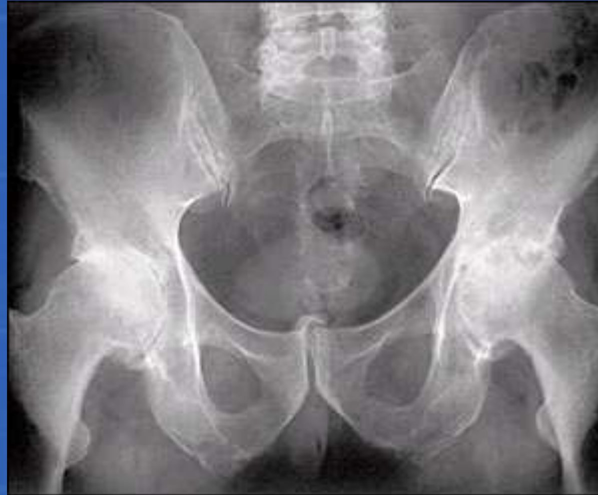
Management Of Hip Pain



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Intra-Articular

OR

Extra-Articular

Extra-Articular Causes

Gynaecological - fibroids, endometriosis

Urological – UTI, testicular pathologies

Gastrointestinal – Hernias

Vascular – Aneurysm, Claudication

Musculoskeletal – Spine, Entheseopathies, Myopathies

Other – Primary or secondary tumours

Spire Healthcare

Specialist Primary and Revision Hip and Knee Arthroplasty

400 Primary Hips and Knees

>30 Revisions

10-20% @ Spire Yale

NHS

History And Examination

- Pain and stiffness
- Walking Distance
- Sleep Pattern
- Shoes, socks etc
- Activities of Daily Living
- Swelling
- Wasting
- Range of Movement
- Other Joints
- Location of Pain

GROIN

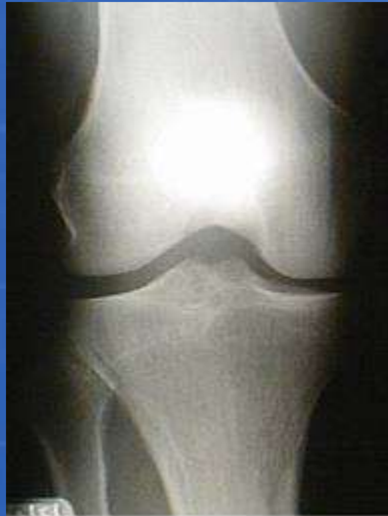
THIGH

KNEE

SHIN
30%

Sartorius
Rectus femoris
Vastus intermedius
Adductor longus
Vastus lateralis
Vastus medialis
Patella

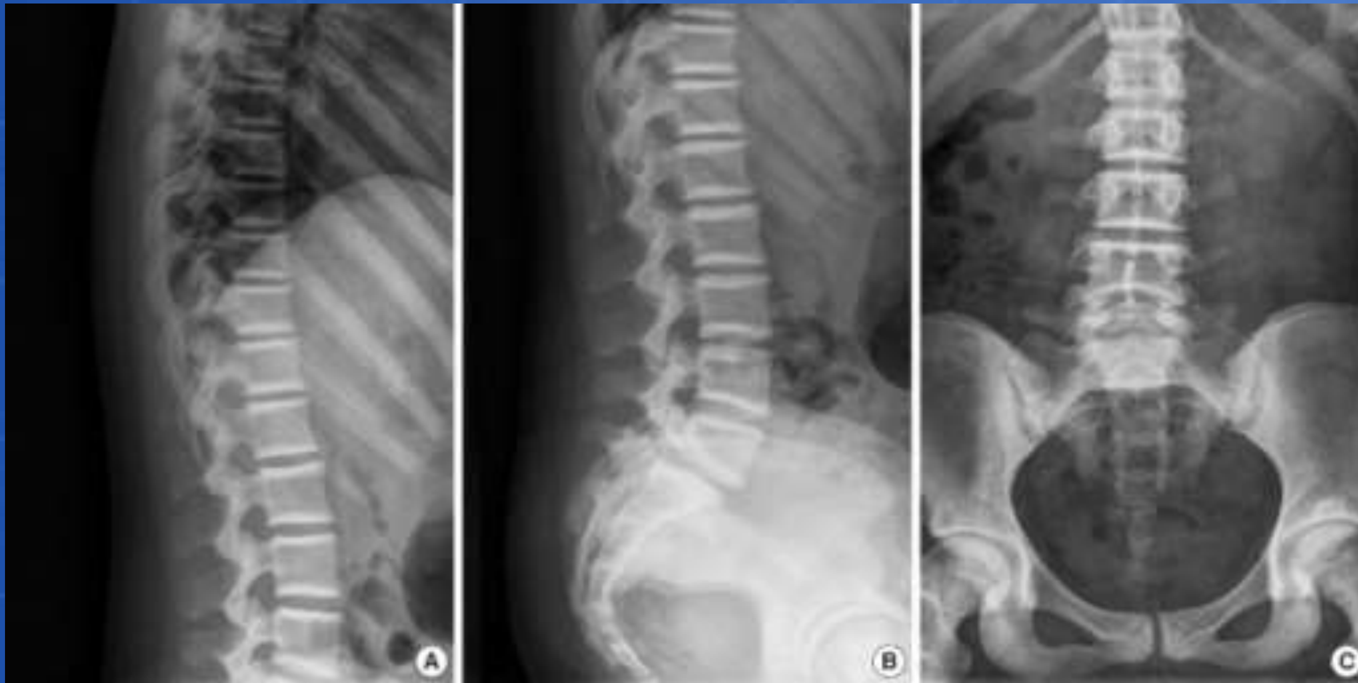
Normal Knee Xray, think HIP (THEN think soft tissue knee)



