An In-Depth Review of Community Foot and Ankle Services: Should Surgeons Take Complete Control of Foot and Ankle Care?

Foot & Ankle Category: Other

Author(s):
Raju Singh Ahluwalia, FRCS (T & O)
Dina Perfanis
Raman Dega, FRCS (T & O)
Nick Cullen, FRCS

Introduction
Today’s movement towards primary/community (PC) care led diagnostic and intervention services has not been tested. The aim of these systems is to take away the pressure on the foot and ankle surgeon, but do they provide appropriate management and therefore are they cost effective? These services are directed towards patient centered care, but the question of how effective they are still needs to be addressed? In, what we believe, this is the first in-depth review of primary care referrals from general practitioners (family doctors), physiotherapists and podiatrists to foot and ankle surgical services when they felt that primary non-surgical treatment had come to an end. We compared diagnosis and, management in the community to that in a specialist orthopaedic unit. We expected to see very little diagnostic difference between PC and specialist care.

Methods
A total of 150 patients were prospectively reviewed for 1 year after referral from PC care. Seventy-five patients were referred to a tertiary unit and 75 referrals to a regional unit. We reviewed all documentation derived from both trusts and clinics. RSA and DP conducted an assessment by completion of a dedicated audit form, with departmentally agreed terms and domains following the International coding of diseases (ICD) system of all referrals into key areas of care including initial diagnostic assessment – including primary care diagnosis, and investigation and treatment. Secondary care diagnosis, investigations and management.

Results
We found 150 patients, 23 inappropriate referrals (for non foot and ankle problems). The average age of patients was 46.7 years, and there was a slight male predominance 56.5% (72) vs. 43.3% (55) of females in total, 2.2% was diabetic. Our observations showed a 57.4% concordance between secondary and primary care diagnosis. From our 1-year review, the overall conversion rate to surgery was only 29.3% (n=42/150) in the referral group. There were a greater number of conversions to surgery in those correctly diagnosed (n=36/73) than those incorrectly diagnosis (n=8/77) in PC group. Within the complete group the majority of patients were managed conservatively (n=60); and most referrals were for fore foot conditions, the greatest, diagnostic accuracy was in the fore foot group (60%; n=39). Even so the commonest miss-diagnosis was a Morton’s neuroma. Overall we calculated that primary care diagnostics are 28.4% sensitive and 85.1 % Specific. The Positive Predictive Value was 52%. Some patients waited on average 33.6 months out in the community before referral was made, and longer If the diagnosis was not in accordance with secondary specialist care (36.3 months (P>0.05)). We observed eight patients with acquired pes planus from tibialis posterior tendon dysfunction, whom waited 29.8 (15.8-38.6) months until surgical review. At this time they were found to have fixed deformity, AND not amenable to joint sparing surgery.
Conclusion
The modern principle of patient focused treatment is aimed at maintaining or improving outcomes for patients. In the UK and elsewhere PC care is the gatekeeper of care, yet nearly 1 in 3 patients were provided with incorrect diagnoses, and spend up to 3 years with incorrect treatment. Low sensitivity means that PC could commonly misses patients with treatable problems. Thus, referral pathways need improving and require the construction and implementation of referral guidelines to enhance referral and treatment. We advocate further assessment of PC diagnostics, and joint process, and ownership of care to improve PC care diagnostic accuracy to greater than 60%, and provide a continuum of care.