HSE Lipoedema Consensus Guideline 2026

For the diagnosis and non-surgical management of Lipoedema/Lipalgia Syndrome (LLS)

Lymphoedema Framework National NLF IRELAND

LIPOEDEMA ASSOCIATION OF IRELAND
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HSE consensus guideline for the diagnosis and non-surgical management of Lipoedema/Lipalgia Syndrome (LLS) Policy ☐ Procedure ☐ Protocol ☐ Guideline ☐ Clinical Guideline ☐			
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PUBLICATION INFORMATION
Title:
HSE consensus guideline for the diagnosis and non-surgical management of Lipoedema/ lipalgia Syndrome (LLS)
Topic:
Diagnosis and non-surgical management of LLS
National group:
HSE National Lymphoedema Oversight Group
Short summary:
It is the policy of the HSE to ensure that all patients receive standardised, evidence based assessment and treatment. The diagnosis and treatment for LLS is currently under debate and there is a lack of research to provide definitive evidence. This consensus guideline document is to provide the most current opinions on best practice and will be updated as new evidence is agreed internationally.
Description:
The purpose of this policy is to provide guidance on the assessment and treatment of LLS based on available research and expert opinion.

Contents

1. Planning

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1.1 Overview

The LLS working group was set up in September 2023 to agree the diagnosis and treatment of lipoedema for Irish health services. There is ongoing debate regarding best practice and limited research evidence in LLS to support guidelines. It was agreed that the working group would develop guidelines based on current research and expert opinion which will be reviewed as new information/research is developed.

1.2 Purpose

The purpose of the guideline for the diagnosis and management of LLS is to provide an evidence-based, standardised approach for lipoedema management in Ireland.

1.3 Scope

1.3.1 Target Users

The guideline is a clinical awareness and commissioning resource for clinicians, managers and commissioners, and is a guide for academic development and research in this specialist area.

1.3.2 Target population

For the purpose of this document healthcare professionals (HCPs) are defined as Health and Social Care Professionals (HSCP), Nursing and Medical professionals. This document is aimed at healthcare staff involved in the care of people living with LLS. This population is multi-professional in accordance with the causative factors and sequelae of the wider condition and includes those involved in the physical and mental health management of people living with LLS. Each member of the multidisciplinary team is clinically and professionally accountable for implementing the recommendations relevant to their discipline.

Regional Executive Officer (REO), Clinical Director and health service providers have corporate responsibility for the implementation of the recommendations in this guideline. This guideline is relevant for academic and research institutions for future education and research, as highlighted in the guideline recommendations.

This document is also relevant for service user support and to those who provide specific resource support e.g. Lipoedema Association Ireland.

1.4 Objective(s)

To promote a standardised approach to LLS management across all care settings in Ireland.

1.5 Outcome(s)

It is anticipated that this guideline will enhance or improve patient outcomes, education and research opportunities.

1.6 Disclosure of Interests

No conflicts of interest were declared.

1.7 Rationale/Alignment with HSE National Priorities

It is the policy of the HSE to ensure that patients have standardised, evidence based assessment and treatment. The diagnosis and treatment for LLS is currently under debate and there is a lack of research to provide definitive evidence. This consensus document is to provide the most current opinions on best practice and will be updated as new evidence is agreed internationally.

This document aligns with HSE National Quality Improvement Programme / Lymphoedema National Clinical Programme and the HSE lymphoedema/lipoedema model of care 2019.

1.8 Supporting Evidence

- Health Service Executive (2011) Standards and Recommended Practices for Healthcare Records Management
- Health Service Executive (2016) National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs)
- Health Service Executive (2019) Lymphoedema/Lipoedema Model of Care
- Health Service Executive (2017) Integrated Risk Management Policy

2. Methodology

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2.1 List of Key Questions this National 3PG will Answer

What is current best practice to diagnose LLS?

What is current best practice for the conservative treatment of LLS?

2.2 Describe and Document the Evidence Search

A literature review was undertaken which included national and international publications.

2.3 Describe the Method of Screening and Evidence Appraisal

There is limited research in relation to LLS and the main resources are consensus documents that were reviewed by the group.

2.4 Resource Implications

None

2.5 Attach any Copyright or Permissions Sought

No copyright or permissions are required in relation to this document.

3. Procedure

3.1 Introduction

Definitions of LLS

In recognition that there is no ‘oedema’ in lipoedema, there is an ongoing discussion on what may be a more appropriate term. Lipalgia or lipalgia syndrome have been suggested to reflect that those with the condition often experience pain. However, there is no international consensus as yet. The LLS working group has agreed to use the terminology lipoedema/lipalgia syndrome (LLS) until there is international agreement.

The term lipohyperplasia dolorosa (LiDo) has also been used for lipoedema.

Lipoedema was first described by Allen and Hynes (1940) as “large legs due to the subcutaneous deposition of fat in the buttocks and lower extremities and the accumulation of fluid in the legs”. Lipoedema is a chronic disorder of disproportionate increase in adipose tissue (fat cells) in the legs and occasionally in the arms, almost always affecting women. This fat distribution typically occurs symmetrically, affecting both sides of the body equally. Lipoedema can cause the affected areas to appear disproportionately larger compared to the rest of the body.

