

UNIC[®] Trauma

Surgical Technique

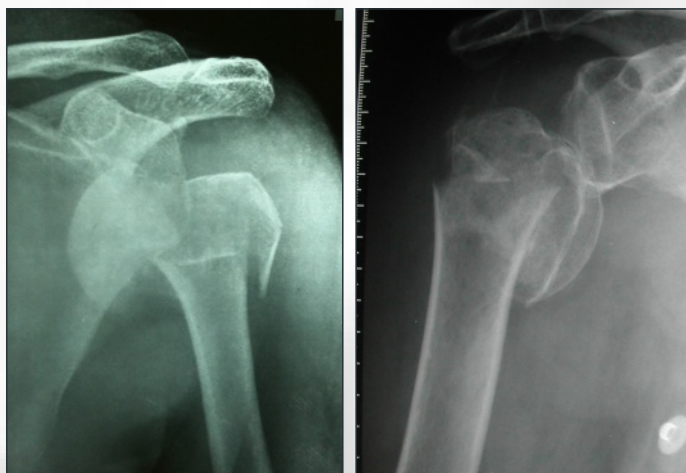


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Disclaimer

This document is intended to be read only by experienced orthopaedic surgeons familiar with the surgical implantation of shoulder arthroplasty, and by individuals related to or acknowledged by the Evolutis company.
This publication is intended as the recommended procedure for using the Evolutis UNIC and UNIC Trauma shoulder implants. It offers guidance only. Evolutis is the manufacturer of the device. As such and claiming no medical skill, Evolutis does not recommend a specific use of a product or a technique.
Each surgeon should consider the particular needs of the patient and make appropriate adjustments where necessary.
For any additional information related to the products, the indications and contra indications, the warnings and precautions of use, and the adverse effects, please refer to the INSTRUCTION FOR USE leaflet included in the packaging of implants. For further advice please contact your local representative.
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Indications

The UNIC Trauma humeral stem is designed to treat fractures around the shoulder joint, especially displaced 3 or 4 part fractures of the proximal humerus, comminutive fractures, humeral head and neck fractures.

The UNIC trauma stem is specially designed with slender metaphyseal volume & non-slip macrotexture.

The suture holes are conveniently positioned for easy access & allowing consolidation of the tuberosities to the stem.

The UNIC stem is truly modular in every sense. It allows for intraoperative corrections of preoperative diagnosis of the patient or intraoperative complications.

The Unic Trauma stem can be used for a hemiarthroplasty or total anatomic if the rotator cuff is in good condition, reverse prosthesis if the cuff is deficient or CTA arthroplasty if the glenoid bone stock does not allow for implant fixation and the cuff is also deficient.

The UNIC Trauma stem is designed for metaphyseal fixation without cement. The proximal HA coating enhances osteointegration of the shaft inside the humerus, and for tuberosity integration on the macrostructures.

In case of pronounced instability of the humeral implant, the distal part is mirror polished to allow for cement use and obtain immediate primary fixation stability.



Pre-operative planning

Pre-operative planning is often useful since intra operative landmarks can be vague and sometimes difficult to find. It is advised to dispose of calibrated bi-lateral x-rays (with size reference, measurement ruler or known sphere diameter).

- Calculate the true height of the humerus by using the contra lateral x-ray. (*illustration 1*)
- Establish where the summit of the humeral head was before the fracture, on the fractured side. (*illustration 2a*)
- Estimate the diameter of the humeral head. (*illustration 2a*)

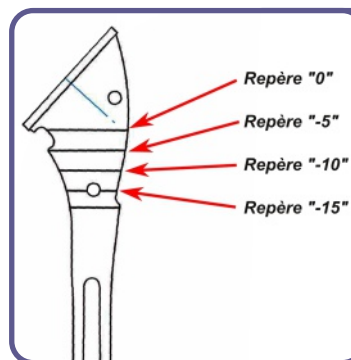
- Place the template of the estimated diameter over the mark made in the previous step. (*illustration 2b*)

- Position template of the stem (size 0) beneath the head template
- Select a bone landmark which can be found intra-operatively, such as the medial summit of humeral fracture (*illustration 2c*)
- Note which horizontal depth marker corresponds to the bone landmark chosen
 - The most proximal marker corresponds to a depth of "0" when aligned with the medial edge of the humeral head
 - The next markers going distally are 5mm apart, from -5 to -20mm
 - The position of the depth marker is reproduced with the rasps and the definitive stem

- The templates used to find the best depth of implantation are also used to determine the best size of implant for metaphyseal fixation (*illustration 2d*)

