This paper describes the construction of an adjustable splint for forearm supination. At Union Memorial Hospital in Baltimore, Maryland, the splint has been a successful adjunct to mobilization treatment for the restoration of supination in selected patients who have lost active supination due to elbow, forearm, or wrist fractures or radial head resections with interosseous membrane shortening.

Since its original design in 1984, the adjustable supination splint has undergone several changes. The major design difference is the addition of an adjustable strap, which the patient can manipulate to increase the tension of the splint.

Certain traumatic injuries to the elbow, forearm, and wrist can result in a significant loss of supination. According to Kapandji (1981), tolerance to the malunion of fractures is reduced “because any alteration in the shape of the bones can and does affect the delicate mechanism of pronosupination” (p. 94). Pronosupination enables the use of the hand for feeding, personal hygiene, various types of work, and various gestures. Kapandji observed that, although shoulder abduction and elbow flexion can compensate for the loss of pronation, nothing can compensate for the loss of supination.

Before a splinting regimen is begun, the stability of the fracture and associated structures, including vascular and neurological impairment and ligamentous injuries, must be considered. A possible complication of a radial head resection is instability at the elbow with subluxation of the distal radioulnar joint. Deficits may include ulnar nerve symptoms, wrist pain, or both (Swanson, Jaeger, & Rochelle, 1981). The therapist must be aware of all of these symptoms and use the supination splint only after consultation with and approval by the physician. After a radial head resection, bone growth at the radial head, which results in decreased forearm movement, cannot be improved through the use of a splint. X rays can assist in the identification of a bony block, which requires surgical intervention. According to Matthews, Kaufer, Garver, and Sonstegard (1982), “[Residual forearm angulation] deformities of 20 degrees or more must be corrected if normal or nearly normal rotation of the forearm is to be expected” (p. 17). In cases where surgical intervention is necessary, the supination splint is contraindicated prior to surgery.

The splint presented in this paper, which pulls the forearm into supination and flexion, provides a basic design that can be modified to the needs of the patient. Serial adjustments can be made by the patient or therapist as range of motion and wearing tolerance increase. An elbow flexion block may be incorporated at 90° if elbow extension is also a goal of treatment. If the patient has difficulty donning and doffing the forearm portion of the splint, the splint can be cut so
that it is not completely circumferential, thus allow-
ing greater ease of use.

**Splint Construction**

The materials used to make the splint are low-temper-
ature thermoplastic material, closed cell foam pad-
ding, touch fasteners (1-in. or 2-in., depending on
arm size), D-rings, and large rivets.

For the forearm portion of the splint, a wrist
gauntlet is constructed (see Figure 1) to mold a cir-
cumferential splint with the radial edge overlapping
the ulnar edge by approximately \( \frac{1}{2} \) to 1 in. on the
dorsal surface of the forearm. Then the splint length is
extended by two thirds up the forearm and the touch-
fastener straps are attached.

For the humeral portion of the splint, the pattern
shown in Figure 2 can be used to construct a circum-
cumferential splint with the edges overlapping along the
medial border of the humerus by approximately \( \frac{1}{2} \) to
1 in. The splint’s proximal border should be extended
to just below the humeral head and distally approxi-
ately 2 in. above the epicondyles. After the patient is
fitted with the splint, the distal portion should be
trimmed back anteriorly to allow for elbow flexion.
The touch-fastener straps are then attached, as shown
in Figure 3. D-rings are attached with loop touch fas-
teners and rivets to the forearm and humeral portions
of the splint, as follows:

1. On the volar surface of the forearm portion,
   the A-1 D-ring is attached just proximal to the
   wrist along the ulnar border. The D-ring must
   be on a diagonal, with the top facing toward
   the A-2 D-ring. The B-1 D-ring is attached in a
direct vertical line with the A-1 D-ring, approxi-
ately 2 in. from the distal end of the
   splint, with the top of the D-ring on a diagonal
   facing up toward the B-2 D-ring.

2. On the lateral–posterior border of the hu-
   meral portion of the splint, the A-2 D-ring is
   attached approximately 2 in. from the top of
   the splint on a diagonal, with the top of the
   D-ring facing toward the A-1 D-ring. The B-2

**Figure 1.** Forearm pattern for the adjustable supination splint.

**Figure 2.** Humeral pattern for adjustable supination splint.

**Figure 3.** Placement of the D-rings and straps for the adjustable supination splint.
wrapped around the forearm before it is attached to the humeral portion of the splint.

