Hip Pain

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Goals

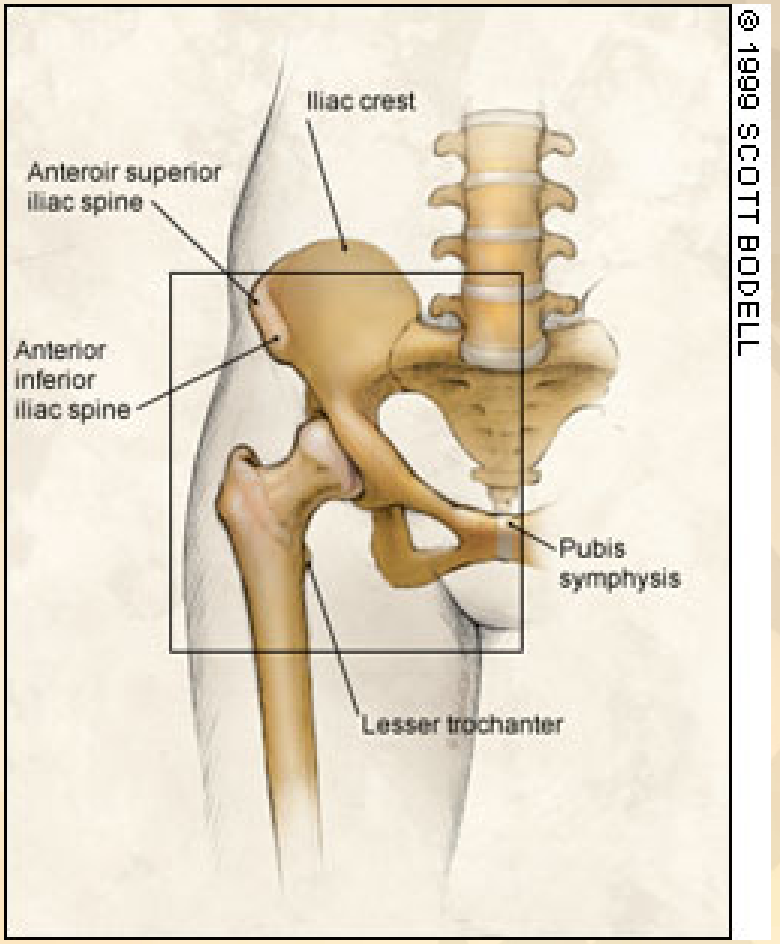
- **Differentiate Anterior, Lateral, and Posterior Hip Pain**
- **Do a good exam—and know why you're doing it**
- **Develop an appropriate differential based on the location and the exam**

Scope of the Problem

- The family physician in a typical practice can expect to see a patient with hip pain every 1 to 2 weeks.
- 0.61% of all visits to family practitioners, or about 1 in every 164 encounters
- Runners report an average yearly hip or pelvic injury rate of 2% to 11%.
- NHANES III—14.3% of patients aged 60 years and older reported significant hip pain on most days over the previous 6 weeks.
- 18.4% of those who had not participated in leisure time physical activity during the previous month reported severe hip pain as opposed to 12.6% of those who did engage in physical activity

Anterior Hip Pain

- **Groin pain = consider hip pathology**

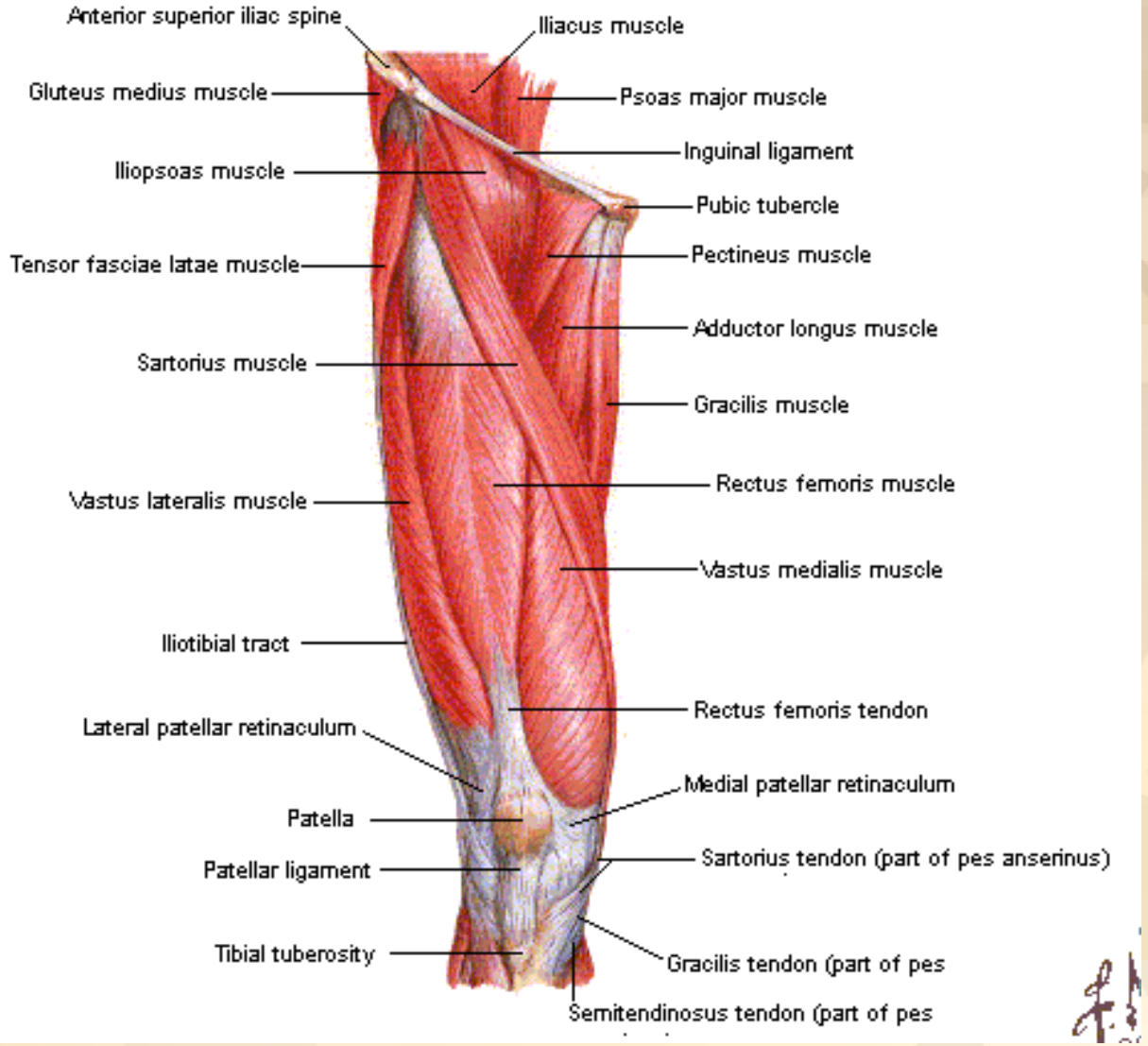


Anterior Hip Pain

- **Differential Dx**
  - **Osteoarthritis**
  - **Inflammatory arthritis**
  - **Muscle and tendon strains**
  - **Tendonitis**
  - **Femoral neck stress fracture**
  - **Sports hernia (Occult hernia or tear of oblique aponeurosis)**
  - **Obturator or ilioinguinal nerve entrapment**
  - **Osteitis pubis**
  - **Acetabular labral tears**