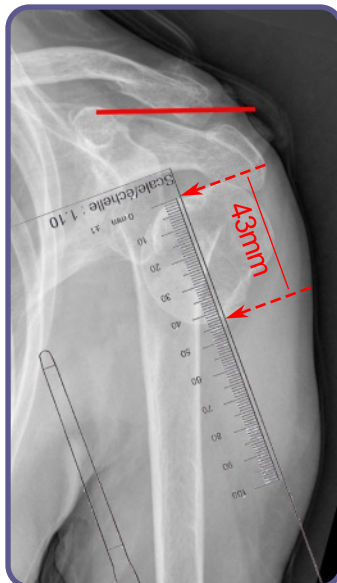
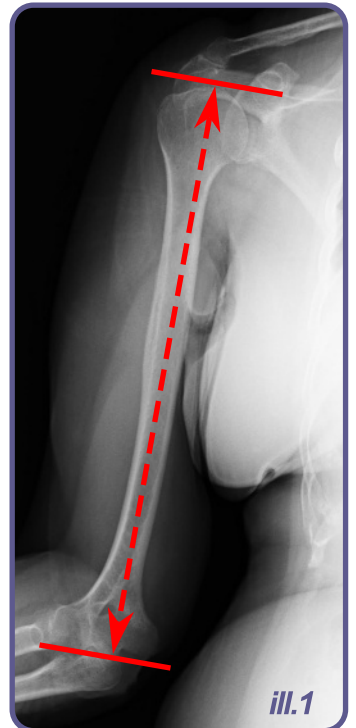
The use of templates to determine the position and size of anatomic implants can also be used for a **reverse prosthesis** since this method of planning is especially of use for positioning the humeral implant at the best anatomical height to recreate the space necessary to re-attach the tuberosities

The operator then needs to adapt the virtual humeral resection level by positioning the humeral stem 3 to 5mm lower than for an anatomic shoulder, and further note which horizontal depth marker corresponds to the bone landmark chosen



Note

The **UNIC trauma rasps and implants** have the same depth markers which are designed to help planning, preparation and implantation of the implant in such a way as to conserve efficient articular space and soft tissue balance



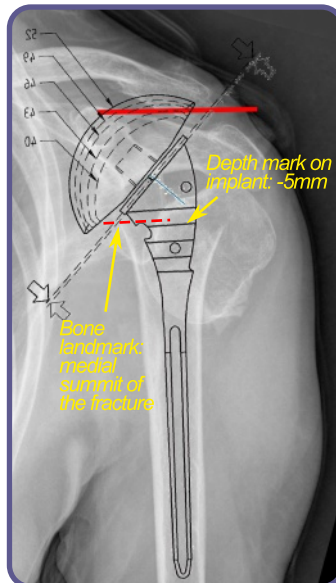
ill.2a

- Indicator of the summit of the humeral head (red line)
- Template of the diameter of the humeral head (in this case 43mm)



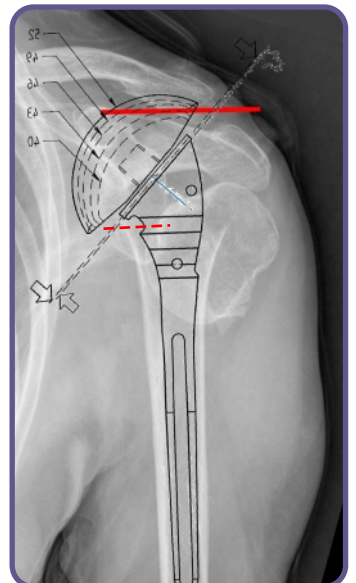
ill.2b

- Positioning the 43mm template at the theoretical summit of the humeral head (red line)



ill.2c

- Positioning of the humeral template size 0
- Identification of the bone landmark easily identifiable intra-operatively (medial summit of fracture)
- Identification of the depth marker which corresponds to the bone landmark (-5mm in this case)



ill.2d

- Determination of the size of the humeral stem, by increasing in size (in this case size 2), at the same depth level

Compatibility of component and instruments

The UNIC trauma humeral stem implants are compatible with:

- Reverse humeral cups and inserts, standard and XS sizes
 - Reverse glenoid implants, standard, XS and revision sizes
 - Heads and modules of Anatomic heads
 - CTA heads
 - +10mm augment ONLY of XS size (**NOT standard +10mm augment**)
- However both augments accept all reverse, anatomic and CTA head possibilities



XS size augment (left)
and std size augment (right)

E28 029 rasp handle

The UNIC Trama humeral stem requires the use of the UNIC general instrumentation tray E28 9105 when associated with a reverse component, and the use of the UNIC complementary instrumentation tray E28 9106 when associated with an anatomic or CTA component. The E28 9105 has to be equipped with the E28 029 "rasp handle" with a 2 positions locking ring. If your instrumentation does not include the E28 029 rasp handle, please do not proceed to the surgery.



