NHS
Dorset
Clinical Commissioning Group

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Intensive Decongestive Lymphatic Therapy for Non-Cancer Secondary Lymphoedema Criteria Based Access Protocol



Supporting people in Dorset to lead healthier lives

NHS DORSET CLINICAL COMMISSIONING GROUP
INTENSIVE DECONGESTIVE LYMPHATIC THERAPY FOR NON-CANCER SECONDARY LYMPHOEDEMA
CRITERIA BASED ACCESS PROTOCOL

1. INTRODUCTION AND SCOPE

1.1 This protocol relates to treatments for primary and non-cancer secondary lymphoedema. The protocol does not relate to existing local services for cancer-related secondary lymphoedema.

1.2 Requests for treatments outside of normal commissioning arrangements will be considered in accordance with the Policy for Individual Patient Treatment.

1.3 Lymphoedema is the accumulation of excess fluid, protein, and other elements in the body due to obstruction of the lymphatic drainage mechanisms. The accumulation causes swelling of one or more limbs, and in some cases trunk/head/neck or genital area.

1.4 Lymphoedema can arise as either primary lymphoedema or secondary lymphoedema. Primary lymphoedema is caused by congenital abnormalities of the lymphatic system. Secondary lymphoedema, however, arises from damage to the lymphatic system e.g. by treatment for cancer (surgery or radiotherapy), trauma, infection, inflammation and chronic venous disease (particularly of the lower limb). Secondary lymphoedema is particularly but not exclusively associated with cancer and its treatment, and in particular breast cancer (around 30% of women who are treated for breast cancer are estimated to have some oedema).

1.5 Treatment of patients with lymphoedema should be carried out through local lymphoedema services where treatment is planned and provided on a holistic basis. The aim of services should be to support patients to self-manage their condition and this may include short-term intensive treatments. It is expected that the majority of patients with lymphoedema will however be cared for within a "maintenance regime" with emphasis on self-management with support from their GP, District Nurses and Community Matrons as and when appropriate. Maintenance and/or prevention treatments will include:

- Self-management and risk reduction, avoiding factors that may exacerbate lymphoedema;
- Simple/Self-Lymphatic Drainage (SLD);
- Skin care, optimising the condition of the skin, treating any complications caused by lymphoedema and minimising the risk of cellulitis/erysipelas;
- Exercise/movement, enhancing lymphatic and venous flow;
- Adequate pain and psychosocial management;
- Compression garments designed to assist and maintain volume reduction, fitted by a trained professional and reviewed/replaced every 3-6 months, and prescribed through FP10.

2. ACCESS CRITERIA

2.1 Criteria based access protocols are underpinned by recognised or evidence based practice. Clinical evidence shows no advantage of Manual Lymphatic Drainage (MLD) compared with standard treatments such as compression bandages, skin care, and exercise. MLD will therefore only be supported where part of a wider treatment plan and subject to specific clinical access criteria as detailed below.

2.2 Manual Lymphatic Drainage will generally only be supported as part of an intensive Decongestive Lymphatic Therapy regime including Multi-Layer Lymphatic Bandaging, for patients within the criteria below and/or if one or more of the following criteria exist:

- Swelling at the root of the limb;
- Trunk and midline oedema (Chest, breast, back, abdomen, genitals, face);
- Extensive subcutaneous skin changes due to protein stasis.

2.3 Multi-Layer Lymphatic Bandaging can be considered for a patient if one or more of the following criteria exist:

- Fragile or damaged skin;
- Distorted limb shape;
- Limb is of a size that compression hosiery will not fit;
- Subcutaneous tissues are thickened or fibrosed;
- PCEV is .20%; (PCEV = percentage change in excess limb volume);
- Lymphorrhea (open lymphoedema with fluid);
- Lymphangiectasia (Dilation in the wall of a lymphatic vessel);
- Pronounced skin folds.

2.4 It will be expected that patients will have intensive treatment packages for 2-4 weeks and then discharged back to a “maintenance regime” with support from their GP, District Nurses, and Community matrons as appropriate.

2.5 Patients will be required to consent to comply with the requirements of maintenance therapy post-intensive treatment. Further intensive treatment packages are not supported and will only be considered on an Individual Patient Treatment Request (IPTR) basis where a case is made for clinical exceptionality in respect of the individual patient.

3. DEFINITIONS

3.1 Any definitions related to this Criteria Based Access Protocol are included as a Glossary at Appendix B.

4. EXCLUSIONS

4.1 Maintenance (prophylactic) Manual Lymphatic Drainage will not be commissioned following a short intensive treatment programme. People will be expected to have been taught self-management techniques and to be wearing compression garments. A short intensive course of Manual Lymphatic Drainage for Lipoedema is not routinely commissioned and is not covered by this protocol. Individual treatment requests would need to be submitted for such cases to be considered.

