INTRODUCTION

In the past days, the management of midshaft clavicle fracture was entirely conservative but due to various complications of conservative management like nonunion, malunion, cosmetic values and the effect in shoulder biomechanics the trend has now shifted to operative management for displaced midshaft clavicle fracture.\(^1\)\(^-\)\(^6\)

The reasons for shifting of management protocol from conservative to operative are maintenance of shoulder biomechanics by preventing shortening, early mobilization of shoulder, early pain relief and early return to work.\(^6\)\(^-\)\(^8\)

Beside this, in recent years there were lots of studies that showed good results with operative treatment.\(^5\)\(^,\)\(^7\)\(^-\)\(^9\)\(^,\)\(^11\)

Even though there are many advantages of operative management of midshaft clavicle fracture, the procedure is not free of disadvantages like effect of anesthesia, scar mark, hardware prominence, nonunion, neurovascular injuries, infection and so on.\(^12\)\(^-\)\(^14\) There are various methods of operative fixation of midshaft clavicle fracture like intramedullary flexible nailing, screw fixation, recon plating and anatomical plating. Open reduction and plating is considered gold standard method...
for midshaft clavicle fracture. The use of anatomical contoured clavicular locking plate is better option because the surgeon does not need to contour the plate which retains the mechanical strength of the plate and has less soft tissue related problems. The precontoured plate has an added benefit of less hardware prominence which decreases the need of removal of implant after healing of fracture as compared to traditional plate.

**MATERIALS AND METHODS**

This was a prospective study. All patients with midshaft clavicle fracture who attended the OPD of orthopedics and emergency department of Manipal Teaching Hospital from January 2017 to January 2018 were evaluated as per inclusion and exclusion criteria of the study.

The inclusion criteria for the study were:
1. Midshaft clavicular fracture with displacement and shortening of more than 2cm.
2. Segmental fracture.
3. Age between 16 to 60 years
4. Type I and II open fracture
5. Bilateral clavicular fracture.

The exclusion criteria were:
1. Age less than 16 years or greater than 60 years
2. Fracture in the proximal or distal third of the clavicle
3. Pathological fracture
4. Fracture more than 3 weeks after the injury
5. Associated neurovascular injury
6. Associated head injury
7. Medical contraindicated to surgery and/or anesthesia.

There were total 30 patients (19 male and 11 female) with one of the male patient had bilateral clavicle fracture that met the inclusion criteria of this study. All the patients were subjected to plate osteosynthesis after obtaining informed and written consent. The pros and cons of the operative fixation were explained individually. Ethical approval was obtained from Institutional ethical Review Committee (IRC) before the study was carried out.

**Operative procedure**

General anesthesia was given in all patients and placed supine in beach chair position. A bolster was placed between the scapulae to allow the shoulder to fall back which helped in reducing the fracture. The head was turned to the opposite side. The part was prepared, painted with 10% povidone-iodine solution and draped in standard fashion. Oblique incision was made centering over the fracture site of the clavicle. Subcutaneous tissue and platysma was raised as a flap. Supra clavicular nerves was identified, isolated and spared wherever possible. Fracture site was opened and curettage done. Open reduction of fracture was done and appropriate size anatomical countered clavicular locking plate was used to fix the fracture on the antero-superior surface of the bone. Inter fragmentary lag screws was used whenever needed. Wound washed with normal saline. After securing proper hemostasis, the wound was closed in layers. Arm sling or pouch was given to all patients for 2 weeks. Wound inspection and dressing was done on 3rd post-operative day and suture was removed after 2 weeks. Patients were usually discharged on 5th post-operative day. Elbow, wrist and finger range of movement exercises were started as soon as the pain decreased. Patients were followed up at 2 weeks, 6 weeks, 3 months and 6 months' time. In every visit, patients were assessed clinically and radiologically for the outcome measures. Figure 1 shows the preoperative X-ray with displaced mid shaft clavicle fracture. Figure 2 shows immediate post-operative X-ray after plating, figure 3 shows uniting fracture at 3 months follow up and Figure 4 shows united fractures at 6 months follow up.
RESULTS

