Valid on 13 Aug 2024

Moto® LATERAL

PARTIAL KNEE SYSTEM

Surgical Technique

Joint | Spine | Sports Med

Medacta International

CAUTION

- Some specific instruments are fixed to the bone by means of dedicated pins. Before using the pins, ensure that they are intact and fully functional. BENT OR DEFECTIVE PINS CANNOT BE USED AND MUST BE REPLACED WITH NEW ONES. Pin extraction must be performed as to avoid pin bending. This results in axial alignment between the pin and the dedicated extractor
- It is strongly recommended not to impact or hammer on any instruments unless otherwise specified in the surgical technique

For detailed instructions contact your local Medacta sales representative.

TABLE OF CONTENTS

1. INTRODUCTION

This brochure describes the surgical technique of the MOTO Partial Knee System for a lateral unicompartmental knee replacement.

MOTO Lateral is designed to replace the lateral compartment of the knee. The system contains both implants and instruments designed to enable the surgeon to perform a safe and reproducible unicondylar reconstruction of the knee; assessing soft tissue balance of the knee at each step. MOTO Lateral consists of femoral, tibial base and tibial insert components.

1.1 INDICATIONS

The MOTO Partial Knee System is designed for cemented use in partial knee arthroplasty, if there is evidence of sufficient sound bone to seat and support the components. Partial lateral knee replacement is indicated in patients with isolated lateral compartment osteoarthritis, isolated trauma to the lateral femoral condyle or tibial plateau requiring joint replacement, avascular necrosis of the lateral femoral condyle.

1.2 CONTRAINDICATIONS

Partial knee replacement is contraindicated in the following cases:

- Progressive local or systemic infection.
- Muscular loss, neuromuscular disease or vascular deficiency of the affected limb, making the operation unjustifiable.
- Osteoporosis or osteomalacia
- Metabolic disorders which may impair bone formation.
- Rapid destruction joint, maked bone loss or bone resorption apparent on radiograph.
- Incomplete or deficient soft tissue surrounding the knee.
- Severe instability secondary to advanced destruction of condylar structures
- Unicompartmental knee replacement is contraindicated in patients who have a permanent valgus or varus deformity that requires correction in order for the knee to function satisfactorily post-operativly

Mental or neuromuscular disorders may create an unacceptable risk to the patient and can be a source of postoperative complications. It is the surgeon's responsibility to ensure that the patient has no known allergy to the materials used.

1.3 TECHNIQUE PHILOSOPHY

Unicompartmental knee arthroplasty (UKA) is primarily a soft tissue surgery, and 1 mm resections of bone truly makes a difference. The MOTO Lateral technique is based on key intra-op erative check points and precise bone resection options with the aim to achieve soft tissue balance and stability of the knee throughout the entire range of motion.

Aim for a slight alignment under-correction and have appropriate ligamentous tension restored, with physiologic gap laxity. It is suggested to aim for a varus/valgus opening of 2 mm in extension and 3 mm in flexion.

The most important feature of this technique is the tibial cut, which drives the remaing bone resections. This is a two-step procedure, performed using adjustable "Shims" and "Spacers" to evaluate the initial resection and refine it, if needed, to ensure the appropriate minimum tibial resection is achieved.

Flexion and extension gaps are then balanced independently by appropriate femoral bone resections.

2. PRE-OPERATIVE PLANNING

2.1 RADIOLOGICAL PLANNING

Full length anterior-posterior, lateral, skyline and Rosenberg radiographs are required to determine the unique alignment and global severity of knee disease. Valgus stress x-rays are used to determine compartment compliance and medial compartment integrity.

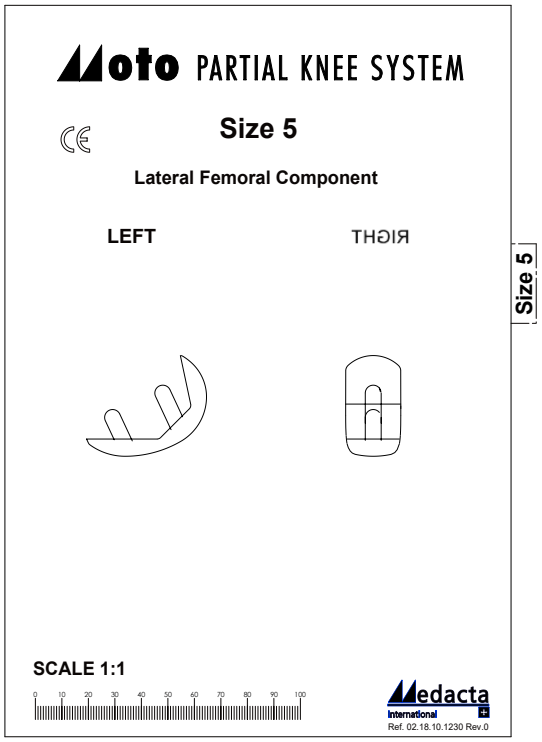
2.2 CLINICAL PLANNING

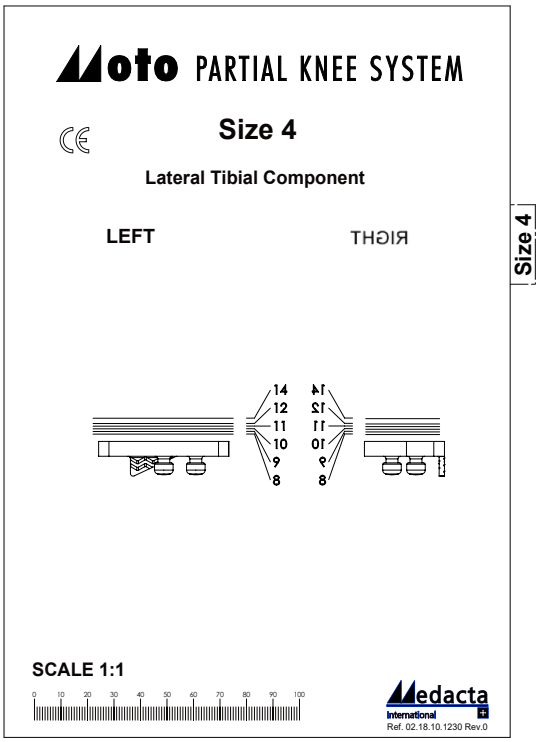
The goals are to assess the location of pain, range of motion, strength, ligamentous stability and patellofemoral function.

2.3 PREOPERATIVE X-RAY TEMPLATE

The size of both femoral and tibial components can be estimated preoperatively by means of X-ray templates.

Available templates allow for a magnification factor of: 100% (1:1, standard), 110% (available on demand) and 115% (available on demand).





3. SURGICAL APPROACH

3.1 LIMB POSITIONING

With the patient in the supine position, two common options for positioning the limb are:

- Adjustable leg holder with the standard operating table: The lower limb is prepped and draped free below the tourniquet (if used).
- Leg free hanging: The non-operative leg is placed in a leg holder and the operative leg is positioned hanging free with about 15-20° of hip flexion. It is prepped and draped free below the tourniquet (if used).

1.

3.2 INCISION AND EXPOSURE

With the knee at 90° of flexion, make a straight incision starting 1 cm above the superior pole of the patella. It should extend distally to just lateral of the tibial tubercle, and overlap the lateral 1/5 of the patella.

Use sharp dissection to expose the capsule and subcutaneous flaps.

Begin the arthrotomy along the lateral border of the patella and extend distally to just lateral of the tibial tubercle. At its upper end, the incision should extend approximately 1 cm into the vastus lateralis.

TIP

Do not hesitate to extend the incision as needed for visualization and/or protection of soft tissues.

2.

Exchange the superficial retractor for a deep retractor. Resect the anterior horn of the lateral meniscus and the lateral portion of the retropatellar fat pad. This will expose the lateral compartment and the intercondylar notch.

Perform a minimal dissection along the lateral joint line from the patellar tendon, laterally, to allow for tibial plateau exposure and retractor placement.

Examine the anterior cruciate ligament (ACL) and medial compartment and confirm the wear pattern on the lateral tibial plateau and lateral femoral condyle.

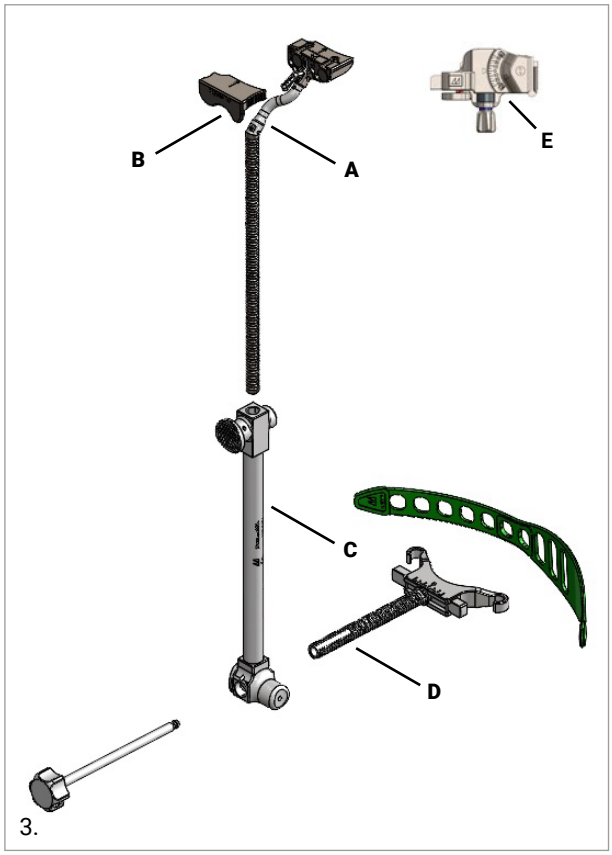
3.3 OSTEOPHYTE RESECTION

Do not initially remove osteophytes from the lateral femoral condyle or lateral tibial plateau. Due to their often small size, the osteophytes may be beneficial for implant stability. (These osteophytes can be judiciously trimmed when trial implants are in place, keeping in mind the effects of osteophyte resection on ligament balance.) However, trim any notch osteophytes and lateral patellar osteophytes upon exposure.

4. TIBIAL RESECTION

4.1 ASSEMBLING AND POSITIONING THE EXTRA-MEDULLARY ALIGNMENT GUIDE

The tibial extramedullary system consists of the following components:

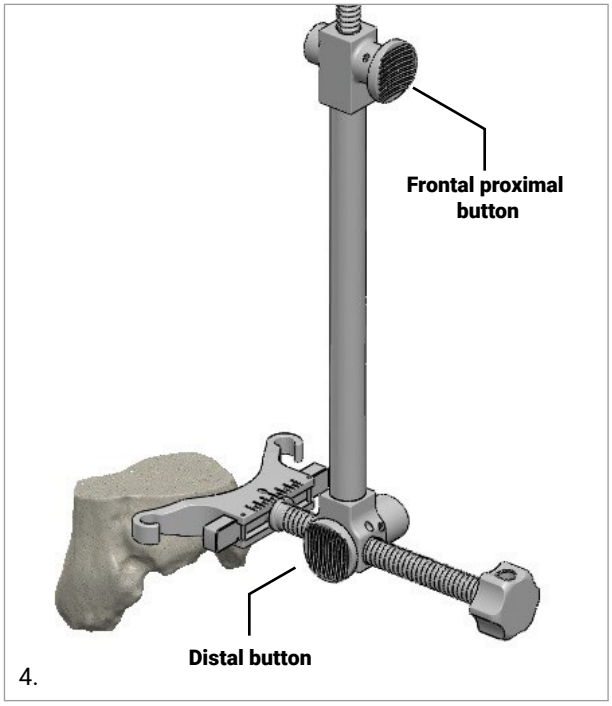


3.

- A - Tibial cutting guide - Right or Left
- B - Shim (0 mm, +1 mm, +2 mm, +3 mm, +4 mm, +5 mm) - Right or Left
- C - Extramedullary guide - distal part
- D - Ankle clamp (body + v/v regulation screw + silicon strap)
- E - Tibial sagittal cutting guide

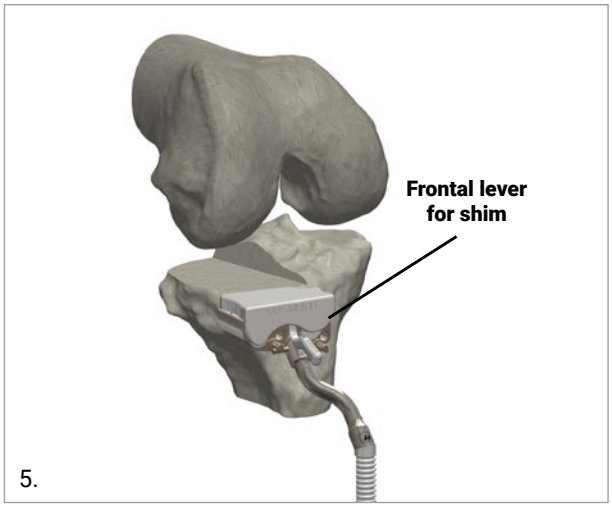
Pushing the distal button of the extramedullary guide - distal part (C), slide the ankle clamp body (D) onto the distal "D-shape" dovetail of the extramedullary guide. Release the button, insert the screw for varus/valgus regulation and tighten the knob to temporarily hold the clamp in place.

Pushing the frontal proximal button of the extramedullary guide - distal part (C), insert the tibia cutting guide of the correct operative side (A) into the proximal end of the extramedullary guide - distal part (C) and release the button.



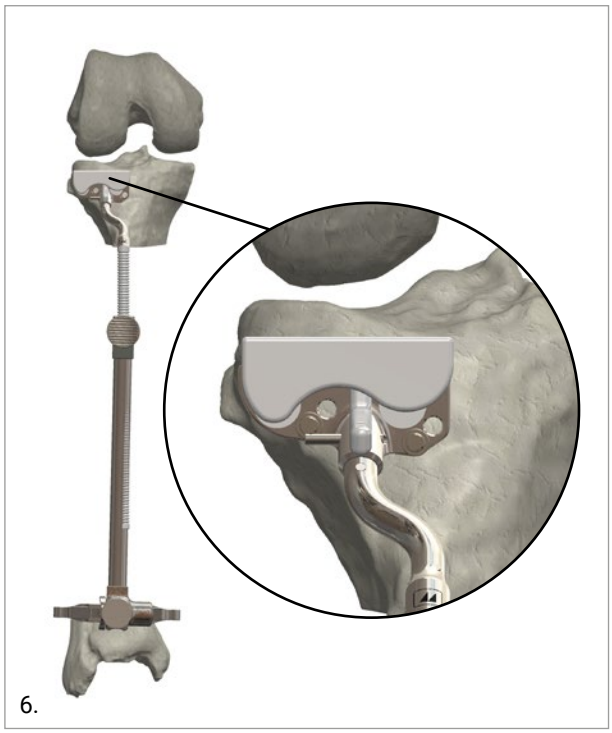
4.

Slide the thickest shim (0 mm) onto the dedicated tracks on the top of the tibial cutting guide. The shim is secured at the top of the tibial cutting guide by the magnetic mechanism. To unlock the shim, push the dedicated lever and slide out the shim.



5.

Position the assembly on the tibia. Secure the distal portion of the assembly by placing the silicone strap around the ankle proximal to the malleoli. Make sure that the ankle clamp points towards the ankle center and the cutting guide is centered on the proximal tibia.

