TRAUMA & EXTREMITIES GROUP

SURGICAL TECHNIQUE

Total Ankle System

DePuy
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CONTENTS

IMPORTANT

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MOBILITY™ TOTAL ANKLE SYSTEM

INTRODUCTION

Until relatively recently the treatment of inflammatory joint disease and painful end-stage arthritis of the ankle was traditionally dominated by arthrodesis. Whilst ankle fusion provides welcome pain relief, the loss of mobility of the joint often means that the outcome of the procedure is less than ideal with associated arthritis developing in the surrounding joints and a pathological gait.

Early designs for total ankle replacement prostheses were largely unsuccessful with high complication and failure rates. The early designs were associated with excessive wear, excessive constraint and a lack of stability, as well as problems such as talar subsidence and component loosening.

The search for a device that resolved these problems ultimately led to the use of unconstrained, three-component mobile bearing prosthesis designs which, through successive advancements have resulted in a viable surgical alternative to ankle arthrodesis.

Despite the principles of mobile bearing total ankle replacements being clinically substantiated, the surgical procedure is complex and typically involves aggressive bone resection. Results can be unpredictable and inconsistent, and success is often dependent on the experience of the operating surgeon.

The Mobility™ Total Ankle System is a three-component, cementless, unconstrained, mobile-bearing prosthesis with a dedicated instrumentation system. The prosthesis incorporates some unique design modifications which allow minimal bone resection and the instrumentation allows repeatable and accurate surgical outcomes.

The Mobility™ Total Ankle System was developed in conjunction with an experienced surgeon design team, Dr Pascal F. Rippstein, Mr Peter L. R. Wood and Dr J. Chris Coetzee.

INDICATIONS

Total ankle arthroplasty is indicated by ankle arthritis. Ankle arthritis originates from a variety of causes including osteoarthritis, traumatic arthritis and rheumatoid arthritis. Each cause has factors that affect whether the implant is suitable for the patient and if a satisfactory outcome is achievable.

In osteoarthritis patients the duration and degree of immobility caused by reduced joint space, osteophytes, scarring and/or pain must be taken into account when considering if the implant is suitable since some patients may have been rigidly fibrosed for many years. If the joint is very stiff, the movement regained after total ankle replacement may be modest. These factors may also pose some additional challenges during surgery.

In traumatic arthritis patients, distal tibial ballooning with associated deformity, including fixed equinus, varus or valgus, must be considered when deciding if the implant is suitable for these patients. The number of surgical procedures performed on the patient, the number and location of previous surgical scars and the condition of the patient's skin should also be considered during patient selection. Ankle replacement for this type of patient should be considered after post-traumatic healing. In many cases, up to 10 years are allowed for healing.

In rheumatoid arthritis patients, the adjacent joints (subtalar and mid-tarsal) should be evaluated. Occasionally, the valgus hindfoot may preclude surgery or at least require corrective surgery either before, or after ankle replacement surgery. If the patient has equally severe symptoms from arthritis of either the hip or knee then these joints should generally be treated first.

CONTRAINDICATIONS

Contraindications include prior ankle joint infection which might still be latent, extended avascular necrosis and peripheral neuropathy from any cause, including long-standing insulin dependency from diabetes, very poor skin condition/vascularity, severe destruction of the ankle geometry, and severe deformity of the ankle joint (greater than 20° varus/valgus).

KEY FEATURES OF THE MOBILITY™ TOTAL ANKLE SYSTEM

Mobility™ Total Ankle System – A three-component mobile bearing ankle prosthesis designed on the principle of mobility with congruency

Cobalt-Chrome Tibial Component

- Short, conical intramedullary stem
  - Provides primary fixation into tibia
  - Allows rotational adjustment of tibial component
  - Allows lateral-medial adjustment
  - Improves stress distribution within tibia
- Long tibial plate
  - Allows posterior overhang of posterior tibial cortex
  - Prevents non-uniform loading of the distal tibia
  - Narrow and rounded posterior aspect avoids impingement with malleolus lateralis and medial soft tissues
- Porocoat® porous coating
  - Provides good primary fixation and subsequent bone-ingrowth

UHMWPe Bearing Insert

- Restoration of normal ankle joint mobility
  - Unconstrained rotation and translation with flat tibial plate
  - Unconstrained dorsiflexion and plantarflexion and a small degree of inversion/eversion with talar condyles
- Fully conforming congruent surfaces to provide low contact stress
  - Flat upper surface of bearing conforms with flat tibial plate and is smaller than the tibial plate to prevent edge loading and reduce wear
  - Fully conforming with profile of talar component condyles

Cobalt-Chrome Talar Component

- Resurfacing tri-plane underside
  - Allows an accurate and reproducible 3-step talar resection technique
  - Allows minimal bone resection and leaves the medial and lateral sides of the talus dome intact
  - Talar resections are the same for sizes 1-4 and sizes 5 & 6 allowing greater system flexibility
- Deep talar sulcus
  - Reduces potential for bearing dislocations
  - Reduces potential of one-sided subsidence.
- Short, deep, anterior talar fins
  - Provide rotational stability and equilateral load transferral
  - Prevent one-sided subsidence
  - Provide good primary press fit fixation
  - Prevent penetration into the thin posterior subtalar joint
- Porocoat® porous coating
  - Provides good primary fixation and subsequent bone ingrowth

Six Sizes of Components with Five Thicknesses of Bearing Inserts

The component sizes were determined to allow an accurate anatomic fit. All three components narrow posteriorly to prevent impingement on the posterior neurovascular bundles, medial flexor tendons and lateral posterior fibula and thereby prevent pain to the patient. The five thicknesses of bearing insert allow for variable joint ligament strengths and soft tissue situations.

Design Validation

Comparative wear, bearing push-out and talar component stability and subsidence testing showed the performance of Mobility™ to be at least equivalent, and superior in wear, when compared with an existing successful three-component mobile bearing ankle design.[1]

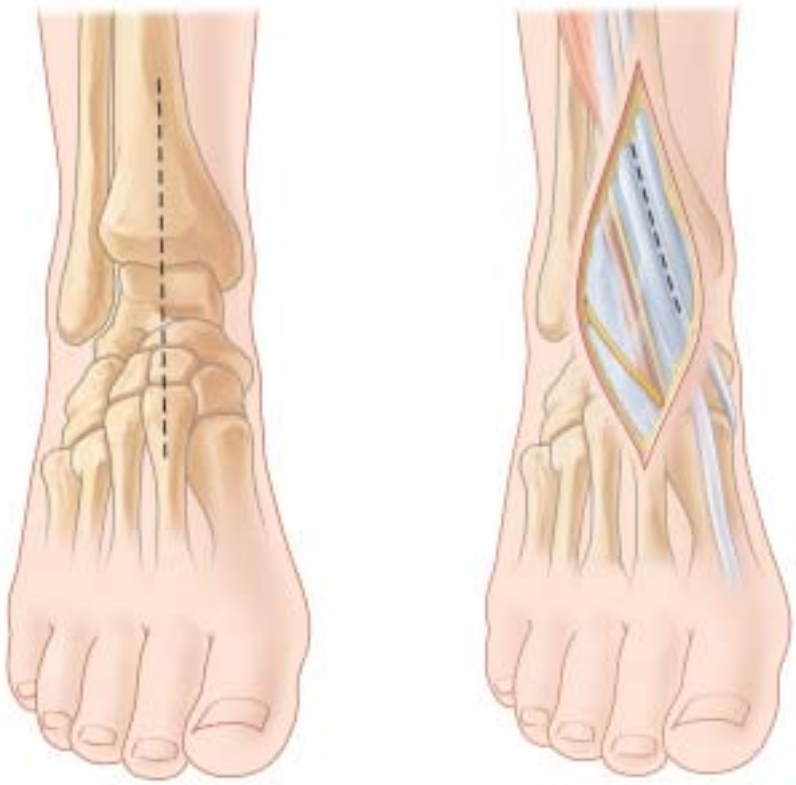
Dedicated Surgical Instrument Set

A comprehensive instrument set allows accurate and reproducible implantation of the Mobility™ prosthesis. The instrumentation allows the tibial component to be accurately centred over the talus component in the frontal and sagittal planes. Bone resection guides allow reproducible tri-plane talar preparations which can all be performed without having to hold the foot in the neutral position. In addition, all resection guide blocks allow good visibility of the joint space so that resections can be checked visually.

