Integra®
Salto Talaris®
Total Ankle System
2015 Instrumentation Upgrade
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Introduction

The 2015 Instrumentation Upgrade represents willingness to respond to our surgeon’s desires and implement change. The updated instrumentation described in this technique is designed with input and ideas from our users. The goals of the updated instrumentation are to increase precision, reproducibility, and efficiency of the bone preparation steps within the Salto Talaris® Total Ankle Prosthesis surgical technique.

This is the third generation of instrumentation for the Salto Talaris implant. We have worked continuously to improve the surgical technique and implantation process of the Salto Talaris implant since its launch in 2006. These changes and those that came before it were all to improve the confidence our surgeons have in their ankle replacement surgery.

Thank you for putting your faith in us to provide you and your patients with an implant that replicates the natural ankle anatomy and a surgical procedure that you can trust.
Specific Indications for Ankle Replacement Surgery

The Salto Talaris® Total Ankle Prosthesis is indicated as a total ankle replacement in primary or revision surgery for patients with ankle joints damaged by severe rheumatoid, post-traumatic, or degenerative arthritis.

All components are intended for cemented use only.

The absolute contraindications that are currently known are:

- Sepsis
- Infection sequelae
- Systemic infection, fever and/or local inflammation
- Complete talar necrosis
- Insufficient quantity of bone stock or poor skin coverage around the ankle joint that would make the procedure unjustifiable
- Persisting skin lesion
- Important ligament laxity
- Severe osteoporosis
- Ankle arthrodesis with malleolar exeresis
- Neuromuscular or mental disorders which might jeopardize fixation and postoperative care
- Neurobiologic diseases
- Nonfunctional lower limb muscles
- Complete loss of ankle collateral ligament
- Charcot’s arthropathy
- Elevation of WBC count
- Distant foci of infection from genitourinary, pulmonary, skin and other sites, dental focus infection which may cause hematogenous spread to the implant site
- Bone immaturity
- Known allergy to one of the materials
- Patient pregnancy
Instrumentation Concept
The instrumentation is designed to achieve accurate and reproducible tibiotalar alignment while adapting to various anatomical conditions, depending on the lesions encountered in the ankle or a particular morphotype.

The broad steps of this Primary operative technique can be summarized as follows.

1) Patient Positioning
The patient is placed in a supine position with a bump under ipsilateral hip to reduce external rotation of the extremity. The heel is placed near the end of the table. A bump under the calf should be used throughout the surgery to keep the heel off the table.

2) Initial Tibial Preparation
The tibial cutting line is first determined using a resection guide to align the cut on the tibia and take into account the geometry and orientation of the tibiotalar joint.

3) Talar Preparation
The talar cut is then refined to approach the resurfacing step in relation to the initial tibial cut.

4) Final Adjustments in the Tibial Implant Position
The mobile-bearing concept has been moved from the implant to the instrumentation at the stage of the trial reduction. The trial tibial base, featuring a highly polished surface that remains mobile against the resected distal tibia, is allowed to rotate into the proper position, thus self-aligning the prosthesis. After this optimal tibiotalar alignment is achieved, the preparation for the tibial keel and plug are completed.

The Salto Talaris® Total Ankle Prosthesis 2015 Instrumentation Upgrade helps to ensure proper positioning of the tibial implant in relation to the talar implant for a successful arthroplasty.
Preoperative Planning:
The preoperative planning for the Salto Talaris® prosthesis is carried out using three standard weight-bearing radiological views:

• Anterior view;
• Anterior view with 30° internal rotation to expose the tibial-fibular joint space.
• Straight lateral.

*Examination of the healthy side should be used for comparison.*

Complementary imaging may be requested to:

• Confirm or reject the indication (CT scan examination for talar necrosis, a relative contraindication for prosthetic replacement);
• Discuss the need for an associated procedure (CT scan of the subtalar joint);
• Modify the technical details (assess the anterior deviation of the knee with panoramic x-ray).

Special consideration should be given to two types of pre-existing conditions.

• Malunions responsible for malalignment of the tibia or imbalance of the malleoli, which may require an initial correction.
• Major ligamentous instabilities demonstrated by an examination under stress will require specific intervention (release of the retracted side or possible need for an associated ligamentoplasty on the lengthened side).

1) Key planning elements determined from the anterior view:

• Choice of an implant size that does not impinge with the lateral malleolus;
• Determination of the ideal joint line level accommodating for articular wear.

*Comparative images are often necessary to assess the prosthetic joint line, which should be located at the theoretical anatomic joint line. The thickness of the tibial resection depends on this determination.*

2) Key planning elements determined from the lateral view:

• Confirmation of the implant size selected from the anterior view;
• Evaluation of the anterior osteophytic margin and assessment of the proposed bone resection required to expose the roof of the pilon;
• Evaluation of talar dome morphology, particularly its degree of convexity;
• Evaluation of talar positioning, which can be centered or retroplaced beneath the pilon. The relative positioning of the tibial and talar components should take into account a possible off-centered location with the understanding that the prosthesis adapts to this position and does not correct it.

