A myelomeningocele child with hip dislocation

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One day after birth:
Open myelomeningocele --- repaired

At age of five:
Community ambulator with AFOs & clutches
  Hydrocephalus (-)
  L3 level with flail ankle
  Quadriceps ---- good
  Hip abductor --- poor

At age of seven:
Right hip ---- subluxation with click
  LLD 0, scoliosis (-), flexion contracture (-)
Myelomeningocele hip
Low-level lesion
with unilateral hip dislocation

Strong quadriceps, weak abductors
Community walker in AFOs
LLD 0
scoliosis (-)
flexion contracture (-)

Should we treat?
Is hip dislocation important?


Flexion contractures interfere with the ability to lie down and stand. Hip dislocation does not cause difficulties. Reduction is unnecessary.

Our strategy

Use of crutches cause difficulties at home. Hip stabilization is important. Reduction is necessary.
1. Adductor tenotomy
2. Open reduction
   interposed tissue removal
   anterior capsulorrhaphy
3. Psoas tenotomy
4. Varus detorsion osteotomy
5. Pemberton osteotomy
6. External oblique
   muscle transfer
Adductor & Psoas tenotomy, Open reduction, DVO, Pemberton osteotomy, External oblique muscle transfer
7Y11M (1M post-op.)
9Y4M (1Y6M post-op.)
9Y4M (1Y6M post-op.)
9Y4M (1Y6M post-op.)
Pemberton osteotomy

Spina bifida

DDH
Spina bifida
DDH
Muscle transfer for more stable gait

Sharrard’s posterior ilio-psoas transfer (1972-1988)

- Tenodesis effect
- No activity as abductor
External oblique muscle transfer (1994- )

Activity (+) on abduction

External oblique muscle
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Upcoming Annual Meeting
2005, November 18-19, Morioka
Dr. HONDA

2006, December 1-2, Fukuoka
Dr. FUJII