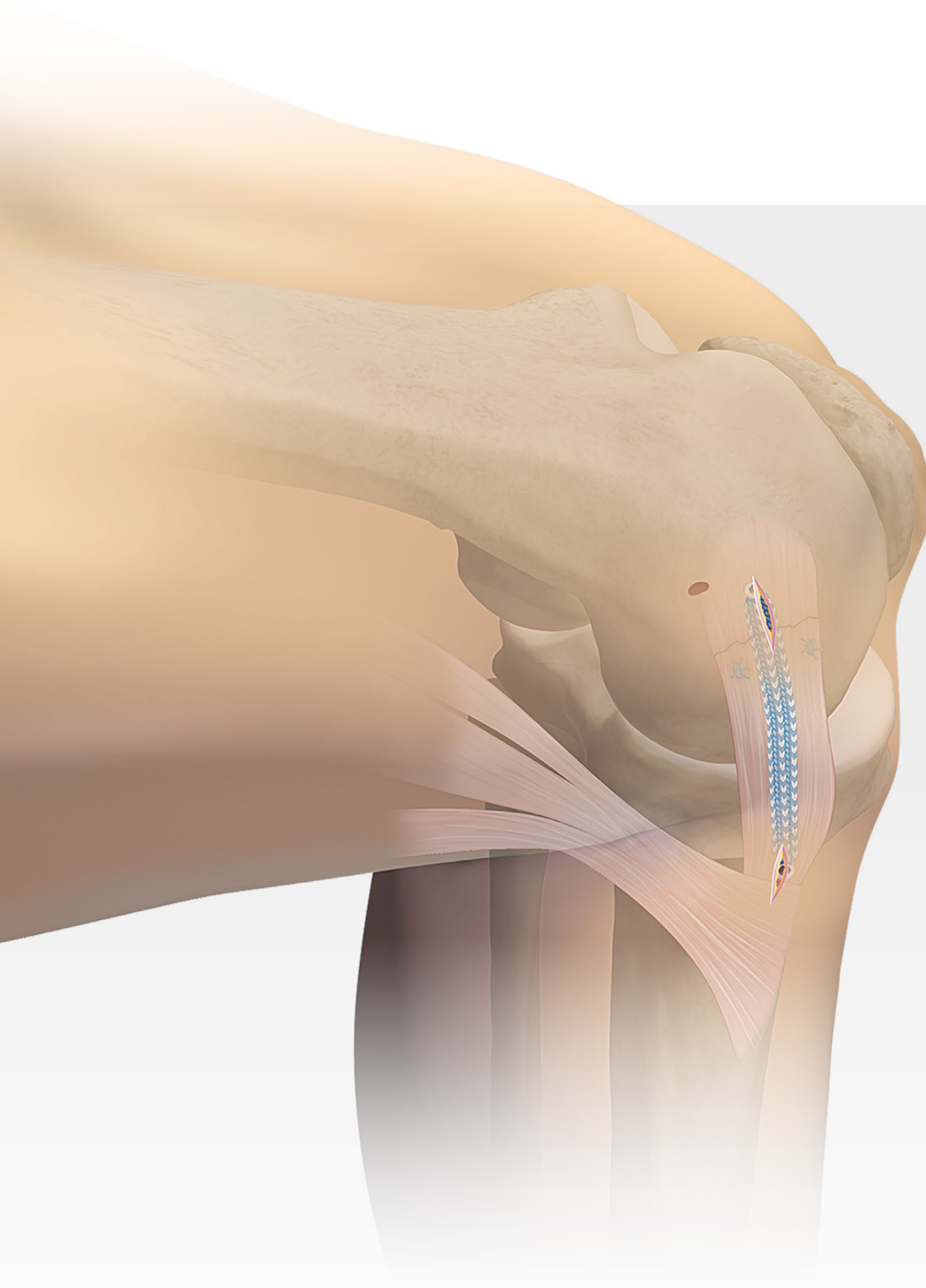


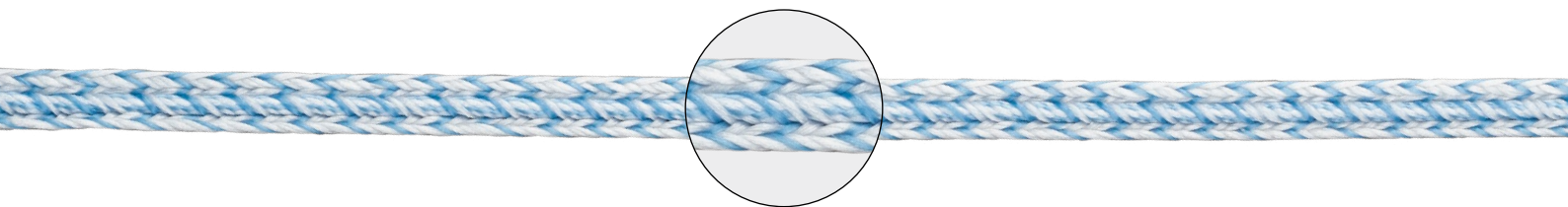
# *Internal/Brace*<sup>™</sup> Technique For Medial Collateral Ligament (MCL) Repair

Surgical Technique



## Simple, Safe, and Reproducible

The MCL *InternalBrace*™ technique consists of a 2 mm-wide FiberTape® suture that spans the distance between two Knotless SwiveLock® anchors. FiberTape sutures have been proven safe and effective