

## Foreword



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When I was in training, we received considerable experience in managing amputations. Typically, most lower limb amputations in the civilian population were due to peripheral vascular disease, and most from the military were traumatic. This was during the Vietnam War, and land mines were a source of nonrepairable injury to the lower limbs.

Fortunately, today land mine injuries are much more rare. And, with better management of diabetes and peripheral vascular disease, there are also fewer dysvascular lower limb amputations. Medical trainees and physicians newly entering practice have reduced opportunities to learn management skills for the dysvascular and diabetic patient.

So it is with appreciation that the *Physical Medicine and Rehabilitation Clinics of North America* can present this issue, guest-edited by Dr. Kevin Hakimi, on this topic. Both peripheral vascular disease from arteriosclerosis and small artery disease from diabetes can result in the same outcome: the dysvascular limb. These 2 causes lend themselves to many of the same management techniques and are included in this issue.

The best amputee management is, of course, to prevent amputation. No matter how sophisticated prosthetics become, they can never replace the original limb. The first step in this management cascade is the identification and management of skin breakdown and development of ulceration. If this fails, the ulcer must then be managed, and infection treated.

If limb salvage attempts fail, then amputation becomes a necessary consideration, and a preamputation assessment plan is necessary for optimal outcome of surgery. Then there is the prosthesis: above knee, below knee, or partial foot. This must be well chosen and matched to the needs and capacities of the patient.

Invariably, amputation takes both a physical and psychological toll. Both of these issues must be managed. Systemic vascular (eg, cardiac disease) and causative neurologic (eg, paraplegia) conditions must also be addressed. Finally, postamputation rehabilitation—physical and vocational—must be facilitated.

It may not “take a village” to achieve all of this, but it certainly takes an integrated team. My thanks go to Dr. Hakimi for taking on this important but challenging issue.

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