Lymphedema: Still a Problem Without an Answer

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It is ironic that we were asked to comment on the article by Dr. McLaughlin in this issue of ONCOLOGY. A few months ago, one of us (LKJ) was attending a patient in the breast clinic who had recovered well from a lumpectomy with sentinel node biopsy followed by completion axillary lymph node dissection (ALND).

It is ironic that we were asked to comment on the article by Dr. McLaughlin in this issue of ONCOLOGY. A few months ago, one of us (LKJ) was attending a patient in the breast clinic who had recovered well from a lumpectomy with sentinel node biopsy followed by completion axillary lymph node dissection (ALND). She handed me an educational packet for me, my fellow, and the support staff. She was extremely appreciative of her surgical and medical care, but she had one complaint. She had developed lymphedema after her ALND. She sought the appropriate therapy approximately 4 months after the start of swelling in her upper extremity and with the aid of compression garments had significant symptomatic improvement in a matter of a few weeks, improving her functional status and quality of life. She became her own advocate and made several copies of the literature she had reviewed, to distribute to all of her providers. This patient identified a need for heightened awareness of this complication.

Early detection of breast cancer at a “curable” stage, combined with remarkable advancements in multidisciplinary care, has resulted in a precipitous rise in the number of survivors. The increased number of women living with the long-term effects of breast cancer treatment is a driving force in the development of survivorship clinics. Lymphedema, the most significant complication of surgical therapy, will be a prominent focus in those clinics. With early diagnosis and therefore fewer axillary node dissections, we may see this complication less frequently than we did in the days of the radical mastectomy. Despite the less aggressive surgical approach of sentinel lymph node biopsy now commonly taken, there is still a risk of lymphedema; the article by Dr. McLaughlin quotes an incidence of up to 7%. For all patients who develop lymphedema, it is a complication that has a significant impact on their quality of life. Much of the challenge in managing lymphedema is the inconsistency in diagnostic standards. If it is impossible to reach a consensus on diagnosis, it is also impossible to reach consensus on treatment recommendations. In Dr. McLaughlin’s article, the incidence is quoted as being between 6% and 70%. Our lack of understanding of the disease results in this tremendous variability and indicates that we are likely grossly underestimating the incidence in our practices. The diagnostic method known to most of us clinically is the inter-arm circumference discrepancy, in which the arm is measured every 4 cm from the wrist to the shoulder. A 2-cm difference between the arms has been adopted as diagnostic of lymphedema. However, this does not account for women with earlier stages of lymphedema who might not have progressed to this degree of swelling yet or who have intermittent swelling. This 2-cm cutoff certainly helps to confirm lymphedema but it should not rule out lymphedema if it is clinically suspected.

As physicians caring for breast cancer patients, can we recite the staging system of lymphedema as readily as the staging system of breast cancer? Do we recognize that symptoms such as pain, aching, or tightness in the extremity may precede the actual onset of the swelling? There must be heightened awareness of lymphedema signs and symptoms in order for the appropriate action to be taken. Careful physical examination may reveal subtle changes in the extremity without gross swelling. Lymphedema may also affect areas other than the extremity, including the chest wall or truncal area and breast. When initiated in the early stages of lymphedema, treatment is most successful and results in better long-term outcomes. That leads to the next question: What are the appropriate therapeutic interventions? Unfortunately, lymphedema specialists are not widely available and compression garments are not always covered by insurance companies. These are areas that will have to be addressed in survivorship clinics. The lack of progress in lymphedema research and treatment can be attributed to the lack of standard diagnostic criteria, limited awareness of and evaluation for lymphedema in follow-up visits, and findings that can be subtle.
Educating patients about risk and management without clear evidence-based data is a significant obstacle to improving treatment. For example, resistance exercise, which is now deemed beneficial, was previously believed to increase the risk of lymphedema, so patients were routinely cautioned to restrict these activities. With the trend toward personalized care, we have been able to select some populations of patients that can be spared aggressive surgical approaches in the axilla, but we are still limited in our ability to inform patients about risks and treatments of lymphedema. The next steps to improved lymphedema management will involve awareness, education, and research. We compliment Dr. McLaughlin on having the insight to shed light on this topic. It is likely that, as we continue to develop survivorship clinics, we will hear more about lymphedema in our practices. As Dr. McLaughlin poignantly stated in her article, “as long as axillary surgery and radiation remain pillars of breast cancer treatment, lymphedema will remain a potential complication.”


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