The Role of Physiotherapy in Breast Cancer Rehabilitation:

By Katie Kelly, PT, member of the Newsletter Subcommittee

Across Canada, numerous physiotherapists are working with patients diagnosed with breast cancer. Sometimes this field of physiotherapy seems shrouded in mystery, or goes unrecognized by the orthopaedic world. I recently had the opportunity to interview a handful of (very busy!) physiotherapists from across the country who work in the area of breast cancer rehabilitation. I'm hoping that this article serves to highlight the work they do and the challenges they face.

INTERVIEWED PHYSIOTHERAPISTS:

JULIE SKALING (JS)	MAYBELLE MURPHY (MM)	ARIANE POMERLEAU (AP)	LOUISE GODIN & SOPHIE DOIRON (LG&SD)	MARIZE IBRAHIM (MI)
Owner and Physiotherapist of Julie Skaling Physiotherapy Clinics, Nova Scotia	Physiotherapist at Central Therapies Saskatoon Health Region Breast Health Centre, Saskatchewan	Physiotherapist at Clinique Physio-Oncologie de Québec, Québec (Responses translated from French.)	Work as a team of physiotherapists at the Dr. Georges-L. Dumont University Hospital Centre, New Brunswick (Responses co-authored by both Louise and Sophie.)	Physiotherapist at Hope & Cope, Jewish General Hospital, Québec

HOW DID YOU CHOOSE TO FOCUS YOUR PRACTISE ON THE AREA OF BREAST CANCER REHABILITATION?

JS: I work in a small town where it is important to have a wide general practise. One of the specialists in my area was very impressed by the results his patient had with VODDER lymphedema management and asked if I would take the training. After I was certified, the referrals gradually started coming in.

MM: The opportunity for CDT training was offered to me by my manager in 2012.

AP: Mostly from observing the growing needs of this clientele related to the lack of services available to them.

LG&SD: A lymphedema certification training course was organized in our area in 2004 and since there was no other therapists certified at our centre, we were both approved to participate. Once this was complete, it was clear that there was a need to develop a post-mastectomy and lymphedema prevention program. The positive response from this clientele and the support from our hospital administration encouraged us to develop further the program and available services.

MI: I chose the field of breast cancer rehabilitation because of the rehabilitative complexities women experience from the cancer-related medical treatment(s) and in turn, the physical challenges they have to overcome. Breast cancer is not only the most commonly diagnosed malignancy in woman, but a disease that does not discriminate. I've treated patients as young as 21 years of age to over 80 years, all with very different rehabilitation needs.

HOW LONG HAVE YOU BEEN PRACTICING IN THIS FIELD AND WHERE DID YOU GET YOUR TRAINING? ARE THERE ANY COURSES THAT YOU RECOMMEND?

JS: I have been practicing in this field for ten years. I got my certification in manual lymphatic drainage and combined decongestive therapy through the Dr. Vodder School, which I would recommend. I have also taken many compression garment fitter training courses, and a Coban II compression course.

MM: Myself, along with 12 other Health professionals from Saskatchewan, received their CDT training (152 hours) from Janet Mcfarland.

This training was a one-time offer by the Saskatchewan Ministry of Health. I have attended several Lymphedema Symposiums in Saskatchewan and Alberta. As well, I have taken a course for neuro-proprioceptive taping for lymphedema, which I highly recommend.

AP: I started to practice in this field in April 2013 following what was, in my opinion, a very thorough training, both from a theoretical and practical point of view. I took the "Breast Cancer Rehabilitation" course which was given by Jodi Winicour in the city of Chicago at that time.

LG&SD: We both took a Lymphedema Certification course from Norton School in 2004 and started in this field from that moment. To truly understand the lymphatic system, we do suggest a full certification from one of the lymphatic schools. Future courses were taken to stay updated and gradually increase our treatment options, including; National Lymphedema Network Conference (2006), Physical Therapy for the Patient with Breast Cancer (2008), Breast Cancer Rehabilitation Course (2009), Advanced Course in Lymphedema at the Foeldi clinic in Germany (2010), Advanced Management of Breast Cancer Rehabilitation (2012), Compression in Lymphedema: New Approaches, Rehab Techniques in Oncology, Lymphedema taping courses and Connecting with the Fascia.

