

Australasian College of Podiatric Surgeons

National Audit Summary Report 2014



Prepared by the ACPS Audit Committee

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Summary

The following report summarises the surgical activity of the College for 2014. All cases of foot and ankle surgery performed in office, day surgery and inpatient settings have been recorded. The ACPS Online Audit Tool was used to capture and report data in real-time. There has been 100% compliance in data capture by all active surgeons of the College since 2013 until the present.

The data presented in this report should be considered a "snap shot" of overall activity. It will form part of the final 2014 report following national peer review during the College AGM and final approval by the ACPS Clinical Audit Committee.

Admissions

There were 1974 admissions for podiatric foot and ankle surgery.

Total number of procedures

1981 procedures were performed.

Cross-sectional analysis of procedures

6 procedure groups were selected to represent a cross section of all surgical activity based on criteria established Menz in 2008 and utilised in the ACPS 2013 National Audit Report [1, 2]. The procedures selected represent the most common forefoot (1st metatarsophalangeal joint, neuroma and toenail) procedures, rearfoot, ankle and amputations procedures as shown in Table 1.

Procedural group	Procedure count / total procedures %	MBS item number
Toenail	421 / 21%	47906, 47915, 47916, 47918
Neuroma	65 / 3.2%	49866
1 st metatarso phalangeal joints (MPJs)	954 / 49%	49821, 49824* , 49827, 49830* , 49833, 49836* , 49837, 49838* , 49839, 49845
Heel, Rearfoot & Tarsal coalitions	22 / 1%	49854, 50118
Ankle	32 / 1.6%	49706, 49709, 49715, 49718, 49724,
Amputation	11 / 0.5%	44338

Table 1: Cross section of procedures. * Bolded item numbers represent bilateral procedures which have been doubled for the count.

The above selection of procedures represents 75% or 1505 procedures performed in 2014. Forefoot surgery comprised 73.2% (1505 procedures) of all activity performed. Rearfoot, ankle and amputation surgery comprised 2.6% (65 procedures) of all activity performed. The mix of procedural times and numbers found in this report concur with similar findings in the literature [1, 3].

Frequency of pathology

The 10 most frequently recorded diagnoses using the International Classification of Disease (ICD 10) code is shown below in Table 2.

Principle diagnosis	Count	Diagnosis code
Hallux valgus (acquired)	518	M20.1
Hallux Limitus	103	M20.2
Hammer toe, congenital	30	Q66.81
Other hammer toe acquired	232	M20.4
Ingrown toenail	443	L60.0
Wart	88	B07
Morton's neuroma	80	G57.6
Mech comp int fixation dev bones limb	58	T84.1
Osteophyte lower leg	42	M25.76
Miscellaneous arthropathies – Osteophyte	31	M25.77

Table 2: 10 most frequent diagnoses

A total of 1625 principle diagnoses were made with 1st metatarsophalangeal joint pathology the most frequent pathology identified.

Complications

The Australian Council on Healthcare Standards (ACHS) requires healthcare organisations collect complication data for 30 days after discharge. The ACHS requires data collection of complications such as deep vein thrombosis and infection only if readmission is required. The College collects data to record complications in line with ACHS recommendation. In addition complications that do not require readmission but occur within 30 days of discharge are collected. Below is a summary of readmissions, DVT, infection and wound breakdown.

Readmission

There were 4 patients or 0.2% of cases required readmission. 2 cases were readmitted for management of medical complications (e.g. chest pain), 1 case of deep vein thrombosis (DVT) and 1 case of pulmonary embolus each required readmission.

DVT

A total of 3 patients or 0.15% of cases developed DVT. 2 were managed in outpatient settings and 1 required readmission.

Infection

Using the ACHS definition of postoperative infection the rate of infection for 2014 was 0%. There were 42 cases or 2.1% of all cases that required outpatient management of infection.

Wound breakdown

10 cases or 0.5% of all cases developed a wound breakdown all of which were managed in outpatient settings.

The above findings regarding complications are either within or below rates reported in the literature [4-9]

References

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