Standing the Test of Time:
Complete Decongestive Therapy

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Every day we continue to make progress in the lymphedema community, and there are exciting days still to come. Twenty years ago, a “Standard of care for LE” did not exist and Complete Decongestive Therapy (CDT) was relatively unknown. Today, evidenced based research for Complete Decongestive Therapy (CDT) is still lacking, but with evidence from contemporary literature we know that CDT is effective in the treatment of LE. Kathryn Thrift and Decourcy Squire share a detailed systematic review of numerous CDT studies. All carry components of CDT (MLD, bandaging, exercise etc.) and many show positive outcomes. Until further research proves otherwise, CDT remains the Gold Standard for patients with LE. Thank you Kathryn and DeCourcy for this encouraging and excellent review.

Bonnie Lasinski, well-known for her many years of clinical experience and observation, provides us with practical applications of the systematic review of the evidence of CDT. Her case scenarios are excellent, and I encourage therapists and patients alike to share her insights with doctors and other health care providers.

Dr. Janice Cormier and colleagues provide us with information about new and encouraging diagnostic techniques for visualizing the lymphatic system in real time using Near-Infrared Fluorescent (NIRF) Imaging. These techniques are still in their infancy, but have great potential to influence positive treatment outcomes for the future.

In our patient perspective, Walter (Wally) Gates, an 86 year old patient with unilateral primary leg LE, recounts 66 years of living with LE. He clearly describes the evolution “known & unknown” and the tremendous progress we have made over the last century. Thank you Wally for your inspiring story. You are a true LE hero!

On the flip side, Lee Nelson, Wally’s therapist, talks about her journey treating him at an advanced stage and how much she learned from him. We catch a rare glimpse into the close relationship between therapists and their patients – each benefitting the other. Thank you Lee for your therapist perspective.

Joachim Zuther who emigrated from Germany in the early 90s has been integral in training hundreds of therapists and physicians in lymphedema care over the years. He eloquently addresses all the components of CDT in the Question Corner. Thank you Joe, we appreciate your passion and expertise in the field.

Cynthia Judge (CJ), a graduate of the 2012 LSAP Program and avid LE advocate, talks about her Lymphedema Mavens Radio Podcast she created in 2010, and how she has reached out to thousands of patients, healthcare providers, and others in the LE community. Thank you CJ for your amazing program! We need many more advocates like you.

Our Inspire site is growing rapidly and patients as well as therapists and physicians are reaching out and starting discussions on our page. We encourage you to sign up on Inspire.com, join the conversation, and network with the many community members who have joined the site.

The NLN staff has been busy with numerous new projects, including the LE Awareness kit. This educational kit will be distributed for free to patients nationwide, and so far we have received hundreds of requests from oncology centers, nurse navigators, doctors’ offices and others. In order to launch this kit, we need your help! Please consider making a contribution to the NLN so that we can provide these kits to the patients who would benefit the most from them.

http://lymphnet.org/aboutNLN/donation.htm

In good health,
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Utilizing Complete Decongestive Therapy to Treat Lymphedema: Evidence from Contemporary Literature

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Introduction

A “Systematic Review of the Evidence for Complete Decongestive Therapy in the Treatment of Lymphedema from 2004 to 2011” was commissioned as part of the American Lymphedema Framework Project’s (ALFP) review of literature concerning 13 various aspects of lymphedema management.

Publications from the 11 major medical indices and from the authors own reference articles were reviewed with the goal of critically analyzing current literature regarding the management of lymphedema (LE) with all the components of Complete Decongestive Therapy (CDT) both singularly and in combination. The Best Practice for the Management of Lymphedema from the International Lymphedema Framework Project (ILFP) was used as the guide for search terms related to articles to be reviewed. Inclusion and exclusion criteria were established for the 99 articles reviewed. Of these, 26 met the inclusion criteria. In addition, 14 review articles and two consensus articles were reviewed. One case study, which did not meet the inclusion criteria, was included as it was a unique case study on genital edema.

Once the articles to be reviewed were determined, the authors categorized the study evidence using the Oncology Nursing Society Putting Evidence into Practice (PEP) guidelines. A consensus of the authors was used to determine not only inclusion/exclusion but also where each article fell within the PEP guideline ratings.

There were several challenges faced by the authors, such as a lack of a uniform definition of what constitutes LE. Many studies did not have control groups or randomization, well-controlled interventions, agreement on the correct dosage of CDT, and the blinding of assessors. Most studies were small in size, and the few having follow-up assessments had a high dropout rate.

Additionally, it was difficult to determine which of the separate aspects of CDT (Manual lymph drainage [MLD], compression bandaging/compression garment [CB/CG], exercise, skin care) were responsible for the success of the therapy.

Some of the studies also incorporated intermittent pneumatic pumps as part of their CDT treatment plans or did not include the exercise component.

These limitations explain why there was only moderately strong evidence for the use of CDT in the treatment of LE.

While CDT has been used successfully in Europe and the United States and Canada for more than 30 years, the “evidence-based medicine” standards have been lacking. It was the purpose of this systematic review to determine the strengths and weaknesses concerning the levels of evidence on CDT as a treatment modality for lymphedema and to guide future research efforts to support the continued use of CDT as a best practice in lymphedema management.

Results

A report on the 26 articles meeting inclusion criteria plus the one unique case study (for a total of 27 studies) follows.

Fifteen articles were rated as “likely to be effective.” They included seven randomized controlled trials (RCTs), four retrospective studies, three prospective studies, and one unique case-controlled study.

Breast-cancer related lymphedema (BCRL) was the most common among the studies, with twelve studies focusing on this aspect of utilizing CDT for patients with LE. Three studies included both upper and lower extremities.

Differing types of measurements were utilized to determine the volume of the lymphedematous limb. Circumference measurement with a tape measure was most common, with nine studies using this method, while two used perometry, five volumetry or a combination of volumetry and circumference. One study used ultrasound and calipers to measure tissue thickness, and one measured the pressure under the compression bandaging.

Studies reviewed had a range of subjects from 29 to 537 participants. Of these studies, nine reported no follow-up, two had a 24-hour follow-up, one had a 6-month follow-up and three had 12-month follow-up.

In 14 of the 15 studies, assessors were not blinded to the intervention. Only two studies measured how lymphedema impacted their quality of life (QOL).

Two studies were judged to be “benefits balanced with harm.” Volume change was the focus of one study with BCRL. It included 31 subjects who had their volume change with exercise alone or in combination of exercise and wearing compression garments. Unfortunately, this study only had a 24-hour follow-up. The other was a prospective study with 57 participants with lower extremity LE. These subjects received between two and four weeks of MLD combined with CB and exercise. There was a one-month follow-up. Measurements were taken circumferentially. Neither study blinded the assessors, but both studies assessed the impact of intervention on the QOL.

“Effectiveness not established” was scored for the remaining ten articles with

Continued on page 4
seven being prospective, two retrospective, and one the single unique case study. Once again, BCRL was the primary focus in six studies while three included lower extremity LE. The one unique case study was included as it reported on genital lymphedema.

Of these ten studies, eight measured volume reduction by circumference, one by volumetry, and one by lymphoscintigraphy. Three studies assessed QOL. Subject size ranged from 1 to 82 participants. Follow-up was reported: four studies, none; one for three months; one for 6 months and one for 12 months. Only one study blinded the assessors.

CMT

Perhaps the 2009 review by Devoogdt et al. best summed up what those in the field treating LE know: “CDT is an effective therapy of lymphedema but the role of each component is unclear...” Leal et al.2 wrote in their review of treatment modalities that “within the therapeutic modalities used for LE treatment, CDT undoubtedly has the strongest scientific support.”

Most authors agreed the methodology for teasing out the effectiveness of the various aspects of CDT resulted in less than stellar studies. Part of the difficulty in determining the effectiveness of each component is the synergistic effect of combining MLD with CB. MLD was never intended to be the sole treatment modality of LE. It was designed to be used in conjunction with CB since once the edematous fluid has been moved out of the tissues, fluid would quickly return without the external support of bandages replacing the tissue pressure.

One study in 2005 by Karadibak et al.3 attempted to isolate the effects of MLD within the CDT treatment in a RCT of BCRL in 53 cancer survivors. One group of 27 received the standard CDT, which included MLD while the control group of 26 received CDT without MLD. The group who did not receive MLD as part of their protocol, received a reduction in their lymphedema by 36% while the group who received MLD achieved a 56% reduction. This greater reduction with MLD does show the contribution of MLD within the context of CDT.

A cross-over RCT study was done by Williams et al.4 in 2002. In this study, 16 participants with more severe, chronic lymphedema received MLD daily compared to a group of 15 who did self-MLD. After six weeks, the groups switched interventions. In this study, MLD compared to self-MLD led to greater reductions in swelling in both the arm and in the trunk.

In another RCT cross-over study of 42 women with mild or early onset BCRL, Andersen et al.5 found that compared to compression alone, MLD was not a significant factor in reducing volume. However, McNeeley et al.6 conducted an RCT study with 50 BCRL participants and found MLD with compression bandaging was more beneficial than the use of compression bandages alone.

A difference in study protocols may be the primary reason for contradictory findings in some of the studies, which points to the need for more research. As an example, MLD was done for 30 minutes, 45 minutes, or 60 minutes a session. Treatments were once a week, 2-3 times a week or 5 times a week, (one study did it twice a day 5 days a week). The course of treatment lasted anywhere from 2 weeks to 6 or more weeks; some were a set length while others went until patient’s volume loss plateaued. During treatment, some protocols used compression bandaging, while others used compression garments. The exercises used were not described and a few protocols did not include exercises in the treatment.

Acute and long-term management of lymphedema with CDT

Most of the articles available for review dealt with the use of CDT or some of its elements or abridged protocols of CDT for the intensive phase of treatment. Only a few articles looked at long-term management of lymphedema.

In spite of the differences in methodology and protocol, the clear outcome in most studies was an immediate improvement in limb volume whether using CDT or a variant. The limb reductions achieved in the different studies covered a range: Jeffs7 reported 70% reduction, Yamamoto et al.8 reported 59% for patients with arm LE and 73.5% for patients with leg LE.

McNeely et al.9 reported 44-46% reduction; Kim et al.10 reported 43.6% reduction; Vignes et al.11 reported 36-38% reduction; Pinell et al.12 reported 22% reduction (this included patients with active tumors).

The long-term results of CDT were harder to determine. Only a few studies included follow-up.

Johnstone et al.13 had a median follow-up of 7.5 months, but a very small sample size (11 patients returned for follow-up out of an initial 82 patients). Of these, the 7 who reported adherence to their home program had continued to reduce and the 4 who didn't had begun to increase in limb volume again. Kim et al.14 had a 6 month follow-up and found that 42% of the subjects had regressed to just being 15% below where they had started. Mondry et al.,15 with a 12 month follow-up, also noted limb size increasing during follow-up. Vignes et al.16 had the largest number of patients (426) of whom 356 were available for 12 month follow-up. These patients had a home program of wearing compression garments daily and bandaging 3 nights a week (and having MLD 1-3 times a week). There were continued reductions of more than 10% in 28% of these patients.

These studies were consistent with previous follow-up studies (Boris et al.17 and Ko et al.18) which also found that adherence to a home program of compression is important to maintaining results and following active self-care, such as decongestive exercises/self-MLD can lead to continued reductions.

Quality of life (QOL)

Quality of life and improved function are two important results of treatment, but they were examined in only a few of the studies. The general outcome was that after lymphedema treatment, quality of life improved, even if the results of treatment (i.e., limb reduction) were not fully maintained.

Williams et al.19 found treatment that included MLD improved emotional function and decreased sleep disturbance, while using self-MLD instead did not have this effect. Kim et al.20 found that for people with either leg or arm lymphedema, the increased size of their
limb led to a decreased QOL and the decreased limb volume from treatment led to an increase in QOL, measured at 6 month follow-up. Mondry et al.21 found that QOL gradually increased during treatment and at 3 month, 6 month and 12 month follow-up, even if limb size began to increase again.

**Compression bandaging**

Badger et al.22 conducted a RCT using compression bandaging, followed by compression garments after reduction compared to using only compression garments as the tool for reduction. This study showed using compression bandaging first was twice as effective in reducing lymphedema as using only compression garments.

Damstra et al.23 compared the effectiveness of low pressure (20-30 mm Hg) and high pressure (44-58 mm Hg) bandages on people with BCRL. They found no significant difference in outcome and the lower pressure bandages were better tolerated. In another study, Damstra et al.24 found that the sub-bandage pressures dropped significantly after a few hours and by 24 hours were 55-63% less. This makes it important to reapply compression bandages daily when possible.

**Lympho-venous disorders**

There were two articles related to this topic: one a 2008 consensus document by an international panel of experts on this issue (Partsch et al.25 which reviewed the literature on compression treatment for venous and lymphatic disorders and the other by Shrubb et al.26 reviewing the literature on general management of DVTs (blood clots) to apply it specifically to people with lymphedema who develop DVTs. The recommendations from these articles were the following:

- To prevent edema and blood clots: low level compression garments of 10-30 mm Hg
- To heal ulcers, to prevent post-thrombotic syndrome (swelling that develops later in people who have had blood clots), or to manage lymphedema: high level compression garments of 30-40 mm Hg
- For situations where compression greater than 40 mm Hg is needed: use inelastic Velcro® compression items or short stretch bandages rather than compression garments
- For patients with lymphedema who develop a DVT (once patient is ambulatory): continue compression in order to prevent swelling from worsening
- For patients who are bedbound: compression may be contraindicated if it impairs blood flow

**Differential Impact of CDT**

A number of studies tried to determine what factors affected the effectiveness of CDT. Among the factors examined were the presence of active cancer; age; weight/BMI; the original amount of swelling; the length of time swelling had been present; and the length of treatment/number of sessions.

Pinell et al.27 found even in patients with active tumors, CDT worked to reduce swelling, but the results took longer to achieve.

