Start Here | The 9-hour-25-minute professional MLD refresher

Audience: a therapist who has previously completed relevant MLD training and wants structured revision, updated safety knowledge, method-specific skill feedback and a return-to-practice plan. **Not a new qualification.**

How to use this private course

1. Set aside **565 minutes** across several study sessions. This is guided reading, observation, written assessments and supervised practice time; **it is not 9 hours of narrated video**. Additional educator time may be needed.
2. Print the **Red-Flag / Stop-Sign Card**. Complete Modules **1–3** before any volunteer practice. Passing Module 3's safety test is mandatory.
3. Have the illustrated atlas beside the relevant lesson. These are original educational schematics, not medical treatment pathway maps; anatomical and hand-position accuracy require educator review.
4. Use the Module 4 video list to observe movement quality. Verify the links and obtain corrections from a suitably trained instructor. A video cannot assess pressure or manual competence.
5. Use the supplied **Client Screening**, **Session Documentation**, **Home Visit** and **Competency** forms. Use fictional information in exercises. Protect actual health records.
6. Do Modules 5 and 6 as structured role-plays and approved healthy-volunteer skill stations only. Defer any unscreened, swollen or medically complex client.
7. Finish Modules 7–8 and assemble the competency portfolio, credential checks, insurer confirmation and plan for hands-on sign-off.

Exact course timing

Module	Subject	Time	Completion evidence
1	Modern MLD / CDT	45 min	Six-question evidence and scope check
2	Applied anatomy	45 min	Annotated diagram and oral teach-back
3	Red flags and referral	75 min	Six case triage and 100% critical-safety answers
4	Vodder technique review	120 min	Five movement observation and feedback records
5	Complete client session	75 min	Mock enquiry, consent, SOAP note, home checklist
6	Regional practice	100 min	Six safe station records, educator observations
7	Conditions and evidence	60 min	Referral/marketing claims audit
8	Return-to-practice	45 min	Portfolio and two-/six-week plan
	TOTAL	**565 min (9 h 25 min)**	**Educational learning only**

Illustrated visual reference index

Find the diagrams within each module, or use the standalone atlas.

Module 01	**Plate 01**	CDT / DLT overview and 2026 source-check note
Module 02	**Plates 02–05**	Whole-body anatomy, microanatomy, watersheds, limb landmarks
Module 03	**Plate 06**	Stop / defer / go screening pathway
Module 04	**Plates 07–09**	Skin stretch, Vodder movement shapes, common faults
Module 05	**Plates 10–11**	Client session and table / bolster arrangement
Module 06	**Plates 12–13**	Six anatomical regions and altered lymphatic networks
Module 07	**Plate 14**	Indications, exclusions and referral boundaries
Module 08	**Plate 15**	Staged 2-week / 6-week practice development

Instruction

Educational schematics only. A qualified instructor must verify technique.

Before you begin

- Locate original MLD course evidence and current relevant professional registration.
- Check your indemnity cover for massage, home visits and specifically proposed lymphatic services.
- Identify an appropriately trained Vodder/MLD educator who can observe pressure, stroke orientation and safety decisions.
- Read the distinction between gentle wellness within scope and specialist CDT/clinical lymphoedema care.
- Be ready to decline or refer new or unexplained oedema, cardiac-related fluid, sudden unilateral swelling, possible infection and altered cancer-treatment pathways.

Reference atlas index

Plate	Illustration	Module
01	Four components of CDT	1
02–05	Whole-body nodes, lymphatic microanatomy, watersheds, limb regions	2
06	Triage and red-flag decisions	3
07–09	Skin stretch and five movement-family mechanics	4
10–11	Appointment steps, bolstering and safe setup	5
12–13	Regional study and changed lymphatic pathways	6
14	Conditions / indications / referrals	7
15	Two-/six-week practice sequence	8

Required sign-off rules

Written knowledge: Mark each module's answers; for Module 3, no missed urgent DVT, PE, infection or heart-failure decision is acceptable. **Practical technique:** An approved instructor should observe and document the five movement families and the regions intended for real use. **Clinical scope:** Specialist lymphoedema, cancer-related drainage, compression prescription and complex postoperative treatment require separate relevant qualifications and professional registration. A written completion statement does not mean certified clinical competence.

Useful first references

- ISL 2023 consensus: https://pubmed.ncbi.nlm.nih.gov/39207406/
- NHS lymphoedema treatment: https://www.nhs.uk/conditions/lymphoedema/treatment/
- BLS 2026 MLD position edition listing: https://www.thebls.com/documents-library/british-lymphology-society-manual-lymphatic-drainage-position-document
- LAOSA: https://www.laosa.co.za/

Workbook prepared 11 November 2026. Verify changes to professional registration rules and specialist clinical guidelines before clinical use.

MANUAL LYMPHATIC DRAINAGE | PROFESSIONAL REFRESHER

MODULE 01 OF 08

Modern MLD and CDT

Guided learning: **45 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Hands of Wellness & Kinetic Flow | Centurion, Gauteng | Educational draft for qualified MLD/CDT educator review, not certification.

Module 1 — What has changed since older MLD training (45 minutes)

Safety context

Never assume that swelling is caused by an isolated lymphatic problem. Clinical investigation, not massage, establishes its aetiology. This refresher does not provide a universal oedema treatment pathway.

Goals

Explain the contemporary distinction between wellness treatment and MLD/CDT; describe the phases of lymphoedema care; recognise changes to consent, documentation and evidence.

The major change: a technique within a system of care

The 2023 International Society of Lymphology (ISL) consensus provides a multidisciplinary management framework. The NHS outlines decongestive lymphatic therapy as compression, movement/exercise, skin care and specialised MLD. Specialist services often describe an intensive reduction phase and a maintenance phase that relies heavily on self-management. Correctly performed manual technique matters, but alone it does not constitute CDT. The choice and safety of compression require professional assessment and suitable training.

Earlier emphasis	Updated approach
Memorise manual sequences	Screen and explain the diagnosis and clinical goal first
MLD presented as central treatment	Compression, movement, skin health and self-management commonly play major roles
Routine lymphatic directions	Individual assessment when lymph nodes are removed or tissues irradiated
Little written documentation	Document screening, consent, response, advice, referral and plan
Simplistic detoxification claims	Avoid claims unsupported by clinical evidence

What evidence says

MLD is used in specialist lymphoedema care but is not a cure. Additional limb-volume benefit beyond compression is inconsistent across studies; some groups may benefit and comfort outcomes may matter, but MLD should not be marketed as uniformly effective. The 2024 lipedema guidance does not support MLD alone as a method of reducing lipedema volume. Statements about clearing toxins, strengthening immunity, or treating cardiac swelling should be removed.

MLD versus SLD

Specialist MLD is delivered by a suitably trained practitioner. Simple lymphatic drainage (SLD) is an individually taught self-management variant, not a teaching model for professional strokes. An SLD video must never be substituted for a Vodder practical assessment.

Safety culture, communication and privacy

Use explicit treatment aims, informed consent, documented health screening, appropriate referral, minimal necessary health data, confidentiality and safe storage. In South Africa, handle health information according to applicable POPIA obligations. Discuss only necessary clinical details when communicating with other practitioners, with appropriate consent or lawful basis.

Knowledge check

1. Why does MLD alone not constitute CDT? 2. Why is newly swollen tissue a screening problem rather than an automatic indication? 3. What is the role of compression and exercise in modern lymphoedema care? 4. Why must marketing avoid detoxification and universal postoperative claims? **Pass:** explain all four in your own words.

Modern CDT: four connected components

A clinical framework, not a claim that MLD alone treats oedema.

1 Compression

Clinical selection and fit; not prescribed by routine massage.

2 Exercise and movement

Graded activity and muscle action support fluid control.

CDT

3 Skin care

Skin integrity, infection prevention and recognition.

4 Specialist MLD / SLD

Selected use, measured benefit and individual self-management.

2026 source update

The British Lymphology Society lists a 2nd edition of its MLD Position Document (25 August 2026). Check the latest edition with your clinical educator before teaching clinical recommendations.

Expanded guided workshop | Module 1

Timed lesson plan (45 minutes)

Segment	Duration	What to produce
Read the 2023 ISL / NHS core concepts	12 min	A five-line explanation of why MLD is not CDT
Compare historical versus contemporary practice	10 min	Mark five changes that matter in Nicky's work
Build a four-component CDT concept map	8 min	Label what belongs to a specialist pathway
Write a boundary statement for each business	8 min	Two short, non-medical descriptions
Complete and mark the knowledge check	7 min	Written answers with corrections

Guided reading: what the evidence actually changes

The 2023 International Society of Lymphology consensus and NHS treatment guidance are the starting points for this refresher. The consensus is not a recipe for a single technique. It recognises different patient populations, available therapies and limitations in the research. NHS guidance describes four elements of decongestive lymphatic therapy: compression, skin care, exercise and specialised manual techniques. A returner should therefore ask not merely *can I do a stroke?* but *what is the diagnosis, clinical goal, treatment team and evidence for adding this stroke?*

The British Lymphology Society's September 2024 position document makes a deliberately cautious statement about MLD: high-quality evidence for routine addition of MLD to lymphoedema care is insufficient; clinical benefit should be assessed and continued only where demonstrated. Do not interpret this as saying MLD never helps, nor as approval to market it as a universal answer. A wellness client reporting deep relaxation may have a meaningful personal outcome, but that is not proof of reduced limb volume, toxin clearance or immune enhancement.

The words *opening nodes*, *clearing the terminus* and *moving toxins* can create misleading mental models. Normal lymph flow involves endothelial uptake, one-way valves, active collecting-vessel contractions, movement and respiratory influences. In a person with intact lymphatics, gentle hand movements can be practised for mechanics. In a person after node removal, the regional lymphatic network and its capacity may differ. Neither a normal-anatomy arrow nor a casual online routine tells the therapist where lymph should be directed in that person.

Worked example: a request for 'drainage'

A caller says: 'I am 68, my ankles are swollen most evenings, and I think I need lymphatic drainage.' An unsafe reply would be to quote an MLD package and assume ageing or sitting causes the problem. The updated reply is to explain that swelling can have several causes, ask about sudden change, asymmetry, pain, skin heat, breathlessness, heart or kidney disease and recent medication changes, then refer for an appropriate medical assessment before accepting an oedema-treatment booking. The therapist can still offer separately suitable relaxation work at a different time, but should not relabel swelling treatment as wellness.

Task 1 — then / now audit (10 minutes)

Fill in the right-hand column with your own professional action, not a slogan:

Old habit or phrase	Updated action to write down
'I do lymphatic drainage for all swelling.'	State referral rule and distinguish indication

Old habit or phrase	Updated action to write down
'Clear the groin nodes first.'	Do not use an anatomical instruction without a validated indication and pathway
'MLD gets rid of toxins.'	Use a defensible description of gentle contact and comfort
'One consultation note is enough for repeat sessions.'	Update symptoms, consent and adverse-event screening each visit
'I used to know this stroke.'	Demonstrate correct mechanics to an instructor before treating

Task 2 — draw a CDT map (8 minutes)

Draw a four-part circle labelled **compression, movement, skin care, specialised manual care**. Around it write **assessment, self-management, measured outcomes and interdisciplinary communication**. Place a boundary across the circle: which tasks can a massage therapist safely discuss, and which require a lymphoedema-trained registered clinician? Include the distinction between education about compression and prescribing a compression garment. Cross-reference Atlas Plate 01.

Task 3 — write two ethical service descriptions (8 minutes)

For Hands of Wellness, draft a two-sentence description of gentle, screened comfort-focused massage that does not promise clinical fluid reduction. For Kinetic Flow, draft a sentence explaining how older adults with new swelling are referred rather than automatically treated at home. Review the wording for any suggestion that a 9-hour refresher equals a clinical qualification.

Knowledge check (7 minutes)

Q1. List the four components commonly described in DLT/CDT.
Q2. Does MLD alone equal CDT? Explain in one sentence.
Q3. What new clinical detail most strongly changes a routine arm sequence after cancer treatment?
Q4. Why is reporting relaxation not equivalent to reporting lymph-volume reduction?
Q5. Does a completed refresher automatically expand AHPCSA scope or establish LAOSA recognition?
Q6. Name two data elements that should be updated at each appointment.

Answers and marking rationale

1. Compression, skin care, exercise/movement and specialised manual techniques, with assessment and self-management woven throughout.
2. No; CDT is a broader, clinically assessed programme and usually includes compression and ongoing self-care.
3. Previous lymph-node removal or radiotherapy and the resulting need for individualised lymphatic assessment.
4. Subjective comfort is a different endpoint from measured limb volume or objective clinical benefit.
5. No; registration, current competence and recognised specialist training must be confirmed separately.
6. Examples: new symptoms or swelling; medication or diagnosis changes; contraindications; consent; response to the previous treatment.

Mastery standard: All six correct, with no unsafe statement about cancer pathways or cardiac oedema. Make corrections on the printed worksheet before Module 2.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- ISL 2023 consensus: https://pubmed.ncbi.nlm.nih.gov/39207406/
- NHS DLT four components: https://www.nhs.uk/conditions/lymphoedema/treatment/
- BLS 2024 and 2026 MLD position documents (verify latest text): https://www.thebls.com/documents-library/british-lymphology-society-manual-lymphatic-drainage-position-document

> **Professional boundary:** illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

MODULE 02 OF 08

Applied Lymphatic Anatomy

Guided learning: **45 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Module 2 — Practical lymphatic anatomy (45 minutes)

Safety first

Watershed arrows are a teaching model for largely intact superficial drainage. They are not a personal treatment map after surgery, radiation, congenital malformation, infection or thrombosis. Do not use a generated diagram to select collateral routes.

Core physiology in therapist language

Tissue fluid is continuously exchanged between microvessels and interstitium. Initial lymphatic capillaries take up fluid and macromolecules; collecting lymphatic vessels have valves and contractile segments that assist transport. Regional nodes contribute to immune surveillance. Lymph ultimately returns to venous circulation near the base of the neck. Intrinsic vessel contractions, bodily movement, respiration and pressure variations influence transport; there is no single lymphatic heart.

Landmarks to know

Head and neck: regional cervical and submandibular lymphatic groups; delicate structures and the carotid vessels require exceptional caution. **Upper limb:** superficial collecting pathways and axillary group. **Lower limb:** superficial collectors, popliteal and inguinal regions. **Trunk:** approximate vertical and horizontal watersheds and axillary/inguinal territories. **Deep lymphatics:** distinct from the superficial structures contacted in classical MLD.

Visual briefs and generation prompts

Visual A — Whole-body anatomy. Diagram: front and back neutral adult silhouettes with superficial green collecting vessels; cervical, axillary, inguinal and popliteal nodes; thoracic duct and right lymphatic duct. **Prompt:** “Medically accurate neutral adult anterior and posterior lymphatic anatomy line drawing, white background, muted green collecting vessels, labelled cervical axillary inguinal popliteal lymph nodes, thoracic duct and right lymphatic duct, professional British English labels, no massage hand arrows, academic poster.”

Visual B — Skin microanatomy. Diagram: superficial capillary, interstitial compartment, initial lymphatic capillary, collecting lymphatic with valves. **Prompt:** “High-resolution instructional medical cutaway of skin showing interstitial fluid exchange and initial lymphatic uptake; collecting lymph vessel with one-way valves and lymphangion; restrained colour palette; no unproven physiology.”

Visual C — Intact trunk drainage territories. Diagram: trunk quadrants with midline and approximate horizontal watershed, axillary/inguinal node groups. **Prompt:** “Anterior and posterior adult torso educational schematic with normal superficial lymphatic watershed regions; distinct soft pastel territories, no post-operative routing arrows, warning caption ‘Not a treatment map after surgery or radiotherapy’.”

Visual D — Altered anatomy. Diagram: intact routes beside post-node-removal schematic, without asserting exact collateral pathways. **Prompt:** “Two-panel anatomical teaching comparison: intact regional lymphatics versus a diagram with axillary node excision marked and uncertain potential collateral pathways shown as dotted question-mark lines; do not invent exact rerouting, clinical assessment required.”

Visual E — Upper limb. Prompt: “Accurate superficial lymphatic anatomy of an intact healthy upper limb, anterior and posterior views, axillary nodes labelled, no treatment steps.”

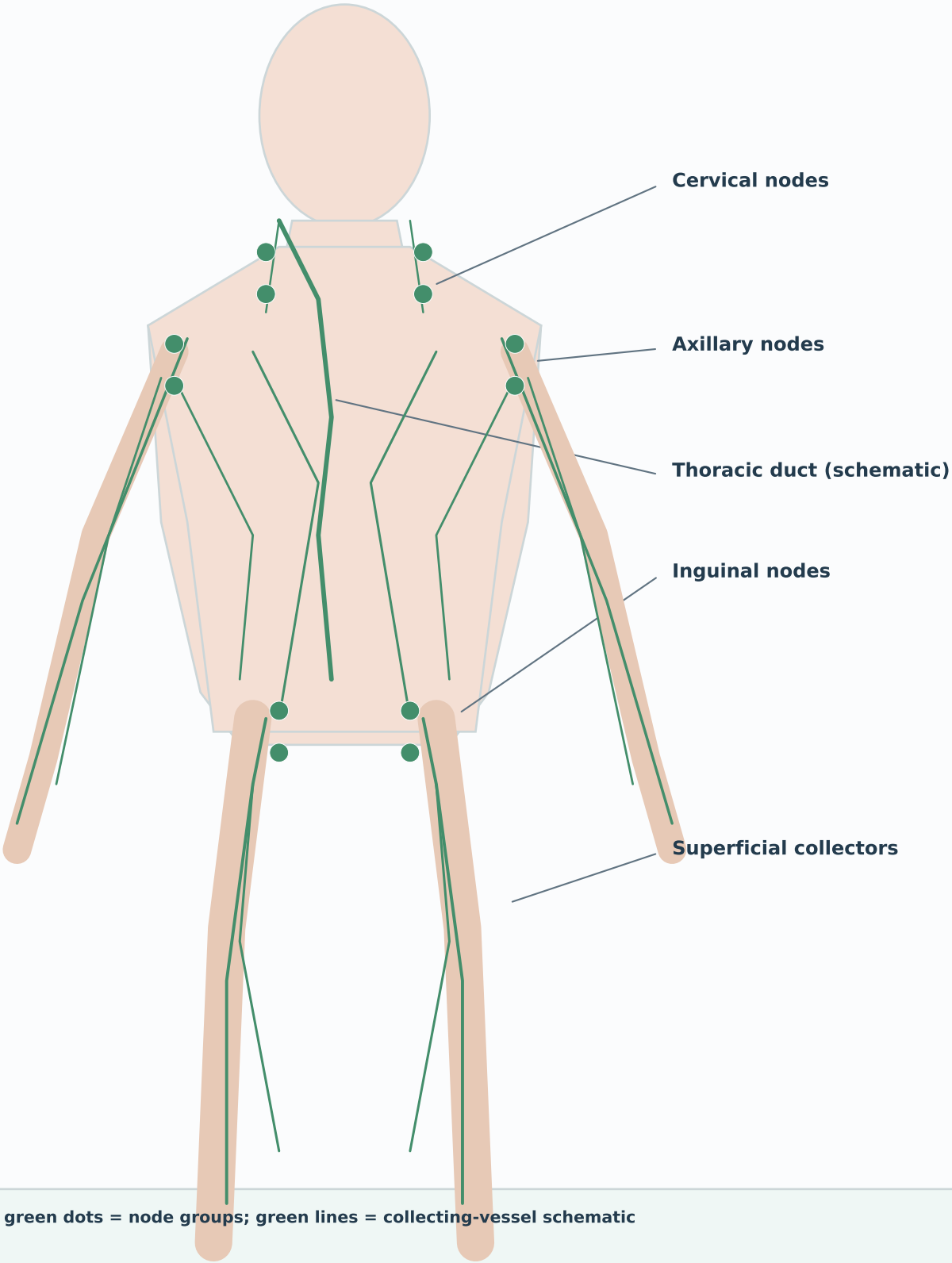
Visual F — Lower limb. Prompt: “Accurate superficial lymphatic anatomy of an intact healthy lower limb, anterior and posterior, inguinal and popliteal landmarks, no claim of clinical drainage routes.”

