### Supplemental Table 1. Interventions for Hand, Wrist, and Forearm

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Objectives</th>
<th>Level/Design/Participants</th>
<th>Intervention and Outcome Measures</th>
<th>Results</th>
<th>Study Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bakhtiary &amp; Rashidy-Pour (2004)</td>
<td>To compare the efficacy of ultrasound and LLLT treatments in mild to moderate CTS</td>
<td>Level I RCT</td>
<td>Intervention 2 experimental groups were randomly selected to receive either ultrasound (1 MHz, 1.0 \text{ w/cm}^2, pulse 1:4, 15 min/session) or LLLT (9 joules, 830 nm infrared laser at 5 points). Treatments were provided 5 times/wk for a total of 15 sessions.</td>
<td>Improvement was significantly more pronounced in the ultrasound group than in the LLLT group for motor latency, motor action potential amplitude, finger pinch strength, and pain relief. Effects were sustained in follow-up assessment.</td>
<td>No placebo or sham group was used.</td>
</tr>
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<td></td>
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<td>Participants N = 50 participants (90 hands)</td>
<td>Outcome Measures Assessment included visual analogue scale for pain, electroneurographic measurements (motor and sensory latency and motor and sensory action potential amplitude), pinch and grip strength testing.</td>
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<tr>
<td>Baur et al. (2009)</td>
<td>To examine the effects of handwriting training and auditory grip-force feedback in people with writer's cramp</td>
<td>Level III Pre–post assessment, single group</td>
<td>Intervention Handwriting training was conducted following principles created by Mai with focus on reducing inappropriate writing strategies. Treatment was conducted over seven 1-hr sessions spread over a 2- to 7-wk period (variation among participants). Each session involved exercises with use of conventional pen, sensor pen, and auditory force feedback.</td>
<td>Improvements were noted in decreased writing pressure and grip force. Subjective writing performance and pain also improved after handwriting training and auditory grip-force feedback.</td>
<td>Small sample size · Heterogeneous group</td>
</tr>
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<tr>
<td>Bleakley et al. (2004)</td>
<td>To assess the evidence base for use of cryotherapy in treatment of acute soft tissue injuries</td>
<td>Level I Systematic review</td>
<td>Intervention Inpatient, outpatient, or home-based cryotherapy used in isolation or in combination with other treatments</td>
<td>Marginal evidence supported that ice plus exercise is most effective in reducing pain after ankle sprain and after surgery. Little evidence indicated that ice added to compression had any effect in hospital inpatient settings. No evidence supported an optimal mode or duration of ice application.</td>
<td>The included RCTs scored an average PEDro score of only 3 and 4; differences in treatment protocols described made it nearly impossible to make comparisons in and among studies. In addition, methodological problems with many studies limited generalizability of the evidence suggested.</td>
</tr>
<tr>
<td>Breger-Stanton et al. (2009)</td>
<td>To examine the evidence regarding the use of contrast baths</td>
<td>Level I Systematic review</td>
<td>Intervention Studies included contrast bath protocols that differed in immersion time from 6 min. immersion in warm water followed by 4 min in cool water to a fixed ratio method of 4:1 warm to cold. Water temperatures varied from 106°F to 113°F for warm water and 47°F to 60°F for cool water.</td>
<td>Contrast baths may increase superficial skin temperature and blood flow, but evidence of the effect on edema is conflicting. No relationship between the physiological effects and function has been determined.</td>
<td>Low-quality studies; no RCTs were found for review.</td>
</tr>
<tr>
<td>Brosseau et al. (2002)</td>
<td>To assess the efficacy of DTFM for treating tendinitis</td>
<td>Level I Systematic review</td>
<td>Intervention DTFM was compared with groups receiving placebo treatment; no therapy or other active treatments were provided.</td>
<td>No evidence was found of clinically important benefit of DTFM for treating tendinitis.</td>
<td>Only 2 studies used as part of review</td>
</tr>
<tr>
<td>Brosseau et al. (2003)</td>
<td>To evaluate the effectiveness of different exercise intensities on people with osteoarthritis</td>
<td>Level I Systematic review</td>
<td>Intervention Therapeutic exercises and high-intensity and low-intensity aerobic exercises</td>
<td>No significant difference was found between high-intensity and low-intensity aerobic exercise in treatment of OA of</td>
<td>Only 1 study included in review</td>
</tr>
</tbody>
</table>
controlled clinical trials, cohort studies, or case–control studies. 

