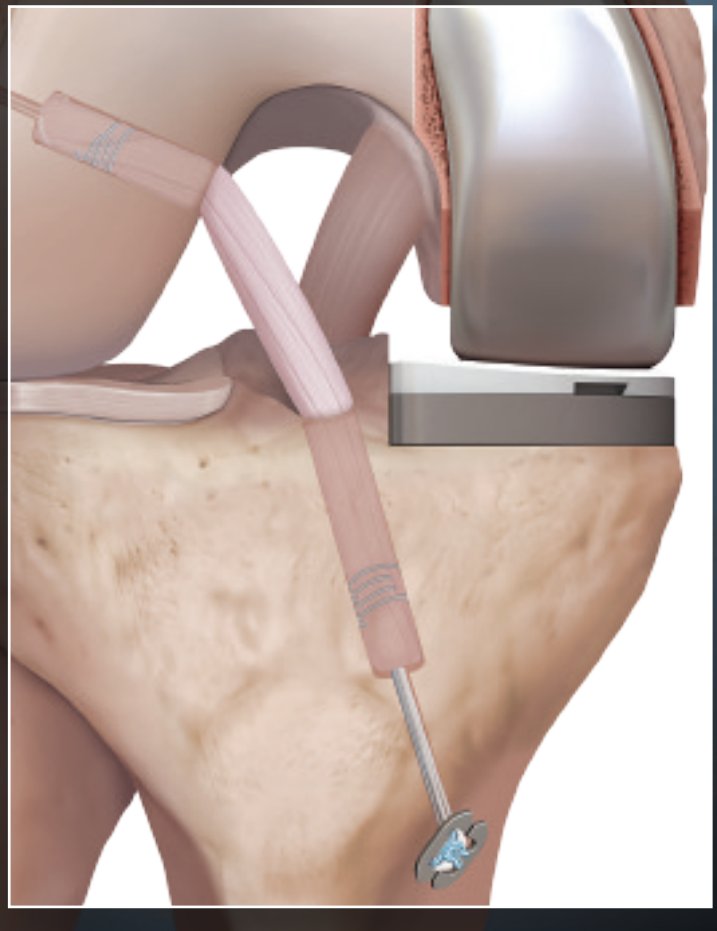
Arthrex®

iBalance® Unicondylar Knee with Concomitant GraftLink® All-Inside ACL Reconstruction using TightRope® ABS

Surgical Technique



GraftBalance™ UKA

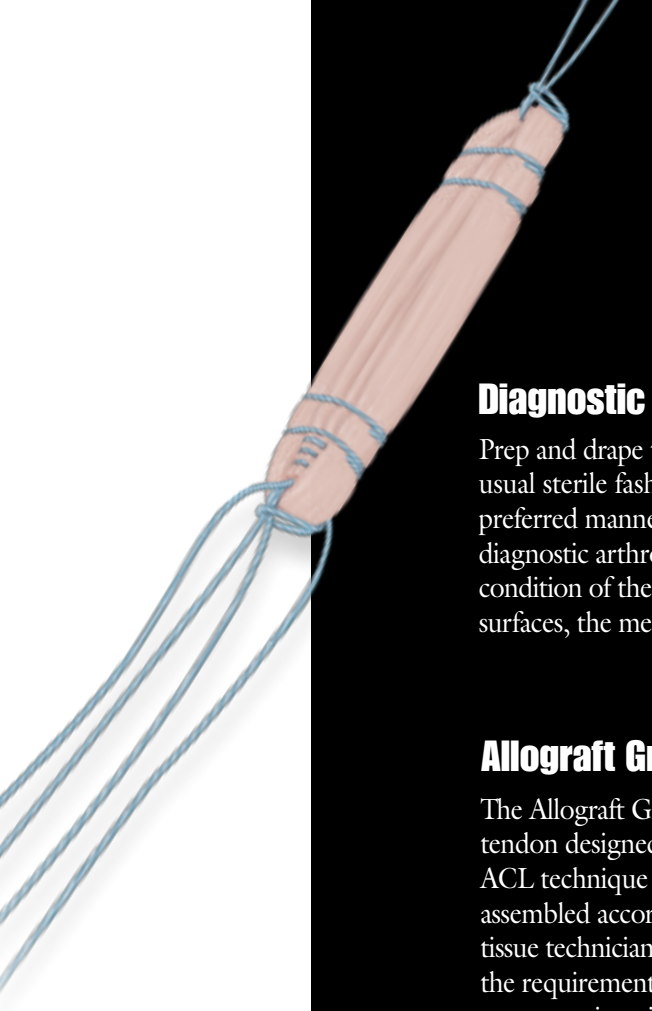
By merging advanced preservation and restoration principles, Arthrex is extending the surgeon's ability to provide a broader continuum of care to treat their patient's entire cascade of knee pathology. We understand that it is important for surgeons to offer their patients the best options to treat the progression of joint degeneration and the underlying injuries they may encounter throughout their lifetime. As a market leader in providing the most innovative solutions for knee preservation procedures, Arthrex is now providing surgeons with improved solutions to extend their reach and help treat their patient's early to late-stage osteoarthritic conditions with the addition of the iBalance family of implant systems. These innovative systems were developed through years of tireless research in understanding how to maintain the most normal joint kinematics possible through minimally invasive tissue and bone sparing techniques. Like our soft tissue and cartilage preservation solutions, these new platforms were designed to facilitate a highly accurate and reproducible surgical technique and an efficient operating room workflow.

Don’t stage procedures when you have all of the best tools at your fingertips…

The iBalance UKA System is a complete, minimally invasive, instrument and implant platform for the treatment of localized unicondylar cartilage degeneration as a result of osteoarthritis or post-traumatic arthrosis in the medial or lateral compartment of the knee. The iBalance UKA System includes highly anatomic femoral and tibial resurfacing implants and a novel and innovative instrument platform that facilitates a highly accurate, efficient and reproducible surgical technique.

The GraftLink Minimally Invasive ACL Reconstruction technique provides the ultimate in anatomic, minimally invasive and reproducible ACL reconstruction. Its independent tibial and femoral socket preparation with FlipCutter® II limits soft tissue dissection, preserves bone/periosteum and facilitates unconstrained placement of the ACL graft in relation to the iBalance UKA resurfacing implants without compromising the bone underlying the UKA implants.

The presutured Allograft GraftLink is a preassembled, sterile allograft tendon that was designed for use with the GraftLink All-inside ACL technique. The availability of this presutured allograft provides surgeons with a high quality, consistent, sterile and strong allograft tendon for use in primary or revision ACL procedures and eliminates the time needed to collect and prepare autograft tendon, speeding up the workflow. The tapered graft and adjustable femoral and tibial ACL TightRope buttons facilitate graft passing, fine-tuning of graft depth and graft tensioning from the femoral and tibial sides. The Allograft GraftLink was assembled according to Arthrex specifications by trained allograft processing specialists to ensure the Allograft GraftLink meets the requirements of the GraftLink technique to allow for an anatomic, minimally invasive and reproducible ACL reconstruction.



Diagnostic Arthroscopy

Prep and drape the knee and lower extremity in the usual sterile fashion and position the knee in the preferred manner using a limb positioner. Perform diagnostic arthroscopy to evaluate and document the condition of the compartments including cartilaginous surfaces, the meniscus, and the cruciate ligaments.

Allograft GraftLink

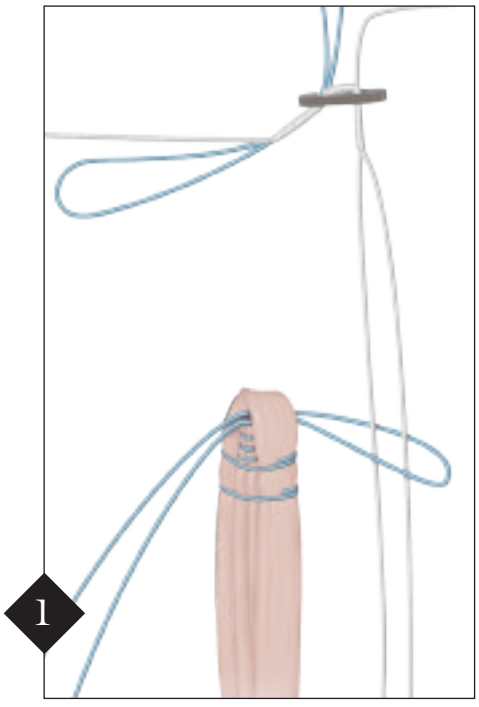
The Allograft GraftLink is a preconstructed allograft tendon designed to be used with the GraftLink All-inside ACL technique and TightRope implants. It was precisely assembled according to Arthrex specifications by trained tissue technicians to ensure the presutured construct meets the requirements of the GraftLink technique to allow for an anatomic, minimally invasive, and reproducible ACL reconstruction.

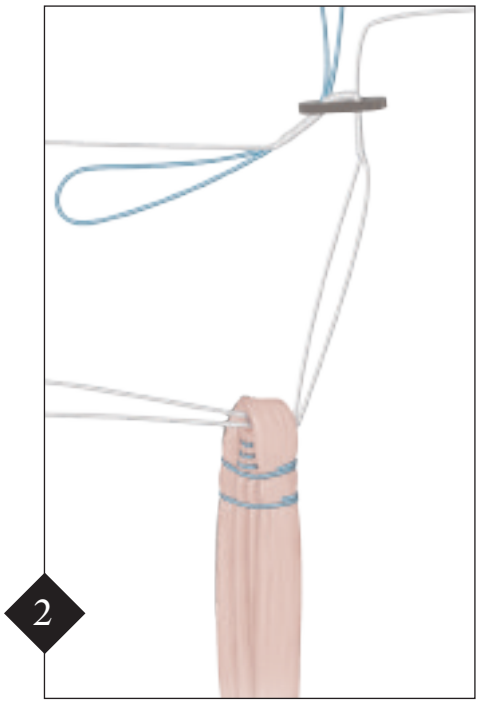
The Allograft GraftLink is provided as a sterile allograft construct via LifeNet Health's ALLOWASH XG® process. ALLOWASH XG is a patented and proprietary sterilization process that removes greater than 99% of bone marrow and blood elements from the soft tissue and internal bone matrix. The ALLOWASH XG technology achieves a 10^{-6} Sterility Assurance Level, a high degree of safety, without compromising biological and biomechanical properties. Since 1995, over 3 million bio-implants processed using ALLOWASH technology have been distributed by LifeNet Health with no disease transmission. ALLOWASH XG has also proven to inactivate enveloped and nonenveloped viruses, and it is validated to provide an effective bacterial log kill.

Allograft GraftLink Benefits:

- Sterile with ALLOWASH XG
- Preassembled with #2 FiberWire®
- Minimal graft preparation time
- Presized to GraftLink All-inside specifications
- Use with GraftLink All-inside ACL technique
- Preloaded with passing sutures to facilitate loading with ACL TightRope implants

Loading of the femoral graft end with BTB TightRope

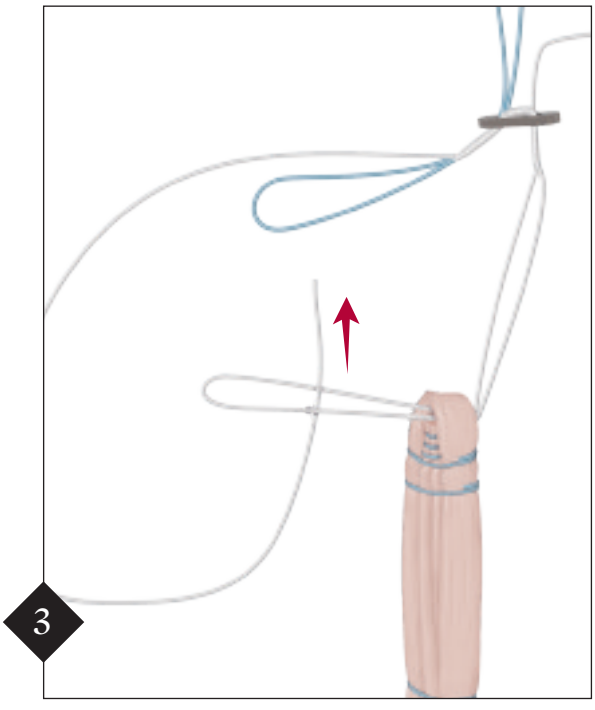


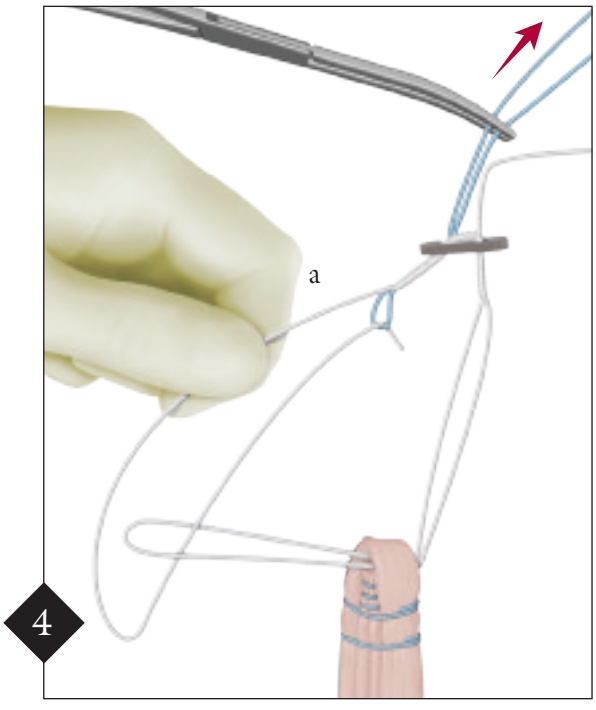


The BTB TightRope, an open loop construct, is used on the femoral side of the graft. Remove the needle from the BTB TightRope loop by cutting the Nitinol wire loop.

