

The 2015 National Conference highlights

Inspiring lives through education, research and partnerships



Thank you to Sandra Macdonald, Casi Shay and Wendy Leroux, certified lymphedema therapists and members of the Canadian Lymphedema Framework Education Working Group, for their contributions and collaboration on this conference review.

The 2015 National Lymphedema Conference welcomed 290 doctors, researchers, therapists, exhibitors, patients and advocates to the Coast Plaza Hotel and Conference Centre in Calgary, Alberta, October 23–24, 2015. The event was co-hosted by the Canadian Lymphedema Framework (CLF) and the Alberta Lymphedema Association (ALA) in collaboration with the University of Calgary. Participant evaluation results showed that 85 per cent of the respondents rated the conference either excellent or very good and 96 per cent thought the conference was a worthwhile investment of their time and money.

This year's conference continued the CLF's themes of education, research and partnerships and featured a variety of plenary sessions that welcomed guest speakers from the UK, USA, Israel and Canada. Concurrent sessions were geared to various streams of learning from the newly diagnosed patient to the seasoned therapist, as well as having a physician's only workshop. In the exhibit hall there were 24 booths; featuring regional clinics that provide CDT as well as vendors of lymphedema specific aids. These companies continue to support the ongoing development of products for the lymphedema community and it was great to see the variety of products available.

FRIDAY – DAY ONE

The opening plenary focused on looking at lymphedema from an international perspective. In the first two days post-earthquake (January 12, 2010), **Dr. John Macdonald** established the wound care program in the University of Miami, Project Medishare, Haitian Relief Tent Hospital in Port-au-Prince. He is, at this time, the Medical Director of the Wound and Lymphedema Program now located at the hospital Bernard Mevs in Port-au-Prince, Haiti. Dr. Macdonald spoke passionately of his work in Haiti.

In Canada, lymphedema is most often recognized and diagnosed after cancer treatment or as a primary condition. However, the greatest cause of lymphedema worldwide is a mosquito carrier, causing lymphatic filariasis. Seven countries in the western hemisphere have the parasite, Haiti being one. Haiti has a population of 10.5 million people and fewer than 2,000 hospital beds. There is a 99 per cent risk of exposure to these mosquitos with 10 per cent of the population being infected. Filariasis causes damage to the lymphatic vessels and results in severe lymphedema, disfigurement, pain, severe disability and social stigma.

Project Medishare is working on distributing medication to kill the filarial

worm and is advocating novel approaches such as the use of DEC fortified salt to limit infections and reduce the incidence of lymphedema. Working in countries like Haiti, Dr. MacDonald's organization is constantly challenged with the need for supplies, equipment and getting compression for these patients. While there is no cure, the condition can be managed with proper resources. His last sobering thought was that even if they eradicate the disease by distributing medication, the current patients will still be around for many years and will need lymphedema therapists.

Dr. Christine Moffatt, Professor of Clinical Nursing Research at the University of Nottingham School of Nursing, questioned how big the problem of lymphedema is. While lymphatic filariasis is the challenge in some places, cancer related lymphedemas are more prevalent in others, and venous disorders present the condition as well. Different clinicians, organizations or countries may define lymphedema differently and use various methodologies for diagnosis, making it difficult to gather and compare information. She spoke of the need for common definitions, methods of measuring, and classifications.

Dr. Moffatt called lymphedema the silent epidemic. Working in the UK, 70 per cent of the patients that she sees have never been diagnosed with lymphedema. Chronic edema



cases are on the rise with demographic changes of an increased elderly population; increased obesity rates and related mobility challenges; and more patients surviving cancer. Hence the LIMPRINT project—to develop a method to describe and validate lymphedema internationally, to merge data so there are definable numbers that will be taken seriously thus changing the myth of lymphedema being rare and creating a drive for better understanding.

The Research Snapshots session covered a number of topics; one being that patients with a history of cellulitis were identified as being at a heightened risk for lymphedema and patients with lymphedema being at greater risk for cellulitis. There was discussion on the use of subcutaneous needle drainage to decrease lymphedema. This could be used in cases of

advanced disease or palliative care where significant edemas may arise and where symptom control and improving quality of life measures are a priority. In a presentation that highlighted impaired antigen delivery during edema, it was stated that the presence of inflammation can suppress lymph vessel contraction. At the same time chronic edemas lead to inflammation, affecting antigen delivery and efficiency of the immune system.

