



Commissioning Policy (EMSCGP047V1)

Policy: Arthroscopy of the Hip

Although Primary Care Trusts (PCTs) and East Midlands Specialised Commissioning Group (EMSCG) were abolished at the end of March 2013 with the formation of 5 Nottinghamshire County wide clinical Commissioning Groups (CCGs) policies that were in place prior to 1 April 2013 remain in place to ensure a consistent approach.

The NHS Nottingham North & East Clinical Commissioning Group have adopted this policy, in its existing form, at a meeting of its Governing Body on 20 August 2013.

This policy sets the overall parameters within which care will be delivered.



Policy: Arthroscopy of the Hip

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East Midlands Specialised Commissioning Group

Arthroscopy of the Hip

i. Version Control Sheet

| Version | Section/Para/ Appendix | Version/Description of Amendments | Date | Author/Amended by |
|---------|---------------------------|--------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------------------|
| 1 | Whole document. | Interim recommendations | Ratified 31/07/2009 | Jon Currington EMSCG NHS Derby City – Recommendations Katy Archer, Public Health Trainee - Evidence |
| 2 | Whole document | Policy document produced | August 2010 | EMSCG |
| 3 | Whole document | Policy document produced | August 2011 | EMSCG |
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East Midlands Specialised Commissioning Group

Arthroscopy of the Hip

ii. Policy Statement

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| Equality statement | The EMSCG is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), sexual orientation, race, religion or belief or social origin. |
| Background | Hip arthroscopy is a minimally invasive technique to gain access to the hip joint. |
| Statement | Hip Arthroscopy is commissioned by the East Midlands Specialised Commissioning Group (EMSCG) for the treatment of sepsis, loose bodies and excision of radiological proven labral tears in the absence of osteoarthritis or other pathology for patients meeting the policy criteria. EMSCG does not routinely commission the use of hip arthroscopy for the management of Hip Impingement Syndrome or other indications. |
| Responsibilities | <p>Each primary care trust to adopt the policy, and incorporate it into Service Level Agreements and contracts with providers as appropriate.</p> <p>Clinicians to comply with the policy, and the criteria in the policy.</p> |
| Training | It is the responsibility of individual acute trusts to ensure clinical teams involved in hip arthroscopy are adequately trained. |
| Dissemination | Postmaster e mail, EMSCG website. It is the PCTs responsibility to disseminate to appropriate staff members, provider Trusts and GPs. |
| Resource implication | There are no resource implications. |

East Midlands Specialised Commissioning Group
Arthroscopy of the Hip
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1. Definitions

1.1. Hip Joint

The hip joint is a ball and socket joint consisting of the femoral head and acetabulum. This joint provides multiple planes of movement and is highly congruent. Articular cartilage covers the majority of the femoral head and acetabulum. The acetabular labrum is a fibro-cartilaginous structure that runs around the periphery of the acetabulum.

1.2. Hip arthroscopy

Hip arthroscopy is a minimally invasive technique allowing surgical access to the hip joint. It is a technically challenging procedure which should only be carried out in specialist units by teams with specific training in the techniques.

1.3. Sepsis of the Hip Joint

A septic joint requires immediate action and is an orthopaedic emergency when in a native (i.e. non-replaced) joint. It can cause irreversible cartilage damage very quickly and can be fatal if pus under pressure is left in situ for any significant length of time.

The long term ramifications of a septic joint if not dealt with expeditiously are subsequent joint replacement or potentially death in the severe cases of fulminant septicaemia (normally seen in the elderly or immuno-compromised).

1.4. Loose Bodies

Loose bodies in the hip joint can present spontaneously (such as in conditions like synovial chondromatosis) or as part of a traumatic insult. A significant number of dislocated hips are reduced closed but as they are relocated 'drag into the joint' a piece of fractured bone (normally the socket rim). The result is a very painful problem which causes locking, giving way, an inability to weight bear and ultimately cartilage destruction due to the attrition effect of the loose body grinding away at the joint surface.

1.5. Excision of Radiological Proven Labral Tears in the Absence of Osteoarthritis or Femoro-Acetabular Impingement Syndrome

This is effectively a cartilage tear of the hip similar to meniscal tears of the knee. Such tears in the hip can be caused by differing aetiologies.