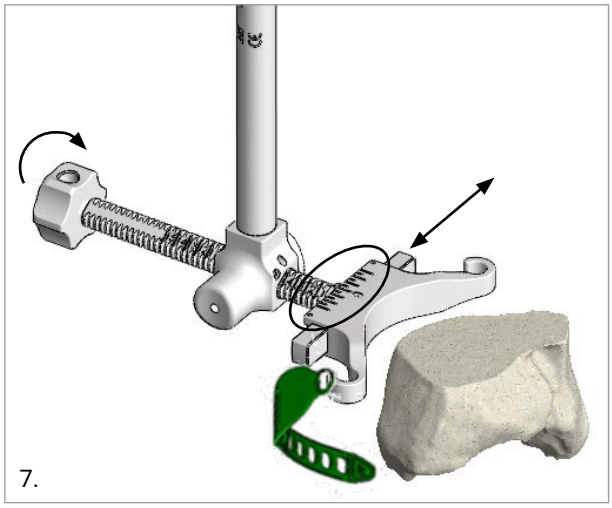


6.

4.2 SETTING THE TIBIAL TRANSVERSE RESECTION LEVEL

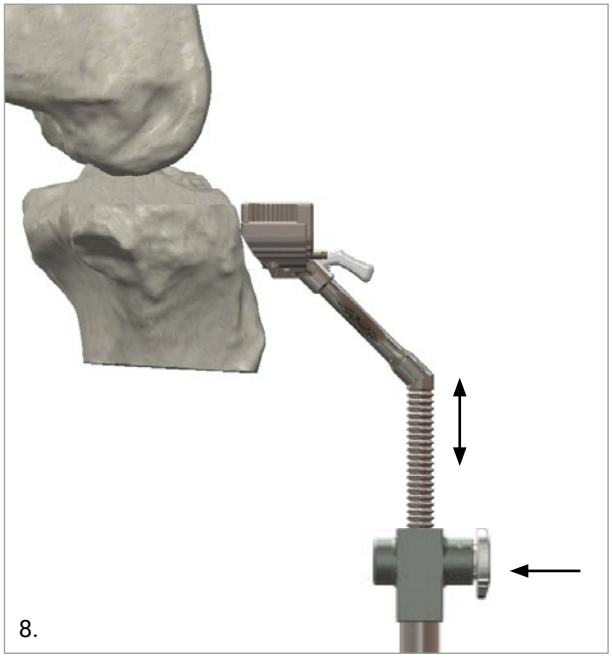
The tibial extramedullary system allows for adjustment in all three planes, coronal (height), frontal (varus/ valgus) and sagittal (slope). The numbers indicated on the malleolar clamp body allows for a reference that has no direct anatomical meaning but could be useful for repositioning or readjustment.

Unscrew the knob and adjust the varus/valgus by translating the guide medially or laterally. To achieve neutral alignment, set the guide parallel to the tibial axis (tibial spine to center of the talus, slightly medial to the midpoint of the ankle) and tighten the knob to secure it in place.



7.

Height is adjusted with the upper push button. Push the button and slide the tibial cutting guide to adjust the height (a graduation in 2 mm increments is permitted).

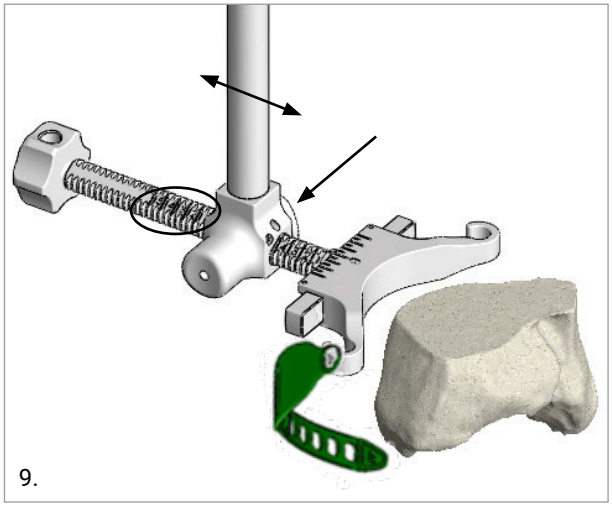


8.

Use an angel wing to indicate if:

- The tibial cut will resect a conservative wafer of bone (about 2 mm) just below the lowest defect on the lateral tibial plateau
- The cut matches the anatomic lateral tibial slope

If more or less slope is required this can be adjusted by pushing the distal button and sliding the extramedullary guide anterior-posteriorly along the ankle clamp rod (a graduation in 2 mm increments is permitted).
When changing the slope, ensure that the ankle clamp still points to the center of the ankle.



9.

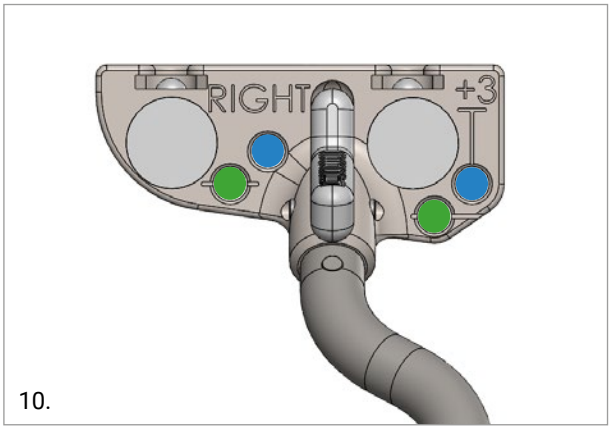
The tibial guide has 0° of posterior slope built-in. If the rod is parallel to the tibial crest, the resulting tibial cut will have a 0° slope.

TIP

Match the anatomic slope of the patient, being sure not to exceed 5°. This is usually flatter than the medial side and this is often perpendicular to the tibial shaft (zero degree slope).

An angel wing can be placed on the plane of the 0 mm shim to confirm the desired resection level and slope. When the height adjustment, frontal alignment and posterior slope are deemed satisfactory, fix the guide with a single threaded headed pin by using one of the pin holes marked with a line (green in the below Figure).

Add an additional pin if better fixation is required.



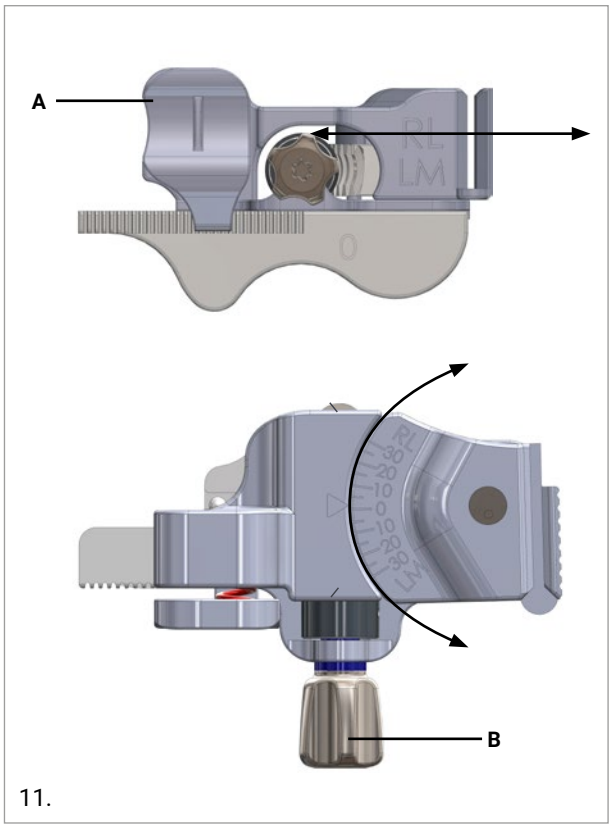
10.

- Reference holes for fixation
- Repositioning holes (+ 3 mm recut)

4.3 SAGITTAL RESECTION

Combine the sagittal cutting guide and the tibial guide by sliding the sagittal cutting guide onto the dedicated tracks at the top of the tibia guide

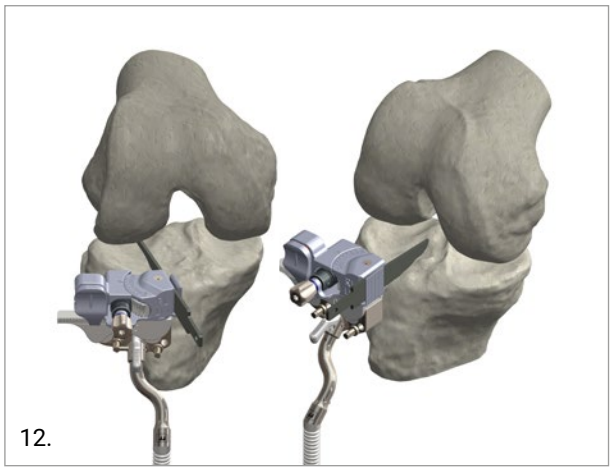
The M/L position of the cut slot can be adjusted by pushing the frontal button (A) and sliding the top body of the sagittal cutting guide medio-laterally. The rotation of the cut slot can be adjusted in a range of ±30° by turning the frontal screw (B). An angel wing may be used through the slot to help visualise the resection plane and rotation and confirm it.



11.

To align the sagittal cut, adjust the cutting guide so that the tip of the sagittal saw is adjacent to the medial border of the lateral femoral condyle in the notch. Internally rotate the slot trajectory such that it covers the lateral tibial plateau in both flexion and extension.

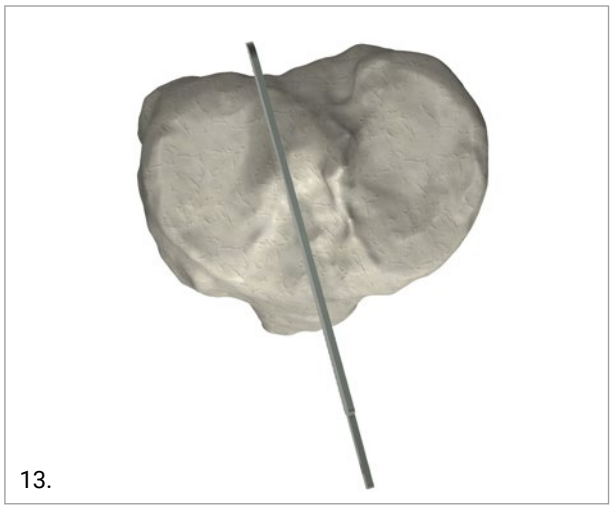
Ensure the sagittal cut is set to the correct position before commencing the osteotomy. Use a single-sided reciprocating saw blade through the vertical slot to perform the sagittal cut.



12.

TIP

It will be easier to accomplish this at about 45° of knee flexion. Most times this cut can be made by simply retracting the patellar tendon medially. If this is not possible, then simply split the fibers of the patellar tendon longitudinally to allow for safe passage of the sagittal saw blade.



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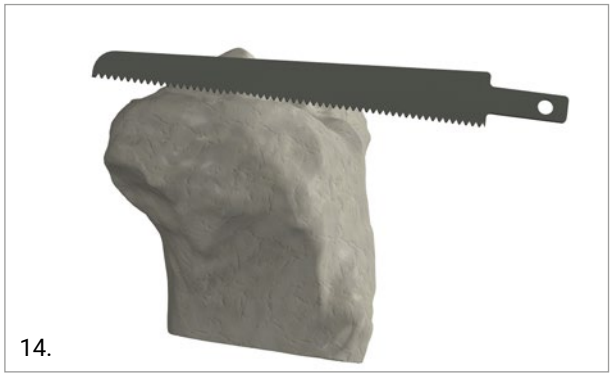


14.

CAUTION

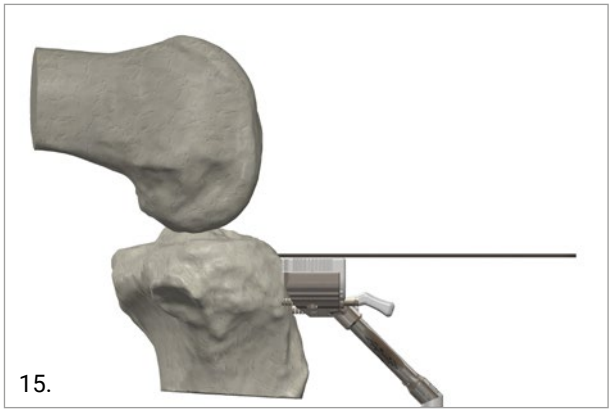
Avoid the following factors which can contribute to the risk of postoperative tibial fracture:

- Notching the posterior cortex during the sagittal cut
- Creating more than two pin holes in the proximal tibia and/or in line with sagittal cut
- Making excessively deep tibia depth resection into softer metaphyseal bone

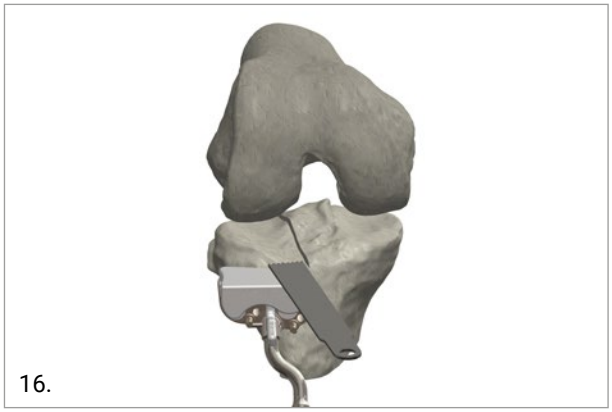
4.4 TIBIAL TRANSVERSE RESECTION

Remove the sagittal cutting guide from the tibial guide and connect the 0 mm shim. Place a retractor laterally to protect the LCL.

Ensure the oscillating saw blade is coplanar with the cutting guide surface of the shim. Perform the transverse tibial cut, stopping medially once the sagittal cut is reached. Avoid undercutting the tibial spine.



15.



16.

TIP

To avoid undercutting the tibial spine, the free reciprocating sagittal saw blade may be placed in the sagittal bone cut.

The wafer of bone can be seen to "jump" once the sagittal and transverse resections are complete.
Remove the wafer of bone, and perform a clean-up cut on any proud areas which are directly visible. Examine the wafer of bone for thickness and slope.

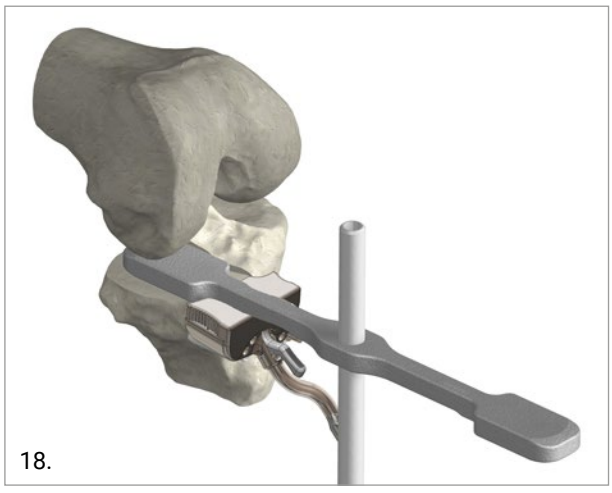
Bring the knee into extension and check that the tibial bone resection completely covers the lateral femoral condyle. If it does not, evaluate for the need to add more external rotation to the sagittal cut, or to medialise the sagittal cut.

