Clinical Outcomes and Practice Guidelines for Lower Limb Amputees

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The Case for Outcomes in O&P

- Historically lacking across orthotics and prosthetics
- Payer scrutiny of prosthetics leads to increased barriers and restrictions to appropriate care for your patients
- As the O&P leader, Hanger Clinic has begun to develop a number of outcomes protocols
Outcomes and Quality of Care

Important questions need to be answered...

• Is prosthetic mobility associated with quality of life and general satisfaction?

• Do comorbid health conditions preclude meaningful prosthetic mobility?

• Do assistive devices enable enhanced prosthetic mobility or act as a marker of limited mobility potential?
Outcomes and Quality of Care

Large data sets are required to accurately answer these questions

- Smaller data sets (personal experience) can be misleading
Our Resources

Over 2000 clinicians and 800 clinics, providing care across a spectrum of patient populations
Outcomes and Quality of Care

We can collect 1000’s of data points. However....

....each of those data points represent a patient/clinician interaction

- O&P has historically struggled with outcomes collection
- No reimbursement for clinician time
- Outcomes are a “value-added” service
- Compulsory outcomes may introduce bias
- How do we encourage collection of accurate outcomes data?
Changing the Outcomes Culture

• Select measures that are meaningful
  • Clinicians
  • Patients

• Select measures that are indexed against peers
  • “How am I doing?”

• Select measures that are sensitive to change
  • Allow tracking of progress and setbacks
### PLUS-M

- Survey of prosthetic mobility
- Rate the difficulty encountered during 12 items
- Progressive degree of difficulty (Item response theory)

#### Instructions:
Please respond to all questions as if you were wearing the prosthetic leg(s) you use most days. If you would normally use a cane, crutch, or walker to perform the task, please answer the questions as if you were using that device.

Please choose "unable to do" if you:
- Would need help from another person to complete the task,
- Would need a wheelchair or scooter to complete the task, or
- Feel the task may be unsafe for you

Please mark one box per row.

<table>
<thead>
<tr>
<th>Question</th>
<th>Without any difficulty</th>
<th>With a little difficulty</th>
<th>With some difficulty</th>
<th>With much difficulty</th>
<th>Unable to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you able to walk a short distance in your home?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>2. Are you able to step up and down curbs?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>3. Are you able to walk across a parking lot?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>4. Are you able to walk over gravel surfaces?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>5. Are you able to move a chair from one room to another?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>6. Are you able to walk while carrying a shopping basket in one hand?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>7. Are you able to keep walking when people bump into you?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>8. Are you able to walk on an unit street or sidewalk?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>9. Are you able to keep up with others when walking?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>10. Are you able to walk across a slippery floor?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>11. Are you able to walk down a steep gravel driveway?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>12. Are you able to hike about 2 miles on uneven surfaces, including hills?</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
</tbody>
</table>
 PLUS-M

- Raw Score
- Indexed to T-score
- Percentile
  - General Amputee
  - Peer specific

Scoring the PLUS-M™ 12-Item Short Form

PLUS-M™ short forms are scored with a T-score. To find the T-score, sum scores for all responses on the short form. This is the raw score. Do not use the raw score for any purpose other than to look up the T-score using the conversion table below. If any questions on the short form are unanswered, refer to the PLUS-M™ Short Form Users Guide for instructions on scoring incomplete short forms.

