

“I think you might have lipedema.”

Recognizing and Acting on Lipedema in Everyday Obesity Medicine Practice

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Disclosures

- Founder and owner, Lumina Vascular Health & Laser Clinic, which provides lipedema, vascular, lymphedema, and menopause care.
- Lipedema Foundation Biobank Site Investigator (unpaid research role).
- Some therapies discussed (e.g., HRT and GLP-1 agents in lipedema) are off-label; clinical judgment and shared decision-making apply.
- No relevant payments from compression, device, or pharmaceutical manufacturers.
- Owner of an online Kajabi Course “Living Well with Lipedema”
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All relevant financial disclosures have been mitigated.

Learning objectives



Recognize the clinical features that distinguish lipedema from obesity, lymphedema, and venous disease.



Sort out the common real-world overlap when several of these conditions coexist in one patient.



Order the universal first steps — venous evaluation, MLD, and the right compression — with confidence.



Deliver the message “I think you might have lipedema” supportively and connect patients to care.

What is lipedema?

- A chronic, progressive, hormonally mediated disorder of subcutaneous adipose tissue — not a behavior or a willpower problem.
- Almost exclusively affects women; symptoms typically begin or worsen at puberty, pregnancy, and the menopausal transition.
- Symmetric, disproportionate fat in the legs (and often arms), classically sparing the feet — producing the ankle “cuff.”
- Painful, tender, bruises easily, with a nodular texture under the skin.
- Diagnosis is clinical — history and exam. There is no blood test or scan that makes the diagnosis.



What makes lipedema tissue different

It's an adipofascial disorder

- Involves connective tissue and fascia, not just fat cells.
- Adipocyte hypertrophy, fibrosis, inflammation, and vascular/lymphatic changes.
- Resistant to caloric restriction, exercise, and even bariatric surgery.
- Higher insulin sensitivity than weight-matched peers — metabolically distinct from obesity.

What patients say it feels like

"My legs ache and feel heavy by the end of the day."

"I bruise and I don't know where from."

"It feels like beans or rice under the skin."

"Even gentle pressure — a waistband, a hug — hurts."

"I've lost weight everywhere but my legs."

MORE COMMON THAN YOU THINK

It's common, and it's genetic

~11%

of women are estimated to have lipedema
— roughly 1 in 9

20–60%

of cases show a family history — strongly
hereditary

3

hormonal triggers: puberty, pregnancy,
menopause

Estimates derive primarily from European screening studies and are likely underestimates given widespread under-recognition.

The metabolic paradox

Many women with lipedema are metabolically healthier than their BMI implies — yet BMI is all we tend to see.



Often normal

Frequently no diabetes, hypertension, or elevated cholesterol despite a high BMI.



Resistant fat

Lipedema fat does not respond proportionally to diet or exercise.



Hidden harm

Many are malnourished or over-exercising from years of being told to 'just try harder.'

THE PART WE DON'T MEASURE

The hidden burden

31–59%

report depression

~42%

anxiety or depression on QoL measures

up to 18%

history of an eating disorder

Driven in large part by chronic pain and by years of not being believed. **Many patients carry deep shame around diet and exercise — having tried everything and been blamed anyway.**

Staging lipedema (1–4)

Stage 1

Smooth skin; enlarged subcutaneous fat. Easy to miss.

Stage 2

Irregular, indented skin surface; palpable nodules.

Stage 3

Large lobules of tissue; deformity around thighs/knees.

Stage 4

Stage 3 plus lymphedema (lipo-lymphedema); foot involvement.

Bedside clues: What's the most amount of weight you have ever lost in one period of time? Did you lose weight everywhere on your body? Painful to touch?

STAGE 1

- Smooth skin with an increase of enlarged subcutaneous fat tissue.
- Fat is often soft, though sometimes small nodules may be felt under the surface of the skin (sometimes described as ("rice-like", "pebble-like", "pearl-sized", or "Styrofoam balls in a plastic bag").



Fat buildup around pelvis, buttocks, and hips. For more images go [here](#).



Fat buildup from buttocks to knees, with folds of fat around the inner side of the knee. For more images go [here](#).



Fat buildup from buttocks to ankles. For more images go [here](#).

