

Hand Surgery After Axillary Lymph Node Dissection for Cancer

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Objectives

After axillary lymph node dissection, patients are cautioned against interventional procedures to avoid an increased risk of wound and healing complications, in particular lymphedema. However there is little supporting literature and no consensus in regards to recommendations.

The purpose of this study is to evaluate if this group of patients has an increased incidence of postoperative complications, including lymphedema and infection.



Fig 1: A warning sleeve placed on post axillary lymph node dissection patients in the preoperative holding area

Methods

A retrospective review of all patients presenting to our hand clinic from 1998-2011 was completed, selecting those with a diagnosis of breast cancer or melanoma, and a history of axillary lymph node dissection.

Patients who were treated without surgical intervention and those who had elective hand surgery contralateral to their lymph node dissection were excluded.

All patients who fit inclusion criteria were contacted if clarification was required in regards to their medical history.



Fig 2: Elective hand procedures such as this open carpal tunnel release are not recommended

Results

147 patients were identified with a history of breast cancer or melanoma, and 52 were treated for various hand issues. 20 patients (19 females with breast cancer, 1 male with melanoma) had axillary lymph node dissection on the ipsilateral extremity.

Procedures included 7 carpal tunnel releases, 6 trigger finger releases, 4 soft tissue lesion excisions, and 1 each of Dupuytren's release, CMC arthroplasty, scar revision, flexor tendon repair, and foreign object removal. 2 patients had concomitant procedures.

The average age at the time of lymph node dissection was 55.1 years (range 37.5-73.6); average age at the time of hand surgery was 64.5 years (range 41.6-83.5). The time interval between surgeries averaged 8.2 years (range 7 days-37.3 years).

4 of these patients had pre-existing lymphedema. Post operatively there was no lymphedema exacerbation and no new cases of lymphedema.

4 patients had periincisional erythema, requiring oral antibiotics for presumed superficial infection. All patients recovered without further intervention. 2 patients had issues with incisional pain and scarring, each resolving after corticosteroid treatment. No patients required a return to the operating room.

Conclusion

We have shown, in our limited number of patients, that routine minor hand surgery does not result in lymphedema and did not increase existing lymphedema in patients who had a previous ipsilateral axillary lymph node dissection. This study suggests ipsilateral upper extremity surgery may be pursued safely. A large scale, prospective study is necessary before a culture change may be achieved.



Fig 3: Trigger finger release, another common procedure avoided after axillary lymph node dissection