AXIOMA TT METAL BACK
GLENOID BONE GRAFTING
SURGICAL TECHNIQUE
GLENOID BONE GRAFTING SURGICAL TECHNIQUE

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Limacorporate spa, as manufacturer of prosthetic devices, does not practice medicine. This surgical technique brochure has been developed in consultation with an experienced surgeon team and provides the surgeon with general guidance when implanting SMR® AXIOMA TT Metal Back. Proper surgical procedures and techniques are necessarily the responsibility of the medical professional. Each surgeon must evaluate the appropriateness of the surgical technique used based on personal medical training, experience and clinical evaluation of each individual patient.

The clinically proven SMRTM System evolves with the pathology, allowing the surgeon to choose the most appropriate solution in resurfacing, fracture replacement, total shoulder, reverse shoulder or revision surgeries1,2,3,4,5,6,7.

BIBLIOGRAPHY:


Based on clinical heritage of the SMRTM System, AXIOMA TT Metal Back glenoid breaks new ground in glenoid replacement, combining unique implant design with the advanced Trabecular Titanium structure. The material, the structure, the mechanical properties and the enhanced initial fixation, are the premises for greater primary fixation followed by an improved biologic integration of the implants.8,10,11.


GLENOID BONE GRAFTING SURGICAL TECHNIQUE
Indications, Contraindications and Warnings

Please follow the instructions for use enclosed in the product packaging.

**INDICATIONS**

The SMRTM Shoulder System is intended for partial or total, primary or revision shoulder joint replacement.

The SMRTM Anatomic Shoulder System is indicated for partial or total primary or revision shoulder joint replacement in patients suffering from disability due to:

- non-inflammatory degenerative joint disease including osteoarthritis and avascular necrosis;
- inflammatory degenerative joint disease such as rheumatoid arthritis;
- treatment of acute fractures of the humeral head that cannot be treated with other fracture fixation methods;
- revision of a failed primary implant;
- cuff tear arthropathy (CTA Heads only).

The Large Resection Stems are indicated for oncology applications.

The SMRTM Reverse Shoulder System is indicated for primary, fracture or revision total shoulder replacement in a grossly rotator cuff deficient joint with severe arthropathy (disabling shoulder).

The patient’s joint must be anatomically and structurally suited to receive the selected implants and a functional deltoid muscle is necessary to use the device.

The Modular SMRTM Shoulder System allows the assembly of components in various humeral and glenoid constructs.

The constructs are intended for cemented and uncemented use as specified in the following table.

In the Anatomic shoulder the humeral construct consists of the humeral stem, the humeral body, the adaptor taper and the humeral head.

In the Reverse shoulder the humeral construct consists of the humeral stem, the reverse humeral body and the reverse liner.

On the humeral side the fixation of the humeral stem determines if the construct is cemented or uncemented.

The Anatomic glenoid construct consists of an all polyethylene glenoid or a metal back assembled with a liner while the Reverse glenoid construct consists of the metal back, the connector and the glenosphere. On the glenoid side, the fixation of the all polyethylene glenoid or the metal back determines if the construct is cemented or uncemented.

The intended use of the Glenoid Bone Graft Instruments is to enable the preparation of the bone graft to restore the glenoid anatomy in case of glenoid deficiency (e.g. glenoid type B2 or C according to Walch’s classification).

The Glenoid Bone Graft Instruments are intended to be used only with Axioma TT Metal Back.
### GLENOID BONE GRAFTING SURGICAL TECHNIQUE

#### Indications, Contraindications and Warnings

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**Material Standards**

**WARNINGS**

In selecting patients for surgery, the following factors can be critical to the success of the procedure:

- **Partial Shoulder Replacement:** In cases with a deficient and unreconstructable rotator cuff, a CTA-head is indicated.
- **Total Shoulder Replacement:** The rotator cuff must be intact or reconstructable. In cases with a deficient and unreconstructable rotator cuff, a hemiprosthesis with a CTA head or a Reverse Total Shoulder Arthroplasty is indicated.
- **Reverse Shoulder Replacement:** The bone stock of the glenoid and humerus must be able to support the implant. In cases with significant bone loss and in which adequate fixation on the glenoid side cannot be obtained, a hemiarthroplasty with a CTA-head should be performed.
- **Bone Grafting:** Once removed the graft should be inspected to ensure the bone quality is adequate for use with the glenoid bone grafting technique. The glenoid bone grafting technique should never be used with poor quality bone, as it may compromise bone healing.