MOBILITY™ TOTAL ANKLE SYSTEM SURGICAL TECHNIQUE

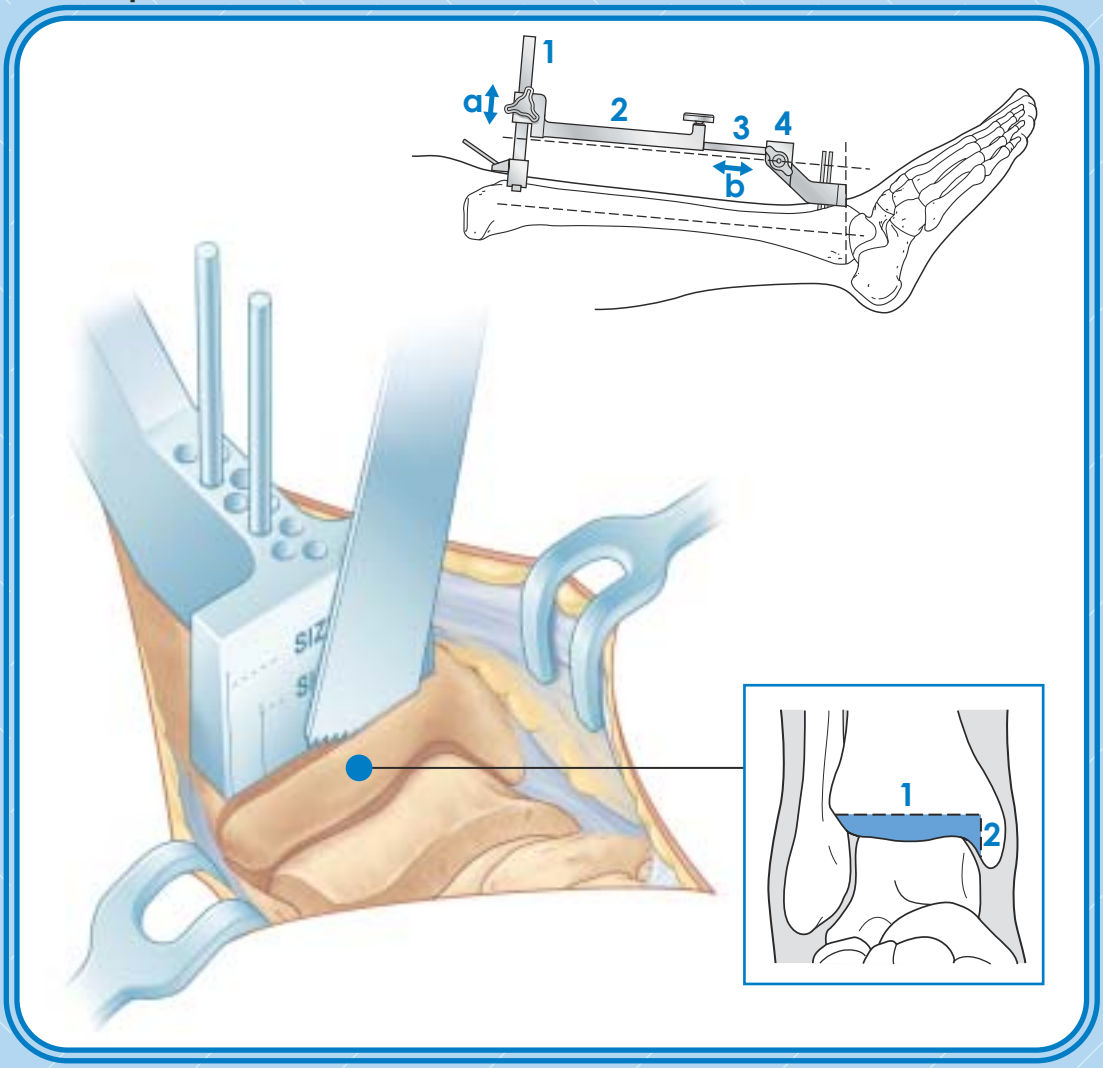
Throughout the procedure, particular care with skin retraction needs to be exercised in order to avoid pressure necrosis and delayed wound healing. Plantar flexion of the foot draws the skin edges together and if a self-retaining retractor has been inserted when the foot was at 90° to the leg, the pressure it exerts will dramatically increase if the foot is plantar-flexed in an attempt to improve exposure. Self-retaining retractors should be released before altering the position of the foot to ensure this does not occur, or preferably their use should be avoided altogether.

Step 1: *Patient Preparation and Ankle Exposure*



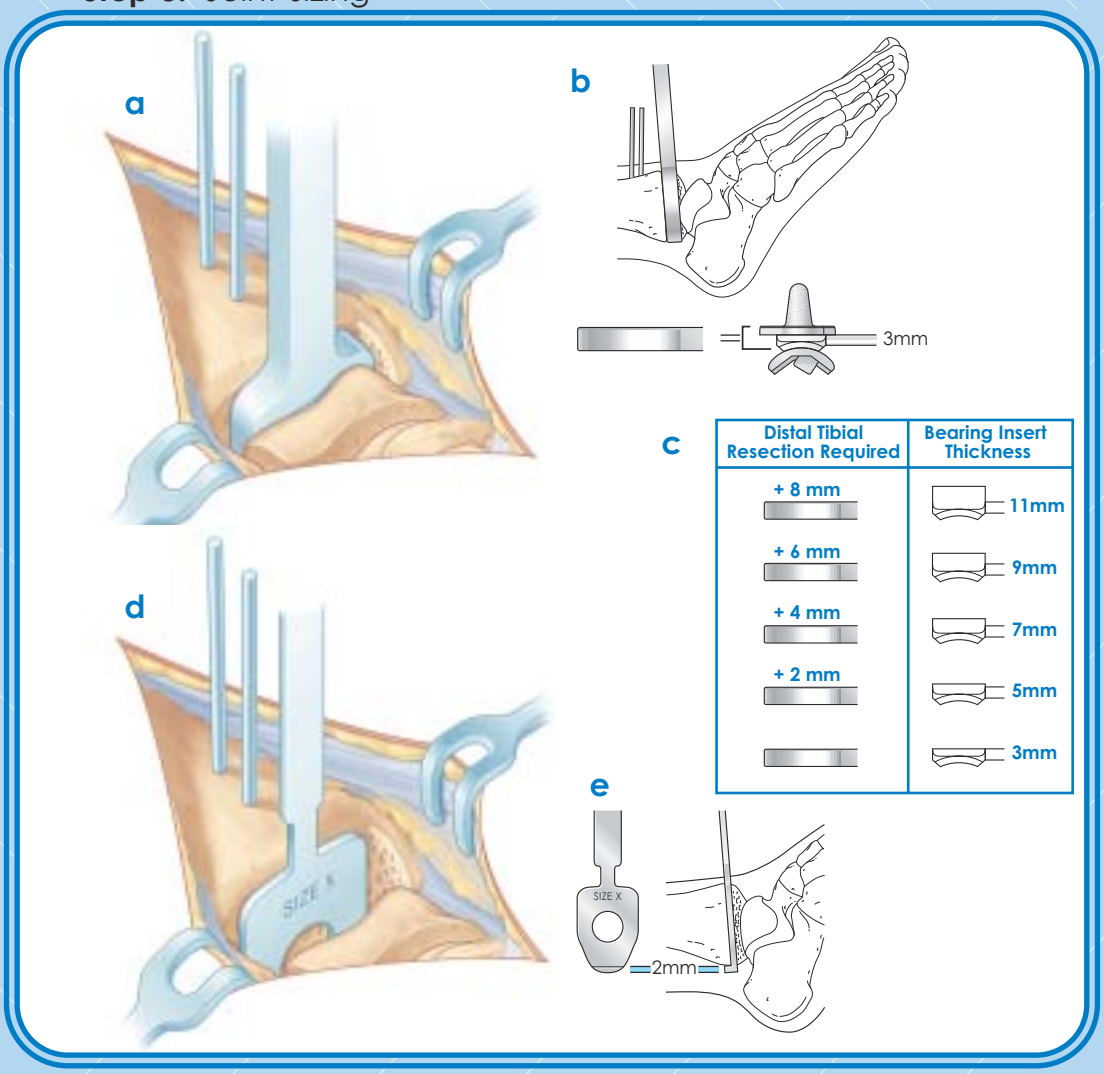
- Place the patient in a supine position and raise the affected side either by using a thigh support or by tilting the table so that the view is directed at 20° from the lateral side.
- Prepare the leg to above the knee using a standard draping technique. Exsanguinate the limb by elevation and apply a tourniquet to the thigh.
- Make a 10-15 cm midline anterior incision with the centre over the middle of the talus at the level of the joint and over the extensor hallucis longus. Identify and retract the medial branch of the superficial peroneal nerve in the distal half of the wound.
- Approach through the extensor hallucis longus sheath leaving the tibialis anterior sheath intact if possible.
- Retract the neurovascular bundle laterally.
- Incise the ankle capsule vertically to expose the distal tibial plafond and talus.

