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# REACH

Research, Education, Achievement & Clinicians in Hand & upper limb therapy around the world.

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## The IFSHT is excited to present edition ten of our newsletter, REACH.

This publication aims to collate Research, Education, Achievement and Clinicians in Hand and upper limb therapy around the world.

# LETTER FROM THE EDITOR

**Daniel Harte**
*IFSHT Publications Committee Chair (2022 – 2025), Northern Ireland*

During the initial weeks of the Covid-19 lockdown in 2020, I spent long days in an eerily quiet fracture clinic. As an occupational therapist working in trauma and specialising in hand therapy, I was always used to treating a high volume of hand injuries during the normal commotion of everyday life.

During "normal" times, sports injuries make up a large proportion of my clinical caseload. In the past the orthopaedic hand surgeon I work with discussed this fact, wondering what we could do to reduce the number of injuries.

Participation in sports is an effective way to improve physical fitness and mental health [1]. On the flipside, injury is always just a misjudged ball catch or unruly tackle away. To put it into perspective, hand injuries are reported to have the largest impact on productivity and economic burden over other types of injury with more people having to take time out of work to recover from these [2].

Therefore it is fitting that this issue of REACH is dedicated to the role of hand therapy in the management and prevent of sports injuries. Please enjoy guest contributions in this issue from Hamish Anderson and Jim Wagner along with our regular features on how to produce research, research updates, Lifetime Achievement Award recipients and spotlight on hand therapy societies (big thanks again to Cynthia Srikesavan, Mia Erickson, Boone Meyer, Stacie Sivertson, and Rita Ator and Susan de Klerk).

It's now 2024. With us all hopefully viewing the COVID-19 pandemic far in the distance through our rear view mirrors, everyday life for most, including sports, has returned to something close to normal. This of course means an increase in work volume! So I am back treating lots of hand injuries, happy to be busy, something which I promised myself back in 2020 that I would never complain about again!

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# Qualitative Research Approaches

Written by Dr Cynthia Srikesavan, Senior Researcher in Physiotherapy, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, University of Oxford.

**Welcome to Part 1 of our series on qualitative research! This series aims to provide you with a basic understanding of the purpose and characteristics of qualitative research. We will begin with a brief introduction, discuss how it differs from quantitative research, and cover the five different approaches to inquiry.**

## Introduction

The purpose of qualitative research is to listen, observe, and summarise a human phenomenon to make sense of the dynamics of reality, behaviour, feelings, perceptions, emotions, and/or lived experience of an individual or group of individuals.

Munhall defines as, 'Qualitative research involves broadly stated questions about human experiences and realities, studied through sustained contact with the individual in their natural environments, and producing rich, descriptive data that will help us to understand those individual's experiences' [1].

## Quantitative vs Qualitative

Qualitative research has unique characteristics and differs in many ways from quantitative research. For example, quantitative research is deductive in nature and may use scales or questionnaires to collect data and test a hypothesis. In contrast, qualitative research is inductive with a flexible design, and uses in-depth interviews, observations, diaries, or audiovisual materials to develop a meaning or theory, or hypothesis. Qualitative researchers collect data themselves by talking to people or observing them directly. They rely on multiple forms of data such as interviews and field

notes to categorise the information into themes. Qualitative researchers focus on understanding the 'meaning' that an individual holds on a problem; interpreting what they hear, see, and observe; and developing a holistic picture of the problem from multiple perspectives [2-4].

## When should I use qualitative research?

Qualitative research is best suited to the following situations:

1. When quantitative designs cannot answer the problem studied
2. When you need a detailed understanding of the problem (concepts or experiences)
3. When you empower people to share their personal stories and real-life experiences
4. When you want to corroborate or elaborate on or contradict findings collected from quantitative methods

## Qualitative approaches, in brief

The five types of qualitative approaches are narrative research, phenomenological research, grounded theory research, ethnographic research, and case study research [2, 3].

