

## SUPPLEMENTARY FILE 10: Panellists' qualitative feedback for research priorities (Delphi Domain 5) for Delphi rounds 1 and 2, and Essential National Health Research (ENHR) ranking exercise

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**Statement and qualitative feedback (including reasons for score boundary changes between Round 1 and Round 2) – Consensus statements in GREEN and non-consensus on YELLOW**

**No RESEARCH PRIORITIES**

48	<p><b>48</b>_Prospective cohort studies to investigate risk factors (aetiological and prognostic) of primary cam morphology in different cohorts</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>• The impact depends on identifying individuals at risk of developing cam morphology, and then having an acceptable intervention to reduce this risk, which is challenging when we wish to promote exercise in youth.</li> <li>• In the long term as most cam morphology does not seem to cause problems - finding out about its aetiology would not be top priority for me - also if its due to athletic loading - how to then deal with this - we don't want to make kids inactive!</li> <li>• For the category APPROPRIATENESS - SHOULD WE DO IT? People might be unaware of the data available. For example, we are now working in Generation R, which is a prospective general population study in children on which we have prospective follow-up imaging data of the hip of around 3000 children at ages 9, 13 and 17 years (the latter is ongoing)</li> <li>• Are the best study design, but have ethical and economic issues</li> <li>• Multicentre studies would really improve knowledge and patient care</li> <li>• Some questions are challenging to be answered. For example Category 3 question 1: infrastructure and supporting systems are different and varying between countries ( for the particular International study). My respond is 'Cannot answer based' on the above comment. My personal view as someone who is privileged to live in a country with great supportive mechanisms and capacity would be excellent 3. I am sorry of I am not able to help with this. Category 4, question 2: Is it the impact on health of the general population or the athletic population? I will base my answer re: the impact the research would have for the athletic population (and overall my answers for category 4). Challenging questions to answer. Thank you</li> <li>• Although I agree hugely with the statement that there is a need for prospective cohort studies, the implications of incidental findings and how imaging outcomes are communicated needs to be developed further</li> <li>• More a general comment. It is clear that well-conducted cohort studies are the first option, but also well-conducted case-control are informative. There are a lot of studies in epidemiology properly done including simulations showing that when appropriately conducted and designed the results are comparable to cohort studies. In the end, a case-control nested in a cohort is a good option especially if the event is rare. It is also true that the bad reputation of case-control derives from the past poor studies and, unfortunately, the majority of the epi studies in sports medicine are poor (methodologically speaking). This is to say that the methodology is important and more important than the design itself. My two cents.</li> </ul>
49	<p><b>49</b>_Prospective cohort studies that investigate how primary cam morphology develops in cohorts with variable loading demands (e.g.; difference sports/dance/physical activity level cohorts; and sedentary cohorts) (causal inference approach to investigate load as a risk factor for primary cam morphology)</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>• Several studies suggested the relation between loading and cam morphology development; but which loading threshold exactly triggers this is unknown. Therefore I changed it to 7 (critical).</li> <li>• The effect of different loading patterns is the salient question, as it may be possible to modify loading in specific athletic populations, but perhaps not in general population cohorts.</li> <li>• Training loads are difficult to accurately capture and future buy-in will be tough. Not sure the field should start here.</li> <li>• This may be challenging given we hope most youth would be involved in multiple sports (avoiding specialization) and/or multiple loading patterns over time. There may be a role for looking at specialization vs not - i.e. would a ice hockey player who plays year round develop cam morphology at higher rate than an age-matched individual participating in several sports?</li> <li>• As per the previous statement re need to develop how findings are communicated. Although I agree that we need to investigate CAM in different cohorts, perhaps a starting point should be something like youth football given its resources and size. It would allow a pooling of attention/research skills and work out from there?</li> </ul>

- My concern with this is in how "load" gets defined in the research. If this is simply step count or impact loading, it may not be as informative as understanding directions of loading.
- It depends on the sports of course, but as an example, there is no way that disciplines such as dance will change something in terms of load to prevent the development of health problems. That's why I indicated fair to moderate in the last question. I balanced the potential impact in relation to the capacity of the sports discipline to implement any recommendations. For some is probably easier than others.

