The incidence of lymphedema is between 6 and 30% following standard axillary node dissection.\(^1\)

Lymphedema can cause pain, functional impairment, skin breakdown and recurrent infection. The management of lymphedema is primarily non-pharmacologic, but some confusion exists over the most effective interventions.

**Common non-pharmacological interventions:**
- Compression therapies: garments (sleeves) + compression bandaging
- Manual lymph drainage (massage)
- Resistance exercise
- Complex Decongestive Therapy: massage + compression therapies

**Best available evidence**

**Compression therapies:**
- reduces upper limb swelling (Grade A)\(^2\)
- small additional benefit when manual lymph drainage treatment is added to compression therapies (Grade A)\(^3\)
- no evidence for stand-alone manual lymph drainage therapy

**Properly prescribed and supervised resistance exercises**
- reduces symptoms and exacerbations of lymphedema (Grade A)\(^3\)
- reduces the risk of developing lymphedema (Grade A)\(^3\)

**Clinical practice implications**
- Compression therapy: recommend as the first-line approach to management
- Resistance exercise: recommend appropriately prescribed and supervised exercise programs
- Complex decongestive therapy: offers small additional clinical benefit but large time commitment (daily 2-4 weeks) and expense
- Manual lymph drainage: not recommended as a stand-alone intervention

Find a physiotherapist who treats breast cancer related lymphedema online at physiotherapyalberta.ca

*Under practice area search women’s health or oncology*
**Physiotherapy Management of Breast Cancer Related Lymphedema**

**Key References:**

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*Patient-oriented evidence measures outcomes that matter to patients: increased function, symptom improvement, quality of life, and cost reduction. Disease-oriented evidence measure: physiologic, or surrogate end points that may or may not reflect improvements in patient outcomes (e.g. ROM, strength, physiologic function, pathologic findings).*