with more than 15 years of clinical application and more than 3.8 million uses, including tendon and ligament-bridging repairs.

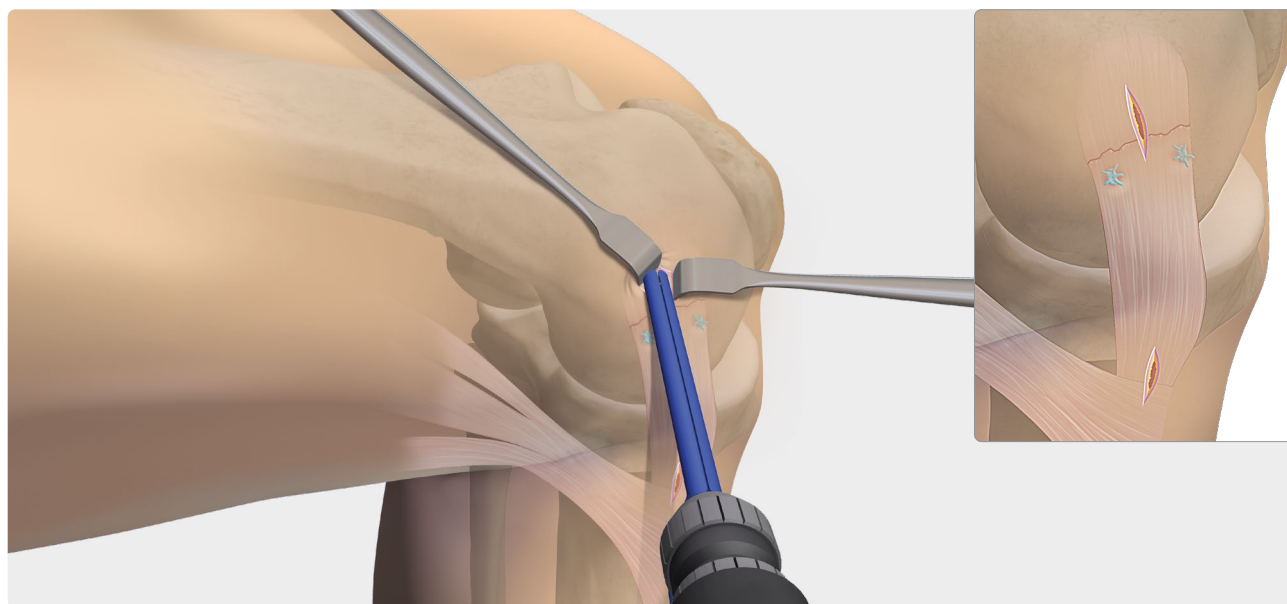


FiberTape suture is an ultra-high-strength 2 mm-wide tape using the long-chain polyethylene structure of FiberWire® suture. FiberTape suture's broad footprint is appropriate for repairs of degenerative tissue where tissue pull-through may be a concern.

