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**Integra® Spin® Snap-Off™ Screw Indications**
The Integra Spin Snap-Off Screw is indicated for fixing the elective osteotomies of the mid-foot bones and the metatarsal and phalanges of the foot only. Examples include: Weil osteotomy, unicortical small bone fixation.

See packaging insert for full prescribing information.

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<td><img src="image" alt="14mm Screw" /></td>
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**Integra® BOLD® Compression Screw Indications**
The Integra BOLD Compression Screw is indicated for fixation of bone fractures or for bone reconstruction such as: fixation of small bone fragments, in long bones or small bone fractures; arthrodesis in hand or foot surgery; mono or bi-cortical osteotomies in the foot or hand; distal or proximal metatarsal or metacarpal osteotomies; fixation of osteotomies for Hallux Valgus treatments such as Scarf, Chevron, etc.

See packaging insert for full prescribing information.

**Integra® Uni-Clip Staple Indications**
The Uni-Clip® Compression staple is indicated for fixation of bone fractures or for bone reconstruction.
- Arthrodesis in foot surgery
- Fracture management in the foot
- Mono or bi-cortical osteotomies in the foot
- Distal or proximal metatarsal osteotomies
- Fixation of osteotomies for Hallux Valgus treatment (such as Scarf, Chevron)

Other possible indications:
- Arthrodesis in hand surgery
- Fracture management in the hand
- Mono or bi-cortical osteotomies in the hand
- Distal or proximal metacarpal osteotomies

7 leg length: 13, 14, 15, 16, 17, 12 & 20 mm.
5 sizes of interaxis: 11, 12, 13, 15 & 20 mm.
Internal notches.
Step 1 • Scarf Osteotomy

1-1 The Scarf osteotomy consists of a horizontal cut and two transversal cuts of the first metatarsal, allowing for a broad range of angular corrections.

Step 2 • The Different Cuts

2-1 First, a medial capsulotomy and a lateral release is performed.

2-2 An inter-articular or inter-metatarsal approach is advised. The lateral sesamoid bone is dissected free by making a longitudinal incision between the lateral sesamoid and the lateral suspensory collateral ligament. This incision is extended anteriorly and the adductor hallucis is released from its phalangeal insertion. This way, after lateral displacement of the metatarsal fragment, the sesamoids will be placed under the metatarsal head.
Step 2 • The Different Cuts (Continued)

The exostosectomy should be as minimal as possible. The longitudinal resection is performed in alignment of the medial aspect of the metatarsal shaft. The proximal midplantar dissection provides a quasi complete exposure of the midplantar margin and the plantar surface. This view is essential for the realization of the Scarf osteotomy. The longitudinal cut is performed parallel to the medial border as well as to the plantar surface.

The transversal cuts are chevron like cuts (45° angle with the longitudinal cut), which are perpendicular to the second metatarsal (slightly backwards).

The dorsal aspect of the distal transversal cut should be 5 mm proximal to the cartilage. The proximal transversal cut is realized at 10 mm distance from the cuneo-metatarsal joint.
Step 3 • Displacement Possibilities

The scarf allows:

3-1 Medial and lateral translations.

3-2 The P.A.S.A. or D.M.A.A. correction.

3-3 The lowering of the metatarsal head.

3-4 Elevation of the metatarsal head.

3-5 Lengthening of the first metatarsal.
Step 4 • Displacement and Drilling

4-1 The stabilization of the bone fragments is accomplished with a specific bone clamp. The clamp is designed to allow compression with variable lateral displacement.

4-2 The clamp can remain in position while the 1mm K-wires are positioned.

4-3 The positioning of the K-wires should be performed while taking into consideration the following:
The proximal K-wire should enter the dorsal fragment from medio dorsal to latero plantar. This way, the lateral sagittal beam is respected. The distal K-wire (less oblique than the proximal one), is positioned so that it enters at the midsection of the dorsal fragment in order to transfix the plantarfragment dorso-plantarly (bi-cortical) or obliquely (mono cortical fixation).

4-4 In order to prepare the drill holes for the screw setting, a specific «2 in 1» drill is used. This cannulated drill is used with the K-wires remaining in place. The distal part of the drill (2.2 mm diameter) is adapted to the body of the screw whereas the proximal part of the drill (3.0 mm diameter) is designed specially to countersink the head. The total length of the drill (18 mm) allows an overall use of the drill in most of the metatarsals.
Step 5 • Screws Settings

5-1 The surgeon will use the drill in order to prepare the two holes.

5-2 Before drilling, once the K-wires are positioned, the length of the screws is measured by using the cannulated measurer screwdriver. The cannulated measurer screwdriver can be applied so that immediate reading of the length to implant can be done.