*In extreme cases, a pronounced anterior or posterior talar subluxation may preclude implantation of a prosthesis.*
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Comparative images are often necessary to assess the prosthetic joint line, which should be located at the theoretical anatomic joint line. The thickness of the tibial resection depends on this determination.

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• Confirmation of the implant size selected from the anterior view;
• Evaluation of the anterior osteophytic margin and assessment of the proposed bone resection required to expose the roof of the pilon;
• Evaluation of talar dome morphology, particularly its degree of convexity;
• Evaluation of talar positioning, which can be centered or retroplaced beneath the pilon. The relative positioning of the tibial and talar components should take into account a possible off-centered location with the understanding that the prosthesis adapts to this position and does not correct it.
In extreme cases, a pronounced anterior or posterior talar subluxation may preclude implantation of a prosthesis.

General Rules
• The Tibial component size is always the same or one size bigger than the Talar component size.
• The polyethylene insert matches the Talar component size except for the size 0 Talar component which has to be associated with the PE insert size 0 if the Tibia is a size 1 and with a PE insert size 00 if the Tibia is a size 0.

Additional Information
• The tibial implant comes in 4 symmetrical sizes that can all be implanted on either the right or the left ankle.
• The PE insert is clipped onto the tibial base to form a single-block component. The insert thicknesses are named for the tibial base thickness. The inserts therefore come in 4 thicknesses, from 8 to 11 mm (includes thickness of the metallic tibial base + thickness of PE). Unlike the tibial implant, the PE inserts are specific for each side, right and left.
• When the patient’s anatomy requires using a size 0 tibial implant, a size 00 insert must be associated with it (available for each side, right and left), whose width and clipping system are compatible with the size 0 tibial implant, and whose curvature corresponds to that of the size 0 talar implant.
• However, when the patient’s anatomy presents a tibia requiring size 1, but requires use of a size 0 talar component, the intermediary insert must be size 0, whose width and clipping system are compatible with the size 1 tibial implant, and whose curvature corresponds to those of the size 0 talar implant.
Step 1 • Surgical Approach and Exostosectomy of the Distal Tibia

The ankle is opened with a longitudinal anterior incision lateral to the anterior tibialis. This allows for an anterior release and broad arthrolysis with resection of all the osteophytes (Fig. 1). The top of the dome as well as the angles between the pilon and each of the malleoli can be identified precisely using this incision.

If necessary, release of any malleolar attachments can be carried out similarly. The most distal anterior aspect of the tibia and osteophytes are removed with the osteotome (provided in the instrumentation), exposing the tibial pilon and providing a precise view of the talar dome (Fig. 2).

Resect until the end of the osteotome reaches the tibial pilon roof. The osteotome placed into the joint space determines the reference position for placement of the tibial alignment guide (see next step).

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 2 • Positioning the Tibial Alignment Guide

The guide should be aligned parallel to the tibia’s mechanical axis; this is a determining factor in all the resections performed during the procedure (Fig. 3).

First check that all of the guide’s set screws are unscrewed.

Place a 110 mm self-drilling pin at the ATT in the neutral hole (Fig. 4), with the alignment guide parallel to the tibial crest.

Items Used:
Tibial Alignment Guide: MJU333T
Pins, 110 mm: MJU093T

Align the pin guide to position 0 at the resection and set this position with the lateral set screw. If necessary, position the osteotome in the joint space, so that it will be parallel with the distal plane of the tibial guide (Fig. 5).

Then position the most distal part of the guide on the osteotome. Translation movement is possible as soon as the central set screw of the tibial alignment guide is loosened. Tighten the central set screw using a screwdriver and remove the osteotome.

Fig. 3: Frontal plane: The axis of the tibial resection guide should be made parallel to the tibia’s mechanical axis. Adjustments for tibial varus/valgus can be made by choosing the proper hole of the proximal pin guide.

Fig. 4

Fig. 5
Insert a second 110 mm self-drilling pin distally through the guide’s medial hole, positioning the alignment guide’s axis in the center of the inferior metaphysis (Fig. 6).

The distal flange of the tibial alignment guide should rest at the level of the exostectomy, elevated slightly off the tibial shaft for smooth translation during the height adjustment.

**Caution**

The other 75 and 45 mm pins provided in the instrumentation are not self-drilling. In the following steps, preparatory drilling with a 2.9 mm drill bit is mandatory before pins can be inserted.

The Tibial Slope Positioning Part can be changed to a 3° posterior slope from the standard 7° posterior slope if desired. To change the part, remove the set screw holding the Tibial Slope Positioning Part in place and replace with the 3° Tibial Slope Positioning Part.

