abdomen was closed. A mesenteric biopsy specimen contained fibrolastic and collagenous connective tissue. Postoperatively the patient’s symptoms regressed slowly and, after one week he was able to take solids.

The haemoglobin concentration was 12 g/dl, erythrocyte sedimentation rate 33 mm in the first hour (Westergren), and blood bence-Jones protein 4·9 mmol/l (29·5 mg/100 ml). Tests were positive for antinuclear factor (1/1000) and rheumatoid factors (sheep cell agglutination test 1:1256; latex test 1:1024). Chest radiography showed bilateral lower zone reticulonodular shadowing consistent with pulmonary fibrosis. Results of barium studies several months after laparotomy were compatible with PSS.1 Barium meal and follow-through examination showed a widened, atonic oesophagus 7 cm in diameter at its lower end. The duodenal loop and proximal two-thirds of the small bowel were severely dilated, and transit was delayed. Barium enema disclosed a voluminous rectum and sigmoid colon, which were atonic and smooth in outline. Reduced xylose excretion (3·2 g 45 min after a 2·5 g load) and increased three-day faecal fat excretion (128 mmol; 36·4 g) were also compatible with gastrointestinal PSS.

The patient was treated with penicillamine and tetracycline and showed modest improvement.

Comment

Acute and chronic complications of gastrointestinal PSS are recognised. Chronic complications may present as malabsorption syndrome secondary to bacterial overgrowth of the dilated, atonic bowel2 or as pseudo-obstruction of the small bowel3 resulting from dilatation, atony, and delayed transit. Acute complications include fatal peritonitis and haemorrhage4 and also acute pseudo-obstruction.

Although colonic volvulus associated with PSS has been reported,5 small-bowel volvulus has not been described before. Several mechanisms have been suggested for the production of various types of intestinal volvulus. The present case appears to have been due to a combination of factors—namely, suspensory ligament dysfunction resulting from the abnormal collagen of PSS; disordered peristalsis after a heavy meal; and the enlarged intra-abdominal cavity, resulting from diaphragmatic evertedation, allowing abnormal movement of the small intestine.

3 Herrington, J L, jun, Archives of Surgery, 1959, 78, 17.
4 Manolo, H, and Albo, D, jun, American Journal of Surgery, 1971, 122, 678.
(Accepted 23 January 1979)

University Department of Gastroenterology, Manchester Royal Infirmary, Manchester M13 9WL
M S HENDY, BSc, MRCP; senior house officer
H B TORRANCE, CHM, FRCS, consultant surgeon
T W WARNES, MD, MRCP, consultant physician

Genitofemoral neuropathy

Genitofemoral neuropathy appears to be a rare entrapment syndrome, and all cases reported have resulted from local injury, usually appendicectomy. I describe a young woman with an apparently idiopathic entrapment neuropathy of this nerve; her condition might have been aggravated by modelling tight jeans.

Case history

A 20-year-old model first noticed an area of numbness about 5 cm diameter just below the middle of the inguinal ligament in November 1977. Occasionally she had an unpleasant tingling in this region and she was sore to touch. It was aggravated by standing and, when severe her hip ached. Modelling jeans in January 1978 aggravated the symptoms. There had been no recent weight increase. She had been taking oral contraceptives for three years. When she was first seen, in March 1978, she had a constant ache in the left groin, hyperpathia, and numbness.

Examination showed impaired pinprick and cold appreciation with hyperpathia to light touch in the cutaneous distribution of the femoral branch of the left genitofemoral nerve. There was no triple response in this area. A depot preparation of methylprednisolone (1 ml) was injected just lateral to the femoral artery and just below the inguinal ligament. This relieved the hyperpathia within 24 hours, and one month later appreciation of pinprick was only slightly impaired. This residual numbness gradually faded, and by the end of May she was symptom-free. In July, however, the symptoms recurred, with tingling and sensitivity to light touch, and in October these symptoms faded a little to be replaced by numbness. As before, standing for any length of time made it worse. Once again the symptoms responded to local injection of methylprednisolone.

A special technique is used to put on jeans that are several sizes too small. It requires the help of three assistants. The model wears nylon pants which extend from the waist to the knees to overcome friction. Two assistants, one on each side, help to pull on the jeans while the model lies on her back. The third assistant kneads at the head of the model holding a wooden coat-hanger, whose hook is looped into the zip fastener ready to pull as soon as a special device to hold the front of the jeans together has been applied, and provided the material does not tear. Once encased it is impossible to stand up without help or to sit down.

Comment

The genitofemoral nerve arises from L1 and L2. It passes down through psoas and divides into two major branches. The genital branch enters the inguinal canal through the deep inguinal ring and continues to supply the cremaster and upper lateral part of the scrotum or mons pubis and labium majus. The femoral branch accompanies the external iliac artery, passes under the inguinal ligament, and enters the femoral sheath lateral to the femoral artery and supplies the upper part of the femoral triangle.

Only 10 cases of genitofemoral neuropathy have been reported.6 7 The patients were equally divided between the sexes, and their average age was 27 years (11–65). In all cases identifiable trauma to the nerve was the cause, usually appendicectomy (eight cases). One patient also had a herniorrhaphy, one a psoas abscess, and one young girl fell off her bicycle and injured her groin on the handlebar. The onset of symptoms was immediate in two patients but was usually delayed by months or years. One of these patients had the nerve decompressed, and in seven others the nerve was cut. Operative treatment was successful in all eight.

Pressure from clothing, usually corsets, is a well-recognised cause of damage to the lateral cutaneous nerve of the thigh, producing meralgia paraesthetica, but this nerve is more superficial and more lateral; the genitofemoral nerve is relatively protected in the hollow of the groin. Wearing tight jeans might have been an aggravating factor in this patient, but the onset of symptoms predated the time she was modelling them. There was good response to local steroid injection on two occasions, but this treatment may not be sufficient when the nerve is damaged by operation, and it might be difficult to locate or reach the site of damage. Exploration and nerve section seem to be effective. In another patient seen recently, whose lesion occurred after three lower abdominal operations, including appendicectomy, the symptoms were relieved by an epidural phenol injection at L1.

1 Magee, R K, Canadian Medical Association Journal, 1942, 46, 326.
(Accepted 8 February 1979)

Department of Neurology, Guy’s Hospital, London SE1 9RT
M D O’BRIEN, MD, MRCP, physician for nervous diseases

Corrections

Campylobacter colitis

We regret that an error occurred in this article by Dr M E Lambert et al (31 March, p 857). On page 858 under “Results” and “Discussion” the word “irritable” should have read “inflammatory.”

Serum ferritin concentration and oral iron treatment in patients on regular haemodialysis

We regret that a printing error occurred in this paper by Mr A M Cotterill and others (24 March, p 790). The eighth sentence in the patients, methods, and results section should have read “Only three patients had received intravenous iron at any time and none had received it within a year of starting the study.”