LETTERS TO THE EDITOR

Occupational meralgia paraesthetica

Meralgia paraesthetica is a common, and usually unilateral mononeuropathy^{1,2} characterised by a particularly unpleasant pain in the anterior and lateral aspect of the thigh, in the territory of the lateral cutaneous nerve of the thigh. Rarely can the cause of the condition be identified. We have seen four patients with meralgia paraesthetica that could be attributed to their work, when it was necessary for them to support heavy bundles on the anterior and superior aspect of the right thigh.

The first case was a healthy 44 year old male. His symptoms began seven months earlier with burning pain in the anterior and lateral aspect of the right thigh. From the age of 13 years he had worked as a sidewalk salesman, carrying large heavy trays which he supported on the anterior superior part of the right thigh.

Examination revealed hypoesthesia in the territory corresponding to the right lateral cutaneous nerve of the thigh. Palpation of the right iliac crest triggered dysaesthesia in this region. Once the patient stopped supporting weight on this thigh his symptoms improved.

The second patient was a 55 year old mason. He complained of a disagreeable "pinprick" numbness of the anterolateral aspect of the right thigh that began a year earlier. He had a history of more than 30 years of loading and unloading heavy sacks catching them on the anterior face of the right thigh as they were dropped from the truck.

Physical examination revealed hypoesthesia with hyperpathia on the anterior and lateral face of the right thigh and Tinel's sign at the level of the anterosuperior iliac spine. The condition improved when he discontinued work.

The third case was a 45 year old male. This mason usually lifted 50 kg bags of cement from the floor to the anterior face of the right thigh and then shifted them to their destination. At 38 years he experienced dysaesthesia of the anterolateral face of the right thigh. Palpation of the anterosuperior iliac spine generated "pinpricks" in the territory innervated by the right femoral cutaneous nerve, which also evidenced hypalgesia. The patient continues his employment and his symptoms persist.

The last case was a 45 year old male. Part of his work consisted of supporting the edge of large sheets of metallised plastic on the right groin. A few weeks after beginning his work he complained of sharp "electrical" pains, which extended to the lateral aspect of the right thigh. Physical examination confirmed painful hypoesthesia of the region and Tinel's sign could be elicited at the level of the anterosuperior iliac spine. Changing his work alleviated the symptoms.

The quality and distribution of the pain, the presence of Tinel's sign, the absence of motor deficits or reflex abnormalities, and the normal results of the complementary tests characterise our patients as typical cases of meralgia paraesthetica. Our patients did not

have diabetes or significant obesity, which have been described as responsible for some cases.³

Although our patients could have been categorised as idiopathic, their working conditions suggest a traumatic origin. In all four cases the right lateral cutaneous nerve of the thigh was compressed by repeated blows to the groin, where the nerve leaves the abdominal cavity. Discontinuing this activity can alleviate symptoms. We therefore suggest that patients should be asked about their occupational history.

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Vertical gaze palsy due to a resolving midbrain lesion

Vertical gaze palsies usually result from midbrain damage due either to tumours¹ or vascular lesions.²⁻⁴ Less frequent causes include progressive supranuclear palsy⁵ and Niemann-Pick disease, type C.⁶ We describe a case of vertical gaze palsy associated with a rostral midbrain lesion shown on magnetic resonance imaging (MRI). Both clinical and MR imaging abnormalities subsequently resolved completely.

A 21 year old female presented with painless horizontal diplopia which had a stuttering onset over a few hours. She tended to stagger to her right. Eight weeks earlier she had developed varicella. Although typical in all other respects, this was a severe infection keeping her bed-bound for three weeks and away from work for seven. Examination revealed residual scarring over her face and trunk. Visual acuities were 6/4, N4-5 in each eye, and fundoscopy was normal. Her visual fields were full to a 1 mm white target at 1 metre. Vertical saccades and pursuit eye movement were considerably reduced and on attempted upgaze there was divergence of the left eye. Horizontal saccades and pursuit movements, as well as convergence were normal. Both horizontal and vertical oculocephalic movements were full. Pupillary reflexes were brisk and symmetrical without evidence of light-near dissociation. Neither lid retraction nor convergence/retraction nystagmus were present. The remainder of the examination was normal.

Cranial computed tomography (CT) with contrast was normal. MRI was performed on a Picker 0.5 T superconducting machine using axial SE_{2360/60} 4 mm slice thickness sequences. A single region of increased signal in the upper midbrain, at the level of the red nuclei, was demonstrated just to the left of the midline and ventral to the aqueduct of Sylvius (fig). Her signs remained unchanged for a week. The vertical eye movements then slowly improved, with reversion to normal over one month. Repeat MRI 14 months later showed that the midbrain lesion had resolved, and that no new lesions had appeared.

Figure MRI: SE_{2360/60}. Paramedian high signal intensity lesion (arrowed).

Lesions affecting both upgaze and downgaze are situated in the rostral midbrain and are thought to involve the interstitial nucleus of Cajal, the rostral interstitial nucleus of the medial longitudinal fasciculus and possibly the nucleus of Darkschewitz.¹ They are usually tumours or infarcts. In this case, however, the spontaneous complete resolution of the lesion is more in keeping with a demyelinating lesion. There is no additional evidence for a diagnosis of multiple sclerosis, though it cannot be excluded. An alternative possibility is that she had a localised post-infectious encephalitis following varicella, a sequence well known to occur even in the adult. Resolution of MRI abnormalities has been reported in both multiple sclerosis⁷ and post-infectious encephalomyelitis.⁸ This is the first report of a remitting vertical gaze palsy in association with an appropriately sited resolving MRI lesion.

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