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National guidelines of care for amputees' health: current challenges and prospects

Diretrizes nacionais de cuidados em saúde para amputados: desafios atuais e perspectivas

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Abstract

Estimates from 2022 showed that in the last 5 years, more than 102,000 amputation surgeries were performed by the Sistema Único de Saúde - SUS (Unified Health System, Brazil). An amputation requires adequate rehabilitation process with support network, allowing autonomy and social inclusion. The aim of this paper is to present and discuss the Brazilian Guidelines on Amputee Health Care and other Brazilian public health policies that dialogue with their recommendations. Eight documents were identified that narrow dialogue with the Guidelines: National Health Policy for People with Disabilities, National Health Plan 2012-2015, Guidelines for the Care of People with Chronic Diseases in Health Care Networks and Priority Lines of Care, National Plan for the Rights of Persons with Disabilities - Living Without Limits, Convention on the Rights of Persons with Disabilities, National Health Policy for the Elderly. Brazil has been discussing the need to implement legal mechanisms to ensure full citizenship of people with disabilities. Among the documents presented, the following guidelines were observed in common with the Amputee Health Care Guidelines: providing support and specialized services within the SUS, the need for training of the multidisciplinary team, supply of assistive technology equipment, prevention of injuries and promoting the inclusion of the amputated person. The main challenges and current perspectives involve the articulation of the various levels of health care for this population, and training of the team for comprehensive care for the full rehabilitation of these individuals.

Keywords: People with Disabilities, Amputees, Public Health Policy.

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Resumo

Estimativas de 2022 mostraram que nos últimos cinco anos mais de 102.000 cirurgias de amputação foram realizadas pelo Sistema Único de Saúde – SUS, Brasil. Uma amputação requer um processo de reabilitação adequado com rede de apoio, permitindo autonomia e inclusão social. O objetivo deste documento é apresentar e discutir as Diretrizes Brasileiras sobre Cuidados de Saúde de Amputados e outras políticas de saúde pública brasileiras que dialogam com as suas recomendações. Foram identificados oito documentos que estabelecem um diálogo estreito com as Diretrizes: Política Nacional de Saúde para Pessoas com Deficiência, Plano Nacional de Saúde 2012-2015, Diretrizes para os Cuidados de Pessoas com Doenças Crónicas em Redes de Saúde e Linhas de Cuidados Prioritários, Plano Nacional para os Direitos das Pessoas com Deficiência - Viver sem Limites, Convenção sobre os Direitos das Pessoas com Deficiência, Política Nacional de Saúde para os Idosos. O Brasil vem discutindo a necessidade de implementar mecanismos legais para assegurar a plena cidadania das pessoas com deficiência. Entre os documentos apresentados, foram observadas as seguintes diretrizes em comum com as Diretrizes de Cuidados de Saúde dos Amputados: prestação de apoio e serviços especializados dentro do SUS, necessidade de formação da equipa multidisciplinar, fornecimento de equipamento tecnológico de assistência, prevenção de lesões e promoção da inclusão da pessoa amputada. Os principais desafios e perspectivas atuais envolvem a articulação dos vários níveis de cuidados de saúde para esta população e a formação da equipa para cuidados abrangentes para a plena reabilitação destes indivíduos.

Palavras-chave: Pessoas com Deficiência, Amputados, Política Pública de Saúde.

Introduction

The last demographic census conducted (Instituto Brasileiro de Geografia e Estatística, 2010) reported the existence of more than 466,000 Brazilians without a member or part of it. Estimates indicate that in the last 5 years, more than 102,000 amputation surgeries have been performed by the SUS (Brasil, 2015).

Most amputations performed by the SUS are of the lower limbs and the most frequent etiologies are external causes (33.1%), infectious diseases (17.9%), circulatory system diseases (16.1%) and diabetes mellitus (13.6%) (Brasil, 2013a).

