



International
Consensus Document



Lipoedema: a paradigm shift and consensus

SUPPORTED BY



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'The great enemy of truth is very often not the lie—deliberate, contrived and dishonest—but the myth—persistent, persuasive and unrealistic. Too often we hold fast to the clichés of our forebears. We subject all facts to a prefabricated set of interpretations. We enjoy the comfort of opinion without the discomfort of thought.'

John F Kennedy, commencement address at Yale University, 11 June 1962

Foreword

Lipoedema is a chronic condition characterised by a disproportionate increase in adipose tissue and pain in the legs and, sometimes, the arms of women. Its prevalence is largely unknown. The disproportionate increase in weight around the legs usually starts in phases of weight gain that are mostly connected to hormonal changes, such as puberty, pregnancy and menopause. Years later and mostly after further weight gain, pain or the feeling of severe heavy legs may occur, at which point the condition meets the diagnostic criteria for lipoedema. Research on lipoedema is limited and there is a lack of diagnostic testing; therefore, clinicians lack a strong enough evidence base for their practice. This, in turn, hampers patient care.

Lipoedema often is confused with lymphedema; as a consequence, many doctors prescribe decongestive lymphatic therapy. As the authors convincingly demonstrate in this supplement, lipoedema neither includes oedema nor is there any scientific evidence for lymphatic insufficiency. For this reason, decongestive lymphatic therapy is an inadequate treatment for patients with pure lipoedema. There is also considerable variation in how clinicians approach lipoedema among different countries. This lack of homogeneity naturally affects patients, who are already distressed by the pain their condition causes as well as their legs not meeting the standards of the current beauty ideal. Overall, there seems to be an urgent need for standardisation of lipoedema management, based on scientific evidence.

The time has come to establish the diagnosis of lipoedema by eliminating old, never proven concepts from the field. In this supplement, the authors disprove with a high level of scrutiny, several unproven dogmas related to lipoedema. Further, they clarify the clinical situation of this ailment and describe the need to adopt new approaches on handling it, taking into consideration new facts regarding its pathophysiology, which are rather complex. Thus far, the scene has been dominated by case reports, rather than scientifically validated information.

In 2018 and 2019, a group of lymphology experts from seven European countries met in Hamburg to

discuss a consensus regarding lipoedema. This group was led by Tobias Bertsch, who is a senior consultant at the Földi Clinic in Hinterzarten, Germany. The consensus proposed by the group attempts to dispel some of the rampant myths surrounding lipoedema and introduces a paradigm shift in the pathophysiology of lipoedema, as it states that lipoedema is not an oedematous condition at all.

The authors of this work should be congratulated for recruiting this outstanding group of international experts as supporters of this work—the number of European countries represented has now grown to ten. It may be hoped that these experts will also be willing to offer opinions on holistic treatment modalities for ‘lipalgia syndrome’—which ‘lipoedema’ should be called henceforth, according to the authors.

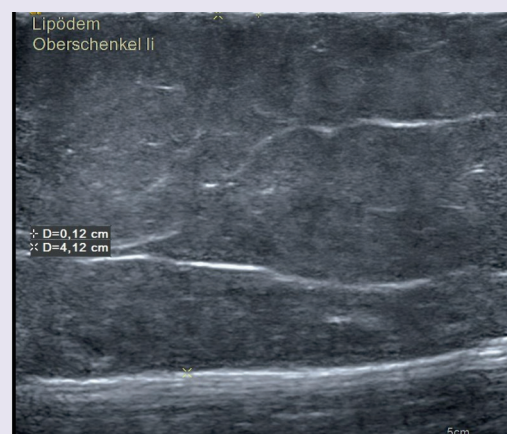
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2. The paradigm shift: there is no oedema in lipoedema

The idea that lipoedema is an oedematous condition seems to be lymphological dogma, and this naturally affects how the condition is managed. This false perception of lipoedema seems to stem from the name given to the condition by Allen and Hines when they first described it in 1940. However, the concept of oedema does not feature prominently in their first two publications.^{1,2} In their second publication in 1951, they wrote: 'Particularly at the end of the day, there may be some evidence of [o] edema, although the evidence is not great enough to explain the patient's statement relative to the degree of swelling which has occurred as a result of orthostatic activity'.² In both publications, the mental health of the patients with lipoedema seemed more a point of interest, but was explored very briefly. In fact, only 24% of the 119 participants in their first study on lipoedema actually had orthostatic oedema ('minimal to mild pitting oedema'), while 29% reported had an 'associated neurosis'.²

By definition, oedema is an accumulation of fluid that manifests the classic pitting appearance of the soft tissues on clinical examination. However, the authors have found no relevant fluid accumulation in their patients with lipoedema who are examined using a high-resolution ultrasound scan (with a 18.6-MH transducer and a Moisture Meter to measure the amount of moisture). Additionally, the findings on clinical inspection and ultrasound scan appear to be identical in patients with lipoedema and those with pure lipohypertrophy (which is painless disproportionate increase in adipose tissue). Figure 2.1 shows a patient with lipoedema, while Figure 2.2 is the ultrasound scan of her thighs (the left and right thighs were identical). There are no abnormalities apart from widening of the subcutaneous tissue; in particular, there is no evidence of fluid. Figure 2.3 shows a patient with lipohypertrophy, Figure 2.4 is the ultrasound scan of her thighs (here, again, the left and right thighs were identical). As can be seen from Figures 2.1 and 2.2, the clinical picture and ultrasound images are virtually identical between a patient with lipoedema and one

Fig 2.1. A patient with lipoedema. **2.2.** Ultrasound scan of the thigh of a patient with lipoedema, showing no evidence of fluid



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Fig 2.3. A patient with lipohypertrophy. **2.4.** Ultrasound scan of the thigh of a patient with lipohypertrophy



with lipohypertrophy. Figure 2.5 shows a patient manifesting three clinical conditions: lymphoedema of the distal lower leg and forefoot; lipoedema that is restricted to proximal lower leg; and morbid obesity (body mass index (BMI) of 48 kg/m^2). Figure 2.6 shows the sustained pitting present in lymphoedema (lower circle) and the non-pitting nature of the soft tissues in lipoedema (upper circle) in the same patient. Figure 2.7 shows an ultrasound scan of the distal right lower leg depicting stage 2 lymphoedema with partial separation of the soft tissue structures, thickened dermis and fluid in the tissues (small arrows). Figure 2.8 (proximal lower leg) shows the typical ultrasound appearance of lipoedema, that is, an unremarkable dermis, thickening of the subcutaneous tissues, and no evidence of fluid in the soft tissues.

After lipoedema was first described by Allen and Hines,¹ the condition received very limited attention until 1980. There were only a few individual case reports on lipoedema or painful adipose tissue in the 1960s and 70s.^{3,4} Then, in 1980, Schmitz published an article entitled 'Lipoedema – the fat leg in the healthy woman' in the journal *Gynäkologie*.⁵ However, oedema, that is, fluid accumulation, did not feature in this report, nor did it in Brunner's 1982 study, which described the patients' condition as a disorder in the distribution pattern of the subcutaneous fat, stating 'The fat layer has a soft consistency and does not allow pitting even over the tibia'.⁶ Gregl described lipoedema as a 'mucoid pseudo-oedema' and stated that, unlike what happened with cardiac and dystrophic oedema, pressing over lipoedema did not cause pitting.⁷ Using the American oedema classification, Rudkin reported only 1/4 + oedema in the pretibial area of those with lipoedema (1/4 + means hardly pitting).⁸

It is clear from the existing literature that oedema does not play a relevant role in the development of lipoedema. Despite this, oedema often forms the basis for the treatment of lipoedema. The two most popular treatments under consideration here are liposuction and manual lymphatic drainage. In one study, structural drainage insufficiency was considered the basis of the need for lymphological liposculpture (that

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Fig 2.5. A patient with lymphoedema of the lower leg and forefoot, lipoedema of the thigh and proximal lower leg and obesity. **2.6.** Upper circle: non-pitting lipoedema tissue; lower circle: pitting lymphoedema tissue

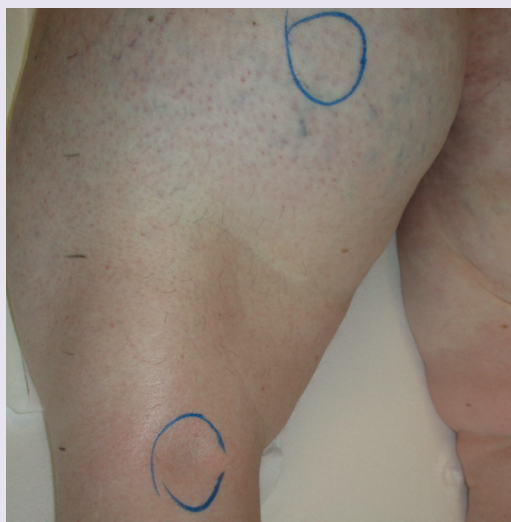
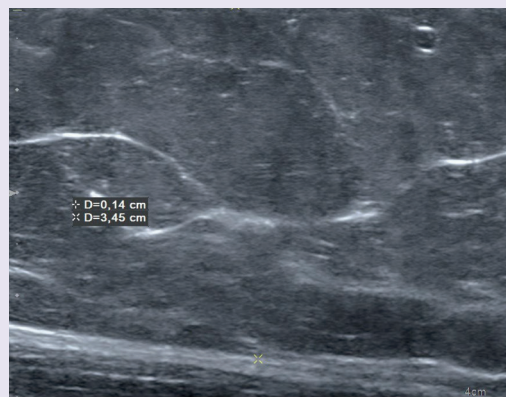
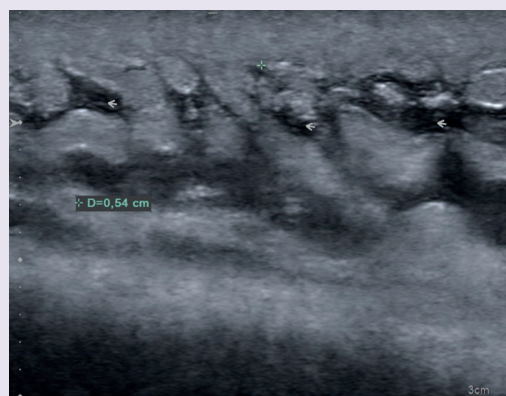


Fig 2.7. Ultrasound scan of the distal right lower leg of the patient in Fig 2.5 showing stage 2 lymphoedema with fluid (small arrows). **2.8.** Ultrasound scan of the proximal lower leg showing the typical ultrasound appearance of lipoedema, with no signs of fluid



is, liposuction) in patients with lipoedema.⁹ The researchers believed that lipoedema leads to overproduction of lymphatic fluid in the arms and legs, which manifests as tenderness; further, they claimed that the adipose tissue is flooded with lymph, and this increases the tension in the thickened extremities.¹⁰ However, these notions are not supported by any scientific evidence. Specifically, the flooding of adipose tissue by lymph cannot be demonstrated clinically or ultrasonographically, nor

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by other imaging procedures, such as computed tomography and lymphoscintigraphy.¹¹⁻¹⁴ In a recent publication, researchers examined patients with lipoedema using magnetic resonance lymphography of the lower extremities. They concluded that the fat tissue was homogenous and showed no signs of oedema in pure lipoedema patients.¹⁵ Histological evidence of oedema in the adipose tissue in lipoedema patients is also lacking. Histological examination of the adipose tissue in patients with lipoedema has shown a localised increase in adipose tissue, isolated foci of fat necrosis and increased numbers of anti-CD68+ macrophages in the interstitial tissue.¹⁶ The latter two findings support the hypothesis that inflammatory and hypoxic processes are responsible for the pain in lipoedema. Laboratory tests on patients with lipoedema also argue in favour of this interpretation. The glutathione status in red blood cells (RBCs) and malondialdehyde (MDA) in the plasma have been studied as biomarkers of oxidative stress, and the levels of both markers in patients with lipoedema were found to be higher than those in healthy patients.¹⁷ Surprisingly, oedema has been cited as the cause of lipoedema symptoms by several researchers.¹⁸⁻²⁰ However, the question then arises: if oedema is the cause of pain in patients with lipoedema, why do patients with cardiogenic oedema or lymphoedema have no pain at all or only very mild discomfort?²¹ In these last two types of oedema, both clinical and ultrasound examinations clearly demonstrate fluid in the tissues. A similarly critical approach to the 'oedema' in lipoedema has been taken in both the UK and the Netherlands. The authors of the 2014 Dutch lipoedema guidelines stated that 'Lip[o] edema is an unfortunate term, as it evokes the idea of swelling due to fluid accumulation. However, it refers to swelling—in a sense of an increase in volume—due to increased fat tissue'.²² Further, the authors of the current Dutch guidelines have not listed 'oedema' in the criteria for lipoedema definition. Similarly, the UK guidelines for lipoedema from 2017 reflect this paradigm shift by defining lipoedema as 'fat swelling', with no reference to a fluid component.^{23, 24}

Many national and international publications consider regular manual lymphatic drainage to be the standard treatment for lipoedema.²⁵⁻²⁹ This recommendation is based on the belief that oedema is responsible for the pain experienced in lipoedema. However, if no relevant oedema can be demonstrated in patients with lipoedema, the rationale for prescribing manual lymphatic drainage is shaky. Two questions need to be answered in this scenario: (1) Is there any scientific evidence that oedema is the cause of the patient's symptoms? (2) Is there any scientific evidence that manual lymphatic drainage improves the symptoms of patients with lipoedema by its drainage effects? The answer to both these questions is no. At the lead authors' lymphology outpatient department, many attending women with lipoedema request manual lymphatic drainage, and they often encounter patients with lipoedema who have been prescribed manual lymphatic drainage (MLD) twice or even three times a week for many years. Many of these patients report that they benefit from lymphatic drainage, but whether it is medically necessary remains debatable. It is likely that patients find MLD pleasant, which has little to do with its decongestive effect. Many patients with lipoedema have mental health issues that require treatment, such as depressive disorders, anxiety and eating disorders.³⁰ There could be other aspects of MLD that benefit patients, such as the massage itself reducing stress and exhaustion. Massage therapy is well-known to alleviate psychological symptoms, such as anxiety and depression.³¹⁻³³ Further, the touch and personal attention corresponding to MLD also produce positive effects. Last, but not least, for any patient, having treatment prescribed means that their condition is recognised as a disease. Patients with lipoedema often report very long durations between when they first experience symptoms and when their symptoms are finally taken seriously and addressed, with the subsequent diagnosis and treatment of lipoedema. Psychological, psychosocial and societal factors have a considerable impact on the symptoms of patients with lipoedema.^{30, 34}