4.5 FLEXION AND EXTENSION GAP ASSESSMENT

Eight two-sided gap spacers (range 4-19) are available for gap measurements, with the following sizes: 4-5, 6-7, 8-9, 10-11, 12-13, 14-15, 16-17, 18-19.

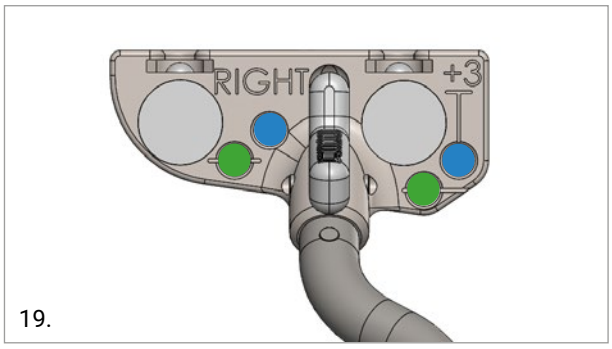
17.

With the knee at 90° of flexion, insert the gap spacer to determine the flexion gap. When determining the thickness of the flexion gap, choose the thickest spacer which fits the gap with little or no resistance. Verify the varus/valgus alignment and slope of the tibial resection by means of the telescopic alignment rod through the gap spacer.



18.

If the first tibial resection is too conservative and the thinnest gap spacer ("4") cannot be inserted into the joint, recut the tibia by repositioning the tibial cutting guide. Use the top row of holes (shown in blue in the next Figure). This will allow for a +3 mm tibial resection.



19.

- Reference holes for fixation
- Repositioning holes (+ 3 mm recut)

At this time, determine the flexion gap with gap spacers. Next, bring the knee into full extension. Check the extension gap using gap spacers in the same manner.

The correct spacer is the thickest spacer that fills the extension gap with little to no resistance while maintaining a slightly under-corrected valgus alignment. The information collected in the flexion and extension gap assessment will be used to determine the bone resection plan to correctly balance the knee, as described below.

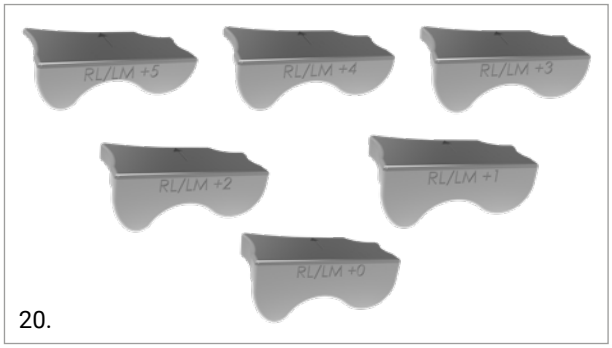
The goal is a combined tibia and posterior femoral condyle resection that allows a final tibial gap of "9" in flexion, with a varus/valgus opening that corresponds to the desired laxity. The authors aim for approximately 3 mm of varus/valgus opening in flexion.

A target flexion gap of "9" is recommended as it provides the surgeon with +/- 1 mm of intraoperative sizing flexibility.

4.6 TIBIAL CUT ADJUSTMENT

If the spacer which fits in flexion is "9", no further tibial resection is needed. If the spacer is less than "9", more resection is needed to achieve the desired "9" gap.

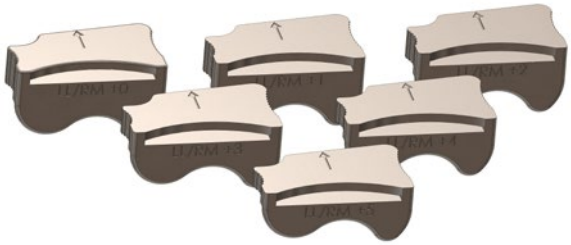
To recut the proximal tibia, shims are applied to the tibial cutting guide, allowing for a resection of +1 mm, +2 mm, +3 mm, +4 mm, or +5 mm. A resection of +6 mm is obtained by directly cutting on the tibia cutting guide, with no shim applied.



20.

OPTION

Slotted shim are available for rigth or left side with the following thickness: 0 mm, +1 mm, +2 mm, +3 mm, +4 mm, +5 mm. Use a saw blade through the horizontal slot to perform the transverse cut.



21.

Determine the appropriate shim thickness to be used to recut the proximal tibia according to the following formula:

Gap Spacer + Shim Thickness = "9"

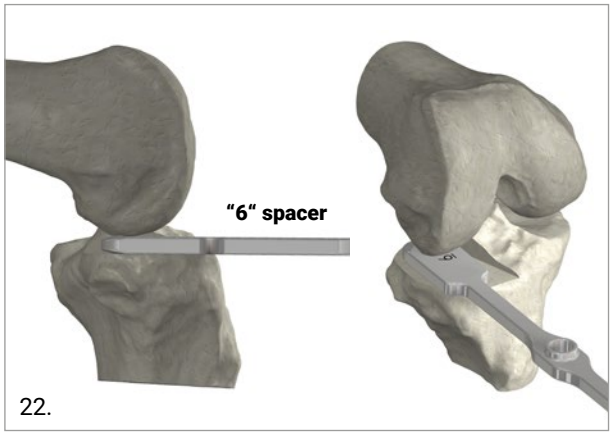
With the aid of the frontal lever on the tibial cutting guide, remove the 0 mm shim. Then apply the appropriate chosen shim onto the tibia cutting guide. Place a retractor laterally to protect the LCL and recut the tibia.

If the resection is greater than 1 mm, deepen the sagittal cut first and then perform the transverse cut. Recut until your flexion gap is "9".

EXAMPLE

After the initial tibial resection, the flexion gap is measured at "6". Remove the 0 mm shim from the tibial guide and replace it with the +3 mm shim, allowing for another 3 mm tibial cut. This will result in a flexion gap of "9".

["6" gap spacer] + [+3 mm shim] = "9" flexion gap



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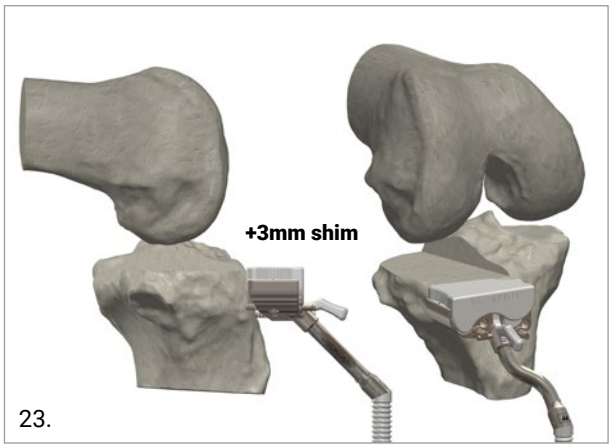

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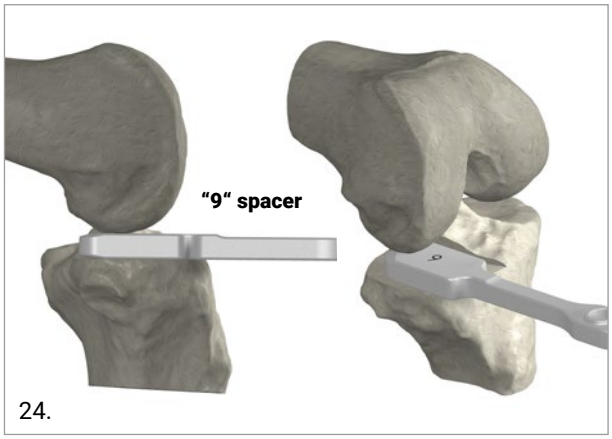


24.

Use the spacers to confirm the gaps and alignment after a tibial recut is made. When the tibia resection is deemed satisfactory, remove the pin(s) and the tibial jig.

OPTION

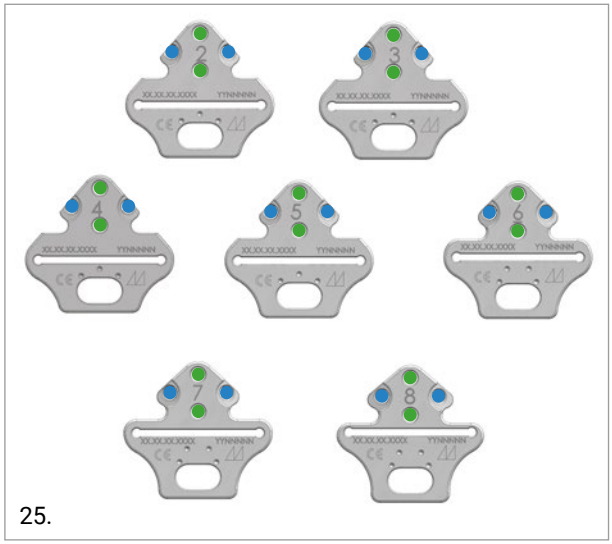
If less tibial resection is desired, see paragraph 5.3 for options to increase the flexion gap adjusting posterior femoral condylar resection.

5. FEMORAL RESECTION

5.1 DISTAL RESECTION

The distal femoral resection can be adjusted depending on gap balancing requirements.

Distal cutting guides are available in the following resection thicknesses: “2”, “3”, “4”, “5”, “6” (corresponding to the distal thickness of the femoral component) , “7” and “8”.



25.

- Reference fixation and repositioning holes
- Oblique fixation holes

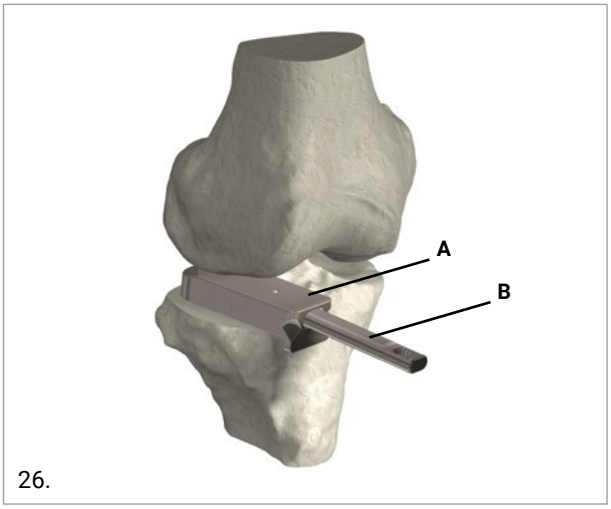
The goal is a distal resection that allows a final extension gap of “15”, with a varus/valgus opening that corresponds to the desired laxity. The authors aim for approximately 2 mm of varus/valgus opening in extension.

The target “15” extension gap reflects the combined thickness of the distal femoral component (“6”) and the “9” tibial tray and poly thickness.

Seven distal spacers are available with thicknesses corresponding to final “tibial + insert” implant (8, 9, 10, 11, 12, 13, 14).

Bring the leg into full extension and insert the appropriate distal spacer thickness into the joint until the anterior lip stops in contact with the anterior aspect of the tibia. The distal spacer thickness should at least equal the gap spacer thickness previously determined in extension. Some surgeons prefer to use a distal spacer 1 or 2 sizes thicker to eliminate the soft tissue laxity, making the distal cut block more stable after pinning. If this is done, it has no influance on the distal femoral cutter, which is selected at the time of gap balancing.

The spacer must be fully inserted into the joint space and sit flush on resected tibia surfaces, both on the sagittal and transverse cut. Test the knee through its full range of motion and, if necessary, change the spacer in order to maximize joint stability.



26.

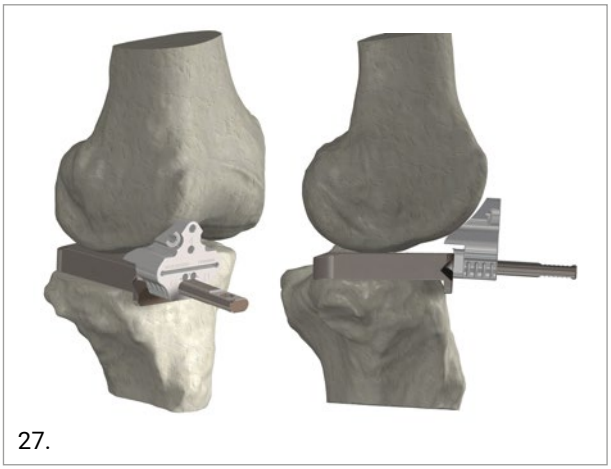
- A – Distal spacers – 8, 9, 10, 11, 12, 13, 14
- B – Connector for distal spacer

Select the distal cutting guide thickness that when combined with the validated extension gap spacer thickness, results in an extension gap of “15”. Insert the connector rod into the distal spacer and place the distal femoral cutting block over it.

EXAMPLE

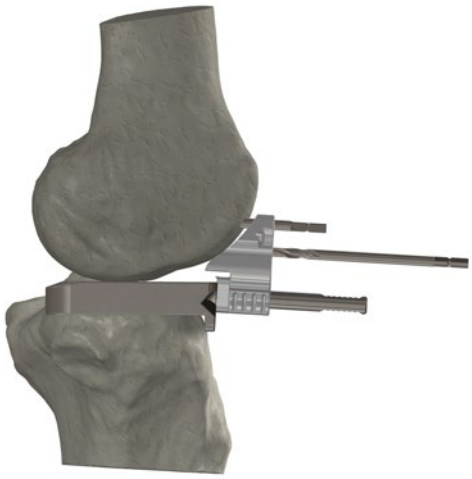
After the tibial resection, the extension gap is measured at “10”. Choose the “5” distal cutting guide. This will result in a final extension gap of “15”.

[“10” tibia only distal spacer] + [“5” distal resection] = “15” extension gap (tibia plus distal femur)


27.

Adjust rotation by confirming that the distal spacer block is flush against the sagittal cut.

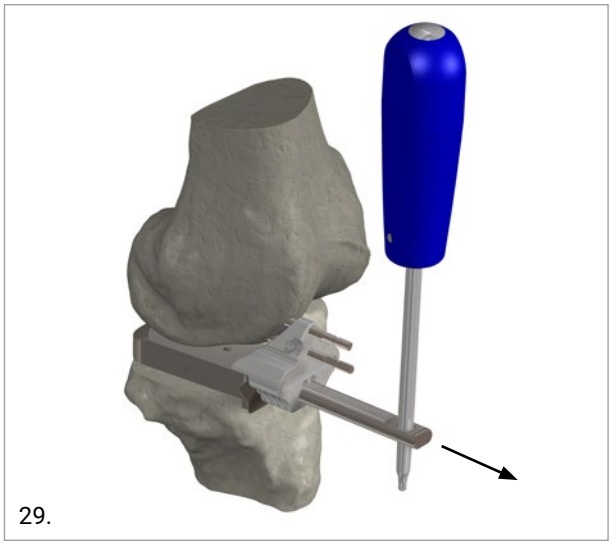
Apply an axial load to make sure that the LCL is not loose and to accommodate the planned desired laxity. Fix the cutting guide by means of two headless smooth drill pins inserted in the central parallel holes (shown in green in the Figure 25). If better fixation is required an additional smooth drill pin can be added in one of the oblique holes (shown in blue in the Figure 25).



28.

With the LCL retractor in place, perform the distal femoral resection through the saw capture slot.

