

Minimally Invasive TKA GENESIS[◇] II Distal Cut First



Instruments



Valgus Alignment Guide
7144-1144

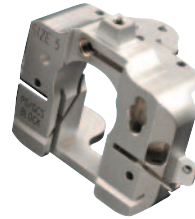


4-in-1 Resizing Block

Size 1 7144-1149 Size 6 7144-1154
Size 2 7144-1150 Size 7 7144-1155
Size 3 7144-1151 Size 8 7144-1156
Size 4 7144-1152
Size 5 7144-1153



Femoral Alignment
Viewing Template
7144-1141



Housing Resection Block

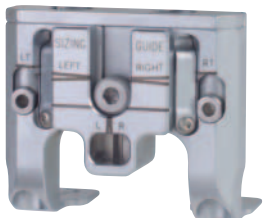
Size 1 7144-1127 Size 6 7144-1132
Size 2 7144-1128 Size 7 7144-1133
Size 3 7144-1129 Size 8 7144-1134
Size 4 7144-1130
Size 5 7144-1131



Distal Femoral
Cutting Block
7144-1147



Tibial Cutting Block Left
7144-1136



Femoral Sizing Guide
7144-1145



Tibial Cutting Block Right
7144-1137



Femoral Sizing Guide Stylus
7144-1140



Tibial Resection Stylus
7144-1135

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Nota Bene:

The technique description herein is made available to the healthcare professional to illustrate the author's suggested treatment for the uncomplicated procedure. In the final analysis, the preferred treatment is that which addresses the needs of the patient.

Introduction

Leg Position

Appropriate leg position is crucial when performing minimally invasive total knee arthroplasty. During the procedure, the knee is flexed to 70-90°. Hyperflexion is used only intermittently for specific portions of the case, such as insertion of the tibial component. To aid in holding the leg, a sandbag is placed across from the contralateral ankle when positioning the patient on the table.

Incision

With the leg fully extended, a longitudinal incision measuring 9.5 to 12 centimeters (3³/₄ to 4³/₄ inches) is made over the anterior aspect of the knee along the medial border of the patella. The incision extends approximately from the middle of the tibial tubercle to the proximal extent of the patella to one finger's breath proximal to the patella.

Arthrotomy

Begin 5 millimeters medial to the tibial tubercle and extend dissection around the medial border of the patella. The arthrotomy is extended up to the proximal border of the patella.

The supra-patella pouch is identified, separated from the underside of the tendon and preserved.

The distal extent of the vastus medialis (VMO) is identified and the orientation of the fibers is determined. An oblique cut is made to the VMO and the muscle fibers are then spread bluntly for approximately 2 centimeters. (Figure 1)

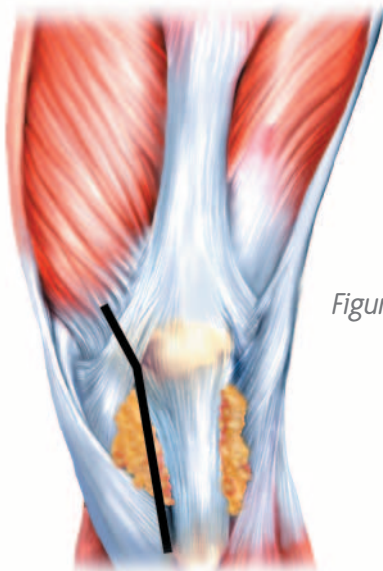


Figure 1

Exposure

With the leg extended, the patella is retracted laterally. The fat pad is excised both medially and laterally leaving a small amount of fat deep under the patella tendon. The patella tendon proximal to the tubercle is dissected from the tibia. The anterior horn of the medial meniscus is divided and dissection is carried around the proximal medial tibia using electrocautery and a boxed osteotome.

A thin bent Hohmann retractor is placed on the proximal medial tibia. The proximal soft tissue attachments extending around the proximal medial tibia are released in the standard fashion. A small window is made along the anterior surface of the distal femur with the use of electrocautery to reference the anterior cortex. (Figure 2)

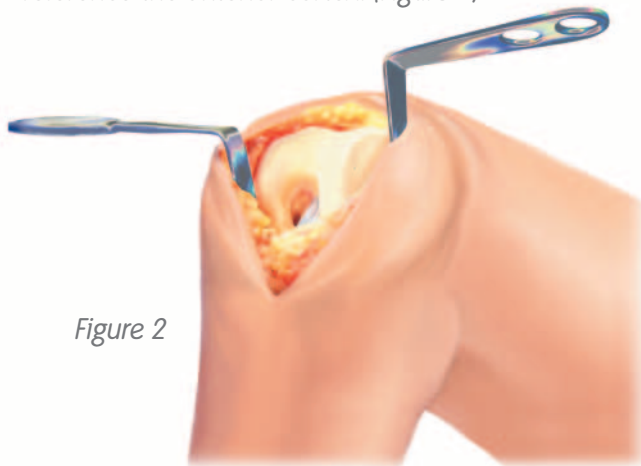


Figure 2

Note: In patients with tight extensor mechanism (usually larger, muscular patients or those with abundant patella osteophytes), the patella is cut at this time (see page 9).

