Dear editors,

the contributions "Treatment of lymphoedema in difficult circumstances" by U. P. Katz (1) and "Complex compression therapy in difficult circumstances" by C. Hampel-Kalthoff (2, 3) concerned the case report of the painstaking treatment of a venous leg ulcer in "decompensated combined lipo-lymphoedema", obesity and post-thrombotic syndrome.

Although exact details of the aetiology and differential diagnosis were not given, the patient was at any rate a woman with chronic, venolymphatic problem wounds. Healing was only achieved after more than 10 years under ambulant care and treatment in a rehabilitation clinic. The reported accrued treatment costs were 1.09 million Euro (!!).

Although the eventually successful therapeutic outcome is to be welcomed, one must nevertheless ask whether a possibly shorter and more rational – and hence less expensive – treatment concept might be applicable to such patients with protracted congestive lesions. Thankfully, after efficient removal of the cause and modern, stage-adapted wound management, leg ulcers caused by congestion generally heal.

Treatment must be based on a rigorous surgical treatment of the varices, venous compression for post-thrombotic syndrome and also an examination of interventional venous recanalization options (iliac vein stent etc.). In the case of lymphoedema, the first phase of decongestive treatment must be completed as quickly as possible.

Such patients with marked chronic symptoms of congestion, usually with additional critical comorbidity, are even more frequently seen in everyday practice. The standard treatment in Germany for these patients, consisting of purely outpatient care and treatment in a rehabilitation clinic, is often insufficient.

Based on the model of the 1st Akutlymphklinik Rheine/Ochtrop, Germany (Medical Director Dr. G. Lulay), in 2011 we began to give such patients short in-patient, complex treatment in the acute hospital (Acute Lymph Department and Wound Unit in the Angiology Clinic).

Here patients, who often passed an odyssey of treatment lasting many years, receive 5–12 (rarely 19) days of intensive lymphatic and angiological treatment, with sensational decongestive results. After removal of the oedema, the wounds generally heal quickly.

From our experiences with such problem patients who have failed to show recompensation after exhaustive ambulant treatment, the in-patient treatment in appropriate specialist units in an acute hospital is highly effective. In the subsequent phase in a rehabilitation clinic, the recompensation achieved should then be stabilised (analogous to the proven techniques in all other forms of circulatory decompensation).

By approach it is possible to shorten the entire process until wound healing on a permanent basis, with a huge economic cost-saving potential. Unless the oedema is firstly and rapidly relieved, wound healing cannot be expected – at least in the short-term.

Unfortunately however, lymphoedema is not accepted by the bearers of health insurance as a disease for an acute hospital. That is a shame, because were lymphology/phlebolology to be given adequate attention in the DRG system for acute care hospitals, a large part of the mentioned millions of Euro could most probably be saved at a cost of a few thousand Euro per patient (hospitalisation approx. two weeks).

Thanks to the authors who, from the case history they presented, indirectly drew attention to this relevant and practical lymphological problem.

References

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