East Sussex MSK Community Partnership

Hip Triage Guidelines

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East Sussex MSK Community Partnership

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Referral reason	Primary Care Management	Thresholds for referral to community MSK	Management Pathway for the Integrated MSK Service
Lateral hip pain **No previous operative intervention** **No history of trauma**	**Assessment:** • Exclude any traumatic injuries • Exclude spinal referred pain e.g reproduced with spinal movements or palpation (see spinal pathway) • Exclude infection e.g palpable mass, redness, oedema, or warmth around the lateral hip • Assess for common causes • No previous surgery • Cluster test diagnosis: including local palpation, resisted hip abduction in side-lying and 30 second single leg stand, all reproducing the local lateral hip symptoms. • Assess range of motion to exclude osteoarthritis. • Consider hormone influence especially in peri-menopausal females • Identify patients' beliefs and needs, include psychosocial issues and chronicity. **Diagnostics:** • Not required (unless suspecting moderate to severe OA, fracture or AVN – see appropriate pathways) **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Patient education, advice and re-assurance that the pain is usually self-limiting. Explain that, although symptoms do persist in a small proportion of people, persistence does not mean that there is a serious underlying condition. Sometimes tendons can be slow to respond to recommended management Gluteal Tendinopathy – East Sussex Healthcare NHS Trust (esht.nhs.uk) • Advice : avoiding direct compression such as lying on the symptomatic side and avoiding stretching of the area such as crossing legs, targeted stretches and asymmetrical postures. • Exercise sheets • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Caution with considering corticosteroid injections as they can provide potent short-term analgesia but long-term benefits are no better than 'wait and see' or other treatments. Corticosteroids have adverse biological effects on tendon health, potentially impacting success of concurrent exercise-based interventions. • Consider the use of Fit notes if patient is working **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • Symptoms persistent and new symptoms present for > 6 weeks • No response to analgesics • No response to advice and exercises in primary care • Symptoms affecting ADLs / occupation. Please state how in the referral **Refer to Advanced practitioner if:** • If previous physiotherapy has been tried and failed • If persistent or recurring pain. • For consideration of injection (unguided / guided) • Diagnostic uncertainty	**Assessment:** **Diagnostics:** • Plain X-ray (if persistent pain) • USS • MRI **Management:** • Physiotherapy • Injection (guided or unguided) • Education **Refer to Physiotherapy (from AP) if:** • Further exercise recommended or has not been fully utilised. • Post injections for continuation of exercises- however see previous note about potential adverse effects can impact on progress with exercise **Referral to Consultant (from AP) if:** • Rarely indicated as surgery outcomes are poor and is not offered locally.

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Anterior Hip / Groin Age <45 **No previous operative intervention** **No history of trauma**	**Assessment:** • Exclude any traumatic injuries • Exclude hernia • Exclude suspected sinister pathology • No previous surgery • Consider FAI, labral tears, early OA, soft tissue strain, congenital hip pathology • Consider AVN if severe pain- See AVN Pathway • Examine hip and assess range of motion and weight bearing status. • Identify patients' beliefs and needs, include psychosocial issues and chronicity. **Diagnostics:** • Consider an X-ray AP view (if planning referral to secondary care): ➢ Suspected stress fracture ➢ Known developmental dysplasia of hip (DDH) with increased symptoms - see iRefer ➢ Persistent hip pain despite previous conservative measures with moderate or severe pain, reduced function and loss of range suspected moderate or severe OA.. Please be explicit in your referral, as to why an x-ray will inform a change in management plus the clinical history and examination findings that support the referral. **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Patient education - DDH, FAI or early OA Royal Orthopaedic Hospital - What is Hip Dysplasia? - Femoro-acetabular Impingement (FAI) – msk - Versus Arthritis osteoarthritis of the hip information booklet • Exercise sheets (see Versus Arthritis osteoarthritis of the hip information booklet above) • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • ADL/activity modifications as required • Consider the use of Fit notes if patient is working **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • Symptoms persistent or new symptoms present for > 6 weeks • Suspected groin strain/soft tissue injury • Symptoms affecting ADLs / occupation • Further management of FAI, early OA, DDH **Refer to Advanced practitioner if:** • If previous physiotherapy (>3/12 DDH, >6/12 labral tears) has been tried and poor response • If persistent or recurring pain • For consideration of diagnostics (x-ray/MRI) • For USGI	**Assessment:** **Diagnostics:** • Plain X-ray • USS • MRI **Management:** • Ensure education and specific exercises have been provided • USGI • Education • Patient choice following SDM **Refer to Physiotherapy (from AP) if:** • Physiotherapy felt not fully utilised and no surgical target **Refer to Consultant (from AP) if trialled 6/12 exercise management and:** • Labral tear confirmed without established OA • DDH in <45-year-old without established OA and considering osteotomy • Severe OA

