Coxa vara valga pdf

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You can help Wikipedia by expanding it.vte This article from the human musculoskeletal system is a stub. You can help Wikipedia by expanding it by expanding it from Drs. Paley and Feldman have extensive experience in treating a wide range of hip problems, with excellent results. At the Paley Institute, we offer the most technologically advanced treatment methods, with an emphasis on joint reconstruction and preservation on joint replacement. The deformity of the hip joint may be due to femoral deformity and acetabular dysplasia. The acetabula is the soque-shaped surface of the pelvis where the femoral head sits. Femoral deformity and acetabular dysplasia are often associated with each other. Femoral deformity may be secondary to acetabular dysplasia and vice versa. Femur deformity will often cause a resulting deformity in the acetabulus, and a deformity of the acetabulus will cause a resulting deformity in the femur. In addition, the shape of the upper femur is affected by any imbalance of the muscle forces around it. For more information, see Dysplasia Hip Deformities can be divided into thigh valve and thigh stick. Thigh valve is a deformity due to increased angle between the head and neck of the femur and its axis (usually 135 degrees). Thigh stick is the opposite: a reduced angle between the head and neck of the femur and its axis. Thigh stick is usually indicated when the angle is less than 120 degrees. Example of normal proximal femoral angles. The MPFA is 85° the NSA is 130° Thigh Valga - NSA Angle is >130° Thigh Stick - NSA angle is <130° Femoral anteversion (inner torsion) can create thigh valve. Thigh valve leads to acetabular dysplasia. In addition, the location of the largest trochanter in a foreseeed femur promotes hip dysplasia. acetabular and femoral anteversion are usually associated with a The Vara Thigh, on the other hand, produces more favorable forces in the acetabula. Therefore, when the thigh stick is seen with hip dysplasia, it is not the cause of dysplasia. Instead, both deformities are caused by the same disease process. An example of thigh stick with hip dysplasia is in congenital femoral deformity may also arise after treatment of hip dysplasia. For example, treatment for avascular necrosis may result in growth in upper femur arrest. This results in greater deformity, such as breva thigh (shortening of the femoral neck) and collapse of the femoral head, resulting in an elliptical or saddle shape. Hip assessment Hip evaluation is important for the development of treatment strategies. The evaluation will include range of motion (ROM), evaluation of hip impact, femoral and tibia rotation profile, hip flexion and abduction strength, and pain. X-rays provide most of the information needed for diagnosis. Computed tomography (CT) may be useful for assessing the shape of the femoral head and acetabula. Magnetic resonance imaging (MRI) can be used to illustrate soft tissues and assess impact. Using X-rays, hip joint orientation angles are measured. These include: Medial proximal femoral angle (MPFA) Neck axis angle (NSA) Lateral distal femoral angle (LDFA) Medial proximal tibial angle (MPTA) Joint preservation surgery Joint preservation surgery for the hip can be divided into two categories: Intra-articular (within the joint) Extra-articular (outside the joint) Indications for surgery are based on the patient's history and physical, x-rays , CT scans and MRI scans. Contraindications to joint replacement include advanced arthrosis and stiffness. When performing osteotomies of the hip joint, it is crucial to consider the surrounding soft tissues. The more extreme and more chronic the hip deformity, the more likely there are associated soft tissue contractures. These should be addressed during surgery with soft tissue releases. In some cases, an osteotomy of the iliac wings of the pelvis is performed to shorten the amount required for muscle relocation. Thigh Valga Correction of the thigh valve is a varus osteotomy of the femur. The normal NSA of the femur is 130 degrees. Angle of range (greater than 135 degrees) put the patient at risk of hip subluxation (dislocation). Treatment involves a pelvic osteotomy combined with varus osteotomy in the upper femur. This will result in good hip stabilization. A good example of femoral osteotomy is nishio osteotomy. This example demonstrates that hip dysplasia can be corrected with osteotomy of the femur and not a pelvic osteotomy. The nishio osteotomy at the base of the neck. Osteotomy allows the proximal femur is turned inward so as not to elevate the largest trochanter. The biggest trochanter is abductor lever arm. Ten years after Nishio's osteotomy, femoral osteotomy should be translated mediated (inward) to avoid a secondary translation deformity. Also, as varus osteotomy shortens the femur this has an effect on the larger trochanter. There is a risk that the larger trochanter may lose both the tension and the lever arm, which can lead to a tilting or trending gear. To avoid this, we will transfer the largest trochanter at the same time as osteotomy. Thigh Stick Correction of the thigh stick is a venomial osteotomy. Thigh stick results from previous treatment or congenital deformity. The angulation center of rotation (CORA) is in the center of the femoral head. Therefore, valgus osteotomy needs to translate laterally (to the outside) to avoid developing a translation deformity. Thigh stick is often associated with other deformities such as flexion and rotation. Correction of deformity often requires correction in the three planes. Therefore, consideration