Unfold the blue passing suture of the femoral end of the GraftLink construct, exposing a loop and two tails. Drop the loop of the BTB TightRope into the blue loop of the passing suture (1).

Pull the tails of the passing suture to pass the TightRope loop through the graft (2).

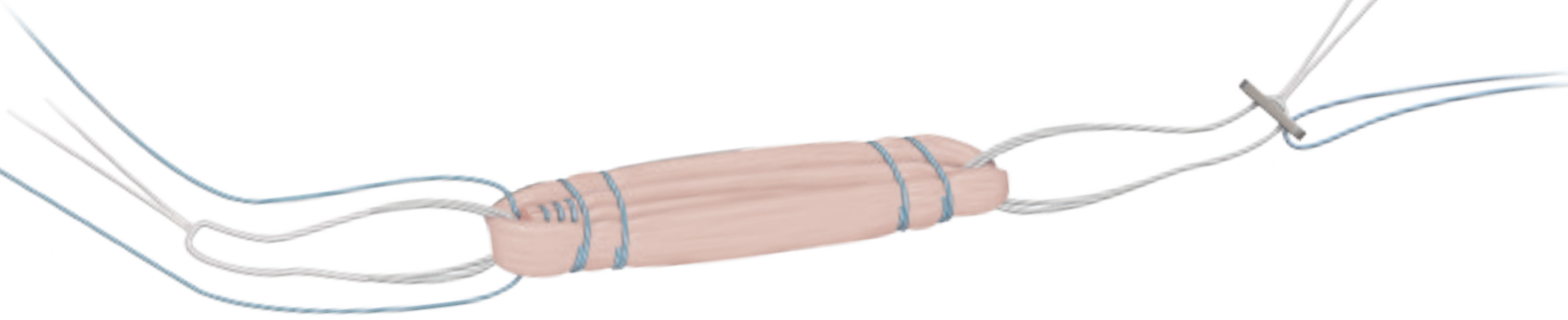




Pass the free end of the TightRope implant through the TightRope loop (3).

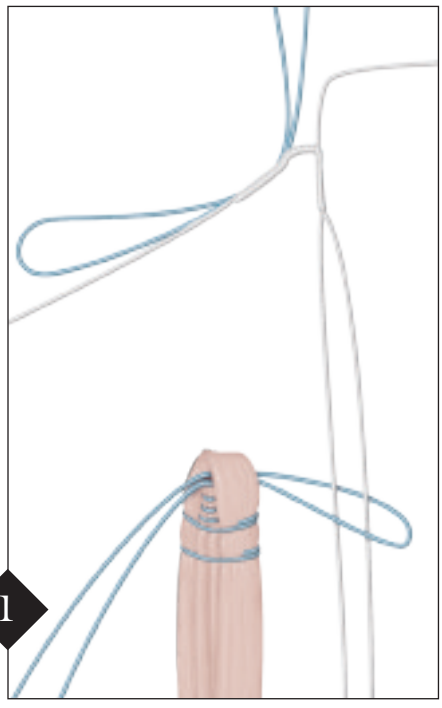
Pass about 2 cm of the free end of the implant through the blue passing suture. While holding the white suture in place, pull proximally on the tails of the blue passing loop until the free end is pinched against the splice of the implant *(this will prevent disassembly during passing)*.

Grip the fixed end of the suture (a) with the left hand. Using a clamp, pull proximally on the blue tails to pass the free end of the implant through the splice and through the TightRope button.

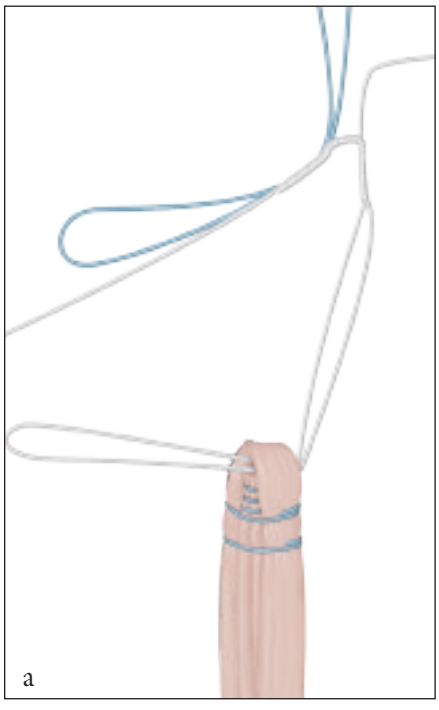


5 Once passed, adjust the loop lengths so that they are equal with the loop connection near the apex of the graft.

Loading of the tibial graft end with Open TightRope ABS

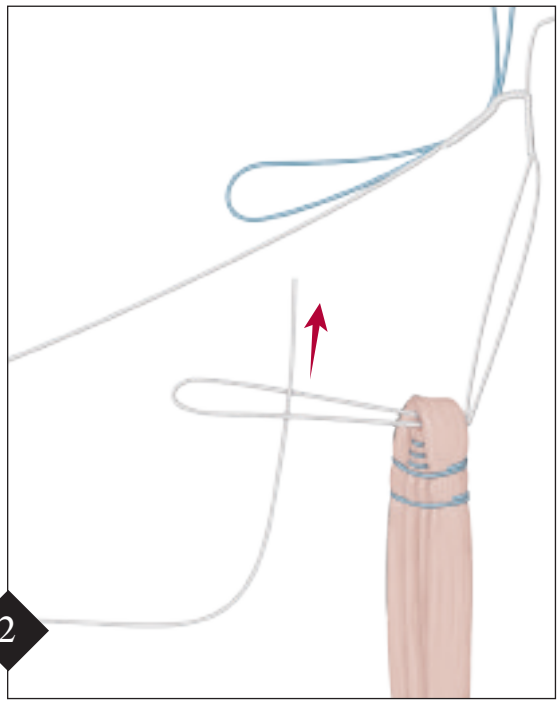


1



An Open TightRope ABS (Attachable Button System) is used for tibial fixation and loaded onto the graft in similar fashion as the BTB TightRope.

Unfold the blue passing suture of the tibial end of the GraftLink construct, exposing a loop and two tails. Drop the loop of the TightRope into the blue loop of the passing suture (1). Pull the tails of the passing suture to pass the TightRope loop through the graft (a).



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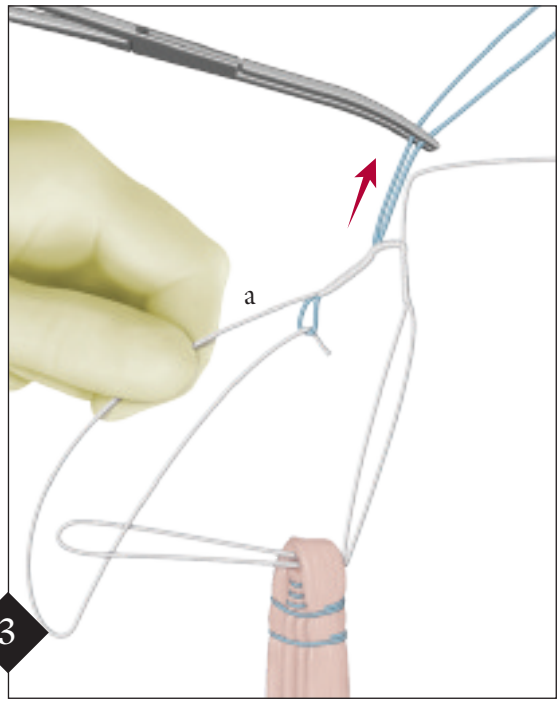
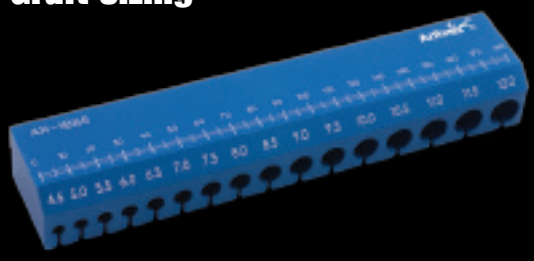


3

Pass the free end of the TightRope implant through the TightRope loop (2). Pass about 2 cm of the free end of the implant through the blue passing suture. While holding the white suture in place, pull proximally on the tails of the blue passing loop until the free end is pinched against the splice of the implant *(this will prevent disassembly during passing)*.

Grip the fixed end of the suture (a) with the left hand. Using a clamp, pull proximally on the blue tails to pass the free end of the implant through the splice.

Graft Sizing

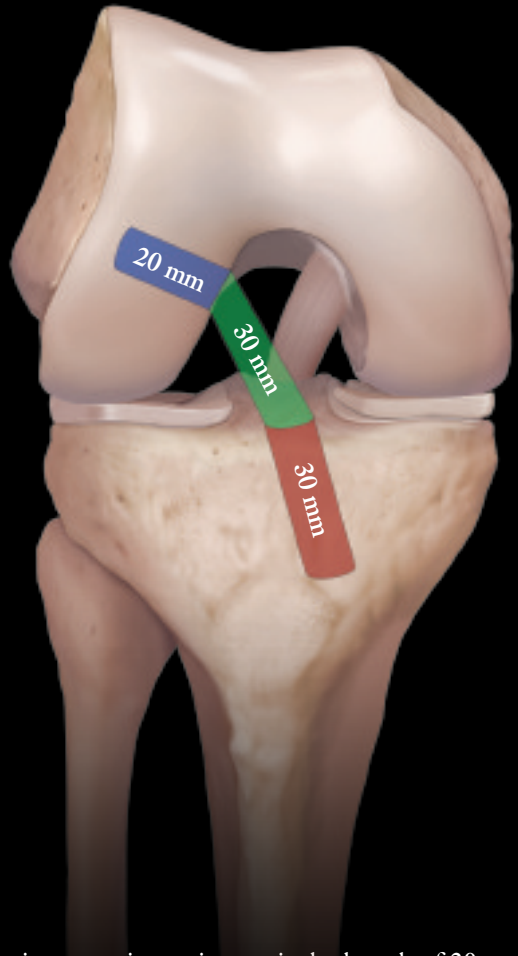


Measure the graft length and diameter. Pass both the femoral and tibial ends of the graft into the sizing block to measure diameter for socket drilling.

Socket Creation

The length from the end of the femoral socket to the end of the tibial socket should be at least 10 mm longer than the graft to ensure that the graft can be tensioned fully.

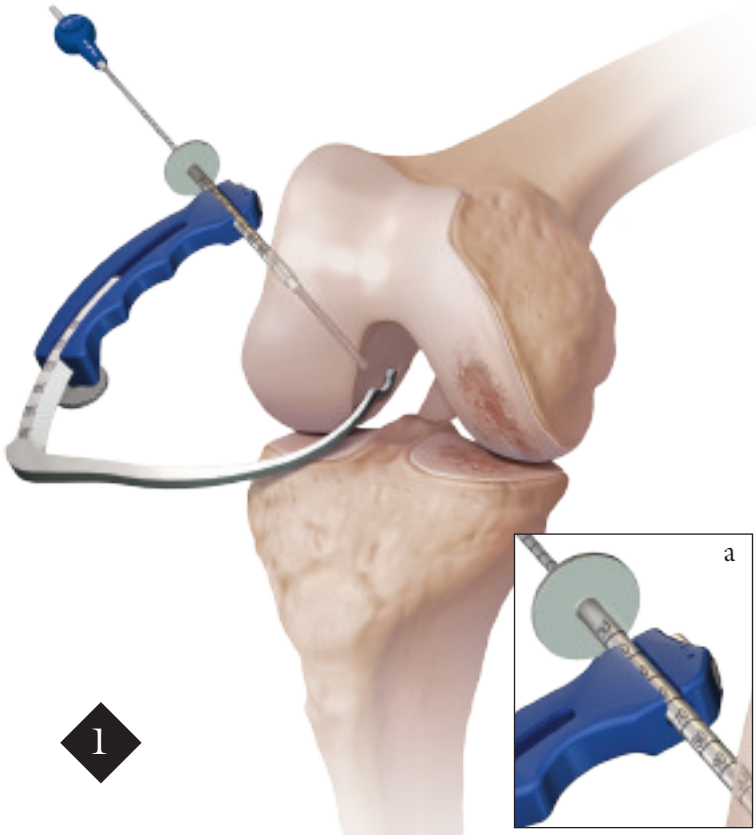
Example: 70 mm graft length



Assuming a maximum intraarticular length of 30 mm, there will be approximately 20 mm of graft in the femoral and tibial socket.

