

ARTHRITIS | *advisor*

Advice and information from a world leader in bone and joint care

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Preserving Hips

Hip preservation techniques aim to prevent further joint damage by restoring the structure and function of the hip joint.

When you think about hip pain, osteoarthritis in older adults may be what comes to mind. Osteoarthritis is a common cause of hip pain. But the hip joint is susceptible to many other conditions as well, and they can affect people of all ages.

If you are having hip pain, don't ignore it. Getting to the root cause and treating it appropriately can allow you to return to the activities you enjoy. It also may prevent further damage to the joint.

"There are techniques and treatments, both surgical and nonsurgical, for people who have structural or mechanical causes of hip pain and still have healthy cartilage," says Atul F. Kamath, MD, Director of the Center for Hip Preservation at Cleveland Clinic. "The goal is to correct abnormal anatomy around the hip that may accelerate joint breakdown."

Hip Anatomy

To understand what can go wrong at the hip joint, it helps to know the anatomy. The hip is a ball-and-socket joint. The bony ball at the top of the thigh bone (femoral head) fits snugly into a socket (acetabulum) in the pelvis. The surfaces of the bones are covered with cartilage, which allows for smooth movement. A band of rubbery cartilage around the rim of the socket, called the acetabular labrum, acts like a gasket to create a tight seal and provide stability to the joint. Ligaments connect the pelvis to the thighbone (femur), and many muscles attach to or cover the hip joint.



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Don't ignore hip pain. Correcting abnormalities can prevent damage to the hip joint.

A lot can go wrong at this complex joint. At the Center for Hip Preservation, Dr. Kamath and his colleagues treat four categories of patients. First are adolescents and young adults who have hip abnormalities from childhood diseases or congenital deformities. Second, athletes and other people who put their hips in extreme or abnormal positions can suffer damage to the hip joint. Third, people in their 30s to 60s who have relatively good cartilage can have a variety of hip problems involving the bones and soft tissues of the joint. The fourth category is people with osteoarthritis in the hip.

We will focus here on the third category of patients and the variety of options to correct issues related to joint anatomy.

The Right Diagnosis

Hip pain can sometimes improve on its own or with some simple measures, such

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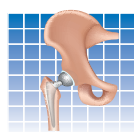
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IN THE NEWS



Blood Sugar Often Not Tested Before Joint Replacement Surgery

Many people with osteoarthritis also have type 2 diabetes. Having high blood sugar levels, which is characteristic of diabetes, can increase risk for complications from surgery. Addressing risk factors and lowering blood sugar levels can reduce complications. However, testing blood sugar levels before joint replacement surgery for hip or knee osteoarthritis is not done often enough, according to a study published in *JAMA Network Open* (September 2019). The researchers analyzed data on over 465,000 people ages 73 to 75 who underwent joint replacement surgery. Among those with diabetes, blood sugar levels were checked before surgery for only 26% of those not taking diabetes medications, 39% of those taking noninsulin medications and 43% of those receiving insulin. Only 5% of people who did not have diabetes had blood sugar levels checked before surgery.



Report Shows Toll of Osteoporotic Bone Fractures

A report published by the National Osteoporosis Foundation (August 2019) sounds the alarm about the dangers of osteoporotic fractures among adults ages 65 and older in the United States. Osteoporotic fractures are bone fractures caused by low-impact events, such as falling from standing height, in people with weak bones from osteoporosis. The authors of the report found that as many as 2 million Medicare beneficiaries suffered 2.3 million osteoporotic fractures in 2015. Women had a 79% higher rate of fractures than men. Hip fractures are the most detrimental. Overall, 40% of bone fractures required hospitalization. For hip fractures, it was 90%. The authors found that osteoporotic fractures are responsible for more hospitalizations than heart attacks, strokes and breast cancer combined. Nearly 20% of older adults died within one year after an osteoporotic fracture. Those with a hip fracture were at highest risk for dying.




Weight Loss Before Knee Replacement Shortens Hospital Stay

People who are overweight or obese put extra pressure on arthritic joints, and they may eventually need joint replacement. Because surgery can be riskier for people who are obese, surgeons often ask those who are morbidly obese (body mass index of 40 or greater) to lose weight before surgery. A study published in the *Journal of Bone & Joint Surgery* (August 2019) examined how much weight loss was necessary. The researchers reviewed data on 203 people who were morbidly obese 90 or more days before knee replacement surgery. Those who lost 20 pounds or more before surgery spent one fewer day in the hospital than those who lost less than that. They also were 76% less likely to stay in the hospital for four or more days, and they had a 72% reduced chance of being discharged to a rehabilitation facility.



