
PREAMBLE

This document is an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. Practice Parameters and Technical Standards are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. For these reasons and those set forth below, the American College of Radiology and our collaborating medical specialty societies caution against the use of these documents in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the practice parameters, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the practice parameters when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of the practice parameters. However, a practitioner who employs an approach substantially different from these practice parameters is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Therefore, it should be recognized that adherence to these practice parameters will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective care.

1 Iowa Medical Society and Iowa Society of Anesthesiologists v. Iowa Board of Nursing, ___ N.W.2d ___ (Iowa 2013) Iowa Supreme Court refuses to find that the ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures (Revised 2008) sets a national standard for who may perform fluoroscopic procedures in light of the standard’s stated purpose that ACR standards are educational tools and not intended to establish a legal standard of care. See also, Stanley v. McCarver, 63 P.3d 1076 (Ariz. App. 2003) where in a concurring opinion the Court stated that “published standards or guidelines of specialty medical organizations are useful in determining the duty owed or the standard of care applicable in a given situation” even though ACR standards themselves do not establish the standard of care.
and safe medical care. The sole purpose of these practice parameters is to assist practitioners in achieving this objective.

I. INTRODUCTION

The clinical aspects contained in specific sections of this practice parameter (Introduction, Indications/Contraindications, Specifications of the Examination, and Equipment Specifications) were revised collaboratively by the American College of Radiology (ACR), the American Institute of Ultrasound in Medicine (AIUM), the Society for Pediatric Radiology (SPR), and the Society of Radiologists in Ultrasound (SRU). Recommendations for physician requirements, written request for the examination, procedure documentation, and quality control vary among the organizations and are addressed by each separately.

This practice parameter is intended to assist practitioners performing sonographic studies for detection and assessment of developmental dysplasia of the hip (DDH). Adherence to the following recommendations will maximize the probability of detecting most of the abnormalities that relate to acetabular morphology, position of the femoral head, and stability.

Ultrasound is the preferred method for diagnostic imaging of the immature hip, when available [1,2]. It affords direct visualization of the cartilaginous components of the hip joint. The value of ultrasound diminishes as the femoral head ossifies, and therefore radiography is preferable for patients 6 months of age or older, unless the acetabulum (including the triradiate cartilage) is adequately visualized sonographically.

II. INDICATIONS/CONTRAINDICATIONS AND TIMING

Indications for ultrasound of the infant hip include, but are not limited to:

1. Abnormal or equivocal findings on physical or imaging examination of the hip.
2. Any family history of DDH.
4. Oligohydramnios and other intrauterine causes of postural molding.
5. Neuromuscular conditions.
6. Monitoring patients with DDH being treated with a Pavlik harness or other splint device.

Two of the strongest risk factors for DDH are: a female newborn with frank breech presentation at birth and a family history of a parent and/or a sibling with DDH [3]. It is recommended that these patients undergo ultrasound screening 4 to 6 weeks after birth.

There are no absolute contraindications to ultrasound of the infant hip for DDH, but as discussed above, the study becomes less reliable compared to radiography as ossification of the femoral head progresses. Due to the presence of physiologic laxity, hip sonography is not performed on patients younger than 3 to 4 weeks of age, unless there are clinical findings indicative of dislocation or significant instability [4].

III. QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

Each organization addresses this requirement individually. ACR language is as follows:

See the ACR–SPR–SRU Practice Parameter for Performing and Interpreting Diagnostic Ultrasound Examinations.
IV. WRITTEN REQUEST FOR THE EXAMINATION

Each organization addresses this requirement individually. ACR language is as follows:

The written or electronic request for an ultrasound examination for detecting developmental dysplasia of the hip should provide sufficient information to demonstrate the medical necessity of the examination and allow for its proper performance and interpretation.

Documentation that satisfies medical necessity includes 1) signs and symptoms and/or 2) relevant history (including known diagnoses). Additional information regarding the specific reason for the examination or a provisional diagnosis would be helpful and may at times be needed to allow for the proper performance and interpretation of the examination.

