Personalised Hip Therapy: development of a non-operative protocol to treat femoroacetabular impingement syndrome in the FASHIoN randomised controlled trial

Peter DH Wall,¹ Edward J Dickenson,¹ David Robinson,² Ivor Hughes,³ Alba Realpe,¹ Rachel Hobson,¹ Damian R Griffin,⁴ Nadine E Foster⁵

ABSTRACT

Introduction Femoroacetabular impingement (FAI) syndrome is increasingly recognised as a cause of hip pain. As part of the design of a randomised controlled trial (RCT) of arthroscopic surgery for FAI syndrome, we developed a protocol for non-operative care and evaluated its feasibility.

Methods In phase one, we developed a protocol for non-operative care for FAI in the UK National Health Service (NHS), through a process of systematic review and consensus gathering. In phase two, the protocol was tested in an internal pilot RCT for protocol adherence and adverse events.

Results The final protocol, called Personalised Hip Therapy (PHT), consists of four core components led by physiotherapists: detailed patient assessment, education and advice, help with pain relief and an exercise-based programme that is individualised, supervised and progressed over time. PHT is delivered over 12–26 weeks in 6–10 physiotherapist-patient contacts, supplemented by a home exercise programme. In the pilot RCT, 42 patients were recruited and 21 randomised to PHT. Review of treatment case report forms, completed by physiotherapists, showed that 13 patients (62%) received treatment that had closely followed the PHT protocol. 13 patients reported some muscle soreness at 6 weeks, but there were no serious adverse events.

Conclusion PHT provides a structure for the non-operative care of FAI and offers guidance to clinicians and researchers in an evolving area with limited evidence. PHT was deliverable within the National Health Service, is safe, and now forms the comparator to arthroscopic surgery in the UK FASHIoN trial (ISRCTN64081839). Trial registration number ISRCTN 09754699.

INTRODUCTION

Femoroacetabular impingement (FAI) syndrome is a motion-related clinical hip disorder with a triad of symptoms, clinical signs and imaging findings.¹ It represents a symptomatic premature contact between the proximal femur and the acetabulum.¹⁻⁴ Typically, the morphology of the hip exhibits shapes that predispose to impingement, often described with the terms cam and pincer morphology.²⁻³⁻⁷ The epidemiology of cam and pincer morphology is not well defined but may be present in 30% of the general population.⁷ Not all patients with cam and/ or pincer morphology develop FAI syndrome,⁶ but the treatment of those who do is controversial. Over the past 10 years, increasing numbers of patients have been treated for FAI syndrome with shape changing surgery, most frequently through hip arthroscopy.⁷⁻⁸ Surgery has been shown to provide improvements in patient symptoms,⁹ although patient expectations are not always met.¹⁰

It has been suggested that clinicians should be cautious in the use of surgery for FAI syndrome and that non-operative approaches should be considered.¹¹⁻¹³ Patients with FAI syndrome have altered hip muscle strength, range of motion (ROM) and gait biomechanics, and these offer potential targets for treatment through physiotherapy.¹⁴⁻¹⁷ While many authors recognise the likely value of non-operative or conservative care, there is very little published guidance and evidence on how this care should be delivered.¹² ¹³

Given the uncertainty and lack of evidence about treatment for FAI syndrome, a randomised controlled trial (RCT) comparing hip arthroscopy and conservative care was proposed to guide future practice.¹¹ ¹⁸ In 2012, the UK National Institute of Health Research (UK NIHR) Health Technology Assessment programme (HTA) commissioned us to perform a feasibility and pilot study for an RCT to compare hip arthroscopy with ‘best conservative care’ for patients with FAI syndrome (FASHIoN HTA10/41/02).¹⁹ At the time, there was no established ‘best conservative care’,¹² and we are not aware of any that has been published since. To design this trial, we needed to develop a suitable conservative care protocol.

The aim of this study was to develop an agreed conservative treatment protocol for patients with FAI syndrome that was deliverable within the UK National Health Service (NHS), was safe, and that could be used in the planned RCT.

