Introduction

There is increased number of breast cancer survivors globally because of population growth and advanced in aging. It is estimated that approximately 1.7 million new cases of breast cancer cases diagnosed in 2012; accounting about 12% of incidence of all new cancer cases and 25% of all cancers in women. BC is classified the 5th cause of mortality among women [1]. In several countries, with advanced oncological techniques developed to manage breast cancer; the survivorship rate of early detection of BC was increased from 80% to 90%, falling to 25 percent for BCs detected at advanced stage [1,2]. BC is more prevalent in developed countries, but estimated 55% of breast cancer deaths occur in lower and developing countries [1]. A relative 5-years survivorship have been improved from 80% to 90% in developed countries, to 60% in developing countries, to below 40% in low income countries; within African continent, it may be as low as 11.99% [2].

Democratic Republic of the Congo (DRC) is a low income country located in middle Africa with life expectancy at birth of total 52 years; males=50 years and females=53 [1]. BC mortality profile in DRC reported by World Health Organization (WHO) in 2014 was 16.00%, age standardized incidence rate (ASIR) of 4.570 per 1000 females at risk [1]. The recent data demonstrate that 60% of population living in DRC are women; the most common cancers in prevalence and mortality for women are cervical cancer and BC (Figure 1 & 2 are attached at the bottom of the manuscript show the burden of cancers in DRC), yet there is no screening program for early detection of cancers [1]. A number of breast cancer patients are diagnosed at delayed stage of the condition and the prognostic is likely poor in most of the cases. Although BC treatment, includes surgery, radiation therapy, chemotherapy and hormonal therapy, have improved the outcomes resulting to prolonged survivorship; these techniques have also led BC survivors to potentially suffer from different comorbidities [3]. Many studies have demonstrated that BCRL is the most prevalent comorbidity associated with BC treatments [4-10]. Lymphoedema (LE) is the stasis of lymphatic fluid in interstitial tissues as result of dysfunction related to lymphatic...
system drainage of protein-rich liquid [5]. The consequences of lymphatic fluid stasis can lead to edema and hypoxia which are more observed in peripheral tissues [5]. The affected area can become swollen and distorted in shape [6-10]. This can result in pain, disfigured body parts, heaviness, discomfort, impairment of movement and it impacts on daily activities [11-14]. The details on international Classifications of Lymphoedema and the common symptoms can be found in International Society for Lymphoedema (ISL) guideline [7]. BCRL decreased the Health Related quality of life (HRQOL) and it is a life-long complication and considered the major sequelae associated with BC management [8]. Given that high incidence of BC in DRC with advanced techniques to manage BC; the comorbidities associated with BC management such as BCRL should be increased. However, there is no standardized BC guideline in DRC, the true prevalence and incidence of BC is not known because of lack of cancer registry in each province, data provided in this paper cannot be representative to all DRC. There is a Scare of data on incidence, risk factors and management of BCRL in African countries such as DRC. This review aims to inform all stakeholders on awareness of BCRL among breast cancer survivors in DRC; so the evidence based healthcare approaches can be developed to mitigate BCRL occurrence.

**Methods**

MEDLINE, EMBASE, PubMed and Cochrane breast cancer registry were searched to identify the published articles focused on prevalence, incidence, risk factors and management of BCRL in DRC. MeSH term included: (“breast cancer lymphedema”[MeSH Terms] OR (“breast”[All Fields] AND “cancer”[All Fields] AND “lymphedema”[All Fields]) OR “breast cancer lymphedema”[All Fields] OR (“breast”[All Fields] AND “cancer”[All Fields] AND “related”[All Fields] AND “lymphedema”[All Fields]) OR “breast cancer related lymphedema”[All Fields]) AND (“democratic republic of the congo”[MeSH Terms] OR (“democratic”[All Fields] AND “republic”[All Fields] AND “congo”[All Fields]) OR “democratic republic of the congo”[All Fields]) AND DRC [All Fields].

**Current Status of Knowledge**

One case report of BCRL was reported in the province of Katanga; a female BCRL patient was identified in Hospital of Lubumbashi after 2 years post mastectomy and actually on Tamoxifen 20mg/ daily [15]. The management of BCRL of this patient was not reported on the paper and the authors concluded that there is no evidence based study on this condition in our country, there is lack of an appropriate organized service to manage this type of complications and the prognosis is poor [15]. Although the incident
cases are common in DRC; but there is lack of knowledge related to
diagnosis and management of BCRL in DRC. Furthermore, financial
concern, scare on appropriate materials related to socio-economic
characteristics of the country, these impact in reducing in QOL and
survivorship of BCRL patients [15].

