

Brief Notes on Pure Obturator Dislocation of the Hip

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Abstract

Hip post-traumatic dislocation is a surgical emergency that is typically brought on by a high-energy trauma in a polytraumatized setting. Pure obturator hip dislocations are quite uncommon. It is regarded as an emergency, and a trained surgeon must address it within six hours in order to lower the danger of iatrogenic fractures and femoral head osteonecrosis. Here, we describe a case of a hip dislocation caused solely by the obturator muscle after a high-energy trauma. Under general anaesthesia, the patient received urgent closure reduction treatment. After two years, the

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Introduction:

One of the least common dislocations in traumatology is hip obturator dislocation, with only a few occurrences documented in the literature. The very specific 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 athletic training. The most frequent type of hip dislocation is posterior; obturator dislocations are rare, accounting for just 6% to 10% of all occurrences. Due to the significant 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

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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 first applying traction to the limb's axis to enable decoaptation, then applying internal rotation to the limb's flexion 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. The reduced challenges and large risk of problems that can result in a surgical approach for an open procedure are highlighted in these conversations. After 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. These two factors will define the hip joint's functional prognosis, and the patient needs to be made aware of any issues. Theoretically, capsulo-labral healing could be aided by post-reduction traction for three to six weeks. A clinical benefit 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 with not bearing any weight and then add it back on completely on the seventh 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