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Osteoarthritis (suspected or diagnosed) Age >45	**Assessment:** • Exclude any recent traumatic injuries • Identify any history of previous operative intervention • Examine hip and assess range of motion and weight bearing status. • Identify patients' beliefs and needs, include psychosocial issues and chronicity. **Diagnostics:** • X-ray (AP pelvis) if clinically indicated and planning referral to intermediate / secondary care. • Criteria met should include: Persistent hip pain despite previous conservative measures with moderate or severe pain, reduced function and loss of range. • Please be explicit in your referral, as to why an x-ray will inform a change in management plus the clinical history and examination findings that support the referral. • Repeat X-rays are not required within 12 months unless significant deterioration in symptoms • X-ray **not** required if referring in for Physiotherapy services. **Management (including condition-specific self-care options):** • Self-management exercises to include aerobic and strengthening • Consider ESCAPE PAIN app • Consider physiotherapy • Pain relief in line with agreed formularies / guidance • Patient education - A Guide To Healthy Hips and Knees – East Sussex MSK Community Partnership • Exercise sheets Information on exercising with hip and knee Osteoarthritis (OA) – East Sussex Healthcare NHS Trust (esht.nhs.uk) • Smoking cessation advice (One You East Sussex | Free Health & Wellbeing Service) • If BMI > 25 weight loss advice beneficial • If BMI 35-40 patient must be offered weight management support. • If BMI 40+, patient must be offered bariatric service/weight loss support. • Consider the use of Fit notes if patient is working **Other useful resources:** • CHESM Resources • Osteoarthritis Educational Videos • Versus Arthritis osteoarthritis of the hip information booklet • NHS_hip_osteoarthritis_decision_tool **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**6 weeks of conservative management in primary care, with appropriate patient advice** **Refer to Physiotherapy if:** • Symptoms persistent or new symptoms present for > 6 weeks • Symptoms affecting ADLs / occupation **Refer to Advanced practitioner if:** • If previous physiotherapy has been tried and failed • Completed at least 3 months of suitable strengthening exercises or physiotherapy without sufficient improvement in pain/function • Significant pain and disability • Diagnostic uncertainty • Advanced OA pathway can be considered if x-ray shows advanced changes and referral indicates wanting to consider surgery. **Refer to Orthopaedic Consultant** • Meets all required CEC criteria • Symptoms substantially affect quality of life • Non-surgical management is ineffective or unsuitable • If BMI > 40 only refer to NHS Trust • Patient choice following SDM NHS_hip_osteoarthritis_decision_tool	**Assessment:** **Diagnostics:** • Plain X-ray • USS • MRI **Management:** • Physiotherapy • Patient Education • USGI • Patient choice following SDM **Refer to Physiotherapy (from AP) if:** • Patient does not want or is not fit for surgery • Patient wants additional physiotherapy input **Refer to Consultant (from AP or Physio) If:** • Meets all required CEC criteria (see below) • Symptoms substantially affect quality of life • Non-surgical management is ineffective or unsuitable • If BMI > 40 only refer to NHS Trust Pre-operative rehab and care (signposting to exercise groups and Keeping well whilst waiting) Keeping Well Whilst Waiting | East Sussex MSK Community Partnership **Only refer to Secondary Care for THR opinion if (as in CCG 'Clinically Effective Commissioning Policy' 2018):** • Uncontrolled, intense, persistent pain . • Moderate functional limitations, substantial impact on quality of life . • Conservative treatment at least 6 months shared decision making (documented) • Decision aid tool • Optimal tolerated doses of analgesia • Guided exercises and muscle strengthening OR physiotherapy (ineffective in bone on bone OA) • Patient education/orthosis (activity modification and lifestyle adjustment) • Smoking cessation • BMI < 35 (ideally), or reasonable attempts been made to reduce

