Case Study re: M[redacted]

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M[redacted] is a 71-year old female referred to me back in September of 2005 for lymphedema of her lower limbs. M[redacted] reported progressive swelling of her legs after her last surgery. In 2003, M[redacted] was told after a standard colonoscopy that she most likely had colon cancer; thus, it was highly recommended by her physician that she should have a colon resection and lymph node removal. In 2003, she underwent the advised surgery and had thirteen lymph nodes removed. However, colon cancer was never confirmed. Healing from her surgery was guarded---she did develop an infection from a healed over stitch in her abdomen, which required further surgery to re-open her incision to clear this infection. A course of antibiotics followed with sufficient healing reported. Chemotherapy and radiation were not recommended. Within two months of surgery, M[redacted] developed increased visible swelling in both her legs, more so in the left than the right. She started having difficulty ambulating up and down the stairs, started showing decreased standing tolerance for activities of daily living and was no longer able to walk long distances. She could not wear standard shoes, and she had much difficulty finding shoes that fit due to progressive edema accumulating around her ankles.

Prior to M[redacted]'s colon surgery, she was very active. Being a retired teacher, she walked without an assistive device up to 45 minutes every day. She also enjoyed reading, gardening and singing. She took care of her ill husband until his unfortunate passing in the spring of 2005. She has lived alone ever since. M[redacted]'s past medical history includes obesity, gall bladder removal, non-insulin dependent diabetes, neuropathy both hands, arthritis bilateral knees, controlled high blood pressure, and acquired ichthyosis of her lower legs---diagnosed in December of 2007. Her medications consisted of Metformin, Glipizide, Prandin, Clonidine, Furosemide, Klor-con, Toprol, Lipitor and Byetta. Martha also takes Advil two times a day for her arthritis pain, Caltrate, baby aspirin and B-12.

Two months after M[redacted]'s colon surgery in 2003, she received bandaging treatment in her home from a visiting nurse to help control her developing lymphedema. M[redacted] reported the nurse bandaged her legs about once a week for a month. She found this process very frustrating because the bandages often slipped down, and she couldn't find any shoes that fit. Finally, she found large men's-sized slippers to wear that fit poorly; as a result, M[redacted] tripped and fell (without injury). At one point, she was fitted for a compressive left leg garment. She tried use of a foot slider for ease of application; however, she could not manage it well due to the lack of strength in her hands from the neuropathy. In the summer of 2004, M[redacted] received physical therapy for treatment of arthritis in her knees three times a week for 3-4 months. Nonetheless, the developing lymphedema in her legs was never addressed by her therapists or by her primary physician. M[redacted] started to notice swelling in her mid torso and became more concerned. As 2005 approached, M[redacted] switched physicians for generalized care. Fortunately, her next physician suspected that M[redacted] needed specialized lymphatic treatment to address the lymphedema of her legs. In September of 2005, M[redacted] was referred for lymph drainage therapy (LDT).

I evaluated M[redacted] in September 2005 with an order for lymph drainage therapy 2-3 times a week for four weeks for her lymphedema. The order asked to "evaluate and treat". Subjectively, she rated aching, stiffness, hardness of the legs and decreased function of the legs at a 3/5; pain of the right leg 2/5, left leg 3/5; and heaviness of the legs 1/5. M[redacted] was unable to wear any standard shoes due to the significant swelling of the ankles. She wore no socks, and simply wore stretchy slip-on shoes with elastic tops that cut into the skin below her ankles. Her goals were to decrease her shoe size, decrease the size of her legs and be able to ambulate easier.

Objectively, M[redacted] performed within functional limits for range of motion of her extremities and basic activities of daily living. Functional mobility was limited. She required a one-point cane to walk and was only able to ambulate short distances with much stiffness in the right knee and occasional aching in the legs. Activities at a static standing level were minimal and M[redacted] became unable to tolerate stair climbing.