**Note:** Alternatively, the Bio*InternalBrace*™ (BioIB™) technique can be used. The BioIB technique uses FiberTape suture coated with Type I bovine collagen, providing a softer coating for improved handling characteristics.

The *InternalBrace* technique reinforces primary repairs as an additional method of tissue approximation to assist in the healing of the primary repair.

## Surgical Technique

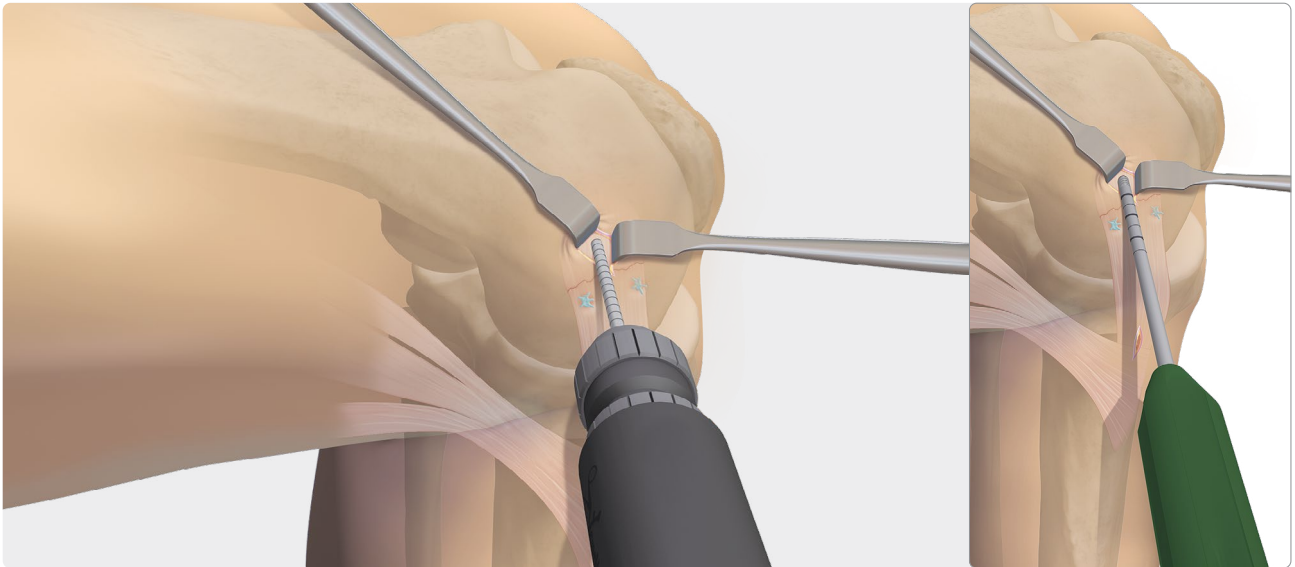


1

Prior to starting the *InternalBrace* technique, the MCL should be repaired or have the femoral SwiveLock sutures attached as referenced in Step 3. With the knee in neutral position, locate landmarks on the medial condyle and the posteromedial crest of the tibia.

