

FORCE ANALYSIS FOR PLA AND PETG MATERIAL IN REHABILITATION

Dr.N. Jayanthi

Associate Professor
Biomedical Engineering
Paavai Engineering College

Dinesh S

Biomedical Engineering
Paavai Engineering College
dhonidinesh3071@gmail.com
jayanthi.nathan1@gmail.com

Sangeethkumar M

Biomedical Engineering
Paavai Engineering College
manimanoj415@gmail.com

Nikash N

Biomedical Engineering
Paavai Engineering College
nikashnikash2423@gmail.com

Suriya P

Biomedical Engineering
Paavai Engineering College
suriya162004@gmail.com

Abstract The hand exoskeleton is a revolutionary assistive robotic device intended to support patients recovering from motor impairments due to strokes, spinal cord injuries, or other neuromuscular disorders. By mimicking natural hand movements through precise mechanical actuation, this wearable technology delivers repetitive and controlled motions necessary for rehabilitation. The goal is to aid in neuroplasticity and muscle re-education, improving the speed and quality of recovery. With the integration of smart technologies such as EMG sensors and microcontrollers, modern hand exoskeletons can now personalize rehabilitation programs, making them accessible, adaptive, and cost-efficient.

1. Introduction The human hand is one of the most complex and versatile parts of the body, capable of intricate movements required for tasks such as grasping, writing, and manipulating objects. However, individuals affected by neurological injuries, such as stroke, traumatic brain injury, or spinal cord damage, often lose partial or complete functionality of their hands. Traditional rehabilitation therapies are labor-intensive, require clinical supervision, and are often limited by the availability of trained professionals. A hand exoskeleton offers a modern alternative by delivering consistent, repetitive movements that are crucial for motor recovery. This device is worn like a glove and assists or resists finger movements, depending on the therapy goals. It has the potential to be used at home, thus enabling continuous therapy and reducing dependence on healthcare facilities.

2. Objectives The primary objective of a hand exoskeleton is to restore hand functionality in individuals who have experienced impairments. This is achieved by enabling consistent, repetitive movements that stimulate neuroplasticity and

encourage relearning of motor functions. The device also aims to provide a cost-effective, home-based solution for rehabilitation, thereby reducing the load on hospitals and physiotherapists. Another key objective is to personalize the therapy by using sensors and adaptive algorithms that adjust the intensity and type of exercises based on patient progress. Ultimately, the hand exoskeleton aims to improve the quality of life for patients by promoting independence and enabling them to perform everyday tasks with greater ease.

3. Working Principle The working principle of a hand exoskeleton is based on the application of external mechanical forces to assist or resist voluntary finger movements. The exoskeleton is typically structured around the hand and fingers and consists of joints, linkages, and actuators that align with the natural anatomy of the user. Sensors, such as flex sensors or electromyography (EMG) electrodes, detect the user's movement intention or muscle activity. These signals are then processed by a microcontroller, which sends commands to the actuators (usually servo motors or pneumatic systems) to initiate motion. Some advanced systems use feedback loops to continuously monitor the movement and adjust the force and direction of actuation to ensure safety and comfort. This real-time adaptation makes the device suitable for dynamic therapy sessions and helps in tracking the patient's recovery.

4. Components Used A typical hand exoskeleton system comprises both hardware and software components:

- **Microcontroller Unit (MCU):** Acts as the brain of the system, processing input from sensors and controlling actuators. Arduino or STM32 boards are commonly used.

- **Actuators:** Usually servo motors or pneumatic actuators that drive the motion of the fingers by mimicking muscle contractions.
- **Sensors:** Flex sensors detect the bending of fingers, while EMG sensors read muscle signals. Inertial Measurement Units (IMUs) can track hand orientation and movement.
- **Power Supply:** A rechargeable lithium-ion battery provides portability and ensures the device can function independently of external power.
- **Mechanical Frame:** The structure of the glove, often made from lightweight materials such as 3D-printed plastic or soft fabrics, supports the actuators and ensures comfort.
- **Software Interface:** A mobile or desktop application may be included to select exercises, track progress, and visualize sensor data.