Narrative research uses 'storytelling' to provide deeper insight into an individual's experiences [2, 3, 5]. Phenomenological research focuses on understanding the 'essence' or 'meaning' of many individuals who have had similar lived experiences of a concept or problem [2, 3, 6]. The purpose of grounded theory research is to develop or identify a theory 'grounded' within the data rather than simply describing it [2, 3, 7]. The qualitative researcher uses ethnography to describe and interpret the beliefs, opinions, behaviours, or values of a group of people who have common meanings or experiences or customs – called a 'cultural-sharing group' [2, 3, 8]. Case studies involve an in-depth understanding of an issue (which can be an activity, event, or a problem) using one or more cases. This design uses multiple sources of information to describe the case(s) [2, 3, 9].

**In the next issue, we will discuss the qualitative data collection and analysis methods. Read more here [10].**

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# New and Noteworthy

## Hand injuries in Rock Climbing

**Written by Mia Erickson** (PT, CHT, EdD. Midwestern University, Glendale, AZ),
**with Rita Ator** (DPT, PT, Orthopaedic Clinical Specialist and Assistant Professor at Midwestern University),
**Stacie Sivertson and Boone Meyer** (Doctor of Physical Therapy Students at Midwestern University)

In keeping with the sports theme, this issue will focus on hand injuries in rock climbing. Climbing sports are becoming increasingly popular. In the US alone, over 10 million individuals were participating in climbing sports in 2021 representing a 200% increase from 2006 [1]. A recent study examining the prevalence of climbing injuries showed that finger injuries have consistently been the most prevalent. In 2018, finger injuries accounted for 41.2% of all climbing injuries [2]. In adults, two common climbing injuries include flexor tenosynovitis and flexor pulley injuries, while periphyseal stress injuries are unique to adolescent climbers [3]. Unfortunately, there is a lack of high-quality evidence on management of climbing-related finger injuries. The purpose of this report will be to provide information on climbing injuries and resources to help hand therapists to identify and manage these injuries.

Mohn et al [4] described a treatment for flexor tenosynovitis in climbers. The intervention included daily gripping exercises to increase forearm flexor muscle strength and use of a silicone gel sleeve to decrease finger swelling. Patient instructions included performing a warmup prior to climbing comprised of finger stretching, avoiding full crimp (Fig. 1) and half crimp (Fig. 2) grip positions, and climbing that did not go beyond the vertical position. The 10-year follow-up (n=65) showed the mean symptom duration was 30.5 weeks and the average amount of time off from climbing was 4.4 weeks. Additional treatments used by the respondents in the study included climbing-related load reduction (90.8%), taping (64.6%), medication (13.8%), and ergotherapy (12.3%). Authors concluded tenosynovitis had a favorable prognosis in this patient population [4]. Unfortunately, specific

*Figure 1*

*Figure 2*

treatment parameters were not provided, and this intervention does not apply to those with pulley rupture or flexor tendon injury.

A systematic review on flexor pulley injuries showed the A2 and A4 pulleys were most frequently injured with the most injured fingers being the long and ring [5]. Tendon bowstringing was not always observed clinically, and imaging was usually needed to confirm the diagnosis [5]. Climbers have tried to address pain in the pulley system with taping. Circumferential taping includes wrapping the digit at the A2 pulley to decrease forces and bowstringing [6]. A study showed taping directly over the A2 pulley was less effective than taping over the distal edge of the pulley, closer the distal aspect of the proximal phalanx and proximal interphalangeal (PIP) joint. Authors concluded that taping could unload the tendon but only when external forces were low, and it was ineffective in offloading when higher forces were applied, such as would be encountered by an advanced climber [6]. Salas et al [7] investigated the effects of H-taping, a more expansive method that covers pulleys A2 through A4. In cadaver hands, authors found no difference in failure rates between H-tape and no H-tape on A2 pulleys [7]. While taping is popular, it may not have much effect on decreasing force during climbing, although it may have a psychological benefit [6]. More research is needed to investigate the effects of taping on climber confidence [7].

