MERALGIA PARESTHETICA AND FOOT CONDITIONS

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Meralgia Paresthetica

“’It’s also called Lateral Femoral Cutaneous Neuritis’”

--ANATOMY

Purely sensory nerve

L2-L3

passes below the inguinal ligament

2 cm medial to the ASIS.

Innervates the skin on lateral aspect of the thigh.
**Meralgia paresthetica**: is a chronic neurological disorder involves a single nerve which is the lateral femoral cutaneous nerve. characterized by tingling, numbness and burning pain in the outer thigh. The cause of meralgia paresthetica is compression of the nerve that supplies sensation to the skin surface of your thigh.

Tight clothing (The disorder has also been nicknamed skinny pants syndrome, in reference to a rise in teenagers wearing skin-tight trousers.), obesity or weight gain, and pregnancy are common causes of meralgia paresthetica. However, meralgia paresthetica can also be due to local trauma or a disease, such as diabetes.

**NOTE**: Injury during local or regional surgery is another important cause of meralgia paresthetica.
**Symptoms:**

1. Tingling and numbness in the outer (lateral) part of your thigh
2. Burning pain on the surface of the outer part of your thigh
3. Usually more sensitive to light touch than to firm pressure
4. Hyper sensitivity to heat (warm water from shower feels like it is burning the area)
5. Occasionally, patients may complain of itching or a bothersome sensation rather than pain in the affected area.
**Diagnosis:** is largely based on patient description (History) and relevant details about recent surgeries, hip injuries, or repetitive activities that could irritate the nerve.

**Examination** checks for sensory differences between the affected leg and the other leg. **Accurate diagnosis** may require an abdominal and pelvic examination to exclude problems in those areas.

**Electromyographic (EMG)** nerve-conduction studies may be required. **X-rays** may be needed to exclude bone abnormalities that might put pressure on the nerve; likewise **CT or MRI** scans to exclude soft tissue causes such as a tumor.
Treatment:
Whatever the cause, typical treatment takes several weeks to months—depending on the degree of nerve damage.

Conservative measures include:
- Wearing looser clothing
- Losing excess weight
- Taking OTC pain relievers such as acetaminophen, ibuprofen or aspirin

If symptoms persist for more than two months or the pain is severe, treatment might include:

1- Corticosteroid injections.
2- Tricyclic antidepressants
3- Antiseizures: Gabapentin, phenytoin or pregabalin.
4- Rarely, surgery to decompress the nerve is considered. This option is only for people with severe and long-lasting symptoms.
HAMMER TOES: is a condition wherein the proximal IP joint is fixed in flexion, while the distal joint and the MTP joint are extended. The second toe of one or both feet is commonly affected, and hyperextension of the MTP joint may go on to dorsal dislocation.
Hammertoes have multiple causes most frequently results from:

1- wearing poorly fitting shoes that can force the toe into a bent position.

2- Having the toes bent for long periods of time can cause the muscles in them to shorten, resulting in the hammer toe deformity. This is often found in conjunction with bunions or other foot problems.

3- It can also be caused by muscle, nerve, or joint damage resulting from conditions such as osteoarthritis, rheumatoid arthritis, stroke, Charcot–Marie–Tooth disease, complex regional pain syndrome or diabetes.
Treatment:

In many cases, conservative treatment consisting of physical therapy and new soft shoes while in more severe or longstanding cases Hammertoe Surgery may be necessary to correct the deformity.
CLAW TOES

The IP joints are flexed and the MTP joints hyperextended.

This is an ‘intrinsic-minus’ deformity that is seen in neurological disorders (e.g. peroneal muscular atrophy, poliomyelitis and peripheral neuropathies) and in rheumatoid arthritis. Usually, however, no cause is found. The condition may also be associated with pes cavus.
Clinical features

The patient complains of pain in the forefoot and under the metatarsal heads. Usually the condition is bilateral and walking may be severely restricted. At first the joints are mobile and can be passively corrected; later the deformities become fixed and the MTP joints subluxed or dislocated. Painful corns may develop on the dorsum of the toes and callosities under the metatarsal heads. In the most severe cases the skin ulcerates at the pressure sites.
Treatment

FLEXIBLE DEFORMITY
So long as the toes can be passively straightened the patient may obtain relief by wearing a metatarsal support or by having a transverse metatarsal bar fitted to the shoe. A daily programme of intrinsic muscle exercises is important. If these measures fail to relieve discomfort, an operation is indicated.

