

Cigna Medical Coverage Policy- Therapy Services Complex Lymphedema Therapy (Complete Decongestive Therapy)

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GUIDELINES

Medically Necessary

Complex lymphedema therapy (complete decongestive therapy) is considered medically necessary for the treatment of intractable lymphedema when ALL of the following are met:

- Documented failure of a reasonable course of conservative medical management that includes home exercises, limb elevation, and compression garments.
- The lymphedema is directly responsible for impaired functioning in the affected limb.
- The complex lymphedema therapy is prescribed by or under the supervision of an appropriate healthcare provider.

Not Medically Necessary

Vasopneumatic compression device use as part of complex lymphedema therapy is considered not medically necessary.

DESCRIPTION

Complex lymphedema therapy (CLT) is a non-invasive treatment for lymphedema with the aim to reduce and control the amount of swelling in the affected limb and restore function. Complex lymphedema therapy (CLT) is a noninvasive treatment that is considered a standard of care for lymphedema. This method has also been referred to as complete decongestive physiotherapy (CDP), and complex decongestive therapy (CDT). The treatment aim is to reduce and control the amount of swelling in the affected limb and restore function. The objective of the technique is to redirect and enhance the flow of lymph through intact cutaneous lymphatics. Programs are generally provided on an outpatient basis in the office setting or in a lymphedema rehabilitation center or clinic (Lasinski and Boris, 2002; MacDonald, et al., 2003). The typical CLT program consists of two phases of treatment—a treatment phase and a maintenance phase. Phase I, the treatment phase, usually last two to four weeks. This phase consists of four components (Lawenda, et al., 2009):

- Skin and nail care: The purpose is to inspect skin, provide moisture and prevent infection.
- Manual lymph drainage (MLD): This is a light, massage-like technique that is performed for 30-60 minutes and is used to stimulate residual lymphatic vessels to carry excess fluid from the affected extremity.
- Compression bandaging: This involves wrapping multi-layered bandages around affected limb.
- Therapeutic exercise: This includes movement of the limb through a range of motion with bandaging in place.

Most patients will be able to progress to a home-based, self-managed program after an initial in-office program of 1–2 weeks. Instruction in self-management should begin in the first week of therapy. Both patients and family are taught bandaging and exercise techniques, as well as the essentials of skin and nail care. After the initial one- to two-week program, patients should be re-evaluated to determine whether continued in-office therapy is necessary or if treatment can be provided in the home.

Phase II, the maintenance phase, consists of life-long self-care to maintain the size of the limb. In this phase, the patient maintains and optimizes the results by applying the techniques learned in the treatment phase including: skin and nail care, wearing an elastic sleeve during the day, bandaging the affected limb overnight and exercises (Petrek, 2000).

Duration and Frequency

A program of complex lymphedema therapy provided 2–5 times per week for two weeks is generally considered medically necessary for the treatment of primary or secondary lymphedema, in the absence of any contraindications. Programs that go beyond a four-week period are generally considered not medically necessary.

Contraindications

Absolute contraindications to lymphedema therapy include:

- acute infections of the affected limb
- venous or arterial obstruction (deep vein thrombosis)
- active malignancy, confirmed or suspected local disease
- unwillingness or inability of the member to participate in the treatment

Relative contraindications to lymphedema therapy include:

- suspicion of deep vein thrombosis prior to starting treatment
- congestive heart failure
- when the local massage is performed in area of irradiated soft tissue

GENERAL BACKGROUND

Lymphedema is defined as the excessive and persistent accumulation of protein rich fluid that collects in the interstitial spaces, due to an inefficiency of the lymphatic system (Szuba et al., 2002; Leal et al., 2009). Lymphedema occurs primarily as a result of malformation, underdevelopment, or acquired disruption of the lymphatic circulation (Szuba et al., 2002). Primary lymphedema is due to congenital defects of the lymphatic system, which can affect from one to as many as four limbs or other parts of the body and is considered rare (National Lymphedema Network, 2011). Secondary lymphedema is acquired and is due to an obstruction or interruption in the lymphatic circulation. Secondary lymphedema can develop as a result of surgery, radiation, infection or trauma. It is a common treatment-related side effect experienced by cancer patients. Patients that undergo surgery for breast cancer that includes node dissection or axillary radiation therapy are at high risk of developing lymphedema.

Historically, lymphedema has been classified into three (3) stages based on its severity and on observation of the patient's condition. Currently, the International Society of Lymphedema is recognizing a Stage 0 in patients, which refers to a latent or sub-clinical condition where swelling is not evident despite impaired lymph circulation. Patients often report a feeling of heaviness in the limb, however many patients are asymptomatic in the latency stage. Stage 0 may be present for months or years prior to a patient exhibiting signs and symptoms of edema. Stage I lymphedema is referred to as spontaneously reversible lymphedema (Lawenda et al., 2009, Bicego et al., 2006) and typically involves pitting edema, an increase in limb girth (usually upper extremity), and heaviness. Stage II is also known as spontaneously irreversible lymphedema and it is marked by spongy consistency of the tissue and non-pitting edema (Bicego et al., 2006). Tissue fibrosis marks the beginning of hardening of the limbs and increased girth of extremity and is often found in Stage II (Bicego et al., 2006). Stage III is the most advanced stage and is often referred to as lymphostatic elephantiasis. During Stage III the swelling is irreversible with tissue being fibrotic and unresponsive including patients who present with very large limb(s) size. It is associated with a significant increase in the severity of the fibrotic response, tissue volume, and other skin changes such as papillomas, cysts, fistulas, and hyperkeratosis (Lawenda et al., 2009; Zuther, 2005). With regards to Stage 0, the literature is insufficient to conclude that the use of CDT is either clinically effective or ineffective in the treatment of subclinical or latent stage of breast cancer related lymphedema.

The best practice or gold standard for lymphedema treatment is considered complex decongestive therapy (CDT), also known as complex lymphedema therapy (CLT). CDT is a noninvasive treatment and consists of four basic components as follows: skin and nail care, manual lymph drainage (MLD), followed by bandaging/compression, education, and exercise. The goal of CDT is to reduce and control the amount of swelling in the affected limb and restore function. A treatment option that may be used to manage secondary lymphedema is intermittent pneumatic compressions (IPC) (vasopneumatic compression) which is added to CDT. However, evidence does not support the addition of IPC to CDT or within any treatment plan. Low-level laser therapy (LLLT) is another treatment option that has been studied as a treatment when used in conjunction with other standard lymphedema treatments. However, low-level laser is currently considered experimental, investigational and/or unproven. Exercise demonstrates improvements in function and QoL, but not in limb reduction. The goal of all conservative treatment is to reduce and control the amount of swelling in the affected limb and restore function.

DOCUMENTATION GUIDELINES

Documentation should support a diagnosis of lymphedema and not tissue edema due to other etiologies (chronic venous insufficiency, congestive heart failure, acute infection(s), etc.). Recent changes in the patient's condition as well as prior unsuccessful therapies (elevation, bandaging, diuresis, etc.) should be reported to justify the need for skilled services.

LITERATURE REVIEW

Lymphedema is a common sequela of cancer or its treatment that affects the lymphatic transport system that results in failure of lymph node drainage. Secondary lymphedema is often a debilitating, chronic, progressive condition that commonly occurs after treatment of breast cancer. A number of health professional and patient instigated conservative therapies have been developed to help treat this condition. A systematic review conducted by Moseley et al. (2007) reviewed the common conservative therapies used for management of secondary arm lymphedema as follows: complex physical therapy, manual lymphatic drainage, pneumatic pumps, oral pharmaceuticals, low level laser therapy, compression bandaging and garments, limb exercises and limb elevation. This study found that the more intensive and health care professional driven therapies, such as complex physical therapy (skin and nail care, manual lymphatic drainage, a

multilayer compression bandage and therapeutic exercises), manual lymphatic drainage, pneumatic pump and laser level light therapy generally yielded the greater volume reductions, compared to self-instigated therapies such as compression garment wear, exercises and limb elevation. These self-care methods showed reductions, however in lesser volumes. All conservative therapies reviewed in this study produced improvements in subjective arm symptoms and quality of life (QoL) issues, where these were measured.

Stout et al. (2008) completed a study on Stage 0 lymphedema. They used infrared optoelectronic technology to identify those at risk for edema based on volume measurements. This technology allows for changes to be noted before they are actually visible to the eye. When these changes are noted, treatment initiated immediately may prevent the development of further stages of lymphedema. However, there is no standard for the treatment of early-stage, subclinical lymphedema. When the diagnosis of breast cancer related lymphedema is delayed, therapeutic management requires intensive decongestive therapy and life-long maintenance. This study suggested that an early intervention protocol with 20- to 30-mm Hg compression garments, significantly reduced the affected limb volume to near baseline measures and prevented progression to a more advanced stage of lymphedema for at least the first year postoperatively. Further research is warranted to confirm the long-term clinical and cost effectiveness of this early intervention model compared with a traditional model in treating breast cancer related lymphedema.

Complete Decongestive Therapy (CDT), Manual Lymphatic Drainage (MLD) and Compression

Methods: A prospective trial of complete decongestive therapy for upper extremity lymphedema after breast cancer was reviewed by Mondry et al. (2004). Patients completed two to four (2-4) weeks (median, 2 weeks) of treatment; including skin and nail care, manual lymphatic drainage, a multilayer compression bandage and therapeutic exercises. Edema of the affected limb was reassessed on a weekly basis. Authors concluded that decreasing girth correlated significantly with decreasing visual analogue scale scores for pain, but not with increasing QoL. Data gathered showed median girth reduced 1.5 cm and median volume reduced 138mL. This study concluded that compliance with the treatment regimen at home decreased with duration of the program and girth reductions contributed to less pain. Increased frequency of treatment sessions provides marked improvement in girth, volume, and weight but resulted in poorer compliance. Longer latency more successfully reduces girth, volume, and pain and increases QoL. QoL and pain are improved by treatment and continue to improve after treatment has ended. A randomized controlled trial conducted by McNeely et al. (2004) looked at the addition of manual lymph drainage to compression therapy for managing breast cancer-related lymphedema. The authors of this study compared the reduction in arm lymphedema volume achieved from manual lymph drainage massage in combination with multi-layered compression bandaging to that achieved by compression bandaging alone. Treatment group one received manual lymph drainage (MLD)/compression bandaging (CB). This group received 45 minutes of daily MLD and CB, Monday-Friday for four (4) weeks. The second treatment group received short stretch bandaging, Monday-Friday for four (4) weeks. Authors concluded that a significant reduction in lymphedema volume was found over the four (4) week period for both the manual lymph drainage/compression bandaging and compression bandaging alone groups. No significant differences existed between groups (McNeely et al., 2004).

Koul et al. (2007) assessed the results of combined decongestive therapy and manual lymphatic drainage in patients with breast cancer-related lymphedema over a two year period. This study was a non-randomized clinical trial that reviewed data from 250 patients with a final analysis reviewed from 138 patients. The pre- and post-treatment volumetric measurements were compared and correlated with age, body mass index, and type of surgery, chemotherapy, and radiotherapy. One group was treated with all four (4) parts of combined decongestive therapy for one (1) hour daily for up to several weeks, depending on the severity and response. Combined decongestive therapy consisted of manual lymphatic drainage, compression, exercises for the arm and shoulder, and deep breathing to help promote venous and lymphatic flow. Patients were also fitted with custom-made garments to be worn daily while awake and removed at bedtime. Self-lymph drainage at least once daily was also recommended. A second treatment group received MLD alone. They were also fitted for custom compression garments. Self-lymph drainage was also recommended. A third treatment group received one hour of home instruction and counseling, including simple self drainage techniques, skin care, and exercise. They also received custom compression garments. Results noted a significant reduction in arm volumes at one (1) year after the beginning of treatment with some or all components of combined decongestive therapy in patients with lymphedema after breast cancer treatment. Patients with moderate to severe lymphedema had a maximal response after combined decongestive therapy, and patients enrolled in the home program had mild lymphedema and less dramatic responses to treatment. Authors concluded that combined

decongestive therapy and manual lymphatic drainage with exercises were associated with a significant reduction in the lymphedema volume in all groups assessed. Long-term management of breast cancer-related lymphedema after intensive decongestive therapy was studied by Vignes et al. (2007). The authors' aim was to describe the effect of the maintenance therapy on lymphedema volume reduction and to analyze the impact of the different components of treatment in women with upper limb lymphedema after breast cancer treatment. The treatment consisted of an intensive phase of CDT, including manual lymph drainage (30 minutes, five [5] times a week), low stretch compression bandaging (24 hours daily), exercises after bandages were applied to enhance lymphatic flow from peripheral to central compartments and skin care. Maintenance therapy consisted of education (3 bandages per week). Authors concluded that bandaging and elastic sleeves are a key component to maintenance therapy after intensive CDT.

