Radiologist training syllabus quiz answers

1) Answer: c: the technology has been there for years, the rest contribute to the non-success of teleradiology in Iraq, and also back in the US.
2) Answer: False: need to stick to simple standards, not all techs are CT techs
3) Answer: b: Only perforating injuries have entrance and exit wounds as they are through the body injuries with no (or minimal) remaining missile remnants.
4) Answer: c: there is no "SIM" however, all the others are true
5) Answer: e
6) Answer: e.
7) Answer: B they do more damage typically, especially high velocity weapons
8) Answer: D (SOP). MCC will let command know, MedRed C and Critical Incident Report for theater-wide evac procedures and Battle Drill 5.
9) Answer: E: during surges, sending studies to the EBW should be wait till after to send any studies to Medweb
10) Answer: D: we only forward US troops to LRMC, so no need of entering others into Medweb
11) Answer: E: none since next step is for least experienced x-ray tech to take x-ray (allowing least experienced tech from another dept) in area of surgery, to look for an unexploded ordinance or bomb that may be booby-traped.
12) Answer: True
13) Answer: True
14) Answer: C: 332 policy
15) Answer: B
16) Answer: B
17) Answer: C: a positive FAST and hemodynamically unstable patient are good indicators for immediate surgery without CT first.
18) Answer: E: in isolated injuries, often isolated scans suffice. PanScans are not unusual in GSW, however.
19) Answer: B, see below:

In the setting of acute trauma in a patient undergoing a panscan- the information is useful. In the patient with complaints consistent with degenerative disease of the spine on the other hand, CT of the lumbar spine is rarely useful, as it will not change patient management. The most pertinent question as we discussed is "can the patient do his job". If the answer to the question is "yes", he or she should do that with medical management as prescribed by the primary care physician. If "no", he or she needs to be evacuated to echelon 4 or beyond to receive further treatment and/or have a medical board initiated. From the perspective of neurosurgical treatment in theater, we are not equipped to offer non-emergent care for degenerative spinal disease. We would consider imaging (non-contrast CT or post-myelogram CT) in the patient with: cauda equina syndrome (perineal sensory loss and sphincteric dysfunction +/- lower extremity weakness) or acute grade 3 or greater weakness of less than 48 hours duration. All others can be evacuated with further imaging at LRMC or their home station as appropriate.