Step 2: *Distal Tibial Resection*



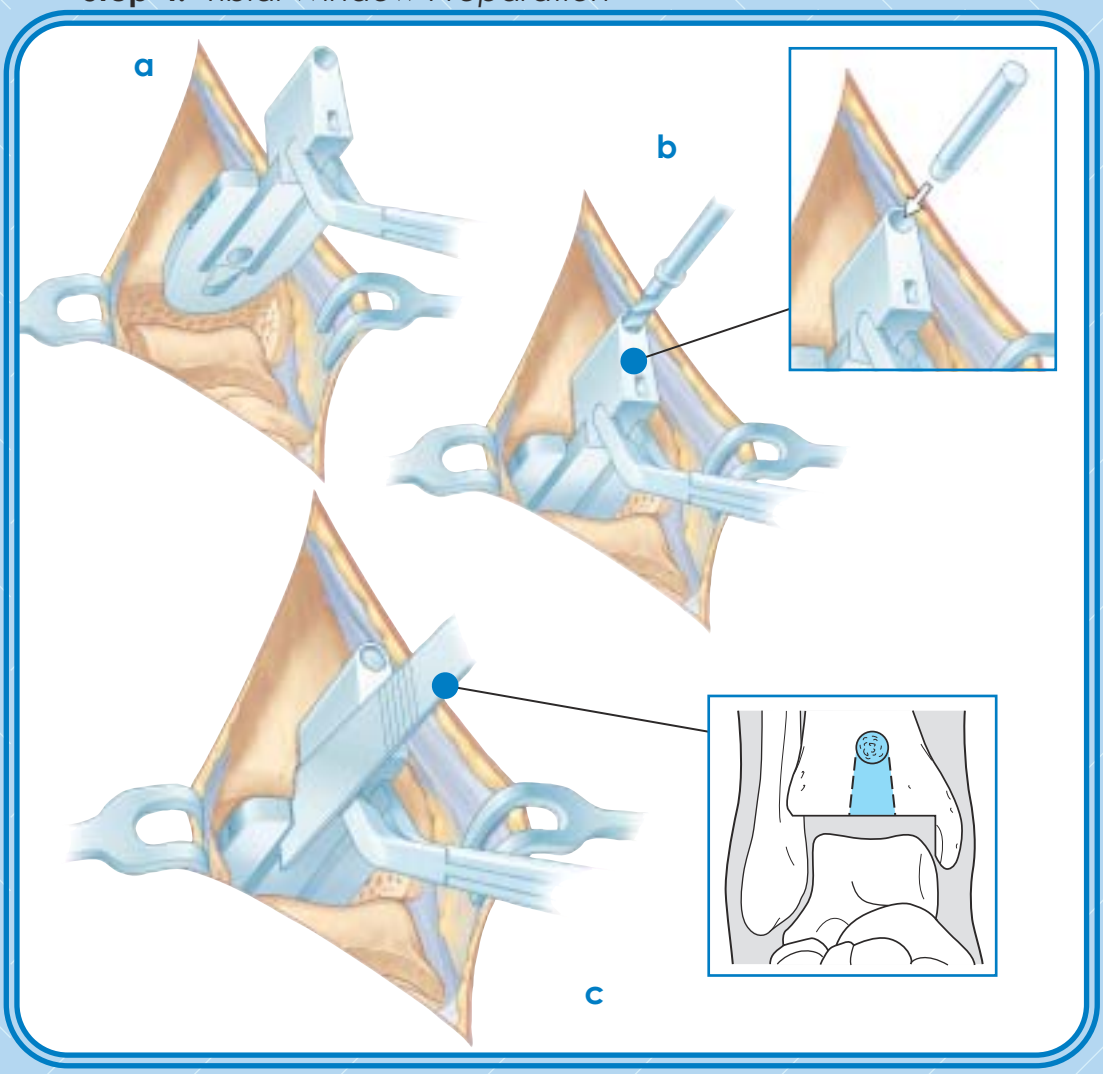
- Assemble the yoke (1), tibial adjustment tube (2), tibial rod (3) and tibial cutting block (4) as illustrated. Position the yoke over the anterior crest of the proximal tibia and secure with 2.5 mm pins. A surgical swab may be used underneath the metal yoke to pad the proximal tibia, although care must be taken not to drive the pins through the swab and channel debris into the body. The tibial cutting block is angled to allow for a 5° slope posteriorly.
- Use the vertical adjustment (a) of the adjustment tube to position the tibial rod parallel to the long axis of the tibia.
- Use the horizontal adjustment (b) of the adjustment tube to position the tibial cutting block so that the tibial resection will remove the roof of the tibial plafond.
- Secure the tibial cutting block with two pins. Place the pins so that they are on the same vertical row of holes with one hole between them as shown above.
- Markings on the cutting face of the tibial cutting block indicate the medial/lateral width of the tibial component (sizes 1-6). Resect the distal tibia using the non-depth marked thick oscillating sawblade. Keep the blade in midline to avoid lateral and medial malleoli and medial neurovascular structures.
- Distract the joint using bone spreaders. Use the reciprocating sawblade to release the medial edge of the tibial plateau by making a vertical cut in line with the medial side of the talus. This may be started with an osteotome.
- Remove the resected bone taking care not to lever against the medial malleolus, which can easily be fractured.

Step 3: *Joint Sizing*



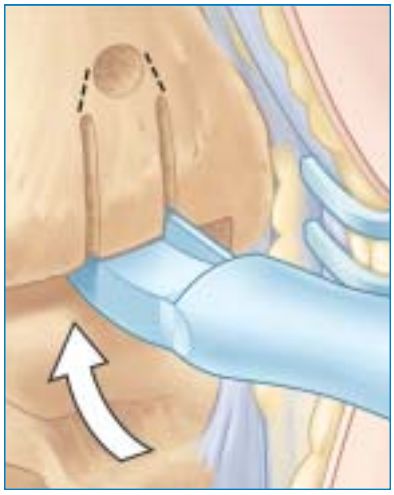
- Insert the joint thickness trial between the resected distal tibia and the unresected talus (a). The joint thickness trial indicates the resection space required for the implantation of the thinnest bearing insert, 3 mm (b). **For the implantation of thicker bearing inserts 5 mm, 7 mm, 9 mm and 11 mm there must be a clearance of 2, 4, 6 and 8 mm, respectively, in the joint space with the joint thickness trial. If the joint thickness trial cannot be inserted into the joint space, more distal tibia should be resected and the joint sizing repeated (c).** With the two pins secured in the bone, the proximal/distal and medial/lateral position of the tibial cutting block can be adjusted until the tibial resection is as required.
- Determine the required tibial component size by hooking the lip of the tibial profile trial behind the posterior aspect of the resected distal tibia (d). The tibial profile must be centred over the talar dome to show the alignment of the tibial and talar components. The tibial profile trial should not impinge with the fibula. This should be checked, especially posteriorly where the fibula converges towards the centre of the ankle. If there is not adequate distance between the fibula and the lateral edge of the tibial profile trial, then a smaller size tibial component is required regardless of the length of the component.
- The tibial component size indicated will most often allow for a 2 mm posterior overhang of the distal tibia (e). If the tibial anatomy is such that the tibia is skewed obliquely posteriorly, the assessment of depth will not be entirely accurate. The width of the component is the important parameter not the length. Due to the long tibial plate design which narrows posteriorly, there will always be some degree of posterior support.
- All subsequent tibial cuts will be specific for the tibial component size selected.

