Trauma FQE

1. **Garden classification of fractures is used in**
2. Supracondylar fracture humerus
3. **Fracture neck femur**
4. Galleazi fracture dislocation
5. Fracture tibia
6. **The following are types of fracture classification EXCEPT?**
7. Anatomic description
8. **ABO classification**
9. Salter-Harris classification
10. Gustillo open fracture classification
11. **Pre-operative management of surgical patient, the following baseline laboratory investigations are useful EXCEPT?**
12. Haemogram
13. Urea, electrolyte & creatinine
14. Blood sugar
15. **C – reactive protein**
16. **Early complications of fracture midshaft humerus include**
17. **Injury to radial nerve**
18. Osteoarthritis
19. Injury to median nerve
20. Compartment syndrome
21. Indications for open reduction include the following except
22. Failed closed reduction
23. **Displaced simple fractures**
24. Displaced Articular fractures
25. Accompanying neurovascular injury
26. The following is the correct direction of pin insertion during traction
27. Distal femur: Lateral - Medial
28. **Proximal Tibial: Lateral - Medial**
29. Calcaneus: Lateral - Medial
30. Distal femur – Lateral – Medial.
31. **Clinical tests of union the following EXCEPT**
32. Absence of mobility between the fragments.
33. **Absence of angulation on observation.**
34. Absence of tenderness on firm palpation over the site of fracture.
35. Absence of pain when angulation stress is applied at the site of fracture.
36. Concerning Thomas Splint?
37. Used in shaft femur fractures
38. Used in shaft Tibial fractures
39. Used in supracondylar fractures.
40. Used in neck of femur fractures
41. Best diagnostic aid in blunt trauma chest is
42. CT Scan
43. Ultrasound
44. **CXR**
45. Pleural aspration
46. One of the following Is TRUE concerning Salter Harris classification
47. Type I - through metaphysis.
48. Type II - through metaphysis & ephysis
49. **Type III - through physis & epiphysis**
50. Type IV - through metaphysis & epiphysis
51. **Signs of inadequate tissue perfusion are except**
52. **Pink skin color**
53. Pale skin color
54. Cool clammy skin
55. Altered level of consciousness
56. **Immediate complications of fractures include the following EXCEPT**
57. Local visceral injury
58. **Muscle injury**
59. Haemarthrosis
60. Ligament injury
61. **Causes of non union include the following EXCEPT**
62. Inadequate blood supply to one or both fragments
63. excessive shearing movement between the fragments
64. interposition of soft tissue between the fragments
65. **Alignment between the fragments**
66. The following is not free concerning Dislocation and subluxation
67. A joint is dislocated or luxated when its articular surfaces are wholly displaced one from the other, so that all apposition between them is lost.
68. A joint is subluxated when its articular surfaces are partly displaced but retain some contact one with the other
69. Dislocation or subluxation of a joint may be congenital, spontaneous traumatic or recurrent.
70. **It is only with traumatic**
71. **Spiral fracture is due to:**
72. Blunt trauma.
73. Axial compression.
74. **Twist.**
75. Direct impact.
76. Supracondylar fracture of the humerus in a child
77. is due to a fall on the point of the elbow
78. is usually compound
79. **requires admission of the patient after reduction**
80. is a fracture dislocation of the elbow
81. Bone dysplasia is due strictly to
82. faulty nutrition
83. osteomyelitis
84. **faulty development**
85. Trauma
86. Non-union is common in fractures of the following bones except the:
87. Carpal scaphoid
88. Neck of the femur
89. Lower third of the tibia
90. **Tuberosity of the fifth metatarsal**
91. In the following types of fractures of long bones,crepitus can be elicited only in:
92. Fissures
93. Subperiosteal cracks
94. **Spiral and oblique fracture**
95. Impacted fractures
96. A lateral blow at the level of the knee joint may cause:
97. Rupture of anterior cruciate ligament
98. Rupture of medial collateral ligament
99. Avulsion of medial meniscus
100. **All of the above**
101. At the stage of clinical union of a fracture of tubular bone
102. The bone bridging the fracture has normal radiological appearance
103. **Local palpation produces little or no tenderness**
104. Consolidation has occurred
105. The swelling at the fracture site has disappeared
106. In posterior dislocation of the hip which one is NOT TRUE
107. The leg is flexed
108. **The leg is externally rotated**
109. Reduction is usually easy
110. 50 % of dislocations are followed by avascular necrosis of the femoral head if there is delay in reduction.
111. Montegia's fracture:
112. **Fracture upper 1/3 of ulna & dislocation of head of radius**
113. Fracture upper 1/3 of radius with dislocation of head of ulna.
114. Fracture lower 1/3 of radius with dislocation of ulna.
115. Fracture lower 1/3 of the ulna with head of radius.
116. Fracture upper 1/3 of ulna with dislocation of head of ulna.
117. Which of the following is NOT a Character of Montegia's fracture:
118. Anterior type is commoner than posterior type (90% and 10%).
119. Anterior (extension) type is unstable fracture.
120. **Anterior type is less liable to complications.**
121. It is better treated by open reduction and internal fixation.
122. Above which level will the patient be tetraplegic rather than paraplegic
123. C7
124. C8
125. T1
126. T2
127. What percentage of patients with blunt trauma to the aorta who survive to hospital will be dead within 24 hours if left untreated
128. 10%
129. 20%
130. 30%
131. 50%
132. Which of the following is NOT a component of vital signs
133. Respiratory rate
134. Pulse rate
135. **Pulse oximeter**
136. Temperature
137. Airway interventions can be supported by
138. Suction of secretions
139. Chin lift/Jaw thrust
140. **Nasopharyngeal airway**
141. Nasogastric tube
142. Immobilization of spinal cord requires
143. **Rigid cervical spinal collar**
144. Long rigid spinal board
145. Immobilization on flat surface such as stetcher
146. Crepe bandage
147. The manoeuvre that is used to open the airway of a suspected neck injury for an unconscious patient is;
148. Head tilt-chin lift.
149. **Jaw thrust.**
150. You do not open the airway because it will damage the spinal cord.
151. You ventilate the nose instead.