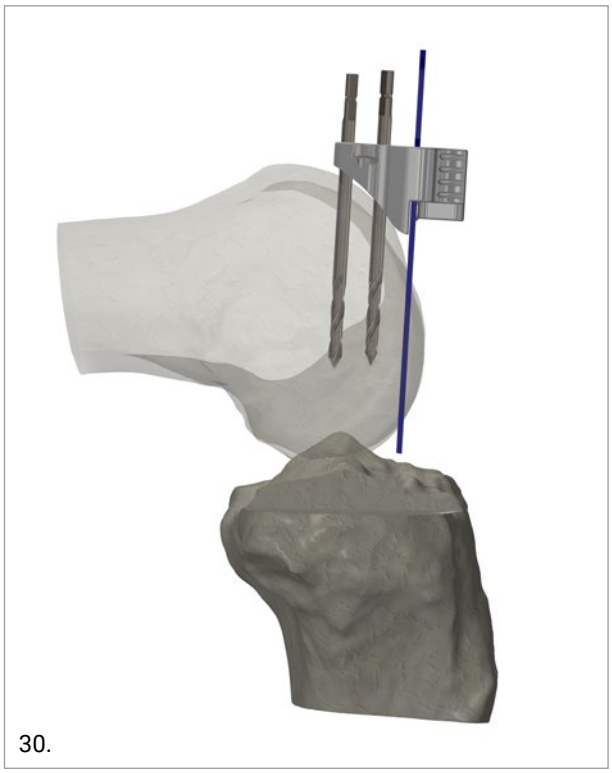
Once the initial cut in extension has been performed, remove the connector rod and the distal spacer block. Flex the knee and complete the distal resection to avoid inadvertent injury to the ACL and/or LCL. It is imperative that the connector rod is removed from the distal spacer block prior to flexing the knee.



29.

TIP

To facilitate the removal of the connector rod, insert a screwdriver into the hole and pull the connector rod out.



30.

5.2 EXTENSION GAP CONTROL

Remove the distal cutting block by sliding it over the pins.

With the knee in extension check the extension gap and the knee stability by means of the "15" gap spacer, simulating the target total implant thickness (distal femur and "9" tibial tray plus poly).

Verify that the varus/valgus opening corresponds to the desired laxity. The authors aim for approximately 2 mm of varus/valgus opening in extension.

Check the correct alignment by means of the telescopic alignment rod.

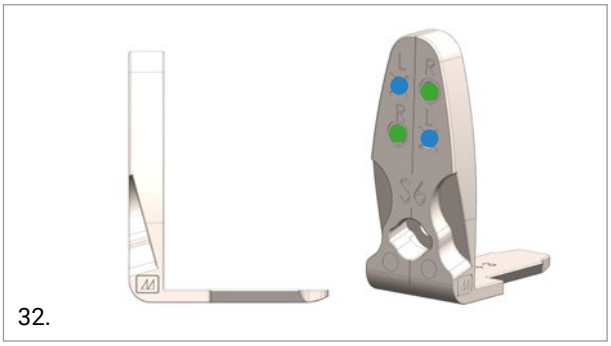
31.

If necessary, recut the distal femur using the appropriate distal cut guide positioned on the previous parallel pins.

Once the distal resection is complete and the correct extension gap and alignment are achieved, remove the pins.

5.3 FEMORAL SIZING AND POSTERIOR CUT AND CHAMFER

Femoral sizers are available to determine the size of the femoral component and the anterior-posterior positioning of the implant.



32.

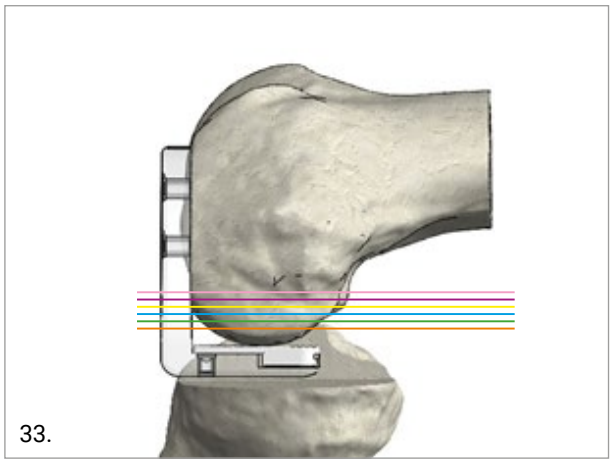
- Holes for built-in pins - Right side
- Holes for built-in pins - Left side

Femoral condyle posterior shims are available to be coupled with femoral gauges, producing different options for posterior femoral resections, shown in table below

OPTIONS FOR POSTERIOR FEMORAL CONDYLE RESECTION

Shim	Reference system
	STD - 2
	STD - 1
	STD
	STD + 1
	STD + 2
	STD + 3 (Femoral gauge without shim)

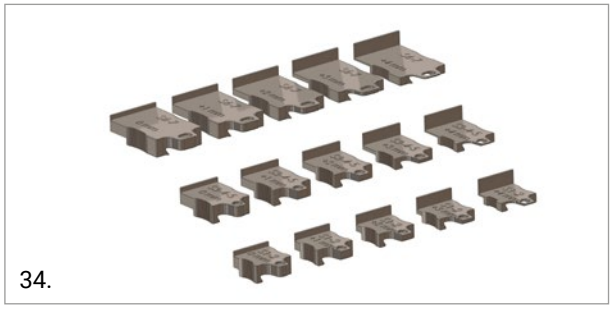
STD cut correspond to final implant thickness +2 mm of additional resection for decompression. Use STD-2 shim to perform a line-to-line resection



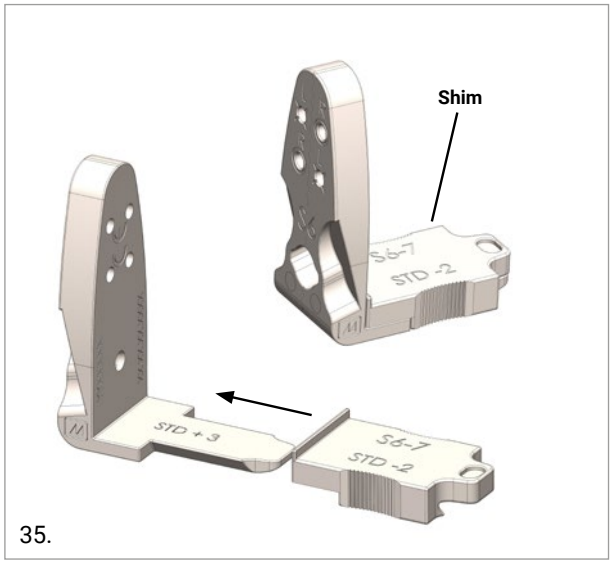
33.

- resection with Shim STD -2
- resection with Shim STD-1
- resection with Shim STD
- resection with Shim STD+1
- resection with Shim STD+2
- resection with Femoral Gauge without Shim (STD+3)

Femur condyle posterior shims are designed into three groups of sizes: sizes 1-2, 3-5 and 6-7.



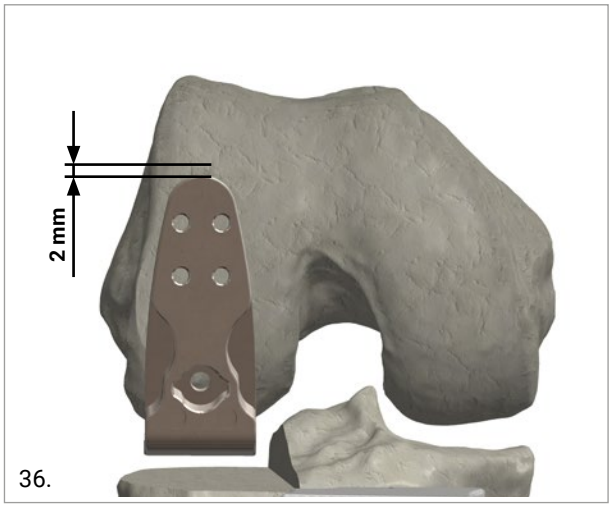
34.



35.

With the knee in flexion, apply the appropriate sizer to the distal femoral cut coupled with a shim (or without it) according to the balancing plan previously defined when planning the tibial recut needed to achieve the target "9" flexion gap. The sizer must be placed flush on the distal resection surface and the posterior plate must be placed in contact with the posterior condyle.

Ensure there is no medial overhang present, and that the block has approximately 2 mm of cut surface at the superior tip.



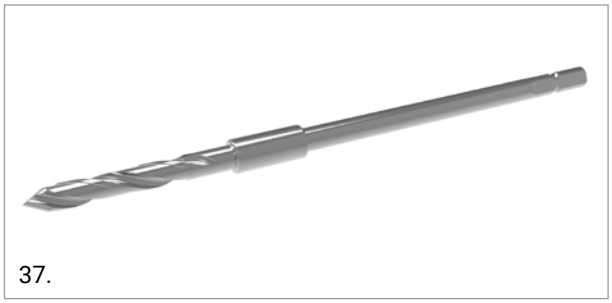
36.

TIP
If between sizes, choose the smaller size. This prevents compartment overhang and patellar impingement.

Confirm rotational alignment and medial/lateral positioning.

TIP
There will be the opportunity to adjust medial/lateral positioning after trial reduction.

When the appropriate size is selected and positioned, drill the upper hole corresponding to the correct side of the operated leg with the 3.2 mm stop-drill (shown in the below Figure). Then fix the femoral sizer position with one pin. The rotation of the component can still be adjusted.
Once the optimal coverage has been obtained, drill the lower fixation hole corresponding to the correct side of the operated leg.



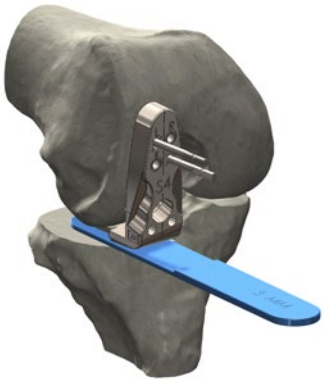
37.

38.

TIP

To increase sizer stability while drilling, the 2 mm or 3 mm spacer can be positioned between the lower surface of the gauge and the tibial resection plane.

39.

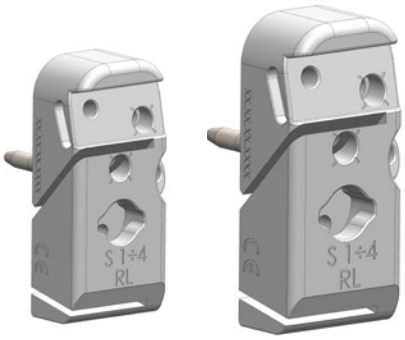


40.

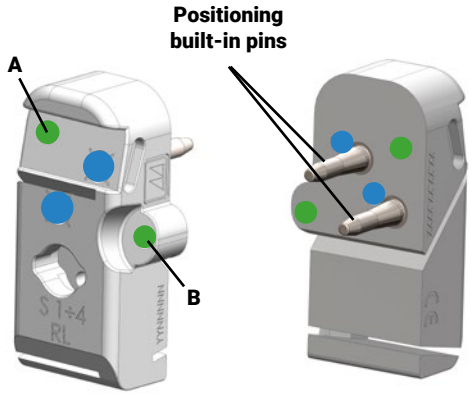
Remove the pin and sizer and position the posterior cutting guide of the corresponding size.

Femoral components are designed into two groups with the same internal profile (distal, posterior and chamfer cuts): sizes 1-4 and 5-7. The two groups of femoral sizes differ for having increasing chamfers thicknesses to add mechanical strength to the biggest sizes.

Posterior cutting guides are available, for each size range, in right and left versions.



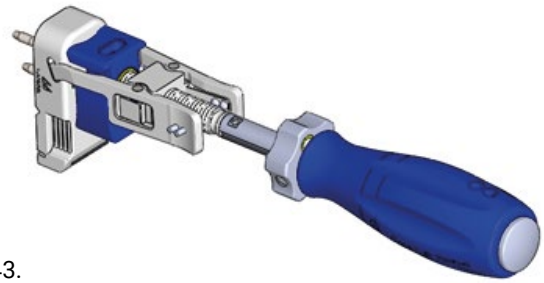
41.



42.

- Fixation holes
- + 2 mm repositioning holes for built-in pins

Position the guide by inserting the built-in pins into the two holes previously drilled through the femoral sizer. The cutting block can be held and positioned on the bone by means of the femoral impactor - slide hammer or the multifunctional handle.



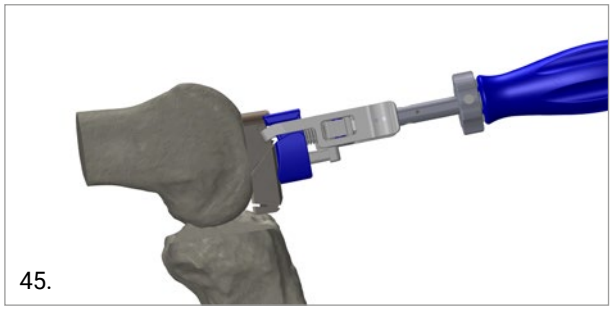
43.

44.

Assemble the posterior cutting guide to the femoral impactor. Open the femoral impactor by turning the handle anti-clockwise. Apply pressure to open the levers and attach the femoral impactor (with "TOP" etching facingdownwards) on the lateral pockets located on the posterior cutting guide. Then release the pressure on the levers.

Turn the femoral impactor handle clockwise until the blue slider is firmly in contact with the posterior cutting guide. Then, position the posterior cutting guide onto the bone. To ensure good contact between the posterior cutting guide and the distal resection surface, unlock the ring of the impactor and use the integrated slide hammer to impact the guide on the bone.

The impaction can also be performed using a mallet on the end of the handle, being careful not to use excessive force.

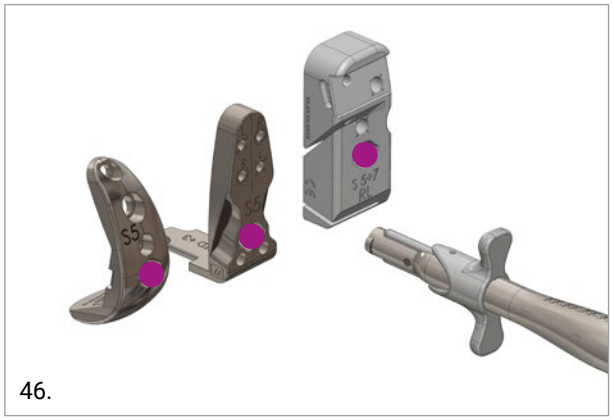


45.

Remove the impactor and check that the posterior cutting guide is perfectly in contact with the distal resection. Fix the position of the cutting guide using a short threaded headed pin, as shown in Figure 42.

OPTION

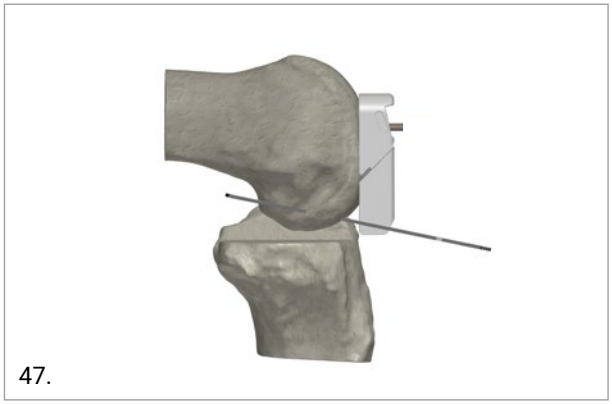
Femoral gauges, posterior cutting guides and femoral trials described at surgical step 5.3 and 7, can be positioned with the multifuncional handle.



