

## **GUIDELINES FOR PHYSIOTHERAPY MANAGEMENT OF WOMEN HAVING SURGERY FOR BREAST CANCER** 2

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# GUIDELINES FOR PHYSIOTHERAPY MANAGEMENT OF WOMEN HAVING SURGERY FOR BREAST CANCER

## ***Background***

Physiotherapists can play an important role in preventing, identifying, and managing many of the side-effects or complications of breast cancer treatment. The recovery of shoulder movement and physical function of the operated arm are particularly relevant to physiotherapists. It has been suggested that physiotherapists may also assist in enhancing women's understanding of their lymphoedema risk within their normal lifestyle (R Box, 1998; T Watkins(a), 2002). Early detection and treatment of lymphoedema is crucial in its successful management (Petrek J, 2000 (IVb)). However, to date, there have been no best practice guidelines to assist physiotherapists in clinical reasoning related to managing women following surgery for breast cancer.

The development of these guidelines followed the recommendations of the National Health and Medical Research Council (NHMRC 2005) The papers reviewed during this process were graded according to the level of evidence that they represented (table 1) and the level of evidence is provided with each guideline.

Table 1. about here

## ***Aims***

The aim of these guidelines is to promote evidence-based clinical practice for the physiotherapy management of women following surgery for breast cancer. The emphasis is on maximising shoulder movement recovery, facilitating the return to normal healthy lifestyle and raising awareness to minimise the risk of lymphoedema. Information related to the psychological symptoms experienced by women diagnosed with breast cancer is included to assist physiotherapists in their holistic management of each woman. The guidelines do not focus on the management of lymphoedema which may be undertaken by a number of health professionals.

## ***The scope of the guidelines***

The guidelines include information related to exercise, education, assessment and warnings appropriate to various stages of recovery during the treatment phase. These stages of recovery include the pre-operative visit, the initial and subsequent postoperative period and the end of primary treatment phase. Guidelines for the management of women who may present at any stage following their primary treatment are included.

Attention was given to the evidence available for managing postoperative complications such as seroma, wound infections, cording and adherent scarring. Such complications present a challenge to the treating physiotherapist and may impact on the subsequent postoperative recovery of women following breast cancer surgery.

## THE GUIDELINES

### 1. The pre-operative visit

Women who have had surgery for breast cancer have indicated a strong preference for a pre-operative visit that includes a baseline assessment of arm size and shoulder function (T Watkins(b), 2001) (Level IVa). This might be considered as an option for women known to require formal axillary dissection or who have pre-existing shoulder problems. Women undergoing sentinel node biopsy alone are less likely to have significant shoulder or arm problems.

Although a pre-operative visit with baseline measurement seems ideal, it is not always possible. In such cases, baseline measure might be taken at the 1-month postoperative visit, or immediately prior to beginning radiation therapy. Such a visit need not necessarily be undertaken by a physiotherapist. Care should be taken to ensure measurement reliability where different members of the breast care team are involved in assessments of arm size and shoulder function. Where different members of the team ARE involved, measurement reliability should be established between each of the clinicians involved in the assessments.

The aims of this pre-operative visit are to outline the individual care plan for each woman, depending on the proposed surgical intervention, to pre-operatively assess her shoulder and arm size and function and to arrange an appointment to review the woman as an outpatient by two weeks post-operatively after the axillary drain has been removed (this is ideal if this fits in with the unit's care plan).

#### **To maximise shoulder function**

It is optimal to have an understanding of a woman's premorbid status. It is recommended that shoulder movement range be measured bilaterally with a goniometer (or other reliability measurement device).

#### Educational aspects

Information provided to the woman should include:

Full recovery of shoulder and arm function will be progressive over three months (R Box et al., 2002(a); H Guttmann et al., 1990; R Jansen et al., 1990) (Level II).

80% recovery of shoulder function should be expected over the first four post-operative weeks. (R Box et al., 2002(a))(Level II). This ensures ease of positioning for adjuvant radiotherapy if it is required.

Pre-operative shoulder function should be achieved with early interventions if problems arise that could interfere with recovery (R Box et al., 2002(a)) (Level II).

Even with pre-existing shoulder dysfunction, improvement can be expected to the level of pre-operative functioning or possibly better (R Box et al., 2002(a)) (Level II).

Early physiotherapy for shoulder mobilisation has been supported by a number of studies that have used various, different structured exercise programs (L

Wingate et al., 1989 ,M Hladiuk et al., 1992) (Level III) (H Guttmann et al., 1990 R Box et al., 2002(a)) (Level II).