**Items Used:**
- Tibial Alignment Guide: MJU333T
- Pin, 110 mm: MJU093T
- Hex Driver, 3.5mm: MLN113T
- 3 Degree Block, Tibial Alignment: MJU668T

**Step 3 • Adjusting the Alignment Guide**

**Frontal plane:** The axis of the tibial cut guide should be made parallel to the tibia’s mechanical axis by choosing the proper hole of the proximal pin guide (Fig. 7).

**Sagittal plane:** With both flanges in contact with the tibia, the cut guide is adjusted parallel to the anterior tibial crest (Fig. 8).

At this stage, a genu varum or a genu valgum deformation can be corrected by moving the (Fig. 3a) proximal guide medially or laterally over the pin, making it possible to implant the prosthesis strictly perpendicular to the tibial axis to compensate for an axis defect, to give greater importance to the horizontality of the tibiotalar joint line. The timing and degree of this compensation should be discussed for each case (possibility of secondary knee surgery, subtalar joint stiffening in a position that compensates the axis).

Once the guide is positioned in the frontal and sagittal planes, the set-up is finalized by tightening the set screw of the superior guide and the medial set screw tightening on the distal 110 mm pin.

**Note**

At the end of the surgery, 7° tibial slope positioning part must be reassembled onto the tibial alignment guide and put back in the YKAL11T box. MJU668T 3° guide must be put back in the YKAL14T box.
Step 4 • Final Adjustment of Cutting Height, Rotation, and Lateral Position Height Adjustment

The cutting level determined during preoperative planning is transferred to the distal resection guide by translating it (Fig. 9).

Caution
When determining the cutting level during surgery, any significant wear or loss of substance on the tibia must be taken into account. For an unworn tibial pilon, the recommended cut is 9 mm above the tibial pilon roof, which corresponds to adding the thickness of the tibial plate (4 mm) to the lowest thickness of the PE inserts (4 mm).

Rotational and mediolateral positioning:
The tibial alignment jig, used for mediolateral and rotational adjustment of the implant, is attached to the tibial alignment guide.

Adjustments are made as follows:
• Utilizing the Foot Holding device. Place the device under the ankle and grasp the midfoot tightly to the device ensuring that the posterior aspect of the foot holder is in contact with the posterior aspect of the lower leg. Use the grip to hold the foot and ankle in a neutral position (Fig. 10)
• Rotational adjustment: Insert a 110 mm pin into the guide’s adjustable arm. The pin in the adjustable arm should be centered in the joint and also be in line between the 2nd and 3rd metatarsal. (Fig. 11)

Once the rotational position has been adjusted, the guide’s rotational adjustment set screw (Screw C) is tightened.

• Mediolateral adjustment: The tibial implant size planned preoperatively is confirmed through a series of lateral and medial holes on the guide.

The different implant sizes available (0, 1, 2, and 3) are on the guide; hence the size is confirmed by inserting two 75 mm pins in the medial and lateral holes and by positioning them at the angles formed by the malleoli (Fig. 11). Once the mediolateral position has been adjusted, the guide’s mediolateral adjustment set screw (screw b) is firmly tightened with a screwdriver.

* Remember, this does not commit you to the selected size.
Step 5 • Preselection of Talar Implant Size

Before proceeding to resecting the tibia and to match the tibial and talar sizes, the size of the talar implant selected preoperatively can be confirmed. Two mediolateral Talar Gauges are included in the instrumentation for the talar implants. The talar gauge (0, 1, 2, or 3) selected during preoperative planning is placed on the first 1/3 of the talar dome (Fig. 12). It should have the same width as the talar dome width. As shown in the implant compatibility table (see p. 6), a talar implant that is one size smaller than the tibial implant can be used.

Items Used:
- Talar Gauge, Size 0, 1: MJU331T
- Talar Gauge, Size 2, 3: MJU364T

Step 6 • Placing the Cutting Guide

Depending on the size chosen at the preoperative planning stage and in accordance with the size determined from the tibial alignment jig, tibial resection guide N°. 0, 1, 2 or 3 is chosen. This unit is attached to the alignment guide by tightening the set screw (Fig. 13).

Caution
Precautions before use: Once all the adjustments have been made and before using the oscillating saw, make sure that the guide is sitting on the anterior tibia and all the set screws have been firmly tightened with the screwdriver provided in the instrumentation. An AP fluoroscopy image may be utilized to ensure proper alignment of the cut guide.