of hip and upper femur muscles is crucial to avoid developing further complications. Our approach is to perform distal osteotomy (down) to the smallest trochanter to minimize tension in the psoas tendon. The larger trochanter is then moved distally (down) increasing tension on the hip abductors and increasing the arm of the abductor lever. The osteotomy is stabilized with internal fixation of the blade plate. This method offers excellent osteotomy control. We developed a method called nail assisted by fixator in which the deformity is first stabilized with an external fixator and then with internal fixation. The external fasteners pins are placed out of the path of the planned nail. Osteotomy is performed and the bone corrected in the desired position. The inner nail is then applied and locked in place. Angled angle for correction of the thigh stick. The blade plate is inserted at an angle of 130° The osteotomy is performed at the base of the smaller trochanter. Lateral translation occurs by aligning the blade plate along the femur. The blade plate is then fastened in place. Excessive growth of the overgrowth trochanteric is evaluated by comparing the medial proximal femoral angle (MPFA) with the neck shaft angle (NSA) of both hips. If the differences are the same, there is no excessive growth of exchangers; if they are different, then excessive trochaneric growth is present. There are three approaches to correct trochaneric overgrowth, each with separate indications: Osteotomy of Wagner Valgus osteotrochantic/subtrochanemic femoral osteotomy combined with lateral-distal transfer of trochanteric osteotomy major Morscher osteotomy Neck osteotomy of intertrochanteric/trochanteric femur increased osteotomy combined with transfer ganz relative osteotomy Approaches have the same underlying goal: to increase the length of the femoral neck. Wagner osteotomy Wagner's osteotomy is used to change the part of the femoral head that is articulating with the acetabula. The other two osteotomies do not change the part of the femoral head that articulates with the acetabula. The main indication is the improvement of congruence and reduction of joint forces when the femoral head is not spherical. The approach is actually two osteotomies: the first is the algo lateral translation osteotomy that reorients the femoral neck of the varus and lengthens the femur; the second osteotomy is a transfer of the largest trochanter to increase the abductor's movement arm. The combination of the two techniques results in greater length of the femoral neck. A - Bilateral severe hip dysplasia with elliptical femoral head on the right sideB - Wagner-type valgus osteotomy performed as well as periacetabular osteotomy (PAO) of the pelvis. The long axis of the elliptical femoral head is now horizontal. The length of the femoral neck is increased Morscher Osteotomy The morscher osteotomy does not alter the orientation of the femoral head in the acetabulum and therefore the congruence of the hip joint remains the same. The indication is when there is no need to change the congruence of the joint. The NSA angle is affected by femoral osteotomy; an osteotomy of 130 degrees will result in an NSA angle of 130 degrees. Then a major exchangenteral osteotomy is performed at the same angle and shifted distally (down) and laterally (out). The effect is to lengthen the femoral neck. A - Conradi-Hünermann syndrome with breva thigh and rod and trochanterB grown - Treatment by Morscher osteotomy with neck elongation and exchangentericaC transfer - Pelvic osteotomy was performed, as well as stretching of the short femur. The hip is well covered, protecting it during stretching of Ganz Osteotomy Ganz osteotomy is combined with a capsulotomy and a safe-surgical dislocation of the hip. There is less danger to femoral head circulation than with the other two approaches because dislocation helps prevent femoral head injuries. A combined intra-articular and extra-articular impact of the hip is best addressed with this approach. This osteotomy creates a relative elongation of the femoral neck by shifting the trochanter laterally (outwards) and distractingly (down). The femoral axis is not laterally moved, however, a big difference with morscher osteotomy. Ganz's osteotomy does not lengthen the femur, as Morscher and Wagner approach. A - Congenital short femur with thigh stick and grown trochanter. An anterior pelvic osteotomy had been performedB - Relative stretching of Ganz's neck and intercanalistic transfer Intra-articular Deformities Of the hip are deformities of the head in his femoral neck connection. An example is the deformity of the shape of the femoral head. Intra-articular and extra-articular surgical procedures can be performed to correct intra-articular deformities. One example is the deformity of the femoral head in relation to the neck created by a femoral epiphysis of slippery capital can be treated by an intra-articular reduction or osteotomy or an extra-articular reorientation osteooritomy. For more information, see Femoral Epiphysics of Slippery Capital Another example is that a non-spherical femoral head can be treated by a Ganz femoral head reduction osteotomy (FHRO). For more information, see Perthes Disease Summary In summary, a personalized a la carte approach to surgery makes more sense for treating the wide range of hip deformities. At the Paley Institute, our approach is to normalize anatomy and muscle forces while preserving the original anatomical structures. This approach has given excellent results, prolonging hip life for our patients while addressing their pain and disability. Disability.