Lipoedema is always painful (Faerber, 2024). A non-painful disproportionate symmetric distribution of adipose tissue is known as lipohypertrophy (Faerber, 2024) and this condition is not the subject of this guideline.

It was thought that LLS is a progressive disease but there is no evidence to support this assertion (Bertsch, 2020, Faerber, 2024). Obesity is a chronic progressive disease and where obesity symptoms worsen, lipoedema may be exacerbated.

There is no current severity classification and staging of symptoms has not been defined to date (Faerber, 2024).

Many people living with obesity can have lower limb swelling and it is more common than lipoedema. Where present it is important to manage all 3 chronic conditions i.e. obesity, lipoedema, and obesity-related lymphoedema.

Obesity related lymphoedema is evaluated using a comprehensive approach that integrates clinical assessment and objective measurements. Tissue dielectric/US can also be used.

3.2 Key Characteristics of LLS

- Bilateral and Symmetrical Fat Distribution: LLS primarily affects the hips, buttocks, and arms. Head, neck, trunk, feet, or hands are usually not affected.

- Pain and Tenderness: Individuals with LLS experience pain, tenderness, or a sensation of heaviness in the affected areas. The pain can range from mild to severe.

- Easy Bruising: LLS can make the skin more prone to bruising, and even minor trauma can lead to noticeable bruising in some patients but not all. This is not included the diagnostic criteria.

- Even with significant weight loss in other areas of the body, the lipoedema presentation can remain relatively unchanged in patients not living with obesity.

- Mobility may be affected due to bulk of the legs and/or fat pads on the medial aspect of the knees. This may involve reduced or poor heel to toe strike during walking, flat feet- Genu valgum (knock knees) and/or muscle weakness.

- Lipoedema can impact mental well-being and may co-occur with eating disorders. The potential presence of body image frustration and misdiagnosis indicate the need for clinical assessment, screening for disordered eating and integrated care models.

3.3 Diagnosis of LLS

There are currently no circulating biomarkers facilitating the diagnosis of lipoedema and investigations may be needed to exclude/identify contributing or exacerbating features, especially if weight gain and lethargy are present.

Although hormonal factors are thought to contribute to the disease, there is no evidence that endocrinological/hormone tests will detect any abnormalities. However, multiple research studies are ongoing and may provide further evidence in the future.

Approximately 80-88% of people living with LLS also are living with a high BMI which can make diagnosis difficult (Bertsch, (2020); HSE data (2023). LLS does not cause obesity and it is coincident in this patient cohort. Obesity is a chronic disease resulting from the complex interactions between genetic, environmental, behavioural and social factors. Obesity is defined by excess or dysfunctional fat tissue causing impaired health.

Obesity has historically been classified using body mass index (BMI) which can give false high values in LLS patients due to the fact that the increase in adipose tissue is in the extremities (Brenner, 2023:Faerber, 2024). For this reason the waist-to-height ratio (WHtR) should also be used. A normal (0.4-0.49) WHtR with increased BMI indirectly indicates a disproportionate increase in subcutaneous fat. A WHtR of >0.5 is related to excess body weight and indicative of obesity. **See Appendix 1. on Page 20**

The WHtR has advantages for assessing health risk as it primarily considers abdominal fat, which is more important for assessing health risks.

The waist-to-hip ratio (WHipR) is also indicative of lipoedema and would indicate disproportionate fat distribution. **See Appendix 1. on Page 20**

Diagnosis of LLS is Based on a Number of Factors;

- **Disproportionate Fat Distribution**

  Weight distribution in the body is a key indicator in the diagnosis of LLS and should be used as a diagnostic criteria:

  A waist to height (WHtR) of 0.4 to 0.49 with increased BMI >35Kg/m^2 is indicative of lipoedema.

  A waist to hip ratio (WHipR) of <0.7 is indicative of lipoedema. **See appendix 1. For further information**.

- **Pain**

  Research supports the hypothesis that inflammatory and hypoxic processes are responsible for the pain in lipoedema (Kayserling, 2021). Pain is an indicator of LLS.

- **Weight Loss does not Affect the Limbs with LLS**

  According to Bertsch, (2020), there is neither any scientific nor any empirical evidence for the notion that weight loss does not improve lipoedema. Persistent weight loss leads to a marked improvement in symptoms, and patients' lipoedema can be in remission. Herbst (2012), stated that, although lifestyle changes and bariatric surgery are effective interventions to address the obesity component, these treatments do not routinely reduce the abnormal subcutaneous adipose tissue seen in lipoedema.

  The consensus of the group is that for patients not living with obesity, weight loss may not affect the limbs with lipoedema.

- **Genetic**

  The aetiology of lipoedema is unknown, although genetic inheritance is believed to be a factor, as suggested by patient reports of a positive family history in 60%–80% of cases (Herbst, 2012).

  A family history of lipoedema is indicative of lipoedema.

- **Hormonal**

  The disproportionate increase in weight around the legs usually starts in phases of weight gain that are mostly connected to hormonal changes, such as puberty, pregnancy and menopause (Bertsch, 2020).

  An onset of signs and symptoms of lipoedema at times of hormonal changes is indicative of lipoedema.

