

DEGENERATIVE AND INFLAMMATORY DISORDERS OF THE HIP Osteoarthritis

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OA is referred to as primary when no predisposing cause can be found, and secondary when it develops after an insult to the hip joint. A multitude of factors, including genetic, in the development of primary OA. The exact mechanism for the development of primary OA remains unknown and it is therefore termed idiopathic. However, FAI has been proposed as an aetiological factor responsible for the development of OA by a Swiss group in 1999 (see Further reading). Secondary OA develops following trauma, A VN, dysplasia, slipped capital femoral epiphysis, inflammatory arthropathy or other known predisposing causes. The causes of OA of the hip are provided in Table 39.5 .

Clinical features OA of the hip affects 10–25% of those aged 65 years or older. The most consistent symptoms are groin pain and limitation of movement. The pain may also radiate down to the knee joint; in some cases the only presenting feature may be a painful knee. In the early stages of the disease, pain is activity related but as the disease progresses the patient also complains of pain at rest. The patient frequently complains of night pain and may also find it difficult to get into a comfortable position while sleeping. Functionally , any activity that involves flexion and rotation is difficult to perform, e.g. putting on shoes and socks and getting into and out of a bath or a car. As the pain increases the hip joint gradually loses its movement because of muscle spasm, capsular contracture and osteophyte formation, leading to further limitation of activities. Clinical examination may reveal gluteal muscle wasting. There may also be a limp, with a positive Trendelenburg's test. Leg length discrepancy , usually shortening, and limitation of movement, particularly internal rotation, are consistent features. Many patients present with a fixed flexion deformity that is best elicited by a modified Thomas's test (see Chapter 35

Investigations The characteristic features on a plain radiograph are (i) a reduction of the joint space, (ii) sclerosis in the subchondral bone, (iii) subchondral cysts, and (iv) osteophyte formation (Figure 39.7). Eventually , a collapsed femoral head may also be evident. Management There is no specific pharmacological therapy for OA; however, non-operative treatment with non-steroidal anti-inflammatories, regular exercise, physiotherapy and -). modification of lifestyle with loss of weight does help. Patients should also be encouraged to use walking aids (usually a walking stick in the opposite hand) to offload the affected hip joint and to reduce the workload of the ipsilateral abductors. The indications for surgery are relentless pain (usually night pain), limitation of lifestyle and activities of daily living and failure of non-operative treatment. The surgical options include an arthrodesis (fusion), an osteotomy (realignment)

TABLE 39.5 Aetiology of osteoarthritis. Primary Cause unknown, termed idiopathic Associations: for example, genetics, obesity Secondary Trauma Avascular necrosis Inflammatory arthropathy (e.g. rheumatoid arthritis) Perthes' disease Developmental dysplasia of the hip Slipped capital femoral epiphysis Septic arthritis Femoroacetabular impingement implicated as a possible cause (b) Figure 39.7 (a) Anteroposterior radiograph of the hip joint showing severe osteoarthritis of the right hip (arrow) and a cemented total hip replacement on the left; (b) lateral view of the right hip.

or a joint replacement (Figures 39.7a, 39.8 and 39.9 indications are based on limitation of lifestyle and individual needs, thereby making it a truly life-improving and life- changing operation. Summary box 39.4 OA of the hip /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF). The

(b) Figure 39.8 Radiographs showing a cemented total hip replacement in situ . (a) Anteroposterior view and (b) lateral view. OA is a degenerative condition leading to progressive damage of the articular cartilage and other joint structures The most consistent clinical features are groin pain and limitation of movement Characteristic radiological features are reduced joint space, subchondral sclerosis, subchondral cysts and osteophyte formation Non-operative treatment includes walking aids, non-steroidal analgesics, physiotherapy and weight loss Surgical options include osteotomy, arthrodesis or a joint replacement (b) Figure 39.9 Radiographs of an uncemented total hip replacement. (a) Anteroposterior view and (b) lateral view.