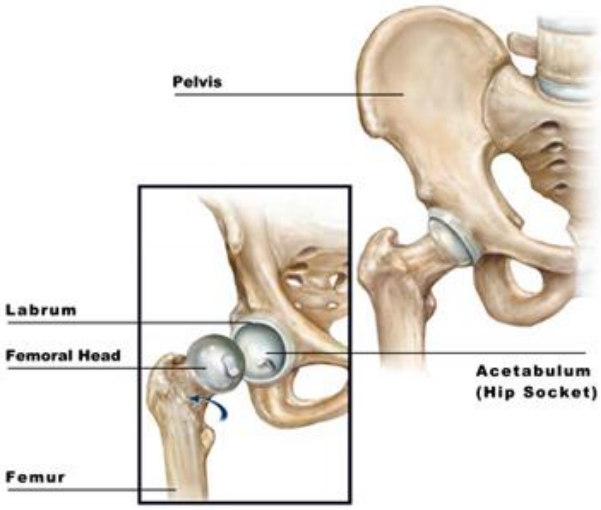
Hip Arthroscopy Booklet

2. **Hip Anatomy**



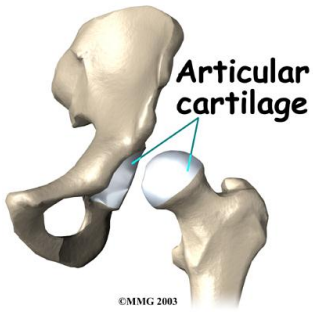
The bones that make up the hip joint are the *femur* (the thighbone) and the *pelvis*. At the top end of the femur is a ball called the *femoral head*. The femoral head fits into a round socket on the side of the pelvis called the *acetabulum*. This ball and socket joint allows a large range of movement required for activities such as squatting , swimming and climbing.

The femoral head is attached to the rest of the femur by a short section of bone called the *femoral neck*. In some patients, there is an overgrowth of

bone at the femoral head-neck junction (cam impingement) or at the edge of the acetabulum (pincer impingement). This can cause a catching pain when the knee comes towards the chest, or across the body, or particularly on sitting activities.

3.

Articular cartilage covers the ends of the bones in the joints of the body. In the hip, articular cartilage covers the femoral head and the acetabulum. It is white and shiny and allows the joint surfaces to slide against one another without causing any damage. When this articular cartilage gets damaged or starts to degenerate, it can cause pain in the joint. If pieces of this cartilage starts to break off, it can cause 'loose bodies' which can get trapped in the joint.



A structure inside the hip called the *labrum* attaches almost completely around the edge of the acetabulum. The shape of the labrum and the way it is attached create a deeper cup for the acetabulum socket. This small rim of cartilage can be injured and cause pain and clicking in the hip.

Hip arthroscopy is keyhole surgery to deal with these problems – to smooth off (debride) damage to the labrum and articular cartilage, remove any loose bodies and to remove any overgrowth of bone that is causing impingement.

4. Before your operation

Once you have decided to proceed with your hip arthroscopy, please contact Mrs Michelle Platt, Practice Manager on 0161 904 0434, to arrange a convenient date for your surgery.

If you are insured, you will need to contact your insurance company and obtain an authorisation number, which you should bring to the hospital on admission. Your insurance company may ask you for procedure codes which Michelle can provide for you.

You may be asked to attend a pre-admission consultation with the pre-op nurse to ensure that you are fit for the operation and to give you an opportunity to ask any questions about your hospital stay

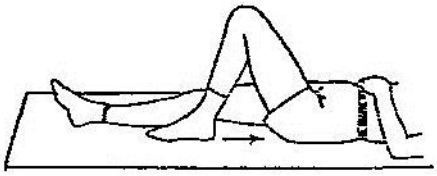
You will be required to fast for a period of time before your operation – you will be given more information regarding this once your surgery is confirmed in writing and you are given an admission time.

When you are admitted to the hospital on the day of your surgery, you will see the anaesthetist who will discuss your previous history and ensure that you are fit for surgery. This will give you an opportunity to discuss any concerns you may have regarding anaesthesia.

