Introduction

Hip dislocations after primary total hip arthroplasty are among the most frequent complications are the third leading cause of revision surgery (after the instability and infectious processes). Frequency dislocation after primary arthroplasty, according to different authors, varies from 0.3 to 12.9%. After the first episode of the likelihood of repeated dislocations is about 33%. Most dislocations (50 to 70%) occur during the first 3 - 6 months after the operation - "early" dislocations. Possibility of hip dislocations is determined by many factors - features of defeat of the hip joint, resulted in the arthroplasty, factors associated with the peculiarities of surgery.

Objective

Analysis of own observations of hip dislocations after primary total hip arthroplasty, the identification of predisposing factors and optimization of program of rehabilitation patients.

Material and methods

After 912 primary total hip arthroplasty (844 patients) have observed 69 cases of primary dislocations of the hip (7.56%). Indications for primary total arthroplasty were coxarthrosis, aseptic necrosis of the femoral head, developmental dysplasia of the hip, femoral neck fractures, arthritis of the hip after conservative or surgical treatment of acetabular fractures. Most hip dislocations (65 patients) occurred within the first 4 to 6 weeks after surgery.

Results

After the reduction of dislocation and a comprehensive rehabilitation in the following artificial joint was stable, providing good or excellent functional results. Dislocations often occurred when using the head 28 mm (10.74 %). Decrease in frequency (4.48 %) when using heads 32 and 36 mm. The need for revision surgery on the hip occurred in 4 patients due to recurrent posterior dislocation, the cause
of lack position of acetabular component. Determined predisposing factors. 1. Violation of motion in the operated hip - the most common (88.4%) the cause of dislocations. The risks of dislocations are higher in overweight patients, in elderly and senile age, transient disorders of consciousness, accompanied by general muscular hypotonic or general hypertonic (hypoglycemia, epilepsy convulsive attack) during the early days after the arthroplasty. With the defeat of both hip joints spinal deformity should take into account the possibilities and conditions for the adaptation of the patient to specific biomechanical disorders after the operation to changing parameters of movements. 2. The axial deformations of the operated limb - at the level of the thigh, the knee, shin and foot. In 4 patients had dislocation of the hip in the early postoperative period were due to the peculiarities of of support on the operated limb in connection with the existing preoperative axial deformation. Hip replacement surgery was performed using the anterior-lateral surgical approach. Forced to external rotation leg when walking, predisposes to recurrent anterior dislocations. After surgical removal of deformations restored the stability of the hip. Stability was restored by surgically. 3. Functional failure of previous pelvic muscles after reconstructive surgery on the hip joint. Predominance of this factor we have seen in 17 patients. 4 of them had been operated on for nonunion femoral neck fracture, 6 - about acetabular fractures. The most difficult situation we have seen in 7 patients with developmental hip dysplasia. Should be anticipated difficulty duo to severe scar changes gluteal muscles, combined contracture, the presence of ossification, the need for bringing down the thigh, and the inability to restore the offset due to the deformation of the trochanteric region. We used percutaneous muscles fixation, restoration of the joint capsule, and plastic with local tissues if defects. It is very important to choose the correct anteversion of "cup" with regard to surgical approach, especially if there is a defect of the anterior wall of the acetabulum.

Conclusion
Possibility of hip dislocations after primary total hip arthroplasty is determined by many factors. Planning for the operation, including the choice of implant design and surgical approach must take into account the somatic and mental status of the patient's local and systemic biomechanical disorders. The rehabilitation period is required an individual choice program of rehabilitation treatment.