46.

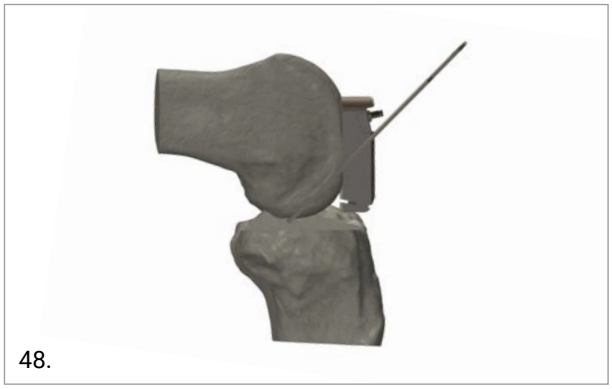
● Multifunctional handle hole

With the knee in flexion, and LCL retractor in position, first perform the posterior cut through the posterior slot of the cutting block.



47.

Next perform the posterior chamfer resection through the chamfer slot of the cutting block.



48.

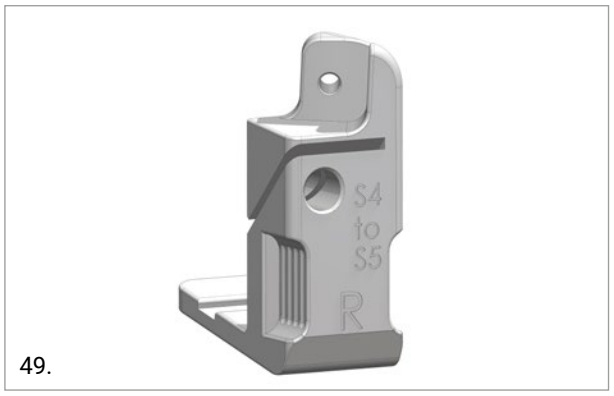
Remove the pin and cutting block and confirm cuts. Position the trial femoral component on the bone and make sure that the resections match the internal profile of the femoral component.

CAUTION

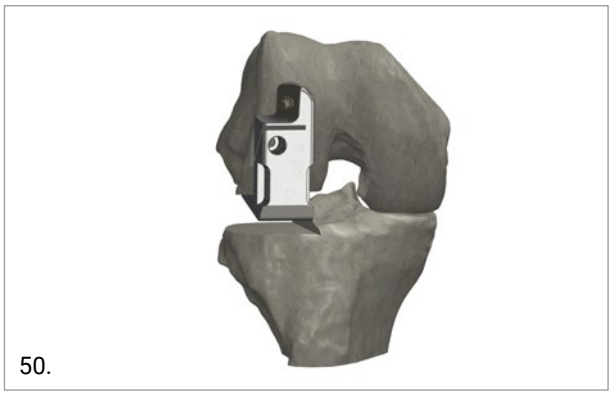
After having performed the femoral resections, ensure that all surfaces are flat. Remove any remaining posterior osteophytes as they could limit flexion or extension, and the remainder of the medial meniscus.

If a downsize from size 5 to 4 is needed, there will be a slight gap at the chamfer that will have to be filled with cement.

If an upsize from size 4 to 5 is needed, the chamfer must be recut. Two dedicated recut guides (right and left versions) allow for the recut of the chamfer to adapt the resections to a bigger femoral size. In all other upsizing cases this step is not required (same chamfer).



49.


50.

Position the posterior chamfer recutting guide flush to the distal and posterior cut surfaces, fix it using a pin and a screw. Perform the chamfer recut through the slot.

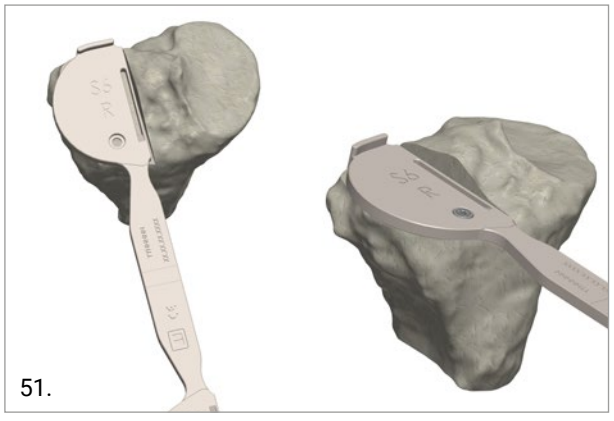
6. TIBIAL FINISHING

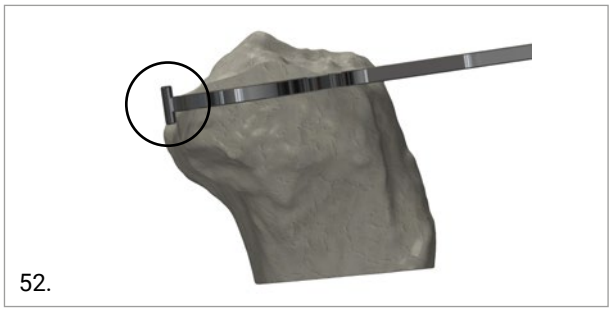
6.1 TIBIAL SIZING AND KEEL PREPARATION

Assess the tibial size using the tibial templates.

Four tibial templates, each bearing two sizes (1-2, 3-4, 5-6 and 7-8), are available. Place the template on the resected surface of the tibia. The straight edge should rest against the surface created by the sagittal cut and the posterior hook in contact with the posterior tibial cortex.

Select the template that best covers the resected proximal tibia in both the antero-posterior and medio-lateral dimensions. The goal is to cover as much of the tibia as possible, without any overhang. Any margin for anterior/ posterior overhang should be anterior.


51.


52.

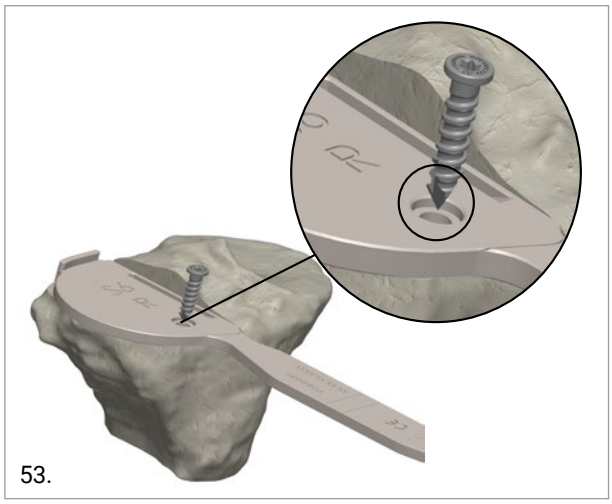
TIP

If the femoral component seems excessively large compared to tibial size, evaluate the sagittal cut. Consider medialising or adding external rotation to the sagittal cut, if appropriate, to gain a tibial component size.

CAUTION

It is very important to have the hook against the posterior tibial cortex. This will help avoid breaching the posterior cortex while preparing the keel.

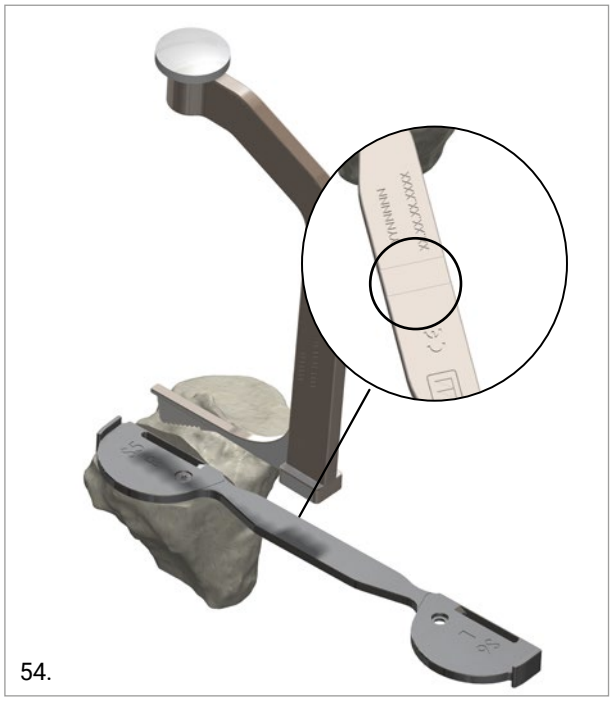
Once the optimal coverage has been achieved, with the appropriate tibial template sizer flush on the tibial surface, insert a short-headed screw into the anterior fixation hole to fix the position of the tibia sizer. The screw is in the same position as the anterior peg of the final tibial implant.



53.

To prepare the keel for the trial and final implant, use the impactor by inserting its keel into the dedicated slot of the tibial template sizer.

Make sure the keel preparation impactor sits flush on the tibial template sizer surface. When the impactor is in line with the mechanical engravings, the optimal position is reached. Hammer on the top of the impactor.



54.

55.

56.

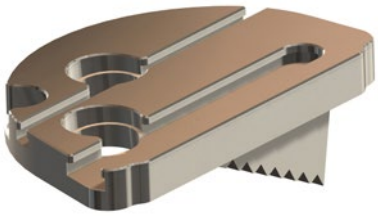
TIP

If the bone is sclerotic you may need to use an osteotome prior to using the impactor for keel preparation.

6.2 TIBIAL PEGS PREPARATION

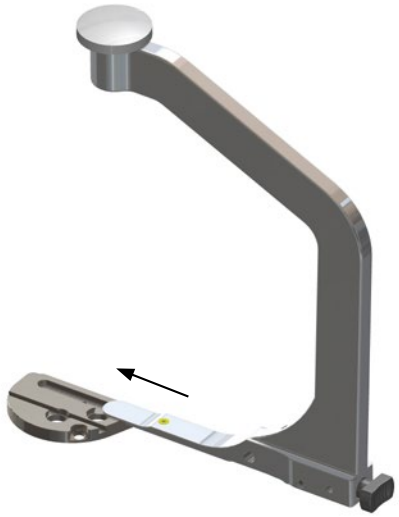
Remove the screw and the tibia template sizer.

Select the correct size tibial baseplate trial with integrated keel.



57.

Assemble the tibial trial to the tibial impactor, sliding the impactor into the dedicated rail of the chosen trial baseplate.



58.

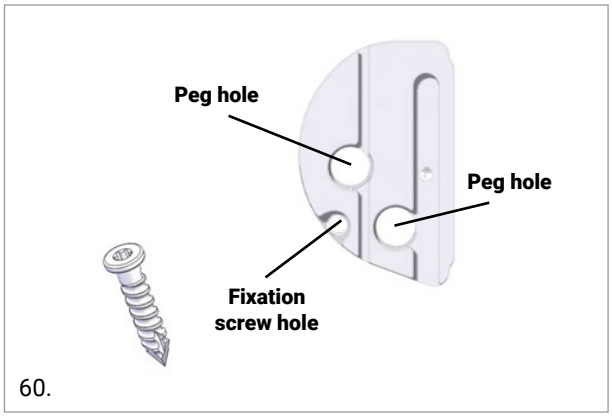
Flex the knee and position the trial baseplate onto the resected tibial surface so that the integrated keel engages into the slot previously prepared. Lightly impact the tibial baseplate so it sits flush on the tibial surface.

59.

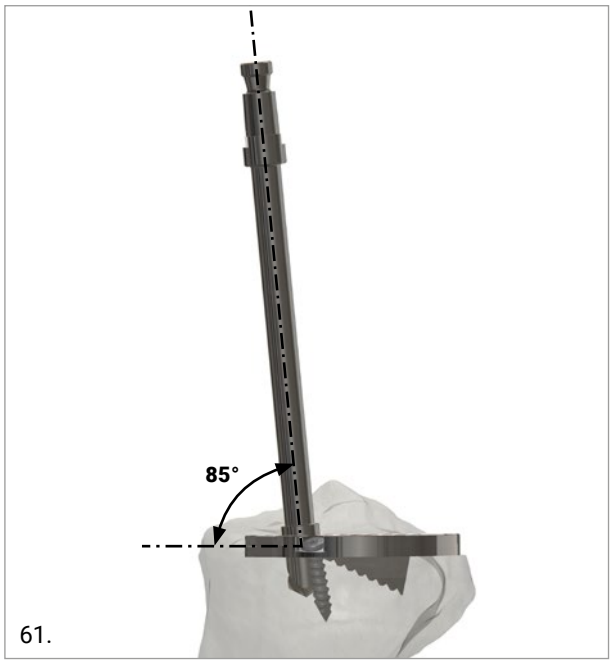
The medio-lateral aspect of the trial baseplate is 1 mm wider than the final implant. This is to avoid impingement during the liner insertion. The keel integrated into the impactor has the same size of final implant keal.

Remove the tibial impactor.

Fix the baseplate using a short-headed screw and drill the two tibial peg holes for the fixation peg using the 12 mm stop drill bit. Peg holes are angled 5° posteriorly to facilitate drilling, to prevent impingement with the femur and to allow for a 1 mm cement mantel around the pegs.



60.



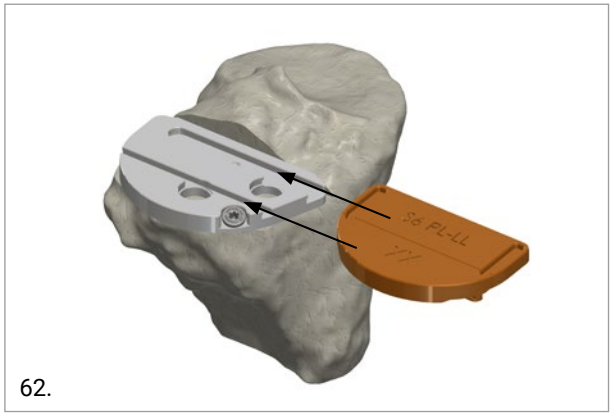
61.

TIP

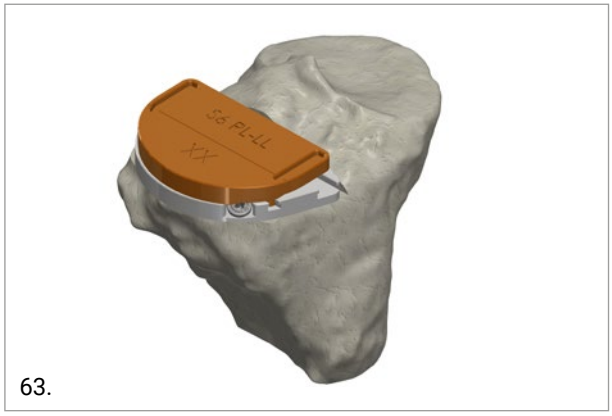
Make certain the tibial peg drill is fully inserted to allow enough depth for the implant pegs.

7. TRIALING

Choose the trial insert (typically 8 or 9) and slide it onto the rails of the trial tibial baseplate.



62.



63.

