Fig. 10.5 Symphysis and para-symphysis fractures: proper placement of the drill guide and pointer. The tip of the pointer extends 15 mm beyond the fracture and is in contact with the lateral surface of the mandible. The undersurface of the pointer must maintain contact with bone during the drilling process.

Fig. 10.6 Anterior body fractures: proper placement of the drill guide and pointer. The tip of the pointer extends 15 mm beyond the fracture and is in contact with the inferior border or lingual surface of the mandible. The undersurface of the pointer must maintain contact with the lateral surface of bone during the drilling process.

Fig. 10.7 Posterior body fractures: proper placement of the drill guide and pointer. The tip of the pointer extends 15 mm beyond the fracture and is in contact with the lingual surface of the mandible. The beveled end of the drill guide is in contact with the lateral surface or near cortex. The undersurface of the pointer maintains equal contact with the inferior border of the mandible during the drilling process. This ensures that the drill bit passes below, and avoids injury to, the neurovascular bundle (this should not be attempted in cases where there is a low-lying nerve).
Condylar Neck Fractures

Condylar neck fractures can be approached transorally and fixated using a lag screw if they occur low into the ramus and are not sagittal. An anterior approach is used (Figs. 10.9, 10.4).

Complications

The guided lag screw technique accurately and predictably places screws, avoiding injury to important anatomical structures. However, the system has no emergency screws. In situations where the screw has lost retention, another screw or fixation device may be applied around it. Once the fracture has been secured, the loose screw is removed. In situations of unstable fractures, a period of intermaxillary fixation may be required for healing.