

Hip Arthroscopy
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Information Sheet

Introduction

This information sheet is aimed to provide a general guide to the common indications for hip arthroscopy, what to expect if undergoing the surgery, the significant risks, and a general guide to the expected recovery pathway. This document is not by any means fully comprehensive, and any particular questions should be addressed with your surgeon.

Indications for Hip Arthroscopy

Since the early 20th century, when hip arthroscopy was regarded as being almost impossible to undertake, the procedure has developed in leaps and bounds. Presently there are many reasons why a surgeon might recommend hip arthroscopy to a patient. Some of these reasons are as follows:

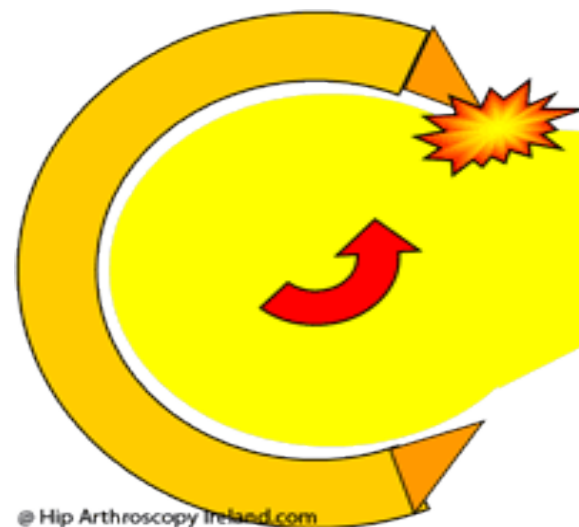
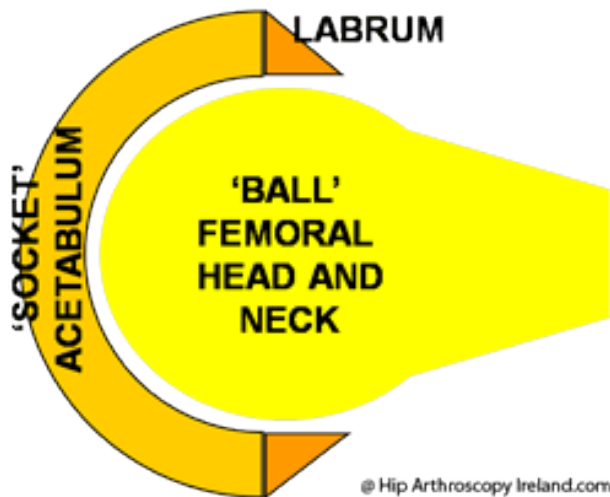
1. To explain unexplained hip pain (diagnostic hip arthroscopy)
2. Removal of loose or foreign bodies
3. Repair of damaged articular cartilage (gristle)
4. Removal or repair of a torn acetabular labrum (see below)
5. Correction of femoro acetabular impingement (FAI – see below)
6. Management of damaged hip ligaments
7. Management of hip joint infection
8. Inflammation of the hip lining (synovitis)
9. Investigation of a painful joint replacement or hip resurfacing

Perhaps the two most common current indications for hip arthroscopy include the presence of symptomatic FAI or an acetabular labral tear, or both. These will be considered in more detail here:

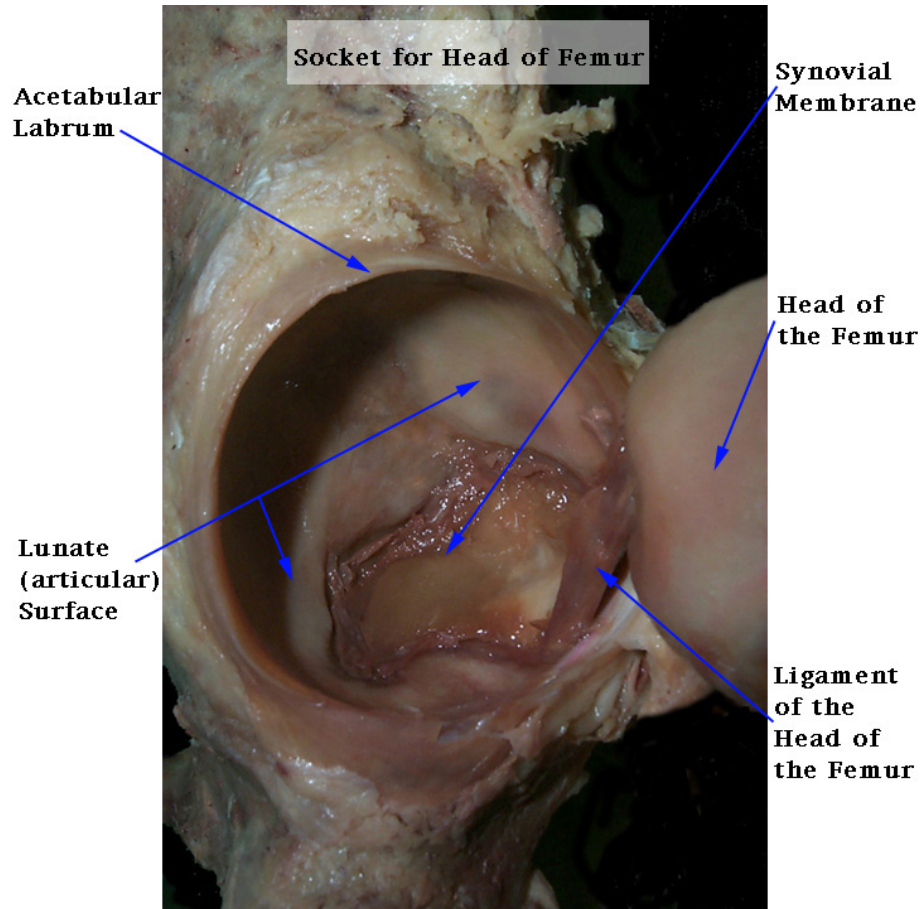
1) *Femoroacetabular Impingement (FAI)* – FAI is a condition affecting the hip joint and is characterised by abnormal contact between the femoral head (hip ball) and the rim of the acetabulum (hip socket) leading to damage to the articular cartilage (lining or gristle) in the acetabulum, or to the labrum of the hip, or both. The labrum is a ring of cartilage that surrounds the acetabulum and looks very like the meniscus of a knee joint, although its function is different. Damage to the labrum and/or articular cartilage will likely cause pain. An abnormality in the shape of the femoral head or acetabulum, or both, may cause FAI. Activities that involve recurrent hip motion can increase the frequency of this abnormal contact, e.g. kicking sports. FAI generally presents in three forms: cam impingement, pincer impingement and mixed impingement (involving both cam and pincer type). FAI can affect all age groups from the early teens to throughout adult life and is being increasingly recognised as one of the predisposing factors for osteoarthritis of the hip. Although scientific evidence is still limited, it is felt by many that without

early intervention surgery, there is a high likelihood of developing osteoarthritis ('wear and tear'), with the subsequent requirement for either a hip replacement or other major hip operations. Hip arthroscopy can be used to reshape the femoral head and socket to prevent impingement, and aims to protect the hip from developing osteoarthritis, as well as relieving current symptoms.

Impingement



2) *Acetabular labral tears* - The labrum, which surrounds the acetabulum, can be partially damaged or torn. This is usually associated with FAI, but not always so. With hip arthroscopy, the labrum can be either debrided (remove the damaged tissue only) or repaired. Occasionally a labrum can also be grafted. MRI and/or CT scans, although often performed before hip arthroscopic surgery is undertaken, do not always reveal every labral tear.