Practical exercise

Label a blank silhouette with major node groups, ducts and watersheds. Explain why nodes cannot be mechanically ‘emptied’ and why deep pressure is not the same as skin stretching. **Pass:** identify all principal structures and state the limits of a normal-anatomy diagram.

Whole-body lymphatic orientation

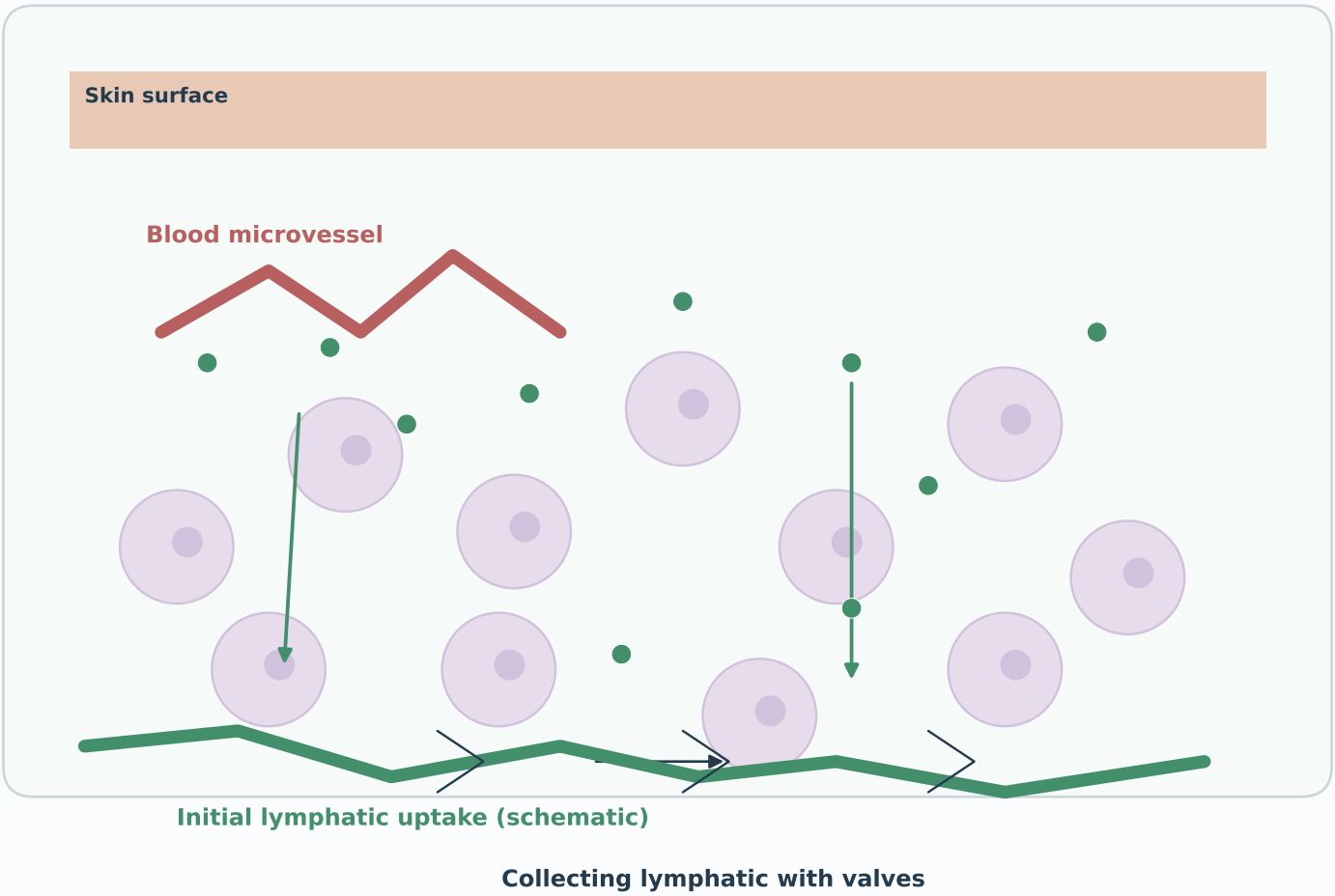
Illustrative superficial collectors, node groups and major venous return.



Key: green dots = node groups; green lines = collecting-vessel schematic

From interstitial fluid to lymph

A simplified functional view of capillaries, initial lymphatics and collecting vessels.



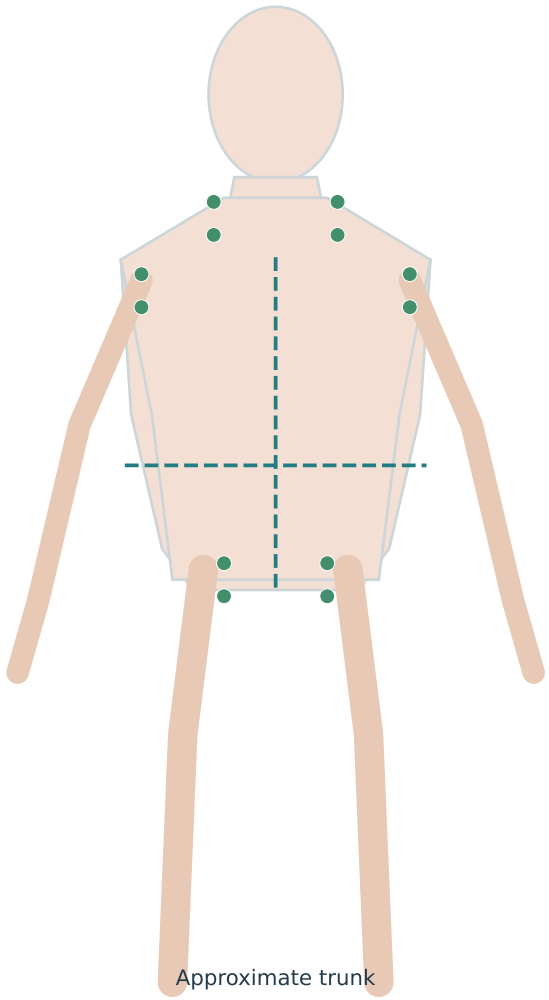
Clinical relevance

Classical MLD uses controlled superficial skin displacement; the drawing does not imply that deeper pressure forces vessels to drain.

Trunk watersheds and altered pathways

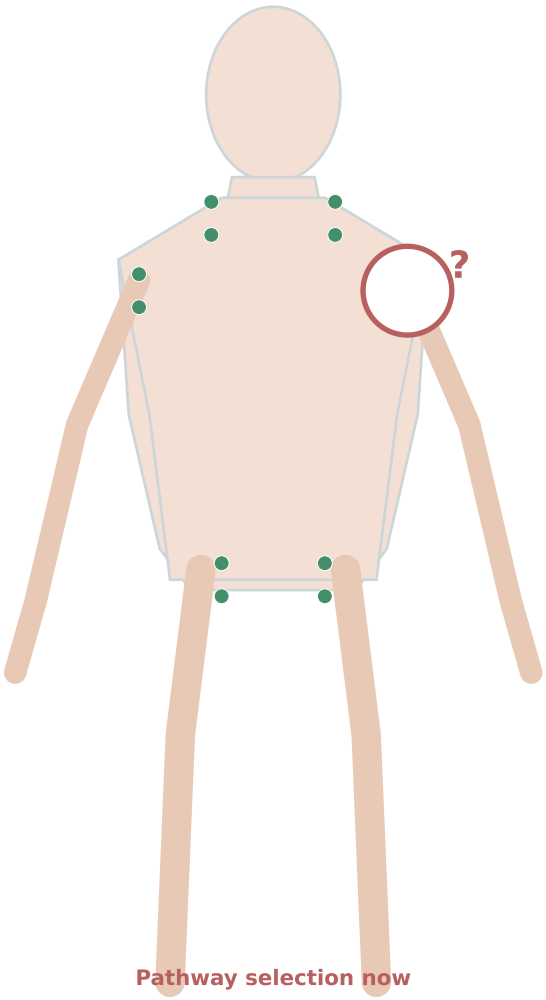
Normal territories are teaching concepts, not individual treatment maps.

Intact anatomy (simplified)



Approximate trunk watersheds

After node surgery



Pathway selection now

requires specialist assessment

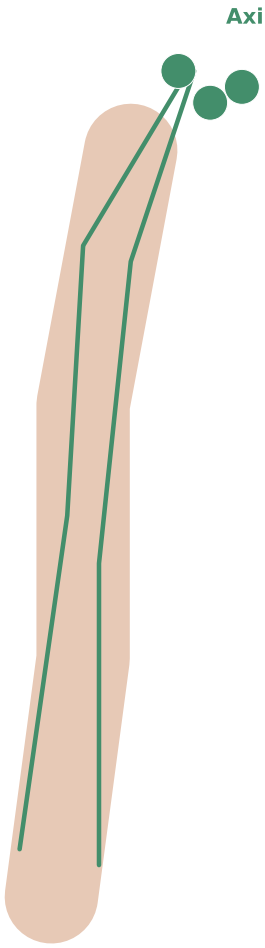
Never infer a route from an arrow

Node removal, radiotherapy, infection or congenital variants may alter drainage.

Upper- and lower-limb landmarks

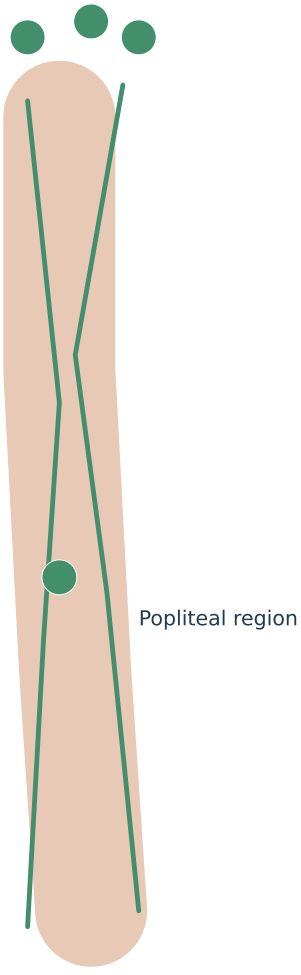
Educational recognition of intact superficial networks; no treatment direction prescribed.

Upper limb



Schematic superficial collectors

Lower limb



Safety reminder

Any new unilateral limb swelling or signs of infection/clot require assessment.

Expanded guided workshop | Module 2

Timed lesson plan (45 minutes)

Activity	Duration	Evidence
Read core anatomy and view Plates 02–03	10 min	Explain the fluid pathway aloud
Label a blank whole-body diagram	15 min	Main structures correctly located
Watershed and altered-pathway comparison	10 min	Four correct safety observations
Five-minute teach-back	5 min	Explain lymph versus venous return
Mini-test and self-correction	5 min	Five answers marked

The fluid pathway, in terms useful at the treatment table

Capillary blood filtration contributes to interstitial fluid. Lymphatic capillaries begin as specialised blind-ended structures that take up fluid and molecules from tissues. Collecting vessels have valves and segments capable of rhythmic contraction. Larger collecting networks pass through regional nodes and trunks before returning lymph to the venous circulation near the venous angles. The lymphatic system is both a fluid-transport and immune-surveillance network; lymph nodes are not bags to squeeze empty. Exercise and breathing may support transport but cannot substitute for diagnosis of oedema.

The distinction between *superficial* and *deep* lymphatics matters. MLD's classical hand mechanics are gentle and primarily engage the skin and superficial tissues. A therapist cannot reach deeper lymphatic structures by adding force. Pressure over a swollen limb, an arterial or venous structure, a surgical site or a node basin is not automatically effective because it is over a 'lymphatic point'.

In the healthy upper limb, superficial drainage commonly reaches axillary territories, but individual anatomy and connections vary. Lower limbs involve inguinal and some popliteal pathways. The trunk has approximate drainage territories and watersheds, illustrated in teaching charts as boundaries. A boundary is a model, not a wall or a personal treatment prescription. Surgical removal of nodes, radiotherapy, advanced disease or injury changes what can safely be assumed. The clinical therapist may need specialist assessment and sometimes imaging to plan individual collateral pathways.

Practical anatomy drill: blank diagram

Print Atlas Plates 02, 04 and 05. Cover their labels with sticky notes or use a blank body outline on paper. In 15 minutes locate: (1) cervical lymph-node region; (2) venous angles; (3) right upper-quadrant lymphatic return concept; (4) thoracic duct; (5) axillary groups; (6) inguinal groups; (7) collecting vessels in the arm; (8) collectors in the leg; (9) superficial anterior trunk watershed; (10) posterior trunk territories. Use a different colour to circle any anatomical relationship that varies between people.

Check against the atlas. If unsure of a location, mark it **verify with educator** rather than guessing. Make a second drawing containing only the *major* structures. A simplified diagram that is correct is better than a detailed but clinically misleading one.

Tissue-level observation exercise

Compare Atlas Plate 03 with your handwritten description of the following pathway:

1. A portion of filtered fluid remains in the interstitium.
2. Initial lymphatic vessels take up fluid and material.
3. Collectors with valves and contractile segments carry lymph through the network.
4. Regional lymph nodes form part of immune surveillance.
5. Major ducts return lymph to the venous circulation.

Now add a line explaining why forceful kneading is not a shortcut to deeper lymphatic transport. Add one line explaining why MLD should not be marketed as removing 'toxins'.

Watershed exercise: intact versus altered (10 minutes)

Compare the intact and altered-pathway illustrations (Atlas Plates 04 and 13). Mark **true** or **false** and explain each decision:

- A normal trunk diagram is a reliable individual map after mastectomy and axillary dissection.
- An approximate watershed is useful for conceptual regional orientation.
- Contralateral drainage is always safer when an axillary group has been removed.
- A therapist should ask about radiotherapy and lymph-node removal during screening.
- Regional lymph-node location gives permission to apply deep pressure over that node group.

Correct logic: False; true; false; true; false. The crucial point is that a diagram can support understanding without establishing a safe patient-specific route.

Five-minute teach-back

Explain to an imaginary trainee why fluid can accumulate even when some lymphatic vessels remain present; why valve function and pumping matter; how skin and muscle differ as contact targets; and why new unilateral swelling needs medical assessment rather than extra drainage.

Mini-test (five minutes)

Q1. Where does lymph rejoin the blood circulation?
Q2. What do collecting-vessel valves contribute?
Q3. Name two major superficial regional node groups.
Q4. Is a watershed illustration an adequate post-cancer treatment map?
Q5. Does stronger massage necessarily produce better MLD?

Answers: 1. Venous junctions near the base of the neck. 2. Support one-way transport. 3. Cervical, axillary or inguinal are examples. 4. No; clinically altered anatomy requires individual assessment. 5. No; Vodder-style skin engagement is gentle and does not equate force with efficacy.

Pass standard: Correct identification of the node groups and all three high-risk misconceptions corrected. Repeat anatomy orientation before any practical lesson if uncertain.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- ISL 2023 consensus: https://pubmed.ncbi.nlm.nih.gov/39207406/
- NHS physiology and treatment orientation: https://www.nhs.uk/conditions/lymphoedema/treatment/
- Dr Vodder School supervised education: https://www.vodderschool.org/training_program_basic

> **Professional boundary:** illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

MANUAL LYMPHATIC DRAINAGE | PROFESSIONAL REFRESHER

MODULE 03 OF 08

Screening, Red Flags and Referral

Guided learning: **75 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Module 3 — Screening, contraindications and referral (75 minutes)

Mandatory triage before any hands-on work

GO: healthy, stable, well-screened client with a wellness aim; within current competence and professional scope; informed consent obtained. **CAUTION/DEFER:** recent surgery, existing cardiac/renal/vascular disease, ongoing oncology care, unexplained or chronic swelling, altered lymph anatomy, anticoagulation, fragile skin or uncertain diagnosis. Seek suitable clinical advice and refer. **STOP/REFER:** suspected acute DVT/PE, cellulitis, lymphangitis, rapidly worsening oedema, severe systemic illness, unstable heart failure, acute renal failure or suspected superior vena cava obstruction. Urgency depends on symptoms; emergencies require immediate medical services.

Presenting issue	Decision and action
Sudden painful one-sided calf or arm swelling, warmth or colour change	No MLD. Urgent same-day DVT assessment.
Chest pain, sudden breathlessness, coughing blood, fainting or collapse	Emergency response; no manual treatment.
Fever with painful, hot, expanding skin change	No MLD. Prompt evaluation of infection/cellulitis.
Breathlessness with rapidly worsening leg swelling or suspected acute heart failure	No MLD; urgent medical assessment.
Severe/unexplained generalised oedema, marked deterioration	Defer; appropriate medical assessment.
Known/possible superior vena cava obstruction	No MLD; specialist urgent review.
Recent surgery with wound, drain, pain, anticoagulation or swelling	Surgical clearance and practitioner-specific competency; generally refer for postoperative lymphatic care.
Lymph-node removal/radiotherapy or diagnosed lymphoedema	Specialist lymphoedema/CDT service; no generic regional routine.
Stable healthy adult seeking relaxation	May proceed only when scope, screening and consent align.

Absolute and relative contraindications

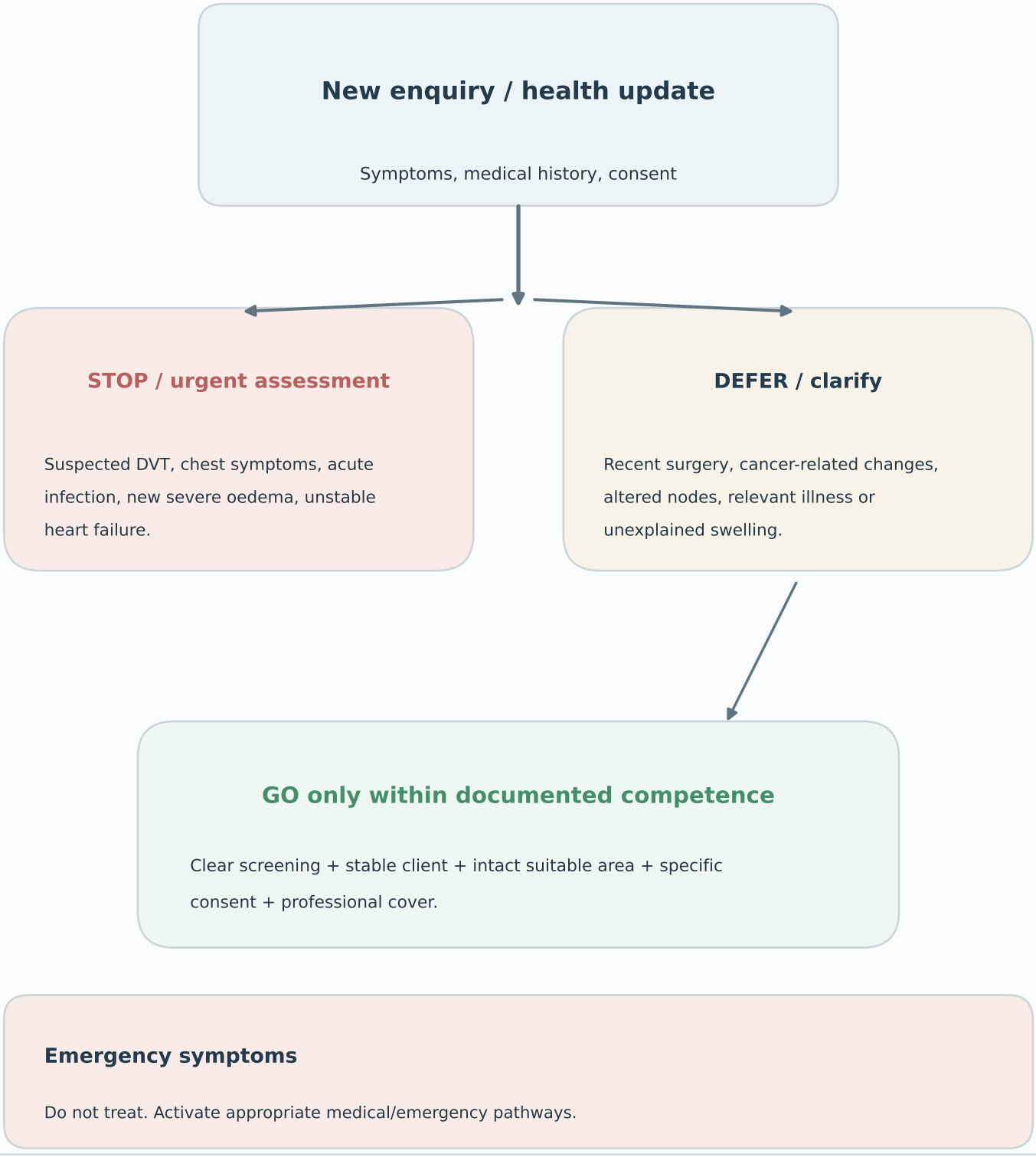
For this course, do not treat: suspected or untreated acute DVT/PE, acute cellulitis/erysipelas/lymphangitis, decompensated or untreated unstable heart failure, superior vena cava obstruction, acute systemic infection, acute renal failure or medically unexplained rapidly worsening fluid retention. Neck work additionally requires caution around thyroid disease, carotid sinus sensitivity, arrhythmias and vascular disease. **Relative caution requiring appropriate review:** stable heart failure, renal/liver disease, pregnancy, bleeding/bruising tendency, anticoagulants, recent abdominal procedures, active cancer treatment, osteoporosis, impaired sensation, significant hypotension, wounds, frailty and cognitive capacity concerns. A clearance letter does not confer missing technical competence.