Patient positioning

The patient should be positioned in a half upright position

The body of the patient on the table must allow for the operated arm to be free of the table edge and to be manipulated freely in extension and adduction without hindrance

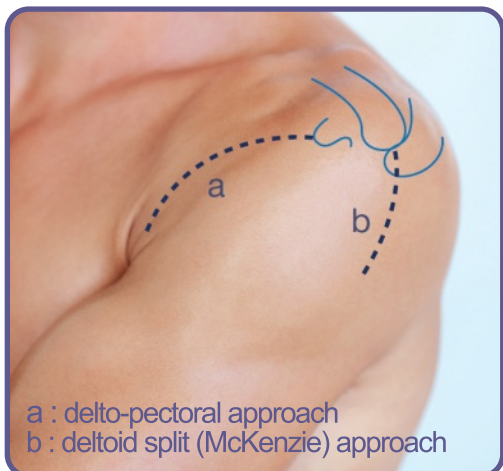
Ideally the whole shoulder should be free and not hindered

A lateral support should be installed to support the arm alongside the body



Technical introduction

In the presence of complex 4 part fragment fractures, the lesser tuberosity is pulled forward and medially by sub-scapularis retraction, whilst the greater tuberosity is pulled proximally and backwards by the combined effects of the supra spinatus, infra spinatus and the teres minor. The humeral head generally loses all vascular attachments and is found lateral and distal to its anatomic position. It can be useful to preserve the humeral head in order to take cancellous bone graft for use between the implant and tuberosities.



a : delto-pectoral approach
b : deltoid split (McKenzie) approach

Surgical approaches

The two most common approaches for prosthetic shoulder surgery are the Delto-pectoral and the deltoid split approaches.

Both approaches present advantages, the main difference between the two approaches is the exposure of the Glenoid.

- deltoid split

- + simplicity
- + easier exposure to the glenoid
- + tuberosity repair is easier
- + sub-scapularis preserving approach
- cut through the deltoid muscle
- if the cuff is intact, the exposure is compromised

- delto-pectoral

- + familiarity, hence most common approach
- + respect of the deltoid muscle and of the supra-spinatus
- + exposure of the axillary nerve possible
- + humeral preparation
- subscapularis cut & repaired: increased risk of subscap rupture
- exposure of the glenoid may be compromised

The preference between delto-pectoral and deltoid split approach is usually related to the necessity of properly exposing the glenoid bone.

In general the delto-pectoral approach will be preferred for a total anatomic shoulder prosthesis, while the deltoid split will be preferred for a total reverse shoulder prosthesis.

Surgical steps

After exposing the fracture, cleaning away the haematoma and removing the humeral head, the surgeon must evaluate regarding the following features

- The rotator cuff
- The glenoid
- The position and quality of bone fragments

Then confirm the indication and tenodesis the tendon of the long head of the biceps muscle

The surgeon can then decide the type of prosthesis and extent of tuberosity / rotator cuff repair

For glenoid preparation and trials please refer to the UNIC op tech (ref EN_UNIC STC E28)

Preparation of the humerus

Assemble the T handle (ref E28 009) onto humeral rasp size 0 (ref E28 084) (Illustration 3)

Calibrate the humeral diaphysis diameter WITHOUT REAMING, as far as the stop (Illustration 4)

Progressively increase the reamer diameters until obtaining scraping cortical contact, but not tight. This step is to calibrate the distal diameter of the diaphysis and help choose the correct size of trauma stem and make sure it does not jam inside the humerus. Do not use a larger stem



ill.3



ill.4

Important notice

UNIC trauma implants are only compatible with rasp holder E28 029. Before operating ensure that this is the rasp/implant holder in the instrument kit

Assemble rasp size 0 (ref E28 000) onto the rasp handle (ref E28 029), and lock it



ill.5



Note

The locking ring of E28 029 handle has 2 positions:

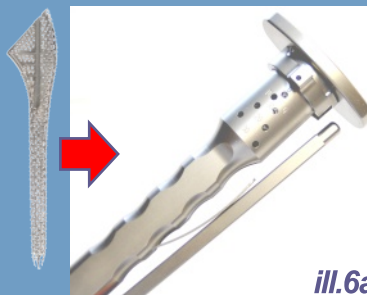
- All rasps except the XS (00) size lock into the second notch (Illustration 6a and 6b)
- The UNIC trauma stems lock into the first notch (Illustration 6c and 6d)

