Prolotherapy Letter to the Editor

Regarding the prolotherapy article ("Prolotherapy relieves groin pain in study of soccer, rugby players," June, page 11) I felt compelled to share some comments. The short term results are very impressive. Prolotherapy, using lidocaine for analgesia and dextrose as a proliferant, over the course of 17 months resulted in significant reduction in pain and return to pain-free sports participation at full capacity, in 20/24 participants. Two subjects were not able to return full capacity and 2 had pain when participating. Limitations of the study can not be adequately ascertained, given the brevity of the article. The use of lidocaine with a proliferant is supported by the results but naturally, a lack of control group fails to separate the two different mechanisms of action.

The athletes who did not achieve a successful outcome may very well experience more than a mild degree of disablement, which will easily spill into other facets of their lives. I have empirical knowledge of abdominal neuropathy/neuropathies (AN/ANs) having sustained a pelvic fracture (diagnosed 25 years later) and 4 AN; all due to a severe motorcycle accident 31 years ago. I submit that the possibility of AN/ANs is worthy of consideration for those who have lasting disablement and unresolved groin pain.

With respect to the sensory distribution of the suprapubic and inguinal areas, the spinal segments can encompass the 12$^{th}$ thoracic, upper 3 lumbar segments and proximal structures may have a sacral sensory distribution. There is considerable overlap and redundancy in the sensory nerves that cover the area, such that caution is mandatory when testing the area from the perspective of dermatomes and of peripheral nerves. Successful ablation of the genitofemoral and accessory obturator nerves has not resulted in sensory loss in my personal experience, yet did provide substantial relief, along with improvement in function. By using lidocaine, the author might have captured the accessory obturator nerve as it loops over the pubic bone. I submit that sensory testing to rule out AN/ANs mandates cautious interpretation in order to avoid false negatives. The zone of hypersensitive left lower abdominal wall has extended over time; such that I can scratch on the right and left abdominal wall and provoke left-sided distal symptoms. Some of the pain generated by AN, is very deep and poorly localized; and can subjectively fit the paradigm of instability of "sacroiliac joint (SIJ) origin." The anterior capsule of the SIJ has the very same segmental innervation as the abdominal wall, and proximal reflex muscle spasm of course, will alter trunk and pelvic posture and movement.

A negative screen for inguinal hernia (no bulge) if extremely painful, can implicate an ilioinguinal neuropathy. Pressure above the inguinal ligament can refer to the medial calf and is easily confused with a co-existing S1 radiculopathy; when in fact the dysesthesia is mediated by the terminal saphenous portion of the femoral nerve. The same pressure can skip the proximal thigh and cause a diffuse sense of warmth in the foot, perhaps mediated sympathetically.

Cautious digital pressure on the scrotal contents can be revealing in the presence of genitofemoral AN, and I have reason to suspect that is not a "standard of care" in screening groin pain.

Other less common hernias should be ruled, such as at the obturator foramen. Referral to a genitourinary or surgical specialist is warranted for recalcitrant groin pain. The proximity of the hip joint mandates traditional screening, and the traditional medical