METHODS

Study design

Research ethical approval was granted for this study (NHSREC11/WM/0389). In phase one, a non-operative treatment protocol for FAI syndrome was developed using established consensus methodology, guided by the principles described by the Medical Research Council for development of complex interventions.¹⁰ ¹¹ In phase two, the protocol was tested in an internal pilot RCT comparing conservative care versus arthroscopic hip

surgery for FAI. Figure 1 presents a flow diagram of the protocol development process. This study formed part of the FASHIoN feasibility trial whose results, including aspects of this study, have been published.23

Phase 1: consensus development

Given the lack of an agreed conservative care treatment protocol for FAI syndrome,12 we formed core and Delphi study groups in order to develop and agree on the treatment protocol.20 The core study group comprised two extended scope practitioner musculoskeletal physiotherapists with an interest in managing FAI syndrome (DR and IH), a senior academic research physiotherapist with expertise in musculoskeletal pain research (NEF) and an academic orthopaedic surgeon (PDHW). The core study group oversaw protocol development and provided the input required for consensus by nominal group technique.20 The use of this consensus methodology is reasonable given the lack of an established conservative care protocol.20 21

To form the Delphi study group, we took a targeted approach to sampling, using networks of physiotherapists most likely to be involved in the management of FAI syndrome. National advertisements were placed in the orthopaedic, rheumatology, pain and manual therapy electronic networks of the Chartered Society of Physiotherapy (iCSP) and in the magazine of the Chartered Society of Physiotherapists, Frontline. The advertisements invited physiotherapists to help develop a consensus for a conservative care protocol for FAI syndrome. Electronic invitations were also sent to physiotherapists in the USA and Australia known to the authors through previous collaborative work on FAI syndrome. To encourage a process of ‘snowball sampling’, physiotherapists were encouraged to invite colleagues with experience and interest in managing FAI syndrome to join the consensus development process.

A systematic review was conducted to identify any previously published protocols for conservative treatment of FAI syndrome.12 The first protocol was drafted using evidence gathered from this systematic review and was circulated via email to the Delphi study group. They completed a questionnaire asking whether they agreed or disagreed with the proposed protocol, and where appropriate provide comments and suggestions for improvement. Additional comments and treatment strategies were grouped into themes and tabulated. An agreement level of 50% for this Delphi consensus technique was used. If no consensus was evident, the core study group refined the protocol in the light of the feedback using a nominal group technique. The refined protocol was then recirculated to the Delphi group and the cycle repeated until a consensus of at least 50% was achieved.

Phase 1: patient panel

As part of the FASHIoN feasibility trial, a qualitative research study among an expert patient panel was undertaken to guide many aspects of the development of the RCT.23 One task for the panel was to name the conservative treatment arm of the RCT. Previous qualitative research has highlighted the importance of naming treatments in order to improve uptake and adherence with treatment, in particular within the context of RCTs.24 Further details of this qualitative research can be found in Griffin et al.23

Phase 2: protocol testing and refinement

Once adequate consensus on the conservative care protocol was reached, the protocol was implemented within a multicentre internal pilot RCT comparing arthroscopic surgery versus...
conservative care (FASHIoN feasibility study ISRCTN09754699). Since the pilot RCT was designed to be
internal to a full RCT, there was no interim analysis of out-
comes; the outcomes will be reported as part of the full
RCT.22 25 The eligibility criteria for the RCT are listed in box 1.

Phase 1: consensus development
The first protocol proposed and circulated to physiotherapists is
summarised in online supplementary file A. The level of agree-
ment with the first protocol among the 36 physiotherapists was
below the 50% threshold. Details of the degree of consensus
reached and a summary of the feedback from the first round of the
Delphi exercise are summarised in online supplementary file B.

Using the additional comments made by the Delphi group,
and drawing on available evidence and underpinning theory, the
core study group derived a second protocol. This had four core
components and four optional components, which are described in
table 1.

The initial round of responses suggested that patients should
be seen over a longer period (the first draft protocol suggested
2–3 weeks26) and more frequently in order to optimise patient
outcomes. Within the NHS, the typical number of treatment ses-
sions given by physiotherapists to patients with musculoskeletal
pain is three or four. Evidence suggests that better outcomes are
achieved from exercise-based regimes when they are supervised
and the contact between the supervisor and patient is
increased.27 28 In order to allow more contact between phy-
sotherapists and their patients, without increasing the burden of
travel to clinic appointments, telephone and email contacts were
also allowed to progress the exercise programme and to support
patient adherence. The core study group decided that the proto-
col could be delivered over a 12-week period and a minimum of
six treatment sessions, of which at least three should be face to
face. The treatment sessions with physiotherapists were to be
supplemented by patients continuing their individualised exercise
programme at home. The duration of care was in keeping with
established theory that suggests that physiological changes in
muscle occur after a 12-week programme of exercise.29

The core study group agreed on the following protocol
exclusions:

- Painful hard end stretches. Although only mentioned by two
physiotherapists in the initial questionnaire responses, there
is some evidence to suggest that painful hard end stretches
and forceful manual techniques in a restricted range of move-
ment may be harmful.4
- Group-based treatment was excluded to ensure that care was
individualised.
- Treatment by a technical or student instructor was excluded
to ensure that care was delivered by qualified physiotherapists
who had received training in the protocol.