  The recommendations from the working group for the diagnosis of LLS based on international consensus:

3.4 Recommendations for Diagnosis of LLS

Recommendation 1. Criteria for diagnosing LLS;

1. Disproportionate adipose tissue distribution

a. Waist to hip ratio of <0.7.

b. A normal WHtR (0.4 to 0.49) with increased BMI >35Kg/m^2 is indicative of lipoedema.

2. Pain/Tenderness on palpation of the fatty tissue.

Pain should be differentiated as heaviness, discomfort, spontaneous pain or pain on pressure. Pain must be assessed as objectively as possible, using a visual analogue scale (VAS) and/or verbal rating scale (VRS).

3. Weight loss does not affect the limbs with lipoedema in patients not living with obesity.

The diagnosis is further supported by a family history of LLS or history of onset in puberty, use of contraceptives, pregnancy and menopause.

Recommendation 2.

If the patient has a BMI>35Kg/m^2 and a WHtR of >0.5 it can be difficult to make the diagnosis of LLS and the accuracy of the WHipR will not be evident. In this case if a patient meets all the other criteria then a diagnosis can be made of obesity with underlying LLS. Referral to an obesity management service should be agreed through the GP with the patient's consent.

Recommendation 3.

A standardised assessment form should be used by all HCP treating people living with lipoedema. (Appendix 2.)

Recommendation 4.

A standardised quality of life tool should be used as part of the assessment e.g. WHOQOL (Appendix 4.)

Recommendation 5.

A database should be kept to record all patient related data and outcomes.

3.5 Treatment of LLS

Principles of LLS management

As with all chronic, long-term conditions, the management of LLS requires a holistic, multi-disciplinary team approach which should include an individualised care plan according to need and person centred treatment goals. The care plan should include management of symptoms including pain, impaired mobility and psychosocial issues as well as assisting and encouraging the patient's ability to self-care. This includes education regarding a healthy lifestyle, physical activity and obesity management.

An empathetic, confidential, person-centred approach to the topic of obesity management is essential. The use of person-first, non-stigmatising language is key. A motivational interviewing structure/supportive conversation is helpful in creating a respectful environment for discussions around lifestyle behaviours. The 5As are recommended to guide conversation.

Ask: Ask permission: "Would it be alright to discuss weight?". Elicit the patient's goals and willingness to make changes.
Assess: Evaluate the patient's current situation, including their weight, diet, and activity levels. Aim to identify root causes, explore medical causes, patient priorities.
Advise: Provide specific, evidence-based advice on healthy eating and physical activity. Speak about benefits and long-term strategies.
Agree: Collaborate with the patient to set realistic and achievable short-term and long-term goals.
Assist: Offer support, resources, and tools to help the patient meet their goals.

See More: https://obesitycanada.ca/wp-content/uploads/2025/03/Canadian-Adult-Obesity-CPG-Appendix-2-5As-Framework-for-Obesity-Management.pdf

Mobility may be affected due to biomechanical changes leading to gait abnormality and/or from muscle weakness. A physiotherapy referral may be appropriate.
Compression therapy can be effective for pain reduction. LLS is not a condition with an oedema component or venous and lymphatic dysfunction so the goal is to reduce symptoms, including pain (Faerber, 2024). As there is no oedema the compression does not need to be graduated. Patients should have a realistic expectation that compression will not reduce the size of the limbs. As compression is for symptom control the selection of compression should be aimed at adherence and efficacy. The lowest pressure should be used that results in symptom improvement (Faerber, 2024).

Psychosocial issues should be considered and appropriate referrals made when necessary through a GP/consultant. People living with LLS should be encouraged to join support groups and to become experts in their condition for supported self-management.

Pain and discomfort symptoms in lipoedema may be improved by complementary therapies.

There is no current research or recommendations on drug therapy for lipoedema.
Due to the fact that pro and anti-inflammatory factors can affect the symptoms of lipoedema, there is some research that an anti-inflammatory and /or ketogenic diet may be effective (Amato, 2020; Cannatero, 2020; Di Renzo, 2012).

3.6 Recommendations for Management of LLS

Recommendation 6.

The recommendations from the working group for the treatment of LLS based on international consensus.

Conservative treatment should include:

1. Weight maintenance

a. It is important that weight is discussed with the patient and support offered in relation to a healthy lifestyle.
b. Referral to a dietitian if indicated.
c. All HCP should be familiar with the 5As and how to advise for a healthy lifestyle.

2. Physical activity

a. Patients should be encouraged to be active as per the WHO guidelines https://www.who.int/news-room/fact-sheets/detail/physical-activity
b. Pool exercise should be encouraged

3. Mobility

a. If mobility is affected then referral to a physiotherapist should be sent for assessment

4. Compression garments (see appendix 3 for guidance).

a. Compression garments should be offered to all patients for pain control.
b. Graduated compression is not required when there is no oedema
c. Initial compression should be active wear for aesthetic reasons and comfort if effective for symptom reduction.
d. If active wear is not improving symptoms then low level pressure compression should be used and gradually increased as needed.
e. The type of compression garment and compression class is based on individual need and should be assessed by a HCP competent in compression garment assessment.