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Post Operative Hip Pain **Previous operative intervention of THR, hip resurface or revision THR (anterior / lateral or posterior** **No history of trauma**	**Assessment:** • Signs of instability • Explore any traumatic injuries • Consider infection and wound check (if acute) • Change in symptoms • Metal on metal • Include date of surgery • Consider excluding back pain - see spinal pathway if pain reproduced more with back movements) • Identify patients' beliefs and needs, include psychosocial issues and chronicity. **Refer to A&E if:** • Acute dislocation • Systemically unwell/fever **Diagnostics:** • X-ray AP Hip if clinically indicated following assessment and following onset of new symptoms **Please be explicit on your radiology request as to why you are requesting an x-ray ie** 1. Significant change in pain levels 2. A reduction in previous levels of function eg sitting to standing 3. A reduction in range of motion • Repeat X-ray not required within 12 months unless significant deterioration or change in symptoms • X--ray not required if referring to physiotherapy • Consider bloods if clinically suspect infection or metallosis (see below) **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Consider physiotherapy • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **Be aware of metal-on-metal prostheses and routinely refer to Orthopaedic Consultant following blood tests for Cobalt & Chromium levels. Where possible, patient should be directly referred to Orthopaedic consultant who operated.** **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • No red flags or radiographic signs of prosthetic loosening **Refer to Advanced practitioner if:** • Unsuccessful course of Physiotherapy • Severe symptoms with sudden onset or deteriorating rapidly **Refer to Orthopaedic Consultant as urgent appointment if:** • Signs of prosthetic loosening • Suspected infection **Routine referral** • Metal on metal prothesis +/- signs of metallosis	**Assessment:** **Diagnostics:** • Plain X-ray AP pelvis and hip • MRI MARS protocol **Management:** • Physiotherapy • Patient choice following SDM • Referral to Pain management for chronic pain not responding to physiotherapy or not appropriate for surgical intervention • Patient education • Referral to appliances / orthotist e.g. leg length discrepancy. **Urgent referral to Orthopaedic Consultant (from AP) if:** • Signs of prosthetic loosening **Referral to A&E (from physio/AP) if:** • Suspected infection/Risk of Sepsis **Routine referral to Orthopaedics (from AP) if**: • Suspected iliopsoas tendinopathy recalcitrant to physiotherapy • Gluteal tendinopathy signs post THR and wanting to be considered for a steroid injection. This will not be offered by all Consultants due to possible infection risk **For all Orthopaedic referrals, please refer back to original Consultant where possible or to a surgeon who does revision surgery.** **Refer to physio (from AP or Consultant) if:** • Surgical intervention ruled out

