T2®
Ankle Arthrodesis Nail
Operative Technique
This publication sets forth detailed recommended procedures for using Stryker devices and instruments. It offers guidance that you should heed, but, as with any such technical guide, each surgeon must consider the particular needs of each patient and make appropriate adjustments when and as required.

A workshop training is recommended prior to performing your first surgery. All non-sterile devices must be cleaned and sterilized before use.

Follow the instructions provided in our reprocessing guide (L24002000). Multi-component instruments must be disassembled for cleaning. Please refer to the corresponding assembly/disassembly instructions.

Please remember that the compatibility of different product systems have not been tested unless specified otherwise in the product labeling.

See package insert (Instruction for Use) (L22000007) for a complete list of potential adverse effects, contraindications, warnings and precautions. The surgeon must discuss all relevant risks including the finite lifetime of the device with the patient when necessary.
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**Technical Details**

**T2 Ankle Arthrodesis Nail**

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<tr>
<th>Diameter</th>
<th>10, 11 and 12mm (Left and Right)</th>
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<td>150, 200 and 300mm</td>
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**Note:**
- Driving end diameter is 12mm for all nails.

### 5.0mm Partially Threaded Locking Screws (Shaft Screws)

- L=25mm – 120mm

**Note:**
- Screw length is measured from top of head to tip.

### 5.0mm Fully Threaded Locking Screws

- L=25mm – 120mm

### Compression Screw (cannulated)

### End Caps

<table>
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<tr>
<th>Standard</th>
<th>+5mm</th>
<th>+10mm</th>
<th>+15mm</th>
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**Fig. 1**
View from distal
Intended Use & Indications

The T2 Ankle Arthrodesis Nail is intended for tibiotalocalcaneal arthrodesis (fusion) and allow to stabilization of the hindfoot and ankle including the transverse tarsal joints coupling the mid-foot to the hindfoot. Examples of specific indications include:

- Post-traumatic or primary arthrosis
- Previously infected arthrosis (second degree)
- Revision of Failed Ankle arthrodesis
- Failed Total Ankle Replacement
- Avascular Necrosis of the Talus (requiring tibiocalcaneal arthrodesis)
- Neuroarthropathy or Neuromuscular Deformity or other neuromuscular disease with severe deformity or instability of the ankle
- Rheumatoid arthritis with severe deformity such as rheumatoid hindfoot
- Osteoarthritis
- Nonunions or Pseudarthrosis of hindfoot and distal tibia
- Malunited tibial pilon fracture
- Charcot foot
- Severe endstage degenerative arthritis
- Severe defects after tumor resection
- Pantalar arthrodesis

Contraindications

The T2 Ankle Arthrodesis Nail should not be used if following conditions are present:

- Tibial malalignment of > 10° in any plane
- Severe vascular deficiency
- Osteomyelitis or soft tissue infection

Note:
Please see package insert for warnings, precautions, adverse effects and other essential product information.

Contraindications:

The physician’s education, training and professional judgement must be relied upon to choose the most appropriate device and treatment. Conditions presenting an increased risk of failure include:

- Any active or suspected latent infection or marked local inflammation in or about the affected area.
- Compromised vascularity that would inhibit adequate blood supply to the fracture or the operative site.
- Bone stock compromised by disease, infection or prior implantation that can not provide adequate support and/or fixation of the devices.
- Material sensitivity, documented or suspected.
- Obesity. An overweight or obese patient can produce loads on the implant that can lead to failure of the fixation of the device or to failure of the device itself.
- Patients having inadequate tissue coverage over the operative site.
- Implant utilization that would interfere with anatomical structures or physiological performance.
- Any mental or neuromuscular disorder which would create an unacceptable risk of fixation failure or complications in postoperative care.
- Other medical or surgical conditions which would preclude the potential benefit of surgery.

Precautions

Stryker Systems have not been evaluated for safety and compatibility in Magnetic Resonance (MR) environment and have not been tested for heating or migration in the MR environment, unless specified otherwise on the product labels.
Pre-operative Planning

Preoperative clinical and radiological assessments are very important for the surgical outcome.

