Care of a client with chronic oedema within a community setting

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NHS Trust

Introduction

Obesity, venous disease and immobility can affect the load placed on the lymphatic system leading to gravitational or dependent oedema (Williams, Craig 2007). Treatment to improve this condition centres around manual lymphatic drainage, skin care, exercise and appropriate compression to reduce oedema and maintain the size and shape of the limb (Lymphoedema Framework document 2006).

Recommended compression for reduction of oedema associated with venous insufficiency is the application of layers of inelastic short stretch bandages which promote reduction in capillary hypertension and lymphatic load (Foldi, Junger, Partsch 2005). The high working and low resting pressures of these bandages create a massaging effect to influence venous and lymphatic haemodynamics (Williams 2005), and this reduces oedema and improves limb shape.

Case study

Barbara (name has been changed) is in her late 70's and has been housebound for over two years. She has always had a fear of doctors and hospitals and therefore refused to ask for help. Her medical history was one of osteoarthritis, obesity and bilateral lymphoedema, with ulcerated areas of two years duration. The ulcers had healed approximately one year ago, following treatment from the district nurses. However, her lymphoedema had never been managed or brought under control. Barbara had not slept in her bed for over one year and was living in her chair which resulted in a worsening of the lymphoedema. This was compounded by the fact that Barbara declined to attend the Lymphoedema Clinic due to her phobia.

In May 2007 Barbabra had developed Lipodermatosclerosis and her lymphoedema and ulcerated areas had become worsened by cellulits and Pseudomonas. At this point Barbara was referred to St George's Hospital in London; again she declined. Antibiotics and antimicrobial dressings were used. Barbara had declined on numerous occasions to be referred to St George's Hospital and with lots of support and counselling from the district nursing team, Barbara eventually agreed to a domiciliary visit by a lymphoedema trainer, who supported the district nurses with the management of Barbara's lymphoedema.

Method

Patient consent was obtained and vascular assessment with the Doppler reassured nurses that it was safe to compress this patient. Compression bandaging using ActiFast® beige line over the limbs post dressing, Flexiban® padding to reshape the limbs, Actico® 8cm on the feet, with the inclusion of toe bandaging and Actico® 10cm to above the knee and 12cm to the thigh. This method was applied daily for two weeks and then gradually reduced over a period of two months to finally two visits per week prior to hosiery being applied.

Recommendations of sleeping in a bed at nightime and a diet plan was followed by Barbara.

When the limbs had reached a size and shape suitable for hosiery, the nurses were able to measure for and fit ActiLymph Class 2 thigh length compression hosiery. These stiffer garments were firm enough to maintain the size and shape of the limb, whilst still being acceptable to the patient.

Results

Quality of life for Barbara and her family is greatly improved as Barbara is now able to sleep in bed at nightime and, for the first time in 2 years, Barbara is now able to leave the house. Effective bandaging has increased Barbara's mobility, which has led to weight and fluid loss and this in turn has led to easing of Barbara's osteoarthritis symptoms. The ulcerated areas have now healed. Teaching and support from the district nurses has enabled her husband to assist with skin care and application of ActiLymph® compression hosiery. This has given Barbara greater independence and a better quality of life. The district nurses' visits have now been reduced to 3 monthly to perform doppler assessments. This has shown the cost-effective elements of Barbara's care.

Discussion

Barbara is not unusual in her dislike of hospitals and many patients would have the same fear. Lymphoedema is often ignored and treatment may be dismissed (Loudon and Petrek 2000) and its physical and psychological impact may often be compounded by the failure of healthcare professionals to offer appropriate care (Todd, 1998). In this case, treatment at home with Actico® bandages and toe bandaging, followed by ActiLymph® hosiery was the most suitable treatment for Barbara.

Conclusion

Support and use of counselling skills has enabled Barbara to accept help with her chronic oedema. Applying Actico® bandages and then following with ActiLymph® hosiery has led to increased quality of life for Barbara. Finally, this episode of care has shown to be cost effective as nursing time has been reduced and Barbara no longer requires dressing and bandaging.

