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Editorial

Morbidity from lymphoedema following treatment of primary breast cancer

Historically, gross arm lymphoedema was a frequent and distressing side-effect of the treatment of primary breast cancer by radical mastectomy with radical radiotherapy (RT) or following the diagnosis of locally advanced breast cancers growing into the axilla.

Presently, this is largely not the case. No advantage has been demonstrated for the use of both RT and clearance for axillary prophylaxis; locally advanced cancer is also less often seen. The proportion of cases without lymph node (LN) involvement at diagnosis has also risen and many units now initially use sampling rather than clearance (increasingly so, with the introduction of sentinel lymph node sampling).

Yet the fear remains. The UK National Breast Cancer Screening Programme demands that breast units have a lymphoedema nurse, even though lymphoedema following the small, node-negative tumours that are generally diagnosed at screening should be very rare.

Many studies of this problem have measured arm diameters and volumes. There is frequently a small increase in arm volume, even following a mid-axillary clearance (levels I–II), but this is not usually associated with a symptomatic problem.

Two papers in this issue suggest that this is the wrong measurement to use. One study simply reports that the complaint of any arm swelling at varying times of follow-up after axillary sampling (four node) is rare. The other shows the significant measurement is that of manual dexterity and that arm volume measurements are of no value by themselves.

I propose that any future reports of 'lymphoedema' following axillary sampling or radiotherapy must be based on this measurement and on the symptomatic distress caused rather than on arm circumferance measurement alone.

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