PERTH HAND CLINIC
EXPERT HAND THERAPY IN THE HEART OF PERTH AND AT HOME

Thermoplastic Splints | Post Operative Care | Scar Management | Sports Injuries | Work Injuries | Arthritis & Degenerative Conditions | Dupuytren's Monitoring

Hand Therapy Referral Guide

Diagnosis	Referral	General Initial Protocol	Splints/Plasters
Trigger finger/ thumb	As patient presents	Splint 6 weeks Passive range of motion (PROM), massage and taping Referral for CSI prn	Thermoplastic (TP) MCPJ blocking splint or finger based immobilisation splint
Osteoarthritis of thumb	As patient presents	Splint as much as possible 2 to 6 weeks Education on management Massage and heat modalities Proprioceptive and stabilising program	TP hand based thumb spica Or neoprene semi-rigid splint
Carpal Tunnel Syndrome	As patient presents	Wrist splint nocte 6 weeks Taping Education and ergonomics Soft tissue release and tendon gliding exercises	TP wrist splint or off the shelf (OTS) wrist brace
Cubital Tunnel Syndrome	As patient presents	Elbow splint nocte for 6 weeks Taping Education and ergonomics Nerve Gliding	TP elbow immobilisaiton splint or OTS cubital tunnel brace
Chronic Regional Pain Syndrome	As soon as possible	Graded Motor imagery (GMI) Oedema Management AROM/PROM exercises Education CMMS casting for stiff hands Vitamin C 500mg for 50 days	Casting or night splinting occasionally used to mobilise stiff hands Doctor to consider Pregabalin script or Pain specialist referral
De Quervains Tenosynovitis	As soon as possible	Splint 2 to 6 weeks Discuss ergonomic alteration Trigger point release Exercises and stretches as symptoms decrease Referral for CSI in conjunction	TP thumb spica splint or semi rigid OTS for new mums
Lateral Epicondylalgia (Tennis Elbow)	As patients presents	Wrist splint 2/52 depending on severity Trigger point release Proximal strengthening	Wrist splint or counterforce brace
Distal phalanx tuft fracture	As soon as possible	4/52 splinting for protection AROM	Mallet style bash guard splint
Middle phalanx fracture (not ligamentous avulsion)	As soon as possible	**Conservative Management:** immobilised in splint for 4 to 6 weeks. Can be highly variable – treat dependant on individual presentations.	Finger based immobilisation splint or hand-based
PIPJ dorsal dislocation (includes volar plate avulsion fractures and tears)	As soon as possible	**Conservative Management:** splint and flexion AROM for 4 to 6 weeks. *If fracture larger the 1/3rd joint consider X-ray with splint on*	Dorsal blocking splint with PIPJ slightly flexed (Volar plate protocol) or lycra buddies if lower grade injury
Proximal phalanx fracture	At time of closed reduction or < 7 days Post op 3 to 5 days	**Conservative Management:** splint and lycra buddy full time 4-6 weeks, full active PIP and DIP joint flexion and extension started immediately. **Surgical Repair:** splint and lycra buddy full time for 4-6 weeks. Full active range of motion if fracture fixation is stable. (if not consider conservative protocol)	Hand-based TPS with MCPJ in maximum flexion for 4 – 6. Lycra buddies

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Metacarpal Fractures	As soon as possible	**Conservative management:** splint full time 4 to 6 weeks. IPJ AROM. Commence exercises Tendon Gliding Exercises at 3-4 weeks. Lycra buddies. **Surgical stabilisation:** splint full time for 4 to 6 weeks. Full AROM if fracture fixation is stable. Lycra buddies	**Head and neck fractures:** managed in hand based MCPJ immobilisation TPS **Shaft and base fractures:** forearm based TPS with MCPJ immobilisation in maximum flexion
Carpal fracture	As soon as possible	Recommendation as per conservative or referral for surgical opinion. Splint 6 weeks AROM to unaffected joints	TP wrist immobilisation splint or wrist and thumb immobilisation splint
Scaphoid fracture	As soon as possible or after POP removal	Full-time splinting until fracture has healed – can be 6 to 12 weeks. Individualised home and in therapy exercises program once fracture is stable	TP forearm based wrist immobilisation splint. Thumb included at Doctors request
Distal Radius Fracture	As soon as possible	**Conservative Management:** 6 weeks in splint AROM to unaffected joints including supination/pronation. Screening for CRPS – Graded Motor Imagery and Vitamin C commenced if risk factors exist.	POP/fibreglass cast or TP wrist splint (depends on stability & specialist preference)
Radial Head Fracture	As soon as possible	**Conservative Management:** Sling full time one week, wean as pt comfortable Gentle AROM supination/pronation and elbow extension/flexion	Sling
Mid shaft Humeral fracture	As soon as possible	**Conservative Management:** Plaster of Paris (POP) for first 2 weeks followed by thermoplastic (TP) splint and collar and cuff for up to 12 weeks **AROM:** gentle shoulder shrugs, scapular retraction, pendulum exercises. AROM to elbow, wrist and fingers.	**Non Op:** Initial U slab POP, then sarmiento bracing
TFCC injury or repair	As soon as patient presents	Splinting for 6 weeks Graded wrist proprioception program and strengthening of secondary stabilisers commenced	TP elbow and wrist immobilisation splint (Sugar-tong) or wrist splint based severity of presentation.
Thumb Ulnar Collateral Ligament Injury	As soon as patient presents	**Conservative:** Splint full time for 3 to 6 weeks depending on severity of injury	TP hand-based thumb spica splint
Extensor Tendons zone 1-2 (mallet finger)	As soon as patient presents	**Bony Injury:** splint full time for 6 weeks and then wean out of splint gradually. **Tendinous Mallet:** splint full time 8 weeks in < 10^{o} hyperextension then wean out of splint	DIPJ extension splint (consider X-ray once splinted if bony fragment > $1/3^{rd}$ joint)
Boutonniere deformity or central slip injury zone 3 & 4 extension tendon	As soon as patient presents	**Conservative Management:** Splint full-time for 6-8 weeks keeping the PIPJ extended and DIPJ free	Circumferential splint of the PIPJ joint
Sagittal band injury zone 5	As soon as patient presents	**Conservative Management:** splint full time for 6-8 weeks.	**Non-Op:** MCPJ blocking orthosis 20-45^{o} flexion
Dupuytrens Contracture	As required for monitoring	6 monthly monitoring (AROM and PROM assessment) to pick the ideal time for surgical intervention or percutaneous needle aponeurotomy	Literature suggests conservative management & splinting is ineffective

The protocols described are based on "general consensus" and the current literature available as of Jan 2023. Individual cases and clinical reasoning may vary. Please discuss with our hand therapists when a varied protocol may be required or if you would like to review a specific protocol or supporting literature in more depth.

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