Prosthetics Considerations for the Female[1]

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I am very happy to have been invited to participate in this symposium on patient management. I do feel that this is an area that has been completely neglected in our professional thinking. In striving to perfect the technology, we have forgotten the patient—and above all—the FEMALE patient. It has been said that there is no difference between the male and female patient. Well, to that, I say 'Vive Le Difference', and will discuss now the problems of the female patient.

To all men, women are an enigma, but no greater problem has any man, than one who must try to rationalize amputation to a female patient. Understanding of the emotional and physical problems of the female patient can influence her adjustment and acceptance of the prosthesis. In many instances, we may eliminate some of the problems by approaching the situation with a little more finesse and better understanding.

One of the very important things that we must not do—that is not to de-personalize the patient. Do not label her—do not call her 'an above-knee amputee' or 'a below-knee amputee' or a 'hip-disarticulation' case. There is no need for that because the patient is a whole being, and it is very important to consider this. Total rehabilitation requires planning by the entire team, beginning with the surgeon and terminating with the fitting of the prosthesis.

The following considerations will be a great help to the patient and to the members of the team. First, a

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woman is a woman, then a patient. Any indication that she is considered only an 'amputee' would be an emotional and psychological setback to her vanity. The physician, in trying to alleviate the initial shock of the amputation, will describe the subsequent prosthesis in such a manner that the prosthesist cannot meet the mental image in the patient's mind. Although the modern prosthesis is an excellent substitute, functionally and cosmetically, for the missing member, there are limitations within which the prosthetist must work.

In my conversations with physicians, many have told me of their unawareness of new developments in our profession. Therefore, I firmly believe that the prescription for a prosthesis should be a cooperative venture between the physician and the prosthetist. The physician being responsible for the medical aspects, the fitting or fashioning of the prosthesis is the responsibility of the prosthetist, and that is where his or her expertise will prevail.

Psychological setback is seen in some surgeons as well as in the patients. And it may surprise you to learn that some surgeons equate amputations to death. (They are not alone in this feeling as insurance companies equate double amputations to death.) However, with immediate post operative fitting procedures, as well as early fittings, I do believe a closer follow-up by the surgeon will relieve him of this frustration and help him to realize he has given the patient the ability to return to being a normal human and leading a useful life.

Many of us in the profession rarely stop to consider the mental image our words convey. Try not to use the word 'stump' which is a degrading and painful word. It has been said that a picture is worth a thousand words, and yet, there are just two words that conjure up most gruesome pictures to persons who have lost limbs. It is our responsibility to replace these words, as well as the limbs. The words are 'amputee' and 'stump'. While these words affect men severely (although they are supposed to be the hardier of the species, in spite of the Women's Liberation Movement), the loss of a limb becomes a traumatic experience to a woman, and not only for vanity's sake.

Little girls are likely to have fewer anxieties and vanities, so they are just great to work with. However, when you go into the teen-age stage, you really have a problem in their manner of dress and how their friends, male and female, are going to accept them.

Then from the teen-ager, we go into the adult stage and you have a young woman who is planning courtship, marriage, and motherhood. There are many problems to be considered at this stage. I wonder how many doctors or prosthetists here have had a young girl request your advice regarding pregnancy. The first trimester does not present too many problems, but during the second trimester, adjustments for comfort and control are necessary. I feel that we should be more aware of these very personal situations, and, of course, we should have the answers.

The below-knee prosthesis presents little problems. However, prostheses for higher amputations and

hip disarticulation cases require adjustments to suspension and refashioning of the socket in the anterior aspect, with perhaps a leather replacement from time to time until confinement.

At the time of confinement, the prosthesis should remain on the patient, as this will permit better positioning on the delivery table and also comfort the patient both physically and mentally.

Now, as you consider higher levels of amputations, this will have to be evaluated by the obstetrician.

We are in a great era regarding clothes for the females—the skirts are long—pant-suits are in—and the shoes are great. However, speaking of shoes, do fit the young ladies, and the not-so-young ladies, with several feet at the initial fitting—that is, high heel, low and flat heels. This will eliminate a bilateral frustration. They will have a selection of shoes and you will have a happier patient, one who is satisfied because she realizes that you fully understand her situation.

I respect whatever procedures you prefer—that is the immediate post-surgical procedure—or a rigid dressing with early fitting—as long as the patient leaves the hospital wearing a preparatory prosthesis with good cosmetic effect. This is true for lower limb cases as well as for upper limb cases. We have been fitting modular prostheses for upper extremities for the last thirty years. The interscapulothoracic amputation is very disfiguring, and a prosthesis should be fitted before the patient goes home.

The measurement and cast can be made prior to the amputation, and final fitting can be carried out when the sutures are removed.

We advise that you fit the patient with an interscapulothoracic joint as well as a complete prosthesis. When relaxing at home this arrangement will be a little more comfortable and will give a better cosmetic effect since it supports clothing in a presentable manner.

I sincerely hope what I have said will answer some little problems you may have. I also hope it will arouse some questions.

In closing, keep this in mind, please—limbs suggest parts of beautiful trees as well as bodies, and in a measure block out the horrendous bloody picture of a sawed off part of one's body. Trees lose limbs through storms or judicious pruning, yet we never refer to a tree as having an amputation. Treat patients as gently with words as you do with your actual treatment.

Try hard—Thank you.