Using the BTE Primus® to Measure Grip and Wrist Flexion Strength in Physically Active Wheelchair Users: An Exploratory Study

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Key Words: hand strength testing • reliability of tests • validity of tests

Objective. The purpose of this study was to establish test–retest reliability values for the newly designed grip and wrist attachments of the BTE Primus® and to determine criterion-related validity of the new grip attachment against the Jamar dynamometer. An additional purpose was to explore the differences in grip and wrist flexion strength between wheelchair users and control participants without disabilities and to examine the effect of body position on strength in persons without disabilities.

Method. Wheelchair users and matched controls (13 per group) were tested for grip and wrist flexion strength on the BTE Primus and for grip on the Jamar dynamometer.

Results. The BTE Primus grip attachment was found to be valid and reliable. No significant differences were found in static and dynamic grip or wrist flexion strength between the two groups or in the sitting versus standing position for the control group.

Conclusion. The findings suggest that the BTE Primus may be used to assess grip and wrist flexion strength validly and reliably for both wheelchair users and persons without disabilities.


Spinal cord injury (SCI) and lower-extremity amputation are two conditions that may lead to wheelchair use. As a consequence of lower body dysfunction, persons with paraplegia and lower-limb amputation must rely on their upper extremities for functional mobility. Repetitive activities, such as wheeling and transferring, place stress on the bones, joints, and soft tissues of the upper extremities, resulting in cumulative trauma disorders that may, in turn, cause decreased strength and function of the upper extremities (Pentland & Twomey, 1994a, 1994b). Wheeling and transferring activities allow persons with SCI or lower-extremity amputation to interact in the community and are thus related to life roles and occupations important for independence, self-esteem, and quality of life (Pentland & Twomey, 1994b).

Findings about upper-extremity pain in wheelchair users are clearer than those about upper-extremity strength. Many authors agree that approximately 60% of persons with SCI experience upper-extremity pain, which is most often either located in the shoulder joint or related to carpal tunnel syndrome (Gellman et al., 1988; Gellman, Sie, & Waters, 1988; Pentland & Twomey, 1994a; Sie, Waters, Adkins, & Gellman, 1992). Additionally, shoulder pain and rotator cuff impingement are common problems in wheelchair athletes (Burnham, May, Nelson, Steadward, &
undergone standardization on persons without disabilities. The two most commonly used attachments are for measuring grip strength (#162) and wrist flexion strength (#701) (Berlin & Vermette, 1985). Reliability and validity data, as well as normative values, have been established for these attachments (Anderson, Chanoski, Devan, McMahon, & Whelan, 1990; Beaton, O’Driscoll, & Richards, 1995; Berlin & Vermette, 1985; Trossman, Suleski, & Li, 1990).

In the static mode, the grip attachment was found to be valid and reliable (Anderson et al., 1990; Beaton et al., 1995; Trossman et al., 1990). The latest version of the Work Simulator, the BTE Primus, was introduced in 1994 and has new grip and wrist attachments. The grip attachment was designed to resemble the Jamar dynamometer: It has five handle positions and is grasped with the elbow at 90°. To date, however, the grip and wrist attachments of the BTE Primus have not undergone standardization. The absence of validity, reliability, and normative values for the new grip attachments limits the interpretation of the results gathered with this assessment.

The purpose of this study was the following:

1. Establish preliminary reliability, validity, and mean data values for static and dynamic grip and wrist flexion on the BTE Primus for wheelchair users and persons without disabilities.
2. Determine whether a significant difference exists in static and dynamic grip and wrist flexion measurements between wheelchair users and seated persons without disabilities.
3. Examine the effects of body position (sitting vs. standing) on grip and wrist flexion measurements in persons without disabilities.

Method

Participants

All participants were adults (18–55 years of age) without cognitive impairment. Inclusion criteria for wheelchair users (mean age = 36.23 ± 6.89 years) were using a manual wheelchair for more than 50% of functional mobility and having an SCI at or below the T2 level, an above-knee amputation, or both (duration of injury = 13.14 ± 8.83 years). Exclusion criteria were having current upper-extremity dysfunction and being ambidextrous. The exclusion criterion for control participants without disabilities (mean age = 34.92 ± 9.56 years) was having a known history of physical disability. Thirteen wheelchair users (10 with paraplegia, 2 with amputations, 1 with both conditions) and 13 control participants gave written consent to testing. The control participants were matched by gender (9 men, 4 women), age (within 5 years), and activity level (low, medium, high) to the wheelchair users. All participants had moderate to high activity levels, and 5 wheelchair users were basketball players. The participants were recruited from the student body at the University of
Florida, the GatorSport Exploration Camp (for adults with disabilities) sponsored by the Occupational Therapy Department at the University of Florida, and from the local wheelchair basketball team.