Service theme rules

Post-surgery: Identify exact procedure/date, surgeon, drains/wounds, complications, surgical restrictions, DVT risk, medication and whether nodes were removed. No fixed safe postoperative day can be stated. **Lymphoedema/cancer:** specialist assessment required; active cancer alone is not a universal evidence-based reason to assert massage spreads cancer, but oncology coordination and scope remain essential. **Older adults:** assess heart/vascular/renal history, falls, skin, consent, medication, transfers and sudden decline. **Heavy legs:** do not assume venous disease or treat unknown oedema; persistent swelling, ulcer or skin change merits medical evaluation. **Heart fluid retention:** exclude cardiac oedema treatment from wellness services. **Lipedema:** modern care targets pain, functioning, compression and exercise; MLD alone is not proven to reduce fatty tissue. **Stress/relaxation:** the only straightforward wellness pathway is a healthy person without contraindications.

Safety triage before every session

Stop, defer and refer decisions must precede all manual techniques.



Screening interview

1. Presenting goal, symptoms and onset? 2. Swelling location, one-sided/bilateral, new or changing? 3. Chest pain, shortness of breath, collapse? 4. Recent surgery, wound, drain or admission? 5. Previous DVT/PE or clot risk? 6. Current infection, fever or skin injury? 7. Heart, renal, liver, venous or lymphatic diagnosis? 8. Cancer treatment, radiation or lymph-node excision? 9. Drugs including anticoagulants, steroids or diuretics? 10. Pain, altered sensation, mobility, falls and positioning problems? 11. Current healthcare team and restrictions? 12. Informed consent and desired treatment boundaries?

Referral documentation

Record the reason treatment was declined/deferred, symptom urgency, advice, clinician contacted where appropriate, and follow-up status. In South Africa, use local emergency pathways; mobile 112 may be used for an emergency. Do not diagnose DVT or heart failure yourself.

Case exercises

- Sudden swollen painful calf: urgent DVT pathway, no touch.
- Older adult with heart failure, growing ankle oedema and breathlessness: urgent medical assessment, no MLD.
- Breast surgery with removed nodes and increasing arm swelling: treating team plus specialist lymphoedema clinician.
- Otherwise healthy adult requesting relaxation: proceed only with consent and verified competence.

Pass criterion: all emergency, DVT and infection cases correctly identified. No hands-on module before pass.

Expanded guided workshop | Module 3

Timed lesson plan (75 minutes)

Learning block	Duration	Product
Study stop signs and referral urgency	15 min	Triage notes
Complete a mock health-history interview	10 min	Screening form
Work through six decision scenarios	25 min	Written GO / DEFER / STOP / REFER decisions
Practise a referral conversation	10 min	Telephone/WhatsApp script
Complete safety assessment	10 min	Answer sheet
Reflect and correct missed decisions	5 min	Signed safety gate

A conservative decision-making sequence

First, ask whether this is a medical problem or a relaxation request. If the reason is new or persistent swelling, diagnosis and appropriate medical assessment take priority. The fact that an older person can walk, has no pain or has previously had massages does not establish safety. Then identify the presenting site and time course: acute versus chronic, one-sided versus bilateral, stable versus worsening, and associated systemic symptoms. Next, screen for fever, painful hot skin, chest pain, breathlessness, recent operations and thrombosis risk. Finally, consider whether scope, competence, consent, insurance and suitable conditions permit the intended service. Only then is a wellness treatment considered.

Emergency symptoms: suspected pulmonary embolism (sudden breathlessness, chest pain or coughing blood), collapse, severe respiratory difficulty, acute neurological deficit, or systemic

deterioration require emergency assessment. In South Africa use an appropriate emergency service; 112 is available from mobile phones. Do not delay emergency care to finish paperwork.

Urgent assessment, usually same day: acute painful unilateral limb swelling suggesting DVT; hot tender spreading skin with fever suggesting cellulitis; rapidly changing oedema; serious postoperative warning signs. Do not try to determine if a clot is 'old' by massaging it. Do not treat an inflamed limb and 'see how it responds'.

Defer pending clinical review: known cardiac, renal or hepatic disease with oedema; unexplained persistent swelling; oncology-related limb change; recent surgery; fragile or damaged tissues; anticoagulants combined with bruising risk; complex vascular history. A doctor's clearance must describe the clinical suitability of the *proposed* intervention, and cannot compensate for inadequate therapist training.

Service-by-service decision rules

Enquiry	Initial focus	Proceed with routine wellness MLD?
Cosmetic or orthopaedic postoperative swelling	Date, operation, surgeon, wounds/ drains, clot/infection signs	Not from this refresher alone
Possible lymphoedema / nodes removed	Clinical assessment and referral to qualified specialist	No clinical oedema work
Older adult with swollen ankles	Heart/venous/renal/medication and mobility history	Not for oedema without medical diagnosis
Heavy legs after standing	Screen for venous changes, DVT, persistent oedema	Only unrelated wellness work if separately suitable
Cardiac fluid retention	Breathlessness, orthopnoea, weight change, prescriber review	No fluid-mobilising MLD under this pathway
Lipedema	Pain, bruising, specialist diagnosis, related swelling	Do not claim lipedema treatment
Stress and relaxation, no medical concern	Standard contraindication screen and informed consent	Potentially within established scope

Six simulated enquiries (25 minutes)

Scenario A — DVT: A 62-year-old has one calf suddenly swollen and tender after a long journey. They want an urgent drainage massage because the ankle feels tight. State the urgency, exact reason for not touching, and what you would say.

Scenario B — Infection: A 76-year-old with known lymphoedema has a hot painful leg, chills and new discolouration. The skin looks darker but not bright red. Decide the action. Explain why skin tone must not be used to rule out cellulitis.

Scenario C — Cardiac: A man of 79 with heart failure requests weekly leg drainage. He now needs more pillows at night and his shoes no longer fit. Decide the action, distinguish routine GP review from urgent assessment and document red flags.

Scenario D — Postoperative: A woman requests 'lymph drainage' four days after cosmetic surgery. She mentions one painful swollen calf and is taking medication she cannot name. Decide immediate action versus surgical follow-up.

Scenario E — Oncology: A woman who had breast-cancer treatment with axillary surgery has gradually increasing arm heaviness and swelling. There is no fever or sudden pain. Decide the referral and why a standard regional routine is inappropriate.

Scenario F — Wellness: A healthy adult requests gentle contact for relaxation, reports no swelling or illnesses, gives informed consent and is comfortable on the table. List the remaining professional checks before an appointment could proceed.

Write these notes for each: **red flags / urgency / action / person referred to / words for client / what not to claim**.

Referral practice (10 minutes)

Use this role-play language: 'Because this swelling is new and you have [concerning symptom], I am not going to massage it. It needs a medical assessment today. I can help you contact your doctor or appropriate urgent service, but I cannot establish the cause here.' Practise a calm, non-alarming tone and avoid suggesting a diagnosis as fact. For an emergency, state what you will do and act immediately.

Documentation example: '17:30 enquiry. Client reports new right-calf swelling and pain after travel. No hands-on treatment. Explained suspected vascular warning sign without diagnosing. Advised urgent same-day assessment; client repeated the plan. Referred to urgent medical service.' Never record an assessment you did not perform.

Final safety examination (10 minutes)

Q1. Name four possible symptoms of DVT or PE requiring no massage.
Q2. What signs of cellulitis may be present even when redness is difficult to see?
Q3. May stable heart failure justify routine MLD for ankle fluid without clinical direction?
Q4. Does 'the surgeon said massage is fine' establish competency to treat postoperative lymphatic swelling?
Q5. Is active cancer automatically a universal contraindication, and does that authorise wellness therapists to treat oncology lymphoedema?
Q6. What requires an individualised lymphatic pathway?
Q7. When should treatment stop during an appointment?
Q8. What must be written in a referral note?

Answer key and decision rationale

A: Urgent same-day DVT assessment, no massage. **B:** Same-day medical assessment for cellulitis; warmth/pain/systemic symptoms matter across skin tones. **C:** No MLD; worsening orthopnoea and oedema require urgent medical review, emergency response if severe acute breathlessness. **D:** Painful unilateral calf after recent surgery raises urgent DVT concern; no massage. **E:** Refer to oncology/treating team and specialist lymphoedema practitioner. **F:** Verify current registration, training, indemnity, proper environment and informed consent.

Q1: Unilateral pain/swelling/warmth or changed colour, breathlessness, chest pain, coughing blood, collapse. **Q2:** Pain, heat, swelling, fever/chills, rapid spread, systemic illness. **Q3:** No; cardiac oedema is outside this pathway. **Q4:** No; clinical clearance is not technical competence. **Q5:** Not universal; specialist oncology assessment remains essential. **Q6:** Previous lymph-node removal, radiation or diagnosed lymphoedema. **Q7:** Any new concerning symptom, pain or distress, changed consent or adverse reaction. **Q8:** Reported symptoms, advice/urgency, person contacted, consent and disposition.

Required pass: 100% of acute DVT/PE, infection and cardiac emergency decisions correct. If any safety-critical answer is wrong, repeat this module before observing or practising hands-on work. Record the correction and date.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- NHS DVT signs: https://www.nhs.uk/conditions/deep-vein-thrombosis-dvt/
- NHS cellulitis: https://www.nhs.uk/conditions/cellulitis/
- NHS heart failure: https://www.nhs.uk/conditions/heart-failure/
- NHS oedema: https://www.nhs.uk/conditions/oedema/

Professional boundary: illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

MANUAL LYMPHATIC DRAINAGE | PROFESSIONAL REFRESHER

MODULE 04 OF 08

Vodder Movement Revision

Guided learning: **120 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Module 4 — Core practical Vodder movement revision (120 minutes)

Safety and teaching conditions

Practise only on a screened, consenting, healthy adult volunteer. A trained educator must review and calibrate movement force, exact hand angle and rhythm. This written guide is not a substitute for the original Vodder method's supervised demonstration. Do not practice over swollen, thrombosed, recently operated, irradiated or infected tissues.

Shared technical principle

The working phase displaces superficial skin in a controlled direction; the release phase reduces pressure and permits tissue recoil. Hand contact is gentle and usually maintained. Avoid vigorous strokes, deep compression, rubbing, oil-induced sliding, pain or bruising. Do not prescribe a universal force in grams or use a fixed beat as a proxy for correctness.

4.1 Stationary circles

Purpose: fundamental small circular controlled skin engagement. **Hand:** relaxed fingers or palm according to taught variant. **Working/release:** gently stretch skin in the small circle, then release without dragging. **Drill:** solo opposite forearm; then 6–10 repetitions on the partner's intact forearm under instructor observation. **Common faults:** rubbing the skin, large circles, tense fingers, too much pressure, fast rhythm. **Hand-position visual:** three frames (resting contact / controlled displacement / release). **Prompt:** “Clinical instructional triptych, therapist's relaxed fingers performing Vodder-style stationary circle practice on healthy forearm, fixed contact, subtle superficial skin displacement, pressure-release phase, accurate hands, understated arrows.”

4.2 Pump

Purpose: controlled rolling/cupped-hand skin displacement. **Hand:** naturally curved palm and relaxed wrist; no muscular squeezing. **Working/release:** develop a small rolling stretch, then unload. **Drill:** rehearse wrist motion without contact, then compare gentle contact on healthy forearm with partner feedback. **Faults:** squeezing tissue, pushing body weight, wrist rigidity, palm sliding. **Visual:** side angle hand shape plus two movement phases. **Prompt:** “Three-panel professional MLD pump hand technique photograph on intact adult forearm, gently curved palm, relaxed wrist, working and release phases, no deep tissue indentation, neutral clinic.”

4.3 Scoop

Purpose: small coordinated curved skin-stretch action. **Hand:** fingers and wrist in controlled rotation with supportive hand contact. **Working/release:** gently develop curved stretch, relax pressure. **Drill:** air rehearsal followed by instructor-observed partner contact on intact limb. **Faults:** exaggerated scooping, tissue grabbing, friction, forceful pulling. **Visual:** overhead and oblique hand positions. **Prompt:** “Educational four-panel close-up of Vodder-style scoop movement on healthy forearm, supported partner, hand orientation, small superficial stretch and distinct release; no deep massage.”

4.4 Rotary

Purpose: larger hand coordination for a broad, selected surface. **Hand:** relaxed hand and wrist with broad skin contact. **Working/release:** controlled rotary stretch, pressure relaxed before repositioning. **Drill:** practise wrist arc in air; then intact upper-back surface with correct draping and educator supervision. **Faults:** rubbing, large forceful circles, unnecessary oil, shoulder tension. **Visual:** three staged positions from overhead plus side view. **Prompt:** “Four-panel educational clinical photography of gentle Vodder rotary movement on appropriately draped upper back of healthy adult; therapist hand position and skin stretch/release, no deep pressure.”

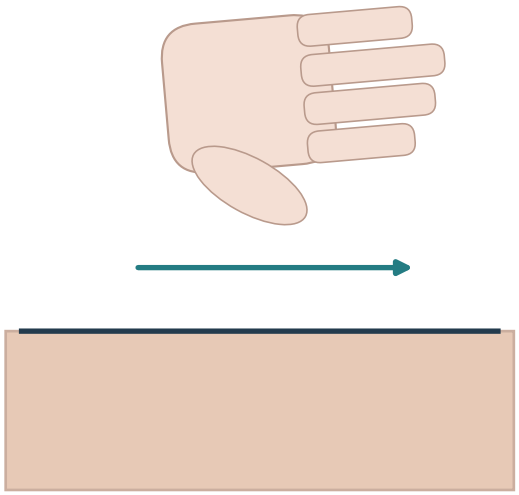
4.5 Thumb circles

Purpose: smaller contact-surface variation in selected areas. **Hand:** relaxed thumb pad with well-supported hand. **Working/release:** subtle local skin stretch, fully release. **Drill:** opposite forearm and partner feedback on point pressure. **Faults:** poking, excessive concentrated pressure, overloading thumb

Superficial skin stretch: two-phase contact

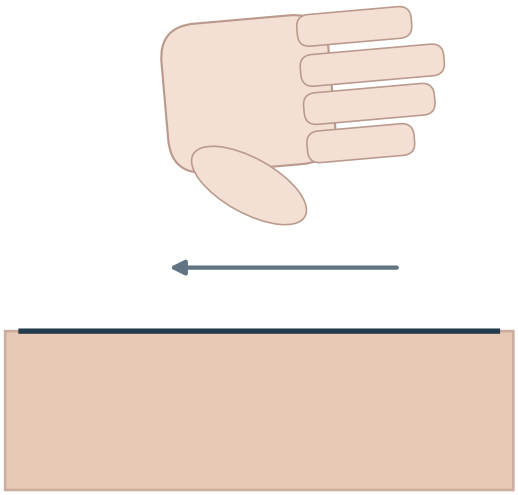
Movement mechanics for method revision; pressure requires instructor calibration.

WORKING PHASE



Small controlled displacement

RELEASE PHASE



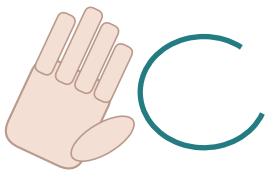
Reduce force; allow recoil

Avoid

Deep kneading, frictional rubbing, large tissue indentation, bruising, pain, or forced anatomical drainage directions.

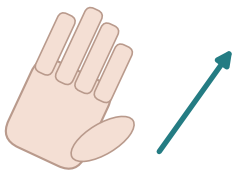
The Vodder movement families

Schematic movement-shapes only. Observe a recognised educator for exact hand orientation.



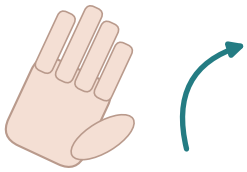
Stationary circles

Small circular skin engagement; stable contact.



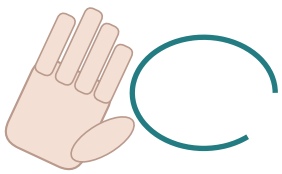
Pump

Curved hand and controlled rolling contact.



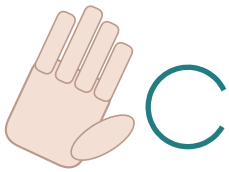
Scoop

Coordinated curved/rotational skin stretch.



Rotary

Broad contact with controlled rotary mechanics.



Thumb circles

Supported thumb-pad contact; no point pressure.

Three moments to observe

Initial contact → controlled working phase → gradual release.

Technique faults: observe and correct

Compare intended superficial work with errors after a long break from practice.

Intended

- \+ Gentle skin engagement
- \+ Distinct release
- \+ Stable contact
- \+ Partner comfortable

Avoid

- \- Sliding or rubbing
- \- Deep muscular squeezing
- \- Forceful large circles
- \- Pain, bruising or distress

Practical checkpoint

The visual cannot calibrate force, rhythm, hand angle or region-specific Vodder technique. Record feedback from a qualified instructor before professional return-to-practice.

joint. **Visual:** thumb close-up in contact/working/release. **Prompt:** “Three-frame instructional clinical close-up thumb-pad circle technique on healthy adult forearm, support hand visible, minimal indentation, no pressure over anatomical vessels.”

Technique assessment grid

For each movement, verify: consent and safe area; contact stable; working phase visible; distinct release; no sliding, deep compression or excessive colour change; natural therapist posture; client comfort; educator sign-off. If any are absent, repeat under supervision rather than advertising technique competence.

Workshop timing

15 min safety review; 20 min videos; 25 min circles and pump; 25 min scoop and rotary; 10 min thumb variation; 15 min partner/instructor feedback; 10 min notes and corrections.

Video observations

- FQM practical Vodder excerpt: https://www.fqm.qc.ca/wp-content/uploads/2021/03/vodder-extrait-bonne-version.mp4
- Akademie rotary: https://www.youtube.com/watch?v=Ehl-TWvY5Xo
- Akademie companion: https://www.youtube.com/watch?v=Cxt0c5JBzWU
- Stationary circles: https://www.youtube.com/watch?v=sy21bfowvxA
- Optional rotary comparison: https://www.youtube.com/watch?v=RgbHc7Wtg5I

Live availability/content could not all be independently checked. Label externally hosted videos as candidate demonstrations requiring instructor verification. PocketMedic-type SLD is useful only as patient self-care comparison. Do not include generic full-body healthy-lymphatic YouTube routines as clinical/ postoperative instruction.

