Dr. Vodder School™
NORTH AMERICA

Therapy News


Robert Harris—Director

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Inside this issue:

Editorial

Life's cycles come and go and we facilitate the journey that our patient's take, wherever we can. Having just witnessed the birth of our daughter and celebrating the glorious birth of life, I took a deep breath and read the wonderful article written by one of our therapists, on working with the dying patient. Thank you Edith, for sharing this important yet often unspoken aspect of our work. This issue of Therapy News also celebrates the innovation of some of our UK therapists and a brand new Australian CD Rom on lymphedema and the lymphatics.

Working in the Palliative Care Setting

Edith Mulhall, RN, Vodder certified therapist.
St. Norbert, MB, Canada

After attending the NLN conference in Chicago recently, several of my colleagues and I were discussing the logistics of caring for patients in a palliative care setting. It became evident from our conversation, that there are a lot of questions and uncertainties when working with this patient specialty. By sharing my own thoughts and experiences, perhaps other therapists will benefit and become more comfortable in this field of service.

Having worked for many years as a nurse on a medical unit, I have had many opportunities to work with terminally ill patients. It is often a scary field for the novice, as the percentage of patients who die is high. It can be a bit daunting to go into work each day, knowing that there is a good chance that at least one of the patients you care for today, will not be there tomorrow.

So how do we, as caregivers, approach the end of life stage of someone in our care?
First of all, I feel it is important to remember that death is a natural part of the life cycle. Reminding ourselves of this may at first seem somewhat clinical. However, if we apply this to our entire life experience, this approach may lose its clinical feel. As we go through each phase of life, we are aware that there are certain behaviours and responses that are appropriate for each of these phases: our children learn to walk, we pick them up when they fall; they learn to dress themselves, we show them how to do up a button; they learn to drive, we teach them to do it safely, and so on. We help them through each phase. In the same manner, when a person nears end of life, we can help them through this phase as well. However, there are several differences with this stage. The person we are helping will only do this once; it may take them a long time to do it; it may be very painful physically and emotionally; they will not have learned a life skill when this phase ends. I would like you to join me in looking at each of these four differences.

First, the dying person will only experience this event once. This may seem like a useless bit of information, but with it comes the truth that we, as caregivers, also have only one chance to do this. The reality of this first came to me some years ago when a patient told me that he needed "a captain to steer the boat" and then informed me that he was only making this trip once so it was my job as captain, to make it as smooth a trip as possible. As a nurse, it became my responsibility to administer pain medication as required to maintain a proper comfort level. Maintaining comfort is extremely important, as pain is probably the greatest dehumanizer. Being in pain can change personalities, lower self-esteem, alter perspectives, and be very abrasive to relationships. End of life is not a wise time to initiate these kinds of challenges. In spite of its importance, giving a medication to separate a patient from his pain is something anyone can do. However, as a hands-on therapist, we can provide pain relief in a unique way. Using massage of any kind to achieve a purpose takes time and personal investment. The therapist needs to be in tune with the patient. There

Working in the Palliative Care Setting, continued

needs to be a genuine caring for that person; insincerity is very quickly translated by touch. People who are in the process of dying are often considered “socially offensive”. They may look gaunt, smell different, talk incoherently, and lose control of normal body functions. Terminally ill patients are very aware, even if they do not say it, that they are not what they used to be. This reason alone, makes touch a vital gift. It tells the dying person that he is not untouchable, that he is not offensive to connect with, that you are not afraid to touch him. The fact that you are willing to touch him where it hurts (which may well be a very ugly area), speaks volumes of your effort to comfort. The fact that you are willing to share a block of close personal time in order to provide comfort tells that person that he is important. You literally become the patient’s “morphine”. But the fact that you can provide comfort without altering the person’s level of consciousness, or clouding his mental acuity, is a priceless attribute. So assisting the dying person through the final stages of life is definitely a once in a lifetime opportunity.

