

# 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. Managing spinopelvic dissociation and 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. Reducing the risk of permanent neurological damage
  - 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 surgical risks outweigh benefits
  - 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 following weight-bearing precautions
  - 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. Balancing flexibility improvement with tissue healing
  - 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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