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Lower Limb Amputation Experience in Individuals with Peripheral Vascular Diseases - Systematic Review Protocol of Qualitative Data Amputation Experience in Individuals with Peripheral Vascular Diseases

Daniel Mourão[1], Luís Paiva[2], Catarina Lobão[3]

[1]Unidade de Saúde de Coimbra, Coimbra, Portugal
[2]Escola Superior de Enfermagem de Coimbra, Coimbra, Portugal
[3]Escola Superior de Enfermagem de Coimbra, Coimbra, Portugal

ORCID ID: D.M. 0009-0007-1785-364X; L.P. 0000-0001-6763-943X; C.L.0000-0002-3664-7004

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ABSTRACT

Objective: To synthesise evidence on the experiences of individuals with vascular pathology undergoing major lower limb amputation.
Materials and Methods: A systematic literature review (SLR) of qualitatively focussed evidence. Qualitative, descriptive, exploratory case studies and surveys in English, Spanish, or Portuguese from 1983 to 2022 were included, reporting experiences.
Results: Utilising Joanna Briggs Institute instruments and assumptions, 10 articles, 213 findings, 15 categories, and five synthesised discoveries resulted in an awareness of the need for amputation, change and difference, the meaning of mobility, facilitating conditions, and the level of preparation and knowledge of professionals.
Conclusion: The disease narrative prepares individuals for amputation. The decision emerges as a last resort in the experience of pain and suffering. A complex event of constant interactions between chronic illness, anticipation of amputation, changes, strategies, and relationships beyond the fear of complications, giving rise to conflicting feelings and doubts about the future.
Keywords: Peripheral arterial disease, systematic review, surgical amputation

INTRODUCTION

In a constantly changing world, human beings experience transition periods, which may lead to the development of capacities to manage or confront these changes (1). The increasing number of individuals with Peripheral Arterial Disease (PAD) subject to amputation is a concerning reality in Vascular Surgery Services. In 2015, 4539 amputations were performed in Portugal, of which 2213 were major amputations of the lower limb, and 1991 were associated with circulatory system diseases (2). Varino et al. (3) stated that PAD is the most common lower limb amputation (LLA) aetiology. It´s a potentially serious condition, associated with a high risk of cardiovascular morbidity and mortality and physical disability, being the leading cause of death in the Western world (4). According to the same document, it has a prevalence of 10%–25% in the population over 55 years old, and approximately 70%–80% of people are asymptomatic, which hinders early diagnosis and initiation of treatment in an early stage (4).

When there is a disruption in blood flow, PAD arises, with atherosclerotic disease being the main aetiology, gradually narrowing or obstructing vessels, impairing the normal flow of peripheral arteries, resulting in reduced transport of nutrients and oxygen to cellular tissues, leading to ineffective elimination of metabolic waste products. Normahani et al. (5) clarified that conditions leading to LLA in individuals with PAD include uncontrollable pain, tissue destruction due to infection, irreversible ischaemia, the existence of joint flexes, and situations of bedridden individuals unable to regain gait after revascularization.

Corresponding Author: Daniel Mourão **E-mail:** djmourao@gmail.com
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Amputation consists of separating a limb or segment of it from the body. It is classified as minor if performed below the ankle joint and major if performed above the ankle. It is a last-resort treatment in various health conditions, determining various factors conditioning individual responses to amputation: aetiology, age, type and level of amputation, time after amputation, social support, and coping strategies (6). It is a procedure that transforms a person's identity in all its dimensions, and the social implications and effects on work capacity, quality of life, and self-image are devastating (7).

Working in a service where the number of amputations is significant, the challenge arises in supporting the transition of the individual and their family to this new condition of life. This fact triggered the need to explore how amputation of vascular aetiology is experienced. With the aim of synthesising the best available evidence on the experiences of individuals with vascular pathology undergoing major amputation, no specific context was defined in the research question (8): How does an individual with vascular pathology experience major amputation of the lower limb?

MATERIALS AND METHODS

This study represents a systematic review of qualitative studies and follows the guiding protocol of JBI (8):

Inclusion and Exclusion Criteria

The inclusion criteria presented below are defined on the basis of the above-mentioned review question:

Search Strategy and Study Identification

"The search strategy identifies published and unpublished studies through a three-phase process" (8). An initial limited search was conducted in the Google search engine, followed by an analysis of the words contained in the title and abstract and the indexing terms used to describe the article. Subsequently, a second search was conducted using all identified keywords and indexing terms in all included databases. Third, the reference lists of identified reports and articles were consulted for additional studies.

