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# LIPEDEMA AS A DIAGNOSTIC CHALLENGE: A NARRATIVE REVIEW OF CLINICAL PRESENTATION, DIFFERENTIAL DIAGNOSIS AND PSYCHOSOCIAL CONSEQUENCES FOR WOMEN

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**ABSTRACT**

Lipedema is a chronic, progressive disorder of subcutaneous adipose tissue that predominantly affects women. It is characterised by symmetrical, bilateral and disproportional subdermal fat agglomeration of lower and upper limbs sparing the hands and feet. Main lipedema symptoms are pain, heaviness in the affected areas, easy bruising and hypersensitivity to touch. The diagnosis of lipedema remains challenging. It is often misdiagnosed as obesity or lipedema due to lack of knowledge about this condition, and absence of standardized diagnostic criteria. Apart from clinical manifestation it is crucial to highlight that lipedema significantly affects patients quality of life. Patients emphasize that lipedema affects their daily functioning, causes mobility problems, and impacts their relationships with others. They often face stigmatizing comments about their body shape and are frequently told that they are lazy and should lose weight, despite the fact that weight loss does not reduce excess adipose tissue in the affected areas. Furthermore, lipedema is associated with an increased risk of depression, anxiety, and eating disorders. Therefore, increasing awareness of the disease, distinguishing it from obesity and lymphedema, and enabling timely diagnosis and treatment are essential to improve patients' quality of life and daily functioning.

**KEYWORDS**

Lipedema, Pain, Differential Diagnosis, Psychosocial Impact, Awareness of Lipedema

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## Introduction

Lipedema is a chronic, progressive condition that most entirely concerns women. This adipose tissue disorder is marked by a disproportional and symmetrical increase in subcutaneous fat agglomeration. It mainly affects lower and upper extremities sparing the hands and feet, causing body asymmetry [1]. It was described for the first time by Allen and Hines in 1940 [2]. The onset of lipedema is typically associated with hormonal changes throughout puberty, pregnancy, or menopause [3]. Patients commonly present with pain and heaviness in the affected areas, hipersensitivity to touch, and increased tendency to bruise. Moreover, lipedema can cause major psychological distress [4].

In 2019 lipedema was listed in ICD-11 in the category "*Certain noninflammatory disorders of subcutaneous fat*" as a separate clinical entity [5]. Although there is an increasing awareness of lipedema it still remains underdiagnosed by health care providers. It is often misdiagnosed as lymphedema, obesity and venous insufficiency. Therefore, it is crucial to distinguish these disorders to accomplish proper diagnosis [6,7]. The diagnosis of lipedema remains challenging due to the fact that there is no validated biomarker or broadly used diagnostic tool. Diagnostics require comprehensive knowledge and relies on clinical examination and medical history [7,8]. Lipedema significantly influences quality of life through physical, emotional, and social activity [7]. Most patients suffering from lipedema express trouble with acquiescing their body shape [9]. This conditon also elevates the risk of depression, anxiety and eating disorders [7,10, 11]. The psychosocial impact and progression of the disease is aggravated by difficulty in diagnosis leading to delay or even lack of appropriate treatment [7,12].

The aim of this narrative review is to highlight diagnostic difficulties, delineate differential diagnoses and present psychosocial burden of diagnostic delay.

**Methodology**

A narrative literature review was conducted using the PubMed, Google Scholar databases and additional sources including consensus and national guidelines. The search combined the disease terms lipedema, lipoedema with differential diagnosis, obesity, lymphedema, delayed diagnosis, psychosocial impact, depression, anxiety, eating disorders, quality of life. Publications were screened with particular attention to clinical features, differential diagnosis, psychosocial impact and consequences of delayed recognition.

**Discussion**

**1. Clinical Presentation**

Lipedema is always associated with pain (pressure and spontaneous). It affects extremities including the legs from hip to lower legs and arms from shoulder region to forearms. A disproportional and symmetrical rise in subcutaneous adipose tissue among limbs without pain, sensitivity and feeling of heaviness shall not be recognised as lipedema [13]. Lipedema is marked by distinct demarcation at the ankles generally known as the "cuff sign" while the feet and hands remain untouched [7,8,14]. Pain is related to physical disability and has a negative effect on patients' everyday activity and basic mobility [15,16]. Common manifestations of the disease frequently deteriorate throughout the day, especially with long-standing or heat exposure [8]. Joint hypermobility syndrome, known as a connective tissue disorder, is suggested to be a comorbid disease as it has been reported among 58% of patients with lipedema [17]. Moreover, lipedema may appear through non-pitting edema, teleangiectasias and patients are prone to bruising due to subdermal capillary fragility [8, 14,18]. There are five types of the disease based on distribution of fat presented in Table 1 [7]. Lipedema advances through four clinical stages shown in Table 2 [8]. Overall, disease advancement is heterogeneous and individual. Some patients suffer from mild lipedema while others present slow, gradual progression of this condition. Abrupt exacerbations are stress-induced, caused by situations like surgery or pregnancy [19].

