Bilateral Congenital Dislocation of the Knee

A female infant was delivered at 39 weeks of gestation via cesarean delivery because of nonreassuring fetal status. Prenatal sonography performed 1 week before delivery revealed oligohydramnios. Postdelivery, both knees were hyperextended, with no other anomalies (**Figure 1**). Radiography of both knees showed posterior dislocation of the femur on the tibia (**Figure 2**); thus, bilateral congenital dislocation of the knee was diagnosed.

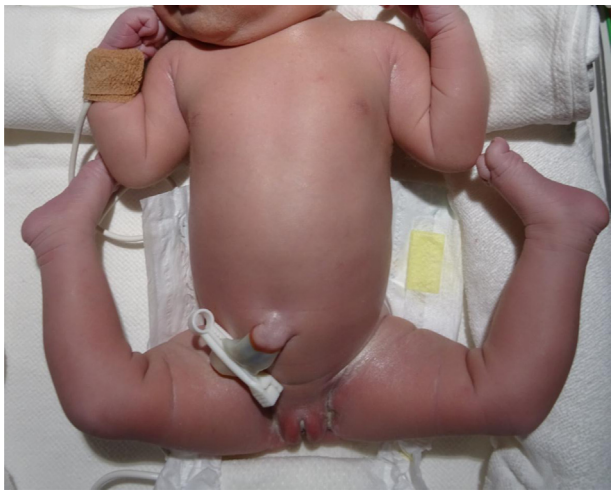

Figure 1. Hyperextension of the knee joints bilaterally.

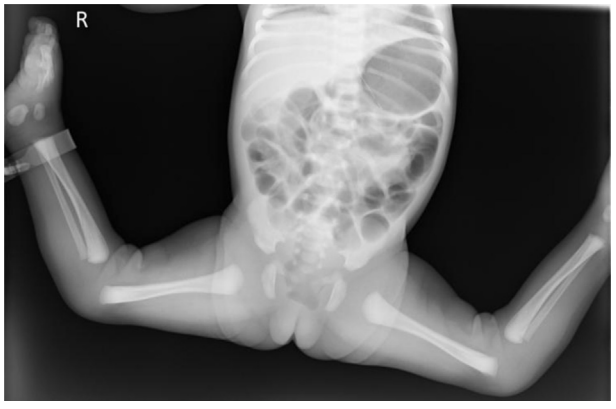

Figure 2. Radiograph showing posterior dislocation of the femurs on the tibias.

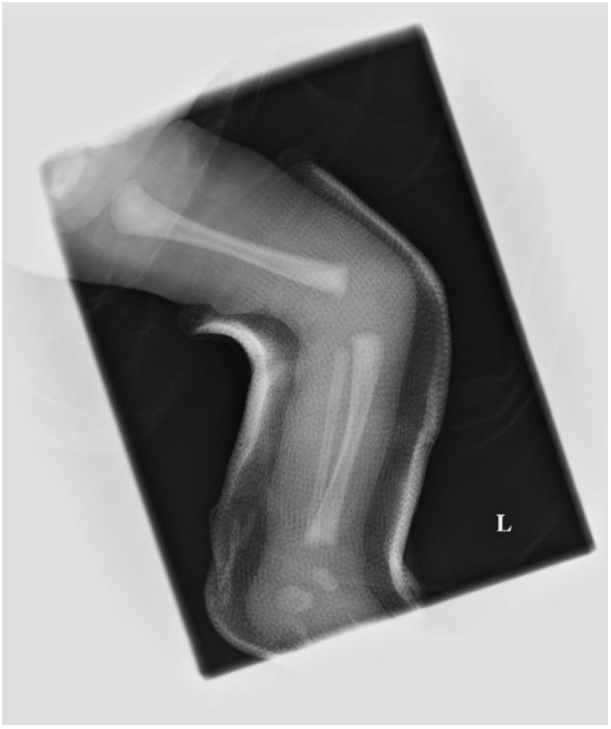

Figure 3. Treatment of both knee joints by serial casting in the functional position.

Both knees could be flexed by manipulation. We performed serial casting for both knees in the functional position (**Figure 3**) for 1 month, after which bilateral congenital dislocation of the knee appeared to have resolved.