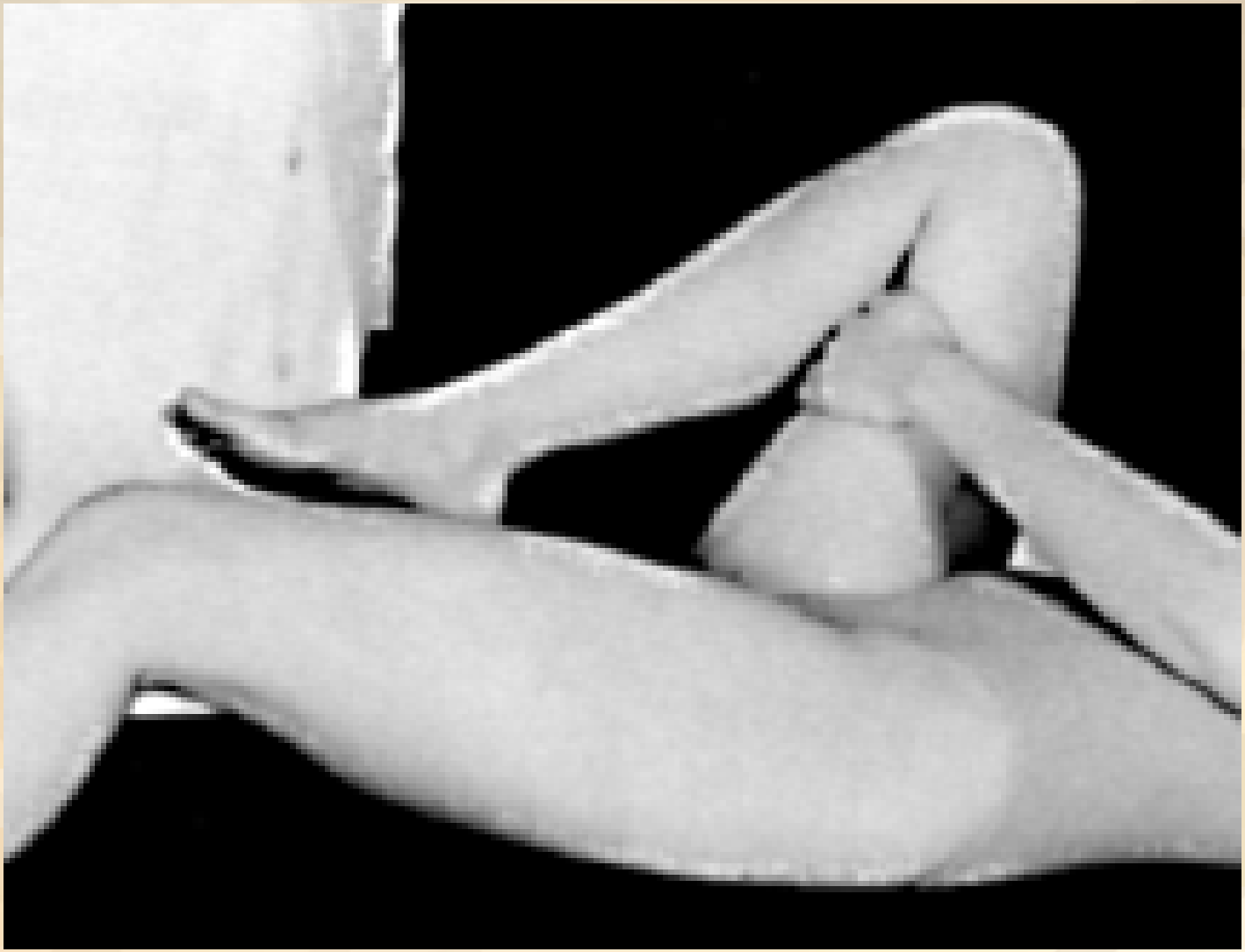
Muscles of Thigh

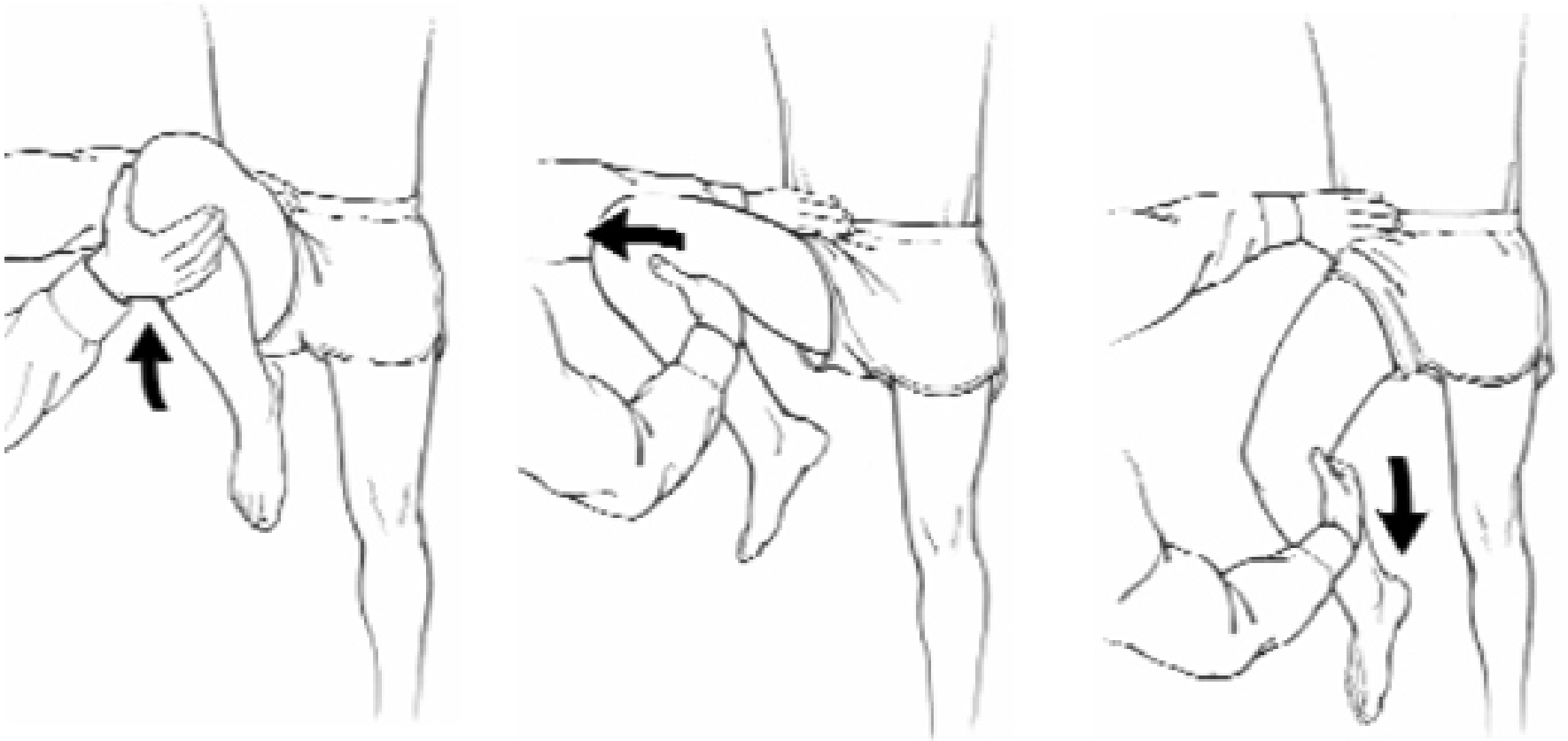
Anterior View - Superficial Dissection

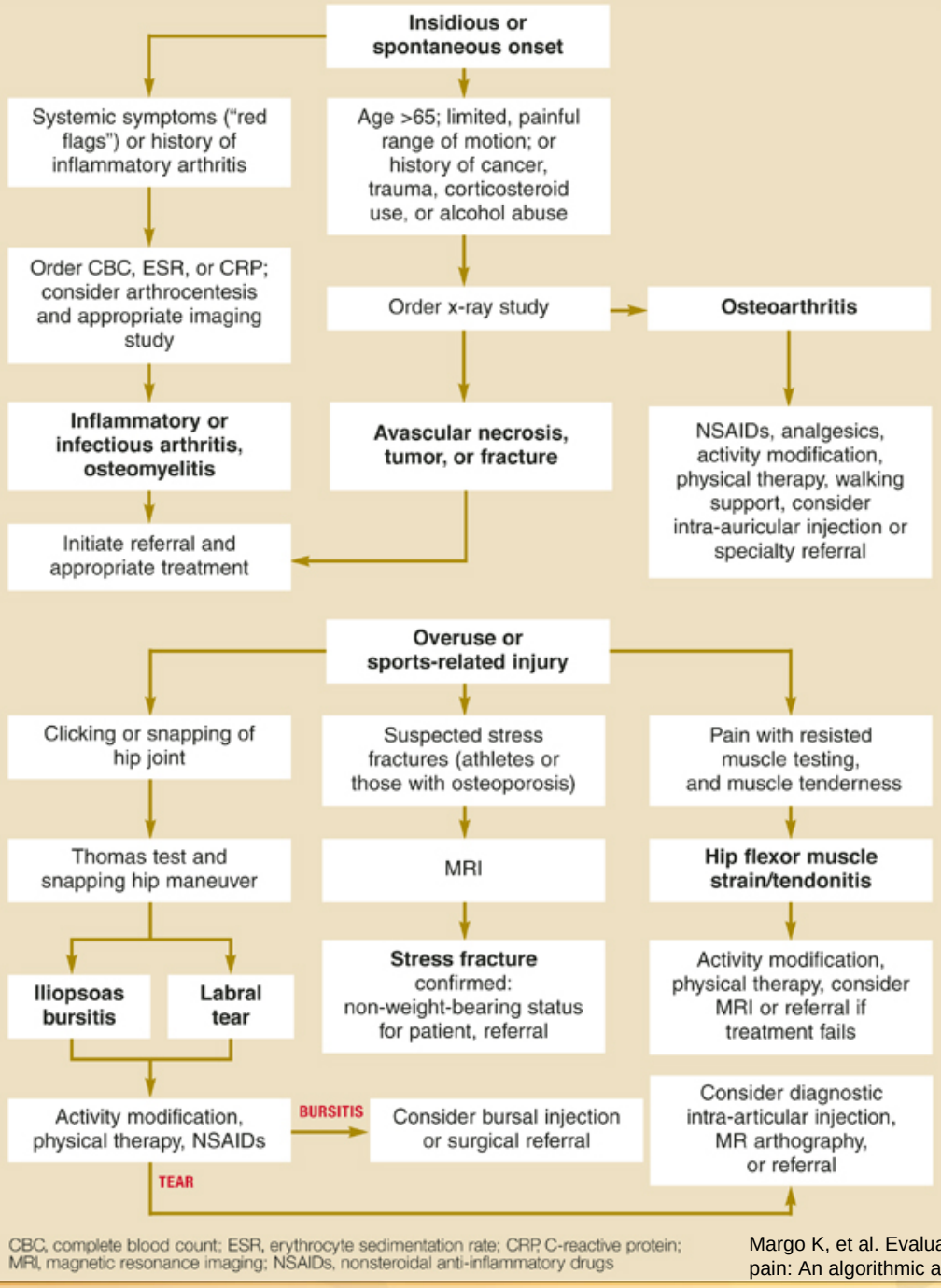


Anterior Hip Pain

- Examination
  - Inspection
    - Walking/Gait
    - Pelvic position/splinting
    - Atrophy/ecchymosis/bony deformity
  - Palpation
  - ROM
    - Flexion/extension/internal/external rotation
