

4<sup>th</sup> Edition



# Textbook of REHABILITATION



**S Sunder**



# CONTENTS

## Section 1 : General Principles

|                                                                                                                                |           |
|--------------------------------------------------------------------------------------------------------------------------------|-----------|
| <b>1. Introduction to Rehabilitation Medicine</b>                                                                              | <b>3</b>  |
| • What is Rehabilitation? 4                                                                                                    |           |
| • Three Phases of Medicine 4                                                                                                   |           |
| • Medical Rehabilitation 5                                                                                                     |           |
| • Preventive Rehabilitation 7                                                                                                  |           |
| • Impairment, Disability, and Handicap 9                                                                                       |           |
| • Goals of Rehabilitation 13                                                                                                   |           |
| • Sociovocational Rehabilitation 14                                                                                            |           |
| <b>2. The Rehabilitation Team</b>                                                                                              | <b>16</b> |
| • Medical 16                                                                                                                   |           |
| • Paramedical 17                                                                                                               |           |
| • Sociovocational 18                                                                                                           |           |
| • Rehabilitation Team 18                                                                                                       |           |
| • Other Team Members 19                                                                                                        |           |
| • Delivery of Rehabilitation Care 25                                                                                           |           |
| <b>3. Community-based Rehabilitation</b>                                                                                       | <b>29</b> |
| • Criteria 31                                                                                                                  |           |
| • Aspects of CBR 32                                                                                                            |           |
| • Members of the CBR Team 32                                                                                                   |           |
| • Role of the Rehabilitation Professional in CBR 33                                                                            |           |
| • Models of CBR 33                                                                                                             |           |
| <b>4. Sociolegal Aspects of Rehabilitation</b>                                                                                 | <b>34</b> |
| • Legislation in India 34                                                                                                      |           |
| • Constitutional Responsibilities in India 35                                                                                  |           |
| • The Rights of Persons with Disabilities Act 36                                                                               |           |
| • Concessions and Subsidies Given to the Handicapped by the Ministry of Social Justice and Empowerment, Government of India 40 |           |
| • Other Schemes 42                                                                                                             |           |
| • Disability Evaluation 45                                                                                                     |           |
| • Practical Difficulties Experienced in Disability Evaluation 48                                                               |           |
| <b>5. Architectural Barriers</b>                                                                                               | <b>50</b> |
| • Ecology of Housing 51                                                                                                        |           |
| • Architectural Design Features and their Accessibility 53                                                                     |           |
| • Space Enclosures 56                                                                                                          |           |
| • Public Buildings 57                                                                                                          |           |
| • Furniture Modifications for the Disabled 61                                                                                  |           |
| • Visual Disability and the Environment 62                                                                                     |           |
| • Auditory Disability and the Environment 63                                                                                   |           |

|                                      |           |
|--------------------------------------|-----------|
| <b>6. Activities of Daily Living</b> | <b>65</b> |
| • ADL Grouping 66                    |           |
| • Assessment 66                      |           |
| • ADL Activities 68                  |           |
| • ADL Training 73                    |           |

