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Hip dislocation after internal fixation without infection

In their paper (A rare case of hip dislocation after internal fixation of a femoral neck fracture without infection. *Can J Surg* 1995;40[1]:56-8) Younge and Loisel reported a case of hip dislocation after dynamic hip screw (DHS) fixation of a femoral neck fracture. They pointed out that it was the second reported case this complication not associated with infection.

I recently reviewed the literature when preparing a report of such a complication, and to my knowledge 2 more cases of nontraumatic dislocation of the hip following fixation of a femoral neck fracture have been published.

In 1981, Iwegbu[1] reported the case of a 78-year-old woman who had dislocation of the hip after Ender nailing (with 5 nails) of an intertrochanteric fracture. On postoperative day 8, a radiograph showed that 3 of the nails had cut out of the head and neck. The 3 protruded nails were removed and replaced. Iwegbu speculated that 1 or more holes had been made in the posterior aspect of the joint capsule during either the initial operation or the revision operation. When the woman began walking after the revision operation, the femoral head subluxated through the breach in the capsule and gradual capsular stretching resulted in dislocation.

In 1995, Munjal and Krikler[2] reported another case of hip dislocation after DHS fixation of a trochanteric fracture, in an 85-year-old man, 2 weeks after surgery. At revision, the capsule was found to be completely detached from the trochanteric line anteriorly. The hip was reduced and the capsule reattached. The authors speculate that a simultaneous major soft-tissue injury was present at the front of the hip joint and was unrecognized at the time of the first operation. They assumed that the dislocation was a complication of the initial injury rather than of the operative technique.

In these reports, as in the case of Younge and Loisel, there was no evidence of infection. The exact cause of the dislocation is difficult to ascertain. The most likely causative factor in Younge and Loisel's case was the medial displacement of the distal fragment. Curiously, in the case of Munjal and Krikler there was also slight medialization of the femoral diaphysis, less pronounced than in the case reported by Younge and Loisel. However, the factor of a torn capsule, that allowed a progressive dislocation, cannot be discarded and is a common factor in these 3 cases.

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2. Munjal S, Krikler SJ. Dislocation of the hip following intertrochanteric fracture. *Injury* 1995;26(9):645-6.

Fournier's gangrene: a historical vignette

The recent article in the Journal on Fournier's gangrene (*Can J Surg* 1996;39[6]:448-9) prompted me to trace the history of this lethal condition. I present an English translation of what appears to be the first report of Fournier's gangrene, from the *Canon of Medicine* by the famous Persian physician Avicenna.[1]

The section on ulceration of the scrotum, penis and the anal verge states:

> Ulcers that occur in this region quickly become violent because these organs allow the corruption to spread rapidly. This is because these organs are lacking in air, and are exposed to heat and humidity and are in close proximity to the waste passages. The appearance of these ulcers resembles those that occur in the viscera and the mouth. The most dangerous ones are those that affect the muscle at the root of the penis and the anus because they need adequate dryness and this is very sensitive and painful. It may also be necessary to amputate the penis itself if these ulcers become corrupt and spread.

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Reference

1. Ibn Sîna [Avicenna]. *The canon of medicine*. Vol 2, book 3. Boulaq editing [Arabic], Cairo; 1877. p 554.