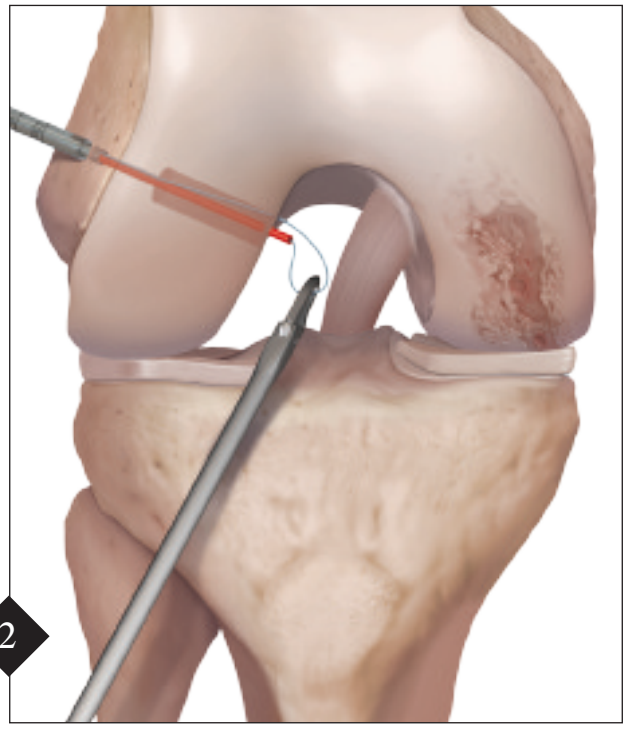
Drill the femur 20 mm deep and the tibia approximately 30 mm deep to allow an extra 10 mm for tensioning.

Arthroscopic Femoral Socket Preparation



1

The FlipCutter may be used to create the femoral socket. Note the intraosseous length on the drill sleeve when pushed down to bone (a).

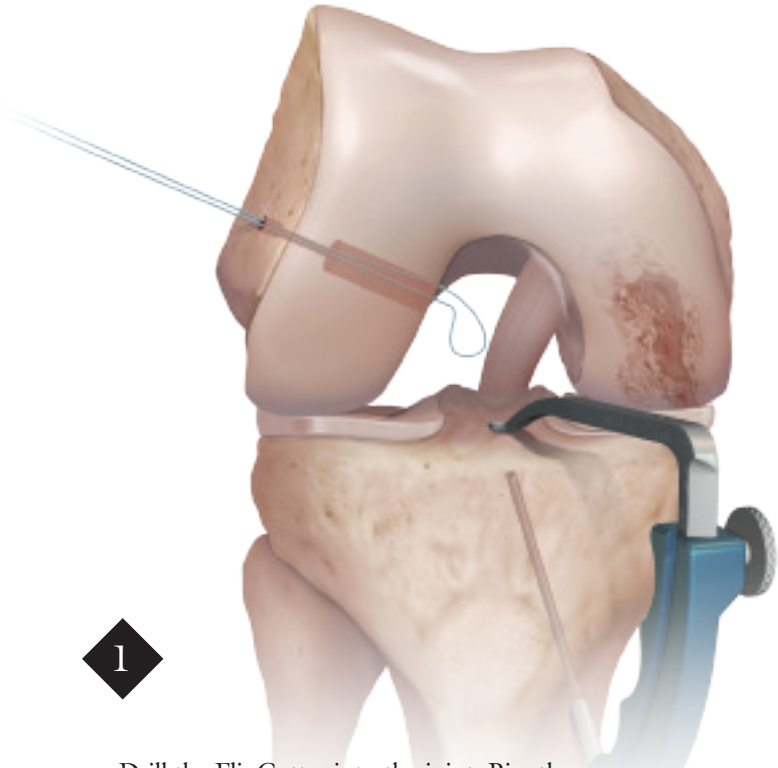


2

After "flipcutting", pass a FiberStick™ suture through the Stepped Drill Sleeve and dock for later graft passing.

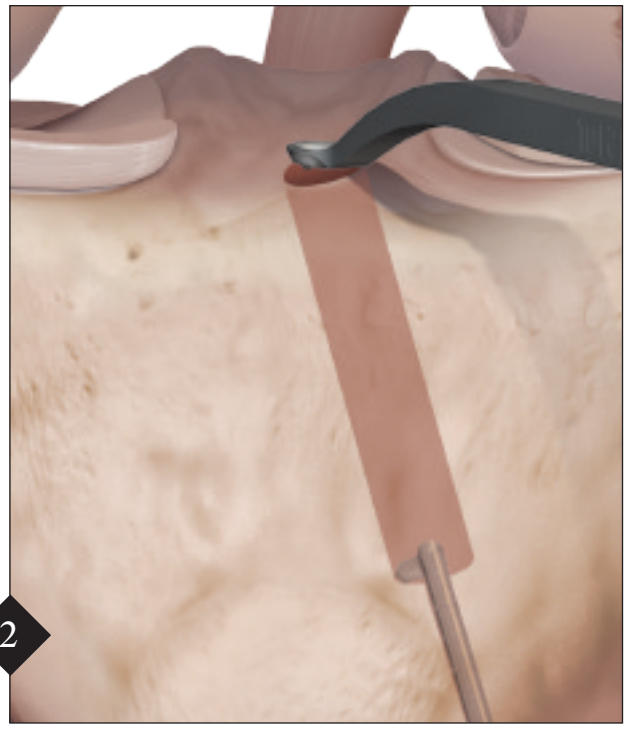
Note: When performing a lateral unicondylar knee replacement procedure, drill the femoral tunnel after preparing the lateral femoral condyle for the iBalance UKA Femoral Component.

Tibial Socket Preparation



1

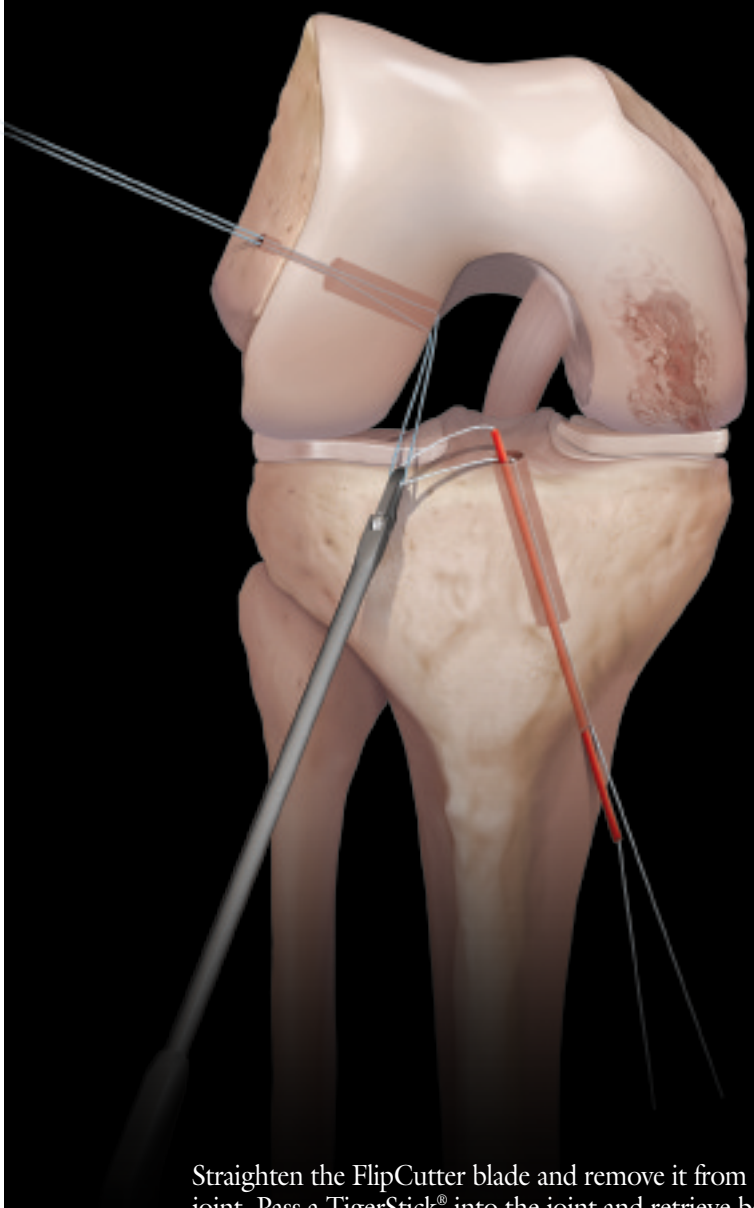
Drill the FlipCutter into the joint. Bias the drill hole laterally towards the tibial tuberosity in order to avoid undermining the medial tibial plateau. Remove the marking hook.



2

Flip the blade and lock into cutting position. Drill on forward, with distal traction, to cut the socket. Use the rubber ring and 5 mm markings on the FlipCutter to measure the socket depth.

Suture Management



Straighten the FlipCutter blade and remove it from the joint. Pass a TigerStick® into the joint and retrieve both the tibial TigerStick and the femoral FiberStick out the lateral portal together with an open Suture Retriever. Retrieving both sutures at the same time will help avoid tissue interposition that can complicate graft passing.

Note: A PassPort Button Cannula™ may also be used in the lateral portal to prevent tangling.

Note: Graft passing sutures from femur and tibia will be docked out of the lateral arthroscopy portal in this step to get them out of the way for the Uni knee medial incision.

Incision and Approach

Incision

When resurfacing the medial compartment, a 3-4 inch longitudinal incision is made medial to the midline of the knee; the quadriceps can be handled with either a sub-vastus approach or by a mid-vastus incision.

When resurfacing the lateral compartment, offset the incision over the lateral compartment and dissect the capsule using a lateral parapatellar approach. Incise the capsule and extend the incision proximally along the distal edge of the Vastus Lateralis. It should be noted that the patellar tendon extends fairly far across the lateral compartment. It is important to retract the tendon medially so that the vertical saw cut can be made sufficiently medial for optimum component placement.

Exposure

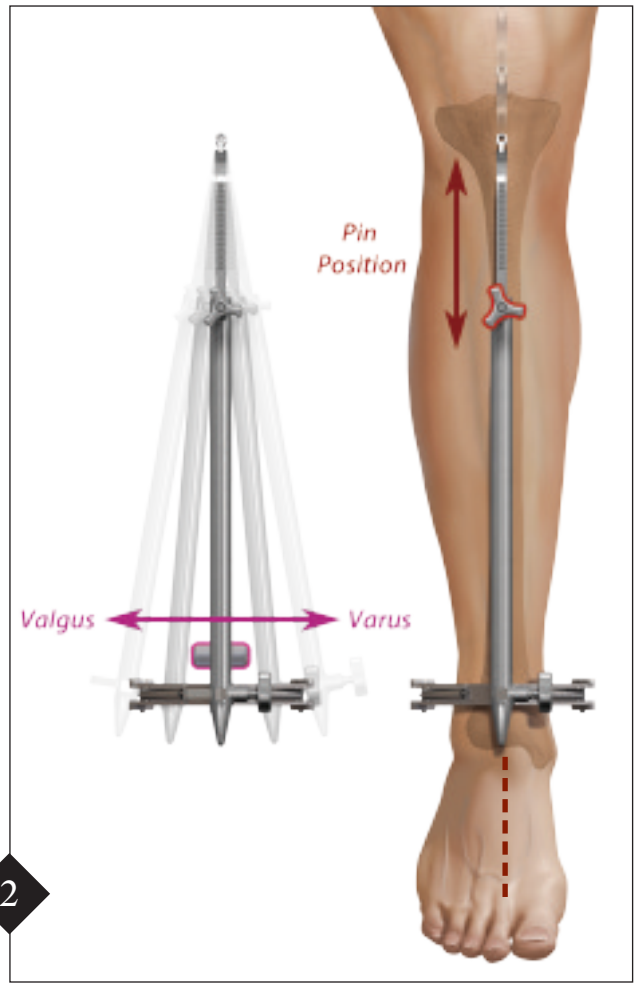
Depending on which compartment is being resurfaced, release the soft tissues from the very proximal edge of the corresponding plateau to allow insertion of a small retractor. Often it is helpful to remove a small amount of the anterior fat pad. Identify the tibial eminence and mark an AP line using an electrocautery device approximately in the middle between the tip of the eminence and its base.