Yamamoto et al.28 found while amount of swelling was correlated with age, the effectiveness of treatment was not; Liao...
The Systematic Review (SR) of the Evidence...concludes that “Complete decongestive therapy (CDT) is effective in reducing lymphedema, although the contribution of each individual CDT component has not been determined...CDT improves overall quality of life and is effective for various degrees of LE...Manual lymph drainage (MLD) enhances the effects of compression and has been shown to improve quality of life (QOL) and symptoms.” (SR – Pg 599)

What does this mean for clinicians in acute care, long-term, outpatient and home care settings? How can this evidence be practically applied to insure that individuals living at risk or with lymphedema (LE) are supported throughout the continuum of care? Physical and occupational therapists, nurses and other practitioners provide care for patients living with or at risk for LE in a variety of healthcare settings. There are some who are well informed about the pathophysiology and management of LE and related lymphatic system disorders such as lipo-lypderma, phlebolymphedema (LE secondary to chronic venous insufficiency or post thrombotic syndrome), however, many are not. Understanding and applying the evidence from the SR supports the patient living with LE and related disorders to continue self-care when undergoing medical treatment, empowering the individual to be proactive in their health maintenance. Identifying potential problems and making appropriate referral to a LE specialist may avoid triggering a latent LE or progression of pre-existing LE.

Following an initial course of CDT, most individuals maintain the reduction in LE by wearing a compression garment during the day and compression bandages (or an inelastic garment) at night. The evidence for adherence with nighttime compression bandaging and daytime compression garment wear correlated with the maintenance of LE reductions achieved through CDT.

Knowledge of a patient’s individual LE management program, including the type of compression garments worn, duration of wear, and exercises/self-MLD regimen is critical information the practitioner must consider when formulating the patient’s plan of care. Incorporating the principles of CDT into some of the self-care activities helps to streamline a patient’s home program, reducing the time/psychological burden for the individual. Consultation/referal to a LE specialist may be indicated and modifications to a patient’s compression garments or exercise program may be needed as the patient progresses through the episode of care.

APPLYING EVIDENCE TO THE CLINICAL SETTING

The following examples illustrate application of the evidence from the SR to common medical issues that may present to patients at risk or living with lymphedema.

- An individual with LE of the upper extremity is diagnosed with impingement syndrome of the affected shoulder. The pain and limitation in range of motion and function of the affected shoulder is severe. Cortisone shot into the shoulder has been recommended. The patient was advised by the orthopedist to discontinue wearing the compression garment for a few days after the shot. The patient is unsure if this is correct and needs to know what to do. Based on the evidence from the SR, it is clear that wearing the prescribed compression garments on the affected limb/s is necessary to prevent worsening of the LE. The patient’s compression sleeve ends at the axilla and should not interfere with the injection. It can be removed for the administration of the injection but should be put back on after the injection to avoid an increase in swelling.

- A patient with lower extremity LE must have an excision of a basal cell skin cancer on the lymphedematous lower leg, the patient has been advised to remove the compression stocking until the surgical wound is healed. The patient is concerned that the leg will swell in the weeks that the area may take to heal. However, the pressure and shear of pulling on a compression stocking may disturb the wound bed and surrounding tissues. A discussion with the surgeon regarding whether the patient could be permitted to apply compression bandages over the surgical site to facilitate wound healing is appropriate. Depending on the patient, the extent of the wound and other co-morbid conditions, it may or may not be appropriate. Obtaining clearance from the surgeon for the patient to continue/modify the home exercise/self-MLD program is important to properly instruct the patient with any modifications needed to enable continuation of the home program without compromising wound healing on the affected limb.

- A patient with lower extremity LE secondary to obesity and chronic venous insufficiency needs a total knee replacement. They are only able to wear knee length compression stockings because of their obesity and immobility. The incision from the surgery will extend from the distal thigh over the knee to the proximal lower leg. The elastic band from the knee high stocking would be located over the incision line so the patient will not be able to wear the compression stocking on the operative side in the first weeks post-op. What can be done to minimize the swelling that may occur in that time? Risk for infection, skin integrity, ability to mobilize the knee post-op, safety in transfers and ambulation will affect recommendations for compression post-op. If compression
bandaging of the operative limb (from the toes to the groin) were permitted early post-op, its effect in limiting knee flexion must be considered. If the patient's foot and ankle swell markedly, safe footwear has to be provided that:

a. fits the patient's foot adequately to provide support and
b. protects the foot/toes to reduce the risk for injury to the skin and for falls.

An adjustable inelastic compression legging may be needed in the first months post-op to allow easy inspection of the surgical wound and to provide adequate compression to the limb.

- A patient presents to an out-patient physical therapist (PT) practice 6 weeks after right mastectomy and DIEP flap reconstruction of the right breast with painful restriction of right shoulder flexion and abduction due to pain and tightness in the right axilla extending down the side of the body including the right upper arm to the elbow. Possible interventions might be moist heat or other modalities to the right shoulder/upper arm/lateral trunk, soft tissue (myofascial) techniques to soften tight/adherent tissues, exercise to improve flexibility and strength. Reduction of pain, maintaining integrity of skin, reducing risk for infection and risk for LE of the right upper quarter while improving functional movement and strength of the at risk limb must all be weighed when program planning.

The SR supports patient education in risk reduction and monitoring limb volumes to assess for LE development. A major weakness in many of the studies cited by the authors was inconsistent documentation of bilateral baseline limb volumes and follow-up measurements to monitor limb volume changes.

Patients with or at risk for lower extremity LE should be reminded not to walk barefoot at anytime, to reduce the risk of injury/infection of the feet/toes. People with lower extremity LE are often unaware that they have cracks in the skin between their toes from fungal infection. This is often the cause of a seemingly "unexplained" cellulitis infection. The healthcare practitioner should review the importance of skin inspection, foot and toe hygiene, and suggest referral to a podiatrist for foot and nail care, as well as to stress the importance of taking the full dose and course of antibiotics prescribed for cellulitis, both oral and topical (if prescribed) to avoid recurrence of infection. Occasionally, lymph fluid may leak from the skin (lymphorrhea) or from blisters/pimples on the skin that erupt during an episode of infection. Adhesive, even from paper tape, can further damage delicate skin, so care should be taken to secure any gauze or dressings on the affected area. Gauze should be taped to itself, not to the patient’s skin.

CONCLUSION

The evidence from the Systematic Review concluded that CDT is effective and has a positive impact on the quality of life in patients with varying severities of LE. Healthcare practitioners must be educated in the anatomy and physiology of the lymphatic system and the implication of reduced lymph transport capacity on an individual's risk for developing LE. Incorporating this information with a patient's function and critical care needs, assist the practitioner in planning interventions needed to...
Introduction

Current techniques for visualizing the lymphatic system, especially lymph capillaries, are limited. The only medically approved method for imaging the lymphatic system is diagnostic lymphoscintigraphy. With this technique, a patient is injected (usually in an area surrounding a tumor) with a radiocolloid tracer, which is subsequently diffused through lymphatic capillaries and then transported through larger lymphatic vessels to the draining (or sentinel) lymph node. The radiocolloid tracer emits detectable gamma photons. The process, which takes several minutes, visualizes major lymphatic vessels and can detect lymphatic obstruction, which is associated with lymphedema.

Lymphoscintigraphy has several limitations. Low photon counts limit its sensitivity, i.e., its ability to detect subtle changes that may indicate early lymphedema. Long camera exposure times, over several minutes, prevent direct, real-time imaging of lymphatic pumping. Lymphoscintigraphy has poor overall resolution, preventing visualization of newly formed lymphatic vessels, which can signal early metastases.

Recently, near-infrared fluorescence (NIRF) imaging has been introduced as a non-invasive technique that overcomes many of these limitations. NIRF can visualize sentinel lymph nodes reliably and directly visualize and quantitate lymphatic function. To image lymphatics using NIRF imaging, patients are given microdoses of indocyanine green which is an NIRF contrast agent. Following the injection, a specially designed camera developed to image the flow of the contrast agent through the lymphatics is utilized.

NIRF in Breast Cancer

In a recent clinical study of sentinel lymph node mapping with NIRF, six women with breast cancer were injected with the standard-of-care sulfur colloid (834 µCi 99mtechnetium-sulfur) as well as indocyanine green (a NIRF dye) before surgery. NIRF detected sentinel lymph nodes that the standard technique did not, and one of those nodes harbored microscopic breast cancer metastases.

The same group evaluated whether blue dye (lymphazurin) in addition to indocyanine green was beneficial for sentinel lymph node mapping in breast cancer patients. Twenty-four women with breast cancer received the standard 99 technetium-sulfur colloid and 1.6 ml of 500µM indocyanine green and were randomly assigned to undergo sentinel lymph node biopsy with or without the blue dye. There was no benefit to adding the blue dye, but the gamma probe in addition to indocyanine green was required for successful sentinel lymph node biopsy in 25% of the patients.

NIRF imaging has also been used to evaluate lymphatic abnormalities in patients with breast cancer–related lymphedema (BCRL). In a pilot study, 18 patients with BCRL in one arm and healthy people underwent evaluation of lymphatic function in their healthy arms using NIRF imaging. In patients with BCRL, lymphatic function in the healthy arm became more disrupted over time. Therefore, lymphedema may have a systemic causal component that warrants treatment of both arms in this setting.

Figure 1 illustrates the contrasting lymphatic structure typically observed in healthy subjects and in subjects with lymphedema.

Figure 1: NIRF images illustrating the degradation of the lymphatics in (a) the left arm of a healthy subject and (b) the foot of a subject with lymphedema of the left leg.
NIRF in Vulvar Cancer

NIRF has been used to identify sentinel lymph nodes in patients with vulvar cancer. Preoperative standard-of-care injections with radiocolloid and blue dye (lymphazurin) are painful and burdensome to patients; NIRF offers a less painful alternative\(^7\). In 10 vulvar cancer patients, the standard radiocolloid detected 29 sentinel lymph nodes, followed by NIRF (which detected 89.7% of those) and the blue dye (72.4%). Because all those patients had a normal body mass index, a broader population needs to be studied before widespread implementation of NIRF\(^7\). Another study sought to determine whether indocyanine green was more effective when bound to human serum albumin\(^8\). Indocyanine green detected all the sentinel nodes that took up the radiocolloid regardless of albumin presence\(^8\).

NIRF in Melanoma

The efficacy of NIRF in sentinel lymph node biopsy and lymph node dissection has been evaluated in preliminary studies of patients with melanoma\(^1,9,10\). In addition, the lymphatic systems of melanoma patients have been preoperatively imaged using NIRF\(^1\). Four melanoma patients received indocyanine green before lymph node surgery in both the affected and the contralateral, healthy limb; in two of those patients who have been imaged to date, lymphatic vessels in the affected limb were more abundant and tortuous than those in the contralateral limb, which were more linear with only one draining lymphatic vessel.

NIRF in Head and Neck Cancer

NIRF may be able to guide procedures involving the lymphatic system. A man with lymphedema of his head and neck following treatment for squamous cell carcinoma (including a hemimandibulectomy, a hemiglossectomy, radiation therapy, and chemotherapy) received manual lymphatic drainage (MLD)\(^11\). NIRF was used to provide a map of his lymphatics to direct the MLD. The treatment had limited success. Although only a case report, this shows the potential for using NIRF to direct standard MLD when treating lymphedema.

Summary

Although NIRF is still in its infancy, preliminary research indicates that NIRF can visualize lymphatics in real time and thus may improve treatment outcomes. At this point in time, this imaging technique is not readily available as further research is needed.

References available online

Physical Therapist with Lymphedema Specialization

Cox Health is seeking a PT to join a hospital-based outpatient LE Clinic. The ideal candidate would be an experienced CLT, but consideration will be given to training a PT with strong interest in LE. Come be part of a dynamic and experienced team of LE therapists in a large health system serving Springfield, MO and the Southwest Missouri Region.

If interested, please contact Alice Wood at 417-269-6841 or Alice.Wood@coxhealth.com. Apply for the open positions at www.coxhealth.com.
PATIENT PERSPECTIVE

66 Years Living with Lymphedema

By: Walter Gates
Burlington, VT

I have coped with lymphedema in one leg for 66 years. I would like this article to be helpful to those who live with LE, as well as those who treat and research it.

In 1946, at age 15, my physician noticed that my right leg was slightly larger than the left. I had not noticed this swelling before, nor had my family. After various specialists failed to identify the problem, Dr. John Homans, (he of the Homans test for deep vein thrombosis) diagnosed it as "idiopathic lymphedema". I played football in high school, ran track in high school and college, lived a normal teen-age life, and took no special care of the leg whatsoever. For about ten years it increased in size, but very slowly.

My first treatment consisted of elevating the foot of our bed but neither my wife nor I were at all happy with the arrangement and, after 20 years I abandoned this practice as unproductive. My next treatment started in the late 1950's, when I was in my late 20's, with what is now called a manually-inflated stocking/pump. There was a serious flaw in that the stocking would not stay up on my leg. I gave it up and moved on to an off-the-shelf medical compression stocking, but it was never happy with it. The seam in the back bunched up behind my knee and was very uncomfortable.

In the early 1960's, I consulted a vascular surgeon who specialized in venous and lymphatic problems. He had developed a seamless elastic stocking in collaboration with a garment manufacturer. This garment worked pretty well, but it required a garter belt which was quite a nuisance. The stocking was quite thick and caused the garters to pop off frequently. However, I wore the full-length stocking every day for the next thirty+ years, but never had physical therapy or other care for my leg. As the years passed, the leg continued to increase in size. I then added a knee-length stocking on top of the full length one, or sometimes wrapped my calf with an elastic stretch bandage. I used no compression at night. I also purchased an electrically-powered pump/garment and tried it for a while, but it provided absolutely no benefit for me.

I moved to the Burlington, Vermont area in 1996 when I was 65 years old. I consulted a vascular surgeon who reviewed my situation and told me that I was generally doing the right things. He gave me two pieces of valuable advice: never, ever, let anyone operate on my leg in an attempt to cure the lymphedema; and receive physical therapy with one of the local therapists who had training in lymphedema care. I considered this to be remarkable advice from a surgeon - not to have surgery, and to seek assistance from practitioners without an MD degree.

I began treatment, primarily with a physical therapist at the local hospital in 1998. By this time, the leg was grossly enlarged with considerable fibrosis in the tissues. She provided intensive massage therapy and bandaging as well as taught me a home care program including compression at night. She prescribed and measured me for custom stockings, a knee-high over a full length garment, as my calf was very swollen.

As my leg improved I became compliant and distracted. In 2001, I was diagnosed with prostate cancer which was my primary focus for a couple of years. I didn’t replace my stockings for 6 or 7 years, nor did I pay enough attention to my skin condition, and this was a serious mistake. The skin on my right heel became very dry and cracked. On Christmas Eve, 2008, I went to the emergency room with a fever, a feeling of malaise, and flushed skin on my leg. I was quickly diagnosed with cellulitis and admitted for 5 days for potent intravenous (IV) antibiotics.

