Screening for the detection of congenital dislocation of the hip

Sir,

We have read with interest the special report on ‘Screening for the detection of congenital dislocation of the hip’ prepared by an advisory committee for the Secretary of State. It is recommended that the Ortolani/Barlow manoeuvre be carried out within 24 hours of birth; first the Ortolani procedure then the Barlow manoeuvre, ‘with the thumb on the inner side of the thigh, backward pressure is applied to the head of the femur,’ if a ‘clunk’ is obtained, ‘the head is said to be subluxable (dislocatable).’ In other words, the hip is dislocated.

One of us (CH) has noticed increasing laxity in the hip joint of an infant who has been repeatedly examined to show physical signs to junior medical colleagues. In view of the risks associated with ‘excessive manipulation of the hip joint’, the advisory committee recommend that ‘duplication of the examination by both midwife and doctor should be avoided. Each maternity unit should determine its own policy in this respect to ensure that there is only one examination.’ We submit that this advice is unrealistic and that in practice a midwife who discovers that she can dislocate a hip will continue to ask the resident doctor to confirm her finding and this will be checked by a paediatric registrar or consultant, or both. The orthopaedic surgeon will probably carry out a further examination before applying a splint for what has become a recurrent dislocation.

The Southampton experience of an increasing incidence of late congenital dislocation in an area practising enthusiastic neonatal screening with a reluctance to undertake unnecessary early splinting leads us to the conclusion that Barlow’s manoeuvre in the first two days of life was converting normal joint laxity into established dislocation.

Barlow’s manoeuvre does not distinguish between a normal hip and one that untreated will develop an established dislocation. Barlow showed that dislocatable hips are much more common in the first three days than later in the first week, and no cases of late dislocation were discovered in his infants who were first examined after the age of 3 days.

We consider that during the first 48 hours of life when ligamentous laxity is so common great care should be taken not to dislocate a baby’s hips either by swaddling with adducted thighs or by Barlow’s manoeuvre. At this time clinical examination should be directed to discovering established dislocation by looking for asymmetry, apparent shortening of the femur, restriction of abduction, and a ‘clunk’ by the Ortolani procedure.

We welcome the recommendation that repeated ex-

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Sir,

It has always been my impression that the chance of detecting congenital dislocation of the hip would be increased if the number of examinations by an experienced observer were increased. In the recent article on congenital dislocation of the hip it is stated, ‘In view of the risks associated with excessive manipulation of the hip joint, duplication of the examination by both midwife and doctor should be avoided.’

What is the scientific evidence that there are such risks, and if there is indeed a risk what is its incidence?

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References


Dr Dunn comments:

Thank you for inviting me as a member of the SMAC/SNMAC working party under the chairmanship of Professor E Stroud to respond to these letters.

Drs Cheetham and Garrow’s first point deals with a semantic problem. Most abnormal hips at birth are of the unstable, subluxatable variety. They can be partially dislocated by backward pressure when the thigh is adducted and flexed. We included the word ‘dislocatable’ in parenthesis because this term is in common use, even though such hips do not fully dislocate, as may be shown at necropsy.

Next they question our exhortation to avoid excessive manipulation of the hip joint, a point also raised by Dr Blumenthal. The working party thought it important to emphasise that repeated examination might damage an unstable hip. While there is no clinical evidence to support or refute this belief, manipulation of the unstable hip at necropsy seems to increase hip instability. The artery in the ligamentum teres is also vulnerable to trauma. Of course, it was appreciated that some repetition of hip examination was necessary as part of the ongoing screening process as well as to confirm the diagnosis in suspected cases.
In their third paragraph Drs Cheetham and Garrow draw attention to the Southampton study, making reference to 'an area practising enthusiastic neonatal screening with a reluctance to undertake unnecessary early splinting' and leads us to the conclusion that Barlow's manoeuvre in the first two days of life was converting normal joint laxity into established dislocation.' My own interpretation is different and may be found elsewhere.1

Next your correspondents claim, on the basis of Barlow's 1962 study, that hips that become stable in the first three days of life will not dislocate later. If this was Barlow's experience then he was indeed lucky. Over the years I have observed 25 occasions when unstable hips became stable in the first week of life but subsequently required treatment for dislocation or dysplasia. This evidence was available to the working party and influenced the advice they gave. It will be published in due course.