Advice should include that the physiotherapy exercise program should be controlled, progressive, sequential and tailored to outcomes (R Box et al., 2002(a)) (Level III). Details about exercise progressions will be given post-operatively.

Written material for reference should be supplied as required. There are many pamphlets available to provide to women, some of which may incorporate the principles outlined in these guidelines.

(See suggested list of some available resource materials at end of this paper.)

#### Demonstration and practice of exercises

Demonstrate and have women practise an early postoperative, gentle shoulder movement program which encourages recovery of shoulder movement and uses the muscle pump to move lymphatic and other fluids from the operated arm. Inpatient instruction may be required immediately postoperatively where women do not attend a pre-operative visit.

An example of early postoperative exercises is available in “After Breast Cancer: Looking Ahead” published by the Cancer Councils in Australia and are available from each State organisation (version 9/2004).

#### **To minimise the risk of lymphoedema**

The risk of lymphoedema is of significant concern for some women undergoing breast cancer treatment involving axillary lymph node dissection. It is essential that awareness of this condition is improved without engendering greater fear or concern (Watkins (a) 2002)).

#### Educational aspects

Inform the woman that in the normal course of events, most women will not get lymphoedema (C Browning, 1997) (Level III).

Provide some preliminary lymphoedema information, tailored to the woman’s information needs. Advise the woman of availability of further education that may be available postoperatively as required.

Sequential exercises from proximal to distal may assist lymphatic transport. Seek and address any concerns of individual women.

#### Measurement

Explain to the woman that the baseline measurement is done to better address any future concerns that she might have and assist in the early identification of lymphoedema.

Measure limb circumference on the intended operation side and the unoperated side according to Standards developed by the Australasian Lymphology Association (ALA) (Level IVb) ([www.lymphology.asn.au](http://www.lymphology.asn.au))

## 2. Postoperative physiotherapy management

In hospital or within 2 weeks

Physiotherapy management should be undertaken in consultation with treating clinicians. Understanding basic lymphatic physiology (lymphatic load and transport capacity) is integral in the exercise prescription to regain shoulder movement. Gradual return to pre-operative levels of function is encouraged with awareness of early warning signs of possible lymphatic overload.

Early recommendations for the first few postoperative days

Elbow, wrist and hand exercises be undertaken to engage the 'muscle pump' associated with such movements to enhance lymphatic and fluid transport from the operated arm.

Initially, self-assisted shoulder movements should be performed. The unoperated arm supports the operated side, to take some of its weight. Exercises should be slow, rhythmical and gentle to reduce risk of damage to regenerating lymph channels.

Exercise should be taken within the limits of discomfort (not pain). Activities of daily living (ADL) within the limits of discomfort are encouraged after the first few days with advice for ongoing progression (R Box, 1998; S Dean, 2003) (Level I).

Recommend gradual progression of exercise type, duration, resistance and repetition over the next months with sustained movements and stretches incorporated after 14-21 days once wound healing is well progressed.

Inform the woman that exercise needs to be continued at this level for 6-12 months, as tissues regenerate, remodel and sometimes contract during this period dependent on adjuvant treatment e.g. radiotherapy.

Inform the woman that scar management may facilitate movement (see later recommendation under scar management) (R Box, 1998; S Dean, 2003) (Level IVb).

Exercise recommendations

Provide guidance and reinforcement of the exercise program that was outlined at the pre-op visit.

Implement and practice of exercises *de novo* when there has been no pre-operative visit.

Inform the woman that there is no risk of lymphoedema if the axilla receives no treatment, surgery or radiotherapy.

Progress gradually to full range of movement (ROM) exercises within limits of discomfort.

Recommendations when there is a drain in situ

Initiate exercises at the surgeon's request if no agreed protocol exists.

Range of shoulder exercises should aim for 90° while drain in situ but working within the limits of discomfort. (R Box et al., 2002(a)) (Level 3).

Thereafter

Recommend progressive sequential shoulder exercise program as described which may help to minimise the risk of lymphoedema while optimising ROM recovery (R Box et al., 2002(b)) (Level II).

Measurement recommendations

Check the quality of movement and range of motion at the shoulder on the operated side.

Arrange to see the woman as an outpatient in one month's time. Information regarding problems that could interfere with movement recovery should be provided to assist a woman to identify when earlier review may be advisable (see below).