The first phase of identifying scientific evidence involved defining the search terms (Table 1). To do this, the Medical Subject Headings (MeSH) Browser® and the CINAHL Subject Headings were consulted.

The first stage of study identification was conducted in January 2022 through CINAHL, MEDLINE, MedicLatina, Nursing & Allied Health Collection, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, Cochrane Methodology Register, Library, Information Science & Technology Abstracts, and Cochrane Clinical Answers, via EBSCO HOST through the Order of Nurses, JBI Evidence Synthesis, PubMed, cielo, and RNCAAP.

No time frame was defined, considering that potentially relevant, seminal, and early studies in the field could be missed (8). After identifying relevant articles for the review question, the time frame was defined as January 1, 1983, to January 31, 2022. The following table describes the search strategy of databases with identified articles.

All titles and abstracts of the identified articles were read by one researcher, who applied the inclusion/exclusion criteria. Two researchers independently evaluated the references and included abstracts, following the same guidance, by thoroughly reading the articles.

Assessment of Methodological Quality (MQ)

The studies selected for inclusion in the systematic review were subjected to rigorous MQ assessment by the researchers using the JBI (8) critical appraisal checklist for qualitative studies (Table 3).

Table 1. Inclusion Criteria

PARTICIPANTS	Qualitative studies involving adult individuals who have undergone major lower limb amputation of vascular etiology. An adult is defined as any person aged 18 years or older.
PHENOMENON OF INTEREST	Studies that report experiences of major lower limb amputation. By experience, it is understood as the "(...) process of organizing the person's relationship with their daily life, with certain life situations (...)," related to "(...) changes, significant events, that cause disagreement between consciousness and existence and that put the person in the face of the need to choose. The person who experiences is, above all, a person who makes choices (9). Studies were sought that described how the amputated person responded to their new health condition.
STUDIES	Qualitative studies (phenomenological, ethnographic, grounded theory, ethnography, and action research). Simple descriptive studies; Case studies and surveys describing experiences of amputation may also be considered; Studies with an exploratory design.

Table 2. Exclusion Criteria

PHENOMENON OF INTEREST	Studies that do not investigate experiences of major lower limb amputation of vascular etiology. Traumatic amputations are excluded.
STUDIES	Opinion articles, comments, and publications related to reader letters are excluded.

Table 3. Descriptors used in the search

	Population		Phenomenon of Interest	
Key Words	Amputated Lower limb loss	Dysvascular Peripheral arterial disease	Vivência Adaptação Experience	Perceção Coping
CINAHL Headings	Amputee Amputation	Peripheral vascular diseases	Life Experience Life purpose Coping	Adaptation and psychological perception
Mesh Terms	Amputee Amputation	Peripheral arterial disease Peripheral vascular disease	Life change events Adaptation and psychological perception	

Data Extraction

Two researchers collected a set of information about each included study, following a systematic process to ensure scientific rigour and avoid biases. In qualitative reviews, "data consist of statements and texts of interest to the researcher, as published in the primary studies" (8). Data extraction followed the JBI (8) model for extracting qualitative evidence. It included details regarding methodology, method, phenomenon of interest, geographical and cultural context, participants, data analysis, authors' conclusions, and reviewers' comments.

Table 4. Databases and search strategy

Database	Boolean Formula and Limiters
CINHAL Complete	("lower limb loss" OR (MM "Amputees ") OR (MM "Amputation ") OR "amputated") AND ("experience" OR (MM "Life Experiences") OR (MH "Life Purpose") OR (MM "Adaptation, Psychological") OR (MM "Perception") OR (MM "Coping") OR "life change events") AND ("dysvascular" OR (MH "Peripheral Vascular Diseases ") OR "peripheral arterial disease")
MedLine	(MH "Peripheral Arterial Disease") OR (MH "Peripheral Vascular Diseases") OR "dysvascular") AND ((MH "Amputees") OR (MH "Amputation") OR "amputated" OR "lower limb loss") AND ((MH "Life Change Events") OR (MH "Adaptation, Physiological") OR (MH "Perception") OR "coping" OR "life purpose" OR (MH "Value of Life") OR "life experiencie")
RCAAP	Amputação E Reabilitação E Doença Crónica
SCIELO	((Amputação) AND (Vivência OR Experiência OR adaptação)) AND (Doença arterial)
PUBMED	((Peripheral arterial disease OR Peripheral vascular disease OR Dysvascular) AND (Amputation OR Amputee OR Amputated)) AND (Coping OR Experience OR Life change events)

