WEB CONGRESS

Phlebology and Lymphology: new starting points

15February / 31December - 2021

Title Phlebo-Lymphology : An Irish Perspective

National Lymphoedema Framework Ireland (NLFI)


IRELAND
Counties &
Provinces


United
Kingdom
Isle of Man
Dublin
Manchester
Ireland
Birminghar
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Phlebology
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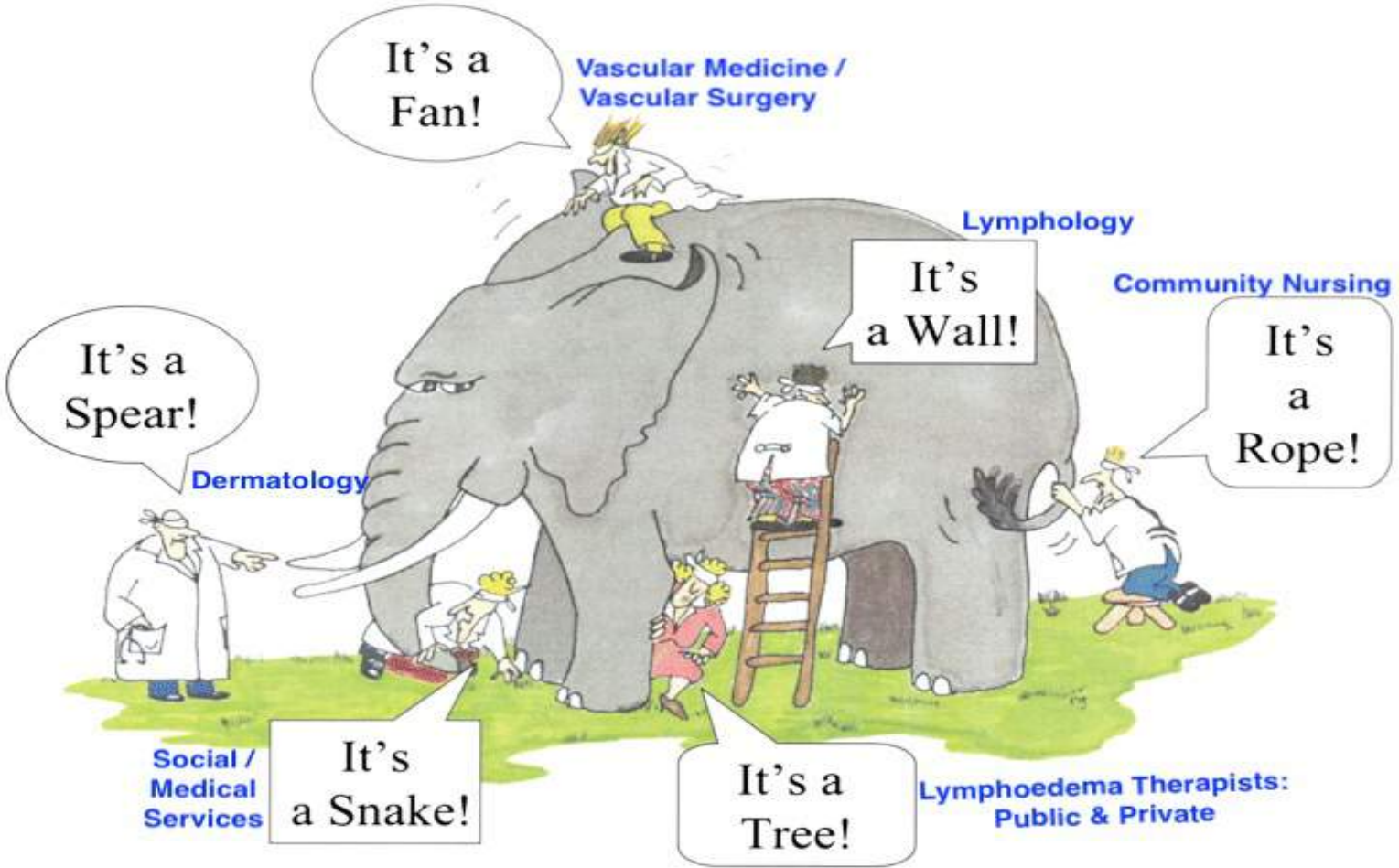
Phlebo – Lymphology : An Irish Perspective



