

EDITORIAL**ALTERNATIVE/COMPLEMENTARY TREATMENT IN LYMPHOLOGY:
TRYING THE UNTRIED AND TESTING THE UNTESTED**

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In this issue of *Lymphology*, the Editors are publishing three preliminary reports dealing with alternative/complementary modalities in lymphedema treatment (see Cluzan et al, Moseley et al, and Godoy and Godoy). The Journal has also received several other articles in this area, and these are currently undergoing the peer review process. Whereas *Lymphology's* main focus is to publish original, scientifically sound, evidence-based articles of interest to our readers, we recognize both the explosion of alternative/complementary treatment modalities used by patients and prescribed by physicians and other health care practitioners worldwide and also the importance of informing and stimulating lymphologists and related specialists to examine and reflect on these practices. Nonetheless, there may be unusual challenges and inherent shortcomings in performing, analyzing, and applying such research.

In the treatment of peripheral lymphedema, a variety of alternative/complementary medicines, devices, and approaches have become popular worldwide [e.g., herbals, benzopyrones, bioflavonoids, horse chestnut seeds, pine bark extract, passive movement devices, microwave diathermy, dietary supplements, homeopathy, and some would even include the massage component of combined physiotherapy (CPT)]. Some have been reported to be effective, others partially

effective, and in several cases to have no effect at all (or even to be dangerous or life-threatening). Because there is no ideal, simple clinical answer or cure for most patients with lymphedema and treatment commitment is life-long, we need to be open to new ideas and creative, low-cost, low-maintenance approaches while at the same time demanding evidence of efficacy and assurance of safety and protection for our patients. In this light, alternative/complementary therapies may in the future be important adjuncts in the developing as well as in the more developed world. They may also be integrated into more traditional treatment regimens or, where the latter are not available or accessible, even used alone.

The three articles in this issue are preliminary efforts to begin this dialog and evaluation. As with much in alternative/complementary medicine/research, design issues arise. There is a more or less heterogeneous mixture of patients included in the studies (different stages and duration of disease, mixtures of primary and secondary lymphedemas as well as unilateral and bilateral presentations) and a lack of population and blinding controls in the latter two of these studies. Some exuberance in reporting is evident along with some "cherry-picking" of the data (i.e., underemphasis of non-supporting data), non-parametric statistical analysis, or even a lack of statistically

analyzed data. In the paper by Moseley et al, several objective parameters were tested, and a statistically significant result in volume reduction was obtained. Although the reduction is minimal at best when compared to CPT as generally reported by other authors, it was also obtained with much less intensive effort. The authors could have strengthened their results with intra- (opposite leg) and inter-method (CPT) controls. In Godoy and Godoy, the apparatus presumably increased lymph flow as measured by lymphscintigraphy (subjective qualitative analysis only). However, complete data and analysis on the entire series of patients are not presented, and the single patient lymphscintigram displayed in the figure is not adequately explained. In the paper by Cluzan et al, we find a very well-designed, double blind, placebo-controlled study, which demonstrates one significant improvement after BN165 (the subjective sensation of limb heaviness) and another significant change (in quantitative lymphokinetics) but the placebo group exhibited similar improvement.

It is not the intention of the Editors to be excessively critical or in any way to discourage future submissions of papers using alternative/complementary methods of treatment. These methods are becoming increasingly popular for use by patients and practitioners, often are simple and generally low-cost. If appropriate evaluation provides proof of efficacy and safety, such methods may supplement or enhance less than satisfactory results with current medical treatments. In this regard, it is interesting that a recent report describes the beneficial effect of an herbal remedy (curcumin in the

spice turmeric; <http://www.sciencemag.org/cgi/content/short/304/5670/600>) on the functional plasma membrane localization of the cystic fibrosis (CFTR) protein in vitro as well as on manifestations of cystic fibrosis in a mouse model. Clearly, allopathic medicine, which discovered the gene for cystic fibrosis more than 10 years ago, has not held the definitive answers for this disease (gene therapy is not yet available, safe or effective, and treatment remains largely symptomatic). However, only through carefully designed trials (proper blinding, use of appropriate controls, comparisons to “gold” standards, etc.) with full and complete reporting of data and disclosures (objective measures, standard data analysis, adverse events, financial conflicts of interest, etc.) and providing pre-clinical “proof of principle” will alternative/complementary treatment studies attain scientific validity, acceptance, and ultimate integration into clinical practice alongside more traditional treatments and newly emerging molecular-based therapies (which also must meet these standards).

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