- Clinical assessment comprises: evaluation of pain, quality and viability of soft tissue at the surgical site, neurological and vascular status.
- Radiological assessment of the ankle includes: weight bearing anteroposterior and lateral views. A lateral hindfoot and Broden’s view are useful in evaluating the subtalar and transverse tarsal joints.
- Appropriate implant size can be selected with the T2 Ankle X-Ray Template (1806-3217).

Locking Options

Based on the clinical and radiological assessment, different locking options can be used to obtain the Tibio-talocalcaneal fusion:

Apposition/Compression Locking Mode:
- Tibio-talo internal compression with or without additional talocalcaneal external compression (static locking proximal)
- Tibio-talocalcaneal external compression (static locking proximal and distal)

Static Locking Mode:
- Talocalcaneal static locking with proximal static locking

Dynamic Locking Mode:
- The proximal oblong hole allows for secondary dynamization
Patient Positioning and Joint Surface Preparation

**Positioning**

Place the patient supine on a radiolucent table (Fig. 2). Care should be taken to assure neutral alignment of the knee and ankle. Prepare the entire foot and ankle and drape the limb free from above the knee to allow intraoperative assessment of lower limb alignment to avoid malalignment later in the procedure.

The lower limbs should hang over the operating table about 15–20cm and the affected limb should be elevated by placing a bolster under the calf.

This position will allow:

- Easy exposure to the C-Arm for the X-Ray control
- Proximal locking from medial side and distal locking from lateral side
- Convenient access for posterior locking of the PA calcaneal screw.

Place the C-Arm on the opposite side and make sure that both lateral and anteroposterior views of the lower limb can be obtained.

**Exposure**

Make a 5–6 cm lateral incision in line with the distal lateral malleolus.

To gain access to the tibiotalar joint, resection of the most distal portion of the fibula just above the tibiotalar joint might be required (Fig. 3). This allows adequate exposure of the tibiotalar joint and may provide source of bone graft if required. Resect the distal fibula at an angle superolateral to inferomedial to prevent prominence after healing (Fig. 4).

Any exposure (lateral or medial) may be used as long as it allows adequate access to the tibiotalar and subtalar joints. In complex cases, exposure of both sides might be required.
Joint Preparation

Correction of any deformity should be addressed at this time. Generally, the contours of the tibiotalar and subtalar joints are maintained with denuding of any articular cartilage. Sometimes a “flat on flat” surface can be used depending on surgeon preference. Tibiotalar joint preparation may be aided by a laminar spreader or distraction of some kind. Care should be taken to avoid excessive bony resection which may later result in limb shortening or loss of talar fixation.

Ankle positioning for fusion

Several authors have attempted to define the optimal position for ankle arthrodesis without objective multiplanar radiographic analysis and consistent reference points (4). Position the foot with neutral ankle dorso-plantar flexion, 5°–10° external rotation in relation to the tibial crest and 5° of hindfoot valgus seems to be the most accepted. (Fig. 5). An assistant should maintain this position for proper entry point determination.

Incision and Entry Point

Incision

After joint preparation and confirmatory X-Ray evaluation of fusion position, the incision point is determined as follows:

Place a K-Wire (1806-0050S) on the plantar surface (1/3 lateral) and take an axial heel view to align it with the longitudinal axis of the calcaneus (Fig. 6). Mark this line with a pen on the skin. Next, place the K-Wire on the lateral side of the ankle aligning the wire along the tibial axis on a lateral fluoroscopic view. Mark this line with a pen on the skin extending the line onto the plantar surface (Fig. 7).

The starting point for the incision is determined by the intersection of the two lines on the plantar surface.

The line marked on the plantar surface which is aligned with the longitudinal axis of the calcaneus will also help align the Aiming Adapter after Nail insertion.