The request for the examination must be originated by a physician or other appropriately licensed health care provider. The accompanying clinical information should be provided by a physician or other appropriately licensed health care provider familiar with the patient’s clinical problem or question and consistent with the stated scope of practice requirements. (ACR Resolution 35, adopted in 2006)

V. SPECIFICATIONS OF THE EXAMINATION [5,6]

Both hips should be examined. The diagnostic examination for DDH incorporates two orthogonal planes: a coronal view in the standard plane at rest, and a transverse view of the flexed hip with and without stress. This enables an assessment of hip position, stability, and morphology when the study is correctly performed and interpreted. If position, stability, and/or morphology cannot be assessed when attempting to perform a complete examination, the report should note the portion not done. It is acceptable to perform the examination with the infant in a supine or a lateral decubitus position.

Morphology is assessed at rest. The stress maneuver (posterior push maneuver) is performed to evaluate for hip instability with the hip and knee flexed and the thigh adducted (Barlow maneuver). If the femoral head is subluxated, subluxable, dislocated, or dislocatable, reducibility can be assessed by abducting and externally rotating the hip (Ortolani maneuver). If the examiner chooses, additional views and maneuvers can be obtained. It is important that the infant be relaxed when hips are assessed for instability. Feeding the infant during the examination can increase comfort and cooperation. (Caution: application of stress is omitted when hips are being examined in a Pavlik harness or splint device unless otherwise requested by the orthopedic surgeon) [7].

A. Coronal View

The anatomic coronal plane is approximately parallel to the posterior skin surface of an infant. If the superior edge of the transducer is rotated 10 to 15 degrees (usually posteriorly) into an oblique coronal plane, the ilium will appear straight. After adjustment to assure that the imaging plane is through the deepest part of the acetabulum (which includes visualization of the triradiate cartilage and the ischium posteriorly), the resulting image will be a coronal view in the standard plane.

The standard plane is defined by identifying a straight iliac line, the tip of the acetabular labrum, and the transition from the os ilium to the triradiate cartilage (see Figure 1). The coronal view in the standard plane can be obtained with the hip in the physiologic neutral position (15 to 20 degree flexion) or in the flexed position femoral head position and displacement are noted. Acetabular morphology is assessed in this view and may be validated by measuring the acetabular alpha angle (≥60 degrees). Validation by angle and femoral head coverage measurement is optional [7]. Performance of stress in this plane is also optional.
B. Transverse Flexion View

The examination is performed with the hip flexed at 90 degrees. The transverse plane is the anatomic transverse or axial plane (similar to the plane of an axial computed tomography (CT) image) (Figure 2). The femoral shaft is seen anteriorly, terminating in the femoral head which rests on the ischium. The hip is tested for position at rest with passive abduction and adduction. Next, gentle stress is applied to assess stability. The transducer is placed in a posterolateral position so that imaging can be accomplished while the hip is abducted and adducted (Ortolani and Barlow maneuvers). If the relationship of the femoral head to the posterior acetabulum changes with gentle stress, the hip is unstable. Transverse view of the hip flexed 90 degrees at the hip.
C. Modification of the Diagnostic Examination

The supervising physician may modify the examination depending on clinical circumstances, such as during or following treatment for DDH.

VI. DOCUMENTATION

Each organization addresses this requirement individually. ACR language is as follows:

Adequate documentation is essential for high-quality patient care. There should be a permanent record of the ultrasound examination and its interpretation. Comparison with prior relevant imaging studies may prove helpful. Images of all appropriate areas, both normal and abnormal, should be recorded. Variations from normal size should generally be accompanied by measurements. Images should include the patient identification, facility
identification, examination date, hip being imaged, image orientation, and whether stress is being applied. An official interpretation (final report) of the ultrasound examination should be included in the patient’s medical record indicating acetabular morphology, position of femoral head, and stability [8]. Retention of the ultrasound examination images should be consistent both with clinical need and with relevant legal and local health care facility requirements.

Reporting should be in accordance with the ACR Practice Parameter for Communication of Diagnostic Imaging Findings.