STAGE 2

- Uneven skin surface – indentations, dimpling, and/or a “wavy” “orange peel” (‘peau d’orange’), or “mattress-like” look.
- Large nodules, walnut to apple size, may be felt under the surface of the skin.
- Fat may be thickened, hardened, fibrotic.



Fat buildup around pelvis, buttocks, and hips. For more images go [here](#).



Fat buildup from buttocks to knees, with folds of fat around the inner side of the knee. For more images go [here](#).



Fat buildup from buttocks to ankles. For more images go [here](#).

STAGE 3

- Large extrusion of fat tissue, lobules, or overhangs of fat causing deformations, especially on the thighs and around the knees.
- Nodularity and thickening of the adipose/fibrosis is very common. Large nodules, walnut to apple size, are often numerous.



Large extrusions of fat tissue causing buildup from buttocks to knees, with folds of fat (lobules) around the inner side of the knee and at the thighs. For more images go [here](#).



Large extrusions of fat tissue causing buildup from buttocks to ankles. For more images go [here](#).

LIPOLYMPHEDEMA (SOMETIMES PREVIOUSLY REFERRED TO AS STAGE 4)

Development of lipolymphedema, which is when both Lipedema and lymphedema (tissue swelling caused by an accumulation of lymph, protein-rich fluid that's usually drained through the body's lymphatic system) are present.

It is important to note that lymphedema can be present at all stages.

You can find more information about [lymphedema here](#).



Large extrusion of fat tissue on legs with comorbid lymphedema. For more images go [here](#).

Clinical image: Lipedema.org (with permission)



Large extrusion of fat tissue on legs with comorbid lymphedema. For more images go [here](#).

These conditions coexist

One patient can have all four at once. The job isn't to pick one — it's to address each.



Venous insufficiency + obesity + lipedema + lymphedema — frequently in the same legs.

How do we sort it out?



Feet spared? Negative Stemmer? Painful, nodular, symmetric fat?



Think lipedema



Visible varicose veins, or skin changes at the medial ankle?



Work up venous disease



Pitting that involves the foot, positive Stemmer?



Think lymphedema



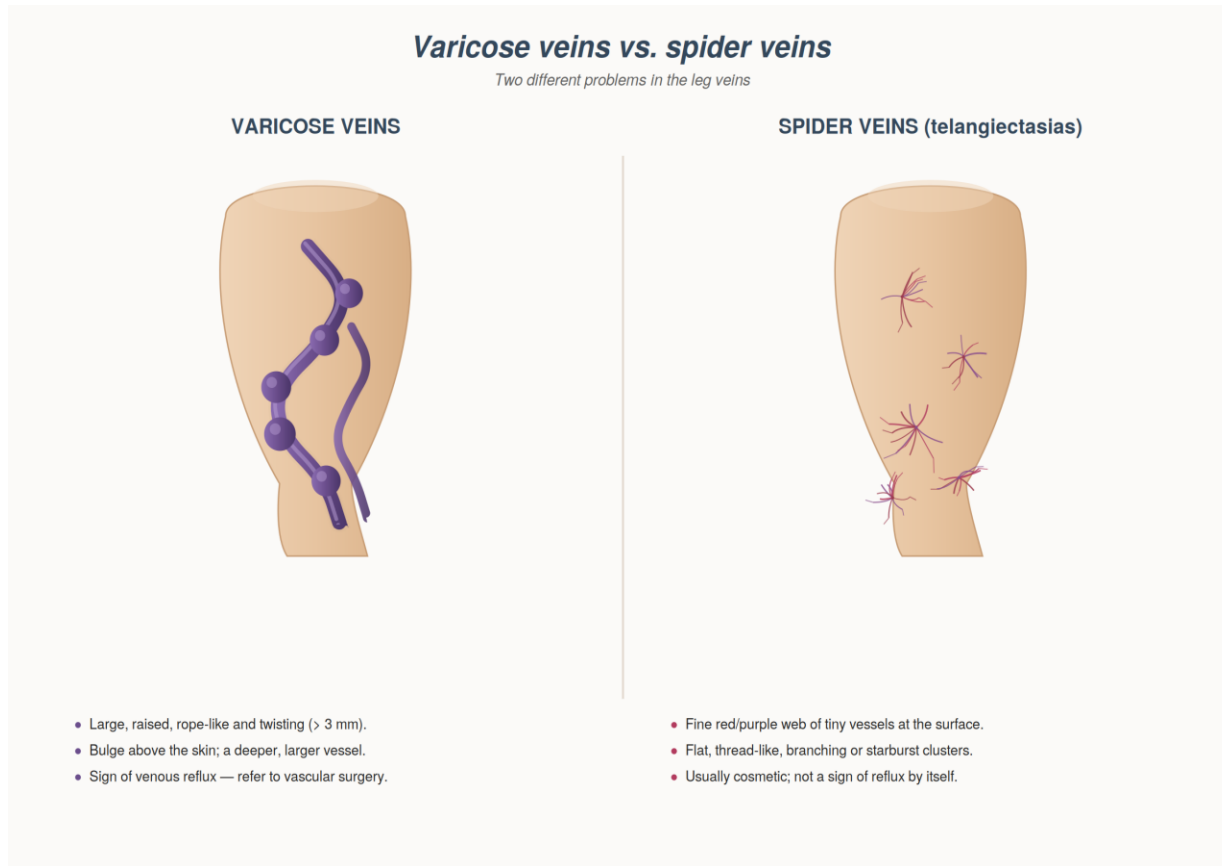
High BMI with proportionate fat that responds to diet/exercise?



