







**Fig. 3** - (A) Left hip x-ray anteroposterior view with a posteromedial femoral neck cystic lesion. (B) Left hip x-ray profile view with a posteromedial femoral neck cystic lesion. (C) Fluoroscopy view of scope in the anterior medial portal (AMP) and bar in the posterior medial portal (PMP) working inside the cyst.

Similar location to the PMP has been described for septic arthritis drainage (6), removal of loose bodies (7) and congenital hip dislocation treatment (8). Polesello et al (2) have described medial portals and their relation to deep structures. The main structure at risk for the posterior portals is the obturator nerve and for the AMP the profundafemoris bundle. To minimise the risk of damaging the anterior branch of the obturator nerve, posterior portals should be positioned at the posterior border of the adductor longus (PMP and DPMP). To minimise the risk to the profundafemoris, the AMP should be placed close to the inguinal crease. All portals should be directed towards the femoral neck junction to avoid the profundafemoris and medial circumflex artery.

The main indication for using these portals would be medial femoral neck affection requiring surgery. An alternative open surgery would be a surgical hip dislocation with trochanteric flip osteotomy or a Ludloff approach, but both would be much more invasive than an arthroscopy.

The limitation of this paper is the small number of cases, which is the result of strict case selection and the rarity of isolated hip pathology manageable through hip arthroscopy.

### Conclusion

The medial portals described were safe and useful for medial hip pathology, especially at the peripheral compartment.

### Disclosures

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