

**Jaime Schwartz, MD**  
**240 S La Cienega Blvd, Suite 200**  
**Beverly Hills, CA 90211**

March 14, 2024

Patient: Rose Averill  
ID #: 912012181  
DOB: 10/26/1961

To Whom It May Concern,

We are requesting a **prior authorization and a GAP EXCEPTION review** for surgery to treat the diagnosed disease Lipedema. We are requesting a 6-month Authorization as the procedures are staged.

I have also attached for your review:

1. Letters and notes from non -surgeons documenting this patients Lipedema diagnosis.
2. Proofs of attempts to manage condition with conservative treatment
3. Letter of medical necessity, exam notes and surgical plan from Dr Schwartz
4. Patient letters describing how Lipedema is affecting her life
5. Photos
6. articles and documentation on the treatment of Liposuction for the treatment of Lipedema.

Patients with Lipedema have been misdiagnosed despite this disease identified by the Mayo clinic in the 1940s. Thank you for your attention to this important matter and ensuring a high-quality review of this request.

Please feel free to contact me if you require any additional information.

Best regards,

Sherry Bodod  
Total Lipedema Care  
Jaime S. Schwartz, MD, FACS  
Board Certified Plastic Surgeon  
Associate Clinical Professor of Surgery- USC Keck School of Medicine  
Division of Plastic and Reconstructive Surgery  
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Jaime Schwartz, MD Total Lipedema Care TLC Surgical Center

February 12, 2024

RE: Rose Averill

DOB: 10/26/1961

To Whom It May Concern:

I am writing on behalf of Rose Averill for coverage of medically necessary lipedema surgery. Miss Averill has a chronic progressive debilitating disorder called Lipedema. This condition is transmitted genetically as an autosomal dominant pattern disease.

The patient has diseased lipedema tissue accumulation in their arms, thighs, legs, and ankles. My approach is to manually extract as much of the diseased tissue as is safely possible per the attached Surgical Plan using a staged process involving 3 surgeries. In early stages, lipedema can be present on the legs, hips, and buttocks and 80% of women have it on their arms. Lipedema, in later stages, can also be present in the lower abdomen or other parts of the body and can negatively interact with obesity. Lipedema surgery includes liposuction of the diseased tissue, manual removal of nodules, and excision of excess skin.

There are published guidelines for diagnosing lipedema and an International Consensus Agreement on diagnosis in 2019. Diagnosis is by physical exam. S1 Guidelines J Dtsch Dermatol Ges 2017 Jul;15(7):758-767; International Consensus on the Prevention of Progression of Lipedema. <https://www.ncbi.nlm.nih.gov/pubmed/3135643> 3

Although there is variability among patients, clinicians look for the following:

- Onset at puberty, pregnancy, and menopause-progressive with age
- The affected limbs feel tight and heavy (especially at end of day even with elevation)
- Increase in adipose tissue usually starting in legs
- Reduced ambulation, decreased social activity
- Pain to the touch or pressure
- Easy bruising
- Hands and feet not affected
- Cuffs or bulges around joints (not in Type 1 or Type II Lipedema)
- Negative Stemmer sign (not in late-stage lipedema)
- Palpable spheroids in lipedema fat

As documented in my attached notes, the patient demonstrates most, if not all, of lipedema diagnostic signs. Note, per the International Consensus, a waist-height and waist-hip ratio are not criteria for diagnosis since, as it progresses, lipedema can occur in other areas like the trunk and arms. Non-

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pitting edema also is present in early stages of lipedema but can be unreliable because secondary lymphedema is common as the disease progresses.

**The patient has tried to manage this condition through conservative measures such as diet, exercise, compression garments and manual lymphatic drainage. The patient's functioning in their everyday life is impacted by lipedema.**

Reduced caloric intake, physical activity, and even bariatric surgery do not reduce the abnormal subcutaneous lipedema tissue which likely results from the growth of a brown stem cell population with lymphatic dysfunction in lipedema. Lipedema, a Frequently Unrecognized Problem, Fonder & Loveless et al., Journal of the American Academy of Dermatology, 2007, 57(2), S1-S3. Thus, lipedema tissue must be surgically removed.

Lipedema is a chronic, progressive disease, which if left untreated, can lead to multiple secondary and life-threatening health problems. These include circulatory problems (due to pressure on lymph vessels); a disruption of the lymphatic system causing dangerous lymphedema; joint problems in the spine and lower extremities; and a reduction in mobility leading to impaired quality of living. Lipedema: An Overview of its Clinical Manifestations, Diagnosis and Treatment of the Disproportional Fatty Deposition Syndrome, Forner-Cordero & Szolnoky, Clin Obes 2012 Jun;2(3-4): 86-95.

The only successful treatment for Lipedema is lipedema surgery. This is not a cosmetic procedure but a medically necessary surgery. Following liposuction surgery, patients can resume activities, return to Miss Averill will be prescribed compression following surgery to assist in her healing and will continue to wear garments long after. Multiple studies demonstrate the long-term effectiveness of lipedema surgery to relieve the pain, swelling, and immobility caused by lipedema. Also, see links to Aetna, Anthem and Premiera Blue Cross plans coverage policy on lipedema surgery that describes the diagnoses and treatment in additional detail. Highmark, Excellus, Care1st, and other smaller plans also cover lipedema.

[http://www.aetna.com/cpb/medical/data/1\\_99/0031.html](http://www.aetna.com/cpb/medical/data/1_99/0031.html)

[https://www.anthem.com/dam/medpolicies/abc/active/policies/mp\\_pw\\_a050277.html](https://www.anthem.com/dam/medpolicies/abc/active/policies/mp_pw_a050277.html)

<https://www.premiera.com/medicalpolicies/7.01.567.pdf>

Please contact me if you require further information,  
Jaime Schwartz, MD

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**SURGICAL PLAN**  
**Rose Averill**

DOB: 10/26/1961

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Diagnosis Code R60.9, M79.603, M79.606

**Stage 1:**

Lipedema reduction surgery bi-lateral lower extremity anterior (thighs)

CPT Code 15879 Modifiers RT/LT

Lipedema reduction surgery bi-lateral lower extremity anterior (legs)

CPT Code 15879 Modifiers RT/LT

**Stage 2:**

Lipedema reduction surgery bi-lateral lower extremity anterior(thighs)

CPT Code 15879 Modifiers RT/LT

Lipedema reduction surgery trunk (abdomen)

CPT Code 15877

Excision excessive skin and tissue (panniculectomy)

CPT Code 15834

**Stage 3:**

Lipedema reduction surgery bi-lateral upper extremity (arms)

CPT Code 15878 Modifiers RT/LT

Lipedema reduction surgery bi-lateral upper extremity (forearms)

CPT Code 15878 Modifiers RT/LT

Lipedema reduction surgery trunk (buttocks) RT

CPT Code 15877

Lipedema reduction surgery trunk (buttocks) LT

CPT Code 15877

Lipedema reduction surgery trunk (hip shelf) RT

CPT Code 15877

Lipedema reduction surgery trunk (hip shelf) LT

CPT Code 15877

Lipedema reduction surgery bi-lateral lower extremity posterior (thighs)

CPT Code 15879 Modifiers RT/LT

Lipedema reduction surgery bi-lateral lower extremity posterior (legs)

CPT Code 15879 Modifiers RT/LT

**Procedures to be staged:**

Bi-lateral excision skin / Subcutaneous tissue upper extremity (arm lift)

CPT code 15836 Modifiers RT/LT

Bi-lateral excision skin / Subcutaneous tissue lower extremity (thigh lift)

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CPT code 15832 Modifiers RT/LT  
Excision excessive skin and tissue (knee lift)  
CPT code 15833 Modifiers RT/LT  
Excision excessive skin and tissue (calf lift)  
CPT Code 15839 Modifiers RT/LT  
Excessive skin excision (Saddlebag)  
CPT Code 15839 Modifiers RT/LT  
Excessive skin excision/ lipectomy (hip roll)  
CPT Code 15834

Note that the surgical plan can change depending on how the patient responds to surgery. It will take approximately 12 months to complete this plan, so we ask for approval to reflect that time period.

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## **EFFECTIVENESS OF LIPEDEMA SURGERY**

There are approximately 1,000 lipedema surgeries performed every year in the United States. They are essential to improving function and reducing pain for patients suffering from this disease.

An August 2014 review of the forty-seven publications from 1982 to 2014, found agreement of the forty-seven publications from 1982 to 2014, found agreement that lipectomy is an applicable and effective treatment for chronic medical conditions such as lipedema. *Liposuction: A Surgical Tool to Improve the Quality of Life after Morbid Medical Conditions: Review of Literature*, Elkhatab HA 2014 Anaplastology 3:133. Lipectomy for lipedema has a definite positive and long-lasting effect. *Liposuction is an Effective Treatment for Lipedema-Results of a Study with 25 Patients*, Rapprich. Stefan, MD et al, Journal of the German Soc of Derm: Vol 9, (2012); p 33-40. (the majority of patients no longer require prolonged further therapy. Reduction of pain and drastic improvement in the patient's quality of life is noted in all patients.)

Liposuction has ceased to define a specific procedure and became synonymous with a surgical technique or tool the same as the surgical knife, laser, electrocautery, suture material, or even wound-dressing products. *Functional and Therapeutic Indications of Liposuction: Personal Experience and Review of the Literature*, Bishara Atiyeh 2015 Annals of Plastic Surgery 75(2). Liposuction results in fewer complications such as hematoma formation, skin necrosis, wound infection, and dehiscence with delayed healing and prolonged hospital stay. *Aesthetic or Functional Indications for Liposuction*, Michel Costagliola, MD et al, *Aesthetic Surgery Journal*, Volume 33, Issue 8, November 2013, Pages 1212-1213. In other words, liposuction is to surgical lipectomy what endoscopic cholecystectomy is to open surgical cholecystectomy.

Lipedema surgery decreases the mechanical stress on lymphatic vessels sufficiently to allow for the cessation of compression garment use beyond the initial postoperative period. *Long-term Outcome After Surgical Treatment of Lipedema*, Anne Warren Peled, MD, et al, Annals of Plastic Surgery Volume 68, Number 3, March 2012.

The international expert in lipedema, Dr. Josef Stutz, has studied the effects on the health of his patients for many years. The effects in a patient's body from the unusual gait from lipedema fat storage around the knees causes multiple joint complications. Stutz concluded that lipectomy is the only treatment that can remove the mechanical impediment to normal gait and prevent joint deterioration. *Liposuction of Lipedema for Prevention of Later Joint Complications*; Stutz, Josef MD, Vasomed, Vol 23 (2011).

Wollina and colleagues reported on 111 patients mostly with advanced lipedema treated by this technique in our center between 2007 and 2018. The median pain level before treatment was 7.8 and 2.2 at the end of the treatment. An improvement of mobility could be achieved in all patients. Bruising was also reduced. Serious adverse events were observed in 1.2% of procedures, the infection rate was 0% and the bleeding rate was 0.3%. Liposuction is an effective treatment for painful lipedema. *Dermatol Ther*. 2019 Mar; 32(2) In another study of 209 patients, quality of life increased significantly after surgery with a reduction of pain and swelling and decreased tendency to easy bruising. Bauer and colleagues, *New Insights on Lipedema: The Enigmatic Disease of the Peripheral Fat*. *Plast. Reconstr Surg*. 2019 Dec. 144(6)



Jaime Schwartz, MD   Total Lipedema Care   TLC Surgical Center

Thus, lipedema surgery is safe, effective, and the standard of care for many, many years. Indeed, the International Consensus Conference on Lipedema issued conclusions that although lipedema has been underdiagnosed in places like the United States, multiple studies from Germany have reported long-term benefits for as long as eight years after lipedema surgery.