Spire Healthcare

NHS

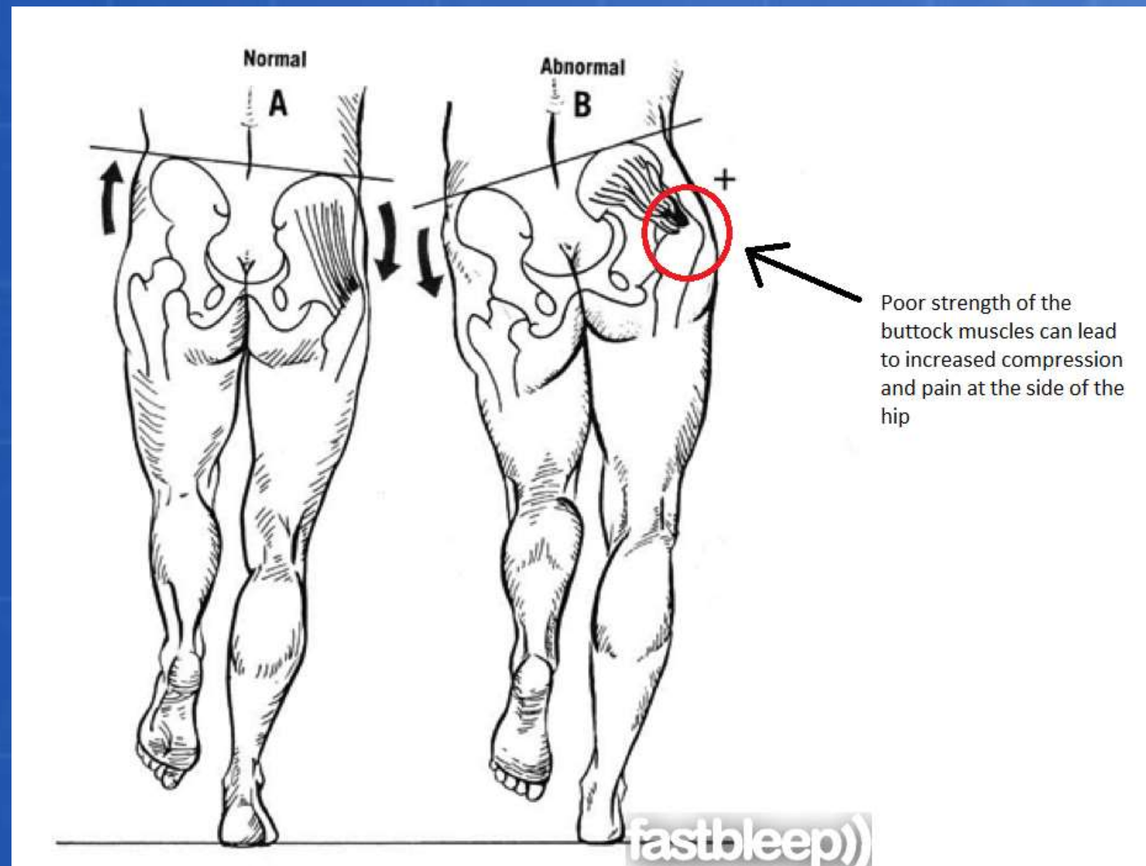
Buttock Pain – Think Spine



Spire Healthcare

NHS

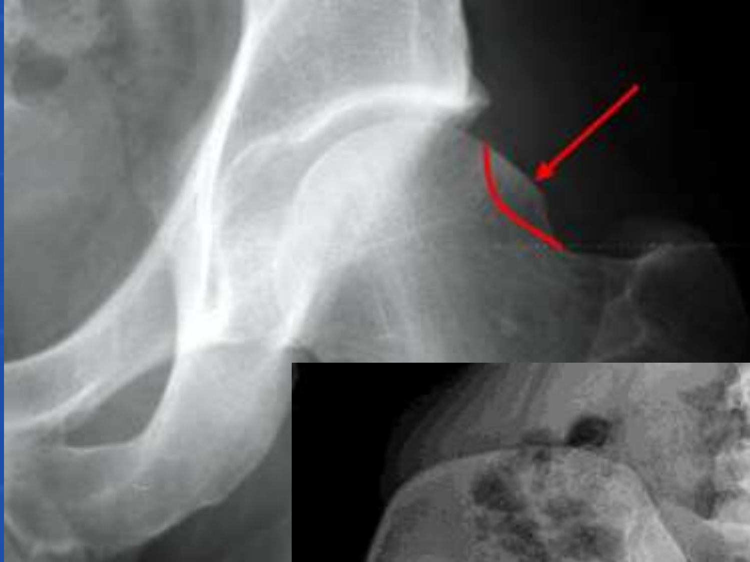
Lateral Hip or Iliac Crest Pain



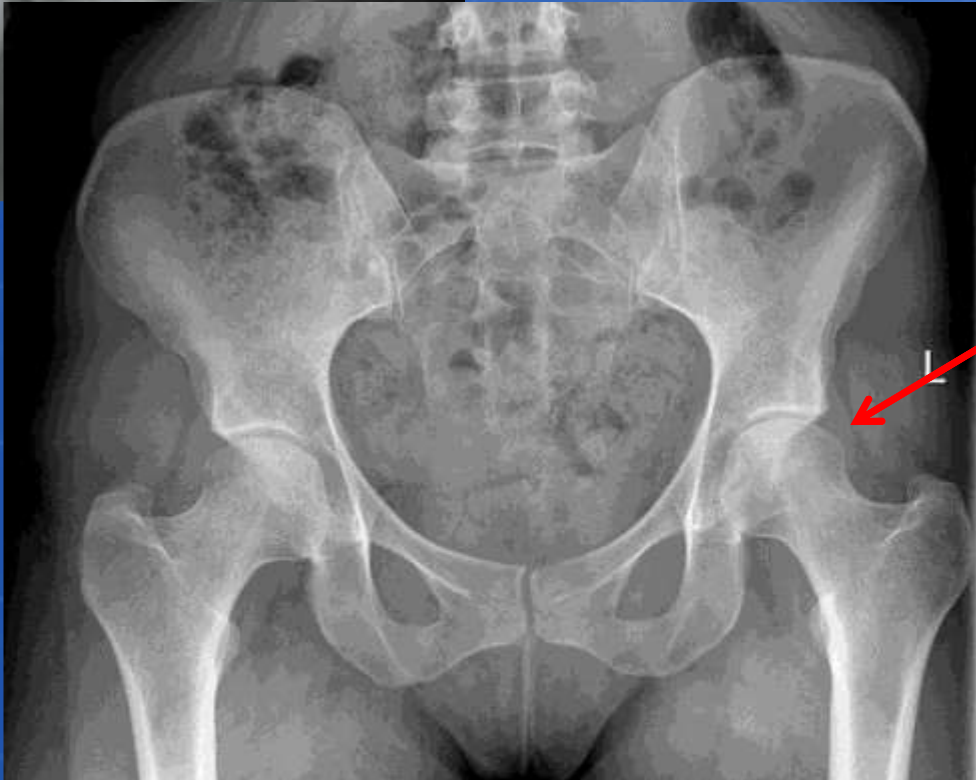
Spire Healthcare

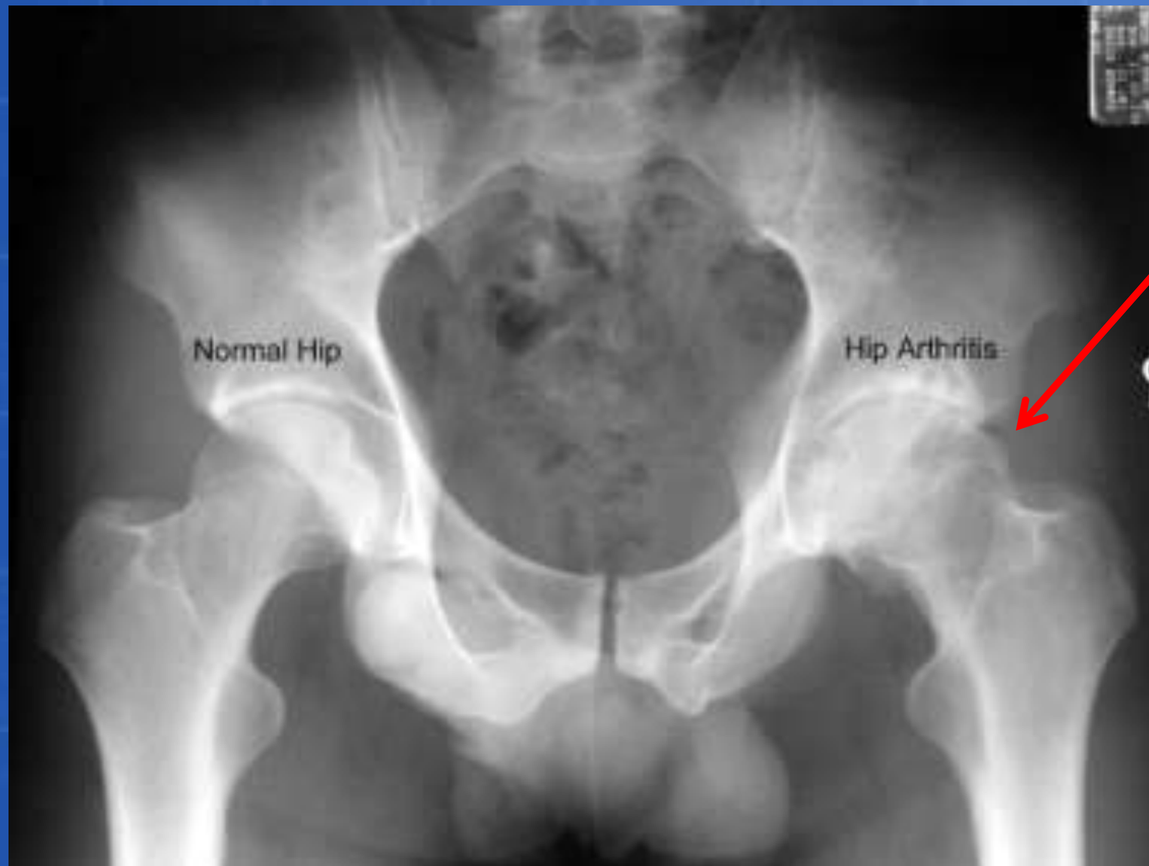
NHS

Over Reporting of Impingement ??



Are these BOTh CAM or Impingement Lesions??





This is NOT Impingement, its Arthritis!!!!!

Spire Healthcare

NHS

Pain And Disability

Pain, Stiffness and Disability

0.7
0.6
0.5
0.4
0.3
0.2
0.1
0

TIME

Duration of Symptoms?

Investigations

History and Examination

Hip Pain/Knee Pain

Diagnosis

Conservative Management

Operative Mangement

Activity Modification
Walking Stick/Crutch
Analgesia
Physiotherapy

Arthroscopy
Osteotomy
Arthroplasty
{Arthrodesis}

Injections
Orthotics
Alternatives

Conservative or Operative?

- When not if ?
- Where - primary care
- Delay or defer - how long
- Who decides?
  - » Patient
  - » GP
  - » GPWSI
  - » Physiotherapist
  - » Nurse
  - » Consultant

Investigations

- X-Ray - poor correlation to symptoms but useful
- Specialist views
- Blood Tests
- (MRI)
- (Bone Scan)

Investigations

Hip Pain/Knee Pain

History and Examination

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Activity/Lifestyle Modification

- Glucosamine/Chondroitin Sulphate
- Cod Liver Oil
- Avoid Citrus Fruits
- Weight loss
- Walking Stick
- Low Impact Cardiovascular Activity
  - Swimming, cycling, walking
- Avoid what makes it worse !!!