Where no pre-operative measures of arm size have been taken, these can be taken after sufficient wound healing has occurred and shoulder movement has progressed to 90°.

### **3. Possible impediments to shoulder movement recovery postoperatively**

A number of postoperative problems can arise following breast surgery which may interfere with optimal shoulder movement recovery. These include seroma, wound infection, cording, soft tissue adhesions or scarring and altered sensory states (particularly hypersensitivity in the medial upper arm).

#### **a. Seroma**

A seroma is defined as a collection of serous fluid around the incision which may be blood stained initially. If the swelling consists of predominantly blood, it is referred to as a haematoma and requires surgical review (R Box, 1998) (Level IVb).

Large seromas feel tight, uncomfortable and may restrict movement.

Seroma management should always be discussed with the treating surgeon. Large volume seromas may require repeated aspirations and should be managed by the treating surgeon. In the long-term, prolonged seromas may also lead to poorer cosmesis.

Repeated aspirations may impact on the condition of the chest wall in terms of fibrosis and adhesions, which can restrict shoulder ROM.

Educational aspects

Education related to postoperative seroma formation, recognition and management should include information about:

The signs and symptoms of seroma which include reduced levels of movement, tightness, bulging and feeling of heaviness along the scar, in the axilla or the breast rather than heaviness in the arm.

The fact that exercise does NOT cause a seroma.

The fact that NOT exercising may cause decreased range of movement in the shoulder joint (R Box, 2003; L Wingate et al., 1989) (Level II).

#### Intervention

Contact surgeon or Breast Care Nurse – the seroma may need to be drained if causing discomfort or impacting on shoulder ROM.

Inform the woman that:

Aspiration might be necessary as the seroma might restrict movement.

However, this should not discourage some exercise. Movement and ROM may improve following aspiration.

Exercises may be resumed on the day of the aspiration.

Massage is recommend in some cases, as it can help to reduce adhesions after the seroma(s) has resolved (S Dean, 2003) (Level IVb).

#### **b. Early post-operative wound infection**

Physiotherapists should be aware of the signs and symptoms of localised wound infection (cellulitis) and refer the woman back to her treating surgeon, breast care nurse or GP as appropriate for immediate attention. The wound may be swollen/bulging from the pressure of the seroma and this should not be confused with cellulitis. The swelling from seroma is quite different from the swelling associated with infection of the wound.

#### Education

Instruct the woman to seek medical advice if her wound becomes red, hot, more painful or swollen, or she is feeling unwell with fevers/high temperatures.

Inform the woman that a symptom of infection may be an increasing feeling of tightness around her chest wall in association with other symptoms.

#### Intervention

Suggest that she should rest while the infection is acute and until antibiotic therapy takes effect (Level IVb).

Advise the woman that she should resume exercises once acute stage is over and the associated discomfort has eased.

#### **c. Cording**

Cording is described as a fibrous band that may run from the axilla to as far as the wrist. These may be accompanied by varying degrees of discomfort and pain, particularly when stretching the operated arm forward or overhead. Its

aetiology is unclear but general consensus is that it is either fibrosing lymphatic vessels and/or an inflammatory process involving the venous system. It has also been described as the 'axillary web syndrome' which is different from 'Mondor's Disease' (Moskovitz, AH, 2001).

#### Educational aspects

The woman should be reassured that this is quite common and often resolves, usually within 6 months (K Johansson et al., 2001) (Level III). Gentle stretching and modification of exercises may assist it to resolve more quickly and reduce the possible effect on shoulder ROM recovery (H Reul-Hirche, 1998).

#### Intervention

Emphasise to the woman that the presence of cording must not be allowed to interfere with her shoulder exercise program and therefore it might be necessary to modify her exercises by using her arm as short lever with elbow flexed to reduce the discomfort.

Recommend and demonstrate gentle stretching of the cord(s) (R Box, 1998).

#### **d. Scar management**

Some women experience thickening or adhesions of the scars on the chest wall, but that these should resolve, or even be prevented by exercise and stretching.

#### Educational aspects

In some cases, scar massage might be beneficial to minimise scar thickening or adhesions and a demonstration and instruction of scar massage is appropriate (H Reul-Hirche, 1998) (Level IVb).

Scars can be strengthened by exercise (MA Hardy, 1989) (Level IVa). Once the scar has healed, that it is acceptable to touch the scar and begin soft tissue massage. (Wounds are waterproof within about 24 hours and are generally intact enough to touch within one week (MA Hardy, 1989) (Level IVa).)

