**Consider a normal X-ray the same as a normal ECG – it’s just a test!**

Always interpret test(s) in light of your clinical concern (your ‘pre-test probability’)

Pre-test probability is determined by the **History** and **Physical exam**
(we don't sell them short for chest pain, abdo pain, fever, headache, etc. – likewise, we shouldn’t sell them short for MSK injuries).

**History** – Details of injury (force, mechanism, events after, etc.) – helps predict likelihood of fracture and likely injury pattern (e.g., external rotation of ankle – syndesmosis injury / Maisonneuve fracture; valgus strain knee – MCL, etc.)

**Physical** – Try to localize the ‘point of maximal tenderness’ (since MSK pathology is found under that point – and the lack of such a ‘point’ is a ‘red flag’ for referred pain from a proximal source)

**X-rays:**
- Ensure **adequate** views (poor trans-scapular views of the shoulder are relatively common, yet uncommonly recognized)
- Consider **extra** views (e.g., scaphoid, axillary, Swimmer’s)
- Consider **serial** imaging – repeat x-rays in follow-up (e.g., ~30% scaphoid fractures not seen on initial views)
- Consider **advanced** imaging - either CT, MRI, bone scan, U/S

Deciding between serial or advanced Imaging is multifactorial - depends on diagnosis contemplated, degree of clinical concern, test availability, etc.

For ? C-spine fracture, x-rays neg – may move to advanced imaging quickly
For ? scaphoid fracture, x-rays neg – most opt for immobilization, reassessment, and if concern persists, then serial imaging.