FIXED DEFORMITY
When the deformity is fixed, it may be either accepted and accommodated by special footwear or treated by one of the following operations: interphalangeal arthrodesis, joint excision or amputation.
Hallux valgus is the commonest of the foot deformities (and probably of all musculoskeletal deformities).

In people who habitually wear shoes the hallux assumes a valgus position; but only if the angulation is excessive is it referred to as ‘hallux valgus’.

**Pathological anatomy**

The elements of the deformity are lateral deviation and rotation of the hallux, together with a prominence of the medial side of the head of the first metatarsal (a bunion). Lateral deviation of the hallux may lead to overcrowding and deformity of the other toes and sometimes overriding of adjacent toes. Prominence of the first metatarsal head is due to subluxation of the MTP joint; In long-standing cases the MTP joint becomes osteoarthritic and osteophytes may then add to the prominence of the metatarsal head.
Clinical features

The commonest complaints are pain over the bunion, worries about cosmesis and difficulty fitting shoes. Often there is also deformity of the lesser toes and pain in the forefoot. With the patient standing, planovalgus hindfoot collapse may become apparent.

The great toe is in valgus and the bunion varies in appearance from a slight prominence over the medial side of the first metatarsal head to a red and angry-looking bulge that is tender. The MTP joint often retains a good range of movement, but in long-standing cases it may be osteoarthritic. Always check the circulation and sensation.
**DIAGNOSIS**

Bunion can be diagnosed by:

1- (X-RAY) plain projectional radiography, which should be weight-bearing.

2- The hallux valgus angle (HVA) is the angle between the longitudinal axes of the proximal phalanx and the first metatarsal bone of the big toe. It is considered abnormal if greater than 15–18

3- The intermetatarsal angle (IMA)

**Treatment**

Conservative treatment for bunions include changes in footwear, the use of orthotics (accommodative padding and shielding), rest, ice, and pain medications. These treatments address symptoms but do not correct the actual deformity. If the discomfort persists and is severe or when aesthetic correction of the deformity is desired, surgical correction by an orthopedic surgeon or a podiatric surgeon may be necessary
HALLUX RIGIDUS

‘Rigidity’ (or stiffness) of the first MTP joint occurs at almost any age from adolescence onwards. In young people it may be due to local trauma or osteochondritis dissecans of the first metatarsal head. In older people it is usually caused by long-standing joint disorders such as gout, pseudogout or osteoarthritis (OA) and is very often bilateral. A family history is common.
Clinical features

1- Pain on walking, especially on rough ground, is the predominant symptom.

2- The patient eventually develops an altered gait, trying to offload the first MTP joint by transferring weight across to the lesser toes;

3- there is also impaired power in toe-off during the gait cycle.

4- The great toe is straight and often has a callosity under the medial side of the distal phalanx.

5-; a tender dorsal ‘bunion’ (actually a large osteophyte) is diagnostic

6- Dorsiflexion is restricted and painful,

and there may be compensatory hyperextension at the interphalangeal joint. It is important to check the state of the other joints in the foot in order to rule out a polyarthropathy.
DIAGNOSIS:

X-rays

The features are essentially those of OA: narrowing of the joint space, subchondral sclerosis and marginal osteophytes.

Treatment:

NON-OPERATIVE TREATMENT

If the condition is not interfering with activity, it can be left alone and the patient can be reassured. Intermittent attacks of pain can be relieved by an intra-articular injection of corticosteroid and local Anaesthetic.

OPERATIVE TREATMENT
Thank You....