

Contemporary Management of Hip Fractures in Older Adults: Current Evidence and Guideline Updates

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Abstract: Hip fractures are a major cause of morbidity, mortality, functional decline, and loss of independence among older adults, with the increasing prevalence of osteoporosis, frailty, sarcopenia, and falls contributing to their growing healthcare burden. Management of these fractures has evolved from an isolated surgical approach toward an integrated strategy involving early diagnosis, timely operative treatment, perioperative optimization, orthogeriatric co-management, complication prevention, and structured rehabilitation. This review summarizes current evidence and guideline-based approaches to the management of hip fractures in older adults, with emphasis on epidemiology, risk factors, fracture classification, initial assessment, preoperative optimization, surgical decision-making, perioperative care, and postoperative rehabilitation. Contemporary treatment options including internal fixation, hemiarthroplasty, total hip arthroplasty, sliding hip screws, and cephalomedullary nails are discussed according to fracture pattern, stability, bone quality, and patient-related factors. The review also highlights the importance of venous thromboembolism prophylaxis, multimodal analgesia, delirium prevention, early mobilization, nutritional support, osteoporosis management, and secondary fracture prevention. Current evidence supports timely surgery following appropriate medical optimization, together with multidisciplinary orthogeriatric care to reduce complications and facilitate functional recovery. Overall, an individualized, evidence-based and coordinated management pathway is essential to improve survival, mobility, independence, and quality of life following hip fracture in older adults.

Keywords: Hip fracture; Older adults; Osteoporosis; Fragility fracture; Orthogeriatric care; Surgical management; Perioperative management; Rehabilitation; Early mobilization; Secondary fracture prevention.

I. INTRODUCTION

1.1 Epidemiology and Global Burden

Hip fractures represent a significant global public health concern and are among the most severe fragility fractures that affect older persons. Due to aging populations, longer life expectancies, and an increase in osteoporosis and frailty, hip fractures have become more common over the past few decades [1][2]. Approximately 1.6 million people worldwide suffer a hip fracture every year; if current demographic trends continue, this figure is expected to rise to almost 6 million by 2050 [3][4]. Due to rapid postmenopausal bone loss, women account for about three-quarters of occurrences among people 65 years of age and older. However, older males continue to have greater mortality rates [5].



Osteoporosis, sarcopenia, poor balance, visual impairment, cognitive dysfunction, polypharmacy, and several chronic comorbidities are significantly linked to hip fractures, which are primarily caused by low-energy falls from standing height [5]. Despite the fact that North America and Northern Europe have historically had the highest incidence, Asia is predicted to experience the most increase in hip fracture cases over the next few decades due to the region's fast demographic shift and growing older population [3]. As a result, hip fractures are a significant problem for healthcare systems around the world and have emerged as a key indicator of healthy aging [4].

1.2 Clinical Significance

Significant morbidity, death, and long-term functional impairment are linked to hip fractures. After a hip fracture, the one-year mortality rate is between 20% and 30%, and many survivors suffer from persistent pain, decreased mobility, irreversible loss of independence, and a lower quality of life. Only a small percentage of patients return to their pre-fracture functional state, and many of them go on to need long-term rehabilitation or long-term institutional care [6].

In addition to the actual skeletal damage, hip fractures can indicate severe osteoporosis and underlying weakness. Perioperative complications such as disorientation, pneumonia, venous thromboembolism, urinary tract infection, pressure injuries, malnourishment, and cardiovascular events are more common in older persons who have hip fractures [6]. In order to maximize perioperative care, minimize complications, and enhance survival and functional recovery, current evidence thus supports a multidisciplinary orthogeriatric model involving orthopaedic surgeons, geriatricians, anaesthesiologists, physiotherapists, pharmacists, nutritionists, and nursing teams [7].

1.3 Healthcare and Socioeconomic Impact

Hip fractures place a significant financial burden on patients, caregivers, and the healthcare system. Emergency care, surgery, hospitalization, rehabilitation, long-term care, outpatient follow-up, and treatment of postoperative complications are examples of direct healthcare costs; caregiver burden, family member productivity loss, and decreased quality of life are examples of indirect costs [8]. Hip fractures continue to be one of the costliest effects of osteoporosis globally because many patients need extended rehabilitation and institutional care after discharge.