Femoral Preparation

Intramedullary Femoral Alignment

1. Flex the knee to 70-90°.
2. Place a thin bent Hohmann retractor laterally around the tibia and retract the patella laterally (not everted).
3. Divide and excise the ACL and the anterior horn of the lateral meniscus.
4. Identify the rotational reference landmarks
 - A-P axis (as described by Whiteside)
 - Medial/lateral posterior femoral condyles
 - Epicondylar axis
5. Open the femoral canal (generally just anterior to the PCL insertion) with the **9.5 mm drill**.
6. Assemble the appropriate **valgus bushing** (5°, 6°, 7°) and **distal cutting block** onto the **valgus alignment guide**. (Figure 3)

Check the bushing position to ensure that “left” is facing anteriorly when operating on a left knee and “right” is facing anteriorly when operating on a right knee.

Check the position of the distal cutting block on the resection stylus to ensure that it is set to “primary”.

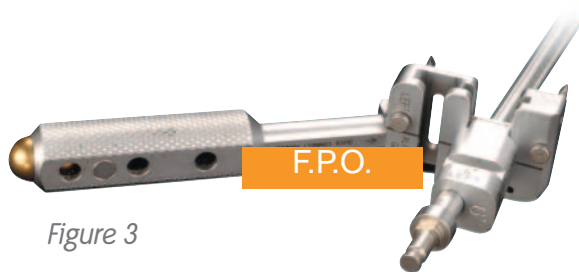


Figure 3

7. Slide the assembly with the **intramedullary rod** into the femoral canal. One side of the assembly should contact the distal femur. (Figure 4)
8. Orient rotation of the assembly neutral to the posterior condyles and impact the floating spikes into the distal femur.

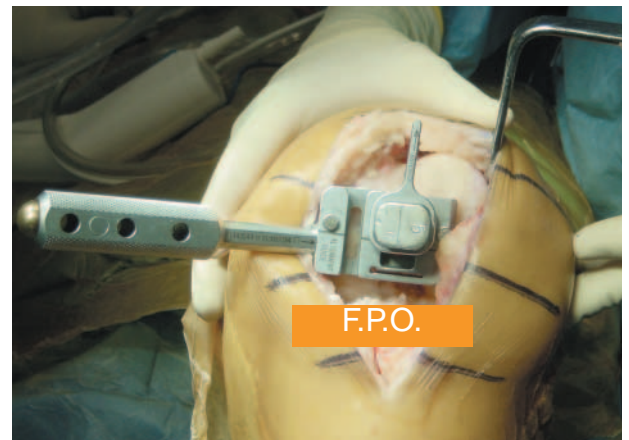


Figure 4



9.5 mm Drill



Modular T-Handle



Valgus Angle Bushing



Intramedullary Rod

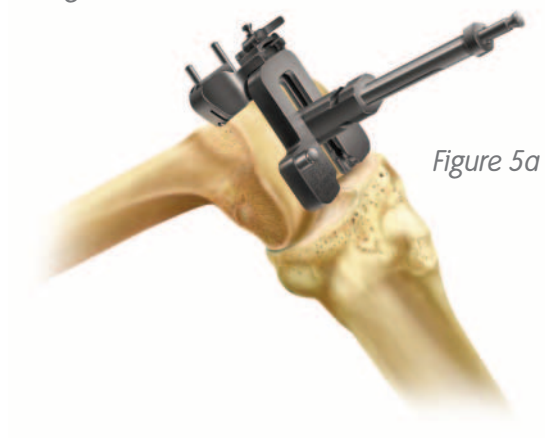


Quick Connect Handle

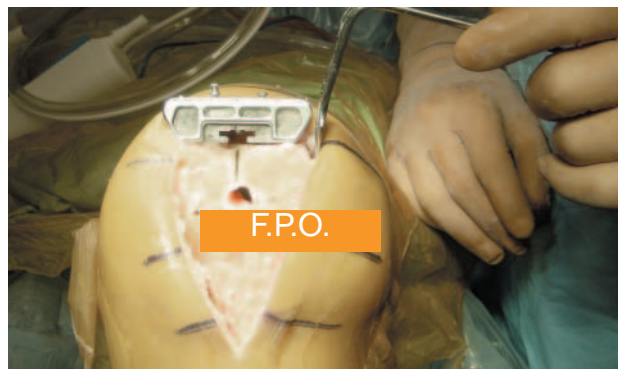
Femoral Preparation (Continued)

Distal Femoral Resection

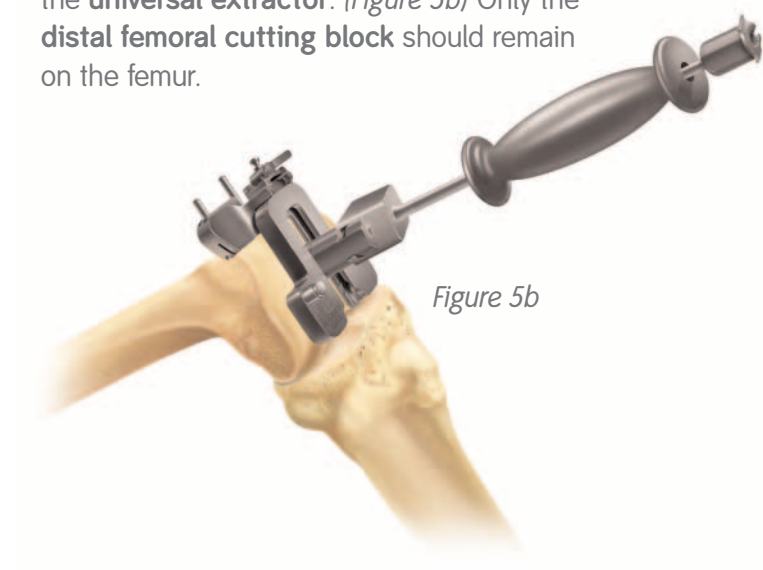
1. Pin the **distal femoral cutting block** to the anterior femur using the holes marked "0". (Figure 5a)



3. Resect the distal femur and remove the **distal femoral cutting block**. (Figure 6)



2. Remove the **intramedullary rod**, unlock the lever on the **distal femoral cutting block**, and remove the valgus alignment assembly using the **universal extractor**. (Figure 5b) Only the **distal femoral cutting block** should remain on the femur.