Table 5: Checklist for critical appraisal of a qualitative study by the JBI

Reviewer:				
Study Reference:				
Title: **Authors:**		**Yes**	**No**	**Not Clear Not applicable**
1	Is there congruence between the declared philosophical perspective and the research methodology?			
2	Is there congruence between the methodology and the research question or objectives?			
3	Is there congruence between the research methodology and the methods of data collection?			
4	Is there congruence between the research methodology and the representation and analysis of the data?			
5	Is there congruence between the research methodology and the interpretation of the results?			
6	Is there a statement that locates the investigator culturally or theoretically?			
7	Was the influence of the investigator on the research and vice versa addressed?			
8	Are the participants and their voices adequately represented?			
9	Is the research ethical according to current criteria, or is there evidence of ethical approval from a specific body?			
10	Do the conclusions resulting from the research derive from the analysis or interpretation of the data?			
Included Excluded Seek more information				
Comments: (including reasons for exclusion)				

Table 6. Operational definitions of meta-aggregatio

Finding	Textual excerpt of the author's analytical interpretation of the results or data.
Illustration	Direct quotation of a participant's voice, field observation, or other supporting data.
Category	Brief description of a key concept that emerges from the aggregation of two or more similar findings.
Synthesis of the Findings	Comprehensive description of a group of categorised findings: This refers to a detailed and inclusive explanation of a cluster of categorised discoveries. It is an explanatory statement that conveys the complete and comprehensive meaning of a group of related categories.

