# Meralgia Paresthetica Surgery Technique

The operation is best performed under general anesthesia. A 4–6 cm oblique incision is centered 2 cm distal to the point of tenderness. Since the course of the nerve is variable, the operation is exploratory in nature, and generous exposure is required. If the nerve can't be located, it is usually because the exposure is too superficial. If the nerve still cannot be found, a small abdominal muscle incision can be made and the nerve may be located in the retroperitoneal area. CAUTION: cases have occurred where the femoral nerve has erroneously been divided.

If neurectomy instead of neurolysis is elected, electrostimulation should be performed prior to sectioning to rule out a motor component (which would disqualify the nerve as the LFCN). If the nerve is to be divided, it should be placed on stretch and then cut to allow the proximal end to retract back into the pelvis. Any segment of apparent pathology should be resected for microscopic analysis. Neurectomy results in anesthesia in the distribution of the LFCN that is rarely distressing and gradually reduces in size. A supra-inguinal ligament approach has also been described [1)].

1)
Aldrich EF, Van den Heever C. Suprainguinal Liga- ment Approach for Surgical Treatment of Meralgia Paresthetica. Technical Note. J Neurosurg. 1989; 70:492–494