CULTURA & SAÚDE

ISSN 2595-7546
Vol. 26 · No. 3 · July 2026
São Paulo, Brasil

ARTICLE · CULTURA & SAÚDE

# Before the Scalpel

*History, haste, and wisdom in the treatment of lipedema*

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Received for publication in July 2026 · Section: Article · Language: English

ABSTRACT

For centuries, medicine has repeated the gesture of cutting before understanding. Drawing on this habit, illustrated by the lobotomy and by the long dominance of surgery in appendicitis, the author examines the present moment of lipedema, a chronic inflammatory disease of adipose tissue. He argues that liposuction relieves but does not cure: about half of patients still require conservative treatment, the fat tends to return, and the underlying inflammation remains untouched. He defends a new order of care, first reducing inflammation, then knowing one's own body, and only then, in selected cases, operating, and reinterprets aesthetic distress as an interoceptive signal of real physical suffering rather than vanity.

KEYWORDS: *lipedema; liposuction; conservative treatment; inflammation; gluteofemoral fat; shared decision-making*

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*Essay for Cultura e Saúde (ISSN 2595-7546).*

## An old habit of medicine

There is a gesture that medicine has been repeating for centuries and of which it is almost never ashamed: to cut before understanding. When we do not understand a disease but have a knife at hand, the temptation to use the knife is enormous, because it offers what understanding cannot yet give: an action that is immediate, visible, and seemingly definitive.

History holds examples that make us shudder today. The transorbital lobotomy, popularized in the 1940s, promised to cure human anguish with an instrument resembling an ice pick inserted through the eye socket. It was quick, it could be performed outside the operating room, and for that reason it spread. Only later did science reveal the extent of the damage. It was, as I like to say, a case in which technical progress outran the progress of knowledge.

There are less tragic and equally instructive examples. For nearly a century, appendicitis had a single conceivable treatment: surgery. And it was a good treatment; it saved multitudes. But the very success of the operation delayed for decades a simple question: what if, in many cases, antibiotics were enough? The question was only taken seriously when someone had the courage to doubt a habit that worked.

The lesson of these episodes is not that surgery is bad. It is that **the apparent success of a procedure can lull curiosity to sleep** and postpone better answers. When the knife resolves what can be seen, we stop investigating what cannot.

## Lipedema's turn

I bring up this history because lipedema is living through its own moment of temptation. It is a chronic disease of adipose tissue, almost exclusive to women, marked by pain, a sense of heaviness, and a disproportionate accumulation of fat in the legs that does not yield to diet and exercise as one would expect. For many patients, after years of being told they were merely "obese women who don't try hard enough," liposuction appears as the long-sought promise: to remove the problem fat and put an end to the suffering.

I operate. I learned the technique from those who have mastered it, and in the postoperative period I see the genuine relief of pain and the joy of women who walk again without discomfort. I do not dismiss this. But precisely because I operate, I feel obliged to say, in plain words, what the euphoria tends to leave unsaid: **lipedema surgery relieves, but does not cure.**

The available evidence is modest and, when the long term is examined, full of warning signs. About half of patients continue to require conservative treatment after being operated on. The fat that is removed tends to return over time, often in a worse place, the visceral abdomen. And the operation treats the fat, the end product of the disease, without touching the inflammation that produced it. It removes the smoke, not the fire.

## Why we are in such a hurry

If surgery is not the definitive solution, why do we rush to it so eagerly? Because pain hurries us. Those who suffer want relief now, not months from now. And there is an old wisdom about this impulse.

The famous "marshmallow test" offered children a choice: eat one sweet immediately or wait and receive two. Those who managed to wait tended to fare better in adult life. The capacity to delay gratification, far from being a mere trait of temperament, is a skill that can be learned, and one that health care rarely teaches. In lipedema, "eating the marshmallow" means rushing to the operating room at the height of a crisis, when the symptoms are screaming and haste seems the only reasonable answer.

To acknowledge this is not to blame the patient. It is the opposite. The decision to operate is usually made at the worst possible moment, at a peak of pain and anguish, a state of emotional vulnerability that closely resembles the "bargaining" phase we describe in grief. To make an irreversible decision in such a state, before someone who stands to benefit from it, brings together all the conditions that should make us breathe before acting. The role of a good professional is not to take advantage of that moment; it is to help the patient through it.

## Fat is not the villain it seems

Much of the haste arises from a misunderstanding about fat itself. We have learned to see it as a nuisance to be eliminated, and the images of lipedematous fat, reddened and fibrous, reinforce the impression of something intrinsically bad that must come out quickly. But the red is inflammation, not malice; and adipose tissue is an organ, not rubble.

The fat of the thighs and hips, in particular, has a protective role. It safely stores excess fatty acids, produces useful hormones, and is associated with a healthier metabolic profile. Removing large volumes of it is a genuine metabolic intervention, whose effects appear neither on a pain scale nor in a "before and after" photo. I always remember Emil Kocher, who won the Nobel Prize when he belatedly realized that removing the thyroid cured one problem and created another. One disease was being exchanged for another. Faced with an organ that also works in our favor, prudence advises thinking twice before removing it in the name of aesthetics.

## Aesthetic distress is a signal, not vanity

Here I touch on the most delicate and most human point. Many women with lipedema are labeled, explicitly or covertly, as being excessively preoccupied with their own appearance, almost as if they had a body-image disorder. This is an injustice, and the data contradict it. In a study by our group of 1,300 patients, aesthetic dissatisfaction tracked far more closely with the **burden of symptoms** than with weight or the volume of the legs. In other words: when symptoms improve, satisfaction with the body improves, even without a major change on the scale.

This changes everything. Distress about the legs is not a psychiatric mirage; it is an internal, interoceptive reading of real physical suffering. A woman perceives her own body through two channels, what she sees and what she feels within, while those around her see only the first. It is no wonder there is a mismatch. And if aesthetic discomfort is, at bottom, the voice of inflammation, then the most logical response is not to cut the skin, but to **calm the inflammation**. Once the cause is treated, much of the aesthetic complaint resolves as a bonus.

## A different order for care

From all of this springs a different, and wiser, sequence for caring for lipedema.

First, **reduce inflammation**. An anti-inflammatory diet, sleep, control of oxidative stress, compression, low-impact movement: this is where most of the relief lies, and this is where almost every patient can improve. We have already shown that lipedema can be managed without surgery, with a real gain in quality of life.

Second, **know yourself**. Learning which triggers ignite inflammation in your own body, a food, a poorly slept night, a period of stress, is a power that no surgery offers. The patient who knows her own body ceases to be a passenger and becomes the pilot of her own treatment.

Only then, and only in selected cases, does surgery enter, in a modest and late role: not as the rescue of a poorly managed treatment, but as a final step, almost a reward, for the patient who has already stabilized the disease. To operate on already deflamed tissue is to operate on favorable ground. To operate in the middle of the fire is to ask the fire to worsen.

## In praise of waiting

We live in a culture that confuses speed with efficacy and that distrusts anything requiring time. Medicine does not escape this: we prize the dramatic transformation, the striking photo, the solution that fits into an afternoon in the operating room. But there is a form of wisdom, ancient and rather unfashionable, that consists in understanding before acting and in respecting what the body does for good reasons.

Lipedema is neither a sentence nor a fate, and the woman who carries it does not need haste; she needs information, care, and time. Surgery has its place, smaller and later than the market suggests. The greatest treatment, almost always, begins long before the scalpel, and sometimes dispenses with it altogether. May the history of medicine, with its hurried knives and its belated lessons, serve us as counsel: not everything that can be cut should be cut, and almost nothing should be cut in haste.

## Readings


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