In view of the alarming data, the need for public policies based on the integral action of the people who suffered an amputation, as well as the professionals involved in the care of the amputated person for early rehabilitation and maintenance of their physical and mental health, allowing the need autonomy and social inclusion of these individuals (Brasil, 2013b). Walcker (2012) highlights the need for early care, still in the hospital environment after immediate amputation and, sequentially, referral to the specialized service, because the rehabilitation process requires, besides the proper physical structure, specialized professionals.

In Brazil, when studying actions and rehabilitation services in SUS, there is a gap in the formulation of policies aimed at people with physical disabilities, whose assistance has been given in a disorderly and disjointed manner, with little participation and organization of the public sector (Walcker, 2012). However, in 2013, the Ministry of Health launched the Amputee Health Care Guidelines so that SUS multiprofessional teams can offer qualified care to amputees. This document provides detailed information on how to

proceed with the diagnosis, characterization of the disease, treatment, control and monitoring of users, among other important aspects within the complexity of the amputee care network, bringing important reflections on their future perspectives.

Over the years, following its publication, there is an incipient but growing concern to ensure rights for persons with disabilities, where amputees are inserted. In this sense, a search was made in the legislation of the public health system in Brazil, in order to find documents that mention the amputated person and that bring subsidies for the discussion of current challenges and perspectives for their care. From this, it will be possible to glimpse the panorama in which amputees are backed by guarantees of health rights in Brazil.

Reflecting on the behaviors provided for in the Specific Guidelines for Amputee Health and deepening how they dialogue with other Brazilian public health policies that mention this population can help both patients and health professionals, regarding the conduct, their rights and duties.

The purpose of this article is to present and discuss the Guidelines on Amputee Health Care launched in Brazil by the Ministry of Health in 2013 and the other Brazilian public health policies that dialogue with its recommendations.

Amputee Health Care Guidelines: A Way to Go

Guidelines are documents with instructions and orientations for establishing treatment plans and goals, guiding health actions integrated with other policies for a systemic approach to population needs. With regard to Guidelines for People with Disabilities, the major milestone can be highlighted by the publication of the World Disability Report in 2011. It underlines the importance of equal access to health care through improved accessibility and equal opportunities, prioritizing the autonomy and dignity of people with disabilities (World Health Organization, 2011).

There is a need for health promotion of lower limb amputees aware that people become disabled due to physical and environmental factors (World Health Organization, 2011). The Report also encourages scientific production to evaluate and expand specialized services, as well as their infrastructure. Notes that the number of people in need of prostheses, orthotics and specialized services is significant, representing 0.5% of the population in developed countries, and that 30 million people in Africa, Asia and Latin America demand an estimated rehabilitation team of 180,000 professionals (World Health Organization, 2011). Therefore, we can see the highlight of the complexity of care and that this worldwide demand involves from the provision of prosthesis to the access of qualified care through access to the rehabilitation team.

Following this global trend, the Ministry of Health launched in 2013, in Brazil, the Guidelines for the Health Care of the Amputee (Brasil, 2013a). The objective is to establish plans and goals to clarify and guide the multidisciplinary team regarding the treatment and follow-up of the amputated person from the perspective of SUS principles.

According to the Guidelines, in order to ensure comprehensive care for the amputated patient, the attention of a qualified multidisciplinary team is necessary. This team should be composed of several professionals, including mainly: doctors, nurses, physiotherapists, occupational therapists, prosthetists, psychologists and social workers, who seek to meet the vast demands that surround the phases of the treatment process (Brasil, 2013a). This multidisciplinary work must occur in an articulated manner between the levels of

attention that make up the health network to the amputated person. It should be noted that there should be performance of teams in hospital care services, rehabilitation centers, home care and Family Health, establishing a flow of communication aimed at greater resolution (O'Sullivan, 2004; Organização Panamericana da Saúde, 2008).

Given this complexity, knowledge and use of guidelines help professionals maintain a standardized and qualified care process from the news of pre-surgical amputation to the rehabilitation and social reintegration phase (Tonon da Luz et al., 2010).

According to this process, in the pre-surgical phase, for patients who need a scheduled amputation, the moment of news is of paramount importance and deserves special attention from the multidisciplinary team. Open communication with the patient is fundamental, which must be based on an enlightening human posture with accessible language that allows family and patient support and a sense of being active in the discovery and treatment process (Fitzpatrick, 1999; Gabarra & Crepaldi, 2009; Brasil, 2013b).

