CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION

Hip osteoarthritis

What you're feeling

Hip arthritis usually starts quietly. The pain often builds slowly over months or years, though it can begin after a minor injury. Most people feel it deep in the groin, at the front of the hip. The ache tends to flare with activity and settles with rest.

Certain movements and positions make it worse. Getting your hip into a bent position can bring the pain on. Prolonged sitting is a common trigger, so car trips, cinema seats and long meetings can become uncomfortable. Walking, running and pivoting or changing direction quickly can also aggravate it. Some people notice clicking, catching or grinding in the hip. These come from wear in the joint lining and the smooth cartilage that covers the bone.

The pain often follows a pattern through the day and night. It can be worse after activity, and stiff or achy on waking. Some people with hip arthritis find it hard to sleep, and night-time discomfort is a real part of the condition for many.

Everyday tasks can become harder without you quite noticing. Standing up from a chair repeatedly, or getting out of a low seat, may take more effort. You might lean forward or shift your weight to one side to get moving. Walking further than usual, stairs, and getting in and out of the car are common sticking points.

Where the pain sits matters. Pain at the front of the groin usually points to something inside the hip joint itself. Pain along the side of the thigh or at the back of the hip and pelvis often comes from other causes, such as irritated structures around the bone on the outside of the hip, or the lower back and the joint where the spine meets the pelvis. Hip arthritis can also sit alongside lower back narrowing that presses on nerves, so both problems can be present at once.

If this sounds like your pattern, your surgeon can help work out what is driving your pain.

What's actually happening

A healthy hip is a ball-and-socket joint. The ball at the top of your thigh bone sits inside a round socket in your pelvis. Covering both surfaces is a smooth layer of cartilage, a tough, slippery tissue that lets the two surfaces glide over each other. Think of it as the joint's own shock absorber and lubricant in one.

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Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

Hip arthritis is what happens when that cartilage wears away. With less cushioning, bone starts to rub on bone. The bone beneath the cartilage thickens and changes shape, and bony lumps called osteophytes form around the edge of the joint. The joint lining, the ligaments holding the hip together, and the muscles around it can all be drawn into the problem. Despite the name, arthritis here is mostly wear rather than ongoing inflammation.

The symptoms you read about above follow directly from this. Cartilage loss means the joint no longer glides smoothly, which is where grinding and catching come from. Deep groin pain comes from the worn surfaces and strained joint lining. Stiffness in the morning happens because the hip has been still overnight. Muscles around an arthritic hip often weaken too, so standing up, stairs and getting moving take more effort than they used to.

Wear does not happen at random. Some hips are shaped in a way that loads certain spots harder over the years. A socket that is too shallow spreads force onto a smaller patch of cartilage. Extra bone at the join between the ball and its neck, or around the rim of the socket, can pinch during movement and grind away at cartilage and the ring of gristle that seals the joint. Old injuries, including hip dislocations, can set up wear years later as well.

For most people this adds up gradually over years. If your hip is heading that way, your surgeon can examine it, look at X-rays with you, and talk through where things stand.

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. A clinic assessment, including your history, an examination and imaging where needed, establishes the diagnosis. For a long-standing problem like this, we usually try non-operative care first and consider surgery when that has not given enough improvement.

The first steps are things you can do yourself. Losing weight may help with pain and getting about. Using a walking stick can help you stay mobile and take pressure off the hip. Changing how you move matters too: cutting back on running and other high-impact exercise, and avoiding stairs, inclines and squatting, can settle things down. Physiotherapy aims to build the muscles around the hip and improve how you move. A six-week physiotherapist-led exercise and education program has shown lasting improvement in pain for people with hip arthritis, including those waiting on a hip replacement. Anti-inflammatory tablets (NSAIDs) have strong evidence behind them for easing hip arthritis pain. Glucosamine sulfate is not supported by the evidence for hip arthritis.

If tablets and exercise are not enough, injections into the joint are an option. Cortisone injections (a steroid medicine placed inside the joint) can give large, meaningful pain relief and better function in the short term, working within days to weeks. The benefit usually lasts up to three months and is not reliably sustained beyond that. Hyaluronic acid injections (a lubricating fluid similar to what joints naturally contain) and platelet-rich plasma injections (PRP, made from a sample of your own blood) can both ease pain and improve function in the short term. PRP, alone or combined with hyaluronic acid, has effects on pain and function lasting six months, longer than hyaluronic acid alone. A single injection of amniotic suspension allograft (a preparation from donated placental tissue) can relieve pain for up to one year in moderate hip arthritis. The most common side

effect of a combined hyaluronic acid and steroid injection is temporary hip pain. Opioid medicines are not recommended for ongoing arthritis pain: their effect is minimal and does not outweigh the risks.

Surgery comes into the picture when pain at rest, with movement or with weight bearing is severe enough to stop you working or managing daily tasks, despite the steps above. Total hip replacement (replacing the worn ball and socket with artificial surfaces) reduces hip pain and improves hip function. We will talk through whether it suits you and decide together.

What to expect

Hip arthritis rarely goes backwards on its own, but it does not always march forward quickly either. For many people it settles into a long-term pattern: flare-ups with activity, quieter stretches in between, and a slow shift in what your hip will let you do. Some hips stay much the same for years. Others wear down faster, especially if the joint was shaped differently to begin with or arthritis runs in your family.

Left alone, the outlook varies. Many hips with early wear never become troublesome: over roughly 25 years, 14% of hips with a shape that pinches during movement developed arthritis symptoms that needed attention, and 4% went on to need a hip replacement. Once wear is established, the picture is less steady. Pain can improve over years even without surgery, though the hip usually loses some movement, particularly bending it and turning it inwards. There is no reliable way to predict which way your hip will go from an X-ray alone, because how much trouble a hip causes does not match up neatly with how worn it looks.

Treatment aims to keep you moving and comfortable for as long as possible. Exercise and physiotherapy can ease pain and improve how you manage day to day, even when arthritis is advanced. Injections can settle flares, though their effects fade over months. If you go on to a hip replacement, it is worth knowing that the hip generally feels and works better afterwards than it did beforehand, though many people still notice some limits in what the hip can do years down the track. Waiting a long time for surgery once it is needed can work against you: the longer an arthritic hip goes untreated, the more the surrounding muscles can waste and stiffen, and that can hold back your recovery afterwards.

How you feel overall before surgery matters too. People who arrive at a hip replacement in better general health and spirits tend to do better afterwards. Your surgeon can help you judge where your hip sits on that path, and what is worth trying before, or instead of, surgery.

When to see someone

See your GP if you have groin pain that keeps coming back with activity, or if sitting, walking or moving around the hip is getting harder over months rather than days. Ask for a specialist review if rest, exercise and simple pain relief have not helped enough, or if the hip is stiffening up and stopping you do your usual work or daily tasks. Let your GP know if hip pain is disturbing your sleep, or if you feel low or worn down by it, as these are worth treating alongside the hip itself. If you have already been told your hip is shaped differently or that it catches during movement, mention that too, because it can change what treatment is worth trying.

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