

You don't need a hip replacement

Total hip replacement is among the fastest growing surgeries in the West, but Dr Mitchell Yass finds most of them aren't necessary. Here's how to resolve your pain, even if you've already had the operation.

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Total hip replacements, known as total hip arthroplasty (THA) by doctors, are one of the most commonly performed elective surgical procedures in the United States. You can't walk down a street without seeing a person waddling along who has had a hip replacement but is saddened and disillusioned with the way it turned out.

In my experience, these are the lucky ones. I've met many hip replacement patients who have ended up requiring a cane, a walker or even being wheelchair bound after having a procedure that promised they'd be dancing in weeks. And saddest of all, the vast majority never needed surgery in the first place.

In 2000, the number of hip replacements performed in the US was 138,700. By 2010, that number had shot up to 310,800, rising sharply in all age groups over 50: by 85 percent for those aged 55-

64, by 62 percent for those aged 65-74, and by 68 percent for those 75 and over.¹

Not only has the number of total hip replacements jumped by 250 percent in just 10 years, but the rate of revision THAs (replacement of the hip replacement with a new prosthetic) performed after the original surgery has also steadily increased to almost 40,000 per year—representing about one in seven first-time surgeries, according to the US Nationwide Inpatient Sample database.²

Doctors claim that the meteoric increase in revisions is due to the increase in hip replacements overall, particularly among younger patients, and the fact that the prosthetic hips eventually wear out. However, over my 25-year career, the vast majority of people with hip replacements I've treated for pain required a single or multiple number of revisions within the first few months of their original surgery. The artificial hip didn't wear out. It was the fact that the patients continued to experience pain after surgery that led the surgeon to conclude it must have something to do with a defect in the original procedure, when the problem was actually pain from a completely different source.

A study by researchers at the University of Pennsylvania presented at the 2018 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS) estimated that by 2030, the number of primary hip replacements carried out in the US alone is projected to grow by 171 percent, with a projected 635,000 surgeries per year. Similar gains are expected for revision hip replacement, growing by 142 percent (72,000 procedures). By 2060, the researchers estimate the number of hip replacements will reach 1.23 million (a 330 percent increase), and revisions 110,000 (a 219 percent increase).³

An article of faith

These figures suggest that over the next 40 years there is going to be a cataclysmic increase in the number of people suffering with joint pain and needing surgery, largely because it has become the only solution to hip pain.

However, what's vital to understand is that the determination of whether you need a joint replacement is simply an article of faith. If you have pain somewhere in the region, an x-ray or MRI scan is taken. If some form of joint space reduction has occurred, the surgeon suggests that this is the cause of your pain and that surgery is required.

The surgeon will put the images up on a screen and point to a decreased joint space between the thigh bone and the socket in the pelvis, which form the hip joint. Based on this image, they will say that your hip has no joint space, is now bone-on-bone, and you have no choice but to get a hip replacement.

However, remember that this image is being viewed with the naked eye, which cannot possibly differentiate between a hundredth, a tenth or a quarter of an inch of joint space—any of which is enough to move the joint.

Getting a joint replacement based simply on the interpretation of an x-ray should be abolished as a legitimate medical practice. Similar variations in the hip joint can be found in people who have absolutely no hip pain.

In a 2015 study led by researchers at Boston University School of Medicine, in a cohort of nearly 1,000 patients, only 16 percent of those with hip pain had x-ray-confirmed osteoarthritis, and

conversely only 21 percent of hips with evidence of arthritis on x-ray were painful. Results from a second cohort of over 4,000 were consistent: only 9 percent of patients with hip pain had arthritis, and just 24 percent of patients with hip arthritis had pain.⁴

As researchers from Manchester University in the UK concluded when reporting similar findings, evidence of mild to moderate structural changes found on x-rays "is very frequent and not related to pain, whereas severe change is rare but strongly related."⁵

As for MRI scans, according to one study of people with no hip pain or symptoms, MRI images nevertheless revealed abnormalities in 73 percent of hips, with torn cartilage (labral tear) seen in 69 percent.⁶

MRI scans reveal structural variations at the hip at roughly the same rate whether people are experiencing pain or not. The obvious question, then, is which came first? Since most structural variations are degenerative in nature, it's very likely that they were present before the pain began. And if structural variations or degeneration are found in almost three-quarters of people who have no pain in the hip region, how can anybody attribute pain to them?

