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Bilateral asymmetrical hip dislocation with one side obturator intra-pelvic dislocation. Case report



Abdullah Saad Abdulfattah Abdullah*, Ayman Abdelhady*, Abduljabbar Alhammoud*

Hamad Medical Corporation, Department of Orthopedic Surgery, P.O. Box 3050, Doha, Qatar

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ABSTRACT

INTRODUCTION: Hip dislocations usually occur as a result of motor vehicle accidents and require high energy trauma. Bilateral hip dislocations are rare compared to unilateral ones. Most reported cases are asymmetrical simultaneous bilateral anterior and posterior dislocations.

CASE PRESENTATION: This case report describes a 32years female passenger who was involved in road traffic accident and had bilateral asymmetrical hip dislocations with one side posterior and the other side obturator intra-pelvic dislocation. Concentric reduction was achieved by closed reduction of both sides under general anesthesia but the patient required skeletal traction applied to the unstable side for three weeks.

DISCUSSION: Hip dislocation is considered an orthopedic emergency and should be reduced as soon as possible to decrease rate of complications. Since hip dislocation usually occurs with high energy trauma so looking for associated injuries is of paramount importance and assessing such patients should be done according to advanced trauma life support.

CONCLUSION: Obturator intra-pelvic hip dislocation is challenging case and can be treated by closed reduction.

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1. Introduction

In general joint dislocations are more common in male with male to female ratio of about 8:1 with highest incidence among individuals in the 20s years of age [6]. Hip dislocation accounts for 2–5% of all joint dislocations [1]. About 90% of hip dislocations are posterior while bilateral ones are very rare constituting 0.025–0.05% of all dislocations [4]. Most of reported cases are caused by road traffic accident [13]. It is very crucial not to miss associated injuries such as acetabular, femoral head or shaft fractures [14–16]. We present case of 32years female passenger who was involved in road traffic accident and had bilateral asymmetrical hip dislocations with one side posterior and the other side obturator intra-pelvic dislocation, case presented according to SCARE Guidelines [25].

2. Case presentation

A 32 year old female previously healthy, front seat passenger was ejected from the vehicle during a road traffic accident, She was intoxicated with alcohol and was not wearing a seat belt. The patient was brought to the trauma room of Hamad General Hospital (HGH) by ambulance. She was complaining of severe pelvic pain and inability to feel her lower limbs. Physical assessment showed that she was hemodynamically stable with Glasgow Coma Score of 15. There were facial lacerated wounds and multiple burns in the lower limbs, left upper limb and left side of the chest. Right lower limb was flexed, internally rotated and adducted. The left lower limb was flexed, externally rotated and abducted. There were no distal neurovascular deficit.

Radiological assessment revealed right hip posterior dislocation. The left proximal femur (head, neck and greater trochanter) was dislocated inside the pelvis through the obturator foramen with fracture of left superior and inferior pubic rami (Fig. 1)

The patient underwent closed reduction of both hips in supine position under general anesthesia in the operating theatre. The left hip was reduced in two steps, first by traction in the line of deformity with some more flexion which brought the hip out of the pelvis and became as a posterior dislocation. Second step was to reduce the posterior dislocation by traction in the line of deformity, with

* Corresponding authors.

E-mail addresses: abdullahsaad21@gmail.com (A.S. Abdulfattah Abdullah), Ayman2882@hotmail.com (A. Abdelhady), aabdulwahed@hamad.qa (A. Alhammoud).