Hip fractures not only have an economic impact but also greatly increase the use of healthcare resources due to longer hospital stays, more frequent readmissions, and higher demand for rehabilitation services [8]. Effective osteoporosis treatments are available; however, many patients do not obtain the proper secondary fracture prevention after being discharged, which raises the risk of further fragility fractures and additional medical costs. In order to improve patient outcomes while lowering healthcare costs, the introduction of Fracture Liaison Services (FLS) and standardized orthogeriatric treatment pathways has become a global priority [7].

1.4 Rationale for an Evidence-Based Review

Over the past ten years, developments in surgical procedures, perioperative optimization, anesthetic, rehabilitation, and multidisciplinary care have led to a significant evolution in the management of hip fractures in older persons. The timing of surgery, the choice of internal fixation or arthroplasty, cemented versus uncemented femoral stems, multimodal analgesia, peripheral nerve blocks, tranexamic acid administration, venous thromboembolism prophylaxis, blood transfusion thresholds, and early mobilization have all been improved by recent evidence [7].

In order to increase survival and functional recovery while reducing complications, the American Academy of Orthopaedic Surgeons (AAOS) and the National Institute for Health and Care Excellence (NICE) have published evidence-based guidelines that place a strong emphasis on prompt surgery, thorough orthogeriatric management, and coordinated multidisciplinary care [1][2]. However, there are still differences in clinical practice amongst healthcare systems, especially when it comes to osteoporosis management, rehabilitation techniques, perioperative optimization, and the use of fracture liaison services [2][7]. In order to help clinicians provide standardized, evidence-based care for older persons with hip fractures, a thorough synthesis of recent guidelines and current data is necessary.



II. EPIDEMIOLOGY AND RISK FACTORS

2.1 Epidemiology

Hip fractures continue to be among the most prevalent osteoporotic fractures in older persons, and they are becoming an increasingly significant worldwide healthcare burden. Because of progressive bone loss, decreased muscle strength, poor balance, and growing frailty, their incidence rises dramatically with age, especially after 65 [9][10]. The absolute number of hip fractures continues to rise globally due to population aging, even if age-standardized incidence rates have stabilized or decreased in several high-income countries due to better osteoporosis care and fall prevention initiatives [10][11].

According to current estimates, there are about 1.6 million hip fractures worldwide each year; by 2050, that number is expected to rise to almost 6 million instances [12]. Due to increased bone loss after menopause, women account for approximately 70–75% of all hip fractures; nevertheless, men have worse functional recovery and a higher post-fracture death rate [13]. Due to rapidly growing older populations and demographic changes, hip fracture incidence is predicted to rise most across Asia over the next few decades [12].

Ethnicity, lifestyle, nutritional status, environmental variables, access to healthcare, and the prevalence of osteoporosis all have an impact on geographic variations in incidence. While developing nations are seeing a sharp rise in the burden as life expectancy increases, Northern Europe and North America continue to record among of the highest incidence rates [10][12].

2.2 Major Risk Factors for Hip Fractures

2.2.1 Ageing and Sex

The biggest unchangeable risk factor for hip fractures is advanced age. Fracture susceptibility is increased by age-related decreases in bone mineral density, deterioration of bone microarchitecture, reduced neuromuscular coordination, weaker protective reflexes, and deteriorating eyesight. Because estrogenic insufficiency after menopause accelerates bone resorption and reduces bone strength, female sex raises risk even more. On the other hand, despite the fact that hip fractures are less common in men, postoperative complications and mortality are typically higher than in women [13][14].

2.2.2 Osteoporosis and Bone Quality

The main pathological disease-causing fragility hip fractures are osteoporosis. Skeletal strength is significantly reduced by progressive loss of bone mineral density and degeneration of trabecular and cortical bone architecture, which makes fractures possible even after little trauma, like a fall from a standing height [15][16]. Vitamin D deficiency, calcium shortage, endocrine diseases, long-term glucocorticoid medication, and physical inactivity all exacerbate reduced bone quality. Therefore, preventing both primary and secondary fractures requires early detection and treatment of osteoporosis [15][17].

2.2.3 Frailty, Falls, and Sarcopenia

Reduced physiological reserve and heightened susceptibility to outside stressors are the hallmarks of frailty, a multifaceted geriatric syndrome. Sarcopenia, poor nutrition, decreased gait speed, muscle weakness, and impaired balance are frequent in frail people, all of which significantly raise the risk of falls and consequent hip fractures [18][19]. Fall prevention is crucial in lowering the incidence of hip fractures, as over 90% of hip fractures in older individuals happen after low-energy falls [18]. Visual impairment, cognitive dysfunction, environmental dangers, improper footwear, and orthostatic hypotension are further factors [19].

