
Post-acute splinting of a hand burn

With grafted or slow to heal hands, static splinting during recovery can minimise contracture formation and protect anatomical structures.

Splinting is most effective when scar formation is most active (first 6 months) and can assist with ROM maintenance by applying a prolonged stretch to affected hands – generally best after the client completes their exercises and stretching program

Two most common splint examples include:

- **Palmar burns** - splinted into extension and abduction using a Pan Splint to the volar surface, to provide a full stretch of the palmar surface of the hand.
- **Dorsal burns** - splinted in the Position of Safe Immobilisation (POSI) – MCPS 90deg, PIPJ and DIPJ in extension and wrist in 20-30deg extension.

Alternating splints may be required if circumferential burns are present, and therefore a slow and prolonged stretch is required to both surfaces

Splinting the hand for extended time periods, (ie 6-12 hours overnight, or during rest periods) provides opportunity for affected tissue to elongate.

Balancing splinting with activity and exercise enables movement and regain of function. Therefore, as AROM increases and function improves, the timeframe for splinting can be reduced.

Extensive hand burns involving tendons and/or significant scar development require a suitable management plan, and can be determined in collaboration between VABS and external clinicians

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