5. Types of Hand Exoskeletons Hand exoskeletons can be categorized based on their actuation mechanism and the level of assistance they provide:

- **Passive Exoskeletons:** These do not use motors or actuators. Instead, they rely on elastic components like springs to assist motion. They are lightweight and low-cost but offer limited functionality.
- **Active Exoskeletons:** These are powered by motors or pneumatic systems, offering precise and customizable movement. They are suitable for intensive rehabilitation but are bulkier and more expensive.
- **Semi-active Exoskeletons:** A combination of passive and active systems. They use minimal power and provide assistance only when required, balancing efficiency and performance.

6. Design and Architecture The design of a hand exoskeleton must consider ergonomics, mechanical alignment with the hand's joints, and user comfort. The exoskeleton generally includes:

- **Mechanical Design:** Includes linkages aligned with finger joints (metacarpophalangeal, proximal interphalangeal, and distal interphalangeal). The design should allow natural hand movements and ensure that actuation does not cause discomfort.
- **Control System:** The microcontroller receives data from sensors and executes commands to actuators. Algorithms control the intensity, duration, and type of movement.

- **Feedback Mechanism:** Position sensors or force sensors provide feedback to the controller, ensuring accurate and safe movements.
- **User Interface:** A user-friendly application may allow the therapist or patient to choose rehabilitation modes, monitor performance, and adjust difficulty levels.

7. Advantages The use of a hand exoskeleton in rehabilitation offers numerous benefits:

- **Consistency:** Provides uniform and repetitive movement patterns crucial for neuroplasticity.
- **Accessibility:** Enables therapy at home, reducing the need for frequent hospital visits.
- **Motivation:** Gamified exercises and visual feedback increase patient engagement.
- **Monitoring:** Real-time data collection allows therapists to monitor progress remotely.
- **Customization:** Therapy sessions can be tailored based on individual patient needs and recovery speed.
- **Reduced Load on Therapists:** Allows one therapist to manage multiple patients through remote monitoring.

8. Applications Hand exoskeletons are used in a variety of rehabilitation and assistive scenarios:

- **Stroke Rehabilitation:** Helps stroke survivors regain control of hand movements.
- **Post-surgical Recovery:** Assists patients recovering from hand or nerve surgery.
- **Neuromuscular Disorders:** Provides support to individuals with conditions like muscular dystrophy or multiple sclerosis.
- **Elderly Care:** Offers hand function support to the elderly with age-related motor decline.
- **Physiotherapy Clinics:** Used as a tool for structured and measurable therapy.
- **Occupational Therapy:** Helps individuals relearn skills required for daily living.

9. Challenges Despite its potential, the hand exoskeleton faces several challenges:

- **Customization:** Designing for different hand sizes and anatomies can be complex.
- **Cost:** Advanced models with smart features can be expensive.
- **Safety:** Ensuring that actuators do not exert excessive force is critical.

- **Battery Life:** Power constraints limit portability and session duration.
- **Technical Skills:** Patients or caregivers may require training to operate the device safely.
- **Data Privacy:** Managing patient data collected through the device raises security concerns.

10. Future Scope The future of hand exoskeletons lies in smarter, more integrated systems:

- **AI-Powered Therapy:** Machine learning algorithms can adapt therapy plans based on patient performance.
- **IoT Integration:** Cloud connectivity enables remote monitoring and global data analysis.
- **3D Printing:** Reduces production cost and allows for customized designs.
- **Brain-Computer Interfaces (BCIs):** Direct control through brain signals can help even fully paralyzed patients.
- **Virtual Reality (VR):** Combined with exoskeletons for immersive rehab environments.

11. Conclusion The hand exoskeleton for rehabilitation represents a fusion of robotics, biomedical engineering, and neurotherapy. It provides a promising path forward for improving the lives of individuals with impaired hand function. Through continuous development in sensors, actuation, and intelligent control systems, these devices are becoming more effective and affordable. Their ability to bring professional-grade therapy to the comfort of patients' homes marks a significant advancement in the field of assistive technology.