**Note.** For glenoid bone grafting techniques it is important to use a peg size Medium, Long or X-Long in order to enable a minimum section of the peg into the native bone, providing component stability. The following table identifies the allowed (√) / not allowed (X) combinations between the bone graft thickness and the pegs dimensions:

<table>
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<th>Bone Graft Thickness</th>
<th>5mm GRAFT</th>
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**Note.** With CTA Heads the use of Trauma Humeral Bodies is recommended to avoid possible impingement between the head and the body when using the Finned Humeral Body.

**Note.** The metal back size “Large” is not suitable for coupling with 36 mm glenospheres.
GLENOID BONE GRAFTING SURGICAL TECHNIQUE
Indications, Contraindications and Warnings

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**CONTRAINDICATIONS**

Absolute contraindications include:

- local or systemic infection;
- sepsicaemia;
- persistent acute or chronic osteomyelitis;
- confirmed nerve lesion compromising shoulder joint function;
- deltoid muscle insufficiency.

Relative contraindications include:

- vascular or nerve diseases affecting the concerned limb
- poor bone stock (for example due to osteoporosis or extended previous revision surgery) compromising the stability of the implant;
- metabolic disorders which may impair fixation and stability of the implant;
- any concomitant disease and dependence that might affect the implanted prosthesis;
- metal hypersensitivity to implant materials.

In cases of bone tumors, use an appropriate system designed to treat cases requiring large bone resections (SMR™ Large Resections Stems). The use of primary or revision implants not designed and intended for use in cases of bone resection may result in a poor outcome and/or failure of the implant or implant fixation.

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**RISK FACTORS**

The following risk factors may result in poor results with this prosthesis:

- overweight;
- strenuous physical activities (active sports, heavy physical work);
- fretting of modular junctions;
- incorrect implant positioning;
- muscle deficiencies;
- multiple joint disabilities;
- refusal to modify postoperative physical activities;
- patient history of infections or falls;
- systemic diseases and metabolic disorders;
- local or disseminated neoplastic diseases
- drug therapies that adversely affect bone quality, healing, or resistance to infection
- drug use or alcoholism;
- marked osteoporosis or osteomalacia;
- patient’s resistance to disease generally weakened (HIV, tumour, infections);
- severe deformity leading to impaired anchorage or improper positioning of implants;
- osteolysis.
GLENOID BONE GRAFTING SURGICAL TECHNIQUE

Introduction

PREOPERATIVE PLANNING

Standard X-rays are used to assist with planning of the operation. It is recommended to use a normal AP-view in internal and external rotation as well as an axillary view, Bernageau or Morrison view. It is recommended to use a CT-Scan in fractures cases and for planning the glenoid insertion.

If required an MRI can be used for clear examination of the extent of the bone deficiency and to see the muscle/capsule quality.

In post-traumatic cases, such as in special cases of disabling shoulder, a neurological exam is helpful for decision making.

Templates are used in all osteoarthritic cases; they can also be used in fracture cases but often in a limited mode, depending on the type of fracture.

The X-ray templates provided for SMR™ have a 105% scale; digital templates are available as well.

ANAESTHESIA

Shoulder surgery is one of the areas in which an understanding of the surgery and participation by the anaesthesiologist is especially important for the outcome of the surgery. This applies to accurate preoperative evaluation of the patient as well as intra op techniques.

They should have a good understanding of positioning on the operating table and postoperative pain management.

Shoulder prosthetic replacement can be performed with regional (scaleneus) anaesthesia combined with sedation and/or with general anaesthesia.

The modern technique of interscalenic block was introduced by Winnie in 1970 and soon became the standard for anaesthesia and postoperative pain management in shoulder surgery.

Requested surgical positioning (beach chair position) must be accurately followed by the anaesthetic staff to avoid hypotension and consecutive brain hypoperfusion.

Postoperative analgesia is important and can be performed by intravenous, single injection or “on demand” application of analgesics. Patient-controlled analgesia (PCA) is recommended.

POSITIONING

Shoulder arthroplasty is normally performed in a “beach-chair” position; the surgeon needs complete access to the shoulder joint. The arm is free or stabilized by arm-holders.

The shoulder must be positioned off the edge of the table to afford unobstructed arm extension.

The patient’s head must be supported and stabilized in the neutral position. Nerve injury due to brachial plexus traction during positioning and surgery must be avoided.

