Some experts categorize DDH into two major groups: (1) **idiopathic**, in which the infant is neurologically intact, and (2) **teratologic**, which involves a neuromuscular defect, such as arthrogryposis or myelodysplasia. The teratologic forms usually occur in utero and are much less common.

Three degrees of DDH are illustrated in Fig. 29-14.

1. **Acetabular dysplasia:** This is the mildest form of DDH, in which there is a delay in acetabular development evidenced by osseous hypoplasia of the acetabular roof that is oblique and shallow, although the cartilaginous roof is comparatively intact. The femoral head remains in the acetabulum.

2. **Subluxation:** The largest percentage of DDH, subluxation, implies incomplete dislocation of the hip. The femoral head remains in contact with the acetabulum, but a stretched capsule and ligamentum teres cause the head of the femur to be partially displaced. Pressure on the cartilaginous roof inhibits ossification and produces a flattening of the socket.

3. **Dislocation:** The femoral head loses contact with the acetabulum and is displaced posteriorly and superiorly over the fibrocartilaginous rim. The ligamentum teres is elongated and taut.

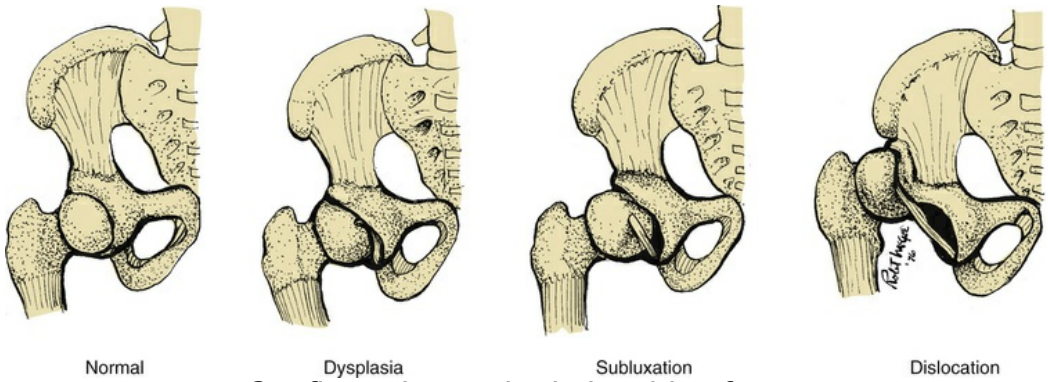

FIG 29-14 Configuration and relationship of structures in developmental dysplasia of the hip (DDH).

Factors related to infant handling are indicated in the Cultural Considerations box.