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Mr Max B Mahendran, Consultant Vascular Surgeon
Phlebology practice in Private sector
Cork & Kerry, Ireland
Director: VeinCare Ireland www.veincare.ie
Contact: maxbmahendran@yahoo.com

With extensive background surgical training in General, Colorectal, Transplant and Cardiothoracic surgery, I joined the St. James' Vascular Institute to specialise in Vascular and EndoVascular surgery. I trained in multiple Vascular Surgical units in Ireland and was appointed as Senior lecturer in Vascular surgery at NUI, Galway. I developed the EndoVascular training programme for the Western Vascular Institute, where I also served as a Director. I helped in developing the PVD clinic and the Venous ulcer clinic at UCHG.
I had then founded VeinCare and now practice in the private sector applying comprehensive technology in venous disease management

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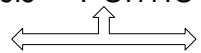
In the macro surgical perspective, the Arterial, Venous and Lymphatics represent three distinct systems and are taught and managed as such.

Venous hypertension at tissue level however blurs this distinction. This is often only appreciated much later in the disease when tissue destruction has occurred resulting in Venous Ulceration. As such, most research is done after the fact, to heal the wound. We need to continue our understanding of persistent venous and lymphatic issues after the wound healing.
Research with newer non-invasive technologies in lymphatic function demonstrate this Lymphatic insult occurs much earlier in the disease and even in people with healthy venous system due to physical/ physiological factors and gravity.

Venous hypertension

Stasis + Permeability



Tissue Hypoxia	Inflammation Microangiopathy Capillary thrombosis	Passive Overflow Lymphangiopathy Lymph occlusion / Reflux	Interstitial Edema

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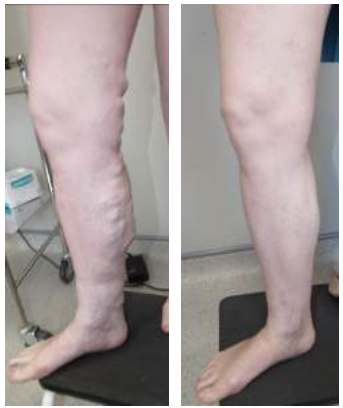
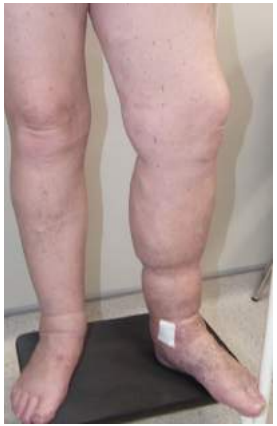
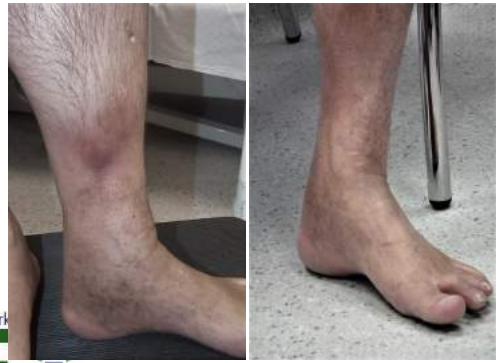


45yr, Female with gross venous incompetence Surgery after 3 months of compression and MLD. Postop image at1yr

70yr, Male with moderate venous disease but with cardiac decompensation. Ulcer healed after 3months with cardiac medication and compression stockings





62yr, Male shop assistant with ankle surgery. SVT with Ankle segment GSV and perforator incompetence only.
Image 6 weeks after Foam sclerotherapy with compression, MLD & physiotherapy for ankle mobility

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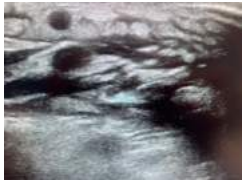
- Those were examples of early and reversible insults. As an interventionalist, my focus is on early elimination of venous incompetence and I have been treating venous ulcers with immediate intervention long before the EVRA trial, with accelerated healing

- However, we then ignore the tissue destruction that had occurred. Nature is a great healer but the QOL improvement stagnates soon. Patients are left with persistent baseline interstitial oedema and painful scarring from Lipodermatosclerosis

