Locked Leg

Türkiye Acil Tıp Dergisi - *Turk J Emerg Med* 2006;6(1):40

Ersin AKSAY,[1] Sedat YANTURALI,[2] Selahattin KIYAN,[1] İbrahim TÜRKÇÜER[3]

[1]Ege Üniversitesi Tıp Fakültesi Hastanesi, Acil Tıp Anabilim Dalı

[2]Dokuz Eylül Üniversitesi Tıp Fakültesi Hastanesi, Acil Tıp Anabilim Dalı

[3]Pamukkake Üniversitesi Tıp Fakültesi Hastanesi, Acil Tıp Anabilim Dalı

7. Türk Acil Tıp Sempozyumu'nda poster bildirisi olarak sunulmuştur (27 Kasım 2004, Gaziantep).

Presented at the 7th National Emergency Medicine Symposium (November 27, 2004, Gaziantep, Turkey).

A 42-year old male present to emergency department (ED) after being extricated by emergency medical services personnel following a high-speed motor vehicle collision.. His initial vital signs were normal. Physical examination revealed a right hip which was locked in flexion, abduction and external rotation (Fig. 1). Passive movement of the hip was painful, and the patient was unable to move his lower extremity about the hip joint. Neurovascular examination of the right lower limb was otherwise normal. Anteroposterior pelvic X-ray revealed external rotation and abduction of the femoral shaft and a displaced femoral head in the obturator foramen (Fig. 2).

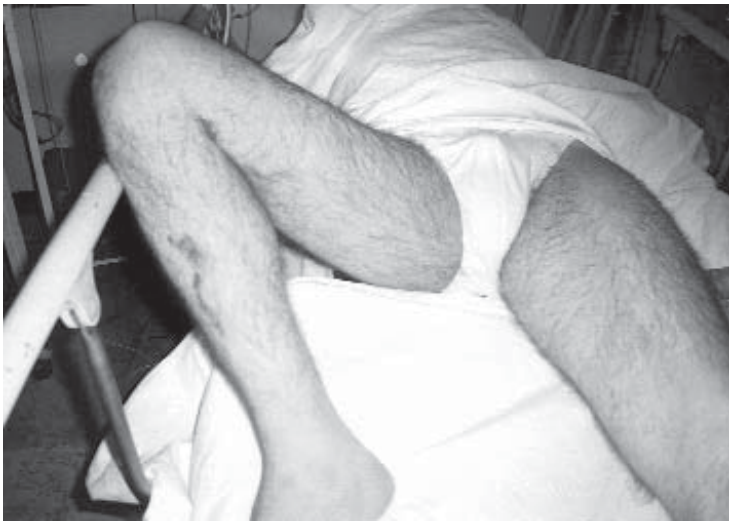

Fig. 1. *The patient as he presented to the emergency department.*

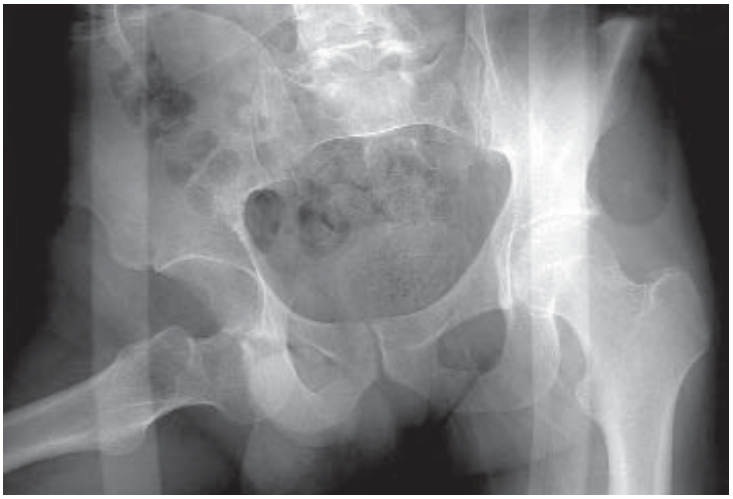

Fig. 2. *Anteroposterior radiograph of pelvis showed a displaced femoral head in the obturator foremen with marked external rotation and abduction of the femur shaft.*

**For the diagnosis and teaching points, see pages 49.*

Correspondence *(İletişim)*

Ersin AKSAY, M.D.

Ege Üniversitesi Tıp Fakültesi Hastanesi,
Acil Tıp Anabilim Dalı,
35100 Bornova, İzmir, Turkey
Tel: +90 - 232 - 390 23 25
e-mail (e-posta): ersin.aksay@ege.edu.tr

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Diagnosis

Obturator Type Anterior Hip Dislocation

Teaching Points

Anterior hip dislocation is an injury related to high speed trauma and is encountered infrequently. It is often associated with automobile accidents, and accounts for 5%-18% of all hip dislocations.[1,2] Obturator hip dislocation results from an abduction, flexion, and external rotation deforming force. The classic appearance of an invidual with obturator hip dislocation is a patient in severe pain with the hip fixed in position of marked external rotation with mild flexion and abduction. In most cases the clinical diagnosis is clear and the anteroposterior radiograph of the pelvis often shows the head of the femur in the obturator foramen.[3]

Hip dislocations are often secondary to high-energy trauma; therefore careful multi-system evaluation for associated life-threatening injuries is essential prior to directing attention solely to the musculoskeletal system. Obturator dislocation is a true emergency; in the absence of potentially life threatening injury when the diagnosis has been made, the reduction should be carried out as quickly as possible. If a closed reduction cannot be achieved under sedation and analgesia with sufficient muscle relaxation, an immediate open reduction is indicated.[4]

References

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