Pour en savoir plus…

L’épaule après cancer du sein


The objective of this study are (1) to determine if upper extremity function, as represented by shoulder ROM, self-reported symptoms and upper extremity functional limitations in activities of daily living could be predictively related to demographic and cancer characteristics post-surgery for breast cancer. And (2) to examine if variables related to early onset impairment contribute to late onset impairments in women after breast cancer surgery. Subjects were assessed preoperatively and 1, 3, 6, 9, and 12+ months post breast cancer surgery for impairments and symptoms and at 12+ months for shoulder functional limitations using a physical therapy surveillance model. Body weight, shoulder ROM, manual muscle testing, and upper limb volume were recorded. At 12+ months, the Harvard Alumni Health Study Physical Activity Questionnaire, and an Upper Limb Disability Questionnaire were administered. Symptoms and ROM impairments were compared by functional limitations. Characteristics significantly associated with early ROM impairment (but not later impairment) were axillary lymph node dissection, removal of ≥15 nodes, mastectomy surgery and stage II breast cancer. Positive nodes, older age, and BMI ≥ 25 were significantly associated with reduced shoulder ROM at 12+ months. At 12+ months, only 10 % of the patients experienced ROM impairments while rates of self-reported symptoms in the affected upper extremity at 12+ months were as follows: pain-49 %, weakness-47.1 %, numbness-55.9 %, feeling tired-42.5 %. The majority of patients used the affected upper extremity for reaching without limitation, but ≥35 % reported limitation with household chores, carrying and lifting. Difficulty carrying and lifting could be predicted by BMI ≥ 25 and use of the dominant affected upper limb. Different factors are associated with early versus later ROM loss. Symptoms reported by breast cancer survivors are frequently associated with
functional limitations in upper extremity tasks and warrant intervention. Physical therapy using a prospective surveillance model of care may reduce severity of ROM loss, symptoms and functional upper extremity limitations 1 year after breast cancer surgery.


Women's experience of breast cancer is complex, affecting all aspects of life during and after treatment. Patients' perspectives about common impairments and functional limitations secondary to breast cancer treatment, including upper extremity motion restriction, lymphedema, fatigue, weight gain, pain, and chemotherapy-induced peripheral neuropathy, are addressed. Women often report being uninformed regarding these side effects and surprised that they do not always disappear after treatment, but remain part of their lives. Breast cancer patients express strong, unmet needs for education, information, and intervention for these side effects. Evidence suggests that rehabilitation and exercise are effective in preventing and managing many physical side effects of breast cancer treatment. Nevertheless, few women are referred to rehabilitation during or after treatment, and fewer receive baseline assessments of impairment and function to facilitate early detection of impairment and functional limitations. The prospective surveillance model of rehabilitation will serve the needs of women with breast cancer by providing education and information about treatment side effects, reducing the incidence and burden of side effects through early identification and treatment, and enhancing access to timely rehabilitation. Integration of exercise as a component of the model benefits patients at every phase of survivorship, by addressing individual concerns about exercise during and after treatment and highlighting the important contribution of exercise to overall health and survival. The prospective surveillance model of rehabilitation can meet the evident and often expressed needs of survivors for information, guidance, and intervention—thus addressing, and potentially improving, overall quality of life for individuals diagnosed with and treated for breast cancer.

The purpose of this paper is to review the incidence of upper-body morbidity (arm and breast symptoms, impairments, and lymphedema), methods for diagnosis, and prevention and treatment strategies. It was also the purpose to highlight the evidence base for integration of prospective surveillance for upper-body morbidity within standard clinical care of women with breast cancer. Between 10% and 64% of women report upper-body symptoms between 6 months and 3 years after breast cancer, and approximately 20% develop lymphedema. Symptoms remain common into longer-term survivorship, and although lymphedema may be transient for some, those who present with mild lymphedema are at increased risk of developing moderate to severe lymphedema. The etiology of morbidity seems to be multifactorial, with the most consistent risk factors being those associated with extent of treatment. However, known risk factors cannot reliably distinguish between those who will and will not develop upper-body morbidity. Upper-body morbidity may be treatable with physical therapy. There is also evidence in support of integrating regular surveillance for upper-body morbidity into the routine care provided to women with breast cancer, with early diagnosis potentially contributing to more effective management and prevention of progression of these conditions.