In the surgical scheduling process, the medical team should take an individualized look at each case and plan each amputation surgery in order to preserve as much as the structures that will serve as the basis for prosthesis. Thus, the National Guidelines provide support recommending that surgery should seek to preserve limb length and categorically present the following levels: shoulder disarticulation, trans-humeral, elbow disarticulation, trans-radial, wrist disarticulation and trans-carpian (for the higher limbs); hemipelvectomy, hip disarticulation, transfemoral, knee and trans-tibial disarticulation (for the lower limbs) (Brasil, 2013a).

In the evaluation of the patient should be observed both the segment involved and the contralateral limbs, aiming to know the range of motion (ROM) of the joints, muscle strength, degree of dependence to perform activities of daily living (ADL), fitness, support social status and patient confrontation in the face of amputation surgery.

It is recommended to use the International Classification of Functioning (ICF) in the Brazilian Guidelines, which corroborates with the World Health Organization (WHO), in order to explore different functional conditions, stimulating the insertion of the diagnosis through it. Thus, the use of ICF by health professionals is recommended for monitoring the rehabilitation of the amputated patient. Through it, functionality and disability are considered as a result of the dynamic interactions between health states (diseases, disorders and injuries) and contextual factors (personal and environmental), proposing a transformation from a disease-based approach to a broader view and complex of health dimensions (World Health Organization, 2001; Toldrá & Souto, 2013).

Among the professionals who work in care, physical therapy plays a key role in the pre and postoperative period, accompanying and stimulating the patient throughout the rehabilitation process. In the period prior to amputation surgery, the Guidelines point out the orientation of postures taken by the patient in bed, as they may provide future muscle shortening and deformities. The position of the trunk, Upper Limbs and Lower Limbs should be oriented, avoiding knee and hip flexion patterns, abduction and external thigh rotation, as well as the immobilization of the segments. An exercise program is recommended to correct and prevent deformities to increase strength, mobility and balance. In cases of lower limb amputations, upper limbs should be strengthened concurrently, preparing the patient for transfers, independence, parallel bar work and wheelchair condition (Brasil, 2013a; Ganz, 2002).

Regarding the immediate postoperative phase, the need for patients to learn transfers and displacements correctly and without risks is reinforced. Most lower limb amputees

use wheelchairs for mobility and this equipment should be adequate. People with amputations at or below the transtibial level should use a stump support, keeping the knee extended to prevent shortening and flexion contractures. Patients moving with crutches should have their accessory adjusted (Schoeller et al., 2013).

The care of the patient in the hospital bed is not restricted to the amputated limb and the mobility of the other joints of the body is recommended. Amputee with good fitness and no cognitive impairment should begin gait training as soon as possible. Weight transfer exercises on the non-amputated limb are important for reestablishing the center of gravity. Gait training can progressively be followed by parallel bars, walker, axillary or Canadian crutches, favoring the patient's better quality of life after amputation.

With regard to stump care, the nursing staff is fundamental in the care of the surgical wound, supporting their needs for integrity and optimal healing, avoiding injuries in the hospital bed. The stump should be mobilized 24 to 48 hours after the amputation and should be guided by health professionals positioning, prevention of deformities, edema control and stump modeling.

The Guidelines already recommend in the hospital phase the compressive bandage on the amputation stump to reduce and prevent the increase of residual edema, stimulating the stump metabolism, in addition to modeling and preparing it for future prosthesis. It is indicated that the greatest pressure of the band should be distal to the stump, gradually decreasing in the proximal direction of the amputated segment. At transfemoral amputation levels, bandage to the pelvic girdle is recommended.

In the outpatient rehabilitation phase, stump muscle strengthening is important. The health professional should guide and train the amputated person to perform isometric exercises on the stump musculature, regardless of the amputation level. An individualized and comprehensive treatment plan such as concentric or eccentric isotonic exercises with different types of load is recommended.