5. Psychosocial support should be included in the treatment plan when indicated, including referral to support groups.

Further information and support for patients can be found at;

https://www.lipoedemasupportnetworkireland.ie

All patients should be encouraged and supported to adopt healthy lifestyle changes and resources supplied to the patient e.g. Make Every Contact Count (MECC)

https://www.hse.ie/eng/about/who/healthwellbeing/making-every-contact-count/;

Talking about weight guideline: www.hse.ie/eng/about/who/cspd/ncps/obesity/programme-resources/hse-talking-about-weight-guide-final-6.pdf

3.7 Specific Roles and Responsibilities

Senior Managers:
- Assign personnel with responsibility, accountability, and autonomy to implement the guideline
- Ensure local policies and procedures are in place to support its implementation
- Facilitate education to all relevant clinical staff to ensure they have the knowledge and skills to implement the guideline
- Monitor the implementation of this guideline
- Ensure audit processes are in place

Heads of Department:
- Ensure all relevant staff members are aware of this guideline
- Ensure staff are supported to undertake education programmes and related training as appropriate

All Clinical Staff:
All clinical staff should comply with this Guideline and related policies, procedures and protocols. Clinical staff should adhere to their professional scope of practice, guidelines, and maintain competency. In using this guideline, clinicians must be aware of the role of appropriate delegation. Refer to Appendix V for a copy the signature sheet. This should be signed to record that all clinicians have read, understood and agree to adhere to this guideline.

4. Consultation

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4.1. Stakeholder Involvement

Stakeholders included representatives from National Lymphoedema Framework Ireland, MLD Ireland, Lipoedema Association Ireland and the HSE.

4.2. External Review

An external review was completed by the National Lymphoedema Partnership and the British Lymphology Society.

5. National Implementation Plan

National 3PG Title: HSE consensus guideline for the diagnosis and management of LLS
Date National 3PG Approved: ____/____/_____
Expected Date of Full Implementation: 01/10/2026
National 3PG Implementation Lead: Kay Morris

The implementation team is the same as the development team

Implementation Action	Implementation Barriers/ Enablers	List of Tasks to Implement the Action	Lead Responsibility For Delivery Of The Action	Expected Completion Date	Expected Outcomes
Dissemination to all stakeholders		Email Available on HSE web page	Kay Morris	**Q2 2026**	HCP aware of best practice for the treatment of lipoedema
Webinar for HCP		Organise Webinar GP tool kit	Kay Morris	**Q2 2026**	HCP aware of best practice for the treatment of lipoedema
Education for Patients		Organise Webinar	Kay Morris	**Q2 2026**	Patients are aware of treatment and expectations
Education for Patients		Patient information booklets	Kay Morris	**Q2 2026**	Patients are aware of treatment and expectations

Education/Training Required to Implement the National 3PG:

Resources on hse.ie/lymphoedema, Webinar training, patient and service user information leaflets, audit tools, conference, patient pathways, GP toolkit.

Adapted from National Clinical Effectiveness Committee (NCEC) Implementation Guide and Toolkit (Department of Health 2018)

6. Governance and Approval

6

The diagnosis and treatment for LLS is currently under debate and there is a lack of research to provide definitive evidence, it was agreed through the National Lymphoedema Oversight Group that a consensus document was required to ensure a standardised approach and ensure patient safety.

This document was commissioned by Geraldine Crowley, AND, and the oversight of the Development Group is through the NLOT.

Approval will be through the CCO.

7. Communication and Dissemination Plan

7

This guideline will be disseminated as soon as it has been completed. The following activities will be undertaken by the HSE to ensure all relevant stakeholders are informed of the updated guidelines:

- Utilise the master list of all relevant stakeholders
- All relevant stakeholders to receive a copy of the guideline (insofar as is possible)
- Use of communication links including healthcare organisations, professional bodies, associated charitable bodies and educational groups and education webinars.
- The identification of local champions to promote the new guideline
- Uploading the policy to relevant webpages
- Dissemination via LLS groups and special interest organisations

8. Sustainability

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8.1. Plan for National Monitoring and Audit

Each service will maintain a database and share with the National Lymphoedema Oversight Group.

The LLS tool will be completed annually and reported to the NLOT for review.

Services external to the HSE can use the audit tool and report to the their governing body.

8.2. National Audit Tool

LLS audit tool, Appendix 7.

9. Review/Update

9

9.1 Next Review Date

1st June 2027.

