



# Northeast Rehabilitation Hospital Network

## Amputee CPG Summary

**Please refer to the full CPG for details of each recommendation:**

VA/DoD Clinical Practice Guideline for Rehabilitation of Individuals with Lower Limb Amputation.  
Department of Veterans Affairs. Department of Defense. 2017

<https://www.healthquality.va.gov/guidelines/Rehab/amp/>

# Amputee CPG Summary

Northeast Rehabilitation Hospital has adopted these Brain Injury Clinical Practice Guidelines to guide the clinical care that is provided by our Rehab Team. Items with a “\*” apply to all patients with a diagnosis of lower limb amputation. The remaining items should be considered for each patient individually.

## A. All Phases of Amputation Rehabilitation

1. \*We suggest that patient education be provided by the rehabilitation care team throughout all phases of amputation rehabilitation. (LOE: weak for)

Topics include: rehab program, prosthetic options, goals and outcomes, and TJC and CARF education topics.

2. \*We suggest an assessment of behavioral health and psychosocial functioning at every phase of amputation management and rehabilitation. (LOE: weak for)

Commonly occurring diagnoses include depression, anxiety and posttraumatic stress disorder.

3. \*When assessing pain, we suggest that measurement of the intensity of pain **and** interference with function should be separately assessed for **each** pain type and location using standardized tools. (LOE: weak, for)

Assessment should include: location, intensity, character, duration, timing, and aggravating factors or triggers.

Pain types include: residual limb, phantom limb, visceral, musculoskeletal, or pre-existing pain syndromes.

4. We suggest offering a multi-modal, transdisciplinary individualized approach to pain management including transition to a non-narcotic pharmacological regimen combined with physical, psychological and mechanical modalities throughout the rehabilitation process. (LOE: weak, for)

Limited evidence for the effectiveness of specific pharmacological and non-pharmacological interventions.

Refer to the VA/DoD Opioid for Chronic Pain CPG (2017) for further guidance.

5. \*We recommend providers consider the patient’s birth sex and self-identified gender identity in developing individualized treatment plans. (LOE: strong for)

There are a number of significant differences between male and female in regards to coping, pain, prosthetic fitting and use, and etiology of amputation.

6. \*We suggest offering peer support interventions, including visitation by a certified peer visitor, as early as feasible and throughout the rehabilitation process. (LOE: weak for)

For patients and caregivers. Best if matched for age, gender, and amputation level.

Can be in person initially and then possibly via phone, email or text message for increased frequency.

(Recommendations 7 and 8 pertain to surgical recommendations and do not apply to IRF.)

## B. Perioperative Phase

9. \*We suggest the use of a rigid or semi-rigid dressing to promote healing and early prosthetic use as soon as feasible post-amputation in transtibial amputation. Rigid post-operative dressings are preferred in situations where limb protection is a priority. (LOE: weak for)

Post-operative dressing management should maintain the integrity of the residual limb and protect the limb, control and reduce edema, facilitate primary wound closure, maintain extension ROM, and facilitate advancement to prosthetic fitting.

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10. \*We suggest performing a cognitive screening (specifically memory and/or executive function) prior to establishing rehabilitation goals, to assess the patient’s ability and suitability for appropriate prosthetic technology. (LOE: weak for)
11. \*We suggest in the perioperative phase following amputation, patients receive physical rehabilitation and appropriate durable medical equipment/assistive technology (LOE: weak for)
12. \*We suggest, when applicable, treatment in an acute inpatient rehabilitation program over a skilled nursing facility. (LOE: weak for)
13. \*We suggest the initiation of mobility training as soon as feasible post-amputation. In appropriate patients, this may include ipsilateral side weight-bearing ambulation with a pylon to improve physical function and gait parameters. (LOE: weak for)
14. \*We recommend instituting rehabilitation training interventions, using both open and closed chain exercises and progressive resistance to improve gait, mobility, strength, cardiovascular fitness and activities of daily living performance in order to maximize function. (LOE: strong for)

Transfers: sit to stand, bed to chair, chair to toilet and tub, in/out of vehicle, on /off floor, real-world challenges.

Patients should have the opportunity to discuss all aspects of functional ADLs including challenges with being intimate with a significant other.

Focus groups identified fluctuations in weight as a concern as it relates to prosthetic device fit.

## C. Pre-Prosthetic Phase

15. We suggest offering microprocessor knee units over non-microprocessor knee units for ambulation to reduce risk of falls and maximize patient satisfaction. There is insufficient evidence to recommend for or against any particular socket design, prosthetic foot categories, and suspensions and interfaces. (LOE: weak for)

## D. Prosthetic Training Phase

16. We recommend the use of valid, reliable, and responsive functional outcome measures, including, but not limited to, the Comprehensive High Level-Activity Mobility Predictor, Amputee Mobility Predictor, 10-meter walk test, and 6-minute walk test. (LOE: strong for)
17. We suggest the use of a combination of measures with acceptable psychometric properties to assess functional outcomes. (LOE: weak for)

It is important to include measures from the patient’s perspective. Some examples include the Activities-specific Balance Confidence Scale (ABC), Locomotor Capabilities Index, and the Prosthesis Evaluation Questionnaire.

18. We recommend an assessment of factors that are associated with poorer outcomes following acquired limb loss, such as smoking, comorbid injuries or illnesses, psychosocial functioning, and pain. (LOE: strong for)

Consider general physical condition, nutrition, infection risk, bowel and bladder function.

Consider comorbid conditions such as obesity, substance use disorders, and chronic low back pain.