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Andrew Brett, Tim Hodgetts

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Keywords: abdominal aortic aneurysm; meralgia paraesthetica

Case report
A 62 year old man presented to the accident and emergency (A&E) department complaining of a sudden onset of pain and altered sensation on the lateral aspect of his right thigh. He had a past medical history of two laminectomies in 1963 and 1965, and a lumbar spinal fusion in 1967. He also suffered from chronic obstructive pulmonary disease and had smoked heavily throughout his adult life. Examination revealed a full range of movement in his lumbar spine and normal motor function in his lower limbs. An area of diminished sensation was noted over the lateral aspect of his right thigh. A clinical diagnosis of entrapment of the lateral cutaneous nerve of the thigh was made and he was discharged with analgesia to be followed up by his general practitioner. He represented the next day with the same symptoms and signs and radiographs were performed of his right hip and lumbar spine which were interpreted as showing no new bony injury (figure). A diagnosis of meralgia paraesthetica was made and he was again referred back to his general practitioner. On both occasions his pulse and blood pressure were recorded as normal.

Six days later he was referred directly to the A&E department with the same symptoms plus increasing back pain. They immediately referred him to the orthopaedic team who admitted him for bed rest and analgesia. His symptoms did not settle with 10 days of bed rest and it was felt that he would benefit from a caudal epidural. At this time it was noted that straight leg raising was reduced to 50% on the right and the femoral stretch test was positive on the same side. After the procedure he was allowed home, to be reviewed in six weeks.

Two weeks later a radiologist’s report on the lumbar spine radiograph was received by the A&E department, commenting on a large abdominal aortic aneurysm. The patient was recalled to the department straight away and following surgical referral elective resection was arranged. At this time he reported that the caudal epidural had not affected the intensity of his back pain, nor had it improved the presumed “root” symptoms. The resection was performed without complication and six weeks later he reported that the symptoms affecting his right thigh had vanished almost immediately after the operation, together with the severe back pain, leaving him with the low grade back discomfort which had affected him for many years.

Discussion
Meralgia paraesthetica is caused by entrapment of the lateral femoral cutaneous nerve and gives rise to symptoms which are entirely sensory. It is a common condition which is most often seen in middle aged males and in pregnant women. The lateral femoral cutaneous nerve arises from the dorsal branches of the second and third lumbar ventral rami. After emerging from behind psoas major it passes laterally, crossing iliacus towards the anterior superior iliac spine. On the right the nerve is lateral to the caecum and is separated from it by the fascia iliaca and peritoneum. On the left the nerve passes behind the descending colon, but both nerves pass either behind or through the inguinal ligament. The anterior branch supplies the skin on the anterior and lateral thigh as far as the knee, connecting terminally with branches of the anterior division of the femoral nerve. The posterior branch penetrates the fascia lata to supply the area over the greater trochanter to the mid-thigh.

It is where the nerve passes under or through the inguinal ligament that entrapment is most likely to occur. It is easy to see how this is possible in obese middle aged men and in pregnancy, but it is not so easy to explain how entrapment or compression might be caused by an abdominal aortic aneurysm. Nevertheless our patient presented with characteristic symptoms of meralgia paraesthetica, which were relieved by laparotomy and resection of a large aneurysm with no evidence of rupture. There are no reports of abdominal aortic aneurysm presenting with symptoms of compression of the lateral femoral cutaneous nerve and although pain in the groin and thigh are well described symptoms, in particular of leaking aneurysm, sciatic or femoral nerve compression is extremely rare.

This case illustrates the danger of a “blinkered” approach to new symptoms in a patient with a chronic condition. It also reinforces the need for the systematic assessment of radiographs in the A&E department and the requirement for a review of the films by a radiologist within a much shorter time period. If
Neck pain in malignant hypertension

Neck pain as a presenting symptom in malignant hypertension

Joanna Stockwell, Grizelda George

Abstract
Neck pain, unrelated to trauma, is relatively common and is usually presumed to be musculoskeletal in origin. A patient presented with an unusual and serious cause of neck pain—malignant hypertension. The mechanism of the neck pain may be incipient tonsillar herniation of the cerebellum caused by raised intracranial pressure.

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Keywords: neck pain; malignant hypertension

We describe a patient who presented to the accident and emergency (A&E) department complaining of neck pain as a presenting symptom in malignant hypertension.

Malignant hypertension is characterised by very high blood pressure with papilloedema and retinopathy. There is associated organ failure, most commonly of the kidneys and heart. The most frequent presenting symptom is headache, often accompanied by other symptoms of hypertensive encephalopathy such as vomiting, blurred vision, and fits. There may also be symptoms of renal and cardiac insufficiency, for example, lethargy and shortness of breath. Neck pain has not previously been described as a presenting symptom in malignant hypertension.

Case report
A 33 year old female patient presented to the A&E department complaining of neck pain on waking for the previous 10 days. She had seen her general practitioner (GP) who had diagnosed musculoskeletal neck pain and had prescribed ibuprofen and a soft collar. On further questioning, she complained of headache and blurred vision. She had, in fact, felt unwell for one month, with loss of appetite, nausea and vomiting, lethargy, weakness, intermittent sharp chest pains, and shortness of breath. She had no significant past medical history. She used an oral contraceptive and smoked 15 cigarettes a day. She was a single mother with four children.

On examination, she looked well. However, she was significantly hypertensive with a blood pressure 250/120 mm Hg. The apex beat was not displaced. She had gross papilloedema. She was mildly photophobic. She was tender over the neck but there was no neck stiffness. There were no other abnormal signs. Preliminary investigation showed advanced renal impairment with a plasma creatinine of 543 mmol/litre. Her urine contained blood and protein. ECG and chest x ray were normal. A diagnosis of malignant hypertension was made and she underwent renal biopsy which showed markedly sclerosed glomeruli. She is currently being treated for a rapidly progressive glomerulonephritis.

Discussion
Malignant hypertension is a potentially life threatening emergency which usually presents with headache. However, in the case described here it presented with neck pain which mimicked non-traumatic, musculoskeletal neck pain.

Although neck pain has not previously been described in malignant hypertension, magnetic resonance imaging (MRI) and single photon emission computerised tomography (SPECT) suggest reasons for it. Hypertensive encephalopathy produces cerebral oedema with regional hyperperfusion of the occipital cortex and cerebellum.1 The cerebral oedema causes raised intracranial pressure—hence the papilloedema, headache (worse on waking), and the vomiting which are so common in malignant hypertension. Hyperperfusion of the occipital cortex may contribute to the visual symptoms, as may the papilloedema. Cerebellar hyperperfusion, together with raised intracranial pressure, would be expected to cause a degree of tonsillar herniation through the foramen magnum. Neck pain has been described as a presenting symptom in tonsillar herniation.2 It therefore seems reasonable to attribute the


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