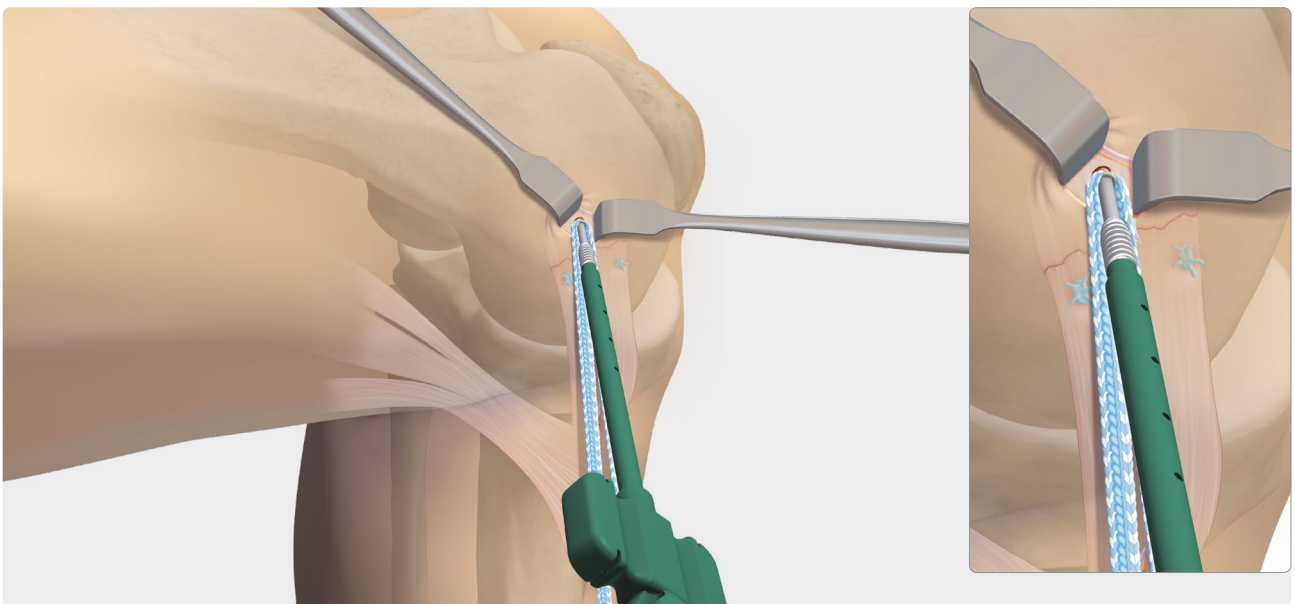
Through the primary MCL repair incision, insert the femoral fixation point of the FiberTape suture for the *InternalBrace* technique slightly proximal (average 3.2 mm) and posterior (average 4.8 mm) to the medial epicondyle. Place the 2.4 mm guide pin (AR-13505SB) through the shoehorn cannula and drill to a minimum depth of 25 mm.

The *InternalBrace* surgical technique is intended only to augment the primary repair/reconstruction by expanding the area of tissue approximation during the healing period and is not intended as a replacement for the native ligament. The *InternalBrace* technique is for use during soft tissue-to-bone fixation procedures and is not cleared for bone-to-bone fixation.



**2**

Drill the 4.5 mm cannulated drill bit over the guide pin to a depth of 25 mm. To breach the femoral cortex, tap the bone socket with the 4.75 mm SwiveLock® punch/tap for at least three turns.