A woman can begin gentle self-massage and use moisturisers from week 2.

Evidence from scar management following burns shows patients report reduction in pain, itching, better acceptance of clothing, less anxiety and improved mood from scar massage. However, the evidence suggests that there is no effect on vascularity, pliability or hypertrophy of actual scar (C Roques, 2002) (Level IV). The possible psychological benefits of massaging the operation site is not known for women following breast cancer surgery.

Intervention

Demonstrate soft-tissue massage if indicated, from week 2. Soft tissue massage and scar massage may be required to increase tissue extensibility which can assist the progression of exercises.

#### **4. Postoperative out-patient physiotherapy management**

Referrals are made by the surgical oncologist to a medical oncologist (chemotherapy) and/or radiation oncologist (radiotherapy) once the woman has been informed of her pathology and node biopsy results. The time period will be dependent upon the Policy and Procedures of each Treatment Centre or Team.

The treating medical clinician may routinely assess postoperative recovery or swelling in the arm and may refer to a physiotherapist for management at this stage.

In other circumstances, physiotherapists may undertake reviews routinely in large, well-established breast care centres for up to 6 months or even 12 months, depending on when the woman's primary treatment review is completed. In smaller centres this may not be the case. There are a variety of other postoperative management scenarios depending on the care plans of individual hospitals and private specialists with which physiotherapists can coordinate reviews.

It is important for physiotherapists to develop strong networks with all members of the Breast Cancer Management Team (e.g. breast care nurses, surgeons, medical and radiation oncologists, radiation therapists). This provides a clinical network to ensure referral for physiotherapy whenever this might become necessary at any stage during the woman's recovery. It also provides the physiotherapist with access to other clinicians when required.

The role of breast care nurses is an integral part of the care and education of women diagnosed with breast cancer. Breast care nurses might refer women to physiotherapists at any stage if they felt physiotherapy intervention to be indicated.

Women might independently choose to visit the physiotherapist as a first point of contact at any time post-operatively. With the woman's permission, it is important that the physiotherapist establishes contact with the other members of the breast care team if at all possible.

Individual women need to be well informed of their proposed clinical course, and their post-operative progress should be related specifically to their particular situation. Each woman should feel that it is appropriate and important to her care, that she contact the physiotherapist or breast care nurse any time she is in doubt about her progress.

## Educational aspects

Information provided during the primary treatment phase should reinforce advice about recognition of early warning signs of poor progress of shoulder ROM or lymphoedema.

Clear guidelines, including warning signs that might indicate the need for further physiotherapy intervention, should be provided to each woman. It is important to ensure that each woman has appropriate information to make decisions regarding her need to contact the physiotherapist at any point in the future.

## Intervention

Exercise prescription to progress exercises and stretches to optimise shoulder ROM, including resistance training advice, should be provided. Advice and education about functional activities and how the woman should gradually progress to her pre-operative status should be given (R Box et al., 2002(a)) (Level II).

Education of strategies to maintain a healthy lifestyle with respect to osteoporosis prevention, cardiovascular fitness and weight control should be incorporated.

Exercises should be conducted within the limits of discomfort (but not pain).

If the woman feels shoulder joint movement recovery is not adequate or fails to progress, advice should be sought sooner rather than later. (H Reul-Hirche, 1998) (Level IVb)

## Measurement

Measurements of bilateral shoulder ROM and function should be undertaken at periodic intervals for comparison with pre-operative status.

Arm size, as determined by limb circumferential measurements using the ALA standard (ALA, 2002) should be monitored. Other methods of measuring arm size such as volume displacement, perometry and bio-impedance are not available to all physiotherapists and the interpretation of these measures requires some experience with lymphoedema assessment and diagnosis.

If available, these methods may be used in conjunction with, or instead of, circumferential measures.

## Review appointments

Follow up program will require tailoring to meet specific need of individual women. The scheduling of reviews should be determined by the woman's adjuvant treatments programme and at the time of symptomatic concerns. Discharge planning from physiotherapy should include a formal measurement

review in conjunction with a clinical assessment for early warning signs and symptoms of lymphoedema. The physiotherapist should ensure that the woman has enough information to make decisions about if, and when she should contact the physiotherapist in the future.