Femoral Preparation (Continued)

Sizing Guide Description

This is an anterior referencing sizing guide which allows the use of anterior referencing with a distal cut first surgical technique. It minimizes the risk of notching the anterior femoral cortex associated with posterior referencing sizing normally used with a distal cut first technique.

Femoral size is read against the anterior surface of the sizing guide which is a reference bar adjustable by the screw mechanism on the distal sizing guide surface. The reference bar is internally attached to the drill guide used to set the pin holes for placement of the A-P cutting blocks. (Figure 7)

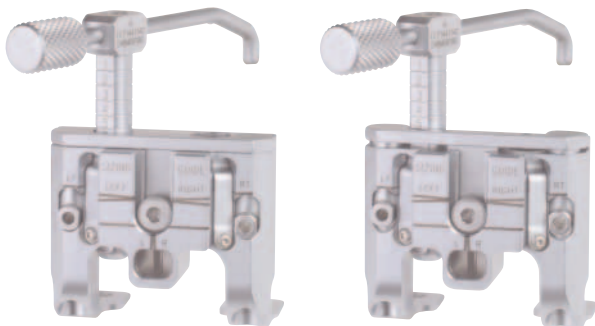


Figure 7

By adjusting the screw, the reference bar can be raised from the lowest position (Figure 8) to read the next smaller size on the stylus (Figure 9). In raising the reference bar, the drill guide is also raised by the same amount.



Figure 8

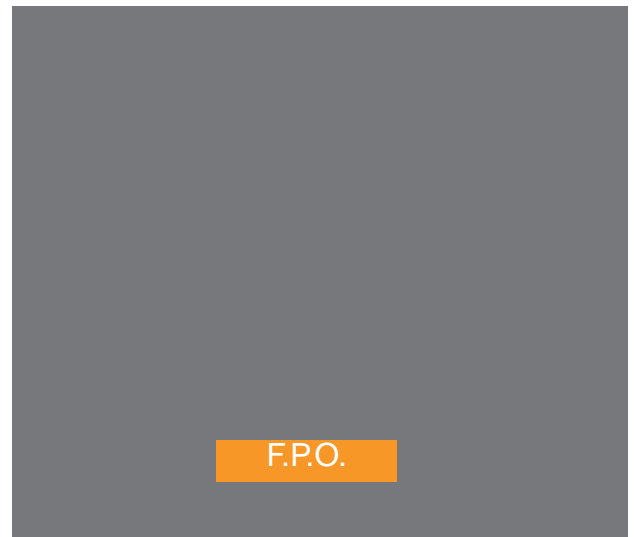


Figure 9

As a result, the drill guide is moved anteriorly by a distance equal to the amount the A-P dimension of the femur is from the next smaller implant size. Additional resection of the same amount is made from the posterior condyles.

Femoral Preparation (Continued)

Sizing Guide Operation

1. Increase flexion to at least 90° and place the **femoral sizing guide** onto the distal femur with the paddles seated against the posterior condyles and in neutral rotation. Check to make sure that the reference bar is adjusted to the lowest level and that the **sizing guide** is flush against the resected distal femur.

Note: If the posterior condyles are deficient, use the 1mm – 5mm shims to set neutral rotation.

2. Move the sizing guide stylus until it contacts the lateral ridge of the anterior femoral cortex (highest point on the anterior cortex of the femur).

Note: The stylus is designed to insert under the skin if necessary. The skin can be retracted to aid in placement of the stylus.

3. Determine the size of the component from the graduations on the shaft of the stylus. (Figure 10)



Figure 10



Figure 11

If the indicated size is in-between sizes, turn the screw to raise the reference bar to the next smaller size. This will raise the drill guide to set the anterior cut to the location of the stylus tip and increase resection of the posterior condyles by the corresponding amount. (Figure 11)

4. Drill the holes to mark the location holes for the A/P cutting block. (Figure 12)



Figure 12

A-P Femoral Resections

1. Choose the correct size **A-P cutting block** and place it against the distal femur while inserting the fixed spikes on the back of the **A-P cutting block** into the location holes drilled into the distal femur using the **femoral sizing guide**.
2. Ensure that the cutting block is flush with the resected distal femur and secure the **A-P cutting block** in place with pins through the holes in the anterior and posterior ears. (Figure 13)



Figure 13

3. Complete the anterior, posterior, and chamfer cuts. The block is designed to allow for angling of the saw blade during the cuts.

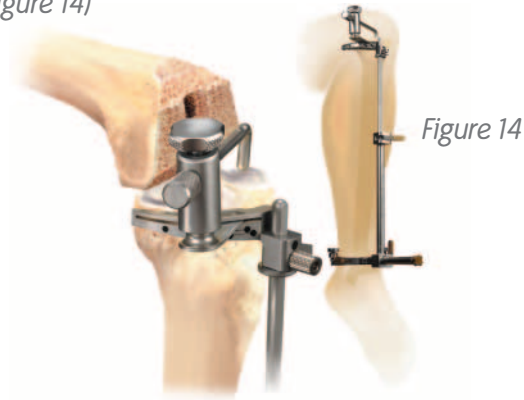
Note: While cutting the posterior condyles, a thin bent Hohmann retractor is placed beneath the MCL for retraction and protection of the MCL.