A longitudinal incision approximately 2–3cm should be made at this intersection. Careful dissection is then utilized to gain access to the plantar surface of calcaneus.
Operative Technique

Entry Point

The entry point is made under lateral and axial heel fluoroscopy control (Fig. 8) by using one of the following options:

- A center-tipped Drill Ø4.2×340mm (1806-4260S).
- Rigid Reamer Ø12mm (1806-2014) or a Stepped Reamer, Ø8×12mm (1806-2013), over a Ø3×285mm (1806-0050) K-Wire.

The Wire should be inserted to the level of the superior aspect of the talar cut or prepared surface. Once this position has been verified as center/center in the talus, the Rigid or Stepped Reamer is inserted over the wire.

It is recommended in this case to use the Protection Sleeve Retrograde (703165).

Note:

Do not use bent K-Wires.

The axial heel view can help center and assure good position within the calcaneal body. Stop the Drill or Stepped Reamer after passing through the tibial articular surface gaining access into the tibial canal.
Operative Technique

Reaming

Insert the Ø3×800mm Ball Tipped Guide Wire (1806-0080S) with the Guide Wire Handle (1806-1095 and 1806-1096) through the talocalcaneal and tibiotalar joints. Reaming is then performed with the Bixcut Reamers in 0.5mm increments until cortical contact is made within the tibia. For easier nail insertion, the medullary canal should be reamed 1-1.5mm more than the nail diameter selected (Fig. 9).

The Ball Tip at the end of the Guide Wire will stop the Bixcut Reamer (Fig. 10).

Note:
Prior to reaming, it is important to check the centered intra-medullary position of the Guide Wire with image intensifier.

Prior to nail insertion, the Ø3×800mm Ball Tip Guide Wire must be exchanged for a Ø3×800mm Smooth Tip Guide Wire (1806-0090S).
Operative Technique

The Guide Wire Pusher can be used to help keep the Guide Wire in position during reamer shaft extraction. The metal cavity at the end of the handle pushed on the end of the power tool facilitates to hold the Guide Wire in place when starting to pull the power tool (Fig. 11). When close to the Guide Wire end place the Guide Wire Pusher with its funnel tip to the end of the power tool cannulation (Fig. 12). While removing the power tool the Guide Wire Pusher will keep the Guide Wire in place.

Caution:
The diameter of the driving end of the 10mm–11mm diameter nails is 12mm. Additional metaphyseal reaming may be required to facilitate nail insertion. 12mm nails have a constant diameter.

Note:
• The Ball Tip Guide wire must be exchanged for the 3 × 800mm Smooth Tip Guide Wire (1806-0090S) prior to nail insertion.
• Use the Teflon Tube (1806-0073S) for the Guide Wire exchange.
Operative Technique

Target Device Assembly

Pre-load the Compression Screw (1818-0001S).
Use the Compression Screwdriver (1806-3210) to insert the Compression Screw into the nail (Fig. 13a).
Make sure the screw is set between the round and the oblong hole.

Prior to nail insertion, the Ball Tip Guide Wire must be exchanged for a Smooth Tip Guide Wire.

The pre-loaded Compression Screw is cannulated but does not allow the ball tip to pass through.

Assemble the Apposition Handle (1806-3215) onto the Nail Adapter (1806-3211). Turn the Apposition Handle until the end of the threads in order not to influence the insertion depth of the nail (Fig. 13b).

Attach the selected nail to the Nail Adapter (Fig. 13c) until it’s 3 connection teeth engage into the corresponding slots of the Nail.

The Nail Holding Screw (1806-3203) is placed through the Nail Adapter and tightened securely with the Insertion Wrench (1806-0135) and Wrench 8/10mm (1806-0130) to avoid loosening during Nail insertion. Engravings on the Nail Adapter will indicate lateral direction.

Insert the Target Arm (1806-3212) over the Nail Adapter and lock it in the “Lateral Locking” position. Attach the Aiming Adapter (1806-3216) and secure the whole assembly by tightening the Nut (1806-3213) (Fig. 14).