Items Used:
- Tibial Cut Guide Sizes 0 - 3:
  - Size 0: MJU645T
  - Size 1: MJU646T
  - Size 2: MJU647T
  - Size 3: MJU648T

Items Used:
- Tibial Alignment Jig: MJU334T
- Pins, 75 mm and 110 mm: LJU098T, LJU089T
- Foot Holding Fixture: MJU664T

Caution
Since this guide is not a cutting guide, do not drill through the holes. The pins inserted in the holes are used only to verify that the tibial plate is properly positioned. They are inserted in the holes but not drilled.
Step 7 • Preparation for Tibial Bone Cut

Using the reamer, drill the pin holes on the guide. Insert a 75 mm pin into each hole. These pins protect the sweep of the oscillating saw blade during the horizontal cut as well as the proximal migration of the reciprocating saw blade during the vertical cuts. (Fig. 14, 15)

Items Used:
Reamer: LJU097T
Pins, 75 mm: MJU907T
Saw Blade, Wide, Stryker 7: SAW5945T
Saw Blade, Wide, Hall Versipower: SAW5947T
Saw Blade, Wide, Hall Powerpro: SAW5949T
Recip. Saw Blade, 75 mm x 8 mm: SAW5950T
Pin Puller: MJU359T

Step 8 • Tibial Cut

The horizontal tibial resection is performed with an oscillating saw blade (Fig. 15), extending carefully to the back, as far as the posterior cortex.

The vertical resection is performed through the slots on the medial and lateral aspects of the guide with the provided end cutting reciprocating saw. Care needs to be taken to avoid unwanted inferior contact in the gutters with the reciprocating saw blade. The cut should extend up to the pins that are seated in the guide. (Fig. 16)

Once the cuts have been made, resect the anterior half of the distal bone, which is easily accessible. The remaining posterior resection is easily completed after the talar resection. At this stage, the goal is to be able to straighten the foot at a right angle below the tibia.

Care should be taken to avoid over penetration of either oscillating or reciprocating saw blade beyond the posterior cortical bone. Be sure to use only the oscillating saw for the horizontal cut and only the reciprocating saw for the vertical cuts.

Items Used:
Reamer: LJU097T
Pins, 75 mm: MJU907T
Saw Blade, Wide, Stryker 7: SAW5945T
Saw Blade, Wide, Hall Versipower: SAW5947T
Saw Blade, Wide, Hall Powerpro: SAW5949T
Recip. Saw Blade, 75 mm x 8 mm: SAW5950T
Pin Puller: MJU359T
Step 9 • Preparing the Posterior
Talar Cut/Inserting Talar Guide Pin

The posterior cut of the talus depends on the tibial cut performed earlier. The talar pin setting guide is positioned on the tibial alignment guide. Drilling is performed while maintaining the foot in neutral, with no rotation, varus, or valgus utilizing the Foot Holder. Grasping the Foot Holder closely to the bottom of the foot will help to maintain a neutral position preventing rotation of the talus and hold the foot in slight (2–3°) of plantar flexion. Choose a hole in the Talar Pin Guide that allows the pin to enter the talus inferior to the articular surface. (Fig. 17, 18).

Confirm in a lateral view that the reamer is pointing to the superior 20% of the subtalar joint. (Fig. 19)

Once reaming has been performed, the talar pin setting guide is withdrawn, a 75 mm or a 110 mm cutting guide pin is inserted in the hole (Fig. 20, 21).

Items Used:
Talar Pin Guide: MJU335T
Reamer: LJU097T
Pin, 75 mm: LJU098T
Step 10 • Setting the Talar Resection Guide and the Talar Pins

Two posterior talar dome resection guides are provided, one for size 1, 2, or 3 talar implants and the other for size 0. To take into account any symmetrical or asymmetrical wear of the talar dome, one or two height-compensating paddles should be assembled on the guide selected. Six augments are provided for 1, 2, or 3 mm height compensations.

The posterior talar dome resection guide with no height-compensating augments should be used when there is no asymmetrical talar dome wear.

The posterior talar dome resection guide is placed onto the talar pin that has been attached on the neck (Fig. 22); then it’s two paddles, with or without height compensating augments, are placed on the superior surface of the talar dome. The paddles should rest on the talar dome and under any of the remaining tibial plafond.

The front set screw stabilizes the resection guide position.

Comment: Before tightening the front set screw, the guide can also be stabilized using two joint distractors, each leveraged on the paddles on one side and the tibial cut on the other side. In this case, care should be taken to position the leverage point of these forceps at the upper edges of the talar dome, to prevent the resection guide from bending the talar pin and thereby tipping anteriorly.

The two pin holes on either side of the cutting slot should be reamed and filled with the 75 mm pins to stabilize the guide and protect from the sweep of the oscillating blade. A lateral fluoroscopy image should be taken to ensure that the paddles are positioned on top of the talar dome. (Fig. 23)

Also, if needed, the ribbon retractors should be used to protect the malleoli from the sweep of the oscillating saw.

Once the guide is stabilized (Fig. 24) the talus can be cut through the guide with the oscillating saw using either the narrow or wide blade depending on the width/size of the talus.