**Table 1.** Classification of lipidemia by type and affected areas.

| Type | Description |
|---|---|
| I | Increased fat deposits in the thighs, hips, and glutes |
| II | Involves the knees with a fat pad in the internal zone |
| III | Reaches down to the ankles |
| IV | Involves the upper limbs |
| V | Involves only the lower legs |

Reference: Mortada, H., Alhithlool, A. W., AlBattal, N. Z., Shetty, R. K., Al-Mekhlafi, G. A., Hong, J. P., & Alshomer, F. (2025). Lipedema: Clinical Features, Diagnosis, and Management. *Archives of plastic surgery*, *52*(3), 185–196. https://doi.org/10.1055/a-2530-5875

**Table 2.** Clinical stages based on morphological changes

| Stage | Description |
|---|---|
| Stage I | Smooth skin surface with thickened but soft subcutaneous tissue containing small nodules; tissue has a spongy consistency |
| Stage II | Uneven skin surface due to larger nodules and the presence of fibrotic tissue; often associated with the "mattress phenomenon" (dimpled appearance) |
| Stage III | Significant fibrosis and hardening of the subcutaneous tissue; presence of large, disfiguring fat lobules, particularly in the thighs and knees, with overhanging masses |
| Stage IV | Development of the secondary lipo-lymphedema, characterized by combined fat deposition and lymphatic dysfunction, leading to swelling and edema |

Reference: Dal'Forno-Dini, T., Birck, M. S., Saalfeld, R. M., Macedo, C. L. D., & Bagatin, E. (2026). Lipedema: pathophysiological insights and therapeutic strategies - An update for dermatologists. *Anais brasileiros de dermatologia*, *101*(1), 501270. https://doi.org/10.1016/j.abd.2025.501270

## 2. Differential Diagnosis

### 2.1 Lipedema Versus Obesity

Distinguishing lipedema from obesity may be challenging due to the fact that these conditions can coexist [7]. Moreover, many patients suffering from lipedema tend to be overweight or obese and only a small percentage maintain normal body weight [9]. Herbs et al. reported that among all patients included in his study 15% were overweight and 76% were obese according to the Body Mass Index (BMI) [20].

There are a few criteria that may help to differentiate lipedema from obesity. Obese patients develop excess fat agglomeration proportionally in all body areas, typically more in central parts, while lipedema patients suffer from disproportional fat accumulation affecting extremities and sparing feet and hands. Fat in obesity is not painful. Patients with lipedema are resistant to restrictive diet, calorie deficit, exercise or bariatric surgery. These changes may even act as stressors and lead to growth of lipedema fat. Moreover, weight loss among lipedema patients can be irritating because it is more visible in the trunk than in affected areas, while obese patients experience symmetrical weight loss. Both men and women suffer from obesity while lipedema almost exclusively concerns women [7,18, 19, 21].

### 2.2 Lipedema Versus Lymphedema

Lipedema is commonly mistaken as lymphedema. The phonetic sound of both conditions is quite alike and may have an impact on incorrect diagnosis. Lipedema is always bilateral, non-pitting and does not involve feet and hands whereas lymphedema may be unilateral or bilateral. A characteristic sign of lipedema is a sharp demarcation at the ankle known as the “cuff sign” or “reverse shouldering” while Stemmer sign, or incapacity to pinch the base of the second toe, is typical for lymphedema. The edema content in lymphedema is made up of lymphic fluid while swelling in lipedema is a consequence of deposition of fatty tissue. Contrary to lipedema, lymphedema is not prone to bruising and tenderness. Lymphedema patients' skin is ordinarily modified and thickened while lipedema patients’ skin remains comparatively normal. These two conditions may co-occur in advanced stages of disease [22, 23].