## Section 2 : Therapeutic Management

|                                                           |            |
|-----------------------------------------------------------|------------|
| <b>7. Therapeutic Exercises and Techniques</b>            | <b>79</b>  |
| • Classification of Exercises 80                          |            |
| • Coordination Exercises 81                               |            |
| • Balance Training 84                                     |            |
| • Relaxation Exercises and Management of Spasticity 87    |            |
| • Re-education Exercises 90                               |            |
| • Strengthening Exercises 92                              |            |
| • Mobilization Exercises 98                               |            |
| • Therapeutic Exercises for Pain 100                      |            |
| • Endurance Exercises 102                                 |            |
| • Massage Techniques 104                                  |            |
| • Alternative Healing Techniques 105                      |            |
| <b>8. Gait Analysis and Training</b>                      | <b>107</b> |
| • Gait Cycle 107                                          |            |
| • Studying Normal Human Locomotion 109                    |            |
| • Gait Analysis 109                                       |            |
| • Energy Expenditure 111                                  |            |
| • Independent Walking 111                                 |            |
| • Pathological Gaits 112                                  |            |
| • Gait Training 116                                       |            |
| <b>9. Hand Function and Occupational Therapy</b>          | <b>120</b> |
| • Major Functions of the Hand 120                         |            |
| • The Parts of the Hand Important to Function 122         |            |
| • The Disabled Hand 125                                   |            |
| • Occupational Therapy 126                                |            |
| • Management of the Disabled Hand 129                     |            |
| <b>10. Management of Communication Impairment</b>         | <b>131</b> |
| • Communication 131                                       |            |
| • Speech 133                                              |            |
| • Communication for the Hearing Impaired 140              |            |
| • Speech Therapy 144                                      |            |
| • Dysphagia 146                                           |            |
| <b>11. Management of Behavioral and Learning Problems</b> | <b>153</b> |
| • Behavioral Medicine 153                                 |            |
| • Psychiatric Problems in the Disabled 154                |            |
| • Behavioral Disorders in Children 157                    |            |
| • Management of Behavior Disorders 158                    |            |
| • Mental Retardation (Intellectual Disability) 160        |            |

- Special Education 161
- Sensory Integration 164
- Sensory Processing Disorders 166

## 12. Orthotics 171

- General Principles of Orthosis 171
- Biomechanics of Orthosis 173
- Classification 173
- Material and Fabrication for Lower Limb Orthoses 177
- Calipers 178
- Foot Orthoses 179
- Ankle-Foot Orthosis 183
- Knee-Ankle-Foot Orthosis 186
- Hip-Knee-Ankle-Foot Orthosis 188
- Functional Electrical Stimulation 190
- Spinal Orthosis 191
- Upper Limb Orthoses 198

## 13. Prosthetics 205

- Causes of Amputation 205
- General Principles of Amputation Surgery 206
- Upper Limb Amputation 209
- Lower Limb Amputation 212
- Rehabilitation of Amputees 215
- Prosthetics 221
- Classification of Prostheses 222
- Upper Limb Prosthetics 225
- Above Elbow Prosthesis 226
- Below Elbow Prosthesis 230
- Myoelectric Prosthesis 230
- Prosthesis for the Lower Extremity 234
- Syme's Prosthesis 236
- Below Knee Prosthesis 237
- Above Knee Prosthesis for Transfemoral Amputation 238
- Prosthesis for Hip Disarticulation 241
- Recent Advances in Prosthetic Fitting 243

## 14. Mobility Aids 245

- Functions of Mobility Aids 245
- Prescription of Aids 246
- Parallel Bars 246
- Walking Frames 246
- Walking Aids 249
- Crutches 250
- Scooting Board 252
- Wheelchair 253
- Tricycles 261

## 15. Vocational Rehabilitation 262

- Vocational Rehabilitation 262
- Vocational Rehabilitation Team 263
- Models of Employment 267

|                                                                                                                                                                                                                                                                                                                                                                              |            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| <b>16. Physical Agents in Rehabilitation</b>                                                                                                                                                                                                                                                                                                                                 | <b>269</b> |
| <ul style="list-style-type: none"> <li>• Physical Agents 269</li> <li>• Cryotherapy (Cold Pack Application) 269</li> <li>• Therapeutic Heat 272</li> <li>• Deep Heat 275</li> <li>• Ultrasound Therapy 278</li> <li>• Light Radiation 281</li> <li>• Biofeedback 290</li> <li>• Mechanical Methods of Treatment 293</li> </ul>                                               |            |
| <b>17. Surgery in Rehabilitation</b>                                                                                                                                                                                                                                                                                                                                         | <b>297</b> |
| <ul style="list-style-type: none"> <li>• Causes of Deformities 297</li> <li>• Prevention 298</li> <li>• Management of Deformities 299</li> <li>• Common Deformities of the Lower Limb 299</li> <li>• Tendon Transfers 307</li> <li>• Torticollis 309</li> <li>• Scoliosis 310</li> <li>• Total Knee Replacement 311</li> <li>• Neurosurgery in Rehabilitation 312</li> </ul> |            |
| <b>18. Frontiers of Rehabilitation</b>                                                                                                                                                                                                                                                                                                                                       | <b>316</b> |
| <ul style="list-style-type: none"> <li>• CAD and CAM in Prosthetics 316</li> <li>• Robotic Exoskeletons 320</li> <li>• Virtual Rehabilitation 322</li> <li>• Osseointegration Prosthesis 323</li> <li>• Bionic Arms 324</li> <li>• Eye Tracking and Voice-activated Environmental Control Systems and Communication Devices 327</li> <li>• Newer Wheelchairs 328</li> </ul>  |            |