10. References

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11. Glossary of Terms

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AND	Assistant National Director
BMI	Body Mass Index
CCO	Chief Clinical Officer
GP	General Practitioner
HCP	Healthcare Professionals
HSE	Health Service Executive
LiDo	Lipohyperplasia dolorosa
LLS	Lipoedema/lipalgia syndrome
MEEC	Make Every Contact Count
NLOT	National Lymphoedema Oversight Team
REO	Regional Executive Officer
WHtR	Waist to Height Ratio
WHipR	Waist to hip Ratio

12. Appendices

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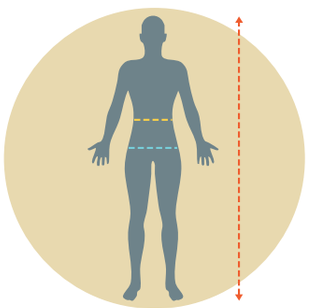
1. Waist to Hip Ratio/Waist to height Ratio
2. Lipoedema Assessment form
3. Compression garment advice
4. Membership of the development group
5. Membership of Approval Governance Group
6. Conflict of Interest Declaration From
7. National Implementation Plan
8. National Audit Tool
9. Checklist

Appendix 1: Waist to Height Ratio (WHtR) and Waist to Hip Ratio (WHipR)

All ratio's are a guideline and should be considered with the overall clinical presentation.

$$\textbf{WHtR} = \frac{\text{Waist Circumference}}{\text{Height}} \qquad \textbf{WHipR} = \frac{\text{Waist Circumference}}{\text{Hip Circumference}}$$

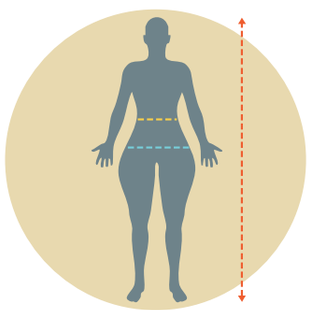
Average



WHtR: Normal: 0.4 - 0.49

WHipR: Normal: <0.8

Lipoedema

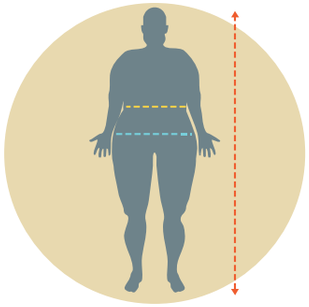


WHtR: Normal: <0.5

WHipR: <0.7

But BMI may be >35

Obesity



WHtR: >0.5

WHipR: >0.85

Waist to Hip Ratio

The waist to hip ratio (WHipR) is a dimensionless ratio of the circumference of the waist to that of the hips, used as a body shape indicator and a measure of health risks.

The waist to hip ratio is an indicator obtained by dividing the circumference of the waist to that of the hips and it is often used to evaluate abdominal fat distribution. WHipR (W:H) = Waist circumference / Hip circumference.

Where both are in the same measurement unit, whether English (inches) or Metric (centimetres).

Taking the Measurements

According to WHO data gathering advice, the waist circumference should be measured at the midpoint between the lower margin of the last palpable ribs and the top of the iliac crest, using a stretch-resistant tape.

Waist measurement can be also taken at the navel but research has shown these tend to underestimate true waist circumference.

Hip size should be measured around the widest portion of the buttocks, with the tape parallel to the floor.

The individual is also advised to stand, arms at the side and body weight evenly distributed during the measurements. Each measurement should be repeated twice. In cases when there is within 1cm (0.4 inches) difference between the measures, the average should be recorded.

Waist to Height Ratio

The waist to height ratio (WHtR) is an indicator obtained by dividing the circumference of the waist to that of the height and it is often used to evaluate abdominal fat distribution.

The waist measurement is taken as for the WHipR and this is then divided by the height.

Appendix 2. Assessment Form

Lipoedema/lipalgia Syndrome Assessment Form & Treatment Plan

Name: _____

Date of Birth: ____/____/_____ Age: _____

Address: _____

Phone: _____

Mobile: _____

GP: _____

GP Phone: _____

Consultant Name, Location and Specialty: _____

_____

_____

_____

_____

_____

Medical Card Number (If Applicable): _____
__

Professionals Chart Sign In

Name	Discipline	Contact Details	Initials	Signature

Consent for Treatment/Photography and GDPR:

Client Name: _____

Address: _____

Date of Birth: ____/____/_____

In view of the explanation given to me by:

i. I consent to Clinical Assessment and Treatment. ☐

ii. I have signed and received GDPR information. ☐

iii. I consent to my record of assessment and clinical being shared with my health care provider and Consultants as appropriate. ☐

iv. I Consent to Photographs being taken purely for my lipoedema care record and these photos to be shared with my Primary Care Team and consultants as appropriate– should it be desired to share these photographs/ recordings in any other way e.g. Medical textbook/online teaching resource your clinician will seek specific permission to do so. ☐

v. **I understand that I can decide to terminate treatment at any stage.** ☐

Signature of Parent/Guardian: _____

Date: ____/____/_____

Lipoedema/Lipalgia Syndrome Assessment

History of LLS

• Location • Progression • Previous Management • Aggravating/Relieving Factors •

Family History: Yes/No

History of Onset: _____

_____

_____

Related to time of Onset?: Yes/No

Comment: _____

• Puberty

• Starting Contraceptives

• Pregnancy

• Menopause

Patients Perception of their Condition: _____

Ethnicity: _____

Symptom	Yes/No	Comment
Functional Restriction		
Heaviness		
Pain on Palpitation		

Vas	
0	10

Weight:

Question	Yes/No	Comment
History of Weight Concerns		
Diet History		
Response to Dieting in the Affected Areas		
Eating Disorders (Anorexia Nervosa/Bulimia/Binge Eating Disorder / Other)		

Past Medical History: (Yes/No)

Surgery		Varicose Veins	
Sleep Apnoea		Renal Disease	
Heart Disease		DVT/VV	
Phlebitis		PE	
Hypertension		Cellulitis	
Thyroid		Skin Disorder	
PVD		Rheumatoid	
PAD		Lymphoedema	

Medication:

Investigations:

Social History:

Occupation:	
Hobbies:	**Smoker:** Yes/No
Accomodation: (Including Type, Access, Stairs, Bathroom/Toilet etc.)	
Sleeps In: Bed Chair	
Services/Carer Support:	
Functional Limitation:	

Current Activity Level: Add the numbers from the type of job and hours of exercise per week to give the overall activity level result.

