MONTREAL

# Femoral Neuralgia Treatment in Montreal.



The condition explained.
Spinal decompression.
**Your care journey.**

Practical guidance to prepare for your visit and track what matters in everyday life.

**Your situation comes first.**

Assessment · options · follow-up

Illustrative image from the TAGMED website.

**Prepare for my consultation** →

COMPLETE GUIDE / MONTREAL

- **Understand**
- **Prepare**
- **Move forward**

## Your path through this guide


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01 / THE CONDITION

# Understanding the terms. Relating them to your situation.

Femoral neuralgia (cruralgia) is nerve-related pain that often travels down the front of the thigh towards the knee. It may arise from irritation of the upper lumbar nerve roots. Pain in this area nevertheless warrants an assessment that also considers the hip and knee. [1]

The crural nerve, also called the femoral nerve, contributes to sensation at the front of the thigh and to quadriceps function, among other roles. Irritation of some of its roots, particularly L3 or L4, can produce pain felt in this area. The back is not necessarily the most painful area. The aim is therefore to look for agreement between the pain pattern, examination and a possible cause, rather than drawing a conclusion from the term “cruralgia” alone. [1]

### Femoral neuralgia and sciatica

Both types of pain may originate in a lumbar nerve root, but their usual patterns differ. Femoral neuralgia mainly affects the front of the thigh and knee; sciatica more often affects the buttock and the back or side of the leg. These areas sometimes overlap. [1]

### Pain and nerve-related impairment

Pain alone does not amount to a loss of strength. Nerve root involvement can also alter sensation, the knee reflex or certain movements. New weakness, a knee that gives way or increasing difficulty on stairs should be reported promptly. [1]

## The connection with symptoms

A nerve root passes through the spine before contributing to a peripheral nerve. Pain may therefore be felt in the thigh even though the irritation is in the lumbar region. A problem affecting the femoral nerve farther along its course can produce similar signs. The examination helps distinguish these situations and pain arising from local joints. [1]

Numbered references and clickable links on page 18.

02 / THE STRUCTURES INVOLVED

# Understanding the structures.

The lumbar discs, small joints and nerve exit openings surround the nerve roots. The region and side involved influence where symptoms are felt; a level written on an MRI report is not a complete diagnosis. [2]

## What matters in this region

Discs distribute loads between vertebrae. A disc bulge or narrowing of a nerve passage can contribute to nerve root irritation. Degenerative changes and joint problems may coexist. An image shows the structure at the time of the examination; it must be considered alongside the patient’s symptoms and actual course. [2] [4]

### A disc-related cause

A lumbar disc herniation or protrusion may affect a nerve root. Its position and relationship to the nerve matter more than an isolated term in the report. Not every visible disc bulge necessarily causes nerve symptoms. [1]

### A narrowed nerve passage

Stenosis can reduce the space available around a nerve root. Disc, joint or bone changes sometimes contribute to the narrowing. Their presence must correspond to the side and area of pain to guide care suited to the clinical presentation. [4]

### The hip or knee

Pain at the front of the thigh or near the knee can also arise from these joints. The symptom history, mobility and clinical tests help avoid automatically attributing all pain to the lumbar disc without looking for other possible explanations. [1]

### Another nerve problem

A nerve can be affected somewhere other than the spine. Medical history, operations and known illnesses are part of the clinical investigation. An unusual presentation may lead to a further medical assessment to clarify the origin of the signs currently observed. [1]

Numbered references and clickable links on page 18.

03 / SIGNS AND SYMPTOMS

# Symptom distribution and activities. Changes to observe over time.

Note the side, painful areas and changes in sensation. In particular, describe tasks that have become difficult: climbing stairs, getting up from a chair or walking. These observations provide a concrete starting point for follow-up. [1]

## Two patterns to distinguish

### Possible L3 distribution

Pain or unusual sensations at the front of the thigh and around the knee. The assessment looks in particular for changes in quadriceps strength and the knee reflex. [1]

### Possible L4 distribution

Pain or altered sensation towards the front of the knee and the front or inner part of the lower leg. The pattern alone cannot determine with certainty which nerve root is involved. [1]

## What changes over time tell us

The course depends on the cause and associated signs. Some nerve root pain gradually settles with appropriate care, while persistent difficulty or impairment calls for reassessment. Follow-up is not limited to pain intensity: knee stability, walking and strength also matter. A neurological change must not wait until the end of a program. [1] [3]

Numbered references and clickable links on page 18.