### Section 3 : Management of Special Populations

|                                                                                                                                                                                                                                                                                                                                         |            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| <b>19. Pain and Spasticity</b>                                                                                                                                                                                                                                                                                                          | <b>335</b> |
| <ul style="list-style-type: none"> <li>• Etiology 336</li> <li>• Classification 336</li> <li>• Theories of Pain 339</li> <li>• Chronic Pain 342</li> <li>• Evaluation of the Client with Pain 342</li> <li>• Pain Management 345</li> <li>• Spasticity 346</li> <li>• Management 348</li> <li>• Interventional Physiatry 352</li> </ul> |            |
| <b>20. Hereditary and Congenital Disorders</b>                                                                                                                                                                                                                                                                                          | <b>354</b> |
| <ul style="list-style-type: none"> <li>• Malformation of the Central Nervous System 354</li> <li>• Hydrocephalus 357</li> <li>• Congenital Malformation of Bones and Joints 359</li> <li>• Congenital Deformities of Skull 367</li> <li>• Mongolism (Down's Syndrome) 368</li> </ul>                                                    |            |

|                                                     |            |
|-----------------------------------------------------|------------|
| <b>21. Ergonomics and Musculoskeletal Disorders</b> | <b>371</b> |
| • Repetitive Strain Injury 371                      |            |
| • Industrial Ergonomics 373                         |            |
| • Low Back Pain 378                                 |            |
| • Neck Pain 379                                     |            |
| • Tennis Elbow 381                                  |            |
| • Golfer's Elbow 382                                |            |
| • Shoulder Pain 383                                 |            |
| <b>22. Sports and Fitness</b>                       | <b>386</b> |
| • Classification of Sports 386                      |            |
| • Sports-specific Injury 387                        |            |
| • Sports Injury Rehabilitation 387                  |            |
| • Training for the Sport 393                        |            |
| • Sports for Persons with Disability 395            |            |
| • Exercises for Fitness 396                         |            |
| • Yoga 401                                          |            |
| <b>23. Geriatric Rehabilitation</b>                 | <b>405</b> |
| • Typical Problems in the Elderly 406               |            |
| • Age-related Changes in the Body 406               |            |
| • Common Complaints Among Geriatric Population 408  |            |
| • Assessment 409                                    |            |
| • Rehabilitation 409                                |            |

## Section 4 : Major Conditions Needing Rehabilitation

|                                                     |            |
|-----------------------------------------------------|------------|
| <b>24. Cerebral Palsy</b>                           | <b>413</b> |
| • Etiology 413                                      |            |
| • Neonatal Reflexes 419                             |            |
| • Aims of Rehabilitation 421                        |            |
| • Principles of Treatment 421                       |            |
| • Management 422                                    |            |
| • Common Deformities in Cerebral Palsy 426          |            |
| • Multiple Disability 428                           |            |
| • Learning Deficits and Behavioral Modification 429 |            |
| <b>25. Poliomyelitis</b>                            | <b>432</b> |
| • Etiology 432                                      |            |
| • Clinical Manifestation 433                        |            |
| • Prevention 434                                    |            |
| • Examination 434                                   |            |
| • Deformities in Polio 435                          |            |
| • Treatment 437                                     |            |
| • Vocational Rehabilitation 439                     |            |
| <b>26. Brain Injury</b>                             | <b>442</b> |
| • Classification 442                                |            |
| • Rehabilitation Assessment 448                     |            |
| • Treatment 451                                     |            |
| • Rehabilitation 452                                |            |