PLUS-M™ 12-item Short Form (v1.2) T-score Conversion Table

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>T-score</th>
<th>SE</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>21.8</td>
<td>4.4</td>
<td>0.2%</td>
</tr>
<tr>
<td>13</td>
<td>25.2</td>
<td>3.4</td>
<td>0.7%</td>
</tr>
<tr>
<td>14</td>
<td>27.2</td>
<td>3.1</td>
<td>1.1%</td>
</tr>
<tr>
<td>15</td>
<td>28.7</td>
<td>2.9</td>
<td>1.6%</td>
</tr>
<tr>
<td>16</td>
<td>30.0</td>
<td>2.7</td>
<td>2.3%</td>
</tr>
<tr>
<td>17</td>
<td>31.2</td>
<td>2.5</td>
<td>3.0%</td>
</tr>
<tr>
<td>18</td>
<td>32.2</td>
<td>2.3</td>
<td>3.8%</td>
</tr>
<tr>
<td>19</td>
<td>33.2</td>
<td>2.2</td>
<td>4.6%</td>
</tr>
<tr>
<td>20</td>
<td>34.1</td>
<td>2.1</td>
<td>5.5%</td>
</tr>
<tr>
<td>21</td>
<td>34.9</td>
<td>2.1</td>
<td>6.5%</td>
</tr>
<tr>
<td>22</td>
<td>35.6</td>
<td>2.0</td>
<td>7.6%</td>
</tr>
<tr>
<td>23</td>
<td>36.4</td>
<td>2.0</td>
<td>8.6%</td>
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<tr>
<td>24</td>
<td>37.1</td>
<td>1.9</td>
<td>9.8%</td>
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<tr>
<td>25</td>
<td>37.7</td>
<td>1.9</td>
<td>11.0%</td>
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<tr>
<td>26</td>
<td>38.4</td>
<td>1.9</td>
<td>12.3%</td>
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<td>13.6%</td>
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<td>39.7</td>
<td>1.9</td>
<td>15.1%</td>
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<td>40.9</td>
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<td>18.1%</td>
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<td>31</td>
<td>41.5</td>
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<td>32</td>
<td>42.1</td>
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<td>21.5%</td>
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<tr>
<td>33</td>
<td>42.7</td>
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<td>23.3%</td>
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<tr>
<td>34</td>
<td>43.3</td>
<td>1.9</td>
<td>25.2%</td>
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<tr>
<td>35</td>
<td>43.9</td>
<td>1.9</td>
<td>27.2%</td>
</tr>
<tr>
<td>36</td>
<td>44.5</td>
<td>1.9</td>
<td>29.3%</td>
</tr>
</tbody>
</table>

For T-scores with standard error (SE) greater than 3.0, use of the PLUS-M™ CAT (www.plus-m.org) is recommended to obtain better measurement precision. Percentile indicates the percent of the PLUS-M™ development sample that reported lower mobility than is reflected by the corresponding T-Score. For more information on interpretation of PLUS-M™ T-scores, please refer to the PLUS-M™ Short Form Users Guide.
Mobility Empowerment (ME) Score Card

T-Score

T-score of 50 = average lower limb prosthesis user’s mobility level based on the University of Washington database of ~1,100 patients. STDEV of 10. Higher T-score = greater mobility. Valuable for documentation in the patient medical record.
Mobility Empowerment (ME) Score Card

Relative percentile of all prosthetic leg users in the general population, trended over time for all assessment dates collected.
Hanger Clinic Outcomes Protocol

- Outcomes packet administered for each patient at:
  - Start of Episode of Care
    - Assess patient’s current mobility
  - 2 Weeks After Prosthetic Delivery
    - Assess immediate impact of our care
  - 6 Months After Delivery + Ongoing
    - Assess long term impact of our care
    - Continuously monitor patient’s mobility
    - Early, proactive intervention when needed

- Longitudinal tracking of self-reported mobility
  - Often goes up
  - May digress
  - Identify success/progress AS WELL AS setbacks/challenges
Why Track Mobility Outcomes?

More consistent care

• Trend mobility scores over time both during and across episodes of care
ME Score Card Case Study

**Mobility Empowerment Score Card™**

**Michael Smith**  
**DOB:** 09/08/1979

**Mobility (ALL Leg Prosthesis Users)**

- **Current:** 60.8%
- **Previous (05/10/2016):** 43.7%
- **Trend:** ⬆

**Mobility Assessment**

- Graph showing mobility assessment from 04/12/2016 to 09/22/2016.

