

deliberately, simply fool themselves and others about their food intake and physical activity.

Lichtman et al. used the new doubly-labeled-water technique to investigate the possibility that a low "metabolism," or basal and total energy expenditure, could explain the inability to lose weight. They were not exploring the many metabolic and neurologic mechanisms that contribute to obesity syndromes in animals and humans. There is a strong heritable component to obesity syndromes. This has been unequivocally documented in several studies of twins in which genetic factors were the major determinants of body fatness and could account for 70 percent of its variance.¹ There are metabolic disorders that lead to inappropriate craving for food, inactivity, and preferential storage of energy as fat.² An inherently low rate of energy expenditure antecedent to the development of obesity has been recognized.³ We apparently did not make it clear that, just as many factors contribute to inappropriate eating behavior, some of these same factors, plus perhaps the intense frustration of living with the problem, may contribute to the faulty reporting.

More than 80 percent of obese subjects who lose weight regain it. "Behavioral therapies" have not provided better results. These findings reinforce the view that obesity is an inherent disorder rather than the result of denial or "bad habits." Blaming the patient for simple misbehavior creates what has been called the "diet relationship trap,"⁴ in which there is a breakdown in the normal therapeutic rapport between doctor and patient. We prefer not to blame a person for a lack of willpower, when he or she is already overwhelmed by a complex problem and therefore lacks self-esteem.

We agree with Dr. Casey about the importance of social and cultural factors, including the high-fat diet that predisposes people to obesity. We believe that physicians must work with their patients to combat these factors. Because behavioral treatment alone has had limited success, the underlying mechanism of obesity should be further identified and addressed directly.

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MASSIVE OBESITY SIMULATING LYMPHEDEMA

To the Editor: The images of massive obesity simulating lymphedema (Dec. 31 issue)* are quite impressive. The photograph clearly shows the condition of lipomatosis of the legs, also known as lipedema. When confined to the thighs, the condition is known as "riding-breeches thighs." When involving the whole leg, it is known as either "billiard-table legs" or "stovepipe legs." If lymphedema were the cause of this degree of leg swelling, there would also be pitting or spreading edema on the dorsum of either foot in response to pressure, with the chronic skin changes of hyperkeratosis and increased skin markings. None of these

*Witte MH, Witte CL. Massive obesity simulating lymphedema. *N Engl J Med* 1992;327:1927.

signs are evident in the photograph. What were the indications for lymphangiography and magnetic resonance imaging when the correct diagnosis could be made by physical examination?

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The authors reply:

To the Editor: Dr. Loughlin is correct that the term "lipedema" is often applied to the peculiar condition this patient had. The magnetic resonance images show that the term is a misnomer, because edema is not present. The patient was given the diagnosis of lymphedema several years before we first saw her. She was being vigorously treated with external pneumatic compression at another hospital to no avail. She was scheduled to undergo a debulking operation for intractable lymphedema. Lipedema bears a superficial resemblance to lymphedema, which also occasionally spares the dorsum of the foot. Little is known about the underlying pathophysiology of lipedema with regard to peripheral lymphatic function, the composition of soft tissues, and the presence or absence of true edema.¹ Because of the ease, accuracy, and safety of intradermal isotope lymphography (also called lymphangioscintigraphy) in demonstrating lymph dynamics² and the unique capability of magnetic resonance imaging to delineate soft-tissue composition, including fluid entrapment,³ we deemed it appropriate to perform these imaging studies.

We sought to diagnose definitively what we suspected clinically and to direct the approach to the patient's long-term treatment. The images establish that in lipedema the peripheral lymphatic system is normal, soft tissue swelling consists solely of fat, and subcutaneous edema is notably absent.

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PANCREATIC AND ISLET TRANSPLANTATION FOR DIABETES

To the Editor: Robertson (Dec. 24 issue)* contends that pancreatic transplantation should no longer be considered an experimental procedure. I do not understand how he can reach this conclusion, when the proper use and results of pancreatic transplantation remain in question. Other less complicated transplantation procedures, such as allogeneic and autologous bone marrow transplantation, are considered experimental for some diseases because of the lack of efficacy and the unacceptable morbidity and mortality associated with the therapy that accompanies these procedures.

*Robertson RP. Pancreatic and islet transplantation for diabetes — cures or curiosities? *N Engl J Med* 1992;327:1861-8.