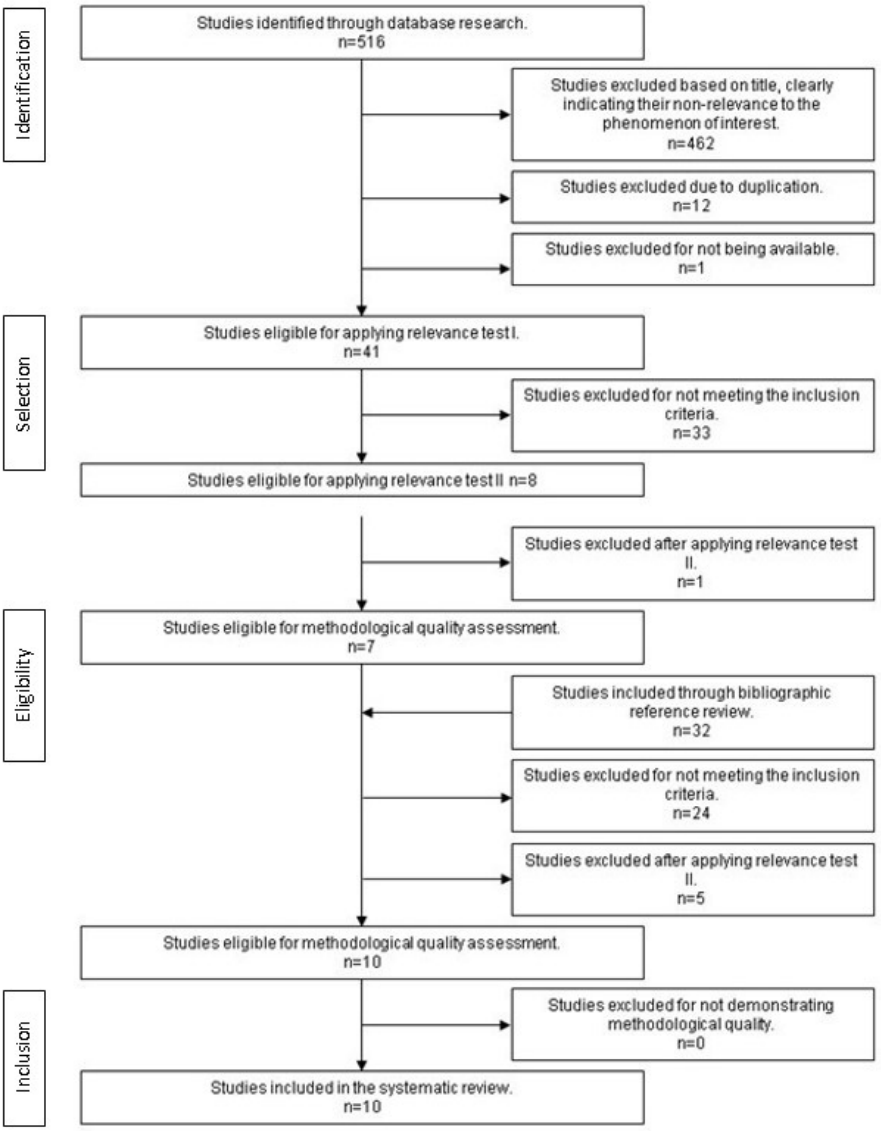

Figure 1: Flowchart of the sample selection process

Data Synthesis

Meta-synthesis is the process of combining the results of individual qualitative studies to create summary statements. It is an interpretive process that requires transparency and expertise to identify and extract results from the included studies, categorise them, and aggregate the categories into a final synthesis, constituting a statement for practise (8).

The units of analysis in qualitative studies are findings presented as themes, metaphors, or concepts identified by researchers. Operational definitions characterising meta-aggregation (Table

Table 7. Assessment of the methodological quality

Study reference	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
C1	S	S	S	S	S	NC	N	S	S	S
C2	NC	S	S	S	S	NC	S	S	S	S
C4	S	S	S	S	S	N	S	S	S	S
M2	S	S	S	S	S	S	S	S	S	S
P1	NC	S	S	S	S	N	NC	S	S	S
P2	NC	S	S	S	S	N	NC	S	S	S
R1	S	S	S	S	S	S	NC	S	S	S
RB1	NC	S	S	S	S	S	N	S	S	S
RB6	NC	S	S	S	S	N	NC	S	S	S
RB7	NC	S	S	S	S	N	NC	S	S	S
%	36%	100%	100%	100%	100%	27%	27%	100%	100%	100%

S: Yes, N: No, NC: Not clear, NA: Not applicable

4) describe the data to be synthesised and explain each stage.

For each finding, a level of credibility is established (8): "Unequivocal (I): The evidence is beyond any reasonable doubt and includes findings that are factual, directly reported/ observed, and not subject to challenge; Credible (C): The evidence, although interpretive, is plausible in light of the data and theoretical framework. Conclusions can be logically inferred from the data, but since the results are essentially interpretive, these conclusions are open to challenge; and Not

Table 8. Studies included in the Systematic Review

Author	Participants	The cultural and geographical contexts	Phenomenon of interest
C1 Washington et al. (10)	Six participants: 4 men with a mean age of 64.2 years and 2 women with a mean age of 69 years; 3 amputated above the knee and 3 amputated below the knee.	United Kingdom, Manchester.	Experience of amputation and its impact on psychological well-being.
C2 *Columbo* et al., (11)	Twenty participants with a mean age of 65 years (ranging from 45 to 88 years). Amputated between 2011 and 2015. Seventeen men and three women, 17 amputated below the knee and three above the knee.	EUA, New Hampshire	Perception of the adaptation and rehabilitation process of the amputated person.
C4 Torbjörnsson et al. (12)	Thirteen participants with major lower limb amputation, 9 men and 4 women with a mean age of 75 years, 11 amputated below the knee, and 2 above the knee.	Stockholm Suécia	Experience of amputation due to PAD.
M2 Madsen Et al. (13)	Eleven participants, eight men and three women, 3 days after unilateral lower limb amputation. Age range between 45 and 84 years. Six participants were amputated below the knee, one was amputated through the knee, and four above.	Rural areas of Denmark	Behaviour of individuals after losing a lower limb due to vascular disease.
P1 MacKay et al. (14)	Thirty-five participants, 23 men and 12 women, had amputated due to vascular disease. Age ranged from 32 to 86 years. There were 23 below-knee amputees, 5 above-knee amputees, and 7 bilateral amputees.	Toronto, Canadá	Perceptions and experiences of individuals with lower limb amputations due to vascular disease.
P2 Couture et al. (15)	Sixteen participants amputated above and below the knee. Most participants returned home after amputation, and 2 were institutionalised. Twelve participants received a prosthesis, and 10 could walk more than 30 steps with the prosthesis.	Québec, Canada	Adaptation to lower limb amputation due to vascular disease.
R1 Pereira and Gomes (16)	Ten participants with major lower limb amputation, all male, aged between 39 and 77 years. Half of the individuals were retired, two were unemployed, and three were working at the time of this illness episode.	Urban area of Portugal	Transition process of the amputated patient: intervention of the rehabilitation nurse.
RB 1 Couture et al. (17)	Sixteen participants had their knees amputated; 12 below the knee and 4 above the knee, 9 men and 7 women; the average age was 65.6 years.	Québec, Canada	Coping strategies and adaptation after an amputation.
RB 6 Suckow et al. (18)	Twenty-six participants were amputated with an average age of 64 years (ranging from 39 to 87 years), 19 men and 7 women. All patients had at least one major amputation, above or below the knee, and eight were bilateral amputees.	EUA, Utah, Salt Lake City, Dartmouth-Hitchcock, and Emory	Quality of life in individuals amputated due to vascular disease.
RB 7 Pedlow et al. (19)	Sixteen participants had lower limb amputations, five women and 11 men, aged between 29 and 82 years (average 64 years), nine above-the-knee amputations, and seven below-the-knee.	Toronto, Canada.	Information needs of individuals amputated due to vascular disease.