At this stage, after the talar dome is resected, the posterior portion of the distal tibial resection and the posterior arthrolysis can be completed. Any remnant of bone laterally on the distal tibia should be removed with rongeurs.

Do not remove the talar pin after this step.
Step 11 • Anterior Talar Chamfer

The anterior chamfer determines the Anteroposterior positioning of the talar implant beneath the tibial implant. There are two sizes. The standard size and the large size correspond to the size of the talus. Selecting the correct anterior chamfer for the talus will reduce the amount of extra bone removal after reaming.

Assemble the correct size of the anterior chamfer guide to the handle (MJU342)

After removal of the osteophytes from the talar neck, the guide for the anterior chamfer is guided into place by the inserting the guide onto the same Talar Guide Pin used to position the posterior chamfer cut guide in Step 10. (Fig. 26)

Before reaming, position the guide by using the Talar Position Spacer, inserted into the oblong window of the anterior chamfer guide. (Fig. 27) Once the spacer is in place, position the foot at 90° in the neutral position. The anterior cortex of the tibia should be tangent to the calibration line on the spacer. (Fig. 28) If the guide is too far anterior or posterior it must be repositioned to correct the resection level of the talus. One or both of the additional talar pin holes may be used to aid in stabilization of the guide by reaming first then using a 45 mm pin.

Items Used:
Posterior Chamfer Guide, Size 1,2,3: MJU642T
Posterior Chamfer Guide, Size 0: MJU641T
Joint Distractor Model A, B: MJU345T, MJU346T
Reamer: LJU097T
Pin, 75 mm: LJU098T
Saw Blade: SAW5944T or SAW5946T or SAW5948T
CARE MUST BE TAKEN TO AVOID BICORTICAL DRILLING OR PIN PENETRATION OF THE INFERIOR ASPECT OF THE TALAR NECK.

The guide can be further stabilized using one or two distractive clamps whose ends fit into the guide’s indentations.

The reaming guide is assembled onto the anterior chamfer guide and the cut is made using the reamer in two steps by turning the reaming guide over (Fig. 29); finishing the resection at the medial and lateral margins requires trimming with a rongeur.

If the size 2/3 anterior chamfer guide is used the specific size 2/3 reaming guides using three steps to complete the anterior chamfer reaming. First ream the medial and lateral sides using the reversing reaming guide, then use the middle reaming guide for the center portion of the anterior chamfer. Finish the anterior chamfered surface on the medial, lateral, and center margins with a rongeur. (Fig. 30)

Note
The use of this specific talar anterior chamfer is not recommended if talar dome is badly damaged. Use common instrument MJU336.

Items Used:
Anterior Chamfer Guide, Size 0.1: MJU643T
Anterior Chamfer Guide, Size 2.3: MJU665T
Talar Position Plug, Size 0.1: MJU644T
Wider Talar Position Plug, Size 2.3: MJU666T
Holding Clamp: MJU048T
Anterior Chamfer Reaming Guide: MJU339T
Anterior Chamfer Bush, Wide, Step 1,2: MJU667T, MJU669T
Anterior Talar Reamer: MJU338T
Pin Pusher: MJU365T
Reamer: LJu097T
Pins, 45 mm: LJu099T
Handle, Lateral Chamfer Guide: MJU342T
Step 12 • Positioning of the Preliminary Talar Trial, Lateral Cut, Plug Instrument

Position the Preliminary Talar Trial that best fits the talus while resting on top of the posterior and anterior chamfer cuts. The trial should cover, but not extend past the boarders of the cortical wall of the talus both medially or laterally. If the size of the talus seems to be between two of the trial sizes align the trial with the lateral cortical boarder allowing the medial boarder to be exposed.

The Apex of the posterior and anterior chamfer should align with the laser mark on the trial from the surgeon’s perspective. At this time a lateral fluoroscopy image can be taken to ensure that the trial matches the anterior and posterior chamfer cuts and that the trial is under the center of the tibial long axis. (Fig. 31)

At this time it is possible to trial the tibial construct to check for ligamentous congruency. See Step 14 for instructions on the assembly of the tibial trial (Fig. 34) with the fluoroscopy check positioning. The lateral view (Fig. 32) should show the crest of the talar dome centered under the long axis of the tibia. The A/P view (Fig. 33) should show the talar trial centered on the talus and in line with the rotation of the ankle mortise.

Once proper position is achieved the trial can be reamed and secured with a 45 mm pin.
A joint distractor can be inserted into the joint to maintain position while performing the bell saw cut. The Bell Saw Drill Bushing is inserted into the trial. The Bell Saw drill is used to make the Bell Cut. Once the Bell Cut is achieved the Fixation Plug is used to maintain the trial position. (Fig. 35)

After removing the distractor the lateral chamfer can now be cut through the trial with a narrow oscillating saw or reciprocating blade. A ribbon retractor can be used to protect the lateral malleolus. (Fig. 36)

Once the lateral cut is finished the Preliminary Trial can be removed and any remaining cortical bone can be removed from the talus with a rongeur.