6a and 6b: locking of the humeral rasp

- 6a Tightening the locking arm
- 6b Locking the locking arm in the second notch

6c and 6d: Locking the UNIC trauma stem

- 6c Tightening the locking arm
- 6d locking the locking arm in the first notch



ill.6a



ill.6b



ill.6c



ill.6d



ill.7

Place the orientation guide (ref E28 007) in the hole in the handle corresponding to the chosen retroversion (*Illustration 7*)

Use the DROIT (RIGHT) holes for a right shoulder and GAUCHE (LEFT) for a left shoulder (*Illustration 8*)

For a reverse shoulder the retroversion is generally included inside the 10 to 20° range
For an anatomic prosthesis it is usually included inside the 20 to 30° range

Place the 0 rasp inside the humerus taking care not to go beyond the preoperative planning mark chosen: for example in the pre-operative planning (Page 3) align the -5mm mark with the medial summit of the fracture

Remove the rasp size 0 from the humerus and remove the handle by turning the locking ring, replace the rasp with size 1 and place it in the humerus
Check its depth with the depth landmark selected pre-operatively

Incrementally increase the rasp size (ref E28 000 to E28 004) until good primary stability is achieved axially and rotationally, with the depth landmark being at the level selected pre-operatively

Disassemble the rasp holder leaving the rasp in the humerus

If necessary remove any bone fragments or spurs with a rongeur or saw (*Illustration 9*)



ill.8



ill.9

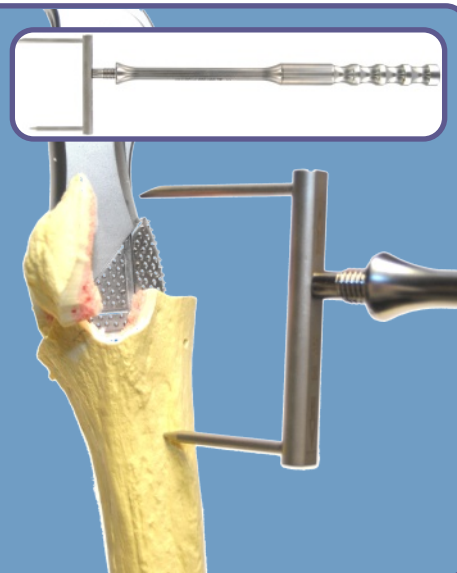
Option

A depth calibrator (ref E28 260) which should be aligned on the superior edge of the tendon of the pectoralis major is available as an option in the instrumentation

It can only be used with a delto – pectoral approach

How to use:

- Identify the humeral insertion of the pectoralis major muscle
- Place the short arm of the calibration device in line with the superior edge of the tendon
- The longer arm of the calibrator shows the theoretical summit of the humeral head at 56mm of the proximal fibres of the tendon insertion (according to Murachowski)
- Dependent on the type or size of the patient, up to 5mm can be added between the calibrator branch and the summit of the humeral head
- Note the depth mark of the rasp in relation to the planned landmark (in relation to pre-operative planning)
- Should the rasp be too deeply impacted, try the next size up rasp and check its depth



Glenoid Preparation

See the UNIC operative technique (ref EN_UNIC STC E28) for glenoid preparation:
- Reverse prosthesis pages 13 to 17

Trial Reductions

The trials allow for verification that the depth of the humeral implant defined by the pre-operative planning and confirmed by use of the rasp correspond to the anatomical situation of the operated shoulder.
The intra-prosthetic stability must be sufficient: at this step the articulation must be stable even **without** fixation and suture of the tuberosities.

However the trials will only be of any value if the rasp is stable within the humerus.
If stability cannot be achieved with the rasp because of the condition of the bone being too fragile to undertake trials, then it is preferable to undertake the trials on the definitive prosthesis.