Participants 

N = 39 participants (1 study) were compared with control or active interventions in people with OA.

Outcome Measures 

Included functional status, gait, pain, aerobic capacity.

Both types of exercise resulted in improvements for the knee OA participants’ functional status. A better result was realized for low-intensity exercise vs. control group than for high-intensity exercise vs. control group. (Result was in pain and function.)

The results of the review were inconclusive. 3 trials showed no effect on pain, 2 found increased knee ROM lower and higher doses yielded same result. Outcomes of joint tenderness and strength were not significant.

Heterogeneity of clinical application of LLLT, including different dosages, wave lengths, and types of LLLT.

Publication bias in articles chosen.

Brosseau et al. (2004) To assess the effectiveness of LLLT in the treatment of OA

Level I Systematic review

Participants 

N = 345 participants (7 trials) with OA, 184 randomized to LLLT, and 161 randomized to placebo laser

Controlled clinical trials of LLLT for participants with a diagnosis of OA were selected for study.

Outcome Measures 

Pain reduction, ROM

The results of the review were inconclusive. 3 trials showed no effect on pain, 2 demonstrated beneficial effects with laser, and 1 found increased knee ROM lower and higher doses yielded same result. Outcomes of joint tenderness and strength were not significant.

• Heterogeneity of clinical application of LLLT, including different dosages, wave lengths, and types of LLLT
• Publication bias in articles chosen

Currently, small sample size with a combination of diagnoses creates difficulty in generalizing results. Participants completed questionnaires, which can evaluate pain, quality of life, and so on. Evaluating the most was not blinded to participant. Evaluating the other was not blinded to participant. Treatments varied among participants on the basis of diagnosis. Treatments were not described beyond descriptive categories.

No control group

Case-Smith (2003) To measure functional outcomes after outpatient occupational therapy for clients who had upper-extremity injury, surgery, or both and to determine the correlation of the Canadian Occupational Performance Measure with other outcome measures

Level III Descriptive study; pretest and posttest after typical hand therapy treatment

Participates 

37 participants were selected according to predetermined criteria of outpatient occupational therapy services they received at that time. 8 therapists provided treatment and had an average of 7 yr of experience.

Intervention 

Treatment was generally described as including physical modalities, manual techniques, and therapeutic activities. Clients received a mean of 13 h of outpatient occupational therapy services; they received no other services at that time.

Outcome Measures 

The COPM, DASH, and SF–36 were administered at time of initial visit and on discharge after 6–8 wk. The CIQ was administered 2–3 mo after discharge. 33 clients completed the study.

Functional performance gains after 6–8 wk of services were significant according to the COPM, DASH, and SF–36. The CIQ, initially created for the brain-injured population, was not found to be as sensitive to changes in client function 2–3 mo after discharge. Use of the CIQ was not beneficial in this setting.

• Relatively small sample size with a combination of diagnoses creates difficulty in generalizing results.
• Participants completed questionnaires, which can introduce error.
• Evaluating therapist was not blinded to participant.
• Treatments varied among participants on the basis of diagnosis. Treatments were not described beyond descriptive categories.
• No control group