Table 9. Results of the meta-aggregation

Finding Example	Illustration Example	Categories	Synthesis of the Findings
They felt that amputation was effectively a choice of life over death.	*"… as it is, you live …" (C1, p.3)*	Amputate to be able to live	**Awareness of the need for amputation**
Acceptance of amputation came with the realisation that they had no choice but to get on with life.	*"… put that part of my life behind me. Just go on from there." (C1, p.4)*	Accepting the consequences of the disease	
When asked, 85% of the patients felt that intolerable ischaemic rest pain was the most appropriate threshold for having their limb amputated.	*''If I could, I would have taken an axe and chopped off my leg sooner just to remove the pain" (RB6, p.726)*	Amputating to relieve pain	
Having a leg amputated was perceived as a life-changing event to which participants had to adjust.	*"My life has changed dramatically with this operation".* (M2, p.6)	Perception of change	**Change and difference**
O facto de se verem com a imagem corporal alterada leva-os a sentirem-se diferentes das outras pessoas e a vivenciarem o estigma da deficiência	*"Ser different dos outrows. Só vejo uma pessoa normal e eu já não sou." (R1, p.77);*	Mirror reflection	
Once at home (T3), people apparently preferred to keep their feelings hidden from others and refused to think about the amputation.	*"I'd rather not think about the amputation. (...) It makes me angry. I'm ready to blow up at any time."; (RB1, p.5)*	The whirlwind of feelings and emotions	
(…) three additional coping strategies associated with the amputation experience were identified in the qualitative data analysis: noticing progress, learning new things, and using humour.	*"From one day to the next, I notice I can do a lot more and that helps me a lot.";* *"I try to find the funny side of the situation instead of always being disappointed." (RB1, p4)*	Coping strategies	
However, a number noted that undergoing an amputation affected friendships.	*"… You determine who your real friends are … since I was in the hospital, I have hardly heard from him at all" C1, (p.5).*	Changes in relationships with others	**Facilitating conditions**
Limited finances were identified as a key challenge for some participants. These participants indicated that a lack of financial resources impacted their social opportunities and required them to make difficult choices.	"it does leave me as an amputee without a job and of course, since I wasn't really planning on going that path, it meant that there was no build-up of cash reserve, so we now live well below the poverty line".(P1, p.5)	Good economic conditions facilitate	
Social and emotional support from family members and friends was uniformly described as "helpful."	*"My wife of 37 years, having somebody to support you help. [She was] always there to support me. If somebodys going to have an amputation, God, I hope they have somebody like my wife";(C2, 266)*	The support network supports overcoming.	
They described how the accessibility of their homes could enable their activities of daily living or act as a barrier to their mobility and independence.	*"Because of the way the bathroom is set up, I can't take a shower anymore. So it's a sponge bath every morning." (P1, p.5)*	Accessibility and access to technical aids facilitate	**Meaning of mobility**
To be able to learn to use a prosthesis meant a lot to the patients. It was not just a tool for learning to walk again; it was a symbol of normality.	*"I became almost normal, I am the person I am. I had never been in a wheelchair before, and now I can suddenly stand up again."* (C4, p.61).	Wearing a prosthesis returns to normalcy	
First, most participants (…) felt that mobility, or the lack thereof, had the greatest impact on their Quality of life.	*''It is always a problem. stairs, doorways, getting around.'';* *''You can't stop or start like you used to. People cut you off, bump into, crowd you"; (RB6, 727)*	Mobility is independence	
Participants indicated that providing this information would have prepared them for what they would be facing and helped them with the coping process.	*"What lies ahead or what you may be going through at that point from a hospital perspective before you go into rehab. If you must stay half of your amputation through the three weeks inside St. Michael's, you should be well-prepared for what to expect after the amputation. Not just go into rehab and expect someone to tell you when you've been dealing with the situation for almost a month now (RB7, p.92).*	Lack of preparation of professionals to prepare	**Level of preparation and knowledge of professionals**
Ao enfermeiro cabe a difícil tarefa de percecionar não só os significados, mas todas as condições pessoais da pessoa de forma a poder orientá-la no sentido favorável da transição, sem qualquer juízo de valor	*"… este internamento tem sido de forte recuperação do meu relacionamento com a minha mulher e a confirmação de que esta casa tem profissionais de todo o tamanho, … parecem que foram feitos para isto … o meu sentimento mais forte é ter força para que o esforço que vocês profissionais têm feito resulte naquilo que vocês querem." (R1, p.96)*	The professionals	