Physiotherapy

- RCT's
- Improves PAIN
- Only MODEST improvement in Disability
- Should be tried in most cases
- Insoles, splints and braces

Injections

- Steroid - 3/4 per year
- Improves pain for 1/12 but no better than placebo for function
- Possible increase in sepsis risk at TKR/THR

- Synvisc (hyaluronic acid substitute)
- Comparable with steroid, no better

Investigations

Hip Pain/Knee Pain

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Oxford Hip and Knee Scores

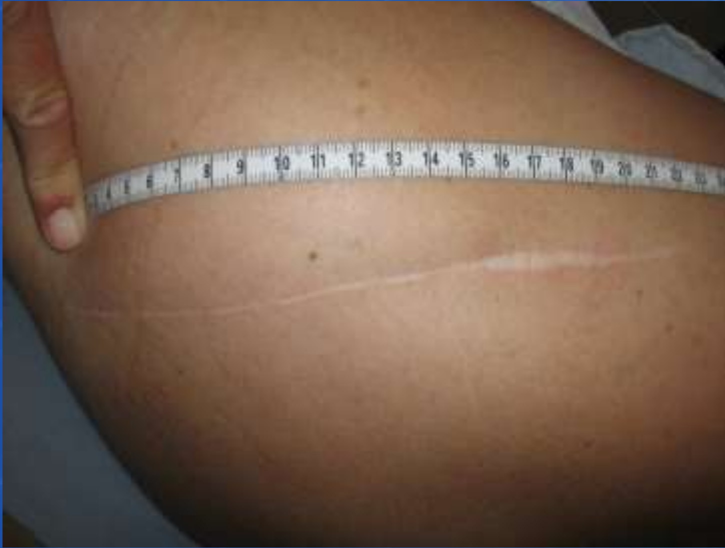
- An outcome score, never designed OR validated as rationing tool
- "Normal" score 48
- Threshold 26 (and variable!!)
- Assesses pain and function

Early Mobilisation (“and discharge”)

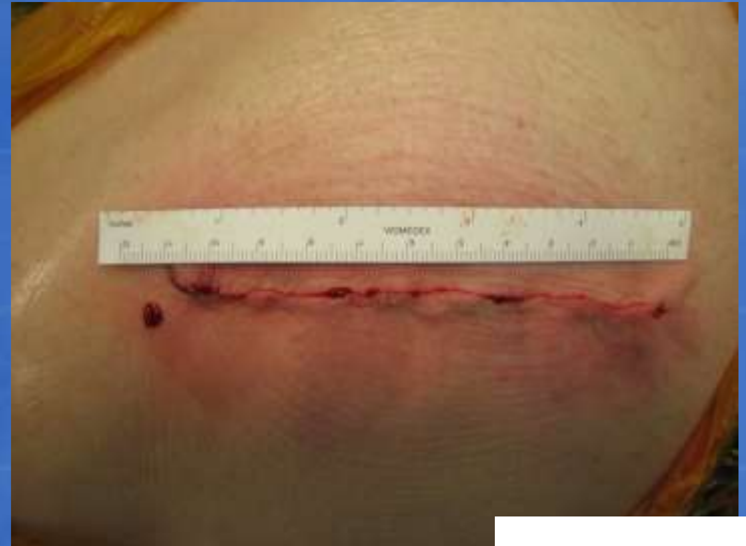
- Patient Education Pre Operatively
- Rapid Recovery/Local Anaesthetic Infiltration (LOS 7 - 9 days to < 3 days)
- Enhanced and early physiotherapy and OT
- Less pain, fewer clots, less exposure to hospital environment, better for all?

NHS

Small Incision Surgery



22cm



10cm – 12c

Tried and tested approach – "mini posterior"
5 – 6 years, approx 800+ patients
No major muscle cuts
Dislocation Rate 1 – 2%

Spire Healthcare

NHS

Surgical Risks

- Anaesthetic (Increasingly regional vs GA)
- Blood Transfusion (<10% vs 25% 10 years ago)
- DVT, PE (NICE guidelines controversial)
- Infection (0.5% RJAH)
- Dislocation (1% - 2%)
- Leg Length Discrepancy
- Implant Failure and Longevity

In Summary

- Clinically assess site, level and duration of symptoms, sleep pattern and ADL.
- Plain Xrays, diagnosis
- Exhaust conservative options in primary care if possible
- Referral need not always lead to surgery
- Does the patient want an operation??
- Very happy to discuss before referral (OAS)

THANKYOU