04 / THE ASSESSMENT

# Connecting your history, the examination and the images.

The assessment looks for a compatible lumbar origin, as well as other local or neurological explanations. Bring any existing test results and describe pain, numbness and any loss of strength separately. [1] [3]

1

## Trace the onset and pattern

Specify the date of onset, aggravating positions, the extent of the pain and previous episodes. Report changes in health, procedures and medications. This history helps prioritize possible explanations and precautions. [3]

2

## Examine the back and limb

The examination may assess walking, the hip, knee, sensation, reflexes and strength. Nerve tension tests are interpreted alongside the rest of the assessment. No movement tested at home replaces this analysis. [1]

3

## Choose useful investigations

Imaging or an additional nerve test is considered if its result could change care. Weakness, an atypical presentation or lasting symptoms may warrant medical advice. Tests are not the same for every patient. [3]

MRI can show discs and nerve passages. An X-ray mainly describes bone structures and alignment. The need for imaging depends on the examination, the course and the care plan; a new MRI should not be requested routinely before every consultation. [3]

**In a report:** “Radicular” means related to a nerve root. “L3-L4” refers to a level between two vertebrae, not automatically to the affected nerve root. “Foraminal” specifies a location near a nerve exit. Ask how these findings relate to your symptoms. [1]

05 / SEEKING HELP

# When to seek care.

Femoral neuralgia accompanied by a significant neurological change must be assessed without waiting for the next appointment. The signs below may indicate a problem requiring urgent care. [1]

**GO TO THE EMERGENCY DEPARTMENT IMMEDIATELY**

- New difficulty urinating, urinary retention or loss of bladder or bowel control requires an urgent assessment.
- New loss of sensation between the legs, around the genitals or anus requires an urgent assessment, even if the pain remains moderate.
- Severe or rapidly progressive weakness in one or both legs, particularly when walking has become difficult, requires an urgent assessment.

**Call 911** if you need immediate assistance.

## Prompt medical advice

• A knee that gives way or new loss of strength in the thigh.
• Pain accompanied by fever, following a significant fall or with a decline in overall health.
• Pain that progresses despite the measures already proposed or greatly limits walking.

## A visit to arrange

If pain persists, worsens or interferes with sleep and your activities, seek an assessment. Describe changes since the onset, measures already tried and a specific activity that has become difficult.

Numbered references and clickable links on page 18.

06 / OUR TREATMENT

# Spinal decompression at TAGMED.

DOC decompression applies controlled traction and adapted positioning. For a clinical presentation selected after assessment, it aims to alter stresses in the lumbar region. This mechanical rationale does not prove that a specific nerve root will be freed or that a herniation will disappear; the functional response must be measured. [6]



Illustrative image of the care journey.

## A non-surgical approach

Motorized traction applies controlled tension to the lumbar region. Setup and settings take into account the selected clinical profile, precautions and the sensations you describe during the session. [6]

### DOC equipment from Pivotal Health Solutions

The device allows adjustment of position, force and cycles. Program selection is based on assessment and tolerance; a device’s capabilities alone do not predict a clinical outcome. [7]

## Goals to discuss

- Improve a limited activity, such as climbing stairs or getting up from a chair.
- Track thigh pain, sensation and strength separately.
- Gradually return to more comfortable and safer walking.

07 / HOW IT WORKS

# Controlled force. Individualized settings.

Traction and positioning aim to modify mechanical stresses. The program can vary the force, its gradual increase, its hold and the relaxation phases. [6]

1

### Position

The region and position are chosen according to the clinical profile, precautions and your comfort.

2

### Program

The practitioner adjusts the force, duration and pattern of the traction cycles.

3

### Adjust

Tension follows the selected program, with phases of reduced tension.

4

### Reassess

Your sensations and response guide whether to continue, adjust or stop treatment.

## What “decompress” means

A reduction in pressure and fluid exchange within the disc are among the proposed mechanisms. They do not demonstrate disc regeneration, lasting widening of bony structures or the certain disappearance of a herniation. A useful effect is assessed in your daily life and during reassessments. [6] [8]

Numbered references and clickable links on page 18.

08 / IS IT SUITABLE FOR ME?

# The right treatment begins with the right clinical profile.

Discussing non-surgical spinal decompression requires a sufficiently plausible spinal origin and verified precautions. Thigh pain or a disc change on an image is not enough to decide on treatment. [1] [6]

## A presentation to discuss

Femoral neuralgia associated with a corresponding disc problem may lead to a discussion of motorized traction among the possible options. The aim would be to improve symptoms and activities. However, studies of other types of low back pain do not provide a success rate specific to L3 or L4 femoral neuralgia. [5] [6]

## Reasons to change direction

Progressive weakness, another cause of pain or a contraindication calls for another strategy. Suitability takes spinal stability, surgeries, implants and overall health into account. Clinical follow-up remains necessary even if a session provides relief. [6] [1]

## Medical history to disclose before any session

The DOC manual lists fracture, spinal instability, infection, tumour, advanced osteoporosis and certain spinal implants among the contraindications. Pregnancy and previous surgeries also require particular attention. [6]

This list is not exhaustive. Bring details of your medical conditions, procedures and treatments.

