Uniglide™

Unicompartmental Knee Replacement
Mk III surgical technique

Corin
Contents

Introduction 4
Congruency of the Uniglide mobile bearing 4
Restoring Biomechanics 4
Component stability 5
Instrumentation design 5
Mobile bearing option 5
Fixed bearing option 5
Operative summary 6
Pre-operative assessment 8
Preparation 9
Incision 9
Approach 9
Medial procedure 10
  Tibial preparation 10
  Sagittal cut 11
  Tibial resection 11
  Check tibial alignment 12
  Tibial sizing 12
  Femoral sizing 13
  EM femoral alignment 13
  Femoral drilling 14
  Femoral reaming: Measure - Ream - Trial technique 14
  Further femoral preparation 15
  Femoral trial 16
  Mobile bearing option (Steps 12-15) 16
    Trial reduction 16
    Final femoral preparation 16
    Implantation of definitive mobile bearing components 17
  Tibial preparation 17
  Fixed bearing option (Steps 16-18) 18
  Fixed bearing final femoral preparation 18
  Fixed bearing tibial preparation 18
  Implantation of definitive fixed bearing components 19
  Lateral unicompartmental replacement procedure 20
  Appendix A: IM femoral alignment technique 21
  Appendix B: Femoral Reaming: Trial - Measure - Ream technique 22
  Compatibility chart 24
  Ordering information 25

Appendix A: IM femoral alignment technique 21
Appendix B: Femoral Reaming: Trial - Measure - Ream technique 22
Compatibility chart 24
Ordering information 25
The unicompartmental knee replacement for any surgical need
Uniglide™

Introduction
The Uniglide Unicondylar Knee Replacement (UKR) is available as either a mobile or fixed bearing design.

Fixed and mobile options are provided for medial compartment UKR. A fixed option is provided for the lateral compartment UKR.

The triple radius design of the femoral component offers bone conservation and maintains both the facet and load centres of the natural femur, thereby providing the promise of a more natural kinematic function.

The overall design and precise instrumentation make Uniglide an extremely effective and versatile unicompartmental knee system.

Congruency of the Uniglide mobile bearing
The outer form of the femoral component consists of three blended radii which closely match the form of the natural femur. The external geometry of the femoral component, coupled with the geometry of the meniscal mobile bearing, offers a compromise between congruency and preservation of the extension and flexion facet centres, thereby providing the combination of a highly congruent, low wear bearing with the promise of a more natural kinematic function.

A mobile bearing knee system allows a high degree of congruency to be coupled with a low degree of constraint. This provides, on the one hand, a high contact area and therefore low contact stresses which act to reduce wear, while on the other hand allowing the mobility required to accommodate knee kinematics without the transfer of shear and torsional forces to the tibia.

The Uniglide femoral component is fully congruent with the tibial insert for angles of flexion up to 18°. Beyond this angle the congruency gradually decreases as the knee goes into flexion and the radius of the femoral component decreases. Knee, studies have shown that the highest forces to the knee joint occur at flexion angles between 0° and 18°. The design of the Uniglide knee retains full congruency during the most loaded part of the gait cycle, lowering contact stress and reducing wear.

Restoring Biomechanics
The design of any joint replacement system can be optimised by fully understanding the loads and kinematics experienced in the joint being replaced.

The design of the Uniglide femoral component aims to restore the prearthrotic shape of the femoral condyle, so as to retain the natural loading pattern of the knee. To this end the radii of the femoral component have been fashioned to closely replicate those found in the natural condyle. It has been shown that the interactions between the shape of the condylar form and the knee ligaments act to move the centre of rotation of the femur posterior from the extension facet centre (EFC) and distal to the flexion facet centre (FFC) as the knee moves into flexion.

This change in rotation centres, and hence line of action of forces in the knee, are closely replicated by the Uniglide knee system.
Component stability

The internal form of the femoral component consists of a double peg and stabilisation keel. The combination of a double peg and keel gives greater confidence in the rotational security of the femoral component when compared with single peg designs. When coupled with accurate femoral alignment instrumentation, this ensures the correct alignment of the femoral component during implantation. In addition to providing rotational stability, the keel section acts as a reinforcing rib to increase the strength of the femoral component.

