CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION

Hip instability and microinstability

What you're feeling

Hip instability and microinstability usually cause pain in the groin or the front of the hip that builds up slowly over time. Many people also notice a feeling that the hip is unstable or giving way, especially during activity. That sense of the hip not quite holding steady is one of the clearest signs of this problem. The pain often sits deep in the groin, but some people feel it at the side of the hip or thigh, or towards the back near the buttock.

Certain movements tend to make it worse. Sitting for long stretches, walking, running and pivoting or changing direction can all flare the pain. Sports that push the hip into extreme positions, such as dancing, are common triggers. If your hip is loose rather than stiff, you may find the pain grows through the day as the muscles around the joint tire.

Everyday tasks can become harder than they should be. Getting into and out of a car, crouching to pick something up, or standing up after a long meeting can all aggravate the hip. Standing on one leg to dress, or climbing stairs, may feel wobbly or uncomfortable as the muscles that steady the hip work overtime to hold the joint together.

Some people with this condition also have wear-and-tear changes in the joint, or a shallow socket that never fully cradles the ball of the hip. That can add stiffness and aching to the mix, particularly after activity or first thing in the morning. The hip may click or catch as you move it.

It is worth knowing that a hip can look unusual on a scan without causing any pain at all, while a hip that looks nearly normal can be very sore. Your symptoms, your examination and your scans all need to line up before anyone can say what is truly causing your pain. If any of this sounds familiar, the next step is a proper assessment to work out exactly what is going on.

What's actually happening

Your hip is a ball-and-socket joint. The ball at the top of your thigh bone sits inside a cup in your pelvis. In a stable hip, the socket holds the ball snugly, and soft tissues around the joint keep it centred as you move.

Three of those soft tissues matter here. The labrum is a ring of gristle around the rim of the socket that works like a gasket, sealing the joint and holding fluid pressure inside it. A capsule of tough tissue wraps the whole

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joint, and three strong ligaments within it stop the ball sliding out of place. When any of these loosen, stretch or tear, the ball can shift slightly inside the socket. That small amount of extra movement is called microinstability. It is subtle, so it rarely shows up clearly on a scan, which is why the diagnosis rests on your symptoms and examination as much as your images.

That small shift is enough to cause trouble. The gasket seal between the labrum and the ball can be lost, and the ball then rides against the labrum instead of gliding past it. Over time this wears the smooth cartilage lining the joint, which can eventually lead to wear-and-tear arthritis. The muscles around your hip try to compensate for the loose tissues, and they can become strained and sore themselves.

Sometimes the shape of the bones is part of the problem. If the socket is too shallow to fully cover the ball, a condition called dysplasia, the soft tissues have to work much harder to hold the hip steady. Bone bumps on the femur or socket can also change how the joint moves, levering the ball slightly as you bend or twist. Sports with lots of twisting and pivoting, or jobs and hobbies that repeatedly push the hip to its limits, can stretch these tissues further over years.

Understanding which of these is driving your hip, the bone shape, the labrum, the capsule or a mix of them, is what guides the right treatment.

What we can do about it

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At your first visit we take a history, examine your hip and arrange scans where they are needed. Once we know what is driving the problem, we work through treatment with you, starting with the simplest options.

Physiotherapy is the first-line treatment for hip microinstability. It aims to strengthen the muscles that hold the hip steady, including the deep hip flexors, the buttock muscles, the groin muscles, the rotators and your core. The muscles at the side of your hip and those that turn your leg outward matter most, because they keep your pelvis level when you stand on one leg. Balance and control exercises can also help, especially if your joints are naturally loose. Stretching is prescribed with caution and is discouraged if your hip already moves further than it should. Alongside physiotherapy, we usually suggest changing the activities that flare your pain, and anti-inflammatory medication can settle things down. We ask you to give this a fair trial before we talk about surgery.

If physiotherapy and activity change have not settled your hip, injections into the joint are sometimes used. Hyaluronic acid is a lubricating fluid that can ease hip pain and improve function for a short period, though any longer-term benefit has not been shown. A steroid injection, sometimes called cortisone, reduces inflammation inside the joint. A positive response to a numbing injection given before surgery suggests you are likely to do well with an operation.

Surgery is considered when a full course of physiotherapy has not brought enough improvement. The main operation is keyhole surgery, called hip arthroscopy, where we look inside the joint through small cuts and

repair or tighten the tissues that keep the ball centred. If your socket is too shallow, an operation called a periacetabular osteotomy may be suggested instead. This cuts and repositions part of your pelvis so the socket holds the ball properly, and it can be combined with keyhole surgery in the same sitting. The choice depends on your bone shape, your symptoms and what you want from your hip. We will talk through the options together and decide what suits you.

What to expect

Hip instability and microinstability tend to build up slowly rather than arrive all at once. The pain and the feeling of the hip giving way usually settle when the underlying cause is treated well, but they rarely go away on their own if the joint keeps moving more than it should. How long symptoms have been present matters. People who have had hip pain for two years or more before treatment tend to have less improvement afterwards than people treated sooner. That is one reason we suggest getting a proper assessment rather than waiting it out.

With the right treatment, most hips do well over the long term. Around 91% of hips are still preserved and working ten years after hip preservation surgery. Improvement usually starts in the first months, and people who notice their hip getting better early tend to keep doing well in the years that follow. People who gain little in the first year tend to have less improvement over the long run, along with more complications and a greater chance of needing another operation. If wear-and-tear arthritis is already well established in the joint, the outlook is not as strong, even when the early weeks after treatment go smoothly.

If the hip is left alone, problems can continue or grow. A shallow socket that is never corrected puts the joint under strain, and the long-term outlook for a moderately shallow socket treated without surgery is poor. There is also a pattern worth knowing about: many people with this condition eventually develop similar trouble in the other hip. Roughly half of people with this condition develop significant symptoms in their other hip over the years that follow, though about half stay comfortable or nearly so.

No treatment is risk free. Keyhole hip surgery has a low complication rate overall, and serious problems are uncommon. But the hip can remain unstable if the underlying cause is not addressed, and a small number of people need further surgery. Being honest about all of this helps you weigh up your options with clear expectations rather than false hope.

When to see someone

See your GP if you have groin or hip pain that keeps flaring with sitting, walking, running or pivoting, especially if it has built up slowly rather than coming on all at once. Ask for a specialist review if you feel the hip giving way or not holding steady during activity, if the pain keeps growing over weeks and months, or if one hip is now troubling you the way the other already has. This matters more if your joints are naturally very loose, if you have a connective tissue condition such as Ehlers-Danlos syndrome, or if you have a shallow socket, because these hips are more prone to instability. If you have already had keyhole hip surgery and the pain has not

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settled, or your recovery has stalled well behind schedule, that pattern can point to lingering looseness in the joint and deserves a proper look rather than more waiting.

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