MI: I have been working in the oncology rehabilitation field since I graduated from McGill University in 2011, making it six years. My interest and curiosity in the field developed when I took the Oncology Rehabilitation course during my graduate studies. The first few years were by far the most difficult professionally as a specialization such as oncology requires an extensive amount of medical and technical knowledge. Furthermore, it requires a different skill set that I have attained from various courses including, and not limited to; Casley Smith Lymphedema certification, Osteoporosis Canada bone fit trained, and various oncology rehab specific continuing education courses, one that I continue to build on. The journey continues to be one that is extremely fulfilling and gratifying as each day brings an immense amount of joy to be able to help such a vulnerable population. It is through my patients' happiness, smiles, laughter, tears and determination that am able to understand the true meaning and value of life. I take with great pride the work I do, and look forward to a long career in the field of oncology rehab.

DO YOU EVER WORK WITH MEN WHO HAVE BEEN TREATED FOR BREAST CANCER AND ARE THERE DIFFERENCES IN TREATMENT BETWEEN GENDERS?

JS: I have not treated a man with breast cancer to relate, however I have seen several men with lymphedema post diagnosis of cancer for treatment/management or palliative care. There would be no difference in the treatment for a man versus a woman as they have the same lymph pathways. Scar management, compression, exercises and advice on management would be the same.

MM: Yes I have pre-oped and treated men having mastectomy surgeries. We even made a male specific booklet for them. No real difference in treatment for post–op issues except when it comes to tissue expander or implant.

AP: To this day, I have not had the opportunity to treat men.

LG&SD: Yes, we do see some. We mostly need to focus on the injured lymphatic system and monitor if any issues arises.

MI: Yes, I have had male patients who have been diagnosed and treated for breast cancer, some of which were metastatic. The approach to treating male breast cancer patients is different because of the stigma associated with the disease as its prevalence lies predominantly among the female population. In addition to the stigma, the services and resources that are available tend to be geared towards women; with little to no focus on men living with breast cancer. Although men present with similar rehabilitation needs (i.e., physical deficits) as women, it is important to assess and identify their goals and tailor the rehabilitation program accordingly.

WHAT ARE THE MOST COMMON REASONS FOR CONSULTATION THAT YOU SEE IN YOUR DAILY PRACTICE?

JS: I have a general practice for orthopaedics, acupuncture and pedorthics, however the majority of my caseload currently is post-cancer patients, both male and female. I do post-surgical management, scar management, edema management, compression garments and bandaging, lymphedema pumps, lymph drainage, exercise programs, palliative care and home visits.

MM: Lymphedema, cording and shoulder pain.

AP: I would say that the majority consult me for stiffness at the shoulder and thoracic areas. Women after breast cancer are mostly aiming to accomplish their daily activities without limitations or pain. It is also not uncommon to see capsulitis or tendinitis conditions after being treated for breast cancer.

LG&SD: As a routine, all patients that have had a mastectomy (partial or total), and/or an axillary or sentinel lymph node dissection are seen. Patients that develop breast pain, loss of mobility or swelling during and after radiation or chemotherapy are also seen. In addition, we will see patients that have had surgery that involves lymph node secondary to different cancers. Lymphedema patients that are not secondary to cancer are also a big part of our clientele.

MI: Consultations vary in the breast cancer population as it is based on the patients' disease and treatment trajectory. Consultations received include and are not limited to: decreased range of shoulder mobility, axillary web syndrome, upper extremity weakness, overall deconditioning, chest wall tightness, upper thoracic and abdominal/core strengthening, postural dysfunctions, scar tissue restrictions, radiation fibrosis, difficulty with activities of daily living, lymphedema, neuropathy, fatigue, and possible complications with reconstruction. Metastatic disease, particularly skeletally, presents with further complications in rehabilitation needs as the lesions may increase risk of fractures, cord compression, skeletally related events, mobility limitations and overall functional sequelae.

WHAT WOULD YOU SAY IS THE BIGGEST CHALLENGE OF WORKING IN THIS FIELD?

JS: Every patient comes with very different issues and concerns. Patients are dealing with present cancers or past cancers. Being supportive emotionally is a huge part of my job along with the other treatment methods mentioned above.

MM: Lack of funding. I only have half a position so most of my work is pre-oping patients. I have a small case load for treatment but could definitely use more time for this. I have no time to do garment measuring so this is done at another site at RUH.

AP: I would say that for me, the biggest challenge was getting used to working with conditions where you are not really aiming for complete, or close to complete cure, like I would normally have done with regular orthopaedics conditions. You never know what is a person's maximal potential for rehabilitation, and have very little impact on the initial cause of the symptoms. Your purposes change greatly and this was an important learning process for me.