Instrumentation design

The instrumentation for the Uniglide knee system has been designed to facilitate the use of a small incision without compromise to the accuracy of implant placement. The tibial cutting blocks are designed to allow the tibial cut to be made without significant displacement of the patella. This acts to reduce trauma to the extensor mechanism and also ensures soft tissue tensions encountered during the procedure are representative of the desired end result.

The femoral alignment guide, posterior femoral cutting blocks and femoral reamers have also been designed with a small incision in mind and as such can be used in the smaller wound with minimum impingement to the surrounding tissues.

Please see the surgical technique for further guidance on implantation of the Uniglide knee through a small incision.

Fixed bearing option

Despite the advantages inherent in a mobile bearing there are occasions when a fixed bearing option is indicated. The Uniglide knee system allows the choice of a mobile or fixed bearing option to be made intra-operatively. The Uniglide fixed bearing tibia is an all-polyethylene component which follows the proven design rationale of the St George Sled. The concept of the design follows the flat on round principle which provides a non congruent and low constraint design. This design eliminates the risk of bearing dislocation and is more forgiving for ligament instability versus a mobile design.

The fixed bearing device can be implanted using the standard instruments, with the addition of only a small number of trials and punches for the tibial preparation. This system offers the surgeon flexibility and means that the decision as to what type of implant is to be used may be delayed until the knee is open and a full assessment of its condition is made. The Uniglide fixed all polyethylene implants are available for both medial and lateral compartment UKR.

Mobile bearing option

The concept of a mobile bearing unicompartmental knee system has been established as offering a low contact-pressure system without introducing a degree of constraint which would transfer loads to the tibial plateau. The design of the Uniglide mobile bearing offers the mobility required to accommodate the rotation and translation of the femoral condyles, while providing the stability against the bearing dislocation required of a modern mobile bearing knee system. The stability against the bearing dislocation is provided by the deep dish produced by the concave articulation surface of the meniscal bearing. The result is a bearing system where the forces required to cause a dislocation of the bearing is significantly higher than in the case of other mobile bearing unicompartmental knee systems.
Operative summary

a. Tibial preparation
b. Sagittal cut
c. Tibial resection
d. Check tibial alignment
e. Tibial sizing
f. Femoral sizing
g. EM alignment of the femoral component
h. Femoral drilling
j. Femoral posterior resection

k. Starter reamer for femur

l. Distal reaming

m. Trial reduction

n. Femoral preparation

o. Tibial preparation

p. Implantation
Indications
The Uniglide Mobile Bearing Unicondylar Knee System is indicated for use in patients with osteoarthritis limited to the medial compartment of the knee and is intended to be implanted with high viscosity bone cement.

The Uniglide Fixed Bearing Unicondylar Knee System is indicated for replacement of the articulating surfaces of one tibio-femoral compartment of the knee where this has been affected by primary degenerative disease, post traumatic degenerative disease or damage due to previous surgical intervention and the anterior and posterior cruciate ligaments are present and functionally intact. The device is indicated for use in the medial or lateral compartment of the knee and is intended to be used with bone cement.

Pre-operative assessment
The Uniglide is indicated for knees with unicompartmental disease and intact ligaments, particularly the ACL. Some wear of the medial or central patello-femoral joint (PFJ) is acceptable, provided the patient does not have symptoms at that site. If the lateral side of the PFJ is involved, total or bicompartamental replacement should be considered. Small areas of full thickness wear on the lateral side are acceptable especially if due to impingement.

Inflammatory arthritis is a contraindication but obesity and modest chondrocalcinosis are not. Fixed flexion of greater than 10-15° cannot be corrected and is a contraindication, as is a significant fixed varus or valgus deformity.

ACL integrity can be assessed clinically and by ensuring that the area of worn articular cartilage does not extend to the back of the femur on the standing lateral radiograph.

Cases with medial or lateral subluxation of the tibia on the femur should be viewed with caution since achieving correct tracking of the mobile bearing can be more difficult. Stress radiographs should be taken to ensure that correction occurs when the worn side is stressed open, as will occur with insertion of the prosthesis.

Especially on the lateral side, the severity of the disease will not be appreciated unless a Schuss Rosenberg radiographic view is taken. Without these views, cases appropriate for lateral unicompartmental replacement are frequently missed.

It is recommended that the fixed bearing device is used on the lateral side, unless the surgeon is very experienced.
Preparation

The leg should be draped free with the foot exposed, and usually with a tourniquet in place. At least 120° of flexion must be possible, either by hanging the tibia or on the operating table.