Refer to the UNIC operative technique (ref EN_UNIC STC E28) for trials

- Trials for reverse prosthesis page 18
- Trials for anatomic prosthesis page 23



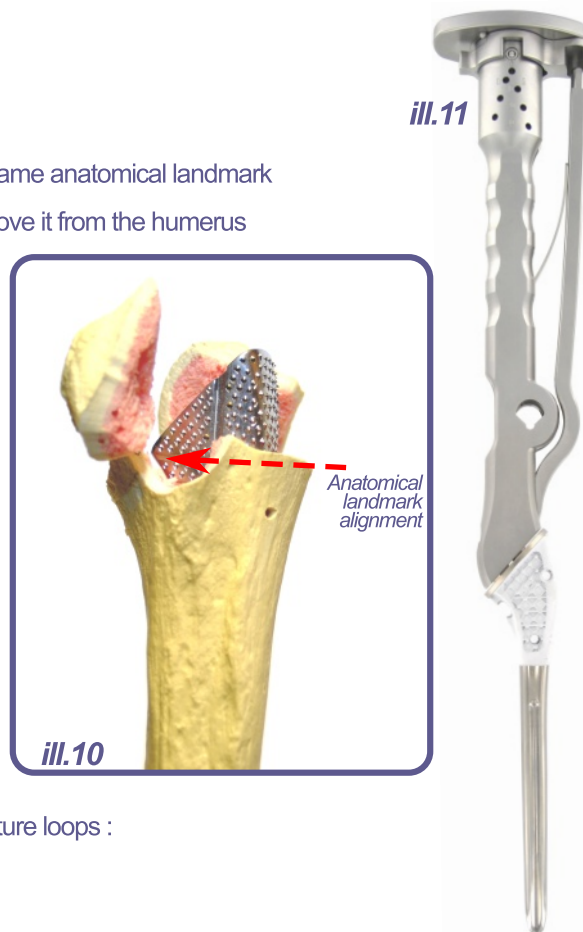
Definitive stem

Identify the horizontal depth marker selected on the rasp using the same anatomical landmark (*Illustration 10*)

Re-mount the rasp handle (E28 028) on the rasp left in situ and remove it from the humerus

Take the corresponding definitive UNIC humeral stem (Ref E27 030 to E27 034) and mount it on the rasp handle (E28 028)

Lock into place on the first notch of the rasp handle (*Illustration 11*)



Preparation of the suture loops

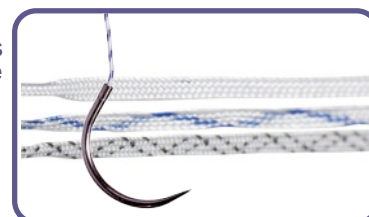
The synthesis of a 4 fragments fracture requires the use of 5 or 6 suture loops :

- 1 or 2 loops for the tension banding
- 2 loops to re-attach the greater tuberosity to the prosthesis
- 2 loops to re-attach both greater and lesser tuberosity together

EVOLUTIS offers suture loops for synthesis with the NICE-KNOTS technique:
EVOLUTIS TAPE SUTURE is a 1.4mm band-woven HS Fiber USP 2 strip that helps preventing shearing during placement and a better distribution of the tension on bone and soft tissue.

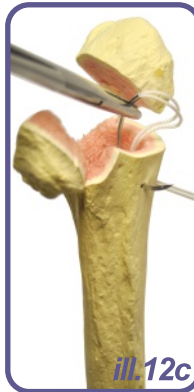
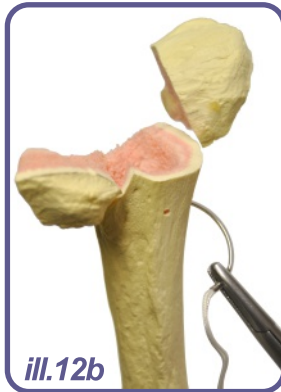
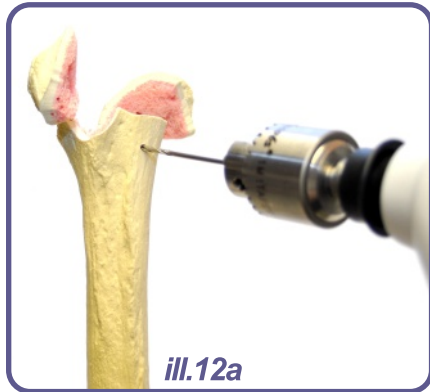
The TAPE SUTURES are set on a CE triangular needle 1/2c 36mm, and available in 3 colors white, white/blue and white/black to facilitate knotting between the strands.

All loops have to be placed on the humerus before introducing the final implant



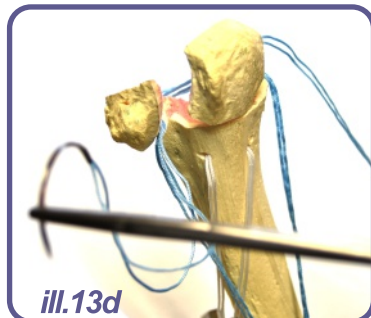
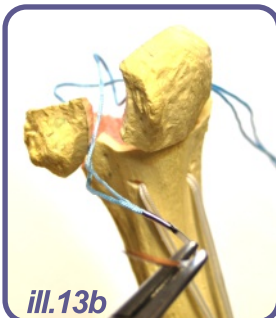
1) Tension banding loop(s)

- drill 2 holes (Ø2.0mm) through the lateral cortex on both sides, 1cm below the fracture and 1cm apart (*illustration12a*)
- introduce the loop from outside-in and then inside-out (*illustration12b & c*)
- grip both ends of the loop with a pair of artery forceps (*illustration12d*)
- or
- introduce 1 loop from outside-in in each hole
- grip both ends of each loop separately with a pair of artery forceps