2. The paradigm shift: there is no oedema in lipoedema

Lipoedema always develops from lipohypertrophy, but only in a small percentage of women.³⁵ It remains unclear why some women develop pain in the adipose tissue, and the underlying pathology of this symptom is still subject to speculation. Apart from the oedema hypothesis presented above, there are several ideas about the cause of lipoedema-related pain in the scientific literature.³⁶ There is, however, a consensus that the pain is located in the subcutaneous adipose tissue of the limbs.²⁸ As patients have usually experienced pain for more than 6 months at the time of diagnosis, it can be considered chronic. The causes of chronic pain are usually degenerative processes in the musculoskeletal system (e.g. osteoarthritis), ischaemia (e.g. peripheral arterial disease), neuropathies (e.g. after a stroke, diabetic polyneuropathy), cancer and inflammatory conditions (e.g. rheumatoid arthritis). The literature on expanding subcutaneous fat mentions two main processes: inflammation and hypoxia.^{16, 37, 38} In their recent work, Crescenzi et al compared the adipose tissue between patients with lipoedema and a control group of women without lipoedema. They found an increase in the sodium content of the skin in patients with lipoedema, an emerging hallmark of inflammatory disease.³⁹ To date, a chronic low-grade state of inflammation⁴⁰ and tissue hypoxia are the most plausible explanations for the pain in lipoedema patients; unlike those with lymphoedema, patients with lipoedema do not have a higher risk of cellulitis. Furthermore, the experience of pain is a multifactorial phenomenon involving not only sensory but also cognitive, affective, motivational and behavioral dimensions. Therefore, therapeutic approaches to lipoedema should focus on these causes of pain.³⁰

Conclusion

There is no evidence that oedema plays a relevant role in lipoedema, and it is certainly not the cause of the pain experienced by lipoedema patients. Lipoedema is a more complex condition than simply painful, fat legs. Comprehensive treatment of lipoedema should take into account all those aspects that are less

apparent than the observable changes and reported symptoms. In addition to alleviating somatic symptoms, lipoedema therapy must also focus on the other aspects of this complex condition and include a thorough work-up, pain management, addressing the psychological vulnerability of women with lipoedema, managing any weight gain and encouraging self-acceptance in an era where skinny is considered aesthetically appealing.

3. Myth: Lipoedema makes patients fat

There are two popular concepts in the field of lipoedema and its common comorbidity—obesity. The first is that lipoedema makes the patient fat and the second is that weight loss has no effect on lipoedema. To the authors' knowledge, there is no evidence to support either of these statements. However, there is also no evidence to support the corollary—that is, that lipoedema does not lead to weight gain and that weight loss does lead to an improvement in lipoedema. It is obvious that there is a close correlation between being overweight or obese and having lipoedema. Of the 2344 women diagnosed with lipoedema at the authors' lymphology clinic in 2015, only 3% were of normal weight; 9% were overweight (BMI=25–30 kg/m²) and 88% were obese (BMI>30 kg/m²).⁴¹ Their patient cohort appears largely representative in this regard. For example, Bosman reported that up to 80% of the lipoedema patients in a centre in the Netherlands were overweight and/or obese.⁴² In 2011, a British research group reported that only 4% of their lipoedema patients were of normal weight, while 11% were overweight and 85% were obese.⁴³ In a study by Herbst et al⁴⁴ from the US, 76% of the lipoedema patients were obese, and, in another investigation by Dudek in Poland, this number was 80%. Around 50% of the patients in the latter study were morbidly obese, which means they had a BMI of over 40 kg/m².^{30,43,45} In short, a lipoedema patient of normal weight is a rarity.

In this context, BMI has only limited value in lipoedema patients who are overweight (BMI=25–30 kg/m²). There is the rare group of patients with a largely slim upper body and marked increase in fat in the extremities. However, in such patients, overweight is an illusion because the fat distribution is uneven, given the lipohypertrophy of the legs. The waist-to-height ratio (WHtR) is the more suitable measure for these patients, as it provides a better indication of the distribution of body fat. At the authors' clinic, both BMI and WHtR are measured in all patients with lipoedema.

So how can this apparent relationship between lipoedema and obesity be explained? Patients as well

as the media are keen to explain the connection between lipoedema and obesity as lipoedema being responsible for the weight gain in women with lipoedema.^{46–49} This notion is even more widespread in the US, where there is a coalition of doctors and patients who explain their weight gain by the disease lipoedema.^{50,51} However, there is no scientific evidence for this view. There is also no conclusive pathophysiological construct to explain how lipoedema leads to weight gain. There is general agreement that a disproportionate increase in fat in the legs (and sometimes the arms) is an important criterion for a lipoedema diagnosis. This initial, often only slight, disproportionality is frequently seen even during puberty, at which point the patients are largely without complaints in the soft tissues; at most, there is mild lipohypertrophy of the legs. The risk of symptoms and, hence, the development of lipoedema usually starts when the weight progresses and the associated disproportionate increase in fat in the lower half of the body occurs. Therefore, the notion that weight gain (often obesity) can, in the case of the relevant (genetic) disposition, result in lipoedema, seems more likely.

The causes of obesity are varied and highly complex, but there is scientific evidence for genetic and especially epigenetic influences.^{52–55} Biological factors such as stress or addictive behaviour can also affect weight,^{56,57} as can psychological conditions such as depression and eating disorders.⁵⁸ Finally, sociocultural changes also play a considerable role in the development of obesity: for example, changes in eating habits, the regular consumption of sugar (particularly in soft drinks) and a sedentary lifestyle, in addition to lack of confidence regarding wearing and being seen in exercise clothing; for example, in the 2016 Lipoedema UK survey, 95% respondents reported difficulty in buying clothes, and 59% stated that embarrassment stopped them exercising in water.⁵⁹ Added to these is the beauty ideal that skinny is aesthetically pleasing, and this is closely connected with a diet culture, which often begins in adolescence and whose long-term course does not lead to weight

3. Myth: Lipoedema makes patients fat

loss but, in fact, to weight increase.⁶⁰⁻⁶⁴ In Germany, roughly 25% of the population is now obese (BMI > 30 kg/m²),⁶⁵ and, in the US, this figure had already reached 40% in 2017.⁶⁶

If lipoedema does not make one fat, how can the broad support for this position be explained? The essential basis for the popularity of this view of lipoedema is the stigmatisation of the disease of obesity, which is frequently considered to be the result of incorrect behaviour, a weak will or lack of discipline. Even among medical professionals, and particularly among doctors, weight-related discrimination and stigmatisation is especially marked.⁶⁷⁻⁶⁹ Stigmatising attitudes towards obese patients can also be found among medical specialists in obesity and dieticians.⁷⁰ ⁷¹The causes of obesity are complex, as also recognised by the World Health Organization (WHO). Simultaneously, data concerning the poor prognosis of conservative weight reduction are extensive. Between 80% and 99% of all patients who lose weight conservatively will put it on again in the long term.⁷²⁻⁷⁹ Particularly in women, attempts to lose weight that were started during adolescence lead to a decades-long dieting spiral, with a resultant continuous increase in weight.⁶⁴

The advice to reduce weight is especially concerning in lipoedema. Studies have shown that women (in contrast to men) regain weight after weight loss disproportionately in the lower half of the body,⁸⁰ and, as stated above, most who diet regain any lost weight. In other words, any recommendation by a doctor to female lipoedema patients to lose weight actually increases the risk of a further increase in fatty tissue in the leg region and, hence, also increases the risk of their symptoms increasing. In the authors' opinion, the 'boom' in lipoedema is due to the way the obesity has been handled. On the part of patients, lipoedema has developed into an 'excuse' or explanation of sorts for weight gain and overweight. Many lipoedema self-help groups as well as the media have proposed that patients are not fat, but have lipoedema.⁸¹⁻⁸³ Women believe the lipoedema is responsible for their long history of progressive weight

gain. It is laborious and time-consuming to convince patients that they are misinformed and that there are other factors that lead to an increase in weight, and it is certainly not due to lipoedema. It is also challenging to convince patients that the frequently desired treatment options—manual lymphatic drainage or liposuction—will in no way result in a substantial, permanent or even only approximately satisfactory weight loss.

Conclusion

There is no evidence that lipoedema leads to weight gain, although weight gain does exacerbate lipoedema symptoms. Given the right genetic disposition for lipoedema, weight gain appears to be a trigger for lipoedema development. From the authors' observations, there certainly are women with normal weight or those who are slightly overweight with highly disproportional fat distribution and soft tissue symptoms, but in view of the overwhelming majority of obese and morbidly obese women with lipoedema, these individuals form a very small minority.

4. Myth: Weight loss has no effect on lipoedema

It is a matter of grave concern that medical professionals often confuse lipoedema with obesity or lymphoedema.^{84,85} Cornely and Gensior stated that lipoedema is rarely diagnosed quickly and accurately.⁸⁶ Karen Herbst, endocrinologist and protagonist in the American lipoedema scene entitled her article that mainly discussed lipoedema 'Rare adipose disorders (RADs) masquerading as obesity'. She said that one of the most common misconceptions about lipoedema is that the condition is lifestyle- or diet-induced obesity.²⁵ Unfortunately, this view is perpetuated by patients and the media, lipoedema self-help groups and internet fora.⁸⁷⁻⁸⁹ What complicates matters further—and what needs to be highlighted—is that most women with lipoedema are actually also obese; the statistical details have been mentioned in Chapter 3. In fact, a woman of normal weight with lipoedema is very rare. Thus, most women concurrently have two conditions: obesity and lipoedema. Focusing only on lipoedema in a woman with a BMI of 35 kg/m² or more seems pointless, as clearly the obesity is a more pressing concern. In the authors' experience, the vast majority of female patients with lipoedema more often complain of a progressive weight increase rather than pain in the legs.

Many self-proclaimed lipoedema experts and, consequently, patients believe that weight loss has no effect on lipoedema, only on obesity. Herbst mentioned that, although lifestyle changes and bariatric surgery are effective interventions to address the obesity component, these treatments do not routinely reduce the abnormal subcutaneous adipose tissue seen in lipoedema.²⁵ Similarly, Schmeller reported that weight loss helps only in the case of concomitant obesity, and it merely reduces truncal circumference. As a result, however, the disproportionality between the trunk and extremities worsens, since lipoedema-specific fat accumulations cannot reduce through weight loss.⁸⁴ Stutz argued that the fat pads on the legs are not the same as stored reserve fat in obesity, declaring that this fat has a different structure and, cannot be lost through dieting and exercise.⁹⁰ This view is also frequently adopted by patients and lipoedema self-help groups.⁹¹

The lead authors of this supplement sought to identify the basic pathophysiological construct for the assumption that weight reduction in obese lipoedema patients does not also lead to substantial loss of fat in the extremities, as well as reduction of lipoedema symptoms. The self-proclaimed experts mentioned above provide no explanatory model in their publications that justifies the published statements. What has been propagated is just the myths, ones that have been passed on and adopted by women with lipoedema for years. The fact that mostly the doctors practising liposuction play a considerable role in propagating these myths gives pause for thought. These myths certainly contradict the publications of Allen and Hines, the first people to describe lipoedema in 1940 and 1951, who wrote that, in cases of generalised obesity, a sharp reduction in weight may help alleviate symptoms.^{1,2} In the lead authors' experience as well, weight loss through conservative therapy has helped reduce the volume of fat in the region of the extremities of women with lipoedema, but this reduction is only temporary, because of weight gain after weight loss. Through the clinic's multimodal obesity programme, in which lymphoedema and also lipoedema patients with a BMI upwards of 40 kg/m² are prepared for surgical obesity treatment, patients have achieved more permanent and more substantial weight loss. The weight reduction achieved with this programme also produces a generally proportional reduction in the circumference of the extremities. In other words, the weight loss achieved within the framework of bariatric surgery (gastric bypass or sleeve gastrectomy) by women with lipoedema occurs substantially and permanently in the region of the arms and legs, although some disproportionality of the legs usually remains after successful weight loss. Nonetheless, asymptomatic disproportionality of the legs is generally not a pathological condition. The overwhelming majority of the authors' patients experience a marked improvement in their symptoms as a result of the fat reduction in their legs, and many even become pain-free. This is what the authors term

4. Myth: Weight loss has no effect on lipoedema

'lipoedema in remission'. If body weight remains largely stable in subsequent years, it is unlikely that lipoedema symptoms will recur. Thus, the condition becomes a generally mild lipohypertrophy that has no pathological significance. The positive outcomes of weight loss on lipoedema have been examined in a study at the University of Freiburg in conjunction with the Földi Clinic.⁹² The authors of this study found a 33.7% adjusted leg volume reduction in lipoedema patients following bariatric surgery.