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### Supplemental Table 1. Interventions for Hand, Wrist, and Forearm (cont.)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Egan &amp; Brosseau (2007)</td>
<td>To review the evidence regarding the effectiveness of splinting for carpometacarpal OA of the thumb</td>
<td>Level I Systematic review; 7 articles of the following designs were included in review: 1 RCT, 1 pretest–posttest study, 1 retrospective cohort study, 1 posttest-only study, 3 RCTs that compared various splints</td>
<td>Use of prefabricated short neoprene splint; custom-made short opponens thermoplastic splint; short opponens, volar long opponens, semirigid orthosis that did not cross wrist; firm elastic splint with semirigid strip along dorsal side of thumb; supple elastic wrist gauntlet; custom-made leather splint; semistable textile splint; and no splint. Wear time of splints varied.</td>
<td>On average, participants who received a splint obtained some relief from it. No splint was found to be more effective than another for reducing pain and enhancing function.</td>
<td>Internal validity challenged by placebo effect and fact that other forms of treatment (NSAIDs) were initiated at same time as splint.</td>
</tr>
<tr>
<td>Ekim et al. (2007)</td>
<td>To evaluate the efficacy of LLLT in patients with rheumatoid arthritis with CTS</td>
<td>Level I RCT 1 group received LLLT once per day on weekdays for a total of 10 days using a gallium–aluminum–arsenide diode laser device (power output = 50mW, wave length = 780 nm). 1.5 J/ per point were applied. Placebo group did not receive actual laser light.</td>
<td></td>
<td>Improvements were greater in treatment group than in the placebo group in pain and functional status score at end of treatment and at 3 mo. Other parameters were not significantly different between placebo and treatment group. Both groups improved in pain and Functional Status Scale scores.</td>
<td>Small sample size and combined diagnosis limit generalizability of results.</td>
</tr>
<tr>
<td>Feehan &amp; Bassett (2004)</td>
<td>To determine whether scientifically valid evidence exists for the effect of early motion (&lt;21 days) on joints surrounding an extra-articular hand fracture on fracture</td>
<td>Level I Systematic review of Q–RCT studies</td>
<td>Studies compared complex postfracture immobilization of both joints proximal and distal to the fracture with motion of 1 or both joints adjacent to the fracture. Joint motion had to</td>
<td>Early motion resulted in earlier recovery of mobility and strength and earlier return to work and did not affect fracture alignment.</td>
<td>• All studies included in review were rated as poor quality. • All were reported as RCTs but were recategorized by review as Q–RCTs.</td>
</tr>
<tr>
<td>Field et al. (2000)</td>
<td>To evaluate the effects of massage therapy on reduction of postburn itching and pain and on reduction of anxiety and depressed mood</td>
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<tr>
<td>Participants</td>
<td>N = 20 participants (mean age = 38.2 yr) randomly assigned to massage therapy (treatment group) or standard care (control group)</td>
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<tr>
<td>Intervention</td>
<td>Control group received standard medical care (physician visits, medication, physical therapy or occupational therapy, cocoa butter to closed wounds without massage). Treatment group received massage therapy for 30 min, 2 times/wk for 5 wk. Massage therapists applied mild to moderate pressure with cocoa butter as a lubricant in a stroking manner; pressed movements from perimeter of wound to center using pads of fingers; circular, transverse, and vertical strokes for 10 min; skin rolling; and long strokes.</td>
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<tr>
<td>Outcome Measures</td>
<td>Participants rated their itching severity, pain, anxiety and depressed moods using a visual analog scale, McGill Pain Questionnaire, STAI, and the Profile of Mood States. Treatment group experienced reduced itching, anxiety, depressed mood, and pain. Long-term improvement occurred in all areas from before 1st treatment day to last treatment day.</td>
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</table>

- No study reported use of a standardized measure of time to clinical or bony union or a score on a standardized hand function test or quality-of-life test instrument.
- Participants were all from a low socioeconomic status group; unclear whether results are generalizable.
- Standard medical care that was continued by physical or occupational therapist is not fully described.
- Unclear whether this standard treatment included methods that may have contributed to outcomes.

Guzelkucuk et al. (2007) To compare the efficacy of therapeutic activities that simulate ADLs with that of traditionally used therapeutic exercises in the management of injured hands in young adult patients