<https://www.ncbi.nlm.nih.gov/pubmed/3135643> 3

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**Medical History**

Arthritis: Orthopedic surgeon noted arthritis in knees 2020  
 Easy bruising: on thighs and hips (lipedema related)  
 Gastroesophageal reflux disease: had EGD with biopsy 5/19/23 with Dr Aviles (biopsy was negative)  
 H/O: obesity: high BMI - can only lose weight in non-lipedema areas. regularly eats low carb and regular interment fasts  
 History of lipoma: ping pong ball sized lipoma removed from back of skull in 1990's  
 History of vasculitis: In ankles. Mainly in the left ankle. Began in the 1990's  
 Lipedema: Diagnosed in 2019 at stage 3. Hips to knees  
 Rheumatoid arthritis: Orthopedic surgeon noted arthritis in hips 2020  
 Maternal illness: none  
 Forceps delivery: No

**Surgical History**

Classical cesarean section: 1988 and 1991  
 Hysterectomy: total  
 Hysterectomy 1990's  
 Other: liposuction for lipedema: 2019 - Dr Byrd in GA and 2020 - Dr Fisher in TX - both were completely unsuccessful. NO reduction in leg size and NO elimination of pain, NO improvement in mobility

**Plastic Surgery History****Plastic Surgery History**

Abdominoplasty and liposuction: 1990's during surgery to reconnect abdominal muscles after 2 c-sections.  
 Repair of abdominal wall: in 1990's after 2 C-sections  
 Weight reduction regimen: various medical and non-medical based diets since 1970's

**Family History of Breast Cancer**

Do you have a family history of breast cancer?: No

**Family History of Malignant Hyperthermia and Anesthesia Sensitivity**

Do you have a family history of malignant hyperthermia or

**Chief Complaint: Lipedema Consultation**

**HPI:** This is a 62 year old female who is being seen for a lipedema consultation for lipedema affecting the legs, thighs, arms, abdomen, upper abdomen, buttocks, hip shelf, and knees.

**Legs:**

- Location: Anterior and Posterior
- Tenderness: Yes
- Lipomas: Yes
- Bruising: Yes
- Pain: Yes
- Cuffing: No
- Dimpling: Yes

**Thighs:**

- Location: Anterior and Posterior
- Tenderness: Yes
- Lipomas: Yes
- Bruising: Yes
- Pain: Yes
- Dimpling: Yes

**Arms:**

- Tenderness: Yes
- Lipomas: No
- Thickened Tender Subcutaneous Fat: Yes
- Spongy Adipose Tissue: Yes

**Abdomen:**

- Tenderness: Yes
- Lipomas: No
- Thickened Tender Subcutaneous Fat: Yes
- Spongy Adipose Tissue: Yes

**Upper Abdomen:**

- Tenderness: Yes
- Lipomas: No
- Thickened Tender Subcutaneous Fat: No
- Spongy Adipose Tissue: Yes

**Buttocks:**

- Tenderness: Yes
- Lipomas: Yes
- Thickened Tender Subcutaneous Fat: Yes
- Spongy Adipose Tissue: Yes
- Dimpling: Yes

**Hip Shelf:**

- Tenderness: Yes
- Lipomas: Yes
- Thickened Tender Subcutaneous Fat: Yes
- Spongy Adipose Tissue: Yes
- Dimpling: Yes

**Knees:**

- Tenderness: Yes
- Lipomas: Yes
- Thickened Tender Subcutaneous Fat: Yes

## Visit Note - February 12, 2024

PMS ID: 13096 Sex: Female DOB: 10/26/1961 Phone: (727) 424-3402 MRN: 13096

severe reactions to anesthesia?:  
No

**Herbal Medications and Supplements**

Do you take any herbal medications or supplements?:  
Yes  
Fish Oil: Relief Factor

**Family History of Melanoma**

Do you have a family history of Melanoma?: Yes  
Sister: older sister

**Social History**

Not sexually active

Patient feels safe at home

EtOH none

Single Question Alcohol Screening: 0 days  
Caffeine Use: Several times a day  
Exercise: Never  
Occupation: CEO (Chief Everything Officer) & co-owner of a medical practice & research center, with my husband who is the physician - pulmonary, sleep & allergy medicine. We have 25 employees and two 6,000 square foot buildings. Long hours and lots of stress!  
Place of Residence: Private home in Clearwater, Florida.  
Smoking status - Never smoker  
Driving status: Drives in the Daytime  
Drives at Night

**Medications**

None reported.

**Allergies**

Other: seasonal plants

- Spongy Adipose Tissue: Yes

Duration: 20 years

Associated Diagnoses: Lymphedema and Varicose veins

Similarly Affected Family Members: mother

Pedicures: Yes (patient is able to tolerate pedicure massages)

Do You Wear Boots: No

Lipedema Worsened By: puberty, pregnancy, oral contraceptive pills, menopause, and hysterectomy

Swelling Occurs With: standing, sitting, end of day, and summer

Previous Treatments: Elevation (better), Compression Garments for 12 weeks or more (no change),

Manual Lymphatic Drainage for 12 weeks or more (no change), Sequential Pumps for 12 week or more (no change), and Diet (Intermittent fasting (better) and Keto (better))

Difficulty Walking: Yes

Flexibility: Not Flexible

Cooler Areas: thighs and buttocks

Easy Bruising: thighs, calves, and buttocks

Pain: all the time (Average Pain Score: 10 out of 10)

Ability to move a chair from one room to another: With much difficulty

Ability to bend down and pick up clothing from the floor: Without any difficulty

Ability to stand for one hour: With some difficulty

Ability to do chores such as vacuuming or yard work: With much difficulty

Ability to push open a heavy door: With a little difficulty

Ability to exercise for an hour: With much difficulty

Ability to carry a heavy object (over 10 pounds /5 kg): With some difficulty

Ability to stand up from an armless straight chair: With some difficulty

Ability to dress yourself, including tying shoelaces and buttoning your clothes: With a little difficulty

Ability to able to dry your back with a towel: Without any difficulty

Due to the patient's lipedema, they are unable to undergo a necessary surgery by another provider (knee replacement).

The patient understands and agrees that they must continue wearing compression garments after their surgery.

**Vitals:**

Date	Taken By	B.P.	Pulse	Resp.	O2 Sat.	Temp.	Ht.	Wt.	BMI	BSA
02/12/24 15:23	Schwartz, Jaime						67.0 in*	310.0 lbs*	48.5	2.5
	FiO2									

\* Patient Reported

**Exam:**

An examination was performed.

**Base**

Appearance: well developed and nourished

Memory: Appropriate recent and remote memory with appropriate history provision

Judgment and Insight: Appropriate judgment, insight, interpersonal dynamics and expectations of encounter and goals of treatment

Orientation: Alert and oriented to person, place, time.

Mood: Mood and affect well-adjusted, pleasant and cooperative, appropriate for clinical and encounter circumstances

Skin Inspection: Normal skin inspection without rashes or concerning lesions

Skin Palpation: Normal skin palpation without rashes or concerning lesions

Visit Note - February 12, 2024

PMS ID: Sex: DOB: Phone: MRN:  
13096 Female 10/26/1961 (727) 424-3402 13096**Comprehensive Upper Extremity**LN Exam: Normal lymphatic exam without lymphadenopathy in cranial, cervical, axillary and inguinal regions

Right Upper arm Inspection: **Vascular manifestation such as cherry angiomas, telangiectasia, venous disease Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema Persistent Enlargement of after elevation of extremity or weight loss.**

Left Upper arm Inspection: **Vascular manifestation such as cherry angiomas, telangiectasia, venous disease Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema Persistent Enlargement of after elevation of extremity or weight loss.**

Right Forearm Inspection: **forearm tenderness. Vascular manifestation such as cherry angiomas, telangiectasia, venous disease Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema Persistent Enlargement of after elevation of extremity or weight loss.**

Left Forearm Inspection: **forearm tenderness. Vascular manifestation such as cherry angiomas, telangiectasia, venous disease Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema Persistent Enlargement of after elevation of extremity or weight loss.**

Right Hand Inspection: Normal alignment, no deformity, no tenderness, no warmth

Left Hand Inspection: Normal alignment, no deformity, no tenderness, no warmth

Right Hand Stability: Stable

Left Hand Stability: Stable

Right Hand Special: Normal

Left Hand Special: Normal

Digit Inspection: **Negative Stemmer Sign Fingers/Toes**

Right UE Peripheral Pulses: normal radial and ulnar pulses, without thrill, good capillary refill

Left UE Peripheral Pulses: normal radial and ulnar pulses, without thrill, good capillary refill

Right UE Peripheral Sensation intact to light touch throughout peripheral nerve distributions

Left UE Peripheral Sensation intact to light touch throughout peripheral nerve distributions

Coordination: Coordination normal.

**Cosmetic Abdominoplasty**

Appearance: **overweight.**

Abdominal Survey: **mass, right lower quadrant, mass, left lower quadrant, tenderness, right lower quadrant, and tenderness, left lower quadrant Superficial masses and tenderness c/w Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema**

Hernia Exam: Normal abdominal wall without hernias or bulges

Respiratory Effort: Normal respiratory effort without labored breathing or accessory muscle use

Right LE Peripheral Pulses: normal femoral, posterior tibialis and dorsal pedis pulses, brisk capillary refill

Left LE Peripheral Pulses: normal posterior tibialis and dorsal pedis pulses, brisk capillary refill

**Comprehensive Lower Extremity**

Gait: **scissor.**

Visit Note - February 12, 2024

PMS ID: Sex: DOB: Phone: MRN:  
13096 Female 10/26/1961 (727) 424-3402 13096

Right Thigh Inspection: **Vascular manifestation such as cherry angiomas, telangiectasia, venous disease**

**Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema, Persistent Enlargement of after elevation of extremity or weight loss**  
**Persistent Enlargement of after elevation of extremity or weight loss.**

Right Knee Inspection: **valgus alignment. Medial Lobules, Tissue Overhanging or Covering Knee.**

Right Leg Inspection: **Vascular manifestation such as cherry angiomas, telangiectasia, venous disease**

**Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema**  
**Persistent Enlargement of after elevation of extremity or weight loss.**

Right Ankle Inspection: **varus hindfoot. Ankle Cuff.**

Right LE Sensation intact to light touch throughout peripheral nerve distributions

Left Thigh Inspection: **Vascular manifestation such as cherry angiomas, telangiectasia, venous disease**

**Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema, Persistent Enlargement of after elevation of extremity or weight loss**  
**Persistent Enlargement of after elevation of extremity or weight loss.**

Left Knee Inspection: **valgus alignment. Medial Lobules, Tissue Overhanging or Covering Knee.**

Left Leg Inspection: **Vascular manifestation such as cherry angiomas, telangiectasia, venous disease**

**Lipedema Nodules, Pain, Tenderness, Skin Hypothermia, Easy Bruising, No Pitting Edema**  
**Persistent Enlargement of after elevation of extremity or weight loss.**

Left Ankle Inspection: **varus hindfoot. Ankle Cuff.**

Left LE Sensation intact to light touch throughout peripheral nerve distributions

### Peripheral Vascular

Lower Extremity Venous:

Right Lower Extremity Venous: **edema, severe**

Left Lower Extremity Venous: **edema, severe**

### Impression/Plan:

1. Lipedema: Associated diagnoses: Localized Adiposity, Obesity, Subcutaneous Fat, Varicose veins of bilateral lower extremities with pain, Lymphedema, not elsewhere classified, and Edema, unspecified

Plan: Counseling - Lipedema

I counseled the patient regarding the following:

Skin care: Treatments include diet, exercise, and compression. If there is associated lymphedema, patients can benefit from manual lymphatic drainage. Liposuction has also been used to treat this condition.

Expectations: Lipedema is a chronic condition characterized by excessive fat deposits on the legs, thighs, and buttocks. It can also affect the upper arms. The condition can be painful and can cause easy bruising. The cause is unknown. It may be genetic and because the condition affects almost exclusively women, it has been postulated that hormones may play a role in development of the condition.

Contact office if: Lipedema causes pain or discomfort.