There are a group of tears that can be caused as part of a degenerate process (arthritis) or by femoro-acetabular impingement (FAI). Treatment of this group is controversial within the orthopaedic community. It is not fully understood what the sequelae of such tears are, but it is thought that they will ultimately prove to cause osteoarthritis if not dealt with. This is an area that requires further evaluation and longitudinal studies to validate treatment options.

Some labral tears are acute and sustained as part of a single injurious process. Patients who axially load the hip and then are subjected to a twisting movement can experience such tears. A common scenario would be someone landing from a jump and twisting with the leg planted on the ground (e.g. basketball players or someone

landing awkwardly having jumped from a height and falling over). These tears are exquisitely painful from the outset, do not develop insidiously and do not resolve. Patients can experience locking and giving way to the degree that they have no confidence in the joint and are very nervous when carrying things (or children) up and down stairs. The joint can lock at any time and bring the individual to ground.

1.6. Hip Impingement Syndrome

Hip impingement syndrome, also known as femoro-acetabular impingement (FAI) syndrome, is caused by friction in the hip joint. The friction between the femoral head and hip socket (acetabulum) can damage the hip joint, restrict movement and be painful. The 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 is characterised by hip pain felt mainly in the groin and can result in chronic pain, decreased range of motion, inflexion and internal rotation.

Two mechanisms have been identified; cam impingement (most common in young athletic males) and pincer impingement (most common in middle-aged women). FAI is also associated with articular cartilage (chondral) damage, labral tearing, and progressive osteoarthritis of the hip.

Management of FAI includes conservative (modification of activity), medical (e.g. non-steroidal anti-inflammatory drugs) and surgery.

2. Commissioning position

2.1. Scope

This policy covers the use of hip arthroscopy in the adult population.

2.2. Sepsis of the Hip Joint

Hip arthroscopy is supported in the washout of an infected native hip joint in patients refractory to medical management, patients with underlying disease or patients who are immunosuppressed.

2.3. Loose Bodies

Hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.

2.4. Excision of Radiological Proven Labral Tears in the Absence of Osteoarthritis or Femoro-Acetabular Impingement Syndrome

Hip arthroscopy is supported for the excision of radiological proven labral tears associated with an acute traumatic episode in the absence of osteoarthritis or femoro-acetabular impingement syndrome. Auditing of pre and post operative pain and function scorings and submission to commissioners is required in all cases.

2.5. Hip Impingement Syndrome

In the absence of reliable information about quantitative health gains over the medium and long term, the associated costs, and complete information about the risks of treatment it is impossible to judge hip arthroscopy for FAI as a cost-effective use of health service resources. It cannot therefore be supported or routinely commissioned.

2.6. Other indications

Hip arthroscopy is not routinely commissioned for any other indications or pathologies

3. Evidence Review

3.1. Sepsis of the Hip Joint

Obtaining accurate information about the epidemiology of septic arthritis (all joints) is problematic but estimated incidence of proven and probable septic arthritis in Western Europe is 4 to 10 per 100 000 patient-years per year. It usually arises in elderly people and very young children. Whilst the incidence of septic arthritis is said to be uncommon (and septic arthritis of the hip represents a subset of these cases, the majority being in the knee), mortality is reported as high as 11% (Mathews 2010).

Map of Medicine summarises the role of arthroscopy in septic arthritis as follows:

Surgical drainage (i.e. via arthroscopy or arthrotomy) may be indicated when:

- The joint is difficult to access with a needle, e.g. hip joint.
- Septic arthritis is not improving with non-surgical intervention.
- Debridement of infected synovium or adjacent tissues is required (especially in patients with other co-morbidities, such as diabetes, liver disease or renal disease).

A recent summary of options for joint drainage (Draper 2011) states:

Surgical drainage may be required in any infected joint which does not respond to medical treatment, although the decision as to whether to use repeated needle aspirations or arthroscopic lavage is chiefly anecdotal and not supported by a large comparative evidence base (Manadan 2004). One study of 40 patients with septic arthritis of the knee suggested that, for this condition at least, needle aspiration should only be performed in the very early stages, arthroscopic debridement being the treatment of choice in all other cases (Balabaud 2007). A mini-arthrotomy, in which a window is cut into the joint capsule, has been attempted successfully in five patients with septic arthritis of the hip (Kaminski 2007). Patients with underlying disease, such as rheumatoid arthritis and diabetes, or the immuno-suppressed, benefit from earlier surgical intervention (Abelson 2010).