<table>
<thead>
<tr>
<th>Participants</th>
<th>N = 36 participants with functional hand loss resulting from injury; 20 allocated to</th>
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</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Control group was provided with an appropriate twice-daily treatment program including passive, active assisted, and AROM and strengthening activities. In Although both groups improved at 2-mo follow-up, there were statistically significant differences (including functional outcomes) between the groups in favor of the</td>
</tr>
<tr>
<td>Outcome Measures</td>
<td>- Study was not blind, compliance with home program was not assessed, chronic and acute conditions were included in both groups, and efficacy of activities with specific</td>
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(Continued)
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<tr>
<td>Haythornthwaite et al. (2001)</td>
<td>To test the efficacy of 2 brief cognitive interventions in supplementing regular medical treatment of pain during dressing change</td>
<td>Level I RCT</td>
<td>The treatment group, 16 to the control group. Addition, physical agent modalities were applied. Treatment group received the same intervention as the control group for 1 session per day, with a 2nd session consisting of 25 activities that simulated ADLs. Treatment continued for 3 wk, 5 days/wk. Patients were discharged to a home program. Outcome Measures: Grip strength, pinch strength, finger pulp–distal palmar crease distance, total active movement, range of opposition, range of abduction, Jebson hand function test, and DASH.</td>
<td>Treatment group, except for total ROM and abduction.</td>
<td>Types of injuries was not determined. Small sample size.</td>
</tr>
<tr>
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<td>Participants</td>
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<tr>
<td>Janssen et al. (2009)</td>
<td>To determine the effects of specific contrast-bath protocols on hand volume in people diagnosed with CTS</td>
<td>Level I</td>
<td>RCT</td>
<td>N = 114 treatments (58 participants before carpal tunnel release; 56 participants after carpal tunnel release)</td>
<td>Group 1: Contrast bath protocol ending with cool water (70°C) included fisting exercises in water&lt;br&gt;Group 2: Second contrast bath protocol ending in cool water (70°C) did not include exercise.&lt;br&gt;Group 3: Control group; exercise-only group</td>
</tr>
<tr>
<td>Karjalainen et al. (2000)</td>
<td>To determine the effectiveness of biopsychosocial rehabilitation for upper-limb repetitive strain injuries among working-age adults</td>
<td>Level I</td>
<td>Systematic review of RCTs and prospective, concurrent controlled trials</td>
<td>N = 80</td>
<td>Study examined outcomes for inpatient or outpatient biopsychosocial program that included a physician consultation plus a psychological, social, or vocational intervention or a combination.</td>
</tr>
</tbody>
</table>
| Michlovitz, Harris, & Watkins (2004) | To investigate the effectiveness of nonsurgical interventions to restore ROM in patients who have sustained fracture, fracture or | Level I | Systematic review included RCTs or ORCTs, cohort study, case series, and case report. Several databases were searched for articles that met | | Studies are described on the basis of categorization of the intervention type. 9 articles dealt with splinting and casting, 6 with joint mobilization, 2 with | Consistent evidence suggested positive effectiveness of splints to increase joint ROM. Moderate support exists for joint mobilization techniques with ROM loss result- | • Moderate to low quality of selected articles  
• Lack of consistent approach to splinting between articles |
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| Michlovitz, Hun, Erasala, Hengehold, & Weingand (2004) | To evaluate the efficacy of CLLHW therapy for the treatment of various sources of wrist pain including strain and sprain, tendinosis, OA, and CTS | Level I  
Prospective, randomized, parallel, single-blind, placebo-controlled, multicenter trial | Participation of moderate or greater wrist pain were randomized and stratified to 1 of the following treatments: efficacy evaluation (heat wrap, oral placebo) or blinding (oral acetaminophen, unheated wrap).  
Outcome Measures  
Pain relief scale (0–5), joint stiffness (101-point numerical rating scale), dynamometer, Patient Rated Wrist Evaluation and Symptom Severity Scale and Functional Status Scale for participants with CTS | CLLHW therapy was efficacious in the treatment of common conditions causing wrist pain and impairment.  
Pain relief and joint stiffness reduction was greater than placebo.  
Heat wrap group demonstrated significant gain in strength over placebo group in short term but not at follow-up.  
CTS group demonstrated improved grip strength through study and follow-up.  
Differences in pain and disability were not significant between participants with OA, tendinosis, and strain or sprain. For those with CTS, change was significant for the heat wrap group. | Study is of good quality.  
- Impact of ROM on disability not described. |
| Muller et al. (2004)            | To determine the effectiveness of hand therapy interventions for CTS              | Level I  
Systematic review                                                                             | Splinting was supported by 5 studies; various types of splint angles were found to be effective  
Magnetic treatment that used splints may have been limited by effect of splint use to hold |                                                                                           |                                                                                   |
Participants

N = 24 trials

for CTS, including splinting, ultrasound, nerve-gilding exercises, yoga, LLLT, magnetic therapy, manual therapy, acupuncture, and combined therapies. Studies explored effects of these therapies on areas such as general symptomatology, severity of pain, sleep, nerve conduction studies, numbness and tingling, morning stiffness, paresthesias, tactile sensation, and pinch-and-grip strength.

