moperitoneum may have resulted in bilateral nerve injury.

The lateral femoral cutaneous nerve (LFCN) can also be injured when the patient is prone and can be damaged by retraction, which may explain the association of meralgia paresthetica with appendicitis, abdominal hysterectomy and postoperative inflammation cited by Rotenberg.

It is important to consider the effects of position in the etiology of nerve injuries detected postoperatively, regardless of how minor an operation.

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[Dr. Rotenberg replies:]

The patient did undergo laparoscopy in the lithotomy position, and the meralgia paresthetica began in hospital a few days later. However, it seems unlikely that the laparoscopy was a major etiologic factor, for the following reasons.

The patient had a longstanding severe pelvic infection. The laparoscopy report stated that "the abdomen was exceedingly tense. . . . Intestine was adherent to pelvic organs by thick fibrin . . . and both fallopian tubes were thickened and heavily injected." Such severe inflammation over weeks, combined with days of bed rest, seems a more likely cause of meralgia paresthetica than 1 hour of pneumoperitoneum in the lithotomy position.

Dr. Knight's suggestion is drawn from a chapter on neurologic complications of anesthesia in obstetrics.[1] Pregnancy itself is associated with meralgia paresthetica. Even if hours of labour in the lithotomy position could precipitate meralgia paresthetica, months of compression of the LFCN by a gravid uterus seems a more likely etiologic factor.

The symptoms of meralgia paresthetica in the patient I described lasted for over a year. During that time they were not affected by hip abduction, adduction or the lithotomy position. However, they were aggravated by bed rest (i.e., hip extension) and relieved only by sitting (i.e., hip flexion), diagnostic features of meralgia paresthetica[2,3] that are explained by the LFCN's anatomic relations: As the nerve leaves the pelvis with the hip extended it angulates as it crosses medial to the anterior superior iliac spine.[4] The angle is reduced and tension on the nerve relieved as the hip is flexed. Most authorities writing about meralgia paresthetica note that hip flexion[2-5] and abduction[6] relieve rather than aggravate strain on the nerve.

Knight implicitly raises an important point: that meralgia paresthetica frequently has a multifactorial etiology. Vulnerability of the LFCN at its point of angulation,[5] severe PID, bed rest and perhaps the lithotomy position may all have been factors in the case that I reported.

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It is 25 000 operations and counting for Dr. Howard Gimbel

Dr. Howard V. Gimbel's lengthy explanation in response to the questions I raised (*Can Med Assoc J* 1990; 142: 14) concerning his claim to have performed 25 000 cataract operations indicates the reason why "misinterpretation and supposition" could occur in the minds of readers of Terry Moran's article about him (*Can Med Assoc J* 1989; 141: 710-711).

I am therefore grateful that my letter allowed Gimbel the opportunity to allay the fear of myself and some of my colleagues that with so many operations the postoperative care would be inadequate. It has now been explained that this care is performed by either another doctor from the Gimbel Eye Centre or the referring doctor (I assume a medical doctor). This information was not given in Moran's article.

With all due respect, a high quality of care, understanding, compassion, dedication, well-trained staff, a calm pace and ophthalmologists visiting from Third-World countries are common features of many, many ophthalmic surgery centres throughout Canada, including ours, where we have received renowned foreign doctors since our lens implant program began, in 1966. So what else is new? There is surely no misinterpretation or supposition here.

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