

Clavicle fractures are common injuries, and both the injury and fixation surgery can be associated with moderate to severe pain.^{1,2} Adequate analgesia provision is desirable for improved patient satisfaction and early return to function. Regional anaesthetic techniques can be useful for analgesia provision and can be a viable option for surgical anaesthesia during fixation surgery for high-risk patients. However, this region has a complex innervation that remains a controversial subject.¹⁻³ Varying fracture locations and injury patterns add further complexity. Current literature comprises heterogeneous studies, and several different regional anaesthetic approaches and combinations of these approaches have been previously described.⁴ These include the cervical plexus, selective supraclavicular nerve, superior trunk, and interscalene blocks.⁴ Additionally, the widespread adoption of ultrasound-guided regional anaesthesia has led to the emergence of interfascial techniques, such as the clavipectoral fascial plane block.⁵

The regional anaesthetic of choice depends largely on whether surgical anaesthesia is required or if analgesia provision without anaesthesia is sufficient for the clinical context. Several studies have demonstrated the reliability of regional anaesthesia as a sole anaesthetic technique for clavicle fixation surgery.^{4,6,7} The option to avoid general anaesthesia is attractive, as patients with clavicle fractures may have concomitant chest or pulmonary injuries. The combination of a cervical plexus block and interscalene brachial plexus block was previously regarded as the technique of choice if surgical anaesthesia is desired.⁴ If analgesia desired as part of a general anaesthetic, a superficial/intermediate cervical plexus block or supraclavicular nerve block may suffice. Although the combination of cervical plexus block (superficial/intermediate) and interscalene brachial plexus block has previously been the technique of choice for surgical anaesthesia provision, it has a propensity for undesirable motor effects such as hemidiaphragmatic paresis; which can be mitigated by the use of a clavipectoral fascial plane block with or without a cervical plexus block.⁸ Clavipectoral fascial plane block may be a promising new tool in the anaesthesiologist's armamentarium for anaesthesia and analgesia provision in clavicle fractures and fixation surgery.

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