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 affecting 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., multicompartent pneumatic pumps and massage). Within the
limits of protecting the patient with
cancer from recurrent disease and
metastases, we should be able to min-
imize the incidence of severe lym-
phedema, 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 al-
ternatives to avert cosmetic and func-
tional deformities from treatment of
cancer. Until then, however, our aim
should be to avoid long-term undesir-
able sequelae once the early signs of
lymphedema appear.

Marlys H. Witte, M.D.
Charles L. Witte, M.D.
Tucson, Arizona, USA

Peter S. Mortimer, M.D.
London, ENGLAND

S. Jamal, M.D.
Madras, INDIA