Hip Pathway (V8.3) 27.11.2023

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

OUTCOME MEASURES

- MSK-HQ
- Oxford Hip Score

Referral reason / Patient presentation	Osteoarthritis Hip – Established

<table>
<tr><td>Primary Care Management</td><td>
Examination, History & Assessment
• Age
• History
• Co-morbidities
• Joint examination
• Signpost patient to NHS England/Versus Arthritis Decision Support Tool NHS hip osteoarthritis decision tool (england.nhs.uk)

Investigation:
AP & Lateral Hip X-Ray

Management (including condition-specific self-care options)
see NICE guidelines NG226 published 19/10/2022:
• Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE
• NG226 Visual summary (nice.org.uk)

Activity and Exercise:
• For all people with osteoarthritis, offer therapeutic exercise tailored to their needs (for example, local muscle strengthening, general aerobic fitness).
• Consider supervised exercise sessions
• Consider combining therapeutic exercise with an education programme or behaviour change approaches in a structured treatment package.
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Weight management:
For people with osteoarthritis who are overweight or living with obesity, offer interventions to help weight loss: Offer Sign Posting to people with osteoarthritis who are overweight or obese: including Health Trainers or specific referral onto weight loss programmes. Those with advanced osteoarthritis wishing to be considered for joint arthroplasty should be advised that having a BMI over 40 will require referral to a bariatric accepting centre and longer surgical wait times. Reducing BMI to below 40 will enable routine pathway care as well broader health benefits.
• For further information see NICE guidelines CG189 Overview | Obesity: identification, assessment and management | Guidance | NICE

Information, support and education
• Individualised and accessible format
• Information leaflet: http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/11/OA-Hip-1.pdf
• Osteoarthritis (OA) of the hip | Hip pain | Versus Arthritis
• ESCAPE-pain online – ESCAPE-pain

Pharmacological management
• Step-wise approach to analgesia – follow the analgesic ladder.
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<tr><td>Thresholds for Primary Care to initiate a referral</td><td>
Refer to General Physiotherapy if:
flare ups are not settling, and patient would benefit from a supervised exercise and education program.

Refer to Advanced Practitioner (ICATS) if:
• Patient wants surgery e.g. night pain / reduced ADLs / failure to respond to analgesia & therapy / tried appropriate exercise programme for more than 3 months
• If severe OA on X-Ray
Comment: if severe pain consider AVN – see relevant pathway
• For further advice on patients who may be suitable for joint arthroplasty, please see the document Clinically Effective Commissioning (CEC).
(X-Ray required patient wants surgery e.g. night pain / reduced ADLs / failure to respond to analgesia & therapy - exercise programme for more than 6 months)

