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EDITORIAL

LYMPHEDEMA IN THE DEVELOPING AND DEVELOPED WORLD: CONTRASTS AND PROSPECTS

At a recent International Conference in Dermatology and Dermatopathology in the Developing World (John Radcliffe Hospital, Oxford), organized by ISL member Dr. Terence Ryan, the impact of skin diseases on mortality and morbidity in the developing world was the primary focus. During the course of the meeting, one of us (PM) organized a symposium on the swollen limb in the developing and developed world, and two others (MHW, SJ) participated as panel members. A summary of the symposium will appear in a future *Lymphology*.

Swollen limbs due to the nematodes *Wuchereria bancrofti* and *Brugia malayi* are a dramatic external manifestation of what may be the most prevalent chronic infection in the world possibly afflicting over 100 million. Clinical manifestations vary widely from intermittent fever, malaise and transient limb swelling to grotesque, elephantine deformities of the extremities and other body parts as well as chyluria with dramatic depletion of the body's lipid stores [see Lymphology 18 (1985), 143-194].

By contrast, the true incidence of different forms of lymphedema in the developed world is not readily obtainable, although lymphologists dealing with this condition on a regular basis may be referred a large number of patients usually after a battery of diagnostic tests and therapeutic alternatives have been exhausted. Largely through efforts by members of the ISL worldwide, attention is being focused sharply on the lymphedematous limb. In the *developing world*, it is the *lack of access* to modern health care and sanitation which has entrenched filariasis as an accepted fact. On the other hand, in the *developed world*, it is paradoxically the *ready access* to modern health care that accounts for most patients with chronic lymphedema. Thus, radical operations and extensive radiotherapy for treatment of malignant disease interrupt lymphatic drainage and produce limbs and body parts that over many years come to resemble those of filarial infestation. To some extent, based on better understanding of the course of some of these malignancies, legitimate efforts are being made to reduce or minimize the adverse effects of ablative treatment. Nonetheless, the attitude, often unspoken, persists that because cancer kills and lymphedema doesn't, the patient should feel fortunate to be alive despite noticeable cosmetic and functional deformity.

Reduction in the incidence of lymphedema in the developing world ultimately depends upon bringing modern public health methods and medical expertise to these countries to prevent filariasis and its complications, detect it earlier, and devise new treatment modalities. In the developed countries, on the other hand, our effort needs to be directed at educating medical professionals regarding those modalities of existing therapy leading to lymphedema and if unavoidable, to make more available simple diagnostic tools (e.g., isotope lymphangiography) and treatment (e.g., multicompartment pneumatic pumps and massage). Within the

limits of protecting the patient with cancer from recurrent disease and metastases, we should be able to minimize the incidence of severe lymphedema, recognize it promptly, and treat its occurrence before irreversible scarring and recurrent infection set in. In the long run, it is desirable to uncover better drug and operative alternatives to avert cosmetic and functional deformities from treatment of cancer. Until then, however, our aim should be to avoid long-term undesirable sequelae once the early signs of lymphedema appear.

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