Just Say No To Hip Replacement

Total hip replacement is among the fastest growing surgeries in the West. Most of them are unnecessary.

July 6, 2019 By Mike Barr

May 2025 Update:

I apologize for how long is has taken me to do this. Many asked— and apparently, had been patiently waiting— for the promised addenda since this first appeared. My excuse, lame as it might be, is that this is a complicated topic-- and I wanted to think it through thoroughly, even organize the different bits, in order to make it as useful as possible. So after a year or two (okay, six) of these thoughts churning around in my brain, here is how I hope I can most succinctly distill the pieces:

1. The FEAR FACTOR-- which comes from not knowing. A not insignificant factor in all MSK pain, be it low back pain, hip pain, knee pain, shoulder pain, other, is that we never really learn how the body is put together. This, to my mind, is criminal. We should all learn this— and not just superficially but "livingly"— in middle school or high school-- or throughout. There comes such an immense freedom in knowing how things are connected. What pain is to be expected, even welcomed. What pain means stop, or back off. And all about referred pain. So my #1 pitch would be to tick this box. Easier said than done when you're in the thick of it, I realize.

2. And number two, alluded to here and included in a recent blog post I did at rootresolution.com, is the STRESS FACTOR. It is perhaps a cliche but only because there is more than a kernel of truth in it that men get low back pain over money worries and women get hip pain over relationship worries. Certainly these are in no way hard and fast distinctions, but the point is to take a deep breath and ask oneself: "What degree of psychological duress am I under (have I been under) right now (recently)?" With the exception of a few falls in 80-year olds, mostly but not exclusively women, who femoral heads were cracked, all the hip and back surgeries (and now one shoulder) I am aware of followed a period of economic/financial fear or outright crisis. For some, it can even be a toxic marriage or difficulty adjusting to retirement/loss of identity/purpose.

3. Number three, I suppose, would be to acknowledge that hip surgery these days has become so routine that— were it not for THE ANESTHESIA— one could liken it to a root canal. Most people are up on their feet in a day or two, although there does seem to be a fair degree of pain, numbness, stiffness, for a few weeks, sometimes longer. Obviously, if you're 90 years old and you fall and break your hip, you'll likely choose to operate.

My biggest worry in these instances is the anesthesia. I know of more than one person who never fully recovered from it. And a school mate's 70-year old mother actually went straight from Step Down post-op to the "Alzheimer's" Wing— after only (completely elective) gallbladder surgery! So please, please, please, if nothing else, know you GLUTATHIONE reserves. Ideally 1,000+ (micromol/L), but minimum of 700-800, going into surgery. And yes, you can measure it yourself, in most states. You could probably even get away with measuring GGT, as it's 1/25th the price: $4 vs. $89 via LabCorp; $2 v. $72 via Access Medical Labs. An elevation (>9 U/L in women and >14-20 in men) suggests depleted glutathione reserves. Personally, I would want to know my overall nutrient status (including amino acids & essential fatty acids) generally (here) before booking any surgery.

For the body to make glutathione it needs the amino acid "building blocks," sulfur-rich cysteine, glycine, glutamic acid, but also the co-factors magnesium, zinc and vitamin B6. For it to function properly (and "re-charge"), it needs selenium, vitamin C, and vitamin B2 (aka riboflavin).

4. I need to paste in something here about "The Problem With Physical Therapy" that I came across on a really cracker jack physical therapist's website a few months back. But I need to find it. (I'm thinking it was Tom Walters of Rehab Science, but I cannot now find the quote that instantly drew me in.) In a nutshell... the 8 weeks or so that your insurance covers for PT not only isn't usually enough to help you (certainly not to teach you how your body is put together & functions) but that they really cannot give you the attention required. And 95% of them are very poorly educated. I worked in a PT-chiro-acu-pain mgt clinic for many years. I also oversaw the (insurance-reimbursed) PT sessions of, first, my father and, later, my mother. Trust me, I know.

5. And now let us return to that "Referred Pain" mention. For most people, the muscles in the hips are the strongest of the entire body. (Lists will tell you masseter, heart, myometrium, soleus even. Maybe. But I'm sticking with the hips.) And, see #1, we learn virtually NOTHING about any of them. Let's to a quick spot test. What can you tell me about gluteus medius, gluteus minimus, tensor fascia latae, ilio-psoas or piriformis? And let's take it a bit further... what did your Sports Medicine or Orthopedic Surgeon tell you about, specifically, glut medius and/or tensor fascia latae (aka TFL)? My guess is nothing.

But were you to come up with the 10,000 or 20,000 CAD required to matriculate into McMaster University's Contemporary Acupuncture Program (or wish to sponsor my own matriculation), you would learn even within the first month or so that tightness in the TFL (which is both common & also flairs up under emotional distress) creates a kind of "pseudo" trochanteric bursitis. What your surgeon & you would likely decide is a "bone on bone" arthritis (sometimes even "osteonecrosis!!") creating annoying maybe even unbearable pain.

A tight glut medius not only creates low back and, er, low low back (as in sacrum) pain, but also exacerbates the effect of a tight TFL. So figures into both low back pain AND hip pain.

I'm going out on a limb here, but am proposing that a full 90% of low back pain (often diagnosed as degenerative disc disease or herniated disc) is due to a tight psoas muscle. Don't believe me?