The next characteristic of end of life care is that it may take a long time. Death does not respect time. Although we are all aware that it is part of the life cycle, we have yet to have full control over how or when this passage actually takes place. Because of this, providing palliative care for someone can be an intense investment of time. I have often heard nurses ask, “What’s keeping him going? He’s had nothing but morphine for weeks.” Giving consistently sincere attention over a long period of time can be very draining for the caregiver. For this reason, it is important to put egos aside. Accept the fact that there may be times when you need a reprieve. As therapists, we are accustomed to meeting the needs of others, and it is very easy to overlook or neglect the fact that we also need care. It is not evidence of weakness to ask for support; it actually develops strength. The old adage is certainly true: you can’t look after others properly if you don’t look after yourself. Even if you are left alone to do the comfort care, speaking with other therapists or friends can go a long way in sustaining you through what could be an arduous experience. Again, a therapist’s inner status is easily detected by the patient. If you are too tired to give, your fatigue may be interpreted as lack of concern, or doing the job out of nothing more than professional obligation. Remember, it’s a long time for the patient too. If a long slow treatment time is wearing you down, get support. You and your patient will both benefit.

Third, dying can be painful, physically and emotionally. These areas have already both been touched on in conjunction with the above topics. However, there are a few points I would like to stress. MLD, because of its gentleness, and effect on the nervous system is a great analgesic. The soothing rhythm of the hands moving over the tissues often has a sedating effect on the patient. I had the privilege of caring for a young man, who had a spinal tumor at L2. He had been a rowing enthusiast before becoming ill. Now he had no sensation in his legs, with no response even to pin pricks. However, when I massaged his legs, he smiled and said it felt like he was gently rocking in a boat. He imagined himself lying in the bottom of his boat, bobbing on the water with total abandon. Although he had no feeling in his legs, he was able to translate his perception of comfort into something that brought him a wonderful sense of emotional pleasure. It was rewarding to know that I was able to replace his physical pain with an emotional comfort.

The last difference I would like to discuss is that the dying person does not gain a life skill through the act of dying. This is where being a therapist, or other caregiver, for that matter, can be extremely rewarding. We are the ones who learn, if we choose to take this as a learning opportunity. As my patient said above, he has only one chance to die. And we have only one chance to help this person die a comfortable dignified death. We as therapists can gain an incredible life skill by providing palliative care. Every terminal patient has unique and individual needs. This challenges us to be creative, to develop communication skills and character attributes that we may otherwise not have had the opportunity to cultivate. When I first began caring for terminally ill patients, I was often afraid to enter their rooms, because I found it so sad, or so demanding. Something that changed my feeling about this again came from a patient. The doctors had told her there was nothing more they could do, that her family should all be called, and she should say her goodbyes. All the machines were stopped. All the tests were cancelled. The patient

> *“As therapists, we are accustomed to meeting the needs of others, and it is very easy to overlook or neglect the fact that we also need care.”*

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Palliative Care……continued

looked at me, took my hand, and said, "It's just you and me, sister. I was wondering how long it would take for them to stop interrupting me with all this stuff they want to do." It was then that I realized that I was totally liberated in the way I could now care for this patient. Nothing else mattered. I did not have to conform to any protocol, other than keeping this patient comfortable for a few more hours. The freedom was exhilarating. The patient had a great day and she died comfortably that evening. I had a great day because I learned that helping someone die respectfully carries more value than watching them struggle to comply with the wishes of an aggressive system that says we must "do to", rather than "do with". One of my colleagues in Chicago mentioned how helpless she felt when her palliative care patient died in spite of all she had done for this patient. One of the skills we can learn is to refocus on the situation, and look at the big picture. We are no longer treating a patient with the intention of aiding that patient in recovery. No more measuring limbs, no more teaching exercises or bandaging. Our focus changes to helping that person pass comfortably through this phase of life and on to the next. The fact that the patient eventually dies is not a consequence of our being a poor therapist, it is the natural progression of a devastating disease. Another colleague mentioned that she could not help but cry when her patient died, and wondered if this was appropriate for a therapist. As therapists and caregivers, we are looked to for strength and support, and often feel that we cannot let our personal side show. Professional common sense will tell you that it would not be well received if you fell apart every time a patient passed away; however, sharing grief appropriately is a natural response to a painful situation.

