BI-LATERAL FEMOROACETABULAR IMPINGEMENT IN A COLLEGE BASKETBALL PLAYER

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**Background:** A 21-year-old male, junior college basketball player presented to the athletic trainer with bi-lateral hip pain. The achy, non-descript pain had been noticeable since the beginning of the regular season without traumatic incident. The pain was localized to the anterior hip and adductor region, without signs of locking or clicking. The athlete reported no previous history prior to the complaint of bilateral hip pain, which increased following activity. The athlete was treated for adductor hip pain. Despite these treatments, the pain continued to increase and the pain shifted to more of an anterior impingement. Evaluation revealed mild pain with staif climbing. Upon inspection, it was noted that the athlete has femoral anteversion bi-laterally. The athlete’s internal and external range of motion in his hips decreased throughout the season and acetabulofemoral joint seemed increasingly stiff. **Differential Diagnosis:** Groin Strain, labral tear, iliopsoas tendinosis. **Treatment:** The athlete was initially treated for bilaterally groin strains due to the location of pain. After a few weeks, with no relief of the adductor pain and an increase in anterior impingement pain, the athletic trainer referred the athlete. The orthopedic diagnosed him with bi-lateral femoroacetabular impingement (FAI) with possible labral tears. An x-ray and MRI were taken and revealed widening of the femoral necks and labral tears with an associated cox vara, confirming the initial suspicions of the physician. Ice was applied to the area as the athlete received pre-mod muscle stimulation throughout the rest of the season. The athlete underwent arthroscopic surgery for right hip labral repair called a Cam lesion femoroacetabular impingement osteochondroplasty, following the season. The athlete was put on crutches following the surgery and was reminded the importance of using them as prescribed during his follow-up with the orthopedic. Rehabilitation began the weekend following the surgery and consisted of hip strengthening, proprioception and range of motion exercises, as well as hip stretching and the application of ice. The athlete underwent the same surgery for his left hip, but had a mixed femoroacetabular impingement, consisting of Cam and Pincer lesions 6 weeks from the day of his first surgery. The same rehab was used for the left hip following the weekend after surgery. Athlete is currently continuing his rehab and has just been cleared to participate in full contact team drills and practices. **Uniqueness:** The exact cause of FAI is unknown although it is thought to occur genetically due to a variety of factors including biomechanical and anatomical issues. In this case it was related to cox vara and an increase in training. Typically, symptoms mimic sciatica and/or low back pain, however this was not the particular case for this athlete. The injury itself presented as an adductor strain, but due to the increase in intensity and frequency of training the athlete increased the load placed upon the acetabular rim resulting in the impingement. **Conclusions:** FAI, particularly Cam lesions, is more common in athletes with cox vara. Although FAI is common in athletes who participate in contact sports, the increase in intensity of the sport should be taken into account when pain in the acetabulofemoral joint is present. Athletes should be referred to an orthopedic if an increase in hip pain is present after first being evaluated. X-Ray images are important in confirmation of the diagnosis, while MR images can help identify the cause of the FAI. **Word Count:** 557