The X-rays should be templated, but final measurement and sizing are performed intra-operatively.

Incision

Any of three incisions may be used for a medial bearing:

1. A full medial arthrotomy with the patella dislocated laterally. This allows total inspection of the joint and best access for implant insertion.

   Note: The patella must be reduced when checking tension and meniscal tracking.

2. A limited medial arthrotomy, probably with a mid or subvastus proximal approach, allowing subluxation but not dislocation of the patella.

3. Small incision approach, in which an 8-10cm medial approach is made, but the patella is left in situ and the quadriceps muscle is not violated.

   It is recommended that surgeons inexperienced with mobile bearing unicompartmental knee replacement initially use incision 1 or 2.

Approach

With all incisions, especially a small incision, it is essential that the patella tendon is assessed and if necessary partially released, the fat pad retracted (or excised as necessary) in order to allow a correctly directed initial sagittal tibial cut.

The knee should be extended at this stage to allow inspection of the articular surfaces and to verify the integrity of the ACL. A thick superior synovial fold should be divided to aid extensor mechanism retraction.

It is also strongly recommended that early in the procedure, osteophytes are removed from both sides of the femoral condyle to correctly define its width and avoid encroachment on the ACL or collateral ligaments.
Step 1. Tibial preparation

Place the tibial alignment cutting block against the anterior aspect of the tibia and align the jig as shown. Initially, correct rotation should be achieved so that the jig rests in the sagittal plane and the tibial clamp points towards the medial malleolus.

Surgeons should try to replicate the individual patient’s tibial slope, (distally, the cutting jig should be approximately 1-2cm further from the front of the tibia than proximally). A 7° posterior slope is built into the jig.

Insert the stylus into the cutting block and adjust the height to resect the desired amount of bone. With a worn tibia 2mm is adequate, whilst with minimal wear a 7mm resection will typically be required.

Fix the cutting block with two parallel pins.

Ideally the surgeon should pre-operatively measure the individual patient’s tibial slope on a lateral X-ray in order to replicate it.

Remove the stylus

The tibial cut should have a 7° posterior slope relative to the long axis of the tibia, and should be neutral for varus/valgus.

⚠️ The tendency is always to make a varus cut.

Remove the tibial alignment jig and check that the alignment is correct using the alignment check rod. When satisfied that correct alignment has been achieved, further impact the original two fixation pins and fix the block with the A-P locking pin.
Step 2. Sagittal cut
The sagittal cut is made parallel to the guide and down onto the tibial cutting block with the reciprocating saw pointing towards the femoral head. This cut should be made as close as possible to the ACL. The direction of this cut is crucial to avoid later tracking problems. For this reason it is advised that the head of the femur is marked with a clip.

Note: The posterior cortex needs to be cut but this must be done cautiously so as not to over-resect the posterior tibia.

Step 3. Tibial resection
Resect the top of the tibia taking great care not to undercut the ACL. Remove the resected bone. This is most easily done with the knee in 20°-30° of flexion.

It is recommended that the resected bone is "loosened" as far as possible with an osteotome before grasping and dividing the surrounding soft tissue. On occasions removal can be difficult, particularly in the presence of significant posterior osteophytes. By looking at the resected bone you can check the slope is correct by ensuring an even thickness anterior and posterior.

Remove the locking pin and block but leave the parallel pins in situ.

⚠️ It is possible to undercut the ACL at this point. This should be avoided.
Check that there is adequate space in flexion for at least a 7mm spacer lollipop to be inserted easily. The 7mm spacer lollipop here represents a combined tibial tray and insert thickness. If the spacer lollipop cannot be inserted easily, further tibial resection will be required.

\[ 7\text{mm} = 4\text{mm insert} + \text{tibial template thickness} \]

**Step 4. Check tibial alignment**

Place the check plate on the cut surface and ensure correct alignment using the rod, which should be directed towards the medial malleolus of the tibia and should indicate a 7° posterior slope.

Make any adjustments necessary. Minor (2°) errors of varus/valgus can be corrected by placing the varus/valgus cutting block on the pins and recutting. The amount removed will be minimal but makes an important difference since the rest of the procedure depends on this being correct.