**Outcomes Assessment Date:** 09/22/2016

**T-Score:** 52.7

**Mobility (SIMILAR Prosthesis Users)**

- **Amputation Level:** Above Knee
- **Etiology:** Injury/Trauma
- **Age Group:** 36 to 49 years

**Satisfaction**

- **Current:** 9/10
- **Previous:** 10/10
- **Trend:** ⬅️

**Quality of Life**

- **Current:** 9/10
- **Previous:** 9/10
- **Trend:** ⬇️

*Hanger CLINIC*
ME Score Card Case Study

Mobility Empowerment Score Card™

Carlos Rodriguez  
DOB: 01/29/1966

Mobility (ALL Leg Prosthesis Users)
Current: 63.9%  
Previous (09/14/2016): 46.4%
Trend: 🟢

Outcomes Assessment Date: 10/26/2016  
T-Score: 53.6

Mobility (SIMILAR Prosthesis Users)
Amputation Level: Below Knee  
Etiology: Injury/Trauma  
Age Group: 50 to 64 years

Satisfaction
Current: 7/10  
Previous: 6/10  
Trend: 🔽

Quality of Life
Current: 7/10  
Previous: 7/10  
Trend: 🔽
PLUS-M

- Peer specific Quartile indices
- Amputation level
- Amputation Etiology
- Age
Mobility Empowerment (ME) Score Card

Peer Indexing

Mobility Meter compares individual’s T-score percentile to similar patients based on amputation level, etiology and age.
ME Score Card Case Study

Mobility Empowerment Score Card™

Mary Jones  DOB: 03/22/1961

Mobility (ALL Leg Prosthesis Users)
Current: 43.7%
Previous (08/03/2016): 21.5%
Trend: 🔄

Outcomes Assessment Date: 09/23/2016
T-Score: 48.4

Mobility (SIMILAR Prosthesis Users)
Amputation Level: Above Knee
Etiology: Vascular Disease/Diabetes
Age Group: 50 to 64 years

Mobility Assessment

Satisfaction
Current: 8/10
Previous: 7/10
Trend: 🔄

Quality of Life
Current: 7/10
Previous: 7/10
Trend: 🔄
Satisfaction and Quality of Life

- PEQ - Prosthesis Evaluation Questionnaire
- Older survey instrument
- Multiple subsections - using the well-being subsection

6. Over the past 4 weeks, rate how satisfied you have been with how things have worked out since your amputation.

1 2 3 4 5 6 7 8 9 10

Extremely Dissatisfied

7. Over the past 4 weeks, how would you rate your quality of life?

1 2 3 4 5 6 7 8 9 10

Worst Possible Life

Best Possible Life
Mobility Empowerment (ME) Score Card

Well-Being

Current satisfaction and QoL scores as assessed by PEQ-WB and trend
T-score of 50 = average lower limb prosthesis user’s mobility level based on the University of Washington database of ~1,100 patients. STDEV of 10. Higher T-score = greater mobility. Valuable for documentation in the patient medical record.

Mobility Meter compares individual’s T-score percentile to similar patients based on amputation level, etiology and age.

Current satisfaction and QoL scores as assessed by PEQ-WB and trend.
Outcomes that Engage the Patient

More satisfied patients

• Empowered to understand and participate in their own care
• Improved mobility over time
• Better case to payers for prosthetic device approvals

Enhanced Participation in Outcomes Collection
Outcomes that Inform Clinical Considerations

**Improved patient care**

- Benchmark patients’ mobility scores relative to peers to set realistic goals
- Partner to intervene and modify care plans to reverse any negative trends
- Adjust patient care plan as needed
We can begin to answer these original questions in a meaningful, supported way

- Is prosthetic mobility associated with quality of life and general satisfaction?
- Do comorbid health conditions preclude meaningful prosthetic mobility?
- Do assistive devices enable enhanced prosthetic mobility or act as a marker of limited mobility potential?
Clinical Practice Guidelines

Evidence Based Medicine
1. Clinical Experience
2. Patient Values
3. Best available research information

-nih.gov
Clinical Practice Guidelines

You can only play the cards that you have in your hand...

1. Clinical Experience
   • Its with clinicians everywhere they go

2. Patient Values
   • Comes in with the patient

3. Best available research information
   • Here’s where they might need help
You can only play the cards that you have in your hand...

3. Best available research information
   - Clinicians don’t have
     - Time...
     - Access...
     - Training...
   - CPG’s package that information for them
Clinical Practice Guidelines

Model CPG

• When there is a strong enough literature base...

