

# Hip Pain

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## Conservative Management of Early Stage Hip Joint Pathology

Chronic hip joint pain sometimes occurs in young to middle-aged individuals, and can be quite disabling. There is growing evidence that such pain is often associated with the later development of hip osteoarthritis. Diagnoses commonly associated with these symptoms include femoroacetabular impingement, labral tears, chondral lesions, and developmental dysplasia. While dysplasia should be apparent on plain imaging, FAI is often missed. And early stage cartilage pathology can only be demonstrated on more sophisticated imaging.

There is conjecture as to the most appropriate initial management for chronic hip pain. No randomized controlled trials have been performed that compare conservative management to surgical intervention. In many cases, when pathology is demonstrated, surgery becomes the first-line approach.

In physiotherapy, there has been growing interest in recent years in *movement pattern training* for treatment and injury prevention. Where appropriate, this forms a large part of my interventions. It is known that faulty movement patterns can lead to pain and dysfunction. Such faulty patterns can be learned and become habitual. Or they may occur in some individuals due to biomechanical predisposition. For instance, there have been tremendous inroads made in prevention of serious knee injuries in adolescent females, using preventative exercises with a heavy focus on neuromuscular training and correct functional movement.

A recent study examined the effect of movement pattern training to treat chronic hip pain in 28 individuals aged between 18-40 years. Symptoms

included anterior groin or deep joint pain present for over three months. Pain was also reproduced on the 'FADIR' test – moving the hip into a combination of flexion, adduction and internal rotation. Patients were randomly assigned to either intervention or control groups, followed up over 6 weeks. Intervention included strengthening for the hip, with the main focus on education to reduce potentially harmful joint loading, and on correcting faulty movement patterns when they were identified.

Poor movement control at the hip will often manifest as excessive hip adduction on single leg bending. In this study, the degree of adduction was measured using video analysis. Patients were then educated how to minimize adduction during a range of daily tasks.

In the intervention group, most patients were able to reduce the degree of hip adduction. Importantly, this was associated with significant improvements in symptoms, and greatly increased scores on self-reported function. Interestingly, nine patients were unsuccessful in reducing the degree of adduction, and these patients had poorer outcomes. Ten patients had an x-ray diagnosis of FAI (eight with CAM-type, and two with pincer impingement), yet this did not affect the response to treatment. Improvements in hip abductor strength alone were not associated with improvements in symptoms. This supports my theory that when faulty movement patterns exist, strengthening alone will not solve the problem. Without movement correction, it only strengthens the faulty pattern.

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## References:

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