Obesity component

These are not mutually exclusive — most patients land in more than one row.

Varicose veins vs. spider veins



- Varicose veins: bulging, rope-like, > 3 mm — a sign of venous reflux. (ICD 10: I87.2 venous insufficiency)
- Spider veins: fine red/purple webs at the surface; usually cosmetic.
- Visible varicose veins = refer to vascular surgery.

Chronic venous insufficiency



- Brown hyperpigmentation at the medial ankle (hemosiderin staining).
- Other signs: edema, eczema, lipodermatosclerosis, healed or open ulcers.
- Marks longstanding venous reflux — and a reason to image the veins.
- Distinct from the lipedema cuff, though the two often coexist.

Clinical photograph: Author's own clinical photo used with written consent signed by patient.

Standing reflux study $\neq$ LEV

Standing venous reflux study

- Performed standing — evaluates for venous reflux (valve failure).
- Tells you whether reflux is driving the leg symptoms.
- If reflux is present $\rightarrow$ refer to vascular surgery.
- Order this when there are no obvious varicose veins but you suspect venous disease.
- Bilateral Standing Reflux Study CPT:93970 ICD10: I87.2
- Unilateral Standing Reflux Study CPT:93971 ICD10:I87.2

LEV (lower-extremity venous duplex)

- Typically done lying down to rule out DVT (blood clots).
- Does NOT assess for reflux — a normal LEV does not exclude venous insufficiency.
- Ordering an LEV when you wanted reflux data is the most common mix-up.
- LE Venous Duplex CPT: 93971 Rule out DVT (ICD10: 182.4/LEG EDEMA R60).

“I think you might have lipedema.”

You do not have to be a lipedema expert. You just have to be aware — and offer a next step.



Give a flyer

Hand them the Lipedema Foundation provider flyer with local clinicians.



Refer to a specialist

Refer to a lipedema-aware clinician for diagnosis and management.



Start the basics

Begin the conservative actions on the next slides yourself.

For Patients



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Every person with Lipedema deserves timely diagnosis, disease-specific care, and access to meaningful support. While there is currently no cure, there are treatments and resources to help you make informed decisions and navigate your healthcare journey.

FIND KNOWLEDGABLE PROVIDERS IN OUR PROVIDER DIRECTORY

The following resources can help you learn more about managing Lipedema and advocating for your own care journey:



What Is Lipedema?

Learn the basics of Lipedema — what it is, how it presents, and how it differs from other conditions like obesity and lymphedema.



Self-Advocacy Guide

A step-by-step guide to help you communicate with your healthcare providers and advocate for yourself.



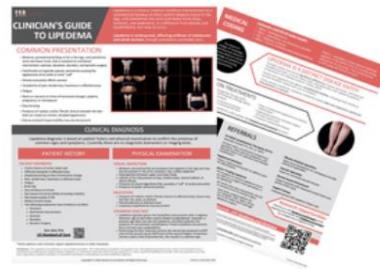
Patient Bill of Rights

Know your rights as a Lipedema patient, including the right to accurate diagnosis, informed treatment options, and compassionate care.