Supported (NS): the findings are not supported by the data and none of the other level descriptors apply."

All data related to the research question, including author observations, were considered findings in the 10 articles. Findings were identified through repeated readings of the texts.

RESULTS

The flowchart presented below (Figure 1) explains the entire process leading to the final number of articles included in the systematic literature review.

The results of the MQ assessment (Table 5) indicate that the congruence between philosophical perspective and research methodology is not clear in most studies. Only three studies provide a statement that culturally and theoretically situates the researcher. The authors, for the most part, do not address their potential influence on the research. These findings are consistent with those found in other qualitative systematic reviews conducted by the investigator.

The 10 studies all met the other inclusion criteria, and the reviewers considered them to have moderate methodological quality and agreed on their inclusion in the systematic review (Table 6).

The reviewer created category descriptions after extracting 213 findings and illustrations from the ten articles, which were discussed with the second reviewer, categorising the findings based on the similarity of meaning. These categories were subjected to synthesis, to produce a single comprehensive set of synthesised findings (Table 7), which can be used as a basis for evidence-based practise (8).

Awareness of the need for amputation: Intense pain in individuals with vascular disease predicts the possibility of amputation, being considered the decisive factor for accepting the procedure, considering its repercussions on mobility and consequently on daily activities. The decision to amputate arises as a consequence of the individual's behaviours and the progression of their disease, presenting itself as the only solution to relieve pain and suffering, but mainly to save their life, facilitating the acceptance of amputation.

Change and difference: Major lower limb amputation is a disruptive event that involves a change in the person's way of being and existing in all dimensions. The feeling of sadness is pervasive in the discourse of the amputated individual throughout the process, contrasting with the feeling of satisfaction from pain and suffering relief. The improvement or lack thereof in health condition is crucial in stimulating positive feelings. Perception of the new body image is the first sign of identity change after amputation. The stigma of disability is manifested as something that hinders them from living life in the same way, leading the amputated individual to feel different and to feel that others see them differently. Maintaining productive work and maintaining pre-amputation status is structuring for the reconstruction of identity.

Facilitating conditions: Social support, especially emotional support from family and friends are recognised by amputated individuals as essential for overcoming difficulties. Lack of technical aids and accessibility at home and in the community are barriers to the mobility and independence of the amputated person, often resulting in the abandonment of activities and/or social interactions. Lack of economic resources is one of the difficulties in coping with the additional costs associated with their new condition (travel, adaptation of physical space, equipment, assistance for activities beyond their reach). Whether facilitator or inhibitor, it is the knowledge that the individual has and how they optimise community resources and services.