Meanwhile, at the pool, **Dorit Tidhar**, a physiotherapist from Israel conducted an Aqua Lymphatic Therapy demonstration for health professionals that demonstrated the effects of water pressure with movement and exercise together to decrease limb volumes. The ALA Advocacy to Alberta Health Services (AHS) Action session reviewed the history of lymphedema services in Alberta. The

meeting was hosted by **Diane Martin** of the Alberta Lymphedema Association, **Dr. Margie McNeely** of the Faculty of Rehabilitation, **Heather Watt**, an occupational therapist at Community Rehabilitation Interdisciplinary Service (CRIS) and **Lisa Warner** at Alberta Health Services. The first AHS lymphedema clinic was established in Edmonton, followed by another in southern Alberta. However, these clinics only served patients with cancer related lymphedema. It was the goal of the ALA to have all lymphedema patients treated and their health services paid. Eventually, CRIS in Edmonton and the Calgary Ambulatory Lymphedema Service for non-cancer related lymphedema was established. This session described how the stakeholders advocated for the funding and worked together to make the implementation of lymphedema services in Alberta a reality.

Later in the day, **Dr. Moffatt's** workshop was an open discussion session whereby she presented some of her cases and asked how we might proceed with a treatment.



Dorit Tidhar and Dr. Christine Moffatt.

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She emphasized that we should not rush into treatment with CDT as there may be other medical reasons for edema that require caution or medical management. This was a very useful session as most therapists are not doctors. Dr. Moffatt provided the participants with possible medical tests that could be requested from the patient's physician to rule out other causes of chronic edema.

Friday evening allowed an opportunity to socialize, network with other professionals and look at the 20 poster presentations that showcased the work of therapists across the country. Many addressed individual cases that describe the challenges of managing patients with complicated lymphedema. One poster assessed the success of an eight-week training of self-care skills based on CDT to patients at Princess Margaret's Hospital in Toronto, Ontario. Others described treating lymphedema in hospital settings in Windsor, Ontario and Montreal, Quebec. There was also a poster that described using elastic taping or kinesiotape as a tool to aid in lymphedema care, and another that discussed the potential of flavonoids as a novel treatment. The University of Calgary presented some detailed lymph physiology in their presentation; looking at inhibition of lymph pumping mechanisms and of looking lymphatic changes with inflammatory processes in the gastrointestinal tract and Crohn's Disease.

Dr. Anna Towers and Dr. David Keast also led a Physicians Only workshop for



Dr. Anna Towers.

local doctors wanting to learn about the basic pathophysiology of lymphedema, the importance of early diagnosis and current treatments as per international guidelines.

SATURDAY – DAY TWO

The second day of the conference opened with Dr. Pierre-Yves von der Weid PhD, Associate Professor at the Department of Physiology and Pharmacology, University of Calgary presenting an interesting review of the lymphatic system. He emphasized its role in the transport of fat and fluid and the modulation of the immune system. He also stressed the role of obesity and antigen exposure in inflammation and the decrease in the efficacy of the lymphatic pump. His research group is presently studying lymphatic dysfunction and the measuring of the effects of some chemical agents in altering the action of the lymphatic pump. Some of the long-term goals of the research are to translate research findings into clinical practice, and to find improved imaging techniques for better diagnostics to ultimately improve treatment for lymphedema. Dr. von der Weid has helped found the Alberta Lymphedema Network, ALNET that brings together scientists and clinicians interested to promote lymphatic and lymphedema research in Alberta.

As noted earlier, it has been established that having standardized measurement tools may help improve the collection of lymphedema data. Dr. Margie McNeely guided participants in hands-on experience

“What an amazing conference. Thank you for the opportunity to network and learn so much new information”. It was an inspiration to better manage my lymphedema”.

using bioimpedance and perometry. Both measurement technologies are time saving in clinical practice and reproducible measurements for consistency. Both can also detect early changes in limbs at risk for lymphedema. Bioimpedance measures changes in the extracellular fluid in the patients' lymphedematous limb. While it has shown reliable results in early detection of breast cancer related lymphedema it is not as reliable in advanced, fibrotic lymphedema. Bioimpedance is a class two medical device and, in Canada, is only being used in research for lymphedema measurement.

Perometry on the other hand measures limb volumes using an infrared optical electronic scanner. It allows the therapist to select certain zones of measurement within the limb as well as the full limb volume. This is useful to detect early lymphedema or to monitor certain areas of the affected limb. Perimeters are classified as a class one medical device and are approved for clinical use in Canada. While the use of perometry or bioimpedance is still not feasible for many clinics, it would be a helpful addition to ensure consistent measurement in lymphedema care.



