Tissue Issue

NEW ZEALAND WOUND CARE SOCIETY

NZWCS Newsletter **LYMPHOEDEMA / OEDEMA** **Feb/March 2018**

WELCOME

The Education Advisory Group is overseeing the newsletter. We have some topics for the year however these are flexible so please let us know what you would like to see or contribute to the 'Tissue Issue' this year. Previous editions click here

Inside this Issue

Happy New Year to All our Members

FOCUS TOPIC - LYMPHOEDEMA / OEDEMA

Lymphoedema Treatment Update

The gold standard treatment for Lymphoedema is Complete Decongestive Therapy (CDT). Historically CDT consists of four components: Manual Lymphatic Drainage (MLD), compression bandaging, exercise and skin care. However, instructions in self-care and implementation of other services (wound care nurse, dietitian, podiatrist…) as needed are also important. Applied appropriately CDT reduces oedema, increases mobility and range of motion, decreases risk of cellulitis and ultimately enhances quality of life allowing patients to feel in control of their condition. Lymphoedema is usually treated intensively for several weeks until adequate decongestion has been achieved and the patient has reached their treatment goals. A self-care/maintenance phase follows this intensive decongestion phase.

Manual Lymphatic Drainage has always been thought to be a cornerstone in the treatment of Lymphoedema and comprises a significant part of Lymphoedema training. However, there has recently been some interesting discussion around the clinical efficacy of MLD. Including discussion regarding recent research demonstrating no additional benefit with the inclusion of MLD to treatment. This challenges the perceptions of therapists who see MLD as a central part of their treatment. There is little to lose by giving our patients multiple tools to utilise in their own self-management, Self-Lymphatic Drainage being one of these, however, in reality, the role of clinical practice of MLD may become less common.

An area of growth in Lymphoedema treatment is surgery. Liposuction and Lymph Node transplant are used more frequently overseas but are gradually being seen more in New Zealand, particularly liposuction. This is an area that may continue to grow with more centres providing this as a treatment option.

by Kylie Parker

Oedema

The most common cause of leg swelling is oedema, and it is important to correctly diagnosis the underlying aetiology as the management plan will be guided by this diagnosis. A full medical history should be taken including mediations and any systemic diseases of the patient. Consider whether the swelling onset was acute or chronic, if it is bilateral or unilateral, and if the oedema is localized or generalized to the affected leg or legs.

Oedema generally arises when the rate of capillary filtration exceeds the lymphatic drainage, either by an increased capillary filtration or a reduction in the lymphatic flow or a combination of both of these systems. There are five common causes of lower leg oedema, chronic venous insufficiency, lymphoedema, dependent oedema, cardiac disease and renal disease. Other types can include deep vein thrombosis (DVT), cellulitis and medication induced oedema.

Aetiology	**Onset and Location**	**Examination findings**
Unilateral predominance		
Chronic venous insufficiency	Chronic Lower extremities	Soft, localized pitting oedema with reddish coloured skin, in medial ankle and calf regions Oedema resolves with elevation and worsens with dependence
Lymphoedema	Chronic, primary or secondary Upper or lower extremities	Early – soft, pitting skin Late – thickened, fibrous, hyperkeratosis skin, Positive Kaposi-Stemmers sign Oedema does not resolve with elevation

DVT	Acute Upper or lower extremities	Pitting oedema with tenderness, with or without erythema
Bilateral predominance		
Cardiac (CHF – R sided))	Acute or chronic Lower extremities	Generalised pitting oedema Chest x-ray, B-type natriuretic peptide levels
Renal disease	Chronic Lower extremities	Generalised oedema Creatinine and eGFR levels
Dependency	Chronic Lower extremities	Generalised oedema If chronic can have trophic skin changes such as lipodermatoslerosis Known to have reduced mobility and/or reduced calf pump action

Adapted from:
Trayes, K.P., Studdiford, J.S., Pickle, S., & Tully, A.S. (2013). Edema: Diagnosis and Management. American Family Physican 88 (2),102-110.

What's On

NZWCS Study Day & Seminars for 2018:

Otago: Study Day - Sat 14 April 2018 - Dunedin Public Hospital
Title - 'Management of Patients with Diabetic Foot Ulcers'

Wellington: Study Day - Sat 26 May 2018 - title & venue TBA

There are no other education events organised as yet.
Please check on the NZ Wound Care Society website for regular updates.

PLANNED FUTURE TOPICS FOR TISSUE ISSUE 2018

- Apr / May - Minor Burns
- June / July - New ANZ Clinical Venous Leg Ulcer Guidelines
- Aug / Sept - Negative Pressure
- Oct / Nov - Pressure Injuries

To contact the New Zealand Wound Care Society please email administrator@nzwcs.org.nz
Email all contributions to future newsletters 2 weeks before issue release.
More in-depth information is available on www.nzwcs.org.nz

The views expressed in this newsletter are not necessarily those held by the New Zealand Wound Care Society.