Without the option of arthroscopy, surgical intervention would be a more formal and extensive arthrotomy (larger incision) in order to evacuate the pus. Recovery is thus hampered not only as a result of the pathological insult but of the operation itself.

An arthroscope and perhaps a limited arthrotomy can be used to adequately see inside and evacuate the pus. This approach is routinely used in the knee, the ankle, the wrist, elbow and the shoulder.

Despite a lack of comparative research evidence, arthroscopic washout is considered an option for infected native hip joints in patients who are refractory to medical management; patients with underlying disease; or patients who are immunosuppressed, improving the chance of both joint and patient survival.

3.2. Loose Bodies

Physiotherapy or conservative treatment will not relieve the pain symptoms of radiologically proven articular loose bodies in the hip joint as it is a mechanical problem that requires a mechanical solution.

The typical procedure is to use an arthroscope to remove the loose body. This approach is routinely used in the knee, the ankle, the wrist and elbow.

In the absence of arthroscopy a more formal and extensive arthrotomy (larger incision) is required in order to remove the loose body. The recovery is thus hampered not only as a result of the pathological insult but also as a result of the operation itself.

Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.

3.3. Excision of Radiological Proven Labral Tears in the Absence of Osteoarthritis or Femoro-Acetabular Impingement Syndrome

All patients should have a course of physiotherapy and an injection of steroid and local anaesthetic should be considered. Arthroscopic excision of labral tears may be considered for pain as a result of mechanical locking only when conservative approaches have failed. Full open debridement carries with it too great a risk benefit ratio.

The evidence base for arthroscopy in the management of labral tears consists of level III and IV evidence. Prospective data collection and consistent use of validated outcomes instruments is required (Bedi 2008).

One systematic review (Schmerl 2005) found that the short-term results of arthroscopic debridement of labral tears have been favourable. However, one study they identified

... related labral tears with relationship to outcome in 62 hips. They classified labral tears according to severity and then correlated this with outcome 2 years after surgery. For minor lesions, they reported 91% to have good to excellent results. The more severe lesions involving labral tearing and subadjacent degrees of acetabular cartilage damage did not fair nearly as well. In hips with marked degenerative change, 78% were associated with a poor result in follow-up, and 43% went on to total joint arthroplasty within 2 years of arthroscopy.

Another

...reported 71% success in patients without evidence of osteoarthritis, and only 21% of arthritic patients reported good results.

Arthroscopy may be beneficial for the short-term relief of symptomatic labral tears; however, long-term consequences are unknown. The outcomes for patients with associated cartilage damage and degenerative change were poorer.

3.4. Hip Impingement Syndrome

Current NICE Interventional Procedure Guidance (IPG) for the treatment of FAI, with open surgery (IPG403, 2011) states:

Current evidence on the efficacy of open femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.

The British Hip Society is establishing a register for open femoro–acetabular surgery for hip impingement syndrome and clinicians should submit details of all patients undergoing this procedure to the register once it is available. One of the main purposes of the register is to provide information about long-term outcomes.

Arthroscopic surgery for FAI is under review but currently (IPG213, 2007) concludes that it:

“does not appear adequate for this procedure to be used without special arrangements for consent and for audit or research.”

Provisional recommendations of the IPG213 review are:

- Current evidence on the efficacy of arthroscopic femoro-acetabular surgery for hip impingement syndrome is adequate for symptom relief in the short and medium-term, and there are no major safety concerns. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit.
- Arthroscopic femoro-acetabular surgery for hip impingement syndrome should only be carried out by surgeons with specialist expertise in arthroscopic hip surgery.
- NICE encourages further research and data collection on arthroscopic femoro-acetabular surgery for hip impingement syndrome. Research studies should in particular address patient selection, and long-term outcomes (specifically relating to the development of osteoarthritis).