## **5. Postoperative lymphoedema education**

Lymphoedema education might be provided either individually or as part of a group lymphoedema risk management program. The education can be presented by various members of the management team, including physiotherapists. It is important for healthcare professionals to actively seek and address any particular concerns of women and to tailor the information offered to suit their individual needs.

The health care professional involved in postoperative lymphoedema education should inform women that sampling procedures such as sentinel node biopsy are associated with less shoulder dysfunction and lymphoedema (U Veronesi et al., 2003) (Level IV).

Controversy exists as to whether different levels of axillary dissection (I, II or III) are associated with varying degrees of shoulder dysfunction or lymphoedema.

Most woman do *not* get lymphoedema (C Browning et al,1997) (Level 1). There is no hard evidence to implicate that any specific activities precipitate the onset of lymphoedema in women who have undergone axillary dissection for breast cancer. In fact, there is increasing evidence that physical activity may have little effect on the precipitation or progression of lymphoedema (Johansson 2001), McKenzie et al 2003, Turner J et al,2004.

There are a number of possible signs and symptoms of lymphoedema, but these signs might also be a normal part of the postoperative healing process. They may be indicative of another problem and the following issues could be highlighted:

Swelling is not the ONLY symptom of lymphoedema (H Reul-Hirche, 1998) (Level IVb).

Upper arm measurements can increase temporarily with overflow swelling from the operation site and during radiotherapy (H Reul-Hirche, 1998) (Level IVb). These may be transient but should not be ignored in the event of persistent or long-term changes.

Postoperative lymphoedema education sessions should also provide information for women related to:

The concept of lymphatic transport capacity and lymphatic load.

The precautions necessary to help balance the load on the lymphatic system. (H Reul-Hirche, 1998) (Level IVb).

Appropriate use and protection of the arm.

Resumption of normal lifestyle including health lifestyle choices for cardiovascular fitness, osteoporosis prevention, weight control and general well-being.

Early warning signs and symptoms of possible lymphatic overload.

## **6. Implications of chemotherapy**

Sometimes the fatigue associated with some chemotherapy agents may limit a woman's ability to maintain her exercise programme. Encouragement to resume after the initial treatment side-effects have subsided is required. Later follow-up may be required for the small number of women who may suffer greater side-effects or require hospital admission during their course of chemotherapy.

There is evidence that the maintenance of regular physical activity during chemotherapy can reduce the severity of the fatigue and assist with quality of life (Mock et al 2001). Any activity programme should be discussed with the treating medical oncologist prior to its introduction and monitoring of its effects or changes in chemotherapy tolerance is essential.(Level II).

In the presence of decreased shoulder ROM, after excluding tight scars or adhesions, routine physiotherapy musculoskeletal assessment of symptoms with relevant physiotherapy intervention should be undertaken (R Box, 1998) (Level IVb).

## **7. Implications of radiotherapy**

The timing of radiotherapy treatment will be depending upon the need of systemic therapy. At the time of publication, systemic therapy tends to be provided initially before or after surgery with radiotherapy planned to start approximately one month following the last chemotherapy cycle.

If/when the woman attends for radiation therapy planning, it will be necessary for her to be able to place her shoulder into almost full external rotation in 90° abduction. If she is unable to achieve this ROM at radiation treatment planning, she may be referred to the physiotherapist for urgent interventions to increase shoulder ROM so that radiation therapy can be undertaken effectively. The early introduction of the recommendations for rehabilitation in these guidelines should ensure that sufficient ROM has been obtained prior to planning.

In instances where the required shoulder ROM is not achievable, the physiotherapist should discuss this with the radiation oncologist and the radiation therapist, as alternative supported arm positions may be required for the woman during radiation treatment.

Following six weeks of radiation therapy, some women develop shoulder problems that might require ongoing physiotherapy management. Women may also develop breast oedema following radiotherapy. This usually resolves but if

significant swelling, tenderness, redness or an unwell feeling persist, the woman's treating clinician should be notified. Persistent breast swelling may be indicative of breast lymphoedema following removal of the axillary lymph nodes.

The effects of radiotherapy can be categorised into acute, sub-acute and long-term. Appropriate treatment planning for radiotherapy aims to treat the cancer cells while minimising damage to normal cells within the irradiated area.

Acute Treatment Effects

Sub-acute effects of radiotherapy

Long-term sequelae

So far – I was unable to find any refs - will check with Radiation oncologist on Monday

It is VERY IMPORTANT to encourage shoulder exercise for at least three months AFTER radiotherapy is finished to counteract the ongoing tissue changes that may continue during the resolving period. Long-term sequelae for shoulder dysfunction and chest wall fibrosis may be reduced.