**Step 5. Tibial sizing**

Measure the tibial size using the feeler gauge for A-P measurement, and check the indicated tibial trial against the resected tibial plateau, ensuring that it gives full cover, especially posteriorly and medially.

The tibial trial must not overhang medially more than 2mm. If this happens either a smaller size must be used or further bone must be resected centrally, being careful not to damage the ACL.
Impact the tibial trial firmly using the C-arm impactor. If the joint space is tight, the plastic foot may be removed to ease its insertion.

Note: Choose the appropriate size and use the dedicated fixed or mobile tibial template to prepare the tibia.

Step 6. Femoral sizing
Pre-operative templating should be checked using the femoral sizing guides, and the appropriate size selected. If borderline, choose the smaller size.

The fit for the femoral component is referenced off the posterior condyle and the anterior limit should not extend into the patello-femoral joint.

Note: The following steps show the setting of femoral alignment using an extra medullary alignment technique. An alternative technique utilising intra medullary instrumentation is shown in Appendix A.

Step 7. EM femoral alignment
Set the femoral alignment jig to the selected size and place it on a lollipop which loosely fills the flexion gap, normally 4 or 5mm. This must be parallel to the edge of the tibial trial. Insert the rod through the anterior hole and align with the femoral shaft in the sagittal plane by adjusting the degree of knee flexion (which should be 97°), erring on the side of flexion rather than extension.

In the coronal plane, the rod should point to the femoral head. If the patella is reduced the tibia must not be rotated to achieve this. If the patella has been reflected, the tibia may need to be rotated back to its correct position. Ensure that the holes will be centred on the femoral condyles.
Step 8. Femoral drilling
Once correct alignment has been achieved, with the knee at 97°, drill the smaller femoral anchorage hole and insert the T-pin or leave the drill in situ. Drill the larger posterior hole to its stopped depth. Remove the femoral alignment jig.

Step 9(ii). Femoral preparation
Position the appropriate sized femoral cutting block using the pre-drilled holes and resect the posterior condyle. 6mm of bone and cartilage is resected. This cut must be done accurately. Remove the block.

Step 9. Femoral reaming: Measure - Ream - Trial technique

Step 9 (i). Measuring for deficiency
Any deficiency in the distal femoral condyle is determined by measuring the existing flexion and extension gaps using the spacer lollipops. The degree of deficiency is the extension gap minus the flexion gap. This measured deficiency is used in step 15 to set the initial depth for distal femoral reaming.

Note: An alternative sequence (Trial-Measure-Ream Technique) to that described in step 9 for achieving the correct depth of reaming is presented in Appendix B.
Step 9(iii). Starter reamer for femur
Set the resection depth on the small starter reamer according to the difference in flexion and extension gaps – i.e. set the resection depth to 3mm minus the deficiency measured in step 9(i). Remove cartilage or bone from the distal femur to the set depth. This is typically 2mm, but the reamer allows 1, 2 or 3mm resection to suit the condition of the distal femoral condyle.

<table>
<thead>
<tr>
<th>Distal deficiency</th>
<th>Starter reamer setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>3mm</td>
<td>only use spherical shaping reamer of correct size</td>
</tr>
<tr>
<td>2mm</td>
<td>1</td>
</tr>
<tr>
<td>1mm</td>
<td>2</td>
</tr>
<tr>
<td>0mm</td>
<td>3</td>
</tr>
</tbody>
</table>

Step 9(iv). Distal reaming
Take the correct sized spherical shaper reamer and ream the distal femur until the level set by the starter reamer has been reached.

⚠️ Care must be taken to accurately align the reamer in the guide hole and maintain alignment whilst reaming. The reamer has a stop to prevent excess bone removal.

Step 10. Further femoral preparation
Remove any excess bone posterior to the reamed surface so that the prosthesis can be seated. Remove any posterior femoral osteophytes using the chisel provided.
Step 11. Femoral trial
Position the femoral trial and tibial template and check the flexion and extension gaps using the spacer lollipops. The gaps must be equal. Remove the lollipop whilst bringing the knee from flexion to extension to avoid trauma to the ACL.

Normally, the initial suggested 2mm distal ream is adequate, but it may be necessary to ream the distal femur further. This is done in small steps, initially using the starter reamer, followed by the spherical reamer, regularly checking the flexion and extension gaps with the spacer lollipop until equality is achieved.