In my 25 years of diagnosing and treating pain, I have found that in more than 99 percent of cases, the person's pain could not be caused by structural variations identified on a scan, because their pain was not localized to the hip joint at all but rather coming from a surrounding muscle.

The bottom line: osteoarthritic findings should not be associated with pain in the region unless the level of arthritic change has compromised the hip joint's full range of motion. Any attempt to identify the cause of pain in the hip region is incomplete without interpreting the symptoms being experienced.

I have prevented thousands of people from getting hip replacements based purely on diagnostic testing. I've also treated thousands who had the surgery and continued to experience the same pain afterward. In both situations, I've found that the tissue in distress was muscle, and by treating the muscles, ultimately these individuals could resolve their symptoms and return to full functional capacity.

How to determine if you have bone-on-bone

Let's start with the first possible cause promoted by the orthopedist, that the joint is 'bone-on-bone,' requiring a hip replacement.

A joint is comprised of two bones separated by a space filled with cartilage—labrum in the case of the hip. This joint space is maintained so that the bones can glide over one another, a necessary mechanical property to enable the joint to move through its full range of motion.

If the joint cushioning is completely worn away and there is no space between the bones of the joint, then the joint surfaces can't glide, and a major restriction of motion occurs, whether the person tries to move the joint themselves or someone else does. When the joint cannot move any further, this restriction would feel as though one bone is hitting another—so-called bone-on-bone contact.

Only that major loss of range of motion, rather than pain, justifies this diagnosis.

In all my years of diagnosing and treating thousands of patients told that a lack of cartilage at the hip joints was the cause of their pain, only two or three actually were truly bone-on-bone at the hip. I am

continuously stunned by the areas people complain are painful on their bodies that are attributed by their doctors to their hip joints.

In almost every case I have ever treated diagnosed with a worn-out hip joint, the individual did not know where his or her hip joint even was. Many people believe that the hip joint is located at the top of the pelvis, which is actually the pelvic rim.

Others place their hands on the side of their pelvis because that's where they are experiencing their pain. In fact, the hip joint is about four to five inches below the pelvic rim (see illustration). To find your hip joint, start with your hand on the pelvic rim and run it down the side of the pelvis about one hand's length, until you feel a protuberance sticking out. That's actually the top or head of the femur (thigh bone) as it enters the hip joint.

If your pain isn't exactly at this location, a structural variation in the hip joint (such as arthritis) isn't causing your pain. Oftentimes, specialists claim that pain being experienced elsewhere is 'referred pain' from the joint, as with people who complain of pain in the groin region.

But in order to confirm or rule this out, just simply lay on the opposite side of your body and then have somebody try to push the head of your thigh bone into the hip joint. If this causes the pain you usually experience in the groin, then it's a true indicator that the groin pain is indeed being referred from the hip joint.

The overwhelming likelihood is that this test doesn't cause any pain in the groin. But now, press on the groin region where the pain is actually being experienced. If this action ignites the pain or makes it worse, you just proved that the pain is not referred from the hip joint but is elicited from a tissue in the groin itself, most likely a muscle

called the sartorius.

If your pain is above the hip joint in the pelvic region, there's a high probability it is coming from a strained gluteus medius. This muscle is responsible for keeping the pelvis level and providing balance and stability, especially when standing on a single leg such as when walking or climbing stairs. If strained, it will elicit pain just above the hip joint on the side of the pelvis.

If you have pain in the gluteal (buttocks) region, then it's most likely coming from a strained muscle called the piriformis. This muscle runs diagonally from the sacral spine across the gluteal region to the hip joint, and it will become strained and elicit pain if the gluteus medius strains first, and the piriformis tries—and eventually fails—to assist in providing balance and stability.

