Subclavian Artery Injury Following Isolated Clavicle Fracture, Which To Repair First?
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Citation

Abstract
Blunt subclavian artery trauma following clavicle fracture is rare. Some controversy exists in the literature regarding the sequence of surgery. We report a case where vascular repair preceded clavicular fixation with excellent outcome. We positioned the graft far away from the fracture site and therefore subsequent manipulation to reduce the fracture was safer. The final decision should be a team one, made by the vascular surgeon, the orthopaedic surgeon and the anaesthetist.

CASE REPORT
A 23-year-old right-handed woman attended the emergency department after being thrown from her horse. Examination revealed a large haematoma over the right clavicle and absent right brachial and radial pulses. Neurological examination was normal. Early vascular input was sought.

Radiographs confirmed a displaced fracture of the right clavicle at the junction of the medial 2/3 and distal 1/3 (Figure 1). There were no other injuries. Duplex studies were performed in the emergency department and confirmed absent radial pulse with no Doppler signal. Formal angiography showed occlusion of the proximal subclavian artery just beyond the origin of the right internal mammary and vertebral arteries. The occlusion measured ~ 5 to 6 cm with sluggish reconstitution of the right axillary artery distally. Radiological stenting was attempted and failed.

In view of the vascular compromise the joint decision was made to perform revascularisation first as an emergency. It was decided to position the graft far away from the fracture site. A right common carotid to axillary artery bypass was performed using reversed long saphenous vein graft. The graft was positioned in a tunnel crossing the medial end of the clavicle far away from the fracture site. Patency of the graft was confirmed with Doppler ultrasound intraoperatively. The clavicular fracture was opened through a separate incision along medial third of the clavicle and then reduced with gentle manipulation using reduction forceps. The fracture was fixed with a locking plate on the superior surface of the clavicle using unicortical screws. The patient
made a good recovery and the fracture went on to heal with
callus formation.

DISCUSSION

Although clavicle fractures are common, accounting for 5 –
10 % of all instances of adult trauma, subclavian artery
injury is a rare complication. This is mainly due to
protection by the scalene muscles. Blunt trauma injuries to
the subclavian artery typically occur at the proximal and
mid-portion of the vessel (1). Clinical features include;
clavicle haematoma, bruit or neurovascular deficit to the
upper extremity or haemodynamic instability (2).

When assessing these injuries, a careful evaluation of
vascular supply is crucial to prevent delayed diagnosis. A
delay reduces the chance of successful repair, with the
optimal period for restorative surgery occurring within the
first 6-8 hours (1). It is also important to exclude
involvement of other structures such as the subclavian vein,
brachial plexus and underlying lung. Important management
issues for fractures complicated by vascular injuries include
early recognition, angiography and involvement of vascular
team (3, 1).

Controversy exists about the order of initial management
of combined injuries and whether orthopaedic stabilisation
should precede vascular repair or vice versa. Proponents of
early vascular repair point to a reduced ischaemic time,
therefore improved limb viability, reduced risk of in-situ
thrombosis as well as reduced risk of iatrogenic disruption of
revascularisation due to subsequent orthopaedic procedure.
Even in the absence of primary vascular injury internal
fixation of the clavicle can result in secondary vascular
damage.

Advantages of early orthopaedic repair include: stabilisation
of the extremity thereby aiding vascular repair, improving
the exposure of vascular injury and reduced risk of
thrombosis in a recently completed vascular repair during
subsequent manipulation to reduce the fracture.

Time is an important factor in decision-making and if
significant delay has occurred then arterial repair is indicated
initially. If the patient presents within a reasonable time then
the fracture may be stabilized very quickly prior to vascular
repair. Stability of the fracture is also a consideration.
Relatively stable injuries can undergo vascular repair with
little risk of subsequent disruption in order to decrease the
duration of ischaemia. If however the fracture is unstable
and the extremity cannot be stabilized for proper exposure of
vascular injury, the orthopaedic repair is performed first.
One option in this scenario is a temporary intraluminal shunt
to maintain blood flow (4).

We chose to perform vascular repair first for multiple
reasons. Firstly, the absence of pulses and capillary refill
made restoration of the blood supply to the limb a first
priority. Secondly, we decided to position the graft far away
from the fracture site and therefore subsequent manipulation
to reduce the fracture was safer. The final decision should be
a team one, made by the vascular surgeon, the orthopaedic
surgeon and the anaesthetist.

CONCLUSION

Despite being a common and, in most cases, uncomplicated
injury, the possibility of underlying vascular injury must be
excluded in cases of isolated clavicle fracture. Sequence of
surgery depends on various factors and close liaison with the
vascular team is paramount.

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