A systematic review was conducted by Karki et al. (2009) on the effects and harms of physiotherapy methods of lymphedema therapy in breast cancer patients. Fourteen randomized controlled studies were included, two of which had moderate risk of bias and the remainder had high risk. There was moderate evidence that compression bandages alone decreased lymphedema, and that pneumatic pumps had no effect on lymphedema compared to no treatment. With the remainder of the studies that had high risk of bias, the interventions and comparisons varied across all trials. This review found moderate evidence to support that compression bandages decreased lymphedema. There was no evidence regarding volume reduction outcomes in any other body part except the upper limb. Evidence on other physiotherapy methods and combinations is limited due to poor quality of the studies. Devoogdt et al. (2010) conducted a systematic review of combined physical therapy, intermittent compression and arm elevation for treatment of lymphedema secondary to axillary dissection for breast cancer. The review included ten randomized controlled trials and non-randomized, experimental trials. The review found that combined physical therapy can be considered as an effective treatment modality for treatment of lymphedema; however the effectiveness of its different components remains uncertain. Szolnoky et al. (2009) compared manual lymphatic drainage with manual lymphatic drainage plus intermittent pneumatic compression for treatment of unilateral arm lymphedema in 27 women previously treated for breast cancer. One treatment group received complex decongestive physiotherapy (CDP), which included manual lymph drainage (MLD) using the Vodder technique. Treatment sessions were for 60 minutes per day for 10 consecutive business days by a specific physiotherapist, followed by skin care, bandaging, and exercise. MLD was performed on the neck, breast, and abdomen. The second treatment group received complex decongestive physiotherapy plus intermittent pneumatic compression (CDP+IPC). This included the same MLD using the Vodder technique for 30 minutes per day for 10 days, followed by 30 minutes of IPC with a Lympha Mat device at a pressure of 50 mmHg. Patient also received skin care, bandaging, and exercise. Each treatment method was effective in reducing limb size, but the combination treatment of CDP+IPC showed statistically significant greater reductions in limb size when compared to CDP alone, with no negative side effects noted. No other statistically significant changes were noted in the patients' subjective reports with either treatment method at any time.

A technology assessment requested by Centers for Medicare and Medicaid Services (CMS) was conducted by McMaster University Evidence-based Practice Center for the Agency for Healthcare Research and Quality (AHRQ) (Oremus M, et al., 2010) diagnosis and treatment of secondary lymphedema. The review included randomized controlled trials or observation studies with comparison groups (e.g., cohort, case control). The assessment included the following:

- Complex decongestive therapy (CDT) has been observed to have a significant effect on edema reduction and is recognized internationally as a successful treatment for lymphedema.
- There is no single treatment that is considered usual care for lymphedema. At this time, CDT, which is a combination of therapies, is suggested as the main method of conservative care for lymphedema. CDT includes manual lymphatic drainage (MLD), application of compression low stretch bandages, exercise and skin care.

A randomized controlled-group study conducted by Kim et al. (2010) investigated the differences between the effects of complex decongestive physiotherapy with and without active resistive exercise for the treatment of patients with breast cancer-related lymphedema. Treatment group one received CDT (manual lymphatic drainage, compression therapy, and exercise, including resistance training) five (5) times a week for two weeks followed by self-administered treatment for another six weeks. The control group received the CDT without the resistance training added to the exercise program. Authors concluded that active resistive exercise with CDT did not create additional swelling and assisted with reduction of arm volume. QoL was also improved for this group. The National Lymphedema Network (NLN) published a

position statement regarding treatment of lymphedema (NLN, 2011). Included in the document were the following statements regarding Complex decongestive therapy (CDT):

- CDT is the main treatment for lymphedema. Experts who treat lymphedema consider CDT the “gold standard” of treatment. The treatment has been shown to be safe and effective. CDT is the current international standard of care for managing lymphedema.
- CDT has been shown to be effective in large numbers of case studies demonstrating limb volume reductions of 50–70% or more, improved appearance of the limb, reduced symptoms, improved quality of life, and fewer infections after treatment. Even people with progressive lymphedema for 30 years or more before starting CDT have been shown to respond.
- Patient adherence during Phase II CDT is critical for preserving volume reduction.
- It is recommended that CDT adaptations or other lymphedema treatments be used on a case by case basis under the supervision of a healthcare provider (e.g., physician, nurse, physician assistant, therapist) with demonstrated expertise in lymphedema management.

In 2013, the International Society of Lymphology (ISL) published a consensus document regarding the diagnosis and treatment of peripheral lymphedema (ISL, 2013). The document makes the following notes regarding lymphedema treatment:

- Complex Lymphedema Therapy (CDT) is included in the statement as a standard treatment for lymphedema that is backed by longstanding experience. The first phase includes skin care, light manual massage, range of motion exercise and compression with multilayered bandage-wrapping. The second phase aims to conserve and optimize results obtained in Phase 1.
- An assessment should be made of limb volume before, during and after treatment. Treatment outcomes should be reported in a standardized manner in order to assess effectiveness of treatment protocols.

Huang et al. (2013) completed a systematic review and meta-analysis on the effects of MLD on breast cancer-related lymphedema. They investigated whether manual lymphatic drainage (MLD) could prevent or manage limb edema in women after breast-cancer surgery. In total, 10 RCTs with 566 patients were identified. Authors concluded that the current evidence from RCTs does not support the use of MLD in preventing or treating lymphedema. However, clinical and statistical inconsistencies between the various studies confounded our evaluation of the effect of MLD on breast-cancer-related lymphedema. Lasinski (2013) summarized the evidence on the management of lymphedema and provided recommendations. Complete decongestive therapy (CDT) is effective in reducing lymphedema, although the contribution of each individual complete decongestive therapy component has not been determined. In general, levels of evidence for complete decongestive therapy are moderate. Fu et al. (2014) aimed to provide healthcare professionals with evidence-based clinical practice guidelines for lymphedema treatment and management through a systematic review. Findings of the systematic review support complete decongestive therapy, compression bandages, and compression garments with highest evidence for best clinical practice. Weight management, full-body exercise, education, prevention, and early intervention protocols are likely to be effective for clinical practice.

Shao et al. (2014) sought to determine whether the use of an intermittent pneumatic pump (IPC) could manage lymphedema effectively. Seven randomized controlled trials, with 287 patients, were included. Results showed that the use of the IPC could alleviate lymphedema, but no significant difference between routine management of lymphedema with or without pneumatic pump existed. Authors concluded that current trials fail to show the effectiveness of the addition of an IPC to the routine management of BCRL. Leung et al. (2015) evaluated the available evidence for the treatment of secondary lower limb lymphoedema in patients with malignancies. Authors concluded that few studies have evaluated the clinical effectiveness and potential side effects of treatments for lower limb lymphoedema. Moreover, symptoms and quality-of-life assessments were inconsistently reported. All included studies report lower limb volume reduction after treatment, which includes complex decongestion therapy, graded compression stockings and lymphovenous microsurgical shunts. Adequately powered randomized controlled trials of these interventions are recommended. Ezzo et al. (2015) assessed the efficacy and safety of MLD in treating BCRL. Six trials were included. Authors concluded that MLD is safe and may offer additional benefit to compression bandaging for swelling reduction. Compared to individuals with moderate-to-severe BCRL, those with mild-to-moderate BCRL may be the ones who benefit from adding MLD to an intensive course of treatment with compression bandaging. This finding however, needs to be confirmed by randomized data.

In trials where MLD and sleeve were compared with a non-MLD treatment and sleeve, volumetric outcomes were inconsistent within the same trial. Findings were contradictory for function (range of motion), and inconclusive for quality of life. For symptoms such as pain and heaviness, 60% to 80% of participants reported feeling better regardless of which treatment they received. One-year follow-up suggests that once swelling had been reduced, participants were likely to keep their swelling down if they continued to use a custom-made sleeve. Finnane et al. (2015) sought to summarize efficacy findings of reviews on lymphedema treatment. Overall, there was wide variation in review methods. The quality of studies included in reviews, in study design and reporting overall, has been poor. Reviews consistently concluded that complex physical therapy is effective at reducing limb volume. Volume reductions were also reported after the use of compression garments, pumps, and manual lymphatic drainage. However, greatest improvements were reported when these treatments formed a combined treatment program. Large, well-designed, evaluated, and reported randomized, controlled trials are needed to evaluate and compare treatments.

Elastic therapeutic taping (e.g., Kinesio taping) has been proposed as a treatment intervention for lymphedema, given its properties and hypothesized mechanism to lift the skin away from the adjacent muscle and allow intercellular fluid to flow more freely. For example, lymph will move more easily out of lymph channels and into larger lymph ducts for uptake. Bialoszewski et al. (2009) studied the effects of KT in reducing edema of lower limbs in patients subjected to limb lengthening. Twenty-four (24) patients developed post-surgical lymphedema. They were randomized into two (2) groups. One group received taping and the other received standard physiotherapy (lymphatic drainage). Both methods reduced edema significantly pre- and post-treatment (after 10 days); however the application of the KT produced a significantly faster reduction of edema compared to standard lymphatic drainage methods. A study by Tsai et al. (2009) hypothesized whether KT could replace the bandage in decongestive lymphatic therapy (DLT) for breast-cancer-related lymphedema. The pilot study looked at standard DLT combined with pneumatic compression (PC) or modified DLT using KT combined with PC; both types of treatments resulted in reduced girth measurements of the upper extremity and other outcomes in forty-one (41) patients with breast-cancer-related lymphedema. Results demonstrated no significant differences between the two types of treatments. Thus, use of KT could replace the bandage typically used in DLT. Morris et al. (2013) reported on a systematic review with the purpose of this study was to investigate the effect of Kinesio Tex tape (KTT) from randomized controlled trials (RCTs) in the management of clinical conditions. The review included eight RCTs: six included patients with musculoskeletal conditions; one with breast-cancer-related lymphedema; and, one included stroke patients with muscle spasticity. Six studies included a sham or usual care tape/bandage group. The review found limited to moderate evidence that KTT is no more clinically effective than sham or usual care tape/bandage. The authors concluded that there currently exists insufficient evidence to support the use of KTT over other modalities in clinical practice. Kalron and Bar-Sela (2013) reported on a systematic review that assessed the effects of therapeutic Kinesio Taping (KT) on pain and disability in participants suffering from musculoskeletal, neurological and lymphatic pathologies. Twelve met inclusion criteria. The final 12 articles were subdivided according to the basic pathological disorders: musculoskeletal (N=9) (four randomized, controlled trials (RCT), three single blinded RCT, one cross-over trial and one case-control study); neurological (N=1) (RCT); and, lymphatic (N=2) (RCT). Regarding lymphatic disorders, inconclusive evidence was reported. The authors concluded that although KT has been shown to be effective in aiding short-term pain, there is no firm evidence-based conclusion of the effectiveness of this application on the majority of movement disorders within a wide range of pathologic disabilities. Gatt et al. (2016) aimed to determine the effectiveness and safety of kinesiotope (KT) in the management of cancer-related lymphoedema (CRL) compared to compression bandaging or hosiery. Five studies were included in the meta-analysis of the primary outcome limb volume (n = 203, KTn = 91, compression n = 112). No significant difference existed between the interventions. An increased risk of skin complications with KT was reported in five studies affecting between 10% and 21% of patients. Where lymphoedema-related symptoms were reported KT was found to be superior to compression. Paradoxically, patients receiving bandaging reported a higher QoL. Thus authors concluded that KT was not found to be more comfortable than bandaging and should only be used with caution where bandaging cannot be used.