Pain all along the side of the thigh and possibly to the knee is often the result of a strained muscle on the outer thigh called the tensor fascia lata, which attaches to the iliotibial band (ITB), a tendon running from the hip to the knee. This muscle is also called in to assist when the gluteus medius fails, leading to straining. So in all these situations—a piriformis, tensor fascia lata or ITB eliciting pain—the ultimate culprit is a strained gluteus medius.

The primary reason for this is because all the muscles required to perform a task must have an equal or greater force output than the force requirement of the activity. If any muscle doesn't, it will strain and lead to pain—and the piriformis and tensor fascia lata can't make up for lost force from the gluteus medius.

If your pain isn't from arthritis or another structural variation at the hip, how can you confirm that one or more of these muscle groups is causing your pain? Since muscles are responsible for both

function and posture, there should be some variation in one or both when a muscle strains. Therefore, examining altered posture and movement patterns is an essential part of identifying the tissue in distress.

Test 1: Your balance

The gluteus medius attaches from the side of the pelvis to the hip joint. When you stand or squat on one leg, the body tends to lean toward the side of the leg that was just raised. The gluteus medius, sitting on the outside of the pelvis of the leg you're standing on, will try to create a counterbalancing force.

When the force output of the muscle is equal to or greater than the force of the body leaning inward, you remain balanced. You should also remain stable with the knee remaining over the foot.

But if the gluteus medius is weak, you will fall to the side of the leg that was lifted, and your knee may move inward during an attempt to do a single-leg squat. These are both telltale signs of a strained gluteus medius.

So if pain exists in the hip region and the cause is thought to be associated with a strained gluteus medius, you can easily confirm it by an inability to do a single-leg stand or squat.

Test 2: How well do you walk?

If a strained gluteus medius is the cause of pain in the hip region, this will affect your ability to walk. If one gluteus medius is strained, there's a tendency for the person to lean to the opposite side of the strain when walking.

The body compensates for this irregularity with a 'waddle': when

standing on the leg with the weakened gluteus medius, you actually lean to the same side, so your body weight moves from the opposite of the leg, where it should be, to the same side.

As a result, the person no longer requires the gluteus medius to support their body weight when standing on the leg with the strained muscle. This type of walking is also very common in people who have received hip replacements, because the procedure actually led to a further weakening of the gluteus medius muscle, which was the likely cause of their pain and dysfunction in the first place.

Test 3: Your posture

If the gluteus medius strains, it's difficult to lift the foot on the opposite side to the strained muscle off the floor because the pelvis on the opposite side drops, decreasing the space between the hip and the floor. This leads to the opposite-side foot catching the floor when being swung through the motion of walking.

To avoid this tripping hazard, the quadratus lumborum, a muscle that attaches from the rib cage to the top of the pelvis, tries to assist by pulling up the pelvis from the rib cage. Because this muscle was not designed to accept this load, it strains and tends to shorten. This causes a postural variation—typically, elevation of the hip on the opposite side from the gluteus medius strain.

Put both hands on either side of the pelvic rim. If the hand on the opposite side from the suspected strain is higher, this confirms that the distressed tissues eliciting your symptoms are muscular, likely caused by a weakened gluteus medius.

Test 4: Feel where the pain is

Another important way to determine the cause of your pain is through 'palpation'—feeling with the intent of identifying a tissue. All you need to do is push on different areas around your hip and groin to identify exactly where the pain is coming from.

In the illustration below depicting the back of the hip joint, the socket of the pelvis and associated muscles surrounding it, you can see how the muscles are connecting to the head of the thigh bone (femur). To feel if the pain you are experiencing is coming from the joint, lie on the opposite side so the painful side is facing up. Then have a practitioner, partner or friend feel for the head of the thigh bone protruding on the side of the upper thigh.