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DHS, Cannulated screws, Hemiarthro-plasty	**Assessment:** • Explore any traumatic injuries • Consider infection and would check (if acute) • Include date of surgery • Consider excluding back pain - see spinal pathway if pain reproduced more with back movements) • Identify patients' beliefs and needs, include psychosocial issues and chronicity. **Diagnostics:** • X-ray AP Hip if clinically indicated following assessment and following onset of new symptoms **Please be explicit on your radiology request as to why you are requesting an x-ray ie** 1. Significant change in pain levels 2. A reduction in previous levels of function eg sitting to standing 3. A reduction in range of motion • Repeat X-ray not required within 12 months unless significant deterioration or change in symptoms • X--ray not required if referring to physiotherapy • Consider bloods if clinically suspect infection **Management (including condition-specific self-care options):** • Pain relief in line with agreed formularies / guidance • Consider physiotherapy • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy if:** • If X-Ray & diagnostics / bloods are normal **Refer to Advanced practitioner if:** • If unsuccessful Physiotherapy or severe symptoms especially if sudden onset or deteriorating rapidly. · NB. Threshold for reimaging within short timeframes should be low due to rapid onset of problems. **Refer to Orthopaedic Consultant (urgent):** • If infection is suspected **Refer to Orthopaedic Consultant (routine):** • If no infection suspected and has tried physiotherapy but ongoing concerns remain.	**Assessment:** **Diagnostics:** • Consider xray if > 18 months ago or symptoms significantly changed. **Management:** • Assessment • Patient education • Patient choice following SDM • Appropriate physiotherapy Management **Referral to Consultant (from AP) if:** • Xray reveals loosening or movement of metal work • Further opinion is required • If patient may require revision, removal of metalwork or conversion to THR • Gluteal tendinopathy signs post THR and wanting to be considered for a steroid injection. This will not be offered by all Consultants due to possible infection risk **Refer to physio (from AP or Consultant) if:** • Surgery ruled out • Patient choice following SDM

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Avascular Necrosis (AVN)	**Assessment:** • Excruciating pain Night pain • Unable to weight-bear • +/-previous hip fracture • HIV / alcohol or steroid usage • Sickle cell anaemia **Diagnostics:** • Urgent X-ray AP pelvis if clinically indicated, please make your cliical concerns explicit on the radiology referral. **Management:** • Pain relief in line with agreed formularies / guidance • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service)	**Refer to Orthopaedic Consultant (Urgent) If:** • X-Ray shows AVN - urgent referral to MSK consultant **Refer to Advanced Practitioner if:** • X-Ray clear but suspicions of AVN persist	**Assessment:** **Diagnostics:** Urgent • X-Ray AP Pelvis (note often AVN does not show for 6-9/12) • MRI **Management:** • If unable to weight bear – patient to use crutches • If patient has sickle cell anaemia – Refer to Haematology • Patient choice following SDM • Patient education • If AVN is diagnosed by AP – review by Orthopaedic Consultant **Referral to Consultant (from AP) if:** • AVN seen on imaging (urgent) referral **If not fit for, or wanting, surgery:** • Referral back to GP for pain management • Consider Pain Management **Referral to physiotherapy (from AP or Consultant) if:** • Surgery ruled out

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Posterior Hip Pain (buttock pain)	**Assessment:** • Consider Mechanical Back Pain – see spine pathway **Isolated ischial pain-** • Examination • Educate about unloading compression in sitting • If co-existing Lx pain is present, see back pain pathway) • Identify patients' beliefs and needs, include psychosocial issues and chronicity. **Diagnostics:** • None **Management:** • Pain relief in line with agreed formularies / guidance • Caution with considering corticosteroid injections as they can provide potent short-term analgesia but long-term benefits are no better than 'wait and see' or other treatments. Corticosteroids have adverse biological effects on tendon health, potentially impacting success of concurrent exercise-based interventions. • Consider physiotherapy • Weight management advice/smoking cessation signposting if appropriate (One You East Sussex | Free Health & Wellbeing Service) • Consider the use of Fit notes if patient is working **Please note: FCP advice and guidance does not constitute a comprehensive physiotherapy programme.**	**Refer to Physiotherapy:** • > 6/52 pain **Refer to AP:** • Previous poor response to physio	**Assessment:** **Management:** • Unloading area advice • Specific exercises • Physiotherapy • Patient choice following SDM • Patient education **Diagnostics:** • USS • MRI **Refer to AP (from physiotherapy) if:** • If failed to respond to physio and education- consider USGI • Note guidelines and research sparse in this area **Referral to Consultant (from AP) if:** • Rarely indicated • Exhausted conservative treatment. **Refer to physiotherapy (from AP/Consultant) if:** • Surgery not indicated • Comprehensive Physiotherapy not previously undertaken