Expanded guided technique laboratory | Module 4

Mandatory practical boundary

This is a movement-**revision** laboratory. It is **not** an independent instruction to treat oedema, cancer-related drainage changes or postoperative complications. Practise on the therapist's own healthy forearm and, when suitable, on a consenting screened healthy adult. Do not simulate clinical clearance of lymphatic node basins. The final practical sign-off must be performed by an educator qualified in the particular method being refreshed.

Timed laboratory schedule (120 minutes)

Segment	Time	Completion evidence
Safety and consent gate	10 min	Screen checked; partner consents
Observe verified demonstrations	20 min	Video observation sheet
Dry-run hand mechanics	15 min	Three errors self-identified
Stationary circles and pump comparison	25 min	Instructor or partner feedback sheet
Scoop and rotary comparison	25 min	Two scored movement drills
Thumb circles and pressure calibration	10 min	Comfort feedback and pressure checklist
Demonstration review and self-correction	15 min	Personal technique development record

Before the first stroke: prepare the practice setting (10 minutes)

Confirm screening and consent; provide stable table or chair support; remove jewellery; perform hand hygiene; keep nails short; and use a relaxed working height. Explain that the activity teaches skin-contact mechanics rather than drainage of a condition. The healthy volunteer should be able to reposition, say 'stop' and describe any discomfort. Check exposed areas for wounds, bruising, local inflammation or unexpected swelling. If in doubt, do not touch.

20-minute demonstration observation task

Open the trainer-approved primary Vodder demonstration and at least one method-specific companion resource. Suggested links are provided below; availability, authorship and accuracy need checking before class use. Divide 20 minutes into **5 minutes** listening and observing, **5 minutes** identifying one stroke family, **5 minutes** comparing another family, and **5 minutes** writing down corrections relevant to your own hands. Replay only brief segments needed for observation; no video playback is included inside this PDF.

During observation, note the therapist's wrist and finger relaxation, contact surface, whether the skin moves relative to the hand, the transition between working and release phases, apparent force, hand reset, pace and partner positioning. **Do not copy a video's drainage direction onto a client with altered lymphatics.** A video can model mechanics but cannot verify your competence or individualise clinical treatment.

Resource	Use	Link
FQM Vodder excerpt	Primary candidate for technique observation	https://www.fqm.qc.ca/wp-content/uploads/2021/03/vodder-extrait-bonne-version.mp4
Dr Vodder Akademie rotary example	Compare rotational hand mechanics	https://www.youtube.com/watch?v=Ehl-TWvY5Xo
Akademie companion	Additional comparison, subject to trainer approval	https://www.youtube.com/watch?v=Cxt0c5JBzWU
Stationary-circle example	Supplemental observation only	https://www.youtube.com/watch?v=sy21bfowvxA
Rotary example	Supplemental observation only	https://www.youtube.com/watch?v=RgbHc7Wtg5I

Do not present a generic full-body 'lymphatic detox massage' clip as a clinical training reference. SLD videos show patient self-care strategies and should not be treated as a therapist Vodder technique examination.

Solo dry-run: mirror and forearm exercises (15 minutes)

Work before a mirror, first with hands in the air, then on your own intact forearm. **Minutes 0–5:** compare a relaxed wrist with a rigid wrist; note whether the shoulder elevates. **Minutes 5–10:** practise establishing light skin contact, moving the skin a little, then releasing without rubbing. **Minutes 10–15:** rehearse the coordination patterns of all movement families at low speed. Record at least three faults you notice. The goal is coordination, not pressure or speed.

Stationary circles: teaching focus

Aim: a small controlled circular displacement of skin, not finger rubbing. **Set-up:** relaxed fingers and comfortable partner arm support. **Working phase:** the hand takes up superficial skin slack and gently displaces the skin in the instructor-demonstrated circle. **Release:** unload the tension smoothly, permitting skin recoil while maintaining appropriate contact. The learner should observe the skin's movement rather than count large circles.

Common faults to diagnose: fingertips skidding; palms pushing down; excessive visible blanching; forearm and shoulder tension; rapid, mechanically repetitive motion; increasing pressure because 'nothing is happening'. **Correction exercise:** stop, reset the hand, release shoulder tension and repeat a

brief set only when comfortable. The instructor should demonstrate acceptable amplitude; do not try to manufacture a measurable force by pressing harder.

Partner feedback questions: Does it feel superficial? Is there any poking, rubbing or soreness? Is the release noticeable? Can the partner ask you to stop easily? Record verbatim feedback without claiming a physiological effect.

Pump: teaching focus

Aim: a softly coordinated hand-and-wrist movement with a gentle working phase and return. **Set-up:** supported healthy limb, curved hand as required by the instructor's variant and neutral shoulders. **Working phase:** a controlled rolling skin stretch rather than tissue squeezing. **Release:** pressure diminishes before the hand resets. The movement must not compress deep muscles or joints.

Typical faults: cupping too tightly around the limb; squeezing the forearm as though milking a vessel; leaning body weight forward; sliding because too much lotion was used; collapsing the wrist. **Correction exercise:** compare the silhouette of the hand in the instructional picture with the teacher's live demonstration. Practise the wrist arc without skin contact. Then apply only the gentle contact approved by the supervisor.

Evidence of progress: teacher confirms correct initial orientation, absence of deep force, clear release, relaxed posture and adequate feedback.

Scoop: teaching focus

Aim: a small coordinated curved stretch achieved with the fingers, palm and forearm working together. This movement is not a grab or lift of subcutaneous tissue. **Working phase:** hand coordination produces superficial skin movement on the selected healthy practice surface. **Release:** controlled unloading and resetting.

Typical faults: dramatic hand scooping, friction, pulling with the fingertips, excessive wrist rotation or pushing the volunteer's limb. **Correction exercise:** compare slow-motion observation of scoop and pump; sketch the different wrist paths on paper. Repeat only on a safe healthy practice site, with small movements, and ask a supervisor to name which movement was shown.

Rotary: teaching focus

Aim: broader coordinated skin displacement with an identifiable release. **Set-up:** appropriately draped, healthy upper-back practice surface; position the therapist so body weight is not dumped into the client's back. **Working phase:** controlled small rotary skin stretch, using the method-specific orientation demonstrated by the instructor. **Release:** pressure eases without fast rubbing or lifting suddenly.

Typical faults: treating rotary as vigorous effleurage, making circles too large, pressing directly over spine, using oil, losing hand contact or working with an elevated shoulder. **Correction exercise:** perform an air demonstration, then a supervised short set on a suitable intact upper-back area. No deep pressure or unilateral pathology work.

Thumb circles: teaching focus

Aim: revise precise, gentle thumb-pad contact for limited areas where the method permits it. **Set-up:** thumb joint neutral and hand supported. **Working phase:** superficial skin stretch rather than thumb-tip probing. **Release:** full unloading without sliding.

Typical faults: isolated thumb-joint force, poking a tender point or repeatedly stressing the joint. **Correction exercise:** rehearse on one's own forearm. Ask the partner to describe any concentrated pressure. If the thumb cannot remain comfortable and supported, omit this movement until corrected by an educator.

Structured partner observation rubric

Score each domain 0 = unsafe/not shown; 1 = emerging; 2 = consistent under direct observation. This is **training feedback**, not certification.

Domain	Score 0–2	Evidence to write
Screening and consent	___	_____
Hand and wrist relaxation	___	_____
Appropriate contact surface	___	_____
Controlled working phase	___	_____
Distinct release	___	_____
Minimal friction or sliding	___	_____
No pain or deep pressure	___	_____
Safe positioning and draping	___	_____
Responds to partner feedback	___	_____
Knows when not to perform MLD	___	_____

A total score is not a clinical credential. **Any zero for safety, consent, excessive force or referral decisions prevents practical sign-off.** A qualified instructor should verify the specific technique in person before professional use.

Knowledge check and answers

Q1. Define the working and release phases without using 'push fluid'. **Answer:** controlled superficial skin displacement followed by reduction of pressure and tissue recoil.
Q2. Why does stronger pressure not necessarily make better MLD? **Answer:** the method relies on gentle superficial engagement; deep force may irritate tissue and depart from the technique.
Q3. Name the four classical movement families. **Answer:** stationary circles, pump, scoop and rotary; thumb circles are an additional variation.
Q4. Why is an SLD video insufficient to teach professional MLD? **Answer:** it is simplified individual self-care, not full professional technique instruction or competency testing.
Q5. What does a passed course self-test prove? **Answer:** knowledge of course concepts, not independently assessed clinical competence.

End-of-module evidence: completed video observation notes, partner feedback, five movement self-assessments and a booked educator session for technical correction. Mark all unverified strokes as **not yet approved for client treatment**.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- Vodder School supervised training: https://www.vodderschool.org/training_program_basic
- Wittlinger and colleagues: Dr Vodder's Manual Lymph Drainage: A Practical Guide (Thieme).
- Demonstration links in this module are observation candidates; verify authorship, availability and content with the educator.

> **Professional boundary:** illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

MANUAL LYMPHATIC DRAINAGE | PROFESSIONAL REFRESHER

MODULE 05 OF 08

Complete Client Session

Guided learning: **75 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Module 5 — Complete appointment framework (75 minutes)

Mandatory suitability rule

A wellness session must not be used to treat an uninvestigated medical swelling condition. Inquire, screen and make a documented go/defer/referral decision before physical preparation. Confirm the therapist is qualified to provide the specific proposed intervention.

Ten-stage workflow

1. **Enquiry:** identify objective, symptom history, intended care (wellness or clinical), and immediate red flags.
2. **History:** record date, diagnoses, surgery and nodal surgery, oncology, DVT/PE, infection, heart/renal/liver/vascular history, medication, swelling pattern, skin, pain, mobility, clinician and previous MLD.
3. **Consent:** describe slow superficial skin contact; acknowledge limitations; confirm areas, communication and right to stop; document consent and any limitations.
4. **Last-minute safety review:** ask again about new swelling, chest symptoms, fever, new operations, medicines and acute pain.
5. **Setup:** stable treatment surface, clean hands, infection control, draping, supportive bolsters, safe transfers, suitable temperature and light, therapist ergonomic posture; avoid slip-producing oil for skin-stretch practice.
6. **Plan:** select only regions within verified skills and consent. Classical proximal preparation is method-specific; it does not physically “open” nodes and is not universal for altered drainage.
7. **Gentle contact:** use an educator-approved movement, slow comfortable rhythm, no pain or deep kneading. For wellness work, 20–40 minutes of hands-on time is an illustrative option, not a validated prescription.
8. **Reassess:** ask about comfort, dizziness, pain, skin response and new symptoms; stop for changes.
9. **Aftercare:** usual movement, ordinary hydration, honest expectations; advise medical help for warning symptoms; do not prescribe diuretics, compression or clinical SLD outside competence.
10. **Record:** health update, consent, time, region, movement family, position, client-reported response, observed response, referral and follow-up.

Client explanation sample

“This is a gentle hands-on approach using controlled skin movements rather than deep massage. It should not hurt, and you can stop at any point. I do not treat unexplained swelling or medical lymphoedema outside my qualifications. If anything in your history requires specialist care, I will recommend the appropriate assessment first.”

Suggested appointment framework, approximately 40 minutes

5 min greeting and health change; 3 min positioning; 4 min gentle introductory contact; 20 min selected appropriate regional movements; 5 min comfort check and closing; 3 min documentation and general aftercare. There is no requirement to work every region or to perform neck/abdominal work.

Home visits

Confirm access, table stability, transfer capacity, privacy, handwashing, clean linens, pets, electrical safety, communication, emergency contact, referral destination and exit route. Never proceed if the location or client transfer is unsafe. For older adults, confirm meaningful consent and avoid coercion by relatives. Document any decline, symptoms or falls and communicate with permitted family/clinicians when necessary.

Stop a series when

New unexplained symptoms develop; swelling worsens; infection appears; tolerance becomes poor; expected wellness benefit does not justify continuing; or a medical referral remains outstanding. Packages are not a reason to continue unsafe treatment.

A complete, documented client encounter

Screen first; choose treatment only where appropriate and within scope.

1 ENQUIRY

Purpose and onset of symptoms

2 HISTORY

Surgery, cancer, DVT, infection, heart, medicines

3 SAFETY GATE

Go / defer / stop / refer

4 CONSENT

Explain contact and region-specific agreement

5 SETUP

Hygiene, privacy, position, draping, transfers

6 PRACTICE

Only approved safe, suitable gentle movement

7 FEEDBACK

Comfort, response, new symptoms

8 RECORD

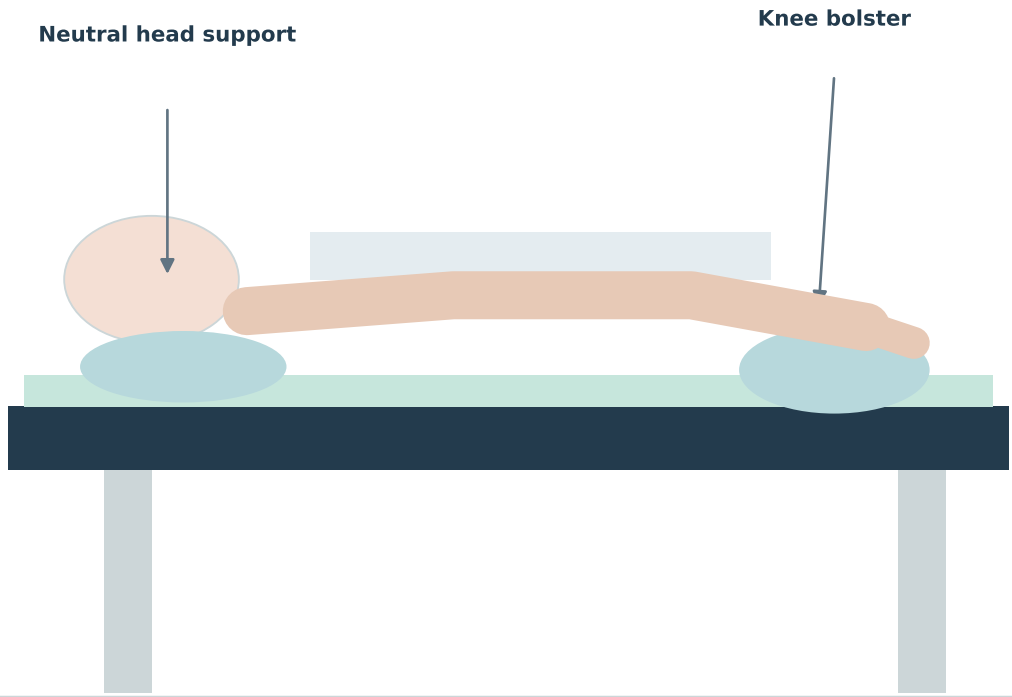
What occurred and referral / aftercare

Important

The sequence is a session framework, not an instruction to treat unexplained oedema.

Treatment-table setup and supported positioning

A safer practical environment for older adults and home-visit wellness work.



Before positioning

Check transfers, breathing comfort, skin integrity and access around the table.

During practice

Use suitable draping, clean linen, hand hygiene and therapist-friendly working height.

Skills test

Role-play a first call and full appointment from enquiry to written note. Another qualified person should review the decision to treat or refer, consent and documentation.

Expanded client-session simulation | Module 5

Safety check and 75-minute study plan

Never schedule a generic drainage routine for unexplained swelling. This module uses simulated consultations and a screened wellness client only; it is not a substitute for clinical assessment of oedema.

Segment	Time	Output
Recheck contraindications and role	10 min	Safety gate
Conduct simulated phone enquiry and history	15 min	Completed screening record
Explain consent, privacy and room preparation	15 min	Consent statement and setup checklist
Rehearse the appointment sequence	20 min	A timed, safe wellness-session plan
Write a SOAP-style note and aftercare	10 min	Session documentation
Review errors and mini-test	5 min	Corrected record

1. Conduct a safe enquiry (15 minutes)

Role-play the client: a 59-year-old office professional, no swelling, requesting a quiet relaxation-oriented appointment after long workdays. The client walks independently, reports no recent illness or procedure, takes no concerning medicine and prefers not to receive neck contact. Their only goal is relaxation. The therapist explains that MLD-style contact is gentle and may not feel like deep massage; checks the health history and distinguishes preference from medical indication. Then perform a second role-play with a client describing sudden swollen ankles and breathlessness. The correct outcome is deferral and medical advice, not a treatment plan.

Practise asking open questions first ('What prompted the appointment?') then specific screening questions. Ask about DVT/PE, acute infection, heart/kidney/venous problems, recent surgery, cancer treatment, medications, skin condition, pain, falls, pregnancy where relevant, ability to lie flat, capacity and communication needs. Do not record irrelevant sensitive information. Use the printable client screening form supplied in the package.

2. Consent and boundaries (15 minutes)

A useful plain-language explanation is: 'I use gentle hand contact and small skin movements, not deep muscle massage. I will only work on the areas we agree. You may ask me to stop or change position at any time. This is not intended to diagnose or treat a cause of swelling.' Confirm specific consent for neck, face or abdomen if contemplated. If the client declines neck contact, omit it. Classical technique diagrams do not override consent or make an otherwise unsuitable area necessary.

Set up a private, clean space with a stable table, appropriately washed linen, hand hygiene, a safe working height, disposal arrangements and accessible contact details. Check suitable room temperature and avoid needless exposure. Practise draping with a towel or training mannequin before working with a volunteer. Offer a bolster under knees or ankles as needed; avoid forcing a prone or flat supine position in someone who becomes breathless. Refer rather than improvising a medically unsuitable position.

Home-visit addition: confirm the correct address, travel and communication arrangements, client presence and consent, room access, pets, trip hazards, lighting, electrical and hygiene supplies,

emergency contact and safe transfer. Do not promise a therapist can lift a frail client alone. If appropriate safety or privacy cannot be achieved, reschedule or refer.

3. Timed clinic simulation (20 minutes)

Use a 20-minute **role-play**, not a 20-minute client treatment prescription. Minutes 0–4: greeting, re-screening and goals. Minutes 4–7: consent, privacy and support. Minutes 7–12: talk through the chosen, already approved healthy-volunteer practice region and explain which regions will be omitted. Minutes 12–16: demonstrate a short instructor-approved movement set on a suitable volunteer, concentrating on contact and release rather than a drainage sequence. Minutes 16–18: check comfort, ask about symptoms and help the volunteer change position. Minutes 18–20: explain aftercare and write down observations. Real professional sessions are individualised; this is an administrative rehearsal.

A client-specific sequence for medically altered lymphatics is **not** supplied. In a genuine specialist clinic, assessment would determine which regions, directions, compression plans and outcome measures are appropriate.

4. Documentation using facts rather than promises (10 minutes)

Write a brief SOAP note:

- **S — Subjective:** Client requests relaxation; reports no swelling; no acute symptoms disclosed; declines neck work.
- **O — Objective:** Skin intact at selected practice area; comfortable positioning; no untoward response observed. Do not claim clinical measurements not taken.
- **A — Assessment within scope:** Suitable for the agreed wellness session based on screening; no diagnostic conclusion about lymphatic function.
- **P — Plan:** Gentle, consented, approved technique; ordinary movement and hydration advice; safety-net for new symptoms; no clinical swelling course prescribed.

Add date, therapist identity, contact time, exact areas, whether consent was revised, client response, adverse symptoms, referral (if any) and relevant documentation storage. If the client later reports new oedema or acute symptoms, stop the series and reassess/referral rather than continuing because appointments were booked.

5. Aftercare and communication

Do not routinely advise extra litres of water to 'flush toxins', eliminate medication, take supplements or buy compression. Encourage ordinary hydration and comfortable routine movement. Suggest medical review for any new swollen, painful or hot limb or symptoms such as breathlessness. For an older client, written advice should use short clear language; obtain consent before updating a family member and follow POPIA requirements for storing or transmitting notes.

