Letter to the Editor

Lipedema—Pathogenesis, Diagnosis and Treatment Options

by Philipp Kruppa, Iakovos Georgiou, Niklas Biermann, Lukas Prantl, Peter Klein-Weigel, Mojtaba Ghods in issue 22–23/2020

The Prevalence Was Probably Overestimated

The authors presented a comprehensive search of the English language literature on lipedema (1). I wish to comment on two points, as a search of the German language literature would have yielded different results.

The prevalence of lipedema was found to be some 10% in the female population. For Germany this would mean that 4.5 million women are affected by lipedema. The reason for the purported prevalence is the lacking differentiation of lipedema (painful) from painless lipohypertrophy and obesity. This differentiation has been known in Germany since 1993 (2). It prevents pointless complex decongestive therapy and thus a waste of health insurers‘ financial resources because complex decongestive therapy or physical edema therapy is indicated only in lipedema (3). In my estimation based on many years of lymphologist activity, the number of patients with genuine lipedema in Germany is about 100 000.

It is incorrect to assume generally that hands and feet are spared from the proliferation of fatty tissues. In lipohypertrophy and lipedema of the arms I also found hypertrophy of fatty tissues on the hands and fingers in 23% and in lipohypertrophy and lipedema of the legs, feet and toes, in 5% of cases (author’s own data). These fatty deposits usually do not cause any problems, as in lipedema, but they are responsible for diagnostic misclassifications as they are erroneously categorized as lipo-lymphedema.

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Stemmer Sign Needs to be Recorded and Interpreted Correctly

The authors define the positive Stemmer sign in this way: “the skin fold between the second and third toe is thickened and cannot be lifted.” (1) This requires some additional explanation.

In 1976 Robert Stemmer described a clinical sign for the early and differential diagnosis of lymphedema. Lymphedema can be determined by means of a thickened longitudinal fold when pinching the skin of the upper side of the proximal phalanx of the second or third toe (2). The Stemmer sign is considered proof of lymphedema, but its absence does not rule out lymphedema. Usually, three severity grades are differentiated in the Stemmer sign (3,4): barely pronounced (stage I) equals a skin fold width of 0.5–1 cm, moderately pronounced (stage II) equals >1 cm, and severely pronounced (stage III) means the skin fold cannot be lifted at all. A thickening of the retromalleolar region and/or evened or ballooning dorsal surface are similarly common in lymphedema and specific, like the Stemmer sign (3). Pathophysiologically, these symptoms are caused by lymphostatic fibrosis.

A Stemmer sign in stage III lipedema does not confirm lipedema but lipo-lymphedema.

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In Reply:

The correspondence once again highlights that for the disorder “lipedema”, some aspects are not sufficiently known or that there is a lack of consensus with regard to the terminology.

Dr Herpertz comments that the prevalence is probably grossly overestimated and mentions his long-standing experience in this area. The authors can confirm that several authors assess a prevalence of 10% as possibly clearly too high (1), but no relevant evidence exists that could be referred to. Several projects (for example, the lipedema registry of the Lipedema Foundation [www.lipedema.org/registry]) are trying to determine the actual prevalence by studying representative populations, but publications are still some way off.

Furthermore, he commented that hands and feet are not always spared, and this is therefore not typical of lipedema. The peer reviewed literature published to date has not described any case series that confirmed a regular involvement of hands and/or feet. A jump in diameter on wrist and ankle, the cuff phenomenon,

have, however, been described in numerous articles and according to current academic opinion, these are considered a classic indication of lipedema (2).

A more precise categorization of the Stemmer sign, as Dr Brauer rightly calls for, would have exceeded the scope of the article because of the extent of the explanations that would have needed to be added (3). We agree that a positive Stemmer sign is by no means pathognomonic for stage III lipedema, but will be positive only in a setting of accompanying lymphedema. Since the terminology "lipolymphedema" is somewhat controversial (lipo-lymphedema versus lipedema with secondary lymphedema versus stage IV lipedema), we did not include this in our article but instead pointed out that in stage III, the Stemmer sign may be positive (4). To correct and rephrase: **"**potentially Stemmer sign positive if accompanied by lymphedema."

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Conflict of interest statement
The authors of all contributions declare that no conflict of interest exists.

Erratum

In the article entitled "The Prevalence of Visual Impairment in the Adult Population—Insights from the Gutenberg Health Study" by Christian Wolfram et al. in *Deutsches Ärzteblatt International* (issue 17/2019), two digits were swapped in *Table 2*.

The correct prevalence figures for the causes of visual impairment and blindness are: **genetic disorder: n = 8 (= 14.5%), severe myopia n = 10 (= 18.2%).** *MWR*

Erratum

In the article entitled "Mushroom Poisoning" by Robert Wennig et al. in issue 42/2020, the summary should have read: "The DRG diagnosis data and the cause of death statistic for Germany over the period 2000–2018 include a total of 4441 hospitalizations and 32 deaths due to the toxic effects of mushroom consumption." Furthermore, here as well as in the methods section the cause of death statistic of the Federal Statistical office should have been cited as the source. *MWR*