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Posterior based circumferential spinal cord decompression in paediatric patients with the vertebral column resection (VCR) technique spares the anterior approach in severe kyphosis (Dunn RN, Horn A)

1. Posterior vertebral column resection in paediatric patients does not:

a.	Obviate intra-operative re-positioning and draping	A
b.	Require nerve root sacrifice	B
c.	Involve rib resection	C
d.	Expose the lung	D
e.	Allow circumferential thecal decompression	E

2. Posterior vertebral column resection in kyphotic myelopathic paediatric patients will:

a.	Improve neurological status in most cases	A
b.	Allow sagittal plane correction	B
c.	Allow resolution of syringomyelia	C
d.	Lengthen the spinal column and increase cord tension	D
e.	Reduce operative time in comparison to dual approaches	E

3. Posterior vertebral column resection does not involve:

a.	laminectomy	A
b.	extensive thecal retraction	B
c.	bilateral costotransversectomies	C
d.	preferably transcranial motor evoked potential monitoring	D
e.	nerve root sacrifice	E

A survey of the use of traction for the reduction of cervical dislocations (Workman MI, Kruger N)

4. A rugby player is referred by your emergency room 2 hours after injury with a C5/6 bifacet cervical dislocation diagnosed on X-rays, motor complete (Frankel A). Your immediate management is:

a.	Closed cervical skeletal traction reduction without MRI	A
b.	Closed cervical skeletal traction reduction after MRI	B
c.	Urgent open reduction in theatre without MRI	C
d.	Urgent open reduction in theatre after MRI	D
e.	Reduction on next available theatre slate	E

5. In a cervical dislocation with normal or partial neurology, what is the risk of causing permanent neurological deterioration during closed cervical traction reduction?

a.	>75%	A
b.	50%–75%	B
c.	25%–50%	C
d.	1%–25%	D
e.	<1%	E

6. What is the time frame, as stipulated by the Constitutional Court, in which a cervical spine reduction should be performed following a facet dislocation?

a.	Within 4 hours of arrival at the emergency rooms	A
b.	Within 4 hours of being assessed by an orthopaedic surgeon or neurosurgeon	B
c.	Within 4 hours of diagnosis by CT or MRI scan of cervical dislocation	C
d.	Within 4 hours of injury	D
e.	Within 4 hours of neurological deterioration	E

Epidemiology and injury severity of 294 extremity gunshot wounds in ten months: a report from the Cape Town trauma registry (Engelmann EWM, Maqungo S, Laubscher M, Hoppe S, Roche S, Nicol A, Navsaria P, Held M)

7. Which statement is true regarding the referrals of gunshot-related injuries?

a.	Most injuries required tertiary care	A
b.	Time to admission was shorter in patients with higher injury severity	B
c.	Most patients with lower injury severity were transferred during the day time	C
d.	Most patients were from the drainage area of the treating hospital	D
e.	Few patients had an interfacility transfer	E

8. Which statement is NOT true regarding injury severity in orthopaedic ballistic injuries?

a.	Patients with upper extremity injury had higher injury severity	A
b.	Most patients were not severely injured	B
c.	Lower limb extremities were injured more frequently	C
d.	Upper extremity fractures had a lower association with nerve injuries	D
e.	Lower limb fractures had a higher incidence of vascular injuries	E

9. Which is true regarding the patient demographics and occurrences of the gunshot injuries?

a.	Most injuries occurred at home	A
b.	Sixteen per cent of victims were underage	B
c.	Most victims were shot by people known to them	C
d.	Most injuries occurred on weekends	D
e.	More than half of the patients were victims of gang-related violence	E

Management of complex proximal humerus fractures in the elderly: what is the role of open reduction and internal fixation? (Bernstein BP, du Plessis JP, Laubscher M, Maqungo S)

10. A 67-year-old woman, who is an avid tennis player, falls onto her dominant shoulder during a tennis match. Examination reveals tenderness and swelling in the shoulder region, but no neurovascular deficits. Radiographs and CT scan reveal a three-part proximal humerus fracture with significant displacement of the greater tuberosity as a part. Combined cortical thickness is 4.2 mm. What is the most appropriate treatment option?