Fatigue is an important aspect of climbing performance and injury risk. In one study, climbers were more likely to report injuries if their climbing sessions were longer than two hours [8]. Central fatigue has been shown to change environmental perception, such as overestimating how far away a ledge can be, while peripheral fatigue, such as forearm muscle fatigue, can decrease overhead reach length and increase the amount of unplanned and exploratory movements [9]. Walsh et al [9] investigated the effect of fatigue on climbing quality and found those experiencing fatigue had 23% more falls than those who were not fatigued. Blood Flow Restriction (BFR) is one effort to address endurance in climbers. Held et al performed a 5-week intervention program and found BFR significantly increased both grip and arm endurance compared to a control group [10].

An injury unique to adolescent climbers is the periphyseal stress injuries. The climber will present with pain on the dorsal aspect of the PIP joint, at the base of the middle phalanx [11]. Injuries may heal without consequences, but if left untreated they can progress to an epiphyseal fracture [11]. Therefore, timely diagnosis and treatment are vital to reduce skeletal growth disruption and deformity [3, 11]. Schöffl et al11 provided a diagnostic algorithm to assist clinicians in identifying and managing these injuries. Adolescents presenting with signs and symptoms consistent with a periphyseal stress injury who have persistent pain following a week of rest receive imaging studies (ie, diagnostic ultrasound to assess soft tissue and/or an MRI or radiograph). Depending on findings, this may be followed by non-surgical management including use of a finger

orthosis and additional rest. Imaging studies are repeated until there is no edema present, or the fracture is healed. According to the authors, surgery is recommended in some cases. Once healed, the individual can restart climbing gradually [11].

The "full crimp" is implicated in finger injuries in climbers. This grip is used to increase finger pressure and thumb grip against small surfaces [6]. With the PIP joints flexed at 90° and the DIP joints hyperextended, the full crimp puts stress on the A2 and A4 pulley, causing microtrauma and stress resulting in pain, inflammation, and possible pulley rupture [6]. Schweizer [6] calculated the force of tendon bowstringing produced during climbing and found a linear increase in force against the distal edge of the A2 pulley with increasing grip force against the distal phalanx equivalent to 373N. The "full crimp" also stresses the dorsal aspect of the growth plate increasing susceptibility to periphyseal injuries. Authors have recommended the "half crimp" as a safer alternative. Another prevention strategy included avoiding use of campus boards that add to already high training loads [11]. Miro et al1 [2, p2] recommended adolescent climbers avoid the "double-dyno" exercise in which "athletes release a campus board rung after a pull-up, catching the next rung with both hands simultaneously."

Teaching patients about modifiable injury risk factors such as early return to climbing after an injury, climbing discipline, difficulty level, supervision, and climbing time may help to reduce injuries [8]. As rock climbing becomes a more popular sport, and as more people take part, there is a risk of more injuries. More research is needed to investigate prevention and treatment strategies for common injuries in adult and youth climbers.

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# Climbing: Additional Resources

This resource provides several articles that are part of a special Research Topic.
https://www.frontiersin.org/research-topics/9383/research-in-sport-climbing/articles

The Evaluation of Energy Availability and Dietary Nutrient Intake of Sport Climbers at Different Climbing Levels.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10049433/

Bouldering psychotherapy is more effective in the treatment of depression than physical exercise alone: results of a multicentre randomised controlled intervention study.
https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020-02518-y

Exploring the relationship between mindfulness and rock-climbing: a controlled study.
https://link.springer.com/article/10.1007/s12144-021-01593-y

Adaptive rock climbing has physical, psychological benefits for people with disabilities.
https://www.research.va.gov/currents/0520-Adaptive-rock-climbing-has-physical-and-psychological-benefits-for-people-with-disabilities.cfm

A randomised controlled trial on effectiveness and feasibility of sport climbing in Parkinson's disease.
https://www.nature.com/articles/s41531-021-00193-8

Affective responses to climbing exercises in children and adolescents during in-patient treatment for mental health disorders a pilot study on acute effects of different exercise interventions.
https://www.sciencedirect.com/science/article/pii/S016517812030593X

Stanford graduate students teach neuroscience through the lens of rock climbing.
https://news.stanford.edu/2019/10/15/neuroscience-lens-rock-climbing/

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# Clinical Pearls

In this section we feature clinical pearls which should be applicable to most hand therapy settings. **We welcome your ideas.** Submit them to informationofficer@ifsht.org.