**Sport et témoignages**


This narrative review summarizes findings from quantitative and qualitative research literature that has been published over the past 15 years since an initial, community-based pilot study first challenged the long-held medical belief that vigorous, upper-body exercise would lead to lymphedema in women who were at risk due to treatments for breast cancer. Dragon boat racing originated in China more than 2000 years ago and has become a popular recreational and competitive support around the world. From the advent of the world’s first breast cancer survivor dragon boat team, Abreast in a Boat launched in Vancouver, British Columbia, in 1996, there are now more than 140 breast cancer survivor dragon boat teams paddling and competing in 12 different countries. The wealth of quantitative and qualitative research that has ensued since that pilot study
further supports the initial hypothesis that resistance exercise, for example, dragon boat paddling, is not only safe for women recovering from conventional breast cancer therapies but also shows that dragon boating has been embraced as a complementary exercise therapy by the cancer survivors participating in this magical sport.

Lymphœdème


Angiosarcoma that develops on a limb with chronic lymphedema is called Stewart-Treves syndrome. This typically appears as a complication of a long course lymphedema located on the arm, after mastectomy and/or radiotherapy due to breast cancer. There are cases of Stewart-Treves syndrome in chronic lymphedema in the upper limb contralateral to the breast treated for cancer and in chronic lymphedema of the leg. We present two cases of this syndrome. The first corresponds to a typical syndrome of Stewart-Treves in an 83-year-old woman who was diagnosed of angiosarcoma in a chronic lymphedema territory secondary to mastectomy and radiotherapy due to breast cancer. The second case is much rarer, since it is a case of diffuse angiosarcoma of the leg in a 42-year-old man with a history of lymphedema. Due to the aggressive nature of this syndrome, knowledge and research on its treatment are necessary.


The impact of arm morbidity following breast cancer surgery on patient-observed changes in daily functioning and health-related quality of life (HRQoL) has not been well-studied.

To examine the association of objective measures such as range of motion (ROM) and lymphedema, with patient-reported outcomes (PROs) in the arm and breast, upper extremity function, activities, and HRQoL.

The National Surgical Adjuvant Breast and Bowel Project Protocol B-32 was a randomized trial comparing sentinel node resection (SNR) with axillary dissection.
(AD) in women with node-negative breast cancer. ROM and arm volume were measured objectively. PROs included symptoms; arm function; limitations in social, recreational, occupational, and other regular activities; and a global index of HRQoL. Statistical methods included cross-tabulations and multivariable linear regression models.

In all, 744 women provided at least 1 postsurgery assessment. About one-third of the patients experienced arm mobility restrictions. A similar number of patients avoided the use of the arm 6 months after surgery. Limitations in work and other regular activities were reported by about a quarter of the patients. In this multivariable analysis, arm mobility and sensory neuropathy were predictors of patient-reported arm function and overall HRQoL. Predictors for activity limitations also included side of surgery (dominant vs nondominant). Edema was not significant after adjustment for sensory neuropathy and ROM.

Arm mobility and edema were measured simultaneously only once during the follow-up (6 months).

Clinical measures of sensory neuropathy and restrictions in arm mobility following breast cancer surgery are associated with self-reported limitations in activity and reductions in overall HRQoL.


Breast cancer patients have voiced dissatisfaction regarding their education on breast cancer-related lymphedema risk and risk reduction strategies from their clinicians. Informing patients about lymphedema can contribute to decrease their risk of developing the condition, or among those already affected, prevent it from progressing further. In this cross-sectional study, a lymphedema awareness score was calculated based on responses to a brief telephone interview conducted among 389 women diagnosed with invasive breast cancer at Kaiser Permanente Northern California from 2000 to 2008 and had a previous record of a lymphedema-related diagnosis or procedure in their electronic medical record. During the telephone interview, women self-reported a lymphedema clinical diagnosis, lymphedema symptoms but no lymphedema diagnosis, or neither a diagnosis nor symptoms, and responded to questions on lymphedema education and support services as well as health knowledge. Multivariable logistic regression [odds ratio
(OR) and 95% confidence interval (CI)] was used to determine the associations of selected sociodemographic and clinical factors with the odds of having lymphedema awareness (adequate vs. inadequate). The median (range) of the lymphedema awareness score was 4 (0-7). Compared with patients <50 years of age, patients 70+ years of age at breast cancer diagnosis had lower odds of adequate lymphedema awareness (OR 0.25; 95% CI 0.07, 0.89), while patients 50-59 and 60-69 years had greater odds of adequate awareness although not statistically significant (OR 2.05; 95% CI 0.88, 4.78 and OR 1.55; 95% CI 0.60, 4.02, respectively; p for trend = 0.09). Higher educational level and greater health literacy were suggestive of adequate awareness yet were not significant. These results can help inform educational interventions to strengthen patient knowledge of lymphedema risk and risk reduction practices, particularly in an integrated health care delivery setting. With the growing population of breast cancer survivors, increasing patient awareness and education about lymphedema risk reduction and care after cancer diagnosis is warranted.