50 **50** Prospective cohort studies that investigate how primary cam morphology develops in different sex/ gender cohorts; specifically women cohorts (causal inference approach to investigate gender as a risk factor for primary cam morphology)

Qualitative feedback

- I do not agree that the concept of Primary and secondary CAM is commonly agreed and established
- The challenge will be suggesting activity modification in general population cohorts when we should be promoting activity for cardiovascular benefits.
- On the one hand we know little about females - but what we do no would suggest lower prevalence - so even larger groups and costs needed to study!
- Straight forward and needs to be done
- It feels like there is an ethical imperative to ensure there is more research in this space around females given the lack of current data.
- As we have no data on the problem, the size and severity of the problem is difficult to quantify.
- Burden of illness seems to be higher in females (>50% of surgeries, and worse outcomes).

51 **51** Prospective cohort studies that investigate how primary cam morphology develops in different parasport cohorts (causal inference approach to investigate load as a risk factor for primary cam morphology)

Qualitative feedback

- non modifiable
- I do not agree that the concept of Primary and secondary CAM is commonly agreed and established
- I do not know the extent of hip-related pain in parasports. This would influence the relevance of further research
- In all my years of treating FAIS very very few Para sporters
- Difficult population to study because infrastructure to support isn't as strong. BUT incredibly important.
- Big challenge is to have a large enough sample size, for sure this has to be an IPC supported activity
- Currently no data for Category 2, so not sure how to respond to that one
- I realize I don't know much about the current research etc in parasport so I ended up answering "cannot answer" a lot.
- Adequate sample size and planning for dropout seem to be challenge to meet this Research Statement.

52 **52** Prospective cohort studies that investigate how primary cam morphology develops in different race/ethnic cohorts (causal inference approach to investigate race/ethnicity as a risk factor for primary cam morphology)

Qualitative feedback

- non modifiable
- I do not agree that the concept of Primary and secondary CAM is commonly agreed and established
- It will be important to have people of diverse races/ethnicities respond to this question
- As race is non-modifiable I would not make this a priority
- I rated this lower simply as I consider the other longitudinal studies of greater importance as a specific Q. Although a sub-group analyses to assess for race/ethnic differences should/could be part of the bigger study.
- Hot topic right now - important one. Will require infrastructure to adequately sample diverse populations
- Comment to category 2 is the same as the previous one.
- "Race" is a difficult construct, especially when treated categorically. I would challenge, what is it that you are categorizing on? And why? Is this about genetic differences (which, well, aren't really about race) or about behavioural differences or socioeconomic differences?

	<ul style="list-style-type: none"> <li>In the US, recruitment for medical studies based on race has challenges based on historical mis-steps.</li> </ul>
53	<p><b>53</b> Prospective cohort studies that investigate other potential risk factors for primary cam morphology (causal inference approach to investigate the following risk factors: anatomical-spine; acetabulum; femur; kinetic and kinematic risk factors; mechanical and biomechanical; other possible risk factors that might emerge over time)</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>unclear how this differs from the first statement --but with more focus</li> <li>I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>Although it is an important question, there is no guarantee that studies will successfully answer this research question.</li> <li>Good to explore other factors - most of the time attention goes to load</li> <li>I think this isn't a current priority but a future one</li> <li>Although I agree with the idea perhaps focussing attention on the big players first before we extend out to "other" risk factors?</li> <li>Examining the mentioned potential risk factor using appropriate methods of causal inference requires a lot of data and some are difficult to collect prospectively on a relatively large scale. Feasibility is in my opinion very low.</li> </ul>
54	<p><b>54</b> Prospective cohort studies that investigate prognosis (consequences) of primary cam morphology in different cohorts</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>Although we may be able to prognosticate, need better evidence for interventions to modify disease trajectory.</li> <li>Really difficult to do these types of studies --but vitally important. Funding always an issue</li> <li>Lower chance of success, in my opinion, due to the time frame necessary (years).</li> </ul>
55	<p><b>55</b> Studies (including diagnostic accuracy studies) to determine the diagnostic criteria for Cam and Pincer morphology</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>The question is unclear to me. If referring to the clinical diagnosis of CAM; I think this potential is limited and research less relevant.</li> <li>Diagnostic criteria are very important. Better quality studies investigating this will improve diagnostic criteria however, like so many other diagnostic criteria, FAIs is a complex 3D dynamic problem and I'm not sure if we can put this all together into a set of very clear diagnostic criteria for FAIs. However, it is certainly worth the effort trying to capture and diagnose at least the 'average' patient with FAIs</li> <li>Considering agreement on cam morphology being a finding and not a diagnosis, I suggest rephrasing diagnostic accuracy - possibly to measurement accuracy and cut-off values or something in that line.</li> <li>Agree a consensus is needed re a gold standard diagnostic tool if possible. But would urge caution here and this research needs to be carefully developed/investigated by focusing not only on imaging outcomes but correlation with clinical outcomes</li> <li>More recently, I've been appreciating the challenge of this "dichotomous" definition of both cam and pincer. Either you have the morphology or you don't, but really, it is about degrees (literally) of risk. So "diagnostic criteria" may focus too much on a dichotomous view.</li> </ul>
56	<p><b>56</b> Studies to develop and validate diagnostic and prognostic models for primary cam morphology in young (maturing) athletes</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>This will be important in the future; but I don't think the field is ready right now. Seems identification of risk factors (e.g. explanatory analyses) is more important right now than risk stratification (e.g. prediction)</li> <li>I averaged the rating. I would not combine prognostic and diagnostic in the same question. For me it is more critical prognostic.</li> <li>I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>Studies in the youth may be a sensitive issue</li> </ul>