Osteophyte Removal

Prior to beginning the bony preparation of the tibia and femur, inspect the operative compartment and remove any peripheral osteophytes from the margins of the femoral condyle, intercondylar notch, the posterior tibial plateau and from beneath either the medial collateral ligament or lateral collateral ligament.

Tibial Preparation

1 Assemble the tibial alignment guide and place it on the operative limb.

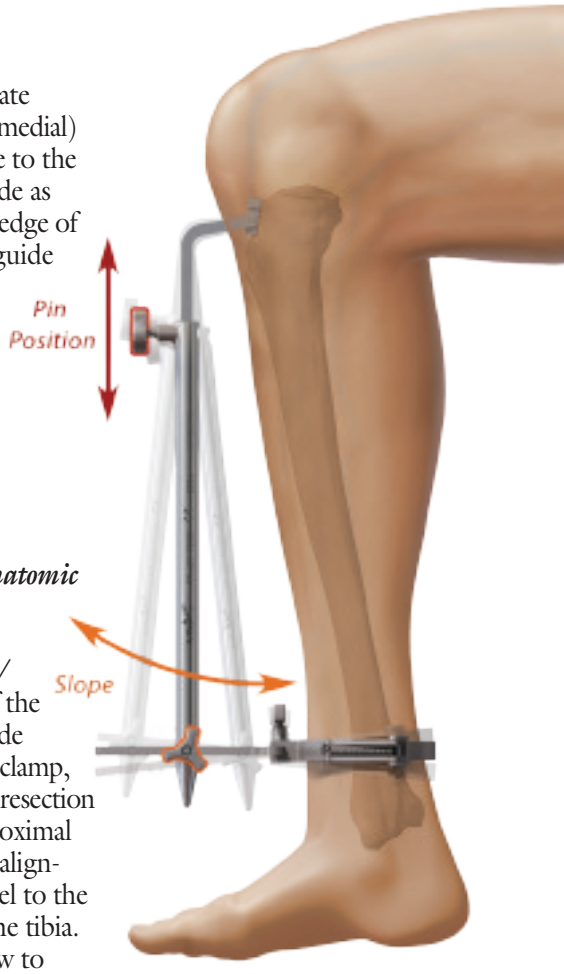


2 Adjust the length of the tibial alignment guide to allow the proximal portion of the guide to reach the area between the tibial tubercle and the tibial plateau and pin the guide with a single pin without interrupting the tibial socket.

Varus/valgus alignment is accomplished by aligning the long axis of the tibial guide between the second and third metatarsals and parallel to the long axis of the tibia.

3

Attach the appropriate (left-medial or right-medial) tibial resection guide to the tibial alignment guide as shown. The curved edge of the tibial resection guide should contact the anterior part of the tibia.



The tibial resection should match the anatomic tibial slope.
Loosen the screw that allows anterior/posterior motion of the tibial alignment guide relative to the ankle clamp, and adjust the tibial resection guide so that the proximal surface of the tibial alignment guide is parallel to the anatomic slope of the tibia.

Tighten the screw to secure tibial slope alignment.

4

Tibial Resection Depth

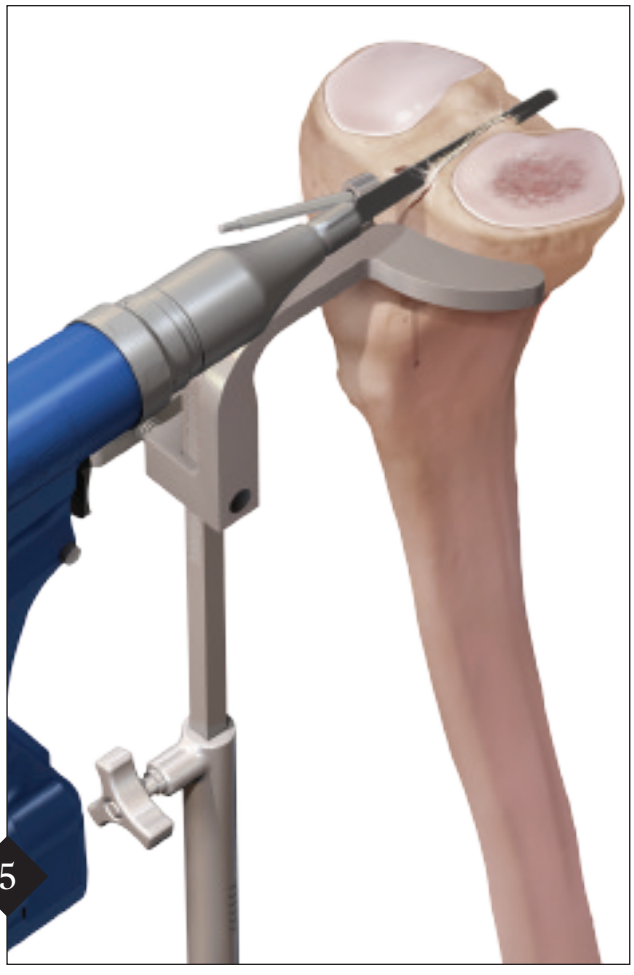
There are two tibial stylus options available. The "0" stylus places the tip of the stylus at the level the saw will cut through, representing zero resection depth. The "5" stylus allows for a 5 mm resection depth below the tip of the stylus. ***Note: The stylus that is chosen and the resultant tibial resection should be based on the amount of bone loss that is present in the native tibia.***

Loosen the tibial resection guide thumbscrew so that the resection guide slides proximal/distal on the tibial alignment guide.

Slide the tibial stylus over the tibial resection guide as shown and place the stylus pointer on the tibial plateau at the lowest point of the chondral defect.

Once the stylus is in the appropriate position and the depth of the cut is determined, lock the tibial resection guide in place on the tibial alignment guide.

The stylus can then be removed from the cutting block. If additional tibial bone should need to be resected, the tibial alignment guide has markings in 1 mm increments that allow the cutting block to be lowered to accommodate additional bony resection.



5

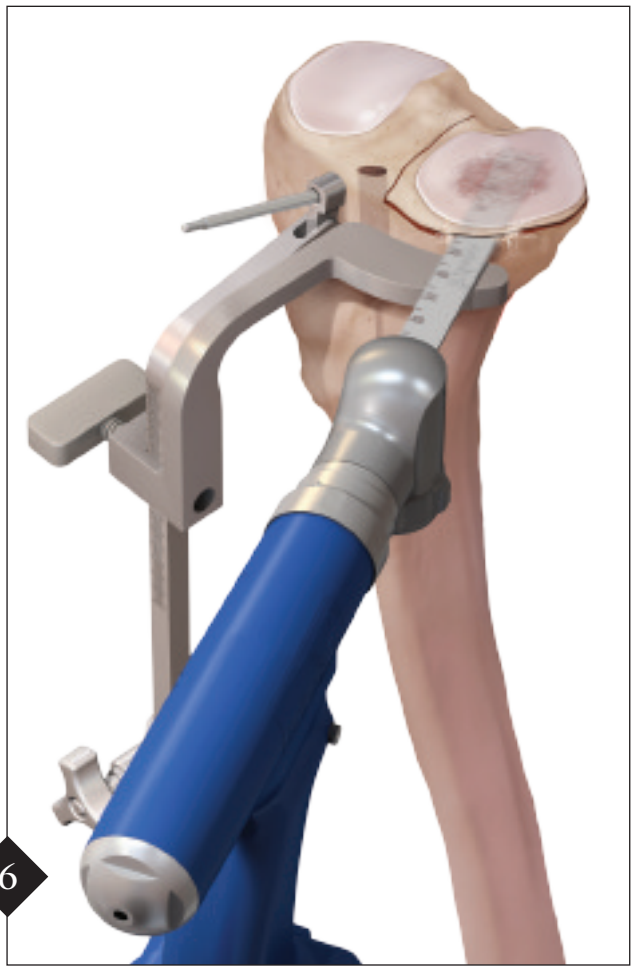
Vertical Tibial Cut

Use a reciprocating saw to make the vertical tibial cut. Make the cut parallel to and located at the edge of the tibial eminence from the plateau to the level of the tibial cutting guide.

Typically, this cut is made at the mid-point between the top and bottom of the tibial eminence. Use caution to avoid cutting into the ACL attachment point or socket.

An electrocautery device is helpful to mark the proper orientation line.

The location and orientation of the vertical cut will directly influence the size and position of the tibial component. Proper attention to this detail is important for optimal component positioning.



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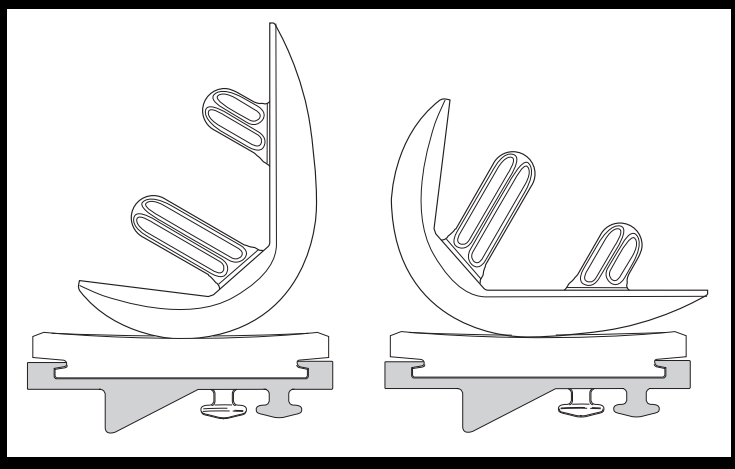
Horizontal Tibial Cut

Use a 1.27 mm x 13 mm sagittal saw to make the horizontal cut. Hold the saw blade flat against the surface of the tibial resection guide and take care not to allow the saw to undermine the tibial eminence. ***Do not flex the blade.*** Remove the resected tibial plateau with a rongeur or osteotome.

Principle of Instrumentation to Achieve Balanced Flexion and Extension Gaps



The iBalance UKA implants have a minimum material thickness of 15 mm (7 mm femoral component thickness + 8 mm tibial thickness). In order to achieve balanced flexion and extension gaps, without affecting the joint line in extension and maintaining an appropriate flexion space, it is important that proper resection of the distal and posterior condyle is carried out. The overall bony resection (tibia + femur) should be in the range of 16 mm to 21 mm, with the target femoral resection being 7 mm.

The iBalance UKA instrumentation allows the surgeon to:

1. ***Measure the resultant flexion and extension gaps after the tibial resection to ensure the proper amount of tibial bone has been resected.***
   It is important to ensure that a sufficient thickness of the tibial plateau has been resected prior to continuing on to the femoral preparation steps. This will allow for the minimum tibial implant thickness of 8 mm to fit in the knee without elevating the joint line. Remove all peripheral osteophytes and any retractors prior to assessing the gaps to ensure an accurate measurement of the joint tension.

2. ***Gauge an approximation of the tibial poly thickness.***
   When choosing the thickness of spacer block to insert into the knee prior to femoral preparation, keep in mind that this measurement will be a determinant, within +/-1 mm, of your tibial bearing thickness.

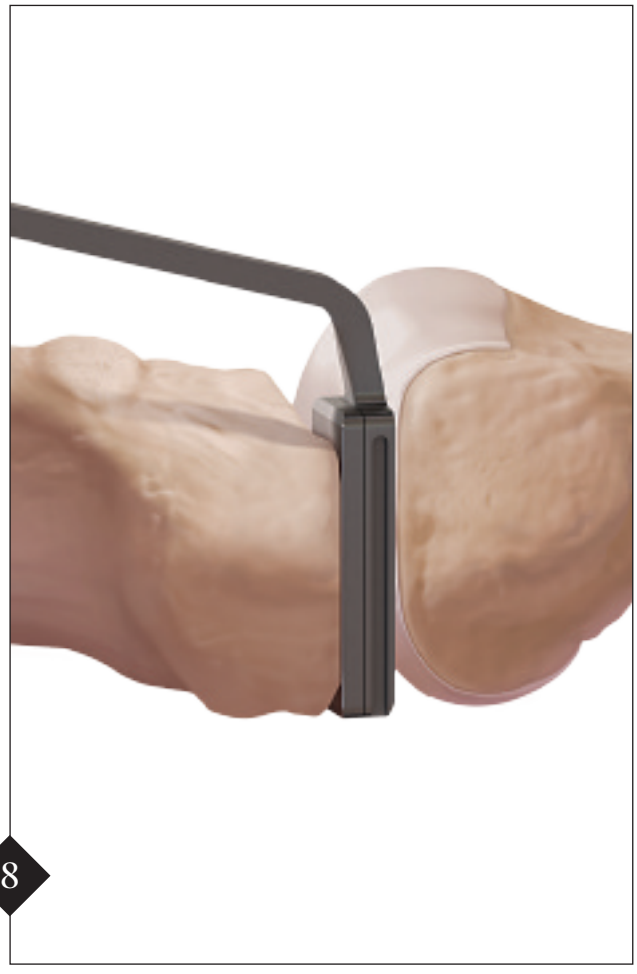
3. ***Use the spacer block as a starting point for a balanced resection of the femoral bone in both flexion and extension.***
   This allows the surgeon to customize bony resection in order to equalize flexion and extension gaps. If the extension gap is greater than the flexion gap, the distal femoral resection may be decreased so that the resultant gaps are equal.