LG&SD: When we first started, the lack of knowledge in the medical community regarding lymphedema was frustrating. Thankfully, that has improved greatly in the breast cancer sector. It seems the other sectors are gradually following but it's taking longer.

MI: The biggest challenge working in the field of oncology is watching how a diagnosis such as cancer not only drastically changes the life of the patient, but the lives of all those who surround them. This disease does not discriminate, is aggressively toxic and is challenging to cope at an emotional level. Unfortunately, there are limited resources, bereavement and debriefing services available for healthcare professionals to express and discuss their emotions as we watch patients advance through the disease. I strongly believe that the rehabilitation that is offered to patients is all encompassing and multi-factorial and is not limited to simple physical rehabilitation. There isn't a day that goes by where I do not share in the patients' (and their family's) tears of joy and sorrow, sighs of relief and happiness, feelings of distress, anxiety, isolation and above all, hope. Cancer can take so much away from individuals, but it cannot take away hope, the most profound, tenacious and universal of all human possessions and one I am honoured to encounter daily.

WHAT WOULD YOU SAY IS THE BIGGEST CHALLENGE FROM YOUR WORK SETTING (PRIVATE/PUBLIC SECTOR)?

JS: The biggest challenge is the lack of money or funding for this group of people in Nova Scotia (there is no public funding for my services). I work in a private practice so if the patient does not have insurance or have a community service group helping, then the services may not be affordable. I often donate extra time and products to patients that cannot afford it. Our local hospitals do not have therapists that practice MLD (Manual Lymphatic Drainage) or CTD, so I have frequently been asked by the hospital staff to come into the hospital to treat patients privately (the patient still has to pay for the service). Compression garments or bandages are also not covered by Nova Scotia Health Care.

MM: I am the only one trained in CDT so when I am away there is no one else to do treatment. A lot of people are from out of town and there are not a lot of resources for out of town people so they often have to drive here for treatment.

AP: Being in the private sector, financial resources remain the main limit for accessibility to care. We have to rely a lot on education, and promote self-care with this clientele.

LG&SD: Lack of insurance or financial resources for patients that require compression garments is a big challenge with few solutions available.

MI: The lack of knowledge and education that still persists among healthcare professionals who do not acknowledge the role of rehabilitation, let alone in a relatively young field such as oncology rehab. The growing number of survivors is undoubtedly a great medical advancement, yet the long term sequelae which patients are left with require a tremendous amount of rehabilitation to ensure good quality of life is attained. I can only hope that the continued education will help improve the referral pathway for our patients and also the overall understand of the vital nature of rehab in the oncology setting.

WHEN IN THE COURSE OF BREAST CANCER TREATMENT DOES PHYSIOTHERAPY USUALLY OCCUR (PRIOR TO SURGERY, POST-OP, UPON RETURN TO WORK/PHYSICAL ACTIVITY)?

JS: I see patients at any and all stages. It depends on the individual.

MM: Our pre-op education is the main portion, if we can't see them pre-op then we see them immediately post –op. Then I only see them for follow up if they have any issues. The surgeons and nurse navigators at the Breast Health Centre are fantastic at referring patients to us that have any issues that need to be addressed.

AP: Mainly post-op, approximately 4-6 weeks following surgery. It is not rare however, to see patients 2 years after their medical treatment. These women consult because they have not recovered enough function to pursue their activities normally. We seldom see them before and during medical treatments, with the objective being to optimize their quality of life throughout these different steps.

LG&SD: We see patients prior to their surgery to fit them for a compression bra that they receive immediately after surgery. They are again seen within a week to be taught a post mastectomy exercise program and receive lymphedema education. A 4-week follow-up is then organized to progress exercises and ensures that they are ready for possible radiation treatment to come. We will follow them during and after their oncology treatment if needed. The goal is for the patient to return to their normal activities without limitation or pain.

MI: Physiotherapy occurs in all stages of treatment; from chemotherapy to the survivorship phase. The goals of rehab will vary depending on the stages of treatment. Additionally, all individuals have unique needs and goals and identifying them is imperative in order to tailor the rehabilitation accordingly and ensure patient-centered care is provided. Knowledge in the different treatment protocols is integral in oncology to help build appropriate measurable and achievable expectations with our patients

ARE THERE MODALITIES, MANUAL THERAPY TECHNIQUES OR EXERCISES THAT YOU USE FREQUENTLY IN YOUR PRACTISE?

JS: Modalities include: occasional use of cupping (suction) over adhered scars along with manual scar mobilization, lymph press pump for advanced lymphedema.