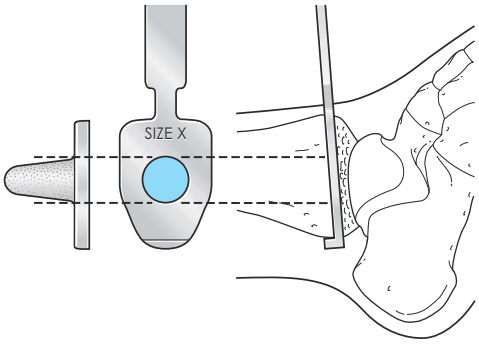
Step 4: *Tibial Window Preparation*

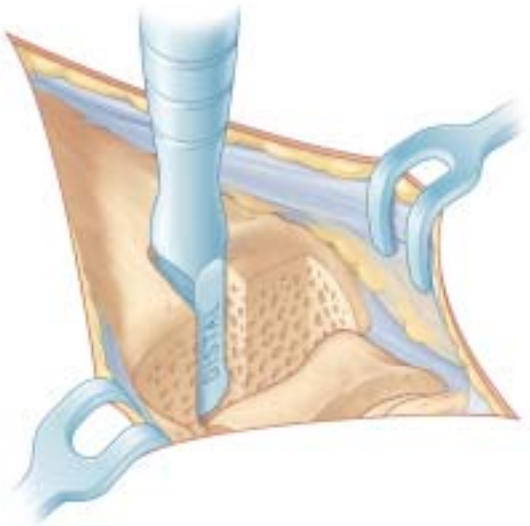


- Select the appropriate tibial template size to match the tibial component indicated and assemble with the tibial window cutting block. Hold together with the positioning forceps as shown (a).
- Position the assembly with the tibial template perfectly placed over the middle of the talus dome and in line with the axis of the talus (this can usually be found by aligning with the second metatarsal, but this is not always the case). The positioning of the tibial and talar component depends on the correct positioning of the tibial window cutting block since the talar component position is determined by the tibial component/jigs.
- The assembly may be further stabilised using the assistant stabiliser against the tibial template if required.
- Use the 6 mm tibial drill to prepare the proximal curvature of the tibial window resection (b). After drilling to the required depth insert the tibial window peg to stabilise the tibial cutting block and template.
- Cut the medial and lateral sides of the tibial window to the depth indicated for the size of the component using the depth-marked oscillating saw (c). Remove all jigs and join the cut sides to the drill hole if necessary.

Step 4: *Tibial Window Preparation (continued)*

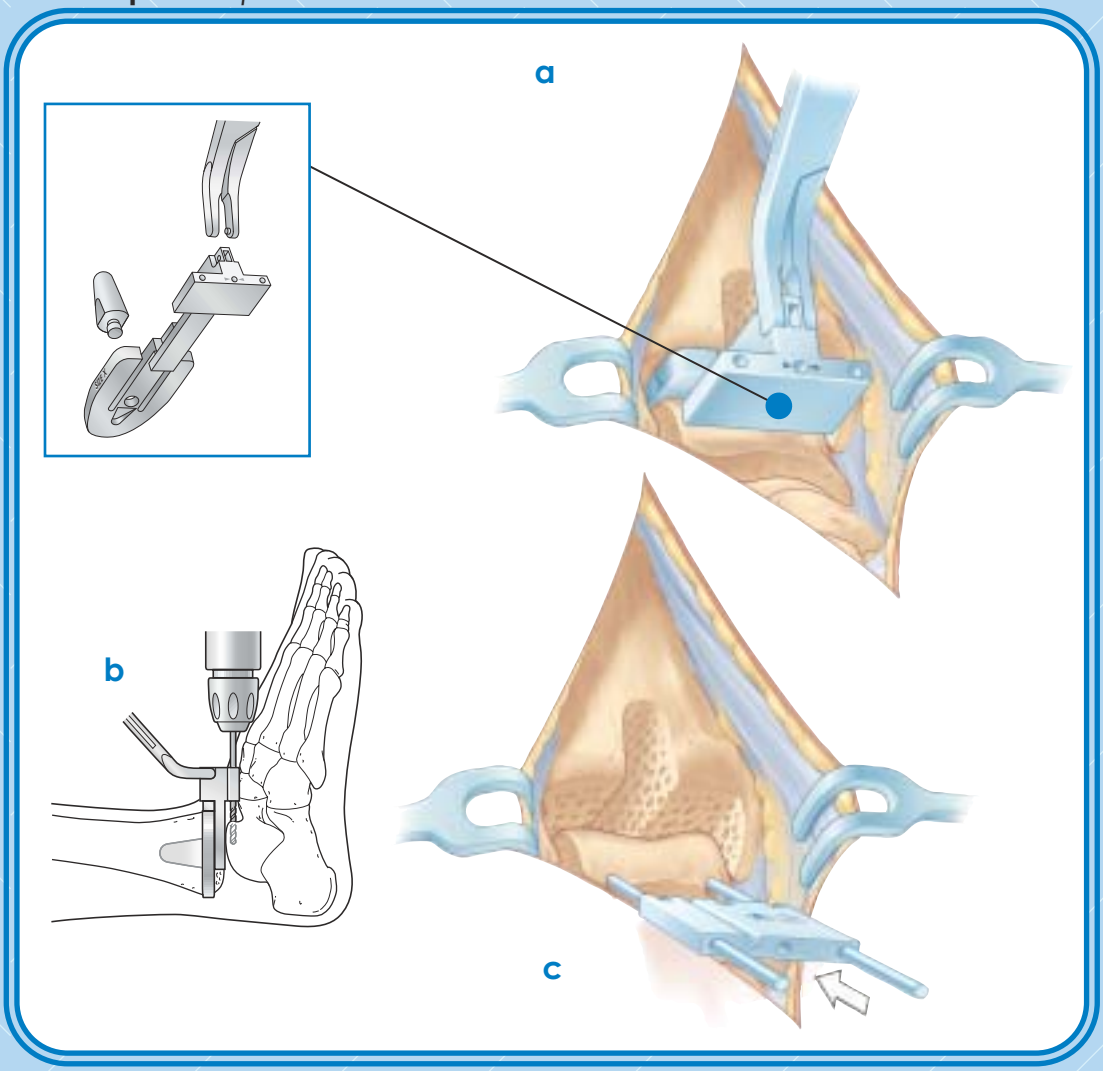






- Use the tibial window extractor to remove the tibial window bone. Slide the leading edge into the right tibial window saw cut and check the depth of the tibial stem with the appropriate depth mark against the anterior tibial cortex.
- With the tibial window extractor at the correct depth, apply pressure to cut into the cancellous bone at the distal posterior end of the tibial window. Cut the subchondral bone by levering the tibial window extractor against the curvature of the talus. The bone can then be gently levered free. Care must be taken not to allow the tibial window bone portion to be projected from the joint space into the air; this bone is required for grafting at the end of the procedure.
- Alternatively the tibial window may be removed using a curved osteotome levered against the talus. The appropriate sized tibial profile trial is used to indicate the depth of the tibial stem for the component size, the depth is marked in the bone through the stem hole in the tibial profile trial and then a curved osteotome may be used to extract the tibial window.
- Once the tibial window is extracted, use the marked tibial window impactor to impact the tibial window to the required depth. If the impactor is placed in the tibial window correctly, then the marking 'DISTAL' will be visible on the instrument.

