Checklist: what makes a limb salvage centre

> No randomised trial has ever compared a limb salvage centre with usual care, and none is likely to be run. Every association below comes from observational data. Use this list the way we use it: not as a certificate, but as a map of the gaps. Score it honestly. Any item you cannot answer with a plain **yes** is a gap.

1. The team

- [ ] One named lead clinician owns each patient from the first call to the healed wound.
- [ ] Vascular / endovascular surgery, wound and foot infection, cardiology and diabetology are reachable **the same day**, not by referral letter.
- [ ] Foot expertise is part of the team, not an outside consultation. (Regional supply of podiatrists is the only specialist supply associated with fewer amputations in diabetic foot wounds: OR 0.74; revascularization specialists OR 1.03 - Popescu, JAMA Netw Open 2026.)
- [ ] The team meets on a fixed schedule, and the meeting changes decisions.
- [ ] Volume is tracked. Low-volume centres report worse limb outcomes (OR 9.94 lowest vs highest quintile - Medhekar, J Vasc Surg 2017; odds, not risk).

2. The wound

- [ ] Someone owns the wound for the whole healing period - a median of about five months (146 days - Shiraki, EJVES 2015), not until discharge.
- [ ] Offloading is prescribed and checked, not advised.
- [ ] Infection is graded and treated by protocol, with same-day surgical drainage available.
- [ ] Nutrition is measured (albumin) and acted on.
- [ ] Wound healing is followed after discharge, with a named date for the next look.

3. The heart

- [ ] Every patient is screened for myocardial ischemia at rest: symptoms plus a resting ECG.
- [ ] Coronary revascularization is **not** routine before limb surgery (CARP: mortality 22% vs 23%, leg surgery delayed 54 vs 18 days - NEJM 2004).
- [ ] A cardiologist can see the patient the same day when ischemia at rest is found.
- [ ] Cardiovascular death is counted in your own outcomes - it is the commonest way these patients die (BASIL-2, Lancet 2023).

4. The drugs

- [ ] A written discharge set exists, and someone checks it was actually issued.
- [ ] High-intensity lipid-lowering therapy, with ezetimibe when the target is not met.
- [ ] An antithrombotic regimen chosen deliberately, not by habit.
- [ ] Blood pressure and glucose control assigned to a named clinician.
- [ ] Smoking cessation offered at every visit.

- [ ] You know your own percentage on each of these. (In BEST-CLI, enrolling in leading centres, only 25% met all four criteria of optimal medical therapy - Menard, J Vasc Surg 2023.)

5. The technology

- [ ] The full toolbox is available in one place: below-the-knee work, re-entry, calcium modification, and a plan for the no-option patient.
- [ ] Indications are written down. Deep vein arterialization is for no-option CLTI only (PROMISE II: limb salvage 76% at 6 months, single-arm, no randomised trial).
- [ ] After arterialization the wound plan is deliberately delayed: perfusion improves while the bed remodels, and the foot looks worse before it looks better.
- [ ] New technology is introduced with outcome tracking from the first case.

6. The knowledge

- [ ] Guidelines are available in the language your doctors actually read.
- [ ] Referring doctors know how to reach you in one step, and get an answer the same day.
- [ ] Your outcomes are reviewed by the team - including the ones that went badly.
- [ ] Training is continuous, and juniors operate with supervision, not instead of it.

How to read your score

Gaps in section 1 or 2 are the ones that cost legs. They are also the cheapest to fix: they need agreements, not devices.

Gaps in section 4 are the most common and the least discussed. We had them too.

A centre with every box ticked does not exist. Ours does not. The point of the list is the next gap you close, not the badge.

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