2.2.4 Comorbidities and Polypharmacy

The risk of hip fractures is greatly increased by a number of long-term medical disorders that affect bone health, mobility, balance, and cognition. Diabetes mellitus, Parkinson's disease, dementia, chronic renal disease, cardiovascular



disease, and prior stroke are common comorbidities [20][21]. By causing dizziness, orthostatic hypotension, reduced awareness, and gait instability, polypharmacy—specifically, the use of sedatives, benzodiazepines, antidepressants, antipsychotics, opioids, antihypertensive medicines, and hypoglycemic medications—further raises the risk of falls [21]. Therefore, deprescribing potentially inappropriate drugs and doing routine medication reviews are suggested as important methods for preventing fractures in older persons [22].

III. CLASSIFICATION OF HIP FRACTURES

3.1 Intracapsular Hip Fractures

Intracapsular hip fractures mainly affect the femoral head and neck and happen close to where the hip joint capsule attaches. Because rupture of the retinacular arteries supplying the femoral head may limit its vascularity, increasing the risk of avascular necrosis (AVN) and non-union, these fractures—which make up 45–50% of all hip fractures in older adults—are especially critical [23][24]. Therefore, before choosing the best course of action for intracapsular fractures, it is necessary to carefully evaluate the fracture displacement, patient age, physiological status, cognitive function, pre-fracture mobility, and bone quality [24][25].

The most popular method for categorizing femur neck fractures is still the Garden classification. Based on the degree of displacement, it divides fractures into four categories: Type I (incomplete or valgus impacted), Type II (complete but nondisplaced), Type III (partially displaced), and Type IV (totally displaced) [26]. While displaced fractures (Types III and IV) in older adults are typically treated with hemiarthroplasty or total hip arthroplasty due to the increased risks of fixation failure, non-union, and AVN, Garden Types I and II are generally regarded as stable fractures and are often managed with internal fixation [24][27].

Individualized treatment based on functional status rather than just age is emphasized by current international standards. While hemiarthroplasty continues to be the preferred option for frail individuals with limited mobility or significant comorbidities, total hip arthroplasty may benefit active, cognitively intact older adults with displaced femoral neck fractures due to improved long-term functional outcomes [24][28].

3.2 Extracapsular Hip Fractures

Extracapsular hip fractures, which include subtrochanteric and intertrochanteric fractures, happen distal to the hip joint capsule. In contrast to intracapsular fractures, avascular necrosis is less common since the femoral head's blood supply is typically maintained. However, due to their extracapsular placement and considerable soft tissue damage, these fractures are often linked to major perioperative morbidity, extended immobilization, acute pain, and large blood loss [29][30]. The standard of therapy is surgical fixation, which is mostly dependent on fracture stability, morphology, bone quality, and patient-related factors [24][30].

Intertrochanteric Fractures

About half of all hip fractures in older adults are intertrochanteric fractures, which happen between the greater and lesser trochanters [30][31]. These injuries, which are characterized by different degrees of fracture comminution and instability, typically occur from low-energy falls in osteoporotic people. In order to distinguish between stable and unstable fracture patterns, implant selection and surgical planning are frequently guided by the AO/OTA and Evans classification systems [31][32].

According to available data, early surgical fixation can ease mobilization and lessen the problems that come with extended immobility. While cephalomedullary intramedullary nails are preferred for treating unstable fracture configurations, reverse oblique fractures, and fractures with lateral wall compromise due to their superior biomechanical stability and reduced risk of fixation failure, sliding hip screws, also known as dynamic hip screws, are an effective treatment for stable intertrochanteric fractures [24][30][33].



Subtrochanteric Fractures

10-15 % of hip fractures are subtrochanteric, involving the proximal femoral shaft that extends from the inferior border of the lesser trochanter to about five centimetres distally [30][34]. Because of the competing stresses of the surrounding muscle groups, this area experiences significant mechanical stress when bearing weight, and fractures are frequently accompanied by noticeable displacement. Common etiological variables include high-energy trauma, osteoporosis, and atypical femur fractures linked to extended bisphosphonate medication [34][35].