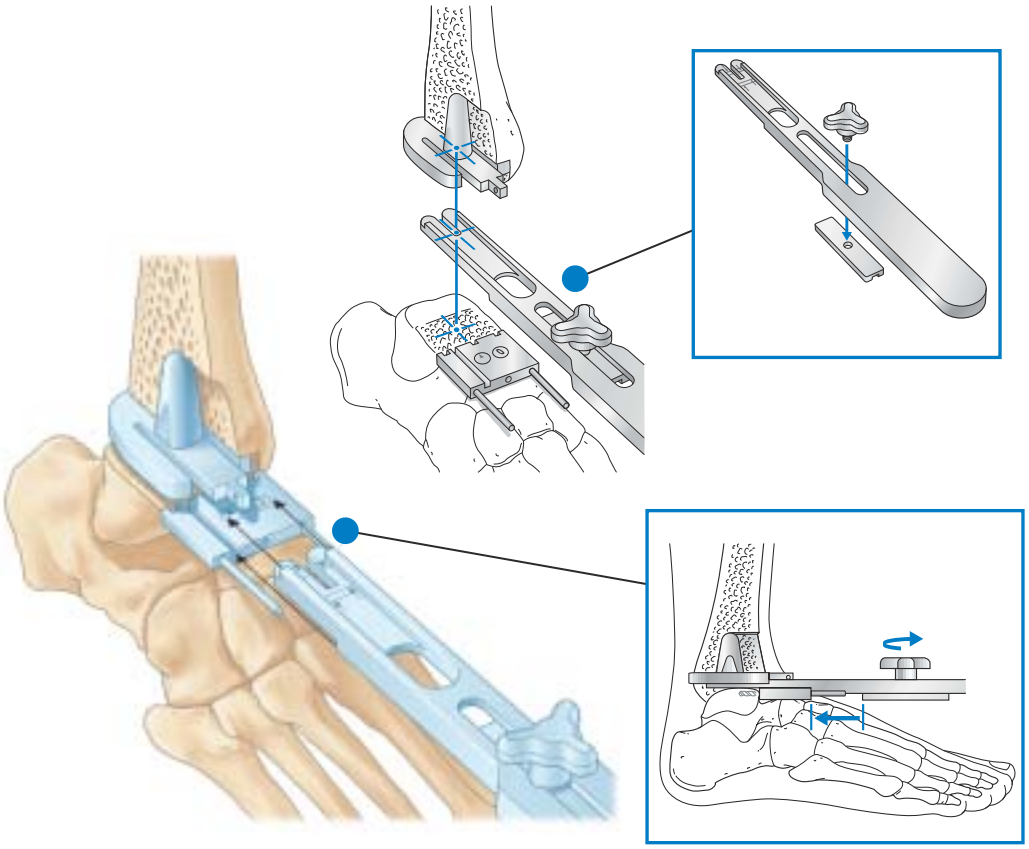
Step 5: *Superior Talar Flat Resection*



- Remove all osteophytes and the subchondral bone on the anterior aspect of the talus with a luer. Assemble the same size tibial template as used for the tibial window resection with the tibial stem and a talar drill guide; hold the assembly together with the positioning forceps. The talar drill guide thickness (+3, +5, +7 or +9-11) estimates the bearing insert thickness that will be implanted. The assembly of the tibial template and selected thickness of the talar drill guide should fit snugly between the resected tibia and unresected talus (a). If the assembly is loose in the joint space, a thicker talar drill guide should be tried until the assembly fits snugly.
- The varus/valgus and flexion/extension of the final implanted talar component is determined by the positioning of two 2.5 mm drill bits inserted into the talus. With the foot held in a neutral position and the appropriately sized tibial template/talar drill guide assembly aligned correctly, drill two 2.5 mm drill bits into the outer two drill guide holes of the talar drill guide (b). Replace the drill bits with 2.5 mm pins after drilling. In the case of a particularly narrow talus, one of the drill bits may be inserted into the central hole of the talar drill guide. **If the central hole is used the pin may impinge with other pins used later in the procedure if placed too deep. Ensure therefore, that the laser marked depth guide on the drill bit is clearly visible and take extreme care not to drill greater than the depth mark on the 2.5 mm drill bit.**
- Remove all instruments except the two pins that are inserted into the talus. Slide the standard talar flat cutting block (marked '0') onto the pins with the arrow pointing posteriorly (c).
- Using the non-depth marked oscillating sawblade resect the superior flat of the talus keeping the blade flat and straight against the cutting block. Should more superior talar resection be required, the low talar flat cutting block ('+1') may be used.

Step 6: *Transferral of Tibial Component Centre*

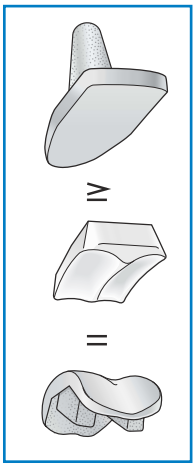
The medial/lateral and anterior/posterior centre of the tibial component is transferred to the talus to allow the talar component to be aligned relative to the centre of the tibial component.

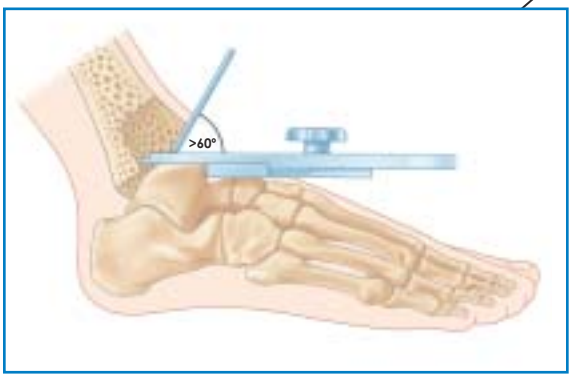


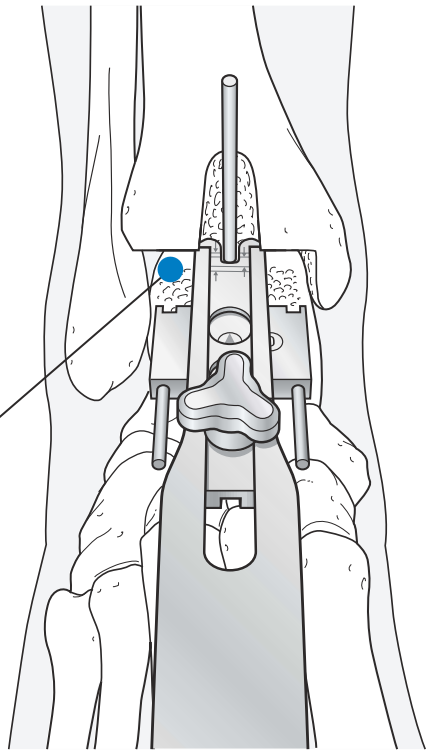
- With the talar flat cutting block still in position on the two pins, re-insert the tibial template/tibial stem assembly. The positioning forceps should not be used at this stage in the procedure as they will impinge on other instruments.
- Assemble the talar centre guide as shown. Ensure that the sliding block is not locked in position and can move freely. Insert the talar centre guide in between the tibial template and the talar flat cutting block so that the superior runners locate with the slots in the tibial template and the inferior runner locates with the slot in the talar flat cutting block. Make sure that the talar centre guide runners are firmly pushed against the end of the tibial template location slots.
- With the foot held in the neutral position, all three instruments (the tibial template, the talar centre guide and the talar flat cutting block) should be parallel. If the instruments are loose within the joint space, the plastic talar centre guide packing can be assembled onto the tibial template to fill the gap so that there is no movement between the instruments.
- Ensure that the talar centre guide is pushed firmly against the tibial template in the anterior/posterior direction.
- Ensure that the talar flat cutting block is firmly against the talus.
- Lift the loose sliding block of the talar centre guide and drop it down until it hits against the talar flat cutting block.
- Lock the sliding block in position when it is firmly stopped against the talar flat cutting block. Remove the talar centre guide assembly from the joint space. **Do not move the position of the sliding block once it has been locked.**

Step 6: *Transferral of Tibial Component Centre (continued)*

From this stage on, the talus will be cut for either sizes 1-4 or sizes 5 & 6. The talar component must be equal to or smaller than the tibial component.