Meaning of mobility: The use of a prosthesis is not just a means to walk again, but rather a symbol of normality. Mobility and functionality are intrinsically linked to the quality of life of the amputated patient.

Level of preparation and knowledge of professionals: Studies show that amputees would like to have structured information about the entire process to better prepare them for what they would face. The nurse should seek to understand personal conditions (meanings, beliefs, attitudes, socioeconomic status, level of preparation) to guide them towards a healthy transition. Some studies indicate that the message from healthcare professionals is not always well perceived and/or their availability is not as desired. They point out that throughout the learning process, there is often not enough time for individuals to express their concerns. Thus, professional interaction focuses on practical aspects, and professional assistance is directed towards self-care in its instrumental aspect.

In the context of this systematic review, a narrative summary of the synthesis of findings was chosen (Figure 2). This narrative synthesis depends on the researcher's response to the research question and epistemological position, aiming to lead to a synthesis grounded in the philosophy of the qualitative paradigm.

DISCUSSION

Transition is a personal process involving definitions and redefinitions of the self and the situation. For a person to truly be in transition, it is essential that they are aware of the changes occurring. Otherwise, it is necessary to help them perceive these changes before facilitating the transition process (1).

Most individuals had a fearful reaction upon receiving the news of limb amputation, thinking they would lose the integrity of their body and their former self. The same authors explain that individuals who have the possibility to decide on amputation, such as those with vascular pathology, begin their grieving process upon making the decision (20).

Response patterns emerge from observable and unobservable behaviours during the transition process, which, despite appearing disrupted or dysfunctional, are not random events. These behaviours encompass patterns that reflect both

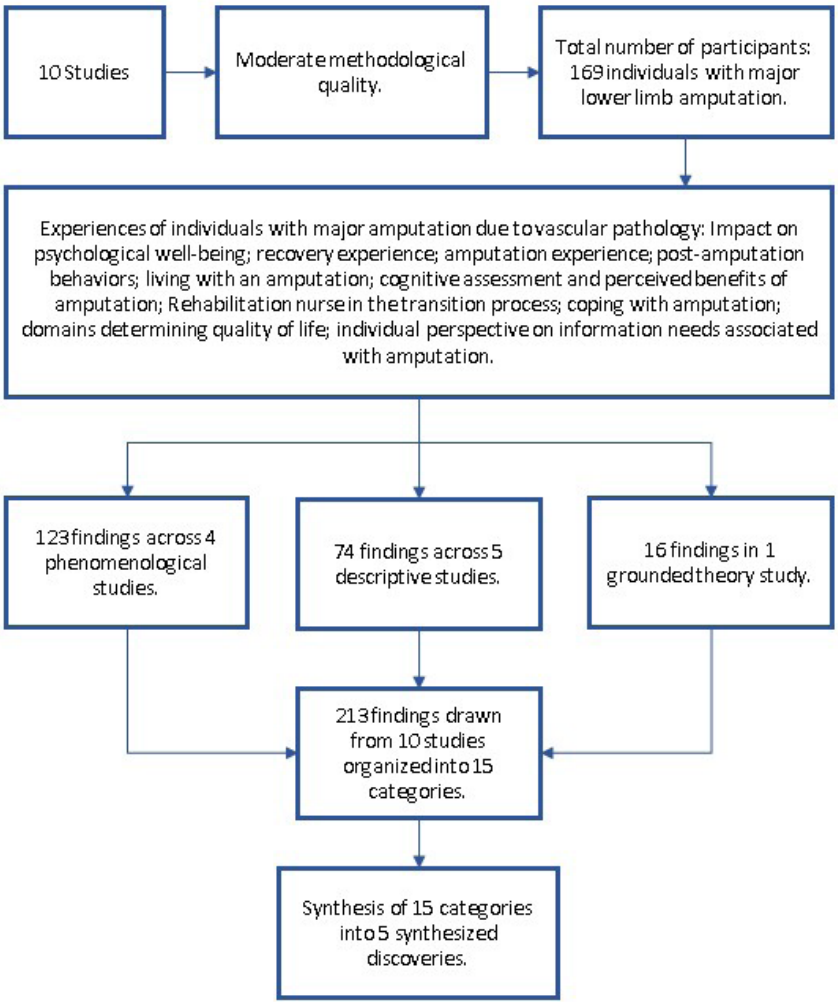

Figure 2: Meta-aggregation of the qualitative study adapted from JBI

intrapsychic structures and processes and changes in the sociocultural context. Examples include disorientation, distress, and possibly euphoria and happiness (1).