The Guidelines recommend that the stump desensitization be performed using massage techniques (with the necessary care in the surgical wound), using various sensory stimuli (hot and cold water, objects of different textures), performing contractions and exercises in front of the mirror.

Regarding psychological follow-up, it should be noted that cognitive aspects should be evaluated to identify the patient's ability to learn, adapt and use the prosthesis, aiming at complete autonomy and functional independence with the use of the equipment. Situations such as post-traumatic stress, denial, anxiety and disorientation should be considered, where such factors may influence the results of the rehabilitation process. Possible neuropsychological changes should be evaluated and treated, as they create difficulties in adapting the individual to the prosthesis and compromise the prognosis.

Corroborating these factors, it is indicated that the amputation process can generate anxiety, depression, body image mismatch and social discomfort, leading to the need for support to experience and understand this process, adapting to the new life condition. Therefore, psychology plays a fundamental role in the assessment of aspects of denial and psychological distress, providing support and encouragement for proper dedication to rehabilitation (Senra et al., 2012; Sabino et al., 2013).

For the pre-prosthetic phase, two evaluations, one general and one specific, are recommended. In the general evaluation, the characteristics of the stump are observed and noted, such as location, shape, scar, scar adhesions, infections, sensitivity disorders,

exertion, presence of neuroma and bone spicules. Radiography, as a complementary exam, should be in at least two orthogonal planes for visualization of the bone structure of the stump. In the specific evaluation, stump measurements are collected and prosthetic components are prescribed according to each patient's characteristics such as age, amputation etiology, activities of daily and working life.

Adaptation to the new routine and social inclusion becomes one of the goals of rehabilitation treatment, so occupational therapy is essential, as this professional acts as a facilitating agent, seeking to organize and adapt the activities so that they come to be developed more independently. Thus, it aims at the accessibility of people with disabilities by eliminating barriers, whether physical or attitudinal for greater social integration (Ponte & Silva, 2015).

Therefore, when the patient has already received the prosthesis, it is important to advise on its correct use. For both prosthetized upper limbs and lower limbs patients, training in daily living activities (DLA) is essential. In the case of prosthetized upper limbs patients, gripping training, adjusting the weight of the objects and the new sensitivity are pertinent. For prosthetized lower limb patients, it is important to instruct them to wear and remove the prosthesis, as well as to perform weight transfers to the prosthetic limb, up and down stairs and ramps, to sit and stand, to avoid obstacles and to walk on uneven ground.

Thus, the Guidelines for Attention to amputees indicate that comprehensive care for the amputees' health should result in the maintenance of their physical and mental health, aiming at autonomy and social inclusion, so that they can enjoy a full life. It also provides for the presentation of the possibilities of return to work, as well as the rights of persons with disabilities and, in the case of work, the law of corporate quotas.

Thus, a person with amputation, or with the potential risk of evolving to an amputation, demands a complex health care process that will permeate all levels of complexity (Vargas et al., 2014). Hence, there is the knowledge that the amputated person needs monitoring of health services, receiving support and guidance also in their community.

Primary health care (PH) is responsible for promotion and protection actions aimed at disease prevention, diagnosis, treatment, rehabilitation and health maintenance. It is the gateway and communication center with the health care network (HCN) and is characterized by decentralization. The health care network acts in the coordination of care, elaborating, monitoring and organizing the flow of users in their various levels of care (Brasil, 2013b).

In this sense, people with limb amputations should be accompanied and assisted by health professionals in primary care, aiming at care with the surgical wound, in addition to medications that are necessary in case of other associated diseases and inclusion in health prevention and promotion groups in the community. From the PH should be referred to the other levels for continued rehabilitation (World Health Organization, 2015).

It is noteworthy that the PH also has great importance in the moment before the surgical procedure, in the case of elective surgeries. It is at this level that practitioners should monitor and inform users who are diagnosed with disease can result in limb amputation, such as infectious, parasitic diseases and diabetes. For this comprehensive care, family health teams (FHT) are anchored to family health support centers (FHSC) and can ensure home care to patients who need these health teams.

