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Reviews

Snapping Hip Syndrome: A Comprehensive Update

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Purpose of review

This is a comprehensive literature review regarding the pathogenesis, diagnosis, and treatment of snapping hip syndrome (SHS). It covers the diverse etiology of the syndrome and management steps from conservative to more advanced surgical techniques.

Recent Findings

Recent advances in imaging modalities may help in diagnosing and treating SHS. Additionally, arthroscopic procedures can prove beneficial in treating recalcitrant cases of SHS and have recently gained popularity due to their non-invasive nature.

Summary

SHS presents as an audible snap due to anatomical structures in the medial thigh compartment and hip. While often asymptomatic, in some instances, the snap is associated with pain. Its etiology can be broadly classified between external SHS and internal SHS, which involve different structures but share similar management strategies. The etiology can be differentiated by imaging and physical exam maneuvers. Treatment is recommended for symptomatic SHS and begins conservatively with physical therapy, rest, and anti-inflammatory medications. Most cases resolve after 6-12 months of conservative management. However, arthroscopic procedures or open surgical management may be indicated for those with persistent pain and symptoms. Different surgical approaches are recommended when treating internal SHS vs. external SHS. Due to advancements in treatment options, symptomatic SHS commonly becomes asymptomatic following intervention.

INTRODUCTION

Snapping hip syndrome (SHS), alternatively known as "coxa saltans," is a condition characterized by an audible or palpable snap of the hip joint.[1] The phenomenon can be bilateral or unilateral, painful or painless, idiopathic, or post-traumatic. SHS is due to "snapping" of the iliopsoas tendon or the iliotibial band. The iliopsoas variant, referred to as the internal type, can be reproduced by extending and internally rotating a flexed, abducted, and externally rotated hip.[2] The iliotibial variant, which is the external type, is due to the iliotibial band sliding over the greater trochanter, posteriorly to anteriorly, when the hip is moved from extension to flexion.[2] These two pathologies (internal and external) are mutually described as "extra-articular." Snapping hip can also occur due to intra-articular pathologies (loose body, torn labrum, fracture), which are generally more harmful than extra-articular.[3] Intra- and extra-articular pathologies can co-exist, particularly with the iliopsoas variant of SHS.[1] Most treatment regimens begin with conservative options, involving NSAIDs, physical therapy, activity modification, and ice therapy. If symptoms persist, corticosteroid injections or surgery may be indicated.[3] The purpose of this review is to provide a comprehensive update

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THE Article

- a comprehensive update of the literature around the epidemiology, risk factors, diagnosis, and management of Snapping Hip Syndrome (SHS)
- published in 2021 by Orthopedic Reviews

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THE Takeaways

- author divides SHS into
  - Intra-articular (IA)
  - Extra-articular
    - Internal (EAI) (audible)
    - External (EAE) (palpable)
- IA caused by muscle tears/damage, loose bodies (particles inside the joint) and is very acute, trauma related, and debilitating

THE Takeaways

- EAI snapping caused by iliopsoas tendon rubbing over femoral head or lesser trochanter

- EAE snapping caused by ITB or tendon of glute max rubbing over greater trochanter

THE Takeaways

- EAI pathophysiology is multifactorial linked to frequent hip rotation, and enlarged iliopsoas muscle
- EAI diagnosis is pain with:
  - Side lying hip Flexion + Adduction + External Rotation into Active Flexion then Passive Extension & Abduction
  - Side lying Hip Abduction with knee at 90 degrees
  - Standing Hip Adduction + Circumduction
- Imaging (MRI, Xray, or even dynamic ultrasound) also used to diagnose

THE Takeaways

- EAE pathophysiology is multi factorial linked to frequent jogging on a sloped surface, and enlarged glute max, or TFL
- EAE diagnosis is pain with:
    - Supine hip flexion w/ knee bent
    - Supine resisted hip flexion at 30 degrees
    - Hip Flexion + External Rotation + Abduction into Extension + Internal Rotation + Adduction
- MRI (looking for enlarged glute max/ITB) also used to diagnose

THE Takeaways

- Treatment:
  - rest, stretching, exercise therapy, (reducing inflammation)
  - deep massage, myofascial release, cross training (specifically core stability and pelvic stability training)
  - reducing activities that induce the painful snapping
- If no relief with the above, consider surgical intervention
- Corticosteroid injection serves for symptomatic relief and to confirm diagnosis

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