From surgical perspective, I have found adjuvant Lymph therapy beneficial

- Dramatic improvement in stagnated QOL after ulcer healing is achieved following focused MLD therapy and technology such as deep oscillation to improve LD skin scarring

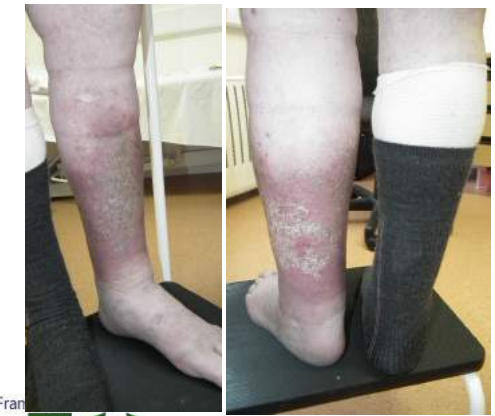
- MLD techniques have also been effective by opening defunct lymph channels and reducing excessive exudation from chronic ulcers that occurs due to tissue revascularisation following elimination of venous reflux



Tissue oedema under healed ulcer

Hospital based and involved with acute and subacute episodes, my awareness was limited to the social and emotional isolation that is present in the elderly population with CVI

Ireland has a dedicated community nursing team; however, the focus is on wound management based on budgetary, research and industry priorities, rather than primary prevention of stasis. A holistic approach is needed in management of Stasis & CVI sequelae by co-operation between various stakeholders and therapists



Elderly man with no demonstrable venous incompetence.
Clinical stasis only

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Dr Mary Paula Colgan
Associate professor of vascular disease at St James's Hospital and Trinity College Dublin

- Founding member, Vascular Medicine Ireland
- Board Member, VAS - European Independent Foundation in Angiology/ Vascular Medicine
- Irish representative on the board of The European Union of Medical Specialists (UEMS) Division of Vascular Medicine/Angiology
- Chair of the UEMS Committee for accreditation of vascular medicine training centres in Europe.
- Founding member of The National Lymphoedema Framework Ireland (NLFI)
- Member of the HSE Working Group on a model of care for lymphoedema/ lipoedema

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LIMPRINT (Lymphoedema Impact and Prevalence INTernational Lymphoedema Framework) is an international study aimed at capturing the size and impact of chronic oedema in different countries and health services around the world.

LIMPRINT

- From 2014 to 2017 , nine countries with forty sites contributed to a dataset of over 13,000 patients.
- Ireland was one of the contributing countries.

LIMPRINT – Ireland

Two sites were chosen

- Site One – Oncology, both in –and out patients
- Site Two – Vascular out -patients

LIMPRINT IRELAND - VASCULAR SITE

All patients attending a vascular medicine
out-patient clinic over a four week period were invited
To be part of the study.

A total of 75 patients were enrolled

There were 42 females and 33 males who ranged in age from 15 to 9 years

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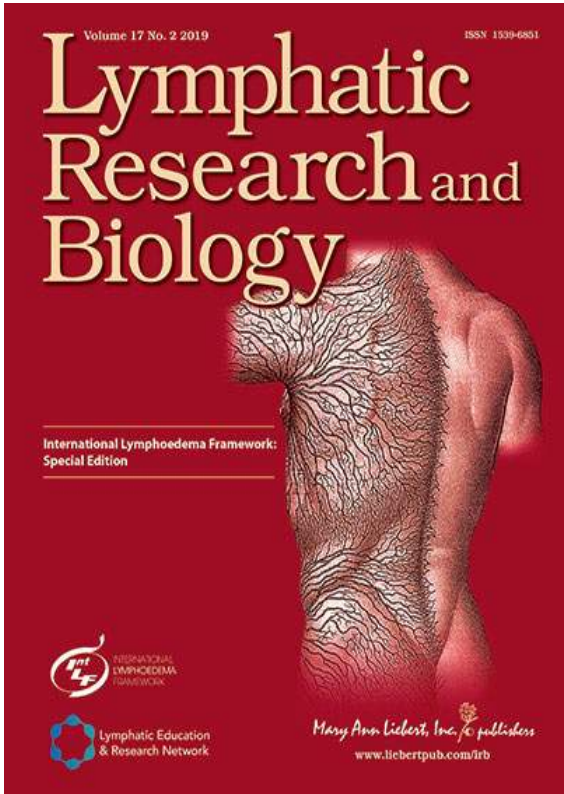
LIMPRINT Ireland – Vascular Site

