

LYMPHOLOGISTS, PHLEBOLOGISTS, VEINS AND LYMPHATICS

Neil Piller

No matter who we are, clinician, allied healthcare professional, scientist, patient or carer, we often focus only on what we know, what we find comfortable and what we have learnt (or been told). In reality, that is not good, we stagnate, our chances for different and perhaps better outcomes are reduced, and strangely, we often become contented with our achievements and what we are trying to achieve.

In the last couple of months I have had the opportunity to talk to the Australian parliament, present what I know of lymphatics and lymphoedemas to a diverse group of clinicians/allied healthcare professionals at an interdisciplinary meeting, and to phlebologists at the Union Internationale de Phlebology meeting (UIP50) in Monaco.

These three different events presented three totally different opportunities to convey my knowledge of lymphatics, lymphoedema and the life of the afflicted and, importantly, to learn from others.

For the political meeting it was about helping them better understand the reality behind lymphoedema, what it means for those at risk and those with it, whether they have had it from birth or have developed it as a consequence of their treatment for some form of cancer. Here there must be a balance between depth and breadth. An opportunity to talk to parliament (especially a healthcare minister) represents a possibility to

promote the status of lymphoedema in terms of its recognition, treatment and management within the community. A few years ago in our national parliament we did have a female politician who had leg lymphoedema and a risk of arm lymphoedema, and that alone helped improve awareness in political circles.

Things are changing but the stimulus from us on those who make political decisions must be constant, subtle, honest, not inflated, and personal rather than general.

Now there is no one (that I am aware of), and so there are few opportunities, such as the one I encountered, to promote political awareness. How do you make a swollen leg exciting to them, how do you tell them so that they will really understand the often excruciating pain of an infected lymphoedematous limb, or the psychological trauma that a swollen arm inflicts on the individual when it identifies to others that they have had cancer. What do you tell them, what images do you use to ensure one paints a balanced picture? Well, I wanted at first to use shock tactics, the worst legs and arm lymphoedemas I could find, the ugliest scar, the worst skin infection. While this might impress and gain a short-term reaction, it is not reality for many of our patients in our developed nations who are relatively well (but certainly not always adequately) dealt with. No country is perfect, but every country has some positives. For example, in India there are culturally and locally

appropriate strategies being put in place to help at a local and community level. For instance, Professor Ryan has indicated that Ayurvedic traditional methods can reduce infection, local honey can seal wounds and locally made cotton wraps can be used in place of expensive bandages (Ryan, 2009). With careful thinking and planning and having local knowledge, even apparently small interventions can have great outcomes. It is a matter of finding and applying them.

So, what did I do for this talk to the politicians? I thought of searching for information about all of our political friends to see if any may have had treatment for breast, bowel, prostate or ovarian cancer. I was looking for a male in particular. But, there were none. After looking at my worst pictures and a few 'in your face' movies of interventions in really chronic late stage lymphoedemas, I decided to pull back. I presented reality, showed and described what I think is an average leg lymphoedema, the most common severity of an arm lymphoedema, pictures and stories of those who regularly walk our streets. I also presented honest, substantial facts and figures that could be easily verified in the literature. The end result was, I believe, an improved awareness and interest in lymphoedema.

Since that talk, five members of parliament have come to our clinic and seen for themselves what can be done to help those at risk and with lymphoedema. A small step, a tenuous improvement in knowledge, but nevertheless in the right direction. Reality rather than fiction can often make the greatest difference. Things are changing but the stimulus from us

Neil Piller is Professor and Director, Lymphoedema Assessment Clinic, Flinders Surgical Oncology, Flinders Medical Centre, South Australia

on those who make political decisions must be constant, subtle, honest, not inflated, and personal rather than general. I sometimes wish we had a male politician with swollen genitals, but that is not nice, inappropriate and not a good idea. Lymphoedema is not a sexy disorder; there is not a great deal of money to be made from it from companies in terms of treatments, but it is a condition that can have devastating effects, both physically and psychologically, on a patient's wellbeing, and which also impacts on family and friends. Thus, all of us should seize any opportunities that might arise to be seen, heard and be active.

