Medical or Research Professionals / Clinicans

Topic area: Clinical topics by disease
Topic: 28. Back pain, mechanical musculoskeletal problems, local soft tissue disorders

EULAR12-1816
A CASE OF FROZEN HIP - A DIAGNOSIS WE SHOULD CONSIDER MORE OFTEN?
E. Ntatsaki [1,*], T. T. Aye [1], M. Sykes [1], I. Riaz [1], K. Dhatariya [2], P. Merry [1]
[1]Rheumatology, [2]Elsie Bertram Diabetes Centre, NNUH, Norwich, United Kingdom

My abstract has been or will be presented at a scientific meeting during a 12 months period prior to EULAR 2012: No
Is the First Author of this abstract an Undergraduate or a Student?: No
Background: Adhesive Capsulitis of the hip or "frozen hip" is not a diagnosis well documented in rheumatological textbooks or literature. There are only a few isolated case reports of adhesive capsulitis affecting joints other than the shoulder, predominantly published in orthopaedic literature.[1-3]
Objectives: To increase awareness of what is probably an under diagnosed condition within the rheumatology discipline and the diabetic population.
Methods: A 42-year-old woman with an 18 year history of poorly controlled, type 1 diabetes mellitus was seen in the rheumatology clinic with a 9 month history of bilateral hip pain and restriction of movement. Her HbA1c had been consistently greater than 119 mmol/mol (13%) for more than 6 years prior to presentation. She had already received 3 steroid injections for presumed trochanteric bursitis. Initial X-rays and MRI scan of her hips showed no abnormality. On presentation she was unable to weight bear on the left hip. On examination her left hip was extremely irritable, with severe capsular restriction of movement. Spinal movement was normal with no nerve root signs.
Results: Blood tests showed an HbA1c of 143 mmol/mol (15.2 %), ESR 36mm/hr, CRP 5mg/L, normal thyroid function, creatine kinase, biochemical and haematological parameters. She was negative for HLA-B27, rheumatoid factor and antinuclear antibodies. Repeat MRI scan of the left hip, lumbar spine and sacroiliac joints looking for underlying psoas muscle pathology or referred spinal pain showed only mild degenerative changes at the L4/5 disc, considered irrelevant. Initial diagnostic fluroscopic guided injection into the left hip with 10mls of 0.5% bupivacaine followed by a further fluoroscopic guided injection 1 month later with 120mg of depomedrone mixed with 10mls of 0.5% bupivacaine resulted in a transient improvement in pain, but not mobility, for 3 weeks. Her symptoms recurred within a few weeks. She continued her treatment with physiotherapy, anti-inflammatory and analgesic medication.
After 18 months she developed a similar pattern of symptoms affecting the right hip. Repeat MRI of the both hips showed only some non-specific oedema in the right tensor fascia lata. She was subsequently diagnosed with bilateral frozen hips. Due to failure of treatment she was referred to the orthopaedic department for manipulation and arthroscopic pressure dilatation under GA.
Conclusions: Adhesive capsulitis is a relatively common condition affecting the shoulder.[4] It is rare and poorly recognised in the hip. There is a common association between adhesive capsulitis of the shoulder and diabetes, with a prevalence of 10.3% in type 1 and 22.4% in type 2 diabetes.[5] Frozen hip shares similar clinical characteristics and associations with the shoulder presentation and it may respond to similar therapeutic interventions. However, as with the shoulder, treatment can be unrewarding. There is a paucity of literature on frozen hip. This case alerts rheumatologists to the possible diagnosis in what is a rare, but nevertheless, a probably poorly recognised condition.
References: 1.MD Chard, JR Jenner. BMJ 1988;297:596-597
2.M Lequesne et al. Skeletal Radiol.1981;6(1):1-10
3.J Byrd,K Jones. Arthroscopy.2006 Jan;22(1):89-94
4. D Lebiedz-Odrobina,J Kay. Rheum Dis Clin North Am.2010 Nov;36(4):681-99
5.PE Arkkila et al. Ann Rheum Dis.1996 Dec;55(12):907-14

Disclosure of Interest: None Declared