## Splinting for Sport

Written by Hamish Anderson* OT / AHT Occupational / Accredited Hand Therapist (as awarded by the AHTA)

When dealing with the injured elite athlete, the pressure to return to the field after a hand injury is significant. Often this means that the athlete will want to play before the fracture or joint is stable. They do this, at least in my world, with a good understanding of the risks and with the blessing of the medical team. The hand therapist's role then is to provide as much protection as the player will tolerate without the splint interfering with their game.

It is vital that the hand therapist is aware of the individual rules as they apply to different sports and different leagues. A protective guard that was legal for NBA basketballers was illegal for my sons' under 12 (those aged 11 and 12) team. Padding may be required, and there may also be a defined permitted thickness of both the plastic used and the padding provided. The referee will often inspect bandaged hands, and usually the guard must be declared on pre-game medical forms.

When making the splint try to minimise material over the palmar surface of the hand. Plastic in the palm or over the fingertips will affect grip and sensation. Taping the splint on is important and tape can also be used to provide extra support under the plastic. Adding Velcro straps is unnecessary and bulky, and should be reserved for post-game splinting. Generally, a 1.6mm thermoplastic is sufficient for most hand and finger injuries.

**Metacarpal fracture post ORIF:** This dorsal splint (Figure 1) works particularly well with metacarpal ORIF's but like most game day splints relies heavily on taping to keep it in place. There is nothing tricky

*Figure 1*

about this splint other than I create an air gap directly over the incision with therapy putty. This acts to disperse pressure away from the fracture itself. Occupy as much dorsal surface as you can to provide stability. Fabricating it as the athlete makes a fist will permit better movement when the splint isin place.

**Figure 8 PIP splint:** This stable splint (Figure 2) will prevent hyper-extension of the PIP joint. Particularly useful post PIP joint dislocation or volar plate avulsion injury. Be sure to fabricate the splint in slight flexion much as you would if just doing a figure 8 taping for the same injury. The natural give in the splint will not prevent hyperextension if it is made with the PIP in neutral. I like splint tape like OrfiCast for this but have also made this from a cylinder of rolled 1.6mm thermoplastic.

*Figure 2*

**Thumb UCL / RCL guard:** Used in conjunction with solid taping and a splint for non-playing times (Figure 3). If more movement is required, creating a hole for the dorsum of the thumb metacarpal. Be sure to round the edges of the hole if you are doing this to reduce pressure at the splint margins.

*Figure 3*

**Mallet finger splint:** A good example of where a dorsal splint is best. However, taping to maintain DIP extension underneath the splint is also crucial. The player must be extremely careful when donning / doffing the splint. Practicing this several times before they use the splint is crucial as it is unlikely that you will be available to do this for them.

There are many ways that skilled hand therapists can augment the options available to medical teams in elite sport. Splinting is the most obvious but must be done with a clear understanding of the risks involved, the limitations associated with it, and the rules that are specific to that sport.

**Hamish Anderson is an Australian hand therapist with special interests in the biomechanics of the wrist and in sport specific injuries to the upper limb. He has worked with professional athletes from most elite sports in Australia and has a permanent role as the hand therapist to the Hawthorn Australian Rules football club (www.hawthornfc.com.au ) Please contact him directly with any questions regarding this article. hamish@actionrehab.com.au*

# Strength Training Principles in Hand Therapy

## A focused look into incorporating exercise into your treatment program.

Written by Jim Wagner* OTD, OTR/L, CHT, COMT, CSCS

Strength training has many benefits which include, but are not limited to, improved overall strength, weight loss, cardiovascular function, increased bone mineral density, improved cognition, improvement in depression scales, and decreased stress levels [1, 2]. As clinicians, we prescribe range of motion (ROM), stretch, manual techniques and targeted exercises as part of our daily treatment regimens for the clients that we serve based on the condition being addressed. The question is how much do we prescribe? Does every program have to be "3 sets of 10 repetitions"? By prescribing too much we "overdose" our clients on exercise causing inflammation, loss of motion, increase in pain and loss of function. By prescribing too little, we "under-dose", rendering our intervention ineffective. Implementing some basic training principles, we can tailor our exercise prescription for a more focused program meeting our clients' needs.

