Overview of the Trauma Patient Pathway and Care

Hanger’s Continuing Education Series

Spinal Orthotics  Lower Extremity Orthotics  Upper Extremity Orthotics  Lower Extremity Prosthetics  Upper Extremity Prosthetics  Trauma Education

Disclosure Statements

Please state your disclosures verbally to the audience.
Goals & Objectives

• Identify current research trends
• Define the trauma patient care pathway
• Instill knowledge and hope to maximize potential

Driving Advancements

Why me?
Continuing Education Series

Amputation Statistics

- Approximately 2 million people in the US are living with limb loss today
- 185,000 amputations occur annually
- Among those with amputation:
  - 54% vascular related
  - 45% trauma
  - less than 2% cancer
- The state of Texas accounts for around 9% of that national total

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Traumatic Amputation Statistics

The most common causes of accidental traumatic amputation injuries are as follows:
1. Traffic accidents (including bicycles, trains, motorcycles)
2. Workplace/factory/construction accidents
3. Agricultural accidents
4. Firearm/explosives/fireworks accidents (includes military casualties)
5. Electrocution accidents
6. Ring traction accidents
7. Building and car door accidents

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Traumatic Amputation Statistics

Most common cause of traumatic amputation in children:
80% of traumatic amputees are:
- Male
- Between the ages of 15-40
- In general good health

• Employed and typically the breadwinner of the family

• Activities
• Goals for Recovery
Trauma patient demographics

Limb Salvage vs. Amputation

Trauma Patient Pathway and Care

Trauma Insight

- Decision maker
- First initial contact w/patient
- Surgeon/ER Staff

- Hospital and Rehab Allied Health Care Partners
- Options
- Outcomes
- Knowledge on resources
- Patient and Family

- Optimize recovery outcome
- Continuity of care
To Finish!!!!

Thank You and Feedback!
Overview of the Trauma Patient Pathway and Care
Visit: HangerClinic.com/ContinuingEducation to provide us with feedback on this presentation.

Citations
- Reference: Hanger Clinic Primary Research
Postoperative Care Following Traumatic Amputation

Objectives
Upon completion of this presentation, the participant will be able to:
• Describe the postoperative & early rehabilitation process for lower extremity traumatic amputation.
• Describe the goals and benefits of postoperative management
• Compare the effectiveness of various forms of postoperative prosthetic treatments
• Develop a post-op & rehab treatment plan

Agenda
• Introduction
• Postoperative & early rehabilitation process for lower extremity traumatic amputation
• Goals/benefits of postop management
• Effectiveness of postop prosthetic treatments
• Rehabilitation Treatment Plan and Peer Support
Rehabilitation from Amputation

Three phases:
1. Healing
2. Maturation
3. Definitive

General Rehabilitation Timeline for Patients with Lower Extremity Amputation

Initial Considerations for In-Patients

Residual limb
- Edematous
- Painful
- Critical state

Patient overview
- Mechanism of injury
- Comorbidities
- TBI
- Background

Emotional well being
**Discharge from Hospital**

- Protect surgical wounds
- Proper prosthetic care can reduce complications
- Quality & amount of attention devoted to patient determine outcomes
- Location and access to f/u drives post-op device selection
- Notify your Hanger prosthetist of date and location of discharge

**Goals of Postoperative Treatment**

- Heal the surgical wound
- Protect the amputated limb from trauma
- Minimize pain
- Reduce swelling & begin shaping amputated limb
- Preserve & improve ROM & strength of entire body

**Goals of Postoperative Treatment**

- Enable patient to learn to use appropriate mobility aids
- Begin controlled weight bearing
- Accomplish functional activities
- Facilitate psychological adjustments to limb loss (Peer support - AMPOWER)
Goal of Prosthetic Rehabilitation

Return the patient to daily life at highest possible level

Benefits of Postoperative Care

Over 400 articles describe postoperative treatment and consistently validate the benefits:

- Reduced pain
- Reduced time to prosthetic use
- Reduced hospital stay

Key to early mobilization:

- Healing the wound
- Shaping the residual limb

Post-op Complications

1. Fall trauma
2. Wound dehiscence
   Infection/slow healing
3. Contractures
4. Edema
5. Pain
Summary of Falls Evidence

- 20% of lower extremity amputees experience a fall in the hospital
- 3% of all LE amputees experience a fall significant enough to require revision surgery
- 47% of those revision surgeries result in a higher level amputation
- Revision surgery due to a fall is reduced through the use of a Removable Rigid Dressing
- Hospital is responsible for falls costs for Medicare patients