Clinical Guideline

Treatment of Pressure Ulcers: A Clinical Practice Guideline From the American College of Physicians

Amir Qaseem, MD, PhD, MHA; Linda L. Humphrey, MD, MPH; Mary Ann Forciea, MD; Melissa Starkey, PhD; and Thomas D. Denberg, MD, PhD, for the Clinical Guidelines Committee of the American College of Physicians*

Description: The American College of Physicians (ACP) developed this guideline to present the evidence and provide clinical recommendations based on the comparative effectiveness of treatments of pressure ulcers.

Methods: This guideline is based on published literature on this topic that was identified by using MEDLINE, EMBASE, CINAHL, EBM Reviews, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effects, and the Health Technology Assessment database through February 2014. Searches were limited to English-language publications. The outcomes evaluated for this guideline include complete wound healing, wound size (surface area, volume, and depth) reduction, pain, prevention of sepsis, prevention of osteomyelitis, recurrence rate, and harms of treatment (including but not limited to pain, dermatologic complications, bleeding, and infection). This guideline grades the quality of evidence and strength of recommendations by using ACP’s clinical practice guidelines grading system. The target audience for this guideline includes all clinicians, and the target patient population is patients with pressure ulcers.

Recommendation 1: ACP recommends that clinicians use protein or amino acid supplementation in patients with pressure ulcers to reduce wound size. (Grade: weak recommendation, low-quality evidence)

Recommendation 2: ACP recommends that clinicians use hydrocolloid or foam dressings in patients with pressure ulcers to reduce wound size. (Grade: weak recommendation, low-quality evidence)

Recommendation 3: ACP recommends that clinicians use electrical stimulation as adjunctive therapy in patients with pressure ulcers to accelerate wound healing. (Grade: weak recommendation, moderate-quality evidence)

For author affiliations, see end of text.
Clinical Practice Guidelines

Postoperative Limb Management

• When there is a strong enough literature base...

• Defined Search Methods

• Key Questions
  • Comparative Efficacy
  • Potential Benefits
  • Potential Harms

• Concise Recommendations
The depth and structure of the CPG will vary with the source documents:

- **Post-op dressing**: Multiple meta-analyses
- **Perioperative Education**: Systematic Review; Structured interviews, Shareholder needs assessment
- **Peer Mentoring**: Narrative literature (i.e., expert opinion)
**Clinical Practice Guidelines Summary**

**Purpose:** Hanger Clinic’s Department of Clinical & Scientific Affairs developed this guideline to present the most current evidence and provide clinical recommendations for perioperative care associated with transtibial amputation. The intent of this guideline is to improve perioperative prosthetic rehabilitation by providing the clinical prosthetist with the findings and recommendations of published evidence with respect to perioperative education, peer-mentoring and post-operative limb management.

**Methods:** The guideline is based upon the best available evidence related to this episode of care. Recommendations are drawn from a systematic review and meta-analysis, supplemented by subject matter experts (SME) and patients, where this standard is unavailable, alternate academic literature is used to identify where additional research remains indicated.

**Clinical Practice Guidelines: Perioperative Management Associated with Transtibial Amputation**

For the individual undergoing transtibial amputation, effective intervention during the perioperative period can provide significant benefits. The perioperative stage begins with the decision to undergo amputation and concludes when the patient is either physically ready for prosthetic fitting or a decision is made not to pursue prosthetic rehabilitation. Appropriate management includes patient education, peer-mentoring and post-operative limb management to reduce swelling and prepare for prosthetic fitting.

**Perioperative Education**

**Recommendation #1:** During the perioperative period, written and/or verbal patient education should be provided and may consist of the following topics:
- Care of the residual limb
- Phantom limb sensation
- The rehabilitation process
- Expectations and range of possible outcomes
- General prosthetic information
- Relevant financial information
- Availability of support groups and peer-mentors

**Recommendation #2:** Perioperative education must account for the following considerations:
- Age and associated comorbidities, e.g. hearing or vision loss, cognitive or memory deficits
- Current pain level and its impact on the patient’s ability to absorb and retain information
- Medication and its effect on a patient’s ability to absorb and retain information
- The current emotional state of the patient
- An environment conducive to information exchange
- The use of non-specialist terms
- The patient’s purpose in receiving information: planning versus coping

**Peer Mentoring**

**Recommendation #3:** During the perioperative period, patients undergoing lower limb amputation should be given access to peer mentors who are appropriately trained.

