TRAUMATIC ANTERIOR DISLOCATION OF THE HIP

R. S. HENDERSON, LONDON, ENGLAND

From the Orthopaedic Department, St Bartholomew's Hospital, London

Traumatic dislocation of the femoral head forwards is much more unusual than dislocation backwards. Careful study of the literature has revealed only one case of an anterior dislocation which proved impossible to reduce by manipulation within twenty-four hours of injury.

FIG. 1
Radiograph showing the anterior dislocation.

CASE REPORT

A man aged twenty-nine years was admitted to the hospital in November 1950, complaining of pain and swelling in his right groin and inability to walk. The day before, during a game of association football, he had sprinted with a ball up the left wing and suddenly stopped, at the same time turning to kick towards the centre of the field with his left foot. He had his full weight on the right foot and was turning to kick when he fell, suffering severe pain. **Condition on admission**—The patient was in pain, but his general condition was good. The right lower limb was held in lateral rotation and slight abduction. Below the inguinal ligament was a rounded prominence, over which the femoral artery could be seen pulsating.

The colour, temperature and pulses of the limb were normal. A clinical diagnosis of anterior dislocation of the femoral head was confirmed by a radiograph (Fig. 1).

Treatment—Attempts were made to reduce the dislocation by manipulation under general anaesthesia, but without success. The next day operation was performed. The hip was approached through a Smith-Petersen incision, and the femoral head was found lying in front of the adductor group of muscles, separated from the skin by the stretched heads of rectus. These were detached from their origins and reflected distally. The psoas tendon appeared to be in its normal relationship to the femoral head. Dissection showed that the femoral head had buttonholed the anterior capsule in a part where it is extremely thick, so that the femoral neck was tightly gripped by it. The opening in the capsule was extended upwards and downwards for a distance of about two inches, and it was then possible to guide the head back into the acetabulum by combined traction and manipulation. The rectus origins were sutured into position with stout catgut and the wound closed in layers. The limb was supported on slings with skeletal traction according to the Fisk principle, to allow early combined movements of hip and knee. At the end of two weeks both could be flexed to 90 degrees, and knee extension was powerful. Movements with traction were continued for six weeks, after which time radiographs showed no new bone formation. Exercises were continued and the patient was allowed up. Eight weeks after the injury he was discharged, with full and painless movements of the hip. Full weight-bearing was not allowed for three months. Hip function has since been full, and there has been no radiological evidence of avascular changes in the head.

COMMENT

A similar case described by MacFarlane (1936) resulted from a ski-ing injury, but no record can be found of an anterior dislocation produced by such a simple mechanism as the one described. The usual type of anterior dislocation can be reduced by manipulation (Choyce 1924, Watson-Jones 1943), but in this case the force which had driven the head through the anterior capsule had been so great that its return could not be effected until the capsule had been opened widely. MacFarlane's findings at operation were similar. His patient also made a complete recovery.

I should like to express my thanks to Mr S. L. Higgs for permission to publish this report.

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