The level of intervention depends on the extent of radiation therapy and sites irradiated

## **8. End of primary treatment review**

At this stage, the woman has had her surgery and is finished with any adjuvant therapies. Wherever possible an appointment should be arranged to review each woman at the end of her planned primary treatment program. This appointment allows the physiotherapist to check functional ability and range of every woman regardless of her treatment regimen NCCI(c) Na. (2003).

Should we refer generally again to the Psycho social guidelines?

At this time, the review should include:

Revision of the tailored shoulder exercise program, as outlined in parts 4 and 11.

Arm measurements

A check that the information provided to date has been understood and that additional information is provided as required. Women have indicated that this is a desirable point postoperatively for this to occur. At this stage, women are ready to move on into the next step of their survival, back into "real life" and ready to face the world (T Watkins(b), 2001) (Level IVa).

At this stage, specific information should be provided for women who are concerned about the resumption of pre-operative sporting activities if they have not already achieved this goal.

Reiteration of early warning signs of shoulder dysfunction or lymphoedema should be provided.

## **9. Interventions at later visits**

The woman may return at any time in the future with concerns about any of the following:

Shoulder movement restriction due to scarring.

The need for a re-check of her arm measurements.

The onset of lymphoedema.

Assistance with palliative care issues such as lymphoedema, pain, functional limitations or mobility issues.

Some women may present for the first time with these concerns.

### Education and intervention

Encourage the woman to revisit the doctor if she has outstanding ongoing concerns about her medical condition. Physiotherapists should be aware of symptoms which require exclusion of local or metastatic recurrence. Sensitivity in facilitating a referral to the woman's treating oncologist is required (see psychosocial section).

Once recurrence has been excluded by her treating clinician(s), women with lymphoedema should be referred to an experienced lymphoedema therapist if the physiotherapist has limited experience in its management.

Following clinical examination, appropriate physiotherapeutic interventions should be provided as required for the individual woman.

Reassure the woman when ongoing physiotherapy is no longer necessary, while reaffirming that she should always contact the physiotherapist if she has specific concerns related to her arm or shoulder in the future, regardless of the time since original treatment.

## **10. Psychosocial issues**

This section aims to provide physiotherapists with an understanding of the psychosocial aspects for women with breast cancer. Some advice and guidelines are provided to enable physiotherapists to develop appropriate skills to use in their consultations with women diagnosed with breast cancer.

### ***a. Responding to emotional concerns***

In general:

Physiotherapists may see women who are distressed, and can help women in these circumstances. Depending on the circumstances of the diagnosis, and

the post-operative course, women may feel angry, frustrated, overwhelmed or anxious. Depression is also common amongst women who have been treated for breast cancer.

People with cancer who are provided with an opportunity to discuss their feelings with a member of the treatment team or a counsellor experience less psychosocial distress than people not provided with this opportunity (E Devine and S Westlake, 1995) (Level III). Sometimes this may involve the person becoming visibly upset or tearful, but this is not harmful, indeed being able to “let it out” in the presence of a supportive empathic health professional is usually very helpful. This is of course counter to common community beliefs and attitudes that people who have experienced cancer should be “strong” and remain “positive” rather than discuss their feelings.

It has also been suggested that women experiencing emotional distress, fear and anxiety are less likely to adhere to prescribed treatment protocols. This is an important factor that needs to be considered by physiotherapists.

If you are interested in learning more about the psychosocial care of patients with cancer, you may find it useful to access the *Clinical practice guidelines for the psychosocial care of adults with cancer* at:

<http://www.nhmrc.gov.au/publications/pdf/cp90.pdf>

The role of the physiotherapist

Encourage the woman to express her feelings (Na NCCI(c), 2003) (Level IV). You do not have to “fix” her distress - the emotional release is self limiting. No-one has ever failed to stop crying (P Barnard, 1992) (Level IV).

‘Normalise’ the experience by this is meant, to reflect that any distress she feels is understandable given her situation. The aim of normalising is to let people know that they are not alone, and that they are understood. However, it is important not to trivialise patients’ experiences, by explaining away distress as “normal” and not worth discussing and dealing with (P Maguire, 2002) (Level IV).