### 2.3 Lipedema Versus Chronic Venous Disease

Chronic venous disease is characterised by pitting edema, improvement of disease manifestations and swelling with leg elevation, after bed rest and exercising. In advanced stages of chronic venous disease skin transform and typical signs include brown coloration (dermite ocra), ulcers, and white scars (atrophie blanche). Contrary to lipedema, in chronic venous disease swelling also concerns ankles and feet with typical negative Stemmer sign. Varicose veins are often observed among lipedema patients and should not be used as a distinguishing hallmark [19, 23].

### 2.4 Lipedema Versus Lipohypertrophy

Lipohypertrophy may morphologically resemble lipedema. It is marked by localized, symmetrical fat accumulation in buttocks, the upper or lower thighs or the lower calves sparing the feet. The most prevailing form of lipohypertrophy is the “riding breeches” obesity. Contrary to lipedema, lipohypertrophy is not linked to pain, edema or bruising. It is suspected that lipedema may develop from lipohypertrophy with time [19, 21].

### 2.5 Lipedema Versus Derum’s Disease

Derum’s disease (adiposis dolorosa) is characterised by generalized obesity, painful, readily bruised fatty tumours (lipomata) in the adipose tissue that generally occur in post-menopausal women. Adipose depositions normally involve extremities, trunk, buttocks and pelvic area and may progress into circumscribed or general diffuse type. In contrast to lipedema, edema does not appear. Derum’s disease is associated with type 2 diabetes, muscular weakness, asthenia, emotional instability, anxiety, depression, confusion and dementia [19, 21, 23].

## 3. Diagnostic Tools and Limitations

### 3.1 Diagnostic Criteria

Diagnosis of lipedema remains challenging due to the absence of specific markers. Lipedema is a clinical diagnosis mainly based on physical examination and medical history [24]. Primarily, diagnostic criteria were proposed by Wold et al. in 1951. Followingly, in 2017 the first Dutch guidelines proposed a modified version fortified with physical examination findings [7, 23]. A diagnosis of lipedema is highly feasible when all criteria from Wold et al and two physical examination findings are met. A subtly adjusted version of the list presented by Halk and Damstra is presented in Table 3 [23]. The Lipedema World Alliance Delphi consensus emphasises the importance of improving diagnosis accuracy for both patients and healthcare providers benefits. It underlines the complexity of diagnosing lipedema due to its dependence on comprehensive evaluation, differential diagnosis, detailed medical history and physical examination. Lack of definitive and universally adopted diagnostic criteria may contribute to diagnostic delays [25].

**Table 3.** Diagnostic criteria of lipedema

| | |
|---|---|
| **Medical history (A) (criteria of Wold et al. )** | |
| A | 1. Disproportionate body fat distribution<br>2. No or limited influence of weight loss on fat distribution<br>3. Limb pain and bruising<br>4. Increased sensitivity to touch or limb fatigue<br>5. Nonpitting edema<br>6. No reduction of pain or discomfort with limb lift |
| **Physical examination (B, C, D, E)** | |
| B | **Proximal part of the lower limb** |
| | 1. Disproportionate fat distribution<br>2. Circumferentially thickened cutaneous fat |
| C | **Distal part of the lower limb** |
| | 1. Proximal thickening of subcutaneous fat<br>2. Distal thickening of subcutaneous fat, accompanied by slender instep (cuff sign) |
| D | **Proximal part of the arm** |
| | 1. Significantly thickened subcutaneous fat in comparison with vicinity<br>2. Sudden stop at elbow |
| E | **Distal part of the arm** |
| | Thickened subcutaneous fat, accompanied by slender back of hand (cuff sign) |
| **Extra criteria** | |
| F | 1. Pain when applying bimanual palpation<br>2. Distal fat tissue tendrils of the knee (popliteus) |
| Modified from Halk and Damstra<br>Diagnosis is highly probable when present: A (1 to 6) + (B [1 + 2] or C [1 + 2] or D [1 + 2] or E).<br>In the absence of at most two of these criteria (A to E), the presence of the extra criteria F(1) or F(2) also support the diagnosis. | |

References: Buso G, Depairon M, Tomson D, Raffoul W, Vettor R, Mazzolai L. Lipedema: A Call to Action! Obesity (Silver Spring). 2019 Oct;27(10):1567-1576. doi: 10.1002/oby.22597. PMID: 31544340; PMCID: PMC6790573.