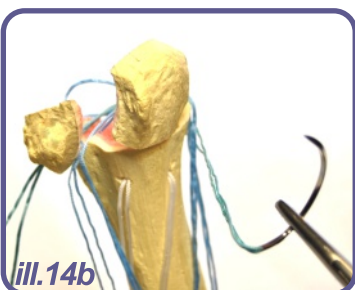
2) Greater tuberosity to the prosthesis re-attachment loops

- introduce a first loop through the lower supra-spinatus fibers medially to the greater tuberosity (*illustration13a & b*)
- introduce a second loop through the higher supra-spinatus fibers medially to the greater tuberosity (*illustration 13c & d*)
- wrap the suture loops around the medial edge of the humerus for the loops, so as not to interfere with the humeral of stem during its introduction
- grip both anterior and posterior ends of each loop separately with a pair of forceps



3) Re-attachment of greater and lesser tuberosity together loops

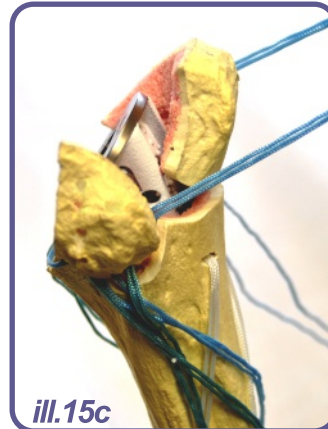
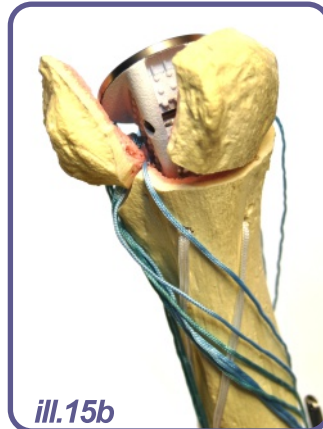
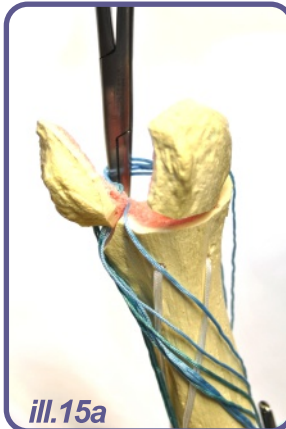
- introduce a first loop outside-in through the lower sub-scapularis fibers medially to the lesser tuberosity (*illustration14a*)
- introduce the first loop inside-out through the lower supra-spinatus fibers medially to the greater tuberosity (*illustration14b*)
- introduce a second loop outside-in through the higher sub-scapularis fibers medially to the lesser tuberosity (*illustration14c*)
- introduce the second loop inside-out through the higher supra-spinatus fibers medially to the greater tuberosity (*illustration14d*)
- wrap the suture loops around the medial edge of the humerus for the loops not to be in the way when introducing the stem
- grip both anterior and posterior ends of each loop separately with a pair of forceps (*illustration14e*)



Final implantation

Precautions when implanting the definite stem

- Wrap the sutures around the medial edge of the humeral bone (*illustration 15a*)
- Introduce the humeral stem without impaction (*illustration 15b*)
- Pull on all the blue and green loops so that all sutures engage in the medial hook of the stem (*illustration 15c & d*)
- Finalize the impaction of the stem



The UNIC trauma stem has been designed for cementless fixation. The proximal third is HA coated.

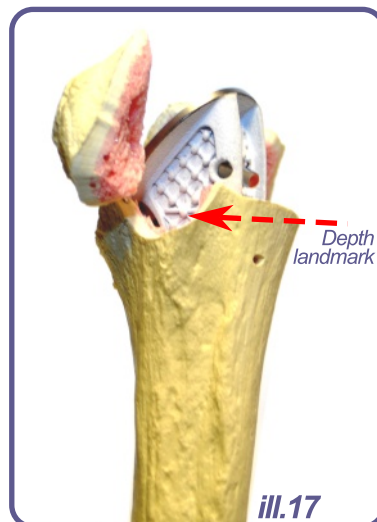
However, if the bone is osteoporotic or of poor quality and so primary stability is difficult to achieve or that there is a risk of peri-prosthetic fracture, it is possible to cement the distal portion of the stem over 8 to 10cm depending on the implant size.