Respond appropriately and with empathy: Empathy is the ability to perceive accurately the feelings of another person and the ability to communicate this understanding to them (G Egan, 1986) (Level IV). The woman whose feelings are acknowledged may think: “At last someone who understands how I feel and doesn’t tell me to put on a brave face.” Move closer, lean forward: Non-verbal aspects of communication are important for conveying attention and openness to a client/patient. Facing patients squarely is a posture that indicates involvement. A slight inclination towards the patient is interpreted as “being with the patient”, and being interested in what they are saying and doing.

Give the patient your full attention: ensure that you have adequate time for the consultation, and avoid answering pagers or telephone calls. If the woman seems upset, ask “Do you want to talk about this now?” Patients may at first feel

reluctant to discuss the reasons behind their distress and, in fact, may not have articulated them previously.

If people do not wish to discuss underlying issues, it is important to leave the way open for this discussion on any future occasions. Don't advise or reassure until all information is on hand: If the person does feel able to talk about their concerns, it is essential that the physiotherapist has all relevant information on hand, before stepping in to advise and/or reassure. The first issues that are raised may not necessarily be those that are causing most distress to patients. Premature reassurance may act to block the person from expressing the issues that are affecting them most (P Maguire(a) and C Piceathly, 2002) (Level IV).

Explore social support: Members of the treatment team should ask people with cancer about their key support people and to define the level of involvement of these people (Na NCCI(c), 2003) (Level IV). Special attention should be paid to the partners of people with cancer, recognising that this may be someone of the same sex.

Refer when indicated: It is important that physiotherapists recognise their own level of training and skill in this area, and refer patients whose problems are complex or beyond their training and expertise to specialised services. It is also recommended that people considered to be at risk for psychological problems are referred to specialised psychological services early in the course of treatment, as this may minimise the likelihood of their developing significant disturbances (C Sheard et al., 1999) (Level III). Some of the characteristics which place patients at higher risk of experiencing psychosocial distress are listed in the section on depression.

#### **b.            *Responding to patients who are angry***

In general:

Anger is a common and normal reaction, signalling frustration and annoyance when events go contrary to expectations and needs are not met. People may react with anger to the knowledge that they have developed a serious disease that may lead to body mutilation and shorten their life. People who experience complications of any treatment commonly feel angry that this has happened. Loss of control is another common cause of anger, for example, when patients find themselves dependent on others, especially if they have previously been highly independent. Some people may become intensely frustrated by even a temporary limitation in their functional ability. Patients may feel angry at their own powerlessness to affect the outcome, and angry with themselves if they feel that their past behaviour has contributed to the disease.

People may also be angry for a specific reason, such as perceived delay in diagnosis, delayed referral, or perceived inadequate care. Inadequately controlled pain undermines normal coping, resulting in anger, frustration or even hopelessness. Importantly, anger may be caused by events unrelated to their illness, such as family problems, or financial strain.

Inappropriate levels of anger, out of proportion to the reasons being disclosed, can lead to verbal and even physical abuse, and decisions which may later be regretted.

### The role of the physiotherapist

**Stay calm:** Initially, it is useful to acknowledge that a difficult situation has arisen and use a calming strategy such as taking a deep breath, counting to ten, or looking away for a moment. **Listen actively:** It is helpful to begin by actively listening to understand what the patient is saying, and why he or she is angry. Active listening involves making good eye contact, nodding, and listening to what the problem is without interrupting (M Girón et al., 1998; D Goldberg et al., 1993) (Level III). Simply “hearing the person out” may help to diffuse the situation, and many patients who are angry report that no-one has ever really listened to their concerns before. (Although this is probably true for more experienced staff, in the first instance I think listening is the critical skill to encourage.) Do not take it personally and do not get defensive or argue with the person: Directly challenging the patient's interpretation or criticising them for their reaction usually escalates the situation. It is more important to try to understand the underlying causes of the patient's anger. Ask yourself: “What is this person communicating?”.

**Acknowledge anger and explore the reasons for anger:** It is important that patients know, in a non-judgmental way, that their anger is recognised. Patients whose anger is acknowledged feel listened to and validated. Furthermore it is hard for the person to maintain anger and argue if you “agree” with them, by saying something like “This has obviously been a very distressing time for you”, or “It must be really tough when nothing seems to go right for you”.

**Focus on the person's needs, not their manner or words:** Unless the person's underlying needs are ascertained and addressed, it is unlikely that the anger will dissipate.

