Hello and welcome to the 5th edition of 3M’s Under Pressure newsletter, we hope you find it interesting and relevant to your everyday clinical practice.

It’s been an exciting year for 3M as we have been thrilled to host some inspiring educational events with Professor Christine Moffatt, CBE from the UK, including Breakfast Symposia at the Asia Pacific Lymphology Conference in Darwin and also at Wounds Australia Conference in Melbourne. We were also privileged to be able to broadcast a live webinar where Professor Moffatt presented on the issues of managing chronic oedema in practice and the latest research and science underpinning compression therapy. Thank you to those of you who joined the live event and registered to receive the recording. If you missed any of these insightful educational sessions you can still watch the recordings that are available through our online learning platform, 3M Health Care Academy at www.coban2.com.au.

As well as these valuable educational sessions, we have also facilitated many practical Coban 2 compression workshops across Australia for both wound and lymphoedema. If you missed these, check out our diary dates for 2017 workshops. We hope that you can join us for a hands-on session which provides lots of tips and tricks and techniques, especially for those difficult-to-manage limb shapes.

3M were also able to host a Venous Leg Ulcer Forum during Wounds Awareness week in October with Australia’s Federal Health Minister, Sussan Ley MP and clinicians from around country. This forum aimed to highlight the burden on patients and health care resources and raise the issues around barriers to implementing best practice for the treatment of Venous Leg Ulcers.

Many of the clinical challenges you face in everyday practice are highlighted in the interesting case studies featured in this edition, which describe the versatility of Coban 2 in meeting these needs. The use of patient self-bandaging techniques are described as well as applications used for scrotum, arm and amputee case studies. Thank you to all our contributors who have shared these cases which provide such valuable insights. An interesting report on the 2016 World Union of Wound Healing Society Conference in Italy is also included which gives a great summary of the conference.

We look forward to another exciting year ahead with many more informative and educational events planned in 2017. If you would like to receive information about upcoming educational events, please email us at 3Mhealthcareedu@mmm.com

Thank you.

We wish you a Merry Christmas & a Happy New Year.

Ruth Timmins
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**STAND UP FOR LEGS!**

Free Mouse pad

Simplifying Venous Leg Ulcer Management

To receive a free mouse pad with the ABC of VLU management, just email us with your details to 3Mhealthcareedu@mmm.com
Rural challenges in treating Arm Lymphoedema.

Pam Mallon, RN Lymphoedema Therapist
Rebecca Goldman, RN Lymphoedema Therapist
Rural Oncology Centre Tamworth NSW

This rural cancer centre is a day clinic that covers patients from all over the North West NSW. Working in the Chemotherapy infusion suite with a clinic for Lymphoedema Patients as the need arises but due to staffing issues it is very limited, but trying to help those most in need. There were no previously trained staff to manage Lymphoedema until recently.

Arm Lymphoedema Case Study- Mrs J

Patient History
78 year old woman
• History of metastatic breast cancer right breast with metastasis to the liver, original diagnosis in 2011.
• ER/PR/ Her2 positive.
• Was given palliative AC and Herceptin in 2011.
• Right mastectomy, right ductal axillary clearance and Radiation to the chest wall and right axillary area.
• Port a cath inserted on the left side.
• Continued Herceptin until 2012. Had nab-paclitaxel until 2014. Then had Kadcyla for 15 cycles 2015. Then was commenced on Herceptin and capcitabine until current date.
• 150km round trip to visit clinic for treatment

Lymphoedema had been present in the right arm for 5 years prior to Lymphoedema management. It was very significant, reducing the Mrs J’s ability to perform daily activities of living and making self-care difficult, becoming dependant on her husband for many daily tasks. Mrs J was using a walker to mobilise because the arm was weighing her to one side and making balance difficult. See photo 1 before treatment.

There was discussion with the oncologist prior to treatment about benefits of treating the lymphoedema and history of metastatic disease. It was agreed the benefit of treatment in improving quality of life was more important than the risk of complicating Mrs J’s disease.

Treatment
Mrs J had a long distance to travel (approximately 150km round trip) and also because of limited staff resources it was decided to use 3M™ Coban™ 2 Compression Systems. As Coban™ 2 is only applied twice a week compared to traditional daily bandaging, it made better use of time in the clinic.

