INTRODUCTION

The pelvis is a massive bony ring interposed between the movable segments of the vertebral column upon which it supports and lower limbs upon which it rests (Johnston T 1969).

Pelvic fractures are a diverse group of traumatic insults which comprise about three percent of skeletal injuries. A small number of pelvic fractures are unstable (Mears D 1980).

Fractures in which the hemipelvis is displaced more than one Cm is considered potentially unstable (Russel T 1992).

Crushing injuries to the pelvis are usually caused by sustained trauma sufficient to cause other injuries that also demand immediate attention (Reynods B 1973).

Clinicians have over the years devised a multitude of classification systems based on a variety of parameters.

Most of early classifications were based on assumption that all pelvic ring pathology had been indentified on the initial anteroposterior films. Later on classifications were based on; types and location factors, stability of the pelvis,

and role of the force and the direction of injury (Burgess A 1990).

Assessment of the degree of the pelvic instability must always begin with a careful history and physical examination (Pennal G 1980).

Plain radiographs of the pelvis should be obtained quickly. CT scans are superior to plain radiographs for exact assessment of the pelvic ring (Young J 1986).

Traumatic disruption of the pelvic ring has both immediate and late complications. Massive intrapelvic bleeding, intestinal injuries, and genito-urinary disruptions are commonly encountered life threatening problems associated with severe pelvic trauma (Buckley S 1987).

The prime consideration of management is the general state of the patient, that is the treatment of shock from associated injuries and early complications.

Definitive management of fracture depends upon its type, the degree of pelvic instability, and the general state of the patient. Several methods of reduction of the pelvic ring and stabilization are available (Tile M 1980).