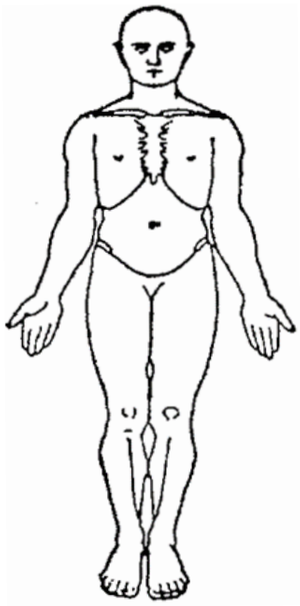
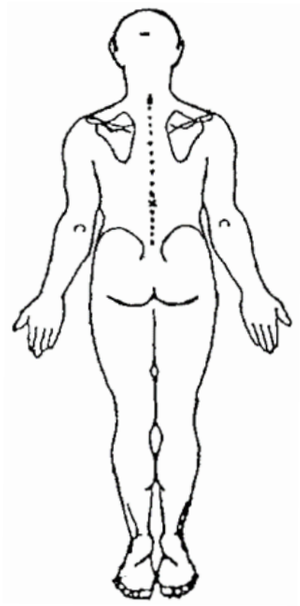
Type of Job:		**Hours of Exercise Per Week:**		**Activity Level Result:**	
Very Sedentary	**1**	0-1 Hours per Week	**1**	**2-3**	Sedentary Lifestyle
Sedentary	**2**	1-2 Hours per Week	**2**	**4-5**	Slightly Active
Moderately Active	**3**	2-3 Hours per Week	**3**	**6-7**	Moderately Active
Active	**4**	3-4 Hours per Week	**4**	**8-9**	Active Lifestyle
Very Active	**5**	5+ Hours per Week	**5**	**10**	Very Active Lifestyle

Height (m)	Weight (kg)	WHipR (<0.7 indicative of LLS)	BMI (kg/m$^{2)}$	WHtR

Objective Assessment:

Posture:	
Gait:	

Observations/Palpation:

	Observations/Palpation ✓ Present ✗ Absent Include key for body chart as necessary		 
	Disproportionate Weight/Adiposity		
	Broken Skin (Site)		
	Fat Pads Knees/Thighs		
	Ankle/Wrist Cuffing		
	Cellulitis		
	Discolouration		
	Fibrotic		
	Fungal Infections		
	Pitting Oedema		
	Scarring		
	Skin Folds		
	Pain on Palpation		
	Skin Changes; Peau D'Orange		
	Lipodermatic Sclerosis		
	Stemmer	+ve -ve	
	Bruising		

ROM:

Upper Limb	0% - 100% (Observed ROM with 100% being Full Range)	Lower Limb	0% - 100% (Observed ROM with 100% being Full Range)
Shoulder		L/Spine	
Elbow		Hip	
Wrist/Hand		Knee	
		Ankle	

Functional Assessment Measure: ✓ or ✗

	Bed Bound (Leave Blank Unless Affecting Patient)		Mobile Independent with Aid
	Wheelchair User		Mobile Independent without Aid
	Mobile with Assistance		

Diagnosis:

Lipoedema/Lipalgia Syndrome	Yes	No
WTHip ratio of <0.7 A WTH Ratio of <0.5 is Considered Normal		
History of onset Puberty, Starting Contraceptives, Pregnancy, Menopause		
Family History		
Pain and Tenderness on Palpation		
Weight Loss not Affecting the Limbs with Lipoedema		

If the BMI>35 the WTH ratio will not be evident. In this case if a patient has all the other criteria then a diagnosis can be made of obesity with underlying LLS.

Problem List: ✓ or ✗ **Discussed and agreed with Patient: Y** or **N**

Altered Limb Shape		
Reduced Activity/Exercise		
Skin Changes		
Poor Knowledge of Lipoedema		
Decreased Range of Movement		
Weight Management		
Pain		
Decreased Strength		

Problem List: ✓ or ✗ **Discussed and agreed with Patient: Y** or **N**

Increase Knowledge of Lipoedema		
Independent with exercise programme		
Improve skin integrity		
Patient able to Carry Out Skincare Regime		
Improve AROM UL/LL		
Weight Maintenance		
Patient able to carry out Skincare Regime		
Improve Strength UL/LL		
Maintain Stable Lipoedema		
Patient able to Don/Doff Garments		

Treatment Plan: ✓ or ✗

	Treatment	Comment
	Weight Maintenance Advice	
	Activity/Exercise	
	Compression Garment Provision	
	Healthy Lifestyle Resources MECC	
	Skin and Nail Care	