Our clients come to us with a variety of needs. These needs may begin in the post-operative phase of intervention or present with a chronic condition which requires a completely different approach to treatment. The negative effects of immobilization, even within a few days, has been shown to have a 3.5% reduction in muscle mass, 9% loss in strength which increases to 23% reduction after 14 days [3, 4]. Many of our clients already function in a deconditioned state prior to injury, illness, or surgery. Age related

sarcopenia and loss in muscle mass has been shown to increase 3-8% per decade after 30 years of age and that percentage increases after age 65 [5]. Prior to programming, it is essential to ask a few basic, however extremely necessary questions. These 3 questions can be employed in clinical reasoning for use in any situation to help in the decision-making process from use of physical agent modalities to strength training. The questions are as follows: What is the target tissue you want to have an impact on? What impact are you trying to achieve? What wound healing phase is your client in? Knowing what phase of wound healing each individual is in and their precautions gives insight on starting a structured strength and conditioning program.

Exercise dosage includes, but is not limited to, repetitions, number sets of exercise, volume (repetitions x sets), load/resistance, rest periods, multi-joint vs isolated exercise, isometric and isotonic exercises [6]. Each of these modifiable factors can be formulated to have a specific impact on the treatment program. Early on in recovery, isometrics may be a prudent choice, and have demonstrated a positive impact on tendon healing, improving load tolerance and having a short-term analgesic effect [7, 8]. Muscle hypertrophy is a complex lengthy process that can take months [9]. In the subacute phases of wound healing, individuals may not be able to sustain high demand loads as this may be contraindicated. Early strength gains are made in neurological adaptation, enhanced motor recruitment, and muscle endurance [10, 12]. In the early phases, neurological retraining may be the programming of choice prior to increasing overall load and volume. Muscle hypertrophy has been defined as an accumulation of contractile muscle protein adding sarcomeres with muscle protein synthesis exceeding muscle protein breakdown [10, 11, 12]. In the later phases of wound healing where skeletal muscle hypertrophy, power, and overall strength are the goal, the programming can then be modified to meet those desired outcomes.

Incorporating strength training for the client in the hand clinic must be individualized for each person's needs. Programming for these needs can prove difficult at times. Is the goal hypertrophy, muscle endurance, explosive strength/power, or muscle endurance/neurological adaptation? Do we use isolated muscle/joint exercise or multi-joint specific resistance training? Making the correct clinical progression without damaging repaired structures or overloading sensitive neural tissues can seem daunting. The following chart (Figure 1) blends the science of tissue healing phases and strength and conditioning programming to help with that clinical decision-making process. Incorporating strength and conditioning into your hand program can help to improve overall performance and functional outcomes.

## Figure 1: Proposed Exercise Algorithm for Wound Healing Phases

| Wound Phases | Inflammatory phase | Fibroplasia/ proliferative phase | Scar maturation/ remodeling phase | |
|---|---|---|---|---|
| **Mode of Exercise** | Strength/Isometrics | Muscle Endurance/ Neurological adaption | Hypertrophy | Explosive Strength |
| **Repetitions** | 5-8 repetitions | 15-20/30 reps | 6-12 reps | 4-6 reps |
| **Sets** | 1-3 sets | 2-3 sets per exercise | 4-6 sets | 6-10 sets |
| **Holds** | 10-30 second iso-hold | 30-45 second rest periods | 30-60 second rest | 120 second rest |
| **Effort** | 10-20% of 1 rep max | 25-30% of 1 rep max | 70-80% of 1 rep max | 60-70% load of 1 rep max |

*Note: This is only a hypothetical algorithm based on would healing and cited research. Sound clinical judgment based on indications/contraindications, tissue reactivity and desired goals need to be addressed. Prescription based on specific patient needs must be modified.*

