

“AWARENESS”

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CONGRATULATIONS TO ALL OF YOU WHO HAVE MADE THE PUBLICATION OF THIS JOURNAL POSSIBLE. WITH THE PERSEVERANCE AND DEDICATION YOU POSSESS, YOU WILL CONTINUE TO GROW BY DISSEMINATING INFORMATION AND THE SHARING OF EDUCATION RELATIVE TO PHYSICAL THERAPY. MY SINCERE BEST WISHES FOR CONTINUED SUCCESS.

이 회지 발간을 위하여 노력하신 여러분께 진심으로 축하합니다.
여러분께서는 헌신적이고 지속적인 노력을 다해서 물리치료에 대한 지식의 함양과 그 지식의 전파에 힘쓰셔서 더욱 발전하시기 바랍니다.
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Too often there is an unawareness of what is going on in own professional field, even though we may be neighbors. We may all be operating in completely different environments, which is true in the present situation, if we are to compare the Korean hospitals and the USAH, Seoul. One truism is That we all have the same mission and objective-to achieve the maximum potential for the patient. We may achieve it by different means but the outcome will be the same.

The purpose of this article is to make you aware of physical therapy at the USAH, Seoul (121st Evac Hospital) and to present a brief history of the hospital. Present written history indicates that the original 121st Evacuation Hospital was organized at Camp Swift, Texas on 24 March 1944 and was moved to Germany. The hospital was quite active during World War II and following the war it became a reserve unit until 1950 when it was reactivated for service in Korea. The hospital operated in many

places in Korea including Inchon, Yong Dong Po, Hamhung, and Pusan. It finally moved to Pupyong in June 1955. The 121st Evac Hospital was located there until May 1971 when it merged with the Seoul Military Hospital to form the U. S. Army Hospital, Seoul.

The hospital has a bed capacity for approximately 300 patients. We have specialists in many fields of medicine of which physical therapy is included. The physical therapy section or clinic is a very busy one with the patient load being primarily hospital in-patients. All hospital patients are seen BID (two times a day) except for the obstetrical patients and others so indicated by the doctor. The services that we become most involved in depend upon the specialties of the medical and surgical doctors assigned at the time. Our work-load is dependent upon them and the consults they send to us. Our services to patients can be broken down into the following categories (at the present writing):

90%	Orthopedic cases
2%	Neurological cases
3%	Surgical conditions
3%	Obstetrical conditions
2%	Dermatological conditions (including burns)

We feel that the conditions that are encountered in physical therapy deal with all of the systems in the human body that control the environment and the functioning of the body. Within each system we can place the types of cases into three sub-sections: injury, disease and surgical conditions. Each of these carry any number of entities, such as the Central Nervous System. Injury could be Cerebral Palsy, disease could be Multiple Sclerosis and a surgical condition could come from a brain tumor.

As shown above at the USAH, we deal primarily with orthopedics so that more emphasis will be placed on that particular field. The field of Orthopedics can very easily be broken down into the three sub-sections mentioned above, without being specific. Prime importance is placed on therapeutic exercise and although we are equipped with various modalities, they are used less frequently unless specifically called for by a doctor. Time would not allow presentation of all of the various programs at the USAH, Seoul, but due to the fact that knee problems are a big majority of our orthopedic cases, their program will be presented, hopefully with the understanding that these are guidelines for treatment only. Each patient must be individually considered due to complications which may occur, i. e. effusion, infection, and unusual pain.

A knee problem case begins physical therapy immediately whether it be surgical or non-surgical. Isometrics of the quadriceps muscles, or quad setting as it is more commonly referred to, is taught and patients are instructed to do at least 100 of these an hour. It is stressed that they can never really do enough of these and that they cannot hurt themselves by doing them. Patients who have been admitted for surgery are sent to physical therapy for a pre-op consultation. At this time range of motion measurements are taken of the knee joint also a measurement of the girth of both knees and both thighs, 6" above the tip of the patella. This tells us the amount of effusion or atrophy that is present in the extremity as compared to the normal side. If the patient has control of this leg, he does straight leg raising (SLR) with weight to check his strength prior to surgery. During the pre-op consultation they are informed that they will be expected to do quadriceps setting following surgery and on their first post-op day they will be expected to do a straight leg raise—hopefully they will be able to do 5 to 10. One of the best times to have a patient do a straight leg raise is following surgery when they are still slightly under anesthesia. If they are able to accomplish this at that time, it has been found that their psychological apprehensions are diminished.

A surgical knee patient remains on the ward from 3-5 days and during that period of time they are treated by the ward therapist. Another part of their program is Physical Reconditioning (PR) for the uninvolved extremities. This is very important in maintaining the strength of a bedridden patient and it does prepare them for crutch gait. Once the patient starts coming to the physical therapy clinic, they come in wheelchairs with a board under their involved leg. They begin their program with 100 quad sets, 50 straight leg raises and then 1 or 2 pound weights are applied for SLR. The patient also does static weight loading with a straight leg. To begin they sustain the weight of their leg 6 inches high for a total of ten seconds, rest for ten seconds and repeat ten times.

Usually on or about their fifth or 6th post-op day they begin PRE or progressive resistive exercise (DeLorme method). For those who are not familiar with the DeLorme method the following explanation is offered. If a patient is able to lift a maximum of 4 pounds, he will lift his leg with half of that weight (2 pounds) 10 times. Then three quarters of the maximum (3 pounds) is lifted ten times and that is followed by the last of the three series lift his full maximum of 4 pounds which is also lifted 10 times. In other words there are a total of thirty straight leg lifts; 10 with 1/2 of the maximum; 10 with 3/4 of the maximum and 10 with the full maximum. They

also start their static weight loading with weight at this time. Our criteria to start crutch gait is 15# SLR (DeLorme method) and 10# static weight loading; unless there are other complications. Prior to the publication of this article a new study will be started and selected patients are going to begin crutch gait as soon as they maintain control of their leg.

Range of motion (ROM) exercises begin following the removal of the sutures which is usually about the 12th post-op day. There are some patients who are able to begin prior to this time. Again it depends upon the individuality of the case. While the patient is in a wheelchair the physical reconditioning program continues. Once the patient is independent on crutches, PR is discontinued. When a patient is ready to be placed on crutches he is instructed in partial weight bearing as tolerated and soon after this they are placed on a home program and discharged. Patients within the area are able to return to physical therapy as an out-patient but most of them are discontinued due to the distance they would have to travel to return to the USAH, Seoul. They return to the Orthopedic clinic in 2 to 3 weeks for a check-up.

The knee program, at USAH, Seoul as presented is strictly our guideline for treatment. Every individual accepts surgery or trauma in a different way, both physically and psychologically; their healing processes are different and their achievement of homeostasis may be rapid or slow for these reasons.

Motivation is a primary factor.

There are many ways that we as physical therapists may aid and assist each other. The best way is communication which is the source of awareness.