AUSTRALASIAN COLLEGE OF
SPORT AND EXERCISE PHYSICIANS

PRACTICE EXAMINATION

Written Short Answer Questions (SAQ) with Answer

For more information about the examination, refer here.

Questions: Registrars@acsep.org.au

NOTE:

The following answers have been provided by the Board of Censors and show the correct responses in a simple dot-point form. The Board of Censors accepts any style of answers, such as long paragraphs or succinct dot points. While Registrars are encouraged to put as much information into the answer, the response should be related to the question and should avoid spurious information.

QUESTION 1 TOTAL MARKS - 10

A 16yo male AFL Academy player is playing Australian Rules Football. He picks the ball up and tries to sprint away from his opponent. As he pushes off the ground he feels a pop in his right anterior hip, with acute pain. He handballs the ball away and falls to the ground. The player is unable to continue playing and requires assistance from the ground.

QUESTION 1.1	**MARKS**
What differential diagnoses would you consider as you review him on the sideline?	0.5
• AIIS avulsion • Lesser trochanter avulsion • Acute rectus femoris muscle tear • Completion of stress fracture (femoral neck or femoral shaft) • Acute hip flexor tear • Intra-articular hip joint injury	0.5 for 4 or more 0.25 for 3

QUESTION 1.2	**MARKS**
X-Ray confirms the presence of a minimally displaced AIIS apophyseal avulsion fracture and reveals a significant femoral head CAM lesion in both hips. The team is 8 weeks out from finals. What is the expected timeframe for return to play? How will you manage his injury up to the point of return to full training?	3
• Educate coach, athlete and parent that timeframe for return to play is 6-10 weeks	0.5
• Explain uncertain to be fit for finals (especially if preferred foot for kicking)	0.5

• Acknowledge CAM lesions but explain not part of the problem and not implicated in this injury or other management if not having preceding groin pain	0.5
• Initial management is to rest till pain free walking	0.25
• Then x-train and no running or kicking initially	0.25
• Allow pain free quads stretching and soft tissue releases	0.25
• Gradual progression of quads strengthening	0.25
• Gradual progression of running from jog to strides to sprinting to change of direction	0.25
• Gradual progression of kicking loads (can start when jogging pain free) -> small ball short distance through to large ball long distance	0.25

QUESTION 1.3	**MARKS**
What are your indications for surgical referral for the AIIS avulsion fracture?	1
• > 2cm displacement from donor site (pelvis)	0.5
• Ongoing mechanical symptoms causing hip impingement	0.5

QUESTION 1.4	**MARKS**
The coach really wants him in the team for the finals. How will you clear him for return to play?	2
• Return to play once clinically normal	
o full strength and flexibility	0.25
o no tenderness over avulsion site	0.25
o normal functional testing including	
▪ full sprinting	0.25
▪ change of direction	0.25
▪ normal kicking power / distance	0.5
o completion of FULL training sessions	0.5

QUESTION 1.5	MARKS
The team physio suggests arthroscopic treatment post season to address the CAM lesions in both hips. Is there any indication for hip arthroscopy in this elite level 16yo AFL player? What are the potential benefits and risks of such a procedure?	3.5
• There is evidence to suggest that asymptomatic CAM lesions are present radiologically in a significant portion of athletes (eg. Ice hockey / footballers).	0.5
• Therefore, if asymptomatic from a hip point of view there is no indication AT THIS STAGE – only potentially indicated if hip pain / groin pain unrelated to the index injury	1.0
• No clear evidence that CAMs = OA, or more importantly that resecting CAMs prevents OA	0.5
• Benefits	
o In this asymptomatic athlete, CAM resection may lead to an increase in hip ROM and help reduce pubic symphseal load, and MAY have some as yet unproven ability to protect the chondrolabral surface.	0.25
o Hard to show defined benefit in a currently asymptomatic athlete	0.25
• Risks	
o Surgical failure – i.e. instability, over-resection of CAM	0.25
o Seneral anaesthetic, infection, bleeding, femoral nerve damage	0.25
o Time out of training / play / deconditioning	0.5