⚠️ The bearing trial can be difficult to take out and removal of the femoral trial component may be necessary. A trial insert introducer/extractor has been included in the kit to aid with this step.

Mobile bearing option (Steps 12-15)

Step 12. Trial reduction
With the femoral and tibial trial components in place, test the tracking by insertion of a trial bearing. This can be done in mid flexion by moving the knee from flexion to extension with valgus stress. Alternatively the trial bearing can be inserted at the same time as the femoral trial component, provided there is adequate flexion on the tibial cut.

A tight fit should be obtained, but the knee must not be forced into over-correction and the bearing trial must move smoothly, without lifting in flexion.

⚠️ If satisfactory tracking cannot be obtained, check that there is no residual meniscus or posterior osteophyte causing maltracking.

Step 13. Final femoral preparation
Position the femoral trial and use a reciprocating saw to create the femoral keel groove. The keel cutter should be used to complete the cut, ensuring that it is sunk to the correct mark. It is also possible to prepare keying holes for cement fixation using a drill.

Note: The first 11 steps apply to both the mobile and fixed bearing operative techniques. Continue to follow Steps 12 to 15 for the mobile bearing option. Advance to Step 16 for the fixed bearing option.
Step 14. Tibial preparation
Position the tibial trial and initiate the keel groove with a reciprocating saw or burr. Bony debris generated can be removed with the keel pick ensuring that it can be sunk to the full depth. The correct size tibial keel chisel/punch should be used next, with the tibial template in situ, impacting down fully with the C-arm impactor. The chisel should be used first, then the punch.

Note: To ensure sufficient bone removal to seat the definitive tibial tray flush against the resected surface, the final tibial preparation is done after removing the tibial template with the tibial punch, sinking it to maximum depth.

⚠️ Take care not to injure the anterior or posterior cortex.

Step 15. Implantation of definitive mobile bearing components
Implantation of device components can then be performed using bone cement.

It is advisable to place the cement on the component rather than the bone, since this avoids displacing cement to the back of the joint.

Place the tibial component in position first, followed by the femoral component.

Note: Ensure the tibial component sits flush against the resected bone.
Maintain the knee in mid-flexion during cement polymerisation, with an adequate lollipop in place. Do not insert a bearing trial at this stage as it can be very difficult to remove. Assess the meniscal thickness using the lollipops and keep in mind the tension achieved with the trial components in place. Once the cement has polymerised, insert the appropriate mobile bearing, moving the knee from flexion to extension with valgus stress to ease insertion.

**Fixed bearing option (Steps 16-18)**

**Step 16. Fixed bearing final femoral preparation**

Femoral preparation for this fixed bearing is exactly the same as the mobile bearing, step 13. Position the femoral preparation trial and initiate the keel groove with a reciprocating saw. Complete the cut with the keel cutter, ensuring that it can be sunk to the appropriate mark. It is also possible to prepare keying holes for cement fixation using a drill.

**Step 17. Fixed bearing tibial preparation**

Take the appropriate size fixed tibial trial (size 3, 5 or 7) and remove bone from the anchorage hole using an osteotome. The burr and keel pick may also be used.
Use the punch (size 3, 5 or 7) to ensure an adequate recess has been created to accommodate the keel of the fixed bearing tibial component.

**Step 18. Implantation of definitive fixed bearing components**

The all polyethylene fixed bearing component must be cemented into place. Place the tibial component in position first, followed by the femoral component. Maintain the knee in mid-flexion during polymerisation. Great care must be taken not to displace cement to the back of the knee. To prevent this, it is advisable to place the cement on the component rather than the bone.
Step 1. A lateral parapatellar approach is made and the patella retracted medially or subluxed to give better vision.

Step 2. With the knee flexed to 90°, the lateral femoral condyle is marked at the contact point with the tibia, the tibial contact is also marked 1. This process is repeated with the leg in full extension 2. The two points are then connected with diathermy to guide the orientation of the implant. This guides the direction of the tibial cut which is internally rotated by about 30°.

Step 3. The tibial alignment jig is applied to the leg and pinned in place. It is usually only necessary to resect a small amount of tibial bone, since there is frequently some femoral loss or hypoplasia. This should be done with a 3° posterior slope rather than 7° on the medial side.

Step 4. Perform the tibial sagittal cut in the line of the ACL (the cruciate cut) which is in some 30° of internal rotation (see fig. 1). The saw does not point to the femoral head but towards the iliac crest.

