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At the earlier 9th International Congress of Plastic and Reconstructive Surgery held in New Delhi, India, I was asked to give the first paper in a panel on lymphedema with the title "Why Do I Not Like My Surgical Results?". Advocating conservative or nonoperative therapy as the initial treatment of choice, I fully expected all the other panelists to diagree vigorously. I was pleasantly surprised to learn, however, of a general consensus that following operations for lymphedema, patients don't just get up and walk away cured, and thus conservative therapy at first is generally favored. What does conservative therapy entail? Unfortunately, each therapist believes it to be something different. Thus, in some patients lymphedematous extremities are elevated continuously for a few days, other patients receive diuretic drugs, some therapists use compressive pumps or perhaps even more energetically forcible bandaging of the limb. Commonly an elastic compression sleeve or stockinette is prescribed to be worn over the lymphedematous leg or arm prior to complex "decongestive" therapy. Even reduced intake of oral fluids is occasionally advocated!

Over ten years ago, Földi and Földi, having worked previously in experimental and pharmacological lymphology, started a hospital-clinic exclusively for patients with lymphedema and a complementary school for training physiotherapists in highly specialized nonoperative management of lymphedema designated as "complex decongestive physiotherapy." The results thus far have been spectacular. In a course that lasts four weeks, they have trained over 10,000 physiotherapists in techniques of manual and compression therapy to facilitate lymph drainage, and skin care, as well as emphasizing the importance of patient self-care.

The Zurich meeting (under the presidency of a plastic surgeon) for the first time brought together more than 200 physicians interested in lymphology, 600 physiotherapists treating lymphedema, and in a public seminar, approximately 200 lymphedema patients. The main scientific topic was devoted to the skin in lymphedema. Presentations included closed-circuit TV demonstrations of dermal and mucous membrane lymphatics in the living rat and in human cadavers, current imaging techniques including fluorescent microlymphography, isotope lymphangiography, xeroradiography, the patent Blue test, the cumbersome and frustrating experience with conventional direct (oil-contrast) lymphography, and some of the newer contrast media. There were wide-ranging discussions about erysipelas (a much broader subject than "just" streptococcus cellulitis), the lymphatic watersheds in the skin including their therapeutic significance, the divergent types of lymphatic collateral circulations, and up-to-date immunohistochemical aspects of lymphangiosarcoma or the Stewart-Treves syndrome. A number of practical instructional courses designed primarily for physiotherapists were also given involving special problems in lymphedema. The basic elements of the patient seminar were reported by Swiss national television broadcast during the evening news.

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