Obese patients with a BMI below 40 kg/m² or those ineligible for surgery for obesity are advised to undertake long-term weight stabilisation. At the same time, patients at the authors' clinic are explicitly advised against diets or conservative weight reduction

programmes. This approach is justified based on the disastrous long-term prognosis of attempts at conservative weight reduction as proved by the consistent data⁷²⁻⁷⁹ and confirmed by the authors' clinical experience with patients whose weight has continuously increased during their 'dieting careers'. Instead of 'diet and exercise', the authors recommend 'stabilise and exercise'. The promotion of self-acceptance is of overriding importance for patients. Only when this is achieved is it possible for them to escape from the vicious circle of diets, its yo-yo effects and worsening of the lipoedema. As well as experiencing improvements in their lipoedema symptoms, women who have undergone bariatric surgery also experience a marked increase in mobility and, therefore,

Fig 4.1 and 4.2. Front and side views of a patient with lipoedema before a sleeve gastrectomy (leg volume=19 L)



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improvements in their quality of life.^{93,94} There are also cardiovascular benefits to surgical treatment of obesity: diabetes mellitus, high blood pressure and sleep apnoea syndrome improve, or are often resolved completely.⁹⁵⁻¹⁰⁰ Finally, several large-scale studies have shown the efficacy of bariatric surgery in reducing long-term mortality. Following sleeve gastrectomy or gastric bypass operations, patients live longer and healthier lives than comparably obese patients who do not undergo such procedures.¹⁰¹⁻¹⁰³ The assertion that the outcomes of conservative nutritional programmes are comparable to those of sleeve gastrectomy or

gastric bypass lacks scientific evidence. In fact, the failure of conservative weight reduction programmes in the long term has been documented in many high-quality studies.^{72-79, 104, 105}

There are concerns surrounding bariatric surgery that must be acknowledged. Patients require intensive postoperative care, including the nutrition and psychological aspects. Nonetheless, the authors are convinced that more widespread training of nutritional specialists and dieticians in the postoperative care following bariatric surgery would be more useful than dissuading patients from

Fig 4.3 and 4.4. Front and side views of the same patient 11 months after sleeve gastrectomy (leg volume=9 L)



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Fig 4.5. Patient with lipoedema and obesity-related lymphoedema before gastric bypass. **4.6.** The same patient 1 year later after gastric bypass and dermatilipectomy of the left leg



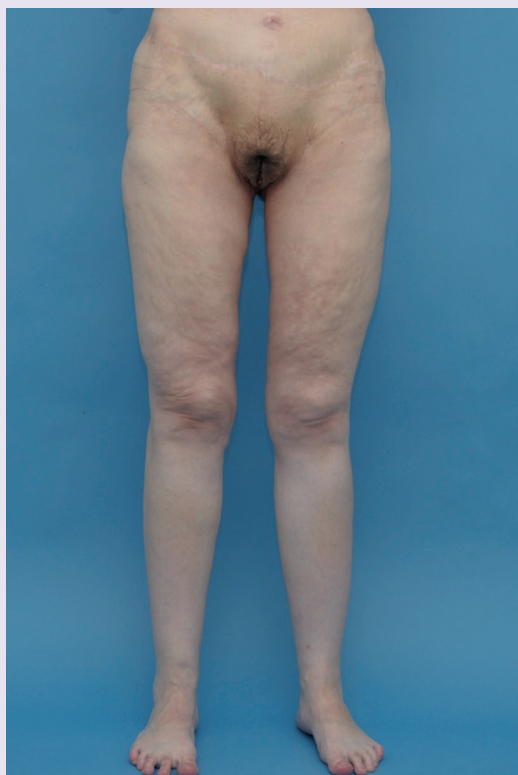
undergoing a treatment that could give many of them the chance of a healthier, longer and easier life. Opponents of surgery for obesity have cited a higher rate of suicide among those who have undergone bariatric surgery compared with the general population.¹⁰⁶⁻¹⁰⁸ However, on critical reflection, it becomes apparent that this comparison is not appropriate. This view does not take into consideration the fact that people with a higher BMI—which those who undergo bariatric surgery are likely to have—also tend to have mental health conditions.¹⁰⁹ If obese patients prepared to undergo a bariatric procedure are compared with a group of obese patients from the general population, then the groups do not differ in terms of self-harming behaviour or the frequency of attempted suicide.¹¹⁰ Therefore, the assumption that

those who undergo bariatric surgery have a higher rate of suicide is incorrect; it is rather a consequence of the psychological vulnerability of patients with severe obesity.¹⁰⁷ Importantly, this vulnerability must be addressed through thorough preparation and aftercare of patients who undergo surgery for obesity, and it is essential that patients who require psychotherapeutic support are identified and provide it promptly and competently. The treatment of morbidly obese people is only successful in the long term if specialised professional groups collaborate effectively: nutritionists, psychotherapists, specialists in internal medicine, GPs, as well as surgeons.

Figures 4.1 and 4.2 show a lipoedema patient (weight=122 kg; height=168 cm; BMI=43 kg/m²) before a sleeve gastrectomy. The volume of each leg is 19 L.

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Fig 4.7. Patient with lipoedema at 14 months after sleeve gastrectomy. **4.8.** After weight stabilisation for 1 year after that, the hanging abdomen overlying the genital region was tightened, and the loose thigh skin was removed



Kindly provided by Prof. Nestor-Toro Padron

Figures 4.3 and 4.4 show the same patient 11 months after bariatric surgery. Her weight was 74 kg (BMI=26 kg/m²) and the leg volume per leg was 9 L. The patient was completely free of symptoms, or in other words, her lipoedema was in remission. Plastic surgery to tighten the thigh skin was not requested by the patient. **Figure 4.5** shows a patient with lipoedema and distal obesity-related lymphoedema of the legs, and **Figure 4.6** shows the same patient 1 year later after gastric bypass and dermatolipectomy of the excess skin on the left leg. The lipoedema symptoms are mild and infrequent; the obesity-related lymphoedema of the legs is also greatly improved. The lipoedema patient shown in **Figures 4.7 and 4.8** lost

65 kg within 14 months after a sleeve gastrectomy. After weight stabilisation for 1 year, the hanging abdomen overlying the genital region was tightened, and the loose thigh skin was removed. She did not experience any symptoms of lipoedema. In the case of this patient, there was certainly no longer any liphypertrophy.

Conclusion

There is neither any scientific nor any empirical evidence for the notion that weight loss does not improve lipoedema. Persistent weight loss leads to a marked improvement in symptoms, and patients' lipoedema can be in remission.

5. Myth: Lipoedema is a progressive disease

A progressive disorder is one that gets worse with time and leads to a general decline in health and body function. Various scientific publications, as well as lipoedema portals on the internet and magazines produced by lipoedema self-help groups,¹¹¹⁻¹¹⁴ state that lipoedema is a progressive condition. The current German S1 Lipoedema Guidelines also define lipoedema as a 'progressive disorder',²⁷ and the internet portal 'Lipoedema Help Germany', which is frequently accessed by patients, even states: 'Lipoedema is always progressive, meaning that it gets worse'. Some patients present with a hugely disproportionate increase in fatty tissue, usually isolated in the legs, although these patients form a very small minority of the patient population. The term 'progressive' suggests that this tendency to develop disproportionate fatty tissue, which is usually genetic in origin,⁴³ increases virtually autonomously and independently of general weight gain.^{26, 115} This increase in fatty tissue occurs in three stages (or four, according to some publications).^{18, 44, 116} The NDR Health Advice Booklet states: 'Fat cells reproduce in an uncontrolled way'.¹¹⁷ However, to the authors' knowledge, there is no scientific evidence for this pathophysiological construct. There does not seem to be any data to confirm the progression of lipoedema. Allen and Hines, who initially described lipoedema and, in their 2nd publication in 1951 (together with Wold) first used the term 'progressive enlargement of the limbs ...',² are often cited. However, Allen et al subsequently realised that the progressive course of lipoedema is ordinarily associated with weight gain. This weight gain in lipoedema had already been emphasised in their first publication in 1940.¹ A current Spanish investigation on this question confirms the correlation of lipoedema with weight gain, where the authors describe the lipoedema to be stable in two-thirds of their patients, and progression in the remaining one-third was related to weight gain.¹¹⁸ Therefore, it remains questionable whether the leg circumference increases because patients experience an overall weight gain or in isolation, as is supposed. In the former case, it would

be the body weight increase that is progressive, and not the lipoedema. An increase in leg circumference would then be expected as part of the weight gain. Pathophysiological findings clearly support this view. A glance at the patient population attending the Földi Clinic highlights the close association that exists between excess weight and/or obesity and the clinical picture of lipoedema, and as mentioned above, patients with lipoedema and normal weight are very rare.

From this, it is clear that there is no evidence that lipoedema is progressive. It is, in fact, often the body weight that is progressive. The reason that it is vital to reconsider the use of the term 'progressive' to describe lipoedema is that, in addition to their symptoms, many patients with lipoedema have one feature in particular: they are afraid that their lipoedema is progressive. The vast majority of patients have already looked up their condition on the internet, which often shows images of severely obese patients with an extreme (but, in reality, very rare) fatty tissue increase in the legs or arms. Consequently, most patients express great concern that their lipoedema could also reach such proportions.

In the authors' daily clinical experience, extreme cases of lipoedema (in patients who are of normal weight or have only mild obesity with extremely disproportionate accumulation of fat in the affected limbs) are quite rare. They regularly see lipoedema patients, both as inpatients and outpatients, who present with stable lipoedema over many years, provided, however, that their weight has remained stable. They are now seeing disease courses extending over 20 years, where patients have stable—non-progressive—lipoedema; the lipoedema is stable because these patients have stabilised their weight (at varying initial weights). Consider the following case as an example. One patient has been receiving treatment as an outpatient for lipoedema for approximately 10 years. This patient's BMI, although high, has been stable at 30 kg/m² during this time, and her WHtR has been around 0.45. In this patient, leg volumes (thighs and lower legs measured

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separately) have remained virtually unchanged during these 10 years. By wearing flat-knit compression hosiery every day and undertaking regular exercise 2–3 times every week, the patient has remained largely asymptomatic (**Figure 5.1**).

If lipoedema is not progressive, then the term 'lipolymphoedema' also seems inappropriate. 'Lipolymphoedema' suggests progressive lipoedema leading to lymphoedema; it suggests that the lipoedema causes the lymphoedema. In some classifications, the lipolymphoedema is also classed as stage IV lipoedema. Lipoedema is believed to be a pre-lymphoedema condition.⁵⁰ However, it must be emphasised that there is no scientific evidence for this viewpoint. There are neither histological investigations supporting the construct of lipolymphoedema nor medical imaging procedures that have provided any confirmation. When discussing lipolymphoedema, the vast majority of studies refer to the work of Amann-Vesti from 2001 and Bilancini et al from 1995,^{119, 120} both of which only investigated 12 patients each. While Bilancini et al¹²⁰ used dynamic lymphoscintigraphy and found slowed lymph flow in patients with lipoedema, Amann-Vesti et al¹¹⁹ used fluorescence microlymphography and found the now frequently cited microaneurysms of the lymph capillaries. However, the transport capacity of the lymphatic system was not found to be impaired in Amann-Vesti et al's study.¹¹⁹ Further clinical studies using indirect lymphography and lymphoscintigraphy also showed that lymph transport from the subepidermal compartment functions in lipoedema, but does not in lymphoedema.^{24, 121, 122} A weakness of the data of both Bilancini et al¹²⁰ and Amann-Vesti et al's¹¹⁹ studies is the lack of any description of the patients' weight; neither publication provides the patients' BMI. However, knowledge of the BMI is essential in order to determine whether the irregularities in the lymphatic system are in fact due to the lipoedema, as postulated and often cited, or whether they are more likely to be obesity induced. Amann-Vesti et al's study even states that 'lipoedema is a special form of obesity.'¹¹⁹ It can,

Fig 5.1. Patient with lipoedema whose symptoms were managed using daily flat-knit compression hosiery and regular exercise 2-3 times a week



therefore, be assumed that the patients with lipoedema who were investigated were obese and that some were, perhaps, severely obese. Consequently, the changes observed in the lymph capillaries were probably obesity induced. The pathophysiology of obesity related lymphoedema is known and well established.¹²³

The authors' experience with thousands of patients with lipoedema in recent years also lends clinical support to this assumption. If a patient with lipoedema

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who is 165 cm tall and weighs 90 kg gains a further 20 or 40 kg, lymphoedema can develop in addition to the lipoedema. This lymphoedema is then not lipoedema-induced lymphoedema, but rather obesity-associated lymphoedema. The term 'lipolymphoedema' should, therefore, be eliminated from lymphology.

Conclusion

There is no scientific evidence that lipoedema takes a progressive course. Rather, it is weight gain and obesity that are very often progressive. An exacerbation of the lipoedema can first occur as part of the progressive weight gain. The term 'lipolymphoedema' is also incorrect from a medical viewpoint. It is important to share this perspective of lipoedema with patients, who will find it reassuring. Patients can be informed that their condition may neither progress nor deteriorate and can be stabilised provided that their weight remains stable.

6. Myth: Lipoedema causes mental health disorders

Women affected by lipoedema can experience a variety of problems. In particular, they experience lipoedema-related pain, which leads to a reduction in quality of life.^{124, 125} Many women with lipoedema are dissatisfied with the disproportionality of their bodies and the associated stigma. They have problems in accepting their own bodies, and the consequences of this lack of self-acceptance are severe.^{124, 125} Even physicians who treat women with lipoedema may display an initial lack of understanding of their problems;⁵⁹ it often takes several years before a diagnosis of lipoedema is made and appropriate therapy provided.

It has often been reported that patients with lipoedema have mental health disorders.^{59, 126-129} Overall, however, data on the relationship between lipoedema and mental health are limited. A study in 100 women with lipoedema conducted in the Stutz Liposuction Clinic concluded that 74% had chronic eating disorders,¹²⁸ and 8% attempted suicide at least once.¹²⁹ In a 2015 worldwide, internet-supported survey initiated by Smidt with 1416 participants, 39.7% women with lipoedema self-reported as having depression (compared with a prevalence of 3–17% in the general population) and 16.5% cited eating disorders (compared with a prevalence of 1–5% in the general population).¹²⁷ In another internet-based investigation by Dudek et al in 2016¹²⁶ with 328 participants, 31.8% cited eating disorders in the self-assessment. Depression and anxiety were diagnosed in these participants by using the Patient Health Questionnaire (PHQ-9), and 56.8% of them showed high to very high scores for depression.

The role of psychological factors in the origin of other somatic disorders, such as cancers, has been considered for years.¹³⁰ For example, in rheumatoid arthritis,¹³¹ psychological factors such as stress are known to play an important role. To date, with regard to lipoedema, the implicit impression has been that mental disorders, such as depression or eating disorders, are the result of lipoedema. However, it remains to be determined whether this is true.

In general, there are two main problems related to researching a condition: first, there is a risk of

important aspects being overlooked when complexity is reduced. Second, statistical associations in the sense of a correlation are often incorrectly interpreted as a causality.