Tibial Preparation

Extramedullary or intramedullary alignment guides may be used. First, a thin bent Hohmann is placed around the proximal medial tibia and also laterally to retract the patella. Osteophytes are removed from the anteromedial and medial tibia.

Extramedullary Tibial Alignment

1. Assemble the **extramedullary tibial alignment guide** and place it onto the tibia.
(Figure 14)



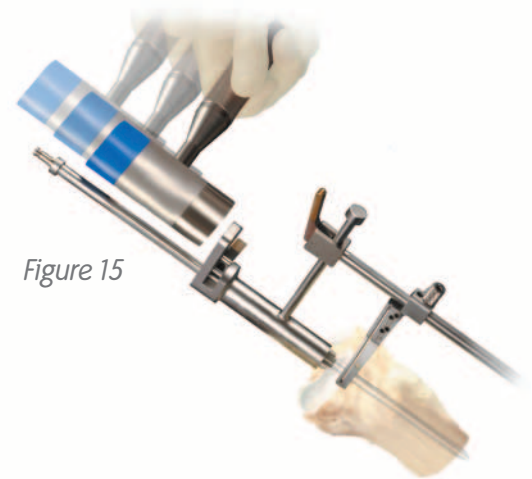
Ensure that the correct **left or right tibial cutting block** is chosen and that the **alignment guide** is correctly set distally for the left or right leg. The distal portion of the guide is adjusted over the center of the ankle and the proximal portion is aligned with the tibial crest.

2. Assess rotation of the alignment guide and slope of the cutting plane. Rotational alignment is critical due to the 3° posteriorly sloped cut. The goal is to align the **extramedullary alignment assembly** rotationally so that it aligns over the medial third of the tibial tubercle and over the second toe. The slope can be adjusted according to the patient's anatomy.

Note: 4° of slope is built into the articular insert and 3° of slope is built into the tibial cutting block. Neutral alignment should be used.

Intramedullary Tibial Alignment

1. Open the tibial canal (generally 5 mm medial to the midline) with the **9.5mm drill**.
To determine correct placement, the hole can be made through the **tibial drill guide** with the **11 mm tibial collet**. (A preliminary resection of the tibial spine may facilitate seating of the **tibial drill guide** onto the proximal tibia.)
2. Attach the correct left or right **tibial cutting block** to the **intramedullary tibial alignment assembly** and pass the **intramedullary rod** through the cannulated alignment sleeve on the alignment assembly.
3. Slowly insert the rod into the tibial canal.
4. Assess rotation of the **intramedullary tibial alignment guide**. Rotational alignment is critical due to the 3° posteriorly sloped cut. The alignment rod of the **intramedullary tibial alignment assembly** should align with the medial third of the tibial tubercle.
5. Impact the proximal end of the cannulated alignment sleeve to drive the distal spikes into the proximal tibia to lock rotation. (Figure 15)



Extramedullary Tibial Alignment Guide



Intramedullary Tibial Alignment Guide

Tibial Preparation (Continued)

Tibial Resection

1. Attach the **tibial stylus** to the **tibial block** by inserting the stylus foot into the cutting slot.
2. Lower the **cutting block** until the **stylus** touches the less affected side of the tibia. This allows placement of the 9 mm articular insert. The stylus can also be used to adjust the depth of the tibia cut (adjustable to 9, 11 or 13 mm).
3. Pin the **tibial cutting block** to the tibia. Note that the cutting block sits along the medial half of the tibia. Insert pins first through the central holes. The medial hole may also be used to secure the **tibial cutting block**.
4. Remove the intramedullary alignment assembly leaving the cutting block on the anterior tibia. The extramedullary guide may be left in place.
5. Cut the tibia by first directing the blade in the posterior direction and then laterally.
6. Inspect the surface for any cortical ridges. The proximal tibia can be visualized by extending the leg, placing a laminar spreader, and retracting the patella laterally.
7. Place the leg in 90° of flexion, insert a laminar spreader and remove remnants of the medial and lateral menisci and posterior osteophytes.

(Figure 16)



8. Check alignment and balance with spacer block and rod. Balance ligaments in standard fashion.

Tibial Sizing

1. Determine the tibial implant size using the **tibial viewing template**.
2. Place the appropriate **tibial drill guide** or **stemless tibial trial** on the tibia.
3. Centralize and pin the **tibial drill guide** or **stemless trial**.
4. Drill through the **stemless trial** or place the **11 mm tibial collet** in the **drill guide** and drill with the **11 mm tibial drill**.
If a 9.5mm drill has been used for the intramedullary tibial alignment assembly, only the **11 mm tibial punch** is needed.
5. Punch with the **11 mm tibial punch**. (Figure 17)



Figure 17

6. Remove the **tibial drill guide** if used and place the tibial trial onto the proximal tibia to assess coverage.



Tibial Viewing Template



Tibial Drill Guide



11 mm Tibial Collet



11 mm Tibial Drill



11mm Tibial Punch



Spacer Block

Patellar Preparation

The easiest time to prepare the patella is after all tibial and femoral cuts are made, but prior to trial placement. In some cases, the patella is cut just after arthrotomy to facilitate exposure.

