NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement Hip Arthroscopy

<table>
<tr><td>Condition or Treatment:</td><td>Hip arthroscopy</td></tr>
<tr><td>Commissioning Position:</td><td>This commissioning statement refers to arthroscopic hip surgery for children and adults with:
• Femoroacetabular impingement
• Labral tears

Policy Exclusions:
• Patients with advanced / severe degenerative OA on a preoperative X-ray
• Patients who have hip dysplasia or considerable protrusion unless they have mechanical symptoms
• Patients with osteonecrosis with femoral head collapse
• Patients with joint ankyloses

The commissioning of hip arthroscopy (from surgeons with specialist expertise in this type of surgery) is in line with the requirements stipulated by NICE IPG 408 Details of all patients undergoing this procedure should be entered into a register established by the British Hip Society (4). The current evidence and guidance supports referral of patients with the following conditions to the hospital services and only for patients who fulfil all of the following criteria:

Diagnosis of definite labral pathology and/or hip impingement syndrome and/or other conditions where a minimally invasive approach is preferred as defined through clinical and radiological investigation (e.g. X-rays, MRI, CT scans)

AND

A surgeon with specialist expertise in hip arthroscopy has confirmed the diagnosis, which should include imaging reported by a specialist musculoskeletal radiologist

AND

Severe symptoms with compromised function measured by objective scoring tools and with a duration of at least six months where diagnosis has been made

AND</td></tr>
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	Failure to respond to conservative treatment including activity modification, comprehensive physiotherapy with review by advanced practice physiotherapist, and drug therapy (non-steroidal anti-inflammatory drugs and paracetamol) for a period of three months. Intra-articular injection (steroid / anaesthetic) is recommended for diagnostic clarity or to support further, effective conservative management. This should be image guided in a specialist practice setting. Patients under the age of 16 or over the age of 50 should only proceed to surgery after a wider multidisciplinary team discussion. **Conservative management** • Patients with hip pain, and without red flag or acute trauma indications, should be managed in line with the locally agreed MSK pathway and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective. • Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment. • Patients with persistent pain which is not amenable to surgical intervention should be considered for referral to pain management services. **Lifestyle factors** • All patients being referred for hip pain should have an assessment of their BMI and smoking status, as well as other ‘lifestyle factors’ that may influence their long-term health outcomes, as part of a ‘making every contact count’ approach to providing health care services. • All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at appropriate stages in their conservative management and in all instances before referral is made for surgical assessment. **Shared decision-making** • Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision-making conversation to consider referral for surgical assessment. This should include an understanding of rehabilitation requirements and likely

	duration. The evidence for risks, benefits and differences in outcomes between surgical intervention and continued nonoperative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals. The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention. **Diagnostic and imaging requirements** • AP X-ray of pelvis with marker ball. This should be done prior to referral for specialist assessment to exclude structural pathology. • Lateral hip X-ray of affected side • Hip MRI OR arthrogram (Secondary Care only) **MRI scans should not be requested by primary care, and should only be requested following specialist clinical assessment** • MRI or MR arthrogram should be reported by and MSK specialist radiologist or reporting radiographer • Imaging technique will be determined by availability of 1.5T or 3T MRI • Hip CT should only be requested following assessment by orthopaedic specialist or when the patient is not suitable for MRI See also the 2017 commissioning guide for pain arising from the hip in adults from the British Hip Society.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1st July 2021
Summary of evidence/ rationale:	Hip impingement syndrome is caused by abnormal contact between the top of the thigh bone and the hip socket. This results in 'clicking' of the hip, limited movement and pain, which can be made worse when the hip is bent or after sitting for a long time. The condition may be caused by an unusually shaped thigh bone or hip socket and usually affects young, often active people. Hip impingement syndrome is usually managed by changes to lifestyle and drug treatment.

	Rational for surgical treatment of FAI / labral tears in selected patients In patients nonresponsive to conservative measures, open or arthroscopic surgery for proven FAI / labral tears has been shown to produce short and medium term benefits in terms of pain management and functional improvement in the hip (1-5). Evidence for reduction in progression to advanced hip osteoarthritis is speculative. **Rationale for arthroscopic vs open surgical treatment of FAI** No significant differences in outcome have been demonstrated between open and arthroscopic surgery for FAI. As the HRG Code costs are the same, but arthroscopic intervention is a day case procedure, requiring no excess bed day costs, and is associated with a faster patient recovery time, surgical FAI interventions should be arthroscopic for a quicker recovery and to minimise costs. **Rationale for treatment in specialist / high volume centres** The number of operations performed for FAI, particularly hip arthroscopy, has increased rapidly in recent years in the UK. Hip arthroscopy is technically demanding with a steep learning curve. It is also important to identify which patients are appropriate to select for surgery, to streamline their work-up and perioperative care, and in particular to fine-tune rehabilitation protocols to optimize outcomes for both rehabilitation and surgery.
Date:	May 2021
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Contact:	Dr Christopher Ives, Governing Body GP/Acute Commissioning lead

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