**Bedfordshire and Hertfordshire INTERIM Priorities Forum Guidance**
**Number: 70**
**Subject: Hip Arthroscopy**
**Date: August 2015**
**Date Review Due: August 2016**

**Guidance**
[This guidance is based on Dorset CCG policy]

**Guidance**

Beds and Herts CCGs will fund hip arthroscopy for patients who have been worked up within the disease pathways as detailed below:

**Femoro-Acetabular Impingement (FAI):**

The CCGs will fund open or arthroscopic hip surgery for the treatment of femoro-acetabular impingement (FAI) ONLY when patients fulfil all of the following criteria:

- Diagnosis of definite femoro-acetabular impingement defined by appropriate investigations, X-rays, MRI and CT scans.
- An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis. This should include discussion of each case with a specialist musculoskeletal radiologist.
- Severe symptoms typical of FAI with duration of at least six months where diagnosis of FAI has been made as above.
- Failure to respond to all available conservative treatment options including activity modification, pharmacological intervention and specialist physiotherapy.
- Compromised function, which requires urgent treatment within a 6-8 months time frame, or where failure to treat early is likely to significantly compromise surgical options at a future date.
- Treatment with more established surgical procedures is not clinically viable.

**Sepsis of the hip joint:**
Hip arthroscopy is supported in the washout of an infected hip joint in patients refractory to medical management, patients with underling disease or patients who are immunosuppressed.

**Loose bodies:**
Hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.

**Excision/repair of Radiological Proven Labral Tears in the Absence of OA or Femoro-Acetabular Impingement Syndrome:**

Hip arthroscopy is supported for the excision of radiological proven labral tears associated with an acute traumatic episode in the absence of OA or FAI syndrome.

**Exclusions:**

Hip arthroscopy is not routinely commissioned for any other indications or pathologies other than those outlined above.

In addition, the CCGs will not fund hip arthroscopy in patients with femoro-acetabular impingement where any of the following criteria apply:

- Patients with advanced Osteo-Arthritic change on preoperative X-ray (Tonnis grade 2 or more) or severe cartilage injury (Outerbridge grade lll or lV).
- Patients with a joint space on plain radiograph of the pelvis that is less than 2mm wide anywhere along the sourcil.
- Patients who are a candidate for hip replacement.
- Any patient with severe hip dysplasia or with a Crowe grading classification of 4.
- Patients with generalised joint laxity expecially in diseases connected with hypermobility of the joints, such as Marfan syndrome and Ehlers-Danlos syndrome.
- Patients with osteogenesis imperfecta.

**NICE Guidance**

In considering the use of this procedure in 2007, NICE reported the following concerns:

- Efficacy outcomes have been poorly reported and assessment assessments are mostly qualitative.
- Specialist scores have not been developed to objectively measure outcome. There are a limited number of studies but demonstrating differences in surgical techniques.
- Data on patient selection is unclear (degree of impingement and arthritic degeneration of hips of patients included in the studies were not well defined).
- There was a lack of evidence to show whether the procedure successfully slows progression to osteoarthritis.

In the updated NICE guidance IPG 203, 213, 408, it is stated that the treatment should be restricted to centres experienced in treating this condition and staffed by surgeons adequately trained in techniques addressing FAI. All governance and audit should be undertaken in accordance with these guidelines.

**Governance**

Clinicians wishing to undertake hip arthroscopy must ensure they meet 5.2 above and provide a regular audit and review of activity, submitting details of all patients undergoing this procedure to the British Hip Society to enable long-term outcomes to be evaluated.

**Cases for Individual Consideration**

Should a patient not meet the protocol criteria, the requesting clinician must provide further information to support the case for being considered as an exception.

**Audit**

Audit should be conducted on an annual basis collecting:

- Six week post-operative follow up identifying complication rates and increased

symptoms;

- Pre and post operative information at one year (not necessarily undertaken face to face but by email or postal) using the dataset defined within the reporting format collected by the British Hip Society.
    - MAHORN (Multicenter Arthroscopy of the Hip Outcomes Research Network) Hip Outcome Tool (MHOT14)
    - EQ 5-D
    - Modified Harris Hip Score
    - UCLA (University of California, Los Angeles) Activity Score
    - Non arthritic Hip Score
    - HOOS (Hip disability and Osteoarthritis) Score
- Proportion registered with the British Hip Society – standard set at 100% compliance.

## Definitions

**Hip arthroscopy**

Hip arthroscopy is an innovative technique which allows for the inspection of the interior of the hip. The instrument used is a type of endoscope which is a tube shaped instrument inserted into a cavity in the body to investigate and treat disorders. It is flexible and equipped with lenses and a light source. It is a technically challenging procedure which should only be carried out in specialist units by teams with specific training in the techniques.

**Sepsis of the hip joint**

A septic joint required immediate action and is an orthopaedic emergency when in a native (i.e. non-replaced) joint. It can cause irreversible cartilage damage very quickly and can be fatal if pus under pressure is left in situ for any significant length of time. The long term ramifications of a septic joint if not dealt with expeditiously are subsequent joint replacement or potentially death in the severe cases of fulminant septicaemia (normally seen in the elderly or immune-compromised).

**Loose bodies**

Loose bodies in the hip joint can present spontaneously (such as in conditions like synovial chondromatosis) or as part of traumatic insult. A significant number of dislocated hips are reduced closed but as they are relocated “drag in to the joint” a piece of fractured bone (normally the socket rim). The result is a very painful problem which causes locking, giving way, an inability to weight bear and ultimately cartilage destruction due to the attrition effect of the loose body grinding away at the joint surface.

**Excision/repair of Radiological Proven Labral Tears in the Absence of OA or Femoro-Acetabular Impingement Syndrome (FAI)**

This is effectively a cartilage tear of the hip similar to meniscal tears of the knee. Such tears of the hip can be caused by differing aetiologies. There are a group of tears that can be caused as part of a degenerative process (arthritis). This is an area which requires further evaluation and longitudinal studies to evaluate treatment options.

Some labral tears are acute and sustained as part of a single injurious process. Patient who axially load the hip and then are subjected to a twisting movement can experience such tears. These tears

are painful from the outset, do not develop insidiously and do not resolve. Patients can experience locking and giving way. The joint can lock at any time and bring the individual to ground. If a simple labral tear is suspected, at the clinician's discretion, an MRI hip arthrogram is recommended.

**Hip Impingement Syndrome (Femoro-Acetabular Impingement (FAI))**

Hip Impingement (FAI) is a result of abnormality in the femoral head, acetabulum or both. Impingement may be caused by the jamming of an abnormally shaped femoral head into the acetabulum during forceful motion (especially flexion), or as a result of contact between the acetabular rim and the femoral head-neck junction. Its precise relationship with osteoarthritis of the hip is unclear but it may lead to the development of osteoarthritis.

The diagnosis of FAI is made from characteristic findings (Macfarlane, Haddad 2010) increasing duration and intensity of groin pain, initially intermittent on exercise, becoming constant and intense, with stiffness, clicking or popping sensation and reduced flexion and internal rotation.

Two mechanisms have been identified; cam impingement (most common in young athletic males) and pincer impingement (most common in middle-aged women). FAI is also associated with articular (chondral) damage, labral tearing and progressive OA of the hip.

**Human Rights and Equality Legislation has been considered in the formation of this guidance statement.**