Theoretical Framework of National Policies that Dialogue with the Health Care Guidelines of Amputees

The struggle for social rights and health care is a historical issue that has been gradually conquered by people with disabilities, including those who suffered amputation. In order to know the relationship of the other public health policies in force in Brazil, which specifically dialogue with the needs of amputees in relation to the life expectancy of those who depend exclusively on SUS, we bring together in Table 1 those that address the theme of amputations.

Table 1. Relationship of Brazilian public policies with limb amputations and rehabilitation of amputees.

Public Policy / Author	Year / page	Relation with limb amputations
National Health Policy for the Elderly Brazil	2006 6-24	Aging, therefore, must be actively healthy, free from any kind of functional dependence, which requires health promotion at all ages. It is important to add that many elderly Brazilians have grown older and older despite the lack of resources and the lack of specific health promotion and prevention care. These include the elderly who live below the poverty line, illiterate people, the sequelae of work-related injuries, those amputated for arteriopathies, the hemiplegic, the elderly with dementia syndromes, and they also need to find answers and take specific actions.
Convention on the Rights of People with Commented Disabilities Brazil	2008 75-76	[...] For a person with disabilities, some limitations are imposed: people who have an amputated limb; [...] when the environment is tooled by assistive technologies, people's disabilities disappear; [...] these technologies can be prostheses or orthoses.
National Health Policy for People with Disabilities Brazil	2010 9 and 13	[...] relevance to the possible evaluation of each case for the dispensing of orthoses, prostheses and mobility aids, as well as the monitoring of the adaptation processes to the equipment; [...] receive the technical aids, orthoses, prostheses and mobility aids they need, complementing rehabilitation work and therapies.
Strategic action plan to address chronic non-communicable diseases in Brazil (NCDs) 2011-2022 Brazil	2011a 35-36	[...] 1998 statistics already showed that NCDs were responsible for 66% of disability-adjusted lost years of life (DALYs), associated with circulatory (13%), musculoskeletal (6%) and diabetes (5%) diseases. Relationship with insufficient physical activity [...] deaths and disabilities has grown, requiring immediate intervention.
National Health Plan (PNS) 2012-2015 Brazil	2011b 21	[...] the major economic impact of diabetes stems from the rising costs of treatment and, above all, complications such as amputation surgeries; [...] mentions the enormous challenges and their urgent confrontation, considering the external causes of morbidity related to traffic accidents, and the segments represented by people with disabilities.
Guidelines for the care of people with chronic diseases in health care networks and priority care lines Brazil	2013c 7	[...] chronic diseases make up the set of chronic conditions, which can often lead to disabilities, and which require lifestyle changes, often in a continuous care process that does not always lead to healing; [...] In addition to mortality, chronic diseases have a strong burden of related morbidities; [...] they are responsible for a large number of hospitalizations, as well as being among the main causes of amputations and loss of mobility.
Living Without Limit – National Plan of Rights For Person With Disabilities Brazil	2013b 31 and 40	[...] expansion of specialized rehabilitation centers; [...] among the therapeutic guidelines, the Amputee Attention Guideline is highlighted; [...] broadening access to orthopedic workshops and expanding the supply of orthoses, prostheses and mobility aids.

Source: Brazilian Health Policies that dialogue with the National Guidelines for Amputee Health Care. Brasil (2006); Brasil (2008); Brasil (2010); Brasil (2011a); Brasil (2011b); Brasil (2013b); Brasil (2013c).

The Convention on the Rights of Persons with Commented Disabilities seeks to disseminate the definition of independent living to all individuals, indicating that they have autonomy and independence, based on actions capable of emerging social transformation and the desire for a society without exclusion. It is considered that a person with a disability tends to live with the limitations imposed on them, including amputees. It spreads the instrumentalization of these people through assistive technologies, emphasizing that people's disabilities disappear when they make use of these tools. These include limb prostheses for locomotion (Brasil, 2008).

