Background: A 24 year old Division I male hockey player has a six year history of bilateral hip pathology. The initial injury was in March 2005 (age 18). The patient was battling for a puck and felt a pop in his left hip. He presented with an inability to skate, a notable limp, decreased hip flexion and rotation, and pain. Differential Diagnosis: Hip flexor strain, avulsion fracture of the iliac spine, interarticular bone fragment, acetabular labral tear. Treatment: The patient was diagnosed with a left hip strain; initial treatment was physical therapy. After six weeks of treatment, symptoms persisted and a CT scan showed a 1cm bony fragment medial and superior to the greater trochanter. Also included was a 1.5 x 1cm bony fragment at the lateral most aspect of the acetabular roof, indicative of avulsed fragments and labral acetabular rim syndrome. Diagnosis of a possible labral tear with internal impingement was made on the left hip in May 2005. An MRI in August 2005 revealed a labral tear with impingement and slight loss of OS at the femoral head and neck junction. Out-patient surgery was then performed, fixing the displaced labral tear and noting grade II-III changes on the femoral head and synovitis in the joint capsule. The surgeon placed one suture anchor posteriorly and two anteriorly and performed a debridement and chondroplasty on the patient’s left hip. The patient required physical therapy and began sport-specific conditioning three months post-surgery. In November 2008, the patient felt a strain over his right hip flexor and a “pinch” deep within his right hip during a game. Diagnostic imaging showed a cam-type femoral acetabular impingement with a superolateral labrum detachment. The patient was given injections of .25% Marcaine and Kenalog for pain management with instructions to continue playing conservatively. In February 2009, a CT scan on the left hip showed a 2cm bony fragment along the anterior rim of the acetabulum. The patient was given an injection of Depo-Medrol for pain management. In March 2009, images of the patient’s post-surgical left hip showed cam-type femoral acetabular impingement, a loose bony fragment, and an abnormality to the acetabular labrum superior to anterior with ossification. The patient underwent a second surgery to the left hip to fix the patient’s second labral tear, remove the OS acetabuli which was attached to an anchor from surgery one, debride the chondromalacia, and remove the cam-type impingement. Early onset arthritis was noted in the patient’s left hip. Three and a half months post-second left hip surgery, the patient reported that the pain in his right hip was worsening. In October 2009, the patient forwent his competitive season. The patient’s left hip pain returned; x-rays revealed beginning sclerosis. Right hip surgery was performed in November 2009 with limited labral debridement from ten to two o’clock, chondroplasty of acetabular cartilage, a labral repair, and osteoplasty of the cam lesion. As of October 2010, the patient is playing his final season as a Division I hockey player. Uniqueness: Despite the low incidence rate of hip and groin injuries in the adult population, femoroacetabular impingement with an unknown etiology is rising in prevalence. This patient suffered two femoroacetabular impingements and underwent three hip surgeries in a five year span. Conclusion: This case highlights the importance of considering underlying pathologies when evaluating patients with chronic hip pain. Athletes at risk
for developing femoroacetabular impingement could engage in specific conditioning programs that may assist in reducing their likelihood of occurrence. **Word Count:** 579