**Size Zero Talar preparation: For size 0 talar preparation the size 0 drill Bushing needs to be used along with the 7.9 mm drill for the talar plug hole.**

**Items Used:**
- Talar Guide/Trail, Size 0, Left: MJU661T
- Talar Guide/Trail, Size 1, Left: MJU653T
- Talar Guide/Trail, Size 2, Left: MJU655T
- Talar Guide/Trail, Size 3, Left: MJU657T
- Talar Guide/Trail, Size 0, Right: MJU660T
- Talar Guide/Trail, Size 1, Right: MJU652T
- Talar Guide/Trail, Size 2, Right: MJU654T
- Talar Guide/Trail, Size 3, Right: MJU656T
- Handle, Lateral Chamfer Guide: MJU342T
- Bell Saw Reamer: MJU344T
- Drill Guide, Bell Saw, Size 1,2,3: MJU649T
- Drill Bit, Talar Stem, Size 0: MJU362T
- Drill Guide, Bell Saw, Size 0: MJU662T
- Joint Distractors A and B model: MJU345T/MJU346T
- Fixation Plug, Size 0: MJU082T
Step 13 • Placing the Trial Talar Implant

The trial talar implant corresponding to the operated side and the size that has been chosen beforehand is put in place first.

Available for both right and left sides, properly positioning the trial implant is vital to respect the patient’s anatomy and ensuring long-lasting postoperative results:

- In accordance with the talus anatomy, the talar implant is wider anteriorly than posteriorly.
- The lateral side of the malleolus reproduces the talofibular joint.

Once this has been checked, the trial implant plug is inserted in the blind hole that was made previously with the bell saw for sizes 1, 2, and 3, or with the drill for size 0.

The trial implant is impacted with the talar component impactor. (Fig. 37)

Items Used:
- Talar Component Impactor: MJU351
- Talar Trial, Size 0, Right: MJU100T
- Talar Trial, Size 1, Right: MJU101T
- Talar Trial, Size 2, Right: MJU102T
- Talar Trial, Size 3, Right: MJU103T
- Talar Trial, Size 0, Left: MJU110T
- Talar Trial, Size 1, Left: MJU111T
- Talar Trial, Size 2, Left: MJU112T
- Talar Trial, Size 3, Left: MJU113T

Fig. 37

Fig. 38 Placing the trial talar implant: The trial implant is impacted with the talar component impactor. Confirm talar position is squarely under the mechanical axis of the tibia.
Step 14 • Dynamic Test and Drilling of Tibial Plug

The plastic trial insert is selected depending on:

• Size and side, which must be identical to the size of the talar implant. A color code is used to simplify this step (see compatibility table, p. 36).

• Thickness: they vary from 8 to 11 mm and correspond to the accumulated thicknesses of the metallic base and the PE.

The trial tibial base is selected to conform to the planned tibial implant size.

The trial insert (right or left) is clipped on the trial tibial base forming a monoblock device. A correct orientation system automatically checks that the trial insert is properly oriented on the tibial trial. The tibial base is then inserted between the trial talar implant and the tibia. (Fig. 39)

A dynamic flexion/extension test is performed on the foot to check the joint’s kinematics. The tibial trial will naturally find its optimal position in the frontal and sagittal planes as well as in the rotational plane (Fig. 40, 41).

At this stage, one must check that the engraved line on the superior surface of the tibial trial (the side in contact with the tibial cut) is aligned with the anterior cortex of the tibia.

If this line simulating the final anterior extremity of the tibial implant is too far anterior, the alignment must be forced when drilling the tibial plug. On the other hand, if the line is located posterior to the anterior cortex of the tibia, the final tibial implant should be positioned in the same way.

AT THIS POINT, IT IS ESSENTIAL TO VERIFY THAT THE TRIAL TIBIAL IMPLANT BASE IS PERFECTLY PLACED ON THE RESECTED TIBIA.
A lateral fluoroscopy image is taken to confirm that the tibial plate is flush with the distal tibia prior to drilling.

Preparation of the tibial implant keel begins using the drill (2.9 mm diameter). The two inferior holes are drilled, then the trial tibial base is held by a 45 mm pin in the distal hole (Fig. 42). This operation will prepare for the tibial keel. The tibial plug is performed using a drill bit (7.9 mm), guided into the trial’s upper hole. (Fig. 43)

Drilling through the tibial base guide gives a 4° angle from the tibial base plate, aiming for a press-fit of the final implant between the keel and the distal cut during impaction.