**Dr. Wagner is an occupational therapist/certified hand therapist with 30 years of clinical experience working in the upper extremity orthopedic setting. He received his post professional clinical doctorate from Rocky Mountain University of Health Professions with a specialty in hand therapy. Dr. Wagner is credentialed in physical agent modalities, certified strength and conditioning specialist, and credentialed as a certified orthopedic manual therapist. Jim is currently the team leader of the Guthrie Hand Center and is an adjunct professor at an accredited occupational therapy program. Jim has been involved in competitive powerlifting/ bodybuilding for 35 year and has been in 28 competitions. He has traveled extensively teaching on topics such as kinesiology taping, cupping, instrument assisted soft tissue mobility, orthotic fabrication, and blood flow restriction training. Jim is a member of the American Society of Hand Therapists and National Strength and Conditioning Association. He has been published in the practice forum section of the Journal of Hand Therapy and serves as the webinar committee coordinator for the education division of the ASHT.*

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# Lifetime Achievement Awards

IFSHT celebrated the careers of a number of Hand Therapists at the 2022 IFSHT congress. Each of them was presented with the prestigious IFSHT Lifetime Achievement Award for Contribution to Hand Therapy. In the REACH newsletter we profile those therapists who, as you will see, have trail blazed and left an enduring mark on the specialism.

**Written by Sara Larson, Certified Physiotherapist Specialised in Orthopaedics, PhD, Department of Translational Medicine, Hand Surgery, Lund University, Sweden**
**Edited by Susan de Klerk, IFSHT information Officer**

## Birgitta Rosén

Birgitta graduated as an OT 1977 in Gothenburg, Sweden and started working within the field of hand therapy in 1981. She has a special interest in outcome and rehabilitation after nerve injuries – sensory re-learning using guided plasticity or extrinsic modulation of brain plasticity mechanisms, and sensory feedback in hand prostheses. She has 97 original scientific articles and 6 book chapters in the field. The latest book was released 2023 in Swedish on Hand Rehabilitation, co-written with a hand surgeon and a physiotherapist. She has also designed, introduced and researched methods for measurement of outcome following nerve repair (the Rosen Score and the STI-test) that are now recommended and used internationally.

Birgitta finished her PhD thesis in 2000 with the title "The Sensational Hand: clinical assessment after nerve repair". She has been active with clinical work with hand patients full or part time since 1981 which has been her drive and inspiration in scientific as well as in educational work. Apart from being a researcher and clinician, Birgitta has been course leader and organizer of a commissioned education at Lund University "Rehabilitation in Hand Surgery" since 2000. The 9th course is planned for 2025/26 and Birgitta is then handing over the course leadership to the next generation. Over 250 OTs and PTs from 17 countries have participated in this course over the years. Since 2009 she has had a position at Lund University, with a combination of research, clinical work at the department of Hand Surgery in Malmö, and lecturing (Functional Anatomy, Hand Rehab and Outcome, Hand and Brain in Rehabilitation, Hand Ergonomics) at the department of Health Science Lund University. This academic position also included supervision of PhD students and Master students. She continues to hold a 20% expert position at Lund University.

She was one of the founding members of the Swedish Society for Hand Rehabilitation, and she was the Chairman of EFSHT scientific committee for three years. In addition, Birgitta was the co-chair of the scientific program committee for the 13th triennial IFSHT congress in Buenos Aires in 2016.

Birgitta is an experienced invited speaker nationally and internationally for more than 20 years on topics about outcome after nerve injuries, rehabilitation after nerve injuries - sensory re-learning using guided plasticity mechanisms, to name a few. She was invited as key-note speaker at the Philadelphia hand meeting twice (2004, 2014) and was awarded The Inaugural Cristina Alegri Award, IFSHT Congress, Buenos Aires 2016 for her contribution to the understanding of the hand and sensibility and in addition was presented with a lifetime achievement award for her contribution to the field at the IFSHT Congress in London in 2022.

Birgitta has indeed pioneered both clinical work and research related to neural plasticity and sensory feedback and has been a major force and inspiration in the field of hand therapy, both nationally and internationally.