12. References

1. Aggogeri F., Mikolajczyk T., O'Kane J. (2019). Robotics for rehabilitation of hand movement in stroke survivors. *Adv. Mech. Eng.* 11, 168781401984192. 10.1177/1687814019841921 [DOI] [Google Scholar]
2. Armando R. C. J., del Carmen L., Valentín snachez G., Datta Banik S., Argáez S., J. (2012). Dinamometria de manos en estudiantes de Merida, México. *Rev. Chil. Nutr.* 39, 45–51. 10.4067/S0717-75182012000300007 [DOI] [Google Scholar]
3. Ates S., Haarman C. J., Stienen A. H. (2017). Script passive orthosis: Design of interactive hand and wrist exoskeleton for rehabilitation at home after stroke. *Aut. Robots* 41, 711–723.

4. Baker K., Cano S., Playford E. (2011). Outcome measurement in stroke: A scale selection strategy. *Stroke* 42, 1787–1794. 10.1161/STROKEAHA.110.608505 [DOI] [PubMed] [Google Scholar]
5. Bo Nielsen J., Willerslev-Olsen M., Christiansen L., Lundbye-Jensen J., Lorentzen J. (2015). Science-based neurorehabilitation: Recommendations for neurorehabilitation from basic science. *J. Mot. Behav.* 47, 7–17. 10.1080/00222895.2014.931273 [DOI] [PubMed] [Google Scholar]
6. Bütefisch C., Hummelsheim H., Denzler P., Mauritz K. H. (1995). Repetitive training of isolated movements improves the outcome of motor rehabilitation of the centrally paretic hand. *J. neurological Sci.* 130, 59–68. 10.1016/0022-510x(95)00003-k [DOI] [PubMed] [Google Scholar]
7. Cameirao M. S., Badia S. B. i., Zimmerli L., Oller E. D., Verschure P. F. M. J. (2007). The rehabilitation gaming system: A virtual reality based system for the evaluation and rehabilitation of motor deficits. *Virtual Rehabil.* 2007, 29–33. 10.1109/ICVR.2007.4362125 [DOI] [Google Scholar]
8. Carmeli E., Peleg S., Bartur G., Elbo E., Vatine J.-J. (2011). Handtutor™ enhanced hand rehabilitation after stroke - a pilot study. *Physiother. Res. Int.* 16, 191–200. 10.1002/pri.485 [DOI] [PubMed] [Google Scholar]
9. Chien W., Chong Y., Tse M., Chien C., Cheng H. (2020). Robot-assisted therapy for upper-limb rehabilitation in subacute stroke patients: A systematic review and meta-analysis. *Brain Behav.* 10, e01742. 10.1002/brb3.1742 [DOI] [PMC free article] [PubMed] [Google Scholar]
10. Císnal A., Gordaliza P., Turiel J., Fraile J. (2023). Interaction with a hand rehabilitation exoskeleton in emg-driven bilateral therapy: Influence of visual biofeedback on the users' performance. *Sensors* 23, 2048. 10.3390/s23042048 [DOI] [PMC free article] [PubMed] [Google Scholar]
11. Císnal A., Lobo V., Moreno V., Fraile J.-C., Alonso R., Pérez-Turiel J. (2018). Robhand, un exoesqueleto de mano para la rehabilitación neuromotora aplicando terapias activas y pasivas [robhand, a hand exoskeleton

