CASE STORY - Physiotherapy

Flexibility in the management of secondary lymphoedema in a palliative context.

This case story describes a 55 year old woman, Mrs. C, with lung cancer who presented with complications of her advanced disease, including extensive oedema of her right upper limb. Previous treatment had included surgery and radiotherapy, and also chemotherapy, which was continuing. Mrs. C was now experiencing the consequences of advanced disease with obstruction to the apex of her right lung and extensive bone metastases. A pathological fracture of her right neck of humerus, with an axillary vein thrombosis at the site of the fracture and a further thrombosis in the right sub-clavian vein, had been recently diagnosed.

On presentation, Mrs. C’s right arm was generating significant pain. Very limited assisted movement was available at the shoulder, elbow, wrist and fingers. She had significant pitting oedema from the mid upper arm down to the fingers. The oedema extended to Mrs. C’s right breast. The skin of her arm and hand was intact, but was taut and shiny, and there was peripheral neuropathy involving her fingers. Mrs. C was short of breath at rest and had a persistent cough with haemoptosis. Mrs. C expressed high levels of distress with respect to both her pain and to the condition and physical appearance of her arm.

Treatment

In consultation with supervising medical staff, risks associated with treatment in respect to the thromboses were considered, as treatment of lymphoedema, especially compression, can be considered a contraindication where thrombosis is present. Given her medical status and the significant distress she was experiencing, her medical team agreed that treatment for the oedema would proceed.

In the initial phase of treatment, manual lymphatic drainage (MLD) techniques were applied to left chest, right upper arm, right breast and whole arm to fingers. A two layer bandaging system was used. This involved gauze bandage which were applied to fingers, thumb and dorsum of the hand. A soft underliner (Samma Frottee™) was applied from MCP (Metacarpophalangeal) joints to axilla against the skin and then single layer short stretch bandaging (Comprilan™) overlapping by 50%, to the whole arm and hand from MCP joints to axilla. Lymphtaping was used on the posterior trunk to contralateral axilla and on the lateral trunk to the ipsilateral groin to aid trunk lymphatic drainage.

Daily compression bandaging treatment and MLD was provided to Mrs. C. Family members were educated and participated with bandaging and were taught simple lymphatic drainage (SLD). After ten days of treatment, following reduction of oedema, a FarrowWrap™ Light adjustable armpiece was successfully introduced to replace the daily bandaging. A Pertex Light™ glove was used, interchanging with the gauze bandages, dependent on Mrs. C’s tolerance.

Subsequent treatments were adjusted to changing circumstances in the face of Mrs. C’s general deteriorating condition. Mrs. C’s family continued with daily SLD and compression, with regular support from the therapist.
Discussion

Despite some potential contraindications to treatment, lymphoedema management was successfully undertaken. Of particular concern at the commencement of treatment was the presence of the thromboses, and the potential for these to be a contraindication to treatment (ILF 2010). The treating team and family agreed that the benefits of oedema management, especially for Mrs. C’s psychological wellbeing, outweighed possible risks at this stage of life.

Treatment resulted in a dramatic reduction in the oedema of Mrs. C’s arm, which was then maintained with adjustable “wrap style” compression. There was a concurrent significant reduction in the levels of pain and the emotional distress associated with her oedematous limb. The therapist involvement continued until end of life. Responsiveness and sensitivity to Mrs. C’s physical, emotional and psychosocial needs and maintaining continuity of care towards end of life were important therapist considerations. Reducing the pain and disability from the pathological fracture and the extensive oedema had significant quality of life benefits. Mrs. C’s experience of distress and disturbance by the look and implication of her swollen arm/breast and the extent of her disfigurement were significant. In addition, the fact that she was now able to wear her normal clothes, afforded Mrs. C her personal dignity when engaging with friends and family near end of life.

Conclusion

This case story outlines the challenges of supporting a client with refractory disease. Guided by the principles of palliative care, the lymphoedema therapist can contribute to the quality of life of the palliative client where oedema is a significant issue for the client.

Maintaining quality of life and minimising the psychological and physical impact was a major focus of care for Mrs. C. The benefit of oedema management described in this case story demonstrates that, by prioritising the goal of reducing the client’s distress and discomfort and resulting disability, the client was able to be as comfortable as possible in the final phase of her terminal condition, with her human dignity always respected.

The presentation of complex lymphoedema in the palliative context requires an approach which is first and foremost responsive to the immediate and prioritised needs of the client. This approach may require modifications of the guidelines for lymphoedema management (International Lymphoedema Framework 2010), as well as flexibility in the provision of treatment. Clinical integrity in the context of palliative care includes opportunity for the best available treatment and care as their health care needs change (NHMRC 2011). Primary concerns include the client’s quality of life and psychosocial and emotional needs.

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References


National Health and Medical Research Council (NHMRC). An ethical framework for integrating palliative care principles into the management of advanced chronic or terminal conditions (599kb pdf). Canberra: NHMRC; 2011 Sep.