### 3.2 Physical Examination

Physical examination is a foundation of diagnosis. Kruppa et al. notified clinical criteria including major manifestations of lipedema: bilateral, symmetrical, disproportionate fatty tissue hypertrophy on the limbs; sparing of the hands and feet (cuff phenomenon); approximately 30% involvement of the arms; negative Stemmer sign; a feeling of heaviness and tension in the affected limbs; pain on pressure and touch; marked tendency to form hematomas; stable limb circumference with weight reduction or caloric restriction; worsening of symptoms over the course of the day; teleangiectases and visible vascular markings around fat deposits; hypothermia of the skin. The tissue sensitivity, a hallmark of lipedema, can be examined by a pinch test, which is painful in affected areas but causes no pain anywhere else. Moreover, patients' frequently have a positive family history of the disease. Physicians should ask about present illness, time of onset and progression of initial manifestations over the time. The beginning of lipedema is often provoked by hormonal changes during puberty, pregnancy or menopause which helps to differentiate it from simple obesity. During examination doctors should take into consideration psychiatric comorbidities [6].

### 3.3 Anthropometric and Body-Composition Measures

Anthropometric measures support the recognition of disproportionate fat distribution in lipedema. A routine clinical follow-up should include: body weight, body-mass index (BMI), waist-to-hip ratio (WHR), waist-to-height ratio (WHtR) and the circumference and volume of the extremities [6].

### 3.4 Imaging Diagnostic Tools

Diagnosis is based on medical history and physical examination, which if needed may involve imagining procedures [24]. Computer tomography (CT) and magnetic resonance imaging (MRI) have been proposed to distinguish lipedema from lymphedema but there are some crucial limiting factors such as their high costs and limited availability [24]. MRI allows differentiation between lipedema and lymphedema with high sensitivity. Both MRI and CT show homogenous subcutaneous fat thickening in lipedema while it reveals fluid accumulation and honeycombing with muscle hypertrophy in lymphedema [7].

A study fulfilled by Naouri et al. demonstrated the efficacy of high-resolution ultrasound for distinguishing lipedema and lymphedema. The ultrasound images on three different sites of each lower extremity were interpreted by an independent dermatologist. A relevant distinction in dermal thickness was seen between lymphedema and lipedema patients. Dermal hypo-echogenicity was encountered among 100% lymphedema patients' and it infested the entire dermis in all lymphedema cases except one. In lipedema hypoechogenicity was located at the ankle and occurred in the upper dermis [25].

Dual-energy X-ray absorptiometry (DXA) is another noninvasive technique used for establishing and diagnosing lipedema. DXA is able to measure body composition (BC) and analyze fat mass distribution (FM). [24] In comparison to MRI, DXA is a comparatively uncomplicated and low-cost technique capable of testing regional body fat distribution. Busso et al. studied body composition in 222 women - 74 with lipedema and 148 controls. Their study showed that BC assessment by DXA, especially the leg FM/total FM index, might be a useful diagnostic tool. An optimal cut-off value distinguishing lipedema was 0.384, while values below 0.383 were considered exploitable for excluding lipedema. This index may be notably helpful in patients with suspected clinical lipedema not meeting all traditional diagnostic criteria. DXA may also be used to differentiate lipedema from obesity by objectively measuring body fat distribution [27].

Lymphoscyntygraphy and indocyanine green lymphography may present impaired lymphatic flow in the affected limb of lipedema patients but there are no morphologic abnormalities seen in lymphedema [19, 23]. Tartaglione et al. evaluated 54 women with clinical diagnosis of lower extremity lipedema. They injected intradermally two doses of 99mTc-nanocolloid at the first intermetatarsal space and in the lateral malleolar area. Immediately after injection two static planar scans were taken at rest and then after performing 2 minutes isotonic muscular exercise to monitor the tracer pathway. Later patients were requested to take a 30-40 minute walk and then delayed scans were received. In early stages of lipedema the lymphatic flow is often preserved and the rest/stress intradermal lymphoscyntygraphy may show a normal lymphatic drainage with a repeated pattern of the leg lymphatic pathway but in advanced stages of lipedema lymph stagnation regions were observed [28]. Indocyanine green lymphography (IGG) present normal or increased lymphatic function in lipedema [7].