References

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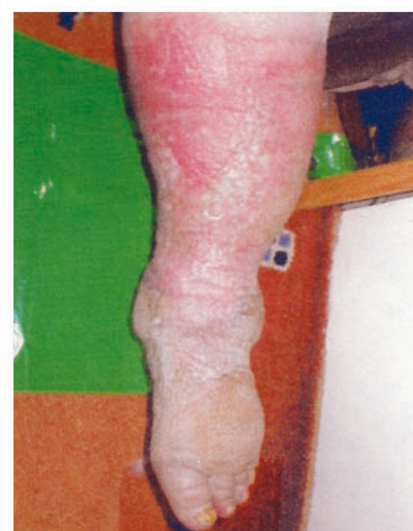


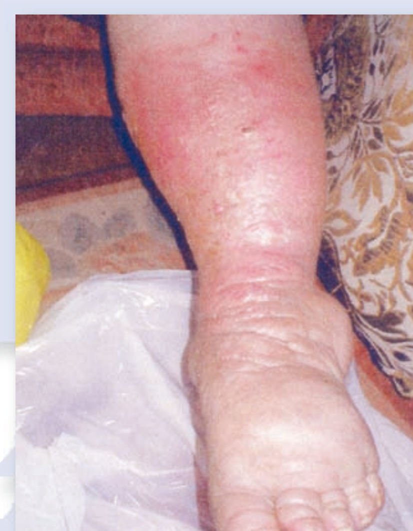
Left leg

9th May 2007

ankle 39cm
calf 59cm

Lymphorrhoea, cellulitis, oedema on foot and poor skin condition

Daily bandaging



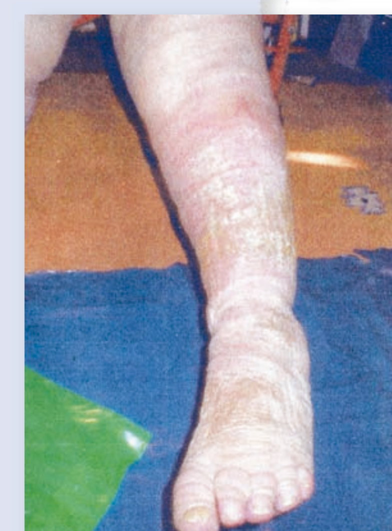
Left leg

11th May 2007

ankle 37cm
calf 53cm

Hyperkeratosis has softened, less lymphorrhoea (drier leg), reduction of oedema on dorsum of foot