Consideration must be given to possible adjunct soft tissue balancing procedure at this stage (i.e. Achilles tendon lengthening, ligament release and repair

**Items Used:**

Tibial Trial, Size 0: MJU380T
Tibial Trial, Size 1: MJU384T
Tibial Trial, Size 2: MJU385T
Tibial Trial, Size 3: MJU386T
Drill Bit, 7.9 mm: MJU353T
Pin, 45 mm: LJU099T

Trial Insert Size 00:
Right: MJU545T to MJU548T
Left: MJU555T to MJU558T

Trial Insert PE Size 0:
Right: MJU565T to MJU568T
Left: MJU575T to MJU578T

Trial Insert PE Size 1:
Right: MJU585T to MJU588T
Left: MJU595T to MJU598T

Trial Insert PE Size 2:
Right: MJU605T to MJU608T
Left: MJU615T to MJU618T

Trial Insert PE Size 3:
Right: MJU625T to MJU628T
Left: MJU635T to MJU638T
Step 15 • Finishing Touches on the Tibial Keel

Once the plug has been placed, the monoblock trial insert is removed. (Fig. 44)

The tibial holes are rejoined using a small osteotome; then the thickness and depth of the engraved line are checked with the graduated osteotome. (Fig. 45)

The distal part of the anterior groove of the tibia is beveled using the rasp, so that the tibial implant lies flush on the resection. (Fig. 46).

With the different tibial implant sizes (0, 1, 2 and 3) marked on the upper surface of the rasp, the trimming done in this manner perfectly matches the length of the implant selected.

The trial talar is then withdrawn.

Items Used:
Osteotome, Tibial Keel: MJU387T
Rasp, Tibial Flange: MJU350T
Osteotome, Thin: MJU357T
Step 16 • Placing Final Implants

1 - The talar implant is placed first, following the same procedure as described during the placement of the trial talar implant. It is impacted with the talar component impactor (Fig. 47).

The size and side selected during the implant trials must be retained.

2 - The final PE and tibial implant form a single-block unit and therefore they should be assembled with a clamp available in the instrument kit.

**ASSEMBLY OF THE INSERT ON THE TIBIAL IMPLANT**

The polyethylene insert is assembled to the tibial implant with the tibial press.

The tibial implant is mounted onto the press. The PE insert is positioned on the implant and manually pushed to engage approximately 1/3 of the depth (Fig. 48). Close the press arm over the assembly and continue to press down until the PE is fully engaged. The tibial assembly must be visually checked by the operator. Generally, an audible “click” is heard. (Fig. 49)

The tibial component now composed of the base and PE insert, is grasped in the implant assembly between the metallic plug and the central anterior zone of the tibial, using the tibial impactor. (Fig. 50)

**Items Used:**
Insert Assembly Press, Primary: MJU663T
Tibial Impactor: MJU361T
Talar Component Impactor: MJU351T
The tibial component is impacted until the position of the tibial trial is reproduced.

During tibial implant impaction, maintain good contact between the upper side of the implant and the tibial resection to prevent any risk of a posterior gap between the tibial cut and the implant (Fig. 51).

Flexion/Extension movements are applied to check the ankle kinematics. Shaped using the osteotomes provided in the instrumentation, a bone graft is applied to it using a graft remover in the tibial window (Fig. 52).

Note: The Salto Talaris is indicated for cemented use only. Cement may be applied to the bone contact surfaces of the tibial and talar component.

Step 17 • Revising or Removing Implants

If the implant must be revised, revision should begin by removing the PE insert.

This is disassembled from the tibial base by inserting the insert extractor blade between the base and the PE. A towel clamp holds the PE component for its extraction, after a lever maneuver using the extractor has separated the two components. If necessary, the tibial base can then be removed as follows:

• To precut the bone around the tibial plug, use the osteotomes provided for this purpose in the instrumentation.
• Hook the posterior aspect of the tibial implant with the tibial component extractor.
• Insert the extractor plug by screwing the slap hammer on the tibial extractor.
• Push and pull vigorously with the slap hammer until the implant is fully removed.

The talar implant is separated from the talus with the osteotome.