The substantial biomechanical loads over the fracture site make managing subtrochanteric fractures technically challenging. Compared to extramedullary fixation devices, intramedullary fixation using cephalomedullary nails has become the preferred treatment due to better load sharing, increased fracture stability, quicker weight bearing, and less implant failure [24][33][35]. Accurate fracture reduction, limb alignment restoration, and early postoperative rehabilitation are all necessary for successful results [24][35].

IV. INITIAL ASSESSMENT & PREOPERATIVE OPTIMIZATION

An evidence-based treatment strategy and a multifactorial approach are used in the medical therapy of hip fractures. When a patient first arrives at the emergency room, they are medically stabilized and assessed for potential concomitant injuries [36]. Basic laboratory test results (e.g., complete blood count, Basic Metabolic Panel (BMP), Prothrombin Time (PT)/international normalized ratio, and urinalysis) are obtained after initial stabilization in order to document a preexisting condition and assess anemia, renal function, and coagulation status. At this time, imaging is also done. In most situations, a simple film of both hips and the lateral femur and anteroposterior pelvis is deemed sufficient [37].

4.1 Venous Thromboembolism Prophylaxis

For the majority of orthopedic surgeries, preoperative care is crucial to lower the risk of potentially catastrophic hip fracture consequences such venous thromboembolism. Low-molecular-weight heparin (LMWH) is advised by the American College of Chest Physicians for the majority of patients for a minimum of 10 to 14 days following surgery, with the possibility of an extension to 35 days. The main advice is to begin prophylaxis at least 12 hours before surgery, if at all possible.

In addition, intermittent pneumatic compression devices should also be used for a minimum of 18 hours daily. These recommendations stem from pooled data of hip fracture surgery, total knee arthroplasty, and total hip arthroplasty meta-analyses, revealing the rate of fatal and symptomatic pulmonary embolism and deep vein thrombosis balanced against hazard of symptomatic bleeding events [38].

4.2 Adverse Cardiac Event Risk

Congestive heart failure medications deserve special consideration, as heart failure incidence in the hip fracture population is twice that of nonfractured control patients [39].

The American Heart Association/American College of Cardiology (AHA/ACC) jointly recommends the continuation of beta-blockers in all patients if already instituted. However, the current recommendation discourages the administration of beta-blocking agents on the day of surgery based on the results of the Perioperative Ischemic Evaluation (POISE) trial, which showed a decreased number of cardiac events but an increased risk of stroke and overall mortality with new administration of these agents [40].

The AHA/ACC also recommends continuing statins and the consideration of initiation of statin therapy preoperatively because they have been shown to be acutely beneficial in patients with 1 clinical risk factor for cardiac disease [41].

In 1 meta-analysis of mostly of observational studies, there was improved perioperative outcomes including a 44% reduction in mortality with the acute administration of statin agent [42].



4.3 Pulmonary Evaluation

Pulmonary evaluation is very important in the preoperative evaluation of patients with hip fracture because postoperative complications owing to pulmonary function are equally prevalent as those resulting from cardiac issues. A systematic review by the American College of Physicians (ACP) recommended all patients have an assessment of preoperative risk factors with a specific focus on COPD and congestive heart failure, which were associated with increased morbidity and mortality. Chest radiography is not routinely used because only 0.1% of preoperative chest radiographs result in the modification of perioperative management [43].

The only preoperative evaluation from a pulmonary standpoint that is categorically endorsed by the ACP is a thorough history to evaluate for chronic lung disease, a pulmonary examination and an oxygen saturation measurement.

V. CONTEMPORARY SURGICAL MANAGEMENT

Contemporary surgical management of hip fractures in older adults focuses on early operative treatment, procedure selection based on fracture pattern, and coordinated perioperative care to improve survival and functional recovery. Current guidance recommends surgery as early as possible, preferably within 24 to 48 hours, once reversible medical issues such as dehydration, anaemia, or anticoagulation-related risks have been addressed.

For femoral neck fractures, nondisplaced fractures are usually treated with internal fixation, whereas displaced fractures in older adults are generally managed with arthroplasty. In low-demand patients, hemiarthroplasty is commonly appropriate, while total hip arthroplasty may be considered for healthier, independent, and cognitively intact patients.

For intertrochanteric and subtrochanteric fractures, stable intertrochanteric fractures may be treated with a sliding hip screw or cephalomedullary device, while unstable patterns are best managed with a cephalomedullary nail. Contemporary guidance also supports cemented femoral stems in many arthroplasty cases because they reduce the risk of periprosthetic fracture.