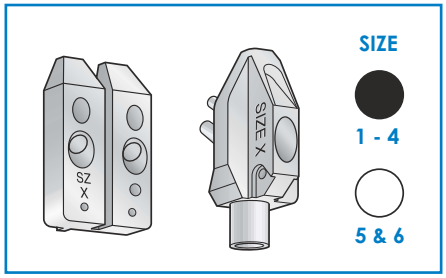


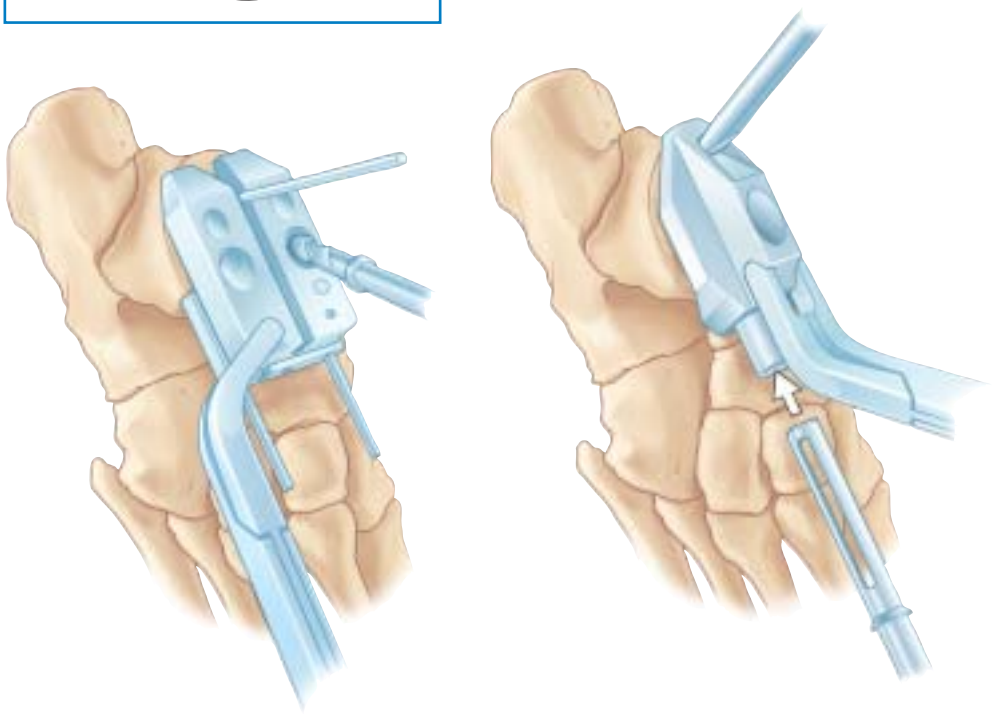




- Remove the tibial template/tibial stem assembly from the joint space but leave the talar flat cutting block on the two talar pins.
- Plantarflex the foot and relocate the talar centre guide onto the talar flat cutting block so that the locked sliding block meets the talar flat cutting block in exactly the same position as it did in the previous step.
- Again, ensure that the talar flat cutting block is pushed firmly against the talus.
- With the talar centre guide and the talar flat cutting block in place, the end of the slot in the talar centre guide indicates where the central point of the tibial component is with respect to the talus. Insert a 2.5 mm drill bit through the forked end of the talar centre guide into the talus. The drill bit must be inserted as close to the end of the forked slot in the talar centre guide and at an angle of at least 60°. Once drilled, replace with a 2.5 mm pin.
- Remove the talar centre guide leaving the central pin and talar flat cutting block in position. The position of the pin is where the centre of the tibial component will be over the talus and will become the centre of the talar component. Confirm visually that the insertion point of the pin is in the centre of the talus medially/laterally and that the pin is in the centre of the tibial window when the foot is held in the neutral position. If the pin is not in the centre of the talus medially/laterally or it is not central in the tibial window, check the positioning of the tibial component.
- Check the anterior/posterior position of the pin – this will be the anterior/posterior centre of the talar component. If the anatomy of the joint is such that there is any anterior protrusion of the talus, the pin will be positioned more posteriorly. It is at the discretion of the surgeon to decide if the centre of the talar component should be left posteriorly or if it should be moved slightly anteriorly to implant the talar component in relation to the talar anatomy. The centre of the talar component as indicated by the central pin can be checked at this stage by using a C-arm.

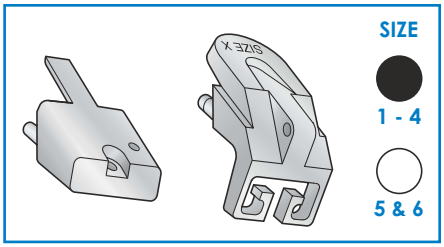
Step 7: *Talar Preparation: Superior and Posterior Sulci*

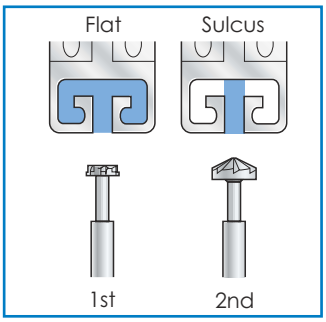


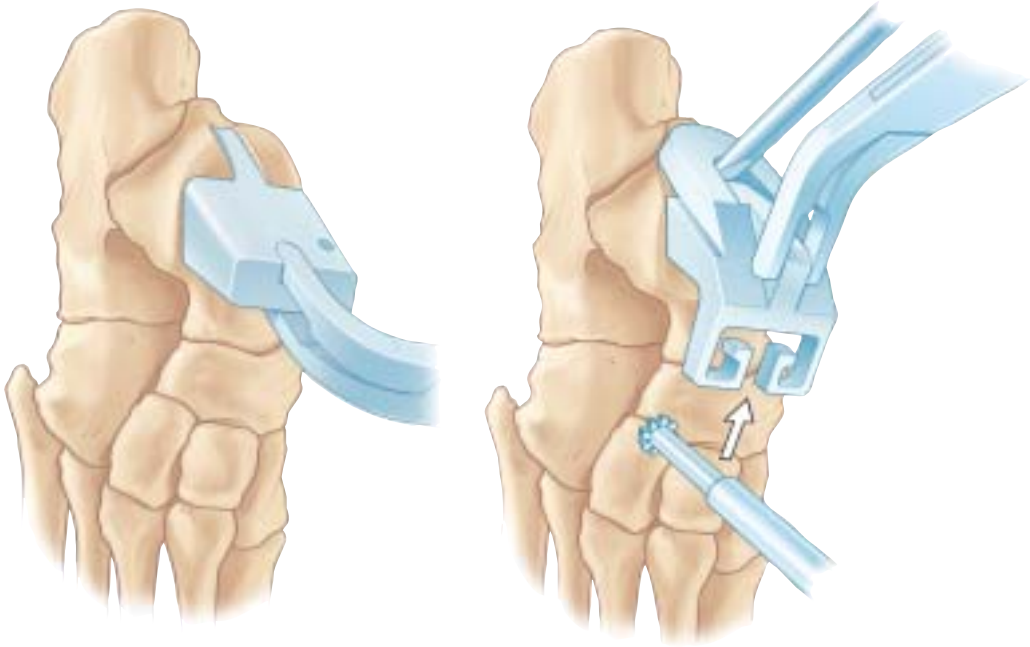


- The talar component size should be equal to or less than the tibial component size. The talar component should never be wider than the talus and ideally there should be approximately 1-2 mm talar bone on both the medial and lateral sides. In case of doubt, always undersize, never oversize. The talar jigs allow preparation for either sizes 1-4 (Black) or sizes 5 & 6 (White).
- Select the required size talar fin drill guide (1-4 Black; 5 & 6 White). Use the positioning forceps to hold and place the talar fin drill guide onto the top of the talar flat cutting block. Slide the talar fin drill guide along the talar flat cutting block and the resected superior talar flat until the forked end is stopped by the central pin which is inserted in the talus.
- Use the 4.5 mm talar drill bit to drill four, full depth holes into the talus. The position of these four holes determines the position of the talar jigs and the final position of the talar component.
- Remove all instruments and pins.
- Select the required size of talar trephine guide block (1-4 Black; 5 & 6 White). Use the positioning forceps to hold and place the block onto the resected talus. The four pegs in the talar trephine guide block fit into the four drill holes in the talus. Ensure that the trephine guide block is flat on the resected superior talus.
- Using combinations of the positioning forceps and assistant stabiliser to hold and secure the guide block in position, trephine the superior and posterior talar sulci using the talar trephine.
- Remove the trephine guide block by lifting it off the talus in line with the pegs. Extreme caution must be taken not to break the talus by exerting medial or lateral force through the four pegs during removal of the guide block.

