Spinopelvic injuries (SPI): high-energy trauma & axial overloading through the sacrum:

1. Characterized by spinopelvic dissociation: complex injury with
   - Biomechanical discontinuity spine-pelvic ring.
   - The own spine and the pelvis can suffer, in turn, biomechanical instability within their anatomy.
   - Common cranioencephalic, thoracic, and abdominopelvic trauma with causing visceral lesions, major bleeding, and functional disability.

2. Diagnostic approach to SPI: Commonly difficult a
   - Anamnesis may become impossible
   - Transferring the patient for contrast CT-scan –the preferred diagnosis method by most spine and trauma surgeons for detecting anatomical lesions and bleeding sources- may be dangerous.

3. Emergency treatment:
   - Damage control orthopedics: imperative!
     - Pelvic ring closure by a binder.
     - Secure body immobilization in bed.
     - Surgical approach to major bleeding sources (if necessary).
     - Eventually: angiography and embolization (useful but prolonged and limited to smaller vessels).
   - Neurological deficits prevention.
     - Immobilization in bed.
     - Early decompressive surgery (related to the general situation).

4. Definitive surgical stabilization: To provide stability to spine-pelvis continuity & secondary decompressive surgery.
   - Iliosacral screwing followed by spinal instrumentation.
   - Current: As these instrumentations formed part of two separated hardware better: one-construct instrumentation connecting the spine and the pelvis [the combination: iliosacral screw (horizontal stability) + A one-block construct spinal & iliac pedicle screw instrumentation (vertical stability)].
   - Yet the role of circumferential restoration of pelvic ring anatomy: uncertain in case of SPI associated to an anterior pelvic ring disruption.
   - Potential complications are discussed: Skin, neurological, non-union, instability, hardware failure, and others.