Compression Garment:

	Class	Body Part	Size	Make
Off the shelf				
Made to Measure				
Active Wear				

Onward Referral: ✓ Relevant Categories

	Activity Resources		Obesity Clinic		Vascular		Dermatology
	Physiotherapy (Elsewhere)		Occupational Therapy		Psychology - through GP		Wound Care/ Tissue Viability
	Podiatry		Social Work		Dietetics		Nurse
	GP						

Analysis:

Plan:

Specify Review Period: _____ (6 Months, 1 Year)

Additional Comments:

Appendix 3. Compression Garment Guidance

Compression Garment Fitting

- Check that the garment fits well, e.g. does not dig into tissues, particularly at the ankles and knees.
- Demonstrate to patients and carers how to don and doff the garment or device including how to spread the fabric evenly, and help them to practise doing the same.
- Advise on application and removal aids — the use of an applicator, along with closely fitting rubber gloves and non-slip matting, is often invaluable; many application and removal aids are available on prescription.
- Educate the patient and carers about when to remove the garment and who to contact if there are problems — signs that indicate compression should be removed immediately include increased pain, numbness, pins and needles or discoloured digits.
- Manage expectations — explain that compression/containment is not a cure and, unless oedema is present will not reduce limb size, but may improve limb outline and improve symptoms.
- Explain care of the garments — the manufacturer's recommendations should be followed: some garments/devices can be machine washed but others need to be hand washed; in general, harsh detergents and fabric softener should be avoided, and the garment/device should be air dried rather than tumble dried.
- Discuss short-term and long-term review and renewal schedules — generally compression garments need to be replaced on average every 6 months.

Appendix 4. Lipoedema QoL Tool

Instructions:

This questionnaire asks how you feel about your quality of life, health, and other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the **last two weeks**.

The Questionnaire:

Please read the question, assess your feelings **over the last two weeks** and **circle the number** on the scale for each question that gives the best answer for you.

Part A- Generic Questions

1	Very Poor	Poor	Neither Poor/Good	Good	Very Good
How Would you Rate the Quality of Your Life?	1	2	3	4	5

2	Very Dissatisfied	Dissatisfied	Neither Dissatisfied/ Satisfied	Satisfied	Very Satisfied
How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the **last two weeks**.

3-9	Not at All	A Little	A Moderate Amount	Very Much	An Extreme Amount
To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
How much do you enjoy life?	1	2	3	4	5
To what extent do you feel your life to be meaningful?	1	2	3	4	5
How well are you able to concentrate?	1	2	3	4	5
How safe do you feel in your daily life?	1	2	3	4	5
How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you have experienced or were able to do certain things in **the last two weeks**. **Circle your best answer number**.

10-15	Not at All	A Little	A Moderate Amount	Very Much	Extremely
Do you have enough energy for everyday life?	1	2	3	4	5
Are you able to accept your body appearance?	1	2	3	4	5
Have you enough money to meet your needs?	1	2	3	4	5
How available to you is the information you need in your day-to-day life?	1	2	3	4	5
To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
How well are you able to get around physically?	1	2	3	4	5

The following questions on the next page ask about **how good or satisfied** you have felt about aspects of your life over the **last two weeks**.

16-25	Very Dissatisfied	Dissatisfied	Neither Dissatisfied/ Satisfied	Satisfied	Very Satisfied
How satisfied are you with your sleep?	1	2	3	4	5
How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
How satisfied are you with your capacity for work?	1	2	3	4	5
How satisfied are you with yourself?	1	2	3	4	5
How satisfied are you with your personal relationships?	1	2	3	4	5
How satisfied are you with your sex life?	1	2	3	4	5
How satisfied are you with the support you get from your friends?	1	2	3	4	5
How satisfied are you with the conditions of your living place?	1	2	3	4	5
How satisfied are you with your access to health services?	1	2	3	4	5
How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

26	Very Poor	Poor	Neither Poor/Good	Good	Very Good
How often do you have negative feelings such as blue mood, despair, anxiety or depression?	1	2	3	4	5

Psychological	
Physical	
Social	
Environment	
6 Minus the Score (Reverse Score)	

Appendix 5. Membership of Approval Governance Group

Membership of Approval Governance Group	
Name	**Role and Position**
Dr David Hanlon MB BCh DCH MICGP IMC	HSE (National Clinical Advisor and Group Lead), NCAGL Primary Care
Add additional lines as required	

Sign-off by Chair of Approval Governance Group

The clinical guideline for the diagnosis and conservative management of LLS was formally ratified and recorded in the minutes of the Approval Governance Group signed of 27/06/2026.

Name: (Print)	
Title:	
Signature: **(E-Signatures Accepted)**	
Registration Number: **(If Applicable)**	

Appendix 6. Conflict of Interest Declaration Form

CONFLICT OF INTEREST DECLARATION FORM

This form must be completed by each member of the Development Group.

Title of National 3PG being considered:

Please indicate the statement that relates to you

I declare that **I DO NOT** have any conflicts of interest ☐

I declare that **I DO** have a conflict of interest ☐

Details of Conflict: (Please refer to specific National 3PG) *(Append additional pages to this statement if required)*

Signature: _____

Print Name: _____

Registration Number (If Applicable): _____

Date: _____

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that Development Group act in the best interests of the members. The information provided will not be used for any other purpose.