With regard to lipoedema, then, the following questions arise: in how many women with lipoedema does their condition cause a mental disorder, in how many is the mental disorder a comorbidity and in how many does the mental disorder possibly have an important involvement in the development of the pain symptoms of lipoedema?

In order to help clarify these open questions, the authors conducted a pilot study at their clinic. The research question was 'Does lipoedema lead to mental disorders?' Some 150 patients during their inpatient stay in the Földi Clinic in the study period from April 2017 to September 2019 were included in the study.³⁰ The requirement was a diagnosis of lipoedema of the legs, which had been reconfirmed medically in the specialist lymphology clinic, with the typical symptoms of disproportional fat tissue of the legs (sometimes also in the arms) and pain of the soft tissue in these regions. A psychological psychotherapist who had specific experience with this patient population conducted semi-structured interviews with the patients. These were usually divided into two sessions and included: (1) ascertaining the patient's mental disorders according to ICD criteria¹³² and all mental disorders in the patient's medical history; (2) the symptoms associated with the lipoedema;¹³³ and (3) the temporal overlap between these parameters. Questionnaires proved ill-suited to the explorative nature of the study, as they reveal a limited range of symptoms¹³⁴⁻¹³⁷ or overestimate psychological symptoms in somatic disorders, for example, depression,^{138, 139} and they cannot reveal the temporal course of the condition.

Among the 150 patients included in the study, a distinction was made between subgroup n1 with BMI < 40 kg/m² and subgroup n2 with a BMI ≥ 40 kg/m². Of the total sample, 80% participants showed pronounced psychological symptoms, which preceded the development of lipoedema-related pain. These

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included mental health disorders, for example, a depressive episode or symptoms only slightly less severe than those of a mental health disorder such as stress eating, a high level of chronic stress and burnout syndrome.¹⁴⁰ The latter is not considered a mental disorder in diagnostic terms of the International Classification of Diseases (ICD-10) but rather a performance-related disturbance in work and motivation. At the time of the investigation, 50.1% of the total sample (n1: 43.2%, n2: 59.4%) had at least one mental health disorder. Depressive disorders were the most common, although only symptoms corresponding at least to a mild depressive episode were included. Dysthymia was classified under 'other'. In terms of clinical diagnostics, 14.7% fulfilled the criteria of having an eating disorder and 12.7% showed an abnormality in their eating behaviour that does not yet fulfill the criterion of an eating disorder according to the ICD.

It should be noted that 5.3% of the participants had developed posttraumatic stress disorder before developing lipoedema. Some 22.7% of the women in the total sample reported having had suicidal thoughts in the past, but they denied any association between these thoughts and the lipoedema. The main triggers were stressful life events, such as the death of a loved one, loss of a job, a life-threatening disorder in a child or serious conflicts at the workplace. One patient had previously attempted suicide due to family problems. Additionally, 56% of the women with lipoedema (n1: 51.9%, n2: 60.9%) showed mental health disorders that definitely manifested in the 12 months prior to the presentation of lipoedema-related pain. Thus, their mental health disorders could not have been a result of the lipoedema. Both current and previous mental health disorders were considered in this study. The 12-month period before the development of lipoedema-related pain was found to be of particular significance in this pilot study.

the onset of lipoedema-related pain. Thus, it is apparent that what temporally precedes the development of lipoedema cannot be its cause. There is no evidence for the popular statement that lipoedema causes mental health disorders. In fact, the opposite seems to be true, that is, psychological issues contribute substantially to the development of lipoedema. Further, depression and posttraumatic stress disorders are significantly related to the pain intensities (on the VAS) reported by patients in everyday life.

Conclusion

The vast majority of women with lipoedema (80%) experience severe psychological symptoms **BEFORE**

7. Myth: Liposuction is effective for lipoedema, producing long-lasting results

For many years, health practitioners who perform liposuction have promoted this procedure as an effective and permanent treatment option for patients with lipoedema.¹⁴¹ One report stated that liposuction can cause 'a significant, sometimes even spectacular improvement in body shape with a marked reduction or removal of the symptoms typical of the disease',¹⁴² and another described liposuction as providing long-lasting improvements in findings and symptoms of lipoedema.¹⁴³ There are three aspects to consider when evaluating these statements for their veracity. (1) Is the effectiveness of liposuction for lipoedema supported by robust data? (2) How permanent are these positive effects of liposuction? (3) The secondary disease in lipoedema—namely, obesity—needs to be taken into consideration.

Studies regarding the efficacy of liposuction for lipoedema

With regard to the efficacy of liposuction for lipoedema, the studies that the German lipoedema guidelines cite and are based on have considerable differences in how they assess the success of liposuction. For example, Cornely (2011) considered lipoedema to be curable through liposuction,¹⁰ stating that 'It is clear that even with large numbers of cases of our own patients, as was already published in 2004, the postoperative need for further lymphatic drainage and compression is zero'.¹⁴⁴ However, this claim is not validated in the article itself or in the wider literature. Further, the other claims, specifically, that once liposuction is performed, conservative therapy to treat the disease is no longer required and the 97% success rate on long-term monitoring of patients for 15 years,¹⁴⁴ were debunked by another research in 2015.¹⁴⁵ It was found that the results of liposuction curing lipoedema could not be reproduced. Finally, the study proclaiming the cure was found not to have been conducted based on scientific criteria, but was merely a survey.¹⁴⁵ In light of these debates, the authors of this supplement are convinced that the

surgical perspective does not do justice to the complexity of the disease of lipoedema, and it tends to oversimplify the treatment of the condition.

Rapprich found that only 16% of patients still required compression therapy after liposuction,¹⁴⁶ which reduced postoperative pain, oedema and haematoma, and in a more recent study, the author noted that most patients no longer required conservative treatment after liposuction,¹⁴¹ although no actual figures are mentioned. Despite the relative volume reduction seen in this study (range: 0.9%–19.8%), the main limitation, which the author acknowledges, is that the time of follow-up was 6 months postoperatively. This is undoubtedly too short a follow-up time for a study investigating the effectiveness of an operation in improving preoperative symptoms and permanently reducing pathological adipose tissue.

In 2010, Schmeller published the results of a single-centre retrospective study in which 112 patients who had undergone liposuction for lipoedema were examined over an average follow-up period of 3 years and 8 months postoperatively.¹⁴⁷ This study reported that liposuction was successful not only in removing the circumscribed and often disfiguring increase in adipose tissue, but also in reducing the spontaneous pain, tenderness and the tendency to bruise. This led to an improvement in mobility, aesthetics aspects and quality of life. In 2014, Baumgartner et al¹⁴⁸ published the results of a second single-centre retrospective study that were meant to confirm the results of the 2010 study¹⁴⁷ over a longer time period. This study also aimed to determine the need for conservative treatment (manual lymphatic drainage and compression therapy) postoperatively over time. The authors stated that liposuction led to complete eradication of symptoms in only about one-third of the patients, whereas two-thirds of the patients still needed conservative treatment, including compression. In the 2010 study, 77% of the patients still required complex decongestion after liposuction¹⁴⁷ and, in the study published in 2014, 70% were still receiving this treatment (although this

7. Myth: Liposuction is effective for lipoedema, producing long-lasting results

number was fewer than those requiring complex decongestion before liposuction). Of all the published studies that investigated the efficacy of liposuction in the treatment of lipoedema, these are of the highest quality. Despite this, these studies have similar limiting factors: both were retrospective and single-centre.¹⁴⁹ In these studies, the success rate of liposuction treatment (defined by Cornely as no further need for complex physical decongestion postoperatively) ranges widely over an equally widely ranging follow-up period (6 months to 15 years):

- 97% with a reported 15 years of follow-up¹⁴⁴
- 84%, but with continuation of any psychological support and dietary advice, with only 6 months of follow-up¹⁴⁶
- 23% after 4 years of follow-up¹⁴⁷
- 30% after 8 years of follow-up¹⁴⁸

Further, the definition of the success rate itself is seriously questionable, as it is the authors' contention that lipoedema patients do not require manual lymphatic drainage (even without liposuction).¹⁵⁰ Since compression has positive effects on postoperative pain, oedema and haematoma, patients have to wear compression stockings even after undergoing liposuction, and they appear to experience improved mobility. In the authors' opinion, improved mobility and a reduction in pain would be more suitable criteria to gauge the success of any intervention.

Certain questions must be considered when determining the success of liposuction. First, is the success of treatment measured attributable to the liposuction or are there other factors at work that have contributed to this measured success? It should be recognised that many lipoedema patients have experienced a long and painful journey until their condition was recognised and eventually treated by liposuction. For instance, in the UK, some women have applied for and been rejected through the NHS individual funding request for specialised services, and others have saved extensively to pay for it themselves. The expectations they have from this treatment have a strong bearing on how these

questions are answered, as it is possible that patients perceive the treatment as successful because of what they have gone through for their condition to finally be addressed. Placebo research provides an indication of whether high expectations from treatment affect perceived improvements in symptoms.¹⁵¹ Additionally, the effects of communication between the patient and health practitioner also need to be considered. The physician could lead the patient to have high expectations from the treatment. The effect of surgical procedures compared to sham operations was investigated in another placebo study. Shivonen et al¹⁵² compared arthroscopic partial meniscectomy with sham surgery in a multicentre, blinded and randomised controlled study. Remarkably, both groups of patients reported a marked reduction in knee pain even after 1 year postoperatively. Louw's review of randomised controlled studies with placebo operations in the field of orthopaedics concluded that sham surgery was as effective as actual surgery in reducing pain and improving disability.¹⁵³ With regard to liposuction for lipoedema then, the true effects of liposuction can only be recognised if a second control group is included, in addition to an untreated control group. However, unlike the orthopaedic procedures described above a sham liposuction operation cannot be performed, because the visible difference in body shape is a significant partial aim of the liposuction; additionally, ethical aspects also need to be considered. Instead of a placebo design that differentiates between the effects of patient expectations and the actual effects of liposuction, a study comparing the effects of liposuction with those of another therapeutic approach might be useful. Different treatments could be compared among themselves and with no treatment. For instance, a comparison between physiotherapy combined with psychotherapy¹⁵⁴ focusing on improvements in fitness levels and self-esteem and liposuction in a study lasting several years seems appropriate. Another potential methodological design would be to compare three groups: one group of lipoedema patients without liposuction (baseline),

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one group that has undergone liposuction and another that has undergone conservative treatment.

The second question to address is: Do the questionnaires used measure the success of liposuction treatment?¹⁴⁵ The questionnaires used in studies on liposuction for lipoedema conducted so far do not meet the quality criteria for questionnaires.¹⁵⁵ For example, the questions are not adequately specific, leading to distorted answers. Further, responses to earlier questions generally have an effect on the responses to subsequent questions.¹⁵⁶ Women who first estimate the spontaneous pain in their legs, the tenderness in their legs, the feeling of heaviness in their legs and their problems walking, may report dissatisfaction with their legs rather than impairment of their quality of life. A good-quality study is required to determine the success of liposuction perceived by patients. Somatic comorbidities and their development also need to be recorded so that improvements or deteriorations can be interpreted. Importantly, psychological symptoms such as depression or anxiety that can intensify pain must be recorded.¹⁵⁷ Lastly, self-assessments (e.g. patient questionnaires) must be supplemented by assessments by diagnosticians who are independent of the treatment providers or by objectively measured data.

Conclusions from studies on liposuction for lipoedema

From summarising the studies on the effects of liposuction on lipoedema, it is clear that evidence for the success of liposuction in curing lipoedema is lacking. This view was mirrored by the Federal Joint Committee (G-BA) in Germany, which decided that outpatient liposuction is not a standard benefit of German statutory insurance schemes (GKV) in November 2017.¹⁵⁸ This assessment was further confirmed by the German Federal Social Court (BSG) in April 2018, in a case brought by a woman with lipoedema who had undergone several liposuctions as an inpatient. The judges ruled that liposuction did not meet the requirements of quality and cost-effectiveness for insurance to be paid out, and that the

long-term effectiveness of the method had also not been adequately confirmed.¹⁵⁹ A recently published review of clinical effectiveness of liposuction concluded that the quality of the evidence was limited, and studies had systematic biases due to lack of randomisation; further, they used instruments that have not been validated for data collection and assessment in lipoedema-related complaints.¹⁶⁰

Does liposuction have a permanent effect?

The second aspect that needs to be addressed here is the permanence of the effects of liposuction for lipoedema. Most studies on liposuction for lipoedema claim that, once the adipose tissue is removed, it does not accumulate again.¹⁶¹⁻¹⁶³ In their 2018 article, Heck and Witte, who describe their liposuction method as lipo-decompression because of its decongestive effects, stated that the lipoedema did not generally recur after this surgery.¹⁶¹ A previous study proposed a similar concept, where liposuction is described to reverse the cause of lipoedema, which in turn is described as the overproduction of lymph in the arms and legs, leading to congested adipose tissue.¹⁰ However, scientific evidence for this pathophysiological construct is virtually non-existent,^{15, 150, 164} and there seems to be no scientific basis for terms such as 'lymphological liposculpture' and 'lipo-decompression'. Additionally, Baumgartner reported that liposuction had a much more long-lasting effect over complex physical decongestion.¹⁴⁷

A vital factor that does not seem to be considered in any of these previous studies, however, is obesity as a comorbidity in those with lipoedema. A large proportion of patients with lipoedema are also obese:⁴¹⁻⁴³ 88% of the lipoedema patients seen in the lead authors' institution in 2015 were obese (detailed data are provided in Chapter 3). In a Dresden-based study, despite having undergone liposuction for lipoedema, 65% of the patients were obese, and 35% were morbidly obese, that is, they had a BMI of >40 kg/m².¹⁶⁵ It is not clear why most of these studies on

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liposuction do not acknowledge the common coexistence of lipoedema and obesity. When listing concomitant conditions, the Dresden study listed arterial hypertension as the most common one ($n = 13/26$), followed by chronic venous insufficiency ($n = 9/26$). Central body obesity was found in four patients. However, if the BMI of patients who underwent liposuction in this study is considered, then it is evident that 17 of the 26 patients were obese (BMI of 30 kg/m^2 or more), with 9 being morbidly obese (BMI of $>40 \text{ kg/m}^2$).¹⁴⁵ Even if the WHtR is considered a better marker of obesity than BMI in patients with lipoedema, it can safely be assumed that lipoedema patients with a BMI of 35 kg/m^2 or higher will have abdominal obesity. In the Dresden study, this would be the case in 12 of the 26 patients.¹⁶⁵ Thus, it appears that obesity was not recorded appropriately as a comorbidity.