Mrs J presented for twice a week Lymphoedema massage and Coban™ 2 Lite compression bandaging. The only adverse event was when she scratched her arm and caused a skin tear in about week three, it was treated with preventative antibiotics and healed quickly.

Results:
As a result of the treatment, Mrs J experienced a large reduction in her arm size. See Graph 1.

Conclusions:
The treatment improved Mrs J’s quality of life greatly. She is now able to do her own dressing and bathing. It made her mobility so much better because she wasn’t being pulled to one side and could go without the use of the walker at home. Mrs J was able to use a pen again to write where she previously found signing a document very difficult. Also after treatment she was able to peg the washing out on the line and attend to chores around the house. Mrs J was so pleased with the results and was even able to go on bus trips again as a tourist. See photo 2

Mrs J was then fitted with a prescription garment for ongoing management. She is now able to wear her other, nice clothing instead of polo shirts to fit her lymphoedema arm. She has now had the sleeve for 6 months and going well.

Don’t forget to use 3M™ Cavilon™ No Sting Barrier Film to protect skin from friction, moisture and adhesives!
Empowerment with Self-Bandaging - Old Vs New

Maree O’Conner
Physiotherapist and Lymphoedema Practitioner Victorian Lymphoedema Practice, Melbourne.
Maree is also an ALA Accredited Lymphoedema course trainer.

Introduction
Compression therapy is commonly used with moderate to severe lymphoedema. In the active phase of treatment and periodically in the maintenance phase, multilayer bandaging is implemented. It is especially used when a large volume reduction is required or to soften fibrotic oedema. It also has increasing use prior to new garments as there is an opportunity for greater reduction.

Most times it’s carried out by the lymphoedema practitioner but for many reasons self-bandaging may be implemented. There are a variety of bandage systems including traditional multilayer bandaging, two layer systems and compression wraps or a combination of these.

Background
Research in self-bandaging is limited. In 2014 Dorit, Tribhar, Pamela Hodgson, Carol Shay and Anna Towers published a paper in Physiotherapy Canada titled: ‘A Lymphoedema Self-Management Programme: Report on 30 Cases’. Patients attended a self-bandaging clinic with multilayer bandaging. The program included an intensive course of self-bandaging for a period of between 3-12 weeks. These clients re-bandaged themselves each day and were assessed weekly by their lymphoedema practitioner who monitored volume, pain and range of movement.

Reductions of 48-92% and reported global rate of change > 80% for 75% of participants was achieved. It assisted selected patients with independence and self-efficacy. At the 2014 International Lymphoedema Framework conference in Glasgow a poster by Debbie O’Halloran explored the topic of ‘Empowering the Lymphoedema Patient to Apply Compression Bandaging’ (See photos 1-3).

Mrs K, a 73 year old with primary lymphoedema in the left leg including a lobule at her knee was unable to wear compression stockings due to lack of strength to apply them. A solution was to wear a compression sock and toe caps and then Coban™ 2 bandage above to the groin. She did this twice weekly and, over a period of 18 months, excess measurements went from 144% to 66%. Once this stabilised, she only needed to self-bandage 1-2 times per week. The result has also meant that she is more mobile and in control of her lymphoedema.

I have previously taught clients and their support people to bandage with multilayer bandaging. With this, often complex technique, there has always been a risk that they would bandage incorrectly and safety issues. The previous poster presentation inspired me to explore the use of Coban™ 2 for self-bandaging and undertake a pilot study.

Why self-bandage?
If there are challenges to access services:
This may be because of limited resources in lymphoedema services. Access may be difficult due to distance, especially if the client lives in a rural setting. Also life commitments such as work, family and relying on carers can prevent the client regularly attending a lymphoedema service.

Promote independence
Self-bandaging enables a client to be actively involved in their own care and have another tool in their toolbox. Lymphoedema can get worse or flare up for a variety of reasons such as heat and activities that aggravate. Most times, this is not when they are due to see their lymphoedema practitioner. Self-bandaging gives them an opportunity to address the issue immediately and take control of their ongoing maintenance.

Choosing the appropriate client
Self-bandaging is not appropriate for all clients. To assess suitability it is important to consider:
- Medical history and current health;
- Location of the lymphoedema;
- Dexterity;
- If it is an arm, a non-dominant arm is easier to self-bandage;
- Vision;
- Cognitive function;
- Mobility;
- Commitment to treatment;
- Previous bandaging by practitioner. It may be easier, for some clients, if they have initial bandaging with the practitioner so they can be monitored, and maintenance or top-ups are performed by the client.