Section B

1. **Stability of fracture spine depends on:**
2. shape of the fracture.
3. **comminuted fractures are less stable than noncomminuted ones.T**
4. intact anterior longitudinal ligament is the most important factor.
5. **intactness of the posterior longitudinal ligament is the most important factor responsible for stability.T**
6. wedge fractures are usually unstable.
7. **Burst fracture of the body of vertebra:**
8. **it occurs on top vertical compression.T**
9. **rupture of body of vertebra and inter vertebral disc.T**
10. it is a stable fracture.
11. **posterior ligament is intact.T**
12. spinal cord is liable to be injured by a piece of bone.
13. **Supraspinatus tendonitis is associated with**
	1. rotator cuff injuries
	2. tendon calcification
	3. painful arc syndrome
	4. frozen shoulder
	5. **Pancoast syndrome**
14. **Stage of spinal shock in complete cord damage:**
15. it occurs immediately after cord injury.T
16. it lasts for 48 hours. T
17. there is complete sensory loss.T
18. there is suppression of visceral reflexes.T
19. retention of urine is characteristic. T
20. Regarding the trimodal distribution of deaths which statement is incorrect
21. 80% of trauma deaths occur in the first hour T
22. 80% of trauma occur days or weeks later
23. Rapid trauma care has greatest level of impact on outcomeT
24. 20% of trauma deaths occur days or weeks laterT
25. 20% of trauma deaths occur immediately
26. Clinical signs of shock include the following
27. Tachycardia T
28. Altered mental statusT
29. **Convulsions**
30. Hypotension T
31. **Hypertension**

SHORT answer.

1. Name 10 common presenting complaints of trauma patients

Pain

Swelling

Deformity

Stiffness

Locking

Instability

Weakness

Abn Sensation

Loss of Function

1. Name 5 local causes of pathological fractures.

LOCAL DISEASE OF BONE

Infections

Pyogenic osteomyelitis (usually in chronic form)

**Benign tumours**

Chondroma (enchondroma) Giant-cell tumour (osteoclastoma) Haemangioma (spine)

**Malignant tumours**

Osteosarcoma (osteogenic sarcoma)

Ewing's tumour

Solitary myeloma

Metastatic carcinoma (especially from lung, breast, prostate, thyroid or kidney)

Metastatic sarcoma (from primary in another bone)