Post-op Complications

Can be also be reduced with careful surgical technique with the goal of “reconstructing” a residual limb designed for prosthetic use:

- Effective length
- Stable distal shape with good muscle coverage
- Proper skin coverage & tension
- Closure in full extension & adduction for good ROM
- Pre-op consultation with your Hanger prosthetist

Post-op Protocols

- Flexible to meet patient needs and surgeon preference
- Should be known by all staff and initiated by the surgical team
- Specific instructions in patient’s chart & bedside
- Communicate with prosthetist and PT
- Regular staff training

www.amputee-coalition.org
Immediate & Early Prosthetic Treatments

1. Soft Dressings & Compression Therapy
   A. Ace Wrap
   B. Tubular elastic &
   C. Shrinker socks
   C. Gel Liners

2. Removable Rigid Dressings (RRDs)
   A. Plaster/fiberglass cast
   B. Bi-valved
   C. AmpuShield™ Program by Hanger Clinic

3. Other Rigid Dressings
   A. Non-weight bearing
   B. Weight bearing

1. Soft Dressings & Compression Therapy

A. Pressure Bandaging =
   Ace wrapping
   - Oldest technique
   - Frequently used
   - Worn 24/7

ACE Wrapping

- **Advantages**
  - Inexpensive
  - Readily available
  - Minimal tension across suture

- **Disadvantages**
  - Re-applied several times a day
  - Requires flexibility, hand strength, dexterity, visual acuity & endurance for independent donning
  - Complication if incorrectly applied
  - Doesn’t limit knee flexion
  - Minimal protection from accidental trauma
  - Non-weight bearing
  - Uncertain amount of compression

© Otto Bock

CSUDH O&P Lusardi, 2013.
1. Soft Dressings & Compression Therapy

B. Tubular elastic
- For bulbous, sensitive limbs
- Double or single layering of material
- Uniform compression

C. Shrinker Socks
- Various lengths, widths & grades of compression
- Apply carefully to avoid wound tension
- May require assistance with donning after recent amputation

Tubular Elastic & Shrinker Socks

• **Advantages**
  - Many sizes readily available
  - Can be more effective than Ace wrap in reducing limb volume

• **Disadvantages**
  - Can be difficult to don without assistance
  - Apt to roll down the transfemoral (TF) limb
  - Must be replaced as they stretch out or as volume decreases
  - May irritate bony prominences or pressure sensitive areas

Lusardi, 2013.

© www.juzo.com
Donning Aid
1. Soft Dressings & Compression Therapy

D. Silicone Liners

- Rolled, not stretched over limb
- Can be removed for incision inspection

Silicone Liners

- **Advantages**
  - Provides equalized compression with excellent adhesion
  - Compression and properties of gel can help to minimize scar tissue
  - Provides patient early opportunity to learn to use silicone liner

- **Disadvantages**
  - Liner traps heat & moisture
  - Skin can macerate
  - Requires hand dexterity & strength to don/doff
  - Minimal protection against trauma
  - Needs daily cleaning
  - Needs more follow-up

2. Removable Rigid Dressings

A. Plaster or Fiberglass Cast

- Worn 24 hours/day
- Compression provided by layers of socks
- Simulated weight bearing
2. Removable Rigid Dressings

B. Bi-valved Design

- Custom made from cast or pre-fabricated shells
- Transtibial extends above knee

C. AmpuShield™ by Hanger Clinic

- Post-operative limb protectors – 4 designs
- Custom-fit or custom-made from Insignia scan or measurements
- Allows for wound inspection, dressing changes & physical therapy
- Light weight & easy to clean
- Not for weight bearing
- Adjustable compression

2. Removable Rigid Dressings

Non weight bearing

- **Advantages**
  - It is removable for limb inspection
  - Protects & compresses limb
  - Improves healing & reduces hospital stays
  - Patient uses & learns concept of ‘sock-ply’ fit
  - Plastic pre-fabricated shells & Ampushield™ designs can be washed
  - Bi-valved Ampushield™ limits knee flexion
  - Mimic partial weight bearing
  - Can be used with soft dressings

- **Disadvantages**
  - It is removable by non-compliant patients
  - Requires skilled team
  - Plaster/fiberglass shorter version doesn’t limit knee flexion
  - May need to be replaced with significant volume loss
  - Not designed for ambulation

