

PROACTIVE TREATMENT NEEDED FOR LYMPHOEDEMA PATIENTS

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No matter what the aetiology of lymphoedema, the physical, social and psychological effects of the condition can have a significant impact (Ahmed et al, 2008).

Literature about lymphoedema targets patients suffering from the condition and therapists who treat it, while also illustrating how many unmet needs there are (Rockson, 2006).

Even seven years ago, we had good knowledge of the molecular targeting of lymphatics as part of a possible therapy (Stacker et al, 2004) and this research has since grown stronger (Tammela and Alitalo, 2010). Don't we now have a means of growing new lymph vessels (Yan et al, 2011)? Don't we have techniques such as reverse axillary mapping to see which lymphatics are unlikely to be draining from the tumour site (Klimberg, 2008)? Don't we have techniques like lymphoscintigraphy to look at changes to the functional status of the lymphatic system (Keeley, 2006)? Don't we have techniques such as bioimpedance spectroscopy that can detect subtle fluid accumulation long before the patient is aware of it (Ward, 2009)? Don't we have screening for the early detection of lymphoedemas (Donovan et al, 2002)? Even when the lymphoedema is well developed, don't we clearly know that early intervention is the best (Lacomba et al, 2010)? At this present time we do.

Why do we have so many lymphoedemas? The incidence/prevalence has not changed much over the decades, although for secondary lymphoedemas there has been a decline and its general

severity has lessened. However, this is perhaps due to the earlier detection of cancers, less invasive surgery and better dosed and targeted radiotherapy.

To me, the main reason why so many lymphoedemas are still present seems linked to our tendency to focus on reactive health care despite claiming otherwise: 'Let's wait and see what happens'. Sure, let's wait for the symptoms to get worse before we do something — reactive health care, is that the best for our patients? Is it best for us, focusing on one patient at the expense of others? What do we mostly talk about at our meetings — large limbs, mixed aetiologies, difficult cases and occasionally 'great' outcomes, but most often just 'good' ones.

We have had a couple of prior debates in *JOL* about early detection of lymphoedemas and the tools and strategies used. We have often found it hard to find people wishing to debate from the negative viewpoint, because it seems the evidence for the benefits of early detection is strong. Even on the *JOL* website (www.lymphormation.org), requests for comment and further debate about this and other areas which we would describe as 'proactive care', have seen limited response.

Are we not at all concerned about preventing and minimising lymphoedemas? We are employed to assess, treat and manage the swelling caused by a malformed or damaged lymphatic system. Without lymphoedema we might not have a job? I think not, we would all still be employed to do similar things.

My question to our readers is: do you think we have moved to proactive identification, care and treatment of lymphoedemas, or are we still too

reactive? Do we have enough (and will we ever find enough) evidence to act as a tipping point to change our thinking? Why don't healthcare systems contribute to early assessment, intervention programmes and screening? Surely, early detection means early reaction, resulting in better outcomes and reducing the time and costs for patients and the system?

Let us know your views on our website. We hope to be able to publish a summary of them in a forthcoming issue of the journal. **JL**

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