Refer to Orthopaedic Consultant if:
• Second opinion advised by another orthopaedic surgeon.
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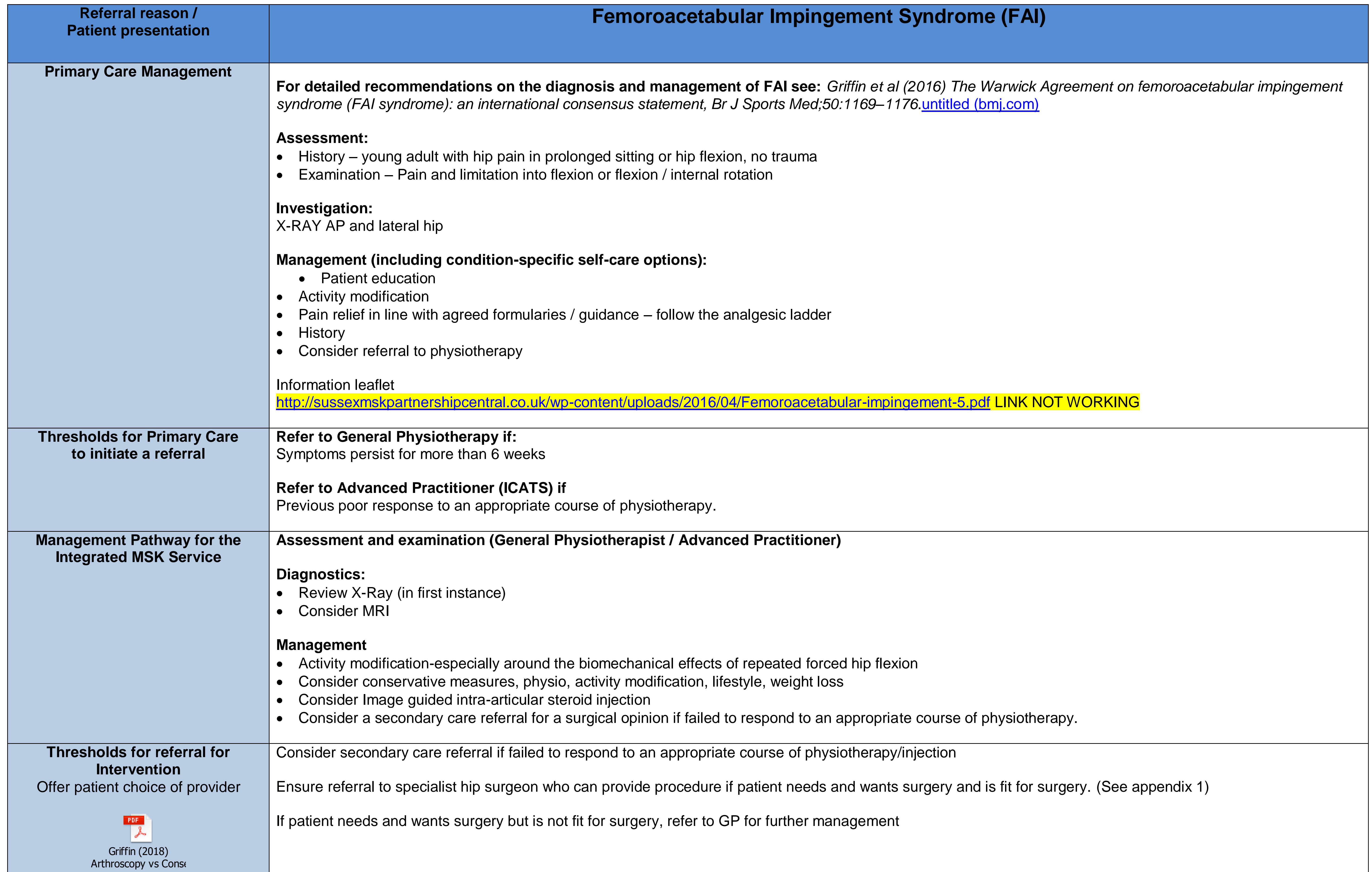
Management Pathway for the Integrated MSK Service	**see NICE guidelines NG226 published 19/10/2022:** Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE **Assessment** • Patient information • Assessment and Examination: • Clinical examination and history **Investigation** • AP & Lateral Hip X-Ray • MRI if considering injection/surgery and X-Ray normal • MRI if symptoms inconsistent with X-Ray findings **Intervention:** • Consider use of Hip Decision Support tool NHS hip osteoarthritis decision tool (england.nhs.uk) • Patient education and information • Offer therapeutic exercise tailored to the patients needs (as appropriate) • Discuss medication • Consider the provision of appropriate walking aids. • Consider Social Prescriber/Health Trainers/Local weight management service for support regarding lifestyle changes and weight-loss as appropriate • Consider signposting options • Consider intraarticular steroid joint injection in early disease. **If considering joint arthroplasty** • Consider using NJR Decision support tool for joint replacement Patient Decision Support Tool for Joint Replacement (shef.ac.uk) • Consider use of Oxford Score
Thresholds for referral for Intervention Offer patient choice of provider	Consider using NJR Decision support tool for joint replacement Patient Decision Support Tool for Joint Replacement (shef.ac.uk) **If consideration of arthroplasty compliance with CEC guidelines: add link (CEC exclusions)** • Established OA on X-Ray • Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of conservative treatment or management • Physiotherapy, patient education, orthosis, lifestyle improvements management framework • BMI > 35 offer weight loss management services • Do not exclude those with a BMI >40 from referral for an orthopaedic opinion on joint arthroplasty, however note those with a BMI > 40 will **not** routinely be listed for arthroplasty • **Those with advanced osteoarthritis wishing to be considered for joint arthroplasty should be advised that having a BMI over 40 will require referral to a bariatric accepting centre and longer surgical wait times.** Reducing BMI to below 40 will enable routine pathway care as well broader health benefits. • Offer patient choice of provider if patient needs and wants surgery.
Management pathway for Specialist In-patient care	Surgery as appropriate (ensure referral to appropriate secondary care provider if considering surgery other than THR-see appendix 1.) Options may include: • THR • Birmingham hip resurfacing (active males < 60 yrs only)

