### Right Clavicle

<table>
<thead>
<tr>
<th>Code</th>
<th>Shaft holes</th>
<th>Hook height</th>
<th>Stainless steel</th>
</tr>
</thead>
<tbody>
<tr>
<td>441.002</td>
<td>6</td>
<td>15mm</td>
<td>241.082</td>
</tr>
<tr>
<td>441.004</td>
<td>6</td>
<td>18mm</td>
<td>241.064</td>
</tr>
<tr>
<td>441.006</td>
<td>8</td>
<td>15mm</td>
<td>241.084</td>
</tr>
<tr>
<td>441.008</td>
<td>8</td>
<td>18mm</td>
<td>241.068</td>
</tr>
</tbody>
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### Warning

This description is not sufficient for an immediate application of the instrumentation. An instruction by an experienced surgeon in handling this instrumentation is highly recommended.

Do not bend the hook.
Benefits
Immediate postoperative early functional aftertreatment and mobilisation thanks to the joint-bridging hook.
Shape, dimension and screw hole arrangement of the hook plate have been designed to fit the anatomy.
LC-DCP screw holes allow dynamic compression of fractures and optimum plate fixation.
High-quality AO/ASIF stainless steel implants
Titanium implants provide excellent biocompatibility and hardly interfere with MRI examinations.

Literature

Incision
Surgical exposure by means of an approximately 8 cm sagittal incision, 2 cm medial of the AC joint. Transverse incision of the muscular fascia and exact fascia preparation to expose the AC joint and the lateral portion of the clavicle.

Insertion
Use bone reduction forceps for the temporary fixation. Prepare the plate seat and, after palpation of the hook path (elevator and scissors), insert the hook under the acromion, dorsal of the AC joint. Determine the hook depth (15 or 18mm), and insert the selected plate.
Position the plate and use the plate holding forceps to press it onto the medial fragment. An improvement of the obtained reduction is possible using other bone holding forceps. In very rare cases, it is possible to perform a temporary reduction with Kirschner wires.

Fixation
Depending on the type of fracture, use one or two screws to occupy the lateral plate holes, possibly 4.0mm cancellous bone screws. In case of several fragments or a very small lateral fragment, these screws can be optimally positioned obliquely through the LC-DCP holes. Place screws eccentrically in the medial plate holes to provide dynamic compression on the fracture gap. As a rule, three screws are sufficient on the medial fragment. In a multifragmentary fracture, the longer eight hole plate may be used as an exception.

Lateral clavicular fracture, Neer type II
AC location, Tossy type III

Incision
Surgical approach as shown in figure 1. Usually, the lateral clavicle is decorticated from the acromioclavicular ligament and capsule, and the acromioclavicular ligament and capsule are still fixed to the acromion and joint disk. Loosening sutures around the acromioclavicular ligament and capsule.

Insertion
Prepare the plate seat and insert the hook under the acromion, dorsal of the AC joint, after having palpated the hook path by using an elevator or scissors. Select the correct hook depth (15 or 18mm). Take special care to avoid overcorrection. Use the plate holding forceps to fix the plate temporarily to the clavicle. Control stability by pulling the arm, and verify the reduction (the acromion must be flush with the clavicle). Position the final plate. Pull the acromioclavicular ligament and capsule under the lateral plate before pressing the plate onto the bone. Now press the plate onto the bone. Repeat control of reduction and stability.

Fixation
Three cortex screws are usually enough to occupy the plate holes. Prior to the final tightening of the screws, either stitch and tie the retaining sutures to the ligament and capsule of the lateral clavicle or pull the sutures through the lateral holes of the plate and tie them together under tension. Proceed to the final tightening of the screws. Verify reduction and stability. Close the wound layer by layer over a drainage taking particular care to exactly reconstruct the muscular fascia. Subsequent immobilisation for two days. Thereafter, rehabilitation by early functional exercises.