Length of stay in hospital:

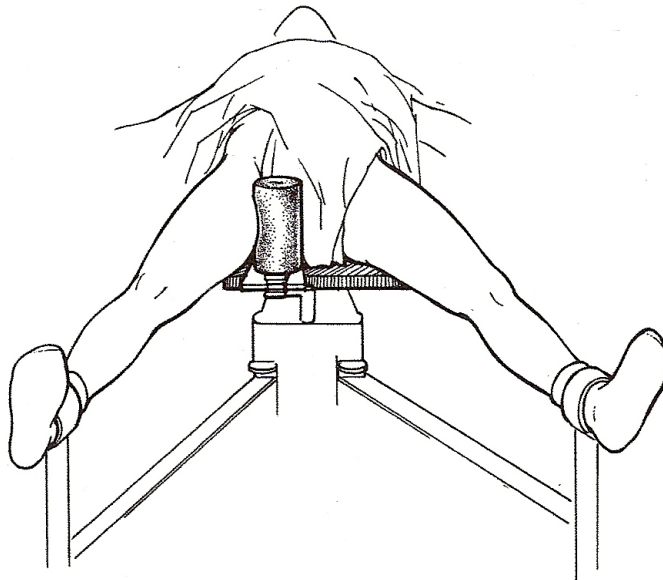
The vast majority of hip arthroscopy cases are done as a day case procedure. If for any reason there are post operative concerns and you are unable to go home an overnight stay may be required.

Anaesthetic:

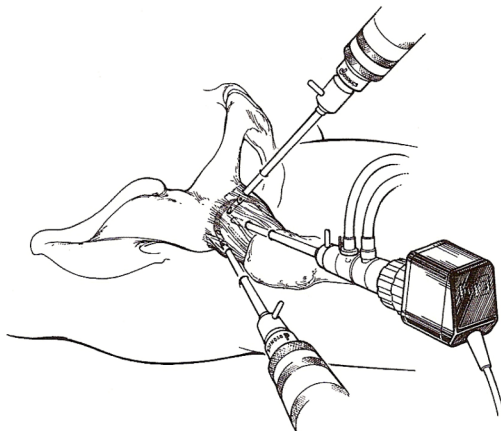
The surgery is performed under general anaesthetic. At the end of the procedure a local block is used for post operative pain relief and can last up to 6 hours.

How we perform hip arthroscopy:

The bones of the hip joint (the ball and socket) are separated by approximately 1cm by applying traction to the foot while wearing a special boot. By distracting the hip, this provides enough room for a small telescope ('arthroscope') to be introduced into the joint. Initially, air and/or fluid are injected into the hip, under x-ray guidance. Once correct placement of the instrument has been confirmed, two, three, or sometimes four small incisions are made on the side of the hip. Each of these incisions generally measures approximately 5-10 mm in length.