Note
As the screw is implanted dorso plantarly in order to achieve a bicortical compression, 2 mm will be added to the measured length. In the event of monocortical (oblique fixation in the metatarsal head) fixation, 2 mm will be deducted in order to avoid penetration into the cartilage.

5-3 Once the drill holes are performed, the BOLD® screws are implanted with the measurer cannulated BOLD hex screwdriver of 2.5 mm.
Step 6 • Finalization

6-1 In order to avoid soft-tissue interference, care should be taken to countersink completely the screw head.

6-2 Finally, the medial «bone-eminence», or pertrussian created due to the displacement of the bone fragments, is resected.
Step 7 • Austin/Chevron Osteotomy

7-1 The plantar cut is performed at a 60° angle towards the metatarsal base, with the center of the M1 head to be considered as the apex. The cut should be stopped back from the blood supply, in order to preserve the plantar vascularization.

7-2 The dorsal cut is identical to the dorsal transversal scarf cut. It is at a 45° angle towards the dorsal cortex, joining the center of the M1 head as the apex.

7-3 The Chevron osteotomy allows a displacement which is equivalent to half the width of the metatarsal head. Should the displacement be more than 50% of the metatarsal width, the stability of the bone fragment, required for good bone healing, can be compromised.
Step 8 • Measuring and Drilling

8-1 Once the displacement is achieved, a 1 mm diameter, 7 cm long K-wire is inserted. Care should be taken not to pass through the cartilage. The K-wire will guide the screw. Due to atraumatic aspects of a K-wire, it can be withdrawn and replaced until perfect positioning is achieved.

8-2 The length of the screw is defined by the measurer cannulated screwdriver.

8-3 The drilling in the bone is performed with the «2 in 1» drill. The dorsal cortex has to be completely countersunk by using the enlarged cutting edge tapered level of the «2 in 1» drill.
Step 9 • Screws Placement

9-1 The screw is placed and screwed with the measurer cannulated screwdriver.

9-2 The head of the screw is completely embedded in the dorsal cortex in order to avoid soft tissue problems.

9-3 The remaining bone eminence edge, due to the lateral displacement of the head, is removed in order to avoid problems with shoe wear.

9-4 This removed wedge can be used as a lateral graft to improve bone healing.
Step 10 • Akin Osteotomy

The Akin osteotomy is a medial closing wedge osteotomy performed at the level of the proximal phalangeal base. This will result in a variation of the proximal phalanx. The procedure is always performed with a definitive hallux valgus correction. The proximal cut will be performed parallel to the metatarso-phalangeal joint line.

The distal cut will be performed parallel to the nailbed of the great toe. The lateral cortex is kept intact.

The medial wedge is removed.

The closing technique is performed by surgical reduction. The BOLD screw is placed in order to achieve compression of the bone fragments.
Forefoot Set Instrumentation

- Bold clamp
- Drill Diam 2.2 mm
- K-wire 1.0 x 70 mm
- «2 in 1» Drill
- Bold Screwdriver 2.0 Hex
- Bold Screws
Spin® Snap-Off™ Screw Surgical Technique

As the manufacturer of this device, Integra does not practice medicine and does not recommend this or any other surgical technique for use on a specific patient. The surgeon who performs any implant procedure is responsible for determining and using the appropriate techniques for implanting the device in each patient.

Step 1 • Surgical Approach - Weil Osteotomy

1-1a The procedure is performed by dorsal approach, starting within the intermetatarsal interspace. There is good exposure to cut between the two extensor tendon muscles, extending as distally as possible.

1-2 The bone cuts should be as parallel (horizontal) to the sole as possible, usually about 25 degrees.

1-3a Pes planus condition, the cut may be too long, so adapt cuts.

1-3b Pes cavus condition, the cut may be too short, so adapt cuts.
Step 2 • Preparing the Cut

2-1 It is the aim to obtain an index plus minus (M1=M2). The head can be positioned and held in place by an important plantar flexion of the toe. However, it is easier to maintain the head in place with a Museux forceps or a Banaleck clamp.

2-2 The cut is horizontal and parallel to the sole. It starts in the cartilage of the head (2 mm from the dorsal border) and should be as long as possible (2.5 to 3 cm in standard foot condition).

2-3 The cut is performed with an oscillating saw.
Step 3 • Cut and Placement

3-1 Immediately after the Weil osteotomy, the metatarsal head will move proximally. The metatarsal formula will be controlled and/or restored.

3-2 The Spin screw is then placed. It is not necessary to prepare the dorsal bone since the Spin is a self-drilling and self-tapping screw, which is introduced by a power drill (Jacobs Chuck).

