Flex Therapist CEUs

Sacral and Pelvic Ring Injuries

1. Which of the following anatomical structures is not part of the pelvic ring?

A. Ilium
B. Sacrum
C. Femur
D. Ischium

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2. What factor significantly contributes to the higher occurrence of sacral and pelvic injuries in urban areas?

A. Low engagement in preventive health measures
B. Increased rates of high-energy trauma
C. Higher prevalence of osteoporosis
D. Greater accessibility to healthcare facilities

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3. Which classification system is used to categorize sacral fractures based on their location and potential neurovascular involvement?

A. Denis' classification
B. Tile's classification
C. OTA classification
D. Young and Burgess classification

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4. When dealing with sacral and pelvic ring injuries, what is a common complication that may arise due to the anatomical proximity of these structures?

A. Neurovascular damage
B. Muscle hypertrophy
C. Rapid bone healing
D. Decreased ligament elasticity

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5. Which of the following statements accurately describes the role of the sacroiliac joints in biomechanics?

A. The sacroiliac joints provide extensive mobility and limited stability.
B. The sacroiliac joints allow limited motion while providing significant stability.
C. The sacroiliac joints allow rotational movements only.
D. The sacroiliac joints are insignificant in weight distribution.

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6. Which factor contributes to the increased risk of pelvic injuries in older adults?

A. High bone density
B. Lower heights of falls
C. Increased muscle mass
D. Decreased bone density

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7. In the Denis classification of sacral fractures, which zone typically requires surgical intervention due to its complexity?

A. Zone 1 - Lateral Zone
B. Zone 2 - Central Zone
C. Zone 3 - Medial Zone
D. Zone 1 and 2 - Combined

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8. What is the primary advantage of percutaneous screw fixation in the surgical management of sacral and pelvic ring injuries?

A. Increases the risk of nerve injury
B. Involves large incisions for better access
C. Minimizes soft tissue disruption
D. Provides less stable fixation compared to open surgery

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9. Which imaging modality is crucial for revealing subtleties in complex pelvic ring injuries when X-rays are insufficient?

A. Ultrasound
B. Magnetic Resonance Imaging (MRI)
C. Computed Tomography (CT)
D. Bone Scan

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10. In sports-related pelvic injuries, what type is commonly characterized by fractures at muscle attachment sites due to sudden movements?

A. Avulsion fractures
B. Compression fractures
C. Shear fractures
D. Lateral fractures

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11. In which situation is lumbopelvic fixation more likely to be utilized compared to iliosacral fixation?

A. Stabilization of sacroiliac joint disruptions with minor instability
B. Sacral fractures with vertical instability

C. Treating simple sacral fractures without nerve involvement
D. Providing support for low-energy trauma fractures

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12. Which of the following is a potential complication specific to iliosacral or lumbopelvic screw placement?

A. Chronic post-operative pain from soft tissue injury
B. Infection resulting from improper incision management
C. Nerve injury due to screw misplacement near sacral roots
D. Limited range of motion due to poorly fitted implants

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13. What is a primary benefit of decompression of neural elements in sacral fractures?

A. Maintaining vascular supply to injured areas
B. Relief of neurological symptoms caused by nerve root compression
C. Increasing sacral fracture stabilization to enhance healing
D. Preventing musculoskeletal compensations

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14. When is nonsurgical management preferred for sacral and pelvic ring injuries?

A. In cases of high-energy trauma with multiple fractures
B. When the fractures are stable and when surgical intervention is not appropriate or necessary
C. For vertical shear fractures with significant displacement
D. For sacral fractures affecting nerve root function

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15. Which early physical therapy intervention helps both in controlling pain and ensuring basic functional independence?

A. Progressive resistance training for lower extremities
B. Use of pelvic binders to stabilize pelvic fractures
C. Gait training with assistive devices
D. Intense cardiovascular exercises to maintain fitness

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16. Which of the following is critical when considering joint mobilization techniques for patients with sacral and pelvic ring injuries?

A. Ensuring minimal movement to prevent further injury
B. Targeting flexibility without considering historical fractures
C. If there is history of a fracture or there is extensive soft tissue damage
D. Focusing on the lumbar spine exclusively

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17. What is a primary focus of conservative management for stable pelvic ring fractures?

A. Encouraging early high-impact activities to test stability

B. Allowing natural healing while managing weight-bearing
C. Immediate surgical intervention
D. Maximizing immobilization to prevent any risks

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18. Which therapeutic approach is recommended for a patient like Lisa with chronic pain and fear of reinjury?

A. Immediate introduction to high-intensity exercises
B. Patient education on chronic pain science coupled with activity restriction
C. Graded exposure to activities along with psychological support
D. Exclusive focus on pharmacological pain management

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19. What key aspect of rehabilitation should a physical therapist prioritize when working with patients like John to enhance gait stability?

A. Focus on isometric exercises only for core strengthening
B. Gradually increase weight-bearing with emphasis on gait analysis
C. Isolate lower extremity strength training
D. Rely solely on balance exercises without addressing muscle weakness

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20. What type of intervention aligns best with addressing psychological challenges in patients with sacral injuries?

A. Exclusive use of cognitive-behavioral therapy for all patients
B. Pain management techniques with minimal patient interaction
C. Collaborative approach involving education, cognitive strategies, and emotional support
D. Strictly focusing on physical symptoms without psychological considerations

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