New Drug for Rheumatoid Arthritis Approved

The drug upadacitinib (Rinvoq™), which is in the class of rheumatoid arthritis drugs called janus kinase (JAK) inhibitors, was FDA-approved in August 2019. Rheumatoid arthritis (RA) is caused by a malfunctioning immune system that attacks joints with unrelenting inflammation. Drugs used to treat it, called disease-modifying antirheumatic drugs (DMARDs), work in different ways to block inflammation. JAK inhibitors have the advantage of being taken as pills, whereas some other drugs are given as an injection or infusion. Like the other two JAK inhibitors (tofacitinib [Xeljanz®] and baricitinib [Olumiant®]), Rinvoq is used for people who have been taking the drug methotrexate, usually the first drug given for RA, but have had an inadequate response. It can be taken with methotrexate. Potential side effects include increased risk for infection and some cancers. 

Relieve Stress, Ease Pain

Exit the vicious cycle of chronic pain with regular meditation.

It's easy to get stressed out from everyday pressures of work, family and other responsibilities. Now that the holidays are here, you may be feeling even more stress and anxiety. For those with arthritis or another chronic condition, the result may be increased pain.

"People with various forms of arthritis often have a chief complaint of pain," says Leonard Calabrese, DO, Section Head of Cleveland Clinic's Clinical Immunology. Pain clearly comes from the disease of the joints, whether it's wear and tear or inflammation. "But pain can have other dimensions as well," he says. For example, research shows that people who are under stress have higher levels of pain.

Two-Pronged Approach

"We view the treatment of people with arthritis as having two major arms," says Dr. Calabrese. The first one is state-of-the-art medical and surgical therapies to address the joint disease. These will vary depending on the type of arthritis you have. They may include medications, physical therapy, exercise, weight loss, braces and joint injections.

"We believe that people also need lifestyle and behavioral strategies to maximize the effects of these standard therapies," says Dr. Calabrese. For example, he recommends an anti-inflammatory diet (which focuses on plant-based foods), daily physical activity, getting six to eight hours of sleep a night, and modifying stresses in daily life.

Effects of Chronic Stress

"Biologically, acute stress is not bad," says Dr. Calabrese. When we are in danger, the "fight or flight" response is triggered, which gets us out of the way of harm. But unrelenting stress over daily worries can have detrimental consequences.

Stress can contribute to increased inflammation, compromise the quality of sleep and cause higher levels of pain. In a vicious cycle, pain can cause even more stress.



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How to Start Meditating

- Stop what you are doing and sit or lie down for a few minutes. Tell yourself, "I don't have anything to do or anything to accomplish."
- Let your mind wind down, and feel the moment. Examine all five senses. Focus on what is happening right now, not yesterday and not tomorrow.
- Pay attention to your breath. Breathe in through your nose and out through your mouth.
- Thoughts will come into your mind. That's normal. Let the thoughts come, but then let them go and return to focusing on your breath.

Do this for a few minutes or as long as it's comfortable.

If mental health is seriously compromised, meaning severe depression or anxiety, Dr. Calabrese recommends getting help from a mental health professional.


Benefits of Meditation

For most people, some simple strategies can help buffer daily stresses. "This is readily achievable if you find the technique that works for you," says Dr. Calabrese. Some examples are tai chi, yoga and mindfulness meditation.

Research shows that for people with chronic pain these techniques decrease stress, which is accompanied by less pain and less fatigue.

The idea of a rigorous and time-consuming meditation practice may be off-putting to some people. "We now know that there are meditation techniques that can be done for even a few minutes a day, and they have many of the same benefits," says Dr. Calabrese.

It can be as simple as setting aside a few minutes each day for quiet contemplation, focusing on your breath and relaxing (see the box to learn how to get started). Numerous online computer programs and apps are available to guide you through the process. Some examples are Stress Free Now (tinyurl.com/yxjx2egz), Ten Percent Happier (tenpercent.com), Headspace (headspace.com) and Insight Timer (insighttimer.com).

These are not techniques that you do a couple of times and you are done. You need to make it a regular practice. "There are many positive side effects of meditation," says Dr. Calabrese. "It might make you happier and less stressed. You might have more energy and less pain." 

Practice Proper Driving Posture

Poor posture while driving can contribute to neck, back and shoulder pain. A few adjustments can help.

