

*EDITORIAL***CONSENSUS AND DISSENT ON THE
ISL CONSENSUS DOCUMENT ON THE DIAGNOSIS
AND TREATMENT OF PERIPHERAL LYMPHEDEMA**

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In this issue of *Lymphology*, we are publishing collected comments from senior members of our Society on the Consensus Document which agree, disagree, or expand its scope. Included are commentaries on the role of operations, particularly liposuction and derivative microvascular surgery, staging, imaging evaluation, and special considerations in primary lymphedema-angiodysplasia syndromes. For those who have attended recent International Congresses, this spirited discussion comes as no surprise. Indeed, the ISL and *Lymphology* have never shied away from such differences of opinion and practice. It is to be expected that with patient benefit weighed against risk as the paramount concern, currently accepted clinical practice will intersect with newer, non-traditional, and even experimental approaches. The result should be greater understanding and ultimately improved outcomes for patients with peripheral lymphedema.

Since one of us was involved at the inception of the Consensus Document and the other has "managed" its evolution over the past 5 years, we can provide some perspective on the intended use and various modifications that have contributed to its current content and format. The ISL membership, lymphologists, and non-specialists around the world look to the Consensus Document for lymphedema treatment guidelines. Some may feel that the wording

should reflect their personal approach and experience. For the ISL as a global community representing ~40 diverse nations where clinical practice parameters, socioeconomic conditions, government control, and healthcare systems differ widely (not to mention language, custom, and politics), balancing these differences in perspective is a challenging task. For instance, as Professor Michael Földi points out in his Commentary, in Germany, CDT is the only accepted treatment by the Social Security system, thereby precluding research studies of relative efficacy compared with other methods. Such is not the case in the United States, South America, India, Sweden, or Italy, where colleagues promulgate the use of microsurgery, liposuction, or benzopyrones.

The ISL Consensus Document has the luxury of stepping back from nationally dictated approaches and can lay out a spectrum of treatment strategies that may be more or less adaptable to different environments or at least worthy of further testing. In striking the balance between members who look to the Consensus as the final authority in financial reimbursement or malpractice issues and those who look simply for guidance tempered by clinical judgment, we have favored an inclusive document. For example, M. Földi's comment #12 states that "highly trained lymphedema therapists" should be specified and the treatment

training course rigorously defined. However, the Consensus Document has recognized that the particular health professional administering treatment varies from country to country and even within the same country, and neither properly trained “nurses” (nor other available health practitioners in many areas of the developing world) should be excluded by fiat. Adaptability and inclusiveness does come at the price that members can rightly be critical of what they see as vagueness or inaccuracy in definitions, qualifiers in the choice of words, and mention (albeit without endorsement) of treatment options supported by limited hard data. Acknowledging these criticisms, we have championed a Consensus that embraces the entire ISL membership, rises above national standards, and identifies promising areas for future research.

M. Földi was gracious enough to submit the full text of his 2003 presentation in Freiburg at the 19th International Congress of Lymphology. These comments open the debate. In response, Håkan Brorson of the University of Malmö offers a rebuttal concerning the value of liposuction, which is supported by Harvard Professor of Plastic Surgery Sumner Slavin. Whereas these commentaries have been edited to conform to space limitations, the more gently edited original versions can be found (in their entirety) along with the Consensus Document itself on the ISL website (<http://www.u.arizona.edu/~witte/consen.htm>).

M Földi’s remarks highlight the difficulties alluded to above that are inherent in generating and modifying the Consensus Document. In fairness to our membership, a spectrum of variations and approaches to the management of peripheral lymphedema are mentioned in passing although most of these have generated few publications and research studies. He correctly points out the failure to conduct a meta-analysis on these methods. But **NO** method has really undergone a satisfactory meta-analysis (let alone rigorous randomized stratified controlled study). He

also justifiably criticizes the use of unquantifiable words like “occasional,” “preferably,” and “unclear” to describe options based on differing medical opinions that are not clearly “evidence-based”. However, in the absence of definitive answers and optimally conducted clinical trials and with emerging technologies and new discoveries on the horizon, some degree of uncertainty and ambiguity as well as dissatisfaction with current lymphedema evaluation and management may be appropriate.

The commentaries of Brorson and Slavin are sure to fan the flames on the already hot topic of liposuction. These surgeons provide a strong case for its selective use in a subset of patients with lymphedema. Other ISL members will still disagree with this approach and continue to raise safety concerns despite this mounting published experience. Brorson’s “discovery” of the importance of adipose tissue changes in lymphostasis was indeed antedated by earlier technically less successful attempts at liposuction and the long-standing recognition by lymphologist-surgeons in endemic areas that “debulked” tissue in filarial elephantiasis was largely fat!

Terence Ryan of Oxford requests more information and details for staging of lymphedema and is critical of current criteria. He has long been a tireless proponent of simple, inexpensive minimalist treatment approaches (washing, skin care) for underdeveloped countries or rural, remote settings where adequate care is inaccessible. His somewhat disparaging comments regarding the value of lymphangiography (potentially adaptable to field use with portable cadmium telluride gamma probe systems), and by implication other non-invasive imaging modalities, are sure to raise some hackles from other members of our Society and also lymphologists in the endemic area who have popularized this technique at least for screening and research purposes.

Professors Corradino Campisi and Francesco Boccardo of the University of Genoa and Sandor Micheline of Rome have

provided the Italian Society of Lymphology's Consensus Document for review [*Eur. J. Lymphology* 12 (2004), 2-12]. This document includes recommendations and guidelines for clinicians following each section and a list of 143 references and is available in its entirety on the ISL website for review. Three excerpted sections are printed here because of their special interest to our readers. The first concerns the role of operative procedures in the treatment of lymphedema and is more extensive than the current ISL document, and the second and third sections deal with primary lymphedema and cover the diagnosis and treatment of "angiodysplasia and lymphedema" and "neonatal lymphatic dysplasia." The latter topic, the subject of a full-length article by Bellini et al in the forthcoming March 2005 issue of *Lymphology*, and also the main thrust of Cristobal Papedieck's ISL Presidency from 1999-2001, will be developed further for inclusion in the Consensus Document at the 20th ICL in Salvador, Brazil in September 2005. Many of our readers may find the section on microsurgical techniques informative but perhaps overly enthusiastic. This document also contains a recommendation on the use of benzopyrones, which has been a topic of controversy for members of our Society. The recently published "1st Latin American Consensus on the Management of Lymphedema" [*Phlebolympology* (2004) 44:258-264], generated by a Latin American

consensus group, led by José L. Cuicci of Buenos Aires with industry support, also includes statements about drug therapy (other than antibiotics) for lymphedema, which have not been officially endorsed by the ISL.

In the final analysis, the ISL Consensus Document will remain a living document to be utilized, challenged, modified and revised as medical science and our Society evolve, clinical practices and expertise are shared, and new discoveries in the laboratory are translated to the bedside and clinic. Lymphologists will continue to agree and disagree (sometimes vehemently) with whatever is the latest version. The Editors pledge to keep the forum open for such collegial discussion and particularly for the exchanges during International Congresses that bring the Consensus Document to the next level.

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