Referral reason / Patient presentation	AVN
Primary Care Management	**History** • Previous history of long-term steroids • Smoking • HIV • Sickle cell • ETOH • Early menopause • Recent IA steroid injection • IVD use • Goucher's disease **Assessment** • Atraumatic • Intolerance to weight-bearing. • Sudden onset • Unrelenting • Night pain **Diagnostics** X-Ray
Thresholds for Primary Care to initiate a referral	**Referral to ICATS – Urgent if:** severe pain but no AVN on X-Ray when AVN suspected **Urgent referral to Orthopaedic Consultant if:** AVN without OA **Routine referral to ICATS if:** AVN in the presence of OA and patient not wanting to be considered for THR
Management Pathway for the Integrated MSK Service	• MRI • Protected weight bearing if evidence of AVN
Thresholds for referral for Intervention Offer patient choice of provider	**Urgent referral to orthopaedic consultant if:** AVN in the absence of OA for consideration of hip salvage surgery **Consider routine referral to orthopaedic consultant if:** AVN in the presence of established OA
Management pathway for Specialist In-patient care	Core decompression THR



Referral reason / Patient presentation	Femoroacetabular Impingement Syndrome (FAI)
Primary Care Management	**For detailed recommendations on the diagnosis and management of FAI see:** *Griffin et al (2016) The Warwick Agreement on femoroacetabular impingement syndrome (FAI syndrome): an international consensus statement, Br J Sports Med;50:1169–1176.*untitled (bmj.com) **Assessment:** • History – young adult with hip pain in prolonged sitting or hip flexion, no trauma • Examination – Pain and limitation into flexion or flexion / internal rotation **Investigation:** X-RAY AP and lateral hip **Management (including condition-specific self-care options):** • Patient education • Activity modification • Pain relief in line with agreed formularies / guidance – follow the analgesic ladder • History • Consider referral to physiotherapy Information leaflet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/04/Femoroacetabular-impingement-5.pdf LINK NOT WORKING
Thresholds for Primary Care to initiate a referral	**Refer to General Physiotherapy if:** Symptoms persist for more than 6 weeks **Refer to Advanced Practitioner (ICATS) if** Previous poor response to an appropriate course of physiotherapy.
Management Pathway for the Integrated MSK Service	**Assessment and examination (General Physiotherapist / Advanced Practitioner)** **Diagnostics:** • Review X-Ray (in first instance) • Consider MRI **Management** • Activity modification-especially around the biomechanical effects of repeated forced hip flexion • Consider conservative measures, physio, activity modification, lifestyle, weight loss • Consider Image guided intra-articular steroid injection • Consider a secondary care referral for a surgical opinion if failed to respond to an appropriate course of physiotherapy.
Thresholds for referral for Intervention Offer patient choice of provider Griffin (2018) Arthroscopy vs Cons	Consider secondary care referral if failed to respond to an appropriate course of physiotherapy/injection Ensure referral to specialist hip surgeon who can provide procedure if patient needs and wants surgery and is fit for surgery. (See appendix 1) If patient needs and wants surgery but is not fit for surgery, refer to GP for further management

Management pathway for Specialist In-patient care	Consider surgical intervention • Arthroscopy Femoroacetabular surgery https://www.nice.org.uk/guidance/ipg408 • Open Femoroacetabular surgery https://www.nice.org.uk/guidance/ipg403/

Referral reason / Patient presentation	Acetabular Labral tear
Primary Care Management	**Assessment:** • History – May be traumatic or associated with FAI (young adult with hip pain in prolonged sitting or hip flexion) • Examination – Frequently groin pain and mechanical symptoms (clicking, catching, locking). Limitation frequently into flexion, adduction and internal rotation for anterior superior tears, Passive hyperextension, abduction and external rotation for posterior tears. **Investigation:** X-RAY AP and lateral hip **Management (including condition-specific self-care options):** • Patient education • Activity modification • Pain relief in line with agreed formularies / guidance – follow the analgesic ladder • History • Consider referral to physiotherapy
Thresholds for Primary Care to initiate a referral	**Refer to General Physiotherapy if:** Symptoms persist for more than 6 weeks **Refer to Advanced Practitioner (ICATS) if** Previous poor response to an appropriate course of physiotherapy.
Management Pathway for the Integrated MSK Service	**Assessment and examination (General Physiotherapist / Advanced Practitioner)** **Diagnostics:** • Review X-Ray (in first instance) • 3T MRI **OR MR Arthrogram which can only be requested in secondary care.** *(1.5T has limited diagnostic accuracy so do not request if labral tear is your primary hypothesis)* **Management** • Activity modification-especially around the biomechanical effects of repeated forced hip flexion • Consider conservative measures, physio, activity modification, lifestyle, weight loss • Consider guided intraarticular steroid injection. • Consider a secondary care referral for a surgical opinion/MR arthrogram if failed to respond to an appropriate course of physiotherapy.
Thresholds for referral for Intervention	• Consider secondary care referral if failed to respond to an appropriate course of physiotherapy. • Consider secondary care referral if you suspect a significant labral tear for MR arthrogram and patient unable to have 3T MRI scan. Ensure referral to specialist hip surgeon who can provide procedure if patient needs and wants surgery and is fit for surgery (see appendix 1).