Mini-test and answers (5 minutes)

Q1. A client says no to neck contact after consenting to treatment. What changes? **Answer:** omit neck work; consent is specific and revocable.
Q2. Is 'lymph detoxification achieved' acceptable in a note? **Answer:** no; it is unsupported and not directly observed.
Q3. The client develops pain and dizziness mid-session. **Answer:** stop immediately, assess urgency within first-aid capability and escalate appropriately.
Q4. May a client with unexplained ankle oedema be booked under 'relaxation' while avoiding the ankle? **Answer:** not automatically; suitability needs assessment and the potentially serious symptom must be addressed first.
Q5. What information must be recorded after a home visit? **Answer:** screening, consent, regions and method used, response, safety issues, advice and any referral or follow-up.

Pass standard: one complete mock screening form, one session note, a consent explanation and a documented decision not to treat the symptomatic simulation case.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- NHS lymphoedema treatment and ongoing management: https://www.nhs.uk/conditions/lymphoedema/treatment/
- Macmillan lymphatic drainage and SLD: https://www.macmillan.org.uk/cancer-information-and-support/impacts-of-cancer/lymphoedema/lymphatic-drainage-for-lymphoedema
- South African POPIA obligations: consult current Information Regulator resources.

> **Professional boundary:** illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

MODULE 06 OF 08

Regional Practice

Guided learning: **100 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Module 6 — Regional technique practice: healthy, intact lymphatics only (100 minutes)

Mandatory safety conditions for every regional sequence

These are **supervised placement and movement rehearsal drills on a screened, consenting, healthy volunteer**, not a complete professional Vodder clinical protocol and not a treatment plan for oedema. Confirm no acute illness, new swelling, wounds, recent surgery, clot symptoms, unsafe positioning, relevant vascular/heart disease, or altered lymphatic anatomy. Apply only movements previously mastered in Module 4, at gentle superficial pressure. Never force lymph towards a particular node group based only on a printed arrow.

Do not use these drills for: post-cancer treatment, removed or radiated nodes, chronic lymphoedema, postoperative oedema, cellulitis, prior DVT without clinical review, suspected venous disease or systemic fluid retention. Specialist CDT assessment is required for individualised alternative drainage routes.

6.1 Neck / terminus orientation (foundational, 15 minutes)

Suitable goal: identify cervical/venous-angle landmarks and practise low-risk contact positioning with an instructor. **Cautions:** carotid disease, thyroid disease, arrhythmia, syncope, carotid sensitivity, older age and vascular risk, neck operations; do not compress carotid sinus, anterior neck or deep supraclavicular tissues.

1. Screen, gain explicit consent to neck-area contact, and choose a safe resting position with head supported.
2. Identify key landmarks on an anatomical model; do not infer that the venous angle must be manually compressed.
3. Rehearse relaxed hand placement and minimal skin contact over an educator-approved superficial lateral neck area only, avoiding major vessels and the anterior neck.
4. Observe the instructor's position and compare the release phase without deep pressure; omit hands-on neck work if the instructor or client is uncertain.
5. Recheck comfort, dizziness, breathing and ability to change position; document the drill.

Prompt: “Four-frame Vodder instructional stills of therapist orientating over superficial lateral neck on a healthy screened adult, head fully supported, no hand over carotid triangle or deep supraclavicular depression, minimal contact, annotation ‘supervised orientation only’.”

6.2 Face: wellness contact only (15 minutes)

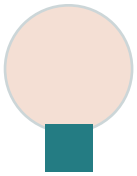
Goal: selected relaxation-oriented contact on intact skin, no promise of postoperative facial swelling reduction. **Cautions:** recent facial surgery/injectables, infection, acute sinus/dental infection, active dermatological disease, eye disorders, thyroid/neck precautions, facial swelling of unknown cause.

1. Complete screening, confirm no procedures or new facial swelling, and obtain face-specific consent.
2. Support the neck in neutral and position the client comfortably.
3. Observe head-and-neck node territories on the chart; do not treat anatomy as an instruction to apply neck pressure.
4. Practise feather-light stationary-circle coordination over a suitable lateral cheek or temple practice area with the instructor; avoid the eyeball and inflamed tissue.
5. Reassess comfort and finish without mandatory neck clearance, deep sinus manipulation or pressure around the eyes.

Prompt: “Clinical teaching photo series of gentle stationary hand contact over healthy adult lateral cheek and temple, full eye protection, relaxed fingers, face supported, no postoperative claims, consent and draping evident.”

Regional anatomy: six areas to recognise

Region maps for safe orientation, not universal treatment pathways.



Neck / terminus

Cervical anatomy; avoid vascular pressure.



Face

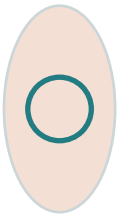
Eyes, sinuses and dental symptoms require caution.

Upper limb

Previous axillary surgery changes suitability.

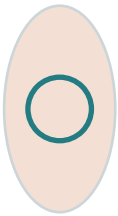
Lower limb

New one-sided swelling means stop / refer.



Abdomen

No deep pressure; screen surgery and pain.



Back / trunk

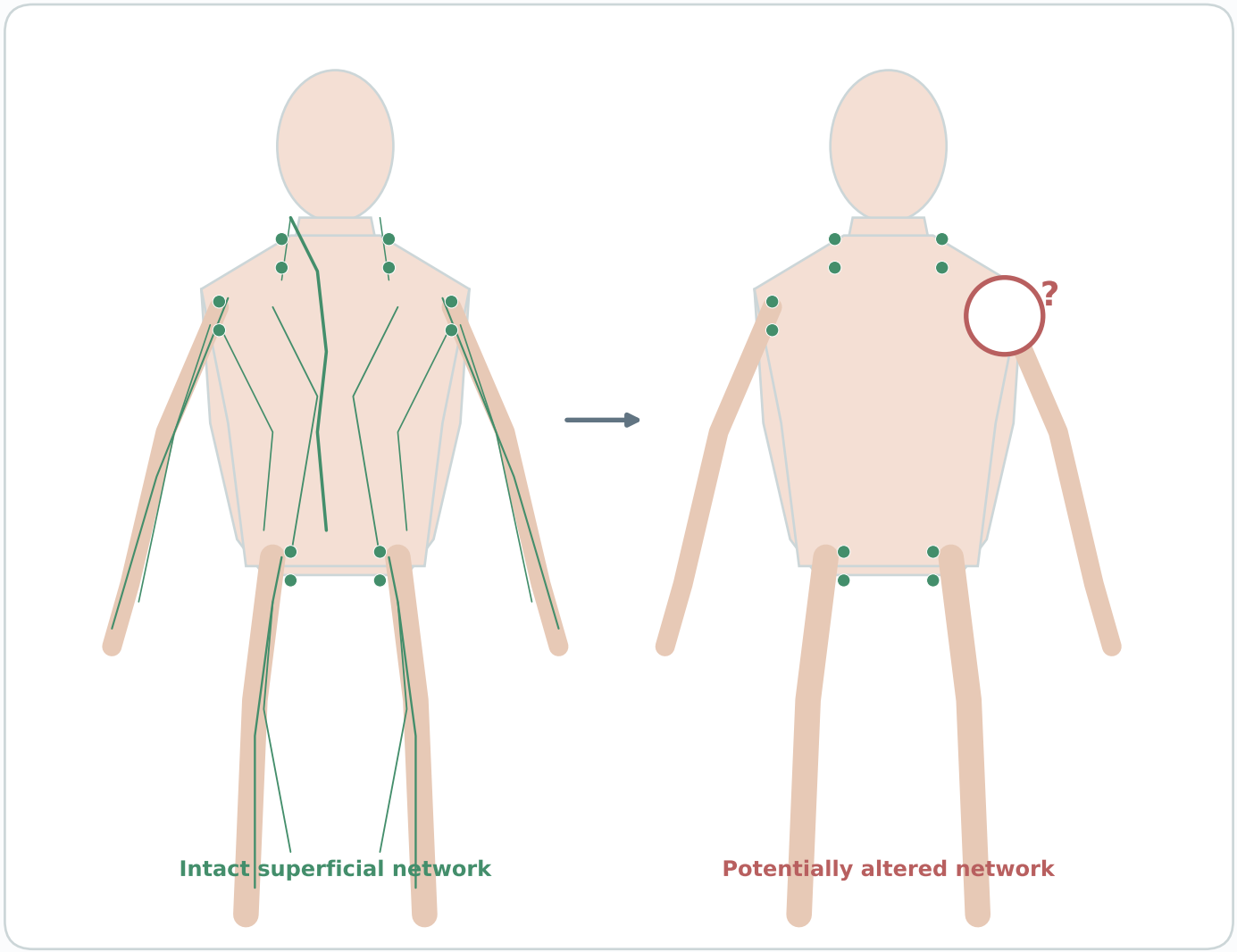
Respect surgery, radiation and skin changes.

Supervisor gate

Practical hand orientations and clinical routes must be confirmed by a qualified instructor.

Why region charts cannot be treatment recipes

Lymphatic anatomy and precautions vary with surgery, radiation and disease.



Specialist decision required

If a client has lymph-node removal, radiotherapy, known lymphoedema, significant infection or unexplained swelling, do not translate the left-hand figure into an alternative route. Clinical assessment and recognised CDT education are required.

6.3 Upper limb: intact healthy adult rehearsal (20 minutes)

Goal: practise hand shapes and progressive working-position changes, not treat arm swelling. **Cautions:** previous mastectomy/axillary nodes, radiotherapy, port/vascular access, infection, recent surgery, unilateral swelling, upper-limb DVT, lymphoedema.

1. Recheck no swelling or previous nodal injury; support shoulder, elbow and wrist in neutral.
2. Identify the normal axillary and upper-limb territories on a labelled diagram; explain why these may not apply after surgery.
3. At a safe, proximal upper-arm practice area, rehearse the approved stationary circle or pump with a controlled release.
4. Move the *practice location* gradually to mid-arm then forearm for comparison of hand shape; this is not an instruction to move pathological fluid.
5. Avoid elbow crease/vascular access, avoid gripping the limb or compressing joints, and ask for feedback after each movement family.
6. Finish with comfort reassessment and record observations.

Prompt: “Six-frame training photo storyboard of female therapist demonstrating superficial movement-family hand placements on an intact adult upper arm and forearm, arm bolstered, arrows only for local skin stretch/release, no clinical drainage arrows, no oil.”

6.4 Lower limb: intact healthy adult rehearsal (20 minutes)

Goal: revise superficial pressure and posture at different limb contours. **Cautions:** new unilateral leg swelling, DVT/PE history, varicose-vein complications, ulcers, severe arterial insufficiency, cardiac/renal oedema, recent orthopaedic surgery, frailty.

1. Exclude new swelling, calf pain, warmth, wounds or systemic illness before touching the limb.
2. Position in comfortable supine or side-lying with suitable knee/ankle support; never force hip or knee extension.
3. Orientate to intact superficial territories on the anatomy diagram without assuming an oedema route.
4. At a safe proximal thigh practice site, rehearse gentle broad contact; do not compress the femoral triangle or groin.
5. Move to a suitable lateral thigh or calf *practice location* after checking the skin, with minimal superficial pressure; avoid varicosities and sensitive areas.
6. Practise a controlled release and compare ergonomics with upper-limb work; stop for pain or discomfort.

Prompt: “Professional instructional photographs of supervised superficial MLD hand placement on intact adult lateral thigh and calf, leg supported with knee bolster, professional draping, no groin compression, no oedema treatment diagram.”

6.5 Abdomen: restricted, mainly observational (15 minutes)

Goal: understand anatomy and consent rather than teach unsupervised abdominal MLD. **Cautions:** pregnancy, recent surgery, hernia, aneurysm, abdominal pain, malignancy, ascites, bowel or bladder inflammation, inflammatory bowel disease, vascular disease; avoid pressure over any suspected pathology.

1. Review anatomical landmarks and contraindications on a diagram rather than on a client.
2. Explain privacy, draping and explicit area-specific consent.
3. Observe an accredited educator demonstrating positioning and hand preparation on a suitable training model; do not infer a standard abdominal drainage route.
4. Practise only non-contact hand alignment or approved superficial hand placement on a model under supervision.

5. Do not perform deep abdominal compression, ‘diaphragm pumping’ or self-invented clearance sequences. Log that abdominal skill remains restricted pending instructor sign-off.

Prompt: “Clinical educational photo showing respectfully draped abdomen, therapist hands hovering to demonstrate safe external orientation on anatomical teaching model, no deep pressure, warning banner ‘observational training — supervised specialist teaching required’.”

6.6 Back and trunk: healthy volunteer rehearsal (15 minutes)

Goal: refresh comfort, positioning and broad-surface rotary or stationary movement mechanics.
Cautions: recent spinal surgery, osteoporosis, wounds, radiation, cancer, altered trunk drainage, breast/axillary surgery.

1. Screen and position prone or side-lying only if comfortable; offer alternative positioning.
2. Expose only the agreed safe upper-back or lateral trunk practice area with appropriate draping.
3. Review trunk watershed diagram as general anatomy, not a personalised drainage map.
4. Rehearse an educator-approved rotary or stationary-circle movement over a safe muscular surface with superficial skin contact.
5. Avoid direct pressure over spine, scars, irradiated or damaged tissues; reassess and record.

Prompt: “Three-panel clinical teaching photograph of supervised hand placement on healthy adult upper back and lateral trunk, professional sheet draping, supported neutral positioning, superficial rotary working/release phases, no clinical pathway arrows.”

Regional pass standard

The therapist must explain the contraindications and referral rule before each drill; show accurate hand shapes on a healthy partner, without pain, pressure or sliding; and identify situations needing specialist CDT. A qualified instructor should sign off any real-world technique claim. A region not signed off should not be offered as MLD.

Expanded regional practical workbook | Module 6

Safety and scope — required at the start of every region

Work with an instructor-approved, screened healthy volunteer; do not treat oedema. Before *each* regional practice: reconfirm consent, region-specific contraindications, appropriate draping, intact skin, comfortable supported posture and clear ability to stop. Never apply any normal-anatomy diagram as a universal drainage route. If lymph-node surgery, radiotherapy, known lymphoedema, a recent operation, infection or possible thrombosis is relevant, do not rehearse a treatment sequence on that person.

The 100 minutes below are timed *regional skill stations*, not validated treatment duration recommendations. The exact stroke contact, direction and repetition count are for instructor demonstration and correction; the descriptions below prioritise safety, orientation and mechanical rehearsal.

Station schedule — 100 minutes total

Station	Duration	Practical evidence
Neck and terminus	15 min	Correctly state vascular cautions; demonstrate non-forceful orientation
Face	15 min	Consent and safe superficial hand-position rehearsal
Healthy upper limb	20 min	Support limb; compare two approved movement families

Station	Duration	Practical evidence
Healthy lower limb	20 min	DVT screening, support and superficial contact
Abdomen	15 min	Anatomical observation and verbal contraindications
Back and trunk	15 min	Draping, upper-back rotary practice and recheck

Station 1 — Neck and terminus (15 minutes)

First 5 minutes — screen: Ask about recent head/neck surgery, radiotherapy, unexplained neck masses, thyroid or carotid disease, significant arrhythmia, fainting and dizziness. Avoid vigorous manipulation, carotid pressure, anterior throat compression and deep supraclavicular force. When in doubt omit neck contact.

Next 5 minutes — anatomical orientation: On the atlas identify the lower cervical region, venous angles and superficial neck tissues. Explain aloud that nodes are not valves that can be opened physically. With hands hovering over a diagram, show the general placement areas that your instructor will subsequently demonstrate on a suitable volunteer. Do not independently press the supraclavicular fossa.

Final 5 minutes — instructor-led practice and note: Observe the hand-resting position and movement shape. On an approved safe lateral-neck surface, the trained instructor may supervise a few superficial movements with controlled release. The objective is safe contact quality, not completing a prescribed node-opening routine. Write a short note identifying any technique requiring correction.

Stop signs: any dizziness, discomfort, neurological symptom, distress or inappropriate tissue response. Record that any unverified neck technique is not cleared for professional use.

Station 2 — Face (15 minutes)

Safety 5 minutes: Confirm no recent facial or dental procedure, infection, acute sinus or ocular symptoms, unexplained swelling, significant pain or skin damage. Ask permission for any contact near the face. No pressure on the eyes or on an infected or tender region.

Observation 5 minutes: Use the face anatomy plate to locate superficial territories and regional groups. Watch the instructor demonstrate a gentle small-contact movement on a healthy cheek or forehead. Explain why the diagram must not be used to devise a unilateral postoperative face/neck oedema route.

Practical 5 minutes: With permission, rehearse relaxed finger posture and a short gentle working/release pattern on an uncomplicated healthy cheek region already approved by the instructor. Do not slide over cosmetic products or use force. Ask the volunteer to report pressure quality. Conclude by recording consent and any area omitted.

Station 3 — Upper limb (20 minutes)

Safety 5 minutes: Ask about arm swelling, pain, infection, wounds, cancer surgery, node removal, radiotherapy, vascular access, injury or anticoagulation-related bruising. A swollen or medically altered limb is not a practice limb.

Anatomy and positioning 5 minutes: Identify the intact axillary and superficial upper-limb network on the atlas; explain why it might differ after treatment. Position the shoulder, elbow and wrist comfortably supported, with no traction on joints and no pressure on vascular access.

Mechanical rehearsal 7 minutes: The educator demonstrates one stationary-circle and one pump or scoop variant on a suitable healthy limb surface. The learner practises a short observed set at an instructor-approved upper-arm or forearm practice site, comparing contact, wrist movement, release, and skin response. Relocating the *practice site* does not equate to teaching a fluid-transport sequence.

Feedback 3 minutes: Ask about comfort; record errors in sliding, squeezing or wrist rigidity. No assumption that a generic proximal-distal drainage pattern applies to disease.

Station 4 — Lower limb (20 minutes)

Safety 5 minutes: Explicitly screen for unilateral swelling, calf pain, warmth, colour change, wounds, postoperative status, varicose complications, heart/renal disease and past DVT or PE. Any possible acute DVT means no practice and urgent medical referral.

Support 5 minutes: Demonstrate safe knee and ankle bolstering. Do not assume everyone can lie flat; do not forcibly elevate or manipulate a limb with pain, instability or serious vascular concerns.

Mechanical rehearsal 7 minutes: With an educator, practise a short gentle contact/release movement over a selected intact unswollen lateral thigh or other safe teaching surface. Avoid pressure over the groin, inflamed varicosities, popliteal fossa and tender calf. Repeat on a different contour only if screening and instruction permit. Record the effect on your own posture rather than making a claim about oedema reduction.

Feedback 3 minutes: The partner rates comfort; the observer records whether the release is distinct and whether the learner kept force superficial.

Station 5 — Abdomen (15 minutes)

Safety 5 minutes: Review pregnancy, abdominal surgery, hernia, aneurysm, ascites, unexplained pain, infection, inflammatory conditions, trauma and any concerning mass. Abdominal work is **not** a default wellness requirement.

Anatomy 5 minutes: With an atlas and a model, distinguish superficial abdominal skin territories from deep visceral and vascular structures. Explain why deeper pressure is not an effective shortcut to the cisterna chyli and why abdominal fluid retention needs medical assessment.

Observation and consent 5 minutes: Practise verbal consent and draping. Observe an instructor demonstration on an appropriate model; rehearse hands in the air or on an anatomical model. Do not carry out unsupported deep abdominal movements. Mark this region 'observation only' unless separately supervised and signed off.

Station 6 — Back and trunk (15 minutes)

Safety 5 minutes: Ask about recent spinal or chest surgery, radiotherapy, skin problems, fragility, altered lymphatic territories, osteoporosis and capacity to lie prone. Offer side-lying or sitting where appropriate and within scope.

Technique and positioning 7 minutes: Drape respectfully and support the volunteer. Observe the teacher's rotary hand movement over an intact upper-back area, then rehearse a brief supervised set with superficial skin displacement and controlled release. No deep spinal force. The watershed image provides orientation only; do not route around axillary removal based solely on it.