Practitioner requirements
When a practitioner undertakes teaching a client self-bandaging they should:
- Practice self-bandaging on themselves to gain competency and confidence;
- Allow plenty of time for teaching, and practice at least twice, and on the third application, check competency for applying and removing;
- Discuss warning signs;
- Ensure client is comfortable and confident to undertake self-bandaging;
- Provide them with educational resources to aid them with their application.

Choosing a self-bandage system – comparing old versus new

Traditional multi-layer bandaging
- Daily
- Client may find it difficult to learn the technique due to several components
- Inconsistency of bandaging
- Potential safety issues
- Bulky
- Restricts activities of daily living
- Difficult to exercise

Coban™ 2 Compression systems
- Twice per week
- Quick to apply
- Straightforward technique and less products
- Less to go wrong
- Provide extra stiffness where needed
- Low profile
- Encourages mobility
- Less impact on activities of daily living
Pilot Study 2014

Subjects
Two clients with non-complex upper limb lymphoedema and lower limb lymphoedema were chosen. Both previously had practitioner applied multilayer bandaging and Coban™ 2 bandaging. There were no medical, mobility or cognitive issues. Both wanted another option for their toolbox of management techniques.

Subject 1
Jill, a 39 year old who is self-employed and has a background in marketing. When she commenced this trial she had a 4 year old and has primary lymphoedema in her left leg since she was 15 years old. The left leg circumferences compared to her right leg ranged from 4 to 10cm greater.

Subject 2
Christine, 61 years of age was diagnosed in 2009 with left metastatic breast cancer. In 2010 she underwent a left wide local excision and axillary lymph node dissection. This was followed by chemo therapy, radiotherapy and hormonal treatment. Due to recurrences she has ongoing chemo therapy.

Method
1. Demonstration of Coban™ 2 bandaging by the practitioner.
2. Three self-bandaging practices with the third videotaped for their use.
3. The clients were supplied with the 3M patient information flier and practitioner bandaging charts for them to use and provide feedback.
4. Initially bandaging 1-2 times per week for 4-6 weeks.
5. Both clients then continued to bandage as required.

Results
The clients reported that self-bandaging with Coban™ 2 was found to be more effective than traditional multilayer bandaging. It was easier to apply and reduced the risk of tourniquet and slippage. (See photos of self-bandaging applications.) Most importantly, they found they were empowered to treat themselves within the privacy of their home and the confidence to manage their lymphoedema between practitioner visits. The flexibility of this bandage allowed them to perform activities that they previously could not undertake.

“I am now able to get all my housework done. I wouldn’t have been able to do that if I hadn’t bandaged – that’s pretty incredible when you think about it. I suppose the most empowering thing is that I can now take this into my own hands at home. You can bandage yourself at home anytime without relying on your physiotherapist. I feel more in control.”

Christine

Tips
• Be prepared: have tape, elbow and finger pieces ready.
• If unable to bandage finger/toes, consider a glove.
• Use a mirror.
• Play the self-bandaging video and watch each stage before attempting.
• Essential to use 3M Cavilon for and does it provide extra compression?

Available to view www.coban2.com.au

Resources
Following this pilot study and with the input of both Jill and Christine the following resources have been developed. These can be used to support the patient after full application training is given by the Health Care Professional and competency is checked:
3M Patient self-bandaging application videos
3M Patient self-bandaging information guides
Available to view www.coban2.com.au

References

Ask Connie Compression

We invite you to send in any questions you have relating to compression therapy or 3M™ Coban™ 2 Layer Compression Systems. We’ll publish a selection of your questions each issue, along with answers from our team of international experts. This month we have collated questions that we are commonly asked in workshops.

If you have a question please e-mail to ratimmins@mmm.com

Connie Compression

Did you know...

Compression therapy is widely recognised as key to the management of VLUs: Despite existing guidance, many patients with a VLU do not receive compression therapy.

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The use of Coban™ 2 Compression Systems for the management of stump oedema: a summary of the clinical rationale, outcomes and limitations.

