Optimal Surgical Plating of Mandibular Angle Fractures: A Validated Finite Element Model

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Introduction

Internal fixation via a surgical mini-plate is the prevailing treatment employed by craniomaxillofacial (CMF) surgeons dealing with a mandibular angle fracture, which is a common type of jaw fracture with relatively high complication rates. The plate serves to counter the zones of tension present in the jaw in vivo, and there are two commonly accepted locations for plating: the ‘Champy’ plate along the superior oblique ridge, and a lateral border plate, as shown in Fig. 1. Medical device manufacturers produce a variety of mini-plates, but they offer only limited advice to surgeons concerning the optimal plate choice, so the decision is largely based on physician’s opinions and preferences. At the same time, it has been shown that plating methods are linked to complication rates and patient outcomes, so there exists a need for a standardized method by which physicians may select the optimal plating technique given a specific patient’s anatomy.

Modeling the jaw is challenging due to complex in vivo biomechanics, so finite element analysis (FEA) has become a well-established tool for producing accurate results. While several studies have used physical experimentation to validate finite element models of the mandible, there exists no physically validated model of a jaw fractured and plated along the mandibular angle.

Methods

Physical Benchtop Model

- Determined resultant muscle force using the Gearev’s model and vector summation.
- Cut standardized angle fractures into Sawbones cortical foam mandible models (SKUF 1338; See Fig. 2) and marked them for video tracking with scale bars and contrasting dots spanning the fracture.
- Plated four jaw models, plating two for each line of osteosynthesis
- Constructed a rig for orienting the jaw, comprising three supports and a pivot for in vivo loading (See Fig. 3), and fastened rig to Instron 8501 servohydraulic machine.
- Using the Instron WaveMatrix Dynamic Testing software, ran a test method ramping to loads of 200 and 400 N.
- Filmed tests from the side and the top under LED illumination using two Canon Vixia HD cameras mounted on the Instron.
- Measured model deformation via video analysis using the open-source Tracker software.

Finite Element Model

- Scanned Sawbones model into a mesh file using 3D Systems’ Sense Handheld Scanner.
- Refined mesh and inserted teeth and fracture using Geomag Studio 2014.
- Converted mesh to solid body step file using InStep (v2.3.11).
- Imported step file into SolidWorks 2017 and virtually plated fracture along each line of osteosynthesis.
- Transferred assembly to ABAQUS CAE 2017 FEA software.
- Run static, elastic body analyses of plated jaws using:
  - Ten node tetrahedral elements (C3D10), averaging 91,340 per model
  - Fully constrained boundary conditions at the teeth and condylar
  - Homogeneous isotropic solid material sections, with
  - Tied constraint interactions between plate, screws, and bone
  - Loads along the same vector as physical testing

Results

Physical Testing

The physical testing, summarized in Fig. 4, showed that lateral border plates result in larger displacement in every plane, and between fracture segments than do ‘Champy’ superior oblique ridge plates under the same load.

Discussion and Future Directions

Direct bone healing occurs when a fracture is reduced and stabilized to within 1 mm. While both the physical and FEA models show clinically large displacements, this study neglects the stabilizing effect of the musculature in vivo, so these results should be interpreted as identifying and accentuating the differences between the two techniques. Such approaches to computational and in vitro simulation are widely used in industry to provide a “worst case scenario” wherein a patient might have severely damaged or missing soft tissue.

The present FEA model is limited by computational constraints that do not permit contact between segments under load. These, combined with simplifying material and boundary condition assumptions, result in overall displacement magnitudes that are smaller than the physical model. Nonetheless, the present results show that this finite element model holds promise because it replicates observed physical motion, and predicts motion vectors that would suggest a prevention of direct healing.

The immediate future direction of this research will be the refinement of the FEA to produce an accurate, and therefore truly physically validated model. Subsequently, the model will be used to identify key anatomical variables that correlate with plate performance, leading to the development of a decision-making tool for physicians, which may be further substantiated by a dataset of patient CT scans and clinical trials.

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References


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