

FROM THE EDITOR IN-CHIEF



Dear colleagues,
It is my pleasure to share with you the seventh volume of *Limb Preservation Journal*, which arrives at a moment of genuine vitality in our field. The contributions assembled here span six continents, a dozen clinical disciplines and the full spectrum, from bench-level pathophysiology to patient narrative. Reading them together, several themes emerge that are worth naming.

The most ambitious argument in this issue belongs to Badr and Maguire, whose comparative analysis of global health system models frames the amputation rate as a structural verdict on health system performance. Their epidemiological paradox is worth sitting with - the United States and resource-constrained 'out-of-pocket' systems produce the world's highest limb loss rates, driven by fragmentation and the absence of infrastructure respectively, while Beveridge, Bismarck and National Health Insurance models consistently achieve lower rates despite comparable metabolic burdens. For a Canadian audience, the provincial variation documented in recent literature is a reminder that universal financing is necessary but not sufficient. What translates health system coverage into preserved limbs is the distribution of vascular specialists, structured referral pathways and functioning multidisciplinary foot teams.

Building and sustaining those teams is the practical preoccupation of several other contributions. Manji's roundtable distills the "irreducible minimum" for a limb preservation clinic to podiatric and vascular surgery working in concert, with honest accounts of how long that takes to establish and how vulnerable the remission surveillance gap leaves patients who have successfully healed. Theodorakopoulos and Armstrong offer the WIfI classification, not merely as a staging tool, but as a clinical mindset: a framework for setting urgency and triggering escalation before the window for intervention closes. Krehbiel and colleagues make the case for the three-minute diabetic foot exam as a population-level prevention strategy, one designed for the primary care clinician and community health worker who will encounter the at-risk patient years before the limb preservation specialist does.

Decision-making at the surgical crossroads is addressed with real depth. Strauss and colleagues present a three-score system for Charcot neuroarthropathy that integrates wound severity with patient wellness and patient goals, correctly insisting that the decision about salvage versus amputation cannot be reduced to the wound alone. The lymphedema case reported by Estfanous reaches a similar conclusion from a different direction: in a patient considering amputation after years of

treatment failure, the decisive intervention was not a clinical technique, but the restoration of hope and therapeutic engagement through shared decision-making. Both articles argue, in effect, that the patient is always a variable in the clinical equation.

Two further contributions address the diagnostic challenge that underlies much limb loss: missed peripheral arterial disease. Beaumier's angiosome-based ABI work demonstrates that 40% of standard ABI calculations in her cohort did not represent the artery irrigating the wound bed, a finding with direct implications for clinical practice. Njokweni's conceptual amputation prevention protocol from a public regional hospital in South Africa addresses the same problem from a system design perspective, arguing that the gap between evidence and outcomes in resource-limited settings is primarily a coordination failure rather than a knowledge failure.

The remaining articles expand the frame. The obesity and Diabetic Foot Ulcer review by Brocklehurst and colleagues makes the case for treating excess adiposity as a modifiable upstream determinant of foot disease rather than a background variable, with important caveats about the nutritional risks of pharmacological weight loss in patients with active wounds. The persuasive email intervention study by Nickel and colleagues explores how digital technology can extend prevention into

patients' daily lives. The Limbloss Connection article by Polese, Gray, and Ramhacklam is a direct account of what the clinical pathway looks like from the other side of the operating table, and a practical argument for peer support as a routine component of amputation care. The two-island Caribbean case report by McConnie and Budhoo is a reminder that multidisciplinary care is achievable across resource limitations and international borders when the team is committed. And the D-Foot International overview by Nair, Gangji and Abbas traces 22 years of global education and advocacy work, with both the impact data and the honest acknowledgement of what remains unfinished.

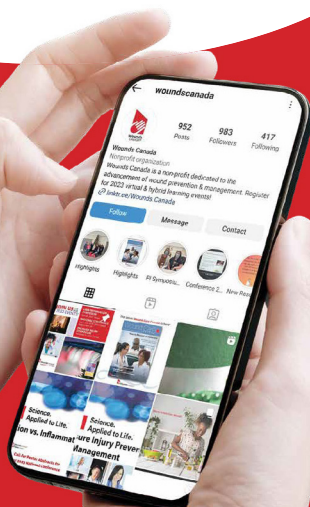
What this issue adds up to is a sustained argument that most preventable amputations are still preventable, and that the obstacles are organizational and structural as much as they are clinical. We are very grateful to the authors, reviewers, and readers who make this journal part of that argument.

Sincerely yours,



Ahmed Kayssi, MD MSc MPH CWSP FRCSC
FACS

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