

Caring for your child with developmental hip dysplasia

The advice in this leaflet should make parents and carers feel more confident in caring for your child who has a dislocation of the hip that is associated with developmental hip dysplasia.

What is developmental hip dysplasia?

Developmental dysplasia of the hip (DDH) is a term used to cover all aspects of infant hip abnormalities, from unstable or 'clicky' hips, to hips that are not in their socket (dislocated hips). The condition may be present at birth or can develop soon after.

What causes developmental dysplasia of the hip?

- The cause of DDH is unclear. However, having a family history of hip dysplasia is a major risk factor.
- Girls are more likely to have DDH than boys.
- Breech presentation incurs a risk of DDH.
- An increased release of hormones to relax the pelvic muscles in childbirth at the time of delivery also affects the baby by increasing the baby's joint laxity.

Managing DDH

If a child is over 5 months old when DDH is picked up, or if splintage (use of splints) has not been successful, a time in hospital will be needed to manage the condition and attempt to relocate the dislocated hip.

The process for the management of your child's hip would have been explained to you prior to admission. This process will be that your child will be taken to the orthopaedic theatre where she/he will be given a general anaesthetic. While she/he is asleep, a dye is injected into the hip joint that allows clear X-ray pictures to be taken of the hip socket.

The hip is examined and, if possible, the femoral head is manipulated back into joint. The hips are then plastered in a 'frog-like' position, which keeps the femoral head in the socket.

This allows for re-growth of the socket and to stabilise the hip. Re-development of the hip can take many months to years.

The plaster will need to be changed at 6 weeks. At this point, your child is re-admitted for the day to have this done under a short general anaesthetic.

The type of plaster cast can vary. In most cases, the affected side is fully plastered.

Care of plaster (hip spica)

- The plaster – known as a hip spica – takes 48 hours to dry fully. After this time, a waterproof tape is applied, to help protect the plaster from soiling.
- Always check the edges of the plaster for rough or tight areas. These can cause problems so seek advice from the nursing team.

- Observing the temperature and colour of toes helps to alert you to any problems of the plaster becoming too tight and restricting the circulation. Toes should be warm and pink.
- While wearing the plaster, no baths are allowed. Regular washes will help to keep your child comfortable and clean.
- Regular nappy changes will help reduce soiling to the plaster. Use disposable nappies. Ask the nursing staff on the ward for assistance before you go home.
- Most modern buggies are suitable to carry a child in a normal size hip spica. Check the size of car seats to make sure that it will be large enough to fit your child in a plaster spica.
- Beanbags are a good form of moulded seating.

Removing the plaster and fitting a splint

The plaster will be removed after a total of 12 weeks. A specialist usually does this in the plaster room. When the plaster is taken off, a splint known as a hip abduction splint is applied.

An X-ray is then taken in the new splint. The splint will stay on until the socket has developed fully the time period varies with each child. You will be given a further outpatient appointment for 6-8 weeks' time.

The splint should not be removed. However, looking after the splint is easier than the plaster and it is a lot less cumbersome. Allow your child to start moving around at their own pace. Remember, they will now be able to be more active, so make sure their environment is safe. Regular follow-ups will be arranged and it is only when your child's hips appear stable and the socket has developed sufficiently that the splint will be removed.

After the splint is taken off, your child should be allowed free movement. Never be tempted to hurry them along. Their hips may stay in a 'frog' like position for a while until their legs reposition themselves back to the neutral position.

Follow-on care continues for a number of years. This is to ensure that the hip continues to develop correctly.

Contacting us

If you require any further advice, please contact:

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Please ask if you need this information in another language or format.

A Lee, Paediatric Orthopaedic Unit, April 2021

Next review due: April 2023