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Figure 1

A 39-year-old lady presented to accident and emergency department with pain in her buttock and anal region following an accidental fall. She landed on her buttock in a sitting position while skating three days before. She started experiencing pain in her nether region after the fall and took some simple analgesics for the pain. But the pain intensity increased while driving and sitting which led her to seek medical advice. A sacral xray was taken (Figure 1).

What is the diagnosis?

Answer: refer to page 110

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(Refer to page 95)

Answer: Anterior Dislocation of the coccyx

This is an anterior dislocation of the coccyx (**Figure 1**). The patient was admitted to the department of Orthopaedics. Under spinal anaesthesia, reduction of the coccyx per rectum was attempted but failed. Patient was discharged with analgesics and advised avoid putting pressure on her coccyx for three weeks and regularly followed up in orthopaedic clinic. After six months of the incident, the patient had no further pain or tenderness in the coccyx region. The patient resumed all her activities normally without any discomfort.

Acute anterior dislocation of coccyx is extremely rare. In current literature, this type of dislocation occurs sporadically following some form of accidental fall or trauma to the sacral region and treatment are usually either closed or open reduction of the fracture or conservatively with analgesia.^{1,2,3} The result of both types of treatment are reported to be satisfactory.

Kim et al. reported a closed reduction of the dislocation using a joy stick technique

new technique have shown promising results. Fang et al. reported the 56 cases of fracture dislocation of coccyx with the application of both open reduction and internal fixation (ORIF) and closed reduction methods with similarly good results.³

Coccygeal instability and coccydynia are also common complications after dislocation or fracture dislocation of the coccyx.⁴ Surgical resection for such complications of coccygeal fracture is still controversial, with intractable post-traumatic coccydynia being an indication to surgery and results after the surgical resection are not very encouraging.⁴

Our patient agreed for a trial of closed manipulation under anaesthesia, failing which she refused for further surgical intervention and opted for conservatively treatment with analgesia and rest. The later is just as effective although recovery time may be prolonged.

CONCLUSION

Coccyxal dislocation is an extremely rare and can be treated conservatively with excellent result.

REFERENCES

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