Step 8: *Talar Preparation: Posterior Flat, Anterior Flat and Anterior Sulcus*

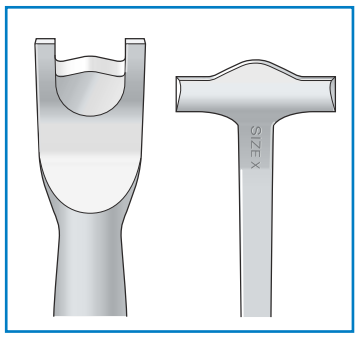






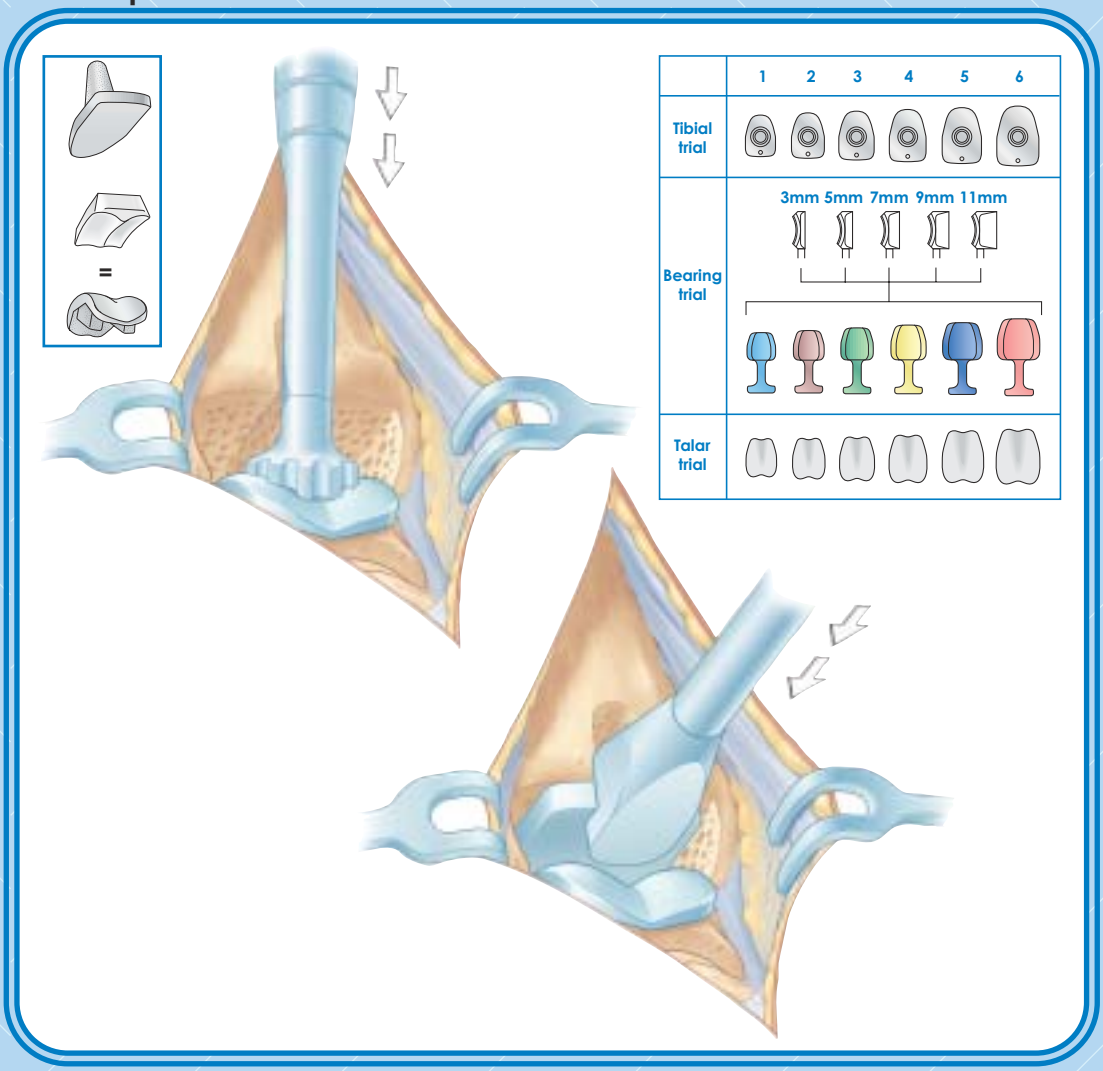
- Select the posterior cutting block of the chosen size (1-4 Black; 5 & 6 White). Hold with the positioning forceps and place the two pegs marked 'A' into the two anterior talar holes. With the pegs inserted in the correct talar holes, the tongue of the posterior cutting block will fit flush into the posterior sulcus.
- Resect the posterior talar flat using the non-depth marked oscillating sawblade taking care not to drift medially or laterally with the blade and damage the soft tissue.
- Remove the posterior cutting block. Take care not to break the medial or lateral sides of the talus with the pegs of the block.
- Select the anterior burr jig of the chosen size (1-4 Black; 5 & 6 White). Hold with the positioning forceps and place the two pegs marked 'P' into the two posterior talar holes. The flat posterior portion of the jig will be flush against the posterior cut surface of the talus.
- Use the assistant stabiliser and the positioning forceps to steady the anterior burr jig during burring of the anterior talar flat and sulcus. Guide the depth stopped anterior flat burr around the template of the burr jig to burr the talar anterior flat. Guide the anterior sulcus burr through the centre of the anterior burr jig to shape the anterior sulcus. The anterior sulcus burr will only fit in the anterior sulcus slot and will not fit around the whole template. Take care not to break the medial or lateral side of the talus by shaking the jig whilst using the burrs.
- Once the anterior talar flat and sulcus are prepared, remove the anterior burr jig from the talus. Take care not to break the medial or lateral side of the talus with the pegs of the block.

Step 9: *Talar Profile Finishing*



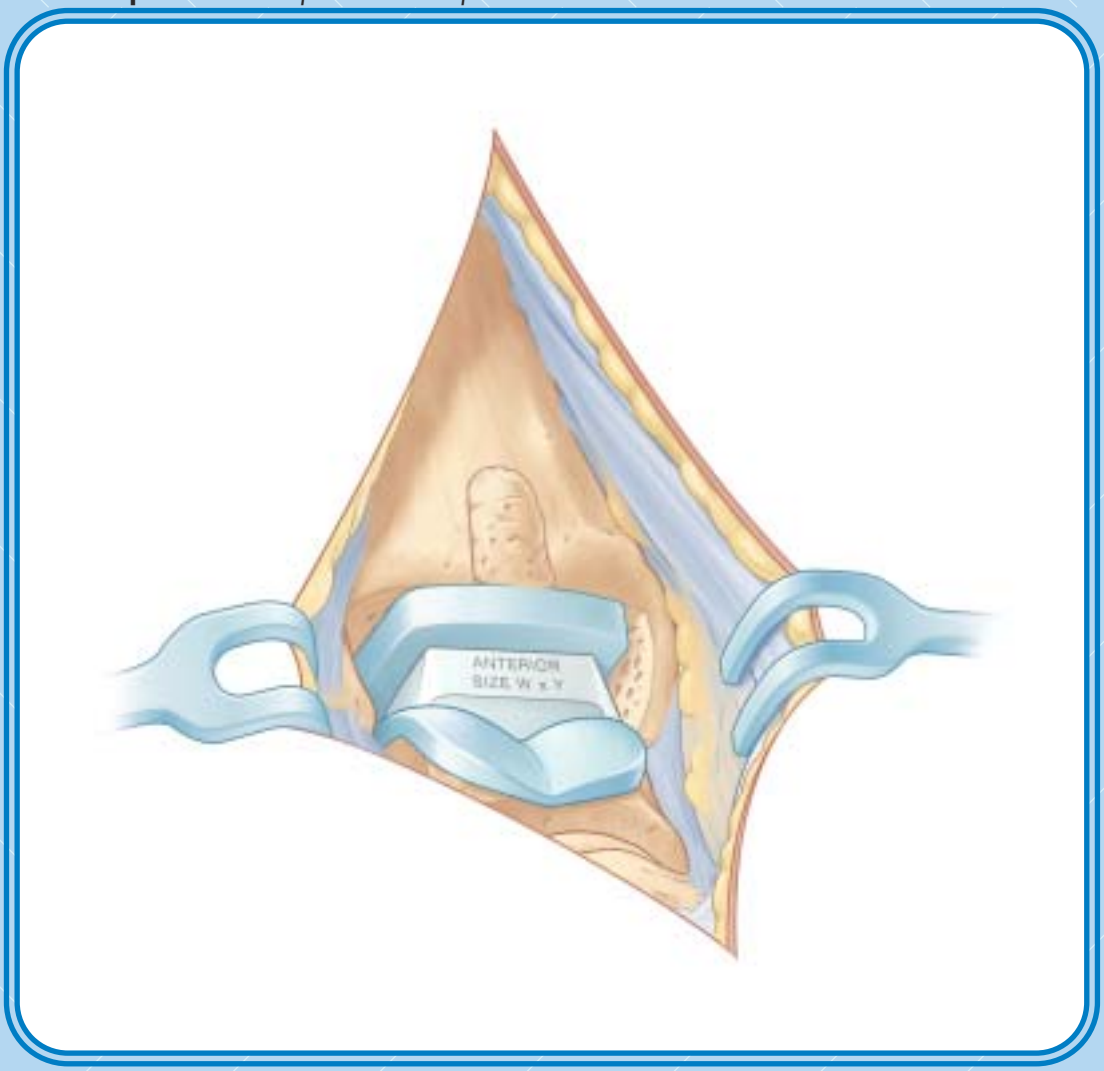
- Finish the superior and posterior sulci by using the talar sulcus osteotome with a gentle tapping action until the finished surface of the talus matches the talar profile template. Care must be taken when using the talar sulcus osteotome not to break off the posterior part of the talus.
- Gently place the plastic fin angle guide in one of the two pairs of talar drill holes. This indicates the direction in which the osteotome is placed to cut out the small portion of bone between the anterior and posterior drill holes. Remove bone between the holes. Repeat for the other pair of holes.
- Extreme care must be taken not to break the medial or lateral sides of the talus by twisting or rocking the fin angle guide or the fin osteotome.

Step 10: *Trial Insertion*



- Select the appropriate size trials. There are six sizes of each component (tibial, bearing and talar) and five thicknesses of bearing (3 mm, 5 mm, 7 mm, 9 mm and 11 mm). The size of the talar component must be the same or smaller than the tibial component; the bearing matches the talar component and must be the same size.
- Insert the talar trial with narrow aspect directed posteriorly and the fins located in the prepared fin slots. Do not use excessive force or rotation. Use the talar trial impactor with the handle directed through the resected tibial window to impact the talar trial. Ensure the talar component is well seated posteriorly.
- Insert the tibial trial straight into the tibial window, using the positioning forceps to hold the component if required. The curved aspect of the tibial trial should be directed posteriorly and the flat should be level with the anterior cortex of the tibia. There should be a 2 mm overhang on the posterior aspect of the tibia in the mid-section. However, and more importantly, if the tibial and talar components have been centred correctly, the medial and lateral sides of the tibial component should extend far enough for the bearing to be totally covered by the tibial plate. If this is not the case it is still possible at this stage to adjust the position of the tibial component by removing a slice of bone from either the medial or lateral sides of the tibial window (depending on which direction you need to move the component) and replacing the side of bone on the opposite side.
- Use the tibial trial impactor to impact the trial into place. Do not use excessive force or rotation.
- Finally, insert the correct size of trial bearing insert. The small handle assists removal. Use a swab looped around the handle to apply gentle traction if needed.