Feedback 3 minutes: Ask for comfort feedback, record any undesired friction or shoulder tension, and confirm that the volunteer can sit up without dizziness.

Six-station practical record

Complete one line per station. Leave a field blank only if a task was intentionally not performed; then explain why.

Region	Screening verbalised	Consent/ positioning	Movement demonstrated	Educator comment
Neck	_____	_____	_____	_____
Face	_____	_____	_____	_____
Upper limb	_____	_____	_____	_____
Lower limb	_____	_____	_____	_____

Region	Screening verbalised	Consent/ positioning	Movement demonstrated	Educator comment
Abdomen	_____	_____	_____	_____
Trunk/back	_____	_____	_____	_____

Safety-focused rapid questions

1. **A client has previous axillary radiotherapy and unilateral arm oedema.** Which station procedure applies? **Answer:** none of these generic practice stations as treatment; refer for specialist CDT assessment.
2. **The healthy volunteer refuses facial contact.** What do you do? **Answer:** omit it and document revised consent.
3. **You feel the need to press firmly into the lower neck to 'open the terminus'.** Is this appropriate? **Answer:** no; stop and obtain instructor correction, and avoid deep vascular structures.
4. **An older volunteer becomes breathless when flat.** What do you do? **Answer:** stop repositioning for treatment, assess urgency and refer as indicated; do not force supine positioning.
5. **Is abdominal MLD essential for every whole-body wellness session? Answer:** no; omit when uncertain or contraindicated.
6. **What is the meaning of the watershed diagram? Answer:** conceptual map of typical territories, not a patient-specific clinical route.

Pass standard: zero safety failures, complete documentation of regions omitted and practical sign-off by an appropriate educator for any movement to be offered professionally.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- Dr Vodder School method-specific supervised education: https://www.vodderschool.org/training_program_basic
- Macmillan lymphatic drainage and personalised self-care: https://www.macmillan.org.uk/cancer-information-and-support/impacts-of-cancer/lymphoedema/lymphatic-drainage-for-lymphoedema
- Normal anatomy illustrations are not treatment maps for altered lymphatic systems.

> **Professional boundary:** illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

MODULE 07 OF 08

Conditions and Evidence

Guided learning: **60 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Module 7 — Conditions and possible treatment: evidence and scope (60 minutes)

Safety first

The following conditions are not an invitation to treat. Most require diagnosis or specialist planning. Cardiac oedema and new unexplained swelling must not be accepted as wellness MLD indications.

Theme	Therapist-level explanation	What MLD may or may not do	Modern management and scope decision
Post-surgical swelling	Fluid changes and inflammatory response after surgery; infection/clot/seroma must be excluded	Sometimes incorporated into clinician-directed care; no general evidence supporting every cosmetic or orthopaedic case	Surgeon-specific timing, wounds/drains, DVT assessment and scope. Refer until appropriate training and procedure-specific clearance are documented.
Primary lymphoedema	Lymphatic abnormality arising from development or genetics	May be adjunct within specialist CDT; not a cure	Specialist diagnosis, assessment, compression, movement, skin care and self-management; not independent wellness treatment.
Secondary lymphoedema	Acquired disruption of lymphatic pathways	May be adjunct, evidence mixed; not sufficient alone	Specialist CDT and assessment for underlying causes.
Cancer-related lymphoedema	Post-treatment or disease-related lymphatic impairment	Selected patients may benefit from MLD as an adjunct; evidence inconsistent	Current guidance emphasises specialist assessment, management of underlying causes and suitable compression where clinically indicated. No generic post-node-removal sequence.
Venous insufficiency/heavy legs	Venous return problems may cause heaviness, skin changes and oedema	Not a primary correction for venous reflux; relaxation may help comfort	Medical/vascular diagnosis; appropriate mobility, compression when indicated by clinical assessment; no therapeutic claims by wellness practitioner.
Cardiac-related oedema	Systemic fluid accumulation associated with heart disease	Inappropriate as a wellness oedema target	No MLD for cardiac oedema on this pathway; unstable heart failure is a stop sign.
Lipedema	Chronic painful disproportionate fat distribution; not equivalent to ordinary lymphoedema	MLD alone is not proven to reduce fat/volume; may be a symptom adjunct in selected specialist plans	2024 guidance emphasises pain/function, suitable compression, movement and patient-centred care.
Lipo-lymphoedema overlap	Coexisting lipedema and clinically significant lymphatic insufficiency	Complex needs; no standard massage routine	Specialist multidisciplinary assessment.
Immobility-related swelling in older people	Dependent swelling may coexist with venous, medication or systemic causes	Do not assume MLD is appropriate	Medical review for new/worsening oedema; safe movement/function, skin care and positioning as clinically advised.

Conditions and scope: quick reference

A wellness refresher is not independent diagnosis or clinical oedema treatment.

Relaxation / healthy client	Screened wellness within competence
After surgery	Surgeon / rehabilitation assessment
Cancer-related swelling	Specialist lymphoedema referral
Known lymphoedema	Specialist CDT management
Venous heavy legs / persistent oedema	Medical / vascular assessment first
Lipedema or mixed conditions	Specialist diagnostic pathway
Cardiac fluid retention	Do not offer wellness MLD for oedema
Acute infection or suspected DVT	STOP and urgent medical assessment

Evidence reminder

Do not promise detoxification, immune boosting or guaranteed swelling reduction.

Theme	Therapist-level explanation	What MLD may or may not do	Modern management and scope decision
Sport / recovery / relaxation	Non-specific post-exercise feelings, discomfort or relaxation goals	Some report comfort; claims of faster recovery, “detox”, immune boost or objective lymph activation are not reliably established	Offer only honestly described, consented wellness treatment within verified competence; no clinical claims.

Three short cases

Case 1: “I want post-liposuction lymphatic drainage tomorrow.” Ask surgery details and medical symptoms, then refer to the surgeon's postoperative plan and qualified practitioner; do not invent a safe date or work across a fresh surgical site.

Case 2: “I have lipedema and want my fat mass drained.” Explain MLD is not proven to reduce pathological adipose tissue; refer for specialist symptom management.

Case 3: “My ankles are always puffy from my heart medication.” Do not treat presumptive medication/ cardiac oedema. Recommend prescriber review.

Knowledge check

Distinguish outcome claims for comfort, function, limb volume and cure. Determine who must diagnose each condition, what can be offered as wellness, and why a GP/surgeon/vascular or lymphoedema referral is needed. **Pass:** no inappropriate cardiac, DVT, cancer-related or complex lymphoedema care claim.

Expanded conditions and evidence seminar | Module 7

Safety rule and 60-minute study plan

A clinical name is not a booking category. Swelling must be appropriately assessed before a therapist decides which intervention may be suitable. **No medical oedema case in this lesson is an invitation for independent wellness treatment.**

Activity	Duration	Evidence
Review the conditions comparison	10 min	Mark specialist-only conditions
Complete an indication/referral matrix	15 min	Conditions, evidence, scope
Work through five consultation cases	20 min	Written clinical reasoning
Audit five proposed marketing claims	10 min	Safe edited wording
Mark end quiz	5 min	Corrected answers

Updated evidence vocabulary

Use four different statements carefully:

- **Possible comfort benefit:** some individuals report feeling more relaxed or less uncomfortable after gentle contact. This is not an objective measurement of lymphatic transport.
- **Adjunctive clinical use:** a specialist may add MLD to a comprehensive assessed treatment plan for selected people. Use and benefit should be reassessed.
- **Established cornerstone:** skin care, properly assessed compression when suitable, activity and self-management are central parts of many lymphoedema services.
- **Unsupported promise:** eliminating lipedema tissue, curing lymphoedema, 'detoxing' organs, treating cardiac fluid or guaranteeing rapid postoperative recovery.

The 2024 BLS MLD document emphasises the weak evidence for routine additional clinical benefit and the importance of measuring outcomes. The ISL 2023 consensus recognises variability, individual patient considerations and limitations in the research. NHS guidance outlines decongestive treatment as a package rather than massage alone. These sources support a more measured service description than much online wellness advertising.

Indication/referral matrix to complete (15 minutes)

For each item, write an answer to **What is the condition? / Why might the client want MLD? / What is the main treatment pathway? / What can I safely say? / Who should assess or treat?**

1. **Postoperative inflammatory swelling:** A surgical team must exclude complication (infection, seroma, haematoma, clot) and define any rehabilitation strategy. A therapist with a basic refresher cannot set a universal postoperative day or programme.
2. **Primary lymphoedema:** Developmental lymphatic insufficiency needs clinical diagnosis and long-term management from a suitable specialist.
3. **Secondary and cancer-related lymphoedema:** Lymphatic pathways may be altered; compression, skin care, movement and trained care are important. Never apply a normal-watershed route by assumption.
4. **Venous insufficiency / heavy legs:** Assess venous and arterial disease, skin and ulcer history, persistent oedema and DVT risk. Do not equate all heaviness with lymphatic blockage.
5. **Cardiac oedema:** Fluid retention can reflect haemodynamic disease and treatment changes. Do not offer MLD for cardiac swelling in this wellness pathway.
6. **Lipedema / lipo-lymphoedema:** Painful disproportionate adipose tissue and possible superimposed oedema warrant specialist evaluation. MLD is not a fat-removal treatment.
7. **Immobility-related swelling:** Reduced calf-muscle pump can contribute, but chronic disease and medication may underlie swelling. Medical review is needed for new or progressive cases.
8. **Sport and relaxation:** A suitable screened client may value calm touch; do not claim objective sports-performance or immune benefits without appropriate evidence.

Consultation cases (20 minutes)

A. Cosmetic surgery: A client wants a three-session post-liposuction package beginning tomorrow. They have bruising, a wound dressing and are unsure whether a drain remains. **Decision:** defer; clinical surgery plan and properly trained postoperative practitioner needed. Ask about infection, thrombosis and surgical instructions; no generic drainage package.

B. Cancer history: A 64-year-old reports arm swelling after lymph-node removal and says an online chart shows where to redirect lymph. **Decision:** specialist lymphoedema and oncology review; online chart is not an individualised map. Document symptoms and referral.

C. Venous symptoms: A 70-year-old reports bilateral evening heaviness, ankle discoloration and previous ulcers. **Decision:** medical/vascular assessment; do not prescribe compression or treat persistent oedema from this refresher.

D. Cardiac symptoms: A 75-year-old has known heart failure, swollen ankles and increasing breathlessness when lying down. **Decision:** no MLD; urgent medical review, emergency response if acute respiratory distress.

E. Wellness-only: A medically well runner requests 'lymphatic detox' to recover faster after a race. **Decision:** correct the claim, offer only suitable relaxation-oriented bodywork if within competence and consent. Avoid a promise of faster performance or measurable detoxification.

Write a 50-word referral or explanation for each. The answer must name what is known, what is uncertain and what the therapist will not do.

Marketing-claim audit (10 minutes)

Rewrite each unsupported phrase as an accurate statement:

Avoid	Safer alternative
'Flush toxins out of your body'	'Gentle skin-contact techniques intended for comfort and relaxation'
'Cures lymphoedema'	'Known lymphoedema needs assessment and ongoing specialist management'
'Treats all postoperative swelling'	'Postoperative concerns require surgeon direction and suitably trained providers'
'Improves cardiac circulation by draining ankle fluid'	'Cardiac-related oedema requires medical care; we do not offer drainage for it'
'Removes lipedema fat and cellulite'	'We do not claim MLD removes lipedema tissue; refer for individualised care'

Mini-test and answers (5 minutes)

Q1. What role does MLD have in specialist lymphoedema care? **Answer:** potentially one component, with individually assessed benefit; not a replacement for core care.
Q2. Is cardiac oedema a permitted wellness indication? **Answer:** no.
Q3. Does lipedema mean a standard lymphatic blockage? **Answer:** no; it is distinct and may coexist with lymphatic problems.
Q4. Can a massage therapist prescribe compression from this course? **Answer:** no.
Q5. What is a defensible outcome for a screened wellness relaxation client? **Answer:** reported comfort or relaxation, without unsupported clinical physiological claims.

Pass standard: all referral and contraindication decisions correct; no unsupported public-health or postoperative claim left in the proposed marketing copy.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- BLS MLD position document: https://www.thebls.com/documents-library/british-lymphology-society-manual-lymphatic-drainage-position-document
- ISL consensus: https://pubmed.ncbi.nlm.nih.gov/39207406/
- Cancer Research UK: https://www.cancerresearchuk.org/about-cancer/coping/physically/lymphoedema-and-cancer/treating/massage-manual-lymphatic-drainage
- NHS DLT: https://www.nhs.uk/conditions/lymphoedema/treatment/

> **Professional boundary:** illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

MODULE 08 OF 08

Competency and Return to Practice

Guided learning: **45 minutes**

For: Previously trained massage and bodywork therapists, returning to MLD-related learning.

Safety condition: Complete the Module 3 screening gate before practising. No self-study content provides specialist lymphoedema/CDT authority.

Assessment: Complete the timed tasks, knowledge check and relevant practical evidence sheets.

Module 8 — Skills sign-off and return-to-practice plan (45 minutes)

Safety and authorisation principle

Self-study completion is neither a competency assessment nor professional scope expansion. **Do not advertise specialist MLD, CDT, cancer-related lymphoedema or medically directed postoperative management until all required education, professional registration, indemnity and supervised competency have been verified.**

Competency checklist

[ ] Historic training certificate and syllabus located.
[ ] Current professional registration and lawful scope verified.
[ ] Indemnity insurer confirms proposed treatments and home visits.
[ ] Updated anatomy, watersheds and altered drainage principles explained.
[ ] Acute DVT/PE, cellulitis, heart failure and systemic red flags recognised without prompting.
[ ] Current screening, consent, documentation and referral templates completed.
[ ] Stationary circles observed and signed off.
[ ] Pump observed and signed off.
[ ] Scoop observed and signed off.
[ ] Rotary observed and signed off.
[ ] Thumb variation, where relevant, observed and signed off.
[ ] Pressure calibration and release phase verified by instructor.
[ ] Healthy-volunteer regional placements reviewed; restricted regions marked accordingly.
[ ] Infection control, draping, positioning and home-visit procedures checked.
[ ] Marketing language and service descriptions reviewed for scope and honesty.
[ ] Referral links to local GP, surgeon, vascular and lymphoedema clinician established.

Two-week educational refresher plan

Days 1–2: Modules 1 and 2; annotated anatomy and evidence notes.
Days 3–4: Module 3; complete red-flag cases until 100% correct.
Days 5–6: View verified instructor technique videos; practise movement coordination without clients.
Days 7–8: Arrange qualified educator session; begin hand movement correction.
Days 9–10: Module 5 intake/consent/home-visit simulation.
Days 11–12: Module 6 healthy-volunteer placements only with educator approval; note restrictions.
Day 13: Module 7 indications/referrals, revise client-facing claims.
Day 14: Module 8 self-audit and book observed practical evaluation.

Six-week return-to-practice development

Week 1: Foundational knowledge, evidence and scope audit.
Week 2: Full screening proficiency and first supervised movement correction.
Week 3: Second observed practice session; five movement families and ergonomic refinements.
Week 4: Simulated consultation and documentation; home-visit risk assessment; supervised healthy-volunteer sessions only.
Week 5: Educator-led reassessment; review regional restrictions; establish local referral network.
Week 6: Written competence review, insurance and professional registration checks, honest public wording. Only consider limited wellness offering where all current prerequisites are satisfied; otherwise continue supervised development and training.

Further study (South Africa)

- **LAOSA:** https://www.laosa.co.za/ — National Practice Register, standards, therapist referrals. Confirm membership/registration criteria directly.
- **Lymphatic Training Africa:** https://www.ltaafrica.com/lrp — advertises a 135-hour comprehensive programme for eligible degree-level clinical healthcare professionals; confirm current availability and eligibility.

Return-to-practice: staged competence

Time spent revising is not proof of clinical proficiency.



WEEK 1 — **Modules 1–3**

Anatomy, evidence, safety decisions.

WEEK 2 — **Modules 4–6**

Healthy-volunteer supervised movement review.

WEEKS 3–4 — **Structured observation**

Instructor correction and repeat practice.

WEEKS 5–6 — **Competency decision**

Written feedback, scope and insurance checks.

Professional scope

Clinical lymphoedema/CDT requires separately recognised education and appropriate registration.

- **Lymph Africa / Lymph Medical:** https://lymphafrica.com/ — describes a 150-hour lymphoedema programme with theory and hands-on training. Verify professional eligibility and current delivery.
- **ISA Carstens Academy MLD:** https://isacarstens.ac.za/manual-lymphatic-drainage/ — theory and a five-day practical programme, certificate and logged sessions; MLD course alone is not specialist CDT registration.
- **Lymphatic Therapy (South Africa):** https://lymphatictherapy.co.za/advanced-manual-lymph-drainage/ — describes a 25-hour advanced MLD course; provider explicitly says this does not qualify the learner as a lymphoedema therapist.
- **Optional low-cost online wellness courses:** can support vocabulary or theory but do not substitute for Vodder School practical assessment, recognised CDT qualification or clinical registration. For any Udemy course, check instructor credentials, update date, clinical accuracy and limitations; do not call it “Vodder-certified”.
- **Recommended illustrated book:** Wittlinger H, Wittlinger D, Wittlinger A, Wittlinger M. *Dr Vodder's Manual Lymph Drainage: A Practical Guide*, 2nd ed. Thieme, 2019, ISBN 9783132411449 (print) / 9783132411470 (ebook).

Required sign-off: Date; educator name/qualifications; demonstrations observed; suitable treatment scope; any unresolved restrictions; date for reassessment. Do not generate a certificate of clinical competence from this site.

Expanded return-to-practice and evidence portfolio | Module 8

Scope and timing: 45 minutes

Self-study cannot restore a credential, create a new registration category or demonstrate hands-on mastery. The purpose of the final module is to build a credible record of what Nicky knows, what still needs supervised evaluation and exactly what services can be offered after that evaluation.

Activity	Duration	Output
Locate training and scope evidence	10 min	Credentials and insurer checklist
Self-assess safety and technique	10 min	Competency matrix
Write 2-week / 6-week learning plan	15 min	Dated development plan
Professional decision exercise	5 min	Two referral answers
Compile sign-off portfolio	5 min	Evidence inventory

1. Registration, competence and insurance audit (10 minutes)

Locate the original certificate and any syllabus, identifying precisely what was taught. If training was approximately 15 years ago, confirm whether it covered only intact lymphatic systems, supervised MLD, postoperative protocols or accredited CDT. A memory that one 'did lymphatic drainage' is not an adequate statement of scope.

Verify the current South African professional registration relevant to the actual services being offered. For specialist clinical lymphoedema roles, consult the **Lymphoedema Association of South Africa (LAOSA)** and the associated recognised postgraduate and relevant professional-registration requirements. The LAOSA site highlights recognised postgraduate training and HPCSA registration for practitioners in its clinical therapist-finding pathway. Some professional backgrounds may involve other regulators; the exact rules must be verified rather than guessed. AHPCSA therapeutic massage registration alone does not establish specialist CDT competence.

Ask the professional indemnity insurer to confirm **in writing**: (a) permitted treatment category; (b) home visits; (c) cancer/postoperative exclusions; (d) whether any specific MLD certificate is required; and (e)

whether referral arrangements are expected. Also check hygiene policies, POPIA handling of medical details, professional boundaries, informed consent and emergency plans.

2. Competency matrix (10 minutes)

Mark **K = knowledge checked**, **P = partner practice observed**, **S = signed off by qualified instructor**, **N = not yet competent / not applicable**. Do not mark 'S' yourself.