Torres-Lacomba et al. (2020) compared the effects of four types of bandages and kinesio-tape and determine which one is the most effective in women with unilateral breast cancer-related lymphoedema. A total of 150 women presenting breast-cancer-related lymphoedema were randomized into five groups (n = 30). All women received an intensive phase of complex decongestive physiotherapy including manual lymphatic drainage, pneumatic compression therapy, therapeutic education, active therapeutic exercise and bandaging. The only difference between the groups was the bandage or tape applied (multilayer; simplified multilayer; cohesive; adhesive; kinesio-tape). The main outcome was percentage excess volume change. Other outcomes measured

were heaviness and tightness symptoms, and bandage or tape perceived comfort. Data were collected at baseline and finishing interventions. This study showed significant differences between the bandage groups in absolute value of excess volume. The five groups exhibited a significant decrease in symptoms after interventions, with no differences between groups. In addition, kinesio-tape was perceived as the most comfortable by women and multilayer as the most uncomfortable ($P < 0.001$). The most effective were the simplified multilayer and the cohesive bandages. The bandages/tape with the least difference were kinesio- and adhesive bandage.

Zasadzka et al. (2018) compared the effectiveness of multi-layer compression bandaging (MCB) and complex decongestive therapy (CDT) for treating lymphedema in elderly patients. One hundred three patients (85 women and 18 men) aged ≥ 60 years, with unilateral lower limb lymphedema. The subjects were divided into two groups: 50 treated with CDT and 53 with MCB. Pre- and post-treatment BMI, and average and maximum circumference of the edematous extremities were analyzed. Results noted a reduction in swelling in both groups was achieved after 15 interventions. Both therapies demonstrated similar efficacy in reducing limb volume and circumference, but MCB showed greater efficacy in reducing the maximum circumference. Authors concluded that compression bandaging is a vital component of CDT. Maximum lymphedema reduction during therapy and maintaining its effect cannot be achieved without it. Sezgin Ozcan et al. (2018) evaluated the effects of complex decongestive therapy (CDT) on upper extremity functions, the severity of pain, and quality of life. A total of 37 women with breast cancer-related lymphedema (BCRL) [age, 53.6 ± 11.2 (28-72)] were included in this study. All patients underwent CDT-phase 1 program, including meticulous skin care, manual lymphatic drainage, remedial exercises, and compression bandages. The mean of the posttreatment volume of the affected limb was lower compared to pretreatment volume. A statistically significant reduction in pain and heaviness VAS scores and improvement of shoulder mobility among upper extremities with lymphedema ($p < 0.001$) was noted after CDT. The mean of posttreatment DASH score was lower and all subgroups of the SF-36 parameters were increased after the CDT application. Also, being under 65 years old, having a body mass index above 30 and short duration of lymphedema were found to be related to greater improvement in upper extremity functions. Authors concluded that CDT provides enhancement of upper extremity functions and quality of life in patients with BCRL. Tzani et al. (2018) investigated strategies and methods for physiotherapeutic rehabilitation of lymphedema. Approaches for conservative management of lymphedema included the following: manual lymphatic drainage, lymphedema rehabilitation exercises, compression therapy, skin care, pneumatic compression, elevation of the extremities, thermal therapy, complete decongestive physiotherapy (CDT), taping, and aqua lymphatic therapy. Treatment of lymphedema with CDT, which is a combination of four methods (manual lymphatic drainage, lymphedema rehabilitation exercises, compression therapy, skin care), can achieve a 45-70% reduction in lymphedema volume. Upon review of the literature, CDT was found to be the most effective treatment as it reduces the symptoms of lymphedema and improves patients' functionality, mobility, and quality of life.

Michopoulos et al. (2020) evaluated the effectiveness and safety of complete decongestive therapy (CDT) of phase I in the Greek population with lymphedema. CDT was implemented in all patients for 20 sessions in a four-week treatment period. The edema's (excess volume (EV) and percent of excess volume (PEV)) measurements were carried out four times in the treatment period, whereas the percent reduction of excess volume (PREV) was calculated at the end of phase I. Every infection, trauma of skin, and pain of limb during the treatment was also recorded. One-hundred five patients with lymphedema were enrolled, of whom 31.4% had upper limb lymphedema and 68.6% had lower limb lymphedema. A significant reduction between the pre-treatment and post-treatment values of EV and PEV was found for both upper and lower limb lymphedema. For patients with upper limb lymphedema, the average PREV was 66.5%, whereas for patients with lower limb lymphedema, a 71.5% median value was measured. No side effects from the treatment were recorded during CDT. Authors concluded that the proper treatment of the CDT phase I ensures safety and a great reduction in edema in patients with lymphedema that predispose the success of phase II of CDT. Thompson et al. (2020) evaluated the effectiveness of MLD for those at-risk of or living with lymphedema. Seventeen studies with a total of 867 female and two male participants were included. Only studies examining breast cancer-related lymphedema were identified. Some studies reported positive effects of MLD on volume reduction, quality of life and symptom-related outcomes compared with other treatments, while other studies reported no additional benefit of MLD as a component of complex decongestive therapy. In patients at-risk, MLD was reported to reduce incidence of lymphedema in some studies, while others reported no such benefits. Authors concluded that reviewed articles reported conflicting findings and were often limited by methodological issues. They suggest the need for further experimental studies on the effectiveness of MLD in lymphedema. There is some evidence that MLD in early stages following breast cancer surgery may help prevent progression to clinical

lymphedema. MLD may also provide additional benefits in volume reduction for mild lymphedema. However, in moderate to severe lymphedema, MLD may not provide additional benefit when combined with complex decongestive therapy.

Watanabe et al. (2020) authored an article on the development and themes of diagnostic and treatment procedures for secondary leg lymphedema in patients with gynecologic cancers. They note that for the treatment of lymphedema, complex decongestive physiotherapy (CDP) including manual lymphatic drainage (MLD), compression therapy, exercise and skin care, are generally performed. In recent years, CDP has often required effective multi-layer lymph edema bandaging (MLLB) or advanced pneumatic compression devices (APCDs). If CDP is not effective, microsurgical procedures can be performed. They conclude that the most important concern is the prevention of secondary lymphedema, which is achieved through approaches such as skin care, weight control, gentle limb exercises, avoiding sun and heat, and elevation of the affected leg.

In accordance with the most recent Consensus Document of the International Society of Lymphology (2020), CDT should include two phases: 1. Phase I: characterized by skincare, manual lymphatic drainage (MLD), with or without deeper techniques including muscle pumping exercises or hydraulic pressotherapy, followed by multilayer compression bandage, aiming at improving lymphedema volume; 2. Phase II: characterized by skincare and compression garments wearing, including lowstretch elastic stocking or sleeve, aiming at avoiding complications and conserving the results obtained in Phase I.

Thompson et al. (2021) examined the methodologies used in recent research and evaluated the effectiveness of MLD for those at-risk of or living with lymphedema. Seventeen studies with a total of 867 female and two male participants were included. Only studies examining breast cancer-related lymphedema were identified. Some studies reported positive effects of MLD on volume reduction, quality of life and symptom-related outcomes compared with other treatments, while other studies reported no additional benefit of MLD as a component of complex decongestive therapy. In patients at-risk, MLD was reported to reduce incidence of lymphedema in some studies, while others reported no such benefits. Authors concluded that reviewed articles reported conflicting findings and were often limited by methodological issues. This review highlights the need for further experimental studies on the effectiveness of MLD in lymphedema. Wanchai and Armer (2021) examined the effects of manual lymphatic drainage (MLD) on reducing the risk of and managing breast cancer-related lymphedema (BCRL). A total of 39 studies were further inspected, and 27 articles were excluded because they were not randomized controlled trials, did not measure BCRL, and/or were an incomplete study. Ten studies were included for the final review. Based on the results of this systematic review, it cannot be concluded that MLD helps reduce the risk of BCRL for women after breast surgery. Regarding the effect of MLD on managing BCRL, the findings indicate that MLD alone or MLD combined with other treatments was likely to give similar benefits in terms of reducing arm volume for women diagnosed with BCRL. Authors concluded that scientific evidence to support the benefits of MLD on preventing or reducing BCRL remains unclear. More rigorous studies to confirm findings on the effectiveness of MLD are needed.

Kalemikerakis et al. (2021) authored an article on the diagnosis and management of cancer-related lymphedema. They note that early diagnosis and treatment of lymphedema is related with better therapeutic outcomes. Women with breast cancer confront more problems with lymphedema than with mastectomy. Its effect on patients' quality of life is relevant to changes in body image, self-esteem, feelings of weakness, fear and anxiety about disease progression, financial costs, and reduced limb function. Relative to conservative management, authors summarize that CDT remains the treatment of choice and in combination with exercise, weight control programs and self-care training seems to significantly improve patients' quality of life. Forner-Cordero et al. (2021) assessed whether treatment with intermittent pneumatic compression plus multilayer bandages is not inferior to classical trimodal therapy with manual lymphatic drainage in the decongestive lymphedema treatment. 194 lymphedema patients, stage II-III with excess volume > 10% were stratified within upper and lower limb and then randomized to one of the three treatment groups. Baseline characteristics were comparable between the groups. For interventions all patients were prescribed 20 sessions of the following regimens: Group A (control group): manual lymphatic drainage + Intermittent Pneumatic Compression + Bandages; Group B: pneumatic lymphatic drainage + Intermittent Pneumatic Compression + Bandages; and Group C: only Intermittent Pneumatic Compression + Bandages. The outcome was the percentage reduction in excess volume (PREV). Results demonstrated that all patients improved after treatment. Global mean of PREV was 63.9%, without significant differences between the groups. Most frequent adverse events were

discomfort and lymphangitis, without differences between groups. A greater baseline edema, an upper-limb lymphedema and a history of dermatolymphangitis were independent predictive factors of worse response in the multivariate analysis. Authors concluded that decongestive lymphatic therapy performed only with intermittent pneumatic compression plus bandages is not inferior to the traditional trimodal therapy with manual lymphatic drainage. This approach did not increase adverse events.

De Vrieze et al. (2021) investigated the effect of fluoroscopy-guided manual lymphatic drainage (MLD) versus traditional MLD or placebo MLD for the treatment of breast cancer-related lymphoedema (BCRL) when added to decongestive lymphatic therapy (DLT). All participants received standard DLT (education, skin care, compression therapy and exercises). Participants were randomised to also receive fluoroscopy-guided MLD (n = 65), traditional MLD (n = 64) or placebo MLD (n = 65). Participants received 14 sessions of physiotherapy during the 3-week intensive phase and 17 sessions during the 6-month maintenance phase. Participants performed self-management on the other days. All outcomes were measured: at baseline; after the intensive phase; after 1, 3 and 6 months of maintenance phase; and after 6 months of follow-up. The primary outcomes were reduction in excess volume of the arm/hand and accumulation of excess volume at the shoulder/trunk, with the end of the intensive phase as the primary endpoint. Excess lymphoedema volume decreased after 3 weeks of intensive treatment in each group. The effect of fluoroscopy-guided MLD was very similar to traditional MLD and placebo MLD. Authors concluded that in patients with chronic BCRL, MLD did not provide clinically important additional benefit when added to other components of DLT.

