REPRINTED ARTICLES

A limited number of articles published elsewhere, which are considered by the Editorial Board to be of special interest, are reprinted in this section, either in full and without change in the text, or in condensed form.

NEURITIS OF THE LATERAL FEMORAL NERVE[1]

By Otto Sittig

Of Prague

Scarcely any other form of neuritis respects so precisely the area of distribution of its nerve as that of the lateral femoral nerve, so its diagnosis is easy. It is not rare—I have seen forty-nine cases since 1922—yet it seems not to be well known. Martin Bernhardt, of Berlin, especially drew attention to it, and in Germany it is often called Bernhardt's disease. Roth suggested "*meralgia paraesthetica,*" which is most used, but Stookey proposed "neuritis of the lateral femoral nerve," to which I agree.

It consists in paresthesia, or pain, or both, in the area of the lateral femoral nerve, i. e., on the outer surface of the thighs, beginning below the *crista ossis ilei* and spreading to above the knee. Laterally the area reaches from the midline anteriorly and passes a little onto the hind part. The paresthesiae are formication, sensation of pins-and-needles, or of cold, insensitiveness. The pains are burning, twitching, or pricking, sometimes comparable to toothache. Often the pain arises only when the patients is standing or walking; in some cases not until he has been walking awhile.

On examining the sensibility we find in a few cases no disturbance whatever, but in the majority there is diminution or abolition of some or all qualities of sensibility. I tried in some cases to find out the borders of protopathic and epicritic sensibility (Head),

[1] Condensation of an article which appeared in the *Medical Press and Circular* (1933), Supplement No. 3, Neurology in General Practice, and was reprinted in *Leprosy in India* 6 (1934) 89.—Editor.

but got no unequivocal results. Liebers found that at the beginning the protopathic and epicritic sensibilities are disturbed in the same extent; recovery having begun, protopathic disturbance disappeared and simultaneously a part of the epicritic sensibility improved—slight touch of cotton-wool, and discrimination of intermediate degrees of temperature—while the discrimination of compass points remained unimproved.

The area affected changes little. In the majority it spreads from the middle of the outer side of the leg to a little above the knee. Often the sensory disturbance increases downwards. In some cases the disturbance reached up to the *crista ossis ilei*. In others the area was small and affected only a part of the lateral side of the leg. This difference depends obviously upon which branches of the nerve are affected. The disturbance mostly remains in the lower part above the knee, whereas it vanishes in the upper part. Often there are points that are painful on pressure in the area of the diseased nerve. Preti found a palpable cord-like induration of the nerve, with nodules.

As to the etiology—alcoholism, trauma (gunshot wounds), pressure, pregnancy, spondylitis, infectious diseases, rheumatism, phlebitis, myositis and pes valgus have been mentioned. It may occur after abdominal operations; I have described eight cases that occurred after appendectomy, all of the right side. The patients said that they had noticed a dead feeling, immediately or on the second day after operation, and one had had the same disturbance lasting for two or three months after a right-sided herniotomy two years before. I have met seven other postoperative cases: 1 myoma uteri (left side affected); 2 extirpations of kidney (right side); 1 hernia (left); 1 abdominal tumor (left); 1 tubal pregnancy (right), and 1 cholecytectomy (right). Further, I have seen this neuritis occur twice after grippe, once after pneumonia, and once in tuberculous pleurisy. Oliveira mentions a case after grippal pneumonia, Lade after scarlet fever, Roch and Mozer after vaccination, the neuritis being preceded by shingles in the area of the lateral femoral nerve.

In one of my cases spina bifida was found, and spondylitis deformans in another. Rosenheck considers arthritis of the lumbar part of the vertebral column to be the only cause of Bernhardt's disease. It sometimes occurs as a secondary symptom of another dis-

ease, like tabes, haematomyelia, dysbasia arteriosclerotica (Klimke). I have seen evidence of it in one undoubted case of tabes, and in three other cases tabes was suspected. In still another one there was tabes with optic atrophy, but the patient stated that the paresthesia had arisen immediately after an appendix operation. Zalkind supposes that the syndrome may also be of central origin, from lesions of the optic thalamus; he describes a case of epidemic encephalitis in which Bernhardt's syndrome developed on both sides. The ineffectiveness of treatment he considers further evidence for a central origin.

There is a certain disposition to neuritis of other kinds in patients with neuritis of the lateral femoral nerve. Three patients of mine had suffered from sciatica, three had pains in their arms, two had had palsy of the facial nerve, and one had had shingles in the face. One patient—a physician—had had shingles in the area of the lateral femoral nerve several times, and afterwards he had pains and paresthesia in the same area.

The disease occurs more frequently in men than in women; among my patients there are thirty-one men and eighteen women. Rather often medical men suffer from it. In my cases it was right-sided twenty-seven times, left-sided fourteen times, and on both sides eight times. It does not cause much trouble generally, but in some cases the pains may become rather severe. However, it can last a very long time; one patient suffered from it thirty years.

Treatment is usually not necessary. Inunctions, analgetics, electricity, diathermy, treatment by fever can be used. One case was improved by infiltrating the anesthesia with novocain. Fischer and Krieg used an isotonic solution of antipyrin with isoalkalin for perineural infiltration of the nerve. In severe obstinate cases resection of the nerve or neurexairesis have been recommended (Arther Israel, Racz, Bergsma).

Few anatomical studies have been made. Nawratzki found in one case perineuritis and interstitial and parenchymatous neuritis. In Chipault's case the nerve was voluminous, with varicosities filled with blood. In Warda's case the nerve was thickened. On the other hand, in the cases of Soques, Chipault, and Bramwell microscopic examination of the nerve revealed no pathological changes.

[To help in bringing the condition here described to the attention of leprologists generally this article in somewhat reduced form is reprinted here. As recently reprinted in *Leprosy in India* it was preceded by an editorial comment to the effect that in the past few years a number of patients had been examined who, because of loss of sensibility on the outer side of the thigh, had been suspected of having leprosy. That diagnosis had not been made, because no other sign of leprosy was detected, but the cases had been puzzling. The condition described by Professor Sittig corresponds closely to that observed in some of these cases. In a personal communication Muir, editor of *Leprosy in India,* states that the condition is fairly common in Calcutta and that since this article was reprinted two or three more cases have been seen. We ourselves have had an opportunity to see a case of probably the same condition under decidedly unusual circumstances, which are recounted in a case report published elsewhere in this issue of the JOURNAL.—EDITOR.]