Competence	K	P	S	N
Explains modern CDT and evidence	___	___	___	___
Locates primary anatomy and watersheds	___	___	___	___
Detects DVT, infection and cardiac warning signs	___	___	___	___
Gives clear informed consent	___	___	___	___
Demonstrates stationary-circle mechanics	___	___	___	___
Demonstrates pump mechanics	___	___	___	___
Demonstrates scoop mechanics	___	___	___	___
Demonstrates rotary mechanics	___	___	___	___
Uses thumb variation when indicated	___	___	___	___
Positions and drapes safely	___	___	___	___
Records wellness visits appropriately	___	___	___	___
Recognises altered lymphatic systems	___	___	___	___
Makes timely medical/specialist referrals	___	___	___	___
Confirms lawful professional scope and insurance	___	___	___	___

Any deficiency in safety, consent or referral means **no unsupervised treatment**, regardless of scores in movement mechanics.

3. Two-week refresher plan (15 minutes)

Days 1–2: Modules 1–2; produce an anatomy sheet and updated 'what MLD can and cannot do' statement.
Days 3–4: Module 3; practise the six simulated triage cases until every stop sign is answered correctly.
Days 5–6: Module 4 observation and solo movement rehearsals; prepare instructor questions and note which videos were available.

Day 7: Review weak points and prepare for partner practice; do not use an unscreened volunteer.
Days 8–9: Supervised movement observations and hands-on correction with a qualified MLD educator, if available.
Day 10: Module 5 consultation simulations and home-visit setup.
Days 11–12: Module 6 regional stations on a suitable volunteer only with appropriate supervision.
Day 13: Module 7 evidence and claims audit.
Day 14: Module 8 written review and portfolio assembly. Record what remains outstanding.

4. Six-week competency development plan

Week 1: Complete theory and screening, retaining written pass evidence.
Week 2: Observe validated movement demonstrations and arrange live technique correction.
Week 3: Repeat the five movement families on suitable healthy practice volunteers with educator feedback; do not count client sessions as supervised practice by default.
Week 4: Review region-specific positioning, consultation forms and safeguarding in home settings; run two complete mock appointments.
Week 5: Ask the educator to assess all safety gates and technique families. Repeat failed skills; document the actual observations and remaining exclusions.
Week 6: Verify regulator, insurer and referral network; decide which *wellness* services fall within proven competence. If seeking cancer-related, postoperative or lymphoedema work, enrol separately in recognised clinical education rather than adding those services.

This is a suggested schedule, not a guarantee that six weeks suffices to restore proficiency. Timing must follow the educator's assessment.

5. Further learning in South Africa

- **LAOSA:** ask for current recognised specialist therapist training expectations, professional-eligibility criteria, member directories and CPD resources. https://www.laosa.co.za/
- **Dr Vodder School International:** confirm current course levels, method-specific instructors and what constitutes retraining versus advanced CDT certification. https://www.vodderschool.org/
- **ISA Carstens Academy:** offers an MLD training route with practical components; confirm current dates, qualification level and whether it is recognised for the specific scope sought. https://isacarstens.co.za/product/manual-lymphatic-drainage-mld001/
- **Other local providers (including Lymph Africa and Lymphatic Therapy SA):** check current course existence, entry requirements, clinical recognition and hours directly. Do not infer CDT specialist status from a short workshop.
- **Reference text:** Wittlinger and colleagues, *Dr Vodder's Manual Lymph Drainage: A Practical Guide* (Thieme). Compare all illustrated hand postures with the instructor rather than copying pictures uncritically.

An online wellness video or an inexpensive commercial course may be supplementary revision, but it is not Vodder certification or recognised clinical CDT training.

Final professional decision exercise (5 minutes)

Decision A: A prospective client wants a named lymphoedema-treatment package after mastectomy; Nicky has completed these 9 h 25 min but has no new supervised assessment. **Correct action:** explain that the refresher does not confer specialist competence; refer for qualified CDT care and pursue recognised training if clinically appropriate.

Decision B: A healthy adult seeks gentle relaxation. Nicky has current relevant registration, verified insurance and an instructor has signed off appropriate techniques. **Correct action:** a carefully screened, consented wellness service may be considered within her actual scope, with clear limitations and accurate marketing.

Final portfolio for educator review (5 minutes)

Include: original qualification; current registration and indemnity evidence; Modules 1–3 completed written quizzes; anatomy drawing; five movement feedback records; six regional safety observations; a

simulated intake and SOAP note; 2-week / 6-week plan; a written contraindication and referral algorithm; educator sign-off with date and any restrictions. Store securely; do not place patient identifiers in a learning platform.

Course completion label: 'Completed structured 9 h 25 min educational refresher activities — practical competence subject to separate instructor evaluation.' Do **not** issue a certificate claiming clinical CDT competence or specialist registration.

Source and currency notes

Core clinical references are provided for review, not as a substitute for the latest locally relevant guidance. The BLS published a second MLD position edition in August 2026; confirm its full findings directly with the educator before updating any course claims.

- LAOSA therapist resources: https://www.laosa.co.za/
- LAOSA find therapist scope: https://www.laosa.co.za/find-a-therapist/
- Dr Vodder School: https://www.vodderschool.org/
- ISA Carstens MLD training: https://isacarstens.co.za/product/manual-lymphatic-drainage-mld001/

> **Professional boundary:** illustrations, scripts and practice stations are teaching aids. Exact Vodder movements and clinical drainage pathways require appropriately qualified hands-on assessment; medically unexplained swelling requires referral.

Final Safety and Competency Review

Private study form — not a certificate of clinical competence. Learner: _____ Date: _____

Part 1 — Written final review

Answer before checking the key. All urgent stop-sign and professional-scope questions must be correct.

1. An older client has newly swollen ankles and breathlessness when lying down. What is the appropriate next step?
2. A client has one hot, painful, swollen calf after a journey. Can the therapist begin with gentle proximal massage?
3. A client with cancer-related arm swelling asks for a standard upper-limb routine. What changes the pathway?
4. Explain why the four CDT components are not interchangeable.
5. Name the four broad Vodder movement families and the additional thumb variation.
6. Distinguish a superficial working phase from the release phase.
7. Why cannot an SLD video be used to assess a professional MLD stroke?
8. When should a therapist stop an appointment if the client initially gave consent?
9. What must an appropriate session note contain?
10. Is a six-week study plan proof of clinical competency?
11. Does medical clearance from a surgeon create skills not already possessed by a therapist?
12. Is 'detoxification of lymph' a defensible guaranteed outcome claim?

Part 2 — Answer key with required reasoning

1. No MLD for cardiac-related oedema. Medical reassessment urgently when worsening; emergency pathway for acute respiratory distress.
2. No. Possible DVT: stop and urgent medical assessment; no palpation or regional drainage workaround.
3. Lymph-node dissection/radiotherapy may alter pathways; referral to qualified lymphoedema specialist and treating team.
4. Clinical care requires coordinated assessment, suitable compression, movement, skin management, self-management and selected manual interventions.
5. Stationary circles, pump, scoop, rotary; thumb circles as an additional specific variation.
6. Working phase gently displaces skin; release unloads tension and permits recoil, avoiding deep tissue kneading.
7. SLD is simplified, individual self-management and does not verify professional hand mechanics, pressure or client selection.
8. At any request to stop, new concerning symptom, discomfort or loss of consent.
9. Screening, consent, exact regions and techniques, tolerance, adverse events, advice, any referral and follow-up.
10. No; hands-on assessment and legal scope must be confirmed separately.
11. No; medical suitability and therapist competence are separate checks.
12. No; unsupported clinical/marketing claim.

Part 3 — Practical instructor observation (complete in person)

Practical domain	Observed safely?	Corrections / restrictions
Consent, screening and immediate stop rules	Yes / No	_____
Anatomy and altered-pathway recognition	Yes / No	_____
Stationary circles	Yes / No	_____
Pump	Yes / No	_____
Scoop	Yes / No	_____
Rotary	Yes / No	_____
Thumb-circle variation if needed	Yes / No / N/A	_____
Positioning, hygiene and draping	Yes / No	_____
Documentation and referral decision	Yes / No	_____
Practice limited to approved indications	Yes / No	_____

Any unresolved safety issue means no practical sign-off.

Instructor name and qualifications: _____

Instructor signature: _____ Date: _____

Restrictions or further training needed: _____

Professional registration / indemnity verified separately (by whom and when): _____

Status statement: completion of this workbook is educational only. No claim of certification or specialist CDT authorisation is made.

Illustrated visual reference index

Find the diagrams within each module, or use the standalone atlas.

Module 01	**Plate 01**	CDT / DLT overview and 2026 source-check note
Module 02	**Plates 02–05**	Whole-body anatomy, microanatomy, watersheds, limb landmarks
Module 03	**Plate 06**	Stop / defer / go screening pathway
Module 04	**Plates 07–09**	Skin stretch, Vodder movement shapes, common faults
Module 05	**Plates 10–11**	Client session and table / bolster arrangement
Module 06	**Plates 12–13**	Six anatomical regions and altered lymphatic networks
Module 07	**Plate 14**	Indications, exclusions and referral boundaries
Module 08	**Plate 15**	Staged 2-week / 6-week practice development

Instruction

Educational schematics only. A qualified instructor must verify technique.

Modern CDT: four connected components

A clinical framework, not a claim that MLD alone treats oedema.

1 Compression

Clinical selection and fit; not prescribed by routine massage.

2 Exercise and movement

Graded activity and muscle action support fluid control.

CDT

3 Skin care

Skin integrity, infection prevention and recognition.

4 Specialist MLD / SLD

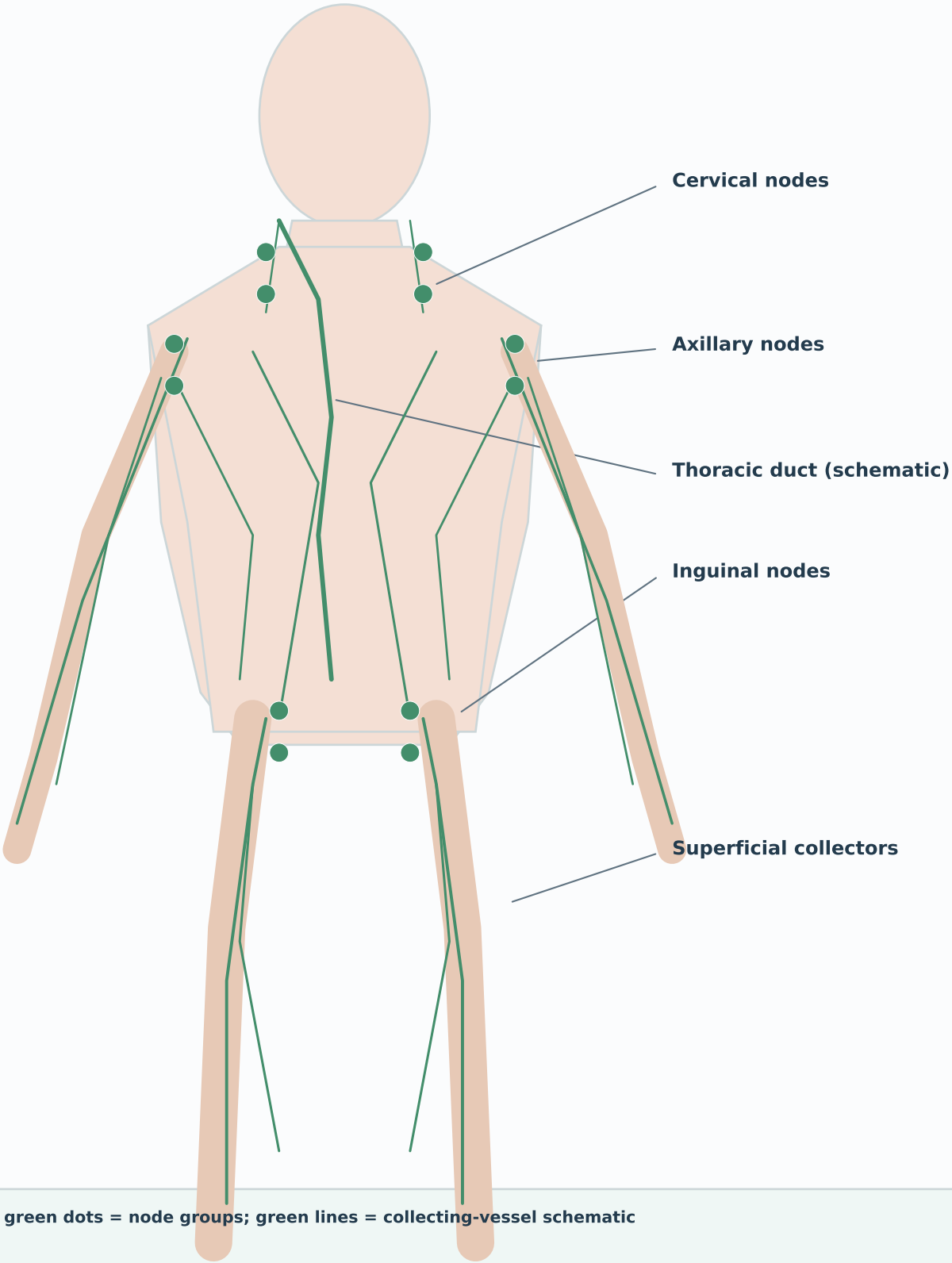
Selected use, measured benefit and individual self-management.

2026 source update

The British Lymphology Society lists a 2nd edition of its MLD Position Document (25 August 2026). Check the latest edition with your clinical educator before teaching clinical recommendations.

Whole-body lymphatic orientation

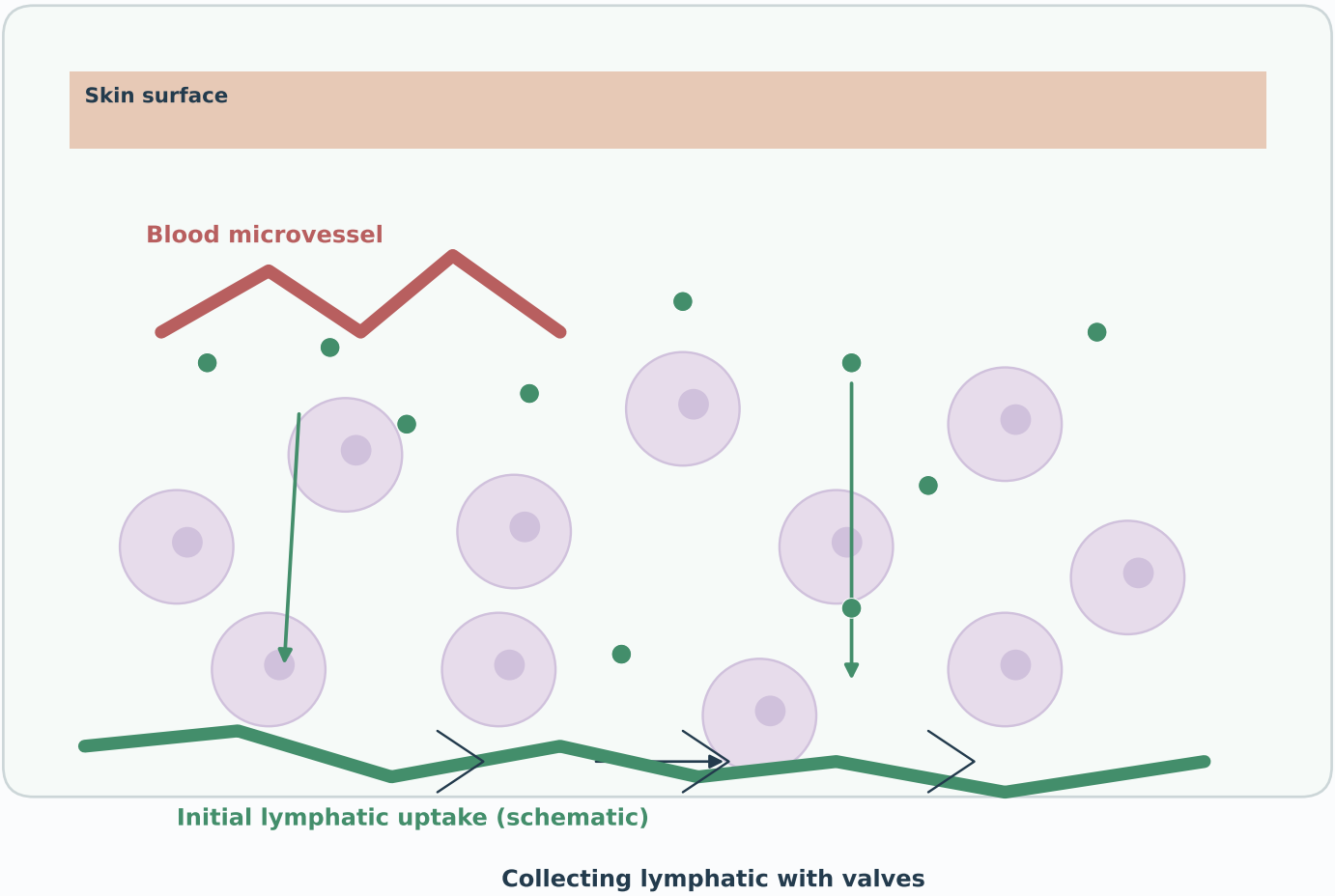
Illustrative superficial collectors, node groups and major venous return.



Key: green dots = node groups; green lines = collecting-vessel schematic

From interstitial fluid to lymph

A simplified functional view of capillaries, initial lymphatics and collecting vessels.



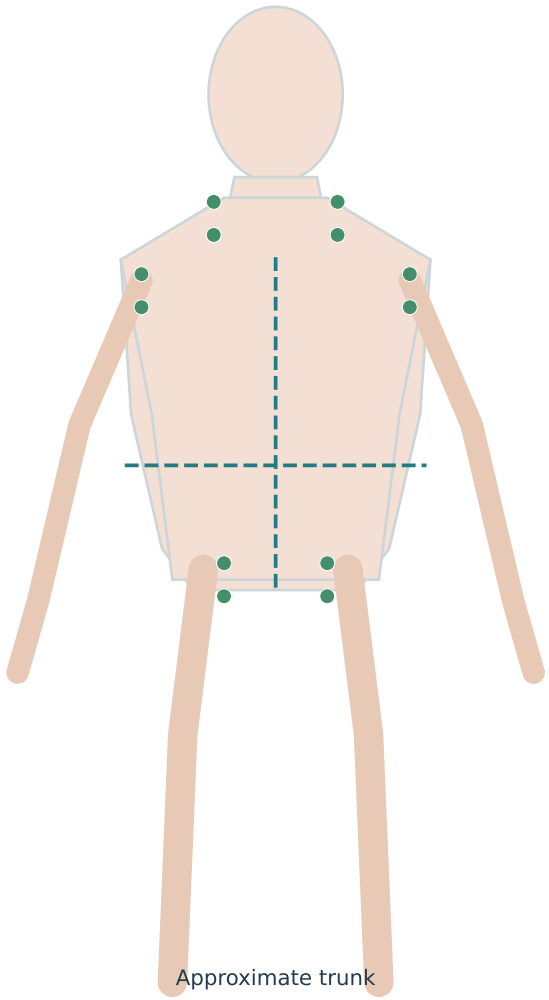
Clinical relevance

Classical MLD uses controlled superficial skin displacement; the drawing does not imply that deeper pressure forces vessels to drain.

Trunk watersheds and altered pathways

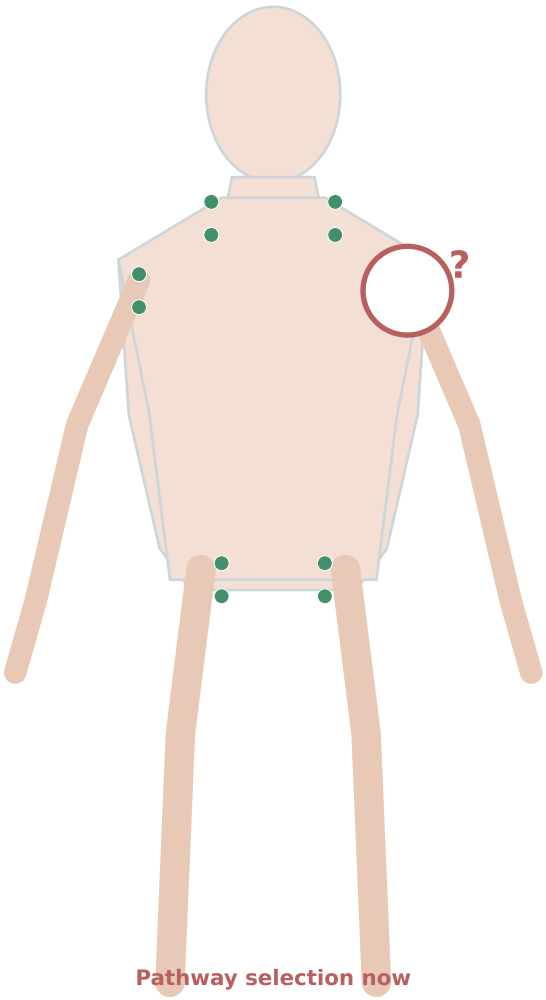
Normal territories are teaching concepts, not individual treatment maps.