**Instruments**

Attachment #162 (grip; see Figure 1) and attachment #701 (wrist flexion; see Figure 2) of the BTE Primus were used for the static and dynamic grip strength measurements. The Jamar dynamometer was used as a gold standard criterion measure for establishing the validity of static grip strength testing on the BTE Primus.

All participants completed a demographic questionnaire designed to ensure matching between wheelchair users and control participants for age, gender, and activity level. In the activity level portion of the questionnaire, participants listed all physical activities that they performed regularly, including duration (min/day) and frequency (days/week). They were then asked to classify their activity level into one of the following categories: low (≥30 min, 1–2 times per week), moderate (≥30 minutes, 3–5 times per week), or high (≥30 min, 6–7 times per week).

Participants also completed the McGill Pain Questionnaire (Melzack & Katz, 1992), which was used to exclude participation in the study because of upper-extremity dysfunction. The McGill Pain Questionnaire was found to be a reliable and valid tool for pain measurement (Melzack & Katz, 1992). The score is based on a combination of words chosen from 20 subscales describing different aspects of pain. The word combination is used to specify the sensory and affective qualities of pain and to express the subjective overall present pain intensity. We modified the McGill Pain Questionnaire by instructing participants to respond on the sole basis of their upper-extremity and back pain, thereby excluding phantom pain in participants with amputation and lower-extremity pain related to injury in participants with SCI.

**Procedure**

Before strength testing, all participants signed the consent form (approved by the Institutional Review Board of the University of Florida’s Health Science Center) and completed the demographic and pain questionnaires. They then began strength testing with their dominant arm. Hand dominance was determined by asking the participants if they were right-handed or left-handed and which hand they used for writing. Participants performed all static grip tests first, followed by dynamic grip tests.

**Static strength tests.** Three static strength tests were performed in random order: a static grip strength test on the Jamar dynamometer, a static grip strength test on the BTE Primus, and a static wrist flexion strength test on the BTE Primus. Each test consisted of three repeated trials, and each trial was held for 6 sec. A 30-sec rest interval was provided after each trial and a 2-min rest period was given after each test. After completion of the three static strength tests, a 10-min rest period was given. During this rest period, the participant completed the past pain version of the McGill Pain Questionnaire. Following the rest period, the series of three static strength tests was repeated.

Overall, in the two sessions of static strength testing, each participant performed 12 grip trials (6 on the Jamar, 6 on the BTE Primus) and 6 wrist flexion trials (all on the BTE Primus) with the dominant hand. The average of the three trials on each test was recorded as the maximal static strength score and used in subsequent analyses.

**Dynamic strength tests.** After completing two sessions of static strength testing, another 10-min rest interval was given, followed by dynamic strength testing. Both dynam-
Dynamic grip and wrist flexion strength tests were performed on the BTE Primus. Each test consisted of three trials of as many maximal dynamic contractions as possible in 10 sec at a load of 50% of maximal static strength. A 30-sec rest interval followed each trial, and a 2-min rest period was given between the dynamic grip and wrist flexion strength tests. The series of dynamic strength tests was repeated after an additional 10-min break. The average of the three trials, expressed in engals, was recorded as the participant’s maximum dynamic strength and used in subsequent analyses. An engal is a unit of power defined as the effort required to move a load of 1 in.-lb 1° in 1 sec (BTE, 1995). The rest periods were an attempt to eliminate the effects of fatigue as indicated by Trossman and Li (1989). For a flow chart demonstrating a sample testing order, see Table 1.