|                                                 |            |
|-------------------------------------------------|------------|
| <b>27. Stroke</b>                               | <b>457</b> |
| • Etiopathogenesis 457                          |            |
| • Rehabilitation 459                            |            |
| • Rehabilitation Management 462                 |            |
| • Occupational Therapy 466                      |            |
| <b>28. Peripheral Nerve Injuries</b>            | <b>469</b> |
| • Classification 469                            |            |
| • Hansen's Disease 472                          |            |
| • Erb's Palsy 476                               |            |
| • Mononeuropathy 477                            |            |
| • Ulnar Nerve Paralysis 478                     |            |
| • Median Nerve Paralysis 478                    |            |
| • Radial Nerve Paralysis 480                    |            |
| • Facial Paralysis (VII Nerve Palsy) 481        |            |
| • Foot Drop 483                                 |            |
| • Peripheral Neuropathy 483                     |            |
| <b>29. Myopathy</b>                             | <b>485</b> |
| • Classification 485                            |            |
| • Diagnosis 486                                 |            |
| • Clinical Examination 486                      |            |
| • Muscular Dystrophies 487                      |            |
| • Duchenne Muscular Dystrophy 487               |            |
| • Becker Muscular Dystrophy 490                 |            |
| • Limb-Girdle Muscular Dystrophy 490            |            |
| • Facioscapulohumeral Muscular Dystrophy 491    |            |
| • Nondystrophic Myopathies 491                  |            |
| • Rehabilitation (Common to All Myopathies) 492 |            |
| <b>30. Spinal Cord Injury</b>                   | <b>496</b> |
| • Staging 497                                   |            |
| • Management 501                                |            |
| • Rehabilitation 502                            |            |
| • The Bladder 510                               |            |
| • Management 511                                |            |
| • Management of Bowels 513                      |            |
| • Sexual Dysfunction 514                        |            |
| • Complications in Spinal Cord Injury 516       |            |
| • Autonomic Dysreflexia 519                     |            |
| <b>31. Movement Disorders</b>                   | <b>523</b> |
| • Multiple Sclerosis 523                        |            |
| • Parkinsonism 526                              |            |
| • Other Movement Disorders 530                  |            |
| • Cerebellar Diseases 530                       |            |
| • Motor Neuron Disease 531                      |            |
| <b>32. Cardiopulmonary Rehabilitation</b>       | <b>534</b> |
| • Cardiac Rehabilitation 534                    |            |
| • Inpatient Rehabilitation Program 537          |            |
| • Pulmonary Rehabilitation 539                  |            |

|                                                     |            |
|-----------------------------------------------------|------------|
| • Classification of Functional Pulmonary Disability | 540        |
| • Conditions Needing Pulmonary Rehabilitation       | 540        |
| • Postural Drainage                                 | 548        |
| <b>33. Vascular and Hematological Conditions</b>    | <b>551</b> |
| • Hemophilia                                        | 551        |
| • Ischemia of the Upper Limb                        | 553        |
| • Arteriosclerosis Obliterans                       | 553        |
| • Acute Arterial Occlusion                          | 556        |
| • Thromboangiitis Obliterans (Buerger's Disease)    | 557        |
| • Varicose Veins                                    | 557        |
| • Deep Vein Thrombosis                              | 557        |
| • Lymphedema                                        | 559        |
| <b>34. Burns</b>                                    | <b>561</b> |
| • Assessment                                        | 561        |
| • Causes                                            | 562        |
| • Classification                                    | 562        |
| • Pathology and Healing                             | 562        |
| • Complications of Burns                            | 563        |
| • Management in the Acute Phase                     | 563        |
| • Rehabilitation                                    | 564        |
| <b>35. Arthritis</b>                                | <b>570</b> |
| • Classification                                    | 570        |
| • Rheumatoid Arthritis                              | 571        |
| • Juvenile Rheumatoid Arthritis                     | 577        |
| • Systemic Lupus Erythematosus                      | 578        |
| • Polymyositis and Dermatomyositis                  | 579        |
| • Degenerative Arthropathies—Osteoarthritis         | 580        |
| • Seronegative Spondylarthropathies                 | 582        |
| • Ankylosing Spondylitis                            | 583        |
| • Diffuse Idiopathic Skeletal Hyperostosis          | 585        |
| • Psoriatic Arthritis                               | 585        |
| • Reiter's Syndrome                                 | 586        |
| <b>36. Fractures</b>                                | <b>588</b> |
| • Types of Fracture                                 | 588        |
| • Management of Fractures                           | 590        |
| • Fracture Spine                                    | 594        |
| • Pathological Fractures                            | 595        |
| • Osteoporosis                                      | 595        |
| • Complications after a Fracture                    | 599        |
| • Myositis Ossificans                               | 600        |
| • Reflex Sympathetic Dystrophy                      | 601        |
| • Volkmann's Ischemic Contracture                   | 602        |
| • Avascular Necrosis                                | 603        |