## SPOTLIGHT ON:

# Uruguayan Hand Therapy Association


Submitted by Dr Janine Hareau, PhD, OT, PT, HT; IFST delegate for Uruguay

The Uruguayan Hand Therapy Association was founded by a very small group of therapists in Montevideo in 2001. The aim of the association was to expand knowledge on hand therapy and upper extremity rehabilitation in a country where very little was known at the time about this specialised area.

Uruguay has a population of only 3,423,316 persons. The membership number of the association reflect this reality. The current membership is ten Occupational Therapists (OTs) and three Physiotherapists (PTs).

Education: Due to the shortage of therapists working within this field and the need for special attention to the subject, many courses have been presented over the years to improve the knowledge on hand therapy and upper extremity rehabilitation. These courses were presented at a University level and courses were open to advanced OT and PT students and to OTs and PTs interested in advanced training in hand therapy.

In the OT program, students take a compulsory course for the duration of two semesters namely: Upper Extremity Biomechanics. As part of the course students undertake a two month internship in a hospital or clinic that specialises within the field of upper extremity rehabilitation. The fact that educational courses are accredited by a university is a wonderful way to promote the specialty.

Some course topics were:

- Obstetrical Brachial Plexus Injury Rehabilitation and Splinting.
- Upper extremity Neuro - muscular Electrical Stimulation
- The role of OT and PT in the rehabilitation of the hand and of a person following Cerebrovascular Accident
- Upper extremity splinting
- Upper extremity serial casting
- Oedema control of the Upper Extremity

Uruguay has a universal health system which means that any person can access either a public or a private hospital. Hand surgeries are mostly performed by trauma or hand surgeons with some experience in the field.

Therapy is provided by therapists with little to no experience in the field. In addition, in many cases patients have to wait weeks or even months to be seen by a therapist. This is believed to be due to poor referral pathways between the surgeons and the therapists.

In December 2023 the Latin American Hand Federation initiated and presented a course on hand surgery and rehabilitation. This course brought together surgeons and therapists from Argentina and Uruguay. This was the first of its kind and was aimed at promoting hand surgery and therapy as a specialty, fostering collaboration between surgeons and therapists in order to improved patient outcomes. Speakers from our sister country (Argentina) generously provided information on the topic in order to help develop the speciality in Uruguay. Many young Uruguayan surgeons and therapists were present at the event. Fernanda Coscueta and Yamila Nicora, both from the Argentinian Chapter of Hand Therapy, shared their experience and therapy tips to the Uruguayan audience.

There is a long way to go, the Uruguayan Health System changes slowly, but big step are taken and the challenge is to continue working!

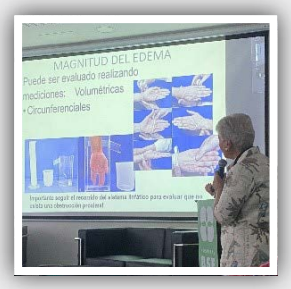
*Edited by Susan de Klerk, IFSHT Information Officer*


*Advertisement of the Latin American Hand Federation educational initiative, December 2023*

*In this picture from L to R: Janine Hareau, PhD, OT, PT, HT; IFST delegate for Uruguay, Fernanda Coscueta, PT, HT, and Yamila Nicora, OT, HT both from the Argentinian Society of Hand Therapists*

*Group picture of some of the event organisors: From L to R: Ezequiel Zeidemberg, (Arg), Gabriel Klembosky, (Arg), Yamila Nicora (Arg), Fernanda Coscueta, (Arg), Fernando Menvielle, (Arg), Sergio Daroda, (Arg) Janine Hareau (URU), Eliana Camacho (URU) Antonio Costa, (BR), Matías Craviotto, (URU), Nicolás Tamón (URU)*


*Distal radius fracture panel: speaking Nicolàs Tamòn, Traumatologist. Seated form L to R: Daniel Matera, Traumatologist, Janine Hareau, Hand Therapist, Gabriel Klembosky, Traumatologist*




*Dr. Janine Hareau speaking on Oedema evaluation*

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