Management pathway for Specialist In-patient care	Arthroscopy Osteotomy if associated with hip dysplasia

Referral reason / Patient presentation	Lateral hip pain / GTPS / gluteal tendinopathy
Primary Care Management	**Assessment** • History – trauma / trigger / insidious / red flags • Examination – Pain local to lateral hip +/- referral • +ve pain provocation tests • Trendelenburg gait (a lateral trunk lean towards the supported limb during the stance phase). **Investigation** • AP & Lateral Hip X-Ray if suspicion if acute fracture or established osteoarthritis. • Consider US scan if suspecting gluteal tear (+ve Trendelenburg gait, hip abductor weakness on testing) **Management** • Patient education / exercise sheet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/03/Greater-Trochanteric-Pain-Syndrome.pdf • Recommend weight loss • Pain relief in line with agreed formularies / guidance • Activity modification • Consider referral to physiotherapy if not improved within 6/52 • If LBP is the primary pain suggest spine pathway / physiotherapy
Thresholds for Primary Care to initiate a referral	**Urgent Referral to Physiotherapy if:** If no obvious tear suspected but high pain levels / significant loss of function / disturbed sleep / work **Referral to Physiotherapy if:** No improvement at 6/52 OR ADLS affected **Urgent Referral to Advanced Practitioner (ICATS) if:** • If suspect acute/sub-acute gluteal tear (+ve Trendelenburg) refer urgently to AP clinic **Referral to Advanced Practitioner (ICATS) if:** • No improvement with 3/12 physiotherapy • +ve Trendelenburg / history of trauma suggesting gluteal tear (non-acute/sub-acute) • Diagnostic uncertainty

<table>
<tr><td>Management Pathway for the Integrated MSK Service</td><td>Assessment
• History – trauma / trigger / insidious / red flags
• Examination
• +ve pain provocation tests

Diagnostics
If suspected gluteal tear/severe pain/significant functional loss, consider urgent: MRI (better defn) / US (dynamic ax)
XR if limited hip ROM consistent with OA
Suspected fracture XR

Management (including condition specific self-care options). E.g.:
• Weight loss
• Activity modification
• Sign-post to relevant self-management services
• Consider further physiotherapy
• Consider steroid injection (initial injection guided)
• Consider surgical opinion if diagnostics +ve for tear</td></tr>
<tr><td>Thresholds for referral for Intervention

Offer patient choice of provider</td><td>Secondary care
• Acute/sub-acute Gluteus medius tendon tear needing surgical repair-patient fit for surgery
• Chronic tear not responded to conservative management / severe pain / loss of function
• Intractable tendinopathy unresponsive to conservative management
• If diagnosis uncertain in patient with previous THR consider Consultant opinion</td></tr>
<tr><td>Management pathway for Specialist In-patient care</td><td></td></tr>
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<table>
<tr><th>Referral reason / Patient presentation</th><th>Hip fracture</th></tr>
<tr><td>Primary Care Management</td><td>Assessment
• History
• Mechanism of injury or trauma
• Range of movement, weight bearing and load
• +ve fulcrum test

Diagnostics essential, urgent referral to A&E for X ray

Management
NWB, analgesia and immobilisation.
• Pain relief in line with agreed formularies / guidance
• Activity modification/ immobilisation
• Advise if pain increases, re-present to GP</td></tr>
<tr><td>Thresholds for Primary Care to initiate a referral</td><td>Urgent referral to A+E if:
• Suspecting a recent hip fracture</td></tr>
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Management Pathway for the Integrated MSK Service	Patients with suspected or confirmed hip fracture should not be sent to MSK service
Thresholds for referral for Intervention Offer patient choice of provider	
Management pathway for Specialist In-patient care	