3. Other Rigid Dressings

A. Non-Removable
- Not as frequently done due to advances in removable systems
- Plaster or fiberglass cast applied by trained personnel in operating room
- Controls edema, pain & protection
- Left on 7-15 days or less with signs of complications
- By itself or with prosthetic components attached for ambulation

B. Weight Bearing Immediate
- Also known as Immediate Postoperative Prosthesis (IPOP)
- Rigid dressing with a pylon and foot
- Touch down weight bearing within 24 hours
- Discontinue weight bearing if wound healing complications arise
- Patient compliance is mandatory

3. Other Rigid Dressings

- Advantages
  - Can help reduce falls
  - Assists in acceptance of limb loss with early ambulation
  - Early introduction to ambulation therapy & prosthetic use

- Disadvantages
  - Bulky & heavy, poor suspension
  - Patient can apply too much weight too soon
  - Must have compliant patient
  - Trained and diligent rehab team required
  - Time consuming
  - Visual wound inspection is not possible
  - Postop pain maybe mistakenly attributed to dressing
Rehabilitation Treatment Plan

- Postoperative Pain Management
  a. Massage & Tapping
  b. Desensitization
- Scar Mobilization
- Emotional Well Being
- Functional Mobility
- Gait Training
- Assessment of other injuries

- Exercise Program
  a. Strengthening
  b. Stretching
  c. Balance
- Weekly follow-up
- Patient/Family Education
- Contraction Prevention

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Rehabilitation Treatment Plan

Patient-centered plan
Treatment Plan

Postoperative Pain Management
1. Massage & Tapping
   – 2-5 minutes
   – 3-4 times/day

2. Desensitization
   – 2-5 minutes
   – 1-2 times/day

Images from Amputee Coalition of America.
www.amputee-coalition.org

Treatment Plan

Emotional Well Being
• Patient counseling
• Regular follow-up with prosthetist and therapists
• Peer support
  – Individual
  – Group face-to-face
  – Online
  – Trauma Survivor’s Network

www.empoweringamputees.org

www.amputee-coalition.org

Treatment Plan

Functional Mobility
• Bed mobility
• Transfers

Gait Training
• With crutches
• Non-weight bearing

Images from CSUChin O&M Program and Otto Bock
Treatment Plan

Exercise Program
1. Strengthening
2. Stretching & ROM activities
3. Balance activities

Images from CSU Dominguez Hills O&P Program and Otto Bock

Treatment Plan

Exercise Program
1. Strengthening LEs

Images from www.kramesonline.com

Treatment Plan

Exercise Program
2. Stretching
3. Balance & Endurance

Images from CSU Dominguez Hills O&P Program and Otto Bock
Treatment Plan

- Residual limb assessed weekly
  - Circumference
  - Wound healing

- Patient/Family Education
  - Positioning, skin inspection, assistance by family members

Images from CSU Dominguez Hills O&P Program

Treatment Plan

Contraction Prevention

- Positioning

Treatment Plan

Patient Training and Education

- Hygiene
- Donn /doff
- Sock management
- TBI considerations
Summary

• Post-op care is critical to positive outcomes
• Fully evaluate each patient
• Select most appropriate device and protocol
• Team input and communication are critical
• Educate patient, family & rehab team
• Follow-up, follow-up, follow-up

Questions?

Citations

Citations, cont’d.


References


Prosthetic Goal

Provide appropriate function to meet each individual’s goals & abilities with realistic expectations.

UE Etiology

- Traumatic
  - MVA
  - Farming
  - Burn
    - Thermal
    - Electrical
- Congenital
- Tumors
- Vascular
  - PVD
- Infection
Patient Considerations
Limb Condition
Socket Interface

- Flexible socket material
- Extremely flexible plastic material
- Improves socket comfort

Prosthetic Options

- Oppositional prosthesis
- Body powered prosthesis
- Externally powered prosthesis
- Hybrid prosthesis
- Activity specific prosthesis
Oppositional Prosthesis

**Benefits:**
- Provides opposition
- Can be lightweight
- Most are simple
- Usually little maintenance

**Limitations:**
- No active prehension
- Limited function
- Patient can have unreal expectations for cosmesis

Body Powered Prosthesis

**Benefits:**
- Can be less expensive
- Can be heavy duty construction and function
- Environmentally resistant

**Limitations:**
- Grip strength or pinch force
- Restrictive and uncomfortable harness
- Poor static and dynamic cosmesis
- Axilla anchor (possible sound side nerve problems)

Electrically Powered Prosthesis

**Benefits:**
- Increased grip strength
- Harness system reduced or eliminated
  - Improved comfort
  - Increased functional range of motion
- Minimal energy expenditure

