

Brief Notes on Pure Obturator Dislocation confeitine Hipction was accomplished by pulling on the

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Abstract

pressure. ere was a non-weight-bearing post-operative proc Traction was withdrawn a er two weeks, and light weight bearin functional and radiological findings were satisfactory and freepframmer and freepframmer and free processing was accomplished.

K 🕅 🚬 : Obturator; Dislocation; Hip post-traumatic

One of the least common dislocations in traumatology is hip obturator dislocation, with only a few occurrences documented in the literature. e very speci c architecture of the hip joint, one of the most congruent joints in the human body, can be used to explain this uniqueness. Numerous stabilisers, including muscles, capsulo-labral structures, and ligamentous structures, surround it. To dislocate the hip, high-energy trauma is required due to the congruency's high level of stability for this joint. Hip [1-5] dislocations is a rare occurrence in e most frequent type of hip dislocation is posterior; athletic training. obturator dislocations are rare, accounting for just 6% to 10% of all occurrences. Due to the signi cant risk of avascular necrosis, which might impact the prognosis and long-term functional outcomes, reduction must be completed within 6 hours. 6 Here, we provide was determined that she had a pure obturator dislocation of the hip. A reduction via external manipulation was carried out while the patient



Figure 1: the intra-articular area are confirmed by a post-reduction scanning.

MS finc **Discipline Fide** Ction was accomplished by pulling on the limb's axis, then bending the hip internally and abducting it and it was successful on the rst try. Fluoroscopy and post-operative radiography proved the reduction (Figure 1). e hip was determined to be stable and in a concentric posture following assessment of post-reduction hip stability and neurovascular health. To rule out an intra-articular osteochondral fragment and to further evaluate the femoral head, a CT scan of the pelvis was performed. For two weeks, the limb was kept in traction to encourage capsulo-labral healing and lower intra-articular pressure. ere was a non-weight-bearing post-operative procedure. Traction was withdrawn a er two weeks, and light weight bearing was

months a er the reduction, sports activities were permitted. Serial radiographs were taken every three months for the rst two years, then monthly, to monitor the patient's condition. e hip was stable and radiographs revealed no evidence of osteonecrosis a er two years of follow-up.

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Hip exion, abduction, and forceful external rotation are followed by obturator dislocation. 2 A similar instance was described in 2015 by Dellanh [6]. ey noted that the most frequently reported mechanism is the shock wave's propagation from the medial side of a bent knee to the hip in exed abducted and externally rotated position. e great trochanter's cam in uence on the iliun in maximum abduction was emphasised by Toms et al. e orthopaedic reduction is crucial to the therapeutic therapy and is urgently needed. Like other writers, we insist on a reduction performed by an experienced surgeon under general anaesthesia with complete muscular relaxation. While Toms et al.7 recommend using an orthopaedic table and combining axial traction with lateral thigh traction, slowly releasing the traction while impregnating an addiction movement and internal rotation, Epstein and Wiss3 and Brav8 recommend traction in the axis of the femur followed by progressive exion of the hip in internal rotation and



abduction. Cases that are irreducible require open reduction using the ilioinguinal method. A case of an open reduction with rectus femoris muscle release was reported by Toms et al. In our situation, the procedure involved rst applying traction to the limb's axis to enable decoaptation, then applying internal rotation to the limb's exion to return it to extension adduction and internal rotation. We believe that this approach is more suitable in light of the femoral head's displacement in an obturator dislocation. Authors have opposed abduction because it can result in femoral neck fractures. e reduced challenges and large risk of problems that can result in a surgical approach for an open procedure are highlighted in these conversations. A er reduction, it's important to [7-10] exclude out acetabulum anterior wall fractures; for this, a CT scan of the pelvis is particularly helpful. Additionally, it will enable the diagnosis of any femoral head osteochondrial lesions or an infra-radiological fracture that is usually linked to this kind of dislocation. ese two factors will de ne the hip joint's functional prognosis, and the patient needs to be made aware of any issues. eoretically, capsulo-labral healing could be aided by post-reduction traction for three to six weeks. A clinical bene t of its use on the long-term risk of avascular necrosis of the femoral head is not, however, supported by current studies. Catonné and co. In the case of anterior dislocations, it is advised to start o not bearing any weight and then add it back on completely on the eenth day. In 85% to 100% of cases, the course of an isolated hip dislocation is good. Necrosis of the femoral head and coxarthrosis are the two primary