Good posture can go a long way toward relieving chronic musculoskeletal pain, especially in the neck, back, hips and knees. But, “it’s not likely that any of us has picture perfect posture,” says Cleveland Clinic physical therapist Mary Morrison, PT, DScPT. “Over the years, we tend to become less flexible in our muscles, connective tissue and joints, and our bodies start to adapt to how we typically align ourselves in our daily activities.”

Faulty posture puts abnormal stress on the body. Over time, the accumulated stress can cause pain for anyone. For someone with arthritis, it can exacerbate an already painful condition.

Many people spend time setting up their work environment (desk, chair, computer) to promote optimal posture. Why not do the same thing for your car? “I have a half an hour to drive to work, so I want to be in a position that is not detrimental to me,” says Morrison.

Let the Seat Do the Work

“Driving can be restorative if you are supported in good alignment,” says Morrison. “It is an opportunity to optimize alignment, allowing for less stress to joints and muscles while not having to think about it.”

A seat that supports the whole body is important. “A lot of people think good posture means sitting up straight and perching,” she says. “I encourage people to sit back, and let the chair do the work of supporting



Tips for Pain-Free Driving

- **Seat.** Adjust the seat position so your body is optimally aligned. Figure out the position that works best for your low back.
- **Hands.** Position your hands at 4 and 8 on the steering wheel (instead of 10 and 2) so you don’t hike up your shoulders or round them forward.
- **Legs.** Knees should be bent about 30 to 40 degrees, which causes less stress on joints.
- **Head.** Your head should be aligned over your spine and level. The back of your head should touch the head rest.
- **Arms and shoulders.** Keep your shoulders back against the seat, with arms relaxed and supported, if possible.
- **Take breaks.** During long drives, stop at least every two hours to stretch.

your neck, your arms, your back, etc.” The seat should allow for a little reclining.

You’ll have to experiment to find the seat position that works best for you. In general, your buttocks

and knees should be at the same level. “Having your seat lower than your knees promotes slumping,” says Morrison.

The position that is most comfortable for your back will depend on individual factors. For example, a lumbar pillow that supports the curve in your lower back may be helpful. But it’s not right for everyone. For people with spinal stenosis, arching the back can cause more pain.

Sit Back and Relax

Sit back with the back of your head touching the head rest. If you hold your head forward all the time, the muscles at the back of your neck and upper back may tense up and then set in that position.

“If the muscles are supported, they may be better balanced with other muscles, and this may decrease tension,” says Morrison.


Relax your arms with a gentle bend in the elbow. Use the arm rest, if possible, to help keep the spine upright and take some pressure off your shoulders and spine.

Adjust Your Posture

You shouldn’t have to keep adjusting the mirrors. “If you set the mirror position and later you have to crank it down, it’s because your posture is deteriorating,” says Morrison.

This could be a sign that you have the flexibility to sit upright but not the muscle stamina to keep it up.

Once you set the mirrors, try to leave them alone. “Sit to reclaim your upright posture,” says Morrison. You may get tired and have to adjust the mirror. But over time, you may be able to sustain it.

See the box for more tips and advice. “Driving shouldn’t be more stressful than it already is, and it shouldn’t cause pain,” says Morrison. 

When to Treat Dupuytren's

This usually painless condition should be treated when fingers bend and can't straighten.

While engaged in a wood-working project you plane a board, and then you run your hand over it to make sure it's nice and smooth. But your hand won't lay flat against the board. Or, you are washing windows and you find that when you press the cloth against the window pane, your hand doesn't lay flat.

These are some common ways people discover they have a condition called Dupuytren's contracture. "Some people call this Viking's disease because the genetic origins trace back to the Vikings," says *Arthritis Advisor* Editor-in-Chief and orthopaedic surgeon Steven Maschke, MD. The condition is most common in older men of Northern European and Scandinavian descent. It is rare among Asians and African Americans.

What Is Dupuytren's?

Dupuytren's occurs when, for unknown reasons, cells in the hand called myofibroblasts start to lay down collagen, a type of protein in the body. At first, this creates bumps (nodules) underneath the skin, especially near the creases in the palm of the hand. In some cases, that's as far as it goes.

Sometimes the nodules develop into cords that run up the fingers. Once this happens, the ropelike cord can draw the finger down into a flexed position, called a contracture. The finger can no longer straighten. This most often affects the ring finger, followed by the small finger. It can occur, but is less common, in the thumb and the other two fingers.

Dupuytren's contracture usually isn't painful. "As long as it is confined to nodules in the palm, we tend to leave those alone," says Dr. Maschke. Treatment is aimed at managing the contracture if it occurs.

The way to tell if treatment should be considered is the tabletop test. "If you can place your hand flat on a table without your fingers being significantly flexed up, that's a sign you don't need to do anything," says Dr. Maschke.