Prior to nail insertion please check correct alignment of the Targeting Device by inserting a Ø4.2×340mm Drill (1806-4260S) through the assembled Tissue Protection (1806-0185) and Drill Sleeve, Long, (1806-0215) placed into the Targeting Arm and targeting all “Lateral Locking” holes of the implant.

Note:
• If the Apposition Sleeve (1806-3214) is to be used, slide it over the nail and Nail Adapter prior to nail insertion.
• The Aiming Adapter should be attached only when the Target Arm is mounted on the Nail Adapter in the “Lateral Locking” position. Check alignment of the P/A calcaneal hole by passing a K-Wire through the Aiming Adapter.
Operative Technique

Nail Length Determination

The nail length can be determined pre-operatively by the X-Ray Template or intra-operatively after a correct placement of the Guide Wire and measurement by the Guide Wire Ruler.

Nail Insertion

Insert the nail over the Smooth Tip Guide Wire (Fig. 15) to the desired depth.

A chamfer is located on the medial side of the nail driving end to help avoid soft tissue impingement after insertion.

Verify correct position of the nail by checking the correct depth and rotation.

Depth of insertion is determined by correct placement of the distal oblong hole in the center of the talar body. This should be approximately the mid-talar region to ensure satisfactory purchase of the locking screw (Fig. 15a).

Two circumferential grooves are located on the insertion post at 2mm and 7mm from the driving end of the nail (Fig. 15b). Depth of insertion may be visualized with the aid of fluoroscopy. Additionally, the 3×285mm K-Wire can be inserted through the Targeting Device to identify the junction of the nail and insertion post (Fig. 15).

Rotational alignment is determined by a K-Wire placed into the Aiming Adapter. This indicates the position of the P/A calcaneal screw and aligns the screw with the anatomic calcaneal body axis (Fig. 16).

Correct position is achieved when the K-Wire is in line with the vertical line marked on the plantar surface (used for determining the entry point) (Fig. 16a).

The K-Wire may be inserted 1cm into the calcaneus to help maintain position.

Remove the Guide Wire and proceed with locking screw placement.
Operative Technique

Guided Locking via Target Device

**Apposition/Compression Locking Mode**

The T2 Ankle Arthrodesis Nail provides the option to achieve active mechanical apposition/compression.

**Note:**

Proximal static locking with two Fully Threaded Locking Screws must be performed prior to applying active, controlled tibio-talar apposition/compression.

**Step 1:**

**Guided Dynamic Locking of the Talar Screw**

If clinical and radiological assessment allow for applying tibio-talar compression, a 5mm Shaft Screw should be placed in the **Dynamic position of the oblong hole**. This will allow for a maximum of 5mm of active, controlled apposition/compression. Make sure the Target Arm is locked in the “**Lateral Locking**” position to place the screw from the lateral side of the talus.

Insert the Tissue Protection Sleeve, Long, (1806-0185) together with the Drill Sleeve, Long, (1806-0215) and the Trocar, Long, (1806-0315) into the “**Talus Dyn./Compr.” hole of the Targeting Arm** by pressing the Safety Clip (Fig. 17a). This mechanism helps keep the sleeve in place and prevents it from falling out. It also helps prevent the sleeve from sliding during screw measurement. To release the Tissue Protection Sleeve, the Safety Clip must be pressed again.

Advance the assembly through the skin incision that was used for joint preparation until it is in contact with the lateral cortex of the Talus (Fig. 17).

The Trocar is removed, with the Tissue Protection Sleeve and the Drill Sleeve remaining in position (Fig. 18).
To ensure accurate drilling and determination of the screw length, use the centered tipped 4.2×340mm calibrated Drill (1806-4260S). After drilling both cortices, the screw length may be read directly from the calibrated Drill at the end of the Drill Sleeve (Fig. 18a).

Next, drill the near cortex only, with the Ø5×230mm Drill (1806-5000S).