**Apologise if appropriate:** If a genuine wrong has occurred for which the physiotherapist is responsible, it is important to apologise. Patients who have undertaken medical litigation report that an explanation and apology would usually have satisfied them and averted the need for legal action (C Vincent et al., 1994) (Level IV).

**Brainstorm options and offer help:** Once there is a clear understanding of the problem, it may be appropriate to brainstorm solutions with the person. However, it is important that the physiotherapist does not leap in to ‘fix the problem’. A useful technique is to ask the person what hopes and expectations they have of the consultation, to establish a framework for treatment, and allow for exploration of any misperceptions, and exploration of solutions, by saying “Is there anything that you feel I could do to help?” Sometimes this may involve referral to another health professional.

### **c.            *Responding to patients who are depressed***

In general:

Depression is a common condition in Australia, but is frequently under diagnosed and under treated. There remains considerable stigma about mental illness, and patients treated for cancer are often reluctant to discuss low mood, and difficult coping for fear that they are seen as ungrateful, or not “being positive”. There are also stereotypes about the nature of psychiatric treatments.

Up to 45% of women with early breast cancer have been found to be anxious or depressed (D Kissane et al.,(1998) ( IVa). It is important to recognise depression and facilitate referral for appropriate treatment, as untreated depression is associated with poorer ability to cope with disease burden, and reduced quality of life for the patient and their family.

Depression refers to sustained lowering of mood (lasting more than 2 weeks), often associated with tearfulness, guilt, loss of pleasure or interest in usual activities, and disturbances in sleep and appetite. Depression may also present with irritability, social withdrawal, and increased difficulty coping with physical symptoms (Na NCCI(c), 2003). Anyone who has experienced a previous episode of depression is at increased risk of becoming depressed after the diagnosis and treatment of cancer. Other risk factors include social isolation and lack of support, stressful life events and financial strain. Women who are younger, are also at higher risk.

#### Role of the physiotherapist

State that any person coping with cancer is bound to find things difficult at times.

Let her know that how she is feeling is important, and you are interested in discussing any concerns she has. Ask her if she feels worried, upset, or is finding things difficult. You might ask her: “Would you go so far as to say you feel depressed?”.

Tell her that feelings of depression are common, they do not mean she is weak or not trying hard enough, and you are aware that getting some professional help makes a huge difference to most women. Ask how she would feel about you discussing this with her treating doctor, and let her know that you feel confident that assistance can be offered.

Table 2 About here

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Table 1. The Classification System\*

Level of Evidence	Type of Study/Article
I	Evidence is obtained from a systematic review of all relevant randomised control trials
II	Evidence is obtained from at least one properly designed randomised control trial
III	Evidence is obtained from well designed control trials without randomisation, or from well designed cohort or case control analytic studies, preferably from more than one centre or research group: or from a multiple time series with or without the intervention.
IVa	Evidence is obtained from descriptive studies of provider practices, patient behaviours, knowledge or attitudes, or a systematic review of the descriptive literature.
IVb	Represents the opinions of respected authorities on clinical experience or reports of expert committees

\*Table adapted from the NHMRC Guidelines for the Management of Women with Early Breast Cancer. Canberra, Government Publishing Service, 1995<sup>1</sup>, adapted from the system developed by the US Preventive Task Force<sup>2</sup>

Table 2: Summary of Physiotherapy Guidelines

Time	Exercise	Education	Measurements	Warnings
Pre-operative		Post operative expectations related to: Shoulder movement Lymphoedema prevention	Shoulder Range of motion (ROM) Arm Circumference (o)	
Within 2 weeks postoperative	Immediate post op: Full ROM hand, wrist elbow. Shoulder ADL/ROM within limits of discomfort	Shoulder movement Lymphoedema awareness and preventive strategies	Shoulder ROM	Seroma Wound infection Cording
Within 6 weeks postoperative	Exercise /rehab program e.g. STRETCH program		Shoulder ROM Arm o	Seroma Wound infection Cording Scarring
Chemotherapy	Exercise /rehab program STRETCH program		As required	Fatigue Side effects
Radiotherapy	Need close to full range abduction and ext rotation to enable radiation positioning.  Continue X's program for three months (minimum) post irradiation	Reiterate: Lymphoedema awareness and preventive strategies	Shoulder ROM	Acute or late effects
End of Primary Treatment	Only where specifically relevant	Reiterate: Lymphoedema awareness and preventive strategies	Shoulder ROM Arm o	
Later Presentation	Only where specifically relevant		Shoulder ROM Arm o	Exclude recurrence?