In the authors' experience, this 'obesity blindness' is shared by many self-proclaimed lipoedema experts. To the authors' knowledge, only one study by Frambach considers that obesity in lipoedema patients is a significant aggravating factor in the pathogenesis of lipoedema. This study found that obesity is the most common comorbidity in lipoedema, indicating that increased body weight not only worsens the appearance of the extremities but also lipoedema symptoms.¹²⁵ These findings are mirrored by the authors' own experiences in clinical practice with lipoedema patients. The acknowledgement that obesity is an aggravating factor in lipoedema is vital, but unfortunately seems to be unrecognised by many colleagues who perform liposuction. The course of body weight after liposuction deserves special attention and leads to the following questions: How does the weight of patients diagnosed with lipoedema who have undergone liposuction change with time? Could the patients investigated in the previous studies mentioned above maintain their weight for the duration of follow-up after liposuction? And did the patients who underwent liposuction not experience any increase in weight in the subsequent years? None of the studies mentioned here provide any information about the course of body weight.

Nonetheless, these figures are essential because the permanence of the effects of liposuction could only be expected if the patients' weight remained largely stable after liposuction. Overall, the authors' experience indicates that a weight increase would lead to an increase in symptoms, and the long-term stability of body weight in most lipoedema patients would contradict the authors' many years of experience with this group of patients. Many patients with a diagnosis of lipoedema experience a constant increase in weight with time. All health practitioners who treat lipoedema patients know their difficult history regarding body weight and have heard the tales of weight gain merely interrupted by diets and the subsequent yo-yo effect. Obesity experts have spoken for years of an obesity epidemic, but weight increase among people with an initially normal weight is now being observed.¹⁶⁶⁻¹⁷⁰ Why should this individual weight gain in lipoedema patients, whose weight has often varied considerably over many years, stop after liposuction? And what happens in the case of patients who have undergone liposuction and then regained weight subsequently? It stands to reason that there would be a renewed increase in adipose tissue in the legs and a consequent increase in symptoms typical of lipoedema. During the course of their clinical work, the authors regularly see patients diagnosed with lipoedema who have undergone liposuction and yet continue to experience symptoms of lipoedema. Almost all women report a transient improvement in symptoms after liposuction. However, most of these individuals gain weight and, therefore, also experience worsening of soft tissue pain in the legs. This increase in adipose tissue after liposuction was also observed in another prospective randomised, controlled study conducted in the US.¹⁷¹ Patients with normal weight who had undergone liposuction for lipoedema showed an increase in the adipose tissue removed by liposuction within 1 year postoperatively.¹⁷¹ The fat accumulated in both visceral as well as subcutaneous depots.¹⁷¹ The authors of this study also provided information about which regions of the body were particularly affected by the increase in adipose tissue, namely, the abdominal

7. Myth: Liposuction is effective for lipoedema, producing long-lasting results

region. Fat accumulated more slowly in the hip and thigh regions.¹⁷¹

Conclusions regarding liposuction having permanent effects on lipoedema symptoms

In summary, the prospective, randomised, controlled study by Hernandez and Eckel¹⁷¹ suggests that:

1. Within a year, the weight of suctioned adipose tissue (body fat) will increase
2. The cosmetic effect on the thigh after 1 year (in a study population of normal weight) will persist, but here too, the adipose tissue in the operated legs will increase
3. There will be an increase in predominantly visceral fat in the abdominal region that is known to be associated with an increased cardiovascular risk.

Based on the findings of this study, one American expert—Anne Peled—stated that avoiding postoperative weight gain is essential for the results of the study to be maintained.¹¹

Obesity coexisting with lipoedema

The authors regularly see liposuction recommended and performed for morbidly obese patients, with BMIs of 40, 50 or even 60 kg/m². This weight is often closely associated with metabolic, cardiovascular and orthopaedic concomitant diseases. In the authors' view, the indication for bariatric surgery should be examined instead of liposuction.

Let us consider a case. **Figures 7.1 and 7.2** show a patient who presented to a large German dermatology

Fig 7.1 and 7.2. Patient with morbid obesity, lipoedema and obesity-related lymphoedema



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clinic specialising in the treatment of lipoedema, where she was diagnosed with 'lipolymphedema' of the legs and arms, which, as mentioned above, is not a correct diagnosis. Although she weighed 147 kg and was 1.65 m tall, obesity was not a diagnosis listed in her report; she had a BMI of 54 kg/m².¹¹ The patient also had several concomitant conditions that are closely linked to morbid obesity: obesity-associated lymphoedema in the legs, arterial hypertension, reflux disease, chronic venous insufficiency with a history of venous leg ulcer on the left leg, as well as lipoedema. The clinician proposed 7 sessions of liposuction at a total price of 18228 euros. In the authors' opinion, this assessment makes little sense either from a medical or an economic viewpoint. At their clinic, where the patient sought a second opinion, the authors were able to convince the patient that the proposed liposuction would not yield any significant

benefits and certainly not permanent resolve her condition. They proposed bariatric surgery as a better alternative treatment. The patient agreed and was prepared for a gastric bypass operation within the clinic's multimodal obesity programme. Surgery was performed a few months after discharge from the clinic. **Figures 7.3 and 7.4** show the same patient 14 months after the gastric bypass. The patient's weight almost halved to 76 kg. The leg volumes, which were originally 21 L per leg more than halved to 10 L per leg. This has led to improvements in obesity-associated lymphoedema as well as the other comorbidities. She stopped using the antihypertensives and has no symptoms of reflux. With compression treatment using flat-knit compression stockings for the lymphoedema, the patient is also free of the preoperative soft tissue leg pain typical of lipoedema. The long-term effect of bariatric surgery has been

Fig 7.3 and 7.4. The same patient 14 months after gastric bypass



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demonstrated previously.^{96, 100-102} After weight stabilisation over more than 1 year, the plastic surgeon could remove the excess skin over the legs as well as the abdomen.

Conclusions about obesity coexisting with lipoedema

In summary, liposuction is not a therapeutic option for treating obesity, and disregarding the diagnosis of obesity in obese lipoedema patients is unhelpful. It is essential to take obesity, the most common comorbidity in lipoedema, into account in order to offer the best treatment to patients with lipoedema.

Conclusion

The current data for liposuction are quantitatively and qualitatively inadequate. If liposuction is performed, the selection of suitable patients and the incorporation of liposuction into a multimodal treatment plan are essential. The consensus of the European Lipoedema Forum describes the conditions and limitations of this surgery (please see page 41 of this supplement).

8. Overview of European best practice consensus on lipoedema

This supplement proposes a paradigm shift in the concept of lipoedema—that there is no component of oedema in lipoedema, and any efforts to address this nonexistent component of the disease are misguided. Neither clinical examination nor diagnostic imaging has shown there to be a significant accumulation of fluid in the tissues of patients with lipoedema, which makes decongestion of the tissues by manual or automated lymphatic drainage techniques obsolete. The term ‘lipoedema’ is, therefore, outdated and should be reconsidered.

On the basis of the authors’ experiences with thousands of patients and the existing medical literature, arguments are made to dispel other myths surrounding lipoedema and clarify certain features of the condition. In addition, research has shown that there is no scientific evidence at all for the pathophysiology previously thought to underlie lipoedema. Although it is often said that lipoedema is a progressive disease, there is no evidence to support this assertion.¹⁷² On the other hand, obesity is often progressive, and lipoedema may worsen as the patient’s weight increases in those with obesity and lipoedema as comorbidities. For this reason, the term ‘lipolymphoedema’ is also obsolete and needs to be reconsidered. Progressive obesity rather than lipoedema is the cause of any lymphoedema. Many patients, therefore, have three diseases that need to be treated: obesity, lipoedema, and obesity-related lymphoedema. The authors’ data also show a high level of psychological vulnerability in the great majority of patients with lipoedema.^{30, 172} However, it must be highlighted that mental health issues were present before the onset of the typical lipoedema symptoms and, therefore, have an influence on patients’ perception of pain. Next, the data have reversed the claim that losing weight has no effect on lipoedema—a view widely shared by many lipoedema experts, especially those who offer liposuction—and they have also dispelled the belief that lipoedema makes patients fat. In fact, it is obesity that makes patients fat. In purely physiological terms, weight gain

involves an increase in the adipose tissue in the legs. Therefore, it would follow that weight loss would involve a reduction in the adipose tissue in the legs.¹⁷³ A recent study of the University of Freiburg together with the Földi Clinic found dramatic improvements in volume reduction of the legs and lipoedema symptoms after bariatric surgery.⁹² And finally, the authors have shown that research on liposuction is severely lacking, and liposuction is not a cure for lipoedema.¹⁷⁴

Despite this lack of reputable studies, the German Ministry of Health has been effectively campaigning for liposuction for lipoedema to be covered by healthcare insurance,¹⁷⁵ and the Federal Joint Committee (G-BA) has approved this. Since 1 January 2020, it is possible to prescribe liposuction for ‘stage 3 lipoedema’ under statutory healthcare insurance.¹⁷⁶ However, importantly, the staging of lipoedema is itself debatable in terms of its value. At present, the classification depends on a subjective assessment by the examiner and is based on morphological criteria alone, without taking the patient’s actual symptoms into consideration. These stages therefore ignore the clinical reality. There are some women with (what was formerly referred to as) stage 3 lipoedema who have highly disproportionate adipose tissue in the legs (or arms) but only mild symptoms or none at all. On the other hand, some women have only mildly disproportionate adipose tissue (formerly, stage 1 lipoedema) but experience intense pain in the soft tissues of the leg. The classic patient with stage 3 lipoedema referred to the authors’ outpatient clinic is a severely overweight woman whose main disease is obesity. Therefore, liposuction for such morbidly obese patients cannot be rationalised, and yet, it is now reimbursed at the expense of the statutory health insurance in Germany.

The paradigm shift

The paradigm shift in lipoedema proposed in this supplement necessitates a radical change in the views surrounding lipoedema. It will mean moving away from the idea of oedema in lipoedema and, hence,

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away from the idea that decongestion is necessary, and towards the actual problems faced by patients with this condition. Naturally, this paradigm shift in a disease that has been described and approached in a particular way for decades will need widespread efforts for adoption. For this reason, the lead author of this supplement invited renowned lipoedema experts from various European countries to discuss the subject. The first European Lipoedema Forum was held in Hamburg in June 2018, with participants from five countries. The second forum in March 2019 included experts from seven countries. The goal of these meetings was to establish a consensus that would reflect the view shared by these European countries, on the basis of the available literature and the experts' many years of clinical practice with lipoedema patients. To reflect the clinical complexity of lipoedema, the experts provided an interdisciplinary approach and included psychologists, physiotherapists, nutrition and obesity experts, lymphoedema/lipoedema nurse specialists, doctors responsible for conservative treatment, surgeons and patient support groups. Nearly all participants in the European Lipoedema Forum had published work on lipoedema, had been involved in drawing up their own national lipoedema guidelines, or were on the executive board of their respective specialty society.

The consensus was established using the open space technique (OST) and the formation of interdisciplinary working groups that then presented their results to the entire expert group so the consensus could be reached.

The consensus statements on the scientific background and diagnosis of lipoedema are given in **Box 8.1**.³⁴

It is clear that, through the consensus meetings, a substantial change in perspective has taken place, not only in the scientific understanding of but also in the diagnostic approach to lipoedema. There has been a shift in focus: while the disproportionate increase in adipose tissue in the limbs and the symptoms associated with this fatty tissue increase are still considered major symptoms, oedema (and the

tendency to developing haematoma) is now considered to be a very minor symptom in the diagnosis of lipoedema. Instead, greater importance is given to obesity and patients' mental health (which has a significant effect on pain perception).

Pathophysiological model of lipoedema

The lead authors have proposed a pathophysiological model to explain the symptoms associated with lipoedema to the patients. When patients present with a history of being diagnosed with lipoedema, routine practice at the lead authors' is now to ask not only about any changes in weight but also about the time of onset of the pain. It is known that one of the main complaints in patients with lipoedema is weight gain, but this is a result of obesity, not lipoedema: some patients put on only 6 kg, some gain 40 kg or more, but any weight gain is usually accompanied by a disproportionate increase in the legs (and less commonly in the arms). An increase in weight basically means an increase in adipose tissue. A hormonal pattern may develop in the expanded adipose tissue, resulting in low-grade inflammation and hypoxia of the fat cells.¹⁷⁷ In particular, an increase in adipose tissue leads to a local increase in pro-inflammatory hormones (adipokines).^{11, 37} The subcutaneous fatty tissues appear to be associated with chronic inflammation. Further, Rutkowski et al reported that increase in adipose expansion results in tissue hypoxia.³⁸ Fat cells are only able to expand with increased vascular growth. The vessels' inability to keep pace with the expanding adipose tissue may lead to hypoxia, and hypoxic conditions in this tissue lead to an increased expression of hypoxia-inducible factors (HIF1a).¹⁷⁸ HIF1a, in turn, induces inflammation of the adipose tissue.¹⁷⁹ An earlier study also reported similar findings: histological analysis in patients with lipoedema revealed an increase in crown-like structures indicative of dying fat cells.¹⁶ More recent data confirmed the occurrence of inflammatory processes in the subcutaneous adipose

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Box 8.1. Consensus on the scientific background of and diagnostic approach for lipoedema

1. There is **NO** scientific evidence that:

- lipoedema is an 'oedema problem'
- manual lymphatic drainage reduces patients' complaints due to its drainage effects
- lipoedema is a progressive disease
- weight loss is not effective
- lipoedema is the cause of lymphoedema
- 11% of the female population has lipoedema
- the onset of lipoedema is during puberty.³⁴

2. Then, the consensus agreement regarding the diagnostic approach for lipoedema states that orthostatic oedema does not have to be present for lipoedema to be diagnosed, since oedema is only present in a small subgroup of lipoedema patients. Thus, oedema is not pathognomonic for lipoedema.

