

EDITORIAL**QUALITY OF LIFE**

It is almost axiomatic nowadays when one refers to patient satisfaction that not only the efficacy of treatment of the medical ailment (mental or physical) be evaluated but also some measure of quality of life (QOL) be included to determine "true" benefit of the outcome. In fact, two articles in greater (1) or lesser (2) detail in this issue of *Lymphology* address QOL in patients undergoing treatment for peripheral lymphedema. Whereas both studies conclude that edema reduction alone is not in of itself the whole therapeutic goal, one wonders whether these findings a) are so surprising; b) call attention to issues that competent physicians have not long already appreciated; and c) realistically bear on whether or how arm and/or leg swelling should be optimally treated.

For example, after treatment for breast cancer as currently managed with axillary staging/dissection often combined with regional irradiation, the patient (almost always a woman) runs the risk of developing arm lymphedema. Many, of course, do so and they appropriately seek edema reduction to ease local symptoms or improve cosmesis and limb function. Unfortunately, current tools to alleviate this condition successfully are less than perfect whether one embarks on non-operative compression physiotherapy, "debulking," lymphatic-venous shunts, or even lipo/lymph suction. Each carries its own distinct undesirable features of either labor intensiveness or morbidity/mortality of an operation. Yet, success or failure in reducing arm edema while paramount in assessing treatment outcome is not synonymous with

full patient satisfaction. Besides the morbid complication of the original cancer treatment (which typically is unexpected by the patient and seldom addressed by the treating oncologist/surgeon beforehand), the woman has to contend with the psychological trauma of real or imagined tumor persistence/recurrence, the side effects of cytotoxic chemotherapeutic agents including fatigue, nausea, and hair loss, the social embarrassment of wearing a compression garment especially with a glove attachment in public, and the incalculable effects these and other preoccupations bear on family life and conjugal relations with the same or opposite sex. Whereas these are genuine concerns and must be considered, assimilated, contemplated, and managed by the physician responsible for the overall care, the fact remains that arm edema for which treatment was initially sought is still a top priority. Indeed, to a major extent, the success or failure of edema reduction has a profound beneficial or detrimental effect on patient satisfaction. In other words, therapy directed at the presenting and often pivotal physical ailment is still key to a successful clinical outcome while the other so-called QOL issues albeit relevant and significant are ameliorated or exacerbated by whether or not edema reduction occurs.

That said, various positive features can emerge from examining phenomena that bear indirectly on the QOL associated with a swollen arm. Thus, Johansson et al (3) in a related study on factors that influence lymphedema occurrence document that the

popular dogma of avoiding physical activity especially of the affected arm after breast cancer therapy is clearly misguided. In brief, continued activity at the pre-cancer treatment level is not only more satisfying for the patient but it is not associated with exacerbation of arm swelling. Of course, one presumes that these women with lymphedema faithfully wear a compression garment during exercise. Although most of the increase in blood flow with exercise goes to the muscle compartment (which is not swollen in lymphedema), a small increase in circulation concomitantly occurs in the skin and subcutaneous tissue. Without sufficient external compression, one would anticipate that with a greater microvascular surface area for fluid exchange and capillary filtration, tissue fluid/lymph formation would be enhanced and without the countervailing force of elevated interstitial pressure generated by a low stretch elastic sleeve, edema accumulation would worsen.

In the final analysis, however, QOL issues, while relevant and important to clinical outcome, only indirectly relate to the physical disability associated with secondary arm lymphedema. Not unexpectedly, the benefit of edema reduction has its greatest effect on physical well-being and less so on emotional and psychological symptomatology. Whereas important to address as part of the full clinical picture, QOL is really irrelevant to the success or failure of edema reduction except insofar as motivating compliance. Simplistically, when you correct the physical problem [as Weiss and Spray document (1) and as de Godoy suggests (2) in the case of

lower extremity lymphedema], the mental outlook on life typically improves. On the other hand, it is equally clear in the clinical setting of cancer or other life-threatening ailment, edema reduction alone cannot solve myriad other anxiety-provoking concerns. Perhaps, we make too much of an ado about QOL when we address peripheral edema or other physical ailments because correction of the presenting physical abnormality is at least a legitimate beginning to improve patient outlook and performance, and failure to do so is almost certain to aggravate an already compromised attitude toward life. As clinician/researchers, we should still direct most of our efforts and energy to resolving the central physical disability to alleviate suffering, while recognizing that each individual carries a host of co-morbidities and complex ideations that demand understanding and compassion.

REFERENCES

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