Lipedema is a chronic disease presenting in women during puberty or other times of hormonal, weight and/or shape change such as pregnancy or menopause, characterized by symmetric enlargement of nodular, painful deposition of inflamed and fibrotic subcutaneous adipose tissue. Lipedema was first named as a medical condition in 1940 at the Mayo Clinic<sup>1</sup> and in Germany.<sup>2</sup> The diagnosis of lipedema is largely clinical and based on criteria initially established in 1951 by Drs. Wold, Allen and Hines.<sup>3</sup> Lipedema starts in the lower extremities leading to circumferential bilateral lower extremity enlargement typically seen extending from the below the umbilicus to the ankles resulting in edema, pain and bruising; with secondary lymphedema, fibrosis and spreading of abnormal tissues to the trunk and arms occurs during later stages. Unfortunately as the lipedema tissue grows, the deep fascia and muscle are also affected reducing the function of the lymphatic pump.

Lipedema is a hereditary disease and recently the first mutated gene AKR1C1 was discovered resulting in a slower and less efficient reduction of progesterone to hydroxyprogesterone and increased subcutaneous fat deposition in variant carriers,



confirming hormones as important in lipedema.<sup>4</sup> Lipedema also clearly manifests as a connective tissue disorder characterized by loss of elasticity in the skin<sup>5</sup> and the aorta,<sup>6</sup> hypertrophic adipocytes, inflammatory cells, and dilated leaky blood and lymphatic vessels.<sup>7, 8</sup>

She has lipedema in her legs, arms and trunk that includes nodules and pain in these areas. Her hands, feet, and upper trunk have been spared. She has other signs of lipedema including a negative Stemmer's sign and abnormal fat pad development, disproportion, pain and dysmobility.

She also might be developing early stages of lipo-lymphedema and thus her lipedema needs to be treated.] She has tried conservative measures for many months and while conservative therapies can reduce swelling and pain for a short time, removing the diseased tissue with surgery is necessary to reduce symptoms and progression long-term.

Lipedema is distinct from non-lipedema obesity, although some, not all, patients can be obese. The adipose tissue accumulation is bilateral and symmetrical in the extremities, with the feet and hands spared from lipedema fat accumulation unless there is loss of elasticity as in hypermobile Ehlers Danlos where the skin has lost elasticity and fat can grow on the hand (with or without obesity). A hallmark of earlier stages of lipedema is the discrepancy in fatty tissue of the extremities compared to the trunk. This is in contrast to the fat associated with lifestyle-induced obesity, which is usually global and proportionate, affecting the abdomen equal or greater than the hips.

Women with lipedema find it difficult to lose weight before a needed surgery or other procedures. There is a significant number of women with lipedema who have failed bariatric surgery because they were already controlling their diet but just not losing weight.<sup>9-11</sup>

Besides the many painful nodules that women with lipedema have, studies indicate that women with lipedema do not have the muscle strength like people who have non-lipedema obesity, are subject to more injuries and have poorer functional capacity.<sup>12</sup> Thus, to improve function and reduce pain, lipedema surgery is recommended.<sup>13</sup>

I counseled the patient regarding the following:

**Lipodystrophy Care:** Cosmetic body contour dissatisfaction may be due to excess skin, stretch marks, bulging, fat excess, muscle weakness, and other complaints. Abdominoplasty, liposuction and other body contouring techniques are performed to help correct these issues. Surgery is commonly performed on an outpatient basis, although overnight hospitalization may be indicated in some patients, particularly those undergoing large body contouring operations. Aesthetic body contouring deformities may improve somewhat with diet control, exercise, rest, and proper skin care, including avoidance of excess sun and abstinence from nicotine. Specific preoperative and postoperative instructions will be provided for surgery.

**Expectations:** Body contour aesthetic concerns may be the result of obesity or overweight, pregnancy, genetic factors, sun damage, prior surgery, hernias, and other factors. Aesthetic surgery for these concerns is generally not performed for the purposes of weight loss. Rather, overweight patients are advised to lose weight in a controlled, supervised manner until a maintainable plateau weight is achieved before undergoing body contouring operations, in order to optimize results and reduce surgical risks. Liposuction often does not correct wrinkling, roundness, or laxity or fullness on the abdomen or other body locations. Liposuction is also performed for contouring purposes, rather than weight loss intent. Skin retraction may not be complete with liposuction, and excess skin may require surgical removal for full correction. Use of garments after surgery is advised and instructions will be provided. Risks, benefits, expectations and alternatives to liposuction have been explained in detail, including, but not limited to, the risks of infection, bleeding, injury to nerves or abdominal organs, bulging, contour irregularities, inadequate skin retraction, persistent deformity, seromas, deep venous thrombosis, pulmonary embolism, fat embolism, scarring, delayed healing, and other risks. Aftercare and possible use of drains have been explained. No guarantee or warranty regarding cosmetic outcome or longevity of results was given or implied.

**Contact office if:** the patient develops concerning symptoms such as severe abdominal pain, nausea, vomiting, diarrhea, fever, excessive or unusual drainage, swelling, redness, difficulty breathing, bleeding, or other concerning symptoms. Please contact the office if additional procedures or a change to the recommended treatment plan are desired. Fees for cosmetic procedures are valid for a limited time, as specified on the fee schedule, and are subject to change at the practice's discretion. Please contact the office with any questions regarding fee schedule, payment policy, product concerns, or preoperative and postoperative questions.

The risks, benefits, expectations and alternatives of liposuction were discussed and include but are not limited to: infection, bruising, lumpiness, pain, anesthesia reaction, dysesthesia, scarring in treatment area or puncture point, vasovagal reactions, tachycardia, nausea, necrosis, ulceration, color change and asymmetry.

I discussed the following surgical options with the patient:

**Abdominoplasty:** Abdominoplasty is the medical term for what is commonly referred to as a tummy tuck. It is a procedure performed to remove excess skin and draping fat from the lower abdomen. It is performed for the purpose of body contouring, not for the purpose of helping patients lose weight. While tissue removed during the procedure has some weight, the procedure is strictly not a procedure for weight loss. Patients seeking to lose weight are best suited by losing the weight through supervised diet and exercise until a stable, more desirable weight is achieved and maintained prior to the surgery. Abdominoplasty is performed through an incision low in the abdomen, usually in the same crease as a C-section would be performed in the suprapubic crease. The skin and fat are undermined off the muscle layer and the muscle layer is typically tightened with a plication procedure. An



incision is also performed around the belly button (umbilicus) to allow it to be repositioned when the skin is redraped. After release, the excess tissues are removed and the belly button is delivered through a hole in the tightened skin. Typically, the hole created for release of the umbilicus is within the skin that is ultimately removed. However, in some cases, the hole must be closed and results in a small scar in the lower abdomen below the new hole created for delivery of the belly button. Drains may be used to evacuate fluid from under the fat layer to permit healing. They are usually removed within the first 10-14 days. A postoperative garment and/or binder will be required for several weeks to 2 months to aid in shaping. The scar will usually go through changes over the course of 6-12 months before final maturity. Scar revisions are occasionally required. Placement of the surgical incisions may be aided by the patient bringing typical swimwear, which can help to optimize concealment of the scar. Early ambulation after surgery is important to reduce risks of blood clot formation.

**Back Lift:** A Back Lift involves removal of adipose tissue and skin. Significant incisions may be required to remove redundant skin. The risks, benefits, expectations and alternatives (including incisional approaches and minimally invasive or noninvasive techniques) have been discussed and include, but are not limited to, the risks of infection, bleeding, injury to nerves/vessels/other structures, contour irregularities, asymmetry, fat necrosis, delayed healing, visible scarring, dissatisfaction with cosmetic outcome and possibility of unplanned return to the operating room. All questions were answered to the patient's satisfaction. No guarantee or warranty was given or implied regarding cosmetic outcome, longevity of results, or satisfaction therewith.

**Brachioplasty:** Brachioplasty involves removal of the redundant skin, and some excess fat, on the upper arm. The incision is either fashioned along the inner arm seam, or along the back of the arm, and it may be extended into the axilla (armpit) area. It may traverse the length of the upper arm all the way to (and even beyond) the elbow crease. The excess skin is removed and the remaining skin is closed together to improve the cylindrical shape of the arm. Care is paid to avoid overresection of skin in order to reduce the risk of inability to close the incision completely at the time of surgery, which is a possibility with significant skin removal when the skin swells. The incision may be numb and may take 3-5 weeks to heal to closure. Scar maturation may take 6-12 months. Drains may be used for up to 10-14 days in many patients.

**Breast Reduction:** Breast reduction involves removal of breast tissue and skin. Significant incisions may be required to remove redundant skin. The risks, benefits, expectations and alternatives to breast reduction (including incisional approaches and pedicle selection) have been discussed and include, but are not limited to, the risks of infection, bleeding, injury to nerves/vessels/other structures, contour irregularities, asymmetry, fat necrosis, nipple loss, loss of nipple sensation, delayed healing, visible scarring, dissatisfaction with cosmetic outcome and possibility of unplanned return to the operating room. All questions were answered to the patient's satisfaction. No guarantee or warranty was given or implied regarding cosmetic outcome, longevity of results, or satisfaction therewith.

**Fleur-de-Lis Technique:** The fleur-de-lis technique involves both horizontal and vertical incisions resulting in an inverted-T shaped scar. This variant of abdominoplasty design is appropriate for many patients with massive weight loss, who have excess skin and fat in both horizontal and vertical directions. The vertical scar is not easily concealable in two-piece bathing garments but may be a reasonable trade-off for many patients in order to secure a better overall contour and correction of skin redundancy. Healing may take 1-2 weeks longer than what would otherwise be required for standard abdominoplasty incisions.

**Liposuction:** Liposuction may improve contour irregularities and volume excesses. Tumescant fluid with local anesthetics and other medications is used to reduce postoperative bleeding and pain. Fat removal may be enhanced by ultrasound, Vaser, power or other assisted techniques. Repeated sessions of liposuction may be required. Liposuction is a procedure to contour the body's shape, not to help the patient lose weight. A very small amount of weight may be lost as a result of the suctioning of fat, but sustained weight improvement requires attention to diet and exercise. Under no circumstances should the patient expect liposuction to create significant weight loss through the surgery itself. The risks, benefits, expectations and alternatives to liposuction have been discussed and include, but are not limited to, the risks of infection, bleeding, injury to nerves/vessels/other structures, contour irregularities, asymmetry, fat necrosis, nipple loss, loss of nipple sensation, delayed healing, visible scarring, dissatisfaction with cosmetic outcome and possibility of unplanned return to the operating room. All questions were answered to the patient's satisfaction.

**Lower Body Lift:** A lower body lift is an extensive technique that includes abdominoplasty, often combined with circumferential correction of excess skin on the back (belt lipectomy or circumferential torsoplasty), as well as bilateral medial and lateral thigh lifting. Incisions include the standard abdominoplasty incision as well as scars on the inner thighs, and a possible extension of the abdominal scar all the way around the back. This procedure is often performed on a hospital setting where overnight hospitalization can be offered, due to the typical length of surgery and extent of incisions. Delayed healing, seromas and scars are common issues with this operation, but the resultant improvement in body contour is often rather dramatic. Early ambulation after surgery is important to reduce risks of blood clot formation. Multiple drains are usually required.

**Medial Thigh Lift:** A medial thigh lift is a procedure done to remove excess skin on the thighs, and may be combined with abdominoplasty or body lifting (belt lipectomy or circumferential torsoplasty). Incisions are made on the inner thighs, and may be

confined to the groin creases in some cases, though many patients require extensions of the incisions down the thigh to remove the excess properly. When combined with body lifting, incisions also include a lower abdominal incision and a possible extension of the abdominal scar all the way around the back. Standard medial thigh lifting may be performed on an outpatient basis, usually under general anesthesia. Delayed healing, seromas, numbness in the thighs and scars are common issues with this operation, but the resultant improvement in body contour is often rather dramatic. Concealment of scars may be difficult in shorts, skirts or bathing suits. Early ambulation after surgery is important to reduce risks of blood clot formation. Drains are often in place for 10-14 days, although some patients require longer periods of drainage due to proximity of the thigh lymphatic vessels to the treatment area. The postoperative garments can also help significantly reduce the fluid accumulation.

