Affinia Health Network

Hip Pain

Suggested pre-referral evaluation and management guidelines:

1. Osteoarthritis
    a. Typically presents with insidious onset of groin pain, occasionally radiating down to the knee. Pain increased with walking, sitting, exercise.
    b. Exam findings include: pain with log roll, pain with flexion and internal rotation of the hip, limited internal rotation
    c. Radiographic views needed are AP pelvis and lateral Hip
    d. Management: If mild to moderate changes on xray, consider Tylenol or anti-inflammatories and weight loss counseling if indicated. Physical therapy may be helpful as well for milder degenerative change. Patients may also consider a home exercise program that can be found at orthoinfo.aaos.org, keyword: hip conditioning program. Corticosteroid injection under fluoroscopy is an option as well in our office.
    e. Referral to orthopaedics for hip arthritis not responding to conservative management, severe arthritis, severe pain or patients wishing to consider injection.
2. Avascular Necrosis
    a. Presents with insidious onset of groin/anterior thigh pain and difficulty in ambulation. More common in alcoholics and patients with a history of corticosteroid use.
    b. Exam findings include pain with log roll and pain with flexion and internal rotation of the hip.
    c. Radiographic views needed are AP pelvis and lateral hip. May consider MRI if suspicious and xrays normal.
    d. Management: Refer to orthopaedics for cases of avascular necrosis.
3. Hip Impingement
    a. Abnormal contact between the femoral head/neck junction and acetabulum due to excess bone on femur (cam lesion), acetabulum (pincer lesion) or both.
    b. Typically seen in younger patients without significant degenerative change. Often insidious onset of pain or after mild injury. Pt commonly presents with pain related to prolonged walking, sitting, and stairs. Typically, pain is anterior in groin, but can be lateral as well. Pain can be reproduced by flexion, adduction and internal rotation. Less pain with flexion, abduction and external rotation.
    c. Radiographic views needed are AP pelvis, lateral hip, and Dunn view. MRI is warranted for failure of conservative management. Needs to be done on 3T scanner or be an MRI arthrogram.
    d. Management: Includes oral anti-inflammatories and physical therapy to work on core strengthening/posture. Patients should be instructed to avoid deep flexion positions as this exacerbates symptoms.
    e. Referral to orthopaedics for pain not responsive to conservative management, worsening pain or severe pain.

4. Hip Labral tear
    a. Can be acute, but most commonly related to hip impingement. Treatment and referral guidelines are the same as for Hip Impingement. Note: Many patients over the age of 50 have asymptomatic labral tears.
5. Trochanteric Bursitis/Greater trochanteric pain syndrome
    a. Lateral hip pain related to tendonitis of the gluteal muscles or bursitis of the greater trochanteric bursa.
    b. Pain is typically on the lateral aspect of the hip over the trochanter, sometimes radiating down the lateral aspect of the leg.
    c. Patients will have point tenderness over the trochanteric bursa. If significant weakness with abduction, consider MRI to rule out abductor tear.
    d. Radiograph views needed are AP pelvis and lateral hip.
    e. Management: Includes home exercise program or Physical therapy referral, corticosteroid injection and oral analgesics.
    f. Refer to orthopaedics for pain resistant to conservative management.
6. Posterior hip/Buttock pain
    a. Often vague, toothache type pain, though conditions such as proximal hamstring tendonitis present with point tenderness over the ischial tuberosity. Radicular type pain will travel down the leg past the knee. Hip mediated pain can travel to knee but not past. Pain often occurs when walking and is better with sitting.
    b. More commonly related to referred pain from the SI joint or the lumbar spine as opposed to hip joint pathology.
    c. Exam findings vary by type of pathology, but can include pain with flexion, abduction, external rotation for SI mediated pain, positive straight leg raise testing for radiculopathy
    d. Radiographic views needed are AP pelvis, lateral hip and AP and lateral lumbar spine films.
    e. Management: Depends on pathology, but includes Physical therapy for lumbar mediated pain and referral to Physiatry if failing therapy or for SI mediated pain. Referral to Physical therapy is the first line treatment for proximal hamstring tendonitis as well. Unclear etiologies can be referred to physiatry or orthopaedics for further workup.
7. Stress fractures
    a. Rare, but more common in the pubic rami in elderly. These typically heal well and can be managed by protected weight bearing as tolerated.
    b. Femoral neck stress fracture more commonly seen in runners or other active individuals. Fortunately, rare. Patients present with progressive worsening of groin pain with activities. Suspicion requires urgent orthopaedic referral.