**Splint Application**

**Case 1**

R.C., a 13-year-old right-hand-dominant girl, sustained a left Colles fracture in a fall and was placed in a short arm cast for 6 weeks. After the cast was removed, she was referred for treatment to increase forearm and wrist active range of motion. Measurements taken at that time were as follows: active supination, 0°; passive supination, 10°; active pronation, 45°; and passive pronation, 60°.

Treatment involved the use of moist heat, mobilization, and range of motion exercises three times a week. After six treatment sessions, R.C. gained 5° of passive supination. Because such little progress was made in the first 2 weeks of treatment, I fabricated the adjustable supination splint (see Figure 4). R.C.'s passive supination improved to 25°, a 15° gain, within 1 day of wearing the splint. After 1 week of wear, her range of motion was 45° passive supination and 35° active supination. Wearing time was initiated for 5 to 10 min approximately five times a day during waking hours; within 2 days, wearing time increased to 20 min at a time. R.C. was able to tolerate the splint for 2 to 3 hr a day at 1/2- to 1-hr intervals by the end of the first week. She was instructed to perform active range of motion exercises after the splint was removed and to wear the splint before attending therapy. Her treatment regimen of moist heat, mobilization, and range of motion exercises remained the same. R.C. was treated twice a week for 2 months, with periodic splint adjustments as indicated. The splint was found to be a useful adjunct to treatment and, after 2 months, R.C. was discharged with 80° of active supination and full active pronation.

**Case 2**

E.L., a 47-year-old right-hand-dominant woman, sustained a right radial head fracture, and the radial head was removed 4 weeks postinjury. After surgery, she was placed in a long arm cast, which was removed in 9 days. Treatment, which consisted of mobilization, moist heat, and range of motion exercises, was initiated on the 10th day and was carried out three times a week. Active range of motion measurements taken at that time were as follows: supination, 10°; pronation, 70°; elbow flexion, 100°; and elbow extension, −85°.

An occupational therapist constructed a static night elbow extension splint and a dynamic supination splint the first week of therapy. E.L. was able to tolerate wearing the supination splint four to five times a day for 15 min each time.

After 3 weeks, her active range of motion measurements were as follows: supination, 45°; pronation, 70°; elbow flexion, 105°; and elbow extension, −30°. At that time, a dynamic elbow flexion component was added to the supination splint to be used intermittently with the supination component.

Three weeks later, E.L.'s active range of motion measurements were as follows: supination, 72°; pronation, 70°; elbow flexion, 112°; and elbow extension, −22°.

E.L. was discharged 1 month later with the following active range of motion measurements: supination, 90°; pronation, 70°; elbow flexion, 120°; and elbow extension, −18°.

This splint has been used in the treatment of postradial head resections with variable success, depending on how early in the patient's treatment regi-

---

**Figure 4.** The adjustable supination splint: Lateral view (left), showing the attachment of the adjustable straps to the humeral portion of the splint; medial view (right), showing the attachment of the adjustable straps to the wrist gauntlet and the direction of pull of the forearm into supination.
men it was implemented and on the patient's compliance. The best results occurred with early use and with patients who concurred with the treatment program. Patients who had subsequent surgery to remove a bony block had considerably poorer results, with little or no functional gains in supination.

For patients with elbow, forearm, or Colles fractures, for whom traditional mobilization therapy had not produced adequate improvement, variable results were found with the supination splint. Younger, compliant patients with less serious injuries had better results.

Splint wearing time varied among patients, depending on each patient's tolerance, need to function without a brace (i.e., ability to wear the splint at work), and response to splinting. The splinting program usually lasted from 3 weeks to 2 months and was discontinued when range of motion plateaued.

**Summary**

The adjustable supination splint is used in select cases in which traditional mobilization therapy is not productive in supination gains. The success of the splint varies depending on many factors, including the type and severity of the injury, the timing of the intervention, the patient's age, and the patient's tolerance of and compliance with the treatment program. The therapist must consult with the physician and have his or her approval before initiating the treatment regimen.

Splint use is contraindicated in patients with unstable fractures or with injuries that require surgical intervention before splinting. Therapists should watch for edema, pain, and neurological changes. Depending on the severity of these symptoms, the splint may need to be discontinued or the wearing time and tension adjusted.

In our experience at Union Memorial Hospital and in our weighing of the above considerations, we have found favorable results in the use of the adjustable supination splint, with gains in range of motion and function in select patients.

**Acknowledgments**

I sincerely thank Marlene Riley, director of rehabilitation services at Union Memorial Hospital, Baltimore, Maryland, for encouragement and editorial assistance; David Motta for the medical illustrations; and Peter Andrews for photography.

This splint design was first presented at the 1987 Annual Conference of the Maryland Occupational Therapy Association, Timonium, Maryland.

**References**