Nerve-gilding exercises reduced pain and increased ROM compared with no treatment. 1 session of brief magnetic therapy did not decrease pain more than sham treatment; both decreased pain. Prolonged therapy in wrist support wraps improved symptoms of numbness and tingling and improved nerve conduction studies more than sham treatment. Laser therapy was supported by 1 study.

All studies reported either no difference between rest and early mobilization protocols or benefits from early mobilization. Benefits of mobilization included earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved ROM. Early mobilization caused no increase in deformity, complications, or residual symptoms.

Nash, Mickan, Del Mar, & Glasziou (2004)

To determine whether benefit or harm comes from mobilizing or immobilizing an acute limb injury in adults

Systematic review

Participants

N = 3,366 participants

49 trials of immobilization for soft tissue injuries and fractures of both upper and lower limbs were identified. 2 reviewers selected articles.

Studies were divided into 4 groups: lower-limb fractures, other lower-limb injury, upper-limb fractures and other upper-limb injuries. Groups were further divided into trials using limb support vs. no support.

Outcome Measures

- Patient-centered outcomes
- Measures of global function, including subjective and objective criteria: pain, stiffness, swelling; use of magnets in place; splints alone have been found to be effective.

Manual therapy results depended on particular techniques being used.

- Reviewers did not contact authors for clarification or updated research. Many studies were of poor quality; review focused on studies of higher quality only.
- Reviewers did not list all diagnoses included in all studies; it is not known whether acute tendon repairs, nerve injuries, or joint replacements (as examples) were considered
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| O'Brien & Pandit (2006) | To determine the effect of silicone gel sheeting for prevention or correction of hypertrophic or keloid scarring in people with newly healed wounds and people with established scars | Level I Cochrane Systematic Review                   | Prevention studies: number of people who developed these scars, as determined by blood flow, hyperpigmentation, erythema, scar thickness and regularity of scar  
Treatment studies: change in scar size (area, length, volume, height, or width) measured with ruler, impression or ultrasound | Prevention trials, when compared with no treatment, indicated reduced incidence of hypertrophic scarring.  
Gel sheeting increased scar elasticity in established scar. | Both prevention and correction studies were highly susceptible to bias and considered poor-quality studies by reviewers.  
Reviewers suggest caution when using the results of these studies. |
<p>| O'Connor et al. (2003) | To evaluate the effectiveness of nonsurgical treatment (other than steroid injection) for CTS vs. a placebo or other nonsurgical, control interventions in improving clinical outcomes | Level I Systematic review of randomized and QRCT studies | Treatment methods included splinting, ultrasound, yoga, carpal tunnel mobilization, ergonomic keyboards, magnet therapy, laser acupuncture, exercise, chiropractic care. Only steroid injection was excluded. | Moderate indication of short-term benefit from oral steroids; limited evidence has suggested that splinting, ultrasound, yoga, and carpal bone mobilization can be effective. Equivocal results have been shown for the use of ergonomic keyboards to reduce pain and improve function. Other nonsurgical techniques (magnet therapy, | Several studies had high levels of bias. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Objective</th>
<th>Level</th>
<th>Design</th>
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<th>Intervention</th>
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<th>Findings</th>
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<tr>
<td>Oerlemans, Goris, de Boo, &amp; Oostendorp (1999)</td>
<td>To determine the influence of various treatments (occupational and physical therapy) on the severity of permanent impairment of people with reflex sympathetic dystrophy</td>
<td>Level I</td>
<td>Prospective, randomized controlled, single blinded clinical trial</td>
<td>N = 135 participants assigned to physical therapy or occupational therapy treatment groups or control group</td>
<td>Participants underwent 30 min of treatment per session consisting of methods and techniques outlined in a treatment protocol. Occupational therapy protocol included reduction of inflammation, normalization of sensation, functional activities, and ADL retraining.</td>
<td>Joint ROM, grip strength, 2-point discrimination</td>