One other aspect of working with palliative care patients, that I found to be very helpful for me, was knowing what my own feelings are about death. If death or dying is something that creates a great discomfort for a caregiver, that again will be detected by the patient. In my years of experience of working with end of life patients, I find that the best caregivers are those who are comfortable with their own philosophy of death. It may be totally different than that of the patient; however, if you are secure in your own self, that strength and assurance will be visible in your work. This is where peer support groups, pastoral care, a trusted friend or a co-worker can be an invaluable resource. Sharing your feelings and misgivings with a supporter has immeasurable benefits.
To all my co-workers in this wonderful field, I would like to say, "Keep on. We have a great challenge ahead of us. We possess a unique skill. Our profession is what we make it." §

Edith Mulhall: emulh@hotmail.com

> *"Our focus changes to helping that person pass comfortably through this phase of life and on to the next."*

An Arm & A Leg Limited

A different concept for lymphoedema care

Dee Jones, MT, Instructor & Vodder certified therapist. London, England

Four years ago An Arm & A Leg Limited was launched in the UK. Based on the experiences of several lymphoedema clinics in Europe and designed to ease some of the problems we encounter here, the clinics set up by An Arm & A Leg Limited have a unique place within the UK lymphoedema scene.

One of the most striking differences is that the clinics are residential and are run in a hotel rather than as part of a hospital or hospice setting. The founders of An Arm & A Leg Limited, Dee Jones & Elizabeth Nicholson, realised that a large percentage of both primary and secondary lymphoedema patients find it difficult to be seen as a part of the palliative cancer scene – particularly if the treatment offered is on an inpatient basis. They feel strongly that the treatment can be greatly enhanced by pleasant, non-institutional surroundings and comments from patients have reinforced this.

The pattern of each clinic is the same. Therapists are briefed the day before the patients arrive. At this point not only has each patient completed a Medical Questionnaire but An Arm & A Leg Limited has already been in communication with local clinics, GP's and/or consultants so each case history is quite detailed.

An Arm & A Leg - *What is offered?*

The patients are greeted, shown to their rooms and left to settle themselves in before gathering together in the early evening to meet the therapists and ask any questions they might have. This is also the time they are shown around and given general and housekeeping information.

The next day each patient is measured and assessed by Dee Jones and Professor Peter Mortimer. Treatment days follow consisting of two sessions of MLD and bandaging per day as well as daily physiotherapy and pool sessions – a minimum of 5 hours of active treatment each day. Each patient's first appointment is as early in the day as possible and their second session is as late as possible. In between they have physiotherapy exercises, long walks (if appropriate!) in the countryside and just before their second MLD & bandaging appointment, a chance to get out of bandages and into the pool for a second physiotherapy session.

There are 15 full treatment days including group support and education about maintenance as well as the core treatment. To finish, either `off the shelf' or made to measure hosiery is fitted – again in consultation with the patient's local lymphoedema clinic. Final measurements are taken and a full report is prepared. This is sent to the patient's doctor and lymphoedema clinic as well as to the patient themselves. In most cases it has been possible to arrange appointments with local clinics within 48 hours after patients leave An Arm & A Leg Limited.

> *"……it is well worth spending three weeks in this unique set-up."*

The Lymphoedema Therapists

The company maintains a bank of qualified and experienced lymphoedema therapists, all of whom have been interviewed and have had to give practical demonstrations of their work as well as references. They must have superlative MLD and bandaging skills as well as an interest in working as part of a team. Those who have taken time out of busy jobs or practices to work at An Arm & A Leg Limited confirm that it is well worth spending three weeks in this unique set-up. It's a great place to exchange ideas on bandaging or to discuss difficult aetiologies.

All of the therapists are Vodder-School trained and some have also trained at other schools in addition to their Vodder training. The team shares all types of backgrounds, with physiotherapy, nursing and massage mixing well in a lively clinic.

An Arm & A Leg Limited offers two to three clinics each winter. Patients are followed-up after 6 months so that the effectiveness of the treatment can be measured and audited. In nearly all of the cases to date not only has the reduction gained in clinic been maintained – often 50% or more of their oedema - but has continued to decrease over the 6 months following. §

For further information go to:
www.anarmandaleg.co.uk

Dee Jones: deemld@hotmail.com

American Cancer Society Awards Grant to Increase Lymphedema Education

Patti Loebs, RN, CHTP, Vodder certified therapist, Murrells Inlet, USA

In Myrtle Beach, South Carolina, a Community Action Grant has been made possible through the American Cancer Society. This is a year-long collaborative effort linking Coastal Carolina University's Women's Advocacy Center, the Zeta Phi Beta Sorority and the Coastal Center for Mind-Body Therapies and Lymphedema Treatment Program. They will work together to educate the community about the condition of lymphedema, to include proper home care and treatment options. The grant will also

Education ……continued

help to provide funding for expensive compression supplies and garments which are needed during treatment and for home care.