VII. EQUIPMENT SPECIFICATIONS

Hip ultrasound for detecting developmental dysplasia of the hip should be performed with the highest frequency transducer that permits penetration of the soft tissues, preferably a linear transducer. Acetabular measurements reported in the literature are made with a linear transducer. Total ultrasound exposure should be kept as low as reasonably achievable (ALARA), while optimizing diagnostic information.

VIII. QUALITY CONTROL AND IMPROVEMENT, SAFETY, INFECTION CONTROL, AND PATIENT EDUCATION

Each organization addresses this requirement individually. ACR language is as follows:

Policies and procedures related to quality, patient education, infection control, and safety should be developed and implemented in accordance with the ACR Policy on Quality Control and Improvement, Safety, Infection Control, and Patient Education appearing under the heading Position Statement on QC & Improvement, Safety, Infection Control, and Patient Education on the ACR website (http://www.acr.org/guidelines).

Equipment performance monitoring should be in accordance with the ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment.

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This practice parameter was revised according to the process described under the heading The Process for Developing ACR Practice Parameters and Technical Standards on the ACR website (http://www.acr.org/guidelines) by the Guidelines and Standards Committee of the ACR Commission on Ultrasound in collaboration with the AIUM, the SPR, and the SRU.

Collaborative Committee – members represent their societies in the initial and final revision of this practice parameter

ACR
Henrietta Kotlus Rosenberg, MD, FACR, FAAP, Chair
Richard M. Benator, MD, FACR
Dorothy I. Bulas, MD, FACR
James S. Donaldson, MD, FACR

AIUM
Brian D. Coley, MD
T. Rob Goodman, MD
Harriet J. Paltiel, MD

SPR
Lynn A. Fordham, MD, FACR
Boaz K. Karmazyn, MD
Dayna M. Weinert, MD

SRU
Harris L. Cohen, MD, FACR
Valerie L. Ward, MD

Committee on Practice Parameters – Pediatric Radiology
(ACR Committee responsible for sponsoring the draft through the process)

Eric N. Faerber, MD, FACR, Chair
Committee on Practice Parameters - Ultrasound
(ACR Committee responsible for sponsoring the draft through the process)

Beverly E. Hashimoto, MD, FACP, Chair
Sandra O. DeJesus Allison, MD
Marcela Bohm-Velez, MD, FACP
Helena Gabriel, MD
Ruth B. Goldstein, MD
Leann E. Linam, MD
Maitray D. Patel, MD
Henrietta Koltus Rosenberg, MD, FACP, FAAP
Sheila Sheth, MD, FACP
Robert M. Sinow, MD
Maryellen R.M. Sun, MD
Sharlene A. Teefey, MD, FACP
Jason M. Wagner, MD

Marta Hernanz-Schulman, MD, FACP, Chair, Pediatric Commission
Deborah Levine, MD, FACP, Chair, Ultrasound Commission
Debra L. Monticciolo, MD, FACP, Chair, Quality and Safety Commission
Julie K. Timins, MD, FACP, Vice Chair, Practice Guidelines and Technical Standards

Comments Reconciliation Committee
Philip L. Lund, MD, FACP, Chair
Wendy D. Ellis, MD, Co-Chair
Kimberly E. Applegate, MD, MS, FACP
Richard M. Benator, MD, FACP
Dorothy I. Bulas, MD, FACP
Harris L. Cohen, MD, FACP
Brian D. Coley, MD
James S. Donaldson, MD, FACP
Eric N. Faerber, MD, FACP
Howard B. Fleishon, MD, MMM, FACP
Lynn A. Fordham, MD, FACP
T. Rob Goodman, MD
Beverly E. Hashimoto, MD, FACP
Marta Hernanz-Schulman, MD, FACP
Boaz K. Karmazyn, MD
Deborah Levine, MD, FACP
REFERENCES


*Practice parameters and technical standards are published annually with an effective date of October 1 in the year in which amended, revised, or approved by the ACR Council. For practice parameters and technical standards published before 1999, the effective date was January 1 following the year in which the practice parameter or technical standard was amended, revised, or approved by the ACR Council.

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