Testing protocol. The order of the three static strength tests was randomly assigned for the wheelchair users, and that same order was used for their matched controls. The randomization was as follows: Each wheelchair user was randomly assigned to begin strength testing either with grip or with wrist flexion; then, the grip strength testing, beginning with either the Jamar dynamometer or the BTE Primus, was randomly assigned. The second session of static strength tests was given in the same order as the first, as were the dynamic strength tests (excluding the Jamar dynamometer). The wheelchair users performed both series of static strength tests sitting, whereas the control participants performed one series of static strength tests sitting and one standing. The order of sitting and standing also was randomly assigned.

The BTE Primus and Jamar dynamometer were balanced and calibrated daily (BTE, 1995; Fess, 1987). During testing, the computer monitor of the BTE Primus and the dial of the Jamar dynamometer were positioned so that the participant could not see the display. No visual or auditory feedback was provided. To ensure consistency, the participant was not coached during testing and only standardized verbal directions were given. To test all subjects while sitting, a standard chair with four legs, full back support, and no armrests was used. When testing on the BTE Primus while sitting, the chair’s leg position was marked with tape on the floor to ensure that the exact position was replicated in subsequent testing sessions. To familiarize the participants with each task, the test administrator demonstrated the test and gave a submaximal practice trial immediately before each test in the first session.

For both static and dynamic strength testing on the BTE Primus, the participant either was seated in a chair or was standing. The height of the attachment was adjusted and recorded to ensure consistency during subsequent testing. The position of other body parts was the same as for testing on the Jamar dynamometer and as recommended by the American Society of Hand Therapists (ASHT; Fess, 1992). In short, the participant was sitting with shoulders level, adducted, and neutrally rotated. The elbow was flexed at 90°, forearm in neutral, and wrist in 0° of dorsiflexion. The participant grasped the tool in a handshake position. The only differences in position for the wrist flexion test were as follows: the forearm was pronated as well as supported by and strapped to the platform of the attachment to maintain position. The wrist was positioned in neutral for the static testing and was initially positioned in full extension for the dynamic power testing. During all strength tests, the participants held a small block between the upper arm of the dominant hand and the lateral thorax to prevent substitution patterns. One deviation from the ASHT-recommended position was that the control participants were instructed to place their legs in an outstretched position while sitting in an attempt to equalize the stabilizing ability of wheelchair users and controls by preventing the control participants from stabilizing themselves with their legs. Another deviation from the ASHT-recommended position was when the control participants were tested while standing. Both the Jamar dynamometer and the BTE Primus grip attachments were placed at the second handle position for all participants (Fess, 1992).

Data Analysis

The average of three trials of each strength test was calculated for each participant and used in the subsequent data analyses. Descriptive statistics were conducted on static and dynamic strength scores for men and women in the two groups. Correlation coefficients were calculated to establish validity and test–retest reliability of the BTE Primus grip and wrist attachments. To determine the criterion-related validity, a Pearson product-moment correlation coefficient was calculated on the average scores rendered from the BTE Primus versus the average scores on the Jamar dynamometer. To determine test–retest reliability, Pearson product-moment correlations were calculated on scores in the first versus the second testing sessions (Portney & Watkins, 1993).

Comparisons were conducted on groups (wheelchair

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Table 1
Sample Testing Order

<table>
<thead>
<tr>
<th>Test</th>
<th>Duration</th>
<th>Rest (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Static</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grip (Jamar dynamometer)</td>
<td>3 trials (6 sec each) with 30-sec rest</td>
<td>2</td>
</tr>
<tr>
<td>Grip (BTE Primus)</td>
<td>3 trials (6 sec each) with 30-sec rest</td>
<td>2</td>
</tr>
<tr>
<td>Wrist flexion</td>
<td>3 trials (6 sec each) with 30-sec rest</td>
<td>2</td>
</tr>
<tr>
<td>Repeat static</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grip (Jamar dynamometer)</td>
<td>3 trials (6 sec each) with 30-sec rest</td>
<td>2</td>
</tr>
<tr>
<td>Grip (BTE Primus)</td>
<td>3 trials (6 sec each) with 30-sec rest</td>
<td>2</td>
</tr>
<tr>
<td>Wrist flexion</td>
<td>3 trials (6 sec each) with 30-sec rest</td>
<td>10</td>
</tr>
<tr>
<td>Dynamic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grip (BTE Primus)</td>
<td>3 trials (10 sec each) with 30-sec rest</td>
<td>2</td>
</tr>
<tr>
<td>Wrist (BTE Primus)</td>
<td>3 trials (10 sec each) with 30-sec rest</td>
<td>10</td>
</tr>
<tr>
<td>Repeat dynamic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grip (BTE Primus)</td>
<td>3 trials (10 sec each) with 30-sec rest</td>
<td>2</td>
</tr>
<tr>
<td>Wrist (BTE Primus)</td>
<td>3 trials (10 sec each) with 30-sec rest</td>
<td>Finish</td>
</tr>
</tbody>
</table>