Items Used:
Tibial Implant Extractor: MJU368T
Osteotome, Thin: MJU357T
Insert Extractor: MJU058T
Slap Hammer: MJU358T
Osteotome, Tibial Barrel, Revision: MJU356T
### Instrumentation Case Reference: YKAL11T Top

**Top Tray – Reference: YRAL11T Top**

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![Image of Instrumentation Case Reference: YKAL14T Top](image)

**Reference: YRAL14T Top**

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### Talar Implants: CoCr

<table>
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<tr>
<th>Reference - Left</th>
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<th>Size</th>
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<tbody>
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<td>LJU210T</td>
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</tr>
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<td>LJU211T</td>
<td>LJU201T</td>
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</tr>
<tr>
<td>LJU212T</td>
<td>LJU202T</td>
<td>Size 2</td>
</tr>
<tr>
<td>LJU213T</td>
<td>LJU203T</td>
<td>Size 3</td>
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### Fixed Inserts: UHMWPE

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<th>Thickness</th>
<th>Size</th>
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<tbody>
<tr>
<td>LJU241T</td>
<td>LJU240T</td>
<td>8 mm</td>
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<tr>
<td>LJU241T</td>
<td>LJU240T</td>
<td>9 mm</td>
<td>Size 0</td>
</tr>
<tr>
<td>LJU242T</td>
<td>LJU241T</td>
<td>10 mm</td>
<td>Size 0</td>
</tr>
<tr>
<td>LJU242T</td>
<td>LJU241T</td>
<td>11 mm</td>
<td>Size 0</td>
</tr>
<tr>
<td>LJU225T</td>
<td>LJU225T</td>
<td>8 mm</td>
<td>Size 1</td>
</tr>
<tr>
<td>LJU226T</td>
<td>LJU226T</td>
<td>9 mm</td>
<td>Size 1</td>
</tr>
<tr>
<td>LJU227T</td>
<td>LJU227T</td>
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<td>Size 1</td>
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<tr>
<td>LJU228T</td>
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<tr>
<td>LJU255T</td>
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<tr>
<td>LJU256T</td>
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<td>Size 2</td>
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<tr>
<td>LJU257T</td>
<td>LJU257T</td>
<td>10 mm</td>
<td>Size 2</td>
</tr>
<tr>
<td>LJU258T</td>
<td>LJU258T</td>
<td>11 mm</td>
<td>Size 2</td>
</tr>
<tr>
<td>LJU275T</td>
<td>LJU275T</td>
<td>8 mm</td>
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<tr>
<td>LJU276T</td>
<td>LJU276T</td>
<td>9 mm</td>
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</tr>
<tr>
<td>LJU277T</td>
<td>LJU277T</td>
<td>10 mm</td>
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</tr>
<tr>
<td>LJU278T</td>
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Disposables – Sterile Single Use Only

### Saw Blades

<table>
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<tr>
<th>Integra No.</th>
<th>SAW5944T</th>
<th>SAW5945T</th>
<th>SAW5946T</th>
<th>SAW5947T</th>
<th>SAW5948T</th>
<th>SAW594T</th>
<th>SAW5950T</th>
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<tbody>
<tr>
<td>Depth</td>
<td>70.0 mm</td>
<td>85.0 mm</td>
<td>80.0 mm</td>
<td>90.0 mm</td>
<td>75.0 mm</td>
<td>90.0 mm</td>
<td>70.0 mm</td>
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<tr>
<td>Width</td>
<td>13.0 mm</td>
<td>21.0 mm</td>
<td>13.0 mm</td>
<td>21.0 mm</td>
<td>13.0 mm</td>
<td>21.0 mm</td>
<td>12.5 mm</td>
</tr>
<tr>
<td>Mtl Thk</td>
<td>1.24 mm</td>
<td>1.24 mm</td>
<td>1.24 mm</td>
<td>1.24 mm</td>
<td>1.24 mm</td>
<td>1.24 mm</td>
<td>0.94 mm</td>
</tr>
<tr>
<td>Cut Thk</td>
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<td>1.27 mm</td>
<td>1.27 mm</td>
<td>1.27 mm</td>
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<td>1.27 mm</td>
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</tr>
<tr>
<td>Hub</td>
<td>Stryker System 7</td>
<td>Stryker System 7</td>
<td>Hall Versipower</td>
<td>Hall Versipower</td>
<td>Hall Power Pro</td>
<td>Hall Power Pro</td>
<td>Brasseler</td>
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### Pin Pack: LJU095T Includes:

<table>
<thead>
<tr>
<th>Description</th>
<th>Reference</th>
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<tbody>
<tr>
<td>3 x 110 mm Self-drilling Pins</td>
<td>LJU089T</td>
</tr>
<tr>
<td>5 x 75 mm Pins</td>
<td>LJU098T</td>
</tr>
<tr>
<td>3 x 45 mm Pins</td>
<td>LJU099T</td>
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<tr>
<td>Reamer</td>
<td>LJU097T</td>
</tr>
</tbody>
</table>

### Drill Bit

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DWD060T</td>
<td>1 x 3 mm length 220 mm</td>
</tr>
</tbody>
</table>
Compatibility Table

Component Comparison Chart
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Available in US Only

- 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.

For more information or to place an order, please contact:

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USA 800-654-2873 • 888-980-7742 fax
International +1 609-936-5400 • +1 609-750-4259 fax
integralife.com/contact

Manufacturer:
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8700 Cameron Road, Suite 100
Austin, TX 78754 USA