3-3 Sometimes it is necessary to initiate the snap-off effect by moving the drill forward (osteoporotic bone), whereas sometimes a predrill with a K-wire (1 mm diameter) can be advised in extremely solid cortical bone.
Step 4 • Final Fixation

When the head of the Spin gets into contact with the dorsal cortex, the holding device snaps off. If necessary, the screw setting can be finalized by handling the specific screwdriver.

Once the osteotomy is stabilized, the peak is removed handling the saw or the bonecutter. If necessary, the extensors can be lengthened by a Z-shaped release (Green Technique) after the metatarsal shortening.

Step 5 • Other Cases

In case of metatarso-phalangeal luxation, the metatarsal shortening should be at least equivalent to the initial phalangeal retraction.
Forefoot Set Instrumentation

- 2.0mm Spin Snap-Off Screws
- Spin screwdriver (3 prong)
Uni-Clip® Compression Staple Surgical Technique

As the manufacturer of this device, Integra does not practice medicine and does not recommend this or any other surgical technique for use on a specific patient. The surgeon who performs any implant procedure is responsible for determining and using the appropriate techniques for implanting the device in each patient.

Step 1 • Surgical Approach

Through a medial surgical approach of the great toe, it is possible to have a perfect phalangeal view. A guide pin (1 mm diameter K-wire) will be inserted into the anatomic fossa which is located at the proximal part of the phalanx. The guide pin should be transcortical and horizontal (no upward or downward direction).

Step 2 • Use of the Drill Guide

A cannulated drill (2.2 mm diameter) is placed over the guide pin. A 2.2 mm hole will be drilled through both cortices, taking care to stop drilling as soon as the lateral cortex is perforated. The cannulated drill remains in place.

The drill guide is adjusted in the desired position relative to the interaxis (size of implant) of the Uni-Clip. The drill guide is positioned over the 2.2 mm diameter cannulated drill.
Step 2 • Use of the Drill Guide (Continued)

2-3 The level of the proximal cut is determined at mid-distance between the two legs of the drill guide.

Step 3 • The Resection

3-1 At first, the proximal cut is performed. The cut should be parallel to the 2.2 mm cannulated drill which is still on place. The proximal cut will not be finished completely at first in order to maintain some stability.

3-2 Then, the distal cut is performed which takes into account an eventual variation and/or rotation (supination). Finally, the proximal cut is completely finished.
Step 3 • The Resection (Continued)

3-3 The bone segment is then removed.

3-4 A temporary K-wire (1.0 x 100 mm) is placed as dorsally as possible in order not to compromise the following surgical steps. The reduction of the bone fragments will be performed handling this temporary wire, whereas the dorsal phalangeal aspect will be restored in a sagittal plane.

Step 4 • Distal Drilling

4-1 The drill guide is repositioned over the remaining 2.2 mm proximal drill. The second distal drill hole is performed handling non-cannulated 2.2 drill. The guide should be placed so that the distal drill will enter as plantar as possible. Both cortices should be perforated.

4-2 Once the two parallel holes are drilled, the drill guide, the 2.2 cannulated proximal drill and the proximal guide pin are all removed.

The axial temporary wire is still in place. A final control of the reduction and position of the drill holes is performed.
Step 5 • Setting the Staple

5-1 With the depth gauge, the length of the two legs of the staple is defined. If two different lengths are measured, the longest leg length will be chosen, and the shortest leg can be cut to the appropriate length.

The spreading forceps is used to implant the staple. After inserting the forceps into the olive of the staple, a mild pressure on the forceps allows holding the staple.

5-2 The staple is implanted in the phalanx. The axial wire is removed.
Step 6 • Staple Compression

6-1 The staple is finally impacted using the staple impactor.

6-2 Once the staple is in place, compression is performed by using the spreading forceps to open the olive. The spreading forceps is removed.

Caution
Legs can diverge if too much compression is applied. Figure 6-3 shows the mechanical mechanism of the Uni-Clip.

6-4 Figure 6-4 demonstrates placement of the Uni-Clip in the phalangeal shortening osteotomy.
Step 7 • X-Rays

The x-rays demonstrate the surgical application of Uni-Clip.
Forefoot Set Instrumentation

- Uni-Clip Spreader
- Cannulated Drill Diam. 2.2 mm
- Drill Diam. 2.2 mm
- K-wire 1.0 x 100 mm
- Uni-Clip Impactor
- Depth Gauge
- Uni-clip Drill Guide
- Uni-Clip Staples
## Forefoot Staple and Screw System Ordering Information

### Spin Snap-Off Screw

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### Uni-Clip Compression Screw

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### Container

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- Always refer to the appropriate instructions for use for complete clinical instructions.
- Non contractual document. The manufacturer reserves the right, without prior notice, to modify the products in order to improve their quality.
- Warning: Applicable laws restrict these products to sale by or on the order of a physician.

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