McNeely et al. (2022) examined the efficacy of nighttime compression as a self-management strategy for women with chronic breast cancer-related lymphedema. Authors conducted a parallel 3-arm, multicenter, randomized trial. Women were recruited from 3 centers in Canada and randomized to group 1 (daytime compression garment alone [standard care]), group 2 (daytime compression garment plus nighttime compression bandaging), or group 3 (daytime compression garment plus the use of a nighttime compression system garment). The primary outcome was the change in excess arm volume from the baseline to 12 weeks. Participants from all groups used a nighttime compression system garment from weeks 13 to 24. One hundred twenty women were enrolled, 118 completed the randomized trial, and 114 completed the 24-week follow-up. The rates of adherence to nighttime compression were $95\% \pm 15\%$ and $96\% \pm 11\%$ in the compression bandaging and nighttime compression system groups, respectively. After the intervention, the addition of nighttime compression was found to be superior to standard care for both absolute milliliter reductions ($P = .006$) and percentage reductions ($P = .002$) in excess arm lymphedema volume. Significant within-group changes were seen for quality of life across all groups; however, no between-group differences were found ($P > .05$). Authors concluded that this study demonstrated a significant improvement in arm lymphedema volume from the addition of nighttime compression whether through the application of compression bandaging or through the use of a nighttime compression system garment.

Borman et al. (2022) evaluated the effects of complete decongestive therapy (CDT) in patients with breast cancer-related lymphedema (BCRL), in regard to volume reduction, functional status and quality of life (QoL). Fifty patients with unilateral BCRL were included. All patients received combined phase 1 CDT including skin-care, manual lymphatic drainage, multilayer bandaging and supervised exercises, 5 times a week for 3 weeks, as a total of 15 sessions. Patients were assessed by limb volumes and excess volumes. The functional disability was evaluated by quick disability of arm, shoulder and hand questionnaire (Q-DASH). QoL was assessed by the European Organization for Research and Treatment of Cancer Core Cancer Quality of Life Questionnaire (EORTC QLQ-C30) and its breast-cancer-module (EORTC QLQ-BR23). Fifty females with mean age of 53.22 ± 11.2 years were included. The median duration of lymphedema was 12 months. There were 22 patients in stage1, 26 in stage2 and 2 patients in stage3. The mean baseline limb and excess volumes were significantly decreased at the end of therapies. The Q-DASH and EORTC QLQ-C30 and BR23 scores were also decreased significantly. The improvements in volumes were related negatively with the duration of lymphedema, and the stage of lymphedema. Authors concluded that CDT in a combined manner performed daily for 3 weeks, greatly reduces the volumes as well as improves the disability and QoL, especially when performed earlier.

de Sire et al. (2022) completed a review to characterize the comprehensive management of lymphedema, providing a broad overview of the potential therapy available in the current literature. They conclude that a multidisciplinary treatment should be truly integrated for lymphedema patients, and

rehabilitation should be considered the cornerstone of the multidisciplinary treatment not only for patients not suitable for surgical interventions but also before and after surgical procedures. Rehabilitation should include (CDT), which includes manual lymph drainage (MLD), skin care, specialized exercises, compression garments and self-education.

Rangon et al. (2022) investigated the immediate, short-term, and long-term effects of complex physical therapy and multimodal approaches on lymphedema secondary to breast cancer. Fourteen studies were identified for the systematic review and 11 studies for the meta-analysis. The common outcomes involved total volume, pain, and physical function of the upper limb. Complex physical therapy has shown a favorable tendency to control outcomes in the short- and long-term. The meta-analysis indicated a small effect for volume reduction and a moderate effect for short-term pain reduction. Authors concluded that high-quality evidence suggests a more significant effect of complex physical therapy on multimodal approaches to the control of the upper limb total volume, substantiating the absence of changes in the current clinical practice in the management of lymphedema secondary to breast cancer. Future research should aim to identify concrete effect of therapeutic modalities in the immediate-, short-, and long-term.

Lin et al. (2022) analyzed the effectiveness of manual lymphatic drainage (MLD) in breast cancer-related lymphedema (BCRL) patients in a systematic review and meta-analysis. In total, 11 RCTs involving 1564 patients were included, in which 10 trials were deemed viable for inclusion in the meta-analysis. Due to the effects of MLD for BCRL, statistically significant improvements were found on the incidence of lymphedema and pain intensity. Besides, the meta-analysis carried out implied that the effects that MLD had on volumetric changes of lymphedema and quality of life, were not statistically significant. The current evidence based on the RCTs shows that pain of BCRL patients undergoing MLD is significantly improved, while our findings do not support the use of MLD in improving volumetric of lymphedema and quality of life. Torgbenu et al. (2023) aimed to describe and compare international guidelines on lymphedema diagnosis, assessment, and management. This systematic review of 1,564 articles and 159 web pages yielded 14 guidelines. All guidelines were from high-income countries. Ten focused exclusively on lymphedema, and four on cancer. Most ($n = 13$) guidelines recommended an integrated medical, psychological assessment, and physical examination, with a limb volume measurement of $>10\%$ in the affected limb compared, confirming a lymphedema diagnosis. Recommended management involved Complex Decongestive Therapy (CDT) followed by self-management using skincare, self-lymphatic drainage massage, exercise, and compression.

Qiao et al. (2023) analyzed the efficacy of MLD for BCRL. A total of 457 patients were included in the analysis. There was no significant difference in the amount of upper extremity edema between the MLD treatment and control or no MLD groups. However, when the treatment course was ≥ 20 sessions, there was a significant reduction in the upper extremity volume. There was also a significant reduction in the upper extremity volume when treatment duration was >2 weeks. Authors concluded that manual lymphatic drainage treatment statistically did not reduce the upper extremity limb volume of BCRL, but upper extremity volume was reduced at statistically significant levels when treatment number were ≥ 20 sessions or the duration of treatment was >2 weeks.

Donahue et al. (2023) summarized current BCRL prevention and treatment strategies. They report that complete decongestive therapy (CDT) remains the standard of care for patients with BCRL. Intermittent pneumatic compression, nonpneumatic active compression devices, and low-level laser therapy appear promising in lymphedema management. Currently, no pharmacological approaches have proven successful. Senger et al. (2023) summarized current concepts in primary lymphedema. Primary lymphedema is a heterogeneous group of conditions encompassing all lymphatic anomalies that result in lymphatic swelling. Primary lymphedema can be difficult to diagnose, and diagnosis is often delayed. As opposed to secondary lymphedema, primary lymphedema has an unpredictable disease course, often progressing more slowly. Primary lymphedema can be associated with various genetic syndromes or can be idiopathic. Diagnosis is often clinical, although imaging can be a helpful adjunct. The literature on treating primary lymphedema is limited, and treatment algorithms are largely based on practice patterns for secondary lymphedema. The mainstay of treatment focuses on complete decongestive therapy, including manual lymphatic drainage and compression therapy. For those who fail conservative treatment, surgical treatment can be an option. Microsurgical techniques have shown promise in primary lymphedema, with both lymphovenous bypass and vascularized lymph node transfers demonstrating improved clinical outcomes in a few studies.

Marotta et al. (2023) aimed to assess the role of KT among the CDT to treat BCRL. Rehabilitation has a key role in the comprehensive management of this condition with several studies reporting positive results after performing complex decongestive therapies (CDT) in women. Kinesio taping (KT) is a rather recent therapeutic approach to treat BCRL, however, evidence in literature regarding its effectiveness is far from being fully characterized. Out of the documents identified, 123 were eligible for data screening, and only 7 RCTs satisfied the eligibility criteria and were included. Authors found that KT might have a positive effect on limb volume reduction in patients with BCRL, studies are of low quality. Authors concluded that this systematic review showed that KT did not significantly reduce the upper limb volume in BCRL women, though it seemed to increase the flow rate during the passive exercise. Further high-quality-studies are needed to improve the knowledge to include KT into a multidisciplinary rehabilitative approach for the management of BC survivors affected by lymphedema.

Cheng et al. (2023) identified and appraised the current evidence for rehabilitation interventions in HNCaL. Of 1642 citations identified, 23 studies (1.4%; n = 2147 patients) were eligible for inclusion. Six studies (26.1%) were randomized clinical trials (RCTs) and 17 (73.9%) were observational studies. Five of the 6 RCTs were published during 2020 to 2022. Most studies had fewer than 50 participants (5 of 6 RCTs; 13 of 17 observational studies). Studies were categorized by intervention type, including standard lymphedema therapy (11 studies [47.8%]) and adjunct therapy (12 studies [52.2%]). Lymphedema therapy interventions included standard complete decongestive therapy (CDT) (2 RCTs, 5 observational studies), modified CDT (3 observational studies), therapy setting (1 RCT, 2 observational studies), adherence (2 observational studies), early manual lymphatic drainage (1 RCT), and inclusion of focused exercise (1 RCT). Adjunct therapy interventions included advanced pneumatic compression devices (APCDs) (1 RCT, 5 observational studies), kinesio taping (1 RCT), photobiomodulation (1 observational study), acupuncture/moxibustion (1 observational study), and sodium selenite (1 RCT, 2 observational studies). Serious adverse events were either not found (9 [39.1%]) or not reported (14 [60.9%]). Low-quality evidence suggested the benefit of standard lymphedema therapy, particularly in the outpatient setting and with at least partial adherence. High-quality evidence was found for adjunct therapy with kinesio taping. Low-quality evidence also suggested that APCDs may be beneficial.

Other Treatments:

Low Level Laser Therapy (LLLT): Carati et al. (2003) performed a double blind, placebo controlled randomized, single crossover trial use of low-level laser therapy (LLLT) for a treatment option for patients with post mastectomy lymphedema (PML). Participants received either one cycle or two cycles of LLLT to the axillary region of their affected arm. The authors monitored for reduction in affected limb volume, upper body extracellular tissue fluid distribution, dermal tonometry and range of motion. The result yielded that two cycles of low level laser treatment improved lymphedema; however limb volume reduction was not immediate and was reported two to three (2-3) months post-treatment (Carati et al., 2003). A study conducted by Dirican et al. (2011) reviewed the authors' short-term experience with low-level laser therapy in the treatment of breast-cancer related lymphedema. Treatment consisted of laser therapy using 300mJ for one minute to 17 different points on the surgical scar tissue of the axilla. Patients were also treated with compression garments or bandaging. Two of the patients in the study also had sessions using an intermittent compression device. Authors concluded that patients with breast cancer gain additional benefits in the form of volume reduction from low level laser therapy when used in conjunction with other standard treatments (Dirican et al., 2011). Further studies are needed to confirm these findings. Smoot et al. (2015) examined the literature on effectiveness of LLLT in reducing limb volume and pain in adults with breast cancer related lymphedema (BCRL). They concluded that moderate strength evidence supports LLLT in the management of BCRL. The overall review of literature investigated conservative therapies for secondary arm lymphedema that can be divided into intensive treatments administered by trained healthcare professionals and limb maintenance that are carried out by the patient. Treatments that are predominantly administered by healthcare professionals, such as CDT, MLD, and pneumatic pump therapy generally yielded the larger reduction in limb volume. LLLT may be a potential treatment option, but more well-designed studies are needed. Maintenance therapies generally carried out by the patient in a self-care program (e.g. wearing compression garments, performing limb exercises, limb elevation, and self-massage) yielded smaller limb reduction. Baxter et al. (2017) evaluated the effectiveness of LLLT in the management of BCRL in a systematic review. Primary outcome measures were limb circumference/volume, and secondary outcomes included pain intensity and

range of motion. Eleven clinical trials were identified, of which seven randomized controlled trials (RCTs) were chosen for analysis. Results indicated that there is strong evidence (three high quality trials) showing LLLT was more effective than sham treatment for limb circumference/volume reduction at a short-term follow-up. There is moderate evidence (one high quality trial) indicating that LLLT was more effective than sham laser for short-term pain relief, and limited evidence (one low quality trial) that LLLT was more effective than no treatment for decreasing limb swelling at short-term follow-up. Authors concluded that based upon their current systematic review, LLLT may be considered an effective treatment approach for women with BCRL. However, due to the limited numbers of published trials available, there is a need for well-designed high-quality trials in this area and the optimal treatment parameters for clinical application have yet to be determined.