    - Strength
  - Special Tests
    - Thomas test
    - Snapping Hip Test
    - Hernia exam







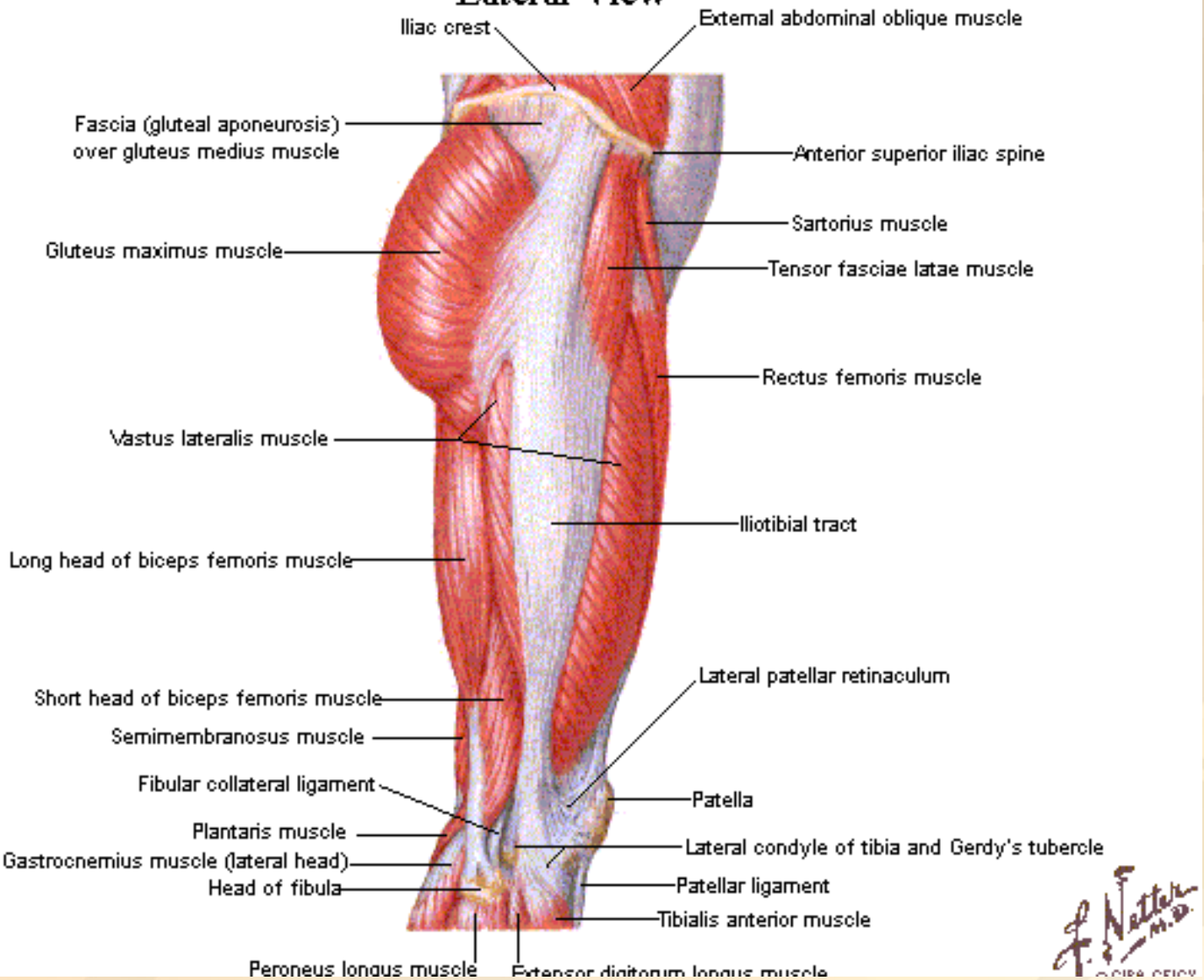
Margo K, et al. Evaluation and management of hip pain: An algorithmic approach J Fam Pract. 2003, 52:8

Lateral Hip Pain

- **Differential Dx**
  - **Greater trochanteric pain syndrome**
  - **Iliotibial band syndrome**
  - **Meralgia paresthetica**