## Community-based Rehabilitation

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### INTRODUCTION

Community-based rehabilitation (CBR) is a strategy within the community for the rehabilitation, equalization of opportunities and social integration of people with disabilities in low-income and middle-income countries, by making optimum use of local resources. All members of the community—the disabled people themselves, their families, their friends, the local health, educational, and socio-vocational services, partner with the rehabilitation professionals in the common goal of achieving self-dependence among the groups of disabled individuals. CBR is currently implemented in over 90 countries.

Community-based rehabilitation (CBR) was initiated by the World Health Organization (WHO) following the Declaration of Alma-Ata in 1978. In recognition of this, the ESCAP (Economic and Social Commission for Asia and the Pacific) had declared the decade 1993-2002 as the Asia and Pacific decade for the disabled. Later key recommendations were made in 2003 at the International Consultation in Helsinki to Review Community-based Rehabilitation.

The guidelines that evolved out of these recommendations focus on empowerment through the inclusion and participation of disabled people, their family, and communities in all rehabilitation-related development and decision-making processes. Earlier, CBR was a service delivery method using primary health care and community resources, in low-income countries. They were mainly focused on physiotherapy, appliances, and medical or surgical treatment.

With the involvement of other UN agencies, such as the International Labour Organization (ILO), United Nations Development Programme (UNDP), and United Nations Children's Fund (UNICEF) an international meeting in Helsinki decided to focus on reducing poverty, and promoting community involvement and ownership, involving disabled people's organizations in their programs. Later in 2004, the definition of CBR was reworded to include **"poverty reduction, equalization of opportunities and social inclusion of all people with disabilities"**.

The goals of CBR are to ensure that the benefits enshrined in the Convention on Rights of Persons with Disabilities reach the majority by:

- Supporting people with disabilities to maximize their physical and mental abilities.
- Helping them access regular services and opportunities, and to become active contributors to the community and society at large.
- Activating communities to promote and protect the rights of people with disabilities by removing barriers to participation, improve awareness about disability and lobby for their inclusion in society.
- Empowering PWD and their families.

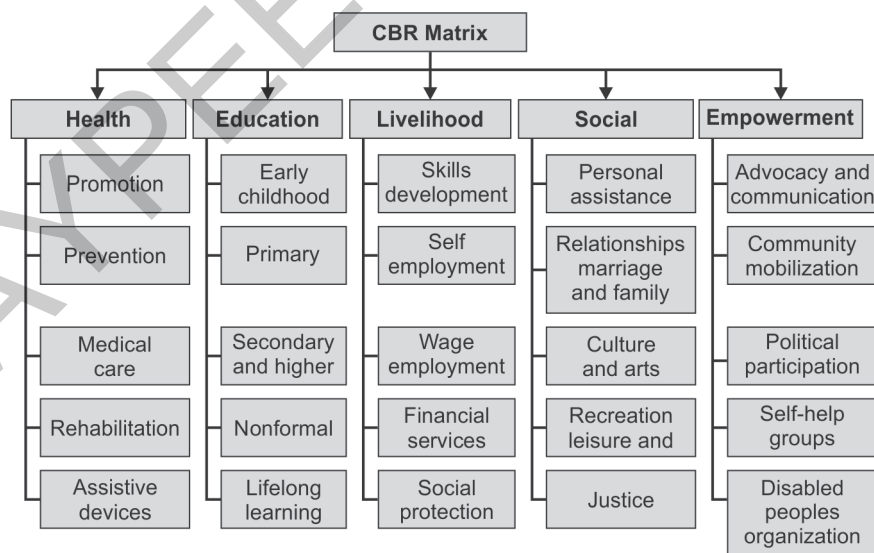
The community-based rehabilitation (CBR) matrix consists of five components (Health, Education, Livelihood, Social, and Empowerment) (Fig. 3.1).

