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COMMENTARY

A SEARCH FOR CONSENSUS ON THE STAGING OF LYMPHEDEMA

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At the International Congress of Lymphology held in Freiburg last year I chaired a session on staging. After this session, I had correspondence with a number of experts and I have had to conclude that we are unlikely to reach consensus. The issues of concern especially for those active in the morbidity control of lymphatic filariasis (LF) is the clinical setting worldwide that needs to record a stage when first seen in the clinic or field and progression or improvement at later stages. Such staging may be based on swelling alone, but staging of complications and a description of their site, localization or systemic effects is also needed. Such complications would include recurrent inflammatory episodes and the gross changes seen in the various components of the tissues including the epidermis, dermis and adipose tissue.

Lymphoscintigraphy, an expensive and heavyweight technology using radioactive isotopes, clearly is a tool we can use for staging in the hospital setting and not in the field. It is especially favored as a tool for staging by members of the International Society of Lymphology. It is simply not available in many regions covered by LF. Lymphoscintigraphy reveals abnormal anatomy, abnormal flow to and from sites, abnormal clearance and blockade. But all of this can occur without clinical signs, and we have not enough information to tell us whether normal people can from time to time show reversible altered anatomy, clearance or blockade.

Some degree of lymphatic failure is much more common in the general population than most of us would have at one time believed as studies in London have recently demonstrated. Also when for instance one uses a much favored early clinical sign of stiffness of the skin over the toes as an indicator of lymphedema, we are told that 20% of 20 year olds will be found to be positive. Barefoot agricultural workers in some threatening environments may well show an even higher prevalence.

The lawyer, increasingly in the developed world making a case for compensation after inappropriate surgery or accident, demands that the clinician describe the degree of harm in percentages and predict how much disability there will be in the future. This may be a client in whom there is no detectable clinical lymphedema but who gives a history of swelling or recurrent inflammatory episodes. Since there is a history also of the removal of lymph nodes or the sectioning of lymphatics, there can be no doubt that the lymphatic system is impaired. What is the point of lymphscintigraphy when one knows that gross impairment has been inflicted? How do we measure coping and the drainage through lymphatic collaterals or tissue planes with or without assistance from a therapist? Can such measures become part of a staging

system? In lymphatic filariasis, known involvement of the lymphatic system by parasites can precede swelling by many years but impairment is shown up earlier by lymphscintigraphy.

I would like to open up this discussion to the opinion of persons working in the field of LF as well as members of the ISL. How important is staging to you? You will have read descriptions of staging that classifies the various complications into different stages. I have heard that some of you working with LF think this is useful while others say it is too detailed. Clearly it is possible to list complications as an addendum to staging.

Your opinions would be of value in writing before the 20th International Congress of Lymphology September 26-30 2005 in Salvador, Brazil.

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