# A randomised trial of rigid stump dressing following trans-tibial amputation for peripheral arterial insufficiency.

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# Author's reply (to letter Woodburn et al. A randomised trial of rigid stump dressing following trans-tibial amputation for peripheral arterial insufficiency) (letter)

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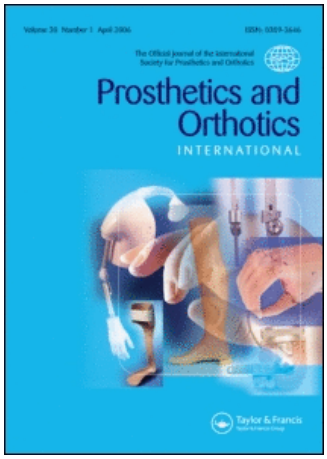


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# Letter to the editor

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# Letter to the Editor

Dear Editor

Following the publication of the article "A randomised trial of rigid stump dressing following trans-tibial amputation for peripheral arterial insufficiency" by Woodburn, Sockalingham, Gilmore, Condie and Ruckley in the April 2004 issue of Prosthetics and Orthotics International we felt that a response was necessary. Our combined thoughts and opinions can be found below.

This is one of the few prospective investigations in rigid stump dressings following amputations. It is well written but we would like to comment on the paper and some statements in the paper ask for some kind of clarification.

Since 14 surgeons participated in this study it is clear that surgical skill and surgical preference of amputation (skew flap or long posterior flap) will introduce serious bias in the outcome of this study. It is not clear from the text if and how the authors have analysed the distribution of surgical procedures and the distribution of the surgeons over the intervention group and the control group. Besides, these surgeons were working over 7 different centres. All these centres have their own influence on post-amputation rehabilitation determined by equipment of the hospital nursing staff, physiotherapy, household facilities, behaviour and professional skills etc. Again it is not clear from the text if and how the authors have analysed the distribution of the different centres over both groups. Apart from this no detailed information about the randomisation procedure was provided.

The authors state that if the rigid dressing was removed after 7 days and the wound was inspected and satisfactory plaster was then reapplied. The authors do not describe criteria for "satisfactory", further the procedures if the wound is not satisfactory are not described; in that case it is unclear if the patient is considered as a drop-out or not fitted (see Table 1).

"At a time when the nursing and physiotherapy staff felt that referring for limb fitting was appropriate, the final decision as to the suitability of a limb for casting was made by the local prosthetic team who were blinded to the post-operative dressing regime employed". This procedure indicates that the decision was based upon clinical expertise and not upon strict criteria in the research protocol provided for limb fitting. It might be that the prosthetic team was kept blind for the postoperative stump care but a prosthetist has to identify stump care by means of inspection and palpation and measuring. It is not clear from the text and the tables which patients completed the trial and which patients did not complete the trial.

Finally it is not clear from Figure 2 what the actual numbers of days were to prosthetic fitting (mean, sd, range or median and interquartile ranges). Therefore it is impossible to use these data for a meta analysis or future trial planning.

We admit that it is very difficult to initiate a multicentre trial as described by Woodburn *et al.* However, we believe that the authors ought to show some more detailed information especially the differences between the different surgeons, and/or different used procedure and/or the comparability of the groups. As a result this study is not repeatable. We hope the authors can clarify our questions and remarks and secondly we hope that this letter invites other readers to write to the editor and initiate discussion about papers in general but especially on this subject published in this journal.

*Yours sincerely*

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