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Inadequate reduction of congenital dislocation of the hip

JA Herring

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To the Editor: In their recent article, "Congenital Absence of the Thenar Muscles" (63-A: 1014-1015, July 1981), Dellon and Rayan report two cases of this condition without an anomaly of the long flexor or extensor tendons. The authors indicate only two previously reported cases. In fact, a number of these cases have been reported. Riordan et al. described treatment of sixteen cases, and we described treatment of ten cases. An additional case was reported by Wissinger and Singesen. While all congenital anomalies of the hand are uncommon, a clinic specializing in these anomalies should see a number of these patients with congenital absence of the thenar muscles and normal extrinsic muscles.

The authors do not specifically state whether congenital anomalies were present in the contralateral hand of their two patients. In our series, most patients also had manifestations of radial dysplasia in the opposite hand. The absent thenar muscles and lax metacarpal-phalangeal ulnar collateral ligament in the "better" hand were frequently overlooked by patients, parents, and referring physicians. We prefer to emphasize that this diagnosis is easily missed, not that it is rare.

We feel that an awareness of the associated metacarpal-phalangeal ulnar collateral ligament laxity is important for appropriate treatment planning. Various authors have described different joint anomalies associated with congenital absence of the thenar muscles. Su et al. described gross hypermobility of the MP joint in both flexion and radial

deviation. Wissinger and Singesen described subluxation of the MP joint and instability of the CMC joint. Our patients all had laxity of the ulnar collateral ligament. Dellon and Rayan describe radial deviation of the interphalangeal joint in one of their patients. In our series, we felt that the ligamentous laxity was due to a primary defect in the joint, not a secondary effect due to absent opposition. Whether there are any important patterns of association between absent thenar muscles and joint anomalies remains a topic for study.

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2. RIORDAN, D. C.; POWERS, R. C.; and HURD, R. A., JR.: The Huber Procedure for Congenital Absence of the Thenar Muscles. *In Proceedings of the American Society for Surgery of the Hand. J. Bone and Joint Surg.*, 57-A: 725, July 1975.
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Dr. Dellon replies:

We thank Dr. McCarroll and Dr. Manske for bringing these additional references to our attention.

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To the Editor: The article by T. S. Renshaw, "Inadequate Reduction of Congenital Dislocation of the Hip" (63-A: 1114-1121, Sept. 1981), by careful selection, proves the point that persistent lateralization after closed reduction of the hip sometimes persists. Severn, in 1950 (and even earlier, in 1941), clearly showed that non-persistent lateral subluxation doesn't persist. In other words, each author, in case after case, proves the opposite point — one showing that lateral subluxation after closed reduction is a very ominous sign and the other, that lateral subluxation after closed reduction frequently resolves. What we really need to know is the answer to the question, "How often does the hip which is somewhat lateral after closed reduction sink in and become satisfactory?" If things work out well only half the time, the indications for open reduction — be it medial or anterior — are much clearer than if, say, it happens 95 per cent of the time.

The other point I would emphasize is that most of the obstructions are things that are pushed into the joint by being unable to pass the hourglass constriction. Thus the labrum is not an offending object, but rather the anlage of the acetabulum. I mention this to discourage the idea of scraping things out of the acetabulum and to encourage the idea of a very thorough release of the inferior medial part of the hip capsule in the transverse acetabular ligament area.

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Dr. Renshaw replies:

To the Editor: The point of our article was simply to document that soft tissues, interposed between the femoral head and the acetabulum at the time of closed reduction of complete dislocation of the hip, can in some cases persist and lead to extremely poor results. Therefore, every patient with CDH must have highly individualized, very closely monitored care. Whether soft-tissue interposition persists and leads to a poor hip half the time, 5 per cent of the time, or 1 per cent of the time is irrelevant to the patient in whom a perfect reduction cannot be achieved by closed means. The indications for open reduction are clear for that patient. Anecdotally, if lateralization persists for more than three weeks, in my experience it is unlikely that closed reduction will succeed, and I would proceed with open reduction. The cartilaginous labrum is the normal rim of the acetabulum and only becomes a problem if the femoral head pushes a fold of hourglass capsule against the labrum and into the acetabulum, these structures adhering and producing the so-called infolded limbus. This situation is best managed by a comprehensive anterior open reduction, dealing with the limbus by making two radial incisions and carefully hinging it out of the acetabulum, as one would open a door. The articular cartilage of the acetabulum should never be injured. The inferomedial hip capsule and transverse acetabular ligament should be released.

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