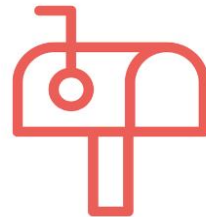
Find a Provider

Search our directories of diagnosing clinicians and therapists who are knowledgeable about Lipedema care.



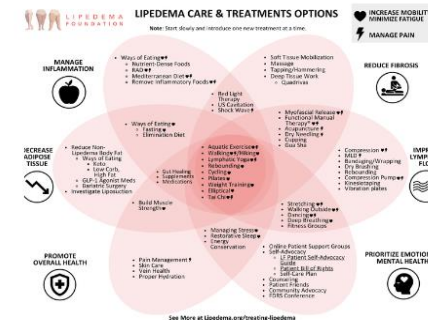
Clinician's Guide

Share this evidence-based clinical guide with your



Order Resources

Download or order free brochures and educational



Lipedema Treatments

Explore the range of treatment options, from conservative



Photo Stories

View our SmugMug gallery with more than 500 photos of

CLINICIAN'S GUIDE TO LIPEDEMA

Lipedema is a chronic medical condition characterized by a symmetrical buildup of often-painful adipose tissue in the legs, and sometimes the arms and lower trunk (hips, buttocks, and abdomen). It is different from obesity and lymphedema, but may co-occur.

Lipedema is widespread, affecting millions of adolescent and adult women, though prevalence estimates vary.

COMMON PRESENTATION

- Bilateral, symmetrical buildup of fat in the legs, and sometimes arms and lower trunk, that is resistant to nutritional intervention, exercise, elevation, diuretics, and bariatric surgery
- Feet/hands are typically spared, sometimes causing the appearance of an ankle or wrist “cuff”
- Almost exclusively affects women
- Complaints of pain, tenderness, heaviness in affected areas
- Fatigue
- Starts or worsens at times of hormonal changes: puberty, pregnancy, or menopause
- Easy bruising
- Presence of nodular and/or fibrotic texture beneath the skin that can create an uneven, dimpled appearance
- Edema and joint hypermobility may also be present



CLINICAL DIAGNOSIS

Lipedema diagnosis is based on patient history and physical examination to confirm the presence of common signs and symptoms. Currently there are no diagnostic biomarkers or imaging tests.

PATIENT HISTORY

PATIENT REPORTED

- Family history of similar body type
- Difficulty losing fat in affected areas
- Onset/worsening at time of hormonal change
- Pain, tenderness, heaviness in affected areas
- Fatigue
- Brain fog
- Easy tendency to bruise
- Decreased functional ability (including mobility)
- Decreased quality of life
- History of joint issues
- The following treatments have limited to no effect:
 - Elevation
 - Nutritional Interventions
 - Exercise
 - Diuretics
 - Bariatric Surgery

See also the
US Standard of Care



PHYSICAL EXAMINATION

VISUAL INSPECTION

- Bilateral, symmetrical fat accumulation that appears in the legs and may also be present in the arms, buttocks, hips, and/or abdomen
- Disproportion between upper and lower body
- Lobules of fat may present at hips, medial knees, lateral malleoli, or above elbows
- Presence of raised ridge/fold of fat, possibly a “cuff” at wrists and ankles
- Presence of spider veins/varicosities

PALPATION

- Presence of nodular and/or fibrotic texture in affected areas; tissue may feel like rice, peas, or walnuts
- Pain/tenderness in affected areas
- Cutaneous hypothermia may be present

STEMMER SIGN TEST

- Lipedema typically spares the hands/feet and presents with a negative Stemmer sign (a test often used to detect Lymphedema). However, a positive sign does not rule out Lipedema, and likely indicates the presence of concomitant Lymphedema. If both conditions are present, this is termed Lipo-Lymphedema.
- Performing the test: Examiner pinches the dorsal skin proximal to MTP joint of the second toe (or MCP joint of the second finger). If examiner cannot create a fold of pinched skin, this results in a positive sign.

*Some patients and clinicians report Lipedema tissue in other locations

Disclaimer: The Lipedema Foundation is not a medical provider. The information provided in this guide is for informational purposes only, and is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Seek the advice of your physician or other qualified healthcare provider with any questions you may have regarding a medical condition or treatment and before undertaking any new healthcare regimen.

