Results of Questionnaire on Professionalism

There were seven respondents who replied as follows:

1. Do you believe the profession's Carons of Ethical Conduct benefit the public?
   Yes—6 (85%) No—1 (14%)

2. Do you believe they are adequately enforced?
   Yes—0 No—7 (100%)

3. Do you believe that society has benefited from the presence of various governmental bodies in the area of self-regulation (of all professions)?
   Yes—4 (47%) No—3 (43%)

4. Define professionalism
   A. "Treating people in courteous, candid, and knowledgeable fashion in accordance with our most current state-of-the-art and in harmony with the physician's prescription."
   B. "Professionalism means conducting your actions and interactions in such a way that people respect you whether they agree with you or not."
   C. "Having a commitment to ethical conduct within a certain job or industry."

5. Other comments
   A. "Notify funding agencies of our concern that non-credentialed people are providing services."
   B. "It seems that all professions have a few who are looking out for their own best interests. It seems that greed and the awareness that a strong enforcement agency does not exist to put them out of business motivates these few."

A Case History

Clinical Indication for Flexible Above-Knee Prosthetic Socket

Howard Adelglass, M.D.*, Don Sung Chu, M.D.*, H.R. Lehneis, Ph.D., CPO*

R.W. is a 62 year old male with a 32 year history of insulin dependent diabetes mellitus. He was in a normal state of good health until August, 1982 when he developed gangrene of the first three toes of his left foot. A left femoral popliteal bypass was performed unsuccessfully. He then underwent a left below-knee amputation which also was unsuccessful and, in October, 1982, a left above-knee amputation was done. In December, 1982, he was admitted to the Institute of Rehabilitation Medicine, NYU Medical Center(IRM-NYU) for a prosthetics rehabilitation program. At that time, his stump became infected and dehissed, requiring stump revision.

In July, 1983, he was readmitted to IRM-NYU and started on gait training with an AK prosthesis with a semi-suction socket, hip joint and pelvic belt, polycentric knee joint (Lang) and SACH foot (Figure 1). During the course of his rehabilitation training, he began complaining of pain at the distal stump. The socket was adjusted numerous times by alternately relieving painful areas distally and placing padding above these areas, but with little success. Subsequently, x-rays taken of the stump revealed a small amount of soft tissue calcification distally with a small spur at the posterior lateral side of the femur (Figure 2). The patient was started on anti-inflammatory agents which provided a moderate amount of pain relief. However, he still had difficulty ambulating secondary to stump pain.

A lateral pad above the distal end was inserted into the prosthesis which relieved some of the pain. However, within a few days, the patient developed a skin break-

Figure 1.

*Institute of Rehabilitation Medicine, NYU Medical Center (IRM-NYU).

Figure 2.

Figure 3.

down in the left peroneal area, and an erythematous area on the distal stump. The patient was not allowed to wear his prosthesis for 2½ weeks. During this time, a repeat stump x-ray showed a large spur in the posterior lateral side of the distal stump and more soft tissue calcifications on the anterior surface of the stump (Figure 3). Consequently, a new socket was designed to give relief over the distal anterior and posterior stump in order to decrease the pain and improve ambulation.

This socket consisted of a vacuum-molded inomer (Surlyn™) flexible socket contained in plastic laminated socket. There were fenestrations put into the anterior (Figure 4) and posterior walls (Figure 5) of the rigid outer

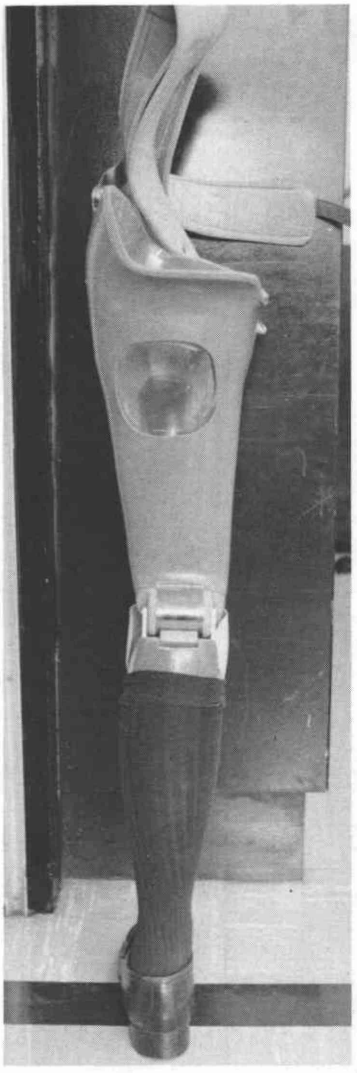

Figure 4.