Our review shows that there is lack of data on risk factors,
incidence and management pathway of BCRL in DRC. A number of
barriers were identified through the case report; these including
lack of awareness on BCRL risk assessment, lack of healthcare
workers knowledge in management of BCRL, lack of national
guideline and policy for cancers prevention and control, lack of
specialized facilities in lymphedema management and socio-
economic determinants of the country are more concerned [15].
This condition need awareness of health systems providers and
policy makers for it prevention.

The incidence of LE among women undergoing BC treatment
varies from 6% to 83% in literature [6]; the pooled incidence rate
of LE reported in recent systematic review was 40% in 2010 [9].
BCRL incidence increases with the time since the diagnosis period.
The incidence rates of LE can be under or over reported because of
lack of standard protocol for diagnosis and measurement tools [9].
Further, the incidence of BCRL depends on the number of nodes
removed during the breast surgery, types of BC treatment and the
techniques used to measure LE volume [13].

There is a possible inaccuracy related to risk factors of the BCRL
in many studies. The notable predictor of LE is extended BC surgery;
this including axillary lymphatic node dissection and number of
lymphatic nodules removed [9]. Other study have revealed that
radiotherapy is associated with increased risk of developing BCRL
[9], but other studies did not find the association between LE and
radiation therapy [13, 14]. This contradiction may be partially
related to radiation doses used to treat the patients [9]. Of the clinical
parameters associated with high risk to develop BCRL, the elevated
body mass index (BMI>25), being obese (BMI>30) are the most
consistent risk factors to LE [13, 14]. In addition, positive lymphatic
nodes and advanced stage of diseases are also reported in the
review [15]. Moreover, recent development in molecular analysis
demonstrated that congenital lymphatic system dysfunctions can be
associated with various candidate genes to be established in early
onset of LE for it prevention or management [15]; these including
genes FLT4, FOXC2, HGF, GJC2 and SOX-18 [15]; American African
women has also been reported being associated with BCRL risk
factors in one pathway study [14]. In contrast to one review, such
association was not statically significant. Growing in age, high level
of education and socioeconomic indications were found to be both
risk factors and risk reduction in some studies [9]. ISL purposes to
promote all activities associated with knowledge translation in the
field of lymphedema management, establishes relationship between
researchers and clinicians working in the field of lymphology as
well as allied healthcare workers [7]. ISL provides the platforms to
exchange the ideas with different experts in lymphology field and
collaborate with other national and international organizations
[7]. Further, ISL also organizes international congresses yearly and
postgraduate training in lymphology and wound care [7].

Table 1: BCRL risk assessment.

| The following questions are about your experiences with movement on your affected body side today or in the past three month. The word “affected” means the same body side(s) on which you received breast surgery or radiation. |
| --- |
| On which body side was your cancer treated? | Right: ☐☐☐☐ left: ☐☐☐☐ |
| Do you have limited movement of your affected? | How severe? |
| NO=0 | A little=1 | Somewhat=2 | Quite a bit=3 | Very Severe=4 |
| 1. Shoulder | |
| 2. Elbow | |
| 3. Wrist | |
| 4. Fingers | |
| The following questions are about symptoms in your affected arm, hand, breast, axilla (under arm), or chest today or in the past three month. |
| How Severe? |
| Have you had ___? | NO=0 | A little=1 | Somewhat=2 | Quite a bit=3 | Very Severe=4 |
| 5. Swelling | |
| 6. Breast swelling | |
| 7. Chest wall swelling | |
| 8. Firmness | |
| 9. Tightness | |
| 10. Heaviness | |
| 11. Toughness or thickness of skin | |
| 12. Stiffness | |
13. Tenderness
14. Hotness/increased temperature
15. Redness
16. Blistering
17. Pain
18. Numbness
19. Burning
20. Stabbing
21. Tingling
22. Arm or hand fatigue
23. Arm or hand weakness
24. Pocket of fluid develop

Table 2: International classification of lymphedema: 2013.