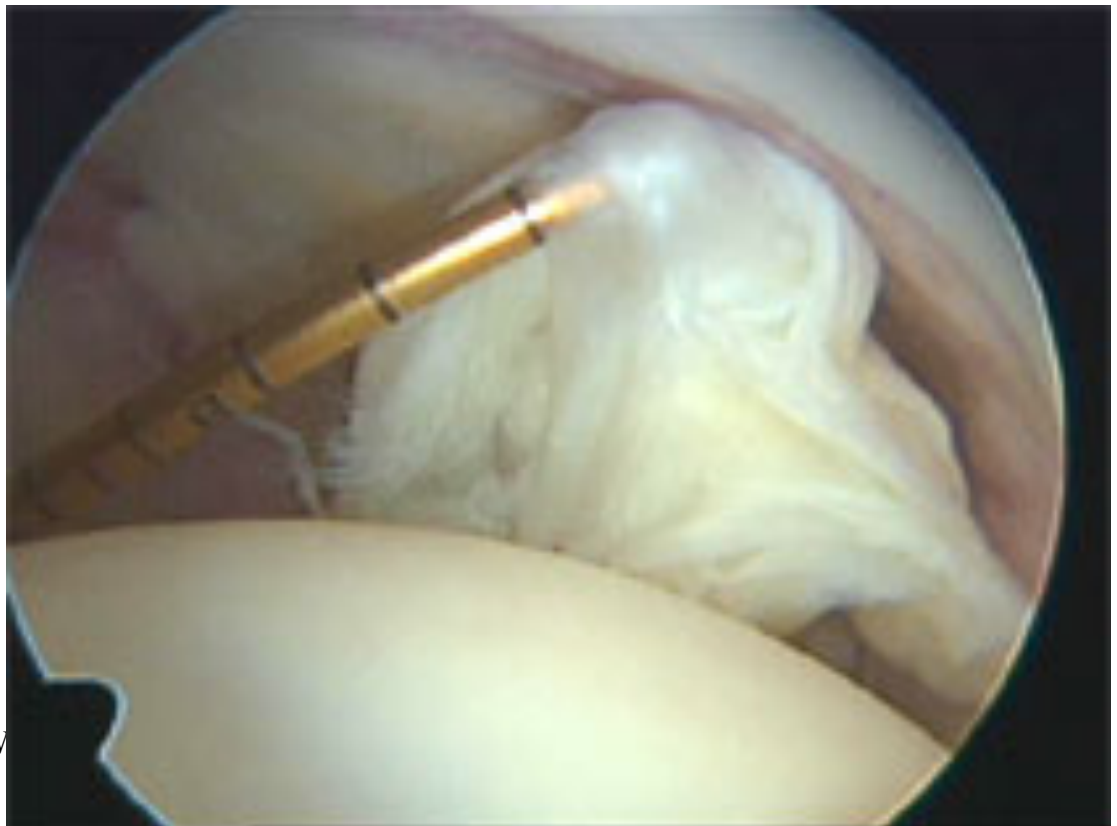


Through these small holes, the telescope and instruments are passed into the joint. The surgeon will then be able to visualise the hip joint, identify the problem(s), and proceed appropriately. Very occasionally it is not possible to insert an arthroscope into the hip joint. The operation duration will vary depending on the problem in the hip joint but can last from 30 minutes to 120 minutes, or even more. During the surgery, further x-rays may be taken, for example, to confirm adequate removal of bone.





At the end of the procedure medications may be injected into the hip to minimise pain after the surgery. The small holes are often closed with one to two stitches each or tapes, although some surgeons choose to let the wounds heal naturally, without closure. Finally, a further dressing is placed over the holes.



After hip arthroscopy:

Usually, you will feel some discomfort in your hip. In addition, the discomfort can be experienced in the lower back, buttock, knee and ankle. The discomfort can normally be reduced with the appropriate pain relief. In the majority, there will be some swelling in the groin, buttock and thigh. This is caused by the fluid used during the surgery. The swelling reduces over the following few days. Patients can experience excessive urine production after absorbing the fluids during surgery that is then excreted by body.

You will receive specific rehabilitation instructions from your surgeon. In some circumstances you may be asked to limit the amount of weight you put through your operated leg, while in others you may be allowed to fully weight-bear immediately after surgery. Consequently, you may require crutches for a few days, or weeks depending on what specific surgery have been undertaken. Your surgeon and physiotherapist will decide when it is appropriate for you to stop using the crutches.

Observe the wound for any signs of infection (increasing pain, redness or swelling). The skin incisions can sometimes leak fluid or blood slightly for a few days; this is normal.

Approx 4 weeks after surgery you will be reviewed by your surgical team. At this appointment, your wound may be inspected. A further explanation of the surgery undertaken can then be provided and there will also be an opportunity for specific queries to be answered. Any subsequent appointments will be arranged and will be guided by the surgery performed.

Your surgeon and physiotherapist will develop an appropriate rehabilitation programme for you following the surgery. Your physiotherapist will guide your return to sporting activities (running etc.) depending on your progress. This is extremely variable between individuals, depending on the surgical findings and the length of symptoms prior to surgery.

In the majority, by 8 weeks after surgery you should be walking relatively pain-free. By this 8-week point, running can be commenced if that is your wish. Remember, however, that it may take 3 to 6 months (or more) to return to an elite level of competition/fitness. Any unexpected increase in pain can be treated with ice packs and anti-inflammatory medication. The broad strategy for rehabilitation is to regain early range of movement and stability, followed by strength and endurance. Return to work will depend on pain levels and the nature of your job.