There is a difference between CBR projects and CBR programs. While projects are usually small scale and have specific outcomes in one area of CBR, programs tend to be large scale, complex and without specific outcomes.

**The programs in CBR broadly aim at:**

- Prevention of disabilities
- Identification of high-risk infants and mothers
- Early detection of disability and management
- Assessment of felt needs of the people with disability and the family
- Home-based or neighborhood-based programs
- Parental involvement
- Play groups and integrated schooling for children
- Organizations for and by the people with disability.

India is a vast country with a huge rural-based population. Mahatma Gandhi has said that India lives in its villages. It is not possible to provide professional expertise across the length and breadth of the land at the doorstep of the people with disability. Hence, we have to take up an approach which is simple and benefits a larger population.



**Fig. 3.1:** Community-based rehabilitation (CBR) matrix.

Source: CBR summary, WHO.

The basic concept inherent in the multi-layered approach to CBR is the **decentralization** of responsibility and resources, both human and financial to community level organizations. Those with disabilities are enabled to participate fully in the social, economic and political life of the community.

CBR is the appropriate rehabilitation program for the rural people with disability delivered at their doorstep with the use of local resources and with the involvement of local people (Fig. 3.2). CBR is a need-based rehabilitation done in the community at the community level by utilizing the contribution of the community. The people with disability and their families are intensively involved in the decision making process, as are the members of the community.

**CBR is a self-help movement based on:**

- Awareness and concern of the community
- Initiatives from the community
- Planning from the community
- Resources from the community
- Implementation by the community
- Evaluation by the community
- Modification by the community
- Benefits to and from the community.

Sustainable CBR programs are initiated by very large organizations or by the government. They need **good leadership**, usually good CBR program managers. The programs network with other organizations as **Partnerships**. Successful CBR programs have a strong **participation of the community**. **Local resources** are used with ample consideration of **cultural factors**. Stakeholders are empowered to plan, and manage CBR programs, so that they become **sustainable**. **Money** also has to be provided by government funding (grants), or donor funding. Sometimes, income is generated by selling products, or services. For a long standing CBR program, there must be **political will**, and support from the government. Disabled people's organizations are a great resource for strengthening CBR programs, and many play meaningful roles in them.



**Fig. 3.2:** Community-based rehabilitation—an amputee being rehabilitated in his house in a village.

## CRITERIA

CBR programs must coordinate service delivery at the local level, and people with disabilities must be included in CBR programs; at all stages, they must have distinct decision-making roles.

## ASPECTS OF CBR

CBR has four important aspects:

- Medical
- Educational
- Economical
- Social

The medical aspect usually starts with evaluation of the disability by a group of professionals. A comprehensive program is charted out, which is followed up by diligent grassroots level trained personnel. Usually the relatives of the patient are also trained. Whenever required, education is imparted to those who need basic knowledge and skills. This gains more significance in children suffering from cerebral palsy. The educational vocational and avocational skills imparted will provide a springboard for the patient to register himself for a job, or open up opportunities for self-employment, and avenues for economic betterment.

**Society needs to be involved in CBR:** The success of any CBR program depends upon factors like cost-effectiveness, individualized values as well as social acceptability.