I resolved not to get sloppy with my condition again. In early 2009, I reconnected with physical therapy, this time with another physical therapist, also a specialist in lymphedema treatment. I had an initial series of treatments in which my leg swelling went down considerably. Since then, I have been receiving treatment regularly (1 session every 6-8 weeks), as well as replacing my stockings when needed. My leg has stayed smaller for the past 4 years and I have not had cellulitis again.

In my 81 years, I hope that I have learned some important lessons about lymphedema. I have managed my condition reasonably well, due to a combination of factors: compression stockings and compression wrapping; skin care; excellent physical therapy; regular exercise; weight control; and a positive outlook. Unfortunately, there does not seem to be any strong scientific evidence to help conclude which of these factors may be most critical to a patient’s care. I wish that such evidence could be determined in time to help others. I hope this chronicle will be helpful to others.
Walter Gates – 66 Years Living with Lymphedema

By: Lee Nelson PT, DPT, MS, CLT-LANA
University of Vermont; Champlain Physical Therapy, Burlington, VT

It is an incredible pleasure and privilege to offer my perspective on caring for and collaborating with Mr. Wally Gates in his efforts to manage his right leg lymphedema during the past 4 years. As evidenced by his story (see Patient Perspective), he has traversed life for 66 years with a chronic condition for which there were few, if any, treatment options available in the U.S. until fairly recently. He has been a skilled teacher for me and has insights that I trust will help others.

Wally was diagnosed with lymphedema at age 15, not ever realizing that his right leg was larger than his left leg, when he had a physical exam in preparation for playing football in high school. In exploring this aspect of Wally’s history, he indicates that he had no relatives that he knew of with a history of swelling or “puffy” legs and even his parents had not observed asymmetry in his legs. He also does not recall any injuries, illnesses or surgeries in his childhood. He recalls being shorter than his classmates until he grew 12 inches between ages 14 and 17.

Wally states that at age 19 while in college, he flunked a physical exam for Advanced Army ROTC due to his leg swelling. This was of concern to him, however, the precipitating factor for him seeking treatment for his leg was not until he applied for life insurance and received a “rating” for which he had to pay “extra” because of his lymphedema. This was at age 24 or 25. When he was eventually referred to specialist physicians, he said that all of them inquired about insect bites, injuries etc. and whether he had travelled to the tropics. Wally said when he responded in the negative to these questions, they seemed “stumped” about the cause of his leg swelling. One physician (Dr. Homans) did diagnose him with idiopathic lymphedema.

He feels the first offers of help he received were early compression pumps, but he did not find them helpful and therefore used non-custom compression garments for many years without any other assistance or care. In looking back on his long history with lymphedema, he says that he never felt his leg was “an issue” and that it never occurred to him that he couldn’t do something because of the lymphedema. He skied throughout his life searching for boots, pants etc. that would accommodate his leg swelling. He recalls that clothes in the ’50s and ’60s were “bigger” than they are now and in the next few decades, he noticed that they became “narrower”. Because of this, he had suits custom-made and his wife sewed plackets into all of his casual pants so that they would fit him.

He feels his biggest challenge to date in dealing with his leg lymphedema occurred just recently when he fractured his wrist and encountered considerable difficulty in donning and doffing his garments. This has caused him to wonder how other people manage this daily task with garments as they age and lose strength and mobility. He has always considered garment management “just part of my day”.

In reflecting on the economic side of living with lymphedema, Wally didn’t receive custom garments until he was of Medicare age. Subsequently, he was surprised that such necessary medical items were not financially covered. He says he doesn’t mind contributing to these costs but suggests that Medicare should pay a significant percentage of garment costs for individuals with lymphedema.

Clinical Perspective:

As Wally describes, he did not have complex decongestive therapy until 1998. I was not involved in his care until 2009. Measurements from 1998 could not be located, but leg circumference measurements from 2000-2002 were retrieved and compared to the most recent 4 years of physical therapy (P.T.) treatment (see graphs). As can be discerned from the graphs, when Wally had treatment from 2000-2002, his right leg volume fluctuated and was between 30% and 48% larger than his left leg.

From 2002-2009 he did not receive treatment for his lymphedema. And, for the first time in more than 60 years of living with lymphedema, he had an episode of cellulitis in 2008. When he re-entered PT care in early 2009, his right leg had increased significantly, to the point where it was 67% larger than his left leg. He presented with Stage 3 lymphedema with significant fibrosis throughout his leg. He underwent brief intensive treatment, and then committed to a consistent maintenance program of decongestive therapy.
(a treatment of MLD/fibrotic massage every 6-8 weeks), compression garment use, as well as timely reordering of these custom garments. Although this MLD treatment is infrequent, it has effectively managed the degree of fibrosis in his leg as well as kept the edema volume reduced. He has now been able to maintain a lower edema volume more consistently and his right leg remains in the range of ~30% larger than his left leg. He is consistent, as he always has been, with daytime use of 2-layered compression garments and only occasional use of a night garment.

As therapists, we teach and talk about skin care, manual lymphatic drainage, compression bandaging, the importance of exercise, good nutrition and maintenance of optimal body weight. However, as Wally has addressed, because the evidence for best practices in the management of lymphedema is not well developed, it is a challenge to know which factors are most important and what dosage of any one factor is needed, on a daily or weekly basis. Wally’s ending statements on lessons learned encapsulates our common teachings and supports the importance of episodic surveillance of lymphedema. It also highlights one of the serious, medical concerns of lymphedema, that being risk for cellulitis. Wally’s story helps us better understand how individual the timeline and path is for each and every person with lymphedema. The impact of lymphedema on quality of life is well reviewed by Jane Armer, RN, PhD. She not only cites the research, she paints a human face on the disease by quoting patients as they describe the daily struggles of living with lymphedema. Later, she explains the various methods used to measure swelling and the psychosocial factors pertaining to breast cancer survivors with LE. Michael Bernas, MS discusses Lymphedema Genetics and Lymphatic Imaging, both new topics in this edition. Teresa Conner-Kerr, PT, CWS presents an interesting section on wound and skin lesions often seen when treating people with LE. She offers helpful clinical pearls to facilitate healing. Later, John Beckwith, PT tells us what to consider when bandaging in the presence of wounds. Judith Nudelman, MD describes the various approaches to diagnosing lymphedema. It is her candid words regarding the general lack of physician education in this area that reinforces the essential role that we, as LE therapists, play in disseminating information to patients and doctors about the benefits of Complete Decongestive Therapy (CDT).

There is a chapter giving an overview of Complete Decongestive Therapy (CDT), with some thoughts on exercise by Maureen McBeth, PT and advice on CDT for Cancer Survivors by Linda Boyle, PT.

For this author, the meat of the book is in the extensive chapter on treatment. There is a wealth of information here starting with Zuther’s description of MLD techniques and treatment sequences for adult and pediatric populations.

New to this edition, Steve Norton presents treatment strategies for common lymphedema complications with seven scenarios to aid in making clinical treatment decisions. Photographs document a variety of skin conditions and treatment challenges, especially helpful for therapists with limited exposure to advanced disease. He discusses the differences between pure Lipedema, Lipolymphedema, Lipo-Phlebo-Lymphedema and Lympho-Lipedema, beautifully expanding upon Zuther’s earlier discussion, and providing more specifics than we have ever seen in an English text. He even offers helpful hints when challenged to measure these patients for custom compression garments. His insights on adapting CDT to the palliative patient will be quite helpful to therapists working in hospice or home care.

If you have not had the pleasure of sitting in on Brad Smith’s M.S., CCC-SLP, CLT highly informative NLN conference
This text is a collaboration between two respected teachers and colleagues who share a common interest in the management of lymphedema and a goal of passing their knowledge on to the next generation of lymphedema therapists. Their respective schools will each use this book as their course guide which further emphasizes the generosity of our Lymphedema Community where patients come first, our expectations are high and in a cooperative model, we enjoy teaching and learning from each other. With information that is evidence based, easy to understand, clearly documented in text and photographs, this book is a must have for all Lymphedema practitioners. Given the amount of self-management ideas presented, the authors may want to consider a companion text for patients as their next project.

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presentation on Head and Neck Lymphedema, it is well documented here. Nicolle Samuels, PT gives practical guidelines for Kinesiotaping that I have successfully used in my clinic. Joy Cohn, PT, CLT-LANA turns her experienced eye to the world of compression garments, describing the various materials, the differences between custom and non-custom choices and how to select an appropriate garment. Then, she insightfully tackles the lymphatic challenges of the patient with morbid obesity. Sarah Stoker, MSPT, CLT-LANA, provides an overview of truncal lymphedema highlighting this often-overlooked diagnosis with photos that showcase specific problem areas. Janice Cormier, MD reviews surgical treatment of Lymphedema while Marga Massey, MD explains current recommendations for breast and axillary reconstruction. She offers special considerations for patients including the need to be proactive for lymphedema care, implant failure issues and the potential problems of a latissimus dorsi flap reconstruction. Mr. Zuther completes the chapter with well-written step-by-step patient education instructions. This chapter contains photographs of self-MLD and limb bandaging, offering a good review for therapists, and clear directions for patients looking for an adjunct to their clinical training.

The final chapter on administration is a welcome discussion of the basics of starting a Lymphedema Clinic including sample forms and templates that may be adapted as needed.

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The Flexitouch system delivers dramatic results for patients suffering from lymphedema. Our at-home pneumatic compression therapy helps patients to maintain or reduce limb volume between clinic visits, thereby increasing range of motion and decreasing the pain associated with chronic swelling.

To read the full case study on the patient above, please visit:

flexitouch.com

1. “Home based lymphedema treatment in patients with and without cancer related lymphedema”, Oncology Nursing Forum, 2008; Vol. 35(4), Authors: Sheila H. Ridner, PhD, RN, Elizabeth McMahon, PhD, Mary Dietrich, PhD, Sunday Hoy, Esq.

2. “Stage III lymphedema treatment using PT in conjunction with the Flexitouch” http://www.tactilesystems.com/flexitouch/completed_studies.html Author: Julie Fulton, PT, CLT

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The Lymphedema Mavens podcast is the brainchild of my co-host Coach Christine Wunderlin. Christine and I were patients at the Lymphatic Center of Las Vegas. Although we had never met personally, our paths crossed while filming a commercial for the center. Shortly thereafter, Christine asked if I would be interested in co-hosting a radio podcast with her, and of course I agreed. Little did I realize how much my life would change on September 15, 2011, the day of our first podcast.

As breast cancer survivors with lymphedema, Christine and I wanted to help get the word out about this condition. We were appalled that few physicians knew little if anything about lymphedema. Although, Christine facilitated a support group, we felt that the podcast would help those who would benefit from listening in the comfort of their homes.

We decided to call ourselves the Lymphedema Mavens, and dedicate our show to taking our listeners on a journey of understanding, healing, recovery and restoration. We wanted to give our listeners a forum to share their personal stories of living with lymphedema. And, as time and the show progressed we invited experts in the field to be featured guests, to share medical information, and strategies to living a fuller more enjoyable life.

We both support the Lymphedema Treatment Act; the show has been a source for updates on the advocacy efforts in progress to change the laws regarding treatments. We’ve had Heather Ferguson on the show several times. On October 19, 2011 the Lymphedema Mavens were given a Proclamation by Las Vegas Mayor Carolyn Goodman and the Las Vegas City Council deeming October 19, 2011 as Lymphedema Awareness Day and giving their full endorsement of the Lymphedema Diagnosis and Treatment Act.

I developed lymphedema in 1980, one year after my first modified radical mastectomy. My lymphedema went untreated until November 2009. Living with untreated lymphedema affected my self-esteem and overall health. As it is with most lymphedema patients, I suffered in silence, until a bout of cellulitis and a case of rigor sent my health spiraling. I ultimately found treatment and it was a life-changing event for me, I discovered my true calling. I became an outspoken advocate for lymphedema patients.
## LE Therapist Training Programs

### Academy of Lymphatic Studies [A]
- **Home Office:** Sebastian, FL  
- **Telephone:** 800-863-5935  
- **Fax:** 772-589-0306  
- **Website:** [www.acols.com](http://www.acols.com)  
- **Director:** Joachim E. Zuther, CI, MLD/CDT  
- **Course Length:** 135+ hours, 11 days  
- **Classes Held:** Across the U.S.  
- **Student Codes:** D,N,PPTA,PA,O,OTA,ATC,M  
- **Program Codes:** C,PA  
- **CASLEY-SMITH COURSES IN THE U.S.**

#### 1) CLT Courses [B]
- **Home Office:** Minneapolis, MN  
- **Telephone:** 679-596-1785  
- **Email:** CLTcourses@cs.com  
- **Website:** [www.casley-smith-lymphedema-courses.org](http://www.casley-smith-lymphedema-courses.org)  
- **Director:** DeCourcy Squire, PT, CLT-LANA, CI-CS  
- **Course Length:** 135+ hours, 17 days  
- **Classes Held:** Across the U.S.  
- **Student Codes:** D,N,PPTA,PA,O,OTAM,COTA  
- **Program Codes:** C,PA

#### 2) Boris-Lasinski School [B]
- **Home Office:** Woodbury, Long Island, NY  
- **Telephone:** 516-356-2200  
- **Fax:** 516-356-1967  
- **Director:** Bonnie B. Lasinski, PT, MA, CI, CLT-LANA  
- **Medical Director:** Marvin Boris, MD  
- **Course Length:** 135 hours, 14 days  
- **Classes Held:** Across the U.S.  
- **Student Codes:** D,N,PPTA,PA,O  
- **Program Codes:** C,PA

### Klose Training & Consulting [G]
- **Home Office:** Boulder, CO  
- **Telephone:** 866-621-7888  
- **Fax:** 303-245-0334  
- **Email:** info@klosetraining.com  
- **Website:** [www.klosetraining.com](http://www.klosetraining.com)  
- **Director:** Guenter Klose, CI, CLT-LANA  
- **Medical Director:** Kathleen Francis, MD  
- **Course Length:** 135 hours, 9 days  
- **Classes Held:** Across the U.S.  
- **Student Codes:** D,N,NP,PPTA,PA,O,OTA,M,ATC  
- **Program Codes:** C,PA

### Monarch Continuing Education [M]
- **Home Office:** Christiansburg, VA  
- **Telephone:** 540-357-2084  
- **Fax:** 540-301-0750  
- **Email:** carmen@lymphedema-hope.com  
- **Website:** [www.lymphedema-hope.com](http://www.lymphedema-hope.com)  
- **Director:** Carmen Thompson, B.S., CLT-LANA, LPTA, CMT  
- **Course Length:** 140 hours, 18 days  
- **Classes Held:** Across the U.S.  
- **Student Codes:** N,PPTA,O,M  
- **Program Codes:** C,PA

### The Norton School of Lymphatic Therapy [N]
- **Home Office:** Matawan, NJ  
- **Telephone:** 732-290-2888  
- **Fax:** 732-290-2278  
- **Email:** info@nortonschool.com  
- **Website:** [www.nortonschool.com](http://www.nortonschool.com)  
- **Director:** Steve Norton, CLT-LANA  
- **Medical Director:** Andrea Cheville, MD  
- **Course Length:** 135 hours, 9 days  
- **Classes Held:** Across the U.S.  
- **Student Codes:** D,N,NP,PPTA,PA,O,M  
- **Program Codes:** C,PA

### University of Arizona Medical Ctr with Healthsouth Rehabilitation Institute of Tucson [V]
- **Home Office:** Tucson, AZ  
- **Telephone:** Marlys H. Witte, MD  
- **Medical Director:** Christine Heim, MD  
- **Course Length:** 160 hours, 20 days  
- **Classes Held:** Across U.S. & Canada  
- **Student Codes:** D,N,PPTA,O,COA,M  
- **Program Codes:** C,PA

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**Diagnostic Centers**

**University of Arizona Medical Ctr with Healthsouth Rehabilitation Institute of Tucson**  
Tucson, AZ  
Marlys H. Witte, MD  
Michael J. Bernas, MS  
520-626-6118

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**IMPORTANT DISCLAIMER:** The following listing constitutes neither an accreditation nor an endorsement by the NLN or the NLN Medical Advisory Committee. Currently, there are no government-recognized national standards for treatment of lymphedema or accreditation of lymphedema training courses. Therefore, a certificate received from any lymphedema training program in the U.S. represents only a certification of attendance and completion of that particular course.