Treatment Options

There's no cure for Dupuytren's contracture, but if a finger is significantly bent, there is treatment. Any bend in the middle joint of the finger or a bend of 30 degrees or more at the knuckle can be treated with one of three options.

The most common treatment involves injecting the drug Xiaflex®, which is made from the enzyme collagenase. This breaks down the fibers in the cord.

Treatment involves two trips to the doctor's office. At the first visit, the drug is injected. A few days later, the doctor will numb the hand and then manipulate the cord to break it up. Tendon rupture and ligament damage are rare side effects.

Another treatment option is needle aponeurotomy. After a numbing agent is injected into the hand, the physician inserts a needle into the area to sever the cord in several locations.

"Recovery after these procedures is quite quick," says Dr. Maschke. However, the rate of recurrence is

What You Need to Know


- Dupuytren's contracture is a hand deformity that starts as small lumps in the palm of the hand.
- Nodules can develop into thick cords that extend up to the fingers (usually the ring or small finger).
- The cord can draw the finger down into a flexed position that cannot be straightened.
- Nodules alone do not require treatment.
- Dupuytren's can't be cured. But if the finger is bent, there are treatments to dramatically improve hand function.

high and unpredictable. "Some people don't have a recurrence for 40 years, while others have it come back in a year," he says.

The third treatment option is surgery to remove the cord. This is done for more severe contractures and often for recurrences. Surgery is more invasive and requires a longer recovery period. It usually involves several weeks of physical therapy. But there's a lower rate of recurrence.

Catch It Early

Dupuytren's contracture can't be cured and doesn't always need to be treated. But if you have nodules in your palm or a finger bends and can't be straightened, Dr. Maschke recommends getting it checked.

"If the finger becomes too contracted, it is much more difficult to treat," he says. 

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Hip Preservation ... from page 1

as activity modification. “If someone has ongoing issues around the hip, such as groin pain, clicking and catching or pain with activities like climbing stairs, squatting, bending or lifting, I suggest getting an evaluation,” says Dr. Kamath.

Correct diagnosis is the key, and hip pain is not always easy to diagnose. Your doctor will look for a likely cause based on the characteristics of your symptoms, your age, activities and other factors that might point to a specific reason for the pain. X-rays will usually be taken as a screening measure.

Unless there was an injury or sudden change in symptoms, the first step often is conservative treatment, such as nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy, weight loss (if overweight) and possibly joint injections. “I usually try these methods first,” says Dr. Kamath.

If symptoms persist, and the X-rays show no significant signs

of osteoarthritis, Dr. Kamath usually proceeds to more advanced imaging tests, such as magnetic resonance imaging, to identify an underlying cause.

Impingement

One possibility is a condition called femoroacetabular impingement (FAI). “The ball part of the joint can roll in a certain way and pinch the lining of the socket,” says Dr. Kamath. This can happen because of the shape of the hip bones. There are two main types of FAI, called cam and pincer impingement, depending on whether the ball (cam) or socket (pincer) is affected.

“There’s really no such thing as a ‘normal’ shape of hip,” says Dr. Kamath. “Everyone falls along a spectrum from very tight sockets, which can lead to impingement, to looser sockets, because of dysplasia.”

Impingement can cause damage to the cartilage that covers the bones or a tear in the lining of the socket, called a labral tear. These can often be repaired using minimally invasive arthroscopic surgery. With arthroscopy, a video camera on the end of a small tube is inserted through a small incision, allowing the surgeon to see inside the joint. Other surgical instruments are inserted through similarly small cuts to perform the procedure.

If the deformity or the extent of damage is significant, an open surgical procedure will be needed.

Gluteal Tears

Just like the shoulder is surrounded by a cuff of tendons and muscles, the hip also is covered by these muscular and tendinous structures. These abductor muscles (gluteus medius and gluteus minimus) can tear. This can occur from a sudden trauma, but in most cases it occurs

over time from repetitive movement and overuse.

Physical therapy and other nonsurgical treatments are tried first. If that doesn’t work, tears can be repaired surgically, either with arthroscopy or standard open surgery.

Avascular Necrosis


Another condition that can affect the hip is avascular necrosis (AVN), which results from decreased blood supply to the ball of the joint. If the blood supply is disrupted, bone can start to die, which can lead to destruction of the hip joint.

This painful condition is most common in adults in their 30s to 50s. Some causes of AVN include excessive alcohol consumption and use of corticosteroid medications for conditions such as asthma, rheumatoid arthritis or lupus.

