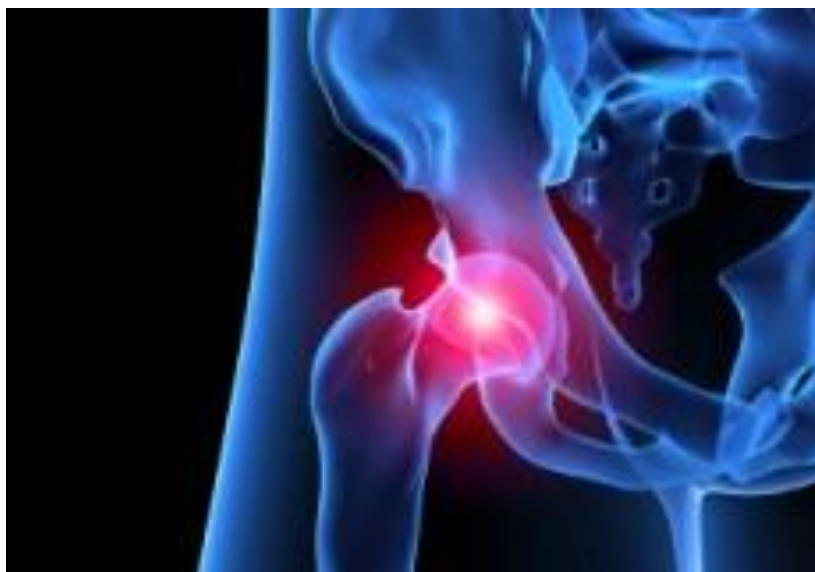


A patient guide to Hip Impingement Non-Surgical Management



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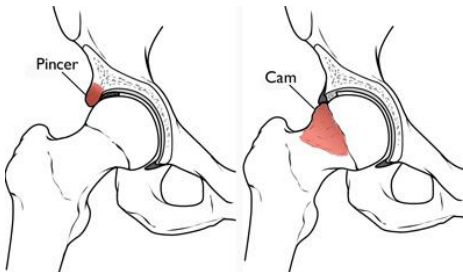
What is it?

Femoroacetabular impingement or FAI is a condition where there is unwanted contact between abnormally shaped parts of the head of the thigh bone and socket. Basically, the ball (femoral head) and socket (acetabulum) rub abnormally creating damage to the hip joint. Damage can occur to the articular cartilage (smooth white surface of the ball or socket) or the labral cartilage (soft tissue bumper of the socket).

FAI generally has two types:

The Cam type describes the situation where the neck of the femur is thickened as it forms the femoral head. This causes a loss of roundness of the femoral head which contributes to abnormal contact between the head and socket.

The Pincer type describes the situation where the socket or acetabulum has increased bony lay down at its edges causing increased overage of the ball or femoral head. This bony protrusion typically exists along the front-top rim of the socket and causing the labral cartilage to be “pinched” between the socket rim and front of the femoral head-neck junction.



Often the Cam and Pincer forms exist together i.e. mixed impingement.

FAI is associated with cartilage damage, labral tears, early hip arthritis, hypermobility, sports hernias, and low back pain. It is common in high level athletes, but also occurs in active individuals.

Conservative Rehabilitation

Non-surgical treatment should always be considered first when treating impingement. This condition can often be resolved with rest, modifying activity behaviour to adapt to change in hip structure, physical therapy input and/or appropriate painkillers. Conservative treatment can be successful in reducing pain and swelling in the joint, thus reducing symptoms.

The physiotherapist may use mobilisations and manual therapy to compliment the exercise programme.

Hydrotherapy would be beneficial.

Your physiotherapist will closely monitor your personal programme and adjust it to suit you as appropriate.

Why should I have Physiotherapy?

Physiotherapy is a conservative and often a very helpful method of restoring improved movement, strength and function and thus avoiding surgical intervention.

We believe that commitment to a rehabilitation programme monitored closely by an experienced physiotherapist provides the best chance of improvement and therefore avoidance of surgical intervention.

Mobilizing the hip joint and stretching are essential components of the treatment program. This direct mobilisation of the hip performed by the physiotherapist can provide significant improvements in hip mobility in a relatively short space of time.

It is important to strengthen the gluteal muscles and deep hip rotator muscles of the buttocks. Additionally the abdominal and thigh muscles benefit from strengthening because weakness of these muscle groups means the hip joint has reduced support causing excessive force/strain to be placed on the ligaments/joint capsule and cartilage of the joint.

Exercises / Guidelines for Week 1-4 and 5 - 8

Exercises	Week 1 – 4 (Early)	Week 5 – 8 (Middle)
Hip ROM exercises: Ext rot / abd / ext / flex to tolerance	•	
Stretches – Hip flexors, Quads, Hams, Add,	•	•
Trans Abs recruitment supine with heel slides	•	
Trans Abs recruitment supine with BKFO	•	
Hams curls	•	
Supine double bridging	•	
4 point kneel with rocking	•	
Standing abduction, extension	•	
Double calf raises	•	
Wall slides – mini squats 60 -90	•	
Sit to stand (high seat)	•	
Swiss ball work (early)	•	
Proprioception work - wobbleboard	•	•
4 point kneel with leg lift		•
Single leg balance		•
Swiss Ball (progressed)		•
Double bridge + heel lift / leg lift as able		•
Isometric adduction (if not overactive)		•
Side lying hip abduction		•
Sit to stand squat (normal seat)		•
Leg press against resistance band		•
Plank		•
Trans Abs recruitment (progressed)		•
Step ups – forward and lateral		•

Exercise Guidelines for Week 8 – 12 and Week 12+

Exercises	Week 8 – 12 (Late)	Week 12 + (End)
Side steps with resistance band	●	
Resistance band kicks	●	
Lunges $\frac{1}{4}$ - $\frac{1}{2}$ - full, forward, back, walking as able	●	
Plank – side, advanced	●	
Forward bends - arabesques	●	
Single leg bridging / bridging with ball roll out	●	
Light jogging / walking	●	
X- trainer	●	
Running drills		●
Lunges with weights		●
Skiping		●
Hopping / jumping		●
Bounding		●
Sports specific training		●

Adapt programme to suit individual's needs. Education regarding avoiding and reducing hip impingement positions would occur from physio.

Additional Exercise Prescription Form.....