**LISTING GUIDELINES:** In 2001, the Lymphology Association of North America (LANA) was founded to establish minimum competency standards for lymphedema therapists and provide a national standardized certification examination (CLT-LANA). This examination is available twice annually. Preliminary minimum standards have been set by LANA, and the NLN has adopted them for qualification of training programs, treatment centers and therapists in the United States. As of November 1, 2002, the NLN requires lymphedema training programs to offer a minimum of 135 hours of intensive training (1/3 theoretical, 2/3 practical) in order to qualify for a listing in the NLN Resource Guide (referred to as Sponsorship). Lymphedema therapists (independents) must have completed a recognized 135-hour training program, and treatment centers must have on staff at least one lymphedema therapist who has completed such a program.

**PLEASE READ:** This list is offered to our members for reference only. Although we do interview/review applications from each individual and facility, the NLN is not responsible for quality of service or rates charged. Therapists vary in experience, expertise and skill, and you are encouraged to inquire about training, background, fees for service, and to verify coverage with your insurance company prior to treatment. And, as when making any medical decision, research your options, ask questions, then decide on the best course of treatment for you.

**NOTE:** The NLN Resource Guide includes only NLN sponsoring facilities/clinicians. Each sponsor has submitted detailed information about their facility/practice including a questionnaire, copies of professional licenses/certificates, and paid a fee to be listed. This list does not represent all centers/clinicians currently in practice in the U.S.
### Resource Guide Legend

The following codes appear in the Treatment Center and Manual Lymphatic Drainage Therapist listings. Codes indicate the school attended by each on-staff therapist. If a school attended by a therapist is not an NLN-Sponsoring Training Course, only an asterisk (*) will appear in the listing, indicating that no information has been provided. See the Training Course column for program descriptions.

- **A** = Academy Of Lymphatic Studies
- **B** = Boris-Lasinski School, Casley-Smith U.S. Affiliate
- **C** = Monarch Continuing Education (formerly Lymphedema Care Specialists, LLC)
- **G** = Klose Training & Consulting
- **N** = The Norton School of Lymphatic Therapy
- **S** = Complex Lymphatic Therapy Courses, Casley-Smith U.S. Affiliate
- **V** = Dr. Vodder School-North America
- **L** = CLT/LANA Certified

### SPECIAL NOTE:
Training Programs no longer in existence:

- **C** = Casley-Smith School
- **I** = Lymph Drainage Therapy ~ Upledger Institute
- **K** = Kessler Lerner LE Academy
- **LL** = Lerner LE Services Academy
- **T** = The Lymphedema Consultants

### TRAINING PROGRAM LEGEND

**Program Codes**

(Indicate what is covered in the program)

- **C** = Complete Program (Manual Lymph Drainage, bandaging, garment review, exercise, diet/nutrition, self care, skin care)
- **P** = Use of pumps reviewed
- **A** = Additional types of compression garments/devices reviewed

**Student Codes**

(Indicate who is eligible to attend the course)

- **MD** = Doctor
- **RN** = Nurse
- **NP** = Nurse Practitioner
- **PT** = Physical Therapist
- **PTA** = Physical Therapist Assistant
- **PA** = Physician Assistant
- **OT** = Occupational Therapist
- **OTA** = Occupational Therapist Assistant
- **MT** = Massage Therapists
- **ATC** = Athletic Trainers Certified

(Note: Massage therapists should contact the school for minimum practical hours and experience required to attend this course.)

### Physicians

- **Jay W. Granzow, MD, MPH, FACS**
  Plastic Reconstructive Surgery
  Manhattan Beach, CA  310-882-6261

- **Yasemin Ozcan, MD**
  Physical Medicine and Rehabilitation
  Palos Heights, IL  708-923-5055

- **Nancy A. Hutchison, MD, CLT-LANA**
  Physical Medicine and Rehabilitation
  Minneapolis, MN  612-863-2123 or 612-863-8947

### Treatment Centers

#### ALABAMA

HealthSouth Lakeshore Rehabilitation Hosp
10300 Medical Drive
Birmingham, AL 35242

- **Therapy Achievements**
  
  [2G,1*L] Huntsville
  Karen Allen Hsiup, OTR/L, CLT, ATP  256-509-4398

#### ARIZONA

**CORAL (Center for Oncological Rehabilitation and Lymphedema)**

[2G,1*L] Phoenix
Natalie Fogelson, PT, MSPT, CLT-LANA  602-580-9323

- **Yavapai Regional Medical Center**
  
  [1S,1*L] Prescott
  Donna Hannah, OTR/L, CLT-LANA  928-771-2777

**HealthSouth Scottsdale Rehabilitation Hospital Lymphedema Treatment Program**

[1S,1*L] Scottsdale
Andrea Brennan, OTR/L, CLT-LANA, DAPWCA  480-551-5436

**Scottsdale Healthcare LE Treatment Ctr**

[1N,1V,2*L] Scottsdale
Katie Hughes, MA, OTR/L, CLT-LANA
Christy Kim, PT, CLT-LANA  480-323-1100

#### ARKANSAS

**Arkansas Lymphedema and Therapy Providers**

- **1G,1A,2G** North Little Rock
  Troy Alberson, MSPT, CLT-LANA  501-772-3224

#### CALIFORNIA

**City of Hope National Medical Ctr**

[1A,2G,2*L] Duarte
Jennifer Hayter, MA, OTR/L, CLT-LANA
Belinda Torrez, MOT, OTR/L, CLT-LANA  626-256-4673 Ext. 62412

**TAG Lymphedema Ctr**

[1N,1V,1*L] El Segundo
Cathy Tarte, PT, CLT
Richelle Drake, CLT-LANA  310-426-9570

**New Horizons Physical Therapy, PC**

[1G,1L,1A,1*L] Encinitas
Tammy E. Mondy, PT, DPT, MSRS, CLT-LANA
Joe Mondy, PT, DPT, MSRS, CS, CLT  760-230-6472

**St. Agnes Cancer Ctr Lymphedema Program**

[1A,1*L] Fresno
Denise Ketcham, PT, CLT-LANA  559-450-5500

**Long Beach Memorial Medical Ctr – Lymphedema Clinic**

[2N] Long Beach
Barbara Stone, PT, CLT
Lisa Smith, PT  562-933-5864

**Providence Holy Cross Medical Ctr**

JoAnne Shahnazi, OTR/CLT  818-898-4529
Kathy Caplan, RPT/CLT  661-288-5925

**Hoag Memorial Hospital Presbyterian**

[1A,1G,2N,2*L] Newport Beach
Danielle Allison, PT  949-764-5645

**St. Joseph Hospital, Lymphedema Center**

[2A,1C,2N] Orange
Jeanne Fahring, PT, CLT  714-542-8002

**Casa Colina Centers for Rehabilitation**

[3N,1*L] Pomona
Kathy San Martino, PT, CLT-LANA
Debbie Huskey, PT, CLT  909-596-7733 x3500

**Motion Recovery Physical Therapy, Inc.**

[2A,1G] Sacramento
Amy Finn, PT, CLT-LANA
Kristin Ferguson, PT, CLT  916-649-0700

**Sharp Rehab Ctr**

[2V,1*L] San Diego
Linda Hackabees, OTR/L, CLT-LANA  858-939-3938

**Saint Francis Memorial Hospital**

[2A] San Francisco
Shanna Humphrey, OTR/L, CLT, WCC
Irene Dedina, MPT, CLT, WCC  415-353-6275

**St. Mary’s Medical Center Outpatient Therapies**

[1N,1G,2A] San Francisco
Fiona McCusker, PT  415-750-5900

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**Arkansas Lymphedema and Therapy Providers**

- **1G,1A,2G** North Little Rock
  Troy Alberson, MSPT, CLT-LANA  501-772-3224

**California**

- **City of Hope National Medical Ctr**
  [1A,2G,2*L] Duarte
  Jennifer Hayter, MA, OTR/L, CLT-LANA
  Belinda Torrez, MOT, OTR/L, CLT-LANA  626-256-4673 Ext. 62412

**TAG Lymphedema Ctr**

- **1N,1V,1*L** El Segundo
  Cathy Tarte, PT, CLT
  Richelle Drake, CLT-LANA  310-426-9570

**New Horizons Physical Therapy, PC**

- **1G,1L,1A,1*L** Encinitas
  Tammy E. Mondy, PT, DPT, MSRS, CLT-LANA
  Joe Mondy, PT, DPT, MSRS, CS, CLT  760-230-6472

**St. Agnes Cancer Ctr Lymphedema Program**

- **1A,1*L** Fresno
  Denise Ketcham, PT, CLT-LANA  559-450-5500

**Long Beach Memorial Medical Ctr – Lymphedema Clinic**

- **2N** Long Beach
  Barbara Stone, PT, CLT
  Lisa Smith, PT  562-933-5864

**Providence Holy Cross Medical Ctr**

- **1N,1*L** Mission Hills
  JoAnne Shahnazi, OTR/CLT  818-898-4529
  Kathy Caplan, RPT/CLT  661-288-5925

**Hoag Memorial Hospital Presbyterian**

- **1A,1G,2N,2*L** Newport Beach
  Danielle Allison, PT  949-764-5645

**St. Joseph Hospital, Lymphedema Center**

- **2A,1C,2N** Orange
  Jeanne Fahring, PT, CLT  714-542-8002

**Casa Colina Centers for Rehabilitation**

- **3N,1*L** Pomona
  Kathy San Martino, PT, CLT-LANA
  Debbie Huskey, PT, CLT  909-596-7733 x3500

**Motion Recovery Physical Therapy, Inc.**

- **2A,1G** Sacramento
  Amy Finn, PT, CLT-LANA
  Kristin Ferguson, PT, CLT  916-649-0700

**Sharp Rehab Ctr**

- **2V,1*L** San Diego
  Linda Hackabees, OTR/L, CLT-LANA  858-939-3938

**Saint Francis Memorial Hospital**

- **2A** San Francisco
  Shanna Humphrey, OTR/L, CLT, WCC
  Irene Dedina, MPT, CLT, WCC  415-353-6275

**St. Mary’s Medical Center Outpatient Therapies**

- **1N,1G,2A** San Francisco
  Fiona McCusker, PT  415-750-5900
Eden Medical Center Lymphedema Program [1A,1V,2*] San Leandro
Ally Martinez, MA, OTR/L, CLT-LANA
Rina Villarey, OT, CLT-LANA 510-618-1804

Central Coast Lymphedema Therapy [1A,2*] San Luis Obispo
Leeslyn Keith, MS, OTR/L
Michelle Johnson, OTR/L 805-782-9300

Central Valley Physical Therapy [1A, 1] Stockton
Chip Hacker, PT, MPT
Virtu Arora, PT, CLT 209-473-2383

Jennifer Vonarbs, MPT, CLT
Tessa Waggoner, MS, PT, CLT 805-497-9300

National Lymphedema Center [1G,2N,1*] Torrance
Julie M. Soderberg, MPT, ATC, CLT, CSCS
Shayla Storz, PT 310-882-6261

Los Robles Hospital Lymphedema Clinic [4N,1A] Westlake
Charlene Anderson, PT, CLT
Lori Jackson, PT 805-370-4001

CONNECTICUT
Greenwich Hospital [1A,1N,1L,2*] Greenwich
Janet Freedman, MD, CLT 203-863-4290
Heather Studwell, MS, OTR/L, CLT-LANA 203-863-3291

Middlesex Hospital - Physical Rehabilitation Center [3N,2G,1*] Middletown & Essex
Patric Thomsat, MS, PT, CLT 860-358-2700
Elizabeth Jones, OTR/L, CLT 860-358-3970

Norwalk Hospital Rehabilitation Services [2G] Norwalk
Diana Rich, PT 203-852-3400

Rifkin Physical Therapy & Lymphedema Ctr, LLC [3G,1V,1*] Prospect
Carmelita V. Rifkin, PT, MS, CLT-LANA
Lynn Beard, OTR/L, CLT 203-758-6569

The Stamford Hosp Outpatient Rehab at Tully Health Ctr [1A,2G,2N,1S] Stamford
Jennifer Rokicki, OT
Gina Aiello, PT 203-276-2660

Rehabilitation Associates, Inc. [2A,1G,1V,2*] Stratford
Jan Hollerbach, MA, OTR/L, CLT
Patricia Warner, OT, CLT-LANA 203-378-0092

Aventura Hospital – Lymphedema Management Program [1A] Aventura
Trudy Ferguson-Pitters, RPT, CLT 305-937-5802