The evidence overview for this NICE update was prepared in May 2011. It found no new studies comparing arthroscopy with other interventions or against natural history. With regard to the validity and generalisability of the studies, the review found:

- A range of outcome assessment scales are used; validation of these scales is often not reported.
- The description of hip impingement pathology/lesions is not well defined in all studies.

- The intervention required is usually individualised to each patient, making comparison between studies difficult.
- Study quality is generally poor, with little prospective data collection in case series.

A report (Sharma, 2009) for Yorkshire and Humber Specialised Commissioning Group on hip arthroscopy for hip impingement syndrome and other hip joint pathology identified two other reviews by commissioner. (AETNA, 2008 National Public Health Service for Wales, 2005) Both of these reviews concluded that there is insufficient evidence to support the use of hip arthroscopy.

Other studies identified were overviews of current issues in hip arthroscopy, clinical studies or reports detailing developments in techniques. The majority of the studies identified in the searches were case series and no randomised controlled trials were identified.

For the development of this policy a further search of the more recent literature (see Appendix 1) has revealed three additional systematic reviews of hip arthroscopy which are equally cautious and highlight some of the issues that need to be addressed (Longo, 2010; Stevens, 2010; Baldwin, 2009). The majority of studies are uncontrolled case series and, illustrated by the tables detailing the studies in the reviews, these do not routinely report on the harmful outcomes of the procedure.

"Our review shows that almost all the studies reporting on the outcome of hip arthroscopy are only of moderate scientific quality only, and the evidence-based knowledge regarding results of hip arthroscopy arises from studies with a short-term follow-up period. Thus, the future of hip arthroscopy will require better visualization, access, instrumentation and implants with longer follow-up studies to prove its equivalence to or superiority over arthrotomy. Therefore, this technique will require further investigation to evaluate its usefulness." (Longo, 2010)

Baldwin also highlights the lack of consistency in the use of outcome measure and this is further explored by Thorborg (2010) in their systematic review of patient reported outcome measures for hip and groin disability.

Stevens does suggest that the level of evidence available is higher for FAI than for other indications, but agrees that the "higher-quality trials (Level I and Level II) are needed to provide support for the increasing application of this surgical technique".

Since June 2009 no controlled trials of the efficacy of hip arthroscopy compared to alternative therapies have been published and there are no trials currently registered. There is a wealth of case series published in this time period including two studies with a longer follow-up period (Byrd, 2010; Haviv, 2010). Two case series reported outcomes with arthroscopy plus modified open osteochondroplasty for symptomatic FAI (Nepple, 2009; Clohisy, 2010). Case reports of adverse events have been published (Vermer, 2010; Ladner, 2010; Fowler, 2010; Jones, 2009) with Souza (2010) reporting on a 9-year experience with hip arthroscopy and associated complications.

Research on arthroscopy for shoulder impingement shows that there is at least the potential for observational studies to over-estimate the benefit of an orthopaedic intervention, when compared with the gold standard of controlled clinical trials (Odenbring, 2008; Ketola, 2009).

Further doubt on the possible utility of hip arthroscopy is cast by the failure to find an association in the community between one of the structural malformations treated by arthroscopic surgery and hip joint pain (Gosvig, 2010). Assembled by Aetna, there is also evidence that a “hip with cam impingement is not always destined for end-stage arthritic degeneration” and also that there is limited data on the natural history of FAI (Aetna, 2008).

In the absence of reliable information about quantitative health gains over the medium and long term, the associated costs, and complete information about the risks of treatment it is impossible to judge hip arthroscopy for FAI as a cost-effective use of health service resources.

4. Acknowledgements

University of Sheffield. The School of Health and Related Research
Yorkshire and the Humber Specialised Commissioning Group.

Mr Arthur Stephen, Consultant Orthopaedic Surgeon, Derby Hospitals Foundation Trust.

