shorter than traditional invasive surgery and the procedure eliminates many of the risks associated with traditional surgery.

CONTINUED ON PAGE 11
**EXPLORING HAND THERAPY**

**Test Your Knowledge**

Answers (from ? on page 6)

1. Extensor carpal radialis brevis (ECRB)
2. Radial Tunnel
3. To rest the wrist extensors (ECRB and ECRL)
4. a. Extended pronated elbow  
   b. Bent supinated elbow
5. Four to five weeks
6. Rice: rest, ice, compression, elevation
7. True
8. True
9. True
10. 65%

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**Ergo Tips and Tricks**

**Musicians and Ergonomics**

Instrumental musicians are a special risk group for repetitive motion injuries. Sizable percentages of them develop physical problems related to playing their instruments; and if they are also computer users, their risks are compounded and complicated. Computer-induced tendonitis is aggravated by instrumental playing such as the guitar or violin. Playing may not begin to improve until all instrumental playing is stopped for several months.

Instrumental injuries often include the same conditions experienced from computer use and are particularly common among keyboardists, fretboardists, flute, and string players. Some of the common diagnosis among instrumentalist and computer users are: carpal tunnel syndrome, deQuervain’s tenosynovitis, tennis elbow, trigger finger, TOS, and cubital tunnel. The particular demands of different instruments produce other problems as well, including hearing loss or TMJ.

While these problems are common, they are NOT an unavoidable part of being a musician. If musicians are willing to listen to what’s being learned in the field of arts medicine, they may be able to escape the bullet of occupational injury and recover their ability to play.

What can a musician do?

**Get informed.** Read articles, ask other musicians and become proactive. Learn causes and realize prevention is the key. These conditions are complex and require prompt attention.

**Evaluate your technique:** Athletes do not abruptly start vigorous physical activity without warming up and stretching because they know it is an invitation to injury. Musicians are putting athletic demands on fine motor musculature and should similarly be religious about warming up before practice or performance.
Extracorporeal Shockwave Treatment (ESWT) has been used effectively for many years around the world. It was first approved in the United States by the FDA in October 2000 for treatment of Plantar Fascitis, a type of heel pain. The FDA subsequently approved ESWT for Lateral Epicondylitis, commonly referred to as Tennis Elbow, in March 2003.

Patients may experience discomfort in the treated area after the effects of anesthesia have subsided. Some bruising, swelling, and temporary numbness is normal and expected. In the immediate days following treatment, many doctors will recommend RICE – Rest, Ice, Compression, Elevation.

Patients may continue to experience pain similar to pre-treatment for up to 2 weeks. Restrictions or precautions following the procedure consist of avoiding stressful activities (e.g. jogging, heavy housework, yard work, participating in sports) involving the affected area for four weeks. Four to five weeks post treatment patients can typically resume normal activity.

Healing is generally complete at about 12 weeks. However, patients may continue to experience pain relief for months. Shockwave Treatment is an exciting and encouraging new approach for the surgeon/hand therapist/patient when treating the challenging lateral epicondylitis pathology.

Biography:

Dr. Dale Bramlet received his medical education from Southern Illinois University, School of Medicine. Dr. Bramlet is the President/Board of Directors at All Florida Orthopaedic Associates. He is involved in the medical community through research, teaching, mentoring, and private practice. Dr. Bramlet is the Founder and CEO of Advent Clinical Research Studies, Inc. He is the Director of Clinical Research at All Florida Orthopedic Associates, in St. Petersburg, Florida. He is on the Board of Directors at St. Petersburg College Development Foundation, Inc. Dr. Bramlet is also the Medical Director for the Hand Trauma Program, at Bayfront Medical Center in St. Peters burg, Fl. He is a Clinical Assistant Professor for the Department of Family Medicine at the University of South Florida, Tampa. Dr. Bramlet, is the Mission Coordinator for Faith in Practice leading a yearly mission to Antigua, Guatemala to provide volunteer surgical services. Dr. Bramlet is an asset to the hand therapy and surgery communities.

Dr. Bramlet performing surgery.

Thank you Dr. Bramlet for your immeasurable support and contribution to this newsletter and our profession.

What’s HOT!

The Similarities and Differences Between Carpal Tunnel Syndrome and Computer-Associated Carpal Tunnel Syndrome

By Dr. Eberbach

Recent dependence on computer keyboards and mice in the workplace has resulted in a dramatic increase in wrist and hand complaints. There is a general failure to recognize that computer-associated CTS is a different form of median nerve compression neuropathy, and not traditional CTS. Computer-associated CTS masquerades as CTS but is not the same injury. With computer-associated CTS, the damage comes from the force of external contact pressure not from swelling in the carpal tunnel. Nerve conduction studies cannot distinguish this different location or cause. Splinting will only add to the pressure. The first goal of treatment must be to maximally protect the nerve from contact pressure trauma before it starts.

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** Take lots of breaks to stretch and relax: This means both momentary breaks every few minutes and longer breaks every hour or so. This may be the single most important thing to remember. Constant tension and repetitive motion does not allow the body to flush away metabolic waste products and this is traumatic to tissues over time. Even in the middle of playing a piece you may have a moment to relax a hand or arm to restore circulation. The marathon rehearsals that musicians pride themselves on have great potential to hurt in the long run. Emerging research on athletes reveals that overtraining actually decreases performance. Try two or more shorter rehearsals in a day rather than one long, intense session, and limit total time on your instrument.

** Pay attention to your body: Pain is your body yelling that it's in big trouble, but learning what is comfortable or awkward for your body before you're in pain may prevent injury.

