

EDITORIAL

LYMPHOMAS, LYMPHOIDS, AND LYMPHOLOGISTS

Spurred on by my lymphologic colleagues at the 12th International Working Conference on Filariasis in India and the 10th International Congress of Lymphology in Australia this year, I have been contemplating how the lymphologist's unique perspective contributed to those conferences and might enrich almost any other medical conference. Consider these comments under the rubric "lymphomas, lymphoids, and lymphologists" and indicative of the breadth of our discipline's approach to the integrated working of the four components of the lymphatic system—lymphatics, lymph, lymph nodes, and lymphocytes.

At a recent surgical conference, while listening attentively as the accumulation of fluid beneath the flap of a post-mastectomy wound was referred to as a "seroma", I thought to myself, "That is really a lymphoma, a tumorous accumulation of lymph." But that particular word had already been usurped to designate a malignant tumor of lymphocytes, i.e., a "lymphocytoma". A little while later while perusing the library stacks, I came across a recent text entitled "Diseases of the Lymphatic System" (Springer-Verlag, 1984), but to my surprise found it dealt exclusively with pathology of lymph nodes, shunning lymphatic channels and lymph fluid along with disorders of those components of the lymphatic system. Leafing through random periodicals and books, I realized how often the term "lymphoid" was used to designate lymphatic tissue, even acknowledging that I had done so myself. But "-oid" means resembling, and lymphatic tissues (lymph nodes, spleen, and thymus) are the real

thing! They are not "-oid", and lymphatic elements are present in nearly all tissues including the "nonlymphoid". Since "lymphoid" literally means resembling lymph or lymph-like, the closest thing to "lymphoid" is edema fluid or effusion as in ascites or hydrothorax. In other words, nonlymphologists view the lymphatic system as lymph nodes hung together by strings, or as subpopulations of lymphocytes studded with specific biochemical markers, to be scrutinized under a microscope or in a test tube. In contrast, lymphologists envision and explore a vast renewing circulation of fluid, macromolecules, particulates, lymphocyte subpopulations, macrophages, and other cellular elements, both confined in vessels and suffused throughout tissue spaces. Under various physiologic and pathologic conditions, the lymphatic system changes dimension, organization, and pattern, at different sites and times.

Summary reports from the two aforementioned international conferences, featured in this issue of LYMPHOLOGY, focus on the global problem of lymphedema. Indeed, the grotesque elephantine extremity and incommensurate hydrocele of tropical filariasis and similar phenomena in nonfilarial conditions are a vivid testimonial to what happens when the lymphatic system does not perform its assigned tasks. The affected organ or part gradually swells, high-protein edema accumulates, new vascular channels proliferate, fat and collagen deposits appear, local immunity deteriorates, and repeated opportunistic infections ensue. As unremitting lymphostasis persists for a prolonged period, exuberant

bossellations of hyperplastic tissue erupt, grossly resembling the liver of cirrhosis and leonine facies of leprosy. Furthermore, benign and occasionally malignant endothelial neoplasms arise in the setting of intense angiogenesis. Thus, disruption of the lymphatic circulation, whether from operation, congenital aplasia, malignant infiltration, or chronic infestation with filarial nematodes, stimulates four fundamental but still mysterious processes: angiogenesis (both

lymphangiogenesis and hemangiogenesis), lipogenesis, fibrogenesis, and neoplasia. Perhaps no stronger statement can be made for the importance of the lymphatic system and no greater challenge presented to the lymphologist than when lymph drainage fails, the integrated system goes its separate ways, and these basic biologic processes escape control.

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