Manual therapy includes: MLD, edema techniques, scar massage, manual therapy for shoulders (including passive stretching), myofascial release for stiff joints or axillary webbing.

Exercises will vary depending on the problem the patient presents with – range of motion, strengthening, general physical activity, posture and positioning, pacing and self-massage.

MM: I don't use modalities generally, occasionally ultrasound for a shoulder tendinopathy or impingement, otherwise I use joint mobilizations, soft tissue stretching and MLD for lymphedema and strengthening exercises. We provide everyone having breast cancer surgery with a booklet that covers post –op exercises/stretches and has information on lymphedema signs and symptoms and what to avoid/be cautious about. And as stated before we have a male specific booklet. We have also taken pre-op baseline arm measurements of all breast cancer surgery patients where lymph nodes are being removed, whether it is a SLNB (Sentinel Lymph Node Biopsy) or ALND (Axillary Lymph Node Dissection). We have done this since we started in 2012. It would be nice to do some research with these numbers.

AP: The exercises I have learned from Jodi Winicour are very effective in reducing tensions and stiffness secondary to an axillary cord condition. I also find that myofascial release techniques appear to be very efficient in relieving stiffness in the chest and shoulder.

LG&SD: Education, active-assisted, passive and active shoulder mobility exercises, shoulder and scapula strengthening exercises, postural awareness, scar massage and myofascial stretching are commonly used with the breast cancer population. If oedema is an issue, then compression, manual lymph drainage, and kinesiotaping might also be utilized.

MI: Treatment in oncology encompasses different techniques, from range of motion exercises, individualised exercise programs to more advanced balance and coordination training. Traditional modalities are seldom used in this setting for cautionary measures as the focus of treatment continues to primarily relay on physical activity and exercise.

WHAT IS THE MOST REWARDING ASPECT OF WORKING WITH THIS POPULATION?

JS: This group is so grateful for any help to restore their functional and appearance as close to their life before cancer. They are very open about everything and I find myself often laughing and crying with them. I often meet many family members, and many times I teach the family members how to do treatment and how to support the patient with recovery, or with palliative care.

MM: They are a very motivated, positive, inspiring group of women and men.

AP: I would say that for me, is the most rewarding aspect is to see that I have helped these women finally go on and turn another page in their cancer story, which became possible from finally being able to resume their regular role in their daily lives.

LG&SD: You are part of a team that helps navigate this patient through difficult times. Patients are very compliant and greatly appreciate all the time you give to them.

MI: There is nothing that gives me greater satisfaction and appreciation for life then to see the progression of my patients. Their happiness is really my own, as they continue to strive to regain their function and battle their disease. The work that I do is really nothing compared to the determination and dedication my patients teach me about life, the infinite capacity of the human body and resilience of the human spirit. It is with great honour that I wish to continue assisting patients with cancer.

ARE THERE ANY SPECIFIC RECOMMENDATIONS OR INFORMATION THAT YOU THINK IS IMPORTANT FOR ORTHOPEDIC/MSK PHYSIOTHERAPISTS TO KNOW?

JS: You cannot book a fifteen minute slot or multitask with other patients present. It is a one-on-one service in a quiet environment for at least thirty to sixty minute treatments with undivided attention, to the patient and their loved ones.

MM: We are currently working with the University of Saskatchewan and recruiting participants for a shoulder study. We take pre-op shoulder ROM, strength, posture and we do a shoulder SPADI questionnaire. The research assistant at the U of S then follows up with them at 3, 6 and 12 months to see if there are any surgery related issues. If so, then we may be able to get funding for more physio positions!

AP: One must be vigilant as to the presence of an axillary cord, which may be at the origin of the articular restrictions to the shoulder. Soft stretching exercises are generally preferred with this clientele.

LG&SD: These patients should receive education regarding the lymphatic system. Obtaining full mobility and healthy scar healing will help the lymphatic system do its job. Patients should be able to recognize signs and symptoms of possible lymphedema and be told to consult immediately if they do occur. That being said, patients should not be afraid of this diagnosis as risks vary greatly depending on the surgery and treatments. The goals remain to return to full function and activities prior to the surgery.

MI: The most important recommendation I can provide to orthopaedic/MSK physiotherapists is to be able to identify the red flags that might illicit a cancer diagnosis. Taking a good patient history is critical as it can facilitate in identifying any red flags and rule out any possible signs of oncology. Furthermore, specializing in a field is not only an asset to the advancements of the science and practice of physical therapy, but one that is underutilized.