## MEMBERS OF THE CBR TEAM

First and foremost, **the patient** has to be involved in all decision-making processes, because he is the recipient of the services. People with disabilities can be more effective than nondisabled people as role models for and counselors of other people with disabilities. Local people, like families of people with disabilities, and members of the community who know the lie of the land, its economy and the local environmental conditions, are in the best position to implement the program. Support will be given by the governments (local, regional, national), nongovernmental organizations and medical inputs by the medical professionals. Allied health science professionals, educators, social scientists, and other professionals are often used in their capacity as educators. The corporate sector, comprising of profitable companies and industries have recently coined a term **corporate social responsibility (CSR)**, implying an obligation to plough back some of the benefits of its operations to the community, in which it operates.

The other members are locally available skilled workers, e.g. carpenters who could be trained to make appliances and aids, local leaders who can lobby for barrier-free environment, the school teacher, who contributes her spare time for children with special needs, the multipurpose rehabilitation worker: (a trained person who can identify disability, and give the basic physiotherapy and prescribe orthotics), and the PHC staff. The medical officers and workers of the PHC need to be trained in identifying handicap and managing it. One of the largest orientation programs of its kind in the world was introduced by the Rehabilitation Council of India for PHC doctors all over India, to orient them toward rehabilitation.

## ROLE OF THE REHABILITATION PROFESSIONAL IN CBR

The rehabilitation professional, whether he is medical, paramedical or socio-vocational, is seen as a **leader, teacher and guide** instead of as a health provider. He imparts training, demystifies the rehabilitation concepts, solves specific problems, organizes the set up and generally functions as an advisor.

## MODELS OF CBR

**WHO model** uses trainers and distributes booklets on health conditions.

**Neighborhood model:** A resource center in the community adopts another center, trains the personnel, and in due course this becomes another resource center.

**DRC models:** The District Rehabilitation Scheme (DRC) was launched by the Government of India in January 1985 on a pilot basis in collaboration with the National Institute of Disability and Rehabilitation Research, the US Department of Education and UNICEF as an outreach activity for providing comprehensive services to the persons with disabilities at the grass root level. The infrastructure and capacity building of rehabilitation professionals was also taken up.

The DRCs surveys disabled population, and works on all aspects of rehabilitation like prevention, early detection and medical intervention. Deformities are corrected surgically, physiotherapy occupational therapy and speech therapy are given and amputees are provided with artificial limbs. The entire gamut of socio-vocational rehabilitation like facilitation of disability certificate, barrier-free environment, training, job placement, and self-employment opportunities to PWD is also catered to under this scheme.



# Textbook of REHABILITATION

## *Salient Features*

- Comprehensive textbook of rehabilitation by renowned physiatrist
- For all rehabilitation professionals
- Conforms to the syllabus of major universities in India
- Brings in new insights to frontiers of rehabilitation and includes new subjects like ergonomics and interventional aspects of rehabilitation.

**S Sunder** is a Medical Graduate from Stanley Medical College, Chennai, Tamil Nadu, India, and holds a postgraduate degree (MD) in the field of Physical Medicine and Rehabilitation. He specializes in ergonomics and in rehabilitating the handicapped. He is the Founder Medical Director of the **PREM Center for Physiotherapy and Rehabilitation Medicine** in Chennai, which is one of the largest centers of its kind in the city.

He was until recently Senior Consultant and Head, Department of Physical Medicine and Rehabilitation in Global Health City. He has been visiting faculty in the subject of rehabilitation to several colleges, and has been the editor of the bulletin of the Indian Association of Physical Medicine and Rehabilitation.

He is one of the few physiatrists in the field of ergonomics and has done more than four hundred programs on Office Ergonomics among computer professionals. He has been industrial medical consultant to several companies, and has served as President of the Indian Association of Occupational Health, Tamil Nadu branch.

He has presented several papers and chaired several scientific sessions in national and international conferences and has delivered several prestigious national orations.

He founded the **Freedom Trust** under which banner he conducts regular camps for the physically disabled and gives away mobility aids. Over 25,000 physically challenged persons all over India have received mobility aids from the trust. In recognition of his services, he received the coveted **Presidents award for Best Individual in Social Service in the year 2008, and the Tamil Nadu State award for Best Doctor**. In 2017 on World Disability Day, he was awarded the Lifetime Achievement award by the Chief Secretary, Tamil Nadu. Several other organizations have honored him for his valuable contributions to the society.

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