



**Veterinary Voice: Tips of the Trade**

<b>Surgery – Traumatic Hip Luxation</b>	
<b>What is a traumatic hip dislocation?</b>	Coxofemoral luxation is most commonly a result of external trauma such as vehicular trauma but especially in small breed pets and those with underlying hip dysplasia, it can be seen during grooming, restraint and sometimes without direct trauma. There is often damage to the joint capsule, ligament of the femoral head and potentially cartilage surfaces of the hip joint. In some cases there can be fractures of the femoral head or acetabulum seen with a luxation. If there is history of external trauma there may be concurrent injuries such as thoracic or abdominal trauma.
<b>How is hip luxation diagnosed?</b>	On physical examination there is a non-weight bearing lameness of the affected pelvic limb with pain on manipulation of the hip joint. With a craniodorsal luxation (the most common direction of luxation), the greater trochanter is elevated on the affected side and the space between it and the tuber ischii is increased. With a craniodorsal luxation there is a shortening of the limb and the dogs will often stand with the leg externally rotated and adducted. With a ventral luxation the trochanter is very difficult to palpate and there is a lengthening of the limb. Many cranioventral luxations and caudodorsal luxations are a result of manipulation of a craniodorsal luxation. Caudoventral luxations can occur spontaneously. Radiographs of the pelvis (both lateral and VD) are imperative to confirm luxation, assess direction of luxation, to rule out concurrent fractures and to assess hip conformation.
<b>What is the treatment?</b>	<p>Closed reduction should be attempted within 48 hours as long as the patient is stable for anesthesia. General anesthesia is required for joint reduction.</p> <p><b><u>Craniodorsal or caudodorsal -hip luxation</u></b> – using a soft rope placed around the leg (in the groin) with an assistant pulling on the rope for traction the leg is externally rotated, traction is applied and then it is internally rotated putting direct pressure on the trochanter. If there is successful reduction the hip should be rotated, flexed and extended while there is continued direct pressure on the trochanter to force any blood clots or joint capsule out of the acetabulum. An Ehmer-type, non-weight bearing sling should be applied for 14 days.</p> <p><b><u>Cranioventral hip luxation</u></b> – using a soft rope placed around the leg (in the groin) with an assistant pulling on the rope for traction, manipulate the hip back into the acetabulum or convert it to a craniodorsal hip luxation. Place leg in hobble type bandage or just advise cage rest for 14 days. Ehmer sling is contraindicated.</p> <p><b><u>Caudoventral hip luxation</u></b> – using a soft rope placed around the leg (in the groin) with an assistant pulling on the rope for traction apply traction to the limb with one hand while the other hand applies counter traction against the ischium to affectively lift the femoral head laterally into the acetabulum. Place leg in hobble type bandage or just advise cage rest for 14 days. Ehmer sling is contraindicated.</p> <p><b>ALWAYS TAKE POST REDUCTION RADIOGRAPHS AFTER THE BANDAGE HAS BEEN APPLIED TO CONFIRM REDUCTION PRIOR TO DISCHARGE FROM THE HOSPITAL.</b></p> <p>If the hip cannot be reduced, is unstable after manual reduction, or if the hip reluxates, then surgery should be considered.</p>
<b>What are the surgical options?</b>	Depending on the size of the patient and the conformation of the hip joint, open reduction and capsulorrhaphy (primary repair of the capsule) or toggle pin fixation are options for open reduction. If there is concurrent fracture, or hip dysplasia then total hip replacement or femoral head and neck ostectomy should be considered.
<b>What is the prognosis?</b>	<p>Approximately 50 % of dislocated hips that are treated with single attempt closed reduction will reluxate requiring a second attempt at closed reduction or surgical correction.</p> <p>Prognosis with open hip reduction is generally good as long as the luxation is not chronic or there is not underlying hip dysplasia or avascular necrosis of the femoral head. In those cases the surgeons at VSCT would recommend total hip replacement or femoral head and neck ostectomy.</p> <p><b>The surgeons at VSCT always assess each patient’s radiographs to make the best recommendation for that pet.</b></p>
<b>Questions? Surgical Experts: Jim Boulay, DVM, MS, DACVS Barb Gores, DVM, DACVS Sharon Shields, DVM, DACVS</b>	The Veterinary specialty Center of Tucson has board-certified surgeons available for questions and consultations on surgical conditions during the weekdays. A member of the surgery team is on-call 24/7 to provide consultations to VSCT emergency doctors and to perform emergency surgery for patients seen by the VSCT emergency service. Board-certified surgeons have four additional years of training and are certified by the American College of Veterinary Surgeons to assure competency in advanced veterinary surgery.