**Limitations:**
- Initial cost
- Maintenance cost
- Weight
- Requires battery power
Adaptive Prosthesis

- A prosthesis that is designed for a specific activity
- An adaptation to an existing prosthesis

Thorough Evaluation Process

- Design a device that MOST APPROPRIATELY meets:
  - Activities of Daily Living
  - Medical Need
  - Gainful employment
    - Vocational need
  - Psychological need
  - Avocations
  - Specific tasks

Advancements in Upper Limb Components
Available Multi-articulating Hands

| Vincent standard | Vincent small | bebionic small | bebionic medium |

Custom Silicone Sockets

- Harness
- ROM
- Skin Conditions

Mechanical Fingers

Fingers for partial and complete loss of digit.
Powered Fingers
- Powered Finger Systems
  - Requires “complete” loss of digit
  - 4 & 5 finger systems most common
- VERY complex fitting and fabrication

Polytrauma

Types of Polytrauma Effecting UE Prosthetic Fittings
- Over 80% of ALL UE amputations are trauma related...
Amputated Limb Involvement

- Scarring and grafted skin
  - How to protect tissue?
  - Can I still fit early?
- Orthopedic issues
  - Should the limb be revised prior to fitting?

Lower Limb Involvement

- Loss of function
- Amputation
- Donning and Doffing
- What is the priority for rehabilitation?
- Are they in a wheelchair?
- Do they need an assistive device for ambulation?

TBI or Other Cognitive Issues

- Memory issues
- Problem solving
- Follow instructions
- Can they don the prosthesis correctly?
- Can they maintain the system?
- Simplify system to match ability and goals
- Stage introduction of new concepts
Vision Complications

• Vision is commonly used to counteract the loss of proprioception in hand...
• How does it effect:
  – Prosthetic recommendation
  – Goals
  – Training

Pain

• Phantom pain
• Complications from medications
• Limit prosthetic use

Advancements in Upper Limb Technologies
Osseointegration
Summary

- Multidisciplinary Support
- Patient Education
- Understanding Prosthetics Options
- Thorough Evaluation Process

Questions?

Stephen Mandacina
Upper Limb Program
Hanger Clinic

(800) 642-6682
Smandacina@Hanger.com
Primer on the Trauma Orthotic Patient

Disclosure Statements

I have the following relevant relationships in the products or services described, reviewed, evaluated or compared in this presentation.

Please state your disclosures verbally to the audience.

Other Disclosures (if any):
- Financial
- Nonfinancial relationships (i.e. board member, association committees outside of Hanger Clinic)

Objectives

Upon completion of this presentation, the participant will be able to:
- Identify spinal fracture management orthoses (TLSO, LSO, HALO, CTO, CO)
- Identify transparent facial orthoses, TFO, in the treatment of scar management
- Identify lower limb fracture management orthoses (HO, KAFO, ROM orthoses)
- Explain the benefits of family and peer support resources
- Discuss the importance of developing an interdisciplinary health care team
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Fracture Orthoses - Spine

Patient Evaluation Process

• Posture
• Functional level
• Alignment
• Pain relief
• Post-operative stabilization

Orthotic Management Goals

• Limit range of motion
• Decrease pain
• Support
• Stabilize
• Align
• Prevent or correct deformity

© Ben Lack
Biomechanical Principles

- Kinesthetic reminder
- Increased intra-cavitary pressure
- Three-point force systems
  - Re-establish spinal alignment

OTS, Custom Fit & Custom Fabricated

Off the Shelf
- S, M, L, XL, XXL
- Require no modifications or fitting adjustments

Custom Fit
- Prefabricated
- S, M, L, XL, XXL
- Materials tend to be less durable
- Lower cost
- Acute usage
Custom Fabricated

Custom Fabricated
- Designed, prescribed, fabricated, fitted & aligned specifically for an individual
- Made to casting or digital scan
- Long-term &/or permanent usage

Spinal Orthoses
- Flexible
- Semi-Rigid
- Rigid

Terminology

<table>
<thead>
<tr>
<th>Orthotic Nomenclature</th>
<th>Description</th>
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<tbody>
<tr>
<td>CO</td>
<td>Cervical Orthosis</td>
</tr>
<tr>
<td>CTO</td>
<td>Cervicothoracic Orthosis</td>
</tr>
<tr>
<td>CTLSO</td>
<td>Cervical-Thoracolumbosacral Orthosis</td>
</tr>
<tr>
<td>TLSO</td>
<td>Thoracolumbosacral Orthosis</td>
</tr>
<tr>
<td>LSO</td>
<td>Lumbosacral Orthosis</td>
</tr>
<tr>
<td>SIO</td>
<td>Sacroiliac Orthosis</td>
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By international agreement, orthoses are named by the body segment they encompass.
Cervical Orthoses