**Panniculectomy:** Panniculectomy is a procedure involving removal of the excess apron of skin and fat below the belly button. In contrast to abdominoplasty, it usually does not involve undermining of the skin well above the belly button. In addition, muscle plication of the abdominal wall may not be performed in panniculectomy. Panniculectomy may be required medically in patients with severe recurrent infections or rashes in the crease below the pannus. Delayed healing and fluid collections are not uncommon. Risks also include, but are not limited to, infection, bleeding, deep venous thrombosis (blood clots), scarring, persistent excess tissue, cosmetic dissatisfaction, and other risks.

**Power-Assisted Liposuction:** Power-assistance involves the use of a power source to oscillate the suction cannula device to reduce manual effort for the surgeon. In other respects, it is similar to standard liposuction.

**Lipodystrophy Option Other: Lipedema Reduction Surgery with Lymphatic Sparing Liposuction (LSL) with Manual Lipedema Extraction (MLE) along with Skin Reductions**

LRS surgical stage options:

Anterior thighs - 15879-22 RT/LT

Anterior legs - 15879-22 RT/LT

Abdomen - 15877-22

Arms - 15878-22 RT/LT

Forearms 15878-22 RT/LT

Buttock Shelf/Hips 15877-22 RT/LT

Posterior Thighs - 15879-22 RT/LT

Posterior Legs - 15879-22 RT/LT

Panniculectomy - 15839-22

Arm lift - 15836-22 RT/LT

Thigh lift - 15832-22 RT/LT

Knee Lift - 15833-22 RT/LT

Calf Lift - 15833-22 RT/LT

Saddle Bag Excision 15839-22 RT/LT

Anterior Hip Roll Reduction 15839-22

After counseling, we decided on the following plan: Lipedema Reduction Surgery with Lymphatic Sparing Liposuction (LSL) with Manual Lipedema Extraction (MLE) along with Skin Reductions based on planned surgical stages for safety:

1-2. Anterior thighs - 15879-22 RT/LT

1. Anterior legs - 15879-22 RT/LT

2. Anterior thighs - 15879-22 RT/LT

2. Abdomen - 15877-22

2. Panniculectomy - 15839-22

3. Arms - 15878-22 RT/LT

3. Forearms 15878-22 RT/LT

3. Buttock Shelf/Hips 15877-22 RT/LT

3. Posterior Thighs - 15879-22 RT/LT

3. Posterior Legs - 15879-22 RT/LT

To be staged:

Arm lift - 15836-22 RT/LT

Thigh lift - 15832-22 RT/LT

Knee Lift - 15833-22 RT/LT

Calf Lift - 15833-22 RT/LT

Saddle Bag Excision 15839-22 RT/LT

## Visit Note - February 12, 2024

PMS ID: Sex: DOB: Phone: MRN:  
13096 Female 10/26/1961 (727) 424-3402 13096

Anterior Hip Roll Reduction 15839-22

Posterior body might potentially need to be staged due to volume.

I discussed the following miscellaneous information with the patient:

May need to stage procedures more due to volume as well as medical clearance.

Nicotine Abstinence: I counseled regarding the risks of nicotine exposure, including delayed healing, infection, perioperative cardiovascular events and possible need for extended wound care or return to surgery.

Imaging Studies: Imaging studies including CT scans or MRI's may be appropriate to help determine the extent of deformity or to rule out hernias, and to help guide treatment.

### Follow up PRN for: Preoperative Appointment, Discussion of Procedure, Additional Consultation, Preoperative Marking

#### Staff:

Jaime Schwartz (Primary Provider) (Bill Under)

Kaory Silva

Electronically Signed By: Jaime Schwartz, 02/12/2024 03:23 PM PST

## Rose Averill - Lipedema Story

Since puberty, my lower body (below waist to knees) has been disproportionately larger and not responsive to reduction by diet or exercise. My thighs grew so quickly that I had stretch marks on them as a teenager, though I was very active and not overweight. (Measurements wise at 18, my waist was 26" and my hips were 36".) In my early 40's, I had a total hysterectomy, afterwards my lower body increased tremendously, and "bumps" (masses) appeared in my legs, even though I continued on my healthy eating and exercise that I normally did. The growth of large pads in my medial knees were particularly noticeable. The knee masses impacted my stance and gait. I also started to feel pain in these masses and my legs in general.

By my early 50's, the pain became constant, with occasional spikes, and my mobility became limited. (A trip to my mailbox was undertaken slowly, with deliberate steps and a cane.) My legs felt like they were 500 pounds apiece. My daily life became limited by my exhaustion, pain, and lack of mobility. I was issued a permanent disability tag. Every aspect of my daily life became a challenge.

For decades I sought help from various doctors and weight loss programs, to no avail, since none of them were aware of lipedema. In 2019, I saw Tami Horner, MD. When over six months of diet, hormone therapy and other treatments had no effect on my legs, Dr. Horner diagnosed me with lipedema. She said that I was, "The most compliant patient that she ever had". In 2019 I got confirmation of my lipedema diagnosis by Elizabeth Kurman, ARNP, Dr Anup Desai (my primary doctor) and Dr. Byrd. Dr. Byrd performed surgery on my lower legs and knees. In 2020, Dr. Fischer confirmed that I had stage 3 lipedema (in my legs, lower body, and arms) and performed liposuction for lipedema on my thighs. After the surgery, he told me that my legs were too diseased and fibrotic for the liposuction technique that he used to be effective.

I have used compression, low- carb/ keto anti-inflammatory diets, intermittent fasting, exercise (recumbent bicycle and water exercises), a full suit Flexitouch pneumatic compression, massage gun, vibration plate and MLD (Manual Lymphatic Drainage). And despite everything I have done, the disease has advanced.

I am now in my early sixties. Each decade I have experienced increased pain, suffering and exhaustion and a decrease in functionality, mobility and the ability to do and enjoy basic normal activities. Things like getting in and out of a car is a painful challenge. I have to make sure that a wide base cane is by my side at all times, even to get from room to room in my home. I have great difficulty getting up from a chair, standing, and walking even a few yards. My arms also feel heavy and limit my ability to lift and carry items and do activities like dyeing my hair. I struggle to get through each day.

My activities and events that I once enjoyed are derailed. Recently, I had to miss a once in a lifetime reunion with my siblings because of my inability to travel. I have a great desire to help people. Despite my struggles I still work full-time. I run a medical practice. I'm deeply committed to the care of our patients and the lives of our employees and their families. Every weekend I volunteer at a tent city homeless shelter. In the last few years, my volunteer activity has been limited to more of a ministry of voice and presence. Others have to carry the equipment and supplies that I use, since I can no longer do so. It would break my heart to not be able to serve others, and even worse to be a burden.

I have been told by orthopedic surgeons that I need double knee replacements, but they cannot proceed because of my lipedema. Successful lipedema reduction, only possible through surgery, could provide me with the ability to get the knee replacements that I need.

I am encouraged by Dr Jamie Schwartz's experience with lipedema reduction surgery and the outcomes of other patients, who like me, have advanced lipedema. People who also have tried everything that have improved mobility and decreased pain with Dr Schwartz's techniques. Basically, I am looking

forward to a chance to live a more normal life again and stop or slow the progression of this debilitating disease.

## Conservative Lipedema Treatments in the last 6 months:

I have used:

- compression
- low- carb/ keto anti-inflammatory diets, intermittent fasting
- exercise (recumbent bicycle and water exercises)
- a full suit Flexitouch pneumatic compression
- massage gun
- vibration plate
- RoseAverill....~~8-70-8680~~.

# F A X S H E E T

Date: Oct-22-2019 04:27:21  
To: Averill, Frank  
Subject: Progress Notes  
Fax Number: 727-210-4600  
To Company: Averill, Frank  
From Name: Paulsen, Jennifer  
From Company: Anup Desai MD PA  
From Facility: Anup Desai MD PA  
Support Contact: 727-442-5138  
Number of Page(s): 4

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### Progress Note

**Patient:** Averill, Rose C  
**DOB:** 10/26/1961 **Age:** 57 Y **Sex:** Female

**Provider:** Anup Desai, MD  
**Date:** 10/03/2019

---

#### Reason for Appointment

1. This patient is here for the first time. She wants to get establish with the doctor.
2. She is having lipedema surgery in Georgia October 25th. She is not sure if she needs pre-op clearance

#### History of Present Illness

##### Constitutional:

This patient is here for the first time and she wants to get establish herself with a primary care physician. She is obese and she also gives history of Lipedema. She has tried various kinds of treatment including treatment for lymphedema and compression therapy. She is also planning to have surgery at the end of this month for liposuction. According patient she has a lot of pain. She has been using ibuprofen as needed but she wants to try something stronger. She also has osteoarthritis in her knee joints.

#### Current Medications

##### Taking

- Vitamin B-12 1000 mcg/mL solution as directed intramuscularly once a week
- Claritin 10 mg tablet 1 tab(s) orally once a day
- Zyrtec 10 mg tablet 1 tab(s) orally once a day

#### Past Medical History

Lipedema.  
Prediabetes.  
Morbid obesity.  
Hyperlipidemia.  
Osteoarthritis of knee joints.  
Allergic rhinitis.

#### Surgical History

Surgery for varicose veins  
Hysterectomy  
C-section  
Abdominoplasty  
Liposuction

#### Family History

Father: deceased 61 yrs, High cholesterol diabetes, coronary artery disease S/P CABG, diagnosed with Diabetes, Heart Disease, Stroke  
Mother: deceased 71 yrs, Ovarian cancer, diabetes, Diabetes  
Paternal Grand Father: deceased, family history unknown  
Paternal Grand Mother: deceased 68 yrs, family history unknown  
Maternal Grand Father: deceased, family history unknown  
Maternal Grand Mother: deceased, Cancer  
Paternal uncle: unknown, family history unknown  
3 sister(s) . 1 son(s) , 1 daughter(s) - healthy.  
sister has pituitary tumor.

#### Social History

Marital Status: married, lives with her husband.  
Alcohol: socially, Occasionally.  
Occupation: Office manager.  
Smoking Are You a: never smoker.

#### Allergies

N.K.D.A.

## Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

## Review of Systems

### CONSTITUTIONAL:

Appetite normal. Nutrition Fair. Fall No. Fever none. Chills none. Weight Loss none. no Weakness. no Fatigue.

### ALLERGY:

no Sinus congestion. Cough yes. no Ear Symptoms. Nasal Congestion yes. Post-nasal Drip yes. no Sore Throat.

### DERMATOLOGY:

no Rash. no Mole. no Hives. no Eczema. no Bruising.

### ENT:

no Epistaxis. no Hoarseness. no Ringing in Ears. no Sinus Pain. no Ear Pain.

### CARDIOLOGY:

no Chest Pain. no Palpitations. no Leg Edema. no Dizziness. no PND (paroxysmal nocturnal dyspnea). no Orthopnea.  
no Irregular Heart Beat.

### ENDOCRINOLOGY:

no Polydipsia. no Polyuria. no Cold Intolerance. no Hair Changes.

### GASTROENTEROLOGY:

no Abdominal Pain. no Nausea. no Vomiting. no Diarrhea. no Blood in Stool. no Heartburn.

### HEMATOLOGY/LYMPH:

no Swollen Glands. no Easy Bruising.

### MUSCULOSKELETAL:

Joint Pain yes. Joint Stiffness yes. no Joint Swelling. no Back Pain. no Myalgias. no Leg Cramps.

### OPHTHALMOLOGY:

no Blurred Vision. no Change in Vision. no Eye Redness.

### RESPIRATORY:

no Shortness of Breath. no Chest Congestion. no Wheezing. no Cough, wheeze, SOB worse with exercise.

### UROLOGY:

no Dysuria. no Urinary Frequency. no Urinary Urgency. no Blood in Urine. no Urinary Incontinence.

