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Aseptic Necrosis of the Femoral Head, Etiopathogenesis Early Diagnosis and Treatment

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Abstract: Common risk factors for aseptic femoral head necrosis include alcoholism, the use of glucocorticoids, chemotherapy and immuno suppressants, and sickle cell anemia. It is necessary to perform an MRI of the hip joint and refer to an orthopedic traumatologist every patient with hip pain that persists for more than six weeks onnormal radiographs. Early treatment increases the chances of hip joint survival by 88 % over seven years.

Keywords: Heads, Doctors

What is aseptic necrosis of the femoral head. ANGBC causes a violation of the integrity of the subchondral bone structure due to microcirculation disorders. The underlying pathogenesis is unclear; risk factors probably affect microcirculation in some way, but not one theory is scientifically confirmed. The usual end point is microcirculation disorders and necrosis. The subchondral bone subsequently collapses, leading to progressive secondary arthritis. The average age of the population of the CIS countries affected by this pathology is 58.3 years, with a frequency of 2 cases per 100,000 patients. On average, angioedema occurs at an earlier age than typical osteoarthritis. The disease is more common in men, and the highest prevalence is observed in men aged 25 to 44 years and in women aged 55 to 75.3 years . The following factors are associated with an increased risk of angioedema: Steroids were found to increase the chances of osteonecrosis (not localized) by three times, and immuno suppressants-by six times. Zhao He reported that the odds of angioedema were 35 times higher in patients taking corticosteroids and six times higher in patients with alcoholism status. Why do doctors miss the early signs of angina? ANGBC is rare. Patients with this condition may have concomitant chronic rheumatic and hematological diseases, which can lead to diagnostic uncertainty, especially given the use of chemotherapy, immunomodulatory agents, and steroids, which are risk factors for angioedema. A clinical examination can help identify anatomical structures that may be causing pain, as hip pain can come from either the joint or not. Clinical symptoms may be overlooked because accurate detection of groin pain with isolated hip movements may not occur in primary care settings due to limited conditions. Baseline radiographs in the early stages of angioedema may be falsely encouraging and delay diagnosis. If the X-ray is negative and the patient continues to complain of hip pain, the doctor may make a diagnosis of non-specific hip pain (given that musculoskeletal symptoms are common in the primary care unit) and refer the patient for physical therapy.18.75% of cases can only be diagnosed by MRI. Why is early diagnosis important. Early diagnosis and referral to a doctor is extremely important, as bone destruction usually occurs within two years of the onset of the disease, which makes it impossible to preserve the joint. Early detection of angioedema gives an interdisciplinary team of physicians time to change treatments that may trigger the onset of angioedema. Surgical decompression of the femoral head reduces the need for further operations in the short and medium term, but is only suitable for the early stages of the disease.5 Once patients have developed secondary hip arthritis, joint replacement is usually

unavoidable. However, given the younger age of patients with angioedema, the lifetime risk of revision surgery and associated morbidity is high. How is angioedema diagnosed. Diagnosis of angioedema begins with a thorough medical history and examination to determine what is the source of joint pain. Ultimately, an MRI scan is required to diagnose angioedema, which it can also diagnose other causes of hip pain. A history of pain lasting more than six weeks, usually localized in the groin and hip and worse with weight and movement, is key. Usually, there is no history of injuries. Carefully inquire about the risk factors and refer the patient for an MRI of the hip joint if the patient has any "red flags" (Figure 1). Angioedema is often bilateral, and the risk of bilateral angioedema is highest within two years after unilateral lesionris. 2. Hip rotation tests to detect hip pain when the patient is sitting (A) and lying on his back (B, C, D) Radiological methods. Early ANGBC is not visible on conventional radiographs. If the patient continues to experience pain, further examination and referral to an orthopedic traumatologist is necessary. ANGBC is diagnosed by hip MRI, which can also diagnose a wide range of treatable hip pain (such as rheumatological diseases, musculoskeletal diseases, and bone diseases) when carefully correlated with clinical symptoms

Other tests, such as blood tests, should only be performed if they are indicated for other reasons or if a rheumatological disease or infection is highly suspected. If the patient shows signs of angioedema on the MRI of the hip joint, consult an orthopedic surgeon for consultation (Figure 4). When providing secondary care, the diagnosis of angioedema should be brought to the attention of any medical team involved in the appointment of glucocorticoids, chemotherapy and immunological therapy. Medical and surgical treatment depends on the characteristics of the patient and the stage of angioedema. Pre-collapse drug treatment with prostacyclin analogs and bisphosphonates may reduce symptoms and prevent loss of joint congruence, but their effectiveness is currently uncertain. Surgical treatment remains controversial, but most patients with pre-collapse angioedema are offered decompression surgery, with or without additional pharmacological therapy, to reduce pain and potentially prevent the need for total replacement surgery. hip replacement in 88% of patients for up to seven years. Postoperative recovery includes a period of no exercise for 12 months and a gradual return to work and driving after 8 weeks. The full effect is usually felt 12 months after surgery. Specialized centers can offer new treatments, such as bone grafting and osteotomy, to stimulate the resumption of vascular growth and relieve the damaged joint surface of the hip joint, respectively. After a collapse, a complete hip replacement can provide patients with rapid and reliable pain relief and improved function, but it is associated with the risk of revision in the future, especially in young patients. A full description of all options is beyond the scope of this article, and patients should discuss all available options with their surgeon to ensure that informed decisions are made together. Clinical case A 36-year-old woman went to a general practitioner with complaints of pain in her left groin radiating to the knee. The pain was severe, worse when walking, and accompanied by a limp. A year later, the patient visited the general practitioner again with persistent pain, despite pain relief. Survey radiographs of the hip and knee joints show a slight narrowing of the hip joint gap without any other features, and therefore, she was referred to the specialized center of traumatology and orthopedics. MRI of the hip joint shows classic signs of angioedema with collapse. The patient was severely debilitated by hip pain. She had recently given birth to her second child and was struggling to cope with household chores. She felt that her concerns weren't taken seriously because she was young. The case is a shortened version of the patient's history with angioedema. The patient highlighted her disappointment when she was initially released from primary care due to symptoms of hip pain and a normal X-ray. We hope that this article will inform primary health care teams about potential problems associated with angioedema and how they can be prevented for future patients.

Conclusion-a question. How often do patients with normal radiographs get re-examined and referred to specialized centers, even if there is constant pain in the hip joint? List of used information

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