

**PATIENT
INFORMATION
LEAFLET**

**Femoral Acetabular
Impingement (FAI)**

Introduction

Femoroacetabular impingement (FAI) is a condition where the anatomy of the hip joint changes. In some cases, these can result in abnormal contact between the rim of your hip socket (acetabulum) and the head/neck of your hip bone (femoral neck).

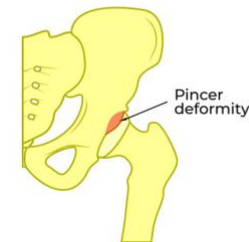
This can also be a normal physiological change that does not always result in symptoms. Research has shown that around 30% of adults will have some form of FAI related changes without symptoms.

FAI can be classified into three types 'Cam', 'Pincer' and 'Combined'. Cam refers to FAI where the shape of the neck and head of the femur (hip bone) change. Pincer type impingement occurs when the socket (acetabulum) changes shape. Combined FAI is where there is a combination of both Cam and Pincer related changes.

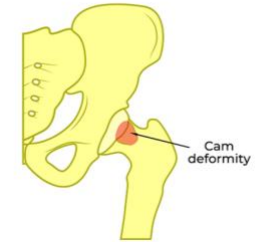
Healthy hip joint



Pincer femoroacetabular impingement (FAI)



Cam femoroacetabular impingement (FAI)



Causes of a Femoral Acetabular Impingement

Due to the anatomy of the hip joint all hips impinge at the extremes of movements, however with FAI the hip impinges much earlier in movement and can be aggravated by repetitive movements like kicking or swimming. There is no definitive cause identified for FAI however some people may have had hip issues as children and develop FAI as secondary consequence. There is some research to suggest a genetic predisposition to this condition.

Symptoms of Femoral Acetabular Impingement

Common symptoms include:

- Movement or position related hip or groin pain e.g. climbing stairs or sitting in a low chair
- Sometimes clicking, stiffness, locking, reduced range of motion or giving way
- May also present with back, buttock and/or thigh pain

Diagnosis of Femoral Acetabular Impingement

Diagnosis of FAI is based on a combination of symptoms, clinical signs and diagnostic imaging (most commonly X-rays of the hip joints). All of these must be present for clinical diagnosis of FAI. You may be referred to physiotherapy prior to or following diagnosis. Research suggests that physiotherapy can help to manage symptoms and improve function. If symptoms are well controlled and having no significant impact on quality of life or function.

Self Management of Femoral Acetabular Impingement

Ice

Place an ice pack over the area of discomfort. Place a material between your skin and the cold object. Use this for no more than 20 minutes consecutively.

Mediation

Anti-inflammatory tablets or gels can be used. If you are unsure about taking anti-inflammatories please speak to your pharmacist or GP.

Weight loss

Excess weight increases the pressure of weight bearing joints including your hips. Losing even a small amount of weight can help to reduce the strain on your joints when performing normal daily tasks such as walking and climbing stairs.

To find out if your weight is contributing to your symptoms check your BMI here (<https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/>).

If your BMI is raised, decreasing this will improve your symptoms. If you want advice on how to reduce your BMI, use the following link (<https://www.nhs.uk/live-well/healthy-weight/start-the-nhs-weight-loss-plan/>).

Activity modification

Managing training demand/load is key to prevent recurrent aggravation of symptoms. Please see return to sport/activity section below for further information.

Exercises for Femoral Acetabular Impingement

Exercise 1: Pelvic tilts



- Lie on your back with your knees bent and your feet flat on the floor.
- Put your hands on your hips. Slowly roll your pelvis - tilt your tailbone - upward and close the space between your low back and the floor.
- You'll feel a gentle stretch of your low back.
- Return to the original position.

Exercise 2: Clam Shell



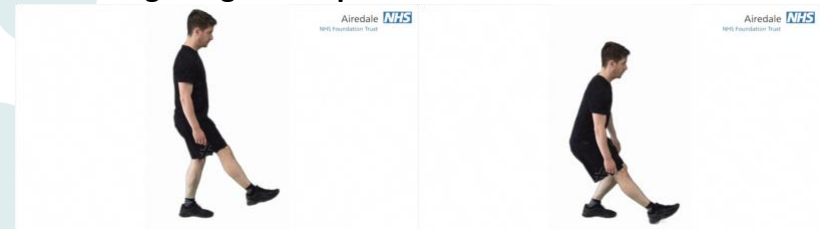
- Lie on your side with hips bent to 45 degrees.
- Your knees should be bent and stacked on top of one another.
- Your lower arm supports your head and the upper arm should be placed in front of you. Roll forward slightly and maintain this position.
- Lift your top knee away from the bottom knee while keeping feet together, lift the knee as far as you can without moving your pelvis.
- Return to the start position and repeat.

Exercise 3: Bridge



- Lie face up on the floor, with your knees bent and feet flat on the ground. Keep your arms at your side with your palms down.
- Lift your hips off the ground until your knees, hips and shoulders form a straight line. Squeeze your buttocks.
- Hold your bridged position for a couple of seconds before easing back down.

Exercise 4: Single Leg Mini Squat



- Stand on one leg with the other leg stretched out in front of you.
- Your heel should be slightly off the ground.
- Slowly bend the knee going into a single leg squat position.
- ALL of your weight should be on this leg.
- Return to the starting position.

What next?

If you are still experiencing symptoms despite following the above advice, it is important you seek advice from your GP. Your GP may decide to refer you to the musculoskeletal clinic or to a physiotherapist.

Return to Sport:

Return to sport should be guided by symptoms. Pain is not an indicator of tissue or structural damage; it is often a warning sign. It is fine to participate in sport/activity as long as pain remains manageable and settles within 24 hours. With appropriate gradual increase in activity/demand the body is able to adapt and develop a tolerance.

If you return too quickly and notice a return or worsening of symptoms use the strategies above to manage symptoms. Once symptoms settle, you can begin to gradually build back to exercise/activity again.