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Developmental dislocation of the hip (DDH) is an abnormal formation of the hip joint.

The ball at the top of the thighbone (femoral head) is not stable in the socket (acetabulum).

Also, the ligaments of the hip joint may be loose and stretched. The degree of instability or looseness varies.

A baby born with DDH may have the ball of his or her hip loosely in the socket, the looseness may worsen as the child grows and becomes more active, or the ball may be completely dislocated at birth.

Treatment is easier and safer the earlier the diagnosis is made. Hips found normal at birth can be found abnormal later, but this is rare. Pediatricians screen for DDH at a newborn's first exam and at every well-baby checkup thereafter.

A child's hip may not be dislocated at birth, which means the condition may not be noticed until a child begins to walk, by which time treatment is more complicated and uncertain.

Left untreated, DDH or hip dysplasia

Leads to pain and osteoarthritis by early adulthood.

It may cause legs of different lengths or a "duck-like" walk and decreased agility.

Even with appropriate treatment, especially in the child who is 2 years or older, hip deformity and osteoarthritis may develop later in life.

Risk Factors / Prevention

DDH has a familial tendency.

More in Girls

First born child more chance of dislocation

Babies born in the breech position

Multiple pregnancy

Symptoms

Routine assessment: Pediatrician, Orthopedic surgeon, Midwives

Legs of different lengths.

Uneven thigh skin folds.

Less mobility or flexibility on one side.

In children who have begun to walk, limping, toe walking and a waddling "duck-like" gait are also signs.

Treatment Options

Treatment methods depend upon the child's age.

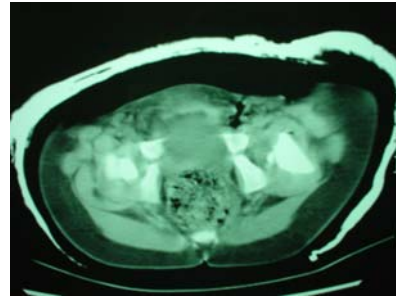
Newborn:

An unstable hip recognized at birth is treated with a soft, simple positioning device (Pavlik harness) for one or two months to keep the hip bone in its socket. This may help tighten ligaments and stimulate normal hip socket formation. In the presence of risk factors or when clinically hip feels unstable, diagnosis is confirmed with an ultrasound examination.



1-6 months

The method is usually successful; if it is not, the joint may be positioned into place under anesthesia (closed reduction) and maintained with a body cast (spica). It is essential to check whether joint is reduced in the spica with a CT scan.



6 months-2 years:

Manipulation of the socket under anesthesia (closed reduction) is the major method of treatment. Open surgery may be necessary. Both require a body cast (spica).

After 2 years:

Deformities may have become severe, making major open surgical intervention necessary to realign the hip. This is followed by a body cast (spica).

The child will need a body cast and/or brace to keep his or her hip bone in the joint while healing after operations. X-rays and other regular follow-up monitoring are needed after DDH treatment until the child's growth is complete. Complications may include a small delay in the development of walking if he or she uses a cast. Positioning devices may cause skin irritation, and a difference in leg lengths may remain. Growth disturbance of the upper thigh rarely occurs

Dislocation in older children: >6months

Need anaesthesia and arthrogram

Arthrogram suggest how good is the reduction or whether it is required to open the joint to place the head of the femur in normal place.