## 4. Psychosocial Impact

### 4.1 Impact on Health-Related Quality of Life (HRQOL)

Health-related quality of life refers to the extent to which an individual's health status influences their perceived well-being and their capacity to function across physical, psychological and social domains [29]. Alwardat et al. evaluated four observational studies, three of them showed aggravation of HRQOL and psychosocial status in patients suffering from lipedema [30]. An online survey conducted by Dudek et al. among 130 Polish women presented that quality of life, assessed by the WHOQOL-BREF, was lower in all domains (psychosocial health, physical health, social relationships and environment) than in the general population [31]. Falck et al. conducted a national cross-sectional study using an online survey with participants from Lipoedema Association groups in Sweden. HRQOL was assessed using the Swedish version of the RAND-36. Generally, in most age-groups, women suffering from lipoedema scored lower in both physical and mental health than an age-matched general Swedish female population. The utmost difference in points was visible in physical role-functioning which points out difficulties with work or other daily activities. [29]. A study on 14 women located throughout Sweden was conducted to describe their experiences of living with lipedema. They characterised their bodies as burdensome in their daily lives. They felt limited by their bodies and weighty, swollen and sore legs. They were seen by others as lazy and lacking in character. Even healthcare professionals were skeptical and made hurtful comments and glances [32].

### 4.2 Mental Health, Body Image, Eating Disorders

Kunzová conducted an exploratory cross-sectional study on 47 participants in Czechia using an anonymous online survey to demonstrate disordered eating risk among women with lipedema. Disordered eating risk was measured by the Eating Attitudes Test (EAT-26). Moreover, behavioral items of the EAT-26 were applied to diagnose the presence of eating-related behaviors such as binge eating, laxative use, excessive exercise, self-induced vomiting or rapid weight loss within the previous six months. EAT-26 is used as a screening tool for eating disorder-related attitudes and behaviors. Scores ≥20 state elevated risk of disordered eating. 66% of participants had scored at or above the EAT-26 screening cut-off. When incorporating behavioral risk indicators 70,2% fulfilled criteria for a positive screening outcome [33]. A case report of a young woman with disproportionate fat build-up located in the lower half of her body, self-identified as having obesity, who developed restrictive eating behaviour and became preoccupied with weight loss, ultimately leading to anorexia nervosa. Lack of knowledge about lipedema and mistaken it for obesity most likely played a role in development of an eating disorder by this young woman [34]. A survey conducted by Lipoedema UK on 250 female participants showed that 45% of them reported eating disorders such as over or under-eating, dieting, binge eating, bulimia, anorexia nervosa. [35].

Depression and anxiety are very common among lipedema patients thanks to lengthy time to diagnosis, multiple advice on diet and exercise by healthcare providers when neither of them is notably effective, and due to huge and occasionally rapid body metamorphosis over a lifetime [36]. Lipedema has a great influence on patients' lives. Approximately 85% claim that lipedema affects their mental health and ability to deal with life. Moreover, altered body shape causes low self-esteem and is frequently linked to low confidence, depression and thoughts of self-harm or suicide. In addition, lipedema may have a negative effect on social interactions and relationships, including sexual activity [11]. The prevalence of depression ranges from 31 to 59% and is higher among patients with BMI ≥ 40 [7]. Al-Wardat et al. conducted a study on 26 females with lipedema and 26 sex- and age-matched healthy controls to investigate the difficulties in emotional regulation among lipedema patients. Difficulties in emotional regulation can concur to developing psychological disorders. Lipedema patients are woefully susceptible to developing psychological disorders like anxiety. In this study the emotional regulation abilities were estimated using the Italian version of the Difficulties in Emotion Regulation Scale (DERS) and the severity of anxiety was assessed by Hamilton-Anxiety (HAM-A) scale. The findings of this study indicate that individuals with lipedema experience greater difficulties in emotion regulation compared to those without the condition. Alterations in emotional processing were observed in individuals with lipedema compared to healthy controls, particularly regarding emotional awareness, including clarity and acceptance of emotions. These difficulties, which persist independently of BMI, suggest that patients with lipedema may struggle to identify and understand their emotional states, thereby hindering effective emotion regulation [10].