**If warning signs are present:** appropriate medical assessment is the priority. See the emergency guidance on page 6.

Numbered references and clickable links on page 18.

09 / THE SESSION

# What happens during a decompression session.

The first consultation establishes the clinical profile and the proposed plan. On the day of a session, setup and settings depend on what has been selected for you. [8]

1

## Review your situation before starting

Report changes since the last visit: pain, symptom distribution, sensations, strength and reactions to care.

2

## Get comfortably positioned

The support system suited to the region is positioned. The operation of the stop control is explained to you. [6]

3

## Apply the selected program

The force and cycles are set. Describe your sensations; an increase in symptoms warrants stopping and checking. [6]

4

## Check the response after the session

Tension is released, then you get up gradually. Instructions and what to monitor before the next visit are explained. [6]

**Time to allow:** the discussion, setup, treatment phase and final check. Your appointment length is confirmed when you book.

Numbered references and clickable links on page 18.

10 / THE PLAN AND REASSESSMENTS

# A structured care journey. Progress to measure.

The frequency and number of sessions are individualized. Reassessments allow comparison of your response and adjustment of care, rather than automatically continuing a program. [8]

01

## Establish the starting point

Describe the main problem and choose measures to track: low back or limb pain, walking, sitting and sleep.

02

## Assess tolerance and response

Compare observations over the course of visits. Function, tolerance and clinical signs contribute to the decision to continue.

03

## Adapt the next steps

Depending on progress, modify the parameters, frequency, advice or referral. Persistent or new symptoms may warrant another opinion.

### Before agreeing on the plan, clarify together:

The goals, proposed frequency, costs, first reassessment and options if progress is insufficient.

Numbered references and clickable links on page 18.

11 / POSSIBLE BENEFITS AND EVIDENCE

# What you can expect. What remains uncertain.

It is necessary to distinguish the description of femoral neuralgia, the identified cause and the evidence for a treatment. Data on low back pain or sciatica do not automatically apply to all thigh pain. [1] [5]

UNDERSTANDING THE DIAGNOSIS

## A useful distribution, without certainty on its own

The COFER reference describes upper lumbar nerve root problems and the sensory, motor and reflex examination needed to assess them. This approach helps recognize a nerve-related presentation and distinguish some possible causes. On its own, it does not demonstrate the effectiveness of non-surgical spinal decompression for every situation described as femoral neuralgia. [1]

LOW BACK RECOMMENDATIONS

## Reservations about traction

NICE advises against traction for low back pain with or without sciatica. This recommendation should be known when discussing motorized traction of the lumbar spine. The precision of a device’s settings does not, on its own, demonstrate superior clinical benefit or allow a result to be promised for a particular case of femoral neuralgia. [5]

BROADER CARE

## Function, activity and medical advice

Information, activity adjustment and rehabilitation may form part of a conservative care plan. Their selection depends on the cause, abilities and severity of signs. A mechanical option must be assessed alongside these other possibilities; it must never delay medical advice for a new loss of strength or an unusual course. [3]

**Key point:** Possible decompression is discussed after clinical selection, with realistic expectations and follow-up criteria. Ask why your presentation might be suitable and when another opinion would be indicated. The goals remain concrete: walking, getting up and preserving nerve function. [6] [3]

12 / DAILY LIFE

# Simple actions. A pace to adjust.

In the absence of warning signs, the goal is to continue activities you can tolerate. Advice and exercises are adapted to your symptoms and abilities; ask what is appropriate for your situation.

01

## Keep moving

Break activities into periods you can tolerate. A gradual return may be preferable to prolonged immobility, taking into account the advice you have received.

02

## Vary your positions

Alternate tasks and postures, particularly at work or during travel. Record how long you can tolerate them rather than seeking a perfect posture.

03

## Find comfort at night

Look for a comfortable position. A support cushion may help, depending on your tolerance. Avoid maintaining a position that clearly increases symptoms.

04

## Ask for advice

Discuss medications with your physician or pharmacist. Report any decline in strength, sensation or function instead of pushing through these changes.

## A specific goal to choose with your practitioner

The activity I want to resume: _____

My starting measure (time, discomfort or distance): _____

Numbered references and clickable links on page 18.