Kozanoglu et al. (2021) investigated the long-term effectiveness of combined intermittent pneumatic compression (IPC) plus low-level laser therapy (LLLT) versus IPC therapy alone in patients with postmastectomy upper limb lymphedema (PML). The patients were allocated into two groups in this single-blinded, controlled clinical trial. Group I received combined treatment with IPC plus LLLT (n = 21) and group II received only IPC (n = 21). IPC treatment was given 5 sessions per week for 4 weeks (20 sessions). LLLT was also performed 5 sessions per week for 4 weeks (20 sessions). Clinical evaluations were performed before and after the treatment at the 3, 6, and 12-month follow-up visits. According to within-group analysis, statistically significant improvements in the circumference difference and grip strength were observed in both groups. Visual analog scale values for arm pain and shoulder pain during motion were decreased only in group I. Authors concluded that interventions have positive effects on lymphedema, grip strength, and pain. Long-term effects of combined therapy, especially on pain, are slightly superior to the pneumatic compression alone.

Wang et al. (2022) critically analyzed the evidence from existing systematic reviews investigating the effectiveness and safety of low-level laser therapy (LLLT) in patients with breast cancer-related lymphedema (BCRL). In addition, an updated and comprehensive systematic review was conducted, which aimed to provide updated evidence about this topic. Seven systematic reviews and ten RCTs met the eligibility criteria. Conflicting results regarding the effectiveness of LLLT were presented by the overview of systematic reviews. The updated systematic review showed that LLLT may offer additional benefits as compared to compression therapies (pneumatic compression or compression bandage), placebo laser, or no treatment for patients with BCRL. However, when compared to other types of active interventions, LLLT did not improve outcomes significantly. None of the treatment-related adverse event was reported. Many trials had a high or unclear risk of bias for two or more items, and our updated systematic review showed low quality of evidence per outcome using GRADE approach. Due to insufficient data and poor quality of evidence, there is uncertain to reach these conclusions that LLLT is superior to another active or negative intervention and is safe. More RCTs of high methodological quality, with large sample sizes and long-term follow-up, are needed to inform clinical guidelines and routine practice.

Chiu et al. (2023) aimed to organize existing research and determine the optimal combination of LLLT parameters for BCRL treatment in a meta-analysis. Although low-level laser therapy (LLLT) has been explored as a treatment option for BCRL, they could not find a regimen that is more effective than others, which prompted their study. Authors focused on the aspects of the treatment area, treatment regimen, and total treatment sessions across the included studies. The comparisons between LLLT and non-LLLT were performed through a meta-analysis. Post-treatment QOL was significantly better in the axillary group. The group treated "three times/week with a laser density of 1.5-2 J/cm²" had significantly better outcomes in terms of swelling reduction, both immediately post-treatment and at 1-3 months follow-ups. The group with > 15 treatment sessions had significantly better post-treatment outcomes regarding reduced swelling and improved grip strength. According to these results, LLLT can relieve the symptoms of BCRL by reducing limb swelling and improving QOL. Further exploration found that a treatment approach targeting the axilla, combined with an increased treatment frequency, appropriate laser density, and extended treatment course, yielded better outcomes. However, further rigorous, large-scale studies, including long-term follow-up, are needed to substantiate this regimen.

Exercise: Kwan et al. (2011) conducted a systematic review of the contemporary literature to distill the weight of the evidence and provide recommendations for exercise and lymphedema care in breast cancer survivors. Seven studies were identified addressing resistance exercise, seven studies on aerobic and resistance exercise, and five studies on other exercise modalities. Studies concluded that slowly progressive exercise of varying modalities is not associated with the development or exacerbation of breast cancer-related lymphedema

and can be safely pursued with proper supervision. Combined aerobic and resistance exercise appear safe, but confirmation requires larger and more rigorous studies. Authors concluded that strong evidence is now available on the safety of resistance exercise without an increase in risk of lymphedema for breast cancer patients. Buchan et al. (2016) compared the effect of progressive resistance- or aerobic-based exercise on breast cancer-related lymphedema extent and severity, as well as participants' muscular strength and endurance, aerobic fitness, body composition, upper-body function and QoL. Authors concluded that participating in resistance- or aerobic-based exercise did not change lymphedema status, but led to clinically relevant improvements in function and QoL, with findings suggesting that neither mode is superior with respect to lymphoedema impact. As such, personal preferences, survivorship concerns and functional needs are important and relevant considerations when prescribing exercise mode to those with secondary lymphedema. Overall, the consensus of managing lymphedema includes an appropriate diagnosis based on the patient's history and physical examination and a determination that there is consistent evidence to indicate that lymphedema can be reliably measured using circumferential measures or volume displacement. Complex decongestive therapy is suggested as the main method of conservative care for lymphedema and is a combination of therapies that includes manual lymphatic drainage (MLD), application of compression low stretch bandages, skin care, education, and exercise. Johansson et al. (2015) reported on the evidence-based or traditional treatment of cancer-related lymphedema. Authors concluded that with accumulating evidence and experience, it is time to consider if altering these treatment principles is needed. Based on accumulating evidence, authors suggest less emphasis on manual lymph drainage and more on early diagnosis, compression, weight control and exercise for improvement of strength and circulation. Bakar and Tuğral (2017) reviewed the current management strategies for lower extremity management of lymphedema after gynecologic cancer surgery. Studies indicated that the incidence of lower extremity lymphedema ranges between 2.4% and 41% after pelvic lymph node dissection in patients with gynecologic malignancies. Thus, management of lower extremity lymphedema in patients after gynecologic cancer surgery is an important issue. Complex decongestive therapy method is still the gold standard of lymphedema management.

Nelson (2017) summarizes the results of recent randomized controlled trials (RCTs) investigating the effect of resistance exercise in those with, or at risk for, BCRL. He also wanted to determine whether breast cancer survivors can perform RET at sufficient intensities to elicit gains in strength without causing BCRL flare-up or incidence. A total of 6 RCTs, involving 805 breast cancer survivors, met the inclusion criteria and corresponded to the aims of this review. The results of this review indicated that breast cancer survivors can perform RET at high-enough intensities to elicit strength gains without triggering changes to lymphedema status. There is strong evidence indicating that RET produces significant gains in muscular strength without provoking BCRL. Do et al. (2017) investigated the effects of a complex rehabilitation (CR) program and complex decongestive therapy (CDT) on edema status, physical function, and quality of life in patients with unilateral lower-limb lymphedema after gynecologic cancer surgery. CR comprised of stretching, strengthening, and aerobic exercises was performed for 40min, five times a week for 4weeks. Intensive CDT was administered by a physical therapist during weeks 0-2 and by the patients themselves during weeks 2-4. Results demonstrated that the edema status, fatigue, pain, and GCLQ-K scores were significantly improved in both groups after the 4-week intervention. Physical function and fatigue and the 30-s chair stand test and quadriceps muscle strength were significantly improved in the CRCDT group compared with the CDT alone group. Authors concluded that CR improves physical function, fatigue, and muscular strength without increasing edema status in patients with unilateral lower-limb lymphedema after gynecologic cancer surgery. Yeung et al. (2018) conducted a systematic review and meta-analysis on aquatic therapy compared to other lymphedema interventions. Four RCTs of moderate quality were included. There was moderate level evidence of no significant short-term differences in lymphedema status (relative volume) between patients receiving aquatic lymphatic therapy compared to land based standard care. There was low level evidence that no significant difference between aquatic lymphatic therapy and standard care for improving upper limb physical function. Authors conclude that current evidence indicates no significant benefit of aquatic lymphatic therapy over standard land-based care for treatment of lymphedema. Further research is needed to strengthen the evidence. Baumann et al. (2018) assessed the effect of different types of exercise on breast cancer-related lymphedema (BCRL) in order to understand the role of exercise in this patient group. Eleven randomized controlled trials that included 458 women with breast cancer in aftercare were included. The different types of exercise consisted of aqua lymph training, swimming, resistance exercise, yoga, aerobic, and gravity-resistive exercise. Four of the studies measured a significant reduction in BCRL status based on arm volume and seven studies

reported significant subjective improvements. No study showed adverse effects of exercise on BCRL. Authors concluded that the evidence indicates that exercise can improve subjective and objective parameters in BCRL patients, with dynamic, moderate, and high-frequency exercise appearing to provide the most positive effects. Hasenoehrl et al. (2020) performed a systematic review analyzing resistance exercise (RE) intervention trials in breast cancer survivors (BCS) regarding their effect on breast cancer-related lymphedema (BCRL) status. Authors concluded that RE seems to be a safe exercise intervention for BCS and not to be harmful concerning the risk of lymphedema. Lymphedema assessment methods that allow for a qualitative analysis of arm tissue composition should be favored. At the current time breast cancer related lymphedema is incurable but well manageable by a number of physical therapy modalities, especially complete decongestive therapy (CDT). One of the encouraging treatment methods is resistance exercise.

Kilbreath et al. (2020) investigated whether an exercise program reduced breast lymphoedema symptoms compared to a non-exercise control group. This single-blinded randomized controlled trial was conducted in which women with stable breast lymphoedema (n = 89) were randomized into an exercise (n = 41) or control (n = 47) group. The intervention comprised a 12-week combined aerobic and resistance training program, supervised weekly by an accredited exercise physiologist. All participants completed a weekly symptoms diary and were assessed monthly to ensure that there was no exacerbation of their lymphoedema. Changes in the breast were captured physically with ultrasound and bioimpedance spectroscopy and changes in symptoms were captured using European Organization for Research and Treatment of Cancer (EORTC) Breast Cancer (BR23) and Lymphoedema Symptom Intensity and Distress questionnaires. The exercise group reported a greater reduction in breast-related symptoms than the control group, assessed by the EORTC BR23 breast symptom questions. Measures of extracellular fluid, assessed with bioimpedance spectroscopy ratio, decreased in the exercise group compared to the control group. No significant difference was detected in dermal thickness in the breast, assessed by ultrasound. Session attendance in the exercise sessions was high, with two musculoskeletal adverse events reported, but no exacerbations of lymphoedema observed. Authors concluded that combined resistance and aerobic exercise training is safe for women living with breast lymphoedema. Preliminary data suggest exercise training can reduce breast lymphoedema symptoms to a greater extent than usual care. Saraswathi et al. (2021) systematically reviewed the effect of yoga therapy on managing lymphedema, increasing the range of motion (ROM), and quality of life (QOL) among breast cancer survivors. Studies which assessed the outcome variables such as QOL and management of lymphedema or related physical symptoms as effect of yoga intervention were considered for review. The different styles of yoga employed in the studies were Iyengar yoga (n = 2), Satyananda yoga (n = 2), Hatha yoga (n = 2), and Ashtanga yoga (n = 1). The length of intervention and post intervention analysis ranged from 8 weeks to 12 months. Authors concluded that yoga could be a safe and feasible exercise intervention for BCRL patients. Evidence generated from these studies was of moderate strength. Further long-term clinical trials with large sample size are essential for the development and standardization of yoga intervention guidelines for BCRL patients.

Bruce et al. (2021) evaluated whether a structured exercise programme improved functional and health related quality of life outcomes compared with usual care for women at high risk of upper limb disability after breast cancer surgery. Subjects included 392 women undergoing breast cancer surgery, at risk of postoperative upper limb morbidity, randomised (1:1) to usual care with structured exercise (n=196) or usual care alone (n=196). Usual care (information leaflets) only or usual care plus a physiotherapy led exercise programme, incorporating stretching, strengthening, physical activity, and behavioural change techniques to support adherence to exercise, introduced at 7-10 days postoperatively, with two further appointments at one and three months. Main outcome measures included the Disability of Arm, Hand and Shoulder (DASH) questionnaire at 12 months, analysed by intention to treat. Secondary outcomes included DASH subscales, pain, complications, health related quality of life, and resource use, from a health and personal social services perspective. Upper limb function improved after exercise compared with usual care for exercise. Secondary outcomes favoured exercise over usual care, with lower pain intensity at 12 months and fewer arm disability symptoms at 12 months. No increase in complications, lymphoedema, or adverse events was noted in participants allocated to exercise. Exercise accrued lower costs per patient and was cost effective compared with usual care. Authors concluded that the PROSPER exercise programme was clinically effective and cost effective and reduced upper limb disability one year after breast cancer treatment in patients at risk of treatment related postoperative complications.