If possible, one assistant should stay behind the shoulder, the second on the opposite side of the patient, so that the surgeon has a complete anterior view of the shoulder and can move the joint without any obstacle.
Introduction

ACCESS

We recommend two types of surgical approaches to the shoulder joint. As in every surgical procedure, the access depends not only on diagnosis and planned surgical treatment but also on the experience of the surgeon.

Ranges of glenohumeral motion are evaluated with the patient under anaesthesia to confirm the preoperative assessment and the extent of capsular release needed to restore the ROM postoperatively.

DELTO-PECTORAL APPROACH

Anterior vertical incision, starting 1 cm laterally of the coracoid bone, slanting towards the axillary’s pouch. If there is a metaphysal fracture, slanting laterally towards the deltoid insertion at the humerus. The cephalic vein is retracted laterally with the deltoid muscle. The clavipectoral fascia is incised along the lateral edge of the conjoined tendon up to the coracoacromial ligament.

With the clavipectoral fascia incised, a retractor can easily be placed over the superolateral aspect of the humeral head to retract the deltoid. The conjoined tendon is retracted medially.

The musculocutaneous nerve penetrates the lateral coracobrachialis muscle 3 to 8 cm distally of the tip of the coracoid process. The position of the axillary nerve should be indentified along the anterior surface of the subscapularis muscle, below the conjoined tendon. The axillary nerve crosses the inferolateral border of the subscapularis 3 to 5 mm medially of its musculotendinous junction and has an intimate anatomic relation with the inferior capsule of the shoulder joint.

The anterior humeral circumflex artery and veins are visualized, ligated and divided.

The subscapularis tendon is released, divided 1 cm medially to its attachment or with some bone chip of the lesser tuberosity. Separation of the subscapularis from the capsule and incision of the capsule is performed to the inferior border of the glenoid rim, protecting the axillary nerve with a blunt retractor. Release of the subscapularis and 360° capsular release.

Closure: In fracture cases, accurate reconstruction of the minor and major tubercles by suture, bone anchors or cerclage is mandatory.

If the long head of the biceps tendon is intact, reconstruct also the biceps groove to avoid impingement. Closure of delto–pectoral groove.
Introduction

LATERAL (DELTOID SPLITTING) APPROACH

Begin the incision at the anterolateral tip of the acromion and carry it distally over the deltoid muscle about 5 cm. Define the tendinous interval on 4 to 5 cm between the anterior and middle thirds of the deltoid; splitting the muscle here provides an avascular approach to underlying structures.

Incise the thin wall of the subdeltoid bursa and explore the rotator cuff as desired by rotating and abducting the arm to bring different parts of it into view.
Note. The Glenoid Bone Graft Instruments are intended to be used only with Axioma TT Metal Back.

Note. This surgical technique is suitable for structural bone graft only.

HUMERAL PREPARATION

The humeral head preparation is guided using a 2.5 mm K-wire. The K-wire shall be inserted into an area of the humeral head with enough bone stock in order to ensure that the subsequently obtained bone graft has sufficient thickness to achieve the desired bone-offset from the glenoid. Connect the head K-wire handle (E36) to the head K-wire positioner (D36) (Figure 1) and position it on the humeral head (Figure 2), then introduce the 2.5 mm K-wire.
Once the K-Wire has been inserted, connect the glenoid reamer (G30) of the proper size (Small or STD) to the reamers shaft (H30) (Figure 3) and to power tool and ream the bone surface (Figure 4). The aim of this operation is just to remove the cartilage and expose the subchondral bone rather than excessive bone removal.

Remove the reamer leaving the K-wire in place and prepare the central hole. The Axioma TT Metal Back reamer of the proper size (B35) is assembled with the reamer shaft (A35) and power tool (Figure 5), then passed over the K-wire. The reamer is advanced until the stopper is in contact with the surface of the prepared bone (Figure 6).

Once drilling is complete the Axioma TT Metal Back reamer and K-wire can be removed.

The instruments feature colour coding to support the surgical team during implantation. The colour code is yellow for Small-R size and orange for Small/STD size.
Select the proper size of the adaptor for graft cutter (F36 or H36) in function of the size of the Axioma TT Metal Back peg (Small-R or Small/STD) and in function of the required thickness of the bone graft. The adaptors for graft cutters are available in two diameters (Small-R and Small/STD), according to the sizes of Axioma TT Metal Back peg, and in three lengths (5, 10 and 15 mm) for producing the bone graft.