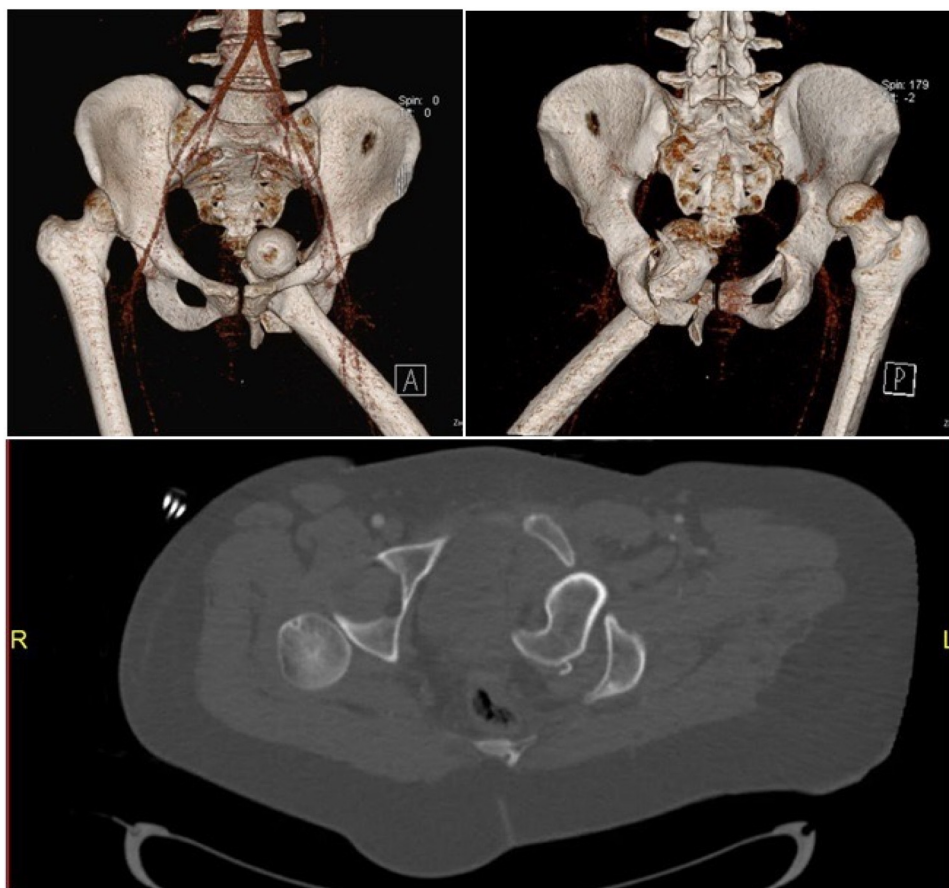


Fig. 1. pre-reduction 3D reconstructive CT Images and axial cuts.

adduction and internal rotation. The right hip was reduced with the same previous technique.

Post reduction the right hip was stable on examination, but the left hip was unstable posteriorly in 90° flexion (although no fracture detected in left acetabulum) plus internal rotation. Thus skeletal traction was applied to the left proximal tibia.

Post reduction pelvic radiograph and computerized tomography (CT scan) of the pelvis showed both hips were concentrically reduced with no intra-articular fragments (Fig. 2).

2.1. Hospital course

The Patient was kept in bed rest for three weeks with abduction pillow then traction was removed and physiotherapy started before she was transferred to burn unit in another hospital for management of friction burn and stayed there for another 3 weeks mobilized on a wheel chair after which she was discharged and travelled outside the country and lost followup.

3. Discussion

In general joint dislocations are more common in male (81%) compared to female (19%) and are commonest in the 21–30 years age group, average age 32.9 years, range 11–65 years [24]. Hip dislocations account for 2–5% of all joint dislocations [1]. Bilateral dislocations of the hip are very rare constituting 1.25% of all hip dislocations [2] and 0.025–0.05% of all joint dislocations [4]. Hip dislocations are 93% posterior with 74.4% associated with fractures mostly hip fractures [7]. Hip joint is very congruent and stable joint

therefore it requires a traction force of more than 400 N for separation [5]. So that hip dislocations whether pure ones or with fracture mostly occur with high energy trauma. Most of reported cases are caused by road traffic accident [13]. Most hip dislocations occur as dashboard mechanism [3]. In this case, our patient sustained asymmetrical bilateral simultaneous hip dislocation with right hip was posteriorly dislocated and left hip was dislocated intra-pelvic through the obturator foramen and was associated with superior and inferior pubic rami fractures.

Buckwalter J et al. reviewed the literatures and found 104 bilateral hip dislocations, 72 in english and 32 in non english literatures, 44 cases were asymmetrical dislocations [24]. Three cases of bilateral obturator hip dislocation, each was reported [21–23]. To the best of our knowledge there were no previously reported bilateral hip dislocations, with obturator intrapelvic dislocation on one side in the English literature.

Hip dislocation should be reduced as soon as possible under general anesthesia in the operating theatre or in the emergency under sedation. In this patient closed reduction was done under general anesthesia in the operating theatre in less than 6 h from the accident. It was reported that avascular necrosis of femoral head is increasing significantly with delayed reduction of hip dislocation from 4.8% if reduced within 6 h to 58.8% if delayed more than 6 h [8]. After hip reduction patient should undergo plain AP radiograph and Computerized Tomography scan of the pelvis with at least 2 mm cuts to detect any intra-articular loose bodies and to ensure concentric reduction [11] and also to detect any associated fractures. In our case the patient had post-reduction Computerized Tomography with 1.5 mm slice thickness. The patient had to

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