### NEUROLOGY:

no Tingling/Numbness. no Seizures. no Gait Abnormality. no Headache.

### PSYCHOLOGY:

no Depression. no Suicidal Ideation. no Anxiety. no Mood Swings.

## Vital Signs

BP 122/72 mm Hg, HR 64 /min, RR 18 /min, Temp 98.7 F, Ht 5 ft 7 in, Wt 290 lbs, BMI 45.42 Index.

## Examination

### General Examination:

General Appearance: pleasant, alert and oriented. Skin: unremarkable. HEENT: Head - NC/AT, PERRLA, clear conjunctiva, nose clear. Oral cavity: unremarkable. Neck, Thyroid : no thyromegaly, no JVD., No cervical adenopathy, no carotid bruit. Chest: normal shape and expansion. Heart: S1S2, no murmur appreciated. Lungs: clear to auscultation bilaterally. Abdomen: soft, Nontender, no hepatosplenomegaly. Back: unremarkable. Extremities: no edema, No calf tenderness., Lipedema on the arms and legs. Peripheral pulses: symmetrical bilateral. Neurologic Exam: non-focal exam.

## Assessments

1. Lipomatosis, not elsewhere classified - E88.2 (Primary)
2. Morbid (severe) obesity due to excess calories - E66.01
3. Hyperlipidemia, unspecified - E78.5
4. Prediabetes - R73.03
5. Bilateral primary osteoarthritis of knee - M17.0

## Treatment

### **1. Lipomatosis, not elsewhere classified**

Notes: Patient is medically cleared for scheduled surgery and advised to avoid Aspirin containing products one week prior to surgery. She is also advised to get endocrine opinion.,

### **2. Morbid (severe) obesity due to excess calories**

LAB: Vitamin D, 25-Hydroxy

LAB: \*\*CBC, CMP, LIPID, TSH, HBA1C, ROUTINE UA, MICROALBUMIN

Notes: discussion with patient about various treatment option for losing weight including dieting and regular exercise. Patient is also advised to cut down calories by low carbohydrate diet and avoid fatty foods.

### **3. Hyperlipidemia, unspecified**

LAB: Vitamin D, 25-Hydroxy

LAB: \*\*CBC, CMP, LIPID, TSH, HBA1C, ROUTINE UA, MICROALBUMIN

Notes: Patient is advised to maintain low cholesterol diet and to do exercise on aregular basis. Get Lipid profile checked once again.

**4. Prediabetes**

Start metformin tablet, 500 mg, 1 tab(s), orally, 2 times a day, 30 day(s), 60, Refills 3

LAB: Vitamin D, 25-Hydroxy

LAB: \*\*CBC, CMP, LIPID, TSH, HBA1C, ROUTINE UA, MICROALBUMIN

Notes: Patient is advised to maintain ADA diet and also to do exercise on regular basis.

**5. Bilateral primary osteoarthritis of knee**

Start tramadol tablet, 50 mg, 1 tab(s), orally, every 8 hours pm, 30 days, 90, Refills 1

Notes: She will qualify for disability parking.

**Preventive Medicine**

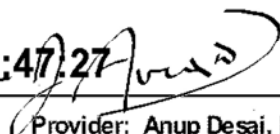
Immunizations: Influenza Have you had the flu shot since the most recent September 1? No Patient wants to get it at work place..

**Follow Up**

3 Months, Give Phone# of Dr Deneker/Dr Dimarco, Obtain old records from previous MD

Electronically signed by Anup Desai MD, MD on 10/22/2019 at 04:34 PM EDT

Sign off status: Pending

10/25/2019 17:47:27 

Patient: Averill, Rose C  
DOB: 10/26/1961

Provider: Anup Desai, MD  
Date: 10/03/2019

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com) This document has been electronically signed by Francis Averill MD

# SAN ANTONIO PLASTIC SURGERY CENTER, P.A.

7950 FLOYD CURL DR., STE. <sup>1009</sup>~~904~~ 78229

OFFICE (210)616-0798

FAX (210)616-0581

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TO:	FROM:
Ross Currell	Jo Ann / Dr P. Fisher
COMPANY:	DATE:
(Patient office)	03/17/2020
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
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RX Date/Time

03/10/2020

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St. Francis  
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# Records Request

To: **Dr Fisher (210)616-0581**Pages: **1** (Including Cover)From: **Christina**Date: **03/10/20**RE: **Averill, Rose**DOB: **10/26/1961**

(Patient's Name)

(Patient's DOB)

	<b>LAB REPORTS</b>		<b>IMAGING REPORTS</b>	<b>X</b>	<b>RECENT VISIT NOTE</b>		<b>SLEEP STUDIES</b>
--	------------------------	--	----------------------------	----------	------------------------------	--	--------------------------

This patient has an appointment on **March 12, 2020**

Notes: **Please provide notes from 08/12/19**  
**and 01/10/20. Thank you!**

**Thank you and have a Blessed day!****CONFIDENTIALITY NOTICE:**

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*Frank Averill MD*



# San Antonio PLASTIC SURGERY CENTER, P.A.

Suite 1009, Medical Center Tower 1 ■ 7950 Floyd Curl Drive ■ San Antonio, Texas 78229 ■ (210) 616-0798 tel ■ (210) 616-0581 fax

**Patient:** Rose Averill

**DOB:** 10/26/1961

**1/10/2020**

**Consultation:** The patient is a 57-year-old lady whom I already consulted with via email and telephone in August. Significantly this patient has severe lipedema diagnosed approximately 2 years ago. She feels that she is probably had this for about 10 years although it is gotten significantly worse over the past 2 years. She feels that it came about after she had a hysterectomy in 2006. She has had 2 C-sections in the past. She remains quite mobile even with the severe lipedema that she has. In October 2019 she had liposuction of the lower legs. 3 L were removed. She unfortunately has quite a bit of swelling from this. Her major issues are her thighs and especially the medial knees which over the past year gotten significantly worse. She also is concerned about her upper arms. She has pain in all these areas. Her general health is excellent. In 1996 she underwent tummy tuck abdominal muscle repair and liposuction of the inner thighs. She has broken the left tibia in 2016 and had torn ACL and left meniscus tear after falling in 2006. She does not smoke. She has no allergies to medications.

**Examination:** She is 5 feet 7 inches tall weighs 292 pounds today. She has obvious lipedema of the thighs with what I believe are large lipomas of the left and right medial knee areas. The left side is considerably larger than that of the right. Well-healed small scars of the lower legs are noted following her liposuction in October of last year. The skin is nice and smooth although there is 1+ pitting edema along the lower leg.

**Impression:** Lipedema of the thighs and upper arms.

**Recommendation:** I recommended as previously discussed going ahead with liposuction of the thighs to be followed at a later date with further liposuction and if possible thigh lift at the same time. Consideration to performing liposuction of the upper arms at some point will be given as well. I have given her a prescription for Lasix to be taken once and possibly twice daily for the next 2 weeks to help reduce swelling in the lower legs.

Peter Fisher, M.D.  
PF

DAVID J. FISHER, M.D.  
Board Certified  
Plastic Surgery

PETER FISHER, M.D.  
Board Certified  
Plastic Surgery



MEMBERS OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS

Rose Averill  
DOB: 10/26/61

Phone Consult 8/12/19

Patient has confirmed diagnosis of Lipedema, stage 3, from Dr. Byrd 1 week ago and also her primary care physician 2 weeks ago. Dr. Fisher does also confirm the diagnosis and agrees most likely stage 3. Patient is interested in treatment with Dr. Fisher's aggressive liposuction technique.

Ms. Averill is 57yrs old, 5'7" and currently 285lbs. She has a history of 2 C-Sections, a tummy tuck with lipo of the inner thighs only in 1996, and she had a full hysterectomy in 2006. Says she did well with anesthesia each time, no problems she can recall. Currently on take supplements and has no allergies to meds. She states that she has been on a keto diet with intermitting fasting for 2 years and says she hasn't really had any weight loss. Patient says she was a very curvy teenager with very large thick thighs and recalls also having stretch marks develop early in childhood. Her mother she feels also had Lipedema even though there was never a diagnosis, says her mother's legs were similar to hers and also had very large "batwings" in her arms. Ms. Averill feels her progression has been at its worst the past few years, noticing that she is experiencing and fatigue as well as her mobility becoming a problem now. She states the swelling by the end of the day is almost intolerable. She says she feels the pain as soon as she wakes up and it continues on for the full day. She is still working, she runs her husband's Pulmonology office for him, but is really struggling.

Dr. Fisher was very up front that she needs multiple surgeries and he most likely will not be able to do them all. The patient carries most of the weight in her hips and thigh area, not much in the calves at all and doesn't show signs of ankle cuffing, though this is from pictures.

Patient is from Florida and brought up a Dr. Su in Florida who typically she says on works on 20 and 30-year old's but has agreed to liposuction her inner knee area and something she calls a "Celebrity Arm Lift". Ms. Averill is also stating she could have Dr. Byrd in Atlanta, GA perform the liposuction on her calves, she really wants Dr. Fisher to be the one to do her thighs. PF though she would need 3 surgeries with the first being hip to knee, second knee to ankle, and quite possibly the 3<sup>rd</sup> as a thigh lift, he isn't sure to say she will NEED a thigh lift, but feels she may WANT a thigh due to so much extra hanging skin that would be left.

Ms. Averill stated that she has family here in the area, a sister in Dallas and friends on Corpus that she can stay with while here or have come to San Antonio and stay here with her. She states again that she really wants Dr. Fisher to be her surgeon. She questioned if she also had Dr. Byrd do her thighs to get a start could Dr. Fisher finish her thighs and do a thigh lift at the same time. He stated he could maybe, it will just depend on how much has been removed and how much would be left for him. He said for now he is only going to quote her for Liposuction of the hip knee for now. He said that he can take a look or she can send photos following other procedures and we can amend the quote as needed. He stated that he was only going to send 1 quote. If there was a chance that a surgeon he is in talks with gives a definite answer and comes aboard to train with him he MIGHT be able to fit her in for a second surgery in Dec 2020, but said there is no guarantee on that and felt if she thought she could get surgery with other physicians she should look into that. She was well aware and verbally stated she understood that currently Dr. Fisher can only do 1 surgery on her. Dr. Fisher went through the compression garment needing to be on for 3-6 months, he prefers 6 months. The patient brought up the vast difference in size of her thighs to her calves and asked how she would find something that would work for her. He said that we can send some things to her for examples, but she may need a custom garment or possibly capri style with full compression thigh highs to put over the capri length. He spoke about the possibility of a blood transfusion and went through the number with her for his patients, 1 in 5 needing one. He confirmed with her that she does accept blood. She does. He brought the risk of bleeding, made sure she understood about dimpling, rippling and excess lax skin. Told her she would be doing nothing for 2 weeks because she will be laying with legs sky high in the air. She laughed and stated she understood everything.