Erbacher and Bertsch conducted a study on 150 participants diagnosed with lipedema syndrome. Recruited individuals underwent two interviews. For this study purposes, psychological stress, was defined as the appearance of mental health disorder (ICD-10 F diagnosis such as depression, eating disorder, post-traumatic stress disorder, anxiety disorder and panic disorder) or the presence of symptoms that may indicate

mental health issues and did not meet the criteria for an “F diagnosis”. The interview also included lipedema symptoms and lipedema-associated pain. Precisely 80% of the women diagnosed with lipedema presented significant psychological stress in the 12-month period before lipedema-associated symptoms occured. Pain intensity among lipedema patients was measured with a visual analogue scale (VAS). Almost 70% of the patients had a VASmax score of 6 or more. Nearly one-fifth of participants gave a VASmin of 5 or more which suggests that approximately 20% of individuals with lipedema do not experience pain levels below 5 in their daily lives, even for brief intervals. Moreover, patients with lipedema who also had comorbid mental health conditions classified as DEAT (depression, anxiety disorders, eating disorders, or PTSD) demonstrated significantly higher VASmax compared to patients without such conditions [37].

**4.3 Psychosocial Distress**

Women suffering from lipedema are relieved after getting a proper diagnosis but then when realizing that treatment may not improve signs of lipedema as much as they hoped they feel frustration. Trouble with self-care; a social stigma tied to increased, disproportionate body size and physical restrictions; depression; anxiety; self-loathing; lack of comprehension from family members, friends and colleagues; verbal abuse in public; lack of success in forming relationships; not fitting into airplanes seats or toilets; all of the above can lead to social shunning, withdrawal and isolation [38].

**4.4 The Stage-Dependent Burden**

A cross-sectional study conducted by Clark et al. reported differences in physical and mental health and health care experiences across lipedema stages. Participants were divided into three groups: Stages 1-2, Stages 3-4, Stages unknown. All participants reported pain, fatigue, loss of mobility and work-related problems, but women from advanced stages of the disease (stages 3-4) were significantly more likely to suffer from those problems than individuals with early-stage disease. Moreover, women from the stage 3-4 group were considerably more likely to inform about depression and eating disorders in comparison to both other groups [15].

**4.5 Awareness of Lipedema**

The aim of a cross-sectional study of 508 medical doctors across different clinical specialties in Turkey was to emphasize a gap in knowledge and awareness of lipedema among medical professionals in Turkey. Although 51% of physicians were familiar with the term “lipedema”, only 29,9% had encountered or managed patients with this disease. Furthermore, 51,4% reported having no knowledge of lipedema clinics, and 50,9% reported lack of awareness regarding available lipedema treatment options [39].

Insufficient awareness among both healthcare providers and the general public contributes to substantial delays in obtaining appropriate diagnosis and treatment, thereby worsening symptoms such as pain, osteoarthritis, and mobility limitations. In the absence of early identification and effective management, lipedema may severely impair physical health, emotional well-being, and overall quality of life [14].

A study among one hundred seventy Polish women was conducted with the intention to evaluate the basic knowledge about lipedema. Participants were recruited from social media groups connecting women searching for tips on body weight disorders or willing to reduce their weight. Only 36 women said that they knew the term lipedema. Nevertheless, the proper definition of the disease was indicated by 22 of them. As little as 7% of all participants presented a correct term of lipedema. Merely 4%, 12% and 37% of women who participated in this study could assess the proper methods of treatment, clinical characteristics and durability of the disease respectively [40].

Bauer et al. created an online survey questionnaire for lipedema patients in Germany. 209 female patients diagnosed with lipedema took part in the survey. Most of them (average age, 38,5 years) had first observed symptoms of lipedema at the age of 16. The diagnosis was established after an average of 15 years [41]. Romeijn et al. conducted a survey among lipedema patients. They have established that the mean time between the beginning of symptoms until diagnosis was 18 years. Most of the participants (61,3%) were diagnosed by a dermatologist after visiting a mean of 2.8 doctors. [11]. Both studies show that patients and healthcare providers lack knowledge about lipedema which leads to delay in diagnosis.

**Conclusions**

Lipedema remains significantly underdiagnosed and misdiagnosed as other disorders such as obesity and lymphedema. It is crucial to differentiate lipedema from other conditions with similar clinical presentation. The lack of awareness among healthcare providers, patients and the general public leads to delay in diagnosis and treatment. This contributes to exacerbation of lipedema symptoms and adversely affects patients' daily functioning, quality of life, and mental health leading to depression, anxiety and eating disorders. There is a pressing need to raise awareness of this condition, for example through clinician education or public campaigns. Moreover, it is important to develop standardized diagnostic criteria. Patients should feel understood and be aware of where to seek help in order to obtain an accurate diagnosis and alleviate reported symptoms.

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All authors have read and agreed with the published version of the manuscript.

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