There were 30 patients with 31 cases (one case with bilateral clavicle fracture) in this study. There were 19 male and 11 female in this study. The mean age group was 37.19 (11.92) years with the range of 21 years to 59 years. There were 21 right side clavicle fracture and 10 left-sided clavicle fracture. In 12 patients the fracture was comminuted. The mode of injury was road traffic accident in 20 (64.5%) patient followed by fall injury in 8 (25.8%) patient and sport injury in 3 (9.7%) patients. There was only 2 (6.5%) cases with type I open fracture. Five patients in our case had associated injuries among whom one patient had ipsilateral distal radius fracture and one patient had contra lateral distal radius fracture. One patient had ipsilateral fracture of shaft of humerus. All three patients had fixation of fracture with operation management. One of the patients had ipsilateral ribs fracture without pneumothorax or hemothorax and did not need any active intervention. One patient had contralateral acetabulum and inferior rami fracture that was also treated conservatively. Clinical union was considered when the patient had painless movement of shoulder. The mean time duration for clinical union in our study was 8.77 (1.17) weeks with the range of 7 to 12 weeks. The mean time for overhead activity was 4.97 (1.27) weeks with range of 4 to 8 weeks. Radiological union was seen from 12 to 22 weeks with the mean time period of 17.03 (3.06) weeks. There were no major complications in our study. Three patients had hardware prominence but did not bother the patient. Only one patient had superficial surgical site infection which was treated adequately with intravenous and oral antibiotics. None of our patient had nonunion.

DISCUSSION

Fracture clavicle is now a common injury around the shoulder joint. Clavicle fracture accounts about 2.6% of all fracture and 44% in shoulder fracture. Among all the clavicle fracture mid shaft fracture accounts about 81%. The incidence of fracture clavicle is increasing day-to-day due to the motor vehicle accidents and sports activity. Since these fractures are usually seen in active people who needs to use the shoulder joint for day-to-day activity and due to need of early return to work the patients now a days choose operative management rather than conservative management. Open reduction and plate fixation gives patient early pain-free movement thus helps the patient return to their daily work soon.

In 1968 Neer's study on fracture clavicle showed that the nonunion rate in conservative management was only 1%. This study became the base for conservative management of fracture clavicle. Later on there were many studies which showed that the rate of nonunion was much higher in patients who underwent conservative management then what Neer's study showed. The study done by Robinson showed nonunion in 9.5% of cases similarly the study done by Hill et al and White et al showed nonunion rate of 15% and 13% respectively. A study done in 2007 by McKee et al compared non operative treatment with plate fixation for displaced midshaft clavicle fracture showed good result in patients who had undergone plating. In his study two (3.2%) out of 62 patient with plate fixation had nonunion. The rate of nonunion was much higher i.e. 7 (14.2%) out of 49 patient in patients with nonoperative management. The wound site infection rate was 4.8% that was treated with antibiotics.

The mean age group in our study was 37.19 years (21-59 years) which was similar to the study done by Bostman et al 33.4 years (19-62 years), Ankur Mittal et al 41.5 years (16-59 years), Prabhu Mitiraj et al 32 years...
In the study done by Poigenfuerst et al 9 patients out of 122 (7.3%) had superficial wound infection but no cases of osteomyelitis or infected pseudo arthritis. Similarly E Mohamed et al found superficial skin infection in 1 of 15 patients (6.66%). In our study group only one patient (3.22%) had superficial surgical site infection which was adequately treated with intravenous and oral antibiotics. This shows that the rate of infection is much less than reported in earlier studies maybe because of good surgical techniques and better implants used.

**CONCLUSION**

Fracture mid shaft clavicle is one of the commonest fracture around the shoulder joint. Undisplaced midshaft fracture can be managed conservatively. Open reduction and plate fixation is a good option for displaced mid shaft clavicle fracture which helps patient for early pain-free movement of shoulder and early return to work. We prefer to use anatomical contoured clavicle plate because it helps in fixation of clavicle to its normal anatomical contour and provides better fixation and stability. Our study favors open reduction and internal fixation with anatomical contoured clavicle plate for displaced midshaft clavicle fracture.

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**REFERENCES**


Author’s Contribution:
PRO - Concept and design, review of literature, statistically analysis and interpretation, manuscript preparation and revision; KS - Data collection, literature search and review; NR - Data collection, statically analysis and manuscript revision; KW - Manuscript revision and literature review; PT - Literature search and review; UJT - Data collection and literature review.

Work attributed to:
Department of Orthopedics, Manipal Teaching Hospital, Phulbari, Pokhara, Nepal.

Orcid ID:
Dr. Pratyenta Raj Onta - https://orcid.org/0000-0002-6013-4014
Dr. Krishna Sapkota - https://orcid.org/0000-0002-2277-8556
Dr. Krishna Wahegaonkar - https://orcid.org/0000-0001-7274-7099
Dr. Niraj Ranjeet - https://orcid.org/0000-0001-5460-5839
Dr. Pabin Thapa - https://orcid.org/0000-0003-1336-5837
Dr. Upendra Jung Thapa - https://orcid.org/0000-0003-1980-5610

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