5.

You will also see one of the inpatient physiotherapy team, who will provide you with crutches and teach you how to use them properly (please note that there is a charge for the crutches that your insurance company may not cover) and give you some basic exercises to do at home following your surgery.

It is important that you do these exercises to regain movement in the hip and also maintain blood flow in the legs, as you will not be fully mobile. You will also be given advice regarding using ice and wound management.



Mr Hoad-Reddick will come to see you before the op to place a mark on your leg and to ask you to sign a consent form for the procedure.

6. **Complications**

All surgical procedures have associated risks and we have listed the risks that are particularly relevant to hip arthroscopy. If you have any concerns, or want to discuss this further, please contact Michelle Platt and she will arrange for you to speak to Mr Hoad-Reddick prior to your surgery.

There are general risks with any operation. These include the tiny risks associated with anaesthetic and a small risk of clots in the leg, (Deep Vein Thrombosis or DVT) which can occasionally lead to pulmonary embolism (when a clot breaks off, lodging in the lungs, a condition which can very rarely be fatal.)

Infection is a rare but serious complication with an incidence of around one in a thousand. If infection occurs in the joint, further surgery would be needed to wash out the joint and the outcome for your hip arthroscopy would be compromised.

Surgery can cause injury to nerves and blood vessels leading to weakness, numbness and bleeding. This is very rare. The traction used in hip arthroscopy can cause some post operative problems with bruising in the thigh and groin, also traction can " pull" nerves leading to numbness in the groin/pelvis and or foot, this usually decreases in 2-3 weeks and is much less common with the use of modern traction equipment.

Excessive bone resection can risk a fracture of the hip in the early post operative period. This risk is minimised by removing the minimum amount of bone necessary to clear the impingement.

7. **The Operation**

You will be taken down to theatre by a porter and handed over to the theatre staff. They will attach devices to monitor your heart rate and oxygen levels before administering the anaesthetic through a cannula (a very thin tube) in the back of your hand.

Once you are asleep, you will be turned onto your side and your hip will be gently distracted before the surgical instruments are introduced through three small incisions in the side of your hip. Mr Hoad-Reddick will then treat any problems he finds in the hip. Common problems include labral tears, chondral damage, loose bodies and an overgrowth of bone on the femoral neck or the acetabulum.

The speed of your post op recovery is dependant on what has to be done during your operation (e.g patients will usually be partial weight bearing on crutches for two weeks and off work for approximately four weeks, however if he has to do a microfracture procedure, you will need to be on crutches for six weeks.)

Mr Hoad-Reddick will have a good idea of what needs to be done (and the length of time you will need off work) before your operation, but please be aware that things aren't always clear until he is actually inside the hip and he will do whatever is required to get you the best result.

8. **Surgical Wounds**

Hip Arthroscopy is keyhole surgery and you will have three small incisions in a triangle shape on the outside of your hip. The incisions will each have two stitches, which will be removed at your two week follow up appointment.

The incisions will be covered with a plastic waterproof dressing and you will be given fresh dressings to change at home every few days. Keep the wounds clean and dry and contact the ward immediately if you have any discharge or redness around the incisions.

A small amount of bruising is normal around the incisions and it will feel sensitive for some time, so it is unlikely that you will want to sleep on that side (most patients sleep comfortably on their back with a pillow underneath the knees, or on their non-operated side with a pillow between their knees.)

Apply ice to the outside of your hip for 10-15minutes, at least 4 times daily to reduce heat and swelling (make sure that you have something between your skin and the ice, e.g a thin tea-towel, to prevent skin damage from the ice)

9. **Pain control following surgery**

There will be some degree of discomfort after any surgical procedure, but we will do everything we can to ensure that you have as little pain as possible.

As pain is an individual experience, the only way to measure it is to ask you how much pain you are in – the nurses will ask you regularly if you have pain or nausea. This enables staff to give the correct amount of medication and measure how effective the treatment has been. If you are in pain at any time, let the nurses know.

