

LETTERS TO THE EDITOR

**SILVER BULLETS, SHOTGUNS, AND INTEGRATIVE
COMMUNITY-BASED APPROACH TO LYMPHEDEMA
FROM LYMPHATIC FILARIASIS IN INDIA**

Keywords: Ayurveda, integrativ medicine, lymphatic filariasis, lymphedema, yoga

This letter is in response to the editorial "Silver Bullets and Shotguns" (1) and an article by Narahari et al "Integrated Management of Filarial Lymphedema for Rural Communities" (2) regarding use of multimodality treatment like ayurvedic massage, yoga, and bioengineering pressure therapy along with allopathic medicines and modalities.

First of all, ayurvedic medicines, spas, and yoga are very expensive. They are no longer cheap modalities in India. All will agree that combined decongestive therapy (CDT or CPT) works in the management of lymphatic filariasis, which was presented by myself and Elizabeth Russell (American Physiotherapist) at the 2006 GEL Congress in Hinterzarten. The only problem with massage therapy is to maintain it in the optimal lymphedema control program. Patients need periodic intensive therapy, which is time consuming and expensive for patients in countries like India. That is why we recommend foot hygiene, elimination of foci of sepsis like carious teeth and fungal infections, and automassage (we teach the patients to do their massage themselves) at their convenience.

If there are skin changes like nodules, ulcers, etc., we do surgical correction, which is rapid, less expensive, and produces long-

lasting results although pressure garments and foot hygiene are needed post-operatively.

Where simple systems work better for the patients, why should we go to five to six modalities particularly when all of them are expensive, time-consuming, and not readily available, and, above all, not a cure for the disease?

Just because a research group started a project necessitating patient participation for 194 days does not mean that this is practical in a country like India with very poor economical level in the community. Many patients and the health workers might feel that they are being offered a cure and in the end will be disappointed!

We cannot afford either a silver bullet or shotgun at this stage since simple measures will help our patients. The readers of *Lymphology* must understand the reality in our country and not be led astray by this publication and its questionable statistics. The local public and patients are not accepting of the methods and protocols outlined by Narahari et al (2).

REFERENCES

1. Witte, MH, M Bernas: Silver bullets and shotguns in lymphedema therapy. *Lymphology* 40 (2007), 1-2.
2. Narahari, SR, TJ Ryan, PE Mahadevan, et al: Integrated management of filarial lymphedema for rural communities. *Lymphology* 40 (2007), 3-13.

**Gurusamy Manokaran, MB, MS, MCh,
FICS
Senior Consultant Plastic Surgery &
Lymphologist
Apollo Hospitals
21, Greams Lane, Off. Greams Road
Chennai 600006, INDIA
Telephone #: 91-44-2829 6636
FAX #: 91-44-2829 4429
e-mail: manokaran_g@yahoo.com**

Dear Editor:

I read with interest the article by Narahari et al “Integrated management of filarial lymphedema for rural communities” published in Vol 40 (1) of your journal.

The results presented by the authors are a successful representation of the “Information Age” model of self-care which is still in its infancy in developing countries like India. This model emphasizes that “self-care” will become key to the development of health provision for people with chronic conditions. Responding to the growing global burden of chronic diseases (estimated to be 50% of the total health care needs in 2002), WHO has developed the Innovative Care for Chronic Conditions (ICCC) model which emphasizes that community partners who are informed, motivated, and armed with the requisite skills are essential partners in the management and care of the chronically ill. The work presented by the authors reflects this belief with the added advantage of “integration” with locally acceptable, familiar and prevalent systems of health care such as Ayurveda and Yoga.

For the first 14 days of hospital stay, the patient and the accompanying family member is educated in the various methods of care including skin care and massage reinforcing the paradigm that “self care” involves “self education.” Throughout the article, the unifying theme has been the transfer of “skills” to the patient and

caregiver in such a way that it facilitates problem solving (specifically, recurrent infections and treatment of entry points) by the patients themselves. This highlights the main difference between the “Industrial Age” model (prevalent in developing countries like India) and the “Information Age” model of the West, i.e., the non-dependency on the physician and the health worker in the latter.

The role of “integration” with other systems of medicine has shown statistical significance. Locally available systems of health care such as Ayurveda and Yoga are widely acceptable in rural communities in India. There is enough evidence in the literature to show that acceptance of these alternative systems is very high as compared to biomedical approaches based on the prevalent myth that allopathic medications have serious side effects and provide only symptomatic relief with no role in the elimination of the cause. The cases presented by the authors had all been treated in the past with conventional anti-filarial treatment and the ensuing lymphedema had been there for many years. Therefore the offer of a new modality of treatment with “familiar” treatment options ensured good patient compliance.

This study is a successful example of “Information Age” model of care and should stimulate other physicians dealing with chronic conditions to consider it.