Step 5. Carry out alignment checks as for the medial side and select the trial tibial baseplate which doesn’t overhang posteriorly by more than 2mm.

Step 6. Use the femoral alignment tower with the knee in 90° of flexion and drill the anchorage holes, keeping as far lateral as possible.

Note: The rod will point towards the iliac crest and not the head of femur, but must be parallel to the femoral shaft.

Step 7. Resect the posterior condyle and complete the procedure as for the medial side.

All instruments are marked for use in the medial compartment. Thus for a left lateral replacement, cutting blocks marked ‘right’ should be used, and vice versa.
Appendix A
IM femoral alignment technique

Step A7(i). IM alignment
The intramedullary alignment guide is added as an option to assure proper alignment of the femoral component by providing for surgeon flexibility using either an extramedullary guide OR an intramedullary guide.

With the knee flexed at about 45°, a hole should be made into the intramedullary canal of the femur using the 6mm drill. The hole should be drilled 1cm anterior to the anteromedial corner of the intercondylar notch.

Step A7(ii). IM rod insertion
Insert the long or short IM rod into the 6mm hole, leaving enough room for the femoral alignment guide. The knee can now be flexed to 97° – take care as the medial border of the patella can abut the intramedullary rod.

Note: The IM rod can also assist as a retractor for the patella.

Step A7(iii). IM femoral alignment
Replace the tibial template; insert the femoral alignment guide with lollipop, as per the EM alignment option. The femoral alignment guide can now be introduced and made to rest in the middle of the condyle.

To achieve 7° of valgus, the IM rod should be parallel to the lateral side of the femoral alignment guide when viewed from above. This can be achieved by internal and external rotation of the tibia.

By adjusting the degree of flexion of the knee, the upper surface of the alignment guide is made to lie parallel with the IM rod when viewed from the side.
Step B9(i). Posterior resection and femoral shaping

Note: Use of this technique replaces steps 12(i) to (iv) in the standard technique.

Position the appropriate sized femoral cutting block using the pre-drilled holes and resect the posterior condyle. 6mm of bone and cartilage is resected. This cut must be done accurately.

Remove the block.

Step B9(ii). Deficiency measurement

Position the femoral trial in place and check the flexion and extension gaps using the spacer lollipops. Both flexion and extension gaps should be checked without the tibial template in-situ. The spacer lollipop here represents a combined thickness of tibial insert and template. eg 7mm spacer lollipop = 4mm insert + tibial template thickness.

Note: In instances where the flexion gap is greater than 12mm the tibial template will also need to be placed during flexion and extension gap checking. In this case the spacer lollipop represents the true insert thickness.

Both the flexion and extension gaps must be equal. Remove the lollipop whilst bringing the knee from flexion to extension to avoid trauma to the ACL.
If the flexion and extension gaps are not equal, it may be necessary to further ream the distal femur by the amount that the gap was tight in extension.

Note: The knee will normally be tighter in extension by 1-3mm. This amount is used in step B9(iii) to proximalise the femoral component.

Step B9(iii). Distal reaming

Set the resection depth on the small starter reamer according to the difference in flexion and extension gaps – i.e. set the resection depth to the difference measured in step B12(ii).

Take the correct sized spherical reamer and ream the distal femur until the level set by the starter reamer has been reached.

Note: Care must be taken to accurately align the reamer in the guide hole and maintain alignment whilst reaming. The reamer has a stop to prevent excess bone removal.

<table>
<thead>
<tr>
<th>Gap difference</th>
<th>Starter reamer setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>0mm</td>
<td>gap balanced, proceed to trial reduction</td>
</tr>
<tr>
<td>1mm</td>
<td>1</td>
</tr>
<tr>
<td>2mm</td>
<td>2</td>
</tr>
<tr>
<td>3mm</td>
<td>3</td>
</tr>
</tbody>
</table>
### Ordering information

#### Femoral component: CoCr
- 514.1200 Size 2 Cementless
- 514.1300 Size 3 Cementless
- 514.1400 Size 4 Cementless
- 515.0500 Size 2 Cemented
- 515.0600 Size 3 Cemented
- 515.0700 Size 4 Cemented