In total, 30 (83%) of the original 36 physiotherapists responded
and agreed with the second protocol and provided no additional
suggestions for change. One did not respond and five disagreed
with the second protocol and made further suggestions for
change. These points were discussed among the core study
group and the following further changes were made:

- All physiotherapists delivering the conservative care protocol
were asked to complete a case report form (CRF) for each
patient treated, which included details about the number, nature
and duration of the patient contacts, the exercises prescribed
and other treatments provided. Given that this was an internal
pilot trial, all patients recruited were followed up for 1 year.
Any adverse events (AEs) were collated from CRFs, hospital
records and follow-up questionnaires. AEs were defined as any
untoward medical occurrence in the RCT.

Phase 2: consensus development conference

After treating patients in the internal pilot RCT, physiotherapists
delivering the protocol were invited to a consensus development
conference chaired by NF to share their experiences of deliver-
ing the protocol and make suggestions for further amendments
prior to the full RCT.

RESULTS

Thirty-six physiotherapists responded and agreed to take part in
the Delphi consensus process, 24 from the UK, 10 from the
USA and 2 from Australia. All 36 had previously managed
patients with FAI syndrome and included physiotherapists from
the military, primary and secondary care, tertiary hip preserva-
tion services, extended scope practitioners, private practice and
elite sport.

All physiotherapists delivering the conservative care protocol
were asked to complete a case report form (CRF) for each
patient treated, which included details about the number, nature
and duration of the patient contacts, the exercises prescribed
and other treatments provided. Given that this was an internal
pilot trial, all patients recruited were followed up for 1 year.
Any adverse events (AEs) were collated from CRFs, hospital
records and follow-up questionnaires. AEs were defined as any
untoward medical occurrence in the RCT.

Phase 2: consensus development conference

After treating patients in the internal pilot RCT, physiotherapists
delivering the protocol were invited to a consensus development
conference chaired by NF to share their experiences of deliver-
ing the protocol and make suggestions for further amendments
prior to the full RCT.

RESULTS

Thirty-six physiotherapists responded and agreed to take part in
the Delphi consensus process, 24 from the UK, 10 from the
USA and 2 from Australia. All 36 had previously managed
patients with FAI syndrome and included physiotherapists from
the military, primary and secondary care, tertiary hip preserva-
tion services, extended scope practitioners, private practice and
elite sport.
Given the level of agreement (83%), the core study group decided to use the second protocol with the modifications discussed above for implementation in the pilot RCT.

**Phase 1: patient panel**

Eighteen UK patients (8 female and 10 male) with FAI syndrome took part in the qualitative study to derive a name for the conservative care protocol, of whom 5 had been treated with conservative care and 13 with arthroscopy. They were asked to choose between four potential names which had been suggested by the core study group, with the option to suggest a different name if they wished.

Personalised Hip Therapy (HPT) appealed to and conveyed a positive message to patients. This combination emphasises that the protocol is an active intervention that differs from other conservative care regimes that patients may have previously tried.

