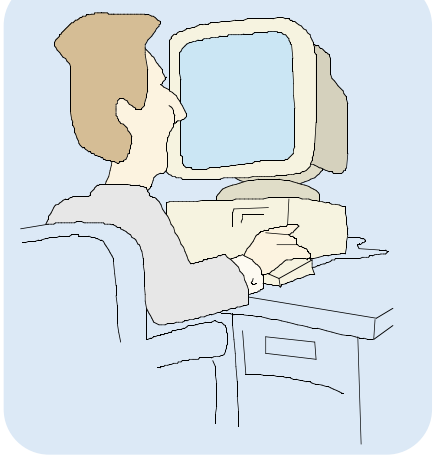
Clinical Audit Bulletin

for Podiatric Surgeons

David Tollafield



IN THIS BULLETIN WE LOOK AT:

- ANONYMITY
- ORIGINS OF PASCOM – FORGOTTEN EVIDENCE 1992
- SCORE SYSTEMS
- SF-36 HEALTH PROFILE SYSTEM

Since the March newsletter and the meeting of surgeons at Loughborough University many have shown interest in the surgical database. Twenty PASCOM CDs are ready for circulation and more enquiries are coming in.

The Working Party (WP) met in May and was very encouraged by the enormous potential for research. A wealth of information could be made available for partners and Faculty. WP feel the delay with rolling out PASCOM was justified and many mistakes that could have been made were prevented.

For those wishing to use PASCOM and become a partner please contact either Lisa Humby or myself (see footnote). Trials of the CD version have been conducted and most of the wobbles have been ironed out – but do let me have any comments good or bad and they will be included in further bulletins.

After our meeting at Fellmongers Path we met with the South East Surgical Podiatry Group. Their interest was most encouraging and through meetings like this many concerns can be dealt with. So, if you are having a meeting, it may be possible for a member of the WP to come along.

Anonymity

Comments are often made in private but not at meetings. Some Fellows have concerns that information will be used to make personal judgements. Let me assure everyone that this is completely at odds with the rationale and objectives of our work. Only our registrar has access to people's identity, and no publication of names or centres would be considered ethical without permission.

In becoming a partner and enjoying the generous sponsorship from SCP each member agrees to share data. This is the only way that the database will grow and be of any value in supporting our work.

I probably share the common thought that the assertion that foot surgery remains the domain of the medical community is now outdated. For many detractors, evidence so far may appear inconclusive, but change is expected in this respect in the near future. We are better placed not just to combine our data but collect it in a way that is similar – 'apples for apples' not 'apples for pears'!

The database has reached over 3000 cases so far and is growing. By next year – with your support – it could be awesome. Our lead in foot surgery is encouraging but this will not remain the case indefinitely.

Origins of PASCOM

I am grateful to the Editor and Editorial Committee for agreeing to republish the original paper upon which PASCOM was based by Tollafield & Parmar.[1] (First part is on p??). An article appeared in the *Journal of British Podiatric Medicine* (*The Chiropodist*) in 1993.

This was the preliminary report. The main report was published in the *British Journal of Podiatric Medicine and Surgery*,[1] published by the Podiatry Association. Unfortunately when the document '*Cost effectiveness of podiatric surgery*' by Carter, Farrell and Torgerson (1997) was published, they omitted the most detailed single study collected in 1992.

The work represents a sponsored study by former Nene College at its school of podiatry – collaborating with the NHS in the days before GP fund holding. Complications and tourniquet times are just two features that have contributed to the high standards set in podiatric surgery in the UK. PASCOM utilises some of the merits of this early paper.

This was not, however, the first British surgical audit study in podiatry. The credit for this goes to Ariori, Graham and Antony in 1989 and covered a six-month study. The Tollafield & Parmar paper[1] was the first to cover a medium longitudinal study over five years for 299 cases.

Reference

1. Tollafield DR, Parmar DG, Setting standards for day care foot surgery. *Br J Pod Med Surg* 1994; **6**(1): 7-20.

A bit more about score systems

As George Bush would say, we need to 'perspectorise' (sic) on the various methods of assessing clinical outcome. In previous bulletins WP has covered such topics as anaesthetic grading or ASA grading for basic medical fitness assessment of the patient (Issue 2).

Audit has been discussed, as have the benefits of assessment schemes such as Nottingham Health profile and American Orthopaedics Foot and Ankle Society (AOFAS) score system (which looks at pre/post operative evaluation systems) quite robustly at PASCOM meetings. Four meetings have been held since 1996, the last being at Warwick University in September 2001.

Fellows have been recommended to use the AOFAS system where this can be implemented but, subject to positive evaluation, there is no strong support for any particular system for foot surgery at present. The AOFAS system is widely cited in American orthopaedic literature and, in particular, the journal *Foot & Ankle International* promotes this score system. The working party has not incorporated the AOFAS system into PASCOM as it would be too cumbersome and complicate the programme (Issue 9).