<td>Improvement in clinical symptoms (pain and parathesias) ≥3 mo post-treatment was shown. Secondary outcome measures included improvement in function, quality of life, or both. Nerve gliding, and chiropractic were not found to be effective. After the 12-mo study period, no significant differences in impairment ratings were detected between the treatment groups and the control group or in the treatment groups themselves. Longstanding symptoms may have already reached a natural plateau.</td>
</tr>
<tr>
<td>Oud et al. (2007)</td>
<td>To review evidence for the effectiveness of sensory reeducation to improve sensibility in people with a peripheral nerve injury of the upper limb</td>
<td>Level I</td>
<td>Systematic review of RCTs, nonrandomized controlled trials, and experiments without a control group (before-after design)</td>
<td>N = 274 (7 trials)</td>
<td>Studies of adults with impaired sensibility to the hand, wrist, and forearm after peripheral nerve injury of the upper limb.</td>
<td>Synthesis indicated limited evidence for the effectiveness of sensory reeducation. Statistically significant improvement in only 1 high-quality RCT.</td>
<td>Several studies had small sample sizes. Subjective experience of patients not taken into account; impairment rating does not measure actual functional disability. Patients were able to switch groups on request. Standard treatment protocols used by physical and occupational therapists in the Netherlands may not match treatment approaches used by U.S. therapists.</td>
</tr>
</tbody>
</table>
| Piazzini et al. (2007)                     | To assess the effectiveness of conservative treatment of CTS               | Level I | Systematic review                                                      | Studies included locally injected steroids, vitamin B6 regimen, steroid vs. NSAIDs | Review found strong evidence in favor of the use of local and oral steroids and moderate | • Several studies had small sample sizes. | (Continued)
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<td>Richard et al. (1987)</td>
<td>To investigate 2 common interventions for increasing finger-flexion ROM, passive exercise, and static wrapping</td>
<td>Level I RCT; counterbalanced repeated</td>
<td>Intervention Passive ROM exercise was administered to involved finger joints (except distal interphalangeal joint) by the therapist for 10 min. Affected joints were wrapped in full mitten configuration by therapist using 3-in. elastic bandage; wrap was left in place for 10 min. 13 trials of each technique. Timeframe was not reported.</td>
<td>Evidence that vitamin B6 is not effective and that full-time use of splints is effective. Limited or conflicting evidence that NSAIDS, diuretics, yoga, laser, and ultrasound are effective, and evidence that exercise and botulinum toxin B are ineffective.</td>
<td>• Review may have overlooked studies that could have added important insight to conclusions.</td>
</tr>
<tr>
<td>Rogers &amp; Wilder (2007)</td>
<td>To determine the effects of 2 yr of whole-body strength training and gripper exercise on hand strength, pain, and function in adults with radiographic evidence of hand OA</td>
<td>Level III Pre- and posttest design with single group</td>
<td>Intervention Participants completed a structured strength-training routine that addressed muscular strength, endurance, and joint mobility. The 25- to 30-min routine included warm-up, strength training, and cool down.</td>
<td>Older adults with radiographic evidence of hand OA and minimal dysfunction demonstrated increase in static and dynamic grip strength by completing whole-body strength training that includes gripper exercise. Those adults with symptomatic OA were able to reduce pain while increasing strength.</td>
<td>• Unclear when pain assessment was completed. • Isotonic hand gripper cannot be evaluated independent of whole-body strength-training routine. • Assessment and training did not include pinch strength.</td>
</tr>
</tbody>
</table>
Rogers & Wilder (2009)  
To investigate the effects of a daily 16-wk home exercise regimen on hands with OA  

**Level I**  
**RCT**  

**Participants**  
*N = 46 adults > age 50 with diagnosis of hand OA*  

**Intervention**  
Both investigational protocol and sham protocol were included. The procedure was 16 wk of activity and a wash-out period of 16 wk with no intervention. Following wash-out period, the groups were switched.  

Investigational group was given 9 hand exercises that involved ROM and strengthening.  

Placebo group was instructed in a hand massage program using a nonvigorous and gentle technique.  

**Outcome Measures**  
Australian Canadian Osteoarthritis Hand Index physical function subscale (includes self-reports), Jamar grip and pinch dynamometers, and Perdue pegboard  

Home-based daily exercise program modestly increased grip-and-pinch strength, but this benefit was not enough to be seen in self-reported hand function or pain. No change noted in Perdue pegboard test.  