Corum et al. (2021) compared the effects of complex decongestive therapy (CDT) accompanied by resistance exercises on extremity circumference, lymphedema volume, grip strength, functional status, and quality of life in

the treatment of breast cancer-related lymphedema (BCRL) in patients with and without pain. Fifty patients with unilateral BCRL were divided into groups: with pain (Group 1, n = 25) and without pain (Group 2, n = 25). Thirty minutes of manual lymphatic drainage and multilayered short-stretch bandaging were applied to all patients five times a week for 4 weeks. In addition, all patients were informed about skin care and given a supervised resistance exercise program throughout the treatment. During the 1-month follow-up period, patients were asked to use low-tension elastic garments and to continue their home exercise program. Differences in upper extremity circumference and volume; grip strength; Quick Disabilities of the Arm, Shoulder, and Hand; and Functional Assessment of Cancer Therapy-Breast scores were evaluated at baseline, after treatment (week 4), and at 1-month follow-up. Moreover, the pain intensity of patients in Group 1 was measured using the visual analog scale (VAS). Patients in both Group 1 and Group 2 showed a statistical improvement in all outcome measures after treatment and at follow-up ($p < 0.05$); however, no significant difference was observed between the groups ($p > 0.05$). In Group 1, a statistically significant decrease was observed in the VAS score both at the end of treatment and at 1-month follow-up ($p < 0.05$). Authors concluded that combined CDT and resistance exercises appear to be effective in BCRL patients both with and without pain.

Hayes et al. (2022) evaluated the effects of exercise on (i) the prevention of cancer-related lymphedema (CRL), and (ii) the treatment of CRL, lymphedema-associated symptoms, and other health outcomes among individuals with CRL in a systematic review and meta-analysis. Twelve studies (n = 1,955; 75% moderate-high quality) and 36 studies (n = 1,741; 58% moderate-high quality) were included in the prevention and treatment aim, respectively. Relative risk of developing CRL for those in the exercise group compared with the non-exercise group was 0.90 overall, and 0.49 for those with 5 or more lymph nodes removed. Improvements post-intervention were observed for pain, upper-body function and strength, lower-body strength, fatigue and quality of life for those in the exercise group. Authors concluded that findings support the application of exercise guidelines for the wider cancer population to those with or at risk of CRL. This includes promotion of aerobic and resistance exercise, and not just resistance exercise alone, as well as unsupervised exercise guided by symptom response.

Maccarone et al. (2023) evaluated the effects of water-based exercise on pain, limb motor function, quality of life (QoL), and limb volume among patients affected by primary and secondary upper and lower limb lymphedema. The search produced a total of 88 studies. Eight randomized controlled trials and one clinical study of patients with primary or secondary lymphedema of upper or lower limbs who had undergone water-based treatment were included in the present study. Most trials had focused on breast cancer-related lymphedema. The shoulder range of flexion, external rotation, and abduction have been shown to improve after performing a water-based exercise protocol. Some evidence has also demonstrated that the lymphedematous limb strength can improve. Moreover, water-based exercise seemed to improve pain perception and QoL for patients with upper or lower limb lymphedema. In contrast, in the control groups, the QoL showed a tendency to worsen over time. Although some studies had not reported beneficial effects on the lymphedematous limb volume, most of the studies examined had reported a reduction in volume, especially in the short term. No adverse events were reported in the included studies. Authors concluded that these findings from the present review have shown the potential for aquatic exercise in lymphedema management. However, at the same time, the findings underline the multiple limitations resulting from the heterogeneity in the study populations and related physical activity protocols. The role of aquatic exercise in the conservative treatment of lymphedema requires further investigation in the future to define specific protocols of application.

Lin et al. (2023) sought to determine the effective exercise methods for different complications of breast cancer patients after surgery in a systematic review and meta-analysis. Aerobic exercise reduced the intensity of the pain, improved shoulder flexion and internal rotation range, lessened upper limb dysfunction and improved muscle strength during flexion and abduction. Shoulder elbow movement improved the range of shoulder external rotation and reduced the incidence of arm lymphedema. Anti-resistance exercise also lessened upper limb dysfunction. Wang et al. (2023) This examined the existing best evidence on resistance exercise for BCRL to accurately describe the current status of the field and offer recommendations for clinicians in a systematic, evidence-based review. Twenty two articles (seven guidelines, four consensus documents and eleven systematic reviews) were included. Six clinical topics involving 43 recommendations were identified. Recommendations were categorised by safety of resistance training, effectiveness of resistance training, evaluation prior to resistance exercise, resistance exercise prescription, resistance training outcome index and points for attention. Based on the available research, there is strong evidence evaluating the safety of resistance exercise. The findings support the assertion that breast cancer patients at risk of or with lymphoedema should be encouraged to do resistance exercise. Resistance exercise could improve patients' muscle strength and

quality of life. Authors also summarized the evidence of resistance exercise prescription which can be used to guide clinical practice. However, there are some inconsistent recommendations in the review, such as the effects of resistance exercise on preventing and relieving lymphoedema. The main heterogeneity comes from different exercise prescriptions in terms of exercise type, frequency, intensity, etc. Future studies are needed to provide high-quality evidence for the specificity of exercise prescription, to identify the appropriate exercise volume for patients at different stages of lymphoedema or at risk of lymphoedema. In terms of whether or not to wear compression garments during exercise, future studies need to focus on patient comfort and compliance with these during exercise: clinicians should not simply take the effects of relieving lymphoedema into consideration.

Measurement of Lymphedema: Hidding et al. (2016) attempted to provide best evidence of which measurement instruments are most appropriate in measuring lymphedema in its different stages. Authors concluded that measurement instruments with evidence for good reliability and validity are Bioelectrical Impedance Spectroscopy (BIS), water volumetry, tape measurement and perometry, where BIS can detect alterations in extracellular fluid in stage 1 lymphedema and the other measurement instruments alterations in volume starting from stage 2. In research water volumetry is indicated as reference test for measuring lymphedema in upper extremities. Limitations included the following: no uniform definition of lymphedema was available and a gold standard as reference test was lacking. Items concerning risk of bias were study design, patient selection, description of lymphedema, blinding of test outcomes and number of included patients.

Şahinoğlu et al. (2024) evaluated the agreement between the American Physical Therapy Association (APTA) criteria, the criteria of Ramos et al., and the International Society of Lymphology (ISL) criteria in patients with upper and lower extremity lymphedema. Several classification systems are used to grade the severity of lymphedema. Their agreement with each other has not been reported. A total of 156 patients (63 and 93 patients with upper and lower extremity lymphedema, respectively) were included. The circumference measurements and limb volume were measured. The severity of lymphedema of the patients was classified as mild, moderate, and severe lymphedema using the APTA criteria, the criteria of Ramos et al., and the ISL criteria. An acceptable and poor agreement were found between the criteria in upper and lower extremity lymphedema, respectively. In pairwise comparisons, an acceptable agreement was found among each comparison in upper extremity lymphedema, and a poor agreement was found among each comparison in lower extremity lymphedema except between the APTA criteria and the criteria of Ramos et al. Authors concluded that patients with upper extremity lymphedema classified according to these criteria can be assumed to be samples of the same population; however, patients with lower extremity lymphedema graded according to the ISL criteria may be included in a different classification when they grade with the APTA criteria and the criteria of Ramos et al.

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPSC Codes	Description
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

HCPSC Codes	Description
S8950	Complex lymphedema therapy, each 15 minutes

Considered Not Medically Necessary:

CPT®* Codes	Description
97016	Application of a modality to 1 or more areas; vasopneumatic devices

*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.

References

1. Ahmed Omar MT, Abd-El-Gayed Ebid, El Morsy AM. Treatment of post-mastectomy lymphedema with laser therapy: double blind placebo control randomized study. *J Surg Res*. 2011 Jan; 165(1): 82-90.
2. Andersen L, Højris I, Erlandsen M, Andersen J. Treatment of breast-cancer-related lymphedema with or without manual lymphatic drainage—a randomized study. *Acta Oncol*. 2000;39(3):399-405.
3. Badger C, Preston N, Seers K, Mortimer P. Physical therapies for reducing and controlling lymphoedema of the limbs [review]. *The Cochrane Review*. In: *The Cochrane Library*, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.; 2004.
4. Bakar Y, Tuğral A. Lower Extremity Lymphedema Management after Gynecologic Cancer Surgery: A Review of Current Management Strategies. *Ann Vasc Surg*. 2017 May 5. pii: S0890-5096(16)30939-6.
5. Baumann FT, Reike A, Reimer V, Schumann M, Hallek M, Taaffe DR, Newton RU, Galvao DA. Effects of physical exercise on breast cancer-related secondary lymphedema: a systematic review. *Breast Cancer Res Treat*. 2018 Jul;170(1):1-13.
6. Baxter GD, Liu L, Petrich S, Gisselman AS, Chapple C, Anders JJ, Tumilty S. Low level laser therapy (Photobiomodulation therapy) for breast cancer-related lymphedema: a systematic review. *BMC Cancer*. 2017 Dec 7;17(1):833.
7. Bialoszewski D, Woźniak W, Zarek S. Clinical efficacy of kinesiology taping in reducing edema of the lower limbs in patients treated with the ilizarov method—preliminary report. *Ortop Traumatol Rehabil*. 2009 Jan-Feb; 11(1):46-54.
8. Bicego D, Brown K, Ruddick, M, et al. Exercise for women with or at risk for breast cancer-related lymphedema. *Phys Ther*. 2006;86:1398-1405.
9. Borman P, Yaman A, Yasrebi S, Pinar İnanlı A, Arkan Dönmez A. Combined Complete Decongestive Therapy Reduces Volume and Improves Quality of Life and Functional Status in Patients With Breast Cancer-Related Lymphedema. *Clin Breast Cancer*. 2022;22(3):e270-e277.
10. Bosman J. Lymph taping for lymphoedema: an overview of the treatment and its uses. *Br J Community Nurs*. 2014 Apr;Suppl:S12, S14, S16-8.
11. Buchan J, Janda M, Box R, Schmitz K, Hayes S. A Randomized Trial on the Effect of Exercise Mode on Breast Cancer-related Lymphedema. *Med Sci Sports Exerc*. 2016 May 17.
12. Canadian Agency for Drugs and Technologies in Health (CADTH). Health Technology Inquiry Service. Manual lymph drainage or intermittent pneumatic compression for adult patients with secondary lymphedema: clinical effectiveness. *Health Technology Assessment*. April 2010. Accessed March 26, 2024. Available at URL address: https://cadth.ca/sites/default/files/pdf/k0173_lymphedema_htis-L1-5.pdf
13. Canadian Agency for Drugs and Technologies in Health (CADTH). Health Technology Inquiry Service. Compression Garments for the Treatment of Primary and Secondary Lymphedema: Clinical Effectiveness

and Guidelines. November 2011. Accessed March 26, 2024 from <https://www.cadth.ca/sites/default/files/pdf/htis/oct-2011/RB0437-000%20Lymphedema.pdf>

