After 25 years of treating patients, it is time, I believe, to look at past therapies and also to look forward to what we may expect in the future.

My interest in lymphedema began in 1972 with the opening of a small lymphedema clinic. I was intrigued with lymphedema because I realized then that most physicians had little interest or experience in diagnosing and treating lymphedema; patients were left to wander about, always looking for help, seldom receiving any and, in some cases, undergoing massive, ill-conceived surgical operations. I refer here to the various debulking operations with or without skin grafts, omental transpositions, enteromesenteric bridge procedures, Kondoleon’s operation, Thompson’s operation, and many others. Some daring surgeons would routinely have lymphangiograms and venograms performed on post-surgical lymphedema patients and would sometimes notice a kinking or narrowing of the axillary or iliac vein. These patients would then have immediate surgery to undo or bypass the narrowed or kinked vessel. These latter interventions invariably made the lymphedema worse and subjected the patient to major serious surgical procedures with their associated morbidity and mortality rates.

Because of my efforts and the work of many others, the medical community has become much more conservative in the last 25 years in recommending surgery for lymphedema patients. Instead of the operations previously listed, various microsurgical procedures are now being done in a few centers around the world to see if a damaged, malformed, obstructed or absent lymph vascular segment can be restored or replaced. These operations are still in their developmental stage and long-term results should be awaited before recommending them.

Apart from the trend away from heroic surgery, what is also apparent is a trend away from unnecessary, invasive diagnostic tests such as lymphangiography and venography. Lymphangiograms are tedious for patients and surgeons, often unsuccessful, harmful to the lymphatics visualized and, if successful, rarely of therapeutic relevance. Venograms are hardly ever needed in lymphedema patients. These have been replaced by lymphoscintigraphy, a safe test that uses a radioisotope to visualize lymph circulation and by sonography to demonstrate venous abnormalities and especially to rule out deep venous thrombosis.

The third development of this quarter century is the increasing sophistication of the lymphedema patient. This has placed great pressure on the medical profession. Patients are demanding that their doctors learn more about lymphedema and its treatment and that they, at least, inform themselves about where a lymphedema patient might be sent for safe and effective treatment. Breast and other cancer patients are asking why the chances of their developing lymphedema were not discussed with them, why they were not told of methods to prevent lymphedema and why they were not referred to a lymphedema treatment center once the condition had become obvious.

Fourth, lymphedema treatment centers have been springing up all across the country ever since I opened the first American CDP center in New York in 1989 and began, soon afterward, to train qualified lymphedema therapists in the techniques of Manual Lymph Drainage and Complete (Complex) Decongestive Physiotherapy.

Because of my perseverance over these 25 years and the better results achieved by CDP, many prestigious hospitals have opened lymphedema treatment centers that use CDP therapy exclusively, i.e., Mayo Clinic in Rochester, MN, Massachusetts General Hospital, Dana-Farber Cancer Center and Brigham & Women’s Hospital in Boston, as well as Memorial Sloan-Kettering Cancer Center in New York (all of which are affiliated with Lerner Lymphedema Services, P.C.), and many, many others. Along with this trend, many insurance companies and Medicare have finally recognized the value of CDP and some of them have begun to routinely pay for such treatments.

The fifth and most important event of the past quarter century has been the introduction of CDP therapy and assuring its availability to patients everywhere.

In the 1970s, I was a faithful practitioner of pneumatic pump therapy. When it became obvious to me that pneumatic pumps were not able to improve most lymphedema patients, that pumps were most effective only in
early (Stage I) lymphedema, that most patients who purchased them soon relegated them to the attic or the basement, and that pump therapy could have adverse side effects, I began looking for other methods of treatment.

Some of my patients were referred to the Föeldiklinik in Germany; others were treated by me and my microsurgical associates, Drs. G. Gestring and R. Requena, by multiple lymphovenous anastomoses\(^6,7\). Those treated in Germany were thrilled with the ability they gained to keep their limbs well under control, to prevent any progression of the lymphedema and to lead relatively normal lives. Those treated by microsurgery did well initially, but after a year or two, it was obvious that the lymphedema had recurred. At that point, we ceased doing microsurgery and opened the first American CDP clinic in New York in 1989.

There are perhaps no clinicians other than myself, who have had great experience in all three lymphedema therapies: pneumatic pumping, microsurgical techniques and CDP. Based on this experience with thousands of patients, it is my opinion that CDP is currently state-of-the-art therapy and that it will continue to displace the other two methods because of its safety, effectiveness and cost-effectiveness.

The final important event of these 25 years was the birth of the NLN ten years ago. Because of its efforts, lymphedema has become better known, treatment options better explained and, much to its credit, the value of CDP immediately grasped. The NLN is now growing rapidly and its influence already has reached into most doctors' offices.

For the future, I am encouraged that prevention will be possible for many patients and that medical innovation will continue to reduce the population of lymphedema sufferers. I believe that advances in therapy will not come from the ingestion of vitamins, minerals, enzymes, herbal products (horsechestnut seed extract, pycnogenol) or benzopyrones. For the moment, lymphedema can be controlled well by judicious CDP therapy.

**Bibliography**