** Check out your instrument: Are you using an instrument that is too large or awkward for you? Is it set up optimally for you? Could you use lighter strings or reeds? Is there a strap or stand that could make playing less stressful? If it's big and heavy (like a string bass), can you get a cart to help transport it? And remember: if it is a new instrument, especially a larger one, you need to take time to adjust to it before you plunge into intense use of it.

** Caution with strengthening: Building up muscle strength with special devices (putty) or musical exercises is very controversial. If you are already injured and in pain, such things may make the condition worse.

** Get medical help: "No Pain, No Gain" is a disastrous policy for a musician. If it hurts, back off. This is serious stuff. What is worse, not playing for a few months, or risking a permanent injury, disability, pain, and never playing again? Remember, don't put off seeking treatment if you are in pain.

Information complied from:
Musicians and Injuries
http://www.educationplanet.com

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** Joint Active Systems (JAS)
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I have used the JAS finger SPS and have found it to be effective, easy, and patient friendly. What I enjoy most about making/modifying the JAS splint is my ability to use my splinting skills. My critical thinking skills and fabrication talents are challenged by fabricating the proper static component; then attaching and adjusting the outrigger properly to the base to achieve the desired motion. The versatility and results have been very promising.

** Ergo Tips and Tricks (Cont.)

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From: www.ASHT.org

Update on R.A.
National Institute of Arthritis and Musculoskeletal Skin Diseases (NIAMS): Coffee and tea are **Not** Risk Factors for Rheumatoid Arthritis!

Contrary to previous reports, drinking four or more cups of any form of coffee or tea a day does not put women at risk for developing rheumatoid arthritis (RA), according to a new study partially funded by the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). The study concluded that there is little evidence to support a connection between consuming coffee, decaffeinated coffee or tea and the risk of RA among women. For more information, please check out the May Government Report at http://www.asht.org/govtnewsctr.html

From: www.AOTA.org

Victory for Occupational Therapy Assistants
(August 9)—AOTA has successfully convinced the Centers for Medicare and Medicaid Services (CMS) that occupational therapy assistants working in occupational therapy private practices should be working under the same level of supervision as occupational therapy assistants who work in all other settings.

Victory on the Horizon for Private Practitioners
(August 9)—Finally, the Centers for Medicare and Medicaid Services (CMS) agree with AOTA that occupational therapy services provided in physicians' offices must be performed by qualified personnel! Qualified personnel consists of a COTA or OT not a technician or aide.

From: www.HTCC.org

Philosophy
From its inception, the Board of Directors of HTCC envisioned a two-step process of Certification and Recertification. Certification is the first step in this process; it provides assurance to the public that a Certified Hand Therapist meets the high standards set by HTCC. Once certified, it is the personal responsibility of each Certified Hand Therapist to maintain the credential in order to demonstrate current knowledge and skills. Because of changes in the profession, every CHT is required to demonstrate continued professional development and competency by recertifying every five years. Currently 80 hours are required every five years for recertification.

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What’s Up Doc?

**Question:** How many treatments are required using the OssaTron to treat lateral epicondylitis?

**Dr. Bramlet:** Single treatment is all that is usually needed.

**Question:** What do you think of your results so far with using the OssaTron technique?

**Dr. Bramlet:** Results so far are encouraging.

**Question:** When are patients sent for therapy after the OssaTron procedure?

**Dr. Bramlet:** Therapy is an integral part of the recovery process, starting shortly after the procedure.

**Question:** Are the patients immobilized for any time after the procedure?

**Dr. Bramlet:** Sling only.

**Question:** Do you have any specific procedures the therapist performs post treatment?

**Dr. Bramlet:** Cold therapy and ice intermittent and then ultrasound and heat to follow as needed.

**Question:** Are their any precautions for the therapist to heed post treatment?

**Dr. Bramlet:** None

**Question:** Do you think the OssaTron procedure will apply to other areas of hand surgery?

**Dr. Bramlet:** It is being explored in other areas of hand surgery. None that the FDA approved as of yet.

**Question:** What downfalls of the procedure have you noticed thus far?

**Dr. Bramlet:** The need for a light general anesthesia in most patients is required.

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Additional sites for information on Tennis Elbow/Lateral Epicondylitis:

http://physicaltherapy.about.com/cs/elbowtohandpain/a/tenniselbow.htm
http://www.tennis-elbow.net/tenniselbow.htm
http://www.medinfo.co.uk/conditions/tenniselbow.html
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Calling all readers: Please send EHT your ideas and contributions to share with others. Don't have time to do formal research? But you see trends? Don't have time to write a detailed paper? PLEASE send your goodies to EHT. EHT will be glad to
share your ideas with over 4,900 therapists. Nancy and I have been educating since 1996 and we continue to learn each day from the people we teach, our mentors, our physicians and YOU, are readers. Don't be shy - go for it. It can be short, it can be long and it can be light and not too intense. It can be a hunch or something you would like to research. We want to hear from you. You can help other therapists with something they thought of but were afraid to try or confirm things they might have seen clinically. Email us direct at susan@exploringhandtherapy.com or call 727-341-1674. Thank you, to each of you, for making this newsletter so popular and packed with great tips/tricks and techniques!

Susan and Nancy
EHT

By the way... what do you think of our new logo? We are having a blast with it. We love how it shows that we, as hand therapists, have so much dimension and depth and will reach inside to get to the true problems. O.K., maybe it only looks like that to us since we created it but drop us a line with feedback about our logo when you can.

See ya next time!!!