Femoroacetabular Impingement Among Physically Active Population.

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Abstract

Background: A 36-year-old male athlete presented with insidious onset of progressive right hip pain and gait disturbance of 7 years duration. The patient participated in contact sports such as soccer, football, and hockey. Physical examination included thorough hip examination with specific emphasis on the iliopsoas compartment, femoroacetabular impingement, and hip internal and external rotation. Pain was exacerbated by External Rotation (ER) and Anterior Rotation (AR) of the hip. Physical examination of the hiprevealed decreased range of motion, pain, and an increased anterolateral gapping with resisted hip adduction and flexion. The patient was referred for further imaging and surgical consultation.

Initial Diagnostic Imaging: Initial diagnostic imaging included plain radiographs and magnetic resonance imaging (MRI). The radiographs revealed anterior femoroacetabular impingement with cam deformity on the right side. MRI confirmed the presence of femoroacetabular impingement, and ruled out other causes of hip pain such as labral tear or osteoarthritis.

Case Discussion: The case was discussed at our weekly joint conference, and it was decided to proceed with surgery. The patient was scheduled for a direct anterior hip arthroscopy with excision of the cam deformity.

Surgical Technique: The patient was placed in the lateral decubitus position with the affected hip facing upward. A 4-5 cm incision was made over the anterior aspect of the hip, just above the anterior superior iliac spine. The fascia lata was incised, and a small skin incision was made over the vastus lateralis muscle. The muscle was split and retracted, and the hip was exposed. The superior gluteus medius and tensor fascia lata were identified, and the iliotibial band was freed. The hip was then fixed in flexion and adduction, and the femoral head was palpated. The cam lesion was identified, and the acetabular labrum was inspected. The labrum was found to be intact, and the cam lesion was excised using a Dormia basket.

Postoperative Care: The patient was discharged the same day of surgery. A week of bed rest was recommended, and the patient was allowed to weight bear as tolerated with the use of crutches. A progressive strengthening and range of motion protocol was initiated, with the goal of returning to full activity within 6-8 weeks.

Discussion: This case highlights the importance of a multidisciplinary approach to the management of femoroacetabular impingement. Early diagnosis and intervention can lead to improved outcomes and a faster return to sport.

References