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ISL CONSENSUS DOCUMENT REVISITED: SUGGESTED MODIFICATIONS

(Summarized from discussions at the 16th ICL, Madrid, Spain, September 1997 and the Interim ISL Executive Committee Meeting)

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GENERAL COMMENTS:

The ISL Consensus Document regarding lymphedema [*Lymphology* 28 (1995), 113-117] has been from the outset a "living" document in that it is intended to be modified and adjusted as theory, understanding, and practice of lymphology advances. Although this point is well understood by most members of the Society, those on the outside (especially in Europe) are using the document as strict practice guidelines, and some members feel the need to revise the document in order to reflect more accurately current medical practice. There have been many useful and thoughtful suggestions (see specific sections below) especially in reference to expanding the scope of the document to include lymphangiodysplasias, treatment guidelines including measurement systems, lymphedema prevention strategies, and issues of therapist accreditation. We, as a Society, however, must find proper balance between keeping this document concise or expanding it to a booklet or manual.

Other general questions or points raised that merit consideration include: the addition of citations and suggested reading lists to the document; publicizing its content on an ISL webpage; publication of the text on a tear-out section placed in Lymphology; and placement of the revised statement in the journals of other societies.

SECTION - General Considerations:

Discussion on this section largely focused on the addition of new material to the document. The suggestions included the expansion of its scope to include lymphangiodysplasias and more precise definitions of lymphedema classification and staging.

SECTION - Diagnosis:

The discussion concerning this section mainly focused on three aspects. The first involved standardization of lymphangioscintigraphy (LAS). Many members expressed frustration at the lack of consistency among images obtained by different diagnostic groups. The question remains, however, whether this is the proper forum to lay out (if possible) an agreed upon

protocol for isotope lymphography, which is still evolving as far as technique, timing, and optimal tracer usage is concerned. Another issue involved the inclusion of additional imaging modalities such as dual energy x-ray absorptiometry (DEXA) or biphotonic absorptiomety to further classify patients in light of the physical findings in regard to percent fat, percent water, lean mass, fat mass, etc. (also to be used post-treatment to follow physical changes) in the lymphedematous limb. Despite the enthusiasm of some members to include this protocol in the Consensus Document, clinical experience is limited and awaits further confirmation and application. The final issue addressed ongoing worldwide interest in genetics. Several members brought up the need for genotype/phenotype analysis especially in light of familial lymphedema in several angiodysplastic syndromes.

SECTION - Treatment:

Non-Operative

This section, as might be expected, drew the most responses. In sub-section 1 (Physical therapy), there was little discussion about the actual wording of the document. Rather, several members voiced strong opinions that the ISL take the leadership position to standardize proper physical treatment and officially take a stance on the accreditation of therapist training acceptable to the Society.

Subsection 2 (Drug therapy) drew several comments including the need to insert a statement concerning the goal of the ISL to promote soundly designed and executed drug testing with consideration of safety, ethics and quality control. There was also a request to add more filariasis related drugs to the current group of therapeutic pharmaceuticals. Antibiotic drug regimens were also proposed along with indications for treatment and prophylaxis.

Operative

Several members expressed concern over a perceived lack of enthusiasm for microsurgical reconstruction of lymphatics (subsection 2). These individuals claimed that in their respective countries, microsurgical lymphoplasty treatment is more prevalent than CPT and that the consensus document as it currently reads is misleading by seeming to place operations in a secondary role (although most do try CPT first). Some members informed the group that their countries were using the document as a guideline for medical treatment, and this omission was inconsistent with their practice.

A new subsection based on liposuction, an old idea that has recently been revived, was suggested and many members support its inclusion in an updated version of the document.

New Additions:

Three new subsections on Treatment were suggested. The first involves standardization of patient assessment. Many feel we need to define outcomes in terms of serial limb volume measurements and the specific methods to determine limb volumes. Society members use several different techniques to measure limb volume, and in part this diversity precludes accurate evaluation and comparison of treatment outcomes among different centers. This subsection could also include acceptable formulations (equations such as for the truncated cone) and examples of calculations in the pre- and post-assessment

of treatment and their limitations. Some members have already published on these issues, and a few short sentences with references could suffice as an addition to the document.

The second section would also deal with evaluation but by imaging. The value of LAS and DEXA to document treatment results was suggested as a useful addition to the armamentarium of treatment assessment.

A few members suggested that an additional section on treatment algorithms be included. These would pertain to diagnosis, evaluation, and treatment. Discussion included the different algorithms currently used around the world and how agreement upon a single path might hinder medical judgments currently used by many while potentially impeding future progress.

NEW SECTIONS PROPOSED:

New ideas were proposed that would require the inclusion of two additional sections to the document. The first concerns the prevention of lymphedema. This section would encompass prevention of secondary lymphedema by changes in operative technique (e.g., sentinel regional node sampling to avert more extensive dissection in breast cancer or melanoma staging, use of diagnostic public health measures in filariasis such as mosquito control and prophylaxis/early treatment of acute infection, and imaging such as isotope lymphography soon after radical nodal dissection and/or regional irradiation to confirm or render unlikely the potential for peripheral lymphedema and the need for a prophylactic compression garment.

The second section would comprise a research agenda developed by the ISL. This listing would include current areas of interest under study by our members and guidelines/principles for designing, performing, and disseminating collaborative research. These issues might bear on assessment for treatment and the establishment of a database registry to study and monitor further the epidemiology of lymphedema-angiodysplasias worldwide.

These suggestions are published now for review and reader comments. The revised Consensus Document will be readdressed in a special session at the 17th International Congress of Lymphology in September 1999 in Madras, India and published in the January 2000 issue of *Lymphology*.

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