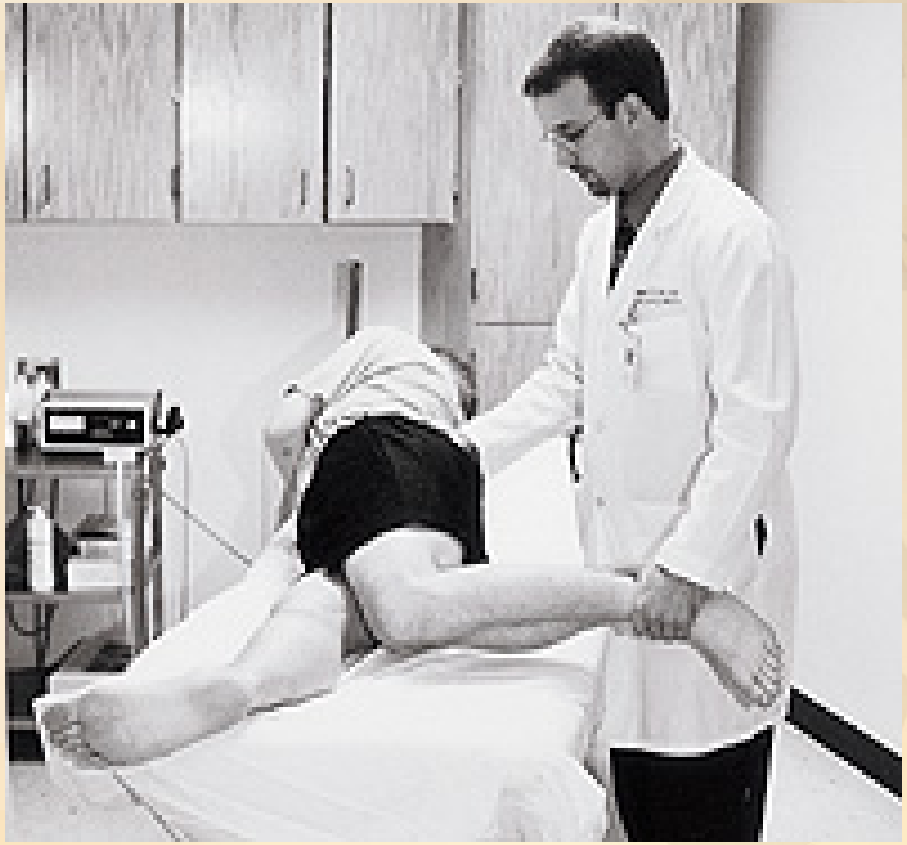
Muscles of Hip and Thigh

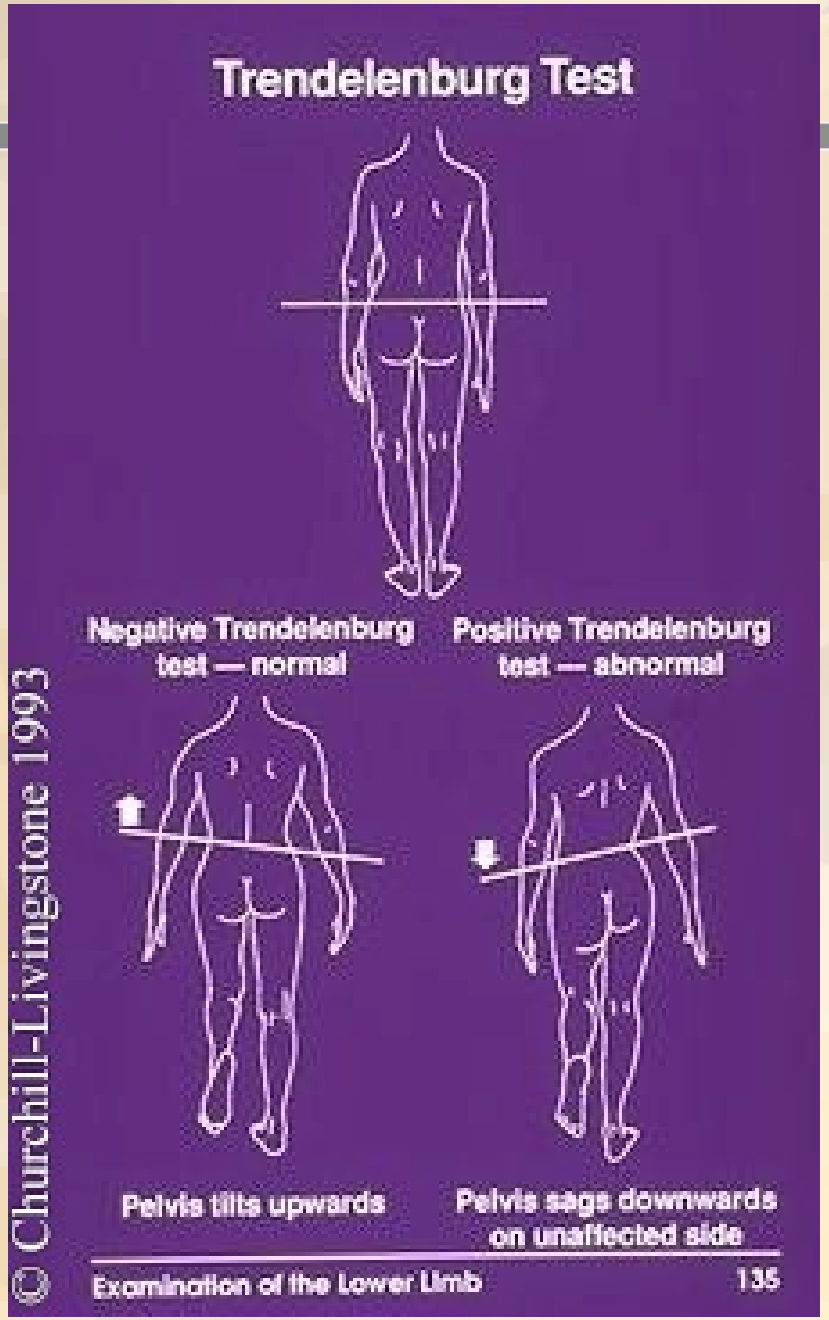
Lateral View

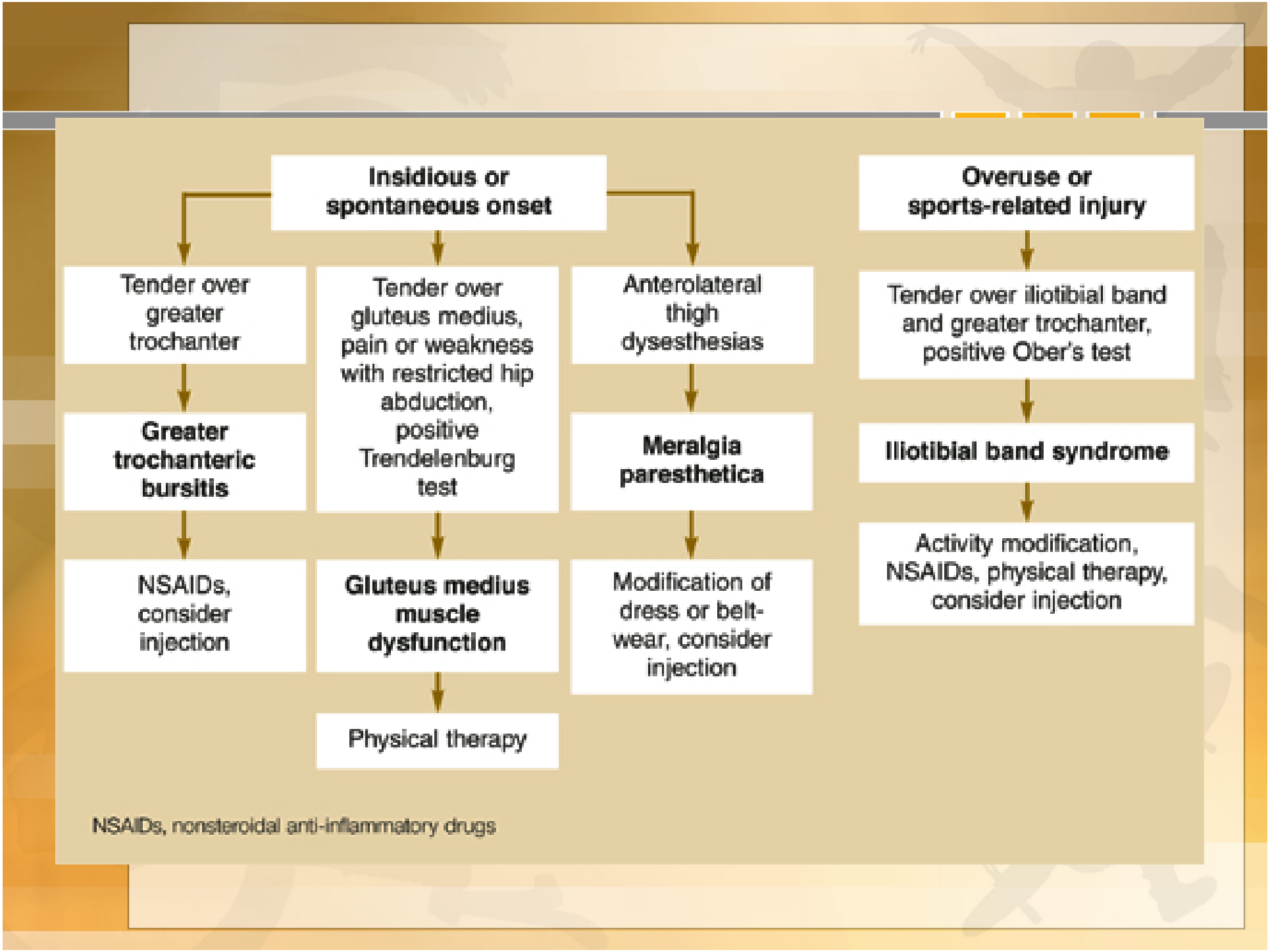


Lateral Hip Pain

- **Examination**
  - **Special Tests**
    - **Ober Test**
    - **Trendelenberg Test**