#### Femoral component: CoCr with TiN coating
- 514.0200 Size 2 Cementless
- 514.0300 Size 3 Cementless
- 514.0400 Size 4 Cementless
- 515.0200 Size 2 Cemented
- 515.0300 Size 3 Cemented
- 515.0400 Size 4 Cemented

#### Tibial component: CoCr
- 525.1200 Size 2 Cementless
- 525.1300 Size 3 Cementless
- 525.1400 Size 4 Cementless
- 525.1500 Size 5 Cementless
- 525.1600 Size 6 Cementless
- 525.1700 Size 7 Cementless
- 525.1800 Size 8 Cementless
- 524.1200 Size 2 Cemented
- 524.1300 Size 3 Cemented
- 524.1400 Size 4 Cemented
- 524.1500 Size 5 Cemented
- 524.1600 Size 6 Cemented
- 524.1700 Size 7 Cemented
- 524.1800 Size 8 Cemented

#### Tibial component: CoCr with TiN coating
- 525.0200 Size 2 Cementless
- 525.0300 Size 3 Cementless
- 525.0400 Size 4 Cementless
- 525.0500 Size 5 Cementless
- 525.0600 Size 6 Cementless
- 525.0700 Size 7 Cementless
- 525.0800 Size 8 Cementless

#### Mobile tibial bearing UHMWPE
- 530.0204 Size 2 4mm
- 530.0205 Size 2 5mm
- 530.0206 Size 2 6mm
- 530.0207 Size 2 7mm
- 530.0208 Size 2 8mm
- 530.0209 Size 2 9mm
- 530.0210 Size 2 10mm
- 530.0211 Size 2 11mm
- 530.0212 Size 2 12mm

#### Fixed tibial component UHMWPE
- 530.0304 Size 3 4mm
- 530.0305 Size 3 5mm
- 530.0306 Size 3 6mm
- 530.0307 Size 3 7mm
- 530.0308 Size 3 8mm
- 530.0309 Size 3 9mm
- 530.0310 Size 3 10mm
- 530.0311 Size 3 11mm
- 530.0312 Size 3 12mm
# Uniglide™

| Instrumentation |  
|-----------------|------------------------------------------------|
| **Mobile tibial preparation** | **Femoral preparation** |
| 268.972 | 268.973 |
| **Tibial preparation and tibial templating instrument set** | **Femoral preparation and insert trials instrument set** |
| **Upper tray** | **Upper tray** |
| BC8K-3B01-000 Tibial template trial - Size 2 | 615.0002 Femoral sizer template - Sizes 2 |
| BC8K-3B02-000 Tibial template trial - Size 3 | 615.0004 Femoral sizer template - Sizes 3 and 4 |
| BC8K-3B03-000 Tibial template trial - Size 4 | BC8J-1G05-000 Femoral alignment tower |
| BC8K-3B04-000 Tibial template trial - Size 5 | BC8J-1G03-000 Femoral tower alignment T-pin |
| BC8K-3B05-000 Tibial template trial - Size 6 | BC8J-4B00-003 Femoral drill 6mm |
| BC8K-3B06-000 Tibial template trial - Size 7 | BC8J-4B00-001 Femoral drill 3mm |
| BC8K-3B07-000 Tibial template trial - Size 8 | BC8J-4B00-002 Femoral drill 5mm |
| BC8K-2G01-000 C-Arm impactor including: | BC8J-1G02-000 6mm IM rod |
| BC8K-2G02-000 Plastic foot | BC8J-1G04-000 6mm IM rod (long) |
| BC8K-3G00-001 Tibial cut check plate | BC8J-1B01-000 Femoral cutting block - Size 2 |
| BC8A-1G01-000 EM rod with bush | BC8J-1B02-000 Femoral cutting block - Size 3 |
| BC8A-2G00-001 Curved osteotome | BC8J-1B03-000 Femoral cutting block - Size 4 |
| 631.000 Femoral alignment spacer lollipop 4, 5mm | 613.0000 Starter reamer |
| 631.002 Femoral alignment spacer lollipop 6, 7mm | BC8J-4B01-000 Spherical reamer - Size 2 |
| 631.004 Femoral alignment spacer lollipop 8, 9mm | BC8J-4B02-000 Spherical reamer - Size 3 |
| 631.006 Femoral alignment spacer lollipop 10, 11mm | BC8J-4B03-000 Spherical reamer - Size 4 |
| 631.008 Femoral alignment spacer lollipop 12, 13mm | BC8J-3B00-011 Femoral trial with slot - Size 2 |
| BC8J-9G01-000 Spherical reamer - 12mm spanner | BC8J-3B00-012 Femoral trial with slot - Size 3 |
| BC8J-9G02-000 Spherical reamer - 14mm spanner | BC8J-3B00-015 Femoral trial with slot - Size 4 |
| 268.921T Tibial templating tray | 616.0060 Femoral slot punch |
| **Lower tray** | **Container** |
| BC8K-1G01-012 Tibial alignment jig consisting of: | 268.900T Stainless steel instrument container, double height |
| BC8K-1G01-013 Inner shaft | |
| BC8K-1G01-014 Outer shaft | |
| BC8K-1G01-003 Ankle clamp | |
| BC8K-1G01-004 Ankle clamp screw | |
| BC8K-1G01-017 Inner shaft screw | |
| BC8K-2L02-000 Tibial resection block left and nut | |
| BC8K-2R02-000 Tibial resection block right and nut | |
| BC8K-1L00-001 Tibial resection block left +2° | |
| BC8K-1L00-002 Tibial resection block left -2° | |
| BC8K-1R00-001 Tibial resection block right +2° | |
| BC8K-1R00-002 Tibial resection block right -2° | |
| 291.512 Angel wing | |
| 268.100 Dialable stylus | |
| 650.002 Pin set | |
| 291.617 Pin impactor | |
| 650.001 Pin puller | |
| 268.920T Tibial preparation tray | |
| Container | |