A person who is covered by this National 3PG* is required to furnish a statement, in writing, of:

i. The interests of the person, and

ii. The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

*policy, procedure, protocol or guideline.

Appendix 7. National Implementation Plan

National 3PG Title: HSE consensus guideline for the diagnosis and management of LLS
Date National 3PG Approved: 27/06/2026
Expected Date of Full Implementation: 01/10/2026
National 3PG Implementation Lead: Kay Morris

The implementation team is the same as the development team

Implementation Action	Implementation Barriers/ Enablers	List of Tasks to Implement the Action	Lead Responsibility For Delivery Of The Action	Expected Completion Date	Expected Outcomes
Dissemination to all stakeholders		Email Available on HSE web page	Kay Morris	**Q2 2026**	HCP aware of best practice for the treatment of lipoedema
Webinar for HCP		Organise Webinar GP tool kit	Kay Morris	**Q2 2026**	HCP aware of best practice for the treatment of lipoedema
Education for Patients		Organise Webinar	Kay Morris	**Q2 2026**	Patients are aware of treatment and expectations
Education for Patients		Patient information booklets	Kay Morris	**Q2 2026**	Patients are aware of treatment and expectations

Education/Training Required to Implement the National 3PG:

Resources on hse.ie/lymphoedema, Webinar training, patient and service user information leaflets, audit tools, conference, patient pathways, GP toolkit.

Adapted from National Clinical Effectiveness Committee (NCEC) Implementation Guide and Toolkit (Department of Health 2018)

Appendix 8. National Audit Tool

LLS Audit tool.

Methodology

Population: All patients With LLs

Sampling: A total of 10% or 10 target users, whichever is greater, should be selected.

Frequency: To be determined locally at least annually

Method: Record **Y** for **Yes**, if the criteria are met. Record **N** for **No**, if criteria are not met or **N/A** for **Not Applicable**.

Compliance requirement: 100%

Is standard/criteria being met for the following statements:	Yes	No	N/A	Evidence
Statement 1 The standardised assessment form is used to assess all patients with LLS				
Statement 2 The QoL tool is being used for all LLS patients on initial assessment, 6 month and 12 month reviews.				
Statement 3 All patients are given the HSE Lipoedema patient information booklet				
Statement 4 WHtR is included in all assessments				
Date of Audit: Audited by (name/title): Compliance Rate %:				
Calculation of Compliance Rate %: The score, expressed as a percentage, is calculated by dividing the number of "yes" and "no" answers. "Not applicable" answers are excluded from the calculation of the percentage score. **Example:** If there are 6 "yes" and 2 "no" answers, the score is calculated as follows: 6 (yes answers) divided by 8 (total of yes and no answers) multiplied by 100 = 75%				

[Your Checklist does not need to be published with your National 3PG, but should be held in the 'master file' by the Document Owner]. [This is the responsibility of the chairperson of the Development Group]

Checklist for Best Practice in Developing HSE National 3PGs		
Stage 1	**Deciding the need**	
	Aligned with HSE National Priorities	
	Clearly Defined Document Type (P,p,p Or G)	
	Approval Obtained To Develop	
Stage 2	**Planning**	
	Governance Clearly Established	
	Appropriate Stakeholder Involvement	
	Defined In-scope And Out-of-scope	
	Development Group (Terms Of Reference/conflict Of Interest Forms)	
Stage 3	**Development**	
	Evidence Methodology Based	
	Creation Of Guidance/Recommendations	
	Explicit Link Between The Evidence To Guidance/Recommendations	
	Circulated For National Consultation/Independent Expert Review (As Required)	
	Audit Tool Developed	
Stage 4	**Implementation**	
	Implementation Plan Completed/Team Established	
	Communication And Dissemination Plan Developed	
	Supports: Advice, Tools, Resources Developed And Where To Access	
Stage 5	**Sustainability**	
	Monitoring And Audit Plan Outlined	
	Audit Outcomes: Structure In Place To Link To Quality Improvement And Risk Management Processes	
Document Control		
	Mandatory Pages 1+2 Of This Template Are Fully Completed	

Chairperson Name:	**Title:**
Signature: (e-signatures accepted)	
Registration number: (if applicable)	**Title:**
Date:	____/____/_____

Appendix 9. Membership of Development Group

Membership of HSE Consensus Guideline for the Diagnosis and Management of LLS	
Name	**Role and Position**
Kay Morris	Chair
Mary Paula Colgan	National Clinical Lead
Mona Wise	Lipoedema Association of Ireland
Siobhan Casey	MLD Ireland
Norah Kyne/Meadbh McSweeney	National Lymphoedema Framework Ireland
Thelma Dunne	HSE, Lymphoedema Specialist
Noelle McMahon	HSE, Lymphoedema Specialist
Kat Reid	HSE, Lymphoedema Specialist
Emer O'Malley	HSE, Centre for Obesity Management
Benjamin Bullen	Podiatry Lecturer, University of Galway
Karen Gaynor	HSE, Obesity Clinical Programme

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