Dr. Fisher asked her if she had any other questions he could answer for her and she said no, just cost. He let her know that Emily, the surgery scheduler, will be emailing her the quote and that if she decided she wanted to schedule she can contact her directly. He mentioned again if she does decide to have surgery with other physicians just to let him know and send updated photos. He also told her he thinks it's a great idea and that he has been impressed with Dr. Byrd's work. She thanked him for calling her. /HM

**ROSE'S MEDICATIONS**

1. PROG 200 MG SR CAP- 1 CAPSULE BY MOUTH 1-2 HRS BEFORE BEDTIME
2. DIM-EVAIL- SERVING SIZE 1 CAPSULE: DIINDOLYLMETHANE 100 MG
3. FISHOIL 675- SERVING SIZE 2 CAPSULES: ULTRA PURE FISH OIL 2554 MG, EICOSAPENTAENOIC ACID 250 MG, DOCOSAHEXAENOIC ACID 1000 MG, OTHER OMEGA 3 FATTY ACIDS 100 MG
4. MULTI NUTRIENTS 2- SERVING SIZE 3 CAPSULES: VITAMIN A 10,000IU, VITAMIN C 425 MG, VITAMIN D 500 IU, VITAMIN E 200 IU, THIAMIN 20 MG, RIBOFLAVIN 7.5 MG, VITAMIN B6 7.5 MG, FOLATE METAFOLIN 200 MCG, VITAMIN B12 250 MCG, BIOTIN 200 MCG, PANTOTHENIC ACID 175 MG, CALCIUM 150 MG, IODINE 112.5 MCG, 137.5 MG, ZINC 7.5 MG, SELENIUM 100 MCG, MANGANESE 3 MG, CHROMIUM 100 MCG, MOLYBDENUM 50 MCG, POTASSIUM 37.5 MG, RIBOFLAVIN 5'PHOSPHATE 5 MG, NIACINAMIDE 55 MG, PYRIDOXAL 5'PHOSPHATE 5 MG, BORON 1.5 MG, VANADIUM 50 MCG
5. MAGNESIUM 150 MG- SERVING SIZE 2 CAPSULES: MAGNESIUM 300 MG
6. RELORA-PLEX – SERVING SIZE 2 CAPSULES: THIAMINE 10 MG, RIBOFLAVIN 10 MG, NIACINAMIDE 10 MG, VITAMIN B6 10 MG, FOLIC ACID 200 MCG, VITAMIN B12 100 MCG
7. SUPER B-COMPLEX – SERVING SIZE 1 CAPSULE: VITAMIN C 60 MG, THIAMIN 25 MG, RIBOFLAVIN 20 MG, NIACIN 25 MG, VITAMIN B6 5 MG, FOLIC ACID 400 MCG, VITAMIN B12 100 MCG, BIOTIN 1000 MCG, PANTOTHENIC ACID 5.5 MG, SODIUM 10 MG
8. ADRENO MEND- SERVING SIZE 2 CAPSULES: A PHYTOCRINE PROPRIETARY BLEND 1020 MG, SENSORIL ASHWAGANDHA EXTRACT 125 MG
9. UBIQUINOL COQ10- SERVING SIZE 1 CAPSULE: 100 MG
10. ADK 10- SERVING SIZE 1 CAPSULE: VITAMIN A 1.5 MG, VITAMIN D 250 MCG, VITAMIN K 500 MCG



# SAN ANTONIO PLASTIC SURGERY CENTER, P.A.

7950 FLOYD CURL DR., STE. <sup>1009</sup>~~904~~ 78229

OFFICE (210) 616-0798

FAX (210) 616-0581

## FACSIMILE TRANSMITTAL SHEET

TO: Att: Natasha	FROM:
St Francis Medical Ctr.	Jo Ann Z
COMPANY:	DATE: 08/28/2020
FAX NUMBER: 727-447-3000	TOTAL NO. OF PAGES INCLUDING COVER: (6)
PHONE NUMBER: 727-210-4600	SENDER'S REFERENCE NUMBER:
RE: Rose Averill	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

operative Report  
Rabs

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DAVID FISHER, M.D.

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# San Antonio PLASTIC SURGERY CENTER, P.A.

Suite 1009, Medical Center Tower 1 ■ 7950 Floyd Curl Drive ■ San Antonio, Texas 78229 ■ (210) 616-0798 tel ■ (210) 616-0581 fax

Patient: Rose Averill  
DOB: 10/26/1961

8/20/2020

**Operative Procedure:**

Suction lipectomy lipedema thighs.

8/28/2020

Is the patient's first postoperative note. She is doing well. She did bleed a lot at the time of liposuction but fortunately never became symptomatic enough to require a transfusion. She has had a lot of pain although today she feels considerably better. Significant swelling is noted with ecchymoses along the posterior lower thigh. The garment is fitting quite tightly. She did start the Lasix and then doubled up on her dose at my request. Although she feels that urine output is not very high it is very clear. She plans on returning back to Florida on Sunday. At this stage she feels she is up for that. She will add compression hose to her lower legs for the trip. Further instructions were discussed with her and her husband who was on the phone with us during this follow-up visit. She will keep me updated on how she is coming along as well as their reduction in swelling. We need to make a decision on what our next surgical plan will be buttock and 90 do that when I see some photos of how her thighs look in approximately 6-10 weeks time.

Peter Fisher, M.D.  
PF

DAVID J. FISHER, M.D.  
Board Certified  
Plastic Surgery

PETER FISHER, M.D.  
Board Certified  
Plastic Surgery



MEMBERS OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS

METHODIST SPECIALTY AND TRANSPLANT HOSPITAL  
8026 FLOYD CURL DRIVE  
SAN ANTONIO, TX 78229

PATIENT'S NAME: AVERILL, ROSE  
DOB: 10/26/61 AGE: 58 SEX: F  
ATTENDING PHYS: Dr. Peter Fisher, MD  
REPORT TYPE: OPERATIVE REPORT

UNIT NO: N00989520  
ACCOUNT NO: N362973236  
PT TYPE: DIS IN  
ROOM NO: N.510

DATE OF ADMISSION: 08/20/20  
DATE OF DISCHARGE: 08/22/20

DATE OF SURGERY: 08/20/2020

TIME OF SURGERY:  
(See anesthesia record.)

PREOPERATIVE DIAGNOSIS:  
Lipedema of the thighs.

POSTOPERATIVE DIAGNOSIS:  
Lipedema of the thighs.

SURGICAL PROCEDURE(S) PERFORMED:  
Suction lipectomy, lipedema thighs.

NAME OF SURGEON:  
Peter Fisher, MD

ASSISTANT(S):  
Matthew Bindewald, MD

ANESTHESIOLOGIST:  
Richard Emery, MD

TYPE OF ANESTHESIA ADMINISTERED:  
General anesthetic.

SPECIMEN(S) REMOVED:  
None.

ESTIMATED BLOOD LOSS:  
600mL

HISTORY:  
The patient is a 58-year-old lady who has developed significant lipedema of the thighs with massive what looked like possibly lipomas of the medial aspects of the knees, worse on the right than the left. The patient has previously had liposuction of the thighs elsewhere, but comes for more aggressive suctioning of the significant lipedema which causes pain and discomfort.

DESCRIPTION OF PROCEDURE:  
The patient was brought to operating suite where following induction of general anesthesia, Foley catheter was placed and the patient was placed on the

PATIENT NAME: AVERILL, ROSE

ACCOUNT #: N362973236

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Patient Care Inquiry \*\*LIVE\*\* (PCI: OE Database COCSN)

operating table in the prone position where she was appropriately positioned, padded, and prepped and draped in standard fashion. Markings were made for multiple stab incisions along the posterior thigh and hip areas. These were infiltrated with 0.25% Marcaine with epinephrine and incised sharply with an 11-blade. Tumescant solution of 1L Ringer's lactate, 1 unit epinephrine was infiltrated using approximately a liter and half. Suctioning was then performed. Of note, the medial knee aspect, specifically on the left side more than the right, bled considerably more. I feel like the most likely reason was that this area was probably an angiolipoma and had considerable amount of vascularity, which the epinephrine was not able to effect. I removed approximately 1750 from the right posterior thigh and 1800 from the left posterior thigh. Incisions were closed with interrupted 5-0 fast absorbing sutures and the patient was then placed on the operating table in the supine position, appropriately positioned, padded, prepped and draped in standard fashion. Again, multiple stab incisions were made over the preoperative marks that I had made; some of them from our old stab incisions where she had liposuction, having infiltrated with 0.25% Marcaine with epinephrine. Once again, same tumescant solution was used, infiltrating approximately 2L into each thigh. Suctioning was then again performed at this time using #4 Mercedes cannula and #3 Mercedes cannula at a more superficial level. Much more aggressiveness was placed around the knees. Again, unfortunately a considerable amount of bleeding was noted in the left medial knee more so than that of the right. This is the reason, estimated blood loss of 600mL. Total of 3600 was removed from the right thigh and 3100 from the left thigh. Both knees and as high up to the hip as possible was wrapped with 6-inch Ace wraps, having closed the incisions with interrupted 5-0 fast absorbing sutures. The patient was given 2.5L of crystalloid, made approximately 200mL of urine. She was now awakened, extubated, transferred to recovery room in stable condition. Her Ace wrappings were removed in recovery room where she remained stable. Hemoglobin obtained in the recovery room, was 13.1.

Peter Fisher, MD

IN: IOP/N.MR/FISPE  
DD: 08/20/2020 2246  
DT: 08/20/2020 2315  
Job #: 5620839  
Cc:

Authenticated by Peter Fisher, MD On 08/24/2020 08:35:36 AM

cpcs rpt#: 0820-0097



PATIENT NAME: AVERILL, ROSE

ACCOUNT #: K362973236

Patient Care Inquiry \*\*LIVE\*\* (PCI: OE Database COCSN)

Electronically Signed by Peter Fisher, MD on 08/24/20 at 0836

PATIENT NAME: AVERILL, ROSE

ACCOUNT #: K362973236

Patient Care Inquiry \*\*LIVE\*\* (PCI: OE Database COCSN)



Report Status: Final

AVERILL, ROSE

Patient Information	Specimen Information	Client Information
<b>AVERILL, ROSE</b> <b>DOB: 10/26/1961 AGE: 58</b> <b>Gender: F Fasting: U</b> <b>Phone: 727.424.3402</b> <b>Patient ID: 10261961RCA</b> <b>Health ID: 8573001399519469</b>	<b>Specimen: TM026439K</b> <b>Requisition: 0002495</b>  <b>Collected: 07/31/2020 / 13:33 EDT</b> <b>Received: 07/31/2020 / 22:16 EDT</b> <b>Reported: 07/31/2020 / 23:12 EDT</b> (* A Copy From)	<b>Client #: Not Given 9999999</b> <b>PETER FISHER MD</b> <b>7950 FLOYD CURL DR</b> <b>STE 1009</b> <b>SAN ANTONIO, TX 78229</b>

**COMMENTS:** FASTING:UNKNOWN

Test Name	In Range	Out Of Range	Reference Range	Lab
BASIC METABOLIC PANEL				TP
GLUCOSE	92		65-99 mg/dL	

Fasting reference interval

UREA NITROGEN (BUN)	13	7-25 mg/dL
CREATININE	0.61	0.50-1.05 mg/dL

For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.

eGFR NON-AFR. AMERICAN	100	> OR = 60 mL/min/1.73m2
eGFR AFRICAN AMERICAN	116	> OR = 60 mL/min/1.73m2
BUN/CREATININE RATIO	NOT APPLICABLE	6-22 (calc)
SODIUM	140	135-146 mmol/L
POTASSIUM	3.9	3.5-5.3 mmol/L
CHLORIDE	100	98-110 mmol/L
CARBON DIOXIDE	27	20-32 mmol/L
CALCIUM	9.3	8.6-10.4 mg/dL
CBC (INCLUDES DIFF/PLT)		
WHITE BLOOD CELL COUNT	4.8	3.8-10.8 Thousand/uL
RED BLOOD CELL COUNT	5.00	3.80-5.10 Million/uL
HEMOGLOBIN	14.4	11.7-15.5 g/dL
HEMATOCRIT	43.3	35.0-45.0 %
MCV	86.6	80.0-100.0 fL
MCH	28.8	27.0-33.0 pg
MCHC	33.3	32.0-36.0 g/dL
RDW	13.6	11.0-15.0 %
PLATELET COUNT	201	140-400 Thousand/uL
MPV	10.0	7.5-12.5 fL
ABSOLUTE NEUTROPHILS	2765	1500-7800 cells/uL
ABSOLUTE LYMPHOCYTES	1608	850-3900 cells/uL
ABSOLUTE MONOCYTES	379	200-950 cells/uL
ABSOLUTE EOSINOPHILS	29	15-500 cells/uL
ABSOLUTE BASOPHILS	19	0-200 cells/uL
NEUTROPHILS	57.6	%
LYMPHOCYTES	33.5	%
MONOCYTES	7.9	%
EOSINOPHILS	0.6	%
BASOPHILS	0.4	%

**PERFORMING SITE:**

TP QUEST DIAGNOSTICS-TAMPA, 4225 E. FOWLER AVE, TAMPA, FL 33617-2026 Laboratory Director: GLEN L HORTIN, MD, PHD, CLIA: 10D0291120

Your request to have a duplicate copy faxed has been acknowledged.  
 Queued to: 12106160581

\* ST FRANCIS SLEEP ALLERGY has requested a copy of this report be sent to you. Ordering Physician: AVERILL, FRANCIS J

## FAX TRANSMISSION COVER SHEET

DATE: 12/12/19 TIME: 11:07

TO: \_\_\_\_\_

FAX #: 727 210 4600

ATTN: DR FRANK AVERILL

**FROM:**

**Marcia V. Byrd, M.D.  
11050 Crabapple Road  
Suite 105-B  
Roswell, GA 30075  
(770) 587-1711  
Fax (770) 518-8810**

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You should receive \_\_\_\_\_ page(s), including this cover sheet. If you do not receive all the pages, please call 770-587-1711.