Modern management extends beyond the operation itself. Multidisciplinary orthogeriatric care, early pain control, regional nerve blocks, thromboembolism prophylaxis, early mobilization, delirium prevention, and osteoporosis assessment are all important parts of recovery. These measures help reduce complications, shorten hospital stay, and improve the chance of returning to baseline function [44].

VI. PERIOPERATIVE MANAGEMENT

Perioperative management of hip fractures in older adults should begin immediately after admission and focus on rapid medical optimization, pain control, delirium prevention, and coordination between orthopaedics, anaesthesia, geriatrics, and rehabilitation teams.

6.1 Timing of treatment

Elderly hip fracture patients need comprehensive preoperative evaluation and management, often involving multiple specialties, because of their frequent comorbidities and complications. Many institutions have implemented hip fracture co-management programs to ensure this coordinated care. Within this environment, guidelines for intervention are established, and the great majority of patients can be medically optimized to undergo operation within 24 hours. It should be rare to require delays of more than 48 hours.

Anticoagulation presents an additional variable. Some medications can be actively reversed, whereas others may need to metabolize. The need for continuous anticoagulation, the extent of the surgical intervention, and the type of anaesthesia required will influence the timing of surgery.

6.2 Complications and perioperative care

Postoperatively, 20% or more of elderly patients with hip fractures will develop at least one medical complication. The frequency of complications is predictably higher in those patients with more severe comorbidities, and they have expectedly higher risks of postoperative death. The involvement of anaesthesia and medical consultants in the perioperative care (co-management) of these patients may improve results.



Routine perioperative care for the elderly hip fracture patient should include:

- Early planning for discharge to an appropriate setting – be it home, rehabilitation facility, chronic care facility, or other setting based upon resources available for the individual patient and the local health care system
- Multimodal pain management with care to avoid excessive use of narcotics (to reduce risk of postoperative delirium)
- Prophylaxis against venous thromboembolic disease (VTE), according to institutional protocols, with particular attention to those patients who have increased risk factors, especially prior VTE
- Antibiotics (usually a first-generation cephalosporin) begun just prior to surgery and stopped soon after (typically within 24 hours)
- Nutritional supplementation, since many elderly patients have unrecognized malnutrition, even in the presence of apparently sufficient socioeconomic resources
- Attention to pressure-sore prevention, particularly on the heel of the affected leg (which should be kept off the bed by a pillow that supports the entire calf without producing knee flexion); frequent turning and early mobilization help prevent pressure ulcers in other locations
- Early mobilization out of bed, with supported ambulation beginning in the first postoperative day; this is facilitated by use of appropriately selected surgical procedures allowing for immediate weight bearing as tolerated with walking aids [44].

VII. ORTHOGERIATRIC CO-MANAGEMENT

Older patients with hip fracture frequently have frailty, multimorbidity, dementia, anemia, dehydration, anticoagulant use, malnutrition, and polypharmacy, all of which increase perioperative risk. A purely surgical pathway often misses geriatric issues such as delirium prevention, medication optimization, pressure injury prevention, and early functional recovery. Orthogeriatric co-management addresses these gaps by combining orthopaedic urgency with geriatric expertise [45].

7.1 Main Goals of Care

The main goals of contemporary hip fracture management are to relieve pain, minimize time to surgery, prevent complications, restore mobility, and reduce mortality. Orthogeriatric care also aims to preserve pre-fracture function, reduce delirium, shorten hospital stay, and start secondary fracture prevention early. These goals are especially important because many patients do not return fully to baseline mobility after a hip fracture [45].

7.2 Core Elements of Orthogeriatric Care

A good orthogeriatric hip fracture pathway usually includes the following components:

- Early comprehensive geriatric assessment on admission.
- Rapid identification and correction of reversible medical problems.
- Medication reconciliation and deprescribing of high-risk drugs where appropriate.
- Delirium prevention and management.
- Pain control using multimodal analgesia.
- Surgical optimization without unnecessary delay.
- Early mobilization and rehabilitation.
- Fall-risk evaluation and osteoporosis treatment.
- Discharge planning with family/caregiver involvement [45].

