Lateral Femoral Cutaneous Neuropathy

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Lateral Femoral Cutaneous Neuropathy (LFCN) or Meralgia Parasthetica is described in medical literature as an entrapment of the lateral femoral cutaneous nerve. Typically LFCN is described as an entrapment in or under the inguinal ligament or anterior hip as a result of an enlarged belly (i.e. with pregnancy). LFCN has also been described in patients who are confined to bed in hip flexed positions for prolonged periods of time. This case study is on a 41-year old male who was diagnosed with LFCN and referred by a neurologist.

Initial Visit

History:
Patient is a very healthy and fit 41-year old male who works as a civil engineer for a power utility company. He describes himself as an avid outdoorsman, who hikes, backpacks, hunts, and enjoys other outdoor activity. He is not overweight and falls in the ideal range for body mass index (BMI). He reports that 4 months ago he was backpacking in the remote wilderness with a fifty pound backpack on a week long outing. By his report he was not hiking on established trails, but was doing a lot of "rock hopping". At the completion of the trek the patient noticed bilateral anterior and lateral thigh pain and a burning sensation. He reports that he thought it would improve. After nearly four months, the symptoms persisted and he sought medical advice.

Subjective:
Upon arrival to physical therapy he reports his right side is improving mildly, but the left is rated as severe. Sitting, bending, and twisting are reported to aggravate the symptoms.

Objective:

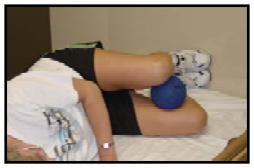
	Left	Right
Adduction Drop Test	+	–
Extension Drop Test	+	–
SLR	95°	90°
Leg Rotation	17.5 inches	16 inches
FA IR	32°	41°
FA ER	34°	28°

Assessment:
Patient presents with a Left AIC pattern without any pathology.

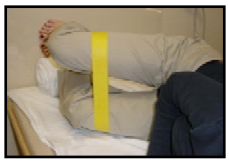
Treatment:

1. *90-90 Hip Lift with Balloon (2nd Edition CD: Integration - Supine #3)*
   - Given for repositioning.

2. *Sidelying Scissor Slides (2nd Edition CD: Left Adduction - Sidelying #1)*



3. *Left Sidelying Left Adductor with Right Glute Max (2nd Edition CD: Right Glute Max #2)*



4. *Prone Inferior Glute Max, Adductor Magnus and Quadratus Femoris Stretch (3rd Edition CD: Sagittal Hip Flexor Inhibition)*

<u>Second Visit (4 days later)</u>

Subjective:
Patient reports that he has had one full day without any symptoms and the other days the symptoms were more intermittent.

Objective:

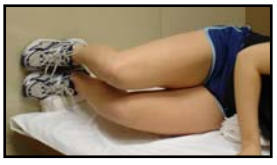
	Left	Right
Adduction Drop Test	-	–
SLR	90°	90°
Hruska Adduction Lift Test	3/5	3/5

Assessment:
Patient returns to the clinic with the ability to inhibit a Left AIC pattern and with Hruska Adduction Lift scores of 3/5 bilaterally. It was determined to introduce patient to integrated standing activity based on the Hruska Adduction Lift Scores.

Treatment:

Reviewed current home exercise program (HEP) and made adjustments. Added two new activities:

1. *Left Sidelying Knee Toward Knee (2nd Edition CD: Left Adduction – Sidelying #5)*



2. *Alternating PRI Wall Squat (2nd Edition CD: Integration – Standing #11)*
   - Emphasis was placed on weight bearing through the left heel.

Third Visit (7 days later)

Subjective:
Patient reports he has not had any symptoms over the past 6 days. He has been compliant with his home exercise program.

Objective:

	Left	Right
Adduction Drop Test	–	–
FA IR	35°	40°
FA ER	40°	40°
SLR	90°	90°
Hruska Adduction Lift Test	4/5	4/5

Assessment:
Patient demonstrated improved FA IR / FA ER, Hruska Adduction Lift Scores, and an ability to consistently inhibit a Left AIC pattern during functional activity.

Treatment:

1. *Sidelying Swiss Ball with Apical Expansion (2nd Edition CD: Integration – Sidelying #18)*
    - Emphasis was placed on left ZOA and frontal plane control of left AF IR and AF adduction.

The patient met all of his goals that were established on the initial evaluation and no further treatments were scheduled at this time. This patient will likely come in for a follow up visit as he begins to condition in the spring for backpacking.