In this context, there is the promise of PH's coverage of all disease and disability demands, early diagnosis and interventions, and services designed to minimize and prevent further disabilities by drawing attention to the elderly, pointing out that they should achieve 100% of the success of the actions by 2016. It also includes the initial and continuing training of professionals and teams working in rehabilitation services, considering the availability, knowledge and use of assistive devices and technologies designed for people with disabilities (Brasil, 2008).

In addition, in 2011, the National Health Policy for People with Disabilities (PNSPD) was established, which supports the prevention of health problems and health protection, including rehabilitation with the aim of protecting the health of people with disabilities. It also highlights the rehabilitation of functional capacity and human performance, helping to include in all fields of social life and preventing diseases that cause disabilities (Brasil, 2010).

The PNSPD perpetuates a case-by-case assessment to dispense with orthoses, prostheses and mobility aids, reinforcing the need for follow-up of equipment adaptation processes, with the help of professionals working in this rehabilitation process (Brasil, 2010). In this sense, it reinforces the need for training, through training courses for orthesist and prosthesist professionals in the country, from 2009 (Brasil, 2010).

This same policy aims at the organization and operation of care services for people with disabilities through a care network, and the PH is the gateway to prevention and health promotion actions for people with disabilities. It also reinforces the role of the physical therapist in the NASF (Family Health Support Center) team and in specialized units of regional scope (Brasil, 2010).

The National Health Plan (PNS) 2012-2015 aims to promote access to quality health actions and services and the strengthening of SUS, highlighting concern about the great economic impact of diabetes mellitus (DM). Emphasizes the increased costs of DM treatment and, especially, complications, such as amputation surgeries (Brasil, 2011a).

The PNS delegates to Specialized Care the attendance of problems and health problems of the population, warning that its practice depends on the availability of professionals and the use of technological resources for diagnostic and therapeutic support. It reinforces that access to health actions and services should also happen with the expansion of NASF teams, including specialized professionals, including the physical therapist as a member of the continuity of promotion, prevention, therapy and rehabilitation actions. Stresses that there is unequal access to these actions in the country due to the concentration of services in certain regions, while in others is lacking or does not exist (Brasil, 2011a).

Through this scenario, there is, thus, the emergence, in 2013, of the Guidelines for the Care of People with Chronic Diseases (Brasil, 2013a) in Health Care Networks

(RAS) and priority care lines, including DM. Where they guide actions in the organization in the model RAS, in PH, specialized and hospital, and organize the work processes aimed at patients with chronic diseases. They seek transformation of the health care model, consolidation of care for people with chronic diseases, ensuring comprehensive care, positively impacting the indicators associated with the disease, avoiding its development and its complications, as well as helping to promote the health of the population.

In the case of limb amputations, one should look back at these Guidelines beyond mortality, as there is the potent burden of chronic disease-related morbidities. Thus, DM disease is considered, especially its main complication, diabetic neuropathy, as the reason for the increase in the number of hospitalizations and one of the main causes of amputations and loss of mobility (Brasil, 2013a).

The RAS of people with chronic diseases reflecting in the amputated person with DM refers to autonomy and corroborates the strengthening of the user's knowledge about their disease to expand their self-care capacity (Brasil, 2013a). It is very comprehensive, is structured in the three levels of care and is concerned with continuous care, reinforcing the need for the organization and operationalization of specific lines of care, considering the most serious problems (Brasil, 2013a).

Member amputations in 2013 are prominent among the prerogatives of the United Nations (UN) to Brazil, receiving the necessary attention regarding the Rights of People with Disability. The expansion of specialized rehabilitation centers in the country is agreed and, among the therapeutic guidelines, the pioneering Amputee Care Directive is launched, in order to expand access to orthopedic workshops and the offer of orthotics, prostheses and auxiliary means of locomotion (Brasil, 2013b).

Brazil has made progress in introducing the necessary support for the full and effective exercise of the legal capacity of persons with disabilities, seeking opportunities and achievements. It has been anchored by the Living without Limits Program, the articulation of government policies concerned with education, social inclusion, health care and accessibility (Brasil, 2013b).

