Massage Today

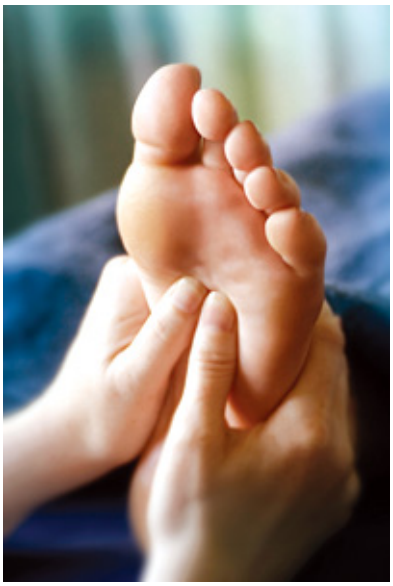
July, 2012, Vol. 12, Issue 07

Additional Insights Into Massage for Peripheral Neuropathy

By Lauren Muser Cates, CMT, S4OM

I have written this as a sort of companion piece to Rita Woods' February article which beautifully explained a protocol to address chemotherapy-induced peripheral neuropathy (CIPN). I use a version of this protocol myself, as do many therapists in the oncology massage community. Much of what Rita shared in the article is good practice and the work that she and Charlotte Versagi have both done in the name of providing massage therapy for people affected by cancer is to be commended. Nevertheless, as the president of the Society for Oncology Massage, I am writing to share some additional background and practical considerations.

I want to start with the assertion about the cause of chemotherapy-induced peripheral neuropathy (CIPN). There is no doubt that many chemotherapeutic agents result in PN, but the exact mechanism is still unknown. There is no clear answer about why certain chemotherapeutic agents cause PN, or even why this protocol works well with PN caused by some agents and not with PN caused by others. The theory Rita proposes is reasonable and is supported by the anecdotal response rate, but the truth is that we really don't know what causes CIPN or why some people get it while others don't.

 Working with a client who is suffering from CIPN is much bigger than simply the feet and/or hands that are affected. Safe application of this protocol with a client who is undergoing chemotherapy requires a good deal of consideration. Even a seemingly basic protocol like this one can have grave consequences for the client with cancer if proper precautions are not taken. When we talk about PN, it's also important to remember that there are other reasons a client affected by cancer treatment may be suffering from PN (tumor-related impingement and surgery-related primary nerve damage to name just two). In addition, there are a number of drugs used to treat cancer (thalidomide, velcade and methotrexate, for example) that do not respond well or at all to this protocol.

In my experience with this protocol, working "to the bone" is unnecessary and, in some cases, unsafe. A variety of cancer-specific concerns come to mind when I consider working this deeply. The four most serious are:

1. Risk of deep vein thrombosis/DVT (treatment for cancer increases a client's risk of developing a blood clot four-fold). Any client undergoing treatment for cancer should be approached with thoughtful consideration of the risk of DVT. Massage therapy that is too vigorous in the area of a blood clot could cause the clot to dislodge, having potentially grave effects.
2. Risk of lymphedema. Many people receiving cancer treatment have had some number of lymph nodes removed and/or exposed to radiation either as part of a diagnostic procedure or part of curative treatment. This removal or damage compromises the lymphatic system putting these clients at lifelong risk for a serious, potentially permanent, protein-rich swelling condition called "lymphedema." Massage therapy that is applied too vigorously can trigger lymphedema.

3. Bone metastases. If a client is living with advanced cancer, there is a possibility that he/she may have what are called "bone metastases." This is when cancer has spread to the bones. It can cause the client pain and make the bones more brittle than normal, thereby increasing this client's risk for fracture and serious discomfort.
4. "Hand and foot syndrome" (another common side effect of chemotherapy). A client who is suffering from hand and foot syndrome may be unable to tolerate even the lightest touch, much less a touch whose aim is to reach a pressure that goes "to the bone." Hand and foot syndrome has periods of "flare up." During a flare, it will be obvious that the client is having a dermatological response to treatment, but between flares, it may not be as obvious. Deep pressure during or between flares would be inadvisable.

It is also important to note (and would be important to communicate to a client) that when CIPN has progressed to the point of total numbness, the application of this protocol will result in the return of pain before the return of normal sensation. Many people describe their CIPN as beginning with tingling and other degrees of paresthesia before it progresses to numbness. For some, it never progresses to numbness. If we imagine the progression of CIPN as a piece of thread going through the eye of a needle, we can imagine this protocol as pulling that thread back through and out of the eye of the same needle. As the protocol begins to take effect, sensation may be returned in reverse order of the way it was lost. Passing back through the eye of the needle, so to speak, can be painful at first.

In addition, it is possible that you may encounter swelling in the extremities. Swelling is a big question mark that can potentially point to serious considerations like vital organ compromise, infection or DVT with any client. When working with a client with a cancer treatment history, this question mark is even bigger.

In closing, it boils down to scope of practice and making good and ethical choices about what is and is not within one's scope. Addressing CIPN is certainly within the scope of practice for a massage therapist with a breadth and depth of knowledge that is appropriate to dealing with a compromised client. It is clearly outside the scope of practice for a massage therapist who does not have this background. It is simply not enough to "just work lightly" (as many therapists say they do with oncology clients) and it is unethical to blindly follow a protocol without a complete understanding of a particular client's medical condition.

Lauren Cates is the current President of the Society for Oncology Massage and an NCBTMB Continuing Education Approved Provider. For additional information related to working with clients with a cancer history, visit the Society for Oncology Massage website at, www.s4om.org. Lauren can be contacted at:

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