If measurement with the Screw Gauge, Long, (1806-0325) is preferred, first remove the Drill Sleeve and read the screw length directly at the end of the Tissue Protection Sleeve.

The position of the tip of the Drill as it relates to the far cortex is equal to where the tip of the screw will end. Therefore, if the tip of the Drill is 3mm beyond the far cortex, the tip of the screw will also be 3mm beyond.

The Screw Gauge is calibrated so that when the bend at the end is pulled back flush with the far cortex, the screw tip will end 3mm beyond the far cortex.

Note:
Make sure the Tissue Protection Sleeve/Drill Sleeve Assembly is seated on bone prior to selecting final screw length. (according to this picture).

Remove the Drill Sleeve and insert the appropriate Shaft Screw length through the Tissue Protection Sleeve using the Self-Holding Screwdriver, Long, (1806-0233) (Fig. 19). The screw is advanced through both cortices. The screw is near its proper seated position when the groove around the shaft of the screwdriver is approaching the end of the Tissue Protection Sleeve (Fig. 19a).

Remove the Tissue Protection Sleeve and proceed with proximal locking.

Note:
The Adapter and K-Wire must be removed before turning the Target Arm to the medial side for proximal locking.
Step 2:

Guided Locking of the Proximal Screws

Note:
Guided Locking of the Proximal Screws must be performed with the Target Arm locked in the “Medial Locking” position.

Do not attempt to use the Target Arm in the “Lateral Locking” position for proximal locking as this will lead to miss-drilling. The 300mm Nails can be locked proximally only with the free-hand technique.

Release the Nut and turn the Target Arm around the Nail Adapter until it can be locked in the “Medial Locking” position (Fig. 20).

Before locking the proximal screws, check with the image intensifier the gap between the tibial and talar surface. If this is more than 5mm, try to reduce the gap by applying gentle pressure on the Nail Adapter.

Insert the Tissue Protection Sleeve, Long, together with the Drill Sleeve, Long, and the Trocar, Long, into the appropriate hole for locking the static proximal hole of the selected Nail length (150mm or 200mm are marked on the Target Arm).

Make a small skin incision in front of the Trocar and push the assembly until the Tissue Protection Sleeve is in contact with the medial cortex of the tibia (Fig. 21).

Before starting to drill for the first proximal locking screw, check correct rotational position for the fusion; an imaginary sagittal line drawn down from the tibia tuberosity, along the tibial crest, should align with the second ray of the foot (Fig. 21).
The Trocar is removed, with the Tissue Protection Sleeve and the Drill Sleeve remaining in position (Fig. 22).

To ensure accurate drilling, it is recommended to use the centered tipped 4.2×340mm calibrated Drill (1806-4260S) to open the first cortex.

Use the centered tipped 4.2×340mm calibrated Drill (1806-4260S). After drilling both cortices, the screw length may be read directly from the calibrated Drill at the end of the Drill Sleeve (Fig. 22a).

The position of the tip of the Drill, as it relates to the far cortex, is equal to where the tip of the screw will end. When the Drill Sleeve is removed, the correct Fully Threaded Locking Screw is inserted through the Tissue Protection Sleeve using the Screwdriver, Long. The screw is advanced through both cortices. The screw is near its proper seating position when the groove around the shaft of the screwdriver is approaching the end of the Tissue Protection Sleeve (Fig. 23).

The countersink (1806-2015) can be used through the Tissue Protection Sleeve to help sinking the proximal screw head. If this is used, undersize the screw length by 5mm.
Operative Technique

Repeat the locking procedure for the second Locking Screw (Fig. 24). This one can only be placed in the dynamic position of the proximal oblong hole.

Remove the Tissue Protection Sleeve and proceed with the tibio-talar compression.

Step 3:

Tibio-talar apposition/compression

Insert the Compression Screwdriver (1806-3210) through Nail Holding screw until the tip of the Screwdriver engages into the Compression Screw.