- Considering agreement on cam morphology being a finding and not a diagnosis, I suggest rephrasing the statement to "develop and validate measurement methods and prognostic models.."
- Again similar to statements 48-54 when developing prognosis models it is important to discuss communication strategies around such models

57 **57** Prospective cohort studies to investigate how exercise intervention influences the development and prognosis of primary cam morphology in cohorts with variable loading demands

Qualitative feedback

- I do not think we are at this stage yet!
- I do not agree that the concept of Primary and secondary CAM is commonly agreed and established
- This can't be effectively done until prospective cohort studies are complete and interventions are developed
- We must focus more on exercise intervention (and then well described programs (type of exercise; repetitions; load)); particularly in the pre surgery phase. Most important to me first is conservative treatment with exercise for symptomatic patients.
- It may be difficult to determine variable loading demands in different sport disciplines. One may need to consider load outside of the structured sporting environment, e.g. people may do other sports/training participation outside of a structured programme?
- I'm not a fan of using cohort study design to study the effects of interventions.
- I am not sure about this statement after reading it again - in my opinion, exercise "interventions" is ill-defined. For me exercise interventions are interventions for existing conditions, are we really looking at load management strategies to mitigate risk as opposed to exercise interventions? Or are we talking about exercise interventions (strength, flexibility etc?) to mitigate risk? Sorry for being pedantic

58 **58** Randomised controlled clinical trials to investigate how exercise intervention (load management) influences the development and prognosis of primary cam morphology in different demographic (e.g. sex/ gender; race/ ethnicity) and load (variable loading demands - e.g. different sports; dance; and physical activity level) cohorts

Qualitative feedback

- I am unsure how randomised controlled clinical trials would differ from prospective cohort studies. In any case; this item seems worthy of further research; however that is done.
- Feasibility for an appropriate RCT seems to me low.
- Well defined exercise intervention in asymptomatic and symptomatic patients.
- I would take an RCT over a cohort study.
- The demographic differences may be a sensitive issue.
- Would be massive study required with huge costs to crack this nut - and at the end of the day - very hard to get people to change behaviour regarding sports activities
- Current knowledge doesn't lend itself to RCTs
- So, I clicked back to see if I had missed something in the previous statement, here exercise intervention is defined as load management, in the previous it isn't. Are they meant to be the same? Agree with the need for load management interventions - but I would define them as thus instead of exercise interventions?