“If the femoral head is still round, there are techniques to stimulate healing in the bone and slow down or even reverse the avascular necrosis,” says Dr. Kamath. In a procedure called core decompression, a metal tube (called a trochar) is placed into the femoral head to relieve pressure in the bone. Bone marrow is harvested to produce stem cells from the patient’s own body, which are then inserted to stimulate growth of new bone tissue.

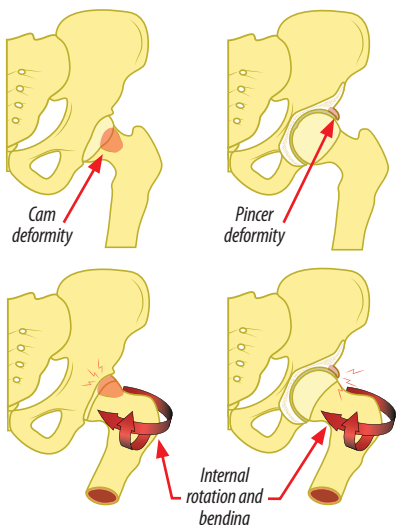
If the problem goes untreated or the femoral head is no longer circular because the bone has collapsed, total hip replacement may be needed.

These are just some of the conditions that can be treated through a hip preservation approach.

“Every hip is unique, like a fingerprint, and therefore the diagnosis and treatment need to be tailored to each individual patient,” says Dr. Kamath. 

CAM DEFORMITY

PINCER DEFORMITY



Hip impingement can be caused by a deformity in the ball (cam deformity) or socket (pincer deformity). As the hip rotates, the lining of the socket can get pinched.

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ARTHRITIS *advisor*

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Locking knees.....Treatment for osteopenia



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Q Sometimes my knee locks up and I can't bend or straighten it. Eventually, I can move it, but it's sore. What's wrong with my knee?

A There are several possibilities, but the most likely one is a torn meniscus. The meniscus is a piece of cartilage in the knee joint. There are two types of cartilage in the knee. Articular cartilage covers the ends of the upper leg bone (femur) and the bone at the front of the lower leg (tibia). This covering provides a cushion keeping the two bones from rubbing against each other. The knee joint also contains two menisci, which are crescent-shaped disks made of fibrocartilage. These are located between the femur and tibia. They act as shock absorbers and disperse body weight across the joint.

A meniscus can tear from an injury. But the menisci can also weaken over time, making them susceptible to small tears from simple wear and tear with age. When there's a tear in the meniscus, it can cause the knee to catch and lock intermittently. There's often pain, usually on one side, when squatting or twisting.

You should see your doctor to get a diagnosis. A torn meniscus can usually be identified with a physical examination and X-rays. Sometimes magnetic resonance imaging is needed. Many people with a torn meniscus from degeneration over time also have osteoarthritis, which is the wearing down of the articular cartilage.


If you do have a torn meniscus, with or without osteoarthritis, it can be treated. The first step will be conservative measures, such as ice to reduce swelling, nonsteroidal anti-inflammatory drugs (NSAIDs) for pain and physical therapy. In some cases, surgery can be performed to trim away the torn part of the meniscus.

Q A bone density test showed that I have osteopenia. I'm 65 years old. Should I be taking a drug to protect my bones and prevent osteoporosis?

A As we age, the density of our bones naturally declines. This happens to everyone. Your bones are not as strong as they were when you were in your teens and 20s. If bones weaken too much, they are more likely to break. For older adults, broken bones can have serious consequences. Bone fractures increase the risk for loss of independence and even dying prematurely.

A bone density test can determine the condition of your bones. The results are reported in terms of a T-score. The T-score compares your bone density to what would be considered normal for a healthy 30-year-old adult. By age 65, it is expected to be lower. Therefore, a T-score of -1.0 or above is considered normal. A T-score between -1.0 and -2.5 is low. This is called osteopenia, and it is what you have. Osteoporosis is diagnosed when the T-score is below -2.5. (Because these are negative numbers, higher numbers indicate lower bone density.)

The question is, what should you do? People with osteoporosis are advised to take an osteoporosis drug. People with osteopenia can have bone fractures as well. In fact, about 75% of fractures occur in people with osteopenia. A tool called FRAX[®] can help decide whether you need treatment. FRAX[®] takes into account a variety of factors, including T-score, age, sex, previous fractures and smoking, to estimate your risk for future bone fractures.

Whether or not you take an osteoporosis drug, you can help to keep your bones strong by getting adequate amounts of calcium and vitamin D and engaging in regular weight-bearing exercise. 

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