Rotate the patella to 90°, measure its thickness, and determine the appropriate diameter implant.

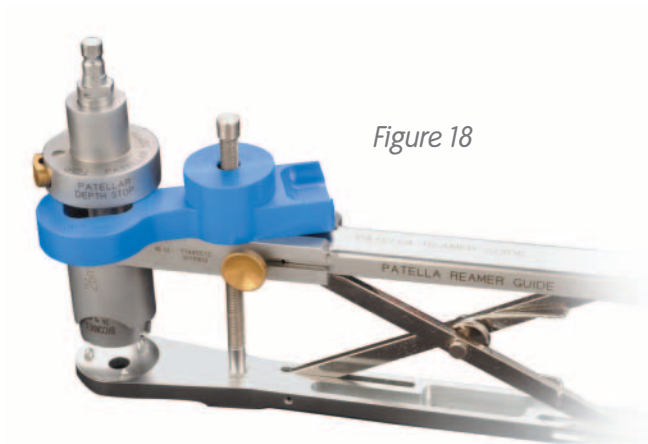
Resurfacing (Onlay) Patella

1. Place two Kocher clamps just proximal and distal to the patella to hold the patella's position.
2. Cut the patella using an oscillating saw.
3. Drill the peg holes using the drill guide.

Biconvex (Inset) Patella

1. Select the correct **patellar reamer collet** and slide it into place on the **patellar reamer guide**.
2. Attach the **patellar reamer guide** to the patella and tighten the reamer guide on the patella. (Figure 18)

3. Use the **calipers** to measure patella thickness.
4. Attach the **patellar depth gauge** for the selected patella design to the **reamer guide**.
The reaming depth for each design is as follows:
 - Biconvex patellae: 13mm
 - Resurfacing patellae: 9mm
 - All-poly with Flex-Lok® peg: 15mm
5. Attach the **patellar reamer dome** and **patellar depth stop** to the **patellar reamer shaft**. Before this assembly is attached to drill, lower it through the **patellar reamer guide** until the **reamer dome** contacts the patella.
6. Swing the **patellar depth gauge** around so that the "claw" surrounds the **patellar reamer shaft**.
7. Lower the **patellar depth stop** until it contacts the **patellar depth gauge** and automatically locks in place.
8. Remove the **depth gauge**.
9. Attach the patellar reamer assembly to power equipment. Ream the patella until the **depth stop** engages the **patellar reamer guide**.



Posterior Stabilized Femur Resection

1. Flex the knee to approximately 90° and center the **P/S housing resection block** on the distal femur. (To assist, the housing resection blocks have the same M-L dimension as the implants.)

Note: The only difference between the cruciate retaining and the posterior-stabilized femoral components is the addition of the housing for the cam mechanism. All other box dimensions are the same. The anterior and posterior chamfer resections can be made through the posterior stabilized housing resection block.

2. Secure with 1/8" trocar pins through the straight holes in the front of the block. If the chamfer cuts are made through this block, the angled holes in the sides of the block should be used.
3. Attach the **P/S housing resection collet** to the **housing resection block**. (Figure 19)

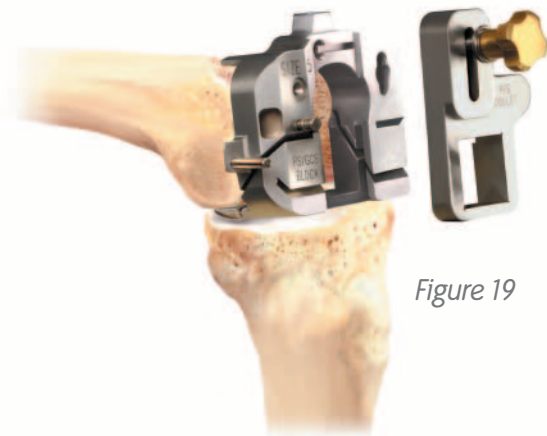


Figure 19

4. Attach the **housing reamer dome** and **P/S reamer sleeve** to the **patellar reamer shaft**.
5. Ream through the **housing resection collet** until the automatic depth stop contacts the **collet** and then move the reamer anterior and posterior until it contacts the automatic stops.

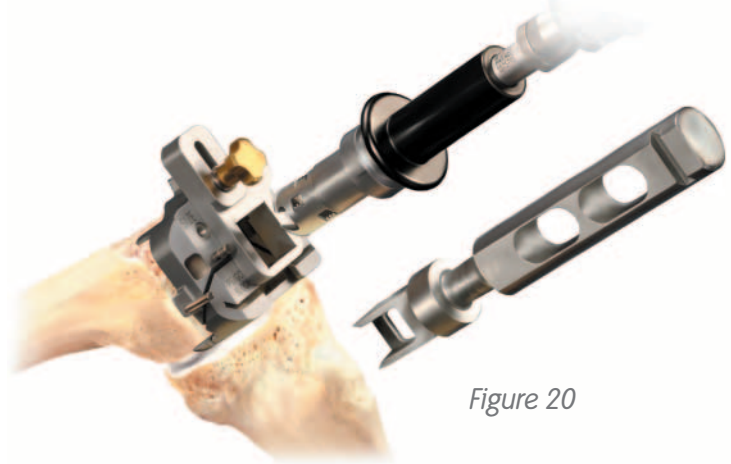


Figure 20

6. Impact the **housing box chisel** through the **housing resection collet** to square the corners of the housing. The **housing box chisel** should be used anteriorly and posteriorly to ensure that the full length of the box is prepared. (Figure 20)
7. If the chamfer resections have not been made, they can now be made by cutting through the chamfer slots in the **housing resection block**.