Measure Flexion and Extension Space

Prior to assessing the gaps using the spacer blocks, remove all retractors from the joint to ensure proper tensioning of the joint space. Measure and record the flexion and extension gaps using the spacer block handle and modular spacer blocks. The modular spacer blocks attach to the spacer block handle magnetically.

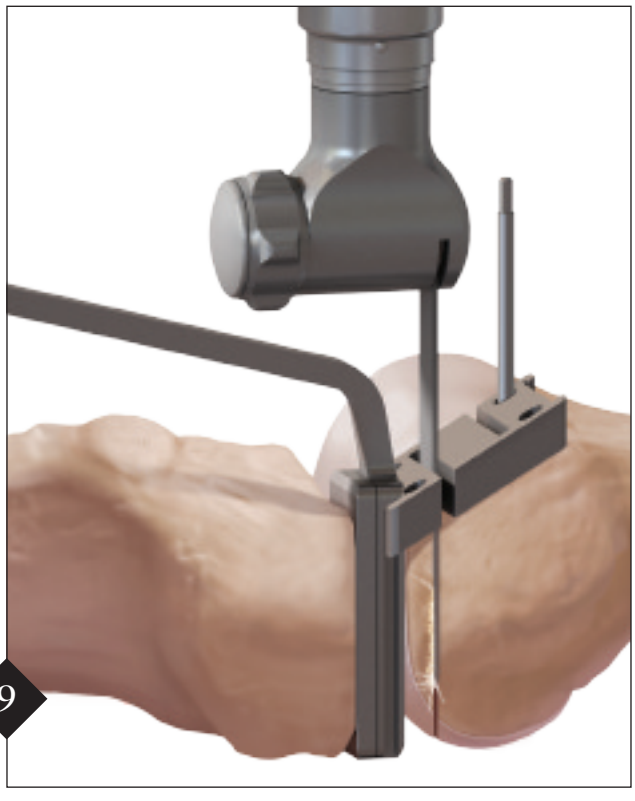
7

Measure the flexion space by inserting the appropriate sized spacer block into the compartment with the leg in 90° of flexion with the leg in proper varus/valgus alignment. ***Note: Varus/valgus alignment is determined through the use of alignment rods applied to the spacer block handle.***



8

Measure the extension space by inserting the appropriate sized spacer block into the compartment with the leg in full extension *(or as close as possible)* and the leg in proper varus/valgus alignment.



9

Distal Femoral Cut

The femoral component has a thickness of 7 mm. The standard distal femoral resection is 7 mm, but this may be decreased so the resultant gaps are equal.

Assemble the distal cutting block on to the spacer block handle and appropriate spacer block as shown with the open end of the cutting slot away from the midline. With the leg in extension, insert the spacer block construct with appropriate distal cutting block into the joint between the distal condyle and tibial cut as shown. ***Note: It is important to avoid making the distal femoral cut in hyperextension. It is helpful to place a bump behind the knee to support the limb.*** Once the position of the cutting block is determined to be correct and flush against the anterior femoral condyle, pin the block in place.

Check varus/valgus alignment before the distal resection is made using the alignment rods. Make the distal femoral cut using a 1.27 mm thick x 13 mm wide sagittal saw.

The spacer block handle, along with collateral ligament tension from the spacer block, are used to keep the distal cutting block in place.

10

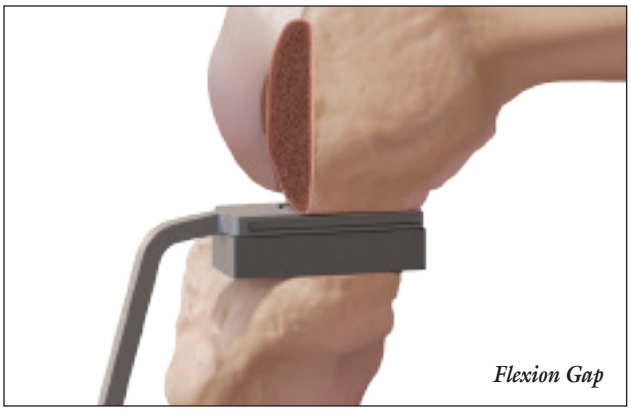
Posterior Femoral Cut

The thickness of the femoral component is 7 mm posteriorly, and a 7 mm posterior resection should be the goal to match this thickness.

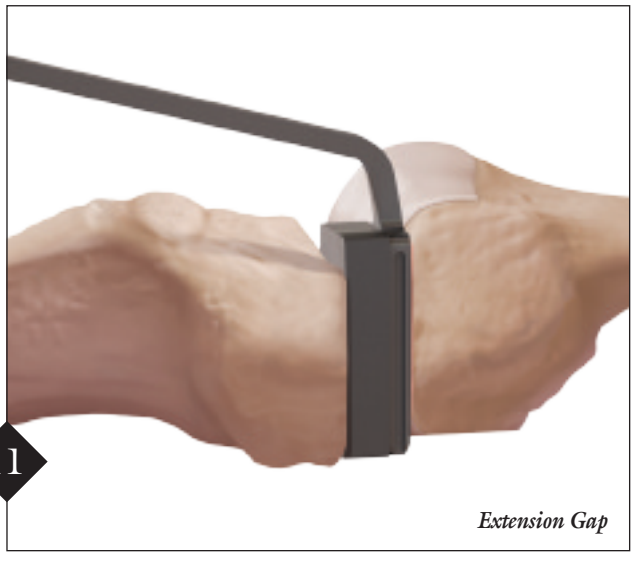
Assemble the posterior cutting block on to the spacer block handle and appropriate spacer block as shown with the open end of the cutting slot away from the midline. With the leg in approximately 90° of flexion, insert the spacer block construct with appropriate posterior cutting block into the joint as shown. Once the position of the cutting block is determined to be correct and flush against the previously made distal femoral resection and tibial resection, to provide the correct angle between the posterior and distal cuts and the correct rotational alignment relative to the tibia, pin the block in place.

Check varus/valgus alignment before the posterior resection is made using the alignment rods.

Make the posterior cut using a 1.27 mm thick x 13 mm wide sagittal saw.



Flexion Gap

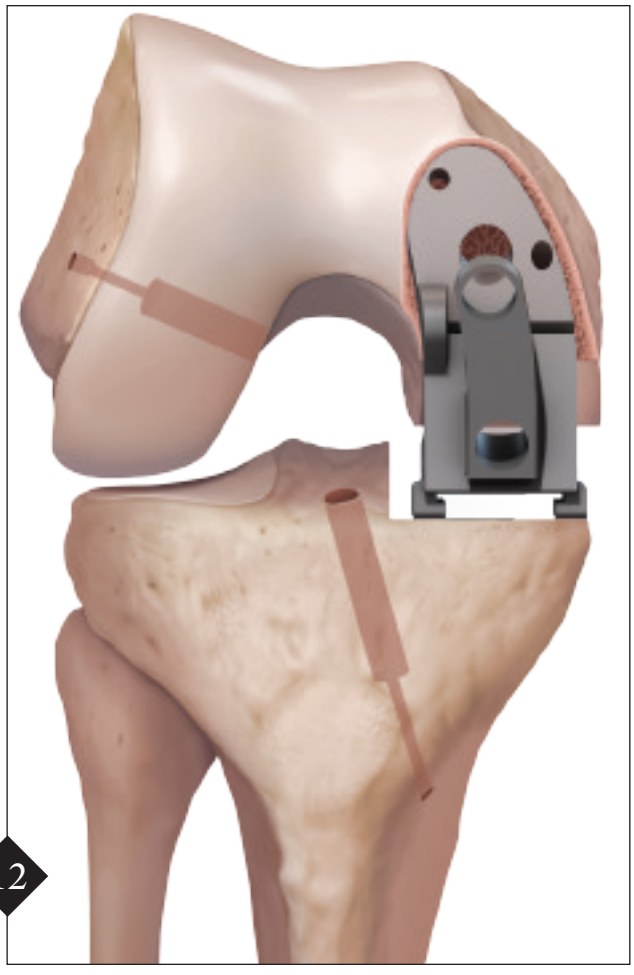


11

Extension Gap

Composite Block Gap Check

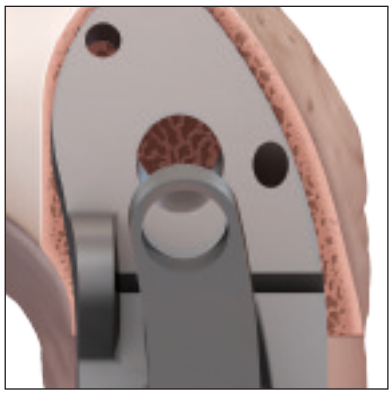
Once both the distal and posterior femoral cuts have been made, a composite block matching the overall resection depth can be placed in the flexion and extension spaces to ensure the gaps are indeed square and the flexion and extension spaces are balanced.



12

Femoral Sizing, Chamfer Cut, and Peg Hole Preparation

Femoral sizing and final preparation is performed using the Chamfer and Peg Guide. With the knee in flexion, place the guide on the distal and posterior resections. The profile of each guide matches the profile of the corresponding femoral implant. When properly sized, there should be a rim of 2 mm to 3 mm of exposed bone above the anterior flange of the guide, with no medial overhang.



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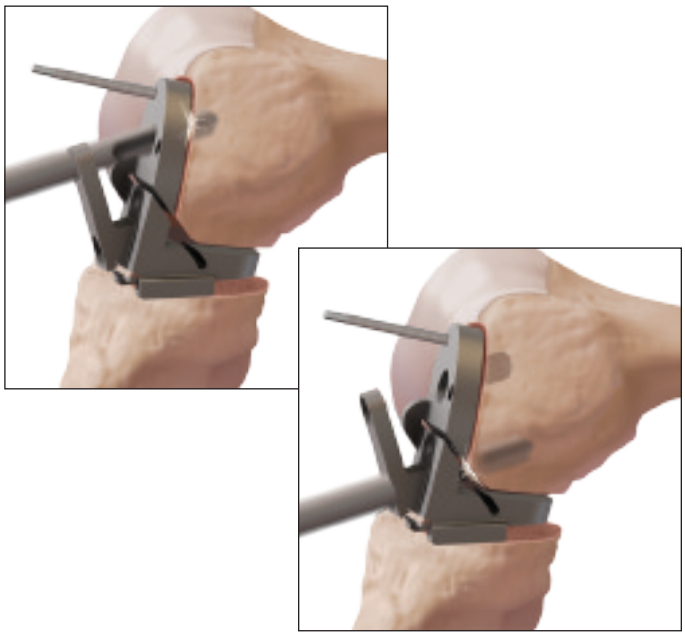
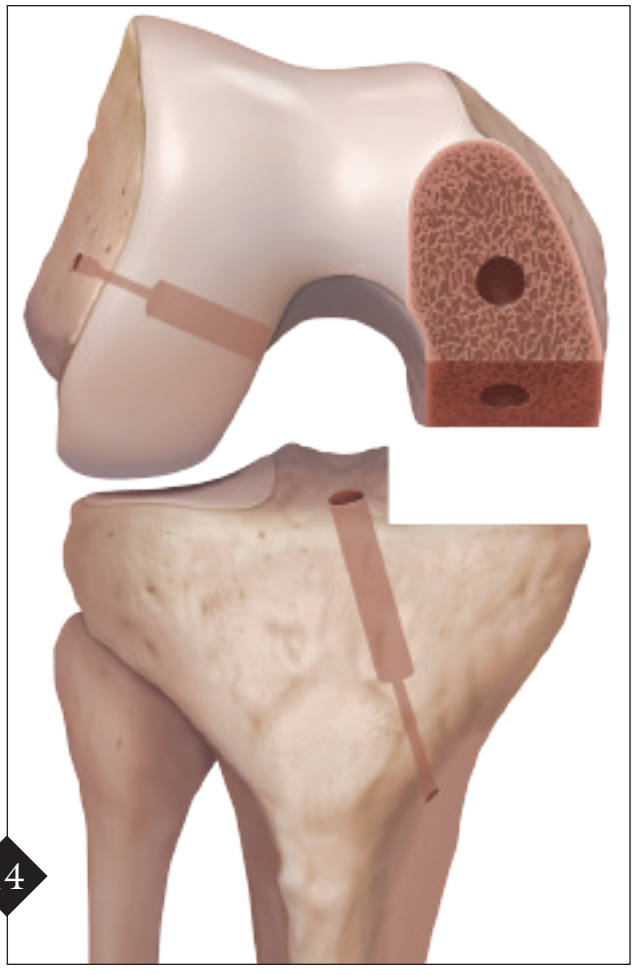
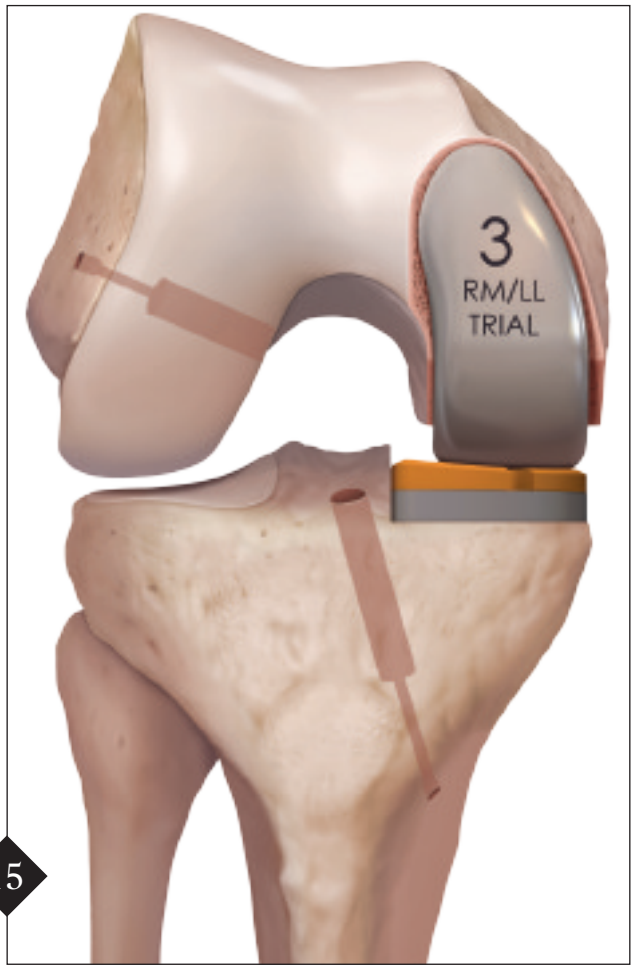
Once the guide is determined to be properly oriented, pin the guide in place. Make the chamfer cut using a 1.27 mm thick x 13 mm wide sagittal saw.