The Coastal Center for Mind-Body Therapies and Lymphedema Treatment Center is a non-profit organization located in Surfside Beach. Patti Loebs, the patient coordinator is an RN and certified by the Dr. Vodder School for Manual Lymph Drainage and Combined Decongestive Therapy. Laura Crabtree, also an RN, is employed by the center and certified by the Dr. Vodder School. Since the Center's opening in March of 1999, it has been supervised by the medical practice of Brian Adler, MD and the awareness of patients and referring physicians has grown tremendously due to their hard work, support groups, and community outreach. The center vows to employ only Vodder certified therapists and adhere to its meticulous and effective protocols of treatment.

Stacy Cretzmeyer, PH.D., N.C.C., L.P.C. is a counselor at Coastal Carolina University's Counseling Center, the director of the Women's Advocacy Center, and a published author. She is the project director for the grant and tailored the grant to specifically target the needs of medically underserved cancer patients who suffer from lymphedema in Horry, Georgetown, and Williamsberg counties. With the help of Zeta phi Beta Sorority at CCU, Dr. Cretzmeyer, as director of the Women's Advocacy Center at the university has been instrumental in developing the educational programming and community awareness aspects of the grant. They are hopeful in the future that they might obtain funding that will also provide free services and Vodder CDT treatment for the medically underserved. §

For more information contact: **Coastal Center For Mind-Body Therapies, Inc. & Lymphedema Program,** 1943 Glenn's Bay Road, Surfside Beach, SC 29575 Phone/Fax (843) 650-5173.

German Society for Lymphology conference October 03–05, 2002

Robert Harris

This was a combined conference of the German Society of Lymphology and the Dr. Vodder Society for Manual Lymph Drainage and brought together over 200 German-speaking lymphologists and therapists from many European countries. The conference began with workshops from the Dr. Vodder School, Austria, as well as Prof. Weissleder on anatomy and physiology of the lymph vessel system and Dr. Schuchhardt on lymphedema diagnosis. Prof. Hutzschenreuter gave a workshop on wound care and Angela Vollmer on garments.

Prof. Hutzschenreuter is the president of the Dr. Vodder Society and he opened the conference with history of the development of the Vodder technique. The first Dr. Vodder Basic course in Germany was actually given in Ulm in 1966 and organized by Dr. Fischer of the Haug publishers. Guenther Wittlinger, who later founded the first Dr. Vodder School with Hildegard Wittlinger, attended this first course in Ulm.

The emphasis of the conference was on evidence-based medicine and there was much discussion on what this is and how to apply it to the field of Lymphology and MLD. Prof. Schaad of Munich mentioned the Cochrane Library which carries out meta analysis of medical studies, crystallizing the results. (www.cochrane.org). It was also a good reminder to us all that the average half-life of medical knowledge is considered to be four years with over 2 million medical articles published per year.

I found the work of Dr. Fischback particularly interesting. He developed the Perometer that is now the gold standard in volume measuring.

Prof. Wittlinger presents the Guenther Wittlinger prize to Prof. Hitzschenreuter.

Conference……continued

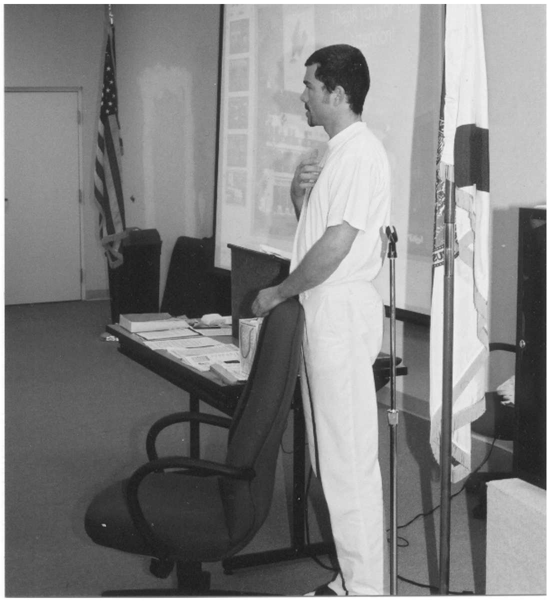
He described a new portable device that is now available in Europe and very recently in North America, which is much less expensive than the stationary model.