Sarah Sage, Clinical Nurse Consultant, Wound Management
Hannah Tudor, Clinical Nurse Consultant, Wound Management
Emily Duke, Prosthetist and Orthotist
Royal Melbourne Hospital, Victoria

Introduction
Post-operative swelling is a common outcome following surgery. For lower limb amputation, many guidelines recommend the management of post-operative stump swelling and oedema to promote healing. Poorly controlled oedema is linked to delayed wound healing and increased time to amputation. Recovery times are often complicated by patient comorbidities including underlying reason for amputation. Complications of diabetes and reduced arterial flow to the limb are some of the common indications for amputation. The current standard of practice post lower limb amputation is to commence active oedema management, usually in the form of a stump shrinker (commercially available compression garment) once wound healing allows. The decision to fit a shrinker is made by the treating team, specifically the medical, nursing and prosthetics team members. Shrinkers are not fitted whilst sutures are in situ due to risk of embedding. Additional limitations in fitting a shrinker include the presence of wounds which require bulky or absorbent dressing or when residual shape is outside the available sizes of compression garments. To address this issue the clinical team decided to explore the use of Coban™ 2 Compression Systems short stretch compression bandaging. Coban™ 2 can be moulded to fit each patient’s unique shape, it can be used with active wounds and wound dressings underneath it, and it can be used by patients with who have concurrent arterial disease. The team trialled this with a total of 3 patients with stump limb circumferences greater than a shrinker garment would fit, had concurrent lymphoedema in the residual limb and had either wounds or lymphorrhhea leaks in the stump.

Presenting clinical issue/ Method:
Coban™ 2 Lite was trialled on 3 patients from the rehab ward with lower limb amputation. (x1 below knee and x2 above knee amputation). The decision was made to use the Coban™ 2 Lite system rather than the regular Coban™ 2 system as all patients had arterial compromise and reduced sensation. Each patient had a residual stump that was too large for an off the shelf shrinker and had active wounds (surgical, blisters, pressure) with high exudate. High exudate output requires a highly absorbent dressing (bulky) which usually excludes the use of a rigid dressing. In each case, the Coban™ 2 Lite system was intended to be used until the patient was suitable for either a rigid dressing or off the shelf shrinker. Patients were seen either once or twice per week depending on the changes in oedema and wounding management needs. Each residual stump was measured at each dressing change at 10cm intervals along the stump.

Results
In all cases, patients had significant limb reduction at each bandage change. The average was 2.5cm at 10cm intervals in the residual limb that was bandaged. Patient 1: Patient had pre-existing lymphoedema prior to the coban™ 2 dressing. Patient was bandaged. Patient 2: Presented with pre-existing limb oedema, poorly controlled type 1 diabetes and above knee amputation as a result of an infected foot wound in a poorly perfused limb. Bandaging was sustained for 3 weeks, (see photos above). After this time, the patient had unrelated bacteraemia and was transferred to intensive care. Patient 3: Above knee amputation due to trauma (motor bike accident) with a customised tubular stocking to manage the oedema. Patient 2 – application of the bandaging was done by Wound CNC (lymphoedema trained) and trained Prosthetist and Orthotist. We combined scrotal and paste principles applied; we didn’t use a hip spica as all patients were bed or wheelchair bound during the trial period. Application technique of Coban™ 2 Lite was modified over time to optimise conformability and comfort. Greatest comfort and wear time were achieved when a ‘follow the roll’ style of application was used. In both patients the rapid drop in initial limb volume prompted more frequent bandage re-application. In patient 2, this occasionally meant the patient was without compression, when it fell off due to limb reduction, for up to 24 hours until trained clinicians could reapply it.

Discussion of limitations
Overall, the use of Coban™ 2 Lite compression in lower limb amputation was effective at reducing limb volume, allowing patients to progress to the current standard of practice (rigid dressings and shrinker garments) who otherwise would not be suitable for these. Rapid reduction in residual limb volume meant that patients at times required more frequent bandage re-application than was anticipated. The patients reported it to be comfortable, and clinicians perceived it to simplify the treatment of patients with complex treatment challenges.

Photos. Patient 2 – application of Coban™ 2 Lite to above knee amputation using ‘cut and paste’ and ‘follow the roll’ techniques.

