Policy for Arthroscopic Hip Surgery for Femoral Acetabular Impingement (FAI)
The CCG policy has been reviewed and developed by the Treatment Policies Clinical Development Group in line with the groups guiding principles which are:

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered; AND
8. All policy decisions are considered within the wider constraints of the CCG’s legally responsibility to remain fiscally responsible.
FEMORAL-ACETABULAR IMPINGEMENT (FAI)

Hip or femoro–acetabular impingement (FAI) (mismatch between the hip ball and socket) results from abnormalities of the femoral head or the acetabulum (mismatch between the hip ball and socket). There are two main types of hip impingement depending on whether the anatomical abnormality lies in the femur (cam impingement) or the acetabulum (pincer impingement). The presence of both types is referred to as mixed impingement. Not all radiologic deformities are symptomatic. It is unknown what proportion of people with asymptomatic cam or pincer deformity, develop FAI symptoms.

Symptoms of FAI include restriction of movement, ‘clicking’ of the hip joint, and pain. Symptoms may occur or be exacerbated during hip flexion activities resulting from sporting activity, although many patients experience pain whilst sitting.

Cam impingement typically occurs in young, athletic males whilst symptomatic pincer impingement is more commonly seen in middle aged females.

Management of hip impingement usually includes a trial of conservative measures, including activity modification to reduce excessive motion and loading on the hip.

In patients who are refractory to conservative treatment, surgical management to improve range of movement and reduce pain may be required. Tears to the acetabular labrum may be debrided and/or re-fixed.

The three surgical approaches commonly used are:

- Open dislocation surgery involving dislocation of the hip joint;
- Arthroscopy;
- Arthroscopy with a limited open approach (mini-open).

Clinical Effectiveness

There are no published randomised controlled trials which directly compare open surgery with arthroscopic surgery for FAI. Evidence from three systematic reviews of low quality studies indicates that arthroscopic surgery for FAI is at least as clinically effective as open surgical techniques with regard to:

- Pain improvement at six months to one year and at two to three years
- non-arthritic hip scores (NAHS) at three and twelve-month follow-up for activities of daily living function and sport function (using various hip outcome score instruments) at all-time points between three months and three years after surgery
- Quality of life improvements at three to six months (no comparator)
- Open surgical dislocation resulted in a significantly improved hip shape (alpha angle).

Safety

Compared with open hip dislocation surgery, hip arthroscopy was associated with:

- Significantly lower time for reoperation rate (relative risk [RR]: 0.40, 95% CI 0.17 to 0.95, p= 0.04).
- No significant difference in complication rates (RR: 0.76, 95% CI 0.12 to 4.63, p= 0.76)
- No difference in conversion to total hip arthroplasty (p=0.06)

Cost effectiveness

- A Canadian study suggests that on a per patient basis, the costs associated with performing a hip arthroscopy are approximately 41% of surgical hip dislocation. This may not be directly generalisable to the NHS in England.
- A small UK cost analysis study based on two years’ data indicated that hip arthroscopy for FAI may be cost-effective with the cost per QALY after one, two and ten years being £19,335, £10,118 and £2,677 per QALY respectively.

Treatment Policy Recommendation

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<th>Prior to surgery for FAI, all patients with FAI should be assessed by an MDT experienced in providing both open and arthroscopic procedures.</th>
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<td>Where surgery is appropriate following a multi-disciplinary team (MDT) assessment, arthroscopic surgery for hip impingement should be promoted as the treatment of choice.</td>
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<td>Compared to open surgery, there is evidence that arthroscopic surgery is similarly effective for reducing pain and improving function and quality of life for patients. It is also associated with lower reoperation rates, as well as increased cost effectiveness.</td>
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Eligibility Criteria

Surgical treatment for Arthroscopic Hip Surgery for Femoral Acetabular Impingement can be undertaken where the provider meets ALL of the following criteria:

- A provider has a verifiable MDT assessment process to decide the appropriate surgery modality: open dislocation surgery involving dislocation of the hip joint, or arthroscopy or arthroscopy with a limited open approach (mini-open). AND

- Patients are offered the choice of modality of surgery: open dislocation surgery involving dislocation of the hip joint, or arthroscopy or arthroscopy with a limited open approach (mini-open), AND

- There is a clear and verifiable shared decision making process in place that can be evidenced.

- Commissioners for each provider that meets the above conditions require the provider to confirm:
  - The provider’s local clinical coding for each surgery modality: open dislocation surgery involving dislocation of the hip joint, or arthroscopy or arthroscopy with a limited open approach (mini-open).
  - The relative volumes undertaken against each procedure by named consultant for 2017/18.
  - All surgical episodes should be submitted and registered with the following: https://www.britishhipsociety.com/main?page=NAHR
    This ensures continued mid and long term monitoring of outcomes and is a driver for clinical effectiveness and quality.
Guidance


12. Nwachukwu BU, Rebolledo BJ, McCormick F, Rosas S, Harris JD, Kelly BT. Arthroscopic Versus Open Treatment of Femoroacetabular Impingement: A