Note. BTE = Baltimore Therapeutic Equipment.
users vs. control participants), instruments (BTE Primus vs. Jamar dynamometer), and body position (sitting vs. standing). To ensure matching of the participants, two-tailed independent $t$ tests (Portney & Watkins, 1993) were conducted to compare mean age and mean activity level between the wheelchair users and the control participants. Two-tailed independent $t$ tests were also conducted to compare the two groups on the scores of the dynamic grip strength test and the static and dynamic wrist flexion tests. A repeated-measures analysis of variance (ANOVA) was conducted to reveal differences in static grip strength scores (Portney & Watkins, 1993). The between-subject factor was group (wheelchair users vs. control participants), and the within-subject factor was instrument (BTE vs. Jamar dynamometer in the seated position for both groups).

Finally, to compare grip and wrist flexion scores between the seated and standing body positions, analyses were conducted on the control group only. For static grip strength, repeated-measures ANOVA was conducted with two within-subject factors: position (sitting vs. standing) and instrument (BTE Primus vs. Jamar dynamometer). For the static wrist flexion test and the dynamic grip and wrist flexion tests, paired $t$ tests (two-tailed) were conducted. All differences were considered significant at the .05 level. Bonferroni corrections were made for multiple $t$ tests (8), setting the significance level at .00625.

**Results**

Pearson product-moment correlations were calculated to assess validity and reliability of the BTE Primus grip and wrist attachments. Criterion validity was established only for the grip attachment by correlating static grip strength scores on the Jamar dynamometer with those on the BTE Primus. Separate correlations were conducted for the two participant groups. For the wheelchair users, good correlation coefficients were found for the first ($r = .634$) and second ($r = .740$) sessions of static testing. For the control participants, high correlation coefficients were found for the first ($r = .819$) and second ($r = .917$) sessions. Test–retest reliability was assessed for the BTE Primus grip and wrist attachments and for the Jamar dynamometer. Good to high correlation coefficients ($r = .79-.98$) were found for static and dynamic grip and wrist flexion in both wheelchair users and control participants (see Table 2).

Group comparisons showed no significant differences between the two groups for age ($t = .400, p = .693$) and activity level ($t = .862, p = .397$), indicating that the matching of the participants according to age and activity level was successful. Group comparisons also showed no significant differences in dynamic grip strength, static wrist flexion strength, and dynamic wrist flexion strength (see Table 3). The two-way ANOVA revealed no significant differences in static grip scores between the two groups ($F = .013, p = .937$) and between the BTE Primus and the Jamar dynamometer ($F = .294, p = .593$) as well as no significant interaction ($F = .088, p = .679$). Effect size was calculated for all nonsignificant findings to determine whether a Type 2 error due to the small sample size was likely. For example, a small effect size was found for both static and dynamic grip strength (see Table 3), which indicated 6% power. To achieve 70% power at an alpha level of .05, 1,924 participants would have been needed in each group. This power analysis indicated that these nonsignificant differences between groups were likely accurate and that a Type 2 error was probably not present.

The effect of body position on strength scores in control participants is presented in Table 4. There were no significant differences between sitting and standing for either dynamic grip strength or wrist flexion scores. A small effect size for both comparisons indicated that the differences were indeed nonsignificant (see Table 4). On the other hand, both static grip and wrist flexion strength were near significance. Their medium and large effect sizes, respectively (see Table 4), indicated that differences in static strength between the seated and standing body positions may be significant with a larger sample size. Specifically, for static grip strength scores, the repeated-measures ANOVA revealed no significant differences for either position (sitting vs. standing, $F = 3.675, p = .08$) or instrument ($F = .042, p = .84$) as well as no significant interaction ($F = .04, p = .95$). Because of the near significance for sitting versus standing ($p = .08$), we further examined this comparison by scrutinizing each instrument separately. No significant differences were found for the Jamar dynamometer ($t = .882, p = .395$) with a small effect size ($d = .349$, power = 11%) or for the BTE Primus with a medium effect size (see Table 4). The power analysis for the BTE Primus revealed that 55 participants would have been required in each group to achieve 70% power. For static wrist flexion strength, no significant differences were found between sitting and standing because of the Bonferroni correction, which set the significance level at .00625. The power analysis for the BTE Primus revealed that 15 participants would have been required in each group to achieve 70% power at an alpha level of .05.