- for neuromotor rehabilitation using passive and active therapies]. *Actas las XXXIX Jornadas Autom. 34, 41. Badajoz, 5-7 de Septiembre de 2018*. 10.17979/spudc.9788497497565.0034 [DOI] [Google Scholar]
12. Cissal A., Moreno-SanJuan V., Fraile J., Turiel J., de-la Fuente E., Sanchez-Brizuela G. (2022). Assessment of the patient's emotional response with the robhand rehabilitation platform: A case series study. *J. Clin. Med.* 11, 4442. 10.3390/jcm11154442 [DOI] [PMC free article] [PubMed] [Google Scholar]
 13. Cissal A., Pérez-Turiel J., Fraile J.-C., Sierra D., de la Fuente E. (2021). Robhand: A hand exoskeleton with real-time emg-driven embedded control. Quantifying hand gesture recognition delays for bilateral rehabilitation. *IEEE Access* 9, 137809–137823. 10.1109/ACCESS.2021.3118281 [DOI] [Google Scholar]
 14. Collaborators G. S., Nguyen M., Roth G. A., Nichols E., Alam T., Abate D., et al. (2019). Global, regional, and national burden of stroke, 1990–2016: A systematic analysis for the global burden of disease study 2016. *Lancet Neurol.* 18, 439–458. 10.1016/S1474-4422(19)30034-1 [DOI] [PMC free article] [PubMed] [Google Scholar]
 15. Corbetta D., Imeri F., Gatti R. (2015). Rehabilitation that incorporates virtual reality is more effective than standard rehabilitation for improving walking speed, balance and mobility after stroke: A systematic review. *J. Physiother.* 61, 117–124. 10.1016/J.JPHYS.2015.05.017 [DOI] [PubMed] [Google Scholar]
 16. Crosbie J. H., Crosbie J. H., Lennon S., Lennon S., McGoldrick M. C., McGoldrick M. C., et al. (2008). Virtual reality in the rehabilitation of the upper limb after hemiplegic stroke: A randomised pilot study. *Clin. Rehabil.* 26, 798–806. 10.1177/0269215511434575 [DOI] [PubMed] [Google Scholar]
 17. de Winckel A. V., Feys H., van der Knaap S., Messerli R., Baronti F., Lehmann R., et al. (2006). Can quality of movement be measured? Rasch analysis and inter-rater reliability of the motor evaluation scale for upper extremity in stroke patients (mesupes). *Clin. Rehabil.* 20, 871–884. 10.1177/0269215506072181 [DOI] [PubMed] [Google Scholar]
 18. Demers L., Rhoda W.-L., Bernadette S. (2000). Item analysis of the quebec user evaluation of satisfaction with assistive technology (quest). *Assist. Technol.* 12, 96–105. 10.1080/10400435.2000.10132015 [DOI] [PubMed] [Google Scholar]
 19. Dudley D., Knarr B., Siu K., Peck J., Ricks B., Zuniga J. (2021). Testing of a 3d printed hand exoskeleton for an individual with stroke: A case study. *Disabil. Rehabil. Assist. Technol.* 16, 209–213. 10.1080/17483107.2019.1646823 [DOI] [PMC free article] [PubMed] [Google Scholar]
 20. Dworzynski K., Ritchie G., Playford E. (2015). Stroke rehabilitation: Long-term rehabilitation after stroke. *Clin. Med. (Lond).* 15, 461–464. 10.7861/clinmedicine.15-5-461 [DOI] [PMC free article] [PubMed] [Google Scholar]
 21. Figueiredo S. (2011). *Box and block test (BBT)*. Stroke engine intervention. [Google Scholar]
 22. Fischer H. C., Stubblefield K., Kline T., Luo X., Kenyon R. V., Kamper D. G. (2007). Hand rehabilitation following stroke: A pilot study of assisted finger extension training in a virtual environment. *Top. Stroke Rehabil.* 14, 1–12. 10.1310/tsr1401-1 [DOI] [PubMed] [Google Scholar]
 23. Flores E., Tobon G., Cavallaro E., Cavallaro F. I., Perry J. C., Keller T. (2009). Improving patient motivation in game development for motor deficit rehabilitation. *Adv. Comput. Entertainment Technol.* 381, 1501839. 10.1145/1501750.1501839 [DOI] [Google Scholar]
 24. Frick E. M., Alberts J. L. (2007). Combined use of repetitive task practice and an assistive robotic device in a patient with subacute stroke. *Phys. Ther.* 86, 1378–1386. 10.2522/ptj.20050149 [DOI] [PubMed] [Google Scholar]
 25. Gil J., Barria P., Aguilar R., Abarza K., Andrade A., Mancilla A., et al. (2022). A robot-assisted therapy to increase muscle strength in hemiplegic gait rehabilitation. *Front. Neurobotics* 16, 837494. 10.3389/fnbot.2022.837494 [DOI] [PMC free article] [PubMed] [Google Scholar]