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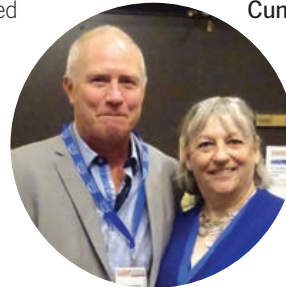
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Dr. John Macdonald's second day presentation focused on the relationship between wounds and lymphedema. Dr. Macdonald is a great advocate for short stretch compression and the recognition of simple wound care management practices. His experiences in Haiti and in Ghana have shown that these can make a difference. He expressed that the edema around wounds is often lymphedema which when untreated slows wound healing. Short stretch bandages use a low resting pressure vs. a higher working pressure and assist the muscle pump. He advocates that the principles of; cleaning a wound, protecting it from trauma, promoting a clean base, maintaining a moist environment and containing peri-wound edema using compression, are key to healing wounds more quickly. Dr. Macdonald emphasized the vital role of lymphedema therapists and how our application of compression therapy is of utmost importance in his perspective in treating patients with wounds, lymphedema, cellulitis and diabetes. "Little compression is better than no compression."

In her session, Exercise: debunking the myths, **Dr. Kristin Campbell**, Associate Professor at the Department of Physical Therapy at UBC reviewed the many studies that look at how exercise programs affect the incidence of lymphedema. She discussed numerous studies and concluded that individuals with secondary lymphedema can safely participate in progressive regular exercise. Another measurable result of exercise and strengthening were quality of life measures which increased after exercise programs. It is important to progress slowly and be monitored for symptoms. She also noted that few studies have been done for lower extremity lymphedema.

Self-Managing Lymphedema – Take control was one of the most popular sessions where patients learned practical tips from therapists **Lori Radke** and **Elizabeth Girling** as well as each other for daily living with lymphedema.

There were several practical exercise sessions available for patients as well—one by physiotherapist **Marie Jutras** (Montreal, Quebec) that promoted the benefits that even just a 15 minute specialized session could have on lymphatic flow and **Barbara**



Dr. Michael Specca and conference co-host, **Diane Martin**.

Cunnings-Versaevel led a group through Healthy Steps – the Lebed Method. Dorit Tidhar (from Israel) customized both a leg and arm session for patients with lymphedema in the hotel pool.

Dr. Specca led participants through a meditation exercise to demonstrate how mindfulness could be

an effective tool for lymphedema patients. His research showed how mindfulness, a meditation technique, can help us focus on positive thoughts instead of negative ones and their effect on healing the mind and body. Mindfulness was found to have positive outcomes for lymphedema patients not only



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in pain reduction but also providing them with a positive coping mechanism that helps them reclaim their life. When stress is always present in our life it causes an imbalance and prevents us from healing. Mindfulness takes us out of that negative coping cycle and provides us with a positive coping mechanism.

Dr. Jay Granzow, a Plastic Surgeon from Los Angeles, CA, discussed surgical options of suction assisted protein lipectomy (SAPL) and Vascularized Lymph Node Transplant (VLNT). He showed some wonderful videos on these procedures and how they select lymph nodes to transfer. He emphasized that with surgery it is important to get the limb volume down first and that he always works with a lymphedema therapist. SAPL is very specific procedure, and requires bandaging not only right after surgery but ongoing. On lymphoscintigraphy after surgery, there was no change from pre-surgery in lymph function, already damaged lymphatics are not further damaged. VLNT releases and removes scar tissue, replaces it with healthy tissue from elsewhere, improves

mobility and reduces the incidence of infection. There may be a risk of lymphedema at the donor site but he does reverse lymph mapping to minimize this risk. He suggests that safe and effective surgical procedures exist but it is not a magic bullet.

The conference wrapped with all the experts who presented during the conference sitting together on a Q&A panel, addressing questions from the audience. Many great questions arose, inspiring more questions. Sharing is so important to the progress of lymphedema care and recognition. One of the very important items that takes place during a National Conference are the stakeholders meetings, committee meetings and meetings of the Provincial Association representatives. These help the organization set priorities for the future and move initiatives forward. We want to acknowledge all the work that is done by the many volunteers in the background before and during the conference. It all came together for a wonderful event. Until next time. 

CONGRATULATIONS To the Poster Presentation Winners

1st Prize: Marie-Eve Letellier *et al*
—Treating Breast Cancer related lymphedema in a hospital setting.

2nd Prize: Rita Wannechko-Koenig- Lymphedema management strategies for Head and Neck Cancer patients: A case series using photographic surveillance.

Honourable Mention: Tracy Smith – The Incredible Shrinking Women.

Peoples Choice Award:
Katherine Styrchak and Jen Dalke - Clinical Case Study: Breast cancer-related lymphedema in a male patient ends in disarticulation.



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