The universal action set



Venous evaluation

Visible varicose veins → vascular surgery. No varicose veins but suspicious → standing reflux study; if positive → vascular surgery.



Refer for MLD

Manual lymphatic drainage for every patient — a cornerstone of conservative care.



Order compression

The right garment, properly fitted (see next slides). The detail that gets missed.

Match the pressure to the problem

Level (mmHg)	Use	Notes
TED hose (~4)	In bed, DVT prevention only	Not therapeutic for standing patients — a common misconception.
OTC 10–20	Mild support	Drugstore S/M/L. Fit poorly. Get measured at a medical supply store, not Amazon.
15–20	Lipedema baseline	The everyday workhorse for most lipedema patients.
20–30	Stronger support	Only with palpable pulses and no neuropathy.
30–40	Ulcers / lymphatic swelling	Often insurance-covered; hard to don — adherence suffers.

“The best compression is the compression they’ll actually wear.”

Exactly what to order

The starting prescription

- 15–20 mmHg — 2 pairs, with 2 refills.
- Style to the patient: knee-high, pantyhose, or bike-short style.
- Add a pair of 20–30 mmHg IF palpable pulses and no neuropathy.
- Flat-knit, properly measured and fitted (e.g., flat-knit compression garments).
- Patients with obesity: prescribe adjustable Velcro wraps (adjustable Velcro wrap systems) — they re-tighten as edema goes down.

GRADUATED COMPRESSION

Enhanced Circulation



circaid[®] juxtalite[®] and
circaid[®] juxtalite[®] hd

applying the circaid juxtalite
and juxtalite hd lower leg

NEW
EZ-on Panel

Measure properly — in person

- Garments are sized to limb measurements, not S/M/L guesses.
- Measure ankle, calf, and thigh circumferences at marked points, ideally in the morning.
- Get fitted at a certified medical supply store — not a drugstore or Amazon.
- A poorly fit garment tourniquets or slips — and never gets worn.

So early you're not sure it's lipedema



Stage 1 (uncertain)

- Age 32 • BMI 27 • normal labs
- Mild symmetric leg fullness; smooth skin
- Vague aching, occasional bruising
- Feet spared; Stemmer negative
- Normal DP pulses
- No varicose veins
- Mother has Lipedema.

Plan

- No varicose veins → standing reflux study; refer to vascular surgery if positive
- Refer for MLD
- Compression 15–20, 2 pairs, 2 refills
- Recommend low inflammatory foods
- Recommend Lipedema Foundation
- Reassure; reassess in 3–6 months

Significant pain and varicose veins



Age 45 • BMI 31 • normal labs

Stage 2 Presentation

- Nodular subcutaneous texture
- Significant pain and pressure sensitivity
- Visible varicose veins
- Feet spared

Plan

- Refer to Lipedema Foundation
- Visible varicose veins → refer to vascular surgery
- Refer for MLD
- Compression 15–20, 2 pairs, 2 refills; add 20–30 if pulses + no neuropathy
- Pain validation and plan

Obesity and lipedema cuffing



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Stage 3

- Age 52 • BMI 38 • normal labs
- Large lobular tissue; pronounced cuff
- Mobility limited by tissue bulk
- No visible varicose veins
- Feet spared

Plan

- No varicose veins → standing reflux study; vascular surgery if positive
- Refer for MLD
- Adjustable Velcro wraps (adjustable Velcro wrap system) given obesity + edema
- Health-focused weight support; set expectations
- Candidate for lipedema reduction surgery. Referral to plastic surgeon.
- Consider starting GLP for obesity and pain.

Foot swelling, obesity, venous disease



Stage 4 (lipo-lymphedema)

- Age 60 • BMI 42 • HTN
- Foot now involved (lymphedema overlay)
- Medial-ankle hyperpigmentation (CVI)
- Varicose veins present
- Marked heaviness and pain

Plan

- Varicose veins + CVI → vascular surgery
- Refer for MLD & CDT
- Coordinate multidisciplinary care
- GLP + Bariatric Surgery?
- Referral to Plastic Surgeon after weight loss.