There were also presentations from other prominent lymphologists such as Dr. E. Főldi on the treatment of children (especially chylous reflux) and Dr. Zőltner on the ultra structure of the lymph vessel endothelium. Dr. Herpertz discussed the incidence of Stewart-Treves syndrome (lymphangiosarcoma) in primary lymphedema patients. We normally think of this affecting secondary lymphedema patients but he indicated a 1:1000 incidence in primary patients. There were many case presentations with a special emphasis on wounds and lymphedema. The Guenther Wittlinger prize for work in the field of Dr. Vodder's MLD was awarded this year to Prof. Hutzschenreuther. His research efforts, often with the Dr. Vodder School in Austria, have brought MLD to the forefront of research knowledge in the field of Lymphology. §

To contact any of the case presenters from the reviews, please go to the Therapist referral page of our website at www.vodderschool.com

Review in St. Petersburg, FL

A very successful Review was held at Eckerd College at the end of January with 48 therapists attending, and with Hildegard and Andreas Wittlinger and Robert Harris instructing. There were many case discussions at this Review and some very interesting small group discussions which were later presented to the whole group. Topics ranged from genital edema to adjunct therapies, compression issues and research. Robert Harris presented his research study with Prof. Neil Piller from Flinders University, Adelaide (see articles on page 8). Andreas Wittlinger, PT did a short introduction to Marnitz Therapy and an interesting presentation on the use of MLD with burn patients. Ruth Coopee gave an introduction to Kinesio Taping for scar tissue, followed later by her workshop. Case presentations were made by Eloise Frey, PT on a patient with metastatic prostate cancer; Kathy Duff, PT on a patient with bilateral leg lymphedema who underwent bilateral total knee replacement; Sara Nelson, PT on a patient with melanoma and delayed wound healing; Betsey O'Neill, PTA on a patient with upper extremity lymphedema after breast cancer with suspected skin cancer metastases; Robert Jordan MT with Francesca Clay MT and Nancy Guillet MT on the use of the light beam generator in patient care. Renee Romero also gave a well-attended workshop in Advanced Creative Bandaging, immediately following the Review. §



Andreas Wittlinger speaks on burn treatment with MLD.

New Vodder Graduates

The first North American Therapy II & III class in the French Language was held in Laval, Quebec last year.

If you would like to contact or refer patients to any of our new Therapists, please check the Dr. Vodder School website at www.vodderschool.com or call the office at (250) 598-9862 between the hours of 8.00 a.m. & 4:00 p.m. Pacific Standard Time, Monday through Friday.

Congratulations to all our New Graduates!

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New Vodder Graduates……continued

Quebec II & III Class - September 2002

Jacques Boissinot	MT	Laval, PQ
Suzanne Daehler	MT	Montreal, PQ
Nicole Deschênes	PT	Montreal, PQ
Luc Dominic Massé	MT	Ste. Therese, PQ
Sylvie Fenet	MT	Foy, PQ
Karine Lachance	MT, PT,RN	Val Brillant, PQ
Isabelle Lombardo	RMT	Prevost, PQ
Isabelle Marter-Huet	MT,RN	Ste-Anne-des-Lacs, PQ
Guylaine Mercier	PT, MT	Val-Bélair, PQ
Helene Mouton	MT	Tremblant, PQ
Jacqueline Rampy	MT, RN	Montreal, PQ


Victoria 2002

Victoria II & III Class - November 2002

Pam Jensen	PTA	Sylvan Lake, AB
Diane Keitges	RMT	Stony Plain, AB
Denny Paccagnan	RMT	Calgary, AB
Tara Kiss	RMT	Kamloops, BC
Daniela Kym	RMT	Victoria, BC
Christine Miller	RMT	Kitimat, BC
Rhonda Hicks	RMT	Smithers, BC
Katleen Verstraete	PT	Hofstade, Belgium
Terri Minkus	OT	Morgan Hill, CA
Nicole Ketterer	PT	Hale Thorpe, MD
Angela Carter	RMT	Lakeville, West Co., NB
Vicki Davis	PTA	Alamogordo, NM
Tara Rohrlack	LMT	Bolton Landing, NY
Cindy Pirrie Schultz	RMT	St. Catharines, ON
Janice Simmonds	RMT	Peterborough, ON
Debra Moore Cox	MT	Banks, OR
Serena Kwa	PT	Singapore
Amy Smith	PT	Arlington, TX
Bradley Axford	RMT	Melbourne, Australia
Redd Graves	LMT	LaCenter, WA

Félicitations à notre première classe de Thérapie II et III langue Française!

