**Bursary Report for the British Association of Hand Therapists**

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**BAHT Level II Radiographic Imaging of the Hand**

**2nd – 4th October 2019**

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| **Introduction:** As an Occupational Therapist working in hand therapy (NHS) my caseload includes trauma and elective surgery, as well as GP referrals. We are now generally the first point of contact for GPs who have often already requested x-rays that I can draw upon as part of my assessment. My colleagues recommended this course to help develop my ability to evaluate radiographic imaging in more depth, to support me in recognising injury and disease on imaging and relate it to hand and wrist function; and also to recognise how anatomical factors may be limiting progression in rehabilitation.  |
| **Topic:**This 3 day course was run by The Pulvertaft Hand Centre at the University of Derby Enterprise Centre. As with all of their courses it was extremely well organised and at a great venue. On all 3 days we benefited from the presence of a Consultant Hand and Wrist Surgeon, Advanced Radiographer Practitioner, Senior Occupational Therapist and Senior Physiotherapist; with additional lectures from a Consultant Hand and Plastic Surgeon and Consultant Radiologist. The first day started with an introduction to normal radiographic anatomy and recognition of standard hand and wrist radiographic views and how they are achieved. In this session we were familiarised with Gilulas arcs, normal radial height, inclination and volar tilt, ulna variance and the saucer, cup and apple which represents the radius, lunate and capitate. We were provided with a systematic approach to interpreting radiographs using the AABCS system and looked at some common hand/wrist injuries on radiograph, including fractured metacarpals, wrist fractures, CMCJ/MP/IPJ dislocation and carpal instabilities amongst other injuries. Day 2 concentrated on the appearance of rheumatoid and osteoarthritis, looking at the pattern of joint involvement, nature of deformity and bony texture with examples such as the difference between soft and hard edged erosions which help to distinguish between rheumatoid arthritis or gout. In the session on bony lesions we learned a number of indicators to help determine the presence of benign or aggressive lesions within the bone and how these can affect fracture healing even if benign. This was followed by an interesting talk on development and injuries to the paediatric hand, and congenital abnormalities. Day 3 summarised the inadequacies of standard radiography and suggested alternative modalities including CT, MRI and ultrasound. The sensitivity of each modality in relation to a range of hand conditions was discussed along with the pros and cons of their use. This session included a demonstration of ultrasound in action. On all 3 days we got to work in pairs to practice interpreting radiographs within workshops, this was much harder in practice but there was plenty of support to answer any questions and feedback on every radiograph looked at. On to the exam .... be warned that this could possibly be the quickest hour of your life! There are lots of x-rays to be reviewed and a question and answer section, the time flies so don’t hang about deliberating for too long. This course will support me in all aspects of my work, whether it is evaluating an x-ray to inform rehabilitation of a fractured wrist or looking for signs of wrist instability for someone presenting with generalised wrist pain by a GP. I am looking forward to sharing the knowledge I have gained with my colleagues and would like to thank BAHT for the bursary and opportunity, and Derby for putting on such an excellent course.  |