and 115 underwent capsular repair. Sixty-five capsular closure patients were matched in a 1:1 ratio to 65 capsular release patients. Both groups saw significant improvements in all mean PROs at latest follow-up. In the repair group, mean PROs, VAS, and patient satisfaction were significantly improved at two and minimum five-year follow-up. In the unrepaired group, there was significant decrease in mHHS (p=0.001) and patient satisfaction (p=0.01) between two and five-year follow-up. More patients in the release group required conversion to hip arthroplasty (18.5% vs. 10.8%). The rate of revision arthroscopy was the same in both groups (15.4%).
Conclusion: This study demonstrates that patients undergoing hip arthroscopy can expect to have significant improvement at minimum five-year follow-up, whether or not the capsule is closed. However, patients who underwent capsular release had a significant deterioration in mHHS between two and five years postoperatively and a higher rate of conversion to arthroplasty.

Independent Risk Factors for Revision Surgery or Conversion to THA after Hip Arthroscopy: An Analysis of 3,957 Patients
SS-31
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Introduction: The use of hip arthroscopy for the management of hip pathology has increased dramatically in recent years. Despite evidence demonstrating excellent outcomes, there are some patients that may require revision arthroscopy or conversion to total hip arthroplasty (THA). Data regarding risk factors for poor outcomes after hip arthroscopy is limited. The purpose of this study is to evaluate the rates of revision hip arthroscopy and conversion to THA in order to identify risk factors for suboptimal outcomes.
Methods: New York State Department of Health Statewide Planning and Research Cooperative Systems database was queried from 2011 through 2014 to identify patients undergoing hip arthroscopy. Patients were longitudinally followed for a minimum of two years to determine the incidence and nature of subsequent hip procedures. Multivariate logistic regression was performed to identify independent risk factors for revision surgery or conversion to THA.
Results: We identified 3,957 patients who underwent hip arthroscopy. Mean age of the sample was 35.8 years (SD±13.1). After a minimum follow-up of two years, overall failure rate was 9.6%: 3.7% (n=148) had revision hip arthroscopy at an average of 15.8 months, while 5.9% (n=235) converted to THA at 14.7 months. Index surgery performed by surgeons in the lowest volume tertile was an independent risk factor for both revision (p=0.001) and conversion to THA (p<0.001). Females (p<0.001), older patients (p<0.001) and those with a history of obesity (p<0.001) converted to THA at a significantly higher rate than other patients. Young patients (p<0.001) and females (p<0.001) were more likely to undergo revision hip arthroscopy.
Conclusion: Hip arthroscopy may be better performed by medium to high volume surgeons. Additionally, patients with identified risk factors for revision or THA conversion should be counseled pre-operatively on potentially adverse outcomes, thus allowing patient-physician engagement during the shared decision-making process.

Low Body Mass Index and Obesity associated with Lower Outcomes Following Hip Arthroscopy for Femoracetabular Impingement
SS-32
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Introduction: The purpose of this study was to comparepatient reported outcomes for patients undergoing primary hip arthroscopy for femoroacetabular impingement(FAI) based upon their BMI.
Methods: 738 patients (Female 353, Male 385) with average age 36 (18-70) diagnosed and treated for primary FAI met the inclusion criteria. Patients were included if they underwent hip arthroscopy with labral repair and femoral and/or acetabular osteoplasty. Any patient that had previously undergone hip surgery, arthroscopic or open were excluded. Patients were divided into four cohorts based upon world health organization BMI classification: 1.< 18.5 kg/m2, 2. 18.5 -24.9 kg/m2 , 3. 25.0 − 29.9 kg/m2, 4. > 30 kg/m2.
Results: Mean weight was 74.0 kg (44 − 144 kg). Mean Height was 174.5 cm (104.1 − 213.4 cm). Mean BMI was 24.1 kg/m2 (15.1 − 44.1 kg/m2). Groups 1 (18:1) and 2 (276:181) were predominantly female while Groups 3 (180:49) and 4 (23:10) were predominantly male. BMI was correlated with age (rho=.10; p=0.006), lateral joint space (rho=.0.09; p=0.016), alpha angle (rho=0.08; p=0.0280), flexion (rho=-0.253, p<0.001), abduction (rho=-0.144; p<0.001), adduction (rho=-0.1;p=0.0150 and internal rotation (rho=-0.27; p<0.001). BMI did not correlate with pre-op or post-op outcome scores (HOS ADL, HOS Sport, MHHS, WOMAC, and SF12). Comparison between the 4 groups showed significant differences in range of motion (Table 1). Pre-op MHHS, and HOS ADL were significantly different between groups, with Group 2 and 3 having the highest scores. Post-op HOS sport was also significantly different between groups.
Conclusion: When a patient's BMI is categorized according to WHO guidelines, obese patients have lower preoperative status and outcomes, patients in the overweight category do not. In addition, patients in Group 1