**Discussion**

**Reliability and Validity**

The results of the present study suggest that the new grip attachment of the BTE Primus is a valid and reliable instrument for measuring grip strength. In terms of validity, good
correlation coefficients were found between grip strength scores on the BTE Primus and the Jamar dynamometer when wheelchair users were tested, and high correlations were found for control participants. Similarly, Beaton et al. (1995) found high correlations \( (r = .896-.987) \) between the BTE Work Simulator’s grip tool and the Jamar dynamometer in seated participants without disabilities. In terms of test–retest reliability of the BTE Primus grip tool, we found high correlations for both static and dynamic grip strength scores. Previous studies showed similar results for the BTE Work Simulator. Anderson et al. (1990) found a high test–retest reliability \( (r = .978) \) when testing static grip strength of 16 men on separate days, and Trossman et al. (1990) found a high test–retest reliability \( (r = .978 \text{ for the right hand, } r = .987 \text{ for the left hand}) \) when testing static grip strength in 30 right-hand-dominant men and women on separate days. We also found high test–retest reliability values for both static and dynamic wrist flexion strength on the BTE Primus in both participant groups. These results are similar to Anderson et al.’s findings for the Work Simulator \( (r = .91) \).

The higher test–retest reliability of the wheelchair users compared with the control participants on the Jamar dynamometer is probably because the controls were tested once while sitting and once while standing, whereas the wheelchair users were tested while sitting both times. Mathiowitz et al. (1984) found somewhat lower test–retest reliability values on the Jamar dynamometer \( (r = .88) \) for their seated control participants. On the other hand, the lower validity and reliability values found for the wheelchair users compared with the controls on the BTE Primus may be attributed to the instrument not being accommodating for persons sitting in a wheelchair. The armrests and wheels of the wheelchairs did not allow the exercise head of the BTE Primus to be lowered far enough to attain the proper positioning of 90° at the elbow. Therefore, the wheelchair users had to sit in an unfamiliar chair without armrests or trunk support and without being able to stabilize themselves with their legs.

In addition, when gripping the BTE Primus, an immovable device, the participant’s position had to be adjusted to the device, whereas when gripping the Jamar dynamometer, the position of the device was adjusted to the participant. Thus, different body mechanics may have been used for stabilizing when gripping the two instruments, and the need of the wheelchair users to adjust their body positions to accommodate the BTE Primus may have decreased their ability to replicate grip trials. This interpretation was further supported by the different relationships between static and dynamic strength in the two groups. The wheelchair users showed a moderate correlation between dynamic and static strength on the BTE Primus \( (r = .624) \) and a low correlation coefficient \( (r = .371) \) between dynamic strength on the BTE Primus and static strength on the Jamar dynamometer. In comparison, the control participants had high correlations between dynamic and static strength on both the dynamometer \( (r = .869) \) and the BTE Primus \( (r = .778) \). These differences may reflect inconsistencies in stabilizing techniques between the wheelchair users and the controls.

**Strength Comparisons**

The group comparisons indicated that physically active wheelchair users and their matched controls did not differ in either static or dynamic grip and wrist flexion strength. The clinical implications of these findings have to do with the use of norms. Normative data are developed to describe a certain characteristic of a specific population, such as grip strength, so that a person’s score can be compared to that of a representative population (Innes, 1999). Thus, norms provide objective data for comparison of patients to a certain population when interpreting evaluation data. Norms are then used to establish treatment goals (Benson & Schell, 1997), predict future performance (Portney & Watkins, 1997), and compare patient performance to that of a certain characteristic of a specific population.
that a larger sample size may have revealed that both static grip and wrist flexion scores. These findings indicate that the static grip and wrist flexion tests in the present study were similar to scores in previous studies that collected normative data on the BTE Work Simulator (Anderson et al., 1990; Berlin & Vermette, 1985). However, static grip strength scores in the present study were greater and dynamic grip strength scores were smaller than the previously established norms (see Table 5). The greater static grip strength scores in the present study may be due to the new grip tool design of the BTE Primus and to different elbow position in the previous studies. This assumption is supported by the fact that the static grip strength scores on the Jamar dynamometer in the present study were within the range of the norms documented by Mathiowetz et al. (1985), which were derived from 638 participants. Alternatively, the lower dynamic grip strength scores in the present study may be attributed to fatigue because dynamic strength was tested after all static strength tests were completed.