### Table 1 Protocol components

<table>
<thead>
<tr>
<th>Core 1</th>
<th>Patient assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full history.</td>
<td></td>
</tr>
<tr>
<td>• Examination; including hip muscle stability, strength, ROM and impingement signs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core 2</th>
<th>Patient education and advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advice about posture, gait and lifestyle behaviour modifications.</td>
<td></td>
</tr>
<tr>
<td>• Advice about activities of daily living to try to avoid FAI (reducing/avoiding deep flexion, adduction and internal rotation of hip).</td>
<td></td>
</tr>
<tr>
<td>• Advice about relative rest for acute pain.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core 3</th>
<th>Help with pain relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use of oral analgesics, including non-steroidal anti-inflammatory medication for 2–4 weeks.</td>
<td></td>
</tr>
<tr>
<td>• Engagement in and adherence to an exercise programme.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core 4</th>
<th>Exercise-based hip programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An exercise programme that has the key features of individualisation, progression and supervision.</td>
<td></td>
</tr>
<tr>
<td>• A phased exercise programme that begins with muscle control work, and progresses to stretching and strengthening with increasing ROM and resistance.</td>
<td></td>
</tr>
<tr>
<td>• Muscle control/stability exercise (targeting pelvic and hip stabilisation, gluteal and abdominal muscles).</td>
<td></td>
</tr>
<tr>
<td>• Strengthening/resistance exercise first in available range (pain-free ROM), and targets: gluteus maximus, short external rotators, gluteus medius and abdominal muscles.</td>
<td></td>
</tr>
<tr>
<td>• Stretching exercise to improve hip external rotation and abduction in extension and flexion (but not vigorous stretching—no painful hard end stretches). Other muscles to be targeted if relevant for the patient include iliopsoas, hip flexors and rotators.</td>
<td></td>
</tr>
<tr>
<td>• Exercise progression in terms of intensity and difficulty, gradually progressing to activity or sport-specific exercise where relevant.</td>
<td></td>
</tr>
<tr>
<td>• A personalised and written exercise prescription that is progressed and revised over treatment sessions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optional 1</th>
<th>Treat coexisting symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Examples of this might include treating coexisting low back pain.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optional 2</th>
<th>Orthotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patients can be assessed for biomechanical abnormalities and have these corrected by the treating physiotherapist. Alternatively, they can be referred to other allied healthcare professionals such as podiatrists for custom-made insoles, etc.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optional 3</th>
<th>Corticosteroid hip joint injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Potentially useful in patients who are unable to engage in the exercise-based programme due to severe pain.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optional 4</th>
<th>Manual Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hip joint mobilisations, for example, distraction, distraction with flexion, anteroposterior glides.</td>
<td></td>
</tr>
<tr>
<td>• Trigger point work.</td>
<td></td>
</tr>
</tbody>
</table>

FAI, femoroacetabular impingement; PHT, Personalised Hip Therapy; ROM, range of motion.
Phase 2: testing and refinement
Forty-two patients were recruited to the internal pilot RCT. Two physiotherapists were Band 6, six Band 7, and two Band 8; NHS bands reflect seniority, ranging from a newly qualified physiotherapist at Band 5 to the most senior and experienced physiotherapist at Band 8. They had previously treated a mean of 30 (range 3–90) patients with FAI syndrome. Of the 42 patients recruited in the pilot RCT, 21 were allocated to PHT. On average, PHT started 38 (range 12–76) days after randomisation, reflecting physiotherapy service waiting times in the NHS. Patients attended a mean of six sessions (SD 2.3). Treatment was judged to have been delivered in line with the PHT protocol in 13 (62%) patients. Reasons for deviation from the protocol included immediate postrandomisation crossover (n=1), no CRF received (n=2) and insufficient number of treatment sessions (n=5). Clinical outcomes are not reported from the internal pilot RCT due to the ongoing nature of the full RCT where pilot data will be included in the main analysis (FASHION ISCTR064081839). The only AE reported was muscle soreness at 6 weeks by 13 (62%) patients.

Phase 2: consensus development conference
A consensus development conference was held at the University of Warwick in May 2013 after 21 patients randomised to PHT were treated. Eight physiotherapists from eight sites attended and provided feedback and discussion about the PHT protocol, content and delivery. Collectively, these 8 physiotherapists treated 18 patients within the pilot RCT. The physiotherapists agreed that the PHT protocol worked well, but that they would like to change the number of treatment contacts and the overall duration of the protocol. As a result, the protocol was amended to include a minimum of 6 and a maximum of 10 contacts over a total period of 6 months. In addition, 3 further exercises were recommended and were added to the original selection of 21 exercises within the exercise template (see online supplementary file C).

An overview of the final agreed protocol is shown in figure 2 with the exercise template provided in online supplementary file C. The full PHT manual, used as a training aid for trial physiotherapists, is available in online supplementary file D.