- A total of 16 patients (21%) had chronic oedema/lymphoedema based on a positive Stemmer sign
- Of these five (7%) were related to underlying venous disease.
- These results confirm the importance of combined venous and lymphatic disease

Data analysis were continued into 2017 & 2018. The results were published in 2019 in a special edition of *Lymphatic Research and Biology*. This special edition contains 17 articles all published with open access..

Another LIMPRINT publication is being prepared for publication in 2021 which will include study results from the Irish contribution.



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Phlebo-Lymphology : An Irish Perspective

I began my career in 2010 as a Tissue Viability Nurse in a community setting in the Midlands of Ireland
2013, I commenced an MScN in Advanced Practice in RCSI and completed a systematic review on the role of Manual Lymphatic Drainage(MLD) in the treatment of lower limb lymphoedema.
2015 I became certified as An MLD Therapist in
2016, I began my journey in the Royal College of Surgeons, Ireland ,as a PhD scholar. My research was titled 'Exploring the experiences of patients with primary and secondary, non-cancer related lower limb lymphoedema during the intensive and maintenance phases of Complex Decongestive Therapy and its' impact on their lives'.
2018 I was awarded a Fellowship to the Faculty of Nursing and Midwifery in RCSI.

2019, my research is complete and I have graduated from RCSI

Contact email: mary.costello2@hse.ie

In my work as a Tissue Viability Nurse in the community, approx. 80% of referrals are lower limb, 55% have a venous aetiology, 15% arterial compromise and the remaining 30% consist of chronic oedema/lymphedema patients. (HSE, 2017)

I receive referrals from General practitioners, nursing, vascular consultants and dermatology for assessment and treatment of lymphedema.

I predominately treat secondary, lower limb, non-cancer-related lymphedema and complex chronic oedemas.

Secondary, non-cancer related Lymphoedema /chronic oedema can be a symptom of a multifactorial combination of environmental, social, functional, psychological and financial burdens that facilitate the development of swelling.

The patient living with lymphedema in the community is far different from the patient in the controlled environment of the Acute services in Ireland

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We need to look at the patient as a whole, not just the swollen legs, and piece the jigsaw together

ENVIRONMENT: Housing, stairs, equipment including bed/chair/ washing facilities/ wheelchair user

PSYCHOSOCIAL :Family support/neighbours /friends/ body image/loneliness/living alone

LIFESTYLE FACTORS: Exercise /diet/ attitude to diet and exercise

PERSONAL CARE: Functional ability to self care/ resources to self care

FINANCIAL / EQUITY OF CARE:Eligibility for medical card .In the absence of a medical card the patient with secondary non-cancer related lymphedema cannot access public health nursing service and equiptment and will not receive assistance with funding for compression hosiery.
Cancer-related lymphoedemas will have access to a lymphedema service.

DIAGNOSIS: Has the patient been given a diagnosis?

LYMPHOEDEMA / CHRONIC OEDEMA AFFECTS MULTIPLE ASPECTS OF DAILY LIVING

>Health professionals lack of knowledge
>lack of diagnosis
>lack of referral pathways
>lack of appropriately trained lymphedema specialists working within the health service
>Poor identification of lymphedema as a chronic condition by governing bodies
>Poor interdisciplinary working within the management of lymphedema
(Murray et al, 2010)

While we all have a part to play in the holistic treatment of lymphedema, we do not collaborate as a team.