We also compared static and dynamic grip and wrist flexion strength scores rendered from the seated versus standing position in the control participants. Although body position did not seem to affect dynamic strength scores as suggested by the small effect size, a medium effect size existed for the static grip scores and a large effect size for the static wrist flexion scores. These findings indicate that a larger sample size may have revealed that both static grip and wrist flexion strength are affected by body position. Thus, separate grip and wrist flexion strength norms may be needed for sitting and standing on the BTE Primus. Indeed, a controversy exists in the literature regarding this issue. Whereas in one study with a sample size of 61 participants, no differences in grip strength existed between sitting and standing (with the elbow in 90° flexion) (Balogun, Akomolafe, & Amusa, 1991), another study with a sample size of 9,543 showed significantly greater grip strength scores in standing than in sitting (with the elbow in extension) (Teraoka, 1979). The differences in the two studies, however, may stem not only from the differences in sample size, but also from differences in elbow position.

The limitations of the present study include the small sample size and the nonhomogeneous wheelchair user group, which consisted of both men and women, athletes and nonathletes, and persons with SCI and amputation. However, the effect size analysis indicates that no differences in strength existed between the two groups. Future research should involve a larger, more homogenous sample, which would include participants with varying activity levels. In addition, protocol-related limitations, including fatigue during the dynamic strength testing (despite the rest intervals) and the use of the second handle position of the grip tools (which may have limited strength exertion in participants with large hands), may have prevented the participants from exerting maximal effort.

**Conclusion**

The findings of the present study indicate that the BTE Primus may be used to assess grip and wrist flexion strength validly and reliably for both wheelchair users and persons without disabilities. However, clinicians should be cautious when using norms established on persons without disabilities to assess physically active wheelchair users’ grip and wrist strength on the BTE Primus. In addition, clinicians should be aware that testing persons in the seated versus standing position may affect the scores of static grip and wrist flexion strength tests.

### Table 5

**Mean Static and Dynamic Grip Strength and Wrist Flexion Scores of Men and Women in Three Studies**

<table>
<thead>
<tr>
<th>Strength Test and Gender</th>
<th>Present Study</th>
<th>Berlin and Vernette (1985)</th>
<th>Anderson et al. (1990)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Controls (Standing)</td>
<td>Controls (Sitting)</td>
<td>Wheelchair Users (Sitting)</td>
</tr>
<tr>
<td>Static grip (in.-lb)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>448 ± 79</td>
<td>4356 ± 80</td>
<td>395 ± 70</td>
</tr>
<tr>
<td>Women</td>
<td>234 ± 40</td>
<td>218 ± 45</td>
<td>277 ± 79</td>
</tr>
<tr>
<td>Dynamic grip (engals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>6444 ± 2396</td>
<td>6584 ± 1545</td>
<td>6025 ± 2448</td>
</tr>
<tr>
<td>Women</td>
<td>4376 ± 798</td>
<td>3899 ± 566</td>
<td>4976 ± 1163</td>
</tr>
<tr>
<td>Static wrist (in.-lb)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>191 ± 31</td>
<td>208 ± 42</td>
<td>207 ± 27</td>
</tr>
<tr>
<td>Women</td>
<td>86 ± 24</td>
<td>88 ± 45</td>
<td>109 ± 26</td>
</tr>
<tr>
<td>Dynamic wrist (engals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>12822 ± 3360</td>
<td>12476 ± 4116</td>
<td>16044 ± 9051</td>
</tr>
<tr>
<td>Women</td>
<td>4755 ± 1524</td>
<td>4764 ± 1734</td>
<td>7787 ± 2892</td>
</tr>
</tbody>
</table>

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References