| Stage 0 (subclinical)          | Stage 1                      | Stage 2                           | Stage 3                           |
|-------------------------------|------------------------------|-----------------------------------|-----------------------------------|
| Swelling is not yet evident, despite the impaired lymphatic system. | Early fluid accumulation that subsides with limb elevation. | Swelling is constant and does not resolve using elevation, and pitting is evident. | Pitting may be absent, although trophic skin changes have developed. |

Various methods can be found in literature which can be used to diagnose or to measure BCRL and its incidence varies according to the methods used, such as circumferential limbs measurements, perometry, bioimpedance Spectrometry (BIS) and water displacement [9,16]. BIS is considered gold standard for LE diagnosis [14]; although; the review advocates that perometry should be more accurate than BIS, but the level of evidence for perometry still need to be established [16]. Table 1 & 2 at the bottom of the manuscript show the most common symptoms considered for LE diagnosis and ISL staging of LE respectively.

LE is does not have a curative treatment; the Complex Decongestive therapy (CDT) is considered the standard care internationally for LE management but the level of evidence is not yet established for each component of this intervention [16,17]. CDT enhances limb functions, maintains arm volume, reduces swelling and pain, and minimize disfiguration of the body shape. It includes four components: Manual Lymphatic Drainage (MLD), compression sleeves, remedial limb and deep-breathing exercises to promote venous and lymphatic flow and patient self-care. There are 2 CDT phases: the intensive phase includes all 4 components provided by LE therapists; in maintenance phase or secondary phase of CDT, a patient practices MLD assisted by physiotherapists or a trained care giver and skin care to prevent infections; this last phase is life-long therapy [17]. Additionally, maintenance phase of CDT is challenged for the patients to monitor and practice self-care which is associated with noncompliance and can result to increase LE volume; recommended exercises purpose to restore range of motility (ROM) and to strength of affected limbs. There is inconsistency on exercise prescription and use of MLD; as the result there is lack of standardized exercise protocol for different stages of BCRL. Moreover; providing patients education on LE risk reduction among patients at risk was proved effective in improving a quality of life [17,18]. This risk reduction program including lifestyle interventions (eating healthy foods and participation in weekly regimen of supervised exercises) to be combined with CDT at maintenance phase of the treatment [19-23].

Conclusion

There is scarce of data on BCRL risk factors and management in DRC. No evidence based standardized guideline have been developed to date to assess the efficacy of a number of treatment options implemented in developed countries. More studies are needed to extend the knowledge, skills, and awareness of secondary lymphoedema throughout all the stakeholders. BCRL is life-threatening condition associated with breast cancer management. Patient education on risk reduction strategies such as lifestyle, proactive risk factor managements, and developing specialized services with acquainted healthcare providers in lymphoedema management pathway should improve patients HRQOL. Cancer registry and innovative clinical studies should be conducted to mitigate its occurrence. The following recommendations are addressing to healthcare providers, researchers, policy makers and the funders:

A. Organisation of undergraduate and postgraduate training in cancer rehabilitation, especially in physiotherapy.
B. Provide evidence based research platforms to inform healthcare providers and patients on awareness of LE.
C. Develop a national cancer clinical guideline and surveying database to inform all stakeholders on impact of BCRL.
D. Develop the preclinical diagnosis (gene expressing) for lymphoedema prevention.
What is already known on this Topic?

BCRL is a common side effect associated with breast cancer management, and it can have a huge impact on patients’ quality of life around the world. The healthcare providers should be able to identify onset symptoms of BCRL, provide patients education on BCRL risk reduction, refer patients to specialized services for compression therapy, breast surgery, radiation therapy, or hormonal therapy, and chemotherapy. Age, menopausal status, high body mass index, and genetic predispositions are the most consistent risk factors for breast cancer-related lymphedema development.

What this Study Adds?

Many healthcare providers in the DRC are not aware of risk factors and management of breast cancer-related lymphedema. Complex Decongestive Therapy is the standard of care for lymphedema internationally, and it comprises four components: manual lymphatic drainage, compression sleeves, decongestive exercises, and self-care. In addition, many countries lack their own guidelines for lymphedema such as DRC. There is no curative treatment for BCRL at clinical stage; genotyping is recommended for BCRL risk prediction among patients at highest risk.

Authors’ Contribution

A. Designing, search strategy, writing, critical appraisal, edition, and collaboration with other experts;
B. Designing figures, tables and critical appraisal, edition and search strategy;
C. Designing figures, tables and critical appraisal, edition and proofreading;
D. Design, search strategy, writing, and critical appraisal, edition and collaboration with other experts.

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