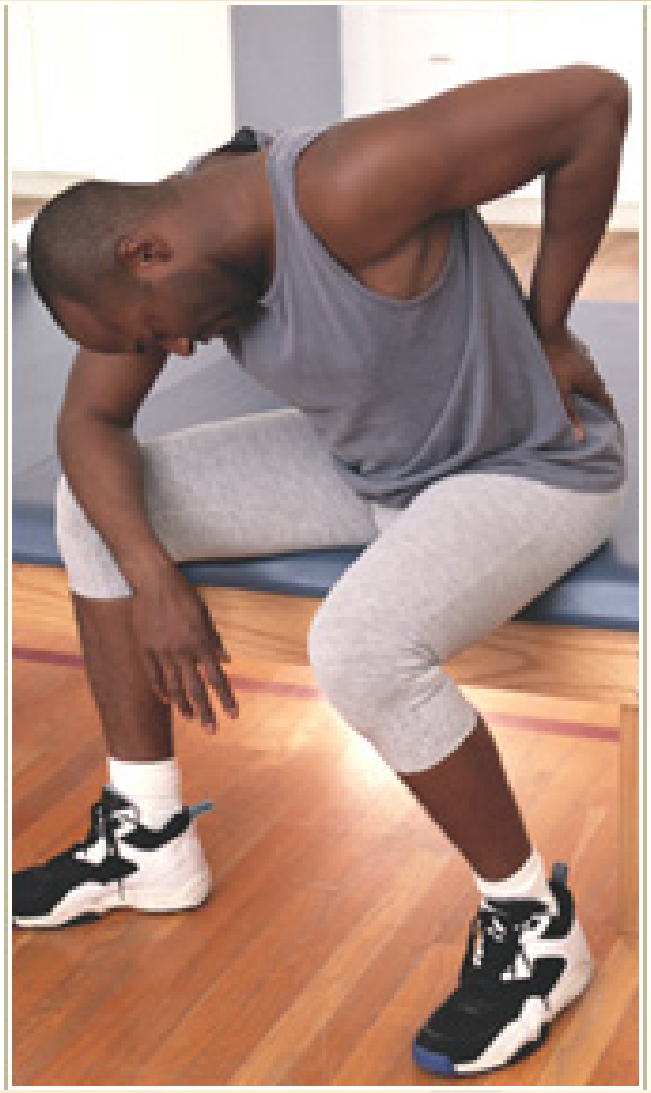



Trendelenburg Test
Negative Trendelenburg test — normal
Positive Trendelenburg test — abnormal
Pelvis tilts upwards
Pelvis sags downwards on unaffected side
Examination of the Lower Limb
135
© Churchill-Livingstone 1993


Insidious or spontaneous onset
Tender over greater trochanter
Greater trochanteric bursitis
NSAIDs, consider injection
Tender over gluteus medius, pain or weakness with restricted hip abduction, positive Trendelenburg test
Gluteus medius muscle dysfunction
Physical therapy
Anterolateral thigh dysesthesias
Meralgia paresthetica
Modification of dress or belt-wear, consider injection
Overuse or sports-related injury
Tender over iliotibial band and greater trochanter, positive Ober's test
Iliotibial band syndrome
Activity modification, NSAIDs, physical therapy, consider injection
NSAIDs, nonsteroidal anti-inflammatory drugs

Posterior Hip Pain

- **Posterior Hip Pain usually means Back Pain**
- **Evaluate for “red flags”**

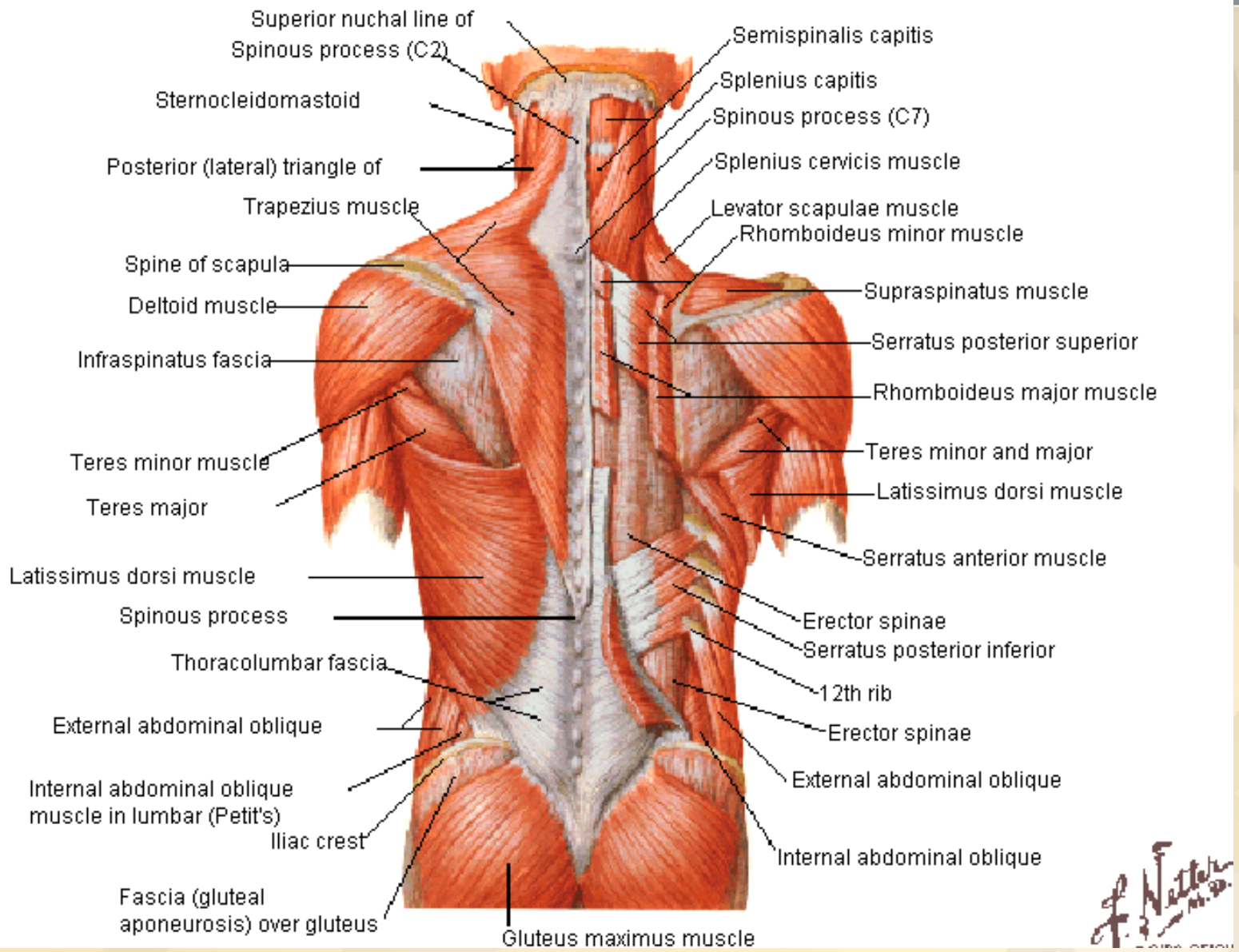


Posterior Hip Pain

- **Differential Dx**
  - **Lumbar spine disease**
    - **Degenerative disc disease**
    - **Facet arthropathy**
    - **Spinal stenosis**
  - **Sacroiliac joint disorders**
  - **Hip extensor and external rotator muscle pathology**
  - **Aortoiliac vascular occlusive disease (rare)**

Muscles of Back

Superficial Layers



Posterior Hip Pain

- **Mostly outside the hip (back)**
- **Examination**
  - **ROM**
  - **Leg Length**
  - **Neurologic**
    - **Reflex**
    - **Strength**
    - **Sensory**
  - **Special Tests**
    - **FABER**
    - **Straight Leg Raise**
    - **Hyperextension**
    - **Gaenslen's**

- **Flexion – 80º**
- **Extension – 35º**
- **Lat Bend – 40º**
- **Rotation – 3-18º**