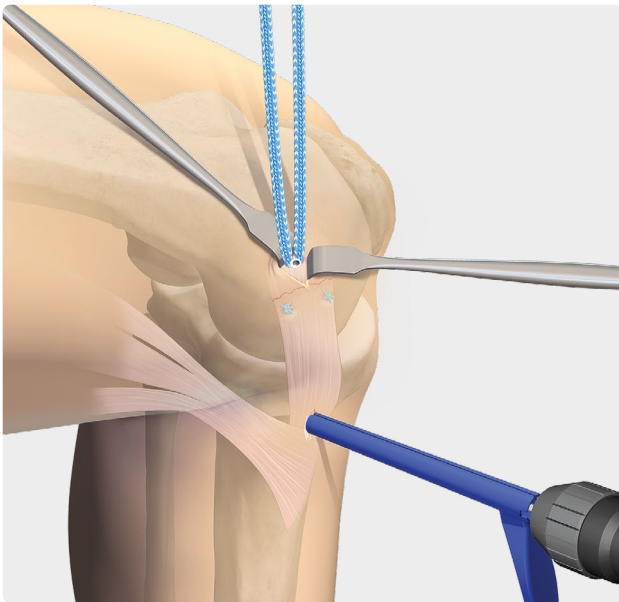


**3**

Pass one end of the FiberTape® suture through the eyelet of the first 4.75 mm BioComposite SwiveLock anchor so that half of the suture is pulled through the eyelet. Push the anchor into the femoral socket until the eyelet is fully seated. Maintain tension on each end of the suture while holding the green paddle on the screwdriver stationary and turning the driver clockwise to screw the anchor into the femur.

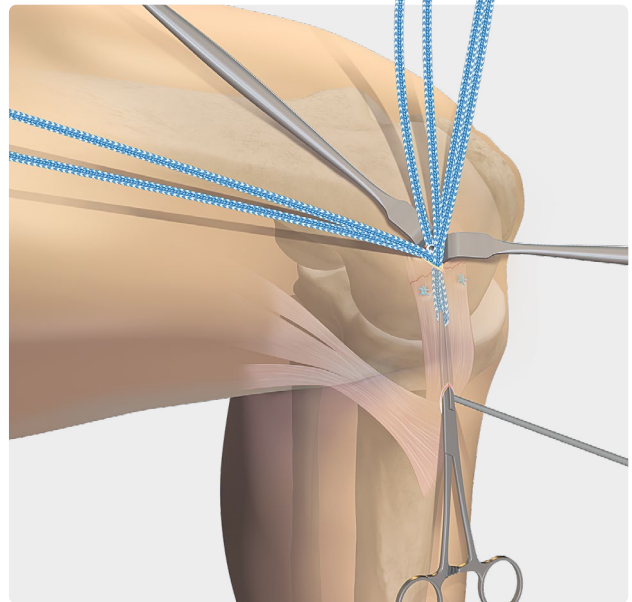
**Note:** Ensure the anchor is seated flush with the cortices before removing the driver.

After removing the driver, the suture can be removed, or it can be used with a needle to repair the torn MCL if it was not repaired prior to anchor insertion.



