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because abduction is symmetrical and ab duction may be normal when there is low muscle tone and joint laxity . In a dislocated hip, the femoral head may be palpable in the buttock. /uni25CF Ultrasonographic assessment . Ultrasonography defines the anatomy and the stability of the hip joint. It is used as a screening tool (universally or selectively for ‘at risk’ patients) (Figure 44.14). Screening scans should be performed between 4 and 6 weeks of age and treatment, when necessary , started by 6 weeks. The sonographic appearance of most hips impro ves (in terms of both hip stability and acetabular dysplasia) spontaneously as the baby grows. /uni25CF Radiography . Plain radiographs are used from 4–5 months of age, when the relationship of the femoral ossific nucleus to the acetabulum can be assessed; late ossi fication of the nucleus is common in DDH (Figure 44.15 Infant Hip checks, looking for limitation of abduction in more than 90° of flexion and limb shortening, are part of developmental monitoring. Child Children present with a Trendelenburg gait and/or unilateral tiptoeing, as the a ff ected leg is short. Abduction in flexion is Friedrich Trendelenburg , 1844–1924, successively Professor of Surgery at Rostock (1875–1882), Bonn (1822–1895) and Leipzig (1895–1911), Germany . The neonatal clinical examination must ask and answer the following questions: /uni25CF /uni25CF /uni25CF /uni25CF). /uni25CF /uni25CF - limited and there may be an extra thigh crease. The signs may be subtle and easily missed in an unsteady toddler. If both hips are a ff ected there will be a waddling gait and a lumbar lordosis. - Adolescent Discomfort after exercise is common but the pain may be in the knee. In all age groups, radiographs may show dysplasia, sublux - ation or dislocation. Summary box 44.6 -). Diagnosis of DDH /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

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