For reasons just discussed Drs Cheetham and Garrow conclude that a baby's hips should not be examined during the first 48 hours of life. In my view this is dangerous advice and in the past is likely to have been responsible for many of the missed cases of congenital dislocation of the hip in babies that have been examined 'at birth'. At the same time they recommend that neonatal examination should seek signs of established congenital dislocation of the hip with limited abduction, shortening of the leg, etc. The working party also made this recommendation, though in fact these classic signs are quite rare at birth and are often associated with neuromuscular disease or severe prenat al oligohydramnios due to Potter's syndrome.

Reference

Case conferences—for child abuse

Sir,

I think it is excellent that the Archives are publishing the beginnings of a debate on the issue of case conferences for child abuse. The policy document on child abuse written by the Society of Clinical Psychiatrists requires response. In my view what is put forward about case conferences is one sided, and although they may represent many professionals' considerable anxieties about the system, there are other views and research.1 The notion that case conferences are 'one of the most pernicious aspects of the (child abuse) procedures' requires challenge.

The notion that because case conferences are dangerously irresponsible because of having no continued existence in their own right is in my view an illogical and unhelpful statement. Professionals attend case conferences in role and they have to be personally accountable for any decisions that they help make. The current draft guidelines from the Department of Health and Social Services (DHSS) (April 1986) emphasise the responsibilities of conferences to 'produce and record clear, timely and reasonable recommendations to the agencies providing services'. Chairing should be 'by an experienced person, not directly involved in supervising the case at field level'. The responsibility for the management of child abuse is not placed on the case conference but on the agencies providing services and both through recommendations about chairing and key work social services departments are given this responsibility in a clear, precise way.

The second point is made that case conferences 'entail a gross breach of professional confidence... 'Character assassination' may proceed without even the safeguards of a court of law and that there is an unrestricted and irrevocable dissemination of defamatory allegations.' Yet on the other hand, inquiry after inquiry indicates that someone somewhere has the information that, if it had been shared, might have prevented the death of Jasmine Beckford. Hallatt and Stevenson have indicated that anxiety about such cases can be massive, case conferences can be contagious, and anxiety can increase and escalate and decisions can be made that are unhelpful and not thought through.2 It is vital that good chairing takes control of what information is shared and is aware of group processes that can be destructive and those that can mobilise resources and concerns for the family. In my view the directive from the Home Office and DHSS,3 which enabled the police and other professionals to take part in conferences and share information, has been a power for good, particularly when decision making is by consensus and respects the interests of the child without an unnecessarily punitive approach to the parents.

There is a criticism that case conferences are ineffectual because:

(a) Conferences cannot make crucial decisions, only highly trained professionals can.
(b) Even if people are there who can make such crucial decisions, they cannot do so unless they have had a proper contact with the case.
(c) Treatment cannot be offered unless the resources, both human and context wise, are known about.
(d) The case must be kept under review by a skilled professional.

In my view this series of arguments about case conferences is fallacious. It is true that often professionals who could make such assessments and therefore contribute to decisions are not present because they are not involved. Child and family psychiatric teams are not used sufficiently to help conferences think about the long term possibilities and needs of particular cases. If such a professional has made an assessment of the family, however, he should have no difficulty convincing the case conference of the needs of that family and the facilities available for it, because so often the court will have to be convinced of the same issues. Case conferences will be only too pleased if such a skilled professional offers to take on the supervision and work with families and to use the conference for statutory professionals to report on progress or otherwise.

Drs Chapman and Woodmansey are really putting forward an impassioned plea that child and family psychiatric professionals do play a role in the management of child abuse.4 As a result of having chaired most child abuse case conferences at Great Ormond Street for almost 20 years, I am in absolutely no doubt that the case conference system can be a highly effective way of bringing together information from many different sources, for