Ask them to press down on the head of the thigh bone into the socket with a good amount of force. If pain is experienced, that's a positive sign that your pain is coming from the hip joint, and the cause is some structural variation within the joint. If your pain isn't at the joint but runs laterally down the upper thigh or even to the side of the knee, this is likely a strained tensor fascia lata and ITB band.

To test if the pain has to do with the gluteus medius muscle, press from the head of the thigh bone upward on the side of the pelvis until you reach the top of the pelvis or pelvic rim. If you feel pain here, that's a positive indication that the hip region pain is actually the result of a strained gluteus medius muscle. If your pain is slightly behind this region and more in the gluteal region, then the likely cause is a strained piriformis muscle, which attaches from the sacral spine (the lowest spine region) and runs diagonally across the gluteal region to the hip joint.

Above the hip joint, you are pressing on the gluteus medius; slightly posterior to the hip joint or into the gluteal region, you are pressing

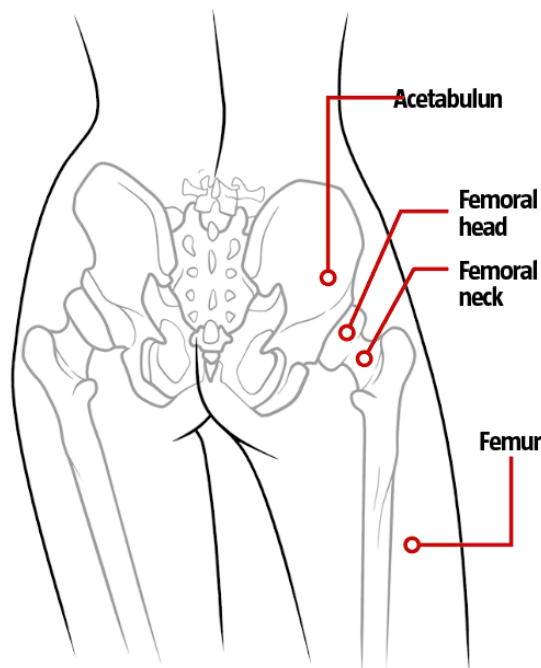
on the piriformis. Along the side of the thigh below the hip joint, you are pressing on the ITB and tensor fascia lata.

Test 5: Range of motion

Unless you find a major loss of motion, feeling like the range can't go any further due to one bone hitting another bone (remember pain is not a factor here), you can dismiss the idea that the cause of the pain is structural, even if your orthopedic specialist says this is what your diagnostic scans show.

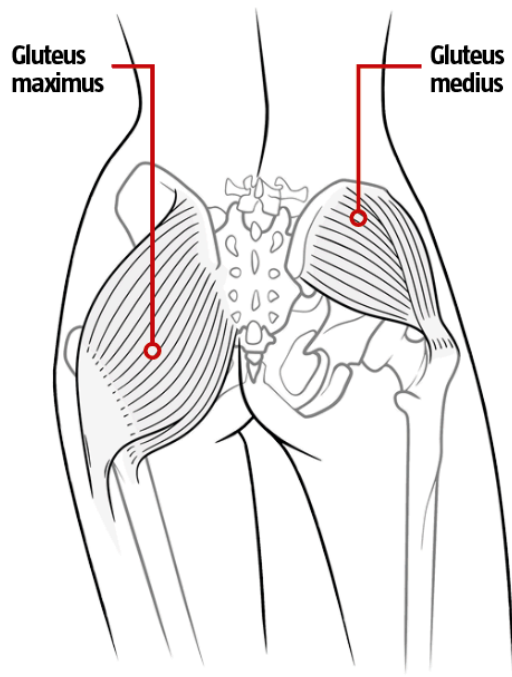
Bones of the hip joint

The hip joint is several inches below the pelvic rim. Most pain attributed to the joint itself derives from nearby muscles.



Muscles of the hip region

The gluteus medius muscle, a common source of hip pain, joins the top of the femur (thigh bone) to the outer surface of the pelvis.