Cementless fixation:

- Place the implant in the diaphysis attached to the handle
- Introduce the orientation rod (E28 007) into the hole indicating the desired retroversion
- Push down the assembly by hand maintaining the retroversion (*Illustration 16*)
- Finish impaction with a hammer up to the horizontal depth indicator pre-selected to align with the chosen landmark (*Illustration 17*)

Cemented distal fixation:

- Put into place the cement restrictor adapted to the humeral diameter (See humeral preparation: page 5)
- Prepare the cement, and fill the canal with retrograde cementing technique using a cement syringe
- Make sure the cement remains distal: use a quantity relative to implant/reamer calibre
- Insert the stem up to the depth landmark as for a cementless stem



Implantation of anatomic heads, CTA heads humeral, reverse cups and glenoid implants

Refer to the UNIC operative technique (Ref EN_UNIC STC E28 xxx) for the following stages

- Glenoid base and sphere on reverse implant EN_UNIC ANATOMIC STC E28 (E28 491) page 15
- Humeral cup on reverse implant EN_UNIC REVERSE STC E28 (E28 494) pages 19
- Preparation and implantation of a CTA head EN_UNIC ANATOMIC STC E28 (E28 491) page 16

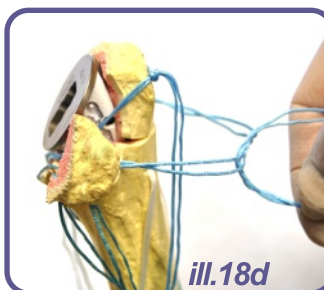
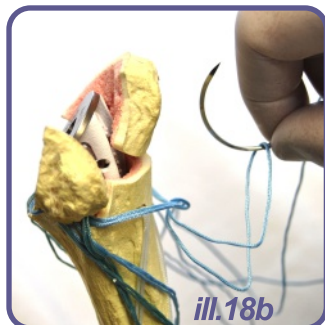


Fixation and suture attachment of the tuberosities

Place the arm in external rotation and at 25° of abduction

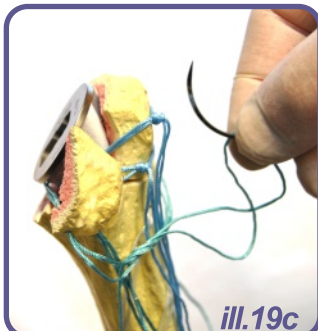
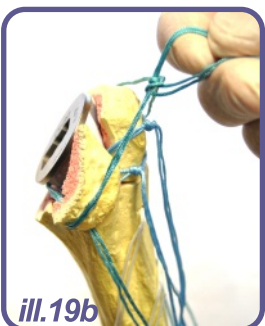
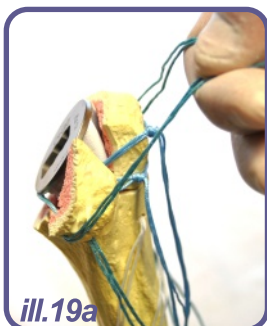
Re-attachment of the greater tuberosity

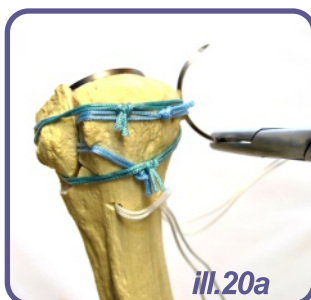
- grab the 2 ends of the proximal blue loop
- adjust the loop until there is only between 5 and 10cm of loop remaining outside of the greater tuberosity
- tie a flat knot (*illustration 18a*)
- pass the needle in the loop extremity (*illustration 18b*)
- tighten the knot by pulling on the 2 threads together (*illustration 18c*)
- repeat the same procedure with the distal loop (*illustration 18d & e*)



Synthesis of the greater and the lesser tuberosity together

- grab the 2 ends of the proximal loop (*Illustration 19a*)
- adjust the loop until there is only between 5 and 10cm of loop remaining outside of the lesser tuberosity
- tie a flat knot (*illustration 19a*)
- pass the needle in the loop extremity (*illustration 19c*)
- tighten the knot by pulling on the 2 threads together
- repeat the same procedure with the distal loop (*illustration 19d & e*)
- tighten firmly all 4 loops (*illustration 19f*) by pulling on the 2 threads of each loop, beginning with the loops





ill.20a

Tension banding finalisation

The basic principle of the tension banding is to cross the 2 threads of the loop (or the 2 loops) between the 2 distal holes in the humerus and the greater and lesser tuberosities: the thread tensioning on the greater tuberosity will be anchored to the anterior hole, while the thread tensioning on the lesser tuberosity will be anchored to the posterior hole.