Reference:
Wounds that appear on the buttocks require differential diagnosis as they can arise from skin tears, incontinence associated dermatitis and pressure injury. Skin tears can often be missed and the wounds become labeled as Category 2 pressure injury.

Something old, something new and “nature” re-visited:
• Topical applications based on turmeric, onion, cinnamon, honey, cannabis and an Australian plant extract called Species 8472 were presented.
• Electrical Stimulation (ES) devices were an intriguing source of discussion with good quality evidence surrounding their efficacy. An interesting indication is the use of ES to manage problematic pruritis.
• Photonics or light therapy was presented as having anti-inflammatory properties but more research is required to know how to adequately use this information.
• Larva (maggots) have been demonstrated to remove biofilm in as little as 2 days.
• Hydrotherapy to reduce lower limb oedema is an increasingly common intervention in Europe. This is done as an adjunct to wearing hosiery. Not recommended for those persons with open wounds.
• The number of portable negative pressure wound therapy (NPWT) devices which deliver topical oxygen to the wound are another growth segment. Indications and guidelines for their use are either available or under development.
• Coming soon will be dressings that become fluorescent when bacterial numbers are high enough to potentially herald infection in the wound.
• A device is now available which can shoot beams of aerosolised plasma into wounds. This painless and non-invasive technology has been demonstrated to clear biofilms and inhibit their re-growth.

The 2016 World Union of Wound Healing Societies (WUWHS) Conference was held in Florence, Italy from September 25-29. The historic city welcomed over 9000 Conference delegates and trade personnel to this event.

The meeting venue was the Fortezza di Basso which provided quality lecture halls, meeting places, open space and was the site of an extensive trade exhibition. Conferences always provide opportunities to catch up with friends, make new acquaintances, expand one’s network, launch into new endeavors and even affirm our own knowledge and practice. What of those moments of enlightenment and discovery? I would like to share just some of those “gems” based on my own learning encounters at WUWHS 2016.

Let’s start with some statistics.
• 93% of venous leg ulcers heal in 12 months whilst 7% remain unhealed after 5 years.
• 3% of people aged over 80yrs have chronic oedema.
• 62% of Multiple Sclerosis sufferers will experience chronic oedema.
• Up to 64% of people with chronic oedema will have an open wound.
• 61% of the morbidly obese have cellulitis.
• 250 million surgical procedures are conducted worldwide per year with a 4% rate of surgical site infection.
• 33% of surgical procedures performed worldwide are conducted in the Asia-Pacific region.

A study conducted in the USA demonstrated that 75% of hospital rooms are colonised with MRSA.
• Up to 84% of surgical site infections are diagnosed after discharge from hospital.
• 80-90% of ischaemic wounds develop biofilms.
• The incidence of incontinence associated dermatitis in aged care facilities in Europe are reported to be as high as 25%.
• 80% of skin tears occur on the upper limbs.
• In Italy, diabetes effects almost 10% of the population.
• Compression therapy is a topic of primary importance for clinicians caring for individuals with limb oedema. So here are some developments in this domain.
• Sensors are being developed which are integrated into hosiery so that data can be sent by Bluetooth to phones, tablets or computers which provide information on sub-hosiery heat, limb movement, body position and pressure dynamics. This will provide an insight into how often hosiery is being used and the compression performance that the stockings are providing.
• Static Stiffness in bandages and hosiery has become a familiar concept. Thinking is turning towards Dynamic Stiffness and how materials can increase their “stiffness” when the limb is in motion – the faster or more powerful the movement, the higher the stiffness becomes. Essentially this is something that the Coban 2 system is already achieving when considering bandage application.
• It has been demonstrated that clinicians do not apply stiff bandages with sufficient pressure around the calf, with less than 10% of the participants studied obtaining therapeutic pressures.
• Individuals with oedematous lower limbs (non-diabetic) where the ABPI is greater than 0.5, should have modified stiff compression, whilst regular stiff bandaging is suggested with ABPIs of 0.8 onwards.
• Skin tears are the most common wounds experienced by aged men and women. The International Skin Tear Advisory Panel (ISTAP) promote skin health by recommending twice daily moisturising, minimising bathing in hot water, improving oral hydration and nutrition and using skin barrier agents more frequently – especially to avoid skin damage from adhesives, moisture and incontinence.