59 **59** Studies to investigate the potential benefits and harms of screening for primary cam morphology in young athletes

Qualitative feedback

- I do not agree that the concept of Primary and secondary CAM is commonly agreed and established
- This isn't as important as some of the other research priorities but I value the desire to study benefit/harm trade-offs
- I think screening is not useful
- Very few people are now screened - those that are come from elite sports backgrounds - and those setting are unlikely to change practice - low priority one for me
- Absolutely agree, this is something that should be taken very seriously and involve all stakeholders
- I cannot really answer because this basically depends on the previously mentioned potential studies

60	<p><b>60</b>_Studies involving economic evaluation to determine the cost-effectiveness of different diagnostic; prognostic; and therapeutic approaches to primary cam morphology</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Maybe once we've established more information; then we can worry about optimising costs of associated treatments; etc.</li> <li>• I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>• I think more of the mechanistic studies will be most helpful to initially move this field forward; though important down the road</li> </ul>
61	<p><b>61</b>_Qualitative / Mixed-methods studies to investigate the perspectives/preferences/attitudes/concerns/experiences of primary cam morphology stakeholders (e.g. but not limited to: athletes/parents/coaches/patients with hip disease/clinicians/researchers)</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>• I think understanding the science behind primary cam morphology has greatest potential for impact; but value stakeholder experiences</li> </ul>
62	<p><b>62</b>_Prospective cohort studies that investigate how pincer morphology develops in different cohorts</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• We can't do RCTs so this is a good method</li> </ul>
63	<p><b>63</b>_Prospective cohort studies that investigate pincer morphology prognosis in different cohorts</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• More important than how: whether it actually matters - i.e. prognosis</li> </ul>
64	<p><b>64</b>_Prospective cohort studies to investigate risk factors for the development and prognosis of femoroacetabular impingement (FAI) syndrome in different cohorts</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• I've scored this higher as it includes CAM; and my understanding is that this is more likely to lead to symptomatic concerns; but I feel the more specific questions asked earlier on are more critical</li> <li>• Development and prognosis is different (or at least not clear here).</li> <li>• Capacity of the system mainly relates to financial implications. Will funding agencies/governments see this as a priority for funding?</li> <li>• The impact on stakeholders and their involvement is a crucial tenant in this statement</li> </ul>
65	<p><b>65</b>_Randomised controlled clinical trials to investigate how exercise intervention influences the development and prognosis of femoroacetabular impingement syndrome in cohorts with variable loading demands</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• One first need to determine the extent of the problem before moving on to RCTs</li> <li>• I have never had surgery so may be a bit biased towards non-surgical treatments</li> <li>• Huge studies and thus huge costs - would be great - but again the crux may then be getting people to modify behaviour or do something preventive - low chance of this impacting real life</li> <li>• I don't think I understand the statement correctly. Development of FAI - prior to FAI. Prognosis of FAI - after FAI i.e. treatment. I would answer differently to these, therefore answers to these combined is difficult.</li> <li>• Agree with the need for studies on this, again as outlined in an earlier statement perhaps pooling of resources/skills to start with one sport/cohort and do this well before extending outwards</li> </ul>
66	<p><b>66</b>_Randomised controlled clinical trials to investigate best practice physiotherapy vs arthroscopic hip surgery vs sham surgery in cohorts with variable loading demands diagnosed with femoroacetabular impingement syndrome</p>