Use of a single loop:

- grasp the needle on the loop out of the anterior hole (see page 8)
- adjust the loop until there is only between 5 and 10cm of thread out of the posterior hole
- pass the needle through the greater tuberosity insertion of the supra-spinatus and from bottom to top (illustration 20a)

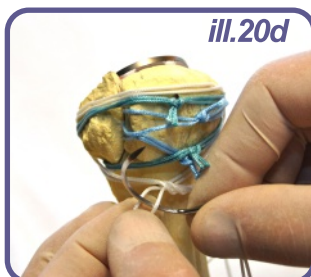


ill.20b



ill.20c

- pass the needle through the lesser tuberosity insertion of the sub-scapularis and from top to bottom (illustration 20b)
- pull on the loop until it is applied on the rotator cuff
- grasp the second end of the loop out of the posterior hole
- tie a flat knot (illustration 20c)
- pass the needle in the loop extremity (illustration 20d)
- tighten the knot by pulling on the 2 threads together (illustration 20e)



ill.20d



ill.20e

Use of 2 loops:

Alternative allowing the surgeon to adjust separately the tension on either tuberosity, and a stronger more resistant synthesis.

- grab the anterior loop needle and pass it through the greater tuberosity insertion of the supra-spinatus and from bottom to top
- grab the other end of the same loop
- tie a flat knot
- pass the needle in the loop extremity
- tighten the knot by pulling on the 2 threads together
- repeat the same procedure through the lesser tuberosity insertion of the sub-scapularis and from bottom to top with the posterior loop

Post-operative care

The rehabilitation protocols for the shoulder following the implantation of a total joint replacement are variable according to the authors.

We recommend immobilization with an IGLOO® splint with abduction cushion, allowing reduction with lateral elevation, to be kept for 30 post-operative days.

The IGLOO® splints system allows you to complement aftercare with a post-operative pain treatment by cryotherapy.

This immobilization, the time of the secondary integration of the cementless implants, makes it possible to apply compression rather than shear-stress to the implants.

Active mobilization in anterior and pendulum can be practiced daily.

After one month of immobilization, active rehabilitation is unlimited and within the limits of the patient's pain.



UNIC® Trauma



• Compatibility with all components of the UNIC range*

• Instrumentation set (E28 9105 & E28 9106) suits all primary indications

• TapeLoops: 3 colours combined with different watermark patterns to easily identify the threads



• "Clover" connection: full compatibility with the UNIC system

• Large collar to limit secondary migration

• Medial hook & holes for suture threads and cerclages

• Narrow and bone preserving metaphysis - one of the narrowest amongst available stems

• Hollowed out anterior, posterior, and lateral surfaces: correct positioning of tuberosities

• 3D macrostructure to enhance fragment mechanical stability

• Fluted shiny-polished distal tip can be cemented

References

UNIC® Trauma

Description		Size	Cat. N°
Humeral Trauma Stem	<i>Tige Humérale Trauma</i>	S. 0	E27 030
Humeral Trauma Stem	<i>Tige Humérale Trauma</i>	S. 1	E27 031
Humeral Trauma Stem	<i>Tige Humérale Trauma</i>	S. 2	E27 032
Humeral Trauma Stem	<i>Tige Humérale Trauma</i>	S. 3	E27 033
Humeral Trauma Stem	<i>Tige Humérale Trauma</i>	S. 4	E27 034
SUTURE TAPE White	<i>Boucle SUTURE TAPE Blanche</i>	60cm	HS237
SUTURE TAPE Wh/Blue	<i>Boucle SUTURE TAPE Bl/Bleu</i>	60cm	HS238
SUTURE TAPE Wh/Black	<i>Boucle SUTURE TAPE Bl/Noir</i>	60cm	HS239
Humeral Augment XS	<i>Réhausseur huméral XS</i>		E27 112

Please note: the references mentioned above are those specific to UNIC Fracture implants. The articular elements (e.g. sphere + cup or head + glenoid) are presented in the brochures UNIC Reverse (E28 430) and UNIC Anatomic (E28 486) as well as in the surgical techniques UNIC Reverse (E28 494) and UNIC Anatomic (E28 491).

Important Notice:

The UNIC TRAUMA implants belong to the class III implantable medical device classification. The UNIC TRAUMA implants are indicated in hemi arthroplasty or total arthroplasty anatomic or reverse procedures of the proximal shoulder joint in post-trauma situations. The surgeon is required to read the instructions for use S12 0314 included in the packaging of the implant or available for download from the www.evolutis-group.com website, as well as the surgical technique manual E28 494 (UNIC Reverse), E28 491 (UNIC Anatomic) and E28 454 (UNIC Fracture) initially delivered with the instrument set, or equally available for download from the www.evolutis-group.com website.

Materials:

Stem: Titanium alloy TA6V according ISO 5832-3. Double coating porous titanium + calcium hydroxyapatite. Vacuum packed & double wrapped. Gamma ray sterilised.

Loop sutures: Thread Ethylene Polyterephthalate (PET) Ø0.7mm - Needle 40mm.



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