DISCUSSION
We aimed to develop and undertake initial testing of a physiotherapist-led non-operative treatment protocol for patients with FAI syndrome that could be compared with arthroscopic surgery in a large pragmatic RCT. We combined results from a systematic review, two rounds of Delphi consensus, relevant literature and the experiences of physiotherapists treating patients with FAI syndrome within the internal pilot RCT, in order to develop the agreed treatment protocol, referred to as Personalised Hip Therapy.10 33 This PHT protocol provides guidance to clinicians and researchers in an area where evidence is limited.8 12 18

Exercise is an effective treatment for many types of musculoskeletal pain.12 33 PHT has many similarities to other non-operative treatment regimens including the EULAR and OARSI guidelines on hip and knee osteoarthritis. These also recommend a comprehensive assessment, education, lifestyle modification and exercise-based programme.34 35 However, these guidelines were unable to make specific exercise recommendations for hip OA due to a lack of evidence, although a mixed regime (quadriceps strengthening, aerobic capacity and flexibility training) was recommended in knee osteoarthritis by EULAR.34

As well as including aspects in common with other non-operative care protocols of hip disorders, PHT includes an exercise-based programme that aims to improve deficiencies in hip function (including muscle weaknesses and ROM) that have been highlighted in FAI syndrome.14 17 Through an individualised exercise-based programme, physiotherapists using PHT are able to target these deficiencies. A recent editorial highlighted what might be included in a non-operative care protocol for FAI syndrome.17 PHT includes all of these points, including hip-specific function and lower limb strengthening, core stability and postural balance exercises.

During the pilot RCT, only 62% of PHT treatments were judged to closely follow the protocol. This raises questions about the deliverability of PHT in the ‘real world’. However, some of the reasons for deviation were teething problems to be expected in a pilot trial. These included an immediate post-randomisation crossover (n=1), no completed CRF available (n=2) and an insufficient number of treatment sessions (n=5); in some circumstances, this may reflect patient improvement, resulting in discharge prior to receiving six sessions. Compliance with home exercises can be problematic,36 but physiotherapists were able to use an exercise diary to monitor patient adherence to the exercise programme at home and did not report any concerns. Muscle soreness was reported in 62% of patients, 6 weeks into the PHT programme. This is to be expected as part of an exercise-based regime as the muscles adapt to the increased demand. Reassuringly, this had resolved in all cases by 3 months follow-up. This is in keeping with similar exercise-based interventions used in RCTs for other musculoskeletal conditions.37–39 On balance, we believe that the results from the pilot RCT show that PHT is safe and deliverable in the ‘real world’ of the NHS. The overall fidelity of PHT is similar to other conservative care protocols used in RCTs,40 so it is also suitable for use in the planned pragmatic RCT.

Limitations of the PHT protocol include that it was developed based on the experiences of clinicians treating patients...
<table>
<thead>
<tr>
<th>1 Patient Education and advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Education about FAI and available treatments</td>
</tr>
<tr>
<td>- Advice about posture, gait and lifestyle behaviour modifications to try to avoid FAI</td>
</tr>
<tr>
<td>- Advice about activities of daily living to try to avoid FAI (reducing / avoiding deep flexion, adduction and internal rotation of hip)</td>
</tr>
<tr>
<td>- Advice about relative rest. In particular, relative rest in a specific ROM where pain in that particular ROM is likely to represent ongoing impingement. Specific activity/sport technique advice and modification.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 Patient Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- History: to include: History of presenting complaint, relieving and aggravating factors, past Medical History, medications, previous treatments, social history including occupation, patients concerns, fears and beliefs, patients individual requirements and expectations.</td>
</tr>
<tr>
<td>- Examination Determine pain-free, passive ROM in the hip, determine the strength of motion in the hip in flexion, extension, abduction, adduction, internal and external rotation and impingement testing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Help with Pain Relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Advice about anti-inflammatory medication for 2 to 4 weeks.</td>
</tr>
<tr>
<td>- Advice about simple analgesics if they do not respond well to anti-inflammatory medication.</td>
</tr>
<tr>
<td>- Engagement in, and adherence to, a personalised exercise programme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 Exercise-based hip programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>- An exercise programme that is individualised, progressive and supervised.</td>
</tr>
<tr>
<td>- A phased exercise programme that begins with muscle control work, and progresses to stretching and strengthening with increasing ROM and resistance.</td>
</tr>
<tr>
<td>- Muscle control / stability exercise (targeting pelvic and hip stabilisation, gluteal and abdominal muscles).</td>
</tr>
<tr>
<td>- Strengthening / resistance exercise firstly in available range (pain-free ROM), and targets: Gluteus maximus, short external rotators, glutus medius, abdominal muscles, lower limb in general</td>
</tr>
<tr>
<td>- Stretching exercises to improve hip external rotation and abduction in extension and flexion (but not vigorous stretching – no painful hard end stretches). Other muscles to be targeted if relevant for the patient include hip flexors and rotators.</td>
</tr>
<tr>
<td>- Exercise progression in terms of intensity and difficulty, gradually progressing to activity or sport-specific exercise when relevant.</td>
</tr>
<tr>
<td>- A personalised and written exercise prescription that is progressed and revised over treatment sessions.</td>
</tr>
<tr>
<td>- Encourage motivation and adherence through the use of a patient exercise diary to review progress.</td>
</tr>
<tr>
<td>- Patients to have access to therabands, exercise balls and exercise mats.</td>
</tr>
</tbody>
</table>