ISTAP have also released guidelines that specify which generic dressing groups are recommended for skin tear management – polyacrylate and foam dressings are on the “safe to use” list, whilst adhesive strips and hydrocolloids are not.
Scrotum and Leg case study using Coban™ 2 Compression Systems.

Kerry Browne
Senior Lymphoedema Physiotherapist at The Andrew Love Cancer Centre and Director of Geelong Cancer Rehabilitation – a private practice specialising in post cancer rehabilitation.

Date of initial assessment: 10 August 2016

CURRENT MEDICAL HISTORY
Mr N is a 55 year old gentleman who initially presented with a penile lesion in 2014 diagnosed with Metastatic Squamous Cell Carcinoma penis. He lives at home with his supportive wife and has three adult children and three grandchildren. He works as an accounts manager and drives long distances for work. He walks daily and attends the gym regularly.

Mr N had been on a recent trip to Bali and since the trip, has a swollen right lower limb including genitals and attends the gym regularly.

PAST MEDICAL HISTORY
Co-morbidities:
- CS decompression – 2004
- L4/S laminectomy 2011, redo 2013
- L4/5 laminectomy 2011, redo 2013

Cellulitis: diagnosed last week by GP – currently on Antibiotics
Family history: sister had lung cancer (non-smoker)

Allergies: none
Diuretics: no
Smoker: no
Alcohol: occasional

Medications: Baclofen, Targin, Endone, Keflex Daily

LYMPHOEDEMA HISTORY
Oedema present – yes
Onset of oedema: Before Bali trip only experienced mild oedema right ankle occasionally – Since trip, right, lower limb swollen including, genitals – Aggravating Factors: worse as day goes on

prior to commencing radiation treatment

OBJECTIVE ASSESSMENT

- Easing Factors: sleep
- Symptoms: heavy, tight, skin, firm and red

MAIN PROBLEMS
- Lymphoedema right lower limb, right buttock, scrotum and penis (see photos 1 & 2)
- Maximal circumferential difference: 6.5cm
- Scar tissue groin thickened
- Pain 8/10 when moving leg and turning over in bed
- Decreased sensation right lower leg and right foot
- Decreased motor function right leg – difficult to weight bear
- Poor mobility – requiring wheelchair to mobilise due to right leg – needs help transferring chair to bed
- Needs 50% reduction to enable radiation therapy to commence
- Skin – dry with wound posterior right knee
- Public clinic so unable to have Multi-Layer Bandaging – wife unsure if she can manage daily bandaging
- Fear of cancer recurrence and loss of independence – not able to work and relying on wife for self-care

TREATMENT OPTIONS
- Coban 2 bandaging – full right lower limb plus scrotum and penis. Bandaging redone every 3 days for 2 weeks until garment arrived. Mr N showered and moisturised prior to Coban 2 bandaging. Wound covered. (See photos 3 & 4)
- Mr N was sent home with Coban 2 to re-bandage penis and turning over in bed
- Multi-layer bandaging followed by garment prescription
- MLD at clinic and also Self Lymphatic Drainage (SLD) at home
- Lymphatic exercises to promote lymphatic flow
- Daily skin care to decrease dryness and ensure skin integrity
- Referral to OT for home care setup
- Referral to Psychologist for strategies to manage fear

DIFFERENTIAL DIAGNOSES
- Cancer recurrence
- DVT
- Lymphoedema
- Cellulitis

TREATMENT PLAN
- Measurements taken and order made for, garment full right leg, left bike short, functional knee zone, class 3 plus scrotal support
- Coban 2 bandaging – full right lower limb plus scrotum and penis. Bandaging redone every 3 days for 2 weeks until garment arrived. Mr N showered and moisturised prior to Coban 2 bandaging. Wound covered.

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Treatment Results

Graph 1

- Liaison with radiation nurses who assisted with wound management on posterior knee before bandaging
- Ongoing liaison with radiation oncologist to discuss progress and commencement of radiation treatment and also pain management
- Lymphatic exercises given to promote lymphatic flow
- Liaison with OT to discuss mobility needs at home
- Taught wife to assist transferring onto toilet and in and out of bed
- Basic exercises for quads and gluts to encourage motor function right lower leg
- Organised pick up frame for home to mobilise short distances

TREATMENT RESULTS

- Decreased right lower limb circumferential measurements (see Graph 1)

There was decreased genital and hip swelling (see photo 5), the skin integrity improved and posterior right knee wound healed.