- There are some activities to avoid or take care with up to 8 weeks following surgery. These include the following :-

- Prolonged standing, especially on hard surfaces.
- Prolonged walking i.e.; around shopping centres.
- Heavy lifting
- Squatting / crouching
- Sleeping on your side. Try to sleep on your back. If you must sleep on your side, sleep on the unoperated side, with a pillow under your operated leg – to hold that leg level with the body.
- Clutch use in manual cars (for left hips) – may flare up symptoms in the first couple of weeks and is best avoided. Exchange cars if possible.
- Sitting with the hips at 90 degrees – a more open seat angle is recommended i.e.; 120 degrees. Car seats should be tilted backwards slightly in order to open the hips out.

Please note that these are only suggestions for minimising discomfort/pain. Your surgeon and/or rehabilitation team may have further ideas and you should listen to them carefully.

Potential risks and complications of hip arthroscopy:

All surgery carries risks, although every effort is made to minimise them. The complications can be temporary or permanent. Reassuringly, permanent complications following hip arthroscopy are rare and the majority are temporary. There are, however, risks which include the standard risks of undergoing general anaesthesia and specific risks associated with hip arthroscopy.

Complications have been reported to occur in up to 5% of patients and are most often related to temporary numbness/altered feeling in the groin, genitalia and leg. This is due to a combination of distraction of the hip joint and pressure on the nerves in the groin at the time of surgery. This is uncommon and although there is a theoretical risk that this numbness could be permanent, in the majority the numbness recovers fully, usually within a few days. Other complications might include, but are not limited to: pressure sores and blistering, infection, fracture, increased pain, impotence, bleeding, nerve palsies, abandoned procedure, deep-vein thrombosis, instrument breakage, avascular necrosis of femoral head, extravasation of irrigation fluid, delayed wound healing, exacerbation of symptoms, Heterotopic bone formation in hip and a rare condition called abdominal compartment syndrome. However, many of these complications are extremely rare. For example, the exact rate of infection following hip arthroscopy is unknown, but would certainly appear to be substantially less than 1 in 1000.

Rehabilitation Guidelines Post Arthroscopic Hip Surgery

Exercise	Week	1	2	3	4	5	6-8	8-10	10-12
Immediate Post Op									
Isometric Gluts (static bridge, prone ext.)		*	*						
Isometric Quads (SQ's, SLR, adductor squeeze)		*	*						
Isometric Hams (static bridge, heel digs)		*	*						
Active ROM (ankle pumps, heel slides)		*	*						
Abdominal setting / deep breathing		*	*						
Stretching (no combined flex/IR x 4 wks)									
Hip flexion (progress as indicated)		<90	<90	<90	<90	90	90+	90+	90+
Abd / Ext rot as tolerated		*	*	*	*	*	*	*	*
Int rotation (progress slowly after 1 week)			*	*	*	*	*	*	*
Strength / control / function									
Side lying clam exercise			*	*					
Hip abd, flex, ext in standing				*	*	*	*	*	*
Bridging – double, progress to single by 4 wks			*	*	*	*	*		
Squats – wall, free wts, unstable surface						*	*	*	*
Lunges – forward, backward, diagonals						*	*	*	*
Core									
Lower abdominal progressions				*	*	*	*	*	*
4 pt kneeling progressions (arms, legs, both)				*	*	*		*	*
Planks (front, side)					*	*	*	*	*
Abdominal curls, rotating planks							*	*	*
Cardiovascular									
Stationary cycling (no resistance)		*	*						
Stationary cycling (progressive resistance)				*	*	*	*	*	*
Stepper / X trainer / Elliptical						*	*	*	*
Jogging / Running								*	*
Dynamic Power / Plyometrics									
Jump lunges								*	*
Box jumps / bounding								*	*
Ski fitter (skate, slide motion)							*	*	*
Hydrotherapy (incision must be clean and dry)									
Walking				*	*	*	*	*	*
Pool running						*	*	*	*
Swimming (no breaststroke whip kick 4-6 wks)			*	*	*	*	*	*	*
Sports									
Walking / hiking						*	*	*	*
Jogging / running							*	*	*
Contact or 'cutting' sports								*	*