Report on the CLF/ALA Conference Oct 23-24, 2015 Calgary
LAS Member at Large: Julie Jensen 15 Nov 2015

The conference was excellent! Not only did we learn from very knowledgeable people in the world of lymphedema but we had opportunities to ask questions of them, read interesting posters, speak with product suppliers, see the latest products and get to know the other CDT therapists from Sask.

Dr. Christine Moffatt is a professor of Clinical Nursing Research. Between her many roles she runs a regular clinic for lymphedema clients, does research, speaks at conferences around the world and is the Joint Chairperson and a Director of The International Lymphoedema Framework. (ILF)

I was able to hear Dr. Moffatt speak in Edmonton in 2008. I knew that her knowledge base was high so I planned my attendance at the symposium around her presentations.

I will try to summarize her talk entitled:
Prevalence and Impact of Lymphedema: the Global Challenge!

Dr. Moffatt addressed the many issues of gathering data to show the impact that Lymphedema has globally with implications for each country. (Lymphoedema Impact and Prevelance - International Lymphoedema Framework or LIMPRINT, the 20,000 ILF dataset).

The ILF is trying to define the stages/severity, profiles (cancer vs non cancer), genetic predispositions and countries of origin (eg the millions of people with Lymphatic Filariasis). However there are challenges in the methodologies such as:

- Definition issues
- Issues on how to measure
- Issues re: limb volume assessment
- The use of mixed methods of assessment
- The difference between prevalence and incidence data

Prevalence: the number of cases of a disease present in a specified population at a given time. (eg: the health region reported that 5 seniors at Care Home XXX were ill with influenza during the week of Jan 7-14)

Incidence*: the frequency of a disease or condition over a period of time and in relation to the population. This frequency value gives the percentage of a condition and can be applied to larger populations.*
*(eg: The reported incidence rate of TB in Canada increased from 4.7 to **4.8 cases per 100,000 population in 2012**.)*

Meaningful outcome measures are:

- Cellulitis history
- Functional mobility
- Work ability
- Income
- Hospitalizations

- Cellulitis is a key predictor. It has been shown by lymphoscintigraphy that is causes damage to the lymphatics.

- People who are immobile will have lymphedema related issues. How to get to work, take of family and personal needs when mobility is limited. Determining if clients are bed bound, chair bound, walk with an aid or without an aid help determine financial costs and loss of productivity to society.

- Families suffer when there is no employment due to lymphedema. 8.9% must stop work, 2% have to change jobs.

- The number of hospitalizations is an indicator of the cost to the system. Wounds and wound care can be counted and the cost followed.

Some interesting data:
Some people are predisposed to lymphedema, i.e. there is a genetic link. This has been found in women with breast cancer.

In western society there is an exploding and silent epidemic: we grow older, fatter with less mobility.
95% of the obese have lymphedema. *BMI 25-30 = over weight. BMI 30+ = obese.*
Over weight people with a BMI of less than 25 have a 14% risk of lymphedema, while those with a BMI greater that 25 have a 65% risk of lymphedema.

We are better at fighting cancer and cancer survivorship is up.

In the United Kingdom:

60% -70% of clients had non-cancer related lymphedema.
Of people in hospital: 26-38% had chronic edema.

In Canada: 3% of the population has lymphedema. Numbers based on the USA incidence.

She had a lot of info and this is what I was able to glean. I continue to appreciate Dr. Moffatt for her teaching talent and ability to share her abundant knowledge of lymphedema.