Referral reason / Patient presentation	**Muscle strain**
Primary Care Management	**Assessment** • History • Examination – pain on activity, stretching, palpation **No Diagnostics** **Management** URGENT Referral to secondary care: where evidence of functional loss (particularly affecting knee extensor mechanism) and clear evidence of injury (# clinic <6w, Orthopaedics >6w) If no significant loss of function or strength • Pain relief in line with agreed formularies / guidance • Patient advice and education: PRICE and HARM • Activity modification, consider immobilisation for a few days or use of crutches • Review after 5-7 days if lack of improvement, difficulty walking or unable to weight-bear.
Thresholds for Primary Care to initiate a referral	**Urgent referral to secondary care** URGENT Referral to secondary care: where evidence of functional loss and clear evidence of injury (# clinic <6w, Orthopaedics >6w) **Urgent referral to ICATS if:** • suspected significant tendon or mm injury but no functional loss • or any diagnostic uncertainty **Routine referral to ICATS if:** Not responding to physiotherapy **Refer to Physiotherapy if:** • No functional loss • Symptoms not showing signs of improvement.
Management Pathway for the Integrated MSK Service	Diagnostics: US or MRI to confirm injury and/or exclude any other cause of symptoms

Thresholds for referral for Intervention Offer patient choice of provider	**Urgent referral to secondary care** URGENT Referral to secondary care: **where evidence of functional loss and clear evidence of injury.** • tendon rupture or complete tear • Acute weakness • Palpable gap • History of trauma • Confirmation of significant muscle/tendon tear with functional loss. **Refer to Physiotherapy if:** • No functional loss • Symptoms not showing signs of improvement
Management pathway for Specialist In-patient care	Surgery for muscle repair taking into consideration • Pain • Functional limitations • Quality of tissue • Patient wants and is fit for surgery

Hip group 10th December 2013
Peter Devlin (GP, BICS)
Matthew Prout (ESP Physiotherapist, SCT)
Ian Francis (Consultant Radiologist, MIP)
Johan Holte (Consultant Physiotherapist, BICS)
Chris Mercer (Consultant Physiotherapist, WSHT)
Samantha Hook (Orthopaedic Consultant, WSHT)
Ruy Dassuncao (Orthopaedic Consultant, WSHT)
Guy Slater (Orthopaedic Consultant, Horder Healthcare)
Matthew Carr (Service Manager, Horder Healthcare)
Nick Patton (GP)
Andrew Kemp (ESP Physiotherapist, MTW)
Mary McAllister (ESP Physiotherapist, SCT)
Helen Harper-Smith (ESP Physiotherapist, ESHT)

Hip group 2nd July 2014
Natalie Blunt (BICS, Service Manager)
Peter Devlin (BICS, Clinical Director)
Johan Holte (BICS, Consultant Physiotherapist)
Ben Hodgson (BICS, ESP)
Mary McAllister (SCT, ESP)
Iben Altman (SCT, Chief Pharmacist)
John Bush (BSUH, Consultant Radiologist)
Anita Vincent (SASH, Service Manager)
Rachel Dixon (Horder Healthcare, Clinical Director)

Hip group 20th November 2018
Kieran Barnard (SCFT, Pathway Lead, Advanced Practitioner)
Georgi Daluiso-King (SCFT, Advanced Practitioner)

James Gibbs (Orthopaedic Consultant)
Ben Hodgson (HERE, Advanced Practitioner)
Andrew Kemp (HERE, Advanced Practitioner)
Alex Kyriacou (SCFT, Advanced Practitioner)
Mary McAllister (SCFT, Advanced Practitioner)
Stuart Osborne (HERE, Advanced Practitioner)
Emma Paskett (SCFT, Advanced Practitioner)
Rahul Pathak (SCFT, Advanced Practitioner)

Hip group (12/04/24)

Georgia Aloof (SCFT, Advanced Practitioner)
Kieran Barnard (HERE, Advanced Practitioner)
Mr James Gibbs (Consultant Orthopaedic surgeon)
Paul, Hegenbarth (SCFT, Advanced Practitioner)
Ben Hodgson (HERE, Advanced Practitioner)
Rachel Hughes (HERE, UHS, Advanced Practitioner)
Paul Jones (HERE, Advanced Practitioner)
Andrew Kemp (HERE, Advanced Practitioner, Hip and knee pathway lead)
Alex Kyriacou (SCFT, Advanced Practitioner)
Victora Lockley (SCFT, Advanced Practitioner)
Ali Loughran (SCFT, Advanced Practitioner)
Oliver Lucas (SCFT, Advanced Practitioner)
Grant McEwan (SCFT, Advanced Practitioner)
Stuart Osborne (HERE, Advanced Practitioner)
Elaine Sawyer (SCFT, Advanced Practitioner)
Toby Smith (SCFT, Advanced Practitioner)
David Stanley (SCFT, Professional lead)