**Postoperative Limb Management:**

**Recommendation #4:** Removable rigid dressings should be used to reduce both the healing time of the residual limb and time to prosthetic fitting following transtibial amputation.

**Recommendation #5:** Removable rigid dressings should be used as the preferred means of reducing postoperative edema following transtibial amputation.

**Recommendation #6:** Given the comparable wound infection rates observed with the two treatment options, removable rigid dressings are preferred over soft dressings for postoperative lower limb management following amputations due to their additional benefits described above.
Perioperative Education

Recommendation #1: During the perioperative period, written and/or verbal patient education should be provided and may consist of the following topics:

- Care of the residual limb
- Phantom limb sensation
- The rehabilitation process
- Expectations and range of possible outcomes
- General prosthetic information
- Relevant financial information
- Availability of support groups and peer-mentors
Perioperative Education

“There was no, no education, but you know what would be useful for a person like myself, is to show more or less even a pamphlet, something to read, or someone to sit down and give a little bit of counseling, or if it was a video, so you have more of an idea what to get into, but basically you’re, you feel kind of, you’re blinded, you walk into something over your head and you don’t know what to expect, so basically you’re in the hands of the, the surgeon, you understand me, and then whatever happens after. You understand, so, you don’t know what’s going to take place.”

Pedlow et al, 2014
Perioperative Education

“Prosthetic users clamored for more information on the recovery path following amputation. They recommended amputees be given comprehensive **information about the entire process** to understand their **treatment, rehabilitation, and the range of possible outcomes.**”

Klute et al, 2009
Perioperative Education

Recommendation #2: Perioperative education must account for the following considerations:

• **Age and associated comorbidities**, e.g. hearing or vision loss, cognitive or memory deficits

• **Current pain level** and its impact on the patient’s ability to absorb and retain information

• **Medication** and its effect on a patient’s ability to absorb and retain information

• The current **emotional state** of the patient

• **An environment** conducive to information exchange

• **The use of non-specialist terms**

• The patient’s **purpose** in receiving information: planning versus coping
Perioperative Education

- Age and associated comorbidities, e.g. hearing or vision loss, cognitive or memory deficits

“My mom has macular degeneration...I would ask her what it [website] said and she would have no idea because with macular degeneration, she loses her sight”

Pedlow et al, 2014
Perioperative Education

- Current pain level and its impact on the patient’s ability to absorb and retain information

“A number of participants explained that they experienced significant pain...and therefore were unable to absorb information that was provided to them.”

Pedlow et al, 2014
Peer Mentoring

- **Recommendation #3**: During the perioperative period, patients undergoing lower limb amputation should be given access to peer mentors who are appropriately trained.

- **There are many losses beyond the limb**
  - **Control, self-esteem, income, perceived attractiveness**
  - **Clinicians can’t usually say, “I know how you feel.”**
  - **Peers can speak to sorrow, anger, denial, depression and fear**

  - **- FitzGerald DM, 2000**
Recommendation #3:

An individual’s perceived social support 1 month post amputation is a predictor of:

- Pain interference, life satisfaction and mobility

This is the time period that many individuals feel marginalized by healthy peers, as well as, a reduction in genuine, emotionally-connected conversation (perhaps family doesn’t know what to say)

Williams et al, 2004
Perioperative CPGs

Recommendation #4–#6

- Postoperative Limb Management

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**Oral Systematic/Meta-Analytic Review Presentations**

**Oral Presentation 330**
Acute Postoperative Care of the Residual Limb Following Transtibial Amputation: A Clinical Practice Guideline

Phillip Stevens (University of Utah School of Medicine), John Rheinstein, James Campbell