	<p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Or what happens if we leave it - i.e. true control/no treatment</li> <li>• We already have 3 trials</li> <li>• Before one need to establish what best practice physiotherapy is</li> <li>• One first need to determine the extent of the problem before moving on to RCTs</li> <li>• The expertise is there but funding will be a challenge given comparison with other research priorities in this population</li> <li>• THE CHANCE OF SUCCESS - CAN WE DO IT? The more studies on this topic are being done and published, the more difficult it becomes to get funding (and these RCTs are generally costly).</li> </ul>
67	<p><b>67</b>_Prospective cohort studies to investigate the prognosis after best practice physiotherapy and/or arthroscopic hip surgery in different sport/dance/physical activity level cohorts with femoroacetabular impingement syndrome</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Researching best practices is somewhat important.</li> <li>• Are we ready for this? Do we know best practice yet such that we can test it in different cohorts?</li> <li>• Better with RCT</li> <li>• I feel this is already covered under an earlier statement on variable loads.</li> <li>• I doubt the concept/idea is controversial but the methods used to capture outcomes has been to date. Need for consensus here on appropriate outcome measures, time points for capture etc</li> </ul>
68	<p><b>68</b>_Randomised controlled clinical trials to investigate what best practice physiotherapy is (e.g. in different populations and settings; pre- and post-surgery)</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Strongly agree w this. My experience of physiotherapy as an elite athlete was v mixed - some good; some poor</li> <li>• RCTs are gold standard but not sure the field is ready for them</li> <li>• This would be my number 1 priority</li> <li>• Taking my bias out of the equation for a minute, if we are going to insist in sham surgery trials should we perhaps do so for best practice PT too? E.g. Best practice vs sham (advice? generic stretching?)</li> </ul>
69	<p><b>69</b>_Studies to determine the best criteria for rehabilitation progression and Return To Sport (RTS) following management of hip-related pain</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• As an elite athlete worries about RTS (which was my living) caused major anxiety for me so this is important.</li> <li>• It is difficult to answer. It is a quite generic statement</li> <li>• Important but other issues may be more important</li> </ul>
70	<p><b>70</b>_Studies to investigate; report and improve the psychometric properties of tests of (1) range of motion; (2) muscle strength (3) functional performance (4) Quality of Life (QOL) and other psychological outcomes for studies on aetiology; diagnosis; treatment and prognosis</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Methodological work is underpinning of strong science</li> <li>• This question is unclear to me</li> <li>• These are patient outcomes that I deem important to study but clinicians may feel more strongly about some of the other research topics</li> </ul>
71	<p><b>71</b>_Studies to investigate the relationship among movement-related parameters (biomechanics; muscle function), symptoms, function, quality of life, and imaging and intra-articular hip findings in individuals with hip-related pain</p>

	<p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• These could be valuable in that primary cam morphology is most likely multifactorial</li> </ul>
72	<p><b>72_</b> Studies (randomised controlled clinical trials; cohort studies; cross sectional studies; qualitative studies) to investigate the clinical effectiveness of other treatments used in people with hip-related pain (hip joint intra-articular injections; analgesic and anti-inflammatory medications; manual therapy adjunctive techniques such as taping; bracing and orthotics)</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Agree - I always saw surgery as a last resort</li> <li>• Happy that this is needed - prefer to leave level of priority to the ENHR process</li> </ul>
73	<p><b>73_</b> Studies to investigate cost-effectiveness of different diagnostic, prognostic, and therapeutic approaches to femoroacetabular impingement syndrome and primary cam morphology</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• I think understanding cost-effectiveness is an important aspect to assessing diagnostic; therapeutic interventions</li> <li>• Cost-effectiveness is less important to me at this stage; but I value its importance to clinicians</li> </ul>
74	<p><b>74_</b> Qualitative studies to investigate the perspectives/ preferences/ attitudes/ concerns/ experiences of femoroacetabular impingement syndrome (including FAI syndrome and primary cam morphology) stakeholders (e.g. but not limited to: athletes/ parents/ coaches/ patients with hip disease/ clinicians/ researchers)</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• In principle I am in favour of including these kinds of stakeholders. But in reality some have whacky views (like anti-vaxxers) which may not helpfully inform clinical progress.</li> <li>• I do not agree that the concept of Primary and secondary CAM is commonly agreed and established</li> <li>• Again; this type of research is important but don't think it is where we should focus research priorities currently. Moved up to indicate importance</li> </ul>
75	<p><b>75_</b> Education intervention studies (pilot studies; RCT) in individuals with hip-related pain to assess the specific effect of patient education (in addition to other interventions; e.g. exercise intervention) on pre-defined patient-related outcomes. For education intervention consider content, modes of delivery and the use of innovative technologies to enhance education benefits.</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Strongly in favour of patient education. As an elite athlete receiving treatment I always felt insufficiently educated about injuries I was having to recover from and scientific jargon from specialists can be bewildering.</li> <li>• Happy that this is needed - prefer to leave level of priority to the ENHR process</li> <li>• Input from clinical or research opinion</li> <li>• Same as above - patient education is important but are we ready to provide them with evidence based guidance? Other research questions more important. Moved closer to center to align with importance of topic</li> <li>• Minor adjustment</li> <li>• Not my cup of tea but since the webinar patients perspective is important and also to teach</li> </ul>
76	<p><b>76_</b> Studies to investigate the performance of the diagnostic criteria for hip disease presenting with hip-related pain in young and active adults</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• This seems like it should be a major priority to ensure accurate and appropriate diagnosis</li> </ul>
77	<p><b>77_</b> Core outcome set (COS) development studies for each of the conditions related to hip disease/hip-related pain in young and active adults</p>