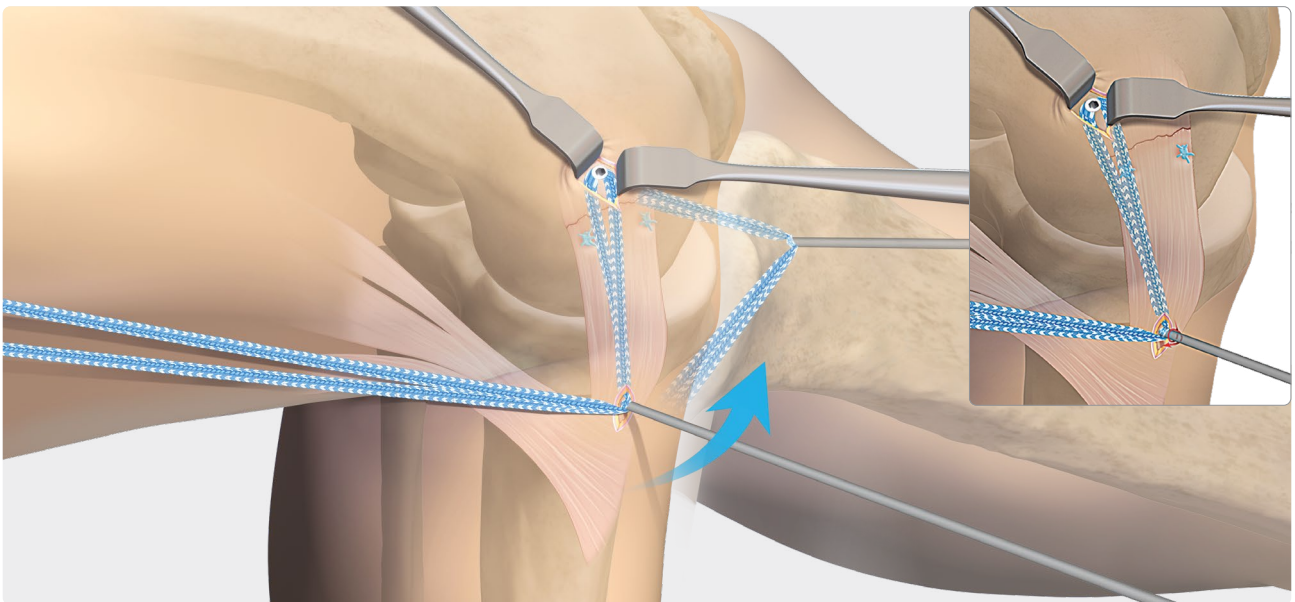
**4**

Insert the tibial fixation point of the FiberTape® suture for the *Internal/Brace*™ technique just proximal to the pes anserine and 3 mm anterior to the posteromedial crest of the tibia. Place the 2.4 mm guide pin through the shoehorn cannula, and drill to a minimum depth of 25 mm.



**5**

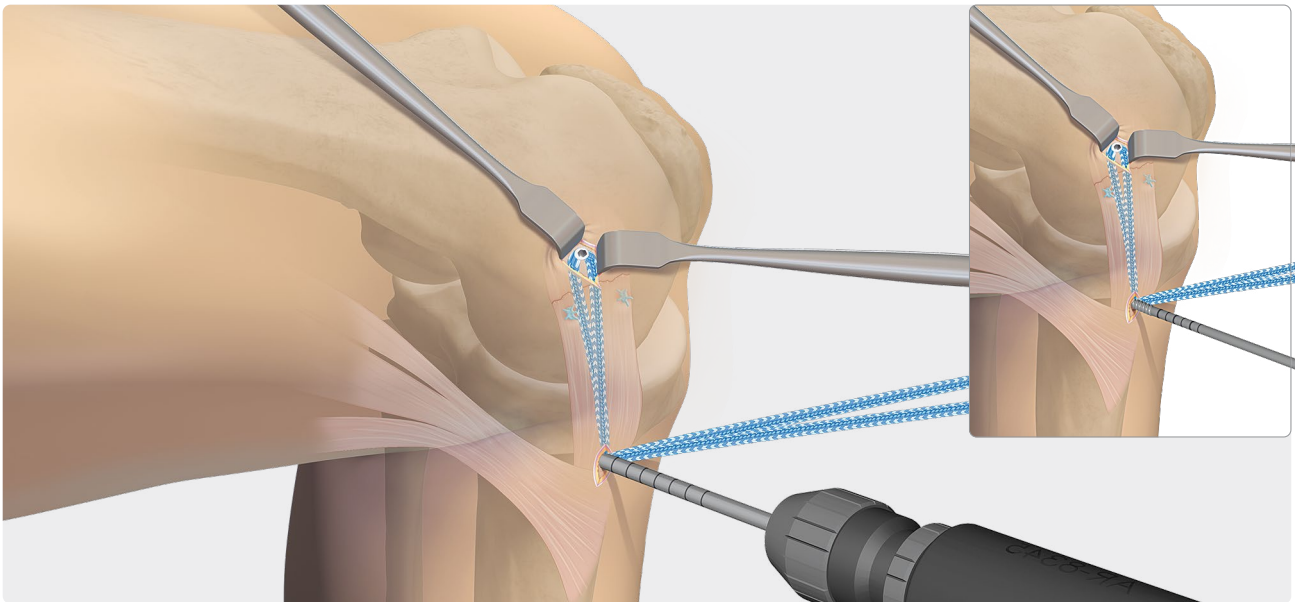
Use a curved hemostat to pass the FiberTape suture distally along the native MCL. To aid the passing of the FiberTape suture, a #2 FiberWire® suture can be used as a passing suture.