3. The consensus agreement regarding the distribution of adipose tissue is that disproportional fat distribution must be present for lipoedema. Differential diagnoses for lipoedema include obesity, that is, a global visceral and subcutaneous fatty tissue increase, and lipo hypertrophy, that is, subcutaneous fatty tissue increase in the legs and sometimes in arms but **NO** pain/complaints in soft tissue. Further, obesity is often progressive, but lipoedema is usually not. The lipoedema can worsen if the obesity progresses.

4. The consensus statement regarding pain or symptoms in the soft tissues is that other diseases must be excluded as the cause of pain before lipoedema can be diagnosed. Pain must be further differentiated as heaviness, discomfort, spontaneous pain or pain on pressure. Pain must be assessed as objectively as possible, using the visual analogue scale (VAS), pain questionnaire, Central Sensitization Inventory (CSI) or similar well-validated tools.

5. The consensus statement regarding overweight and obesity is that these conditions are an aggravating factor of lipoedema. The majority of lipoedema patients are obese (80–88%). Most patients try diet and exercise to lose weight and experience yo-yo effect. Weight gain can impair lipoedema, and obese lipoedema patients often experience a lack of fitness and mobility.

6. Finally, the consensus statement regarding the mental health of those with lipoedema is that psychological issues are an additional aspect of lipoedema. The impact of psychological distress in lipoedema is underestimated, and this psychological vulnerability contributes to patients' pain perception. Patients with lipoedema often have eating disorders that need to be treated. Patients also often lack self-acceptance because of beauty ideals.

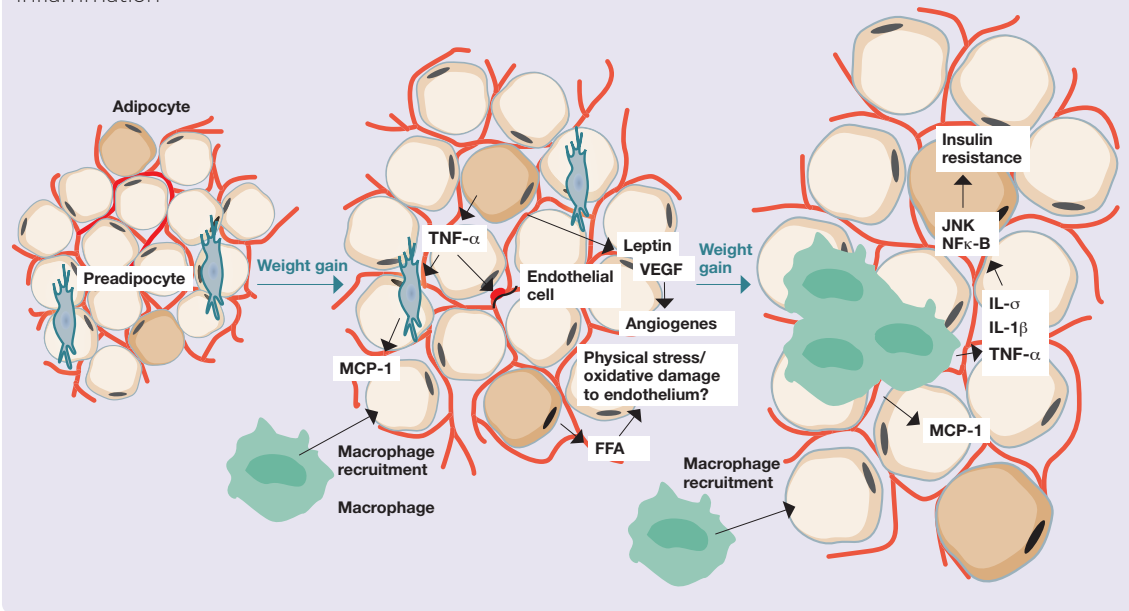
tissue of patients with lipoedema. This study showed an increase in the sodium content of the skin in these patients, which is an emerging hallmark of inflammatory diseases.³⁹ A study published in 2019 also confirmed the inflammatory processes in the adipose tissue; a greater increase in the number of macrophages was found in the fatty tissue of patients with lipoedema than in the control group.¹⁸¹ Similar to the hypoxia, this low-grade chronic inflammation may contribute to the patient's perceived pain.¹⁸¹ **Figure 8.1** depicts these complex pathophysiological processes.

Figure 8.2 shows the somatic aspects of the model that the lead authors use to explain to patients how the

pain develops. This somatic view of lipoedema is just one side of the coin. In the past, the medical profession has viewed pain exclusively as a warning signal for tissue or nerve damage, but more recently, it has come to understand that chronic pain can also be (co-) triggered by stress or even personal conditions. Stress-induced hyperalgesia (SIH) might play a role in lipoedema, especially when patients experience intense pain. The pain that lipoedema patients experience could be less related to tissue damage and more to the way in which the brain and nervous system interpret the stimulus.¹⁸² A study carried out by the lead authors³⁰ (including 150 cases) showed that patients who had

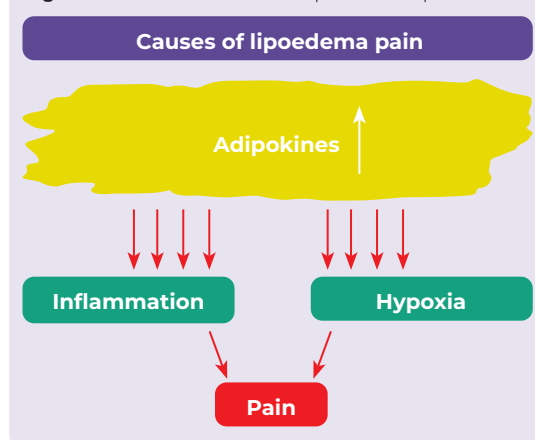
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Fig 8.1. Complex pathophysiological processes underlying pain in those with chronic low-grade inflammation



sustained mental stress over a long period reported higher estimates of the severity of lipoedema pain (7–8 and even up to 10) on the visual analogue scale (VAS) from 0–10, where 10 was considered by the investigators to be ‘amputation pain’. If there were no pronounced mental stress factors, the severity of the pain was usually rated 2–3. Chronic stress, as well as anxiety and depression,^{183,184} lower the pain threshold. Catastrophic thinking,¹⁸⁵ in which attention is focused on the pain, negative assessments and helplessness reinforce the pain and cause it to become chronic.¹⁸⁴ Patients with pain often avoid movements that may trigger the pain, which restricts everyday activities even more and brings about a feeling of helplessness.¹⁸⁴ In addition, chronic stress itself causes an increase in inflammatory markers. Results from recent studies show this to be the case in patients with rheumatoid conditions,¹³¹ in whom a stress-induced increase in inflammatory mediators can be seen, irrespective of disease activity. At the same time, patients with depression,¹⁸⁶ social stress¹⁸⁷ or posttraumatic stress disorder¹⁸⁸ also show

Fig 8.2. Somatic causes of lipoedema pain



an increase in inflammatory markers that is unrelated to any underlying somatic disease. Given the psychological vulnerability of most patients with lipoedema, a vicious circle may ensue, where chronic stress and psychological symptoms intensify the pain

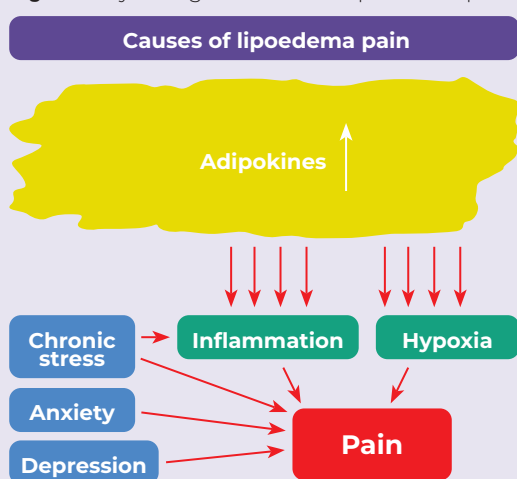
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through inflammatory mediators, which in turn may worsen mental stress. **Figure 8.3** shows the somatic model with these psychosocial factors added in.

Lipoedema is not a mental illness, but psychological factors do play a key role in the associated complaints. Therefore, it is extremely important to be open to the complex interactions between body and mind. This perspective makes it easier to develop effective long-term treatment strategies. Labelling, an additional stigmatisation that many patients with lipoedema have already experienced because of the disproportionality of their limbs or their obesity, is very damaging to mental health and hinders effective therapy.

There are still some questions that need to be answered in the future. For example, why do patients with lipoedema experience pain only in the subcutaneous fatty tissue of the limbs (usually the legs) and not in the subcutaneous fatty tissue over the abdomen or back? Why do treating physicians repeatedly see women with advanced disproportionate fat distribution who do not experience pain (by definition, lipohypertrophy) as well as those with less disproportionality but intense pain in the adipose tissue in these regions?

Fig 8.3. Psychological causes of lipoedema pain

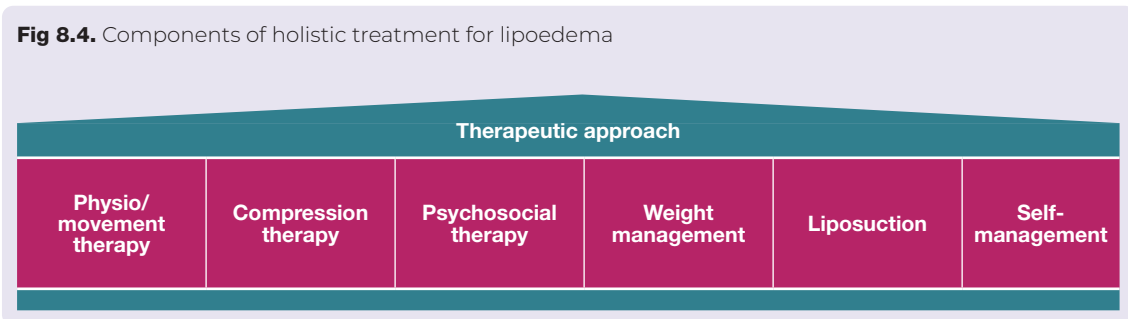


Consensus on the treatment of lipoedema

A key element in the therapeutic concept proposed by the lead authors is to focus on the actual complaints of lipoedema patients. This element, too, represents a paradigm shift in the view of lipoedema. The traditional approach for treatment focused on the oedema, so was centred around decongestion. Naturally, decongestion cannot have much value in new treatment approaches to lipoedema based on this consensus. Crucial questions in the new treatment concept are as follows: What do patients with lipoedema really suffer from? What is the therapeutic goal from the patient's point of view? Valid scientific data on the patients' perspective are lacking, so responses to these questions must be based on the extensive clinical experience of the experts participating in the European Lipoedema Forum. According to the experts, patients with lipoedema suffer to varying degrees from pain/other symptoms in the soft tissues of the legs or arms; greater psychological vulnerability, which may intensify their pain; a lack of self-acceptance, mainly because of current beauty ideals; overweight or obesity with numerous attempts at dieting; and a lack of physical exercise and fitness, especially in obese patients. **Figure 8.4** shows the main components of treatment defined by the experts, compiled into individual therapeutic modules. The results of the interdisciplinary working group were then discussed in plenary sessions in order to reach agreement and develop a consensus regarding lipoedema treatment, presented below. There are certainly some national differences in how this approach could be adopted across Europe. For example, physiotherapists in the Netherlands have greater responsibility and a wider scope of practice than those in Germany. It may, therefore, not be possible for all European countries to follow the consensus recommendations in an identical manner. However, the broader recommendations remain the same irrespective of the country of practice.

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Fig 8.4. Components of holistic treatment for lipoedema



Physiotherapy and movement therapy

Managing expectations prior to treatment is vital in order to know the patients' precise expectations and treatment goals, as well as their subjective illness beliefs. If the patient's expectations are unrealistic or inappropriate, it is important that these are discussed with the patient in order to avoid starting the treatment off on the wrong foot. The conversation should begin with a mutual exchange of expectations.

Patients with lipoedema should receive a holistic assessment that does not just focus on the diagnostic and medical aspects of the disease but considers the impact on daily functioning. In order to establish this overall picture, a patient health profile should be made that includes data on (repeated) clinical measurements to provide a more objective personal history and identify specific individual needs. The International Classification of Functioning, Disability and Health (ICF)¹⁸⁹ may be a useful tool for establishing this health profile and determining a detailed picture of the patient's problems, abilities and goals in all areas. The ICF model offers a fundamental framework for determining human functioning and a classification system based on the biopsychosocial model.^{189, 190} It consists of two parts (**Figure 8.5**). Part 1 describes functional ability and disability based on three components:

1. the physical body (body structures and functions)
2. activities
3. participation.

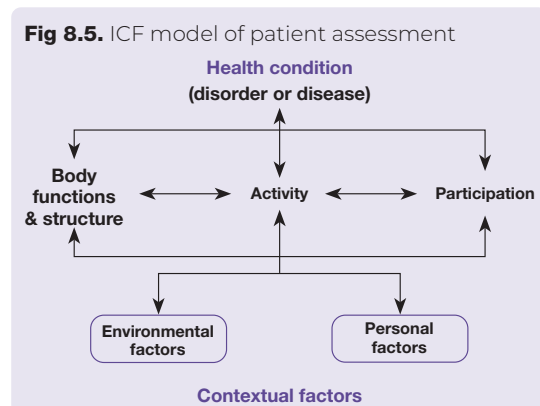
Part 2 is concerned with specific contextual factors and has two components:

1. environmental factors
2. personal factors.

All parts of the ICF model are interdependent.

In order to establish a comprehensive health profile, basic data should be recorded from each patient with lipoedema before they start treatment. The Dutch guidelines^{191, 192} suggest measuring the circumference of the limbs, the body mass index (BMI), abdominal girth and the Dutch standard of normal activity.¹⁹³ In addition, the European experts recommend recording the WHtR to determine body fat distribution. Depending on the individual patient's history, clinical assessment should be supplemented with additional tests and questionnaires, for example, to capture tiredness, pain, quality of life (QoL) and stress. Use of the ICF in combination with clinimetric

Fig 8.5. ICF model of patient assessment



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tools offers the possibility of establishing an individual health profile and drawing up an optimally personalised treatment plan. This should lead to an improvement in function and quality of life.^{189, 190, 194, 195} Monitoring the measurements at regular intervals allows us to analyse treatment progress and adapt the treatment plan as necessary.

