

A multidisciplinary management of lower limb lymphoedema with quality of life as an outcome measure

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Introduction

Patients with venous leg ulceration and lymphoedema frequently have co-morbidities that need to be managed. Partsch (2009) described leg ulceration as a manifestation of underlying pathologies - not a disease in itself - and it is these conditions that present a challenge for the clinical team.

Symptom management is an important consideration for patients who may never heal, but who may be suffering from pain, malodour, excess exudate and loss of mobility. An effective outcome for the practitioner may be end point healing whereas, for patients, improvements in quality of life may be the desired outcome (Brown 2005, Charles 2010). Feelings of helplessness and despair often lead to social isolation, and loss of functionality exacerbates reduced social activity.

This poster describes the care of a patient with Parkinson's disease, Type 2 diabetes and lymphoedema, which developed due to venous hypertension and restricted mobility.

This case study demonstrates outcomes for a patient with complex co-morbidities using available resources by employing a team approach, specialist bandaging techniques and timely referrals to manage the symptoms of lymphoedema.

Method

Mr H is a 79 year old man who was referred to the Parkinson's Specialist Nurse after a series of falls due to mobility-related, bilateral lower limb lymphoedema. At this stage he had become less mobile and had given up his weekly swimming sessions.

Past history since 2006 included circular knit compression hosiery which did not contain his lymphoedema adequately and was difficult to apply by his main carer, his elderly brother. In 2008 a referral to the lymphoedema clinic was unsuccessful, as the service is only available to cancer patients. An added complication and source of pain was cellulitis in 2009 which resulted in hospital admission for IV antibiotics.

In November 2010, on the Parkinson's Nurse's recommendation, the patient was referred by the GP to the Tissue Viability Service. Holistic and vascular assessment confirmed dependency oedema and secondary lymphoedema in his feet and toes. He had venous hypertension with visible skin changes including staining, spider/thread veins and lipodermatosclerosis.

In December 2010 a joint visit was conducted with a commercial clinical team member to discuss management and treatment options. Preplanning ensured structured management, with a fully-trained team to enable continuity and frequency and appropriate units of allocated time for the visits. The limb was

shaped and protected by padding prior to compression bandaging. Multilayers of inelastic compression bandages* were applied according to best practice (Lymphoedema Framework 2006) with full stretch from the base of the toes, across the dorsum of the foot to below the knee.

Results

Within two weeks of bandaging the swelling reduced by 11cm at both the ankle and calf on his right leg, and by 7cm and 10cm respectively at the left ankle and calf.

This enabled made-to-measure hosiery** to be fitted by the senior team. In order to minimise the risk of oedema rebound, the hosiery was worn day and night for the next 5 days, and this monitoring was supported by the community nurses.

Weekly hosiery reviews by the team took place for 2 weeks to enable concordance, comfort and to supervise his brother during the re fitting of hosiery and skin care.

His brother noticed an improvement in ankle movements and the incidence of falls reduced from 5 times a week to once in 14 days. This gave his brother the reassurance to leave him unattended.

Discussion

After many years of remaining undiagnosed and untreated for his lymphoedema Mr H finally received the appropriate treatment, with compression by the multidisciplinary team reducing his swelling and improving his mobility. With improvements in limb size and shape, he was able to walk more steadily, reducing the risk of falls. Recurrent cellulitis was also minimised as his skin became less swollen and permeable. Containing his oedema with the correct hosiery that he and his brother can manage remains a challenge. This has been overcome by regular monitoring to ensure that the oedema is controlled.

Conclusion

The referral pathway for this patient highlights the effectiveness of multidisciplinary team collaboration to ensure quality of life improvements and the best care at each stage of patient management.

References

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* Actico® Cohesive Inelastic Bandage from Activa Healthcare Ltd

** ActiLymph® Made to Measure Hosiery from Activa Healthcare Ltd