Create the anterior and posterior lug holes using the Femoral Step Drill.



14



15

Trial Reduction

Once the tibial and femoral cuts have been made, use the D-ring tibial trials, tibial bearing trials and femoral component trials to assess the fit and position of the implants and the proper tensioning of the compartment.

In extension, the joint should be stable but not excessively tight as this can cause the contralateral compartment to be over-stressed. The correct tibial bearing thickness should allow the joint-space to open up 1 mm to 2 mm under varus/valgus stress and provide the correction desired but not over-stress the collateral ligaments. If the joint is tight in extension, use a thinner tibial bearing or resect additional distal femoral bone to correct excess tightness.

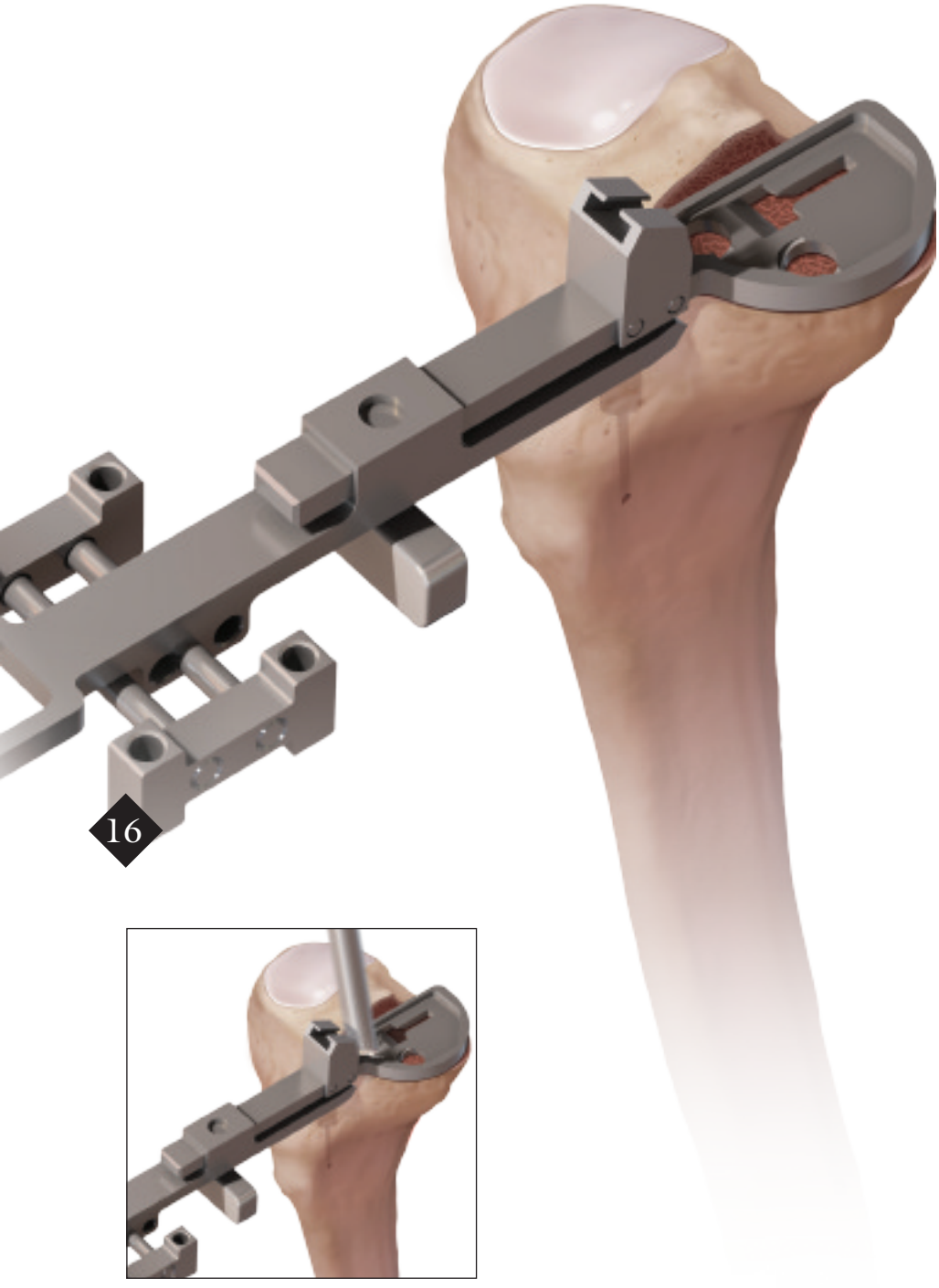
In flexion, the joint space should also open up 1 mm to 2 mm under stress. Another indicator of excess tightness in flexion is if the tibial bearing trial lifts up anteriorly during flexion. Resect additional posterior femoral bone if the joint is tight in flexion but not extension.

Tibial Sizing and Finishing

Choose the Tibial Sizing and Finishing Guide that matches the tibial trial used in the previous step.

The tibia is sized independent of the prepared femoral size and the exposed tibial bone should be well covered, but there should be no overhang. It is important to remove any peripheral tibial osteophytes to ensure the tibial component is fit to the true cortical rim of the tibia.

Insert the guide into the Spurred Handle and lock the guide in the Spurred Handle using the locking screw. Place the guide and Spurred Handle onto the tibia, pushing the spur onto the anterior tibial bone and simultaneously, pushing down onto the tibia to hold the guide in place.



16

Use the tibial peg step drill to drill the two tibial peg holes. The drill bit can be left in the medial hole to add support during punching the keel.

Insert the Keel Punch into the designated slot on the Tibial Guide. Mallet the Keel Punch down into the tibial plateau until it stops. The Keel Punch should be impacted until the tip is flush with the guide.

Implantation

Tibial Component

The tibial component is implanted first. Flex the knee and rotate the tibia externally to aid insertion. Apply cement to the backside of the component and manually place the tibial tray component onto the prepared tibia. Insert the keel of the tibial tray component into the prepared slot in the tibia, keeping the tibial tray parallel to the tibial resection and pushing the component from anterior to posterior and down into the prepared tibial surface at an angle of approximately 30°. Finish seating the tibial tray component using the tibial tray impactor. Remove excess cement from around the component using the Cement Removal Tool.

Femoral Component

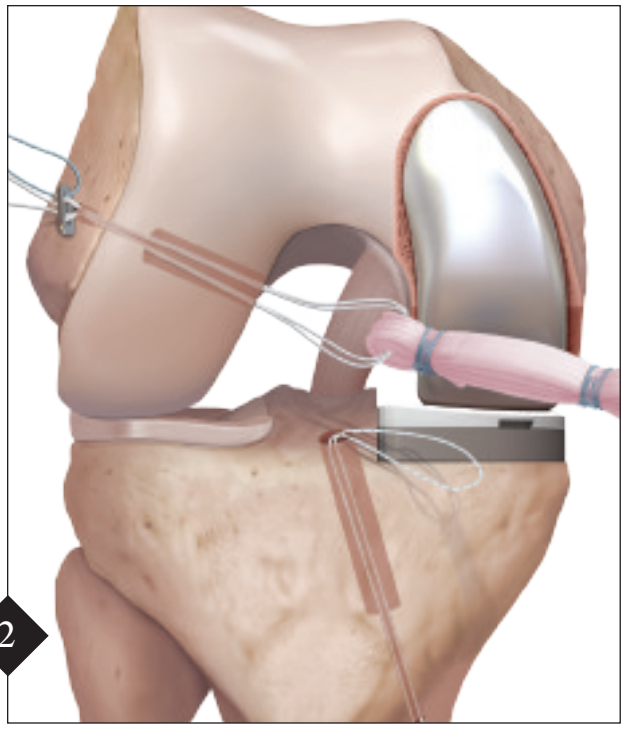
The femoral component is implanted with the leg flexed as much as possible. Apply cement to the entire backside of the component and insert the component manually. Finish seating the femoral component using the femoral impactor. Remove excess cement from around the component using the Cement Removal Tool.

Tibial Polyethylene

Determine the final thickness of the tibial bearing component by using a tibial bearing trial placed in the definitive tibial tray component. As described previously in the "Trial Reduction" section, the correct tibial bearing thickness should allow the joint space to open up 1-2 mm under varus/valgus stress (in both flexion and extension). Leave the appropriate trial bearing in place to maintain pressure on the femoral and tibial tray components while the cement is curing.

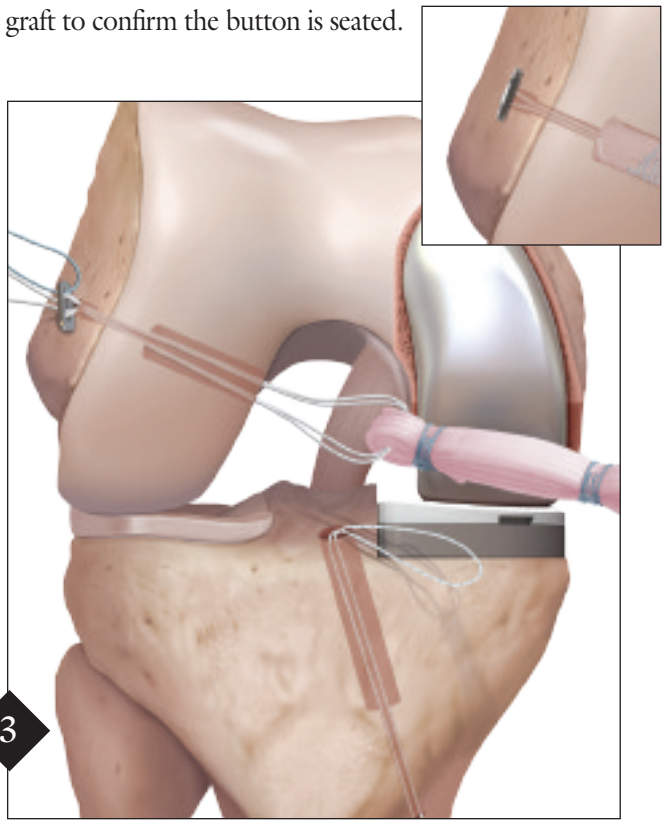
The tibial bearing implant is inserted after the cement has fully cured. Remove the tibial bearing trial using the tibial bearing trial puller instrument. Insert the final tibial bearing component into the tibial tray component anteriorly, with the articulating surface facing the femoral component. Slide the tibial bearing component posteriorly until the posterior slot on the bearing engages the posterior lip on the tibial tray. Push the anterior edge of the tibial bearing down into the tibial tray component using thumb pressure until it snaps into place. ***Note: There is a 5° clearance built in to the tibial bearing to allow for ease of insertion. It is normal for there to be a small gap in between the Tibial Bearing and the implant, once the bearing is fully seated.***

NOTE:
Prior to implanting the GraftLink construct, install the tibial trial bearing into the tibial tray, shuttle the GraftLink construct into place, wait until UKA cement dries, then replace the trial bearing with final poly bearing.