Lymphatx, Inc. [7A,2*]
Boca Raton/Boynton Beach/Coral Springs
Pamela Cohen, RPT, CLT-LANA 561-392-5131
Deborah Miller, LPTA, CLT-LANA 561-733-1012

Bethesda Hospital [1A,1*] Boynton Beach
Melissa Salerno, OTR/L, CLT
Allison Remis, OT/L, CLT 561-292-4950

Jacksonville Lymphedema Clinic, Inc [1A,1G,1S,2V,2*] Jacksonville
Rickie P. Sander, MD 904-398-2829

Jupiter Medical Ctr Health & Rehab Ctr [4A,2*,1*] Jupiter
Wendy L. Smith, PT, DPT, OCS, CLT-LANA
Kelly Raymond, PT, CLT 561-263-5775

Northwest Medical Outpatient Rehab [1A,1V,1*] Margate
Cathi Kleinman-Barnett, MOTR/L, CLT-LANA, LMT, CLM, CLL 954-978-4180

Wuesthoff Rehab Services [6A,1N,2*] Melbourne/Rockledge
Rosanne Bessenaire, PT, CLT-LANA
Adam Rhoads, PT, CLT 321-752-1500
321-433-0288

Mercy Hospital - Kohly Center for Outpatient Rehab [5A,1*] Miami
Mary Harrison, PT
Kathy Stults, PT 305-285-2966

Therapy For You Lymphedema Clinic [1A,2N] Ocala & The Villages
Meenu Jethwani, OT/L, CLT-LANA
352-237-0073
352-391-9500

Healing The Generations, Inc. [2A]
St. Petersburg/Clearwater
Nadine Verdebout, PT
Wouter Vanderhorst, PT 727-535-6746

Florida Hospital Zephyrhills [2A,1N] Zephyrhills
Evelyn Lopez, OTR
Nasly Benavides, PT 813-783-6154

GEORGIA
Northside Hospital (Atlanta & Alpharetta), Northside Hospital Forsyth [3A,3S] Atlanta
Janie Smith, PT, CLT
Gillian Wolfson Piha, PT 404-851-9912

St. Joseph – Candler Hospital [3A,1*] Savannah
Mary Cuquet Feltchlin, CLT-LANA, COTA/L, BA 912-819-8822

The Rehabilitation Institute at Memorial Health [2A,2*] Savannah
Corie M. Turley, MSPT, CLT-LANA
Cheryl Armstrong, OTR/L, CLT-LANA 912-350-7128

HAWAII
Kapiolani Women’s Ctr [1C,1*] Honolulu
Audrey Yoneshige, PT, CLT-LANA 808-527-2588

ILLINOIS
NovaCare Rehabilitation [3N] Chicago, Mt. Prospect, Oak Park
Thomas Rosinski 312-640-2473
Karyn Holtz 847-398-1775

Rehab Institute of Chicago [1A,4G,7N,1*] Chicago
Gail Gamble, MD 312-238-1000
Sammon Sharpe, MD 312-238-1000

Northshore University HealthSystem [4A,9G,3N,7*] Evanston
Joseph Feldman, MD, CLT-LANA 847-570-2066

Delnor – Community Hospital [2G,1V,2*] Geneva
Christine Wietrzykowski, MHS, PT, CLT-LANA 630-208-4592

Ingalls Hospital [2G,2*,1*] Harvey
Sandy Collins, PT, CLT-LANA 708-915-8465

Loyola Rehabilitation Services [4A,2L,1G] Maywood, Oakbrook Terrace & Homer Glen
Elizabeth Russell, PT, CLT-LANA
Julie Nelson, PT, DPT, CLT 708-216-3657
216-3500 Ext. 2

Palos Community Hospital [1N,1K] Palos Heights
Caroline Leflar, PT, CLT-LANA 708-923-5050

SwedishAmerican Health System, Outpatient Therapy Services [2A,2*] Rockford
Janet Davis, PT
Betty Downing, PTA 815-489-4590

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## Midwest Rehabilitation Services, Ltd. [1A,1V,2,2N] ~ Woodridge
- Suresh Bhangare, PT, CLT 630-910-8480

## INDIANA

### Franciscan Alliance: St. Elizabeth Central
- [1A,3G,1N,3,1] Lafayette
  - Stephanie Romig, MS, OTR
  - Amy Dunwoody, PT 765-423-6885

### Saint Joseph Regional Medical Center Outpatient Therapy
- [2G, 1] Mishawaka/Plymouth
  - Joanne M. Hartman, PT, CLT 574-335-6212
  - Dawn Beery, PT, CLT 574-948-5320

## Kentucky

### Memorial Regional Lymphedema Treatment Program
- [6G, 1, 1] South Bend
  - Sharon Klingerman, RN, NP 574-647-1068
  - Priscilla Hellenga, BS 574-647-1068

## Iowa

### Jennie Edmondson Lymphedema Ctr
- [1A,3G,1N,3] Council Bluffs
  - Mary-Ellen Bartels, PT, CLT-LANA 712-396-6025

### Oncology Rehab/LE Program - Genesis Medical Ctr [3] ~ Davenport
- Christine H. Beuthin, PT, DPT, GCS 563-421-1470

## Michigan

### University of Michigan Lymphedema Treatment Program
- [3G, 1N, 1A, 1, 1] Ann Arbor
  - Katherine Konosky, CLT-LANA 734-936-7070

### Spectrum Health Lymphedema Program
- [3A] Grand Rapids
  - Richard Hodgson, MD 616-468-6800

### Lakeland Health Care – Lymphedema Services
- [2G, 3N, 3] St. Joseph
  - Leann Jewell, MS, PT, CLT-LANA 269-983-8242

## Minnesota

### Sister Kenny Rehabilitation Institute Lymphedema Program
- [3A, 22G, 1N, 3S, 1O] Minneapolis
  - Nancy A. Hutchison, MD, CLT-LANA
  - Monica Hein, PT, CLT-LANA, STAR/c, CRLP Lead 612-262-7900

### Fairview Edema Treatment Ctrs
- [9A, 2G, 3N, 1V, 9] Minneapolis
  - Lisa Karrow, PT & Statewide www.fairview.org

### Mayo Clinic – Lymphedema Ctr
- [7A, 7G, 1] Rochester
  - Andrea Cheville, MD 507-266-8721

### HealthEast Vascular Ctr – Lymphedema Program
- [1A, 1N, 2S, 1] St. Paul
  - Sandra K. Rosenberg, MD 651-232-2550

## Missouri

### Ellis Fischel Cancer Rehab Center
- [1G, 1N] Columbia
  - Karen Wingert, DPT, CLT 573-882-8445

### Freeman Lymphedema Clinic
- [1G, 1] Joplin
  - Laura Linville, OTR/L 417-347-3737

## Nebraska

### Alegent Creighton Health Lymphedema Clinic [5A, 1N]
- Omaha
  - Lori Buckley, OTR/L, CLT 402-398-5750

## Nevada

### Lymphatic Therapy
- [2A, 2G, 3N, 2V] Las Vegas
  - Virginia Leeson, OTR/L, CLT-LANA 702-367-6015

## New Hampshire

### Southern New Hampshire Rehab Ctr [4A]
- Nashua
  - Amanda McCann, PT, CLT 603-577-8400

## New Jersey

### CentraState Medical Ctr [3G, 5N, 4, 1]
- Freehold
  - Marilene Japzon, PT, CLT-LANA 732-294-2700

### Atlantic Rehabilitation Institute [2G, 1N, 2, 1] Morristown
- Kathryn Ryans, PT, DPT, CLT-LANA 732-222-8556

## New York

### Delmar Physical Therapy & Lymphedema Treatment Ctr [1V, 1, 1]
- Albany
  - Michele N. Keleher, MS, PT, CLT-LANA 518-439-1485

- Heather Carangelo, PT, CLT-LANA 518-475-1818

### Stony Brook University Hospital [3A, 1, 1]
- East Setauket
  - Candiano Rienzie, DPT 631-444-4240
Gold Standard Physical Therapy [1A.1] New York City
Sandi Shein, PT, DPT, CLT-LANA 212-481-4022

Memorial Sloan-Kettering Cancer Center [1A, 1N, 4A] New York City
Ting-Ting Kuo, PT, DPT, WCSS, CLT
Annelise Savodnik, PT, MPT 646-888-1900

New York University Medical Ctr/Rusk Institute of Rehabilitation Medicine [3A, 1A, 1N, 1G] New York City
Laurie Kliment, PT, DPT, WCSS, CLT-LANA
Olga Kalandova, PT, MS, Cert. MDT 212-263-5601

Callan-Harris Physical Therapy, PC [2A, 2G] Rochester
Susanne Callan-Harris, PT, MS, LLC, CLT-LANA 585-482-5060

Lymphedema Therapy [4A, 1G, 3G] Woodbury
Bonnie Lasiinski, MA, PT, CLT-LANA 516-364-2200

**NORTHERN CAROLINA**

Carolinas Rehab-Main [1A, 1G, 2V, 2A] Charlotte
Vishwa Raj, MD 704-355-0239

Moses Cone Outpatient Rehab At Guilford College [1G, 1N] Greensboro
Marti Smith, PT
Donna Salisbury, PT, CLT 336-315-4760

Caldwell Memorial Hospital Outpatient Rehabilitation Services [2A, 1G] Lenoir
Angela Sigmun, MS, OTR/L
Sandy Cannon, COTA, CLT 828-757-6226

OHIO

Lymphedema Center at UH Geauga Medical Center [2N] Chardon
Dotti A. Thompson, MOTA, OTR/L, CLT
Allison Evans, OTR/L, CLT 440-285-6359

Cleveland Clinic Vascular Medicine [3A, 1N] Cleveland
Leslie Gilbert, MD
Douglas Joseph, DO 216-444-5710

The Stefanie Spielman Comprehensive Breast Center [3A, 1*, 2G] Columbus
Karen Hock, PT, MS, CLT-LANA 614-293-0043

Lima Memorial Health System [1N, 1A] Lima
Gretchen Miller, OTR/L 419-226-5047
Roberta Keenan, OTR/L 419-998-4704

TuDor Physical Therapy Ctrs [2A, 1T, 1G] Youngstown
Gail DeMartino, PTA, CLT
Laura Dye, PT, CLT 330-799-6298

OREGON

Rogue Valley Medical Center [3A, 1G, 1A] Medford
Janette Majors, PT
Connie Miller, PT 541-789-4255

Legacy Health System [2A, 2G, 1A] Portland
Sandra Kirchner, PT, CLT-LANA 503-413-7753
Karen Garrett, PT, CLT-LANA 360-487-3750

New Leaf Physical & Massage Therapy, LLC [2G, 1G] Portland
Chelsea French, LMT, CLT
Mary Gramling, PT, CLT-LANA 503-318-7954

**PENNSYLVANIA**

Orthopaedic Associates of Allentown [1G, 1A] Allentown
Jane M. Roche, COTA/L 610-973-6259

DoylesTown Hospital Physical Therapy [1A, 3N, 3G] Doylestown
Dana Winrow, PT, CLT-LANA
Amanda Scully, DPT, CLT 814-860-7816

Keystone Rehabilitation Systems - Erie South [1G, 1N] Erie
Elizabeth Darling, DPT, CLT, ATC, OCS
Amanda Scully, DPT, CLT 814-860-7816

St. Mary Medical Center [2G, 1N] Langhorne
Brigette DiMarino, MS, OTR/L, CLT
Laura Puglisi, MOTA, OTR/L 215-710-2223

Pinnacle Health Physical Therapy of Camp Hill [2I, 2G] Lemoynes
Donna Kubik, PTA, CLT-LANA
April Evanitsky, PTA, CLT-LANA, LMT 717-214-3688

Fox Chase Cancer Ctr [1G, 2N, 2A] Philadelphia
Wilma Morgan-Hazelwood, OTR/L, CLT-LANA
Janice Buhrer, MS, DPT, OCS 215-728-7000

Penn Therapy and Fitness [3V, 4N, 9G, 7A] Philadelphia/Radner
Joy C. Cohn, PT, CLT-LANA
Nicole Dugan, DPT, CLT-LANA 215-349-5585

Allegheny Chesapeake Physical Therapy [1T, 2G, 1A] Pittsburgh
Suzanne Cavanaugh, DMPT, CLT-LANA
Kristen Carlin, PT 412-661-0400

Schuykill Rehabilitation Center [2N] Pottsville
Patricia Gregas, OTR/L
Lynn Kamarovsky, OTR/L 570-621-9500

**RHODE ISLAND**

Women and Infants Hospital - Investigative Care [1N, 2A, 1G, 1V] Providence
Rebecca Stocker, DPT, CLT
Marc Houle, PT, CLT 401-274-1122

**SOUTH CAROLINA**

Hilton Head Occupational Therapy [1A, 1I] Bluffton
Madeline Chatlain, OTR/L, CLT-LANA 843-757-9292

Palmetto Health Baptist Lymphedema Treatment Ctr [1G, 1N, 1V, 3G] Columbia
Kel Jansen, OTR/L, CLT
Mary McGowan, PT, CLT-LANA 803-296-5486

McLeod Health Lymphedema Treatment Ctr [3A, 2G] Florence
Ashley Atkinson, OTR/L, CLT-LANA, WCC 843-777-4697

**SOUTH DAKOTA**

Regional Rehab Institute [2A, 1G, 2A] Rapid City
Karine Carpenter, PT, CLT 605-719-1100

**TENNESSEE**

Avalon Therapy Services [2A, 1] Chattanooga
Margaret Secrest, PT, CLT-LANA
Douglas Lee, PTA, CLT 423-553-8175

Siskin Hospital Lymphedema Clinic [5A] Chattanooga
John Jordi, PTA, CLT-LANA
Kathy Clark, PTA, CLT 423-634-1246

Marino Therapy Centers [2A, 1S, 2A] Knoxville
Kathleen Westbrook, PT, CLT-LANA 865-990-2671

Vanderbilt Lymphedema Therapy Clinic [3A, 1G] Nashville
Jadranko Franjic, PT, CLT-LANA 615-343-7400
Adrian Mackenzie, PTA, CLT-LANTA (option 2)

**TEXAS**

St. David's Lymphedema Clinic [1A, 1N, 1A] Austin
Esther Coates, OTR/L, CLT-LANTA 512-544-8627
Nancy Kaufmann, OTR/L, CLT-LANTA 512-544-5137

