**Proximal Lower Extremity Mononeuropathies – Table 5**

| Nerve | Nerve Conduction Study (NCS) | Electromyography (EMG) | Normative studies |
|---|---|---|---|
| **Ilioinguinal, Iliohypogastric, Genitofemoral** | None | Ilioinguinal: denervation in lower abdominal muscles | Exclude lumbar radiculopathy or upper plexus lesion with proximal thigh and paraspinal muscle EMG |
| **Femoral** | Technically challenging due to the depth and variable course of the nerve<br>Compare with the unaffected side.<br>A compound motor action potential amplitude of at least 50% of the other side, obtained between 10 days to 1 month after injury, predicts good prognosis for recovery within 1 year.[15,20]<br>Saphenous nerve studies should be compared to the unaffected side. | Iliopsoas and quadriceps muscles help localize the lesion in relation to the inguinal ligament.<br>EMG will be normal in isolated saphenous nerve injuries. | Exclude lumbar radiculopathy with EMG (recommend tibialis anterior, vastus medialis/lateralis, adductor longus, and lumbar paraspinals). |
| **Lateral femoral cutaneous** | Technically challenging given variability in path of the nerve – 80% are located 0-1.5 cm medial to the ASIS but some may run up to 8.5 cm medial[23]<br>If unilateral, recommend first assessing the unaffected side.<br>The use of ultrasound to localize the nerve can improve the ability to record a response.[11,24] | None | Exclude lumbar radiculopathy and plexopathy with EMG (recommend tibialis anterior, vastus medialis/lateralis, adductor longus, and lumbar paraspinals).<br>If bilateral, exclude polyneuropathy. |
| **Obturator** | None | Denervation in adductor longus<br>Possible denervation in adductor magnus (partially sciatic innervated) | Exclude lumbar radiculopathy or upper plexus lesion with EMG (recommend tibialis anterior, vastus medialis/lateralis, adductor longus, and lumbar paraspinals). |