At the end of the day, we physicians must not forget that while we might be experts in our own fields, it is the patient who is the expert on his/her life.

**Dr. Vineet Kaur, MBBS, DNBE, Dip GUM
(UK)
Consultant Dermatovenereologist &
Member,
Advisory Board, International Skin Care
Nursing Group
B-34, Brij Enclave
Varanasi -221005, India
E-mail: vineet@heartnskin.com**

Reply from Authors:

We present the following comments about our program in response to Dr. Manokaran's Letter to the Editor.

Cost: We emphasize that Yoga and Ayurvedic medicines are among the cheapest options available in rural areas. The suggestion that we are a spa misinterprets our objectives. Spas and expensive urban clinics are meant for tourists and the rich who demand that kind of ambience. Any system of medicine when commercialized becomes expensive. Surgical correction is claimed to be less expensive and long lasting by the respondent. Surgery has risks including anaesthesia, hospital infections with "super bugs," along with the cost of surgery and hospitalization in addition to the poor outcomes and recurrences. One cannot only look at the money spent by the patient in the government tertiary hospital ignoring the expenses involved to a public health program performing surgery. Obviously, the costs would be enormous if surgery is attempted on a mass scale in these patients. Our protocol is another option available to the patients to be practiced mainly in their home. Except for compression bandages, materials used in our protocol can be prepared locally with the guidance of a local Ayurvedic doctor. The modalities other than compression bandage mentioned in our protocol, are all inexpensive, possible in a domiciliary situation, and available everywhere. The costs (\$115.9 to \$488) mentioned in our paper are due to the care we are taking to measure and record what we are doing in great detail in a pilot scheme that must be an evidence-based study. It is expected to become cheaper to implement as it becomes a large scale program. Dr. Manokaran appears to use compression in his post surgery-patients. Compression bandages are the biomedical modality in our integrated protocol and 90% of treatment expenditure is due to this alone. In this respect we do not differ from his program.

Frequency of Attendance: When self care is taught to a patient, we have found it has to be reinforced periodically for compliance to be satisfactory. One of the most difficult thrust areas in public health programs is follow up. Furthermore re-attendance to reinforce patient education is the key to the success of any treatment in lymphedema. We are acutely aware of the need for patient education in illiterate masses of developing countries especially for long term compliance as in the case of lymphedema. There is nothing wrong for the patient to come back repeatedly as this practice will ensure that the technique is being used correctly. During our study, patients came back for review only 3 times in 194 days. Four (including the first one) visits to a doctor in 194 days is a small price to pay for a lifetime of comfort.

Statistics: We have used time tested methods in statistics using SPSS version 14. Further information on the relevance of methods is available in the publications by Muralidharan and Narahari (1-2).

Patient Acceptance: The statement that health workers and patients are disappointed and unaccepting is far from the truth. The patients in our center are given baseline counseling before taking them through the integrated treatment. All facts and information are given to the patients, and they are shown the photographs of followup of patients with good and poor compliance. Patients are given the contact address (after obtaining permission) of those who have taken our treatment in their vicinity. Hence, patients choose to take our treatment only after a series of discussions, inquiries, and a consultation process. The many distinguished peer observers of our program from lymphology, general medicine, ayurveda, yoga and paramedics who attended The 2nd National Seminar on Evidence Based and Integrated Medicine for Lymphatic Filariasis, other Chronic Dermatoses and HIV/AIDS, Kasaragod, India are the witness of the level

of patient satisfaction in our integrated treatment protocol (3). Some have stated that patient participation and satisfaction is the most impressive feature of our program.

We have tested a totally new approach based on accepted principles in lymphology and hope to improve the protocol to make it simpler and to reduce the cost as we go along. Karl Popper said that knowledge advances “not by repeating known facts but by refuting false dogmas.” No innovation in the history of medicine has been perfect at the first attempt.

REFERENCES

1. Muralidharan, K. (Ed.): *Data Analysis Using Statistical Application Software*. Central Plantation Crops Research Institute, Kasaragod (2004).
2. Muralidharan, K, SR Narahari: Repeated measurements on patients treated for lymphoedematous limbs: Database management and analysis. In: *Proceedings of the second National Seminar on Evidence Based and Integrated Medicine for Lymphatic Filariasis, HIV/AIDS and other Chronic Dermatoses*. Ryan, TJ, et al (Eds.), IAD, Kasaragod, India, 2007.
3. Narahari, SR, KS Bose, KS Prasanna: Self help and low cost, integrated treatment of lymphatic filariasis for rural communities. *Current Science* 92 (2007), 1665-1167.

S. R. Narahari, DVD, MD
The Institute of Applied Dermatology
Kasaragod, India
srnarahari@satyam.net.in

Prof Terence J Ryan
Department of Dermatology
Oxford Medical School, UK