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### MLD Therapists

**Listed by State / Town / Therapist**

<table>
<thead>
<tr>
<th>State</th>
<th>City</th>
<th>Therapist Name</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>WISCONSIN</td>
<td>Brookfield</td>
<td>Jennifer S. Spencer, DPT, CLT</td>
<td>205-664-8404</td>
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<td></td>
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<td>Laurie G. Feest, OTR, CHT, CLT</td>
<td>928-453-0411</td>
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<td>Natalie C. Fogelson, PT, CLT-LANA</td>
<td>623-580-9323</td>
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<td>Kimberly Murray, CMT #28192, CLT</td>
<td>661-699-5171</td>
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<td>Gay Lee Gulbrandson, CLT-LANA</td>
<td>510-849-1388</td>
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<td>Sharadamba Kota, PT, CLT</td>
<td>510-296-4353</td>
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<td>Gina M. Ross, PTA, CLT</td>
<td>949-716-1800</td>
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<td>Jacqui Maroun, PT, CLT</td>
<td>949-305-8200</td>
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<td>Eleanor Ho, MPT, CLT-LANA</td>
<td>714-527-2289</td>
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<td>Rani Bechar, OTR/L, MA, CLT</td>
<td>310-837-8001</td>
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<td>Mary Rosenberg, PT, CLT-LANA</td>
<td>323-957-9571</td>
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<td>Joan Dillon, PT, LLCC</td>
<td>650-326-1807</td>
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<td>Kim Marshall, PT, CLT</td>
<td>714-547-1140</td>
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<td>Tori Burk, PT, CLT-LANA</td>
<td>707-762-2939</td>
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<td>Debora Hickman, DPT, WCS, CLT-LANA</td>
<td>909-307-0155</td>
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<td>Jennifer L. Vonarb, MPT, CLT</td>
<td>805-497-9300</td>
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<td>Gwen E. Tholkes, RN, CMLDT</td>
<td>303-601-9920</td>
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<td>Erin D. Maranjian, NCMT, CLT-LANA</td>
<td>970-218-1443</td>
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<td>Anne E. Moulton, LLCC, PTA, RMT</td>
<td>719-546-0037</td>
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<td>Nancy Keeney Smith, LMT, MLD</td>
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<td>Scottie Bull, PT, CLT-LANA</td>
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<td>Shyla D. Scott, DPT, CLT</td>
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<td>Joyce Weiser, OTR/L, CLT-LANA</td>
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<td>Wendy Urso, PT, CLT</td>
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<td>Jennifer Beal, DPT, CLT-LANA</td>
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<td>Sandi Stephens McGiff, LMT, CLT-LANA</td>
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<td>Cherisse Sansone, PT, MLD/CDT</td>
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<td>Jody Tucker, LMT, CLT-LANA</td>
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<td>Lori Thomas, MS, OTR/L, CLT-LANA</td>
<td>217-322-5286</td>
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<td>Tracy Clark, APRN-C</td>
<td>913-643-0075</td>
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<td>Dawn M. Hurd, OTR/L</td>
<td>316-207-1435</td>
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<td>James Marc-Aurele, MBA, OTR/L</td>
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<td>Karen Gross, PT, MS, CLT</td>
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<td>Dawn M. Hurd, OTR/L</td>
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<td>Michelle A. Wellen, PT, DPT, MS, CMT</td>
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<td>Dorliah Kraft-Guilfoyle, OTR/L, CLT</td>
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<td>Michelle McLellan, PT, OCS, CLT</td>
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<td>Cynthia Tan, MPT, ATC, CLT-LANA</td>
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<td>Jane T. Reinsch, MA, PT, CLT-LANA</td>
<td>860-242-8427</td>
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<td>Michelle McLellan, PT, OCS, CLT</td>
<td>202-223-1737</td>
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<td>Nicole Scheiman, MHS, OTR/L, CLT-LANA, CKTP, CEES, CSST</td>
<td>386-943-4690</td>
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<td>Cynthia Tan, MPT, ATC, CLT-LANA</td>
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### Resource Guide ~ 7

### Suppliers

(Registered Alphabetically)

#### Alala, LLC
- **Nationwide**
  - 803-569-4373

#### Bandages Plus
- **Domestic & International**
  - 800-770-1032

#### Bellisse
- **Nationwide**
  - 877-273-1683

#### BioHorizon Medical, Inc
- **Nationwide**
  - 866-914-5159

#### Comfort Care Medical Lymphedema & Wound Care Specialist
- **Nationwide**
  - 410-788-2273

#### FarrowMed, Inc.
- **Nationwide & International**
  - 877-417-5187

#### Impedimed, Inc.
- **Nationwide**
  - 877-247-0111, Ext 2

#### Juzo
- **800-222-4999 Cuyahoga Falls, OH or 888-255-1300**

#### Lymph Press USA
- **International**
  - 888-596-7421

#### Lymph Notes – Lymphedema Books
- **Nationwide & International**
  - [www.lymphnotes.com](http://www.lymphnotes.com)

#### LymphDEIVAs LLC
- **International**
  - 866-411-DIVA

#### medi USA
- **Nationwide**
  - 800-633-6334

#### National Rehab (NR)
- **Western/Central PA, Eastern OH, Northern/Eastern, WV**
  - 800-451-6510

#### Solaris
- **Nationwide**
  - 855-892-4141

#### Tactile Systems – The Flexitouch Co.
- **Nationwide**
  - 866-435-3948

#### Wear Ease, Inc.
- **Nationwide, Canada, International**
  - 866-251-0076

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### Attention New CLTs!

If you have recently graduated from a CLT course you are eligible for a FREE one year membership as an NLN Affiliated therapist. NLN Affiliated Therapists get listed on our website and in this section of our LymphLink. Your patients are also eligible to apply for the Marilyn Westbrook Garment Fund.

For more information please see the Affiliate application on our website: [http://www.lymphnet.org/aboutNLN/affiliateMembership.htm](http://www.lymphnet.org/aboutNLN/affiliateMembership.htm)
# Lymphedema Support Groups

## Arkansas
- Fayetteville: 479-587-1700
- Little Rock: 501-686-8145

## Arizona
- Prescott: 928-771-5131
- Scottsdale: 480-323-1100

## California
- Concord: 925-674-2125
- Greenbrae: 415-924-1699
- Los Angeles: 310-259-1972
- Mission Hills: 818-496-1643
- Newport Beach: 949-764-5542
- Orange: 714-731-0233 or 714-420-0233
- Redding: 530-221-6584
- San Francisco: 415-600-6281 or 415-600-3073
- Torrance: 310-517-4665
- Ventura: 805-652-5459
- Westlake: 805-370-4001

## Colorado
- Greenwood Village: 303-651-5188
- Longmont: 720-306-8261

## Connecticut
- Danbury: 203-790-6568
- Windsor: 860-683-0080

## Florida
- Aventura: 305-937-5802
- Boca Raton: 561-392-3340
- Boynton Beach: 561-733-1012
- Clearwater/ St. Petersburg: 727-535-6746
- Ft. Myers: 239-437-1606
- Lady Lake: 352-365-1114
- Margate: 954-978-4180
- Melbourne/Rockledge: 321-752-1500

## Georgia
- Atlanta: 770-442-1317 or 770-330-0036

## Illinois
- Barrington: 847-620-4579
- Geneva: 630-208-4592
- Palos Heights: 708-923-5050

## Indiana
- Batesville: 812-934-6512

## Iowa
- Clive: 515-222-7845

## Kentucky
- Ft. Thomas: 859-301-2273 or 859-441-6484
- Louisville: 502-629-4062 or 502-899-9363 or 502-459-0570

## Louisiana
- Baton Rouge: 225-763-4050

## Maryland
- Lanham: 301-552-8144

## Michigan
- Southgate: 734-246-8125

## Minnesota
- Minneapolis: 612-331-5200
- St. Paul: 651-224-5500
- St. Louis: 612-338-2200

## Missouri
- Columbia: 573-814-2968
- Joplin: 417-625-2196
- Kansas City: 816-751-4141

## Nebraska
- Scottsbluff: 308-633-2900

## Nevada
- Reno: 775-722-1041

## New Jersey
- Somers Point: 609-653-3512
- West Long Branch: 732-222-8556

## New York
- Albany: 518-459-5086 or 518-435-1055
- New York: 212-937-5577
- Poughkeepsie: 845-483-6331

## Oregon
- Medford: 541-789-5543
- Milton-Freewater: 541-938-3208
- Portland: 503-413-7284

## Pennsylvania
- Doylestown: 215-345-2894
- Gettysburg: 717-339-2620
- Langhorne: 215-710-2424
- Philadelphia: 215-728-2592
- Pittsburgh: 412-661-0400

## South Carolina
- Greenville: 864-214-6006
- Myrtle Beach: 843-651-7513
- Myrtle Beach: 843-446-6015 or 843-650-4461

## Tennessee
- Chattanooga: 423-634-1246
- Johnson City: 423-282-8922 or 423-975-9884

## Texas
- New Braunfels: 830-606-4067
- Canyon Lake: 830-660-9107
- San Antonio: 210-872-2424
- Sugar Land: 281-242-5807

## Utah
- Ephriam: 435-283-4327

## Virginia
- Hampton: 757-589-1416

## Washington
- Kennewick: 509-736-6060
- Kent: 206-575-7775

## Wisconsin
- Beloit: 608-364-2337

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If you are an individual NLN member with a FREE ongoing Support Group, or are in the process of starting a new one, let us know. Call 415-908-3681 to request a Support Group application. We will fax or send one to you right away. You can also apply online at [www.lymphnet.org/supportGrpListingApp.htm](http://www.lymphnet.org/supportGrpListingApp.htm). New submissions will appear in the following issue of LymphLink. We are also happy to list your Support Group activities in our Action Corner (see page 32).

Please note that treatment facilities or businesses that offer Support Groups must be an active NLN Affiliate to qualify for inclusion in this listing.

For more information please visit [www.lymphnet.org/patients/supportGroup.htm](http://www.lymphnet.org/patients/supportGroup.htm)
This insufficiency can be caused by developmental abnormalities of the lymphatic system (primary LE), or damage to the lymphatic system such as the removal or radiation of lymph nodes in cancer surgery, or infection of the lymphatic system (secondary lymphedema). Lymphedema most often affects the extremities, but can also be present in the head and neck, trunk, or external genitalia.

In order to reduce the swelling it is necessary to re-route the lymph flow - to include excess protein and water molecules - around the blocked area(s) into more centrally located healthy lymph vessels. This goal is achieved by a combination of different treatment modalities, all of which are integral components of CDT.

**Q: What is Complete Decongestive Therapy (CDT)?**

**A:** Complete decongestive therapy, sometimes referred to as complex decongestive therapy, or combined physical therapy is the internationally recognized “gold standard” treatment system for the vast majority of patients affected by lymphedema.

Backed by long standing experience, CDT has shown to be safe and effective as the standard therapy for lymphedema.

The swelling in lymphedema is caused by an accumulation of protein and water molecules in the tissue and results from the inability of the lymphatic system to perform one of its basic functions, the removal of water and protein from the tissues of a certain portion of the body. This insufficiency can be caused by developmental abnormalities of the lymphatic system (primary LE), or damage to the lymphatic system such as the removal or radiation of lymph nodes in cancer surgery, or infection of the lymphatic system (secondary lymphedema). Lymphedema most often affects the extremities, but can also be present in the head and neck, trunk, or external genitalia.

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**Q: What are the Components of CDT?**

**A:** Elements of CDT include manual lymph drainage, compression therapy, decongestive exercises, and skin care.

**Manual lymph drainage (MLD):** This gentle manual treatment technique, based on four basic strokes, is designed to have an effect on fluid components and lymphatic structures located in superficial tissues, such as the skin and subcutis. LE almost exclusively manifests itself in the subcutis, and the techniques of MLD are ideally suited to gently re-route the flow of lymph around blocked areas.

**Compression therapy:** Utilizing proper treatment techniques, lymphedema can be reduced to a normal or near normal size. However, existing LE damages the elastic fibers in the skin, and even after decongestion, the skin elasticity may never be regained completely. This can result in re-accumulation of fluid and external support of the affected body part is therefore essential. Depending on the phase of the treatment compression is provided by padded short-stretch bandages, compression garments, or a combination of both.

**Decongestive exercises:** Unlike the heart in the blood circulatory system, the lymphatic system does not have an active pump to propel lymphatic fluid back into the bloodstream. Effective lymph flow depends on sufficient muscle and joint activity, especially if the functionality of the lymphatic system is compromised. Decongestive exercises consist of active, non-resistive and repetitive protocols, which should be customized by the LE therapist and/or physician to meet individual goals for patients affected by LE. The stage and type of lymphedema, specific restrictions and limitations of joint and muscle activity, as well as additional medical conditions need to be considered.

Ideally, decongestive exercise protocols are performed two to three times daily for about 10-15 minutes, and the patient should rest with the affected limb elevated for at least 10 minutes following the exercises. Decongestive exercises are most effective if performed while the patient wears compression garments or bandages.

Individuals affected by lymphedema of the leg benefit greatly from an exercise program including diaphragmatic breathing exercises. The downward and upward movement of the diaphragm in deep abdominal breathing is an essential component to support the sufficient return of lymphatic fluid back into the bloodstream. The movement of the diaphragm, combined with the outward and inward movements of the abdomen, ribcage, and lower back, also promotes general well-being, peristalsis and return of venous blood back to the heart.

Skin and nail care: Patients who already have, or had lymphedema are susceptible to infections of the skin and nails. Lymphedematous tissues are saturated with protein-rich fluid, which serves as an ideal nutrient source for bacteria and other pathogens. Lymphedematous skin also tends to be dry and may become thickened and scaly, which increases the risk of skin cracks and fissures. The skin represents the first line of defense against foreign invaders and is usually impermeable to bacteria and other pathogens. However, any defect in the skin such as burns, chafing, dryness, cuticle injury, cracks, cuts, splinters, and insect bites can present an entry site for pathogens or infectious agents and cause infection. The process of inflammation may not only worsen the symptoms of LE by increasing the swelling, but can also develop into a serious medical crisis. The basic consideration in skin and nail care is therefore the prevention and control of infections, which includes proper cleansing and moisturizing techniques with the goal of maintaining the health and integrity of the skin. Suitable ointments or lotions formulated for sensitive skin, radiation dermatitis and lymphedema should be applied before the application of LE bandages while the patient is in the decongestive phase of the treatment. Once the limb is decongested and the patient wears compression garments, moisturizing ointments should be applied twice daily.