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Dr. Marcia V. Byrd, M.D.  
11050 Crabapple Rd., Bldg. B  
Roswell, GA 30075  
770-587-1711

DATE: August 30, 2019  
TO: UnitedHealthcare  
FROM: Dr. Marcia V. Byrd, M.D.  
RE: Rose Averill / DOB 10/26/1961 / Member ID #912012181  
POS: 11 (In office)

---

Attached please find documentation and photos for Reimbursement Purposes, for lymph-sparing lipectomy, for above named patient.



Marcia V. Byrd, M.D.  
11050 Crabapple Road, Bldg B  
Roswell, GA 30075  
UPIN: D-29062  
NPI: 1932112703  
Tax ID: 58-1452561

**Letter of Medical Necessity**

Date: August 30, 2019  
To: United Healthcare  
Patient: Rose Averill  
DOB: 10/26/1961  
Member Name: Rose Averill  
Member ID: 912012181

Dear Madame/Sir,

I request that Ms. Averill be covered by insurance for suction assisted protein lipectomy (SAPL). Ms. Averill has lipedema, a disorder of excess fat cells that bind up fluid resulting in gross enlargement of the fat tissue primarily on the legs, arms, buttocks and abdomen. Lipedema is not rare but the diagnosis is not often made. It is also known as the painful fat syndrome and is almost exclusively found in women. The onset is generally puberty, pregnancy, menopause or times of unusual stressors. There may be a familial occurrence as well. Lipedema is often confused with lymphedema, but differs in many ways including lack of involvement of the hands and feet and the pain associated with it. Lymphedema is not painful.

Although therapies such as manual lymphatic drainage, wrapping, compression garments, exercise and diet along with supplemental medications are helpful, they cannot reduce the fat itself. The only definitive treatment currently for lipedema fat tissue is a lymph-sparing procedure via suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is the standard of care in that country. There is literature in regards to lipectomy for lipedema including the articles listed at the end of this letter. SAPL has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction that has also been used in the treatment of lipedema patients, WAL lessens the risk of fluid overload and the osmotic burden on the patient. As a result, WAL enables a safer and more extensive fat removal and treatment of more areas during the surgical procedure which cuts down the total number of procedures needed.

SAPL is Ms. Averill only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her day to day activities, improve her gait and to minimize future morbidities.

Please do not hesitate to contact me if you have further questions.

Sincerely,

Marcia V. Byrd, M.D.

References:

1. Herbst, Karen L. MD, Rare Adipose Disorders Masquerading As Obesity. *ActaPharmacologicaSinica* 2012; 33: 155-72
2. Fife, Ce Et Al. Lipedema: A Frequently Misdiagnosed and Misunderstood Fatty Deposition Syndrome. *Advances in Skin and Wound Care*. 2010. 23: 90.
3. Warren Ag Et Al. Evaluation and Management Of The Fat Leg Syndrome. *Plastic Reconstructive Sj* 2007; 119:12e.
4. Langendoen, Et Al, Lipoedema: From Clinical Presentation To Therapy. *British J Derm* 2009; 164; 5.
5. Rapprich S, Dingler A, Podd M. Liposuction Is An Effective Treatment For Lipedema. *Jddg*, 2011; 9: 33-40.
6. Schmeler W, Hueppe M, Mejer-Vollrath I. Tumescant Liposuction inLipoedema Yields Good Long Term Results. *British J Derm*, 2011; 166:161-168.
7. Stutz Jj, Krah D. Water Jet Assisted Liposuction For Patients With Lipedema: Histologic And Immunohistologic Analysis Of The Aspirates Of 30 Lipoedema Patients. *AesthPlastSurg* 2009; 33:153-162.
8. Stutz, Joseph J, Et Al; Water Jet Assisted Liposuction For Patients With Lipedema. *J International Society Of Aesthetic Plastic Surgery*, 2008; 9: 1-9.
9. Peled Am, Et Al, Long Term Outcome After Surgical Treatment Of Lipedema. *Ann Plastic Surg*; 2012; 68:303.
10. Stutz Jj, Liposuction Of Lipedema For Prevention Of Later Joint Complications. *Vasomed* 2011; 23:1-6.

Marcia V. Byrd, M.D.  
11050 Crabapple Road, Bldg B  
Roswell, GA 30075  
UPIN: D-29062  
NPI: 1932112703  
Tax ID: 58-1452561

Date: 08/30/2019  
To: United Healthcare  
Patient: Rose Averill  
DOB: 10/26/1961  
Member ID: 912012181

Dear Madame/Sir,

Ms. Averill was recently evaluated in our office for treatment of Lipedema.

Lipedema has received a Medical Subject Heading (MeSH) code and application for ICD code is pending. The MeSH code for Lipedema is D065134.

Additional codes applicable are:

R 60.1	General edema
I 89.0	Edema due to lymphatic obstruction
M 79.609	Pain in limbs
R 20.8	Hyperalgesia, hyperpathia
R26.9	Unstable gait

Water Assisted Liposuction (WAL), a lymph-sparing liposuction procedure that has been proven to be the preferred method for removal of the abnormal diseased fat in lipedema patients is the procedure planned. WAL is the only option to stop progression of her disease, to bring her pain under control, to improve her ability to function in her profession as well as at home, improve her gait and minimize future morbidities.

There is no CPT code that adequately describes the removal of abnormal lipedema fat excision during the WAL procedure. However, the CPT code most applicable to WAL is:

CPT codes:

38999 Other procedures for Hemic or Lymphatic System

Attached you will find support material including history & physical, letter of medical necessity and photographs.

Please do not hesitate to contact me if additional information is required.

Sincerely,

Marcia V. Byrd, M.D.  
Voice recognition used to generate this report. Despite my proofreading, this report may contain typographical errors

Marcia V Byrd, M.D.  
11050 Crabapple Road, Bldg B  
Roswell, GA 30075  
(770) 587-1711

### INITIAL EVALUATION

Patient: Rose Averill  
DOB: 10/26/1961  
Date: 08/30/2019

**Summary of the history** 58-year-old female presenting for evaluation and discussion of lymph-sparing lipectomy (WAL) for the treatment of lipedema/lymphedema. She was diagnosed and is followed by

Swelling was noticed around puberty. Pain to light touch, easy bruising and swelling by the end of the day began shortly thereafter. Over the past few years she has also experienced progression of pain in knees bilaterally. She takes NSAID's on a daily basis for pain. She has tried many diet and exercise plans with weight loss noted only in nonaffected areas. She has increasing pain and swelling in the affected areas despite her continued efforts at non-surgical treatments.

**History of Dercum's or Ehlers-Danlos syndrome:** No

**Areas of concern currently:** Legs, arms, abdomen and buttocks

**When and where swelling started:** Swelling began after pregnancies and increased after hysterectomy.

**Are affected areas painful to touch:** Yes

**Average daily pain on a scale from 1 to 10:** 7/10

**Pain level on a 'bad' day:** 9/10

**Is mobility limited?** Difficulty with gait secondary to thickness and heaviness of thighs.

**History of large bruising after slight bumps:** Yes

**Swelling by the end of the day:** Yes

**Pain resulting from contact with clothing:** Yes

**Number of pregnancies:** G2 P2

**Changes after pregnancy:** Reduced ability to lose weight in affected areas, increase pain and difficulty with ambulation.

**Clothing size:** Upper body: M/L Lower body: 3X-4X

**Joint problems:** Torn meniscus bilateral knees, degenerative arthritis in large joints

**Occupation:** C.E.O of Medical Center

**Previous therapies for lipedema/lymphedema:** N/A

Compression Garments

Exercise

Diet

**PMH:** Hyperlipidemia and degenerative joint disease.

**Surgical Hx:** C-sections 1988, 1991, Abdominoplasty with Liposuction of inner thighs 1996, Hysterectomy 2005.

**Medications:** N/A

**Allergies:** No

**FH:** Mother: Lipedema, Heart disease, High cholesterol and Diabetes.

Father: Triple bypass, High cholesterol, High cholesterol, Diabetes and Stroke.

**SH:** Married. No use of tobacco. Drinks 3-4 glasses of wine a year. No exercise.

**The Lower Extremity Functional Scale is 32.** Scores range from 0 to 80. The lower the score the greater the dysfunction. (Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. *Phys Ther.* 1999 Apr;79(4):371-83.)

**PE:**

Vital Signs: BP:165/80 P 74 reg. PO2: 97 BMI 46.4 Ht 5'6 ". WT287.1 lbs. Waist: 46".

Hips:59 1/4" Waist/hip ratio:0.77 Waist/height ratio: 0.69

General: Alert and oriented. NAD. Disproportionate upper and lower body with upper body being much smaller.

HEENT: Normal thyroid. No adenopathy.

Upper back: No dorsocervical fat pad present.

Mid-back: Minimal fat in the bra area without nodularity.

Lower back: Tender nodules and fat in the upper gluteal area.

Upper arms: Small amount of fat in the upper arms without tender nodules.

Forearms: Small amount of fat on the forearm without cuffing.

Hands: Negative for increased fat or tenderness. Stemmer sign negative.

Abdomen: Generalized adiposity. No nodules or tenderness in the abdominal area.

Buttocks: Dimpling in the buttocks, scattered nontender nodules.

Hips: Tender nodules bilaterally.

Thighs: Thick thighs anteriorly and laterally with forward projection with dimpling and tender nodules. Non-pitting edema.

Medial knee: Tender nodules bilaterally. Slight valgus deformity.

Anterior lower leg: Fat pad medially just below the knee with tender nodules. Non-pitting edema

Posterior lower leg: Tenderness of the lower leg to the ankle without cuffing. Non-pitting edema.

Ankle: Thickness at the malleoli.

Feet: No swelling in feet bilaterally. Stemmer sign negative.

**Assessment:** 58-year-old female with late stage 2 lipedema involving the legs and buttocks. Her symptoms of diffuse pain in the soft tissues and marked decrease in mobility have been progressing at a rapid rate over the past couple of years. She is experiencing pain daily, continual enlargement of the affected areas despite diet and exercise and increasing difficulty with ADLs.

**Plan:**

1. Compression garment – Bioflect on a daily basis. To be worn while out of bed.
2. Low-carb diet with ketone monitoring and use of diary.
3. Walk 30 minutes per day. Swimming pool exercises advisable.
4. MLD done by occupational therapist. Advised not to have custom garments made at this time but wait until after surgery.
5. Patient advised to consider lymph-sparing liposuction. Due to the limitations of lidocaine dosing and maximal aspiration of fatty tissue it is estimated that it will require 4-5 water-jet assisted procedures to complete the treatment of her legs and buttocks. The patient understands that lymph-sparing liposuction is done to reduce pain, stop/slow progression and improve ambulation but it is not a cosmetic procedure.