Connect the graft cutter (G36) to the power tool and insert it into the prepared hole in the humeral head (Figure 7). When the stopper of the adaptor for graft cutter is in contact with the humerus bone, the hook of the graft cutter will come out to cut the bottom part of the graft (Figure 8). Once the cut as been performed, remove the graft cutter.
ASSEMBLING OF THE FINAL IMPLANT

Remove the Axioma TT Metal Back baseplate and peg of the chosen sizes from the sterile packaging.

**Warning.** Peg size must match the baseplate size as described in the warning label on the packaging.

Apply the peg to the baseplate (Figure 9) and secure the connections using the Axioma TT Metal Back press (H35) and the torque wrench (Figure 10).

Turn clockwise the torque wrench to achieve “one click” to confirm the proper tightening. Do not exceed recommended torque as excessive tightening may damage the instrument or implant.


**INSERTION OF FINAL AXIOMA TT METAL BACK**

Screw the appropriate guide (L36 or O36) (SMALL-R or SMALL/STD) to the final implant and apply the impactor (E35) *(Figures 11-12).*

Introduce the Axioma TT Metal Back into the prepared humeral head by tapping it in with the impactor until there is complete contact with the humerus surface *(Figure 13).* Then remove the impactor by pressing the release button from the implanted Axioma TT Metal Back *(Figure 14).*
GLENOID BONE GRAFTING SURGICAL TECHNIQUE

Graft Reaming

Choose the stopper (K36 or N36) that should be assembled to the guide according to the chosen thickness of graft (5, 10 or 15 mm) (Figure 15).

Take care to choose properly the stopper as this will determine the progression of the graft reamer.

Connect the proper size of the graft reamer (J36 or M36) to the power tool and position it on the Axioma TT Metal Back, using the stopper as a guide (Figure 16).

Ream until the graft reamer stops onto the plastic part of the stopper and then remove the reamer and its guide. Reaming will be completed once the coloured plastic is visible in the middle of the eyelet of the reamer (Figure 16). In this way the bone graft cut is completed also on the diameter.
GLENOID BONE GRAFTING SURGICAL TECHNIQUE

Graft Extraction

Use the guide to remove the Axioma TT Metal Back with the graft from the humeral head (Figures 17-18).

If necessary a graft pusher (136) could be used to extract the Axioma TT Metal Back and graft from the reamer (Figure 19).

Once removed the graft should be inspected to ensure the bone quality is adequate for use with the glenoid bone grafting technique. The glenoid bone grafting technique should never be used with poor quality bone, as it may compromise bone healing.
GRAFT PREPARATION

In case a straight bone graft is required move to the section “Glenoid preparation”.

If a sloped bone graft is required, choose the graft shaper (Q36) with the proper inclination according to the glenoid deficiency (15° or 20°). Introduce the assembly composed by the guide (L36 or O36) and Axioma TT Metal Back with bone graft into the connector for graft shaping (Figure 20).

The Axioma TT Metal Back should be positioned in the way that the longer axis of the baseplate corresponds with the longer axis of the connector. Make sure that the Axioma TT Metal Back is in the right position before proceeding to the next step.

Align the arrows of the graft shaper and the connector according to the glenoid defect (Figure 21).

By rotating the shaper, the sloped graft (15° or 20°) could be positioned in the following directions as marked on the instrument:

- POST: Posterior;
- SUP: Superior;
- SUP R 45°: Superior Right 45°;
- SUP L 45°: Superior Left 45°;
- INF R 45°: Inferior Right 45°;
- INF L 45°: Inferior Left 45°.

Finally secure the components by means of the Metal Back impactor (Figure 22). Insert the headed pins into the dedicated holes of the graft shaper. The pins will be enable to keep the graft in place. Connect the reamer for graft shaping (R36) to the high-speed power tool and cut the bone graft guided by the graft shaper (Figure 23). After complete the cutting phase, remove the headed pins with the extracting pliers (V36) and the Axioma TT Metal Back from the graft shaper (Figure 24).
GLENOID PREPARATION

For the glenoid preparation use a 2.5 mm K-wire. The glenoid preparation will determine the final version of the glenoid component. All corrections should be made at this stage as no corrections can be made when impacting the implant.