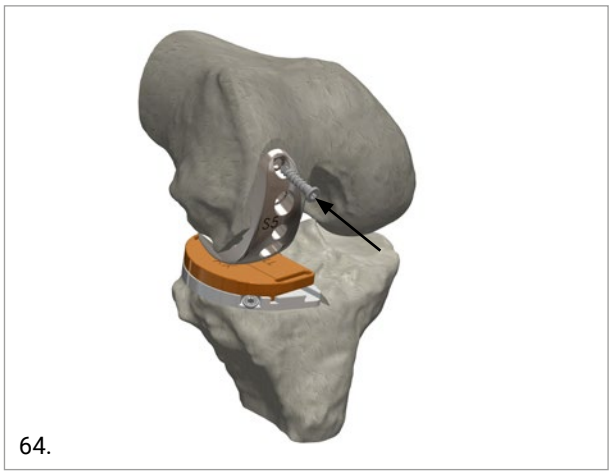
CAUTION
The 7 mm thick trial is only available as an on-demand item for use with the 7 mm E-Cross poly implant. Before surgery, check with a Medacta representative if the instrumentation includes the 7 mm trial insert and if the E-Cross 7 mm poly is available to be implanted.

Place the trial femoral component onto the femur and adjust its medio-lateral position to best articulate with the center of the tibial trial throughout a full arc of motion.

CAUTION
Remove any prominent spurs or osteophytes on the posterior femoral condyle as they could inhibit flexion. Check that there is no posterior overhang of femoral component. If this is the case, a smaller femoral size may be considered.

TIP
Determine the optimal medio-lateral position of trial femur during trial reduction, by viewing the contact between femoral component and trial tibia insert.

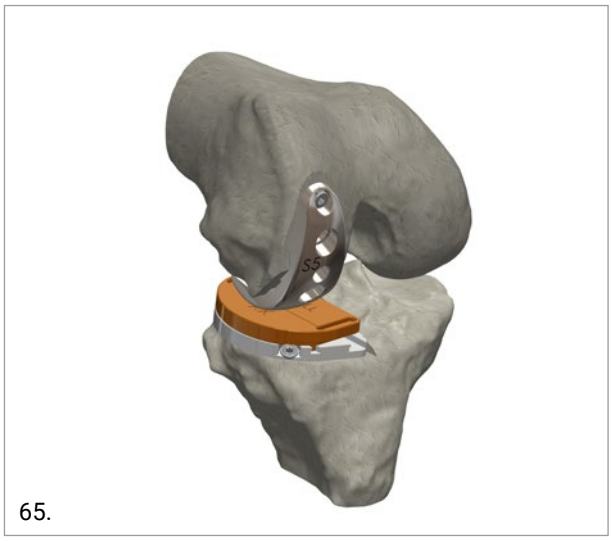
Once the optimal position is acquired, fix the femoral trial using one or two screws. One fixation hole is available for small size 1 .Two fixation holes are available for sizes from 2 to 7.


64.

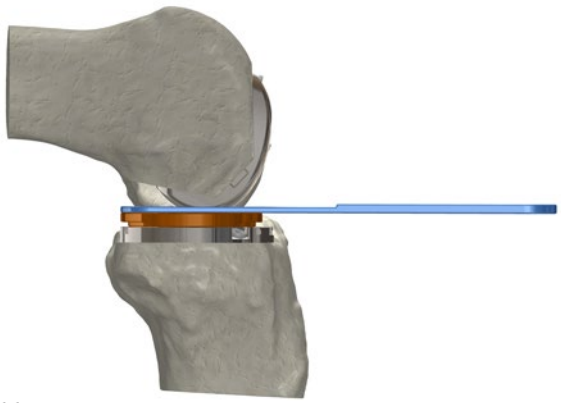
With all trial components in place, test the knee for stability and balance throughout the range of motion. Assess ligamentous balance.

The position of the centerline engraved on the insert top surface, compared to the femoral trial engraving, provides an indication of the medio/lateral final implant position.

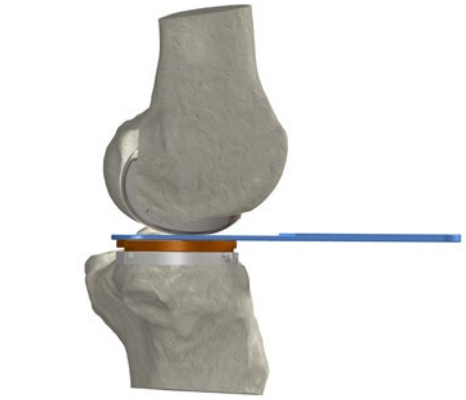
Ideally, with varus-valgus stress, there should be a 2 mm opening in extension, and 3 mm opening in flexion. It is imperative, however, that knee alignment is not over-corrected into varus.


65.

TIP
Insert the 2 mm spacer to confirm flexion and extension gaps and ensure they are not too tight.



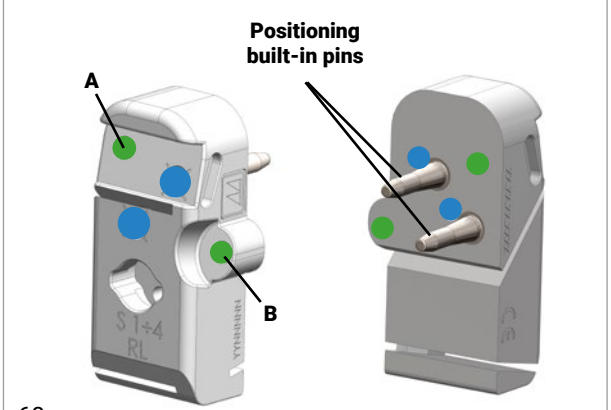
66.



67.

In the event that the trial reduction is tight in flexion and good in extension, an option is to shift the femoral component 2 mm anteriorly.

Re-apply the posterior cutting block previously used to the distal femur, fixing it with the prior threaded headed pin (green A hole shown in the below Figure). Drill the holes marked (blue) with the 3.2 mm stop-drill. Remove the fixation pin and cutting block, and re-apply the cutting block to the distal femur, positioning it by inserting built-in pins into the newly drilled holes (blue). Fix the cutting block with a threaded headed pin in the other hole (green B hole) and repeat the posterior and chamfer cuts. This will increase the flexion gap by 2 mm.



68.

- Fixation holes
- + 2 mm repositioning holes for built-in pins

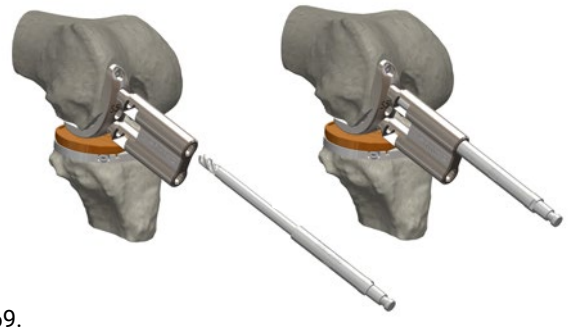
CAUTION

Pay particular attention to the coverage, specifically if a femoral size 5 was chosen. The +2 mm anterior shift could lead to the need to downsize the femur to a size 4, with thinner chamfer. In this case there will be a slight gap at the chamfer that will have to be filled with cement.

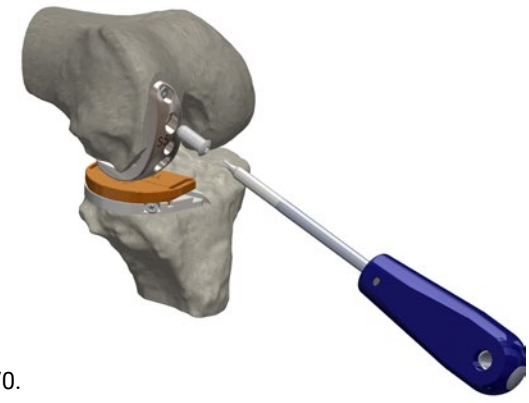
8. FEMORAL FINISHING

Once balance is achieved, confirm the M/L position of the femoral trial. Combine the drill guide with the femoral trial, inserting the two drill guides centering the cylinder in correspondence of the two trial peg holes. Insert the drill into the drill guide for the femoral fixation pegs preparation.

Trial pegs are available to verify the proper peg hole preparation. Use the screwdriver for easier peg handling.

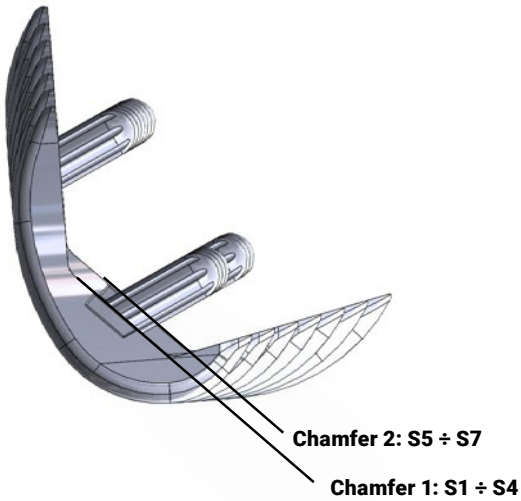


69.



70.

Size 1 through 7 femoral components have two fixation pegs in the same position.



71.

9. FINAL IMPLANT COMPONENTS

When the trials are satisfactory, the femoral and tibial trials can be removed. Next irrigate, the wound and bony surfaces.

If there are any sclerotic areas, these can be prepped with shallow drill holes to aid in cement interdigitation. Dry bony surfaces.

The final implant is intended to be cemented. The bone cement must be prepared according to the relevant instructions for use, provided by the cement manufacturer.

Implant the tibial component first.

9.1 TIBIAL COMPONENT

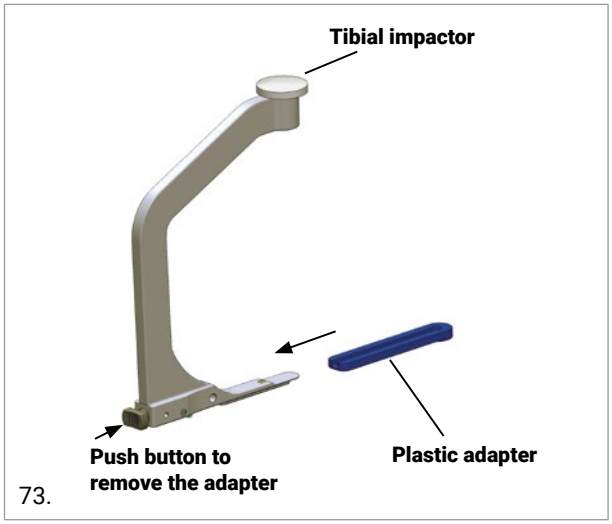
The resected surface should be thoroughly cleaned. Once the cement has reached the right viscosity according to its instructions for use, it must be applied evenly to the undersurface of the tibial baseplate to fill the cement pockets.

Apply cement, and pressurize with gun or manually into the bony surfaces and peg holes, taking care not to extrude excess cement posteriorly.

72.

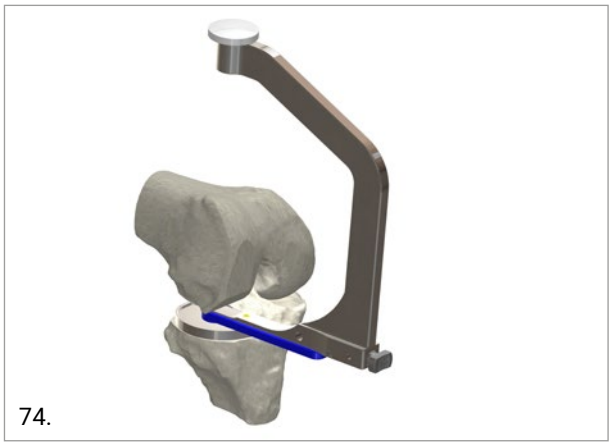
Assemble the plastic adapter on the tibial impactor.

Slide the impactor until a click is heard, confirming the adapter is firmly locked into the impactor.



73.

Place the tibial component. Apply pressure, from posterior to anterior, using the dedicated impactor to allow cement extrusion anteriorly. Tap the final tibial baseplate into position. Remove excess cement at each opportunity, carefully checking that no cement remains on the implant surface, paying particular attention to the locking mechanism grooves.



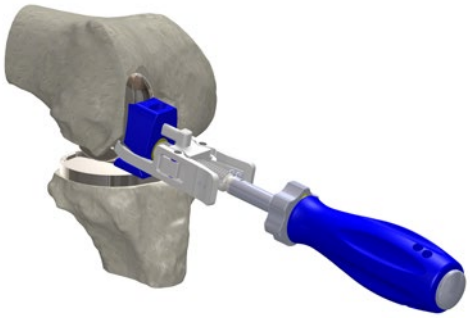
74.

To disassemble the adapter, push the button on the back of the impactor and slide the adapter off.

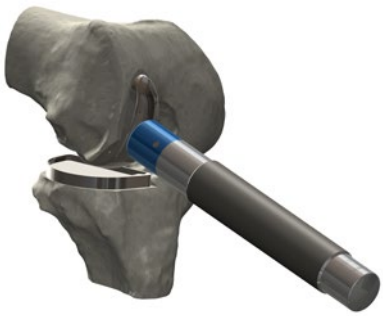
9.2 FEMORAL COMPONENT

The resected surface should be thoroughly cleaned and dried. Apply cement on the internal surface of the femoral component into the corresponding cement pockets. Apply cement and pressurize with gun or manually into the bony surfaces and peg holes, taking care not to extrude excess cement posteriorly.

Engage the femoral impactor onto the final femoral component and complete the impaction with the knee flexed at 90° using the femoral impactor (TOP etching facing upwards). The extruded cement must be carefully cleaned from the femur, checking that no cement remains on the articular surface. Complete impaction of the femoral component using the femoral impactor.



75.



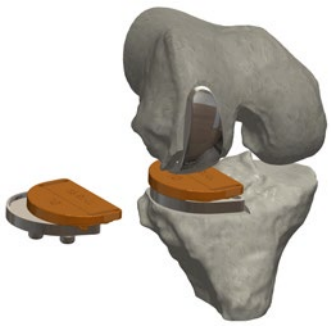
76.

9.3 INSERT COMPONENT

Clip the trial insert to the baseplate and lightly pressurize in extension

TIP

Use the 2 mm plastic spacer to enhance the pressurization. Remove excess cement.



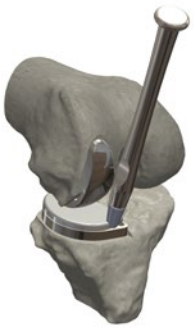
77.

After the cement has cured, repeat the trial reduction with the trial insert clipped in the final tibial component. Confirm the appropriate thickness of the final insert by testing knee stability in flexion and extension to optimize range of motion, alignment, and stability.

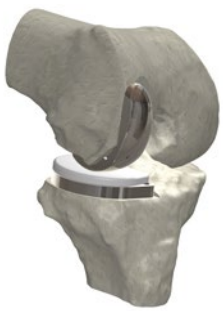
Implant the polyethylene insert to the baseplate by first engaging the posterior flange.

OPTION

The dedicated instrument is available to engage the insert into the tibial baseplate.



78.

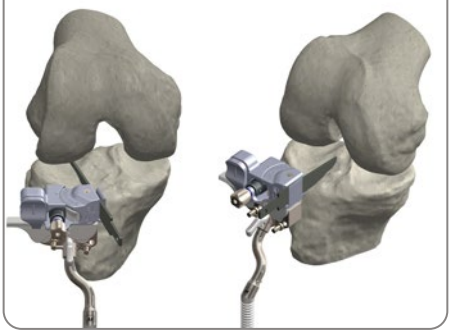


79.