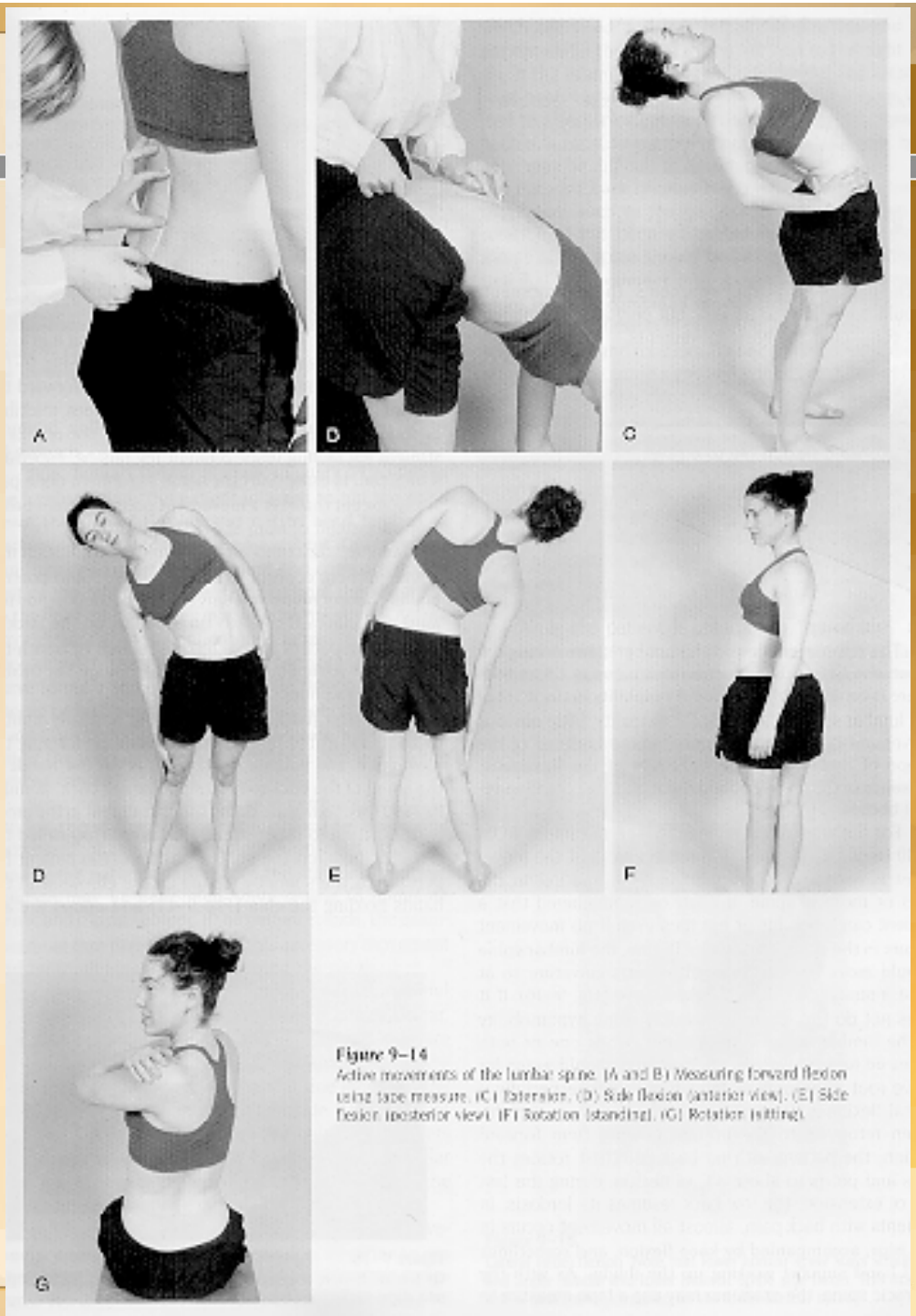
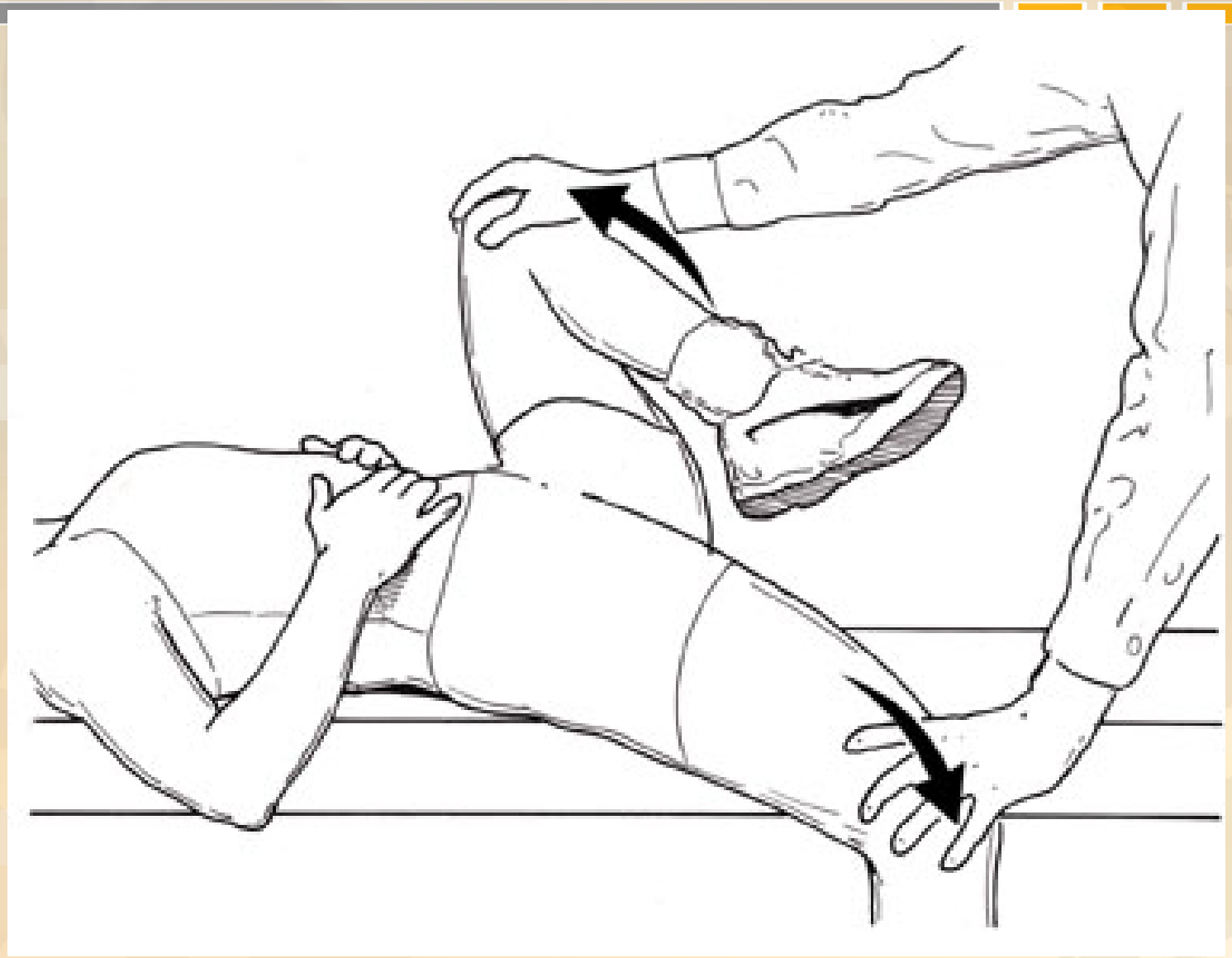
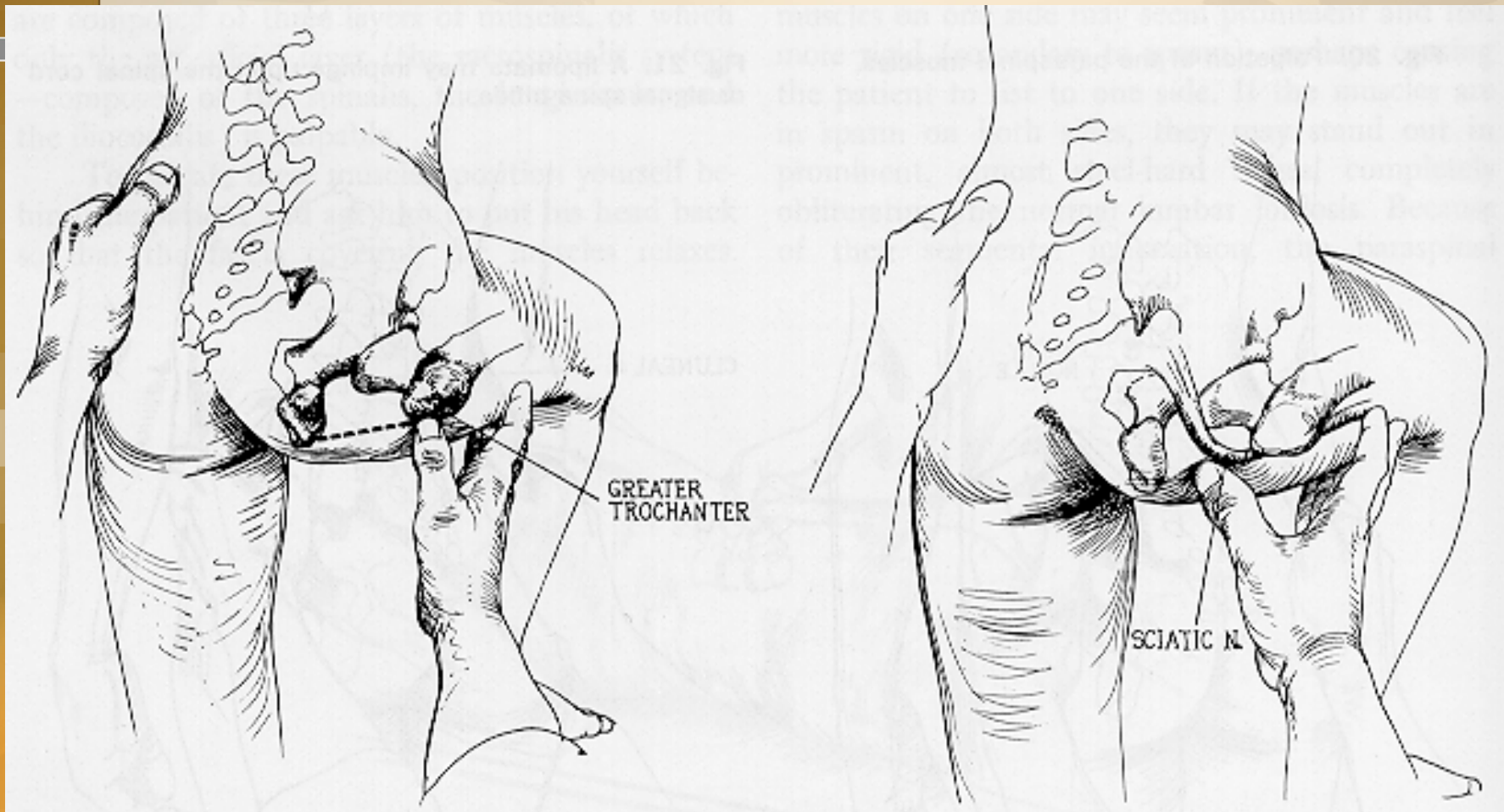


