BRITISH ASSOCIATION
OF HAND THERAPISTS

Standards of hand therapy practice in the rehabilitation of closed, non-surgically managed, extensor tendon injuries: zones I-II (mallet injury)

Endorsed by:
British Association of Hand Therapists

Devised by the Extensor Tendon Injuries Standards Working Group, 2022
Further information is available from: https://www.hand-therapy.co.uk

This BAHT Standard has been developed to compliment the respective BSSH Standard of Care in Hand Trauma. It is based on research and expert opinion.

Standards

1. Assessment and formulation of a treatment plan to be provided by a specialist hand therapist or appropriately trained therapist with direct access to specialist support and following a competent diagnosis. Access to accurate operative details if required.

2. There should be easy communication and rapid access to the Hand team/surgical team if the therapist has concerns at any point.

3. The patient should be seen within 7 days of referral to hand therapy.

4. Non-surgical management (splinting) is the preferred method of treating a patient with a closed mallet deformity. This should be a well fitted splint that should allow PIP joint motion.

5. A closed zone I/II extensor tendon injury:
   a. with an associated avulsion fracture (+/- k-wire fixation) should be immobilised for a minimum of 6 weeks.
      To minimise the risk of joint subluxation consideration in regards to the splint position should be made with bony fragments greater than 30% of the articular surface.
   b. without an associated fracture should be immobilised for a minimum 8 weeks.

6. Patients should be offered hand therapy appointments depending on the patient's clinical need such as tendon integrity, compliance, fit of splint, independence in splint management, swelling, PIP joint mobility and wound / skin quality.

7. Rehabilitation should be supported by verbal, written and/or electronic information.

8. After the initial immobilisation period and once tendon integrity has been established, movement should be progressed. The splint can be gradually withdrawn but some form of splint wear may be required for several weeks.

9. A set of outcome measures should be taken during therapy and upon discharge. Where suitable this should include range of motion (ideally including the contralateral side), strength and patient reported outcome measures (PROM).

10. In the absence of a satisfactory outcome, the patient should be referred to a hand surgeon to discuss other treatment options.

Implementation of these standards should be used to guide and advise therapists in the clinical setting. However, it is recognised that care may be influenced by factors including access to hand therapy, injury as well as patient characteristics. Professional judgement, based on clinical reasoning, will strongly influence the management and outcome.

References

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