P/S Housing Resection Collet



Housing Reamer Dome



Reamer Sleeve



Patella Reamer Shaft



Housing Box Chisel

Trial Placement

Femoral and Tibial Trialing

1. Insert thin bent Hohmanns laterally and medially (an Aufranc retractor can be placed posteriorly to sublax the tibia forward if necessary) and place the tibial trial.
2. Flex the knee to 90° and place the femoral trial.
3. Use the appropriate insert trial (begin with a 9 mm trial) to determine stability and alignment.
4. Perform a trial range of motion. The alignment marks on the front of the femoral and tibial trials should line up. The **quick connect handle** may be attached to the tibial trial and used to set the appropriate rotational alignment.
5. Extend the knee fully with the handle attached to the tibial trial. Pass the extramedullary rod through the handle to assess full leg alignment. Mark correct tibial rotational alignment on the anterior tibia using a cautery knife. Alignment can be checked with the **spacer block**. Since the spacer block has one end for flexion and one for extension, ensure the appropriate end is used.
6. Determine whether a porous or nonporous tibial implant will be used. Select the appropriate **tibial fin punch** to prepare the fins and punch through the tibial trial.

Note: If the tibial bone is sclerotic, begin the fin slot with a burr or thin saw blade before using the fin punch to prevent tibial fracture.

Patellar Trialing

1. Place the patellar trial into the prepared patella.
2. Perform a trial range of motion to assess patellar tracking. With cruciate retaining knees, medial-lateral placement of the femoral trial can be adjusted to optimize patellar tracking.
3. For cruciate retaining femorals, drill the femoral lug holes through the femoral trial with the femoral lug drill.
4. Remove the tibial trial. Attach the end of the **universal extractor** to the femoral trial. Remove the femoral trial. Use a towel clip to remove the patellar trial.



Spacer Block



Tibial Fin Punch



Universal Extractor



Femoral Impactor



Articular Inserter/
Extractor

Implantation and Closure

Maximally flex the knee and place a thin bent Hohmann laterally and medially and an Aufranc retractor posteriorly to subluc the tibia forward.

Tibial Implantation

1. Apply cement on the proximal tibia and seat the tibial implant with the **tibial impactor**. Remove excess cement.
2. If using the porous tray and screws, orient the **tibial screw drill guide** over the holes and drill using the **tibial screw drill**. Determine the appropriate screw size using the **screw depth gauge**. Insert screws with alternating tightening to avoid liftoff.

Femoral Implantation

1. Flex the knee to 90° keeping the thin bent Hohmann laterally and removing the Aufranc retractor.
2. Apply cement only on the femoral component.
3. Place the femoral implant onto the femur and use the **femoral impactor** to fully seat the implant.
4. Remove excess cement. Extend the knee to remove cement anteriorly without retracting the proximal soft tissue.
5. Place the tibial insert trial onto the tibial implant and extend the leg to pressurize the cement.

Patellar Implantation

1. Assemble the **patellar cement clamp** to the **patellar reamer guide**.
2. Apply bone cement to the patella.
3. Place the patellar implant onto the patella and clamp into the bone. Remove excess cement.

Insert Placement

1. Determine the correct articular insert thickness.
2. Clear any debris from the locking mechanism and slide the insert into the tibial baseplate engaging the locking mechanism. For the P/S insert, begin insertion in flexion and extend the leg to engage the locking mechanism.
3. Attach the **articular inserter/extractor** to the tibial tray. Lift the **inserter** superiorly until the anterior lip of the articular insert is fully seated.

Closure

1. Close the arthrotomy by placing three O-Vicryl sutures at the superior border of the patella just distal to the VMO. A stitch is placed to close the VMO fascia. The remainder of the arthrotomy is closed in the standard fashion.
2. Perform routine subcutaneous and skin closure.

IMPORTANT MEDICAL INFORMATION Smith & Nephew Knee System

DESCRIPTION OF SYSTEM

Smith & Nephew Knee Systems consist of femoral components, tibial components, and accessories. The component material is provided on the outside carton label. Femoral and tibial components are available in porous and non-porous options. Non-porous components are to be used with cement. Porous coated devices of the Profix Total Knee System and Genesis II Total Knee System may be used without cement. Hydroxylapatite (HA) coatings include HA that is supplied either on a grit blasted or porous surface.

NOTE: HA coated knee implants are not available in the USA.

Each total knee system is designed as a system and does not allow the substitution of components from other systems or manufacturers. All implantable devices are designed for single use only.

Some of the alloys needed to produce orthopedic implants contain some metallic components that may be carcinogenic in tissue cultures or intact organism under very unique circumstances. Questions have been raised in the scientific literature as to whether or not these alloys may be carcinogenic in implant recipients. Studies conducted to evaluate this issue have not identified convincing evidence of such phenomenon, in spite of the millions of implants in use.

INDICATIONS, CONTRAINDICATIONS, AND ADVERSE EFFECTS

The general principles of good patient selection and sound surgical judgment apply to the total knee procedure. Preoperative planning and meticulous surgical technique are essential to achieve optimum results.

Considerations of anatomic loading, soft-tissue condition, and component placement are critical to minimize a variety of postoperative complications.