Frequently therapists are asked if it is possible to effectively treat lymphedema using only one or two components of CDT. The clear answer is “no”. LE requires a systematic approach, and each of these components is ideally suited to treat and manage the symptoms associated with lymphedema. Successful treatment of lymphedema would not be possible without the combination of individual benefits of all components of CDT.
et al.\textsuperscript{29} also found age did not correlate with effectiveness of treatment.

Vignes et al.\textsuperscript{30} found the weight of the patient did not affect the effectiveness of treatment.

Liao et al.\textsuperscript{31} found the amount of swelling did not correlate with the percent of reduction, although an earlier study by Ramos et al.\textsuperscript{32} had found a correlation.

Yamamoto et al.\textsuperscript{33}, Liao et al.\textsuperscript{34} and Vignes et al.\textsuperscript{35} all found although the duration of the lymphedema correlated with more swelling, it did not affect the amount of reduction in treatment.

Liao et al.\textsuperscript{36} and Yamamoto et al.\textsuperscript{37} also both found the length of treatment/number of sessions was not correlated with amount of reduction. Yamamoto et al.\textsuperscript{38} also found the maximum reduction (about a 50\% decrease in swelling) was generally achieved in the first few days, after which the rate of reduction began to taper off.

Discussion

There was a clear and definite trend indicating CDT, even watered down, led to improvements in the patients’ otherwise progressive condition. There was evidence the results were possible to maintain if patients adhered to their home program.

It was still not clear how much of a role each component of CDT plays in the outcome and how the interaction among the components affects the outcome.

Among the areas needing more research are the following:

1. What is the most effective home program for patients to maintain/improve their results and what are ways to optimize patients’ ability to adhere to this?
2. What are the effects of BMI, co-morbidities, onset/duration, and other factors on the effectiveness of treatment?
3. What are the effects of CDT on improved function and QOL and how can these be further enhanced?

Conclusion

Based on clinical observations CDT is considered the gold standard in treatment and management of lymphedema, but more research with more uniform standards of measurements need to be conducted. This includes RCTs with control groups, blinded assessors, objective measurements of volume, function and/or mobility, larger group sizes with longer follow-up periods, more consistent protocols, with more standard dosing of CDT components. The authors felt a more universal definition of lymphedema also needs to be established.

The authors recognized with the various etiologies of lymphedema (primary and secondary) and with the varying protocols of treatment, it is difficult to state with absolute certainty the effectiveness of each component of CDT. What is recognized, universally among therapists, is CDT, the most effective tool available to clinicians for the treatment and management of lymphedema. The authors also acknowledge better and more comprehensive research is required to understand the varying aspects confounding the successful treatment of lymphedema. These include the effects of BMI, patient adherence during treatment and afterwards to maintain reduction achieved during therapy, co-morbidities, as well as a greater understanding of the lymphatic system and how alteration of it – whether due to birth abnormalities or trauma or surgical intervention -- can influence the transport capacity leading to lymphedema. While limb lymphedema can be successfully managed with CDT, special areas of concern for treatment including breast, truncal, genital, and facial edema which need to be addressed.
Until further research is conducted and analyzed, CDT remains the best option not only for the physical needs, but also for quality of life issues for patients with lymphedema.

**Practical Applications of CDT ...**

Continued from page 7

support their patient from the time of admission to discharge. Practitioners have the opportunity to utilize the practical applications of the evidence for CDT and can assist patients to reduce their risk for LE or minimize worsening of pre-existing LE while they receive needed medical care.

blasins@optonline.net

**LSAP Forum ...**

Continued from page 14

Being the co-host of the Lymphedema Mavens podcast is a dream come true for me, I found my passion. I have always wanted to be in broadcasting, but felt that it was something out of my realm. I must admit that I enjoy booking ours guest and conducting the interviews. There is much research involved in the production of a quality podcast. The production of the podcast is a labor of love.

The Mavens have been privileged to cover a number of important topics on the subject of lymphedema, breast cancer, and healthcare. We are eternally grateful to those who took the time out of their busy schedules to contribute to our podcast. Although there are many to thank, here are just a few:

Dr. David Ansell, Pioneer of the Emergency Medical Treatment and Active Labor Act.

Dr. Nancy Cappello from Are You Dense.org discussing breast density and legislation.

Deborah Cordner Carson, Keynote speaker at the 10th Int’l NLN Conference.

Dr. Elain Schattner, Huffington Post Columnist discussing “Can You Be A Patient Advocate?”

Saskia Thiadens, Executive Director National Lymphedema Network updates from the 10th Int’l NLN Conference.

Jane Dweck, StepUp-SpeakOut sharing resources for the lymphedema community

Linda Anne Kahn on the subject of Integrative Approaches to Lymphedema Management

Michael Altriste, on the subject of Delivering Lymphedema Care to the Homebound Patient

Dr. Paula Stewart speaking about her book 100 Questions and Answers about Lymphedema and the importance of eating anti-inflammatory foods.

Dr. Jay Granzow on the subject of Lymphatic Liposuction as a Lymphedema Treatment for Long-Term Non-Pitting Lymphedema.

The Lymphedema Mavens Podcast is fully funded by the hosts; we look forward to the day when we have a sponsor who will help with the cost of production. In the meantime, we will continue to all that we can to bring all things lymphedema to our audience.

I am blessed to be doing something that brings so much joy into my life.

Cynthia “MsCjay” Judge

mscjay@lymphedema mavens.com

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**The 11th NLN International Conference**

The Campaign for Lymphedema Care Perspectives, Evidence & Practices

**The National Lymphedema Network’s the 11th International Conference**

September 3-7, 2014

Washington Marriott Wardman Park, Washington, DC

Registration Opens October 15, 2013

Abstracts January 1, 2014

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Please Join Us for

The National Lymphedema Network’s the 11th International Conference

September 3-7, 2014

Washington Marriott Wardman Park, Washington, DC
Q: What are treatment goals in the two phases of CDT?

A: Successful lymphedema treatment is performed in two phases. In phase one, also known as the intensive or decongestive phase treatments are administered by trained lymphedema therapists on a daily basis until the affected body part is decongested.

The duration of the intensive phase varies with the severity of the condition and averages two-three weeks for patients with lymphedema affecting the arm, and two-four weeks for patients with lymphedema of the leg. In extreme cases the decongestive phase may last up to six to eight weeks and may have to be repeated several times.

The end of the first phase of CDT is determined by the results of measurements on the affected body part, which are taken by the therapist. Once measurements approach a plateau, the end of phase one is reached and the patient progresses seamlessly into phase two of CDT, also known as the self-management phase, which is an ongoing and individualized part of CDT. In this second phase the patient assumes responsibility for maintaining and improving the treatment results achieved in phase one.

During the intensive phase, the patients are instructed in the individual components of self-management, which include a skin care regimen, home exercises, self-manual lymph drainage and the application of compression garments for daytime use.

Save The Date...

San Francisco, CA, USA
September 5-13, 2015

Joint meeting of International Society of Lymphology (ISL), National Lymphedema Network (NLN), & Sentinel Node Oncology Foundation (SNOF)

www.lymphology2015.com

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JOBST® is the #1 physician recommended brand for compression garments, covering a full range of products for your every need.

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New York State Assemblyman Alan Maisel (D - Brooklyn) at right presents NY State Assembly Resolution to Bonnie Lasinski, PT, CS-CI, CLT-LANA for her advocacy efforts on behalf of individuals living with or at risk for lymphedema and other lymphatic system disorders. Also pictured at left is Joel Armel, long time lymphedema advocate from Brooklyn, NY.

Truman Medical Centers in Kansas City, MO celebrated Lymphedema “D” Day on March 06, 2013 by honoring three therapists with NLN Certificates, and turquoise-frosted cupcakes! Marcia Beck, ACNS-BC, CLT-LANA, a member of the Medical Advisory Committee of the NLN made the “surprise” presentation in conjunction with the Rehabilitation Director, Debra Ward: Pictured L-R: Marcia Beck, APRN, BC, CLT-LANA; Amy Dall, OTR/L, CLT; Karen J. Bock, PT, SWS, CLT-LANA; Julienne Ross, PT, CWS

Nationwide D-Day Celebrations

Thank you to everyone who participated in D-Day this year. Here are a few of the honorees who shared their celebrations with us.

The following patients were honored for D-Day this year:
Breigh
Cherrie Lamon
Margaret Beavers & Francine Hardy Honored by: Physical Therapy for Women, Inc.
Rosemarie Carvalho, Jeanne Gray, Alison Guy, Melanie Hubert, Elizabeth Paige, Erika Roland, Mother Kathleen Talbot, Janet Webster, Theresa Wieczerkowski, & Linda Woermer Honored by Rifkin Physical Therapy & Lymphedema Center, LLC

Patricia Patterson & Ella Wiggins Honored by: West Jefferson RehabConnection

The following medical professionals were honored for D-Day this year:
Sara Cohen, OTR/L, CLT-LANA, Memorial Sloan Kettering Breast Center
Margie Bonanotte, PTA, CLT, Ingalls Hosp, Harvey IL
Rosemary McCarthy, PT, CLT, Ingalls Hosp, Harvey IL

Congratulations to MAC member, Bonnie Lasinski! Bonnie was honored with resolutions in the New York State Assembly and Senate recognizing her years of service in treating individuals with lymphedema and lymphatic system disorders as well as her volunteer efforts in advocacy to raise awareness of and educate both professionals and the public about these conditions. These resolutions were read on the Assembly and Senate floor and entered into the public record of the day. Bonnie was not able to leave her patients to receive the official resolutions in Albany on March 6, Lymphedema D-Day. Assemblyman Alan Maisel (D-Brooklyn, NY) made the presentation to Bonnie at a Health Fair in Brooklyn on Saturday, April 6, 2013. Assemblyman Maisel has been a long time supporter of legislation relating to lymphedema treatment and reimbursement and he sponsored the bill to establish funds supporting a lymphedema research grant in NY State.

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Inspire: Lymphedema Patient Forum

The NLN is proud to announce the launch of our new online support community through inspire.com. It is a great place to connect with other patients, caregivers and even medical professionals in the lymphedema community. inspire.com is free for everyone and we hope that you will take part and help us grow!

http://lymphnet.inspire.com/

Lymphedema Treatment Act Reintroduced to Congress

As of this writing, the Lymphedema Treatment Act is still pending reintroduction in the current Congress by our new sponsor, Representative Dave Reichert of Washington State. In the meantime, we have been busy stepping up our ground game and extending our reach.

This year we embarked on a goal of forming teams of advocates in every state. We already have teams underway in 38 states! Please email us if you are interested in joining your state’s team. More information, including our new comprehensive State Team Handbook, is available on our website. No experience is required and the time commitment is variable based on your interest and availability.

We also still need your help spreading awareness about the Act. We would be happy to provide you with information cards to distribute at your doctor’s/therapist’s office, support group, compression garment supplier, to your friends and family, etc. Just email us your request, including the quantity you need and your mailing address, and we will ship them to you free of charge.

Thank you for your continued support of the Lymphedema Treatment Act!

lymph e-channel

Our new and improved Lymph e-Channel has received a lot of interest and enthusiasm. Lymph e-Channel is designed with out patients in mind and all of the articles provide practical information. We also continue to be inspired by our patients and are proud to share some of their experiences in the patient perspective section.

Interested in contributing? Share your personal stories, therapist perspectives, legislative updates, useful tools for treatment, new products, and much more! Clinicians especially, this is an opportunity for you to share your own unique clinical experiences, wisdom, and/or new product reviews.

Our editorial guidelines can be found http://lymphnet.org/newsletter/submissionGuidelines.htm

Not receiving Lymph e-Channel? Make sure that your email is added/correct in your membership information by contacting the NLN office.

Do you have suggestions for topics/articles, or like to submit an article? Send them to robin@lymphnet.org.

LANA Updates

If your original LANA certification was in 2001 or 2007 your certification is due to expire this year. Please look at your certificate and check the expiration date. If your certification expires in Spring or in the Fall of 2013, you must submit recertification or an application for inactive status postmarked by December 31, 2013. Failure to apply for recertification or apply for inactive status by the deadline will place your LANA certification in expired status. Please visit the LANA website for recertification information www.clt-lana.org.

The next exam cycle will be September 3 through September 30, 2013. Candidates taking the Fall exam should expect to wait 4-6 weeks for exam results. Please visit LANA website for further information www.clt-lana.org.

Please visit LANA’s new website. If you are a CLT-LANA therapist, please make sure all your contact information is correct in the LANA Certified Therapist listing on the website. Take a look at our events calendar with upcoming information that may interest you from LANA and its sponsors.

Questions? Contact LANA at lana@clt-lana.org or call 773-756-8971. Lymphology Association of North America, P.O. Box 466, Wilmette, IL 60091-0466. Fax is 847-868-8324.

Future Meetings & Events

24th World Congress of the International Society of Lymphology (ISL)

Rome, Italy
Sept. 16-20, 2013
www.lymphology2013.com
abstract deadline June 15, 2013

Klose Lymphedema Conference

Warrington, PA
October 10-12, 3013
Health and Wellness Center at Doylestown Hospital
For more information: www.kloseconference.com

The Lighthouse Lymphedema Network and GA Tech cordially invite each of you to our annual lymphedema education and awareness conference.

Emerging Technologies in Lymphatic Research
Saturday, October 12, 2013
Speakers include: Brandon Dixon, PhD
David Zawieja, PhD
Stanley Rockson, MD
Patients: Melanie Chaite and Joan White
Stephanie Kirkpatrick, DPT, CLT-LANA
www.lighthouselymphedema.org
Networking & Educational Seminars or Lymphedema Therapists
Portland, OR
September 27-29, 2013
Palm Springs, CA
November 1-3, 2013
These seminars offer about 10 contact hours.
Visit their website for further information and to download a Registration Form at www.lymphseminars.com or call 805.772.3560.