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6. Glossary

| Word/Abbreviation | Meaning |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Case series | Description of several cases of a given disease, usually covering the course of the disease and the response to treatment in each case. There is no comparison (<i>control</i>) group. (NICE, 2010). |
| Cost effective | Value for money. A test or treatment is said to be 'cost-effective' if it leads to better health than would otherwise be achieved by using the resources in other ways. (NICE, 2010) |
| East Midlands Specialised Commissioning Group (EMSCG) | Specialised Commissioning is the means by which Primary Care Trusts (PCTs) work together to plan, buy and manage services which treat patients with rare conditions. (Taken from www.emscg.nhs.uk) For the East Midlands this is the East Midlands Specialised Commissioning Group. |
| Femoroacetabular impingement or FAI | A condition of too much friction in the hip joint. |
| Hip Arthroscopy | Inspection of the interior of a joint (in this case the hip). The instrument used is a type of endoscope which is a tube-shaped instrument inserted into a cavity in the body to investigate and treat disorders. It is flexible and equipped with lenses and a light source. (Blacks medical dictionary). |
| Minimally invasive surgery | More popularly called 'keyhole surgery', MIS is surgical intervention, whether diagnostic or curative, that causes patients the least possible physical trauma. (Blacks Medical Dictionary, 42 nd Ed). |
| National Institute for Health and Clinical Excellence (NICE) | NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. (NICE, 2010) |
| NICE Interventional Procedure Guidance (IPG) | NICE guidance about whether an interventional procedure is safe enough and works well enough to be used in the NHS. The term 'interventional procedure' means any surgery, test or treatment that involves entering the body through |

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| | skin, muscle, a vein or artery, or a body cavity. (NICE, 2010) |
| Orthopaedic | Area of medicine that deals with disorders or deformities of the spine and joints. |
| Osteoarthritis | A chronic (long term), partly inflammatory and partly degenerative bone condition. (Blacks medical dictionary, 42 nd Ed). |
| Osteochondroplasty | Re shaping of a deformed (mis shapen) femoral head (bone). |
| Quantitative | Research that generates numerical <i>data</i> or data that can be converted into numbers. An example is research using <i>clinical trials</i> . Another example is the national Census, which counts people and households. It might involve questions like: 'How many people visit their GP each year?'; or 'What proportion of children have had this vaccine?'. (NICE, 2010) |
| Randomised Control Trial (RCT) | A study in which a number of similar people are randomly assigned to two (or more) groups to test a specific drug or treatment. One group (the experimental group) receives the treatment being tested, the other (the comparison or <i>control group</i>) receives an alternative treatment, a dummy treatment (<i>placebo</i>) or no treatment at all. The groups are followed up to see how effective the <i>experimental treatment</i> was. <i>Outcomes</i> are measured at specific times and any difference in response between the groups is assessed statistically. This method is also used to reduce <i>bias</i> . (NICE, 2010). |
| Systematic Review | A review, in which evidence from scientific studies has been identified, appraised and synthesised in a methodical way according to predetermined criteria. It may include a <i>meta-analysis</i> (NICE, 2010). |

Appendix 1. Search strategy

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------|---------------------------|
| Question(s) | | | | | |
| <i>Is there new high level evidence on the clinical efficacy and cost effectiveness of arthroscopy for hip impingement syndrome, labral tears, loose bodies and septic native hip joint infection?</i> | | | | | |
| Search strategy <i>Indicate all terms used in the search</i> | | | | | |
| P – Population / Problem | | Hip pathology e.g. Femoroacetabular impingement, chondral lesions, labral tears, loose bodies, joint infection, septic arthritis | | | |
| I – Intervention or exposure | | Arthroscopy or modified arthrotomy or keyhole or minimally invasive surgery | | | |
| C - Comparison | | Open surgery, medical management, physiotherapy, natural history | | | |
| O – Outcomes | | Pain relief, hip joint mobility, adverse events | | | |
| <p><i>Search strategy</i></p> <p>The search strategy combined relevant subject headings relevant to each database e.g. exp FEMOROACETABULAR IMPINGEMENT/ exp ACETABULUM/ exp FEMUR HEAD/ exp HIP JOINT/ exp ARTHROSCOPY/ exp HIP ARTHROSCOPY/ with structured keyword searches using relevant terms identified in the literature e.g. (arthroscop* OR keyhole OR key hole) AND (hip OR femoro* OR acetabul* OR FAI)</p> | | | | | |
| Assumptions / limits applied to search | | | | | |
| <p>High level evidence (systematic reviews or similar) identified in NHS Evidence. Search results in PubMed, Medline and Embase were refined using;</p> <ul style="list-style-type: none"> • Clinical Queries (for treatment studies with high sensitivity) • Pubmed Clinical trials filter • Methodological keywords e.g. ("control group" OR controlled OR random* OR comparative OR versus OR "case control*" OR cohort OR "systematic review" OR metanalys* OR metaanalys* OR "meta analys*"). <p>Database search limits applied were: Publication June 2009-August 2011. No language limits were applied References were selected if they were:</p> <ul style="list-style-type: none"> • Clinical studies of high quality (comparative with at least two groups) • Systematic reviews • Reports from reimbursement bodies <p>Case series with clear outcomes, or case reports of adverse events are included. Technical reports or narrative reviews were not selected.</p> | | | | | |
| Resources searched <i>(suggested sources (not an exhaustive list) in grey)</i> | | | | | |
| Evidence-based summaries | NICE & SIGN | NHS Evidence | Cochrane | Specialist Libraries | NIHR HTA |
| Bibliographic databases | Medline, Pre-Medline & Embase | | Other web-based resources | TRIP | www.controlled-trials.com |
| Searched by | | | | | |
| Linda Ward, Clinical Review and Effectiveness Specialist, East Midlands Specialised Commissioning Group | | | | | |