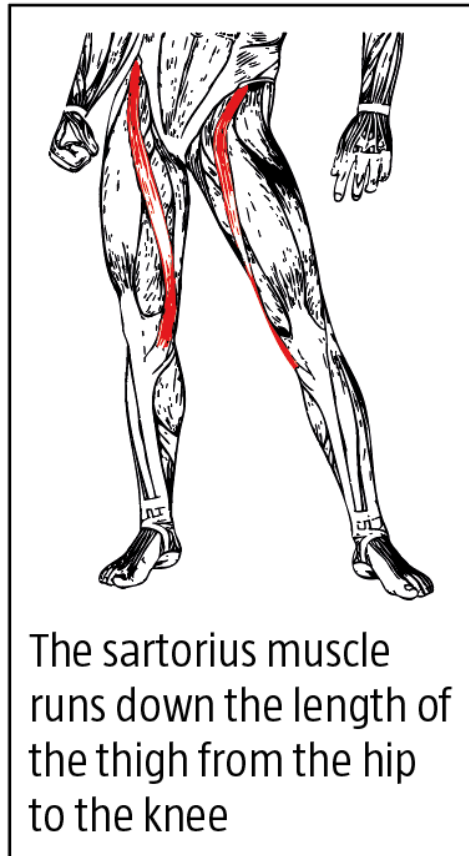


Resolving your pain

If the pain is coming from a strained gluteus medius or piriformis, the exercises to perform are **hip abduction**, **hamstring curl** and **hip extension**. If the pain is coming from the ITB, the exercises to perform are **hip abduction**, **knee extension** and **hip extension**.

One more possible area of pain that might be attributed to the hip joint is pain in the groin, which is typically the result of a strained sartorius muscle (see below).

If you press on the sartorius and confirm that is the tissue eliciting the pain, then perform **hip abduction and extension**, **knee extension** and **sartorius lengthening**.



Hip abduction (gluteus medius)

This exercise can be performed either lying on your side or standing.

Make sure you do not go too far when moving your leg outward.

It's generally believed that the more range of motion you use, the better, but in this case, too much range of motion means you are using the lower back muscle to create the motion, not the gluteus medius.

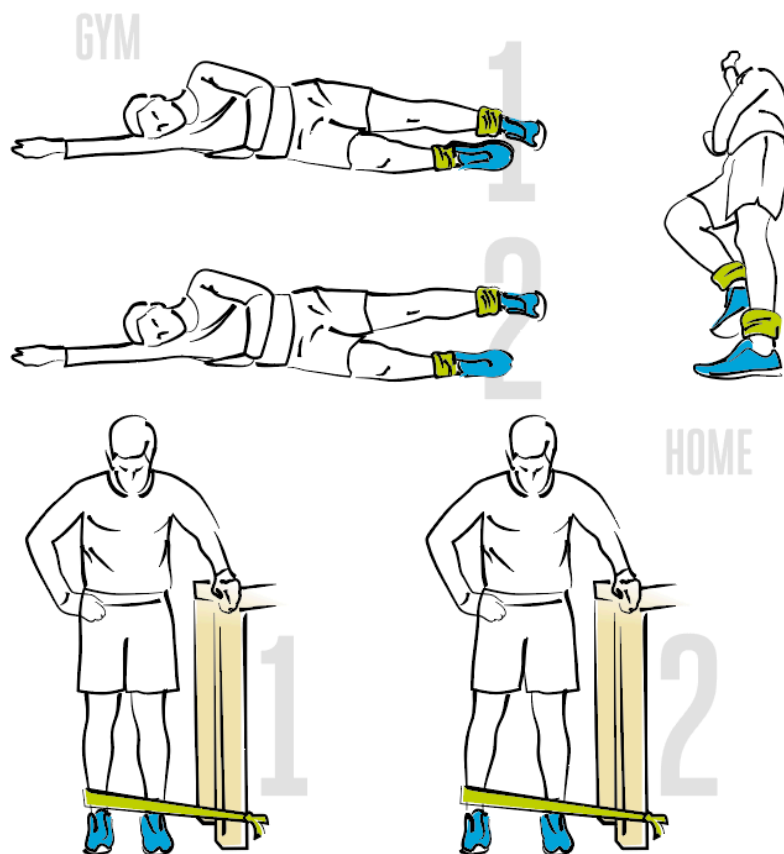
The gluteus medius can only move the leg out to the point where it is parallel with the hip joint. Any outward motion beyond that is created by the lower back muscle.