Daily bandaging



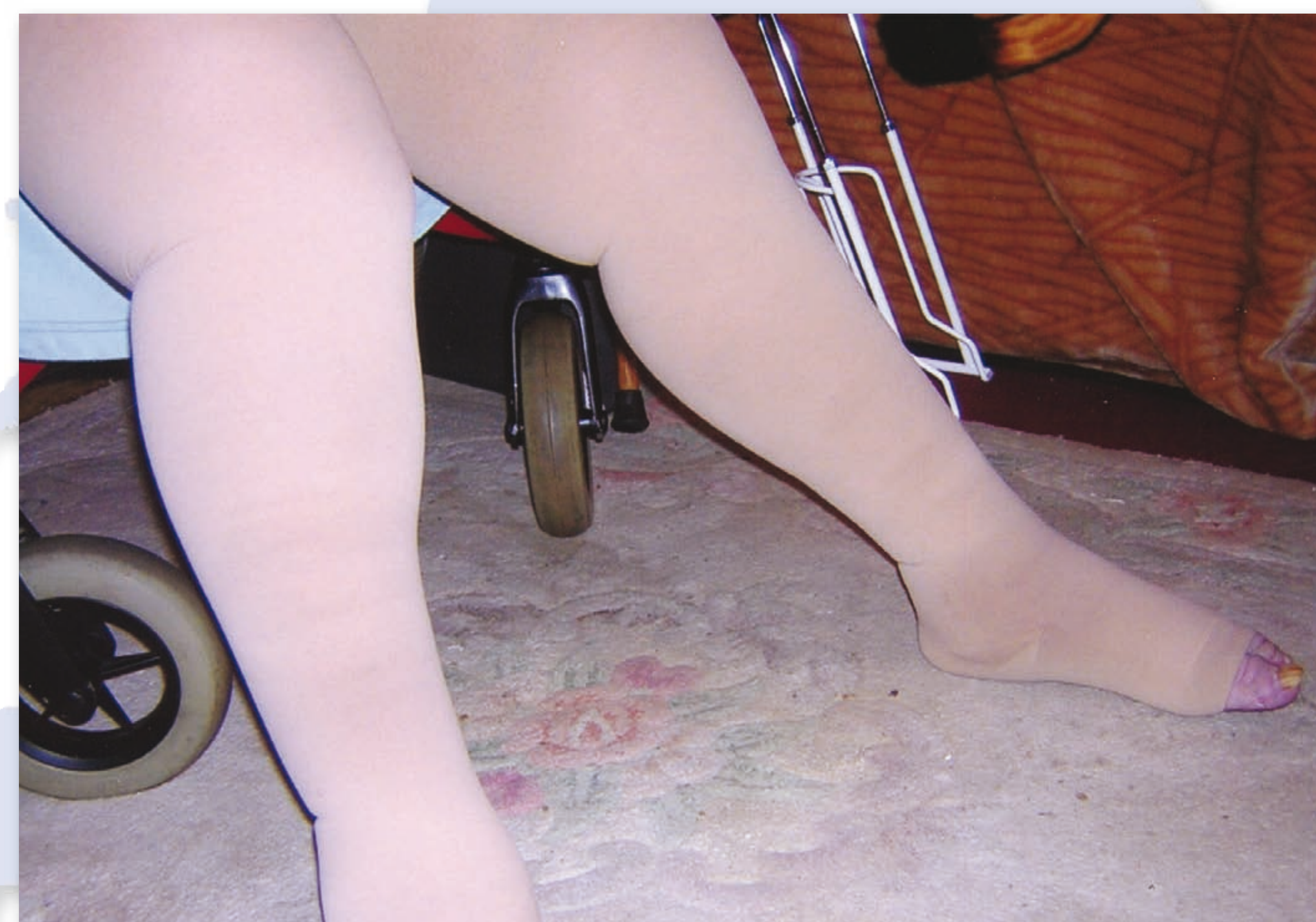
Left leg

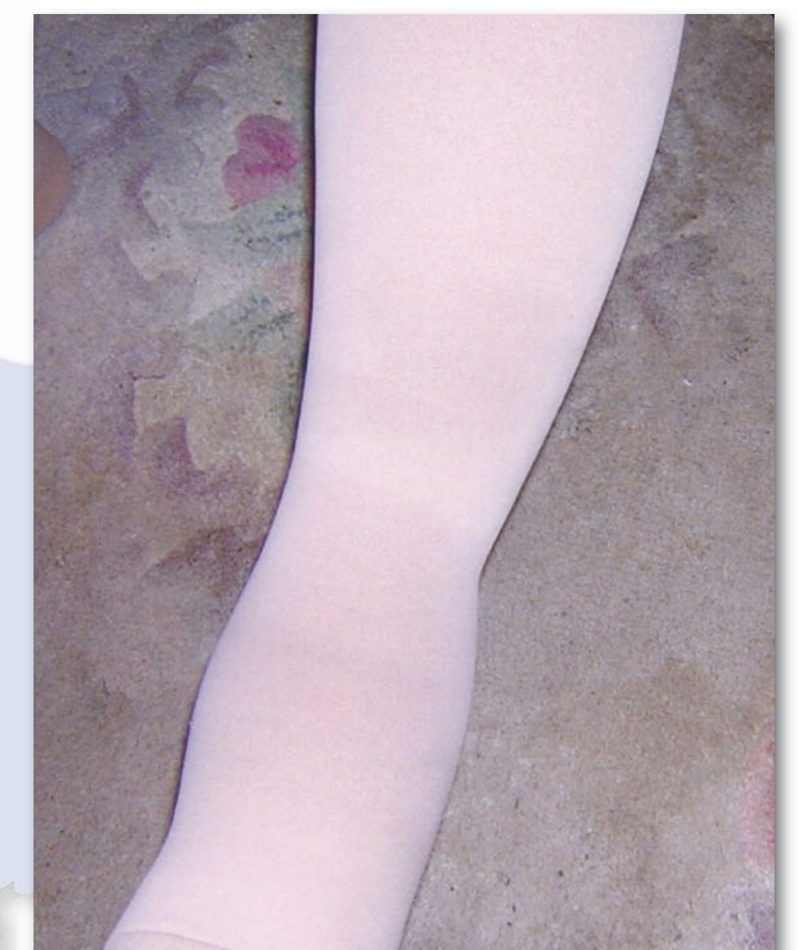
18th May 2007

ankle 32.5cm
calf 44cm

Normal sized limb

Bandaging now every 3 days leaving weekends free when DNs do not need to attend





The patient is now able to walk, sleep in a bed, and is leading a more active life free from painful, wet, swollen legs.

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