Have a look for yourself.

A tight glut minimus can create a “pseudo” sciatica, with shooting pain down either the back of the leg or even the lateral leg. As can a tight piriformis. This is often mis-diagnosed as “spinal nerve compression.” Yes, nerves are being or potentially being compressed-- just not where the (clueless) MD is telling you they are. And his (it’s invariably a man) “fix” for it will not only not help you but very likely make things worse.

And this is just Week 1.

There are muscles in the back of the knee that create big toe pain. A tight rectus femoris can create deep knee pain. A tight vastus lateralis can create “locked patella syndrome” while a tight vastus medialis creates a buckling knee! A tight vastus intermedius creates deep mid-thigh pain. And a tight tibialis anterior can lead to a “dropped foot.”

Surgeons will happily put you under for all of these.

But you can fix them yourself. Although it helps to work one-on-one with someone who understands how the body is put together. I learned from (very good) yoga teachers— back before every Tom, Jen & Shari was one (and one AMAZING pilates teacher: Kara Teitelbaum) who had pretty much all once been dancers. And who understands referred pain patterns. Travell, Simons & Simons is the classic text.

It also helps to make sure you are getting your minerals, especially magnesium & potassium. Calcium supplementation, certainly anything above 200 mg and not taken with either magnesium or vitamin K2, is a NO-NO. Calcium in the form of supplements just ends up lining your arteries or other organ tissues. Ideally, all of these minerals would be derived from diet (3-4 cups of dark, leafy greens daily, nuts, seeds, shellfish, other mineral rich fruits & vegetables, local, in-season, organic), but with magnesium one almost needs to take extra (glycinate, citrate, malate, aspartate, even bicarbonate, 600+ mg in divided doses).

Removing wheat from the diet helps immensely. Maybe even other grains, but certainly wheat.

I hope this helps.

How my heart swooned when I came across this fab new mag at the grocery store checkout a couple months back.

What Doctors Don’t Tell You, WDDTY for short, has apparently existed in the UK since— god, how did I miss it all this time?— 1989, but seems to be just now making a break out in the US, most noticeably with their provocative glossy monthly print magazine. (And they said print media was dead.)

If I learned anything useful at all during my seven gazillion years in acupuncture school and then post-grad advanced ortho training is that just about all low back, hip and knee surgeries (okay,

and gallbladder-ectomies) are more about the surgeon (or medical institution) than the patient. And while the jig is kind of up for back surgery (at least in most parts of the country), way too many people still get suckered into the quick fix promises of hip and knee surgery. So I am editing down WDDTY's "You Don't Need A Hip Replacement!" from their March issue and kind of also filtering it through my own personal and professional experiences. I'm going to put the body bits in BOLD, at first appearance, so that we can come back to them later if you're not familiar with them.(Before acupuncture school, okay and maybe those years of yoga, I certainly wasn't.) Here goes...

You can't walk down a street without seeing a person waddling along who has had a hip replacement– and is saddened and disillusioned with the way it turned out.

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

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.

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.

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bound after a procedure that promised them they'd be dancing in weeks. Saddest of all, the vast majority never needed surgery in the first place.

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 Orthopedic 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).

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 famously "bone-on-bone," and you have no choice but to get a hip replacement.

A surgeon will put images up on a screen, point to decreased joint space, explain that it's a clear case of

“bone-on-bone,” and that you have no choice but to operate.

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.

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.”

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.

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

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.

Is it really "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 (upper leg 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.

In all my years of diagnosing and treating patients who were told that a "lack of cartilage" was the cause of their pain, in only two or three was that actually true.

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 (aka glute 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 glute 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 (aka TFL), which attaches to the iliotibial band (IT band), a tendon running from the hip to the knee. This muscle is also called in to assist when the glute medius fails, leading to straining. So in all these situations—a piriformis, TFL or IT band eliciting pain—the ultimate culprit is a strained glute 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 TFL can't make up for lost force from the glute 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: Single leg balance

The glute 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 glute 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 glute medius.

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

Test 2: Lean sideways when walking?

If a strained glute medius is the cause of pain in the hip region, this will affect your ability to walk. If one glute 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 glute 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 glute 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 glute medius muscle, which was the likely cause of their pain and dysfunction in the first place.

Test 3: Hiked hip or (god, the absolute cheesiest) orthotics?

If the glute 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 (aka QL), 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 glute medius.

Test 4: Find the pain!

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.

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 TFL and IT band.

To test if the pain has to do with the glute 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 glute 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 IT band and TFL.

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.

Match game

If the pain is coming from a strained glute medius or piriformis, the exercises to perform are hip

abduction, hamstring curl and hip extension. If the pain is coming from the IT band, 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. 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.

Let’s do a quick recap:

- Glute medius/piriformis the issue --> Do hip abduction, hamstring curl and hip extension (every other day)
- IT band (including TFL) --> Do hip abduction, knee extension, hip extension (every other day)
- Sartorius (groin pain) --> Do hip abduction, hip extension, knee extension, and sartorius "lengthening" (every other day)

Obviously you can search for these exercises on YouTube, Vimeo or wherever. Maybe find the models that most inspire you. But I will also post in a follow-up. Tks!

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