- Daily progressive protocol may have been too aggressive for older population.  
- Investigator was not blind to treatment vs. sham group.  

Severens et al. (1999)  
To study the cost-effectiveness of adjunctive treatment of patients with RSD of 1 extremity  

**Level I**  
**RCTs**  

**Participants**  
*N = 135 participants with diagnosis of RSD in 1 upper extremity who experienced symptoms for <1 yr*  

**Intervention**  
Treatments were provided to patients per preestablished protocols.  

Participants kept diaries for 2 wk of visits to therapy and other venues needed as a result of RSD and of money spent on medications and related supplies. They also  

The ISS, but not the modified Greentest or the SIP, showed a difference between physical therapy vs. occupational therapy and computed tomography. Physical therapy and occupational therapy were more costly than computed tomography, but none showed higher medical costs.  

- Functional abilities and disability were not measured.  
- Monetary values and cost of medical care in the Netherlands may not be generalizable to the United States.  
- Protocols used or frequencies and durations of treatments were not provided.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Objectives</th>
<th>Level/Design/Participants</th>
<th>Intervention and Outcome Measures</th>
<th>Results</th>
<th>Study Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>van der Windt et al. (1999)</td>
<td>To evaluate the effectiveness of ultrasound therapy in the treatment of musculoskeletal disorders</td>
<td>Level I Systematic review N = 38 trials</td>
<td>Intervention 1 group received active ultrasound and the other received either no treatment or placebo control. Outcome Measures Patient report of general improvement, improvement of pain (visual analog scale, ordinal scale, pain questionnaire), improvement of functional disability, improvement in ROM, or both.</td>
<td>Evidence was not found to support the use of ultrasound therapy in the treatment of musculoskeletal disorders. Statistical pooling for placebo-controlled trials on lateral epicondylitis yielded results that warrant further investigation.</td>
<td>Authors reported possible publication bias because only published trial reports were used in review.</td>
</tr>
<tr>
<td>Verhagen et al. (2006)</td>
<td>To determine whether conservative interventions have a significant impact on short- and long-term outcomes for upper-extremity, work-related musculoskeletal disorders</td>
<td>Level I Systematic review of RCTs and controlled clinical trials Participants N = 925 participants</td>
<td>Intervention Treatments included exercises, manual therapy, massage, ergonomics, multidisciplinary treatment, splint, and individual and group therapy. Outcome Measures Pain intensity (visual analog scale, ordinal scale), global status (overall improvement), disorder-specific functional status (UEFS, NULI), generic functional status or quality of life (DASH, WHMPI), ability to work, health care consumption and cost, recurrence of injury</td>
<td>Limited evidence for the effectiveness of keyboards with alternative-force key displacement or alternate geometry Limited evidence for the effectiveness of individual exercise. The benefit of ergonomic modifications in the workplace was not demonstrated.</td>
<td>Possible selection bias indicated Overall poor quality of studies Wide range of interventions examined Work-relatedness not defined</td>
</tr>
<tr>
<td>Wajon &amp; Ada (2005)</td>
<td>To compare the effects of 2 6-wk splint and exercise</td>
<td>Level I RCT</td>
<td>Intervention The experimental group was issued an abduction exercise</td>
<td>No difference was found between groups after the 2-wk splint program, nor were any factors other than the interventions could have accounted for the significant</td>
<td></td>
</tr>
</tbody>
</table>
Participants

N = 40; participants complained of pain at the base of the thumb and had been diagnosed with Stages I–III trapeziometacarpal OA.

Routine and a thumb splint known as the thumb strap splint, designed to prevent flexion and adduction of the metacarpal, dorsoradial subluxation of the base of the first metacarpal and metacarpophalangeal hyperextension.

The control group was instructed to wear a short opponens splint.

Both groups were instructed to wear the splints full time for a period of 2 wk. For Wk 2–6, splinting continued with the addition of the exercise regiment.

For the experimental group, the exercises consisted of pain-free abduction exercise only; the control group received a typical treatment program that included pain-free pinching exercises with a soft foam block.