Step 11: *Component Implantation and Wound Closure*



- Insert the talar component first with narrow aspect directed posteriorly and the short deep fins in line with the prepared talar fin slots.
- Protect the articulating surface of the talar component with a bearing trial and insert the tibial component with the curved aspect directed posteriorly. Ensure that the tibial component is seated firmly on the resected distal surface of the tibia by inspecting the sides of the component; there should be no gaps between the component and the bone.
- Trim and replace the bone previously resected from the tibial window and secure with slivers of bone from the saw cuts. Check for, and remove any remaining osteophytes that may impinge on the joint, taking care not to damage the articulating surfaces of the prosthesis.
- Insert the bearing insert using the bearing trials as necessary to determine the best fit.
- Test the joint's range of motion and assess the varus/valgus of the hindfoot.

Ankle motion should range from 15° dorsiflexion to 20° plantarflexion. If extension beyond 15° cannot be achieved, lengthening the gastrocnemius soleus complex at the musculo-tendinous junction or heel cord lengthening should be considered.

- Close the wound in layers.

POST-OPERATIVE CARE

For 3 weeks post-operatively, the patient is advised to wear a cast or a supporting, rigid boot of the type used for treating fractures. The boot should be used for a further 3 weeks when walking outdoors. Regaining dorsiflexion presents the main problem for most patients and therefore active and passive dorsiflexion exercises are vitally important. The difficulty restoring dorsiflexion is common following total ankle replacement and is not confined to one particular prosthesis design. Many patients also require the supervision of a physiotherapist to overcome their tendency to walk with the foot turned out.

PRODUCT ORDERING INFORMATION

PART NAME	CATALOGUE NUMBER
2.5 mm Pin Extractors	8555-09-000
Positioning Forceps	8555-37-000
Assistant Stabiliser	8555-38-000
STEP 2	
Tibial Clamp	8555-00-000
Tibial Cutting Block	8555-02-001
Tibial Cutting Block Screw	8555-02-002
Tibial Rod	8555-02-000
STEP 3	
Joint Thickness Trial	8555-39-000
Tibial Profile Trial Size 1-2	8555-11-102
Tibial Profile Trial Size 3-4	8555-11-304
Tibial Profile Trial Size 5-6	8555-11-506
STEP 4	
Tibial Window Cutting Block	8555-16-000
Tibial Template Size 1-6	8555-12-001 – -006
Tibial Window Peg	8555-17-000
Tibial Window Extractor	8555-19-001
Tibial Window Impactor	8555-19-000
STEP 5	
Tibial Template Stem (2 per set)	8555-13-000
Talar Drill Guide 3 mm	8555-18-005
Talar Drill Guide 5 mm	8555-18-007
Talar Drill Guide 7 mm	8555-18-009
Talar Drill Guide 9-11 mm	8555-18-011
Talar Flat Cutting Block Std	8555-20-001
Talar Flat Cutting Block Low	8555-20-002
STEP 6	
Talar Centre Guide	8555-21-000
Talar Centre Guide Packing	8555-21-001
STEP 7	
Talar Fin Drill Guide Assembly Size 1-4	8555-22-104
Talar Fin Drill Guide Assembly Size 5-6	8555-22-506
Talar Trephine	8555-28-000
Talar Trephine Guide Block Size 1-4	8555-23-104
Talar Trephine Guide Block Size 5-6	8555-22-506

PART NAME	CATALOGUE NUMBER
STEP 8	
Talar Posterior Cutting Block Size 1-4	8555-24-104
Talar Posterior Cutting Block Size 5-6	8555-24-506
Talar Anterior Burr Jig Size 1-4	8555-25-104
Talar Anterior Burr Jig Size 5-6	8555-25-506
STEP 9	
Talar Sulcus Osteotome	8555-30-000
Talar Profile Template	8555-32-000
Talar Fin Osteotome	8555-34-000
Talar Fin Osteotome Angle Guide	8555-34-111
STEP 10	
Talar Trial - Sizes 1- 6	8555-01-001 – -006
Tibial Trial - Sizes 1-6	8555-03-001 – -006
Insert Trial Size 6 (3, 5, 7, 9, 11 mm) 611	8555-05-603, -605,-607, -609, -
Insert Trial Size 5 (3, 5, 7, 9, 11 mm)	8555-05-503, -505, -507, -509, -511
Insert Trial Size 4 (3, 5, 7, 9, 11 mm)	8555-05-403, -405, -407, -409, -411
Insert Trial Size 3 (3, 5, 7, 9, 11 mm)	8555-05-303, -305, -307, -309, -311
Insert Trial Size 2 (3, 5, 7, 9, 11 mm)	8555-05-203, -205, -207, -209, -211
Insert Trial Size 1 (3, 5, 7, 9, 11 mm)	8555-05-103, -105, -107, -109, -111
Talar Impactor Head	8555-27-104
Tibial Impactor Head	8555-27-111
Threaded Impactor Handle	8555-27-000
DRILL BITS AND BURRS	
6 mm Tibial Drill (2 per set)	8555-27-060
2.5 mm Talar Drill (2 per set)	8555-06-001
4.5 mm Talar Drill (2 per set)	8555-27-045
Talar Anterior Flat Burr (2 per set)	8555-29-000
Talar Anterior Sulcus Burr (2 per set)	8555-29-001

PART NAME	CATALOGUE NUMBER
SINGLE USE ITEMS	
2.5 mm x 70 mm K Wire (5 per procedure)	8555-06-000
2.5 mm x 45 mm K Wire (optional 2 per procedure)	8555-06-002
Recip Blade Stryker Hub 70 x 6 x 0.64 mm	8555-07-001
Recip Blade Hall Hub 70 x 6 x 0.64 mm	8555-07-002
Recip Blade Aesculap Hub 70 x 6 x 0.64 mm	8555-07-003
Recip Blade Maxi-Driver Hub 70 x 6 x 0.64 mm	8555-07-004
Osc Blade SOP 70 x 13 x 1.27 mm	8555-40-001
Osc Blade EHD2K4K 70 x 13 x 1.27 mm	8555-40-002
Osc Blade LHVP 70 x 13 x 1.27 mm	8555-40-003
Osc Blade LHPP 70 x 13 x 1.27 mm	8555-40-004
Osc Blade AO/SD 70 x 13 x 1.27 mm	8555-40-005
Osc Blade LMD 70 x 13 x 1.27 mm	8555-40-006
Osc Blade dm SOP 70 x 13 x 0.89 mm	8555-40-007
Osc Blade EHD2K4K 70 x 13 x 0.89 mm	8555-40-008
Osc Blade dm LHVP 70 x 13 x 0.89 mm	8555-40-009
Osc Blade dm LHPP 70 x 13 x 0.89 mm	8555-40-010

PART NAME	CATALOGUE NUMBER
INSTRUMENT TRAYS	
Mobility Instrument Tray A	8555-35-000
Mobility Instrument Tray B	8555-35-001
X-RAY TEMPLATES	8555-36-000
IMPLANTS	
Mobility Tibial - Sizes 1-6	9555-03-001 – -006
Mobility Talar - Sizes 1-6	9555-01-001 – -006
Mobility Bearing Insert Size 1 (3, 5, 7, 9, 11 mm)	9555-05-103, -105, -107, -109, -111
Mobility Bearing Insert Size 2 (3, 5, 7, 9, 11 mm)	9555-05-203, -205, -207, -209, -211
Mobility Bearing Insert Size 3 (3, 5, 7, 9, 11 mm)	9555-05-303, -305, -307, -309, -311
Mobility Bearing Insert Size 4 (3, 5, 7, 9, 11 mm)	9555-05-403, -405, -407, -409, -411
Mobility Bearing Insert Size 5 (3, 5, 7, 9, 11 mm)	9555-05-503, -505, -507, -509, -511
Mobility Bearing Insert Size 6 (3, 5, 7, 9, 11 mm)	9555-05-603, -605, -607, -609, -611

REFERENCES
1. Data on file at DePuy International Limited

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Cat No: 8555-00-004 version 2.

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Revised: 10/05