The treatment reality

What to tell the patient

- “We’ll work on your overall health and obesity management — but you might have lipedema. Sometimes we don’t know until after we have tried a GLP and sometimes even surgery. But if it is, we can address that.”
- “Lipedema fat is resistant to diet and exercise — that part isn’t a failure of effort.”
- Focus on what they’re doing right, not just the BMI.
- Health, mobility, and pain — not the scale — are the goals.



The good news

When conservative care isn't enough, insurance can often be obtained for lipedema reduction surgery to improve pain and mobility — a real, disease-modifying option.

Lipedema reduction surgery

- Specialized lipedema-reduction liposuction (not cosmetic) can reduce pain, improve mobility, and slow progression.
- Insurance coverage is increasingly attainable with proper documentation of conservative-care failure.
- Referral to a surgeon experienced in lipedema-reduction surgery is appropriate when conservative care is insufficient.

You don't have to be the expert. Recognize, start conservative care, document, and refer when surgery is on the table.

Conservative measures that help



MLD

Manual lymphatic drainage



Compression

Worn daily, properly fitted



Anti-inflammatory diet

Whole-food, lower-inflammation pattern



Movement

Low-impact; aquatic exercise is ideal



Vibration plate

Adjunct some patients find helpful



Support

Validation, community, mental health

Tip: the Lipedema Foundation publishes a patient-friendly infographic of self-care measures — hand it out.

ICD coding for lipedema

Where things stand

- ICD-11 (WHO, 2019) includes a dedicated lipedema code — but the U.S. still uses ICD-10-CM.
- U.S. ICD-10-CM codes specific to lipedema have been accepted and are anticipated — not guaranteed — to take effect October 1, 2027.
- Until then, use the non-specific interim codes at right — payer preferences vary.

Interim ICD-10-CM codes

E88.2 Lipomatosis, NEC (most commonly used)

R60.0 Localized edema

R60.9 Edema, unspecified

E65.0 Localized adiposity

Q82.0 Hereditary lymphedema — only where hereditary disease is documented

The Lipedema Foundation Biobank



What it is

- A research repository of biospecimens and data accelerating lipedema science.
- Helps researchers uncover causes, biomarkers, and future treatments.
- Patients can contribute as volunteers through a Biobank collection site; a confirmed diagnosis is not required to participate.



How to help

- Tell patients the Biobank exists — many want to contribute to research.
- Refer interested patients to a Biobank collection site to enroll and donate.
- Learn more at the Lipedema Foundation (lipedema.org).

The bottom line

- Lipedema is common (~1 in 9 women), genetic, painful, and resistant to diet and exercise.
- It coexists with obesity, venous disease, and lymphedema — sort each out and treat each.
- Every patient: evaluate the veins, refer for MLD, and order proper compression.
- Say the words — “I think you might have lipedema” — then refer or start the basics.

Worst case: they try conservative measures, it doesn't help — and you reassess for another diagnosis. Low risk, high reward.

Thank you — let's help these women get seen.

Sarah Whitehead, MN, ARNP

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- <https://icd.who.int/en/>

Slide	Likely content (confirm)	SOURCE — where it came from (fill in)
4	Clinical photo — bilateral lipedema (ankle cuff / feet sparing)	Lipedema.org, used w/permission
10	Clinical/stage 1 image	Lipedema.org, used w/permission
11	Clinical/stage 2 image	Lipedema.org used w/permission
12	Clinical/stage 3 image	Lipedema.org used w/permission
13	Clinical/stage 4 image	Lipedema.org, used w/permission
16	Varicose veins vs. spider veins comparison	Claude AI image generated with prompt “create an image of varicose veins vs. spider veins”
17	Chronic venous insufficiency — medial-ankle hyperpigmentation	Author’s own clinical photograph; used with patient’s written consent.
20	Large image on 'The whole point' slide	Lipedema.org, used w/permission
21	Large image (action-set section)	Lipedema.org, used w/permission
22	Vector figure (WMF)	Lipedema.org, used w/permission
25	Compression garment product image	https://goclove.com/products/clove-compression-socks-white
28	Case 1 — leg photo	Lipedema.org, used w/permission
29	Case 2 — leg photo	Lipedema.org used w/permission
30	Case 3 — leg photo	Lipedema.org, used w/permission
31	Case 4 — leg photo	Lipedema.org, used w/ permission