- Foam Collars
- Reinforced Collars
- Rigid Collars

Cervicothoracic Orthoses

- SOMI
- Minerva
- HALO

HALO

© Sam Davies
© Trulife
© Hanger Clinic
LS Corset (OTS, Custom-Fit, Custom), Hyperextension Orthoses

Prefabricated LSO/TLSO

Custom Body Jackets (LSO/TLSO)
Different styles of custom LSO/TLSO

Orthotic Fitting and Follow Up

Initial Fitting Procedures
- Verify fit & function
- Donning & doffing instructions
- Care of the orthosis
- Necessary hygiene

Orthotic Fitting and Follow Up

Wearing Schedule
- Gradual acclimation to full-time usage
- Immediate wear vs. occasional wear
Orthotic Fitting and Follow Up

Continued fitting and follow-up
- Adjustments are expected and necessary
- Patient profiles change over time

Re-evaluation & long-term follow-up
- Patient’s structural and functional requirements may change
- Maintenance to the mechanical device is needed

Multidisciplinary Team Approach

Multidisciplinary Team Approach
- Patient
- Physician
- Orthotists
- Nurse
- Physical Therapist
- Occupational Therapist
- Social Worker

Transparent Facial Orthoses (TFO)
Burn Management: Facial burns/TFO

- Clinical Description
- Anatomy
- Burn Classification
- Hospitalization
- Burn Team
- Role of the Orthosis

Clinical Description

Types of Burn Injuries

Anatomy

- The face:
  - Pliable skin
  - Complex masculature for various functions and dynamic
  - Complex network of nerve endings
**Anatomy**

*Three basic layers of skin*

- Epidermis: Sheets of dead cells that serve a protective function, protect from ultraviolet light.
- Derma: Connective tissue, grows, blood vessels, oil glands, nerve endings.

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**Burn Classification**

*Superficial Burn* and *Partial Thickness Burn*.

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**Hospitalization**

- The burn team consists of a broad team of health care professionals.
- Three phases of treatment:
  - Resuscitative or critical
  - Acute
  - Long-term rehabilitation
- Contracture management is critical at all stages.
Role of Orthotic Management

- Transparent facial orthoses should be recommended early after injury to minimize the effects of scarring.
- Frequent follow-up to ensure accurate fit and function.
- Specific placement and adjustments to silicone sheeting.
- Consecutive TFOs may be warranted.

Role of Orthotic Management

- Physical examination
  - Clinical photographs should be taken at initial evaluation/scanning, and then every three months.

Role of Orthotic Management

Challenges with Fabric Burn Garments

- Apply maximal pressure across bony prominences, increases with movement.
- Apply limited pressure in concavities.
- Require frequent replacements.
- Requires precise measurements.
- May retard bone growth or alter facial structure in growing children.
- May be uncomfortable.
- Cosmetic appearance.
- Claustrophobia.
Role of Orthotic Management

- **Benefits**
  - Face and hair can be seen through mask
  - Evaluate areas of pressure
  - Silicone enhanced healing
  - Monitor skin
  - Protects contours of face
  - Prevent severe face deformities

- **Challenges**
  - Moisture builds up
  - Potential for heat rash
  - Increased expense
  - Rigid material may restrict bony structure growth
  - May be fragile

Facial Fractures and TFO

- TFOs are also prescribed for facial fractures and some postoperative procedures.
- In general, these TFOs should be fabricated from a more rigid and durable material.
Lower Extremity Fractures

- Among the most common orthopedic complaints
- About 6.8 million are treated each year in the U.S.
- The average person can expect to sustain two fractures during their lifetime

