Supplementary data

Amputation codes
Primary major amputations

Above-knee amputation
Hip disarticulation	KNFQ09
Transfemoral amputation	KNFQ19
Other amputation on the femur/hip	KNFQ99

Below-knee amputation
Knee disarticulation	KNGQ09
Transtibial amputation	KNGQ19
Other amputation on knee/tibia	KNGQ99

Revision codes
Stump revision knee/lower leg	KNGQ29
Stump revision after knee disarticulation	KNGQ29A
Stump revision after transtibial amputation	KNGQ29B
Stump revision hip/tight	KNFQ29
Stump revision after hip disarticulation	KNFQ29A
Stump revision after transfemoral amputation	KNFQ29B

Prior minor amputation is defined as 1 or more registered procedures before index surgery with procedure code KNHQ* despite TUL codes.

Minor amputations
Foot amputation	KNHQ00, KNHQ10–18, KNHQ99
Toe amputation	KNHQ02-07, KNHQ14

Osseointegration codes are excluded: KNGQ39, KNGQ49 KNFQ39, KNFQ49.

A case is excluded in the case of a revision code without a prior primary amputation code.

KNGQ99/KNFQ99 are grouped as transfemoral amputation (KNFQ19) or transtibial amputation (KNGQ19), respectively.

Logical consistency in procedures
- If TFA is conducted before a TTA on the same site (both with same TUL*), this is considered an error, and the case is excluded.
- If the same primary amputation code is registered several times on the same site (e.g. TFA day 1, TFA day 50, same site), the second procedure is interpreted as a revision on same level.
- Unspecific procedure: If KNFQ99/KNGQ99 is index, it is interpreted as a TFA/TTA respectively. If it is after index, it is interpreted as a revision.
- If a revision procedure is coded to a higher level, e.g., index KNGQ19 followed by revision with code KNFQ29, the end level is considered at femoral level.

Sarcoma exclusion criteria
A case is excluded if a sarcoma diagnosis (DC40*, DC41* or DC49*) was registered ±1 year from index surgery.

Prior revascularization procedure
Prior revascularization procedure is defined as 1 or more registered revascularization procedures before index: KPDA*, KPDC*, KPDE*, KPDF*, KPDH*, KPDN*, KPDP*, KPDQ*, KPDT10, KPDT30, KPDU70, KPDU74, KPDU82-84, KPDU87, KPDU99, KPEA*, KPEC*, KPEE*, KPEF*, KPEH*, KPEN*, KPEP*, KPEQ* KPET*, KPEU74, KPEU82-84, KPEU87, KPEU99, KPFE*, KPFH*, KPFN*, KPFP*, KPFT*, KPFQ*, KPFU74, KPFU82-84, KPFU87, KPFU99, KPGH*, KPGU74, KPGU83-84, KPGU87, KPGU99, KPGW99.

Definition for diagnoses, ICD10
Diabetes
A patient is categorized with diabetes if 1 of the following ICD10 codes is registered: E10*, E11*, E13*, E14* or the patient has redeemed 2 or more anti-diabetic medicine prescriptions in the same ATC group with the following ATC codes 5 years before the index date: A10A (insulins and analogs) A10B (blood glucose lowering drugs, excluding insulins), A10X (other drugs used in diabetes).

Hypertension
A patient is categorized with hypertension if 1 of the following ICD10 codes I10*–I15* is registered or the patient has redeemed 2 or more prescriptions in the same ATC group 5 years before the index date: antihypertensives (C02–C03, C07–C09).

Dyslipidemia
A patient is categorized with dyslipidemia if the ICD10-code E78 is registered, or the patient has redeemed 2 or more prescriptions in the same ATC group 5 years before the index date: C10.

Cardiovascular disease (CVD)
A patient is categorized with CVD if 1 of the following ICD10 codes is registered: I20–I25* (angina, myocardial infarction, and ischemic coronary disease), I50* (incompensatio cordis), I63–I67 (cerebral infarction, occlusion of vertebral and cerebral arteries), or G45–G46 (transient ischemic attack, TCI).

Renal insufficiency
A patient is categorized with renal insufficiency if 1 of the following ICD10 codes is registered: N18* (chronic kidney disease) or N19* (unspecified kidney failure).

Atherosclerosis/PAD
Atherosclerosis/peripheral arterial disease (PAD) is defined as one or more of the following ICD10 codes: I70, I702, I709, I739A, I739C, or I743.