

CASE REPORT

**Acute ischiofemoral impingement?☆**



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**KEYWORDS**

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**Abstract** We report a case of rare clinical entity, which comes within the spectrum of hip impingements. The case deals with a 36 year old female, Olympic athlete, who developed ischiofemoral impingement 14 months after a surgical hamstring reattachment. She was treated conservatively and fully recovered. When looking into literature on this matter, we found that it is probably an under-diagnosed problem, particularly in patients with no history of prior surgery. To our knowledge, this is the first case reported after a hamstrings tendon reattachment.  
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**PALABRAS CLAVE**

Pinzamiento;  
Cadera;  
Lesiones deportivas

**¿Pinzamiento isquiofemoral agudo?**

**Resumen** Se presenta un caso de una rara entidad clínica que forma parte del espectro de los pinzamientos en la articulación de la cadera. Se trata de una atleta olímpica de 36 años que desarrolló un pinzamiento isquiofemoral 14 meses tras una reinserción quirúrgica de tendón de isquiosurales, en la que se optó por seguir tratamiento conservador constatándose una total recuperación. Revisando la bibliografía probablemente se trata de una entidad infra-diagnosticada especialmente en los casos que no existe antecedente quirúrgico. Es el primer caso comunicado después de cirugía de reinserción de tendón de isquiosurales que tengamos conocimiento.  
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## Introduction

Ischiofemoral impingement is a medical condition that involves narrowing of the space between the lesser trochanter and the ischial tuberosity causing symptomatic changes in the quadratus femoris muscle (QF).

## Aetiology

This condition may have congenital and acquired causes. The congenital causes comprise variations of the angles between the femoral shaft/femoral neck/lesser trochanter (e.g., coxa valga), of the lesser trochanter/femoral neck on the axial plane,<sup>1</sup> and cases due to mass effect in multiple hereditary exostoses have been described. Acquired aetiology is associated with mass effect (hamstrings, psoas bursitis, osteophytes), QF tendinitis,<sup>2</sup> orthopaedic treatment of fracture of femur, hamstring tendon avulsion fracture, and it is also associated with surgical procedures such as hemiarthroplasty (HA), total hip arthroplasty (THA), osteosynthesis of the femoral diaphysis and intertrochanteric osteotomies.

## Epidemiology

The condition affects females predominantly (86%) with no clearly defined age of presentation. Bilaterality<sup>3</sup> has been reported in up to 40% of cases. The series we reviewed covered 275 patients, 270 with no previous surgery (Fig. 1).

## Presentation

Low back pain of gradual onset is characteristic of the condition, and pain to buttocks, groin, posterior hip surface, occasionally radiating to the knee. It can even be associated with snapping and/or crepitus and/or hip locking.

Any movement that pinches the QF muscle between the lesser trochanter and the ischial tuberosity causes pain. These movements are any combination of EXTension, ADduction and External Rotation (EXADER). The pain can increase with other movements associated with compression

or stretching of the QF, such as the Freiberg signs, FADIR, sitting or striding.

## Additional information

Imaging techniques can be useful. Simple radiography can reveal valgus femoral neck, narrowing of the ischiofemoral space, cysts in the ischium or osteophytes. Ultrasound (US) is of great value in dynamic explorations and also to guide injections for diagnostic and therapeutic purposes (but it is operator-dependent). Magnetic resonance imaging (MRI) can reveal narrowing of both the ischiofemoral space (IFS, between the lesser trochanter and the ischial tuberosity) and the QF space (QFS, between the lesser trochanter and the hamstring tendon) muscular oedema of the QF (increased signal on T2<sup>4</sup>) and atrophy of the muscle belly of the QF.

## Diagnosis

Diagnosis should be based on clinical, semiological and morphological criteria, although the narrowings can be purely anatomical, or functional,<sup>1,5</sup> or a combination of both.

## Differential diagnoses

Snapping of the psoas tendon, sciatic pain, chronic hamstring injury, fibrillar rupture of the QF, abductor tendonitis, coxofemoral capsule instability, posterior acetabular labral tears, and pain in the sacroiliac joints.

## Treatment

Good results have been reported from fluoroscopy/CT/US-guided injections (cortico-anaesthetic, prolotherapy), and with rehabilitation. These are the treatments of choice especially for patients who have not undergone any previous surgery. Open and arthroscopic operations are reserved as an alternative for patients who fail to respond.

Author	Year	Patients	After SP*	After trauma without SP*	% female	IFI age range	Controls
Johnson <sup>6</sup>	1977	3	3	-	100	51-69	-
Klinkert <sup>2</sup>	1997	1	-	-	100	-	-
Patti <sup>7</sup>	2008	1	-	-	100	43	-
Torriani <sup>4</sup>	2009	9	-	-	100	30-71	10
Kassarjian <sup>8</sup>	2011	6	-	-	83	13-73	-
Tosun <sup>3</sup>	2012	50	-	-	84	14-77	30
Ali <sup>5</sup>	2013	13	-	-	100	17-80	-
Singer <sup>9</sup>	2015	21	-	-	86	N/A	-
Other authors	2007-2016	173	2	1	82-100	11-84	102
Subtotal		275	5	1	86	11-84	
SP*-naive patients		270	0	1	87	11-84	

**Figure 1** Reviewed articles of cases of ischiofemoral impingement. Approximately 270 cases are covered with an incidence of 87% in females, with no specified age range in patients who have not undergone previous surgery (see ref. 7). \* SP: surgical procedure.

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