When you are discharged from hospital you will probably given painkillers and anti-inflammatories to take home. It is important that you take the medication as prescribed – effective pain control is achieved by taking painkillers at regular intervals, rather than 'chasing the pain' when it occurs.

Make sure that you understand when you should be taking your medication, how much to take and what side effects may occur. It is important that you know who you can contact if you have any concerns about your pain or your painkillers.

10.

A local anaesthetic is often injected into the joint during surgery - this can lull you into a false sense of security as the hip can often feel really good for the first few days after surgery. Don't be tempted to walk around without your crutches (even if you feel you could) as this can cause extra strain on the joint - your awareness of the joint is diminished while the local anaesthetic is working, putting you at risk of further injury.

Patients often complain of spasms in the muscles around the hip in the weeks following surgery – these are perfectly normal and your physiotherapist will be able to show you how to manage them.

Using Crutches

You will be partial weight bearing on two crutches for a minimum of two weeks post-op, to reduce strain on the hip while it recovers following the surgery and the muscles around the hip start working properly again.

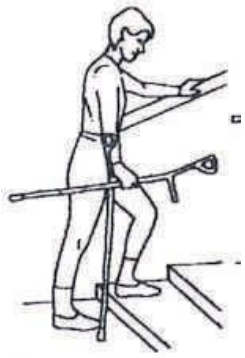
Using two crutches can be difficult as you cannot carry things (e.g cups, plates,) so please ensure that you arrange to have some help at home following the operation (using a rucksack is also useful).

11.

Please do not stop using the crutches until your physiotherapist (or Mr Hoad-Reddick) tells you, as you could place unnecessary strain on the healing tissues (even if you feel you can cope without them.)

If your physio says that you can go down to using one crutch, make sure that it is held on the non-operated side e.g. if the left hip has been operated on, the crutch would be held in the right hand and you would step the left leg and crutch forward at the same time.

When climbing stairs, ascend with the good (non-operated) leg leading and descend with the bad (operated) leg. An easy way to remember this is *"the good go up to heaven, the bad go down to hell."*
The physio will practice the stairs with you before you leave the hospital.



12. **Physiotherapy**

It is important that you have a course of physiotherapy treatment following your hip arthroscopy to restore range of movement, strength and stability to the hip and get you back to full activities. Patients need to be compliant with the advice and exercises that they are given to get the best results from the surgery and avoid ongoing problems.

If you have your own physiotherapist, you will be able to return to them for your post-op physiotherapy at around one week after surgery. We have a comprehensive rehabilitation protocol that we ask physiotherapists to follow – When you come in for your surgery, please let the inpatient physio know if you will be continuing your treatment elsewhere and they can ensure you have all the relevant information to take to your appointment.

If you do not already have a physiotherapist, our outpatient physiotherapy team at the Alexandra Hospital are highly experienced at treating patients following hip arthroscopy and your inpatient physio can arrange a follow up appointment for you for one week post op.

13.

Patients often benefit from attending a few physiotherapy sessions before their surgery for 'Prehab' – a programme of exercises and advice to get them in the best possible condition before the surgery.

If this is something you would like to do, please ask Mr Hoad-Reddick to write you a referral to the physiotherapy department.

Returning to work and sport

This will depend on your job, your sports activities and the procedures that you have had done during your hip arthroscopy. Please discuss this with Mr Hoad –Reddick at your pre and post- op appointments.

Patients are usually back to their sporting activities by four months post op, though it can take up to a year for full recovery.

14. **Outcomes of surgery**

Most people return to sports and other activities at a level they were at prior to the onset of their pain and impingement symptoms. The majority of patients clearly get better, but it is not yet clear to what extent the procedure stops the course of arthritis. Patients with pre-existing degenerative changes may not experience as much pain relief as a patient that simply has impingement.

Overall 85% of patients are delighted with the outcome, 10% see a significant change and only 5% are disappointed with their outcome.

15. **Notes**

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For all enquiries, please contact Mrs Michelle Platt, Practice Manager on 0161 904 0434