Our work is not complete until the patient with lymphedema is empowered to self care . This has to be the greatest challenge to face both the clinician and patient living with lymphoedema

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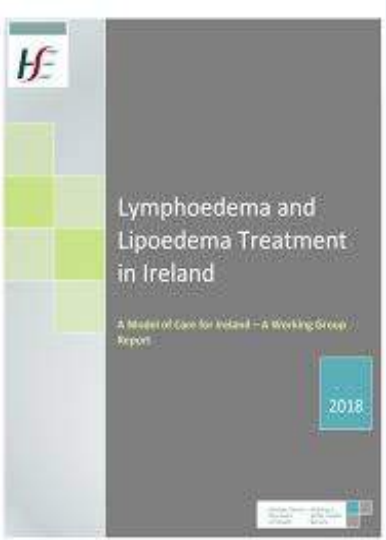

Irish Health Services Executive Model of Care 2019

The proposed 'hub' and 'spoke' model of care will ensure that non-complex lymphoedema/lipoedema cases are maintained in the community with an emphasis on self-care and support. Complex patients will be seen by lymphoedema therapists in a Specialist Lymphoedema Clinic based in primary care with in-reach to appropriate acute services.

The SLC will provide assessment, intensive and modified intensive treatment with pathways to a multi-disciplinary team.

Implementing the Model of Care will ensure that the services are safe, equitable, timely, evidence based and consistent with monitored outcomes and a quality improvement focus.

The commencement of the initial proof of purpose site is planned for 2021.

https://www.hse.ie/eng/services/publications/lymphoedema-model-of-care.pdf

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Clinic Director '*The Lymph Clinic*' www.thelymphclinic.ie
Certified teacher for the Dr Vodder Akademie Austria www.vodderakademie.com
Tutor & Director of Dr Vodder School Ireland
Co-Founding Board Member National Lymphoedema Framework Ireland. www.nlfi.ie
Co-Founder MLD Ireland www.mldireland.com

I work primarily in the private sector as a lymphoedema nurse specialist and medical integrative healthcare therapist.
I completed a Masters in Public Health & Epidemiology with a set of dedicated lymphoedema service KPI's.
These were subsequently published in Journal of Lymphoedema 2019
https://www.woundsinternational.com/journals/issue/580/article-details/developing-key-performance-indicators-lymphoedema-service-ireland-using-ic-delphi-technique.

Teaching is my passion and combining revised clinical and theoretical knowledge has enhanced my clinical practice enormously.

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October 2015, saw the National Lymphoedema Framework Ireland (NLFI) being created under the umbrella of the International Lymphoedema Framework. (ILF).
http://www.nlfireland.ie

The focus of the NLFI is to engage with the relevant stakeholders, educators, government and health care organisations in order to contribute to the development of a strategy for Lymphoedema Services in the Ireland. We have chosen education to be our key component of this engagement… as Nelson Mandela said *"Education can change the World"*… our desire is simply to help change the world of understanding for those who treat lymphoedema patients.

Sharing knowledge to keep pace with research and science thus shaping clinical practice is essential so that we can all see the essence of the same problem;..albeit from different perspectives.

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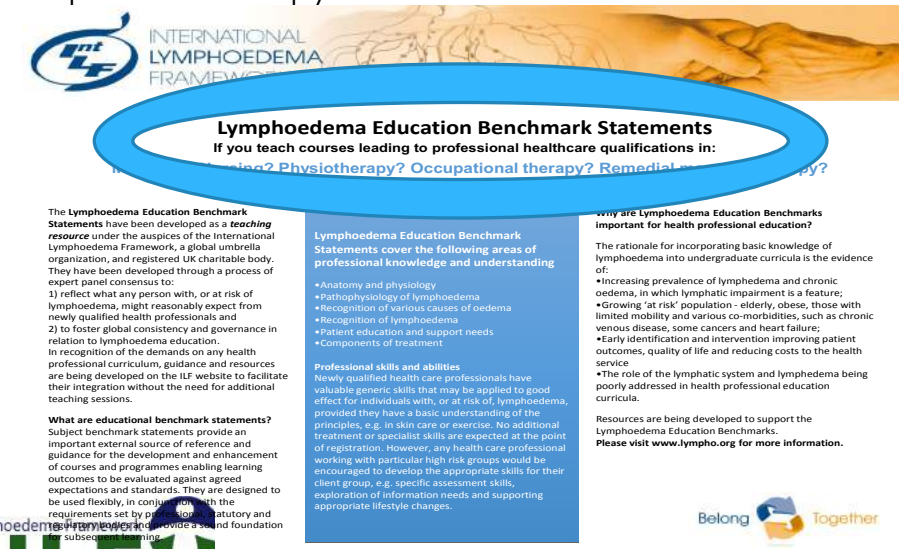
Higher Education Institute confirmed time dedicated to teaching of the lymphatic system in the undergrad programes for those training in:
Medicine: 60-80 mins
Nursing: 30mins -60mins
Physiotherapy: 30mins-60mins
Occupational therapy: 30-60mins