Appendix 2: Prior approval and evaluation form - To be used in conjunction with policy:

Arthroscopy of the Hip

1. Patient details

| | |
|-----------------------------------|--|
| Date of request submission: | |
| Patients NHS Number and initials: | |
| Date of Birth (DOB): | |
| Requesting Trust: | |
| Primary Care Trust (PCT): | |

2. Pre screening prior to Arthroscopy of the hip

Patient meets ALL policy criteria outlined in the EMSCG commissioning policy for the use of Arthroscopy of the hip for any of the 3 following pathologies: (please tick boxes if yes):

| 2.1 Sepsis of the hip joint | |
|--------------------------------------|--------------------------|
| Washout of infected native hip joint | <input type="checkbox"/> |
| Refractory to medical management | <input type="checkbox"/> |
| Patient has underlying disease | <input type="checkbox"/> |
| Patient is immunosuppressed. | <input type="checkbox"/> |

| 2.2 Loose bodies | |
|-----------------------------------------------------------------|--------------------------|
| Radiologically proven loose body or bodies within the hip joint | <input type="checkbox"/> |
| Associated with an acute traumatic episode. | <input type="checkbox"/> |

| 2.3 Labral tears | |
|-------------------------------------------------------------------------------------------|--------------------------|
| Radiologically proven | <input type="checkbox"/> |
| Not associated with osteoarthritis or femoro-acetabular impingement (FAI) syndrome | <input type="checkbox"/> |
| Associated with an acute traumatic episode. | <input type="checkbox"/> |

Approval for the hip arthroscopy procedure is granted on condition that:

- The patient has provided informed consent for the procedure.
- The clinical team provides the clinical information requested overleaf in section 3 immediately following surgery and in section 4 one year later at follow up.

Approved for hip arthroscopy Yes No Date

EMSCG signature.....

Name Job title

Completed forms should be sent FAO Public Health team to:

- ✉ EMSCGfundingrequests@nhs.net or
- ☎ 0116 295 0901 (safehaven fax).

3. Pre-hip arthroscopy disease status

| | |
|-----------------------------------------------------------------------------------------|--|
| Date of diagnosis: | |
| Predominant symptoms | |
| Pain score (TBC) | |
| Mobility/Function score (ADL/SF 36?) | |
| Medical/physiotherapy/further surgery/other support prior to Hip Arthroscopy procedure? | |

4. Follow up at 1 year post procedure

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------|
| Date of re-assessment / / | Clinic letter attached (please tick box if yes) | <input type="checkbox"/> |
| Patient has experienced complications due to Hip Arthroscopy procedure (please tick box if yes) If ticked, please give details | | <input type="checkbox"/> |
| Symptoms post procedure | | |
| Pain score (TBC) | | |
| Mobility/Function score (ADL/ST 36?) | | |
| Medical/physiotherapy/further surgery/other support post Hip Arthroscopy procedure? | | |