Irrigate and close the wound in the standard fashion.

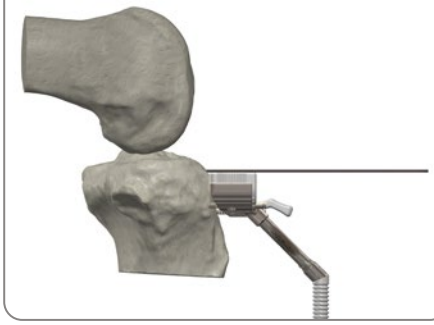
10. SUMMARY STEPS

01



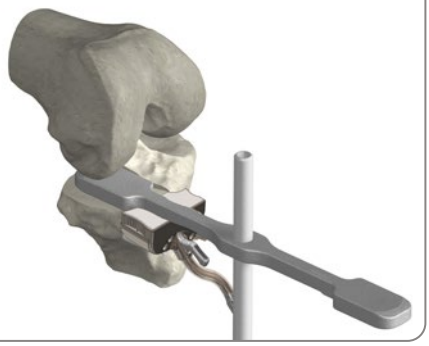
Tibial cut guide positioning.
Sagittal resection

02



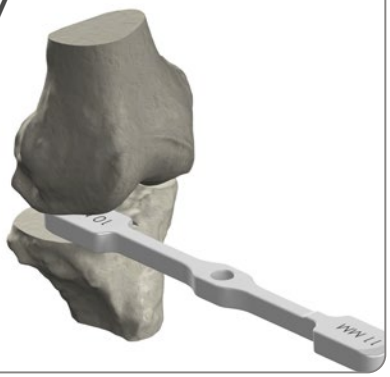
Transverse resection

03



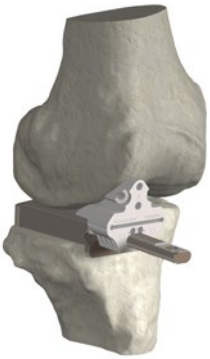
Flexion gap check.
Alignment check

07



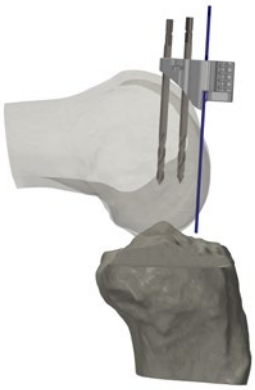
Extension gap check

08



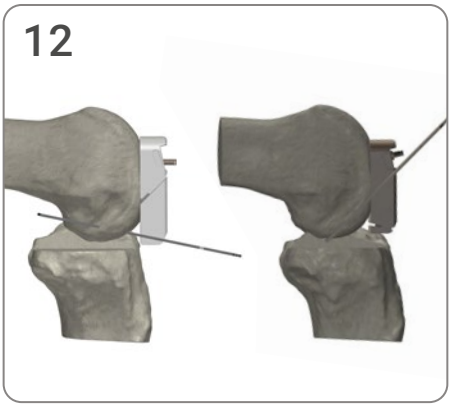
Distal spacer and distal
resection guide positioning

09



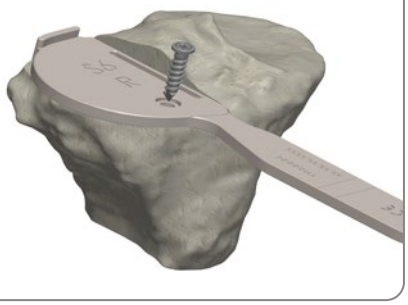
Distal resection

12



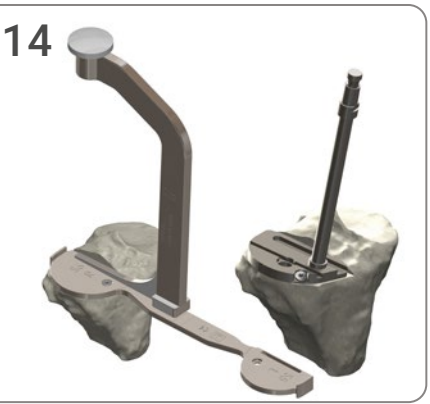
Posterior and chamfer
resections

13



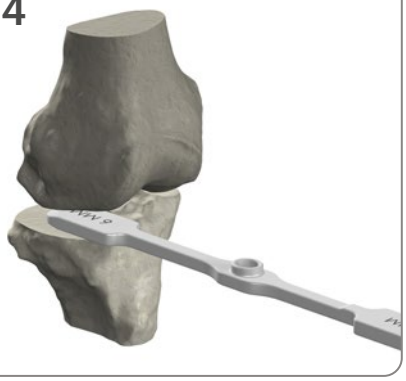
Tibia sizing

14



Tibia preparation:
keel and pegs

04

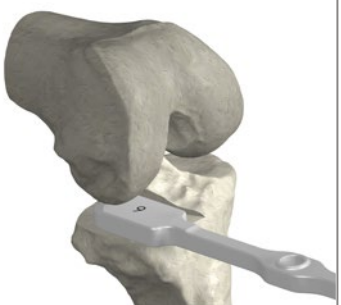


Extension gap check.
Alignment check

05

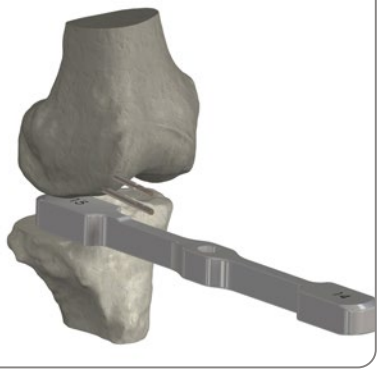
Tibial recut to achieve "9"* flexion gap

06



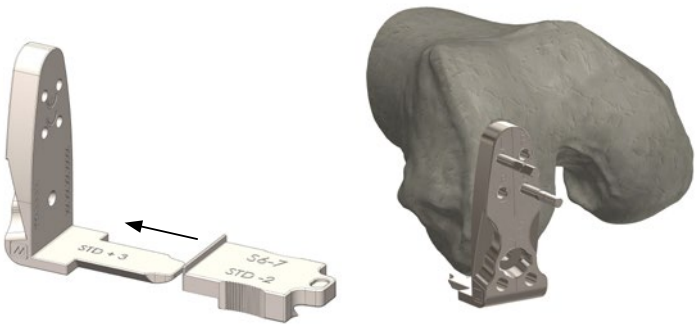
Flexion gap check

10



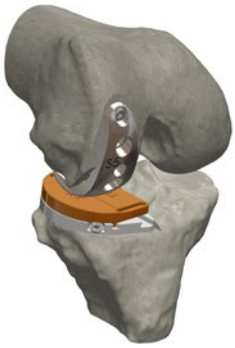
Confirm "15"* extension gap

11



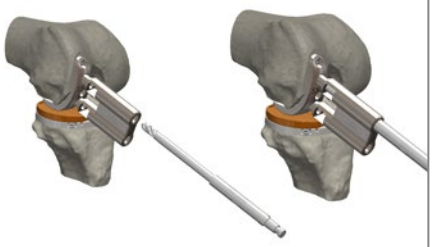
Femur sizing and preparation of posterior guide holes

15



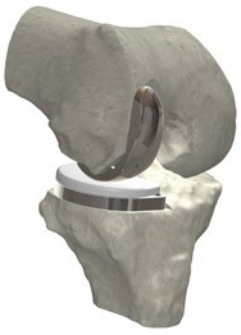
Trialing

16



M/L position adjustment
and peg holes preparation

17



Final component
implantation

* Or desired target thickness

11. SELECTION OF THE PROSTHETIC COMPONENTS - SIZE MATCHING

Tibial inserts must be matched with tibial trays of the same size only. Any tibial insert can be matched with all sizes of the femoral components. The matching capabilities are shown in tables 1 and 2.

TABLE 1: MATCHING CAPABILITIES FOR TIBIAL INSERTS AND TIBIAL BASEPLATE

		Tibial Insert							
	Size	1	2	3	4	5	6	7	8
Tibial Baseplate	1	✓							
	2		✓						
	3			✓					
	4				✓				
	5					✓			
	6						✓		
	7							✓	
	8								✓

TABLE 2: MATCHING CAPABILITIES FOR TIBIAL INSERTS AND FEMORAL COMPONENTS

		Tibial Insert							
	Size	1	2	3	4	5	6	7	8
Femoral Component	1	✓	✓	✓	✓	✓	✓	✓	✓
	2	✓	✓	✓	✓	✓	✓	✓	✓
	3	✓	✓	✓	✓	✓	✓	✓	✓
	4	✓	✓	✓	✓	✓	✓	✓	✓
	5	✓	✓	✓	✓	✓	✓	✓	✓
	6	✓	✓	✓	✓	✓	✓	✓	✓
	7	✓	✓	✓	✓	✓	✓	✓	✓

12. IMPLANT CODES

FEMORAL COMPONENT

Left Lateral and Right Lateral Side	Size
02.18.101LLRL	1
02.18.102LLRL	2
02.18.103LLRL	3
02.18.104LLRL	4
02.18.105LLRL	5
02.18.106LLRL	6
02.18.107LLRL	7

TIBIAL TRAY

Left Lateral Side	Size	Right Lateral Side
02.18.TF1.LL	1	02.18.TF1.RL
02.18.TF2.LL	2	02.18.TF2.RL
02.18.TF3.LL	3	02.18.TF3.RL
02.18.TF4.LL	4	02.18.TF4.RL
02.18.TF5.LL	5	02.18.TF5.RL
02.18.TF6.LL	6	02.18.TF6.RL
02.18.TF7.LL	7	02.18.TF7.RL
02.18.TF8.LL	8	02.18.TF8.RL

FEMORAL COMPONENT TiNbN

Left Lateral and Right Lateral Side	Size
02.18.701LLRL	1
02.18.702LLRL	2
02.18.703LLRL	3
02.18.704LLRL	4
02.18.705LLRL	5
02.18.706LLRL	6
02.18.707LLRL	7

TIBIAL INSERT

Left Lateral and Right Lateral Side	Size	Label height		Left Lateral and Right Lateral Side	Size	Label height
02.18.IF1.08.LLRL	1	8		02.18.IF5.08.LLRL	5	8
02.18.IF1.09.LLRL		9		02.18.IF5.09.LLRL		9
02.18.IF1.10.LLRL		10		02.18.IF5.10.LLRL		10
02.18.IF1.11.LLRL		11		02.18.IF5.11.LLRL		11
02.18.IF1.12.LLRL		12		02.18.IF5.12.LLRL		12
02.18.IF1.14.LLRL		14		02.18.IF5.14.LLRL		14
02.18.IF2.08.LLRL	2	8		02.18.IF6.08.LLRL	6	8
02.18.IF2.09.LLRL		9		02.18.IF6.09.LLRL		9
02.18.IF2.10.LLRL		10		02.18.IF6.10.LLRL		10
02.18.IF2.11.LLRL		11		02.18.IF6.11.LLRL		11
02.18.IF2.12.LLRL		12		02.18.IF6.12.LLRL		12
02.18.IF2.14.LLRL		14		02.18.IF6.14.LLRL		14
02.18.IF3.08.LLRL	3	8		02.18.IF7.08.LLRL	7	8
02.18.IF3.09.LLRL		9		02.18.IF7.09.LLRL		9
02.18.IF3.10.LLRL		10		02.18.IF7.10.LLRL		10
02.18.IF3.11.LLRL		11		02.18.IF7.11.LLRL		11
02.18.IF3.12.LLRL		12		02.18.IF7.12.LLRL		12
02.18.IF3.14.LLRL		14		02.18.IF7.14.LLRL		14
02.18.IF4.08.LLRL	4	8		02.18.IF8.08.LLRL	8	8
02.18.IF4.09.LLRL		9		02.18.IF8.09.LLRL		9
02.18.IF4.10.LLRL		10		02.18.IF8.10.LLRL		10
02.18.IF4.11.LLRL		11		02.18.IF8.11.LLRL		11
02.18.IF4.12.LLRL		12		02.18.IF8.12.LLRL		12
02.18.IF4.14.LLRL		14		02.18.IF8.14.LLRL		14

E-CROSS TIBIAL INSERT

Left Lateral and Right Lateral Side	Size	Label height		Left Lateral and Right Lateral Side	Size	Label height
02.18.EIF1.07.LLRL	1	7		02.18.EIF5.07.LLRL	5	7
02.18.EIF1.08.LLRL		8		02.18.EIF5.08.LLRL		8
02.18.EIF1.09.LLRL		9		02.18.EIF5.09.LLRL		9
02.18.EIF1.10.LLRL		10		02.18.EIF5.10.LLRL		10
02.18.EIF1.11.LLRL		11		02.18.EIF5.11.LLRL		11
02.18.EIF1.12.LLRL		12		02.18.EIF5.12.LLRL		12
02.18.EIF1.14.LLRL		14		02.18.EIF5.14.LLRL		14
02.18.EIF2.07.LLRL	2	7		02.18.EIF6.07.LLRL	6	7
02.18.EIF2.08.LLRL		8		02.18.EIF6.08.LLRL		8
02.18.EIF2.09.LLRL		9		02.18.EIF6.09.LLRL		9
02.18.EIF2.10.LLRL		10		02.18.EIF6.10.LLRL		10
02.18.EIF2.11.LLRL		11		02.18.EIF6.11.LLRL		11
02.18.EIF2.12.LLRL		12		02.18.EIF6.12.LLRL		12
02.18.EIF2.14.LLRL		14		02.18.EIF6.14.LLRL		14
02.18.EIF3.07.LLRL	3	7		02.18.EIF7.07.LLRL	7	7
02.18.EIF3.08.LLRL		8		02.18.EIF7.08.LLRL		8
02.18.EIF3.09.LLRL		9		02.18.EIF7.09.LLRL		9
02.18.EIF3.10.LLRL		10		02.18.EIF7.10.LLRL		10
02.18.EIF3.11.LLRL		11		02.18.EIF7.11.LLRL		11
02.18.EIF3.12.LLRL		12		02.18.EIF7.12.LLRL		12
02.18.EIF3.14.LLRL		14		02.18.EIF7.14.LLRL		14
02.18.EIF4.07.LLRL	4	7		02.18.EIF8.07.LLRL	8	7
02.18.EIF4.08.LLRL		8		02.18.EIF8.08.LLRL		8
02.18.EIF4.09.LLRL		9		02.18.EIF8.09.LLRL		9
02.18.EIF4.10.LLRL		10		02.18.EIF8.10.LLRL		10
02.18.EIF4.11.LLRL		11		02.18.EIF8.11.LLRL		11
02.18.EIF4.12.LLRL		12		02.18.EIF8.12.LLRL		12
02.18.EIF4.14.LLRL		14		02.18.EIF8.14.LLRL		14

13. INSTRUMENTATION CODES

The following trays are needed for a MOTO Lateral Unicompartimental Replacement:

Ref.	Description
02.18S.301A	MOTO Partial Knee System - General Level 1
02.18S.301B	MOTO Partial Knee System - General Level 2
02.18S.302L	MOTO Partial Knee System - MOTO LAT Femoral set
02.18S.303L	MOTO Partial Knee System - MOTO LAT Tibial set