Congenital dislocation of the knee is a congenital malformation characterized by hyperextension of the knee. The deformity can be unilateral or bilateral, with an estimated incidence of 1 in 100 000 deliveries and has a female predominance.[1] The etiology of congenital dislocation of the knee might involve extrinsic factors, including fetal molding due to oligohydramnios or breech position, abnormalities of the anterior cruciate ligament, and quadriceps contracture, or, rarely, intrinsic factors, such as Larsen syndrome, arthrogryposis, Ehlers–Danlos syndrome, and achondroplasia.[2] Successful management depends on the severity of the congenital knee dislocation and includes physiotherapy, serial casting, and/or surgery. Typically, the prognosis is favorable; however, it can be severe in complicated cases. Poor prognostic factors include irreducible dislocation, coexisting general syndromes, and absence of the anterior skin groove.[3] ■

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Asymmetric Overgrowth and a Facial Port Wine Stain

A 3-month-old girl presented with generalized marbling of the skin (cutis marmorata) and a striking port wine stain on the philtrum present since birth (Figures 1 and 2). A bilateral sandal gap between the great and second toes (Figure 3), macrodactyly of the left second toe, overgrowth of both feet, hands, and her right leg as well as joint hypermobility were noted. Upon physical and neurologic examination, including measurement of head circumference, no other pathologic findings were observed. Cranial, spinal, abdominal, and hip ultrasound examination, echocardiography, ophthalmologic examination, and otoacoustic emissions testing were unremarkable. Differential diagnosis include infantile hemangioma, Sturge-Weber syndrome, posterior fossa anomalies, hemangioma, arterial anomalies, cardiac anomalies, and eye anomalies (PHACE) syndrome, Wyburn-Mason syndrome, or a syndrome within the PIK3CA-related overgrowth spectrum (PROS), such as

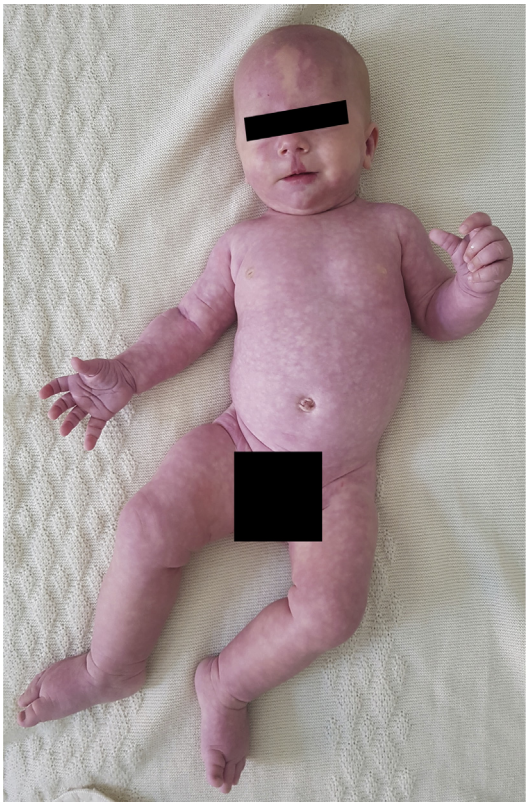

Figure 1. Infant girl with MCAP syndrome at the age of 3 months.

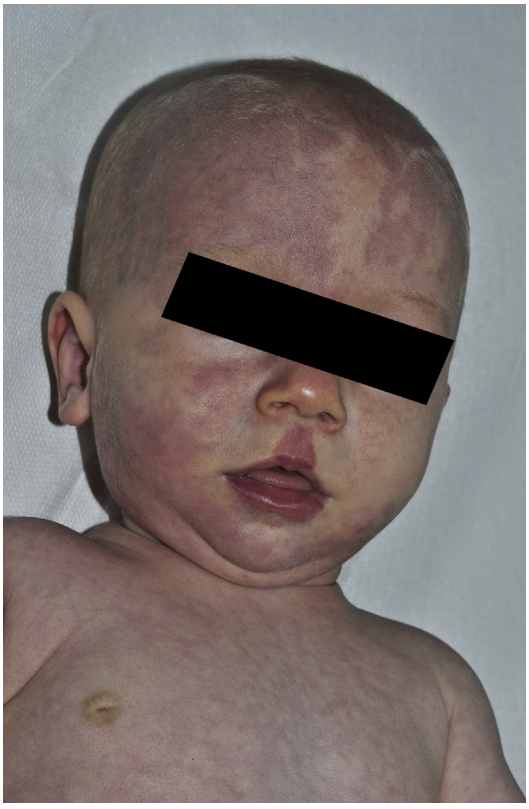

Figure 2. Facial port wine stain at the age of 6 months.

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