She had poor lymph flow throughout her body and stagnated lymph flow in her legs. Through manual lymphatic mapping, normal mapping was palpated with the exception of the colon. She exhibited a balanced craniosacral rhythm with poor vitality and an energy cyst in her right knee. Skin temperature was warm to touch on both legs and extremely dry, flaky skin present below both knees. Moderate fibrosis and moderate pitting edema was present below both knees, and skin was pink in appearance. A vertical 4-inch scar with moderate adhesions existed below her navel. Lymphedema measurements of both legs were as follows:
Right leg = 8373 mL; Left leg = 10,170 mL (a 22% difference).

After evaluation, I had due cause to believe M[redacted] was suffering from secondary lymphedema due to her colon surgery. I strongly recommended a Complex Decongestive Physiotherapy (CDP) program with the addition of CranioSacral Therapy (CST) and Frequency Specific Microcurrent (FSM). Unfortunately, M[redacted] lived alone and did not have any assistance for bandaging; thus, she declined the bandaging but agreed to the rest of the advised treatment. I reluctantly agreed to continue this treatment regimen of manual therapy, education and modalities knowing M[redacted] may only progress so far without compressive bandaging treatments.

Starting in September of 2005, M[redacted] was seen for OT two times a week for five months, a total of 34 visits. Her hour-long treatment sessions consisted of lymphedema education, LDT, FSM for general inflammation and lymphedema protocols, and CST as needed to control pain and improve vitality of the central nervous system. Overall, she tolerated treatment sessions fair---immediately after each session she showed significant stiffness of the legs and increased difficulty walking. However, this side effect only lasted temporarily. M[redacted]'s lymphedema was measured weekly, with slow, progressive improvements exhibited. After 6-8 weeks of treatment, M[redacted] showed increased ease of ambulation, visibly less swelling in her face, mid torso and legs. Her clinging slacks started to become much more loose, and she was overall just "feeling better".

Lymphedema measurements started to plateau around her 34th visit. Thereafter, her insurance for treatment was discontinued. She then agreed to come as a self-pay client for LDT once or twice a month treatment starting in February 2006---and continues to this day for a total of 77 visits. I strongly advised M[redacted] get fitted for an appropriate compressive sleeve to maintain (and continue to improve) her results; however, she declined use of the garment. She told me she had tried one before with the assistance of a foot slider; however, her hands were too weak to pull up on the handle of the device, and could never get the garment on anyway.

In December of 2007, M[redacted] started developing increased redness and dry, scaly skin below both knees. The inflammation worsened, and she was diagnosed with acquired ichthyosis. She started leaking clear lymph fluid in several areas below the left knee. Fortunately, her lymphedema only increased mildly. Her physician treated her with antibiotics and sterile dressings. She continued with her monthly LDT treatments. Her left leg proceeded to leak fluid intermittently through February of 2008. Thereafter, M[redacted] was ordered to receive in-house light box therapy weekly in conjunction with daily water and vinegar soaks to both legs to treat for the ichthyosis. This regimen is continued today.

Since September of 2005, the lymphedema in M[redacted]'s legs has reduced significantly, despite not utilizing compression bandages or garments. Her recent measurements were conducted 8/8/8 and are as follows: Right leg = 7410 mL; Left leg = 8136 mL (a 10% difference). Overall, the right leg has reduced 963 mL and the left leg has reduced over 2000 mL. The light box therapy has improved the dryness in the legs to minimal. There is no longer any leaking of lymph fluid, and the redness of the skin is more pink in color. She has shown good compliance with self-LDT at home and has coped rather well with her lymphedema. Nevertheless, M[redacted] continues to exhibit moderate fibrosis and moderate pitting below the knees. She still is limited to ambulating with a one-point cane, short distances only. Her wishes are to further reduce her lymphedema, if possible; and, to improve her ease of mobility.

I, [redacted], state that the information of this case study done by Colleen Pascoe, OTR, CST, LLCC is true and accurate to the best of her ability. I agree to let the Upledger Institute, Inc. to publish this case study to help illustrate LDT treatment results.

8-8-08

Date

[redacted]

signature

[redacted]

printed name

Colleen Pascoe OTR, CST, LLCC

Witness signature

Colleen Pascoe, OTR, CST, LLCC

Witness printed name