a.	Closed reduction and sling immobilisation for six weeks	A
b.	Closed reduction and sling immobilisation for two weeks followed by early active range of motion exercises	B
c.	Open reduction and internal fixation	C
d.	Hemiarthroplasty	D
e.	Reverse total shoulder arthroplasty	E

11. Prolonged sling immobilisation should be used with caution due to the following negative aspects:

a.	Causes pain	A
b.	Compromises hygiene	B
c.	Confuses caregivers	C
d.	Affects balance	D
e.	Promotes stiffness	E

12. Proximal humerus fragility fractures in the elderly are:

a.	Are uncommon	A
b.	Are more common than vertebral fractures	B
c.	Are more common than wrist fractures	C
d.	Are more common than hip fractures	D
e.	Never occur	E

13. The ProFHER study investigated the outcomes of proximal humerus fractures managed operatively and non-operatively and found:

a.	Three- and four-part fractures had improved outcomes if managed operatively	A
b.	No difference in clinical outcomes between those managed operatively or non-operatively	B
c.	No difference in clinical outcomes at six months but improved clinical outcome scores in those managed operatively at 12 and 24 months	C
d.	A higher rate of revision surgery in the group managed non-operatively	D
e.	A lower rate of revision surgery in the group managed non-operatively	E

Proximal fibular resections for primary bone tumours: oncological and functional results of a case series (Hilton TL, Wiese KR, Hosking KV, Hoffman EB)

14. In patients with high grade osteosarcoma of the proximal fibula, which is the most correct option?

a.	An amputation is the safest oncological procedure to ensure the best prognosis for the patient	A
b.	If the tumour involves multiple compartments, a Malawar type II procedure is advised but the peroneal nerve should be preserved at all costs	B
c.	A Malawar type II procedure is a safe oncological procedure but has poor functional results	C
d.	A Malawar II procedure is indicated to safely resect the tumour with or without sparing of the peroneal nerve to give good functional results	D
e.	None of the above	E

15. Common complications after a Malawar II resection of the proximal fibular include the following, except:

a.	Synovial fluid leak	A
b.	Knee instability	B
c.	Superficial and deep wound infection	C
d.	Foot drop	D
e.	None of the above	E

16. A Malawar II procedure includes resection of the following structures:

a.	Proximal fibula, shark-bite osteotomy of the tibia, peroneal nerve, anterior neurovascular bundle	A
b.	Proximal fibula only	B
c.	Proximal fibula, anterior compartment, posterior tibial artery and vein	C
d.	Proximal fibula, peroneal nerve, anterior and lateral compartments, lateral collateral ligament	D
e.	None of the above	E

17. Contraindications for a Malawar II procedure include:

a.	Involvement of the anterior and posterior tibial vessels, peroneal nerve and tibial nerve	A
b.	Involvement of the tibiofibular joint	B
c.	Involvement of the anterior, lateral and posterior compartments of the leg	C
d.	Involvement of the peroneal nerve	D
e.	None of the above	E

Intraosseous terminal phalanx epidermoid inclusion cyst: a first case of late recurrence (Kruger N, de Villiers A-L, McGuire DT, Solomons MW)

18. The most common tumour that mimics an epidermoid inclusion cyst of the distal phalanx is?

a.	Giant cell tumour	A
b.	Aneurysmal bone cyst	B
c.	Enchondroma	C
d.	Osteoid osteoma	D
e.	Ewing sarcoma	E

19. The radiological feature of an epidermoid inclusion cyst that distinguishes it from infection is:

a.	An absence of periosteal reaction	A
b.	The presence of intralesional calcification	B
c.	The presence of a pathological fracture	C
d.	Significant intralesional sclerosis such as that seen with an osteoid osteoma	D
e.	The absence of surrounding soft tissue swelling	E

20. The definitive treatment most frequently undertaken to treat a symptomatic epidermoid inclusion cyst is:

a.	Initial biopsy, followed by definitive curettage and a second sitting	A
b.	Terminal ablation, as there is a risk of metastasis	B
c.	Symptomatic pain management as it recedes over time and will resolve on its own	C
d.	Excision biopsy through curettage, with or without bone graft as determined by defect size	D
e.	Needle aspiration and bone cement injection to cause thermal necrosis	E