Mr N was able to independently don and doff compression garment and there was slightly improved motor function of the right lower limb. He was able to weight bear and mobilise at home with a pick up frame. There was also decreased pain score of 4/10 and his radiation treatment has commenced.

TREATMENT PLAN

- Monitoring skin and lower limb on a weekly basis taking circumferential measurements
- Increase home exercises as motor function improves to increase mobility
- Weekly MLD at clinic and monitoring home SLD
- Continue to liaise with radiation oncology team to check progress and their plan of management.

3M News

What a fantastic year it has been, with educational events and workshops across Australia and the privilege of being able to hear Professor Christine Moffatt presenting at several special events.


A live interactive webinar with Professor Christine Moffatt and hosted by Gary Bain in May 2016. ‘Making Compression work for Chronic Oedema and Venous Leg Ulcers - Dispelling the Myths.’

Wounds Australia Conference November 2016, 3M Breakfast Symposium. “Compression Unwrapped - Bringing the Science of Compression into Practice”. Professor Christine Moffatt presented on the “Magic of Compression”. These sessions are recorded and are available to view on our Health Care Academy through www.coban2.com.au.

3M were also privileged to host a Venous Leg Ulcer Forum in Sydney on 21 October 2016 in which the Federal Health Minister Susan Ley and Local MP for Bennelong, John Alexander participated along with clinicians from all over Australia. An overview of the burden of this chronic wound on patients and the health system was presented as well as the benefits of compression therapy. A moving address was also given from the patient’s perspective of living with a venous leg ulcer. The Health Minister also answered questions from the audience.

The aim of the VLU Forum was to raise the awareness for the need of compression bandaging reimbursement. A working party was formed following the forum to continue the work towards reimbursement funding for compression therapy. The working group, called the Venous Leg Ulcer Alliance, will work together to address outcomes from the Forum.

Liaison with radiation nurses who assisted with wound management on posterior knee

Photo 3 & 4 - Coban 2 bandaging full leg and scrotum techniques

Photo 5 - post treatment

Graph 1

Treatment Results

20 30 40 50 60 70

80cm 70cm 60cm 50cm 40cm 30cm 20cm

Mid-point TMT Mid-point MTP Mid-point Ankle Right Leg After Right Leg Before

Federal Health Minister Susan Ley addressing the VLU Forum.

Dr Anthony Dyer Wound Management and Innovation CRC presenting the health economics of compression therapy.

Dr Anthony Dyer Wound Management and Innovation CRC presenting the health economics of compression therapy.
Diary Dates

Webinars and special events; if you would like to receive notification of forthcoming webinars and special educational events and to receive this newsletter as soon as it is published please email 3Mhealthcareedu@mmm.com

3M Lymphoedema Workshops

For more information and to register a place, visit www.Coban2.com.au

Basic Level Workshop (Full Day)

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<tr>
<td>AUCKLAND</td>
<td>Friday 3rd March 2017</td>
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<tr>
<td>SYDNEY</td>
<td>Friday 17th March 2017</td>
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<tr>
<td>BRISBANE</td>
<td>Friday 4th August 2017</td>
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Advanced Level Workshop (Full Day)

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<td>BRISBANE</td>
<td>Saturday 5th August 2017</td>
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Refresher Workshop (Half Day)

This workshop is aimed at those who have attended a Basic workshop and would like to update their skills. During these sessions, there is time for feedback and troubleshooting as well as practicing up-to-date techniques, tips and tricks.

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<tr>
<td>MELBOURNE</td>
<td>Friday 5th May 2017 Pre ALA Symposium</td>
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Australia and New Zealand Events

- **ALA Biennial Symposium - New dimensions in lymphatic disorders**
  Date: Saturday 6th May 2017
  Location: Rydges Melbourne

- **New Zealand Wound Care Society Conference**
  Date: 18 - 20th May 2017
  Location: The Energy Events Centre, Rotorua New Zealand

- **Lymphoedema Therapists Hui**
  Date: 19 - 20th August 2017
  Location: Christchurch

- **Inaugural International Wound Practice and Research Conference**
  Date: 6 - 9th September 2017
  Location: Brisbane Convention & Exhibition Centre

Some pictures from our 2016 Coban 2 for Lymphoedema Workshops.