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Be a Hipster and Get Good Results

One definition of a hipster is someone interested in the latest trends. What a perfect persona for a therapist who wants to be in touch with the latest updates in information and treatment. Today's article will explore the latest trends in evidence for treating hip pain. We encourage those who read it to become "hip" to evidence-based medicine.

There is much support for the role of physical therapy in treating hip problems. One of the most recent and strongest support statements came from the Osteoarthritis Research Society International (OARSI) Report in 2008. OARSI met and reviewed all the literature to date for the medical treatment of hip and knee osteoarthritis (OA) and made 25 recommendations. The guidelines that this group created strongly endorsed physical and occupational therapy.

They also questioned the effectiveness of arthroscopic surgery and encouraged providing patients with information about the course of hip osteoarthritis and all options for treatment. Finally, they suggested that thermal modalities, TENS and acupuncture were potentially good interventions for hip or knee osteoarthritis.[1]

At the time the OARSI was strongly endorsing our profession, we were moving forward as well. Sutlive et al. in 2008 developed a clinical prediction rule for diagnosing and treating persons with OA.[2] Clinical prediction rules (CPRs) are useful as they help us use only those tests that establish a physical therapy diagnosis and help lead us toward the most effective treatment.

The CPR for diagnosing unilateral hip OA when four out of five criteria are met can be predictive with 95 percent confidence. The criteria are as follows:

1. Squatting increases the symptoms;
2. The Scour test with hip adduction causes lateral hip pain;
3. Active hip flexion causes lateral hip pain;
4. Active hip extension causes pain;
5. Passive range of motion (ROM) of hip internal rotation is less than 25 degrees.

Strength Strong Points

Other variables are coming to light that may be suggestive of why people have pain in the hip. These variables may eventually be added to the CPR or at least should be assessed as part of a comprehensive evaluation.

One such variable is strength. An article by Rydevik et al. showed that patients with hip OA had significantly lower knee extension strength (all other lower-extremity measures were within normal limits; however, the study did not measure abduction). They also found significantly less ROM in hip extension, flexion, abduction, adduction and internal and external rotation.[3]

There is even a meta-analysis showing the benefits of strength training. One article looked at nine trials that included 1,234 subjects. Their conclusion was that therapeutic exercise especially with an element of strengthening is an efficacious treatment for hip OA.[4]

One last area that has evidence for efficacy in treating hip pain is manual therapy. In an article by Hoeksma et al., manual therapy was shown to be a good treatment choice.[5] This study examined 109 patients seen in outpatient physical therapy. They were seen by a therapist for five weeks and received a total of nine sessions. The outcomes assessed were pain, function, ROM and quality of life.

The manual therapy techniques used were five different mobilizations in all directions and stretching all the hip muscles that were tight. The exercises used were active range of motion, coordination and endurance activities. The results showed that the manual therapy group was superior to the exercise group.

Another article in this area has an excellent description of joint mobilizations and exercises for hip pain. It is a case study of a 73-year-old woman with hip pain two years after revision surgery.[6]

The treatment program includes manual therapy, long-axis traction, lateral hip mobilizations, posterior/anterior hip glides and pendulum leg swings. The patient received three visits with the therapist and the spouse did long-axis traction daily at home and patient did pendulum leg swings twice a day at home.

People over age 50 do not have to be in pain and should not be taking anti-inflammatories as their mainstay of treatment. They need education in the significant role that physical therapy plays in decreasing pain, and in increasing motion, strength and function.

But this only works if we are truly hipsters and current with all the latest evaluation and treatment ideas. ■

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