Figure 9–14
Active movements of the lumbar spine. (A and B) Measuring forward flexion using tape measure. (C) Extension. (D) Side flexion (anterior view). (E) Side flexion (posterior view). (F) Rotation (standing). (G) Rotation (sitting).





Figs. 24, 25. The sciatic nerve may be barely palpable at the midpoint between the ischial tuberosity and the greater trochanter. The hip must be flexed to palpate the nerve.

PHYSICAL EXAMINATION OF THE LUMBAR SPINE

L4 NEUROLOGIC LEVEL

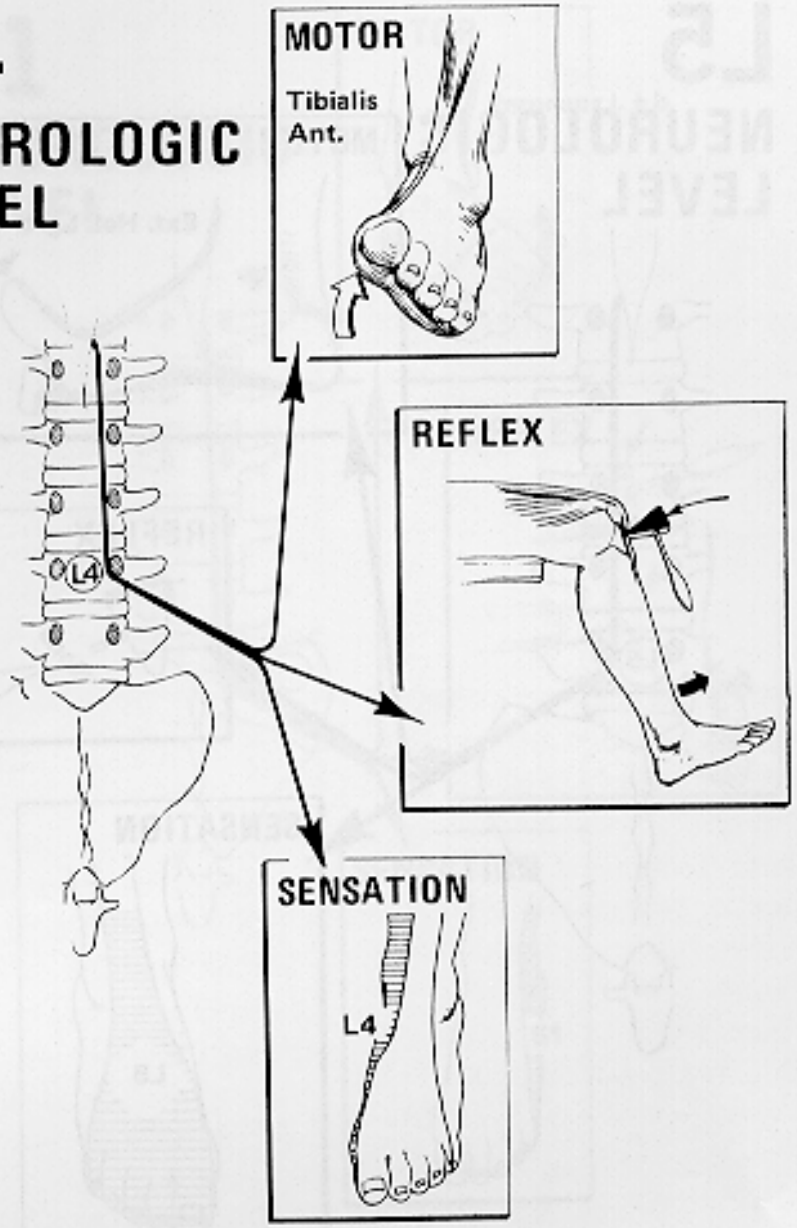


Fig. 30. Neurologic level L4.

PHYSICAL EXAMINATION OF THE LUMBAR SPINE

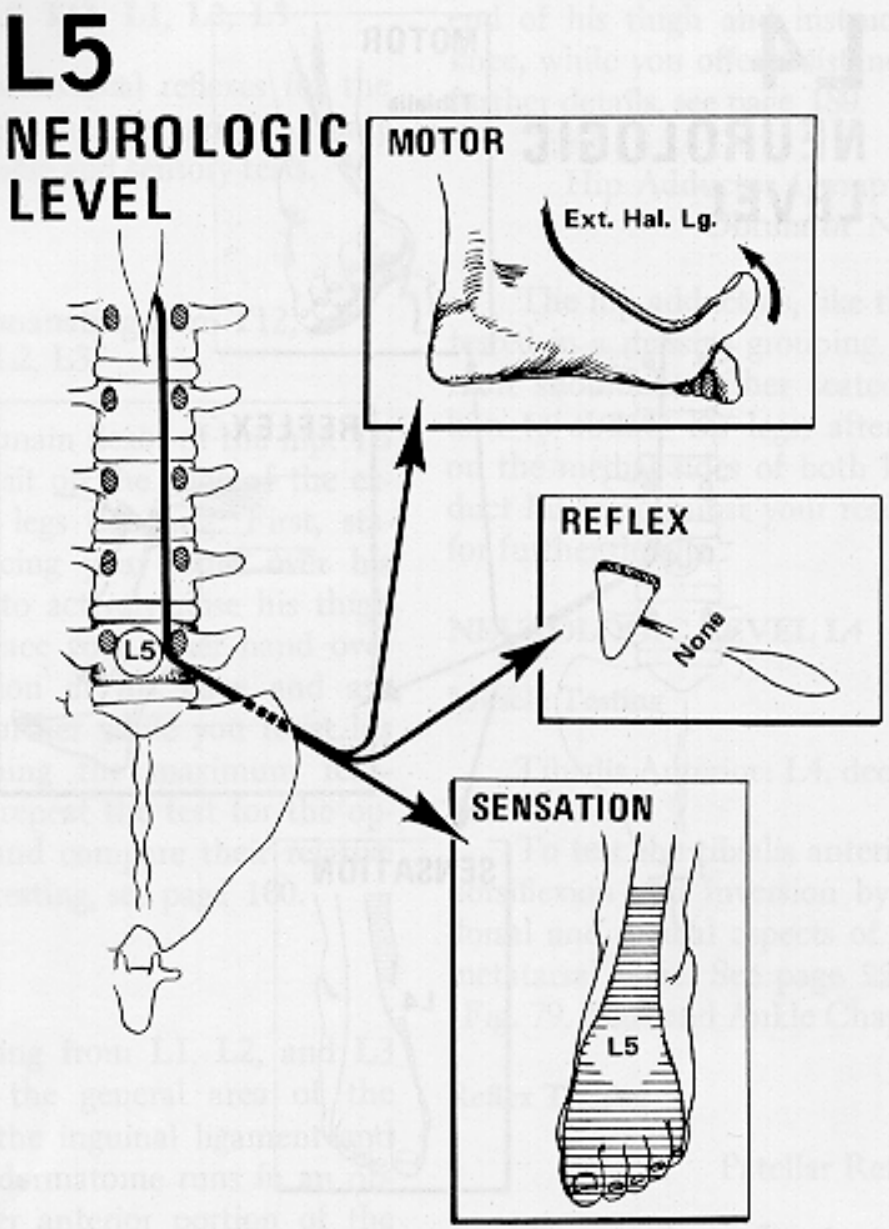


Fig. 31. Neurologic level L5.