Physiotherapy or lipoedema management focuses on reducing the subjective complaints and restrictions as well as preventing the condition from worsening. Each treatment session should consist of a selection of interventions that can be combined according to the patient's needs.

Education

It is important for patients to know and understand what lipoedema is and, perhaps even more importantly, what it is not. It should be made clear that lipoedema is a chronic disease that can be negatively impacted by increasing body weight and a lack of physical activity. Patients should be informed that it is their own responsibility to manage their conditions, not only physically but also mentally. It is important for the treating physician to realise that they can only coach patients, not solve their problems. A stepwise approach to behavioural changes (starting with realistic goals and slowly building upon them) and motivational interviewing may be beneficial in treatment of patients

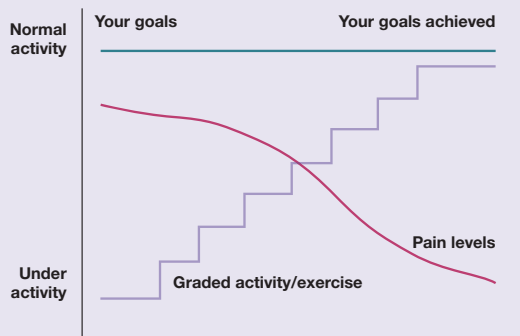
with lipoedema. As with the self-management of lymphoedema, education at an early stage is crucial.¹⁹⁶

Optimising daily functioning and physical capacity

In many cases, patients with lipoedema have a lower level of activity, as well as diminished physical capacity.¹⁹⁷ Graded activity is a structured treatment that is based on cognitive behavioural therapy combined with physiologic principles of training. The goal of gradually increased activity is to augment everyday functional ability; the key training elements are building up muscle strength and aerobic exercises.¹⁹⁸⁻²⁰⁰ The programme starts by determining the baseline based on measurements of pain, activities of daily living (ADLs), physical performance and psychological status. It is incrementally increased, which ensures greater patient compliance.²⁰¹ The method aims to change behaviour to increase the patient's level of activity irrespective of their complaints. Gradual increase in activity improves physical function without increasing pain levels. In a subgroup of patients, graded activity decreases pain levels in the long run²⁰² (**Figure 8.6**). The key element of this programme is the setting of personal goals, which can be used as the basis for determining patient-appropriate physical activities, and the necessity of a sustainable healthy lifestyle is always kept in mind.

The importance of physical activity cannot be overstated. As mentioned previously, inflammatory processes in the adipose tissue are the most likely cause of pain in lipoedema. It has recently been shown that regular physical training leads to a decrease in proinflammatory adipokines and macrophages.²⁰³ In addition, physical exercise increases blood flow and, thus, counteracts the hypoxia in the adipose tissues.²⁰⁴ Physical activity reduces the inflammatory processes in adipose tissue and contributes considerably to pain relief. **Figure 8.7** illustrates the effects of physical activity on the inflammatory processes in adipose tissue. Additionally, physical training acts like a natural antidepressant.²⁰⁵ This is

Fig 8.6. How graded activity reduces pain over time



8. Overview of European best practice consensus on lipoedema

of great relevance in patients with lipoedema, most of whom have an increased psychological vulnerability or have chronic mental stress. Sporting activity in conjunction with basic psychotherapy is more effective in persons with a depressive tendency than more sophisticated psychotherapy alone.²⁰⁶

Manual lymphatic drainage

Manual lymphatic drainage (MLD) has no effect on the lipoedema itself, as it can only influence oedema and not the distribution of fat or the size of fat cells. Lipoedema neither includes any relevant oedema nor impairs the lymphatic system.^{151, 165} Furthermore, the efficacy of MLD for lipoedema has not been demonstrated.^{207, 208} The perceived pain reduction through the application of MLD may be helpful in the initial stages of treatment. However, it is essential to combine this treatment with adequate information for the patient about the neuro-physiology of pain. In addition, if applied, this therapy should be restricted to 1 month because it is vital to protect the patient from dependency on the therapist.

Self-management

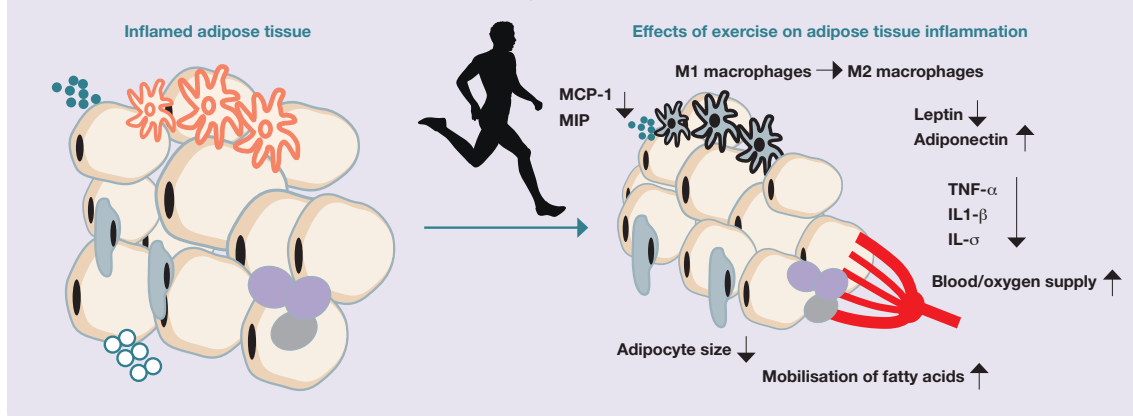
Following the chronic care model (CCM),²⁰⁹ patients should assume a leading role in their treatment in order to achieve behavioural changes. Self-efficacy,

the extent of one's belief in one's own ability to complete tasks and to reach goals, is one of the pillars of self-management.²¹⁰ Because self-management is important, the consensus considers it a mainstay of treatment in its own right.

Compression therapy

Compression therapy has always been and remains an important element of best practice in the treatment of patients with lipoedema. Nevertheless, the change in the pathophysiological view of lipoedema presented above alters the indication for wearing compression stockings. The basis for prescribing compression therapy is no longer the oedema, but rather the frequently demonstrated anti-inflammatory effects it has on the subcutaneous tissue. To the authors' knowledge, no data are available on the anti-inflammatory effects of compression in lipoedema. However, studies in phlebology and sports medicine have shown that compression has a remarkable effect on the inflammatory processes in subcutaneous tissue.^{211, 212} Confocal laser scanning microscopy has been used to show a significant reduction in proinflammatory cytokines and a simultaneous rise in anti-inflammatory mediators in the compressed tissue of patients with venous disease.²¹³ Ligi et al also highlighted these effects in their review,²¹⁴ and Beidler

Fig 8.7. Effect of exercise on inflammation in adipose tissues



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et al demonstrated a decrease in proinflammatory cytokines and macrophages after 4 weeks' compression therapy in patients with chronic venous insufficiency.²¹⁵ Other studies have reported an improvement in the subcutaneous microcirculation from wearing compression stockings.^{216, 217} One noteworthy study on healthy industrial workers and surgical nurses (who spend most of their working life on their feet) showed that wearing compression stockings resulted in a significant reduction in oxidative stress, a finding that also points to improved microcirculation in the subcutaneous tissues.²¹⁸ All these studies are related to compression of the legs in patients or healthy volunteers when standing or walking. There is much to be said regarding the effects of compression as synergistic with the effects of active movement (when standing or walking). Both these therapeutic options have an anti-inflammatory effect and a positive impact on the tissue hypoxia. Importantly, this is why wearing compression sleeves on the arms for lipoedema is less meaningful. The synergistic effects of compression and movement are particularly remarkable with physical activity in water. In the authors' experience, all their patients with lipoedema have reported an improvement in symptoms with swimming or water aerobics. Consequently, the importance of compression now lies in the reduction of pain and other symptoms due to inflammatory processes.

Conveying this information to the patient is a key task in doctor-patient communication. In addition, discussions with the patient should clarify that compression does not reduce the amount of fatty tissue, nor does it prevent an increase in fat in the legs if the patient gains weight. Depending on the clinical picture, custom-made circular-knit or flat-knit compression garments can be used. Flat-knit are generally preferred, not only because they are more comfortable to wear (and hence encourage compliance) but also because the forum experts have observed that they are more effective. Flat-knit stockings should always be used in severely obese patients with lipoedema who have deep skin folds in

fat lobes, as only the flat-knit manufacturing technology can meet the enormous calibre jumps that are characteristic in these patients. Besides providing symptomatic relief, compression also supports the soft tissues, reduces the mechanical impairment of movement from skin lobes rubbing against each other and improves mobility.^{217, 218} Patients' acceptance of compression as a necessary tool to reduce the symptoms of lipoedema increases with appropriate patient education. Aesthetic criteria with respect to the quality, colour and pattern of the material, as well as the contouring effects of the compression, can also increase patient compliance and enhance social participation. The extent of the lipoedema in the individual case determines whether compression pantyhose, leggings, capri-length compression garments or below-knee stockings are required and which compression class is necessary; the decision is always personalised accordingly. The success of compression therapy in the treatment of lipoedema can be established with appropriate tools for measuring biometric, psychological and social parameters.

Psychosocial therapy

The crucial question to ask is: what do women with lipoedema really suffer from? If we keep the relevant problems and symptoms in focus, we can identify those patients who are suffering from severe mental stress. Mental health issues and pain perception are closely related, so this is particularly relevant to lipoedema patients.^{30, 219} Various treatment options and support services are available for the psychosocial problems of patients with lipoedema. Therefore, there is no single psychosocial or psychotherapeutic option to treat all patients. However, there are some general factors that significantly affect all patients, including those with lipoedema, and, at the same time, there are lipoedema-specific issues that can be found in most patients with this condition. Nearly all patients with lipoedema express difficulties in accepting their own bodies, especially the shape of their legs. In this respect, the media, particularly social media, has an

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enormous influence on self-perception. The greater a woman's media consumption, the greater is her dissatisfaction with her own appearance and the more she craves a slim body.²²⁰ The beauty ideal among teenage and young adult women is already far below the normal weight for these age groups²²¹ and yet, the media suggests that this ideal can be achieved. This, in turn, puts pressure on girls and women who think that they have to conform to this ideal and may set off a vicious circle of dieting and subsequent weight gain. Further, psychological assessments found a clearly higher proportion of patients with lipoedema who reported physical or sexual abuse in comparison with the general population.²²² In a recent published study with 150 patients diagnosed with lipoedema, 52% reported having experienced severe violence or sexual abuse.³⁰ These experiences also impact body awareness and increase the risk of chronic pain.^{30, 223} The consensus discussions also identified other problem areas in patients with lipoedema, in particular, a diminished feeling of self-esteem, difficulties in coping with stress and, of course, the typical lipoedema pain whose perception depends on the patient's mental health.

Diagnostic screening

To identify patients with lipoedema who need psychotherapy or other psychosocial services, the consensus proposes the use of questionnaires to encompass the most important psychological symptoms, since it is usually difficult to make an appointment for psychological assessment quickly. All health professionals should be able to use these questionnaires to screen for the most common mental health issues or problem areas in patients with lipoedema. If the scores are remarkable, the patient should be referred to a licensed psychotherapist or counselling service for a psychological evaluation. Further treatment can be planned and the necessary services initiated. Until such time when a validated lipoedema-specific questionnaire becomes available, questionnaires that have already been validated and proved their worth in both clinical practice and

research should be used. Of course, screening does not replace a full mental health assessment. However, the use of screening questionnaires provides the outpatient physician with an indication of which patients with lipoedema must definitely be referred for further psychological assessment. A comprehensive view of the patient's symptoms is essential, especially when the pain intensity score is high. Where this is not possible within formal healthcare settings, patients may be directed to voluntary organisations that provide this support.

Therapeutic approach

Taking all the therapeutic options into account, the relationship between the patient and the treating physician or therapist has an important impact. The ideal relationship is based on empathy and an understanding of what the patient is going through; it acknowledges the burden of suffering felt by the patient but also strengthens the patient's resources to cope.²²⁴

Education

Information and education on how pain develops in lipoedema may start to modulate the patient's perception of pain. There is evidence that education on the neuronal basis of pain has a positive effect in various types of pain.²²⁵⁻²²⁷ When patients attribute severe pain entirely to severe tissue damage, they will be more likely to try to protect themselves and possibly be even more sensitive to pain. A comprehensive understanding of pain, seeing it also as a dysregulated reaction or an overreaction of the stress system, allows patients with lipoedema to develop further strategies for pain relief by relieving stress, strategies that they can then employ themselves. Anecdotally, analgesics appears to have limited benefits for lipoedema pain.

Psychotherapy

If anxiety, depression or severe psychological distress can be lessened by psychotherapeutic intervention, it has a positive effect in reducing pain.^{76, 228} Non-disorder-specific interventions include mindfulness techniques or acceptance and commitment therapy

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(ACT), based on mindfulness, which improve mental wellbeing and increase psychological flexibility. According to the German Association for Psychiatry, Psychotherapy and Psychosomatics treatment guidelines, evidence-based disorder-specific psychotherapy may be used when there is a psychological disorder, such as depression, an eating disorder or anxiety.²²⁹

Additional procedures

Psychotherapy in patients with lipoedema seems to reduce pain more effectively when used in combination with physically oriented techniques, such as embodiment-focused procedures. This may be attributed to a calming effect on the stress system, in addition to the effect of the words at the neuronal level. Under the new ICD-11 terminology, much of the psychological vulnerability found in patients with lipoedema can be described as a stress-related disorder.²²⁴ However, this initial experience needs to be reinforced by research.

