Nurses. However, her lymphoedema had never been managed or approximately one year ago, following treatment from the district ulcerated areas of two years duration. The ulcers had healed was one of osteoarthritis, obesity and bilateral lymphoedema, with and hospitals and therefore refused to ask for help. Her medical history Barbara (name has been changed) is in her late 70’s and has been

Case study

Barbara (name has been changed) is in her late 70’s and has been housebound for over two years. She has always had a fear of doctors and hospitals and therefore refused to ask for help. Her medical history one of osteoarthritis, obesity and bilateral lymphoedema, with ulcerated areas of two years duration. The ulcers had healed approximately one year ago, following treatment from the district nurses. However, her lymphoedema had never been managed or brought under control. Barbara had not slept in her bed for over one year and was living in her chair which resulted in a worsening of the lymphoedema. This was compounded by the fact that Barbara declined to attend the Lymphoedema Clinic due to her phobia.

In May 2007 Barbara had developed Lipodermatosclerosis and her lymphoedema and ulcerated areas had become worsened by cellulitis and Pseudomonas. At this point Barbara was referred to St George’s Hospital in London; again she declined. Antibiotics and antimicrobial dressings were used. Barbara had declined on numerous occasions to be referred to St George’s Hospital and with lots of support and counselling from the district nursing team, Barbara eventually agreed to a domiciliary visit by a lymphoedema trainer, who supported the district nurses with the management of Barbara’s lymphoedema.

Method

Patient consent was obtained and vascular assessment with the Doppler measured nurses that it was safe to compress the patient. Compression bandaging using ActiFast® beige line over the limbs post dressing, Flexiban® padding to reshape the limbs, Actico® 8cm on the feet, with the inclusion of toe bandaging and Actico® 10cm to above the knees and 12cm to the thigh. This method was applied only for two weeks and then gradually reduced over a period of two months to finally two visits per week prior to hosiery being applied.

Results

Quality of life for Barbara and her family is greatly improved as Barbara is now able to sleep in bed at nighttime and, for the first time in 2 years, to go out for walks. Effective bandaging has increased Barbara’s mobility, which has led to weight and fluid loss and this in turn has led to easing of Barbara’s osteoarthritis symptoms. The ulcerated areas have now healed. Teaching and support from the district nurses has enabled her husband to assist with skin care and application of ActiLymph® compression hosiery. This has given Barbara greater independence and a better quality of life. The district nurses’ visits have now been reduced to 3 monthly to perform doppler assessments. This has shown the cost-effective elements of Barbara’s care.

Discussion

Barbara is not unusual in her dislike of hospitals and many patients would have the same fear. Lymphoedema is often ignored and treatment may be dismissed (Loudon and Petrek 2000) and its physical and psychological impact may often be compounded by the failure of healthcare professionals to offer appropriate care (Foldi, 1998). In this case, treatment at home with Actico® bandages and toe bandaging, followed by ActiLymph® hosiery was the most suitable treatment for Barbara.

Conclusion

Support and use of counselling skills has enabled Barbara to accept help with her chronic oedema. Applying Actico® bandages and then following ActiLymph® hosiery has led to increased quality of life for Barbara. Finally, this episode of care has shown to be cost effective as nursing time has been reduced and Barbara no longer requires dressing and bandaging.

References


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