Outcome Measures

Pain, strength, and hand function

In general, the 3 participating hands scored better in the PGWG condition than in the SPGG condition in functional hand tasks. The work glove was unanimously preferred and described as the ideal choice if only 1 glove was to be allocated. Changes in functional hand use were significant.

- Small sample size; convenience sample may not be appropriately generalized to larger populations.
- Likert scale used for rating ADL abilities relied on memory of task difficulty, not on actual task performance. Likert scale may not have been a sensitive instrument.
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</table>
| Werner et al. (2005) | To determine whether night splinting of workers identified with CTS would improve symptoms and median nerve function and affect medical care | Level I RCT               | **Intervention**  
Both groups (treatment n = 63; control n = 49) were given instructions in how to reduce ergonomic stressors in both work and home environments via a 20-min video.  
Treatment group was fitted with a custom hand–wrist orthosis that placed the wrist in neutral. The most symptomatic hand was chosen for study in those participants with bilateral hand involvement. Splints were to be worn at night for 6 wk.  
**Outcome Measures**  
Included a validated CTS symptom severity scale and a 30-day worst-discomfort rating on a 10-point visual analog scale  
Participants underwent nerve conduction testing before the study and again at the 12-month interval. | 6-wk trial of splinting reduced discomfort scores; no difference was reported in the symptom severity scale scores; improvements persisted for 12 mo. Both groups improved over time, but improvements were greater in the treatment group. No difference in nerve conduction studies was shown between the 2 groups between pre- and poststudy measurements. | - Participants were not blinded to their treatment, and the primary outcome measure was a self-reported questionnaire.  
- Participants were not fully evaluated at 3- and 6-mo intervals.  
- Statistical methodology and loss of participants may have confounded the analysis in the logistic model.  
- Symptoms in the control group were found to be more severe than those in the treatment group, despite randomization. |
Interventions included any form of hand exercise such as ROM, strengthening, endurance exercises, or motor control  
**Value of hand exercise in the treatment of RA is not conclusive, although weak evidence exists that appropriate exercises might lead to long-term strength** |  
  
 | - Lower quality studies were used in review.  
- Studies used did not mention expected change that would be considered clinically important. |
### Williams et al. (2004)

**To evaluate the available evidence on workplace rehabilitation interventions for work-related upper-extremity disorders**

**Level I**

**Systematic review**

<table>
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<th>Participants</th>
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<tr>
<td>N = 402 (9 trials)</td>
<td>Workplace interventions included ergonomic modifications to the workplace to decrease repetitiveness, force, and awkward positioning; job accommodations included modified work, light-duty work trials, and graded return to work.</td>
<td>Pain ratings via visual analog scale, pre- and post-EMG testing, program evaluation, demographics questionnaire, Modified Functional Status Scale, 12 wk of keyboard use, 24 wk of keyboard use, self-reports, and workplace accommodations</td>
</tr>
</tbody>
</table>

Evidence is insufficient to identify effective workplace rehabilitation interventions for work-related upper-extremity disorders. Although several studies reported positive findings, some studies identified for inclusion in review and flaws in the studies limited the ability of this review to make generalized recommendations.

Studies were limited by small sample size, lack of standardized outcome measures, and inadequate reporting of interventions and results.

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**Note.** ADLs = activities of daily living; AROM = active range of motion; CIQ = Community Integration Questionnaire; CLLHW = continuous low-level heat wrap; COPM = Canadian Occupational Performance Measure; CTS = carpal tunnel syndrome; DASH = Disabilities of the Arm, Shoulder, and Hand questionnaire; DTFM = deep transverse friction massage; EMG = electromyography; ISS = Impairment-level Sum Score; LLLT = low-level laser therapy; NSAIDs = nonsteroidal anti-inflammatory drugs; NULI = Neck and Upper Limb Index; OA = osteoarthritis; PEDro = Physiotherapy Evidence Database; PGWGs = pressure garment work gloves; QRCT = quasi-randomized trial; RA = rheumatoid arthritis; RCT = randomized controlled study; ROM = range of motion; RSD = reflex sympathetic dystrophy; SIP = Sickness Impact Profile; SPGGs = standard-pressure garment gloves, STAI = State Trait Anxiety Inventory; UEFS = Upper Extremity Function Scale; WHMPI = West Haven–Yale Multidimensional Pain Inventory.

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