Self-help groups

Experiencing self-efficacy and optimism as well as social support from positive, like-minded people in a self-help group increases resilience. According to a review article, well-developed resilience is associated with better mental health in people with physical health problems.²³⁰

Weight management

Obesity is often progressive, while lipoedema is usually not, but if obesity progresses, the lipoedema can get worse. In tertiary referral centres, 80–88% of patients with lipoedema also have obesity.^{41–43} Therefore, in order to treat lipoedema effectively, obesity must be addressed, and weight management plays a major role in the treatment concept. The recommendation for conservative management or additional surgical treatment depends on the patient's weight and their wishes. Nevertheless, the basic precepts of conservative treatment (weight management) must still be followed after surgery.

Recommended conservative approach

There has also been a change in perspective regarding weight management. The consensus does not consider weight loss as the primary concern for moderately obese patients. Instead, both therapists and patients should focus on achieving a state of wellbeing and fitness. Weight management is absolutely mandatory where severe obesity-related disease exists or threatens to develop. The expert panel has drafted a nutritional medicine concept to achieve this purpose:

1. Short-term diets must be avoided by all means. They almost always fail and often result in a yo-yo effect.^{64, 72–79} Instead, patients should be educated on how to change their eating habits towards an individually appropriate and adapted healthy diet that they can follow sustainably for the rest of their lives.

2. The concept of energy balance must be accepted. This does not imply mere calorie counting, since it is by now evident that the different nutrients have different metabolic effects.²³¹ Instead, emphasis must be placed on intake and expenditure of energy.

3. Patients should be informed about the pro- and anti-inflammatory effects of their dietary habits and food choices. In this context, the reduction of hyperinsulinemia and insulin resistance, which are present in most patients with additional visceral obesity, is vital for lipoedema patients.²³² Hyperinsulinemia is the main cause of chronic inflammation; the vicious circle of obesity and gradually increasing hyperinsulinemia leads to a further increase in adipose tissue.^{233, 234} To reduce hyperinsulinemia, the following is recommended: sufficiently long intervals should be maintained between meals: 4–6 hours are recommended during the daytime, and at least 12 hours during the night.^{235–237} Constant grazing should be strictly avoided, especially on sweets and other snacks that raise blood glucose levels. Foods containing refined carbohydrates or sugar should be avoided,^{232, 238, 239} as should processed foods. Consumption of healthy fats should be encouraged (olive oil, wild-caught oily fish,

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pasture-raised meat and milk products), and industrial trans-fats should be avoided.²⁴⁰⁻²⁴²

4. For long-term weight stabilisation, support and coaching are mandatory during and after nutrition therapy in order to prevent relapses.²⁴³

Recommended surgical approach

1. Bariatric surgery is recommended for patients with lipoedema who have a BMI of ≥ 40 kg/m².

2. Bariatric surgery may be considered for patients with lipoedema who have a BMI of 35–40 kg/m².

It has been shown that bariatric surgery is the most effective treatment for losing weight. A comprehensive meta-analysis with 25 prospective studies showed significantly better weight loss after surgical procedures, irrespective of the type of operation, the duration of postoperative care or the severity of the obesity.²⁴⁴ The BMI threshold for recommending obesity surgery is based on historical developments and is in line with the European²⁴⁵ and American interdisciplinary guidelines for bariatric surgery.²⁴⁶ Preoperative examination and preparation for bariatric surgery should be carried out in accordance with the European guidelines.²⁴⁵ The bariatric surgery itself should also be carried out within the framework of this interdisciplinary guideline. A recent study could show the great benefit severe obese patients with lipoedema experience after bariatric surgery.⁹² For patients with a BMI of 35–40 kg/m², the WHtR should also be taken into consideration to identify over-proportional fat distribution in patients with lipoedema. Patients with lipoedema and a WHtR < 0.5 probably do not have a metabolic risk, so bariatric surgery is not necessary for this group.²⁴⁷

Liposuction

The European Lipoedema Forum experts believe that the benefits of liposuction depend strongly on clearly defined patient selection, as not every patient with lipoedema would benefit from liposuction. In order for patients to benefit from this procedure, the participants agreed on the following criteria.

1. The symptoms persist despite at least 12 months of conservative treatment mentioned above

2. The patient has considerable functional disabilities (e.g. restricted mobility)

3. The patient's weight has been stable for at least 12 months. This reduces the risk of the effects of liposuction being cancelled out by postoperative weight gain.¹⁷⁴

4. A preoperative psychological assessment is available, to rule out any eating disorders or relevant mental health issues that might hamper sustained treatment success.

5. BMI no more than 35 kg/m².

Liposuction is not a treatment option for patients with a BMI > 35 kg/m² and central obesity (WHtR > 0.5). In the absence of the latter, liposuction can be carried out in patients with a higher BMI, although this is extremely rare. A lipoedema/liposuction task force comprising members of the executive committee of the German Society of Phlebology (DGP) and the German Society of Lymphology (DGL) has issued a statement to the G-BA, in which they include criteria that should be met by physicians treating lipoedema. According to this task force, the diagnosis of lipoedema is frequently found to be a mistaken diagnosis on referral. For this reason, the physician referring patients for liposuction should also have an additional lymphology or phlebology qualification. It is obvious that clear requirements for the surgeons must be formulated. To ensure the necessary quality standards, doctors performing liposuction must have specialist certification. Patients will then have the possibility of finding a surgeon who meets the defined quality criteria.

Figure 8.8 shows a patient who fulfills all the mentioned criteria. **Figure 8.9** shows the same patient 3 years after liposuction. She was happy with the results and experienced good pain relief, although she still has to wear compression garments.

Self-management

Successful self-management is necessary for patients with lipoedema to reduce their symptoms in the long

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Fig 8.8. A patient with lipoedema who meets all the criteria for liposuction. **8.9.** The patient at 3 years after liposuction



Kindly provided by Prof. Nestor Torio Padron

term. The available studies on self-management are very consistent in terms of their messaging: good self-management improves the state of health, everyday functioning and the quality of life in patients with chronic disease.^{248, 249} The authors regularly see patients with lipoedema who have achieved a considerable long-term reduction in their symptoms with successful strategies to improve their self-esteem, and some even describe themselves as symptom-free. Treating physicians and therapists have high expectations of their patients with

lipoedema: old and relatively unhealthy habits should be relinquished as soon as possible and replaced by new healthier self-management strategies. Following the chronic care model (CCM), patients should adopt a leading role in their treatment.^{209, 250} Nevertheless, the feasibility of establishing new habits is overestimated. Old habits are difficult to overcome, and implementing change depends on the basic principles of motivation. Neurobiology offers a basic insight as to why people adhere to unhealthy habits: unfavourable behaviour often reduces stress quickly and easily. From the

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neurobiological aspect, binge eating can be viewed as a coping method for frustration, and lowers stress levels in the short term,²⁵¹ which the brain interprets as a reward. In motivational interviews, patients talk about the disadvantages of their old automatic behaviour and/or the advantages of the new healthier behaviour.²⁵⁰⁻²⁵³ Many treatment models wrongly assume that sharing information and providing education are sufficient for patients to change their patterns of behaviour. However, even the best advice often has hardly any effect in changing behaviour. Instead, it is important that treating physicians show empathy,²⁵⁴ rather than commenting on behaviour that produces guilt or shame or trying to shock the patient into changing their behaviour.²⁵⁵ Patients often fail to meet their own demands. If they do not reach a set goal (e.g. more physical activity with compression therapy three times a week), they often give up totally. However, studies have shown that deviating from a new habit on a single day it has no measurable influence on long-term success. Not having to feel ashamed or guilty if something does not immediately go according to plan unburdens the patient, reduces stress and increases the likelihood of them establishing new healthier habits.

Consider a patient with lipoedema who is hardly moving about on a daily basis due to her complaints. This patient should be guided to rate each potential self-management strategy (in this case regular physical exercise under compression) on a scale of 0 to 10. For example: How important is it for you to exercise for 30 min while wearing compression three times a week from now on? The second question to be considered is: How much do you trust your own ability to carry out this strategy (e.g. how do you estimate the chances of your being able to exercise for half an hour, three times a week, and what sort of exercise would you enjoy the most)? If the goal is important to the patient, and they are sure that they can achieve it, then they are already highly motivated. If this is not the case, then motivational interviewing would be required. Studies have shown that the effects of such motivational interviews last for a long time after the

end of treatment.²⁵³ In summary, the best way to support patients with lipoedema is to help them develop new self-management strategies by meeting them on an equal footing—as experts on themselves.

9. Renaming the term 'lipoedema'

As already suggested decades ago, it is necessary to change the term 'lipoedema'.²⁵⁶ In terms of histology, indications of both hyperplasia^{9, 256} and hypertrophy²⁵⁷ of the fatty tissue have been found in those with lipoedema. Therefore, the deliberately non-specific term 'lipalgia syndrome' (from the ancient Greek 'lipos' = fat and 'algos' = pain) appears the most appropriate nomenclature. Redesignating 'lipoedema' as 'lipalgia syndrome' also shifts the focus of the illness, which previously was the presence of oedema and its drainage.

This renaming became necessary, as the word 'oedema' proved deceptive. To sum up the notions conveyed in this supplement, oedemas are defined as pathological accumulations of fluid in the tissue. However, relevant oedema caused by the syndrome previously described as a 'lipoedema' has not been detected, either on clinical examination or through imaging studies.¹⁵⁰ A multi-centre study using high-resolution ultrasound focusing on patients diagnosed with lipoedema failed to identify any indication of fluid in the soft tissue in the legs.¹⁶⁴ In a study published in 2020, in which patients with lipoedema were examined using MR lymphography, the authors summarised that 'The fat tissue was homogenous, without any signs of edema in pure lipoedema patients.'¹⁵ In addition, even histological studies have not found the presence of oedema in those with 'lipoedema'.^{34, 150, 164} In a seminal article published in 2012, Reich-Schupke et al called the term 'lipoedema' misleading, stating that 'it is not an oedema or a fluid retention in the tissue'.²⁰⁸ This was also confirmed by the authors of the Dutch Lipoedema Guidelines, in which they describe 'lipoedema' as an 'unfortunate term', as it suggests fluid in the tissue when no fluid is present.²² In a statement to the Federal Joint Committee in 2019, a task force comprising board members of the German Society of Lymphology and the German Society of Phlebology said that the idea that lipoedema involves oedema is no longer valid.²⁵⁸ The European Lipoedema Forum—a high-ranking international group of experts from seven European countries—then concluded in a noteworthy consensus

paper that there is **no** scientific evidence that lipoedema is an oedema problem.³⁴

It should be clarified that patients diagnosed with lipoedema can certainly present with orthostatic oedema, and it is important to ensure that these cases are recognised and managed appropriately. However, this is neither pathognomonic for the diagnosis of lipoedema nor causes symptoms for the patient. Even healthy people experience mild fluid retention in the lower extremities, which is situational and temporary (e.g. after standing for long periods or during the hot summer months).

The renaming of the term 'lipoedema' to 'lipalgia syndrome', which focuses on the soft-tissue pain that is actually experienced by patients, rather than oedema, also shifts the therapeutic focus from oedema treatment to pain management, which has obvious benefits for patients. As described in this supplement, pain is considered to have driven neurobiological research over the last few years, as a complex experience that also includes biographical and psychosocial experiences.³⁰

In order to increase acceptance of the new term while avoiding confusion, both terms should be used in parallel initially, for example, 'lipalgia syndrome (previously, lipoedema)'. It is hoped that the new term 'lipalgia syndrome' will quickly become established and gain widespread usage.

10. Final remarks

The paradigm shift in lipoedema has been gaining greater acceptance over the last two years. Large sections of the executive committees of the professional associations in Germany responsible for lipoedema have adopted this altered perspective. The previously lipoedema/liposuction task force has issued a statement on the fact that lipoedema does not include oedema.²⁵³ The European Lipoedema Forum, with 25 renowned experts from seven European countries, has developed the European Best Practice of Lipoedema outlined here and thus also supports the paradigm shift in lipoedema. After reading the consensus, numerous other national and international experts and opinion leaders from 10 European countries have also pledged their support for changing perspectives in lipoedema. Further, Guenter Klose, founder and CEO of Klose Training in Denver/Colorado, one of the largest and most renowned training institutes for lymphoedema therapy in the world, has also championed the new perspective on lipoedema and will integrate the new treatment concept into the organisation's training catalogue. Thus, it is hoped that this new way of approaching and treating lipoedema will become established in the US.

As always when things change, there is resistance, and even experts in the field of lymphology are challenging the paradigm shift and consensus. It is difficult to accept that the established doctrines of many decades are suddenly proving to be wrong, and people find it painful to question their beliefs and position. It is also associated with a fear of loss: a loss of acquired expertise, a loss of familiar certitude, a loss of control.

Patients who have lipoedema face a different concern when confronted with this change in the perspective of their disease. At a time when patients are stigmatised and discriminated against because of being overweight or because of the shape of their legs, it is easier for them to believe that a medical condition is responsible for all past adversity. Instead, however, it would be more helpful for them to better understand the complex background of lipoedema.

Understandably, it is easier to believe in the accumulation of fluid in the body and receive MLD sessions rather than undertake regular enforced physical activity under compression. It is also easier to think of liposuction as a solution than to deal with psychological vulnerability or problems of self-acceptance. Nonetheless, with patient education and motivation, they can change their way of thinking from the passive attitude of being a victim to adopting an active, positive and self-aware approach to lipoedema, and, therefore, themselves.

The treatment strategy presented in this supplement should show physicians and therapists treating patients with lipoedema the direction in which to guide their patients. The European center of lymphology, the Földi Clinic in Hinterzarten, has radically altered its treatment concept for patients with lipoedema and adapted it to the patient's individual symptoms.²⁵⁹ Nevertheless—and this needs to be emphasised—many patients referred to the specialist clinic with a diagnosis of lipoedema also have two other diseases in need of treatment: obesity and obesity-related lymphoedema. Obesity treatment and complete decongestive therapy are, of course, still the mainstays of treatment for these two conditions, but they are certainly not suitable to treat the complex disease of lipoedema. In the authors' opinion, there is no alternative to the paradigm shift in lipoedema, which is gradually gaining acceptance worldwide. The changes in perspectives on lipoedema described here bring the patient's real symptoms to the forefront, allowing for more comprehensive and sustainable treatment.

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