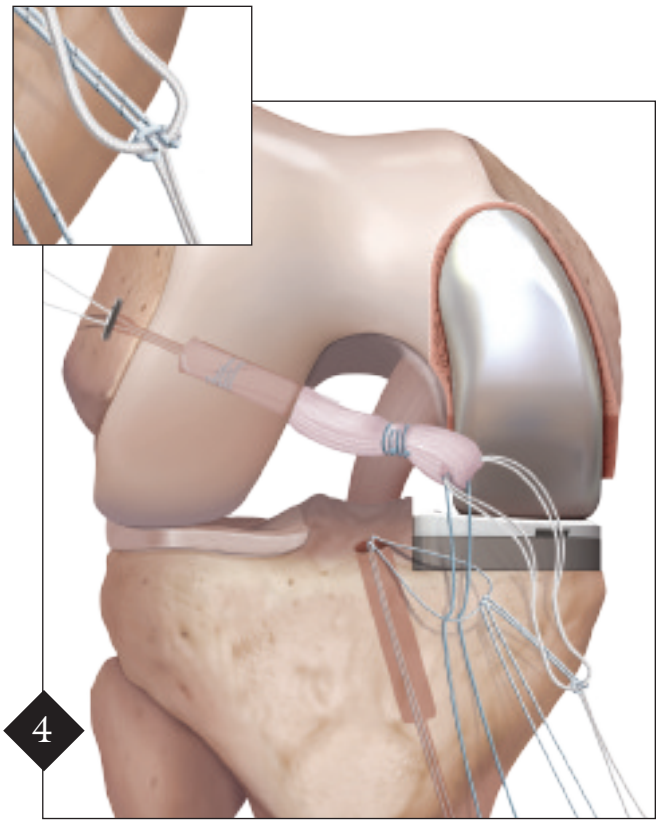
2

Pass the blue button suture and the white shortening strands through the femur. Remove slack from sutures and ensure equal tension. Clamp or hold both blue and white sutures together and pull them together to advance the button out of the femur. Use markings on the loop and arthroscopic visualization of the button to confirm exit from the femoral cortex. Pull back on the graft to confirm the button is seated.



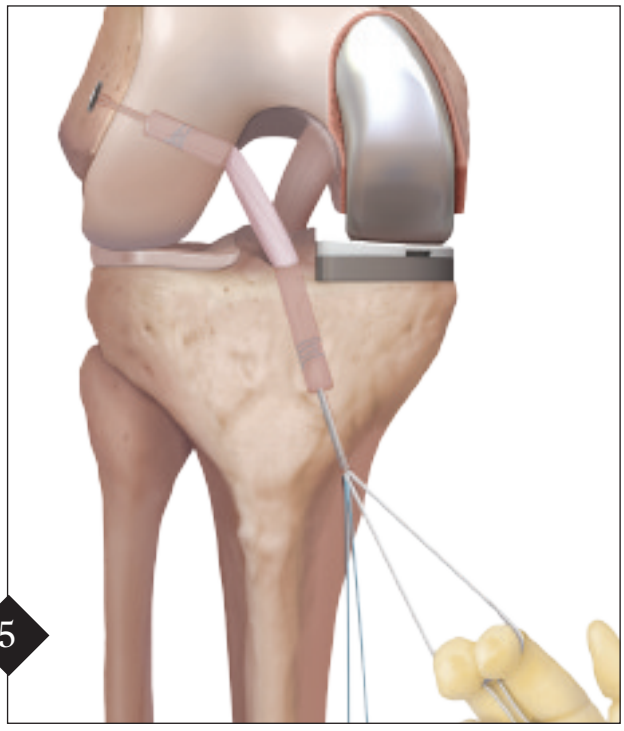
3

While holding slight tension on the graft, pull the shortening strands proximally, one at a time to advance the graft. Pull on each strand in 2 cm increments. ***Note: The graft can be fully seated into the femur or left partially inserted until tibial passing is complete. The latter option allows fine-tuning of graft depth in each socket.***



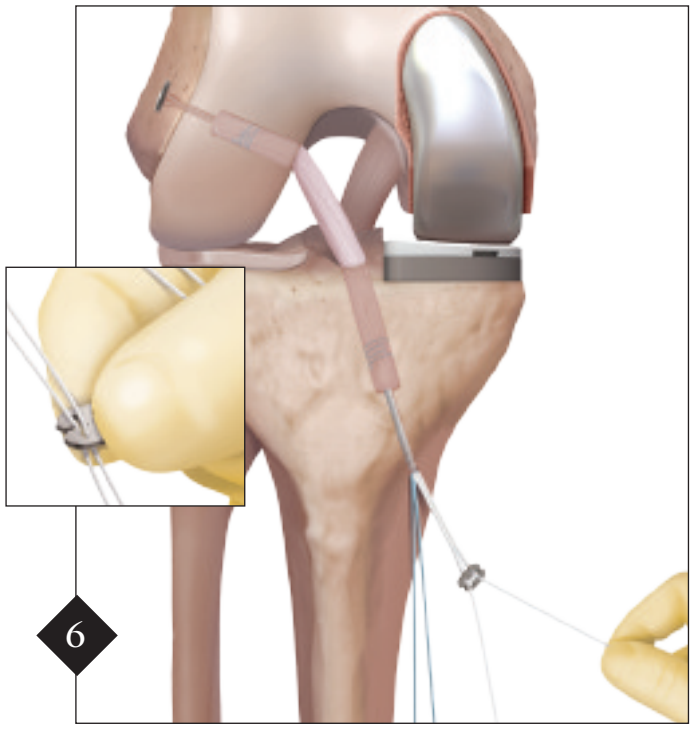
4

Cinch a suture around the end of the TightRope ABS loop to use for passing (inset). Load the cinch suture and the whipstitch tails from the graft into the tibial passing suture. Pull distally on the tibial passing suture to deliver both the TightRope ABS loop and the whipstitch sutures out of the tibia distally.



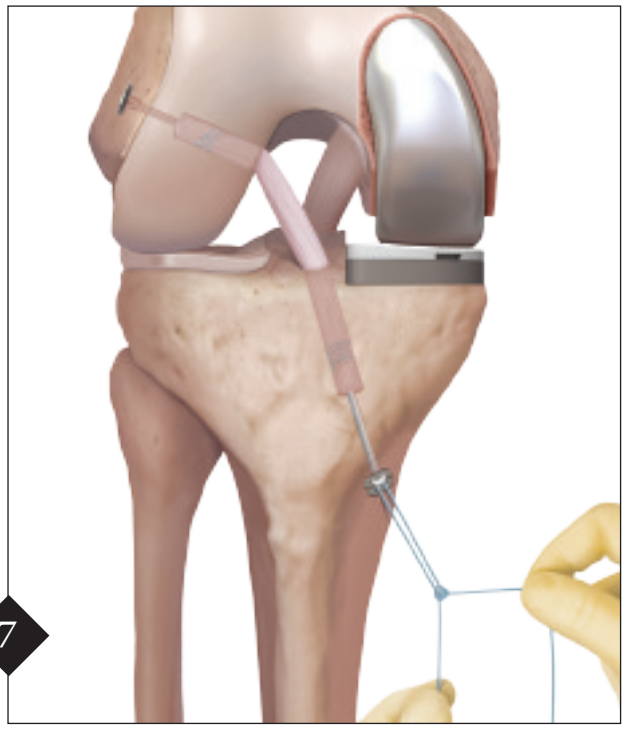
5

Advance the graft into the tibia by pulling on the inside of the ABS loop and whipstitch sutures.



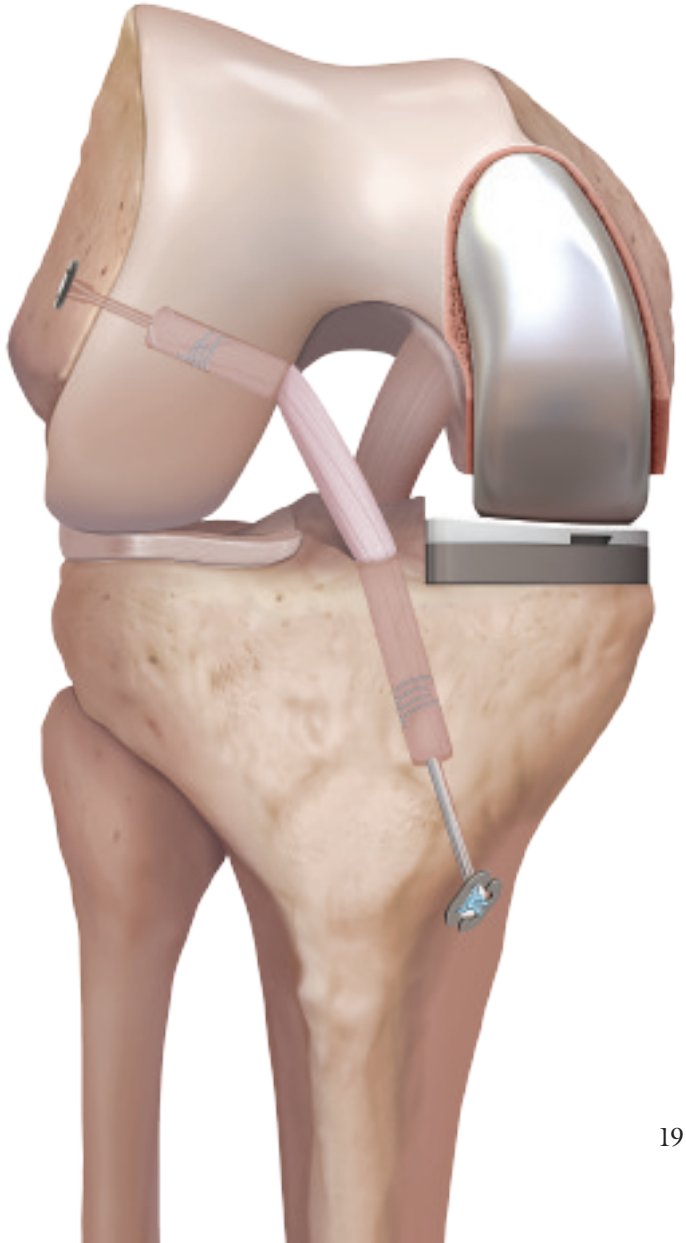
6

Load the TightRope ABS Button onto the loop. Pull on the white shortening strands to advance the button to bone and tension graft. ***Note: Ensure the button has a clear path to bone, as to not entrap soft tissue under the button.***



7

Load the whipstitch sutures into the button and tie a knot for backup fixation.



GraftLink Ordering Information

Implants

ACL TightRope RT	AR-1588RT
TightRope ABS	AR-1588TN
TightRope ABS Button	AR-1588TB
ACL TightRope Convenience Pack, TightRope Drill Pin	AR-1588RTS
ACL TightRope Convenience Pack, FlipCutter	AR-1588RT-07 – 13

Instruments

For FlipCutter Technique

RetroConstruction Drill Guide Set	AR-1510S
Footprint Femoral ACL Guide, right	AR-1510FR
Footprint Femoral ACL Guide, left	AR-1510FL
FlipCutter II, 6 mm	AR-1204AF-60
FlipCutter II, 6.5 mm	AR-1204AF-65
FlipCutter II, 7 mm	AR-1204AF-70
FlipCutter II, 7.5 mm	AR-1204AF-75
FlipCutter II, 8 mm	AR-1204AF-80
FlipCutter II, 8.5 mm	AR-1204AF-85
FlipCutter II, 9 mm	AR-1204AF-90
FlipCutter II, 9.5 mm	AR-1204AF-95
FlipCutter II, 10 mm	AR-1204AF-100
FlipCutter II, 10.5 mm	AR-1204AF-105
FlipCutter II, 11 mm	AR-1204AF-110
FlipCutter II, 11.5 mm	AR-1204AF-115
FlipCutter II, 12 mm	AR-1204AF-120
FlipCutter II, 13 mm	AR-1204AF-130