4.2 The CCG does not support treatment provided on an inpatient basis and will only consider such treatment upon receipt of an IPTR outlining the case for provision on the basis of clinical exceptionality.

4.3 There is only limited case series evidence for the use of reconstructive surgical techniques for the management of lymphoedema. Such interventions include lymph node transfer, lymphatico/lymphatic by-pass surgery and lymphatico-venous anastomoses. Surgery is undertaken primarily for cosmetic reasons and given this and the absence of sufficient evidence of clinical effectiveness, surgery for lymphoedema is not routinely supported and will only be considered on an IPTR basis.

4.4 Liposuction for lymphoedema is not routinely commissioned in view of the absence of published evidence of sufficient quality demonstrating its clinical effectiveness.

5. CASES FOR INDIVIDUAL CONSIDERATION

5.1 Should a patient not meet the criteria detailed within this protocol, the Policy for Individual Patient Treatments (which is available on the NHS Dorset Clinical Commissioning Group website or upon request), recognises that there will be occasions when patients who are not considered for funding may have good clinical reasons for being treated as exceptions. In such cases the requesting clinician must provide further information to support the case for being considered as an exception.

5.2 The fact that treatment is likely to be effective for a patient is not, in itself a basis for exceptional circumstances. In order for funding to be agreed there must be some unusual or unique clinical factor in respect of the patient that suggests that they are:

- significantly different to the general population of patients with the particular condition; and
- they are likely to gain significantly more benefits from the intervention than might be expected for the average patient with the condition

5.3 In these circumstances, please refer to www.dorsetccg.nhs.uk/aboutus/clinical-policies.htm

6. CONSULTATION

6.1 Prior to approval from Dorset CCG's Clinical Commissioning Committee this Protocol was reviewed locally by the Individual Patient Treatment Panel with input from commissioners, clinicians and other relevant stakeholders.

6.2 An Equality Impact Assessment for this Criteria Based Access Protocol is available on request.

7. RECOMMENDATION AND APPROVAL PROCESS

7.1 As documented in NHS Dorset CCG's 'Procedure for the management and development of procedural documents', Criteria Based Access Protocols was recommended by the Individual Patient Treatment Panel, prior to formal approval by the Clinical Commissioning Committee.

8. COMMUNICATION/DISSEMINATION

8.1 Following approval of Criteria Based Access Protocols at Clinical Commissioning Committee each Protocol will be uploaded to the CCG's Intranet, Internet and added to the next GP Bulletin.

9. IMPLEMENTATION

9.1 Following review of this Criteria Based Access Protocol it was agreed there were no new aspects to be included in this version and therefore no requirement for an implementation plan.

10. DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

10.1 This Criteria Based Access Protocol requires a review every three years, or in the event of any changes to national guidance or when new guidance is issued.

APPENDIX A

FREQUENTLY ASKED QUESTIONS

N/A

APPENDIX B

GLOSSARY

N/A

APPENDIX C

A	DOCUMENT DETAILS
Procedural Document Number	116
Author (Name and Job Title)	Michael Cross, Senior Commissioner IPT
Clinical Delivery Group (recommending group)	Individual Patient Treatment Panel
Date of recommendation	November 2017
Date of approval by CCC	November 2017
Version	4.0
Review frequency	Three yearly
Review date	November 2020

B	CONSULTATION PROCESS		
Version No	**Review Date**	**Author and Job Title**	**Level of Consultation**
4.0	November 2017	Michael Cross, Senior Commissioner IPT	Reviewed by Individual Patient Treatment Panel which includes hospital consultants, GPs, and Patient and Public Representatives.

C	VERSION CONTROL				
Date of recommendation	**Version No**	**Review date**	**Nature of change**	**Approval date**	**Approval Committee**
March 2009	1.0	March 2010	Original version developed by Primary Care Trusts	March 2010	Pan Dorset Technologies Forum
September 2012	2.0	March 2014	Title Change. Reference to lipoedema included.	September 2012	Pan Dorset Technologies Forum
August 2014	3.0	August 2017	Clarity provided in respect of intensive therapy packages and maintenance	August 2014	CCC

November 2017	4.0	November 2020	MLD removed. Scheduled review. No new evidence for change No changes to criteria for access to intensive therapy. Commissioning position outlined in respect of surgery.	November 2017	CCC

D	ASSOCIATED DOCUMENTS

- Policy for individual patient treatment, NHS Dorset Clinical Commissioning Group
- Making sense of Local Access Based Protocols, NHS Dorset Clinical Commissioning Group

E	SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES		
Evidence		**Hyperlink (if available)**	**Date**

G	DISTRIBUTION LIST		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
✓	✓	✓	✓