This brings me to the second group I spoke to — clinicians and allied healthcare professionals. These are all part of our 'super health school' with members from a wide range of disciplines such as pharmacology, ophthalmology, dietetics, surgery, etc. Some of those who came had a curiosity about lymphatics and lymphoedema, and about how their fields might be having a positive or negative effect on it, others had no idea and just came (for the food/drinks, or...). However, I believe that all went away better informed. The pharmacologists learnt a little of proteo-genomics from our work with coumarin (Loedema), the dieticians better understood the importance of long-chain fatty acids and their absorption into the lymphatic system from the gut, the surgeons learnt that they should take a little more care of the lymphatics, and the ophthalmologists, well, I am not sure what they took away — maybe it was the sandwiches. You cannot please or inform every one, every time, but you need to be there, to talk and to handle questions.

And now the third group — 1300 phlebologists. What is the collective name for a group of phlebologists? A thrombus of phlebologists, a clot? Whatever, individually or collectively, not all are excited and interested in the lymphatics, but maybe they should be. Maybe also all of us as lymphologists (or at least those of us who help diagnose and manage lymphoedemas)

should be excited about veins. Why? Well, they are intimately related and intertwined, disease or disorder in one can affect the other. Phlebitis in the vein can translate as lymphangitis, lymphadenitis, stripping can mean removal of adventitial lymph collectors, coronary artery bypass graft (CABG) and ligation may mean removal or

Every opportunity should be taken to inform others of the rather delicate partner of our cardiovascular system, it may be a sewer, and the flow is slow and small, but it has a big heart when prompted and can make a difference at all levels from the cellular, tissue and whole body when we acknowledge and prime it well.

accidental tying off of lymph collectors. A thrombus may exert pressure on the lymphatic wall and slow or block lymph flow. Sclerotherapy attempts can occasionally mean these agents accidentally enter the lymphatics. Hypertension and elevated central venous pressure may increase lymph load. Thus, we have many vascular issues (some arterial, some cardio but mostly venous) which will either reduce the lymph transport capacity or increase the load on it. And yet, we often do not consider them in their entirety.

More concerning, perhaps, is that phlebologists are not aware of the issues that the venous system may impose on the lymphatic system, and how improved knowledge of the aetiology of lymphatic disorder and disease can actually help reduced loads on compromised venous systems and help protect from further failure.

We cannot be precious, we must be rigorous and we should work together.

Every opportunity should be taken to inform others of the rather delicate partner of our cardiovascular system, it may be a sewer, and the flow is slow

and small, but it has a big heart when prompted and can make a difference at all levels from the cellular, tissue and whole body when we acknowledge and prime it well.

Those who are most important to us, the lymphatics, the patient and their risk of developing lymphoedema are those who may accidentally cause damage to the delicate lymphatic system or its associated structures. Most commonly these are the surgeons who are focused on removing a cancer, the radiation oncologists who are intent on ensuring that there are no nearby cancer cells, and those who try to remediate vascular (particularly venous) dysfunctions.

We must share our knowledge of the lymphatic system with them, our 'knowns' and importantly, our 'unknowns', so that at very least they give consideration to this rather delicate partner of the more robust vascular system.

The others who are important to us are our colleagues, who also have strong interests in the lymphatic system, and the treatment and management of patients at risk of or with lymphoedemas. Often one is harshest on one's own family, and there is no doubt that we are perhaps more critical than we need be of the efforts of members of our lymphological family. We are all trying to achieve the same goal — better patient outcomes. While we all have different and varied ways of doing this, we all have much to learn from colleagues and much to offer those who are seeking more knowledge by mentorship.

Lastly, our main reason for being interested in lymphology, lymphatics and lymphoedema, the main reason for this journal, are our patients. We look towards a better outcome by sharing our knowledge. In this way this we can make a difference. JL

Reference

Ryan T (2009) *A Healthy Skin for All*. Oxford, UK