

Case report

A Case of Above Knee Amputation with Preoperative High Risks

Hiroki Kinugawa and Yasuyuki Shimada

Department of Cardiovascular Surgery, Yuri-Kumiai General Hospital, Japan

Abstract

An 85-year-old malnourished man was admitted with ischemia-induced necrosis of the right leg and high-risk factors, including chronic obstructive pulmonary disease, pneumonia, and infection of the necrotic leg. We controlled the infection and provided proper nutrition. Using light general anesthesia and a nerve block, we amputated the leg above the knee. The patient could eat and drink the same day following the surgery, and respiratory rehabilitation was begun the next day. His postoperative course was uneventful. Our case suggests that maintenance of good nutrition may play a key role for high-risk elders undergoing leg amputation.

Key words : leg, amputation, elder, risk, nutrition

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Introduction

Major lower extremity amputations are associated with considerable morbidity and mortality^{1).} Most older patients who lose a leg have vascular problems commonly associated with systemic arterial sclerosis or diabetes mellitus (DM), and most have ischemic heart disease, stroke, or renal failure due to their basic disease^{2–5).} In addition, they may have leg ischemia, chronic obstructive pulmonary disease, or infection of an ischemic ulcer of the leg^{6).}

We performed an above-knee amputation on an 85-year-old man who had an ischemic right leg with necrosis to the ankle. He had chronic obstructive pulmonary disease (COPD) and pneumonia and was poorly nourished and emaciated. Based on previous reports^{1–5),} we expected serious complications and possibly death. Because we were

concerned that poor nutrition might mediate pneumonia and infection of the wound, we made a great effort to provide good nutrition, and we obtained a good result.

Case Report

An 85-year-old malnourished man with necrosis of the right leg due to arteriosclerosis bliterans was admitted to our affiliated hospital. He had pneumonia with a fever of 38.8°C, and the necrotic leg was infected. We administered antibiotics for his pneumonia and diclofenac sodium for his leg pain, keeping the wound clean. We provided parenteral nutrition and started respiratory rehabilitation. After 8 days, he began to eat by himself and gradually became better nourished. His body temperature became normal, and his C-reactive protein, 14.1 mg/dl on admission, was 5.21 mg/dl just before the surgery (Figure 1). His necrotic leg became aseptic after 42 days, and he was transferred to our hospital for leg amputation.

Considering his COPD and stiff knee joints and that he had used a wheel chair in a previous hospital, we set his rehabilitation goal based on wheelchair life. His superficial femoral artery was obstructed, but his deep femoral artery was patent. Since we did not need to consider rehabilitation with an artificial leg, we decided to amputate his leg quite proximal to the hip, 10 cm below the groin (Figure 2). We administered β -blockers prior to the surgery^{7).} We use mepivacaine hydrochloride (patient's body weight 47 kg; 1 mg/kg) to block the femoral (0.15 mg), sciatic (0.25 mg), and obturator (0.1 mg) nerves. The anesthesiologist injected 200 μ g fentanyl intravenously, used a laryngeal mask airway, and maintained anesthesia with continuous infusion of a low dose (50–500 g/kg/h) of ketamine^{8).} Spontaneous respiration was maintained. The operation time was 70 min, and only 80 ml of blood was lost.

The patient awakened quickly after the anesthesia was stopped and did not complain of wound pain. He showed

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Correspondence: Hiroki Kinugawa, Department of Cardiovascular Surgery, Yuri-Kumiai General Hospital, 38 Ikeno-ushiro, Aza, Kawaguchi, Yuri-Honjo, Akita 015-8511, Japan
E-mail: shikimic_acid11211@yahoo.co.jp

Icd 9 Code For Below Knee Amputation

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