PHYSICAL EXAMINATION OF THE LUMBAR SPINE

S1 NEUROLOGIC LEVEL

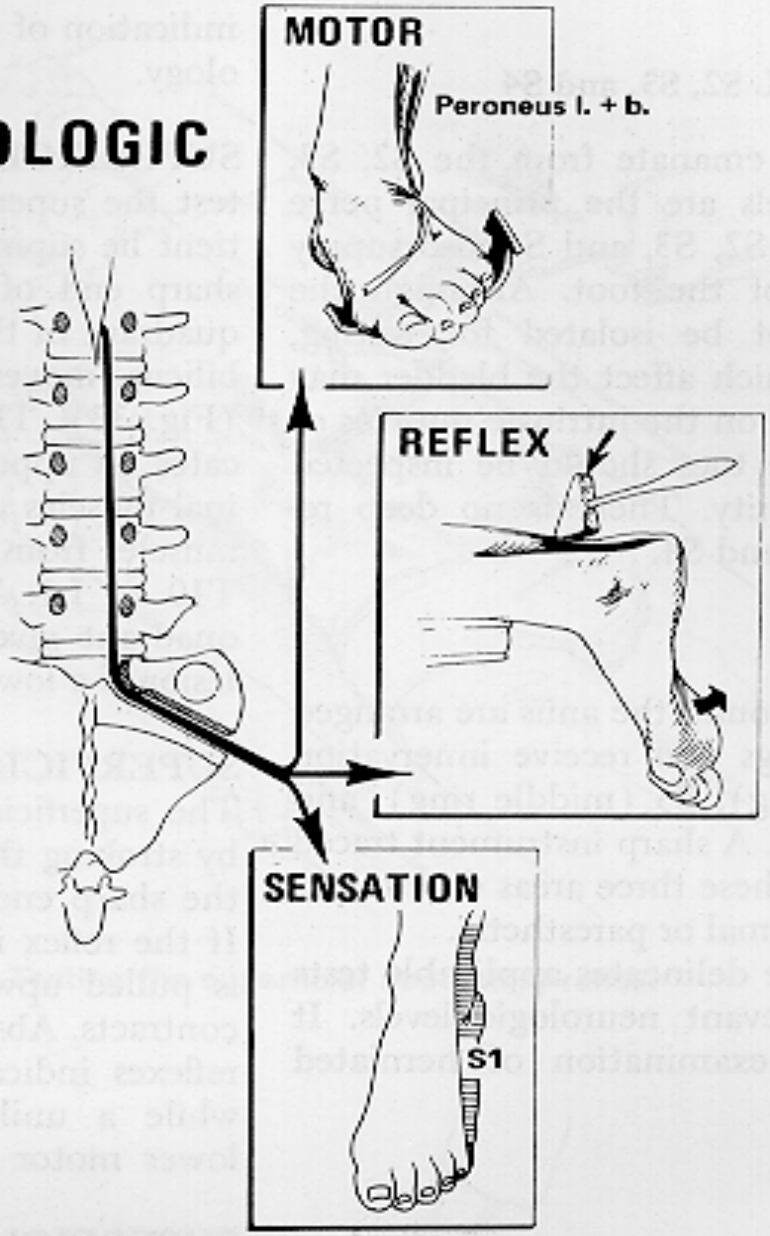
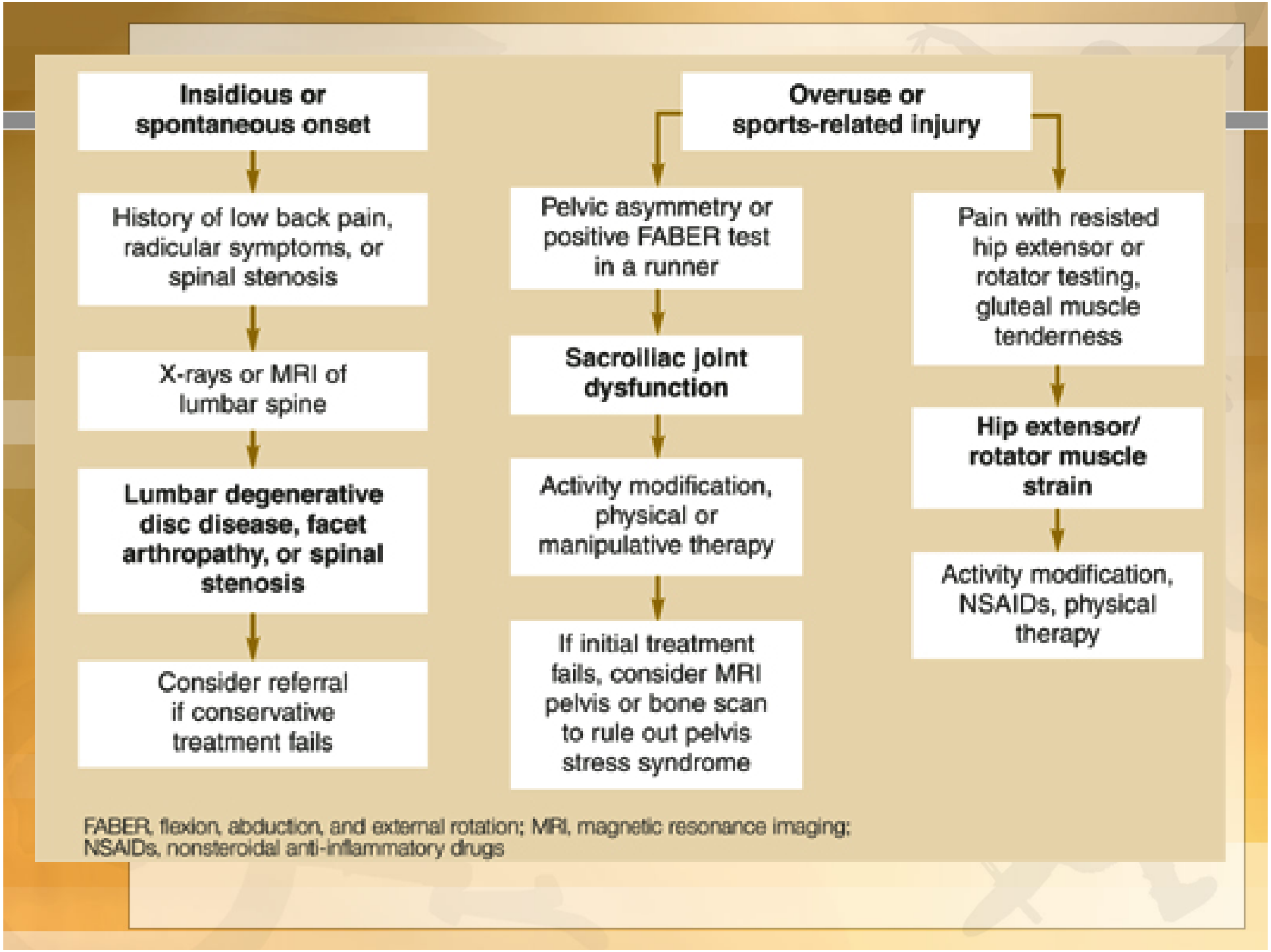


Fig. 32. Neurologic level S1.



FABER, flexion, abduction, and external rotation; MRI, magnetic resonance imaging; NSAIDs, nonsteroidal anti-inflammatory drugs

Conclusion

- Know your anatomy
- Review your texts
- Know why you’re doing an exam