**6**

Wrap the FiberTape suture around the 2.4 mm guide pin, and check for isometry by going through the full range of motion (ROM). Evaluate the tracking and laxity of the FiberTape suture throughout the ROM. If any tension or positioning adjustments need to be made, make the adjustments, and then recheck for isometry.

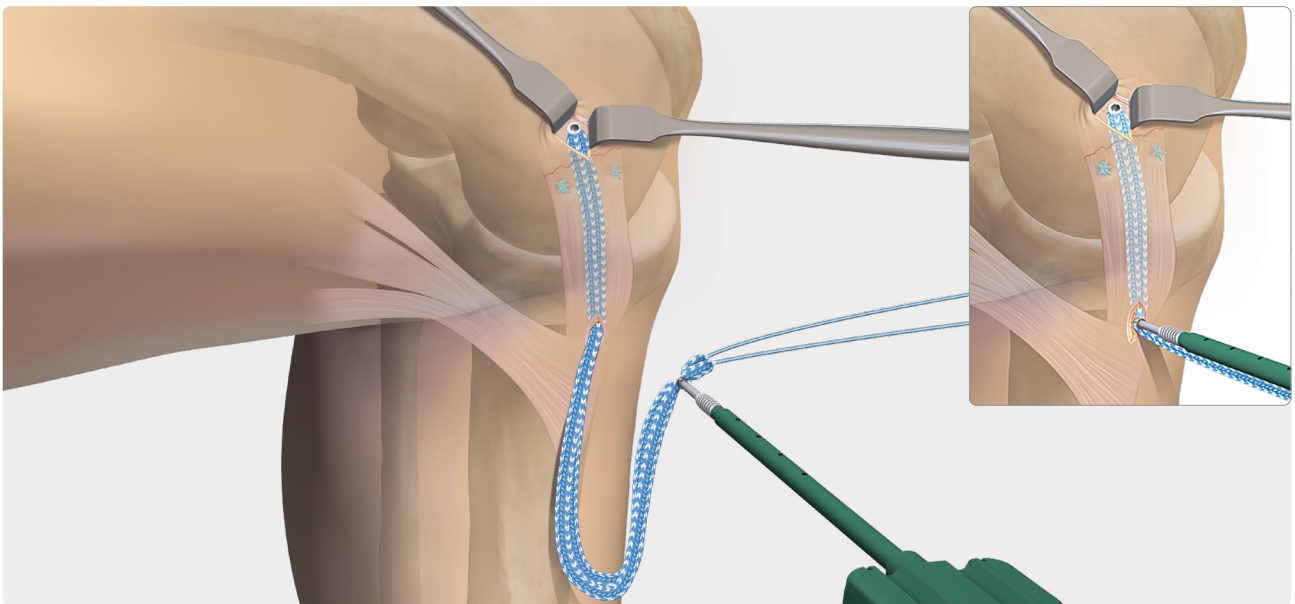




7

Use the 4.5 mm cannulated reamer to drill over the guide pin to a depth of 25 mm. Tap the bone socket to the laser line on the 4.75 mm SwiveLock® tap.