Lie on your side with the knee of the bottom leg bent and the top

leg straight, with the top leg running in a continuous line from the torso. If the leg is angled in front of the torso, you are using a different muscle than the gluteus medius.

Start to raise the top leg off the supporting leg until your leg is parallel with the floor. Try to turn the leg in slightly so the heel is the first part of the foot that moves. This puts the gluteus medius in the optimal position to raise the leg.

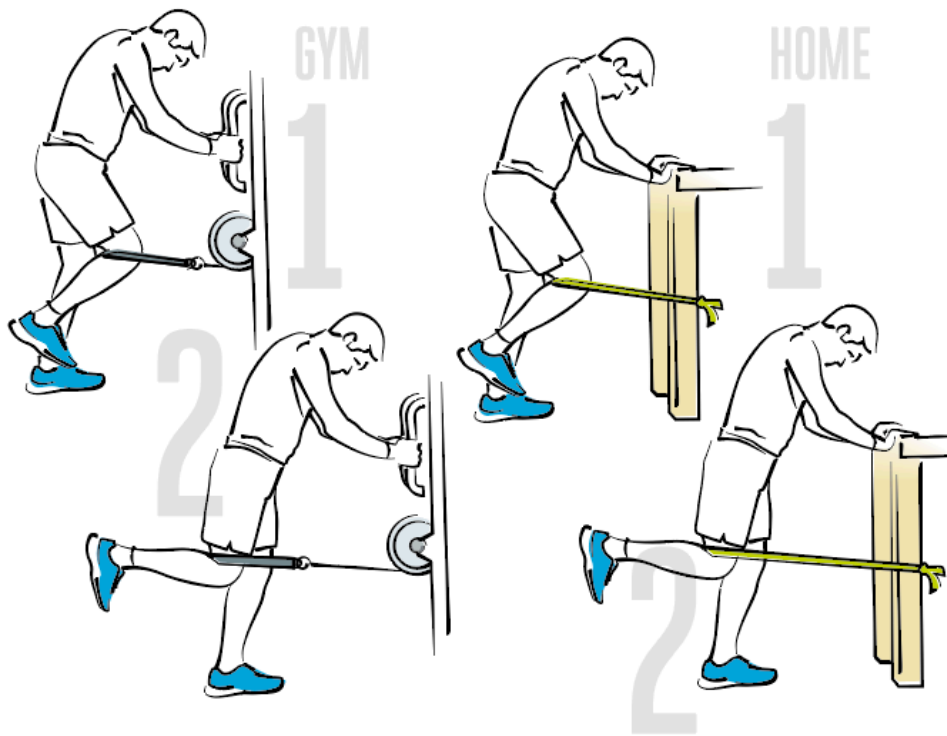
Once your leg is parallel to the floor, lower it onto the supporting leg. If standing, move the leg only as far as the hip joint, toes inward, and return to starting point.



Hip extension (gluteus maximus)