Divided into four axes - Access to Education, Social Inclusion, Health Care and Accessibility - the National Plan for the Rights of People with Disabilities (Living Without Limit) ensures the construction of Specialized Rehabilitation Centers (CERs), expansion and reform of Centers already enlargement of prosthetic workshops of the CERs with qualification of the built and renovated centers (Brasil, 2013b).

Among the documents briefly presented in Table 1 and discussed, the following common guidelines were observed with the Amputee Health Care Guidelines: need for support and specialized services within the SUS, need for training of the multidisciplinary team, provision of assistive technology equipment and disease prevention, and promotion of the inclusion of the amputated person.

Challenges and Current Perspectives for Amputated Patient Rehabilitation Against National Guidelines

Discussing the challenges and current perspectives of amputated patient rehabilitation against National Guidelines is a complex task, as the health care model in place in Brazil still has its focus on curative medical care actions. This pattern is

insufficient and unsustainable given the diversity of needs of this population. Strategic actions in public health policies should aim to transform health education processes, practices and knowledge production (Brasil, 2011a).

There is a need to discuss the barriers to access to health services by the population with disabilities, which stem from the characteristics of the systems and services, such as their geographical distribution, availability and quality of human resources, accessibility for all technologies, as well as the orientation of the current technical assistance model (Brasil, 2011a).

The Amputee Health Care Guidelines emerged on the national scene due to the influence of the world scenario, highlighting in Brazil the launch of the National Plan for the Rights of People with Disabilities - Living without Limit, through Decree No. 7.612, in 2011, and then culminate in 2013 with the launch of the Specific Guidelines. Our Guidelines emphasize concern for the autonomy and quality of life of this population by encouraging team training at the early onset of disability prevention and rehabilitation actions and suggest the solidification of a multidisciplinary vision through the unique therapeutic projects for the amputated patient (Brasil, 2013a).

However, there is a need to implement the care network for people with disabilities in Brazil, making this communication between the different levels of complexity and facilitating the training of multiprofessional teams. Vargas et al. (2014) when analyzing the care network for amputees from the perspective of health professionals inserted in high complexity services reported that the great strength existing in the context of rehabilitation is the adequacy of consolidated legislation established through the RAS, in addition to multiprofessional and interinstitutional work occurred in some spaces.

One of the main weaknesses is precisely the lack of structuring of the RAS so that the reference and counter-reference, as advocated by the SUS, occurs effectively.

The promotion and prevention projects for amputations, establishing the main epidemiological etiologies such as traffic accidents and focus on DM, should be carried out and articulated by this RAS involving professionals from different levels of health care.

Undoubtedly, there are major challenges to be met before the National Guidelines can be implemented. The various obstacles that hinder a focused treatment of the amputated patient are: difficulty in early rehabilitation from the immediate postoperative period due to the lack of a multidisciplinary hospital team with training and knowledge of appropriate referrals after hospital discharge; lack of specific projects in PH to promote, prevent and follow up amputees patients; lack of qualification of the staff to attend to medium complexity, starting the rehabilitation without long waiting periods until the placement of a prosthesis in a specialized rehabilitation center; lack of multiprofessional projects for social inclusion with return to a work activity as prioritized by our Guidelines; lack of projects for inclusion in an adapted physical activity.

The answer to the question of how to make it possible for multiprofessional teams to use the Amputee Health Care Guidelines as a way to follow goes through a linear view on health. It must be understood that treatment after an amputation is long until complete readaptation and social reintegration and there is a great demand for specialized technical assistance from the various professions involved. There is a need for Family Health Strategy (ESF) involvement, Family Health Support Centers (NASF) expansion and professional training and guidance. Currently, the amputated patient

performs chaotic therapeutic itineraries without being able to perform services that may promote their functional and social independence.

Brazil has been discussing the introduction of the necessary support for the full and effective exercise of the legal capacity of persons with disabilities, aiming at opportunities and achievements. In chronological order, policies, guidelines and plans for people with disabilities emerge, in which amputees are inserted. However, it is necessary to advance in the practical implementation of these policies by offering support and specialized services within the scope of SUS, training and supply of assistive technology equipment, prevention of injuries and promotion of the inclusion of the amputees.

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