The K-wire positioning jigs (A36) are used to obtain the optimal metaglene position. Choose the K-wire positioning jig according to the clinical case and the surgical technique (Figure 25). The jigs are available in two sizes (Small and STD) and with different inclinations (0°, 15° and 20° Anterior, 15° and 20° Inferior). In case of sloped bone graft, the K-wire should be positioned perpendicular to the surface of the eroded glenoid to achieve minimal bone removal. In case of straight bone graft, the K-wire should have the same direction of the final implant.

Introduce the K-wire with the proper inclination by using the K-wire positioning jigs connected to the K-wire positioning handle (Figure 26).

Glenoid reaming is performed to achieve intimate contact between the glenoid and the undersurface of the bone graft. Connect the glenoid flat reamer (B36) to the reamers shaft (A35), slide the assembly on the K-wire and ream.

In case of sloped bone graft, after the surface reaming phase, the K-wire should be repositioned perpendicular to the final intended glenoid version by using the proper K-wire positioning jig and handle.
The central hole is prepared using the Axioma TT Metal Back reamers (B35) connected to the reamer shaft (A35).

During this phase, use the glenoid stopper jig (C36) of the proper size (5, 10, 15 mm or 15°, 20° Posterior and Superior) connected to the quick connection handle (S36) (Figure 27).

The position of the stopper onto the glenoid shall reproduce the intended orientation for the final implant. Slide the assembly onto the K-wire and drill the central hole until the stop contacts the jig (Figure 28). In this way the glenoid cavity is prepared according to the thickness and the inclination of the bone graft.
FINAL IMPLANT INSERTION

Screw the appropriate guide (L36 or O36) (Small-R or Small/STD) to the final implant and apply the impactor (E35).

Introduce the Axioma TT Metal Back with the bone graft into the glenoid cavity by tapping it in with the impactor (Figure 29) until there is complete contact with the glenoid surface (Figure 30).

The long axis of the Axioma TT Metal Back should coincide with the larger axis of the glenoid.

Remove the impactor by pressing the release button and unscrew the impactor guide from the implanted Axioma TT Metal Back.

Option - The impactor can be used as a counter torque during the removal phase: first unscrew the guide using the screwdriver (L30) on the top of the assembly, then remove the impactor and the guide together. Press the release button to separate the guide from the impactor.
Once the Axioma TT Metal Back glenoid has been positioned, drill the sites for the fixation screw using the flexible drill shaft (K30) attached to the 3.5 mm drill (M30) and the drill guide (I30) (Figure 31). A 4 mm drill (U36) could be used to prepare the sites of the screws into the graft portion.

After having prepared the seating of the screw, complete the holes preparation by means of the tap drill (T36) (Figure 32).

Finally tighten the two screws using the screwdriver (L30) (Figure 33) at the same time in order to guarantee the best fit of the Axioma TT Metal Back into the prepared glenoid.

Verify that the screws enable the proper graft fixation into the native glenoid bone and are properly oriented to avoid the protrusion through the outside walls of the graft.

Finally, it is important to ensure that the bone graft and Axioma TT Metal Back is fully seated against the native glenoid and to check the proper stability of the implant.

Once the Axioma TT Metal Back has been inserted, the choice of using a reverse or an anatomic prosthesis can be made thanks to the implant modularity. Both cases are described in the standard surgical technique of the SMR™ System.
**GLENOID BONE GRAFTING SURGICAL TECHNIQUE**

**Instrument Set**

- **9013.30.000** Glenoid Instrument Set for SMR™ Shoulder Prosthesis

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<th>Ref.</th>
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GLENOID BONE GRAFTING SURGICAL TECHNIQUE
Instrument Set

9013.35.000 TT Metal Back Set

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GLENOID BONE GRAFTING SURGICAL TECHNIQUE

Instrument Set

\[\text{\textbullet\hspace{1cm} 9013.36.000 Glenoid Bone Graft Instrument Set}\]