**Objectives:** To create succinct, evidence-based clinical practice guidelines for the acute postoperative care of the residual limb following transtibial amputation.
Perioperative CPGs

Postoperative Limb Management

• It’s not just what we said…

….its the strength behind it

Oral Presentation 330
Acute Postoperative Care of the Residual Limb
Following Transtibial Amputation: A Clinical Practice Guideline

Phillip Stevens (University of Utah School of Medicine),
John Rheinstein, James Campbell

Objectives: To create succinct, evidence-based clinical practice guidelines for the acute postoperative care of the residual limb following transtibial amputation.
Postoperative Limb Management

Defined Methods

- Medline Search
  - “amputation” AND...
  - “postoperative management,” “rigid dressing” OR “soft dressing” AND...
  - “systematic review” OR “meta-analysis”

- 24 abstracts
- 4 publications


Postoperative Limb Management

Potential Benefits:

• Reducing the time required for complete healing of the limb
• Reducing the number of days from amputation to discharge
• Reducing the number of days from amputation to the casting or fitting of the first limb prosthesis
• Increasing the rate of edema reduction

Potential Harms:

• The risk of increased wound infection rates experienced post-amputation.
Data Extraction and Synthesis:

• Evidence statements from published meta-analyses and systematic reviews were extracted for subsequent synthesis.
  • Recent publications had explicit statements
  • Older publications required extrapolations
Perioperative CPGs

Postoperative Limb Management

• **Recommendation #4**: Removable rigid dressings should be used to reduce both the healing time of the residual limb and time to prosthetic fitting following transtibial amputation.

• **Recommendation #5**: Removable rigid dressings should be used as the preferred means of reducing postoperative edema following transtibial amputation.

• **Recommendation #6**: Given the comparable wound infection rates observed with the two treatment options, removable rigid dressings are preferred over soft dressings for postoperative lower limb management following amputations due to their additional benefits described above.
Clinical Practice Guidelines

Perioperative Care

• Education
  • Right Content
  • Right Time

• Peer Mentoring

• Rigid Dressings

Clinical Practice Guidelines Summary

Purpose: Hanger Clinic’s Department of Clinical & Scientific Affairs developed this guideline to present the most current evidence and provide clinical recommendations for perioperative care associated with amputation. The intent of this guideline is to improve perioperative prosthetic rehabilitation by providing the clinical prosthetist with the findings and recommendations of published evidence with respect to perioperative education, peer mentoring, and post-operative limb management.

Methods: The guideline is based upon the best available evidence related to this episode of care. Recommendations are drawn from a systematic review and meta-analysis, supplemented by subject matter experts (SMEs) and patients. Where this standard is unavailable, alternate academic literature is used to identify where additional research remains indicated.

Clinical Practice Guidelines: Perioperative Management Associated with Transmetatarsal Amputation

For the individual undergoing transmetatarsal amputation, effective intervention during the perioperative period can provide significant benefits. The perioperative stage begins with the decision to undergo amputation and concludes when the patient is either physiologically ready for prosthetic fitting or a decision is made not to pursue prosthetic rehabilitation. Appropriate management includes patient education, peer mentoring, and post-operative limb management to reduce swelling and prepare for prosthetic fitting.

Perioperative Education

Recommendation #1: During the perioperative period, written and/or verbal patient education should be provided and may consist of the following topics:
• Care of the residual limb
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• The use of non-specialist terms
• The patient’s purpose in receiving information: planning versus coping

Peer Mentoring

Recommendation #3: During the perioperative period, patients undergoing lower limb amputation should be given access to peer mentors who are appropriately trained.

Postoperative Limb Management:

Recommendation #4: Removable rigid dressings should be used to reduce both the healing time of the residual limb and time to prosthetic fitting following transmetatarsal amputation.

Recommendation #5: Removable rigid dressings should be used as the preferred means of reducing postoperative edema following transmetatarsal amputation.

Recommendation #6: Given the comparable wound infection rates observed with the two treatment options, removable rigid dressings are preferred over soft dressings for postoperative lower limb amputation following amputations due to their additional benefits described above.
Thank you!

To learn more, contact:

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