14. Carati CJ, Anderson SN, Gannon BJ, Piller NB. Treatment of post mastectomy lymphedema with low-level laser therapy: a double blind, placebo-controlled trial. *Cancer* 2003; 98(6): 1114-1122.
15. Casley-Smith JR, Boris M, Weindorf S, Lasinski B. Treatment for lymphedema of the arm—the Casley-Smith method. *Cancer*. 1998 Dec 15;83(12 Suppl American):2843-60.
16. Chaput G, Ibrahim M. Cancer-related lymphedema. *Can Fam Physician*. 2023 Oct;69(10):691-695.
17. Cheifetz O, Haley L, Management of secondary lymphedema related to breast cancer. *Can Fam Physician* 2010;56:1277-84.
18. Cheng JT, Leite VF, Tennison JM, Gutierrez C, Kline-Quiroz C, Capozzi LC, Yu S, Krause KJ, Langelier D, Parke SC. Rehabilitation Interventions for Head and Neck Cancer-Associated Lymphedema: A Systematic Review. *JAMA Otolaryngol Head Neck Surg*. 2023 Aug 1;149(8):743-753.
19. Chiu ST, Lai UH, Huang YC, Leong CP, Chen PC. Effect of various photobiomodulation regimens on breast cancer-related lymphedema: A systematic review and meta-analysis. *Lasers Med Sci*. 2023 Dec 22;39(1):11.
20. Cormier JN, Askew RL, Mungovan KS, Xing Y, Ross MI, Armer JM. Lymphedema beyond breast cancer: a systematic review and meta-analysis of cancer-related secondary lymphedema. *Cancer*. 2010 Nov 15;116(22):5138-49.
21. Corum M, Basoglu C, Korkmaz MD, Yildirim MA, Ones K. Effectiveness of Combined Complex Decongestive Therapy and Resistance Exercises in the Treatment of Lymphedema Associated with Breast Cancer and the Effect of Pain on Treatment Response. *Lymphat Res Biol*. 2021;19(4):383-390. doi:10.1089/lrb.2020.0099
22. Dayes IS, Whelan TJ, Julian JA, Parpia S, Pritchard KI, D'Souza DP, et al. Randomized trial of decongestive lymphatic therapy for the treatment of lymphedema in women with breast cancer. *J Clin Oncol*. 2013 Oct 20;31(30):3758-63.
23. Devoogdt N, Van Kampen M, Geraerts I, Coremans T, Christiaens MR. Different physical treatment modalities for lymphoedema developing after axillary lymph node dissection for breast cancer: a review. *Eur J Obstet Gynecol Reprod Biol*. 2010 Mar;149(1):3-9.
24. De Vrieze T, Gebruers N, Nevelsteen I, et al. Manual lymphatic drainage with or without fluoroscopy guidance did not substantially improve the effect of decongestive lymphatic therapy in people with breast cancer-related lymphoedema (EForT-BCRL trial): a multicentre randomised trial. *J Physiother*. 2022;68(2):110-122.
25. Didem K, Ufuk YS, Serdar S, Zumre. The comparison of two different physiotherapy methods in treatment of lymphedema after breast surgery. *A Breast Cancer Res Treat* 2005; 93(1): 49-54.
26. Dirican A, Andacoglu O, Johnson R, McGuire K, Mager L, Soran A. The short-term effects of low-level laser therapy in the management of breast-cancer-related lymphedema. *Support Care Cancer* 2011; 19(5): 685-690.
27. Do JH, Choi KH, Ahn JS, Jeon JY. Effects of a complex rehabilitation program on edema status, physical function, and quality of life in lower-limb lymphedema after gynecological cancer surgery. *Gynecol Oncol*. 2017 Nov;147(2):450-455.
28. Donahue PMC, MacKenzie A, Filipovic A, Koelmeyer L. Advances in the prevention and treatment of breast cancer-related lymphedema. *Breast Cancer Res Treat*. 2023 Jul;200(1):1-14.

29. Executive Committee of the International Society of Lymphology. The diagnosis and treatment of peripheral lymphedema: 2020 Consensus Document of the International Society of Lymphology. *Lymphology* 2020, 53, 3–19.
30. Ezzo J, Manheimer E, McNeely ML, Howell DM, Weiss R, Johansson KI, et al. Manual lymphatic drainage for lymphedema following breast cancer treatment. *Cochrane Database Syst Rev*. 2015 May 21;(5):CD003475.
31. Finnane A, Janda M, Hayes SC. Review of the evidence of lymphedema treatment effect. *Am J Phys Med Rehabil*. 2015 Jun;94(6):483-98.
32. Foldi E. The treatment of lymphedema. *Cancer*. 1998 Dec 15;83(12 Suppl American):2833-9.
33. Fomer-Cordero I, Muñoz-Langa J, DeMiguel-Jimeno JM, Rel-Monzó P. Physical therapies in the decongestive treatment of lymphedema: A randomized, non-inferiority controlled study. *Clin Rehabil*. 2021;35(12):1743-1756.
34. Gatt M, Willis S, Leuschner S. A meta-analysis of the effectiveness and safety of kinesiology taping in the management of cancer-related lymphoedema. *Eur J Cancer Care (Engl)*. 2017 Sep;26(5).
35. Golshan M, Smith B. Prevention and management of arm lymphedema in the patient with breast cancer. *J Support Oncol*. 2006 Sep;4(8):381-6.
36. Haghghat S, Lotfi-Tokaldany M, Yunesian M, et al. Comparing two treatment methods for post mastectomy lymphedema: complex decongestive therapy alone with intermittent pneumatic compression. *Lymphology*. 2010 Mar; 43(1): 25-33.
37. Hamner JB, Fleming MD. Lymphedema therapy reduces the volume of edema and pain in patients with breast cancer. *Ann Surg Oncol*. 2007 Jun; 14(6): 1904-8.
38. Harris SR. Clinical practice guidelines for the care and treatment of breast cancer: 11. lymphedema. *CMAJ*. 2001 Jan 23;164(2):191-9.
39. Hasenoehrl T, Keilani M, Palma S, Crevenna R. Resistance exercise and breast cancer related lymphedema - a systematic review update. *Disabil Rehabil*. 2020 Jan;42(1):26-35.
40. Hayes SC, Singh B, Reul-Hirche H, et al. The Effect of Exercise for the Prevention and Treatment of Cancer-related Lymphedema: A Systematic Review with Meta-analysis [published online ahead of print, 2022 Mar 22]. *Med Sci Sports Exerc*. 2022;10.1249/MSS.0000000000002918.
41. Hidding JT, Viehoff PB, Beurskens CH, van Laarhoven HW, Nijhuis-van der Sanden MW, van der Wees PJ. Measurement Properties of Instruments for Measuring of Lymphedema: A Systematic Review. *Phys Ther*. 2016 Jun 23.
42. Hwang JM, Hwang JH, Kim TW, Lee SY, Chang HJ, Chu IH. Long-term effects of complex decongestive therapy in breast cancer patients with arm lymphedema after axillary dissection. *Ann Rehabil Med*. 2013 Oct;37(5):690-7.
43. International Society of Lymphology. The diagnosis and treatment of peripheral lymphedema. 2009 Consensus Document of the International Society of Lymphology. *Lymphology*. 2009 Jun;42(2):51-60.
44. International Society of Lymphology. The diagnosis and treatment of peripheral lymphedema. Consensus document of the International Society of Lymphology. 2020. Accessed March 26, 2024. Available at URL address: <https://isl.arizona.edu/sites/default/files/2021-09/Consensus%20Document-SM.pdf>
45. International Society of Lymphology. The diagnosis and treatment of peripheral lymphedema: 2016 Consensus document of the international society of lymphology. *Lymphology* 49 (2016) 170-184.

46. Johansson K, Karlsson K, Nikolaidis P. Evidence-based or traditional treatment of cancer-related lymphedema. *Lymphology*. 2015 Mar;48(1):24-7.
47. Kalemikerakis I, Evaggelakou A, Kavga A, Vastardi M, Konstantinidis T, Govina O. Diagnosis, treatment and quality of life in patients with cancer-related lymphedema. *J BUON*. 2021;26(5):1735-1741.
48. Kalron A, Bar-Sela S. A systematic review of the effectiveness of Kinesio Taping--fact or 4 fashion? *Eur J Phys Rehabil Med*. 2013 Oct; 49(5):699-709.
49. Karadibak D, Yavusen T, Saydam S. Prospective trial of intensive decongestive physiotherapy for upper extremity lymphedema. *J Surg Oncol*. 2008 Jun; 97(7): 572-7.
50. Kärki A, Anttila H, Tasmuth T, Rautakorpi UM. Lymphoedema therapy in breast cancer patients: a systematic review on effectiveness and a survey of current practices and costs in Finland. *Acta Oncol*. 2009;48(6):850-9.
51. Kasseroller RG. The Vodder School: the Vodder method. *Cancer*. 1998;83:2840-2.
52. Kilbreath SL, Ward LC, Davis GM, Degnim AC, Hackett DA, Skinner TL, Black D. Reduction of breast lymphoedema secondary to breast cancer: a randomised controlled exercise trial. *Breast Cancer Res Treat*. 2020 Nov;184(2):459-467.
53. Kim do S, Sim YJ, Kim GC. Effect of active resistive exercise on breast cancer-related lymphedema: a randomized controlled trial. *Arch Phys Rehabil*. 2010 Dec; 91(12): 1844-8.
54. Kim SJ, Park YD. Effects of complex decongestive physiotherapy on the oedema and the quality of life of lower unilateral lymphoedema following treatment for gynecological cancer. *Eur J Cancer Care (Engl)* 2008; 17(5): 463-468.
55. Kligman L, Wong RK, Johnston M, Laetsch NS. The treatment of lymphedema related to breast cancer: a systematic review and evidence summary. *Support Care Cancer*. 2004 Jun;12(6):421-31.
56. Koul R, Dufan T, Russell C, Guenther W, Nugent Z, Sun X, Cooke AL. Efficacy of complete decongestive therapy and manual lymphatic drainage on treatment-related lymphedema in breast cancer. *Int J Radiat Oncol Biol Phys* 2007; 67(3): 841-846.
57. Kwan ML, Cohn JC, Armer JM, Stewart BR, Cormier JN. Exercise in patients with lymphedema: a systematic review of the contemporary literature. *J Cancer Surviv*. 2011; 5:320–336.
58. Kozanoglu E, Basaran S, Paydas S, et al. Efficacy of pneumatic compression and low-level laser therapy in the treatment of post mastectomy lymphoedema: a randomized controlled trial. *Clin Rehabil*. 2009 Feb; 23(2): 117-24.
59. Kozanoglu E, Gokcen N, Basaran S, Paydas S. Long-Term Effectiveness of Combined Intermittent Pneumatic Compression Plus Low-Level Laser Therapy in Patients with Postmastectomy Lymphedema: A Randomized Controlled Trial. *Lymphat Res Biol*. 2022;20(2):175-184.
60. Lasinski BB, Boris M. Comprehensive lymphedema management: results of a 5 year follow-up. *Lymphology*. 2002;35 (suppl):301-4.
61. Lasinski BB, McKillip Thrift K, Squire D, Austin MK, Smith KM, Wanchai A, Green JM, Stewart BR, Cormier JN, Armer JM. A systematic review of the evidence for complete decongestive therapy in the treatment of lymphedema from 2004 to 2011. *PM R*. 2012 Aug;4(8):580-601.
62. Lasinski BB. Complete decongestive therapy for treatment of lymphedema. *Semin Oncol Nurs*. 2013 Feb;29(1):20-7.