**Discussion:** Lipedema, a disorder of excess fat cells that bind up fluid resulting in a gross enlargement of the fat tissue primarily on the hips, buttocks, legs and arms, is a medical entity originally described by Allen and Hines in 1940 at the Mayo Clinic. It is a MESH term in the National Library of Medicine and an ICD application has been submitted. Lipedema is not responsive to lifestyle changes and grows in such a manner as to impede mobility and damage joints. In lipedema, the lymphatic system is not functioning as well as it should secondary to it being surrounded by inflammatory disease tissues. Patients typically begin to have symptoms at puberty but are rarely diagnosed until they reach more advanced stages. Patients consistently complain of pain in the areas of fat accumulation, easy bruising, limitation of motion and as progression occurs alterations in gait with subsequent need for knee replacement in many cases. While we use palliative therapies to treat the fluid excess including manual lymphatic drainage, wrapping, compression garments, exercise and diet, supplements and medications that bind to receptors on the lymphatics and induce lymphatic pumping, we cannot reduce the fat itself. Ultimately, even if the patient is adherent to palliative protocol, development of lymphedema typically occurs. It is not uncommon for patients to have significant gait dysfunction or inability to ambulate without assistance often requiring joint replacements.

At this time, the only definitive treatment for lipedema is lymph-sparing excision through suction assisted protein lipectomy (SAPL). This procedure has been performed in Germany for over 20 years and is their standard of care. Liposuction works effectively for lipedema to reduce lipedema fat and pain (Cornely et al., 2006; Schmeller et al., 2006; Warren et al., 2007). According to Dr. Staffan Rapprich from Darmstadt Clinics in Germany, whose sole practice is focused on SAPL for lipedema, the treatment is curative (Rapprich et al., 2011, 2012). I consider SAPL medically necessary to prevent progression, reduce the pain, improve the gait and prevent damage to joints. WAL (water jet assisted liposuction) is the preferred method to remove the abnormal fat in lipedema patients. It has been proven to preserve the integrity of the lymphatics and blood vessels when used in accordance with the German devised parameters for lipedema surgery which is crucial to minimize the surgical morbidity and to optimize the short- and long-term results. In addition, in comparison to tumescent liposuction devised by German surgeons for lipedema fat removal 20 years ago, WAL lessens the risk of fluid overload and the osmotic burden on the patient, and thus, enables a more extensive fat removal and a smaller number of procedures than the earlier tumescent method. Cosmetic improvement, if it occurs at all, is just a bonus. **This is not a cosmetic procedure.**

\_\_\_\_\_  
Marcia V Byrd, MD

\_\_\_\_\_  
Date

Voice recognition used to generate this report. Despite my proofreading, this report may contain typographical errors.

Marcia V. Byrd, M.D.  
11050 Crabapple Road, Bldg B  
Roswell, GA 30075  
(770) 587-1711

## OPERATIVE NOTE

Name: Rose Averill

Date: 10/25/2019

Preoperative Diagnosis: Lipedema

Procedure: Lymph-sparing lipectomy utilizing Water-jet assisted Liposuction (WAL), Power assisted Liposuction (PAL), Vaser Liposuction (UAL)

Areas Treated: Calves to Ankles- Bilaterally and Circumferentially

Attending Surgeon: Marcia V Byrd MD

Indications: Progressive pain, swelling and decreased mobility which has been non-responsive to diet, exercise and other non-surgical measures.

Discussion: This lady presents for liposuction for the treatment of Lipedema. This procedure is not cosmetic but is intended to decrease her pain, improve her mobility/gait and prevent progression of the disease.

CPT code: 38999

### Operative Summary:

Written consent was obtained prior to surgery, which included but was not limited to infection, bleeding, hematoma, seromas, asymmetries, contour irregularity, divots in the skin, DVT, pulmonary embolus. The patient understood and agreed to proceed. The patient was taken to the photo room where photos and markings of the areas were made then transferred to the surgical suite and placed supine on the operating table. After appropriate level of IV sedation was obtained the patient was prepped and draped in a sterile manner. The incisions for the liposuction cannulas were injected with tumescent solution with 30g needle then a 2 mm punch biopsy tool was used to make the incisions. Tumescent solution was infiltrated into the areas for lymph-sparing lipectomy. After this was allowed to take effect adipose tissue was then removed from the areas listed above using a combination of WAL, PAL and UAL in a manner to preserve the integrity of the lymphatics. Total extracted was 3500cc with a supernatant of 3200cc. Incisions closed with single mattress stitch of 4-0 plain gut. Dressings and compression garment were applied. The patient was transferred from the operating table to the recovery room having tolerated the procedure without difficulty.

Signature: \_\_\_\_\_  
Marcia V. Byrd, MD

Date \_\_\_\_\_

Voice recognition used to generate this report. Despite my proofreading, this report may contain typographical errors.



**Marcia V Byrd, MD**

11050 Crabapple Road

Roswell, GA 30075

(770)587-1711

Page: 1

12/12/2019

**Patient:** Rose Averill  
2140 Longbow Lane  
Clearwater, FL 33764

**Chart #:** 26651A V0

**Case #:** 5348

**Instructions:**

Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modifier	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
8/30/2019	Office Visit New Patient Lipedema	99205LI		000.00				1	150.00
8/30/2019	Visa/Mastercard payment	VISA						1	-150.00
9/5/2019	Visa/Mastercard payment	VISA						1	-1,000.00
9/13/2019	Visa/Mastercard payment	VISA						1	-1,000.00
10/11/2019	Visa/Mastercard payment	VISA						1	-8,550.00
10/25/2019	Lymph-sparing lipectomy	15879	22 50	R60.1	I 89.0	L92.9	R20.8	1	8,200.00
10/25/2019	Supplies	99070		R60.1	I 89.0	L92.9	R20.8	1	750.00
10/25/2019	IV sedation first 15 minutes	99152		R60.1	I 89.0	L92.9	R20.8	1	250.00
10/25/2019	IV sedation each additional 15	99153		R60.1	I 89.0	L92.9	R20.8	7	350.00
10/29/2019	MLD bilateral	97140		000.00				1	200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-200.00
10/29/2019	Visa/Mastercard payment	VISA						1	-2,000.00

**Provider Information**

Provider Name: Marcia V. Byrd MD  
License: 023141  
Insurance PIN:  
SSN or EIN: 581452561

Total Charges: \$ 9900.00  
Total Payments: -\$ 12900.00  
Total Adjustments: \$ 0.00  
**Total Due This Visit: -\$ 3000.00**  
Total Account Balance: \$ 6,300.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **St.Francis Sleep Allergy & Lung Institute**

**802 N Belcher Road**

**Clearwater FL 337652103**

**Phone: 727-447-3000 Fax: 727-210-4600**

### **Visit Note - Office Visit**

#### **Provider:**

**Performing: Elizabeth Kurman, ARNP-BC**

**Supervising: Francis Averill, MD**

**Encounter Date: Sep 20, 2019**

**Patient: Averill, Rose (AVERO000)**

**Sex: F**

**DOB: Oct 26, 1961 Age: 57 Year 10 Month 3 Week**

**Race: White**

**Address: 802 belcher rd, Clearwater FL 337652103**

**Primary Dr.: Anup Desai, MD**

#### **Insurance:**

**UNITED HEALTHCARE (PP) Insurance ID: 912012181**

**Description: GENERAL**

#### **Chief Complaint:**

\*\*\* lipedema

#### **HPI:**

\*\*\* Pt is a 58 year old female with PMH

Lipedema

Prediabetes

Morbid obesity

Hyperlipidemia

Osteoarthritis of knee joints

allergic rhinitis

Pt presents to have extremities measured for compression garment fitting.

Compression garments are used after lipedema/liposuction surgery

Pt has history of lipedema and has tried various treatments including manual lymphatic drainage, wrapping, diet and exercise

Will have suction assisted protein lipectomy (SAPL) surgery in 10/2019 with Dr. Byrd in Roswell, Georgia

Pt reports that her legs, arms, and abdomen and buttocks are the area of concern  
Affected areas are painful to touch  
Pt rates pain as 7/10  
Pain level on bad day is 9/10  
Mobility is limited because of difficult with gait secondary to thickness and heaviness of thighs  
pt does report easy bruising  
also reports swelling at the end of the day  
Reports joint problems: torn meniscus bilateral knees  
degenerative arthritis in large joints

### **ROS:**

**Lipedema:** Pain, Fatigue, Fluid retention, Sensitive to touch, Easy bruising, Loss of mobility, Joint Pain.

### **Examination:**

**Lipedema:** Bilateral swelling / edema, Fat pads, Ankle cuff.  
\*\*\* Disproportionate upper and lower body with upper body being much smaller  
Tender nodules and fat in the upper gluteal area  
small amount of fat in the upper arms without tender nodules  
small amount of fat in the forearm without cuffing  
hands negative stemmer sign  
hips with tender nodules bilaterally  
thick thighs anteriorly and laterally with forward projection with dimpling and tender nodules  
non pitting edema

### **Diagnosis:**

R60.1      Generalized edema  
I89.0      Lymphedema, not elsewhere classified  
M79.609    Pain in unspecified limb  
R20.8      Other disturbances of skin sensation  
R26.9      Unspecified abnormalities of gait and mobility

### **Plan:**

\*\*\* Keto low carb diet  
walk 30 mins daily  
Water exercise  
MLD therapy

### **CC:**

Dr. Fisher : 01/13/2020

This visit note has been electronically signed off by following providers.

This visit note has been electronically signed off by Francis Averill, MD.

This visit note has been electronically signed off by Elizabeth Kurman, ARNP-BC.

PATIENT  
**Rose Averill**

DOB 10/26/1961  
AGE 62 yrs  
SEX Female  
PRN AR630669

FACILITY  
**Success by Design**  
T (727) 548-0001  
F (727) 258-4865  
9095 Belcher Road  
Pinellas Park, FL 33782

ENCOUNTER  
**Office Visit**

NOTE TYPE HRT Office Visit  
SEEN BY Tami Horner MD  
DATE 08/06/2019  
AGE AT DOS 57 yrs  
Electronically signed by Tami Horner MD  
at 08/06/2019 01:03 pm

---

**HRT Office Visit**

**Current complaints/Side effects:**

Have you had a **hysterectomy**? yes

If no, any **BREAKTHROUGH BLEEDING** since last visit: n/a

**Acne:** ??

**Facial hair:** ??

**Hair thinning/loss:** ??

**Breast tenderness/nipple sensitivity/breast fullness:** ??

**Symptom Relief** (Are you feeling better on hormone therapy?)

feeling somewhat better.

NS and HF were much better and sleep was somewhat better,  
but mostly pain from her legs that wakes her up at night now.

**What has improved most for you?** sleep, HF, NS

**Anything else you would like to discuss this visit?** wants to discuss lipoedema, She has been doing a lot of research and feels like this is her problem with the fat distribution in her lower extremities and why she cannot lose weight and why she had very little response to 4 treatments of exilis.

She states that as a teenager, her lower extremities were always disproportionate to her upper body but that she was very active and kept her weight overall under control. She does remember though having stretchmarks in teens and wondering why she had stretchmarks when girls carrying more weight than her did not.

also, in her 40s she had a knee injury that left her inactive for over a year and that is when she started to put on a tremendous amount of weight and despite extreme efforts, could not seem to lose it.

in the last 18mos she states that the fat deposition on her legs has progressed substantially, and rapidly.

**PLAN:**

based on limited info out there, there are a lot of theories that this primarily effects women and starts after puberty b/c it is estrogen driven. therefore, we will eliminate estrogen from her pellets and if she is going to continue Testosterone, will increase DIM to 300 mg Daily.

will continue progesterone to balance the estrogen that is most likely being produced by fat cells.

She is interested in seeing a surgeon that specializes in this type fat and needs a dx.

based on her history and my exam she is most likely stage 2-3 Lipoedema.

she has phone consults with two different surgeons over the next 2 wks and will get there opinion about continuing prog and testosterone.

**Follow up visit in** 2 ( x ) Weeks ( ) Months.

if continuing T pellets, or 6 mos if just continuing progesterone capsules at night.



