26. Gilbertson L., Barber-Lomax S. (1994). Power and pinch grip strength recorded using the hand-held jamar® dynamometer and b+l hydraulic pinch gauge: British normative data for adults. *Br. J. Occup. Ther.* 57, 483–488. 10.1177/030802269405701209 [DOI] [Google Scholar]
27. Gilman S. (2006). Time course and outcome of recovery from stroke: Relevance to stem cell treatment. *Exp. Neurol.* 199, 37–41. PMID: 16427047. 10.1016/j.expneurol.2005.12.003 [DOI] [PubMed] [Google Scholar]
28. Gomez Rendon J., Moreno Arango J., Becerra Velasquez J., Humberto C. (1965). Functional evaluation: The barhel index. *Md. State Med. J.* 14, 56– 61. PMID: 14258950. [Google Scholar]
29. Gomez Rendon J., Moreno Arango J., Becerra Velasquez J., Humberto C., Orozco Tellez C. H. (2016). Rehabilitación de la mano con órtesis robóticas. *Rev. Colomb. Med. Fis. Rehabil.* 26, 174–179. 10.28957/rcmfr.v26n2a7 [DOI] [Google Scholar]
30. Hendricks H., van Limbeek J., Geurts A., Zwarts M. (2002). Motor recovery after stroke: A systematic review of the literature. *Arch. Phys. M.* 38, 1629–1637. 10.1053/apmr.2002.35473 [DOI] [PubMed] [Google Scholar]
31. Jones E. (2000). Cortical and subcortical contributions to activity-dependent plasticity in primate somatosensory cortex. *Annu. Rev. Neurosci.* 23, 1–37. 10.1146/annurev.neuro.23.1.1 [DOI] [PubMed] [Google Scholar]
32. Klijn C., Hankey G. (2003). Management of acute ischaemic stroke: New guidelines from the American stroke association and European stroke initiative. *Lancet Neurol.* 2, 698–701. PMID: 14572738. 10.1016/s1474-4422(03)00558-1 [DOI] [PubMed] [Google Scholar]
33. Koumpouros Y. (2016). A systematic review on existing measures for the subjective assessment of rehabilitation and assistive robot devices. *J. Healthc. Eng.* 2016, 1048964. 10.1155/2016/1048964 [DOI] [PMC free article] [PubMed] [Google Scholar]
34. Kutner N. G., Zhang R., Butler A. J., Wolf S. L., Alberts J. L. (2010). Quality-of-life change associated with robotic-assisted therapy to improve hand motor function in patients with subacute stroke: A randomized clinical trial. *Phys. Ther.* 90, 493–504. 10.2522/ptj.20090160 [DOI] [PMC free article] [PubMed] [Google Scholar]
35. Kwakkel G., Kollen B. J., Krebs H. I. (2008). Effects of robot-assisted therapy on upper limb recovery after stroke: A systematic review. *Neurorehabilitation Neural Repair* 22, 111–121. 10.1177/1545968307305457 [DOI] [PMC free article] [PubMed] [Google Scholar]
36. Kwakkel G., Kollen B., van der Grond J., Prevo A. (2003). Probability of regaining dexterity in the flaccid upper limb: Impact of severity of paresis and time since onset in acute stroke. *Stroke* 34, 2181–2186. 10.1161/01.str.0000087172.16305.cd [DOI] [PubMed] [Google Scholar]
37. Langhorne P., Bernhardt J., Kwakkel G. (2011). Stroke rehabilitation. *Lancet* 377, 1693–1702. PMID: 21571152. 10.1016/S0140-6736(11)60325-5 [DOI] [PubMed] [Google Scholar]