63. Lawenda BD, Mondry TE, Johnstone PA. Lymphedema: a primer on the identification and management of a chronic condition in oncologic treatment. *CA Cancer J Clin.* 2009 Jan-Feb;59(1):8-24.
64. Leal NF, Carrara HH, Vieira KF, Ferreira CH. Physiotherapy treatments for breast cancer-related lymphedema: a literature review. *Rev Lat Am Enfermagem.* 2009 Sep-Oct;17(5):730-6.
65. Leung EY, Tirlapur SA, Meads C. The management of secondary lower limb lymphoedema in cancer patients: a systematic review. *Palliat Med.* 2015 Feb;29(2):112-9.
66. Lin Y, Yang Y, Zhang X, Li W, Li H, Mu D. Manual Lymphatic Drainage for Breast Cancer-related Lymphedema: A Systematic Review and Meta-analysis of Randomized Controlled Trials. *Clin Breast Cancer.* 2022;22(5):e664-e673.
67. Lin Y, Chen Y, Liu R, Cao B. Effect of exercise on rehabilitation of breast cancer surgery patients: A systematic review and meta-analysis of randomized controlled trials. *Nurs Open.* 2023 Apr;10(4):2030-2043.
68. Maccarone MC, Venturini E, Menegatti E, Giancesini S, Masiero S. Water-based exercise for upper and lower limb lymphedema treatment. *J Vasc Surg Venous Lymphat Disord.* 2023;11(1):201-209. doi:10.1016/j.jvsv.2022.08.002
69. Macdonald JM, Sims N, Mayrovitz HN. Lymphedema, lipedema, and the open wound: the role of compression therapy. *Surg Clin North Am.* 2003;83(3):639-58.
70. Marotta N, Lippi L, Ammendolia V, Calafiore D, Inzitari MT, Pinto M, Invernizzi M, de Sire A. Efficacy of kinesio taping on upper limb volume reduction in patients with breast cancer-related lymphedema: a systematic review of randomized controlled trials. *Eur J Phys Rehabil Med.* 2023 Apr;59(2):237-247.
71. McNeely ML, Dolgoy ND, Rafn BS, et al. Nighttime compression supports improved self-management of breast cancer-related lymphedema: A multicenter randomized controlled trial. *Cancer.* 2022;128(3):587-596. doi:10.1002/cncr.33943
72. Megens A, Harris SR. Physical therapist management of lymphedema following treatment for breast cancer: a critical review of its effectiveness. *Phys Ther.* 1998 Dec;78(12):1303-11.
73. McNeely ML, Magee DJ, Lees AW, et al. The addition of manual lymph drainage to compression therapy for breast cancer related lymphedema: a randomized controlled trial. *Breast Cancer Res Treat.* 2004 Jul; 86(2): 95-106.
74. Megens, A Harris SR. Physical therapist management of lymphedema following treatment for breast cancer: a critical review of its effectiveness. *Phys Ther* 1998 Dec;78(12):1303-11.
75. Michopoulos E, Papathanasiou G, Vasilopoulos G, Polikandrioti M, Dimakakos E. Effectiveness and Safety of Complete Decongestive Therapy of Phase I: A Lymphedema Treatment Study in the Greek Population. *Cureus.* 2020 Jul 19;12(7):e9264.
76. Mondry TE, Riffenburgh RH, Johnstone PA Prospective trial of complete decongestive therapy for upper extremity lymphedema after breast cancer therapy. *Cancer J* 2004;10(1): 42-48.
77. Moseley A, Carati C, Piller N. A systematic review of common conservative therapies for arm lymphoedema secondary to breast cancer treatment. *Ann Oncol.* 2007 Apr;18(4):639-46.
78. National Cancer Institute (NCI). Lymphedema [Physician Data Query (PDQ[®])]. Last Modified: 9/13/2023. Accessed March 26, 2024. Available at URL address: <http://www.cancer.gov/cancertopics/pdq/supportivecare/lymphedema/healthprofessional/AllPages>
79. National Lymphedema Network (NLN). Position statement of the national lymphedema network. The Diagnosis And Treatment Of Lymphedema. February 2011. Currently under review and revision.

80. National Lymphedema Network (NLN). Position statement of the national lymphedema network. Exercise. December 2011. Accessed March 26, 2024. Available at URL address: <https://static1.squarespace.com/static/5b741fa71aef1d1e6500b325/t/621c4b9fd985833faafd4117/1646021535820/Exercise.pdf>
81. Nelson NL. Breast Cancer-Related Lymphedema and Resistance Exercise: A Systematic Review. *J Strength Cond Res*. 2016 Sep;30(9):2656-65.
82. Oremus M, Walker K, Dayes I, Parminder R; McMaster University Evidence-based Practice Center. Diagnosis and treatment of secondary lymphedema. [technology assessment]. 2010 May 28. Prepared for: Agency for Healthcare Research and Quality (AHRQ).
83. Oremus M, Dayes I, Walker K, Raina P. Systematic review: conservative treatments for secondary lymphedema. *BMC Cancer*. 2012 Jan 4;12:6. doi: 10.1186/1471-2407-12-6.
84. Pekyavaş NÖ, Tunay VB, Akbayrak T, Kaya S, Karataş M. Complex decongestive therapy and taping for patients with postmastectomy lymphedema: a randomized controlled study. *Eur J Oncol Nurs*. 2014 Dec;18(6):585-90.
85. Petrek JA, Pressman PI, Smith RA. Lymphedema: current issues in research and management. *CA Cancer J Clin*. 2000 Oct;50(5):292-307.
86. Poage E, Singer M, Armer J, Poundall M, Shellabarger MJ. Demystifying lymphedema: development of the lymphedema putting evidence into practice card. *Clin J Oncol Nurs*. 2008 Dec;12(6):951-64.
87. Qiao J, Yang LN, Kong YH, Huang X, Li Y, Bai DQ. Effect of Manual Lymphatic Drainage on Breast Cancer-Related Postmastectomy Lymphedema: A Meta-analysis of Randomized Controlled Trials. *Cancer Nurs*. 2023;46(2):159-166.
88. Rangun FB, da Silva J, Dibai-Filho AV, Guirro RRJ, Guirro ECO. Effects of Complex Physical Therapy and Multimodal Approaches on Lymphedema Secondary to Breast Cancer: A Systematic Review and Meta-analysis of Randomized Controlled Trials. *Arch Phys Med Rehabil*. 2022;103(2):353-363.
89. Ridner SH. Breast cancer lymphedema: pathophysiology and risk reduction guidelines. *Oncol Nurs Forum*. 2002 Oct;29(9):1285-93.
90. Ryans K, Perdomo M, Davies CC, Levenhagen K, Gilchrist L. Rehabilitation interventions for the management of breast cancer-related lymphedema: developing a patient-centered, evidence-based plan of care throughout survivorship. *J Cancer Surviv*. 2023;17(1):237-245.
91. Şahinoğlu E, Ergin G, Karadibak D. The agreement between three classification systems used to grade the severity of lymphedema in patients with upper and lower extremity lymphedema: A retrospective study. *Physiother Theory Pract*. 2024 Apr;40(4):874-879.
92. Saraswathi V, Latha S, Niraimathi K, Vidhubala E. Managing Lymphedema, Increasing Range of Motion, and Quality of Life through Yoga Therapy among Breast Cancer Survivors: A Systematic Review. *Int J Yoga*. 2021 Jan-Apr;14(1):3-17.
93. Shao Y, Qi K, Zhou QH, Zhong DS. Intermittent pneumatic compression pump for breast cancer-related lymphedema: a systematic review and meta-analysis of randomized controlled trials. *Oncol Res Treat*. 2014;37(4):170-4.
94. Smoot B, Chiavola-Larson L, Lee J, Manibusan H, Allen DD. Effect of low-level laser therapy on pain and swelling in women with breast cancer-related lymphedema: a systematic review and meta-analysis. *J Cancer Surviv*. 2015;9(2):287-304.

95. Senger JB, Kadle RL, Skoracki RJ. Current Concepts in the Management of Primary Lymphedema. *Medicina (Kaunas)*. 2023 May 6;59(5):894.
96. Sezgin Ozcan D, Dalyan M, Unsal Delialioglu S, Duzlu U, Polat CS, Koseoglu BF. Complex Decongestive Therapy Enhances Upper Limb Functions in Patients with Breast Cancer-Related Lymphedema. *Lymphat Res Biol*. 2018 Oct;16(5):446-452.
97. Stout Gergich NL, Pfalzer LA, McGarvey C, et al. Preoperative assessment enables the early diagnosis and successful treatment of lymphedema. *Cancer*. 2008;112(12):2809-2819.
98. Szolnoky G, Lakatos B, Keskeny T, Varga E, Varga M, Dobozy A, Kemény L. Intermittent pneumatic compression acts synergistically with manual lymphatic drainage in complex decongestive physiotherapy for breast cancer treatment-related lymphedema. *Lymphology* 2009; Dec 42(4): 188-194.
99. Szuba A, Cooke JP, Yousuf S, Rockson SG. Decongestive lymphatic therapy for patients with cancer related or primary lymphedema. *Am J Med*. 2000;109:296-300.
100. The diagnosis and treatment of peripheral lymphedema. International Society of Lymphology. *Lymphology*. 2003 Jun;36(2):84-91.
101. Thompson B, Gaitatzis K, Janse de Jonge X, Blackwell R, Koelmeyer LA. Manual lymphatic drainage treatment for lymphedema: a systematic review of the literature. *J Cancer Surviv*. 2021;15(2):244-258.
102. Torgbenu E, Luckett T, Buhagiar MA, Phillips JL. Guidelines Relevant to Diagnosis, Assessment, and Management of Lymphedema: A Systematic Review. *Adv Wound Care (New Rochelle)*. 2023;12(1):15-27.
103. Torres Lacomba M, Yuste Sánchez MJ, Zapico Goñi A, Prieto Merino D, Mayoral del Moral O, Cerezo Téllez E, et al. Effectiveness of early physiotherapy to prevent lymphoedema after surgery for breast cancer: randomised, single blinded, clinical trial. *BMJ*. 2010 Jan 12;340:b5396
104. Torres-Lacomba M, Navarro-Brazález B, Prieto-Gómez V, Ferrandez JC, Bouchet JY, Romay-Barrero H. Effectiveness of four types of bandages and kinesio-tape for treating breast-cancer-related lymphoedema: a randomized, single-blind, clinical trial. *Clin Rehabil*. 2020 Sep;34(9):1230-1241.
105. Tsai HJ, Hung HC, Yang JL, Huang CS, Tsao JY. Could Kinesio tape replace the bandage 16 in decongestive lymphatic therapy for breast-cancer-related lymphedema? A pilot 17 study. *Support Care Cancer*. 2009 Nov; 17(11):1353-60.
106. Tzani I, Tsihlaki M, Zerva E, Papathanasiou G, Dimakakos E. Physiotherapeutic rehabilitation of lymphedema: state-of-the-art. *Lymphology*. 2018;51(1):1-12.
107. Tunkel RS, Lachmann E. Lymphedema of the limb. An overview of treatment options. *Postgrad Med* 1998;104(4):131-134,137-138, 141.
108. Vignes S, Blanchard M, Arrault M, Porcher R. Intensive complete decongestive physiotherapy for cancer-related upper-limb lymphedema: 11 days achieved greater volume reduction than 4. *Gynecol Oncol*. 2013 Oct;131(1):127-30.
109. Vignes S, Porcher R, Arrault M, Dupuy A. Long-term management of breast cancer-related lymphedema after intensive decongestive physiotherapy. *Breast Cancer Res Treat* 2007; 101(3): 285-290.
110. Watanabe Y, Koshiyama M, Seki K, et al. Development and Themes of Diagnostic and Treatment Procedures for Secondary Leg Lymphedema in Patients with Gynecologic Cancers. *Healthcare (Basel)*. 2019;7(3):101.
111. Wanchai A, Armer JM. Manual Lymphedema Drainage for Reducing Risk for and Managing Breast Cancer-Related Lymphedema After Breast Surgery: A Systematic Review. *Nurs Womens Health*. 2021;25(5):377-383.

112. Wang Y, Ge Y, Xing W, et al. The effectiveness and safety of low-level laser therapy on breast cancer-related lymphedema: An overview and update of systematic reviews. *Lasers Med Sci.* 2022;37(3):1389-1413. doi:10.1007/s10103-021-03446-3
113. Wang L, Shi YX, Wang TT, Chen KX, Shang SM. Breast cancer-related lymphoedema and resistance exercise: An evidence-based review of guidelines, consensus statements and systematic reviews. *J Clin Nurs.* 2023 May;32(9-10):2208-2227..
114. Yeung W, Semciw AI. Aquatic Therapy for People with Lymphedema: A Systematic Review and Meta-analysis. *Lymphat Res Biol.* 2018 Feb;16(1):9-19.
115. Zasadzka E, Trzmiel T, Kleczewska M, Pawlaczyk M. Comparison of the effectiveness of complex decongestive therapy and compression bandaging as a method of treatment of lymphedema in the elderly. *Clin Interv Aging.* 2018 May 14;13:929-934.
116. Zuther E. and Norton, S. Pathology. *Lymphedema Management: The Comprehensive Guide for Practitioners.* 3rd Edition. New York: Theime Medical Publishers, Inc; 2013.

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