## Mobile tibial preparation

- **Upper tray**
  - BC8K-3B01-000 Tibial template trial - Size 2
  - BC8K-3B02-000 Tibial template trial - Size 3
  - BC8K-3B03-000 Tibial template trial - Size 4
  - BC8K-3B04-000 Tibial template trial - Size 5
  - BC8K-3B05-000 Tibial template trial - Size 6
  - BC8K-3B06-000 Tibial template trial - Size 7
  - BC8K-3B07-000 Tibial template trial - Size 8
  - BC8K-2G01-000 C-Arm impactor including:
    - BC8K-2G02-000 Plastic foot
  - BC8K-3G00-001 Tibial cut check plate
  - BC8A-1G01-000 EM rod with bush
  - BC8A-2G00-001 Curved osteotome
  - 631.000 Femoral alignment spacer lollipop 4, 5mm
  - 631.002 Femoral alignment spacer lollipop 6, 7mm
  - 631.004 Femoral alignment spacer lollipop 8, 9mm
  - 631.006 Femoral alignment spacer lollipop 10, 11mm
  - 631.008 Femoral alignment spacer lollipop 12, 13mm
  - BC8J-9G01-000 Spherical reamer - 12mm spanner
  - BC8J-9G02-000 Spherical reamer - 14mm spanner
  - 268.921T Tibial templating tray

## Femoral preparation

- **Upper tray**
  - 615.0002 Femoral sizer template - Sizes 2
  - 615.0004 Femoral sizer template - Sizes 3 and 4
  - BC8J-1G05-000 Femoral alignment tower
  - BC8J-1G03-000 Femoral tower alignment T-pin
  - BC8J-4B00-003 Femoral drill 6mm
  - BC8J-4B00-001 Femoral drill 3mm
  - BC8J-4B00-002 Femoral drill 5mm
  - BC8J-1G02-000 6mm IM rod
  - BC8J-1G04-000 6mm IM rod (long)
  - BC8J-1B01-000 Femoral cutting block - Size 2
  - BC8J-1B02-000 Femoral cutting block - Size 3
  - BC8J-1B03-000 Femoral cutting block - Size 4
  - 613.0000 Starter reamer
  - BC8J-4B01-000 Spherical reamer - Size 2
  - BC8J-4B02-000 Spherical reamer - Size 3
  - BC8J-4B03-000 Spherical reamer - Size 4
  - BC8J-3B00-011 Femoral trial with slot - Size 2
  - BC8J-3B00-012 Femoral trial with slot - Size 3
  - BC8J-3B00-015 Femoral trial with slot - Size 4
  - 616.0060 Femoral slot punch
  - BC8J-2G01-000 Femoral impactor
  - 268.922T Femoral preparation tray
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<th>Fixed add-on option instrument set</th>
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