Fracture Types

Common LE Fractures

- Pelvic fracture
- Fracture of the hip bone
- Duverney fracture - an isolated pelvic fracture involving only the iliac wing.
- Femoral fracture
- Hip fracture (anatomically a fracture of the femur bone and not the hip bone)
- Patella fracture
- Tibia fracture
- Tibial plateau fracture
- Bumper fracture - a fracture of the lateral tibial plateau caused by a forced valgus applied to the knee
- Segond fracture - an avulsion fracture of the lateral tibial condyle
- Gosselin fracture - a fracture of the tibial plafond into anterior and posterior fragments
- Toddler’s fracture - an undisplaced and spiral fracture of the distal third to distal half of the tibia
- Fibular fracture
- Maisonneuve fracture - a spiral fracture of the proximal third of the fibula associated with a tear of the distal tibiofibular syndesmosis and the interosseous membrane
- Bosworth fracture - a fracture with an associated fixed posterior dislocation of the proximal fibular fragment which becomes trapped behind the posterior tibial tubercle. The injury is caused by severe external rotation of the ankle.
- Combined tibia and fibula fracture
- Trimalleolar fracture - involving the lateral malleolus, medial malleolus and the distal posterior aspect of the tibia
- Bimalleolar fracture - involving the lateral malleolus and the medial malleolus.
- Sesamoid fracture - in which one or all of the Sesamoid bones are displaced from the proximal phalanx.
- March fracture - a fracture of the distal third of one of the metatarsals occurring because of recurrent stress.
Union of Fractures

- Refers to the restoration of normal bone structure
  - Lower limb fractures take twice as long to unite as upper limb fractures
  - Adults take twice as long to heal as children
  - Transverse fractures take longer to heal than oblique or spiral fractures
  - Compound and comminuted fractures are very slow to unite
  - No fracture unites in less than three weeks

Non-Union of Fractures

- Defined as atrophic or hypertrophic
  - Atrophic is identified by deficient bone formation at the fracture site
  - Hypertrophic is identified by excessive callus formation

Causes of Delayed Union

- Nature of the initial injury
  - Compound or comminuted
  - Infection of the fracture hematoma delays healing
- Soft tissue between fracture fragments may make it physically impossible for the segments to unite
- Poor blood supply to fracture site
Fracture Treatment

- Control of pain
- Assessment of blood loss
- Management of associated injuries
- Consideration of tetanus toxoid and antibiotics
- Obtain and maintain reduction of fracture
- Allow and encourage the union of the fractured segments
- Restore optimum function

Indications for Operative Treatment

- Compound fracture
- Closed manipulation is likely to be unsuccessful
- Inherent instability
- Time factor
  - Non-operative management will require prolonged immobilization
- Soft tissue management
- Other complications
- Vascular or head injuries

Goals of Orthotic Management of Fractures

- Reduce and Align fracture segments
- Allow proximal/distal joint motions
- Prevent motion that could lead to mal-alignment
- Protect against physical insult
- Accommodate volume changes


Citations

TOBY PLASENCIO
MY TRAUMA VICTORY!
A TRAUMA PATIENT'S PERSPECTIVE: JOURNEY TO SUCCESS

FAMILY

Baseball, Football, Basketball, Soccer...
Hueco Tanks El Paso

May 11, 1996

My Injuries. 2 Months in Hospitals

- 27 Total Surgeries over first 2 years
- Stabilization included 2 resuscitations
- Splenectomy
- Collapsed Lungs
- BKA
- L4 Burst Fracture
- Fractured Humerus, Femur, Calcaneus, Pelvis and Jaw
- Fasciotomy

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The Five Stages of Grief

1. Denial: The initial stage: “It can’t be happening.”
4. Depression: “I’m so sad, why bother with anything?”
5. Acceptance: “It’s going to be OK.”

MY Stages of Grief

- Denial – I did not experience denial.
- Anger – Only at MYSELF.
- Bargaining – My first stage. I wanted to continue live life as best as I could.
- Depression – I had bouts but never for long.
- Acceptance – Golf became my life.
PGA Teaching Professional

Amputee Peer Visitation
Patty Ketchmark, RN

The Role of the Peer Visitor

- A peer visitor volunteers his/her time to assist patients and their families with the transition to life with limb loss.
- A peer visitor’s shared experience allows him/her to relate, first hand, to the feelings and concerns of other amputees.
- Because of the shared experience, a peer visitor has significant credibility with the new amputee. Peer visitors have successfully adjusted to life with limb loss so they serve as living proof that limb loss does not preclude a happy and productive life.
- Post amputation socialization is the number one concern of amputees
Peer Support Resources

www.amputee-coalition.org

- Wrong System for Golf
- How to communicate to a Prosthetist
- Became a Trained Peer Visitor
- Education of New Amputees – Pay it Forward
- National Amputee Golf Association
- New Goals

My Peer Visit - May 2006

- Wrong System for Golf
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2009 National Amputee Golf Championships
Para Long Drive Championship

QUESTIONS

THANK YOU FOR WHAT YOU DO EVERYDAY!