

Letters to the Editor

Treatment of Meralgia Paresthetica with Pulsed Radiofrequency of the Lateral Femoral Cutaneous Nerve

TO THE EDITOR:

I read with interest the case report by Philip et al (1) on the successful treatment of meralgia paresthetica (MP) with pulsed radiofrequency (PRF) of the lateral femoral cutaneous nerve (LFCN). They state that the case reported provides evidence that PRF of the LFCN may offer an effective, low risk treatment in patients with meralgia paresthetica. While we await well-designed studies to test this treatment we would like to report 2 additional cases successfully treated with this approach.

Case 1: An 80-year-old patient presented with a 10-month history of right meralgia paresthetica on standing. Seven months later, after a fall on his lower back, the pain worsened. Treatment with NSAIDs and anticonvulsants was unhelpful, as was using suspenders instead of a belt to avoid waist compression. We performed fluoroscopically guided selective LFCN PRF using a NeuroTherm JK25T (Neurotherm Inc., Hampshire UK) radiofrequency (RF) generator. Three weeks later, pain measured on a visual analog scale had decreased by 75%. A second LFCN PRF brought total relief and the patient remains free of pain after 2 years' follow-up.

Case 2: A 52-year-old patient suffered unremitting right MP for several years. The pain was unresponsive to NSAIDs and the patient did not tolerate tramadol. A fluoroscopically guided selective LFCN PRF, using the same RF generator as in the first case, improved his symptoms and he was free of pain after 3 months follow-up.

Although, as the authors stated, this is a low risk treatment, it is important to bear in mind that the needle is inserted inside the pelvis near the colon (2) and there is the possibility of intestinal perforation. As in our first case, it is worth repeating the procedure if



Fig. 1. Scan showing entry point below the ASIS under the inguinal ligament where the LFCN passes.

necessary to obtain total and long-lasting relief. In our case the entry point was not cephalad to the anterior superior iliac spine (ASIS) but more caudal, below the ASIS (Fig.1), under the inguinal ligament, where the LFCN passes (3).

In summary, it seems that PRF works in MP as in

other peripheral neuropathies although, as the authors state, well-designed studies should be carried out to provide more solid evidence. Some patients might need more than one procedure and there are some risks that cannot be ignored.

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