02.18S.301A - MOTO PARTIAL KNEE SYSTEM - GENERAL LEVEL 1

Ref.	Description	Quantity
02.18.10.0002	Ankle clamp	1
02.18.10.0031	Connector for distal spacer	1
02.18.10.0275	Trial tibia baseplate impactor	1
02.18.10.0276	Adapter for tibial implant impactor	1
02.18.10.0336	4 mm distal cutting guide	1
02.18.10.0337	5 mm distal cutting guide	1
02.18.10.0338	6 mm distal cutting guide	1
02.18.10.0339	7 mm distal cutting guide	1
02.18.10.0340	8 mm distal cutting guide	1
02.18.10.0516	Impactor for keel preparation 2 mm	1
02.18.10.1006	Shim +0 mm - RL	On Demand
02.18.10.1007	Shim +1 mm – RL	On Demand
02.18.10.1008	Shim +2 mm – RL	On Demand
02.18.10.1009	Shim +3 mm – RL	On Demand
02.18.10.1010	Shim +4 mm – RL	On Demand
02.18.10.1011	Shim +5 mm - RL	On Demand
02.18.10.1012	Shim +0 mm – LL	On Demand
02.18.10.1013	Shim +1 mm – LL	On Demand
02.18.10.1014	Shim +2 mm – LL	On Demand
02.18.10.1015	Shim +3 mm – LL	On Demand
02.18.10.1016	Shim +4 mm – LL	On Demand
02.18.10.1017	Shim +5 mm - LL	On Demand
02.18.10.1212	Shim for femoral gauge S1-2 STD -2	1
02.18.10.1213	Shim for femoral gauge S1-2 STD -1	1
02.18.10.1214	Shim for femoral gauge S1-2 STD 0	1
02.18.10.1215	Shim for femoral gauge S1-2 STD +1	1
02.18.10.1216	Shim for femoral gauge S1-2 STD +2	1
02.18.10.1217	Shim for femoral gauge S3-4-5 STD -2	1

Ref.	Description	Quantity
02.18.10.1218	Shim for femoral gauge S3-4-5 STD -1	1
02.18.10.1219	Shim for femoral gauge S3-4-5 STD 0	1
02.18.10.1220	Shim for femoral gauge S3-4-5 STD +1	1
02.18.10.1221	Shim for femoral gauge S3-4-5 STD +2	1
02.18.10.1222	Shim for femoral gauge S6-7 STD -2	1
02.18.10.1223	Shim for femoral gauge S6-7 STD -1	1
02.18.10.1224	Shim for femoral gauge S6-7 STD 0	1
02.18.10.1225	Shim for femoral gauge S6-7 STD +1	1
02.18.10.1226	Shim for femoral gauge S6-7 STD +2	1
02.18.10.1279	Tibial Sagittal Guide (TSG) - LL RM	1
02.18.10.1280	Tibial Sagittal Guide (TSG) - RL LM	1
02.18.10.1289	Shim +0 mm SLOTTED - RL	1
02.18.10.1290	Shim +1 mm SLOTTED – RL	1
02.18.10.1291	Shim +2 mm SLOTTED – RL	1
02.18.10.1292	Shim +3 mm SLOTTED – RL	1
02.18.10.1293	Shim +4 mm SLOTTED – RL	1
02.18.10.1294	Shim +5 mm SLOTTED - RL	1
02.18.10.1295	Shim +0 mm SLOTTED – LL	1
02.18.10.1296	Shim +1 mm SLOTTED – LL	1
02.18.10.1297	Shim +2 mm SLOTTED – LL	1
02.18.10.1298	Shim +3 mm SLOTTED – LL	1
02.18.10.1299	Shim +4 mm SLOTTED – LL	1
02.18.10.1300	Shim +5 mm SLOTTED - LL	1
02.18.10.1301	Distal cutting guide 2 mm - LLRL	1
02.18.10.1302	Distal cutting guide 3 mm - LLRL	1
02.18.10.1303	MOTO Handle	1
02.18.10.0003	Lace for ankle clamp	3
02.18.10.8006	MOTO Partial knee system tray - General 1 of 2	1
02.18.10.1269	Drill for peg preparation through Femur	1
02.07.10.0532	Caliper	1
02.18.10.0375	Drill guide MEDIAL	1
02.18.10.1304	Drill Guide MOTO LATERAL	1

02.18S.301B - MOTO PARTIAL KNEE SYSTEM - GENERAL LEVEL 2

Ref.	Description	Quantity
02.02.10.0788	Pins extractor	1
02.07.10.2294	Pin Ø3.2 L=40 ISO5835-Meche-Head-Triangle	3
02.07.10.2295	Pin Ø3.2 L=70 ISO5835-Meche-Head-Triangle	On Demand
02.07.10.2297	Pin Ø3.2 L=70 ISO5835-Meche-Triangle	On Demand
02.07.10.4673	Trochlear rasp	1
02.07.10.4740	Threaded Pin Ø3.2 L70 longer connection	3
02.07.10.4742	Pin Adaptor Hudson Coupling - Conical Assembly	1
02.08.10.0003	GMK-UNI finger	1
02.08.10.0227	Femoral Impactor	1
02.18.10.0001	Extramedullary guide - distal part	1
02.18.10.0018	Gap spacer 4-5 mm	1
02.18.10.0019	Gap spacer 6-7 mm	1
02.18.10.0020	Gap spacer 8-9 mm	1
02.18.10.0021	Gap spacer 10-11 mm	1
02.18.10.0022	Gap spacer 12-13 mm	1
02.18.10.0023	Gap spacer 14-15 mm	1
02.18.10.0024	Gap spacer 16-17 mm	1
02.18.10.0056	2-3 mm spacer for femoral gauges	2
02.18.10.0087	Screw HA5 - Lenght 20	4
02.18.10.0206	Screwdriver T10	1
02.18.10.0207	Motorized screwdriver Torx T10	1
02.18.10.0208	Drill bit for tibia pegs preparation	1
02.18.10.0209	Telescopic alignment rod	1
02.18.10.0211	UKA femoral impactor - slide hammer	1
02.18.10.0267	Pin Ø3.2 L=55 mm HA3.5 Meche Head Triangle	3
02.18.10.0279	Ø3.2 drill bit for built in pins preparation	1
02.18.10.0281	gap spacer 18-19 mm	1
02.18.10.0518	Fixation Screw	4
02.18.10.0519	Insert impactor	1
02.18.10.1268	Trial peg LLRL - Ø 6.5 mm	4
02.18.10.8007	MOTO Partial knee system tray - General 2 of 2	1
1112	Lombardi Tibia Cement Preparation Drill	1
U40.211.15	Flachmeissel Lexer, gewinkelt 15 mm / 23 cm.	1

02.18S.302L - MOTO PARTIAL KNEE SYSTEM - MOTO LAT FEMORAL SET

Ref.	Description	Quantity
02.18.10.1046	Femoral gauge S1 LLRL - Assembly	1
02.18.10.1047	Femoral gauge S2 LLRL - Assembly	1
02.18.10.1048	Femoral gauge S3 LLRL - Assembly	1
02.18.10.1049	Femoral gauge S4 LLRL - Assembly	1
02.18.10.1050	Femoral gauge S5 LLRL - Assembly	1
02.18.10.1051	Femoral gauge S6 LLRL - Assembly	1
02.18.10.1052	Femoral gauge S7 LLRL - Assembly	1
02.18.10.1261	Posterior cutting guide #1÷4 - RL	1
02.18.10.1262	Posterior cutting guide #1÷4 - LL	1
02.18.10.1263	Posterior cutting guide #5÷7 - RL	1
02.18.10.1264	Posterior cutting guide #5÷7 - LL	1
02.18.10.1063	Posterior chamfer recutting guide S4 to S5 - RL	1
02.18.10.1064	Posterior chamfer recutting guide S4 to S5 - LL	1
02.18.10.1238	TRIAL FEMORAL COMPONENT S1 - LLRL	1
02.18.10.1239	TRIAL FEMORAL COMPONENT S2 - LLRL	1
02.18.10.1240	TRIAL FEMORAL COMPONENT S3 - LLRL	1
02.18.10.1241	TRIAL FEMORAL COMPONENT S4 - LLRL	1
02.18.10.1242	TRIAL FEMORAL COMPONENT S5 - LLRL	1
02.18.10.1243	TRIAL FEMORAL COMPONENT S6 - LLRL	1
02.18.10.1244	TRIAL FEMORAL COMPONENT S7 - LLRL	1
02.18.10.1281	8 mm distal spacer	1
02.18.10.1282	9 mm distal spacer	1
02.18.10.1283	10 mm distal spacer	1
02.18.10.1284	11 mm distal spacer	1
02.18.10.1285	12 mm distal spacer	1
02.18.10.1286	13 mm distal spacer	1
02.18.10.1287	14 mm distal spacer	1
02.18.10.8008	MOTO Partial knee system tray - Femoral	1
02.18.10.1230	MOTO Lateral Implants - Template 100%	1
02.18.10.1231	MOTO Lateral Implants - Template 110%	On Demand
02.18.10.1232	MOTO Lateral Implants - Template 115%	On Demand

02.18S.303L - MOTO PARTIAL KNEE SYSTEM - MOTO LAT TIBIAL SET

Ref.	Description	Quantity
02.18.10.1277	Tibia cutting guide - Left	1
02.18.10.1278	Tibia cutting guide - Right	1
02.18.10.1270	Tibia template size 1-2 Lateral	1
02.18.10.1271	Tibia template size 3-4 Lateral	1
02.18.10.1272	Tibia template size 5-6 Lateral	1
02.18.10.1273	Tibia template size 7-8 Lateral	1
02.18.10.1071	Trial tibial tray size 1 – RL	1
02.18.10.1072	Trial tibial tray size 2 – RL	1
02.18.10.1073	Trial tibial tray size 3 – RL	1
02.18.10.1074	Trial tibial tray size 4 – RL	1
02.18.10.1075	Trial tibial tray size 5 – RL	1
02.18.10.1076	Trial tibial tray size 6 – RL	1
02.18.10.1077	Trial tibial tray size 7 – RL	1
02.18.10.1078	Trial tibial tray size 8 – RL	1
02.18.10.1079	Trial tibial tray size 1 – LL	1
02.18.10.1080	Trial tibial tray size 2 – LL	1
02.18.10.1081	Trial tibial tray size 3 – LL	1
02.18.10.1082	Trial tibial tray size 4 – LL	1
02.18.10.1083	Trial tibial tray size 5 – LL	1
02.18.10.1084	Trial tibial tray size 6 – LL	1
02.18.10.1085	Trial tibial tray size 7 – LL	1
02.18.10.1086	Trial tibial tray size 8 – LL	1
02.18.10.1110	Trial insert size 1 - 8 mm – LLRL	1
02.18.10.1111	Trial insert size 1 - 9 mm - LLRL	1
02.18.10.1112	Trial insert size 1 - 10 mm – LLRL	1
02.18.10.1113	Trial insert size 1 - 11 mm – LLRL	1
02.18.10.1114	Trial insert size 1 - 12 mm – LLRL	1
02.18.10.1115	Trial insert size 1 - 14 mm – LLRL	1
02.18.10.1116	Trial insert size 2 - 8 mm – LLRL	1
02.18.10.1117	Trial insert size 2 - 9 mm – LLRL	1
02.18.10.1118	Trial insert size 2 - 10 mm – LLRL	1
02.18.10.1119	Trial insert size 2 - 11 mm – LLRL	1
02.18.10.1120	Trial insert size 2 - 12 mm – LLRL	1
02.18.10.1121	Trial insert size 2 - 14 mm - LLRL	1
02.18.10.1122	Trial insert size 3 - 8 mm – LLRL	1
02.18.10.1123	Trial insert size 3 - 9 mm – LLRL	1
02.18.10.1124	Trial insert size 3 - 10 mm – LLRL	1
02.18.10.1125	Trial insert size 3 - 11 mm – LLRL	1
02.18.10.1126	Trial insert size 3 - 12 mm - LLRL	1

Ref.	Description	Quantity
02.18.10.1127	Trial insert size 3 - 14 mm - LLRL	1
02.18.10.1128	Trial insert size 4 - 8 mm – LLRL	1
02.18.10.1129	Trial insert size 4 - 9 mm – LLRL	1
02.18.10.1130	Trial insert size 4 - 10 mm - LLRL	1
02.18.10.1131	Trial insert size 4 - 11 mm – LLRL	1
02.18.10.1132	Trial insert size 4 - 12 mm – LLRL	1
02.18.10.1133	Trial insert size 4 - 14 mm - LLRL	1
02.18.10.1134	Trial insert size 5 - 8 mm – LLRL	1
02.18.10.1135	Trial insert size 5 - 9 mm – LLRL	1
02.18.10.1136	Trial insert size 5 - 10 mm – LLRL	1
02.18.10.1137	Trial insert size 5 - 11 mm - LLRL	1
02.18.10.1138	Trial insert size 5 - 12 mm – LLRL	1
02.18.10.1139	Trial insert size 5 - 14 mm – LLRL	1
02.18.10.1140	Trial insert size 6 - 8 mm – LLRL	1
02.18.10.1141	Trial insert size 6 - 9 mm - LLRL	1
02.18.10.1142	Trial insert size 6 - 10 mm – LLRL	1
02.18.10.1143	Trial insert size 6 - 11 mm - LLRL	1
02.18.10.1144	Trial insert size 6 - 12 mm – LLRL	1
02.18.10.1145	Trial insert size 6 - 14 mm - LLRL	1
02.18.10.1146	Trial insert size 7 - 8 mm - LLRL	1
02.18.10.1147	Trial insert size 7 - 9 mm – LLRL	1
02.18.10.1148	Trial insert size 7 - 10 mm – LLRL	1
02.18.10.1149	Trial insert size 7 - 11 mm – LLRL	1
02.18.10.1150	Trial insert size 7 - 12 mm – LLRL	1
02.18.10.1151	Trial insert size 7 - 14 mm - LLRL	1
02.18.10.1152	Trial insert size 8 - 8 mm – LLRL	1
02.18.10.1153	Trial insert size 8 - 9 mm – LLRL	1
02.18.10.1154	Trial insert size 8 - 10 mm – LLRL	1
02.18.10.1155	Trial insert size 8 - 11 mm – LLRL	1
02.18.10.1156	Trial insert size 8 - 12 mm – LLRL	1
02.18.10.1157	Trial insert size 8 - 14 mm - LLRL	1
02.18.10.8009	MOTO Partial knee system tray - Tibial	1
02.18.10.0615	Trial insert size 1 - 7 mm – LLRL	On demand
02.18.10.0616	Trial insert size 2 - 7 mm – LLRL	On demand
02.18.10.0617	Trial insert size 3 - 7 mm – LLRL	On demand
02.18.10.0618	Trial insert size 4 - 7 mm – LLRL	On demand
02.18.10.0619	Trial insert size 5 - 7 mm – LLRL	On demand
02.18.10.0620	Trial insert size 6 - 7 mm – LLRL	On demand
02.18.10.0621	Trial insert size 7 - 7 mm – LLRL	On demand
02.18.10.0622	Trial insert size 8 - 7 mm – LLRL	On demand

NOTES

Part numbers subject to change.

NOTE FOR STERILISATION

The instrumentation is not sterile upon delivery. Instruments must be cleaned before use and sterilised in an autoclave respecting the regulations of the county, EU directives where applicable and following the instruction for use of the autoclave manufacturer. For detailed instructions please refer to the document “Recommendations for cleaning decontamination and sterilsation of Medacta International orthopedic devices” available at www.medacta.com.

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