Intact anatomy (simplified)



Approximate trunk watersheds

After node surgery



Pathway selection now

requires specialist assessment

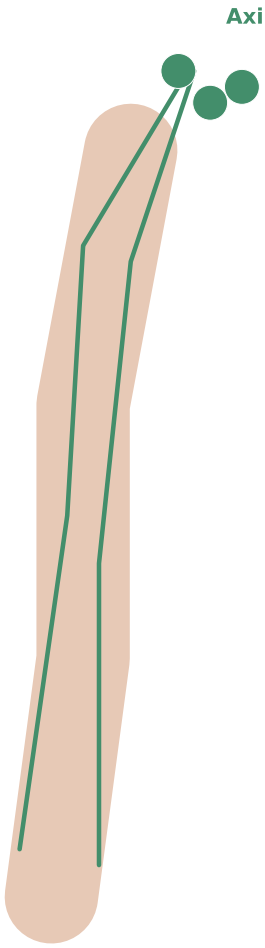
Never infer a route from an arrow

Node removal, radiotherapy, infection or congenital variants may alter drainage.

Upper- and lower-limb landmarks

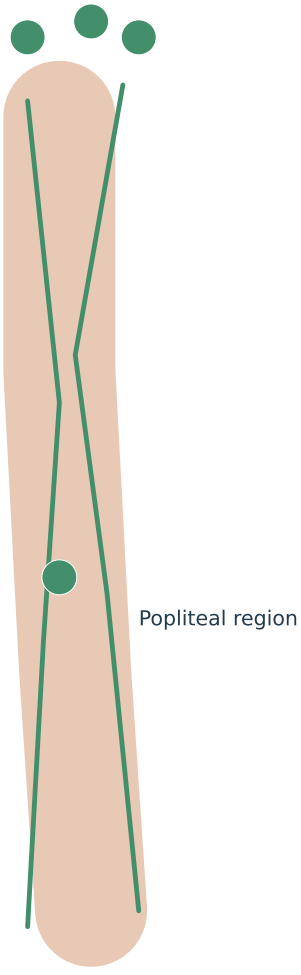
Educational recognition of intact superficial networks; no treatment direction prescribed.

Upper limb



Schematic superficial collectors

Lower limb

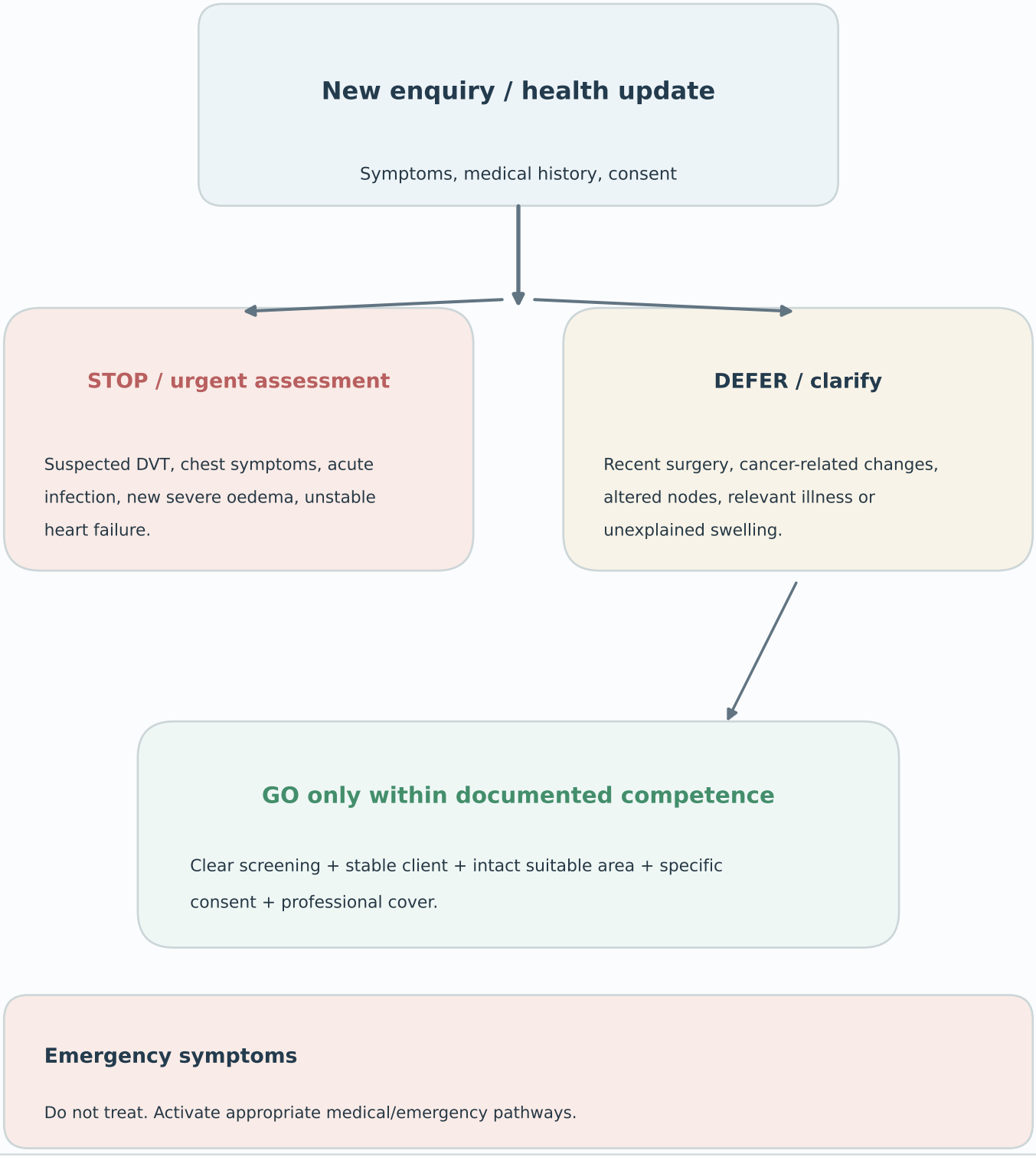


Safety reminder

Any new unilateral limb swelling or signs of infection/clot require assessment.

Safety triage before every session

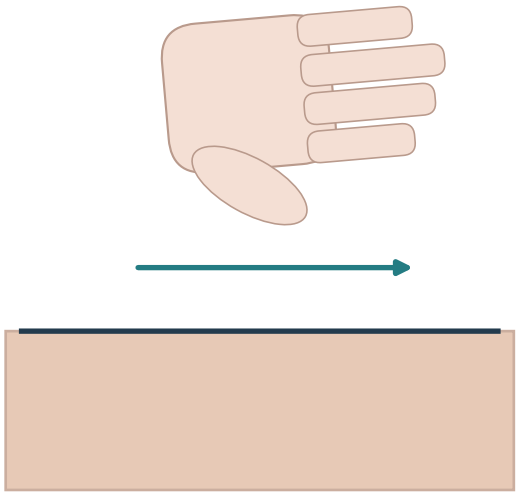
Stop, defer and refer decisions must precede all manual techniques.



Superficial skin stretch: two-phase contact

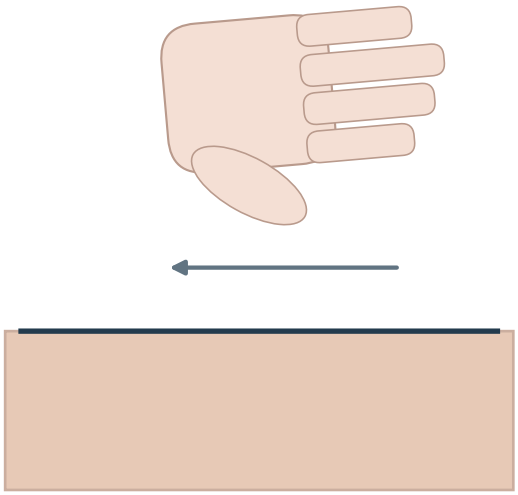
Movement mechanics for method revision; pressure requires instructor calibration.

WORKING PHASE



Small controlled displacement

RELEASE PHASE



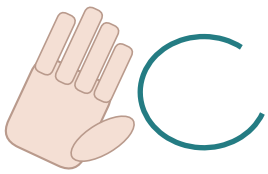
Reduce force; allow recoil

Avoid

Deep kneading, frictional rubbing, large tissue indentation, bruising, pain, or forced anatomical drainage directions.

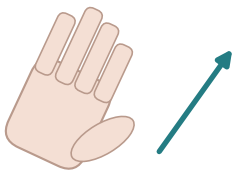
The Vodder movement families

Schematic movement-shapes only. Observe a recognised educator for exact hand orientation.



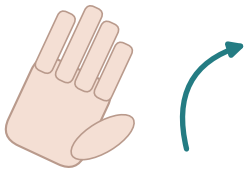
Stationary circles

Small circular skin engagement; stable contact.



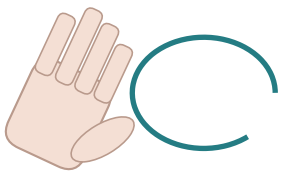
Pump

Curved hand and controlled rolling contact.



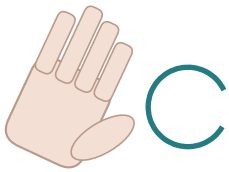
Scoop

Coordinated curved/rotational skin stretch.



Rotary

Broad contact with controlled rotary mechanics.



Thumb circles

Supported thumb-pad contact; no point pressure.

Three moments to observe

Initial contact → controlled working phase → gradual release.

Technique faults: observe and correct

Compare intended superficial work with errors after a long break from practice.

Intended

- \+ Gentle skin engagement
- \+ Distinct release
- \+ Stable contact
- \+ Partner comfortable

Avoid

- \- Sliding or rubbing
- \- Deep muscular squeezing
- \- Forceful large circles
- \- Pain, bruising or distress

Practical checkpoint

The visual cannot calibrate force, rhythm, hand angle or region-specific Vodder technique. Record feedback from a qualified instructor before professional return-to-practice.

A complete, documented client encounter

Screen first; choose treatment only where appropriate and within scope.

1 ENQUIRY

Purpose and onset of symptoms

2 HISTORY

Surgery, cancer, DVT, infection, heart, medicines

3 SAFETY GATE

Go / defer / stop / refer

4 CONSENT

Explain contact and region-specific agreement

5 SETUP

Hygiene, privacy, position, draping, transfers

6 PRACTICE

Only approved safe, suitable gentle movement

7 FEEDBACK

Comfort, response, new symptoms

8 RECORD

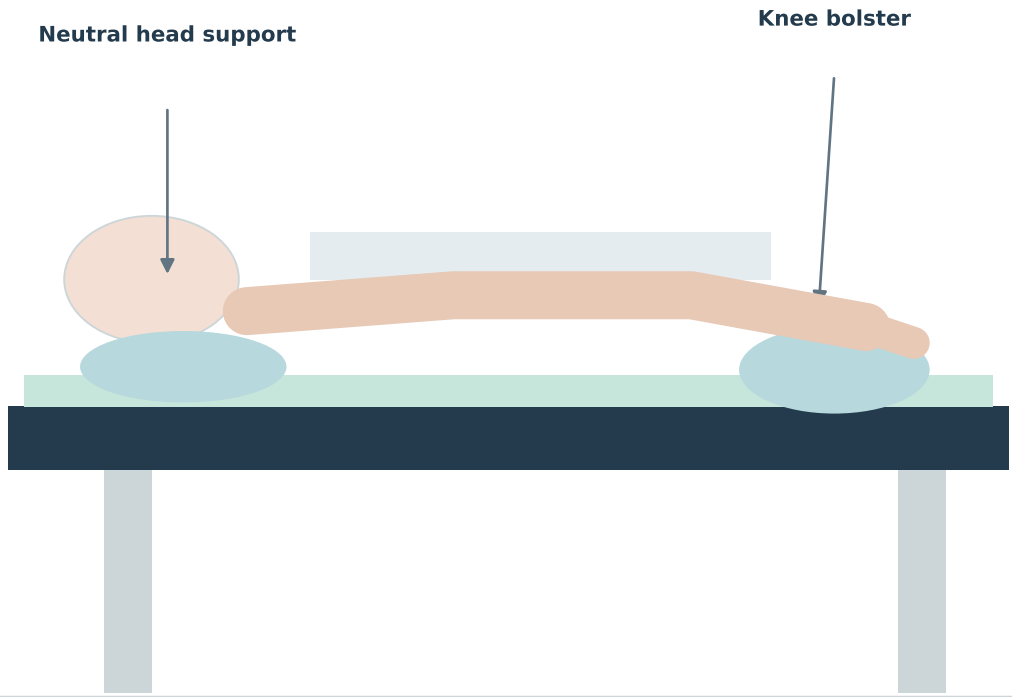
What occurred and referral / aftercare

Important

The sequence is a session framework, not an instruction to treat unexplained oedema.

Treatment-table setup and supported positioning

A safer practical environment for older adults and home-visit wellness work.



Before positioning

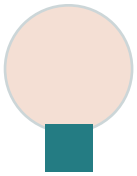
Check transfers, breathing comfort, skin integrity and access around the table.

During practice

Use suitable draping, clean linen, hand hygiene and therapist-friendly working height.

Regional anatomy: six areas to recognise

Region maps for safe orientation, not universal treatment pathways.



Neck / terminus

Cervical anatomy; avoid vascular pressure.



Face

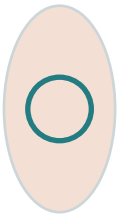
Eyes, sinuses and dental symptoms require caution.

Upper limb

Previous axillary surgery changes suitability.

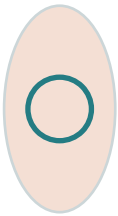
Lower limb

New one-sided swelling means stop / refer.



Abdomen

No deep pressure; screen surgery and pain.



Back / trunk

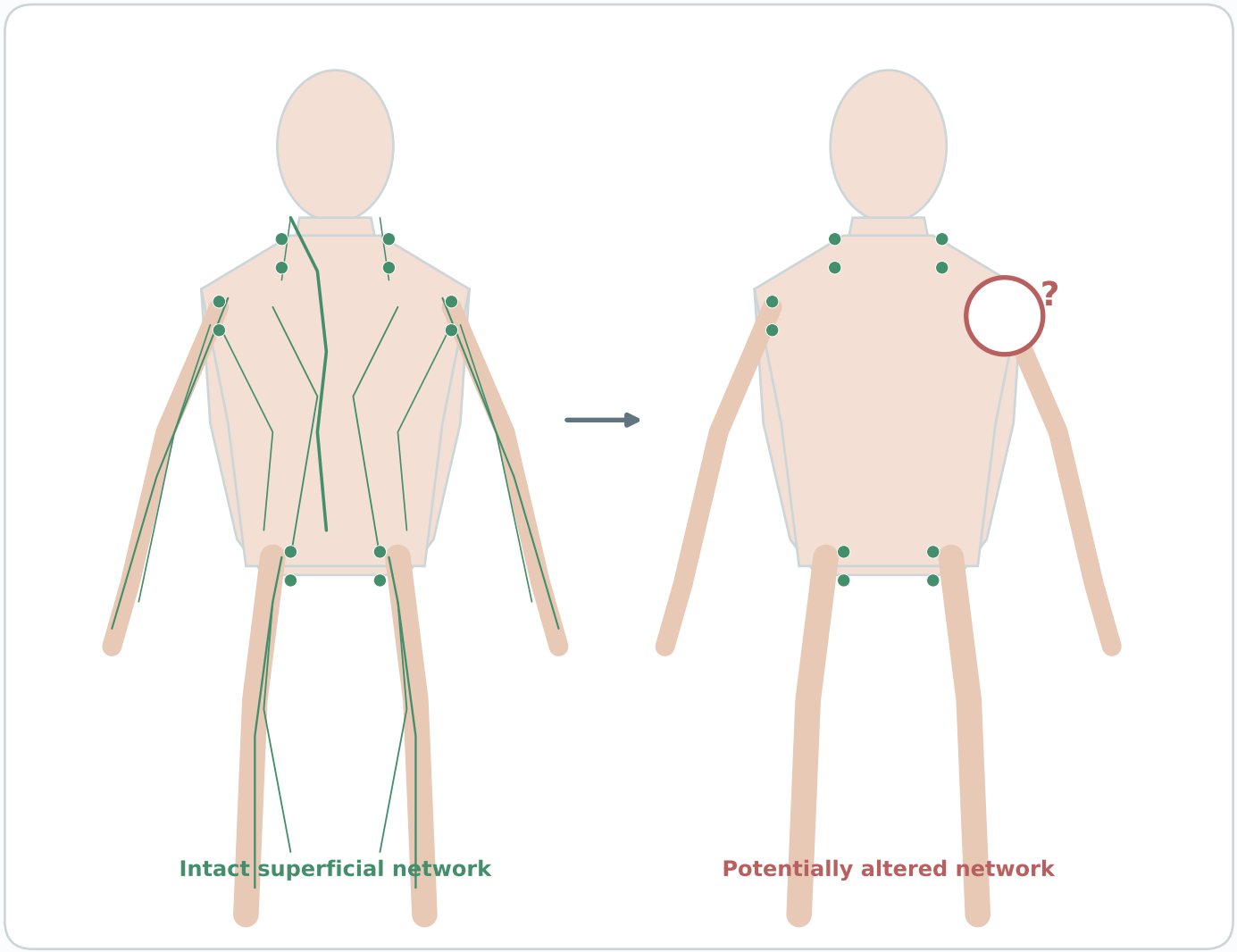
Respect surgery, radiation and skin changes.

Supervisor gate

Practical hand orientations and clinical routes must be confirmed by a qualified instructor.

Why region charts cannot be treatment recipes

Lymphatic anatomy and precautions vary with surgery, radiation and disease.



Specialist decision required

If a client has lymph-node removal, radiotherapy, known lymphoedema, significant infection or unexplained swelling, do not translate the left-hand figure into an alternative route. Clinical assessment and recognised CDT education are required.

Conditions and scope: quick reference

A wellness refresher is not independent diagnosis or clinical oedema treatment.

Relaxation / healthy client	Screened wellness within competence
After surgery	Surgeon / rehabilitation assessment
Cancer-related swelling	Specialist lymphoedema referral
Known lymphoedema	Specialist CDT management
Venous heavy legs / persistent oedema	Medical / vascular assessment first
Lipedema or mixed conditions	Specialist diagnostic pathway
Cardiac fluid retention	Do not offer wellness MLD for oedema
Acute infection or suspected DVT	STOP and urgent medical assessment

Evidence reminder

Do not promise detoxification, immune boosting or guaranteed swelling reduction.

Return-to-practice: staged competence

Time spent revising is not proof of clinical proficiency.



WEEK 1 — **Modules 1–3**

Anatomy, evidence, safety decisions.

WEEK 2 — **Modules 4–6**

Healthy-volunteer supervised movement review.

WEEKS 3–4 — **Structured observation**

Instructor correction and repeat practice.

WEEKS 5–6 — **Competency decision**

Written feedback, scope and insurance checks.

Professional scope

Clinical lymphoedema/CDT requires separately recognised education and appropriate registration.