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NORTH AMERICA


Quebec 2002

Devon, England II & III Class - October 2002

Janet Mowbray	RN	Ely, Cambridgeshire
Mairéad O'Connor	RGN	Portmarnock, Co. Dublin
Lynne Hudson	RN, MT	Tavistock, Devon
Veronica Bell	MT	Pondhead, Holt, Dorset
Annabel Mooney	MT	Cowlam, Nr. Driffield, East Yorkshire
Sally Terry	MT	Ringwood, Hampshire
Paul Riley	MT	Stevenage, Hants
Jasmine Light	RGN	Newport, Isle of Wight
Catherine Ross	MT	Blackheath, London
Jennifer Pallett	BA, MCSP	Forest Town, Mansfield, Notts
Kate Bowes	RN	Sheffield, South Yorkshire
Juliet Cross	RN	Cannock, Staffs
Gail Longhurst	MT	Boxgrove, Guildford, Surrey
Joy Robinson	MT	Dorking, Surrey
Lynda Carter	RGN	Melksham, Wiltshire


England 2002

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Shannon MacGregor
Administrator

New CD ROM available on lymphedema

A brand new interactive CD ROM has been produced by Prof. Piller from Flinders University in Adelaide, Australia. This features animated video sequences of the connective tissue and lymphatic system and gives us a fantastic new educational tool. Robert Harris worked with Prof. Piller on the lymphatic massage section of the CD and the Dr. Vodder method is featured, with a video demonstration on a lymphedema patient. There are sections on anatomy and physiology, diagnostic procedures, treatment options, measuring and recording arm and leg lymphedemas, and much more.

There is a section for health care professionals and a section for patients, answering most questions about lymphedema and the lymphatic system. Prof. Piller has already gained acceptance of continuing education credit for physicians in Australia who view and answer the quizzes in the CD.

I am most impressed with the high quality of the CD and think it will become an invaluable tool for patients, health care practitioners and physicians. Please see the enclosed order form. §

Conferences and Reviews: 2003 / 2004

Lymphedema Association of Quebec, May 28 – 30, 2003, Montreal, Quebec. Contact Rachel Pritzker: infolympho@icomm.ca and web site: www.infolympho.icomm.ca

European Group for Lymphology, June 12 – 14, 2003, Malmö Sweden, Contact: marika.bergman@skane.se, www.plasticsurg.nu

International Congress of Lymphology, September 01 – 06, 2003, Freiburg, Germany. Contact: isl@intercongress.de www.intercongress.de

Reviews:

Stowe, VT: May 30 – June 01, 2003

Walchsee, Austria: July 21 – 25, 2003

Victoria, BC: August 01 – 03, 2003

San Diego, CA: September 26 – 28, 2003

Dallas, TX: January 30 – February 01, 2004

Adelaide, Australia: April 23 – 25, 2004

Next LANA Exam: April 21-May 10, 2003, and application deadline April 7, 2003

Books & Articles

N. Piller, Harris, R: Objective Measurement of the effectiveness of a single session of manual lymphatic drainage on primary and secondary lymphedema of the lower leg. Lymphology, 2002; 35 (suppl), 289-292.

This is the research that was undertaken in Australia at Flinders University, Adelaide to demonstrate the effectiveness of the Dr. Vodder method without any other adjunct therapies. It was a pilot study and will lead to more extensive research. It is a model of how research can be carried out with objective measuring tools to demonstrate the effectiveness of treatment.

A. Szuba, Achalu, R and Rockson, S: Decongestive Lymphatic Therapy for patients with breast carcinoma-associated lymphedema. Cancer, 2002; 95, #11, 2260 – 2267.

This was a randomized, prospective study of a role for adjunctive intermittent pneumatic compression. A cross-over study was performed at Stanford University using the Dr. Vodder method of MLD in combination with the pump therapy. Szuba et. al. reported an improved mean volume reduction in patients who were given both forms of therapies. No adverse side effects were reported on skin elasticity and joint range of motion.

Administration

We would like to extend our best wishes to Robert, Carol & Ryan Harris on the Christmas Eve birth of their new baby girl Caelin Sarah.

Congratulations!

Ryan & Caelin

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