The previous bulletins have covered project ideas, such as the clinical bolt-on system, which

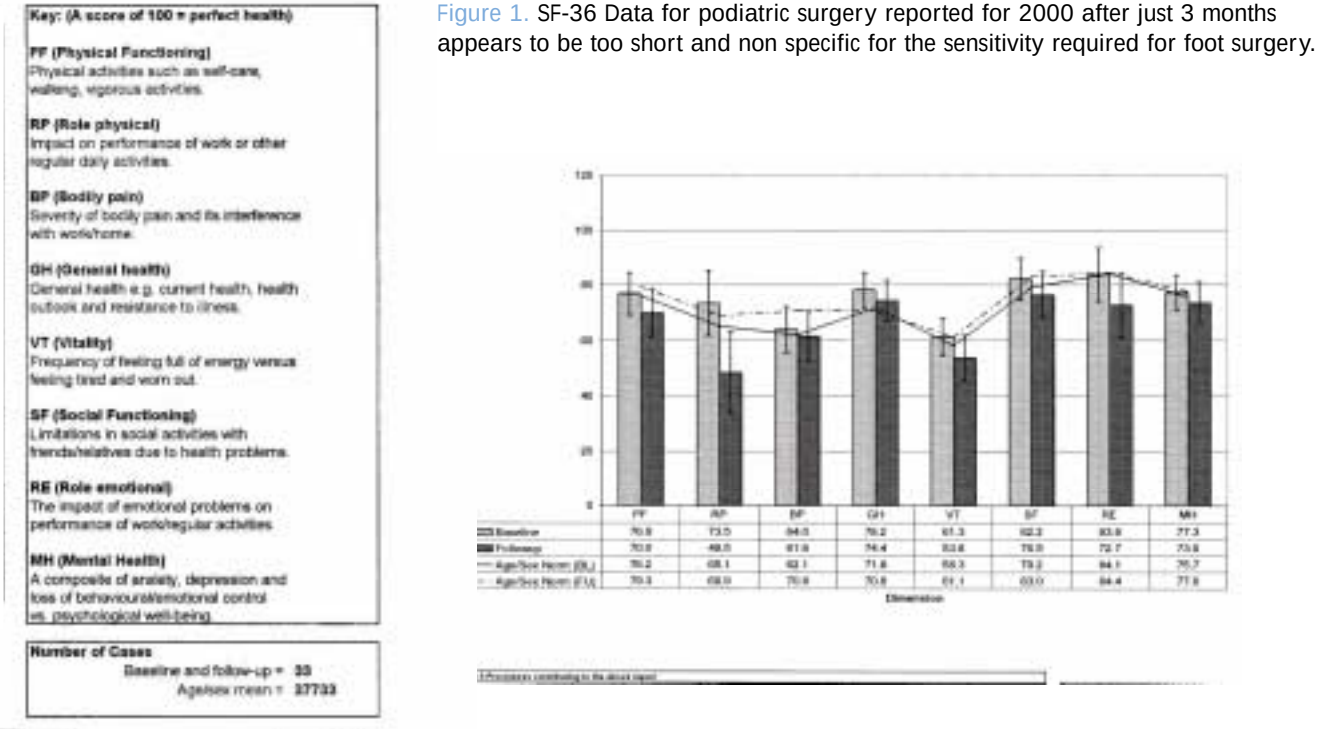


Figure 1. SF-36 Data for podiatric surgery reported for 2000 after just 3 months appears to be too short and non specific for the sensitivity required for foot surgery.

was dropped after a short trial. While pre-clinical data would be useful it has been recognised by the WP party that the electronic health record system (EHR) will fill in this omission. Already we are looking to the intranet to consider how best long-term amalgamation of PASCOM can be incorporated. As always security is our concern.

SF-36 health status profile

For those that work within the BUPA private hospital system, SF36 is a health status profile. I have been involved with this system for the last two years for hallux valgus and neuroma surgery.

The system works on the presumed improvement of the patient's wellbeing following surgery. I noticed that my own patients appeared to do less well after surgery compared with the PASCOM system (patsat score data). Figure 1 illustrates a scan of my results as this typically shows the type of format received from a firm of analysts used by BUPA. All surgeons and their data are anonymised.

A paper in the December issue of *Foot & Ankle International* by Thordarson *et al* (Los Angeles) brings some useful comments about the SF-36 of which I believe podiatric surgeons need to be aware. This paper considers hallux valgus as an outcome study. The section that caught my eye validated some of my own observations, and I quote: 'Previous studies have questioned whether general health questionnaires such as the SF-36 can detect changes on outcome through orthopaedic procedures'. 'Condition specific questionnaires appear to be more sensitive than general questionnaires'. Thordarson *et al*'s findings '…suggests that an SF-36 may not be important in assessing the outcome of bunion surgery due to its generic type of health and functional questions'.

The WP have stood by 'patsat', also known as PSQ-10 now, with little change for the reason that the system does cover a wide range of pertinent points about the effects of foot surgery.

Certainly, to date the WP is fully justified in keeping with a broad-based system that will have meaningful material for users of podiatric surgery. A good introduction to this questionnaire is given in the manual.

Help desk

Lisa Humby is the central point for enquiries from Fellows **ONLY**. Please write to her at

[redacted]

have general enquiries or comments then please write to me

[redacted]

Please do not contact the Society for help with PASCOM. PASCOM is run by a working party under the Faculty of Podiatric Surgery and the Professional Practice Committee.