VIII. REHABILITATION AND FUNCTIONAL RECOVERY

Orthopaedic surgeons used to focus on the surgical treatment of hip fractures, with interest in postoperative treatment remaining relatively low. Proper rehabilitation after surgery has been shown to shorten hospital stays, improve physical



function, and help patients maintain independent daily life, outcomes which reduce the burden of medical and caregiver expenses [46].

Because of the high proportion of elderly patients with hip fractures, the effect of rehabilitation after hip fractures on elderly patients is greater than in younger patients. Orthopedic surgeons' interest and participation in postoperative rehabilitation specifically designed for hip fracture patients who underwent surgery are important for proper rehabilitation planning and functional recovery of the patients. Important factors for optimizing rehabilitation plans include fracture type, localization of other injuries, and mode of fixation [47].

8.1. Early Mobilization

Early mobilization is important for optimal postoperative management of patients with hip fractures. Early mobilization includes getting in and out of bed, sit-to-stand, sit from a chair with arms, and walking with an assistive device. This initial strategy is strongly recommended in many guidelines. Weight bearing is allowed except for patients who: were ordered non-weight bearing by the surgeon and

were non-ambulant before fracture. Early assisted ambulation (started within 48 hours of surgery) accelerates functional recovery and is associated with more direct discharge to home and less discharge to high-level care. The National Institute for Health and Care Excellence (NICE) and Australian and New Zealand (ANZ) guidelines both recommend mobilization on the next day after surgery, unless medically or surgically contraindicated [48].

8.2. Physical Therapy in the Acute Care Phase after Surgery

Patients on average lose more than 50% of their fractured limb muscle strength within the first postoperative weeks compared with their non-fractured limb; those with trochanteric fractures experience the greatest relative loss [49]. In addition, patients following a high-intensive physical therapy program (3 daily sessions) in the acute phase in hospital on average reached functional discharge criteria 10 days earlier than the usual physical therapy group (1 daily session) [50]. Patients can start with ankle pumps that perform dorsiflexion and plantarflexion of the ankle after surgery. Knee extension strength training of the fractured limb is feasible when started in the acute phase [51].

8.3 Score Monitoring during the Acute Care Phase

The primary goal of postoperative rehabilitation is to help patients return to their pre-fracture status; therefore, quantification of preoperative and postoperative scores is needed to objectively assess recovery. Measuring preoperative activity scores and comparing them to postoperative follow-up values can help predict functional outcomes of postoperative rehabilitation⁵².

This system can quantify basic mobility information; it focuses on pre-fracture basic mobility and is designed to be used every day post-surgery from the beginning of rehabilitation until independence in basic mobility is reached or until discharge. The modified new mobility score (NMS) focuses on pre-fracture functional levels. This score is easily applicable and provides the ward personal with a prediction of mortality and rehabilitation outcome [52].

8.4 Physical Therapy after Discharge

In many patients with hip fractures, gait and balance functions recover in the first 6–9 months after surgery. During this period, most patients are discharged from the hospital and live at home (with out-patient follow-up) or in nursing facilities. In the subacute period after surgery, physical therapy focuses on enhancing safe mobility and improving muscle function [53].

IX. CONCLUSION

Hip fractures in older adults require a comprehensive approach that extends beyond the treatment of the fracture itself. The increasing burden of frailty, osteoporosis, multimorbidity, and functional dependence makes individualized management particularly important in this population. Current evidence supports prompt clinical assessment,



appropriate medical optimization, and timely surgical intervention, with the choice of fixation or arthroplasty guided by fracture characteristics, bone quality, pre-fracture function, and individual patient factors.

Successful outcomes also depend on effective perioperative and postoperative care. Multimodal pain control, prevention of venous thromboembolism and delirium, appropriate infection prevention, nutritional support, and early mobilization are important components of recovery. Integration of orthogeriatric co-management can facilitate coordinated treatment of medical comorbidities and postoperative complications while supporting functional recovery. Rehabilitation should begin early and continue after hospital discharge according to the patient's mobility, functional capacity, and care needs.

Importantly, treatment should not end with fracture repair. Assessment and management of osteoporosis, correction of modifiable risk factors, fall prevention, and appropriate secondary fracture prevention are essential to reduce the risk of future fractures. Overall, contemporary hip fracture care is best approached as a coordinated pathway involving timely surgery, comprehensive geriatric management, rehabilitation, and long-term fracture prevention. Such an integrated strategy provides a foundation for improving mobility, independence, and quality of life among older adults following hip fracture.

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