Indications for Total Knee Replacement

1. Rheumatoid arthritis.
2. Post-traumatic arthritis, osteoarthritis, or degenerative arthritis in older patients whose age, weight, and activity level are compatible with an adequate long-term result.
3. Failed osteotomies, unicompartmental replacement, or total knee replacement.
4. Posterior stabilized knee systems are designed for use in patients in primary and revision surgery, where the anterior and posterior cruciate ligaments are incompetent and the collateral ligaments remain intact.
5. Constrained knee systems are designed for use in patients in primary and revision surgery, where the posterior cruciate ligament and one or both of the collateral ligaments (i.e. medial collateral and/or lateral collateral ligament) are absent or incompetent.

Contraindications for Total Knee Replacement

1. Cases where there is poor bone stock which would make the procedure unjustifiable
2. Active, local infection or previous intra-articular infections
3. Mental or neurologic conditions that tend to pre-empt the patient's ability or willingness to restrict activities
4. Neuropathic (Charcot) joint
5. Conditions that tend to place increased loads on implants such as age, weight, and activity level, which are incompatible with a satisfactory long-term result
6. Collateral ligament insufficiency (except in cases where a constrained knee system is indicated and used)
7. Skeletal immaturity
8. Use of a supracondylar nail through intercondylar notch of Profix: primary femoral components
9. Use of slotted femoral and tibial stems without adequate bone support.

Indications for Unicompartmental Knee Replacement

1. Noninflammatory degenerative joint disease including osteoarthritis, traumatic arthritis, or avascular necrosis;
2. Correction of functional deformity
3. Revision procedures where other treatments or devices have failed; and
4. Treatment of fractures that are unmanageable using other techniques.

Contraindications for Unicompartmental Knee Replacement

The contraindications for Unicompartmental Knee Replacement include all of the contraindications listed for Total Knee Replacement.

Possible Adverse Effects

1. Wear of the polyethylene articulating surfaces of knee replacement components has been reported following total knee replacement. Higher rates of wear may be initiated by particles of cement, metal, or other debris which can cause abrasion of the articulating surfaces. Higher rates of wear may shorten the useful life of the prosthesis, and lead to early revision surgery to replace the worn prosthetic components.
2. With all joint replacements, asymptomatic, localized, progressive bone resorption (osteolysis) may occur around the prosthetic components as a consequence of foreign-body reaction to particulate wear debris. Particles are generated by interaction between components, as well as between the components and bone, primarily through wear mechanisms of adhesion, abrasion, and fatigue. Secondly, particles may also be generated by third-body wear. Osteolysis can lead to future complications necessitating the removal and replacement of prosthetic components.
3. Loosening, bending, cracking, or fracture of implant components. Fracture of the implant can occur as a result of trauma, strenuous activity, improper alignment, or duration of service.
4. Dislocation, subluxation, excessive rotation, flexion contracture, decreased range of motion, lengthening or shortening of the leg, looseness of components, unusual stress concentrations, and extraneous bone can result from trauma, improper implant selection, improper implant positioning, improper fixation, and/or migration of the components. Muscle and fibrous tissue laxity can also contribute to these conditions.
5. Tibia, femur, or patella fractures.
6. Acute post-surgical wound infection, late deep wound sepsis and/or low-grade synovitis.
7. Peripheral neuropathies have been reported following total joint surgery. Subclinical nerve damage has been reported, and may be a result of surgical trauma. Temporary or permanent nerve damage can result in pain or numbness of the affected limb.
8. Wound hematoma, thromboembolic diseases including venous thrombosis, pulmonary embolus, or myocardial infarction.
9. Myositis ossificans. Periarticular calcification or ossification, with or without impediment to joint mobility. Periarticular calcification can cause decreased range of motion.
10. Skin sloughs or delayed wound healing.
11. Although rare, metal sensitivity or allergic reactions in patients following joint replacement have been reported. Implantation of foreign material in tissues can result in histological reactions involving macrophages and fibroblasts.
12. Damage to blood vessels.
13. Varus-valgus deformity.
14. Failure of the porous coating/substrate interface or hydroxylapatite coating/porous coating bonding may result in bead/HA separation.

WARNINGS AND PRECAUTIONS

The patient should be warned of surgical risks, and made aware of possible adverse effects. The patient should be warned that the device does not replace normal healthy bone, and that the implant can break or become damaged as a result of strenuous activity or trauma, and has a finite expected service life and may need to be replaced in the future.

Preoperative

1. Use care in handling and storing of implant components. Cutting, bending, or scratching the surfaces of components can significantly reduce the strength, fatigue resistance and/or wear characteristics of the implant system. These in turn may induce internal stresses that are not obvious to the eye and may lead to fracture of the component. Do not allow the porous surfaces to come in contact with cloth or other fiber releasing materials.
2. Surgical information is available upon request. The surgeon should be familiar with the technique.
3. An adequate inventory of implant sizes should be available at the time of surgery.
4. Intraoperative fracture or breaking of instruments can occur. Instruments which have experienced extensive use or excessive force are susceptible to fracture. Instruments should be examined for wear and damage prior to surgery.