The following can be included in the patients care if the treating physiotherapist feels it is appropriate:

- Manual Therapy Hip joint mobilisations e.g. distraction, distraction with flexion, AP glides, Trigger point work. |
- Orthotics Patients can be assessed for biomechanical abnormalities and either have these corrected by the treating physiotherapist. Alternatively patients can be referred to allied health care professionals such as a podiatrist for custom made insoles etc.

- Taping Taping techniques such as taping the thigh into external rotation and abduction to help with postural modification/reminding. |
- Group-based treatments The core programme can be supplemented by but must NOT be substituted with group based treatment. |
- Treatment of additional pathology/symptoms Physiotherapists are free to treat any additional pathology or symptoms that they feel is exacerbating a patient’s FAI. Examples of this might include treating co-existing low back pain. |

- Care provided over at least 12 weeks |
- A minimum of 6 ‘contacts’ with the physiotherapist over 12 weeks |
- Ideally all 6 contacts are face-to-face but at least 3 should be face-to-face, others can be by telephone/email support where that is needed due to geographical distance. |
- Further ‘booster’ follow-ups can be arranged between 12 weeks and 6 months |
- The maximum total number of contacts with physiotherapist is 10 including the optional further booster sessions. |
- Care provided by the same physiotherapist throughout where possible |
- Assessment between treatment sessions will be done by: Subjective assessment, Objective assessment and Exercise adherence |

- Forceful manual techniques Forceful manual techniques in restricted range of movement (Grade V mobilisations, or forceful stretching). No painfull hard end stretches. |
- Student or technical instructor care Care should not be delivered by a student or technical instructor |
- Hydrotherapy Patients should not have hydrotherapy as part of their treatment |
- Acupuncture Patients should not have acupuncture as part of their treatment |
- Electrotherapy Patients should not have electrotherapy as part of their treatment |

---

**Figure 2**  Personalised hip therapy summary. FAI, femoroacetabular impingement.
Key messages

- Femoracetabular impingement syndrome is increasingly recognised as a source of hip pain, especially in young adults.
- A period of non-operative care is recommended, although this is poorly defined.
- A protocol for a physiotherapy-led package of education, exercise and pain relieving techniques for femoracetabular impingement syndrome called Personalised Hip Therapy is described for use in an RCT.
- The package of care is deliverable within the UK National Health Service, is safe, and is acceptable to patients.

Acknowledgements The FASHIoN feasibility trial, which was published in the Health Technology Assessment Journal (Griffin DR, Wall PD, Realepe A, et al. UK FASHIoN: Feasibility study of a randomised controlled trial of arthroscopic surgery for hip impingement compared with best conservative care in Health Technology Assessment 2016;20:324), included the details of the Personal Hip Therapy protocol reported in this study. The authors wish to acknowledge funding for this study from NIHR HTA, support from hospital Trusts, CLRN’s and collaborating surgeons, physiotherapists and research associates, and the work of Ceri Jones, R&D manager at the lead site, University Hospital of Coventry and Warwickshire NHS Trust. Finally, the authors thank the patients who gave so generously of their time in the expert patient panel, and those who agreed to participate in the pilot RCT.

Contributors PDHW, NEF and DRG contributed to the conception, design, analysis and interpretation of the work. EJD, IH, AR, RH and DR contributed to the acquisition, analysis and interpretation of the data. All authors contributed to the drafting of the manuscript and approved the final version.

Funding This work was funded as part of the FASHIoN trial (UK NIHR HTA 10/41/02), for which DRG is the Chief Investigator. NEF, an NIHR Senior Investigator, was supported through an NIHR Research Professorship (NIHR-RP-011-015). The views expressed are those of the authors and not necessarily those of the NHS, NIHR or the Department of Health.

Competing interests None declared.

Patient consent Obtained.

Ethics approval NHS REC 11/WM/0389.

Provenance and peer review Not commissioned; externally peer reviewed.

Open Access This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: http://creativecommons.org/licenses/by/4.0/