Start turning the Compression Screwdriver clockwise. As the Compression Screw is advanced against the 5.0mm Partially Threaded Locking Screw (Shaft Screw), it draws the talus towards the proximal tibial segment, employing active apposition/compression (Fig. 25).

Note:

Caution should be taken when actively compressing across the tibiotalar fusion site in osteoporotic bone to avoid iatrogenic talus fractures due to overcompression. Tibio-talar active compression must be carried out under fluoroscopy control.

Before proceeding with the guided locking of the Lateral Calcaneal Screw, external talo-calcaneal apposition/compression can be applied, if needed.
Operative Technique

Step 4 (optional):

Talo-calcaneal external compression

External compression is achieved by inserting the Apposition Ring (1806-3204) over the Apposition Handle (1806-3215). This will protect the soft tissues by applying compression forces on a larger surface.

Turn the Apposition Handle Clockwise until the Apposition Ring is in contact with the soft tissues. Continue turning the Apposition Handle to apply talo-calcaneal apposition/compression (Fig. 26).

Alternatively, the Apposition Sleeve (1806-3214) can be used to apply external compression directly on the calcaneal cortex in case of poor soft tissue condition.

Note:
The Apposition Sleeve must be inserted over the Nail Adapter before nail insertion.

Step 5:

Guided Locking of the Lateral Calcaneal Screw

Release the Nut and turn the Target Arm around the Nail Adapter until it can be locked again in the “Lateral Locking” position (Fig. 27).

Insert the Tissue Protection Sleeve, Long, together with the Drill Sleeve, Long, and the Trocar, Long, into the “Calcaneus” hole of the Target Arm by pressing the Safety Clip.

Make a small skin incision in front of the Trocar and push the assembly until the Tissue Protection Sleeve is in contact with the lateral calcaneal cortex.

The Trocar is removed, with the Tissue Protection Sleeve and the Drill Sleeve remaining in position.

Use the centered tipped 4.2×340mm calibrated Drill (1806-4260S). After drilling both cortices, the screw length may be read directly from the calibrated Drill at the end of the Drill Sleeve.

Next, drill only the nearest cortex with the Ø5×230mm Drill (1806-5000S).

When the Drill Sleeve is removed, the correct Fully Threaded Locking Screw is inserted through the Tissue Protection Sleeve using the Screwdriver, Long (Fig. 28).

Step 6:

Guided Locking of the Posterior Calcaneal Screw

Release the external compression.

Release the Nut and turn the Target Arm around the Nail Adapter until it can be locked in the “Posterior Locking” position.

Insert the Tissue Protection Sleeve, Long, together with the Drill Sleeve, Long, and the Trocar, Long, into the Calcaneus hole of the Targeting Arm by pressing the Safety Clip (Fig. 29).

Repeat the locking procedure as described for the Lateral Calcaneal Locking.

The countersink (1806-2015) can be used through the Tissue Protection Sleeve to assist in sinking the P/A Calcaneus screw head. If this is used, undersize the screw length by 5mm.
Operative Technique

Static Locking Mode

Step 1:

Guided Static Locking of the Talar Screw

If clinical and radiological assessment does not allow for applying tibio-talar compression, a 5mm Shaft Screw should be placed in the Static position of the oblong hole. Make sure the Target Arm is locked in the “Lateral Locking” position to place the screw from the lateral side of the talus.

Insert the Tissue Protection Sleeve, Long, together with the Drill Sleeve, Long, and the Trocar, Long, into the “Talus Static” hole of the Target Arm by pressing the Safety Clip (Fig. 30).

Follow the same locking procedure as described on page 14 and 15 for the insertion of the Talar Screw in dynamic position.
After the Talar Screw is inserted, remove the Tissue Protection Sleeve and proceed with advancing the compression screw against the Talar Screw (Fig. 31).

Insert the Compression Screwdriver (1806-3210) through Nail Holding screw until the tip of the Screwdriver engages into the Compression Screw.

Start turning the Compression Screwdriver clockwise. The Compression Screw will advance until it locks down onto the Talar Screw providing axial stability of the construct.