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www.lympho.org/lebs

The rationale for incorporating basic knowledge of lymphoedema into undergraduate curricula is the evidence of:

- Increasing prevalence of lymphedema and chronic oedema, in which lymphatic impairment is a feature;
- Growing 'at risk' population - elderly, obese, those with limited mobility and various co-morbidities, such as chronic venous disease, some cancers and heart failure;
- Early identification and intervention improving patient outcomes, quality of life and reducing costs to the health service
- The role of the lymphatic system and lymphedema being poorly addressed in health professional education curricula.

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Key Points of patient care often poorly understood clinically:

1. Lymph transport, not venous capillary reabsorption, is the main process responsible for interstitial fluid drainage
2.All oedema is due to an imbalance between capillary filtration and lymph drainage
3.Elevation and diuretics reduce venous pressure and consequently capillary filtration but do not improve lymph drainage
4.Lymph flow is stimulated by tissue movement and in particular exercise ;in theory an increase in lymph transport, if achievable, should benefit all forms of oedema
5.Calcium channel blocking agents should be contraindicated in the presence of any peripheral oedema unless there is no alternative treatment
6.Diuretics should only be prescribed long-term in circumstances of salt and water overload, eg heart failure, venous disease, and not on an empirical basis for any oedema
7.Movement through active or passive exercise should always be the preferred option for reducing leg oedema due to decompensated lymph drainage, with elevation practiced during the periods of rest

Correct differential diagnosis = correct treatment

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Chronic peripheral oedema: the critical role of the lymphatic system
(Peter S Mortimer and J Rodney Levick :
Clinical Medicine Vol 4 No 5 September/October 2004

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Only a collaborative and multidisciplinary partnership between all stakeholders, recognized as experts, can lead to an improvement in the management of lymphedema.

Improving the management of lymphedema is a dynamic process requiring ongoing research and implementation into practice.

POTENTIAL PROFESSIONAL INVOLVEMENT FOR PHLEBO-LYMPHOLOGICAL PATIENTS :

Vascular physicians, Vascular surgeons, Medical physicians, Dermatologists, Oncologists, GP's
Nurses: Community / Acute care/ Tissue Viability/ Lymphoedema each with a different approach and role in patient care
Physiotherapists & Occupational therapists; adult & paediatric, community & hospital based
Lymphoedema specialist trained therapists. (Dr Vodder / Casely Smith/ Foeldi)

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A HSE 2016/17 survey of current lymphoedema services showed that;

- Service provision for lymphoedema/ lipoedema is inadequate in most parts of Ireland with significant gaps across the country and inequity of access for non-oncology related lymphoedema.
- There is inconsistency in the prescribing and provision of compression garments which are an essential part of lymphoedema/lipoedema management.\
- There is under-utilisation of the current 70 (equivalent to 11.1 WTEs) specialist staff with each working an average of 6 hours per week in lymphoedema services.
- There are long waiting times of up to two years in some areas and patients with non-oncology related lymphoedema have significantly longer waiting times than oncology related.
- There are no consistent treatment standards being used across the country and there are poor identification systems for high risk patients.
- The Treatment Abroad Scheme (TAS), the Cross Border Directive (CBD) and contracted private therapists are currently used which is costly and not sustainable.
- There is very limited lymphoedema education in healthcare-related undergraduate courses.
- Funding for lymphoedema services is not consistent and varies according to health care professional and site of services.
- A gap analysis conducted as part of this review demonstrated a lack of accordance with international best practise in many areas of lymphoedema/lipoedema management.

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Thankyou

Continued multi –disciplinary understanding of the intertwined world of phlebo-lymphology can ensure lymphoedema is viewed less as '*the elephant in the room',* guaranteeing enhanced patient care by specialist individuals within the collective, while empowering the patient in selfcare.

This offers a whole different patient experience, allowing this particular 'elephant' to walk proudly and maybe provide a few surprises.

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THANKYOU