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\text{Ref.} & \text{CODE} & \text{DESCRIPTION} \\
A36 & 9013.75.312 & \text{K-Wire Positioning Jig S 15° ANT} \\
A36 & 9013.75.319 & \text{K-Wire Positioning Jig S 20° ANT} \\
A36 & 9013.75.322 & \text{K-Wire Positioning Jig STD 15° ANT} \\
A36 & 9013.75.329 & \text{K-Wire Positioning Jig STD 20° ANT} \\
A36 & 9013.75.308 & \text{K-Wire Positioning Jig S 15° INF} \\
A36 & 9013.75.318 & \text{K-Wire Positioning Jig S 20° INF} \\
A36 & 9013.75.309 & \text{K-Wire Positioning Jig STD 15° INF} \\
A36 & 9013.75.328 & \text{K-Wire Positioning Jig STD 20° INF} \\
B36 & 9013.75.401 & \text{SMALL-R/SMALL Glenoid Flat Reamer} \\
B36 & 9013.75.405 & \text{STD Glenoid Flat Reamer} \\
C36 & 9013.75.431 & \text{5 mm Glenoid Stopper Jig} \\
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\[\begin{array}{ll}
\text{C36} & 9013.75.432 & \text{10 mm Glenoid Stopper Jig} \\
\text{C36} & 9013.75.433 & \text{15 mm Glenoid Stopper Jig} \\
\text{C36} & 9013.75.435 & \text{Posterior 15° Glenoid Stopper Jig} \\
\text{C36} & 9013.75.436 & \text{Posterior 20° Glenoid Stopper Jig} \\
\text{C36} & 9013.75.423 & \text{Superior Left 15° Glenoid Stopper Jig} \\
\text{C36} & 9013.75.424 & \text{Superior Left 20° Glenoid Stopper Jig} \\
\text{C36} & 9013.75.425 & \text{Superior Right 15° Glenoid Stopper Jig} \\
\text{C36} & 9013.75.426 & \text{Superior Right 20° Glenoid Stopper Jig} \\
\text{D36} & 9013.75.438 & \text{Head K-Wire Positioner} \\
\text{E36} & 9013.75.440 & \text{Head K-Wire Handle} \\
\text{F36} & 9013.75.441 & \text{SMALL-R 5mm Adaptor for Graft Cutter} \\
\text{F36} & 9013.75.442 & \text{SMALL-R 10mm Adaptor for Graft Cutter} \\
\text{G36} & 9013.75.443 & \text{Graft Cutter} \\
\text{H36} & 9013.75.451 & \text{5mm Adaptor for Graft Cutter} \\
\text{H36} & 9013.75.452 & \text{10mm Adaptor for Graft Cutter} \\
\text{H36} & 9013.75.453 & \text{15mm Adaptor for Graft Cutter} \\
\text{I36} & 9013.75.455 & \text{Graft Pusher} \\
\text{J36} & 9013.75.460 & \text{SMALL-R/SMALL Graft Reamer} \\
\text{K36} & 9013.75.462 & \text{5mm Stopper for SMALL-R Guide} \\
\text{K36} & 9013.75.463 & \text{10mm Stopper for SMALL-R Guide} \\
\text{L36} & 9013.75.464 & \text{SMALL-R Guide} \\
\text{M36} & 9013.75.465 & \text{STD Graft Reamer} \\
\text{N36} & 9013.75.467 & \text{5mm Stopper for Guide} \\
\text{N36} & 9013.75.468 & \text{10mm Stopper for Guide} \\
\text{O36} & 9013.75.469 & \text{Guide} \\
\text{P36} & 9013.75.470 & \text{Connector for Graft Shaper} \\
\text{Q36} & 9013.75.471 & \text{15° Graft Shaper} \\
\text{Q36} & 9013.75.472 & \text{20° Graft Shaper} \\
\text{R36} & 9013.75.474 & \text{Reamer for Graft Shaping} \\
\text{S36} & 9013.75.481 & \text{Quick Connection Handle} \\
\text{T36} & 9013.75.485 & \text{Tap Drill for Cortical Screw} \\
\text{T36} & 9013.75.486 & \text{Tap Drill for Bone Screw} \\
\text{U36} & 9084.20.084 & \text{Dia. 4 L40mm Helix Drill} \\
\text{V36} & 9066.22.180 & \text{Extracting Pliers (for Headed Pin)} \\
\text{W36} & 9095.11.C18 & \text{Headed Pin Ø2,5x18mm for Graft Shaper} \\
\text{W36} & 9013.36.990 & \text{Sterilizable Box} \\
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\[\begin{array}{ll}
\text{CODE} & \text{DESCRIPTION} \\
9013.75.301 & \text{K-wire positioning handle} \\
9013.75.315 & \text{K-wire positioning jigs S 0°} \\
9013.75.325 & \text{K-wire positioning jigs STD 0°} \\
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### Product Codes

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