Letter to the Editor

Letter to: ‘How is lymphoﬂuoroscopy mapping altering lymphoedema management?’ – Wigg J. and Cooper G.  

Dear Editor,

With great interest we have read the recent paper of Wigg and Cooper (Br J Community Nurs. 2017) concerning the near-infrared ﬂuorescence lymphatic imaging technique and its use within lymphoedema management. The implementation of two case studies is of great value in conﬁrming the importance and relevance of this topic.

According to the International Society of Lymphology, the consensus treatment for breast cancer related lymphoedema (BCRL) is the decongestive lymphatic therapy (1). This is a two-phase treatment and consists of multiple combined treatment modalities like skin care, manual lymphatic drainage (MLD), compression therapy and exercise. Nevertheless, the additional effect of MLD is still internationally debated since pooled data and meta-analysis only demonstrated a limited non-signiﬁcant contribution to the other modalities of the congestive lymphatic therapy (2, 3). One possible explanation is that in previous studies MLD has been applied blindly, without knowledge of the patient-speciﬁc routes of lymphatic transport. Additionally, the MLD manoeuvres of the therapists applied during previous studies, might not stimulate the lymphatic transport optimally. According to Wigg and Cooper, recently, near-infrared ﬂuorescence imaging has been introduced 1) to visualise the functional superficial lymphatic network, and 2) to optimise the technique of MLD. Refining of the near-infrared lymphatic imaging technique has led to the introduction of a new MLD technique which focuses on 2 approaches involving ‘ﬁlling’ and ‘flushing’, based upon real life images during the assessment.

The physiological effect of one session of this ﬂuoroscopy-guided MLD has been proven (4, 5). As mentioned in the paper of Wigg and Cooper, in Belgrado et al., all patients with BCRL (n=30) showed
an increase of lymphatic transport from the hand to the axilla after 20 minutes of fluoroscopy-guided MLD (4). Furthermore, in a study of Tan et al., lymphatic contractile function before and after one session of fluoroscopy-guided MLD has been compared in patients with BCRL (n=10), showing immediate benefits regarding the lymph flow velocity and lymphatic propulsion period after MLD (5). Whether the application of different sessions of fluoroscopy-guided MLD has any clinical and long-lasting effects on lymphoedema, superior to the traditional MLD, is yet to be established.

Therefore, we are investigating the effectiveness of the fluoroscopy-guided MLD, additional to the other pillars of the decongestive lymphatic therapy and compared to the traditional or a placebo MLD, in the treatment of BCRL (EFForT-BCRL trial; clinicaltrials.gov NCT02609724). The design of the study is a multicentre, double-blind, three groups randomised controlled trial. We are looking forward to inform you about the results of our research within a few years, given the fact it can ratify these new insights into the management of lymphoedema and implications in facilitating self-management in patients (6).
