

# Rotherham OA Hip Pathway

Secondary Care

Patient presents with hip/groin symptoms.  
Confirm diagnosis (see attached notes)

Primary Care

## Moderate to severe Hip OA

### Clinical presentation

Moderate to severe OA usually presents with persistent groin/anterior leg pain, leg length discrepancy, rotational deformity

### Investigations

MRI not indicated.

Consider standard pelvis X-ray

### Management

Consider, analgesia and NSAIDs, walking aids

### Injections

Not indicated

### Referral

**Non-surgical** -If no improvement with 6 weeks of conservative management refer to MSK Service

### Surgical

#### Agreed Clinical Threshold for Hip replacement

If patient is experiencing moderate to severe persistent pain not adequately relieved by an extended course of non-surgical management and pain is at a level at which it interferes with activities of daily living– washing, dressing, sleeping and quality of life. *AND*

The patient is fit for surgery with a BMI <35. Patients with a BMI >35 should be advised and given appropriate support with referral to specialist services if indicated and this should be evidenced.

*AND* X-ray - AP pelvis which confirms evidence of OA has been carried out within the past 6 months.

GP referral letter should contain evidence that:

- The recommended hierarchy of management has been followed (or reasons why a treatment is not appropriate): non-pharmacological treatments first, then analgesia, and then if necessary, surgery.
- Confirmation that patients have been made aware of the options available as an alternative to surgery and given written information including risks associated with surgery;
- Patients fitness for surgery has been properly assessed and they are medically optimized (BP and diabetes etc.)

### Self Help/ patient information

[www.nhs.uk](http://www.nhs.uk) [www.arthritisresearchuk.org](http://www.arthritisresearchuk.org)

## Early Hip OA

### Clinical presentation

Symptoms intermittent groin/anterior leg pain, no leg length discrepancy, no rotational deformity.

### Investigations

X-ray not indicated in the early stages unless symptoms deteriorate.

MRI not indicated

### Management

Conservative management, analgesia and NSAIDs

### Injections

Not indicated

### Referral

If no improvement with 6 weeks of conservative management refer to MSK Service

### Self Help/ patient information

[www.nhs.uk](http://www.nhs.uk)

[www.arthritisresearchuk.org](http://www.arthritisresearchuk.org)

## Please refer the following directly to Secondary Care

History of or suspected malignance investigate and refer as appropriate. Consider red flags of unexplained weight loss, night pain and high inflammatory markers.

Suspected fracture, dislocation or infection, refer to A&E

History of previous THR, severe Osteoporosis, suspected AVN, rotational mal-alignment, Perthes, SUCFE: refer directly to Orthopaedic Surgeon

Suspected inflammatory condition, investigate and refer to Rheumatology

## Rotherham Hip Pathway

### **Differential diagnosis:**

### **Neural entrapment / Referred pain from Lumbar Spine/Lumbar radiculopathy:**

Clinical presentation pain in the leg with or without low back pain. Patients can present with parasthesia/anaesthesia lateral thigh/leg pain

Restricted SLR/PNB. Consider conservative management provide reassurance and postural advice including to remain active. No MRI/X-rays indicated

Refer to MSK services

(Refer to back pathway for further guidance)

### **Spinal stenosis:**

(Refer to back pathway for further guidance)

Exclusions: Inguinal hernia.

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