After amputation, individuals feel satisfaction and happiness because of the improvement in their quality of life, enabling them to overlook physical difficulties. Negative feelings are associated with social factors, physical changes, and persistent pain after amputation (21). Amputees may even experience feelings of abandonment, disappointment, and loneliness related to how they perceive themselves and how others perceive them (22).

Perhaps the most widespread characteristic of transition is the disconnection associated with the rupture of bonds on which a person's feelings of security depend (1). Lindheim and Syme (23), in their study of factors influencing health, identify "the importance (...) of being connected (...)" as a common element. These connexions are not passive but require active engagement among people and the environment.

In response to the loss of independence, individuals develop coping strategies to adjust to their new condition, emphasising positive thinking, humour, and nurturing hope for brighter days. Belon and Vigoda (20) advocated that amputees learn coping strategies primarily from cognitive-behavioural therapies and mindfulness to effectively manage the psychological changes associated with amputation.

Amoah et al. (21) stated that social support is also crucial for supporting the transition of the amputee, particularly from family, providing emotional and financial support and aiding in adaptation and performance of daily life activities. In addition, Reichmann and Bartman (24) stated that it is comforting for the individual initiating this process of amputation to have someone in the same condition accompany and advise them.

Transitions can be influenced by personal factors such as cultural beliefs, attitudes, socioeconomic status, preparation, and knowledge, as well as by community and social conditions. Understanding these factors is crucial for professional

intervention to facilitate a healthy transition (1). Ligthelm and Wright (25) emphasise the role of the healthcare team in physical and functional recovery, but note that professional support may not fully address the emotional and existential needs of amputees.

The experiences of transition can carry positive, neutral, or negative meanings. Whether desired or not and stemming from personal choice, understanding a transition's significance for the individual is crucial for grasping their experience and its health implications (1). Dunne et al. (26) highlighted that the ability to use prosthetics holds significant personal meaning for amputees, fostering dedication, motivation, and engagement in the pursuit of independence and the semblance of normalcy. Foster & Lauver (27), Virani et al. (28), and Amoah et al. (21) mention that lack of mobility hinders the performance of daily life activities, including household and professional tasks, potentially leading them to quit their jobs.

Meleis (1) underscores the significance of nurses comprehending the transition process from the individual's perspective, integrating the meanings ascribed by the individuals themselves, while also highlighting that uncertainty is closely intertwined with the necessity for acquiring new knowledge and fostering new skills to address the demands brought about by the new health condition.

Rassin et al. (29) stated that some individuals had doubts about the amputation process due to a lack of information from the healthcare team. According to Meleis (1), preparation or education is the nursing therapy of choice to create conditions for confronting a transition. Sufficient time is needed to assume new responsibilities and develop new skills for it to be effective.

Limitations

The need for multiple English terms to translate the concept of "experience" may have constrained this research.The studies' inclusion criteria eliminated some potentially relevant articles, but they were not clear on the level and aetiology of amputation.

CONCLUSIONS

This review illustrates the vulnerability of individuals with vascular pathology, an already fragile condition whose disease narrative leads to limb amputation. This decision arises as a last resort in an experience marked by intense pain and suffering.

Thus, concerning the synthesis of findings, we recommend: Understanding personal conditions (meanings, beliefs, attitudes, socioeconomic status, level of preparedness), as well as whether the individual perceives the severity of the disease and the need for amputation; promoting contact with family and amputees; preparing the individual for surgery, allowing time to express their concerns, including information about: surgery; post-surgery; recovery; discharge planning; family involvement in the care process; and safety and well-being precautions; assisting in restoring body image and promoting self-esteem; and redefining negative meanings attributed by the individual to their condition; promoting the development of coping strategies; and assisting in the transition from hospital to home.

Greater knowledge is needed regarding the developmental, functional, and structural reorganisation of the family of an individual with vascular disease who undergoes major amputation. Similarly, more primary studies describing the transition process of individuals with vascular pathology undergoing major amputation, from awareness to mastery, will be necessary.

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