	Qualitative feedback There were no qualitative feedback
78	<p><b>78</b>_ Research studies into the utility of HAGOS and iHOT instruments in a non-surgical treatment context</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• I am not sure if I understand this question properly. The HAGOS questionnaire has adequate measurement qualities for active patients with long-standing hip and/or groin pain. We have used both questioners for non-surgical and surgical pts</li> <li>• Not confident that I fully understood the question</li> </ul>
79	<p><b>79</b>_ Studies to analyse of content and structural validity, and the relationship between individual measurement error and the minimal clinically important change for the recommended PROMs.</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Need to validate the PROMs first</li> <li>• This is linked to need for education for patients above - if patients are better educated; they may produce better self-reporting.</li> <li>• Happy that this is needed - prefer to leave level of priority to the ENHR process</li> <li>• Influenced by scores from other respondents</li> <li>• Having followed webinar; I think that it is important.</li> <li>• I am not sure; the MIC is that important. I am more into PASS</li> <li>• Important perspective of other colleagues to more clearly delineate</li> </ul>
80	<p><b>80</b>_ Studies to investigate the impact of the diagnostic components of a specific hip condition on diagnostic or prognostic thinking (e.g. stratifying patients into high and low risk) in young and active adults</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Stratifying patients in this way has some methodological challenges</li> <li>• I think the diagnostic and prognostic thinking needs further improvement prior to this</li> <li>• Influenced by scores from other respondents</li> <li>• I was worried that the stratification process can falsely label patients as potential non-responders until we have clear prognostic indicators I would prefer to avoid stratification research.</li> </ul>
81	<p><b>81</b>_ Studies to develop and validate diagnostic and prognostic models for the different hip diseases presenting with hip-related pain in young persons</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Important in the future- not yet</li> <li>• influenced by scores from other respondents</li> <li>• Having followed webinar; I think that it is important.</li> <li>• Other issues more important.</li> </ul>
82	<p><b>82</b>_ Studies to investigate the additional benefit of advanced imaging (e.g. magnetic resonance imaging and/ or computed tomography scan) for diagnosis of hip disease presenting with hip-related pain in young and active adults</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"> <li>• Still less relevant than diagnostic/prognostic studies but economics hard to avoid</li> <li>• Influenced by scores from other respondents</li> <li>• Having followed webinar; I think that it is important.</li> </ul>

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83	<p><b>83</b>_Studies to investigate the additional benefit of advanced imaging (e.g. magnetic resonance imaging and/ or computed tomography scan) for agreeing on an appropriate treatment strategy for hip disease presenting with hip-related pain in young and active adults</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"><li>• We need to better select treatment options for patients and imaging may assist this process</li><li>• Influenced by scores from other respondents</li><li>• Having followed webinar; I think that it is important.</li><li>• Minor adjustment</li><li>• I do not think we should put as much effort in imaging as an important factor for prognosis.</li><li>• Global view and reading more in the literature</li><li>• New literature</li></ul>
84	<p><b>84</b>_Studies to investigate the additional benefit of advanced imaging (e.g.; magnetic resonance imaging and/or computed tomography scan) for prognosis of hip disease presenting with hip-related pain in young and active adults</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"><li>• Having followed webinar; I think that it is important.</li><li>• Reconsidered</li><li>• Influenced by scores from other respondents</li><li>• Minor adjustment</li><li>• Global view and reading more in the literature</li></ul>
85	<p><b>85</b>_Studies to investigate cost-effectiveness of different diagnostic and therapeutic approaches in conditions affecting the young person's hip</p> <p>Qualitative feedback</p> <ul style="list-style-type: none"><li>• In one way I think cost should not come into this but in practice if it means eg an institution can/cannot afford imaging equipment that will have a huge impact on its ability to diagnose and treat patients.</li><li>• I think this statement is too vague</li><li>• Second webinar information</li></ul>

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