Intraoperative

1. The correct selection of the implant is extremely important. The appropriate type and size should be selected for patients with consideration of anatomical and biomechanical factors such as patient age and activity levels, weight, bone and muscle conditions, etc. Generally, the largest cross-section component which will allow adequate bone support to be maintained is preferred. Failure to use the optimum size component may result in loosening, bending, cracking, or fracture of the component and/or bone.
2. Modular components must be assembled securely to prevent disassociation. Avoid repeated assembly and disassembly of the modular components which could compromise a critical locking action of the components. Surgical debris must be cleaned from components before assembly. Debris inhibits the proper fit and locking of modular components which may lead to early failure of the procedure.
3. Care is to be taken to assure complete support of all parts of the device embedded in bone cement to prevent stress concentration which may lead to failure of the procedure. During curing of cement, care should be taken to prevent movement of the implant components.
4. Fixation screws, when used, should be fully seated to assure stable fixation, and to avoid interference with the proper seating of components. Use only screws recommended by the manufacturer for the specific prosthesis to avoid improper fit, and to avoid improper mixing of metals.
5. Prior to closure, the surgical site should be thoroughly cleaned of bone chips, extraneous cement, ectopic bone, etc. Foreign particles at the metal and/or plastic interface may cause excessive wear and/or friction.
6. Posterior stabilized knee systems, constrained knee systems, and systems with a deep articular surface should not be utilized without significant adjunctive fixation (stems, screws, etc.).
7. An implant should never be reused. While it may appear undamaged, imperfection may exist which would reduce the service life of the implant.
8. Use the Genesis Torque Wrench to secure the distal femoral wedges and the conversion modules to the Genesis femoral component with femoral lugs. Use the Genesis II Torque Wrench to secure the distal femoral wedges and the conversion modules to the Genesis II femoral component with femoral lugs. The femoral lugs should be torqued to 70 in-lbs. Use the Mobile Bearing Rotation Peg Torque Wrench to secure the rotation peg to the Mobile Bearing Baseplate. The rotation peg should be torqued to 75 in-lbs.
9. Distal fixation lugs should be used with porous cruciate-retaining femoral components when implanted without cement. These lugs provide medial/lateral stability of the prosthesis.

Postoperative

1. Postoperative patient care and directions and warnings to patients by physicians are extremely important. Protected weight bearing with external support is recommended for a period of time to allow healing.
2. Use extreme care in patient handling.
3. Postoperative therapy should be structured to prevent excessive loading of the operative knee and to encourage bone healing.
4. Periodic, long-term follow-up is recommended to monitor the position and state of the prosthetic components, as well as the condition of the adjoining bone.

Packaging and Labeling

Knee implants are sterilized products and should only be accepted if received by the hospital or surgeon with the factory packaging and labeling intact. If the sterile barrier has been broken, refer to the Sterilization/Restoration section below.

STERILIZATION/RESTERILIZATION

Most implants are supplied sterile and have been packaged in protective trays. The method of sterilization is noted on the package label. All radiation sterilized components have been exposed to a minimum of 25 kiloGrays of gamma radiation. If not specifically labeled sterile, the implants and instruments are supplied non-sterile and must be sterilized prior to use. Inspect packages for punctures or other damage prior to surgery.

Metal Components

Nonporous or non-HA coated metal components may be resterilized, if necessary, by steam autoclaving in appropriate protective wrapping, after removal of all original packaging and labeling. Protect the devices, particularly mating surfaces, from contact with metal or other hard objects which could damage the product. The following process parameters are recommended for these devices:

- _ Prevacuum Cycle: 4 pulses (Maximum = 26.0 psig (2.8 bars) & Minimum = 10.0 inHg (339 millibars)) with a minimum dwell time of 4 minutes at 270→F to 275→F (132→C to 135→C), followed by a 1 minute purge and at least 15 minutes of vacuum drying at 10 inHg (339 millibars) minimum.
 - _ For the United Kingdom, sterilization should be carried out in accordance with HTM 2010. The recommended prevacuum sterilization cycle is: Evacuation to 100mBar for 2-3 minutes, Negative Pressure pulsing (5): 800mBar-100mBar, Positive Pressure pulsing (5): 2.2Bar - 1.1 Bar, Sterilization exposure: 3 minutes at 134→137°C, Drying vacuum 40mBar for 5-10 minutes. Note: mBar absolute.
 - _ Gravity Cycle: 270→F to 275→F (132→C to 135→C) with a minimum dwell time at temperature of 10 minutes, followed by a 1 minute purge and at least 15 minutes of vacuum drying at 10 inHg (339 millibars) minimum.
- Smith & Nephew does not recommend the use of low temperature gravity cycles or flash sterilization on implants.

If porous coated or HA coated implants are inadvertently contaminated, return the unsoiled prosthesis to Smith & Nephew for resterilization. DO NOT RESTERILIZE porous coated or HA coated implants. The coating requires special cleaning procedures.

Plastic Components

Plastic components may be resterilized by ethylene oxide gas. The following parameters are recommended as starting points for cycle validation by the health care facility:

Sterilant	Temp.	Humidity	Maximum Pressure	Concentration	Exposure Time
100% EIO	131→F (55→C)	40-80% (70% Target)	10 PSIA (689 millibars)	725 mg/l	60-180 minutes

Suggested initial starting point for aeration validation is 12 hours at 120→F (49→C) with power aeration. Consult aerator manufacturer for more specific instructions.

INFORMATION

For further information, please contact Customer Service at (800)-238-7538 for all calls within the continental USA and (901) 396-2121 for all international calls.

Authorized EC Representative:

Smith & Nephew Orthopaedics GmbH, Tuttlingen, Germany

Caution: Federal Law (USA) restricts this device to sale by or on the order of a physician.

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