13 / YOUR QUESTIONS

# Answers to help you make an informed decision.

### Can pain at the front of the knee come from the back?

Yes, some lumbar nerve roots contribute to this area. The hip and knee can also produce similar pain. The examination must relate the pattern to other signs before concluding that the pain has a lumbar origin. [1]

### Is femoral neuralgia simply sciatica?

Both are sometimes nerve root pain, but they do not usually involve the same roots or pattern. Distinguishing the front of the thigh from the back of the leg helps guide the assessment. [1]

### Is a new MRI always required?

Bring the tests already available. New imaging is decided according to the situation and what it could change in care. Medical advice becomes particularly important if strength changes or the presentation is unusual. [3]

### Does decompression guarantee that the pain will disappear?

No individual guarantee can be given. The assessment first checks the plausible cause and precautions. If a trial is chosen, follow-up must compare pain, function and any nerve-related signs. [6] [5]

### What should I note between consultations?

Note how far the symptoms extend, their intensity, sensations and a reference task. For femoral neuralgia, climbing stairs, getting up from a chair or a feeling that the knee gives way are particularly useful to describe. [1]

### When should I avoid waiting?

New or increasing weakness requires prompt advice. New urinary or bowel problems, loss of sensation in the perineum or severe weakness require an immediate assessment. These signs take priority over any routine care appointment. [1]

Numbered references and clickable links on page 18.

14 / MY PREPARATION CHECKLIST

# Your first visit, with a clearer mind.

Check the items you have prepared. Bring this sheet, your symptom journal and the documents you already have.

Initials (optional): _____ Date: _____

- [ ] **The location and distribution of my pain**
  How long? Which side? How far do the symptoms extend?
- [ ] **Activities that have become difficult for me**
  Walking, stairs, sitting, sleep, work or leisure activities.
- [ ] **Reports and images I already have**
  MRI scans, X-rays, reports and previous opinions, if I have them.
- [ ] **Medications and care I have already tried**
  Effects experienced, procedures, implants and important medical history.
- [ ] **My questions and goals**
  What I want to understand and the activity I want to return to.

## Questions to ask

- What is the most likely cause, and what supports this hypothesis?
- Which options suit my clinical profile, with their benefits and limitations?
- How should we measure progress, and when should I seek another medical opinion?

Personal sheet to keep and bring to the visit.

15 / MY 7-DAY JOURNAL

# Observe changes, as well as pain.

Fill in one row per day. Choose an activity to compare and record your reactions to care. Function and changes in sensation are as useful as the pain score.

**Pain:** 0 = none; 10 = worst pain imaginable. Specify the region.
**Activity:** minutes tolerated or chosen measure. **Sleep:** awakenings due to pain.

| Date | Back / leg 0 to 10 | Walking minutes | Sitting minutes | Sleep awakenings | Notes / care tried and effect experienced |
|---|---|---|---|---|---|
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| | | | | | |

## What has improved

## What remains difficult

New or progressing weakness must be reported promptly.
For emergency signs, see page 6.

16 / YOUR NEXT STEP

# Review your situation in Montreal.

Sylvain Desforges, docteur en ostéopathie

## Montreal

Mont-Royal

1140, avenue Beaumont
Mont-Royal (Québec) H3P 3E5

**1 (877) 672-9060**

**Book an appointment →**

**Web guide / Montreal**

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## Terrebonne

Lanaudière

1150, rue Lévis, bureau 200
Terrebonne (Québec) J6W 5S6

**(450) 704-4447**

**Book an appointment →**

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## Choosing the right appointment portal

### Montreal / Mont-Royal

Medexa displays “Le Centre Neurothérapie de Montréal”. Select the new patient osteopathy pathway and check the selected practitioner.

### Terrebonne

On GOrendezvous, select the new client pathway and osteopathy treatment, then Sylvain Desforges in Terrebonne and an available appointment.

**View fees**

**Sylvain Desforges’s profile**

Availability is shown in the portals. Services are not covered by RAMQ; osteopathy receipts may be issued. Check your insurance policy conditions.

17 / REFERENCES

# Learn more and find the sources.

Numbers in square brackets refer to the sources below. Titles are clickable. Sources accessed on October 22, 2026.

**[1] COFER. Radicular pain and nerve entrapment syndrome, item 95.**

L3-L4 femoral neuralgia, distributions, examination and signs of severity.

**[2] NIAMS. Back Pain.**

Structures and possible causes of low back pain.

**[3] NIAMS. Back Pain: Diagnosis, Treatment, and Steps to Take.**

Examination, imaging and conservative care.

**[4] NIAMS. Spinal Stenosis.**

Narrowing of nerve spaces and manifestations.

**[5] NICE. NG59, recommendations.**

Low back care and reservations about traction.

**[6] Pivotal Health Solutions. DOC, user manual, rev. E.**

Motorized traction, settings and precautions.

**[7] Pivotal Health Solutions. DOC Decompression Table.**

Device features and parameters.

**[8] Clinique TAGMED. Spinal decompression.**

Overview of the treatment offered by the clinic.

General information document from TAGMED Clinic. It does not replace an individual assessment or medical advice. Parameters, suitability and the care plan are determined on a case-by-case basis.