11th NLN International Conference
The Campaign for Lymphedema Care: Perspectives, Evidence & Practices
October 27-30, 2013
Washington, DC
Registration Opens October 15, 2013, Abstracts January 1, 2014
Pre-conference and Instructional sessions available.
Exhibitor and supplier information available at www.lymphnet.org/2014conf/2014conf.htm
Hotel Accommodations will be available starting September 19, 2013 (see page 25)

25 World Congress of Lymphology
Joint meeting of International Society of Lymphology (ISL), National Lymphedema Network (NLN), & Sentinel Lymphnode Foundation (SLF)
Sept 5-13, 2015 Hilton Hotel San Francisco CA
(See page 26)

RECIPE CORNER

Oven Roasted Fish with Fennel and Grapefruit
1 – 2 fillets of a mild, white fish
2 T fronds from a nice, fresh fennel bulb
1/2 grapefruit, juiced
2 T butter, cut into small pieces
Salt and pepper
Lemon, for serving

Preheat oven to 350 degrees
Place fillets on a large piece of tin foil.
Liberally salt and pepper both sides of the fillets. Lay the fennel fronds on top of the fish. Crinkle the sides of the foil up a little and squeeze the grapefruit juice onto the fish. Top with the butter and close the foil package. Cook for 15 – 20 minutes, until the fish is just flaky. Be careful when opening the foil packet, the steam inside is really hot!
Serve fish with a fennel salad and wild rice for a great, healthy summer meal.

Summer Vegetable Gratin, adapted from Ad Hoc at Home:
2 medium zucchini, sliced
2 small eggplant, sliced
3 medium tomatoes, sliced
1 onion, diced
2 cloves garlic, grated
1/2 T plus 1/2 t fresh thyme
1/4 cup olive oil
salt, pepper
1/2 cup parmesan cheese, grated
1/2 cup breadcrumbs (I used panko)

Heat an over to 350 degrees. Saute the onion and garlic over medium low heat in some olive oil for about 20 minutes, until translucent. Add the 1/2 T thyme. Slice the other veggies into 1/4 inch thick slices. Toss them with olive oil, salt and pepper. Pour the sautéed onions into a baking dish.
Top with the zucchini, eggplant and tomatoes, overlapping each slice slightly. I kept mine in cute little rows, but you’re welcome to mix them and spread them in an even layer. Mix the cheese, breadcrumbs and remaining 1/2 t thyme together. Sprinkle that mixture on top of the veggies and drizzle with a little more olive oil.
Bake for 35 – 45 minutes, until the veggies are tender and the top is browned.

Recipes submitted by Emily Voigtlander, http://theanswerisalwayspork.com/
**MISSION HILLS, CA**
Providence Holy Cross Medical Center Lymphedema Support Group
15031 Rinaldi Street, Mission Hills, CA 91345.
North Building, Conference Room “C”
Meets every 3rd Thursday of every month from 4 - 5 pm
Inter-disciplinary support team consisting of certified LE therapists, a clinical oncology nurse educator and an oncology chaplain. Thirty minute educational presentation with thirty minutes for Q&A.
For more information contact: Joanne Shahnaazi, OTR/CLT
PHCMC Lymphedema Clinic 818-496-1643

**BOCA RATON, FL**
Patch Reef Park
James B. Rutherford Conference Room 200 Yamato Road, Boca Raton, FL
When: Meetings are held monthly on the LAST Wednesday of each month from 6:45p.m. to 8:45p.m.
Group Facilitator: Liz Olivas, BFA, MT, CLT
This is a free educational and experiential class that is highly recommend for those who have LE and also for those who have undergone radiotherapy or lymph node dissection.
For more info contact: The Therapeutic Alternative @ 561-392-3340 or therapeauticalternative@gmail.com

**FORT MYERS, FL**
Lymphedema Education Awareness Support Group
Lee Memorial Hospital System Regional Cancer Center, 8931 Colonial Center Drive, Fort Myers, FL 33905
New telephone number: 239-437-1606
Meetings are second Saturday of each month from 10:30 to Noon from October through May.
This is an informal gathering of those currently coping with this affliction or at risk of developing lymphedema. A specific topic or a featured speaker will be the highlight of each session. Caregivers and “significant others” are also welcome.

**ATLANTA, GA**
Georgia Lighthouse Lymphedema Network of Greater Atlanta News
Our many activities and events include participating in a celebration of living sponsored by Emory University Hospital's Winship Cancer Clinic. Our members will be running in the Atlanta Relay for Life and the Gloria Watts Cox Run/Walk.
Our 16th State of Georgia Lymphedema Education and Awareness Conference, “Emerging Technologies in Lymphatic Research”, will take place Saturday, October 12, 2013 at Marcus Nanotechnology Research Center, Georgia Institute of Technology, 7:30 am to 4:30 pm.
For additional information: www.lighthouselymphedema.org/

**BATON ROUGE, LA**
Baton Rouge General – Lymphedema Support Group
Location: Baton Rouge General Medical Center- Mid City campus in Conference room 1 & 2
Time: 12:00 – 1:00 pm
Description: An interdisciplinary team consisting of Certified Lymphedema Therapists, Oncology Social Workers and a Registered Dietician host the group’s meetings. Lunch and all educational materials are provided for participants free of charge. For further information, contact Baton Rouge General Medical Center -Therapy Department at 225-763-4050 or Christine.perkins@brgeneral.org.

**WEST LONG BRANCH, NJ**
Wyatt Rehabilitation’s “Pea Pod” Lymphedema Support Group Meeting
Second Tuesday evening each month at 5:30 pm. We discuss various topics related to lymphedema and work on local projects to increase community awareness. All are welcome to attend. Light refreshments are served.
Wyatt Rehabilitation Physical Therapy and Lymphedema Services
240 Wall Street, Suite 100
West Long Branch, NJ 07740
732-222-8556
Please call or email Tracey Podolsky, MPT, CLT-LANA, CLM for further information. Tracey@WyattRehab.com

**DOYLESTOWN, PA**
We will hold support group the first Wednesday in the months of August and Nov. We will be hosting them in conjunction with Gilda’s Club at Doylestown Hospital and it will be from 12:00-1:30.

**ONTARIO**
October 25-26, 2013: The Lymphedema Association of Ontario (LAO) is bringing 17 years of experience planning lymphedema education conferences to a new collaborative event with the Canadian Lymphedema Framework (CLF), creating an exciting national awareness and education opportunity in Toronto.
The first day (Friday) of the conference will bring together health professionals from across Canada for lectures and practical workshops on Best Practices for lymphedema management. A combined patient-professional conference on Saturday will feature key note speakers and workshops targeted to each audience as well as an opportunity to network with health professionals, clients, exhibitors, researchers and advocates. Email the LAO at info@lymphontario.ca or the CLF at canadalymph@live.ca today to join the conference mailing list and stay abreast of details regarding location, agenda and registration opening date.

Support Groups: Do you have a special upcoming event? Send us your info by January 15th and we will print it in the April/June issue of LymphLink. Send submissions to Robin Miller, Action Corner Coordinator at robin@lymphnet.org
Helping Those In Need

Sandy, like many other patients, worries about how she can afford all of her medical treatment. She has to pay for expensive prescription medications every month and the thought of purchasing an expensive lymphedema garment increases her anxiety. It is a struggle for Sandy who feels that she has to pick and choose which conditions she can take care of this month.

Since its inception, the Marilyn Westbrook Garment Fund (MWGF) has been there to ease the burden on so many patients. The garments give our patients the hope that they need to continue to live and make positive steps in their lives. We rarely turn down an application, and try our best to help all patients in need. The many thanks from our patients is reward enough for continuing the MWGF.

I received a free garment earlier this year and I was very thankful because I needed one to control the swelling in my legs as I am retired and on a limited income. I was unsure of what to do because I really needed two sets of garments (one for day and one for evening) but with the help of the NLN I was able to get one of the sets. It helped reduce my stress due to worrying about my health. It’s really important to have this resource available to people and I wish it was more known that this fund exists. —Sandy J

We are appealing to you to help spread the word and join us in support of the MWGF. Your generosity, no matter how large or small, ensures that the fund will continue to provide help for patients like Sandy. You can visit the MWGF website to make a donation and for more information. http://lymphnet.org/donationFormMWGF.htm

Of course the MWGF would not be possible without the support of our industry partners and volunteers. The sheer generosity of industry allows us to obtain the expensive and often custom garments that we provide to patients. Our MWGF Review Committee, which consists of therapists volunteers, also dedicate their free time after hours to review the many applications that we receive. Thank you all from the bottom of our hearts.

To Apply for Assistance, Patient Must...

Be a member of the NLN
Be treated at an NLN-affiliated clinic
Demonstrate genuine financial need
Complete a brief medical history

Applications are available on the NLN website or we can mail you the printed form. www.lymphnet.org/mwgf

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Note: “LE” is an abbreviation for lymphedema.

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Pertinent Signs/Symptoms of Primary LE to Discuss
Paula J. Stewart, MD, CLT-LANA

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Effects of Radiation Therapy on the Lymphatic System: Acute and Latent Effects
Brian D. Lawenda, MD
Tammy E. Mondry, DPT, MSRS, CLT-LANA

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LE of the Head and Neck: An Overview
Sheila H. Ridner, PhD, RN, ACNP

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Use of “Elastic Taping” in the Treatment of Head and Neck LE
Ruth Coopee, OTR/CHT, MLT, CLT-LANA

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An Assessment of the Role of Low-Level Laser Therapy in the Treatment of LE
Jeffrey R. Basford, MD, PhD
Andrea L. Cheville, MD, MS

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Dawn Brinkman, OTR/L, CLT-LANA, et al.

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Nancy Hutchinson, MD, CLT-LANA

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Bonnie Lasinski, MA, PT, CI, CLT-LANA

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Sheila H. Ridner, PhD, RN, et al.

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Andrea L. Cheville, MD

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Mary Kathleen Kearse, PT, CLT-LANA

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Elizabeth McMahon, PhD

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Lisa VanHoose, PT, CLT-LANA, WCC, et al.

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GJC2 Mutations Cause Primary LE
Kara L. Levine, MS
Eleanor Feingold, PhD
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The Unraveling The Genetics Behind LE with Whole Exome Sequencing and Near-Infrared Fluorescence
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Joseph L. Feldman, MD, CLT-LANA

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Emily Iker, MD
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Kathryn H. Schmitz, PhD, MPH

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Anna L. Schwartz, PhD, FNP, FANN

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Jane C. Coryn, MD, MPH
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Constance M. Chen, MD, MPH
Mei R. Fu, PhD, RN, APRN-BC

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Psychosocial Issues Impacting Self-care Adherence
Sheila H. Ridner, PhD, RN, FAAN

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Mei R. Fu, PhD, RN, APRN-BC

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Vaughn Keeley, MD, PhD, FRCP

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Lipedema and Nutrition
Linda Anne Kahn, CLT-LANA, CDT, CMT, CTN

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Joy C. Cohn, PT, CLT-LANA
Marilin L. Kwan, PhD

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Jodi Winicour, PT, CMT, CLT-LANA
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65 min. DVD © 2006
Designed as a support to the home-care maintenance program of patients who have completed CDT.

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**NEW: LE: An Information Booklet**

This classic NLN® educational publication provides the basics of lymphedema, treatment, diagnosis, and risk reduction.

- **$5.00 incl. s/h**

**NEW: LE Management: A Comprehensive Guide for Practitioners**
3rd Edition ©2012
Joachim Zuther and Steve Norton
Updated chapters plus LE measuring strategies, palliative care, head and neck and Kinesio taping.

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**Lymphedema: A Concise Compendium of Theory and Practice**
Byung Lee, John Bergan, Stanley Rockson © 2011
Experts in the field, representing many disciplines providing personal, clinical and research experience, including extensive references.

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**LE Diagnosis and Therapy**
Profs. H. Weissleder, MD
C. Schuchhardt, MD, 2008
This Fourth Edition has been completely revised and expanded. Features 248 mostly color illustrations and 85 tables.

- **NLN® Member:** $70.00 + $7.00 s/h
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**Dr. Vodder’s Manual Lymph Drainage: A Practical Guide**
By: Hildegard Wittlinger, Dieter Wittlinger, Andreas Wittlinger, and Maria Wittlinger, 2011
An excellent addition and practical guide for students, therapists and doctors.

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**SELF-CARE FOR LYMPHEDEMA PATIENTS:**
**Upper Extremity**
JoAnn Rovig, LMT, MLDT
83 min. ea. DVD © 1996
DVD for patients cover daily self-care including basic self-MLD, self-bandaging, and skin care (upper extremities).

- **NLN® Member:** $34.95 + $7.00 s/h
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**Lower Extremity**
JoAnn Rovig, LMT, MLDT
83 min. ea. DVD © 1996
DVD for patients cover daily self-care including basic self-MLD, self-bandaging, and skin care (lower extremities).

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**NEW: Foldi’s Textbook of Lymphology, 3rd edition**
M. Foldi, E. Foldi, © 2012
Fully revised and updated information in all chapters

- **NLN® Member:** $229.00 + $10.00 s/h
- **Non-member:** $235.00 + $10.00 s/h

Continued on page 34
Where the Sky Touches the Earth: A Lymphedema Therapist's Guide to Working with the Whole Person
Sharon Langfield, Janet McFarland, and David Rankine, 2011
The book takes an eclectic approach to LE therapy, using ideas from multiple New Age methods and ancient healing practices to address caring for the "whole person."
- NLN® Member: $30 + $7.00 s/h
- Non-Member: $35 + $7.00 s/h

100 Questions and Answers About Lymphedema
Paula J. Stewart, MD; Nicole L. Stout, MPT, CLT-LANA; Saskia P.J. Thiadens, RN, 2010
An indispensable quick reference for people living with or at risk of lymphedema. A must read!
- NLN® Member: $19.95 + $7.00 s/h
- Non-Member: $24.95 + $7.00 s/h

Lymphedema Caregiver’s Guide
Mary Kathleen Kearse, PT, CLT-LANA; Elizabeth McMahon, PhD; and Ann Erlich, MA, 2009
First book to provide detailed instructions for caregivers on all aspects of LE home care including physical care; also ways for caregiver to prevent injury and burnout.
- NLN® Member: $34.95 + $7.00 s/h
- Non-Member: $38.95 + $7.00 s/h

Voices of Lymphedema: Stories, Advice and Inspiration from Patients
Edited by Ann Erlich and Elizabeth McMahon, PhD www.LymphNotes.com 2007
Practical information on dealing with lymphedema on a day-to-day challenge presented through a collection of inspiring stories from LE patients.
- NLN® Member: $24.95 + $7.00 s/h
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The Puzzle: An Inside View of Lymphedema
2011
Comprehensive book about lymphedema written by those living with the condition day by day. The book intends to encourage and educate patients and loved ones about lymphedema.
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