Figure 5.

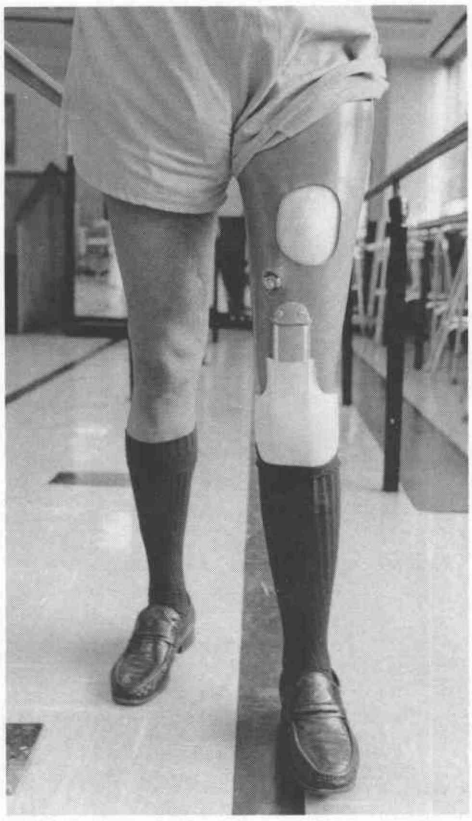

Figure 6.

socket, which afforded relief to the area of spur formation and soft tissue calcification.

The flexible inner socket was chosen for several reasons:

1. Flexibility of the socket results in a more comfortable fit and reduces pressure concentration.
2. Its transparency allows direct visualization of the stump, if skin breakdown is a problem, and to monitor pressure areas.
3. It permits quicker heat dissipation because of reduction in socket wall thickness.
4. The socket allows improved sensory feedback, especially while sitting, due to flexibility in fenestrated areas.

The patient tolerated the prosthesis well, however, he still had pain over the anterior distal stump. Thus, new x-rays of the patient were taken while he was wearing the prosthesis to determine if the fenestrations were, in fact, over the spur and the soft tissue calcifcations. Because of the design of this socket, it was easy to determine that the fenestrations needed correction.

The anterior cut out was then enlarged to better accommodate the soft tissue calcification (Figure 6). This afforded the patient the relief needed. He is presently ambulating independently with a straight cane and the above-knee prosthesis without any pain.

In summary, this flexible socket technique allows improved accuracy in fitting not only routine cases, but is especially suited for problem cases as illustrated here.

Meetings and Events

Please notify the National Headquarters immediately concerning additional meeting dates. It is important to submit meeting notices as early as possible. In the case of Regional Meetings, it is mandatory to check with the National Headquarters prior to confirming date to avoid conflicts in scheduling.

1984

January 25–29, Academy Annual Meeting and Seminar, Dutch Resort Hotel, Lake Buena Vista, Orlando, Florida. Contact: Academy National Headquarters, 703-836-7118.

January 29–February 2, AOPA Business Procedures and Data Committee seminar, Rose Hall Beach and Country Club, Montego, Jamaica. Contact: AOPA National Headquarters, 703-836-7116.

April 6–7, New England Academy Chapter Annual Meeting, Worcester Marriott, Worcester, Massachusetts.

April 11–15, The Pacific Rim Orthotics and Prosthetics Conference, Hotel International, Maui, Hawaii. Endorsed by the Academy and INTERBOR.

April 12–15, AOPA Region IV Annual Meeting, Waverly Hotel at the Galleria, Atlanta, Georgia.

May 3–5, AOPA Regions I, II, and III Combined Annual Meetings, Concord Hotel, Kiamesha Lake, New York.

May 24–26, AOPA Region V Annual Meeting, Amway Grand Plaza Hotel, Grand Rapids, Michigan.

June 1–3, AOPA Region IX, COPA and the California Chapters of the Academy Combined Annual Meeting, Lake Arrowhead, California.

June 21–24, AOPA Region VI and the Academy Midwest Chapter Annual Combined Meeting, Holiday Inn, Merriville, Indiana.

June 28–30, AOPA Regions VII, VIII, X, and XI Combined Meeting, North Shore Convention Center, Lake Coeur d'Alene, Idaho.

1985

January 30–February 3, Academy Annual Meeting and Seminar, Cathedral Hill Hotel, San Francisco, California. Contact: Academy National Headquarters, 703-836-7116.

June 7–9, AOPA Region IX, COPA, and the California Chapters of the Academy Combined Annual Meeting.

October 15–20, AOPA Annual National Assembly, Town and Country Hotel, San Diego, California. Contact: AOPA National Headquarters, 703-836-7116.