Lymphedema, characterized by long-term arm swelling from disruption of the lymph nodes (Moffatt et al., 2003), is a physically debilitating condition that may develop following breast cancer surgery and treatment (Erickson, Pearson, Ganz, Adams, & Kahn, 2001; Loudon & Petrek, 2000). An estimated 20% of people treated for breast cancer will develop lymphedema (Hayes, Janda, Cornish, Battistutta, & Newman, 2008). Removal or irradiation of axillary lymph nodes (Bani et al., 2007; Goffman, Laronga, Wilson, & Elkins, 2004; van der Veen et al., 2004), infections, and obesity (Richner & Dietrich, 2008; Swenson, Nissen, Leach, & Post-White, 2009) are known lymphedema risk factors. Compromised quality of life and psychological morbidity during short- and long-term survivorship have been associated with lymphedema (Armer, 2005; Greenslade & House, 2006; Mansel et al., 2006). Sentinel lymph node biopsy (SLNB), a less invasive surgical technique than axillary lymph node dissection (ALND), has reduced lymphedema incidence (Francis et al., 2006; Lucci et al., 2007) up to one year postsurgery (Langer, Guenther, Haigh, & Difronzo, 2004; Mansel et al., 2006; Purushotham et al., 2005). However, not all women are candidates for SLNB, and at least 35% of women who initially undergo SLNB return later for ALND following the detection of more extensive cancer (Husen, Paaschburg, & Flyger, 2006; Langer et al., 2007; Leidenius, Leivonen, Vironen, & von Smitten, 2005). Therefore, despite the availability of less invasive surgical techniques, a substantial number of women with breast cancer will undergo procedures that increase their objective lymphedema risk (Cheville, 2007).

Any means by which lymphedema risk can be minimized is beneficial. National breast cancer organizations publish guidelines that recommend lifetime adoption of strategies to minimize lymphedema risk and highlight the importance of early detection and treatment if