Sir:

Surgical treatment for lymphedema is expanding at a rapid pace. The following case demonstrates a critical need for communication between surgeons, whether they are invested in microsurgical techniques or debulking liposuction.

A 57-year-old woman with bilateral lower extremity primary lymphedema tarda underwent a right transverse cervical artery vascularized lymph node transfer to the left lower extremity (the first surgeon was Marga F. Massey, M.D.; the second surgeon is not identified but was in an independent practice in a different state than Dr. Massey). Her preoperative lymphoscintigram (Fig. 1, left) demonstrated no lymph node tracer uptake in either groin. Eight months after surgery, the patient presented with intermittent mild right arm swelling. Repeated lymphoscintigraphy showed no tracer uptake in the right axilla (ipsilateral to the cervical donor site) and a new finding of tracer uptake in the nonoperative right inguinal region (Fig. 1, right). The patient was subsequently lost to in-person follow-up after having

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related dissipation of her right arm swelling by means of several follow-up phone consultations.

Approximately 18 months after transverse cervical artery vascularized lymph node transfer, the patient presented to a second surgeon requesting debulking liposuction of the left leg. Right arm swelling was noted on physical examination by the second surgeon. A third lymphoscintigram was obtained (not shown). No tracer uptake was demonstrated in either groin or in the right axilla (these results were reported in an abstract presentation by the second surgeon at the National Lymphedema Network Annual Meeting in Washington, D.C., in September of 2014). She reportedly underwent uneventful left lower extremity liposuction debulking performed by the second surgeon without any contact with the initial surgeon, thus leaving the initial surgeon unaware of the progression of the donor-site morbidity.

This communication relates the first reported case of iatrogenic upper extremity lymphedema from a transverse cervical artery vascularized lymph node transfer. Teaching has focused on the potential risk of secondary lymphedema of the head and neck in the setting of a supraclavicular flap harvest. This case highlights the need for the use of ipsilateral upper extremity reverse lymphatic mapping when using a cervical approach.\(^1,2\) Furthermore, this case illustrates variability in the quality of lymphoscintigraphic imaging versus a putative dynamic presentation of primary lymphedema. Review of the three sequential lymphoscintigrams of the nonoperative right lower extremity revealed an illusive appearance of inguinal regional lymph nodes only on the second study. Such variability begs further investigation.\(^3\)

This case demonstrates the importance of coordinated care and collection of outcomes data in the expanding field of lymphatic reconstruction. Because lymphedema patients are often moving from surgeon to surgeon hoping for a surgical cure for this chronic, debilitating disease, it is not uncommon for patients to be lost to in-person clinical follow-up. Therefore, it is imperative that we as surgeons develop a system that allows tracking of patient-centered outcomes and morbidity. I would call on the American Society of Plastic Surgeons to initiate a patient registry for the surgical treatment of lymphedema to track patient outcomes and morbidity. Surgeon participation in a national registry would result in total transparency and an improvement in the quality of care for this high-risk patient population.

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DISCLOSURE

Dr. Massey is on the Medical Advisory Board of the National Lymphedema Network. The authors have no commercial associations that pose a potential conflict of interest.

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Trust

Sir:

It is impossible to ignore the election season, with the candidates’ advertisements a constant presence on my television screen. No matter the party, the message is always the same: you should trust me. Trust is important in the practice of medicine as well. Every day, we ask patients in our care for their trust. Yesterday, I went into the operating room to greet my patient who has severe rheumatoid hand and wrist deformities. I outlined to her, as I always do before surgery, the potential for complications and adverse events. My patient did not say anything as she listened intently to the descriptions of the surgical procedures I would perform. When I was done, she uttered a few compelling words, “Dr. Chung, I trust you; that’s why I came to you.” At that moment, I did not think much of what she said; I have heard it many times from the patients who seek me out to care for them.

As a daily routine, I reflect on the events of the day so I can appreciate what I have done well and learn from what I can do better. What my patient uttered to me today, “I trust you,” resonated with me. When someone says they trust you, it has profound emotional meaning. People say trust takes years to build, seconds to break, and forever to repair. As physicians and surgeons, the trust that our patients put in us is an incredible, intense bond between two people who, let’s be honest, hardly know each other. I always feel an immense responsibility to my patients even for the simplest procedures such as carpal tunnel surgery or cyst removal because the patients have placed their trust in me to make their lives better. This trust is even greater when parents put the lives of their children, their most precious gifts, in my hands when I conduct surgery. On reflection, when that patient utters those words, “Dr. Chung, I trust you,” the gravity of those words underscore the special relationship between the physician and the patient.

Changes in the health care environment have made most of our communications with patients electronic.