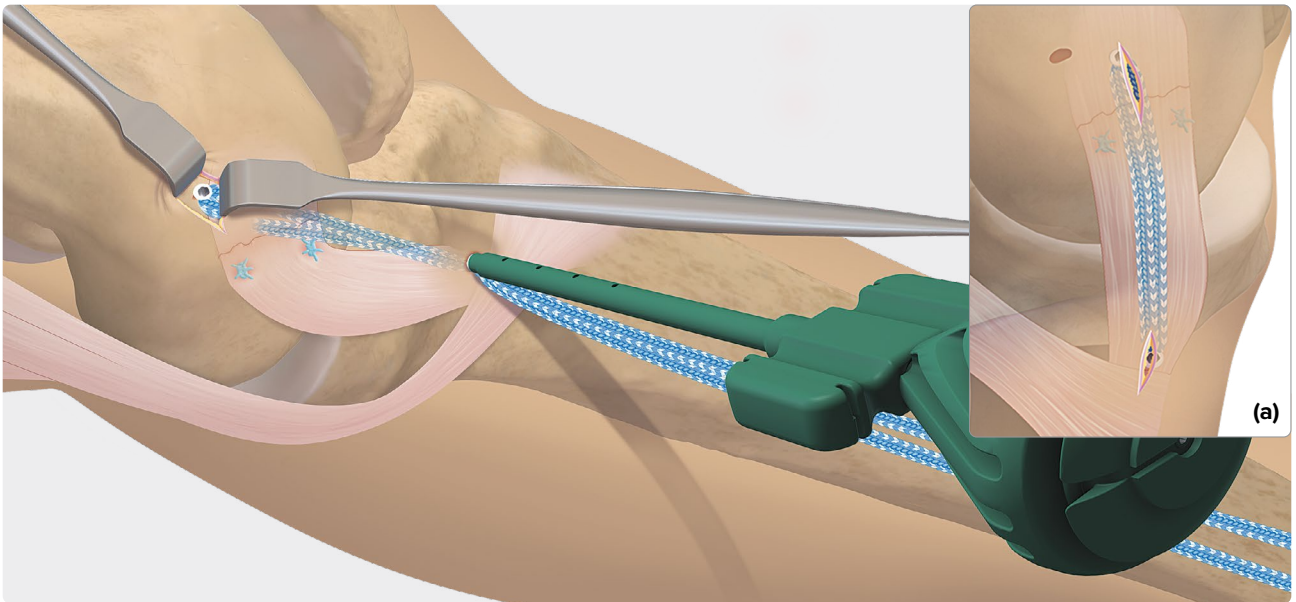
| **Note:** Incomplete tapping may compromise anchor fixation.



8

Pass both limbs of the FiberTape® suture through the eyelet of the 4.75 mm BioComposite SwiveLock anchor and insert the anchor. This step occasionally requires a gentle tap with the mallet.

| **Note:** Do not over-tension. The FiberTape suture should be slightly looser than the MCL when the repair is complete.



9

Place the knee joint between 0° and 20° of flexion with neutral rotation and slight varus reduction while inserting the SwiveLock® anchor fixation. Maintain tension on each end of the FiberTape® suture and screw the anchor into the tibia. Remove the driver and then remove the suture. Close the wound according to surgical preference. Final fixation **(a)**.

# Ordering Information

|  |            |
|--|------------|
| MCL InternalBrace™ Kit   | AR-5511-CP |
| <ul style="list-style-type: none"> <li>➤ BioComposite SwiveLock® anchor, 4.75 mm, qty. 2</li> <li>➤ Shoehorn cannula</li> <li>➤ Cannulated drill bit, 4.5 mm</li> <li>➤ Guide pins, 2.4 mm × 8 in, qty. 2</li> <li>➤ SwiveLock punch/tap, disposable, 4.75 mm</li> <li>➤ FiberTape® suture, 17 in</li> <li>➤ #2 FiberWire® suture, qty. 1</li> </ul> |            |
| FiberTape suture, 2 mm, 7 in (blue), each end tapered to #2 FiberWire suture, collagen-coated (for BioIB™ technique)   | AR-7237-7B |

Products advertised in this brochure/surgical technique guide may not be available in all countries. For information on availability, please contact Arthrex Customer Service or your local Arthrex representative.



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. Postoperative management is patient-specific and dependent on the treating professional's assessment. Individual results will vary and not all patients will experience the same postoperative activity level or outcomes.



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information