For Medial Portal Technique

Transportal ACL Guides (TPGs), 4 mm – 8 mm	AR-1800-04 – 08
Low Profile Reamer, 5 mm	AR-1405LP
Low Profile Reamer, 5.5 mm	AR-1405LP-50
Low Profile Reamer, 6 mm	AR-1406LP
Low Profile Reamer, 6.5 mm	AR-1406LP-50
Low Profile Reamer, 7 mm	AR-1407LP
Low Profile Reamer, 7.5 mm	AR-1407LP-50
Low Profile Reamer, 8 mm	AR-1408LP
Low Profile Reamer, 8.5 mm	AR-1408LP-50
Low Profile Reamer, 9 mm	AR-1409LP
Low Profile Reamer, 9.5 mm	AR-1409LP-50
Low Profile Reamer, 10 mm	AR-1410LP
Low Profile Reamer, 10.5 mm	AR-1410LP-50
Low Profile Reamer, 11 mm	AR-1411LP
Low Profile Reamer, 11.5 mm	AR-1411LP-50
Low Profile Reamer, 12 mm	AR-1412LP
Low Profile Reamer, 12.5 mm	AR-1412LP-50
Low Profile Reamer, 13 mm	AR-1413LP
TightRope Drill Pin, open	AR-1595T
TightRope Drill Pin, closed	AR-1595TC

Accessories

Suture Retriever	AR-12540
Graft Sizing Block	AR-1886
Graft Prep Station Base	AR-2950
GraftLink Prep Attachment	AR-2951-1
GraftLink Prep Attachment with Tensioner	AR-2951-2
Suture Cutter for ACL TightRope	AR-4520

Suture

0 FiberWire, 38" (blue) w/Tapered Needle, 22.2 mm 1/2 circle	AR-7250
FiberStick, #2 FiberWire, 50" (blue), one end stiffened	AR-7209
TigerStick, #2 TigerWire, 50" (white/black), one end stiffened	AR-7209T
#2 FiberLoop w/Straight Needle, 20" (blue), 76 mm needle w/7 mm loop	AR-7234
#2 TigerLoop w/Straight Needle, 20" w/TigerWire (white/green), 76 mm needle w/7 mm loop	AR-7234T

UKA Ordering Information

IMPLANTS

Femoral Components

Femoral Component, Size 1, Left-Medial	AR-501-UFLA
Femoral Component, Size 2, Left-Medial	AR-501-UFLB
Femoral Component, Size 3, Left-Medial	AR-501-UFLC
Femoral Component, Size 4, Left-Medial	AR-501-UFLD
Femoral Component, Size 5, Left-Medial	AR-501-UFLE
Femoral Component, Size 6, Left-Medial	AR-501-UFLF
Femoral Component, Size 1, Right-Medial	AR-501-UFRA
Femoral Component, Size 2, Right-Medial	AR-501-UFRB
Femoral Component, Size 3, Right-Medial	AR-501-UFRC
Femoral Component, Size 4, Right-Medial	AR-501-UFRD
Femoral Component, Size 5, Right-Medial	AR-501-UFRE
Femoral Component, Size 6, Right-Medial	AR-501-UFRF

Tibial Components

Tibial Tray Component, Size 1, Left-Medial	AR-501-TTLA
Tibial Tray Component, Size 2, Left-Medial	AR-501-TTLB
Tibial Tray Component, Size 3, Left-Medial	AR-501-TTLC
Tibial Tray Component, Size 4, Left-Medial	AR-501-TTLD
Tibial Tray Component, Size 5, Left-Medial	AR-501-TTLE
Tibial Tray Component, Size 6, Left-Medial	AR-501-TTLF
Tibial Tray Component, Size 1, Right-Medial	AR-501-TTRA
Tibial Tray Component, Size 2, Right-Medial	AR-501-TTRB
Tibial Tray Component, Size 3, Right-Medial	AR-501-TTRC
Tibial Tray Component, Size 4, Right-Medial	AR-501-TTRD
Tibial Tray Component, Size 5, Right-Medial	AR-501-TTRE
Tibial Tray Component, Size 6, Right-Medial	AR-501-TTRF

Polyethylene Components

Tibial Bearing, Size 1, 8 mm	AR-501-TBA8
Tibial Bearing, Size 1, 9 mm	AR-501-TBA9
Tibial Bearing, Size 1, 10 mm	AR-501-TBA0
Tibial Bearing, Size 1, 11 mm	AR-501-TBA1
Tibial Bearing, Size 1, 12 mm	AR-501-TBA2
Tibial Bearing, Size 1, 14 mm	AR-501-TBA4
Tibial Bearing, Size 2, 8 mm	AR-501-TBB8
Tibial Bearing, Size 2, 9 mm	AR-501-TBB9
Tibial Bearing, Size 2, 10 mm	AR-501-TBB0
Tibial Bearing, Size 2, 11 mm	AR-501-TBB1
Tibial Bearing, Size 2, 12 mm	AR-501-TBB2
Tibial Bearing, Size 2, 14 mm	AR-501-TBB4
Tibial Bearing, Size 3, 8 mm	AR-501-TBC8
Tibial Bearing, Size 3, 9 mm	AR-501-TBC9
Tibial Bearing, Size 3, 10 mm	AR-501-TBC0
Tibial Bearing, Size 3, 11 mm	AR-501-TBC1
Tibial Bearing, Size 3, 12 mm	AR-501-TBC2
Tibial Bearing, Size 3, 14 mm	AR-501-TBC4
Tibial Bearing, Size 4, 8 mm	AR-501-TBD8
Tibial Bearing, Size 4, 9 mm	AR-501-TBD9
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Tibial Bearing, Size 4, 11 mm	AR-501-TBD1
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Tibial Bearing, Size 5, 8 mm	AR-501-TBE8
Tibial Bearing, Size 5, 9 mm	AR-501-TBE9
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Tibial Bearing, Size 5, 11 mm	AR-501-TBE1
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Tibial Bearing, Size 5, 14 mm	AR-501-TBE4
Tibial Bearing, Size 6, 8 mm	AR-501-TBF8
Tibial Bearing, Size 6, 9 mm	AR-501-TBF9
Tibial Bearing, Size 6, 10 mm	AR-501-TBF0
Tibial Bearing, Size 6, 11 mm	AR-501-TBF1
Tibial Bearing, Size 6, 12 mm	AR-501-TBF2
Tibial Bearing, Size 6, 14 mm	AR-501-TBF4

iBalance UKA Instrument Set	*AR-601-S*
Instrumentation	
Ankle Clamp	AR-005-AC00
Alignment Rod	AR-601-AR00
Bone Caliper	AR-601-BC00
Cement Removal Tool	AR-601-CR00
Distal Cutting Block, 4 mm	AR-601-DB04
Distal Cutting Block, 5 mm	AR-601-DB05
Distal Cutting Block, 6 mm	AR-601-DB06
Distal Cutting Block, 7 mm	AR-601-DB07
Distal Cutting Block, 8 mm	AR-601-DB08
Distal Cutting Block, 9 mm	AR-601-DB09
Distal Cutting Block, 10 mm	AR-601-DB10
1/8" x 3" Headless Fixation Pin	AR-601-FP30
Femoral Impactor Body	AR-601-FPB0
5/16 Step Drill, Femoral	AR-601-FPD0
Femoral Impactor Head	AR-601-FPH0
Headless Pin Driver	AR-007-HPD0
Spacer Block Handle Assembly	AR-601-KSBH
Posterior Cutting Block, 3 mm	AR-601-PB03
Posterior Cutting Block, 4 mm	AR-601-PB04
Posterior Cutting Block, 5 mm	AR-601-PB05
Posterior Cutting Block, 6 mm	AR-601-PB06
Posterior Cutting Block, 7 mm	AR-601-PB07
Posterior Cutting Block, 8 mm	AR-601-PB08
Posterior Cutting Block, 9 mm	AR-601-PB09
Posterior Cutting Block, 10 mm	AR-601-PB10
Spacer Block Insert, 6 mm	AR-601-SB06
Spacer Block Insert, 7 mm	AR-601-SB07
Spacer Block Insert, 8 mm	AR-601-SB08
Spacer Block Insert, 9 mm	AR-601-SB09
Spacer Block Insert, 10 mm	AR-601-SB10
Spurred Handle	AR-601-SH00
Modular Plus Spacer Block, 5 mm	AR-601-SM05
Modular Plus Spacer Block, 10 mm	AR-601-SM10
Trial Bearing Puller	AR-601-TBP0
Tibial Alignment Guide Assembly	AR-601-TG00
Tibial Impactor Body Assembly	AR-601-TIB0
Tibial Impactor Head	AR-601-TIH0
Keel Punch	AR-601-TKBR
5/16 Step Drill, Tibial	AR-601-TPD0
Tibial Resection Guide, Lt. Medial	AR-601-TRLM
Tibial Resection Guide, Rt. Medial	AR-601-TRRM
Tibial Stylus, 0 mm	AR-601-TS00
Tibial Stylus, 5 mm	AR-601-TS05
Chamfer & Peg Guide, Size 1, Lt. Medial	AR-601-CLMA
Chamfer & Peg Guide, Size 2, Lt. Medial	AR-601-CLMB
Chamfer & Peg Guide, Size 3, Lt. Medial	AR-601-CLMC
Chamfer & Peg Guide, Size 4, Lt. Medial	AR-601-CLMD
Chamfer & Peg Guide, Size 5, Lt. Medial	AR-601-CLME
Chamfer & Peg Guide, Size 6, Lt. Medial	AR-601-CLMF
Chamfer & Peg Guide, Size 1, Rt. Medial	AR-601-CRMA
Chamfer & Peg Guide, Size 2, Rt. Medial	AR-601-CRMB
Chamfer & Peg Guide, Size 3, Rt. Medial	AR-601-CRMC
Chamfer & Peg Guide, Size 4, Rt. Medial	AR-601-CRMD
Chamfer & Peg Guide, Size 5, Rt. Medial	AR-601-CRME
Chamfer & Peg Guide, Size 6, Rt. Medial	AR-601-CRMF
Tibial Sizing & Finishing Guide, Size 1, Lt. Medial	AR-601-TTL1
Tibial Sizing & Finishing Guide, Size 2, Lt. Medial	AR-601-TTL2
Tibial Sizing & Finishing Guide, Size 3, Lt. Medial	AR-601-TTL3
Tibial Sizing & Finishing Guide, Size 4, Lt. Medial	AR-601-TTL4
Tibial Sizing & Finishing Guide, Size 5, Lt. Medial	AR-601-TTL5
Tibial Sizing & Finishing Guide, Size 6, Lt. Medial	AR-601-TTL6
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Tibial Sizing & Finishing Guide, Size 2, Rt. Medial	AR-601-TTR2
Tibial Sizing & Finishing Guide, Size 3, Rt. Medial	AR-601-TTR3
Tibial Sizing & Finishing Guide, Size 4, Rt. Medial	AR-601-TTR4
Tibial Sizing & Finishing Guide, Size 5, Rt. Medial	AR-601-TTR5
Tibial Sizing & Finishing Guide, Size 6, Rt. Medial	AR-601-TTR6

Instrumentation continued

Trial Tibial Baseplate, Size 1	AR-601-TBP1
Trial Tibial Baseplate, Size 2	AR-601-TBP2
Trial Tibial Baseplate, Size 3	AR-601-TBP3
Trial Tibial Baseplate, Size 4	AR-601-TBP4
Trial Tibial Baseplate, Size 5	AR-601-TBP5
Trial Tibial Baseplate, Size 6	AR-601-TBP6
Trial Bearing, Size 1, 8 mm	AR-601-TBA8
Trial Bearing, Size 1, 9 mm	AR-601-TBA9
Trial Bearing, Size 1, 10 mm	AR-601-TBA0
Trial Bearing, Size 1, 11 mm	AR-601-TBA1
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Trial Bearing, Size 6, 11 mm	AR-601-TBF1
Trial Bearing, Size 6, 12 mm	AR-601-TBF2
Trial Bearing, Size 6, 14 mm	AR-601-TBF4
Femoral Trial, Size 1, Lt. Medial	AR-601-FTLA
Femoral Trial, Size 2, Lt. Medial	AR-601-FTLB
Femoral Trial, Size 3, Lt. Medial	AR-601-FTLC
Femoral Trial, Size 4, Lt. Medial	AR-601-FTLD
Femoral Trial, Size 5, Lt. Medial	AR-601-FTLE
Femoral Trial, Size 6, Lt. Medial	AR-601-FTLF
Femoral Trial, Size 1, Rt. Medial	AR-601-FTRA
Femoral Trial, Size 2, Rt. Medial	AR-601-FTRB
Femoral Trial, Size 3, Rt. Medial	AR-601-FTRC
Femoral Trial, Size 4, Rt. Medial	AR-601-FTRD
Femoral Trial, Size 5, Rt. Medial	AR-601-FTRE
Femoral Trial, Size 6, Rt. Medial	AR-601-FTRF

Optional Instrumentation

Tibial Trialing Shim	AR-601-BBS0
Tibial Measuring Guide	AR-601-TMG0

This description of technique is provided as an educational tool and clinical aid to assist properly licensed medical professionals in the usage of specific Arthrex products. As part of this professional usage, the medical professional must use their professional judgment in making any final determinations in product usage and technique. In doing so, the medical professional should rely on their own training and experience and should conduct a thorough review of pertinent medical literature and the product's Directions For Use.

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