

Hip Pain

For information on all types of injuries visit:
<http://www.cssphysio.com.au/Doctors/fordoctors.html>



Update on Identification of Acetabular Labral Tears

In the last 10 years, acetabular labral tears have been increasingly recognized as a potential cause of hip pain and disability. However, pain in the hip and groin region can be due to a number of causes, and accurate clinical diagnosis is challenging. The following is a summary of a recent paper examining what we currently know about diagnosing symptomatic labral tears.

Depending on which study is quoted, the prevalence of acetabular labral tears (ALT) in patients with hip or groin pain ranges from 22% to 55%. In one study, a labral tear was identified in 90% of patients with 'mechanical' hip symptoms. However tears are common and frequently asymptomatic. 96% of cadaver hips (mean age 78 years) had ALT, and 74% of these were in the anterosuperior region of the joint.

Currently, diagnostic tools include clinical history, examination, MRI, MRA (MR arthrogram), CT arthrogram, and diagnostic anaesthetic blocks.

Causes: The literature identifies possible causes as traumatic, congenital (eg dysplasia), degenerative, capsular laxity, and idiopathic. It has been found to be associated with femoro-acetabular impingement (FAI) and iliopsoas tendon impingement.

History: Most are characterized by an insidious onset of symptoms. Pain will generally be in the anterior region of the groin, and worse with prolonged standing, sitting or walking. The pain will often be described as sharp, and sometimes there will be clicking or a sensation of giving way. Pain can refer into the buttock and anterior thigh. Predisposing factors include a history of repetitive twisting or pivoting in a flexed position while

weight-bearing. The sports most associated are tennis, ballet, hockey, football, & soccer.

Examination: These findings do not provide an accurate diagnosis in isolation, but are considered with all other findings. As with degenerative hip disease, pain &/or restriction is generally reproduced with combined flexion, adduction, internal rotation. An antero-to-posterior glide in slight flexion & internal rotation may also reproduce symptoms.

Imaging: both ALT & FAI are common in asymptomatic individuals, so results need to be correlated with all other assessment findings.

X-ray: Include weight-bearing AP, lateral, and possibly Dunn (flexion 90° / abduction 20°) or modified Dunn (flex 45° / abduct 20°) views. X-ray is useful to assess for abnormal morphology of the acetabulum & femoral head, including FAI or dysplasia.

MRI: This provides excellent visualization of the fibrocartilaginous labrum, and will also be useful for assessing joint morphology.

Reference:

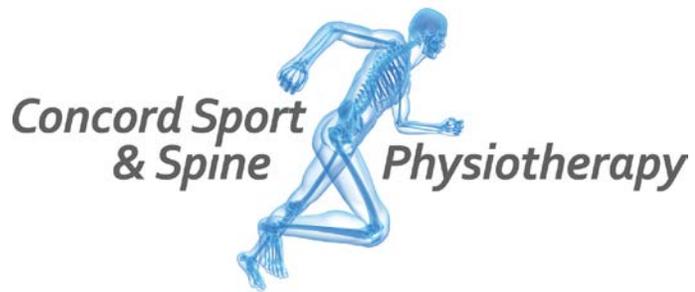
Reiman, M et al (2014). Examination of acetabular labral tear: a continued diagnostic challenge. *BJSM*, 48, 311-319.

Please contact us if you would like a printable copy of this document.

For information for doctors on physiotherapy management of all types of injuries visit:
<http://www.cssphysio.com.au/Doctors/fordoctors.html>

Information for patients is at:

<http://www.cssphysio.com.au/forpatients.html>



Concord Sport & Spine Physiotherapy
202 Concord Road
Concord West, NSW 2138
Sydney, Australia.

Ph (02) 9736 1092

Email: info@cssphysio.com.au

Web: www.cssphysio.com.au

Copyright © 2012 Paul Monaro. All Rights Reserved