Caution:
The coupling of Elastosil Handles contains a mechanism with one or multiple ball bearings. In case of applied axial stress on the Elastosil handle, those components are pressed into the surrounding cylinder resulting in a complete blockage of the device and possible bending.

To help avoid intra-operative complications and promote long-term functionality, we mandate that Elastosil handles be used only for their intended use. DO NOT HIT on them.

Step 2:
Guided Locking of the Lateral Calcaneal Screw

After locking the Talar screw in place with the compression screw, leave the Target Arm in the “Lateral Locking” position and proceed with the Lateral Calcaneal screw insertion.

Follow the locking procedure as described on page 19 for the Lateral Calcaneal Screw.
**Operative Technique**

**Step 3:**

**Guided Locking of the Proximal Screws**

**Note:**

Guided Locking of the Proximal Screws must be performed with the Target Arm locked in the “Medial Locking” position (Fig. 32). The 300mm Nails can be locked proximally only with the free-hand technique.

Proceed with the locking procedure as described on pages 16-17 for the Apposition/Compression Locking Mode.

**Step 4:**

**Guided Locking of the Posterior Calcaneal Screw**

Release the Nut and turn the Target Arm around the Nail Adapter until it can be locked in the “Posterior Locking” position (Fig. 34).

Insert the Tissue Protection Sleeve, Long, together with the Drill Sleeve, Long, and the Trocar, Long, into the **Calcaneus hole of the Target Arm** by pressing the Safety Clip.

Repeat the locking procedure as described on page 19.
Operative Technique

Freehand Proximal Locking of Long Nails

The freehand technique is used to insert locking screws into both M/L proximal holes of the T2 Ankle Arthrodesis Long Nails (300mm).

Multiple locking techniques and radiolucent drill devices are available for freehand locking. The critical step with any freehand locking technique, proximal or distal, is to visualize a perfectly round locking hole or perfectly oblong locking hole with the C-Arm.

Hold the center-tipped Ø4.2×130mm Drill (1806-4280) at an oblique angle to the center of the locking hole (Fig. 35). Upon fluoroscopic verification, the Drill is placed perpendicular to the nail and drilled through the medial and lateral cortex of the tibia. Confirm that the Drill passes through the hole in the nail in both the A/P and M/L fluoroscopy views.

After drilling both cortices, the screw length may be read directly from Screw Scale, Short, (1806-0360) at the green ring on the center-tipped Ø4.2×130mm Drill(Fig. 36). Alternatively, the Screw Gauge (1806-0480) can be used instead of the Screw Scale to determine the screw length.

Routine locking screw insertion is employed with the assembled Screwdriver Shaft, Short, (1806-0294) and the Teardrop Handle (702429).

Repeat the locking procedure to insert the second proximal locking screw.
Operative Technique

End Cap Insertion

The End Cap (1826-0003S) can be inserted:

Either through the Nail Adapter, with the Screwdriver, Long, (after removal of the Nail Holding Screw)

or

With the Screwdriver Shaft, Short, and the Teardrop Handle (Fig. 37), after removal of the Target Device (Fig. 37).

Note:
This is the same End Cap used for the T2 SCN. The End Cap will lock on the distal P/A calcaneal screw providing additional axial stability.

Extension End Caps of +5, +10 and +15mm are also available to adjust nail length and lock down on the distal P/A calcaneal screw. These End Caps cannot be inserted through the Nail Adapter due to the larger diameter of the head.

Extension End Caps are not cannulated.

Fig. 37
Operative Technique

Nail Removal

Nail removal is an elective procedure.

If used, remove first the End Cap and the most distal Screw with the Screwdriver, Long (Fig. 38).

Remove the Lateral Calcaneal Screw.

Release the Compression Screw to allow removal of the Talar screw.

Insert the Universal Rod into the driving end of the nail.

Remove all other Locking Screws and use the Slottet Hammer (1806-0170) to extract the nail in a controlled manner (Fig. 39).
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