SOME ASPECTS OF TRAUMATIC DISLOCATION OF THE HIP

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On an average about ten cases of traumatic dislocation of the hip are seen yearly in the orthopaedic department of the General Hospital, Kuala Lumpur. Over the last few years the numbers have been increasing each year, the reason being an increase in population together with automobiles.

Traumatic dislocation of the hip is rare and comprises from two to five per cent of all dislocations, whereas for the shoulder the figure is fifty per cent. This is due to the inherent stability of the hip joint. Hence considerable force is required to dislocate it.

There are two types of dislocation: (1) Anterior which is subdivided into (a) a pubic or high and (b) an obturator or low dislocation.

(2) Posterior which is also divided into (a) an iliac or high and (b) an ischiadic or low dislocation. Central or acetabular dislocation is not a true dislocation but essentially a fracture of the floor of the acetabulum with the head of the femur driven into the pelvis.

It has been noted that there is locally a high incidence of these dislocations in children. It is difficult to attribute this to any one cause. A possible explanation may be the poor general standard of nutrition of these children. The stability of the hip depends on its bony architecture, a suction pressure, the articular ligaments and the sturdy musculature around the hip. In undernourished children seen locally the muscles are weak and underdeveloped. There is also a lack of padding of adipose and connective tissue around the joint.

In a certain number of cases closed methods of reduction failed and operation was performed. In the majority this was an open reduction using the anterior Smith Peterson approach. Where reduction was not possible a low subtrochanteric osteotomy was done to correct the deformity and re-align the leg.

Figures 1 to 6 depict some of the things that have been stated.

Fig. 1. This shows bilateral anterior dislocations. The patient, a 32 year old male was involved in an accident while driving a truck. He was found by the truck attendant with both hips abducted and flexed. He also had a fracture dislocation of the left shoulder and a subluxation of the left sterno-clavicular joint. The hips were reduced by manipulation and they were immobilised by tieing the limbs together for six weeks. Follow up to one and half years failed to show any avascular changes of the femoral heads.

Fig. 2. This shows a posterior dislocation with fracture of the neck of the femur in a six year old boy following a fall from a height thirteen days previous to seeking medical attention. Closed reduction failed and an open reduction was resorted to. It is still too early to comment on the final result.

Fig. 3. Here one notes a fracture of the shaft of the femur that was associated with a dislocation of the hip. The fracture was fixed internally and an open reduction was done for the dislocation. The picture is of a post-operative X-ray. This reminds one of the importance of excluding a hip dislocation in any fracture of the lower extremity. It has been missed on many occasions due to the fact that the severe fracture had distracted the clinician.

Fig. 4. Illustrates a dislocation with fracture of the acetabulum where a closed reduction has been done. The acetabular fragments need to be replaced.

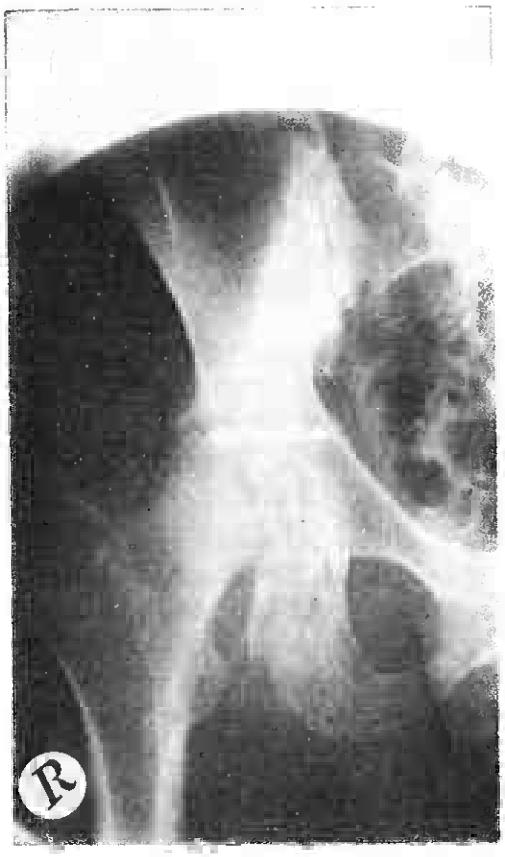

Fig. 5. Shows the same hip as in Fig. 4 following screw fixation of the upper fragment. The lower fragment was jammed into place by the head of the femur.

Fig. 6. This shows a corrective low subtrochanteric osteotomy done in an old posterior dislocation.