



HIP JOINT ARTHROSCOPY

Introduction

This information sheet provides an overview of the common indications for hip arthroscopy, what to expect if undergoing the surgery, the risks involved, and the expected course of recovery. This document is by no means fully comprehensive, and any specific questions should be discussed with your surgeon. Many different hip procedures can be performed arthroscopically, and there are significant variations between surgeons both here and around the world.

Indications for Hip Arthroscopy

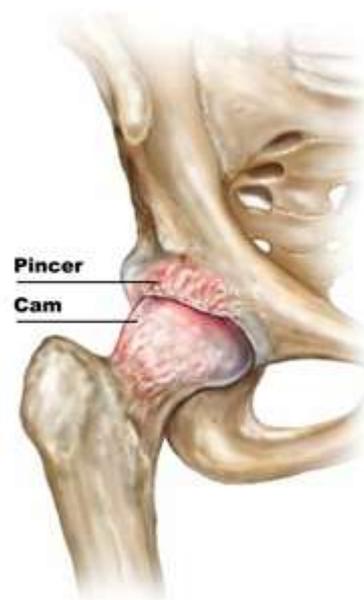
Since the early 20th century, when hip arthroscopy was regarded as being almost impossible to undertake, the procedure has developed in leaps and bounds. Presently there are many indications for recommending hip arthroscopy. These include:

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 femoroacetabular 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

The two most common indications for hip arthroscopy include the presence of symptomatic FAI or an acetabular labral tear, or both.

- 1) *Femoroacetabular Impingement (FAI)* – FAI is a condition affecting the hip joint (Figure 1). It is characterised by abnormal contact between the femoral head (hip ball) and the rim of the acetabulum (hip socket). This leads 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, as this can result in abnormal contact between the two surfaces.



Activities that involve recurrent hip motion can

increase the frequency of this abnormal contact, e.g. kicking sports. FAI affects all age groups from early teens throughout adult life. It is one of the predisposing factors for osteoarthritis of the hip. Although there is little scientific evidence as yet, it is likely that without early intervention surgery, the likelihood of developing osteoarthritis of the knee is high. The likely progression of hip osteoarthritis is to a need for hip replacement or other major hip surgery. 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 relieving current symptoms.

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.



Length of stay in hospital:

The length of stay will depend on the complexity of the surgery, your general health, the distance you may have to travel after surgery, and other factors. You should check this with your surgeon beforehand.

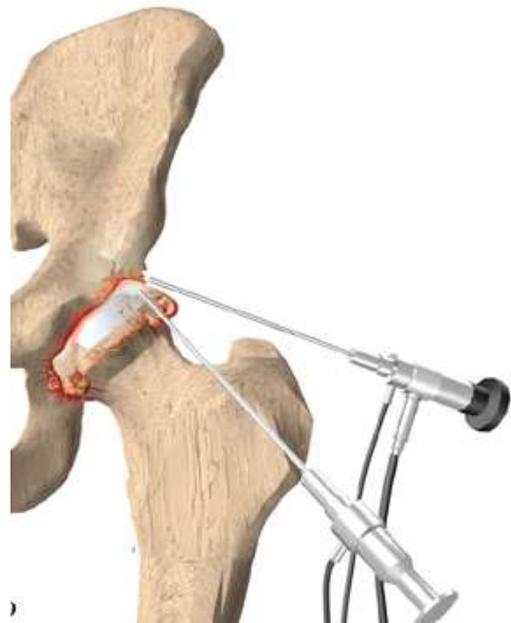
Anaesthetic:

The surgery is most commonly performed under general anaesthetic. Additional regional local anaesthetic block is often used in conjunction with the general anaesthetic. Other options may be available. This should be discussed with your surgeon.

How we perform hip arthroscopy:

The bones of the hip joint (the ball and socket) are separated (distracted) by approximately 1cm by applying traction to the foot while wearing a special boot. Distracting the hip 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 length of the operation will vary depending on the problem in the hip joint but can last from 30 minutes to 2 hours 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, discomfort may 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 a few days.

A physiotherapist will most likely see you following your surgery. They will make sure you are safe to mobilise with or without the aid of crutches. This will depend on the instructions received 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 has 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 small amounts of fluid or blood for a few days; this is normal.

At a variable point after surgery you will be reviewed by your surgical team. At this appointment, your wound may be inspected and, in some cases, the sutures removed if that has not already been performed. 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 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 including 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, most complications are temporary. Permanent complications are rare. 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 and genitalia. 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. However, many of these complications are extremely rare. For example, the exact rate of infection following hip arthroscopy is unknown, but is substantially less than 1 in 1000.