


Pelvic disruption: principles of management.

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[Tile M](#), [Pennal GF](#)

[Clinical Orthopaedics and Related Research](#) [01 Sep 1980(151):56-64]

Type: Journal Article

Abstract

Using the previously outlined classification of pelvic disruption to assess the displacement and stability, a logical method of treatment for the individual case follows. Anteroposterior fractures of the open-book variety and with intact posterior sacroiliac ligaments require simply reduction of the fracture (closure of the book), and immobilization by a sling, plaster spica or external skeletal fixators. The lateral compression types all produce some degree of inward rotation of the hemipelvis. If the supine position does not reduce the hemipelvis spontaneously, a general anesthetic and the application of external rotation forces are often required. Immobilization can be maintained either by complete bed rest with traction through a supracondylar femoral pin or with external skeletal fixators. Pelvic slings or binders will increase the deformity and are contraindicated. The very unstable types of vertical shear fractures can be reduced easily with traction, but maintenance of reduction is difficult. Fracture healing may be delayed because of instability through the hemipelvis and some degree of compression through the posterior fracture is desirable, either by various forms of external skeletal fixation, or occasionally by open reduction. Pelvic fractures associated with acetabular disruption and requiring open reduction of the acetabular fracture also require anatomic repositioning of the pelvic fragments simultaneously, in order to anatomically restore the integrity of the acetabulum. Finally, the pelvic fracture should not be neglected during the early phase of general resuscitation of the patient, but management should proceed concomitantly with the management of the associated injuries. Delay in treatment of the pelvic injury makes management much more difficult and even hazardous at a later phase.



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