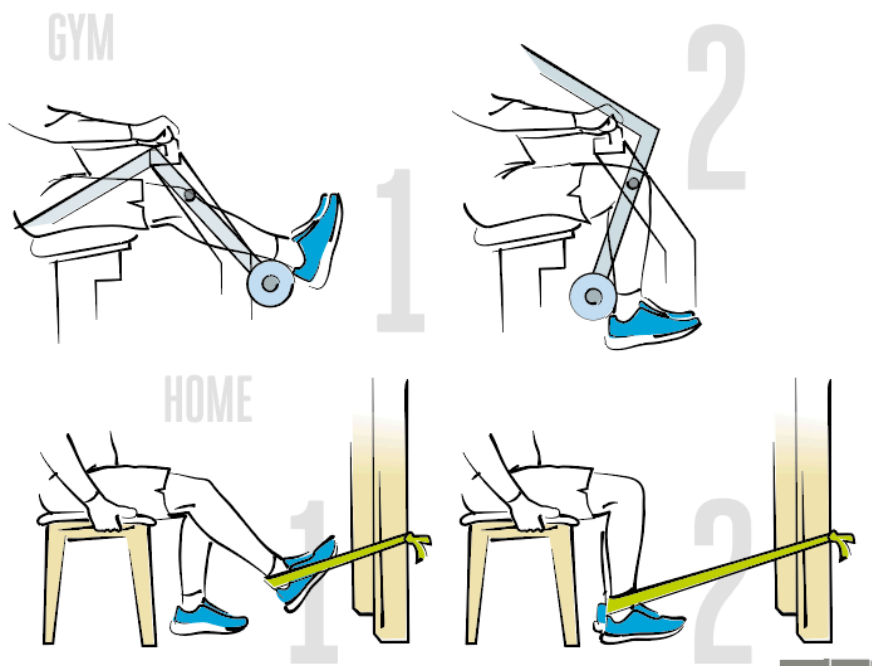
In a sitting or standing position, place the resistance behind your knee. Start with the hip flexed to about 60°. If you are sitting, bring the knee down to the surface you are sitting on. If you are standing,

bring the knee about 10° behind the hip. Then return to the start position. If standing, make sure your back is rounded and the knee of the leg you are standing on is unlocked.



Hamstring curl (hamstrings)

In a seated position, place the resistance at the back of the ankle. Make sure you are supported in the seat. Start with the exercising leg pointing straight out with the knee unlocked. Begin to bend the knee until it reaches 90°, then return to the starting position. To isolate the hamstrings better, flex the toes of the exercising leg toward the face as the exercise is being performed. If you're using a seated hamstring curl machine, make sure the pivot point of the machine is aligned with the knee joint.



Frequency

All exercises should be performed three times a week (either Monday, Wednesday, Friday or Tuesday, Thursday, Saturday) in three sets of 10 repetitions, with a minute rest taken between sets. Limiting the exercise to three times a week gives the muscles a chance to heal and grow.

The key to the entire process is the use of progressive resistance through resistance bands, gym equipment or dumbbells and barbells. The exertion level for this resistance should feel like an 8 out of 10, with 10 feeling like you are going to tear a muscle and 0 feeling like you are doing nothing. Using 80 percent of your maximal strength has been found to be the most effective level of exertion to grow muscle without straining. As the muscle adapts to the resistance, it grows and the exertion level decreases.

When your exertion begins to feel like a 5, increase the resistance by making the band shorter, moving away from the attachment point of the band or using a thicker band, so that you create an exertion level of 8 again. Stay with this until it becomes a 5 and then

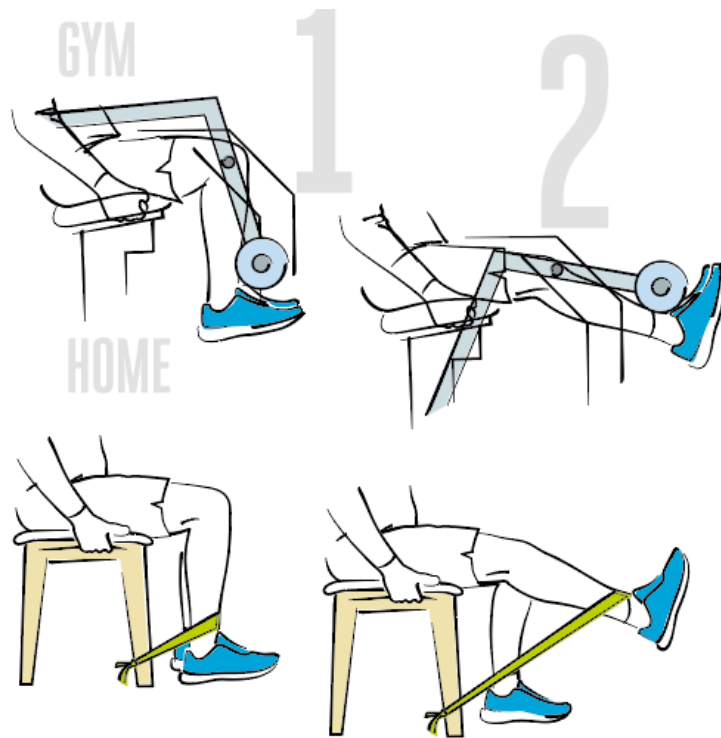
increase the resistance again.