**Miscellaneous**

Simple bone cyst

Monostotic fibrous dysplasia

Eosinophilic granuloma

Bone atrophy in paralytic conditions such as poliomyelitis

Tabes dorsalis

Osteonecrosis after irradiation

1. name 5 complications anticipated in joint injuries
2. infection (after open dislocation)
3. injury to important soft-tissue structure (artery, nerve)
4. avascular necrosis of one of the articulating bone ends from damage to the vessels supplying it
5. persistent instability leading to recurrent dislocation or subluxation
6. joint stiffness from intra-articular or peri-articular adhesions, from reflex sympathetic dystrophy or from post-traumatic ossification about the joint ('myositis ossificans')
7. osteoarthritis from damage to the articular cartilage or from persistent incongruity of the joint surfaces.
	1. ).
8. Name the three types of hip dislocation
9. posterior dislocation or fracture-dislocation;
10. anterior dislocation;
11. central fracture-dislocation.
12. What are the 5 clinical features of a displaced fracture neck of femur
13. A typical history is that the patient—usually an elderly woman
14. tripped and fell, and
15. was unable to get up again unaided.
16. She was subsequently unable to take weight on the injured limb.
17. *On examination* the most striking feature is the marked lateral rotation of the limb.
18. This is often as much as 90°. so that the patella and the foot point laterally.
19. The limb is shortened by about 2-3 cm.
20. Any movement of the hip causes severe pain.
21. Name the Injuries of the ligaments of the knee:
22. tear of the medial ligament (with or without the cruciate ligaments);
23. tear of the lateral ligament (with or without the cruciate ligaments);
24. tears of the cruciate ligaments alone:
25. strains or incomplete tears

Long answer

1.Discuss anterior shoulder dislocation under the following

1. **Clinical features .** Pain is severe, and the patient is unwilling to attempt movements of the shoulder. On examination, the contour of the shoulder below the tip of the acromion—normally made strongly convex by the prominence of tlie humeral head—is flattened, so that the tip of the acromion is now the most lateral point of the shoulder region. A noticeable prominence, caused by the displaced humeral head, is seen and felt in the infraclavicular fossa
2. **Treatment** Anterior dislocation. The well-known Kocher manoeuvre may still be used: the steps (slightly modified) are as follows. (1) With the elbow flexed to a right angle, steady but gentle traction is applied in the line of the humerus: (2) the arm Subscapularis is rotated laterally; (3) the arm.is adducted by earrying the elbow across the body towards the midline; (4) the arm is rotated medially so that the hand falls aeross the opposite side of the chest.The alternative technique of reduction—now widely preferred—is to pull firmly and steadily upon the semi-abducted arm against counter-traction in the axilla, which may be provided either by an assistant or by the surgeon's stockinged foot; at the same time, direct backward pressure may be applied over the displaced humeral head by an assistant.Reduction should be confirmed both by clinical tests and by radiographic examination. Thereafter the limb may be rested in a sling for a few days, but as soon as the pain has subsided active movements should be encouraged.
3. **Complications**

**Injury to the axillary nerve.** The axillary (circumflex) nerve is often damaged in anterior dislocations of the shoulder, with a reported incidence of 5-30%. There is consequent paralysis of the deltoid muscle, with a small area of anaesthesia at the lateral aspect of the upper arm. It is important that axillary nerve function be checked and the result recorded before any attempt at reduction of the dislocation. *Treatment* is expectant, as for other nerve injuries complicating closed injuries of the limbs (p. 64). Recovery in a few weeks or months is the rule, but if the nerve has been severely damaged by traction the changes may be irreversible and the paralysis permanent.

**Other nerve injuries.** Occasionally other branches of the brachial plexus are damaged, especially the posterior cord.

**Vascular injury.** In anterior dislocation the displaced humeral head may occasionally damage the axillary artery, especially if the vessel is atheromatous; or the artery may be damaged during attempted late reduction of a dislocation that has been overlooked (Johnston and Lowry 1962, Curr 1970).

**Associated fracture.** Dislocation of the shoulder is often accompanied by fracture of the greater tuberosity of the humerus. Treatment is not difficult, because once the dislocation has been reduced the fracture may be treated along the usual lines.

A more serious association is that between dislocation of the shoulder and fracture of the neck of the humerus. Again the plan of treatment should be first to reduce the dislocation (if necessary by operation) and then to deal with the fracture.s

2. In detail clearly discuss the Late complication of fracture and the preferred treatment.