With enough progression of resistance, the muscles will strengthen, so their force output is greater than the force requirements of your activities, and within weeks, you will be pain-free and fully functional.

The bottom line is that in almost all cases, your pain isn't a medical issue; it's a matter of fitness. There is no specialty in the medical field educated or trained to address these types of issues. You and you alone will have to take the responsibility to resolve your pain with the help of the information found here.

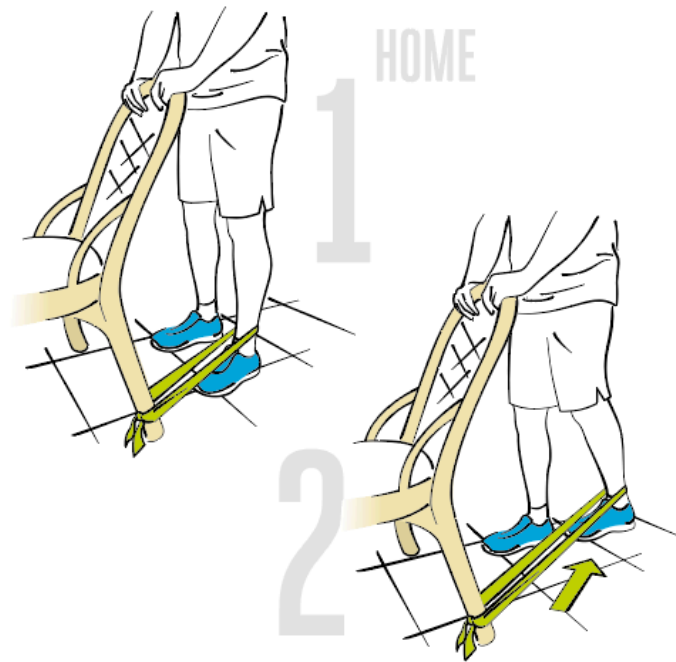
Knee extension (quads)

In a seated position, place the resistance around the front of the ankle. Make sure the foot of the opposite leg is on the floor and that you are supported in a seat. Begin with the knee bent to 90°, straighten the knee until it is almost locked and then return the leg to the start position. Make sure the thigh of the leg that is being exercised remains on the seat and does not rise with the lower leg as the exercise is performed.



Sartorius exercise (lengthens the sartorius muscle)

Make sure you are holding on to a sturdy object when performing this exercise to help you with your balance. In a standing position, place the resistance around the back of the ankle of the leg to be strengthened. Start by rotating the hip of the leg performing the exercise so the toes are pointing inward slightly. Then begin to place the foot of the exercising leg behind the foot of the leg you are standing on. Once the foot of the exercising leg is placed down on the floor behind the other leg, return it to the start position. Make sure the resistance is appropriate so you can get your exercising foot behind the foot that you are standing on. You want to use a resistance that helps lengthen the sartorius, but, because there is a balance element to this exercise, caution should be used in determining the right level of resistance.



Find more information at

www.mitchellyass.com or in his books, *The Pain Cure Rx* (Hay House, 2015) and *The Yass Method for Pain-Free Movement* (Hay House, 2018)