DT MedTech, LLC

A DATA TRACE COMPANY

Empowering Innovations

Hintermann Series H2®

Total Ankle Replacement Prosthesis

SURGICAL TECHNIQUE

Hintermann Series H2®
Total Ankle Replacement Prosthesis

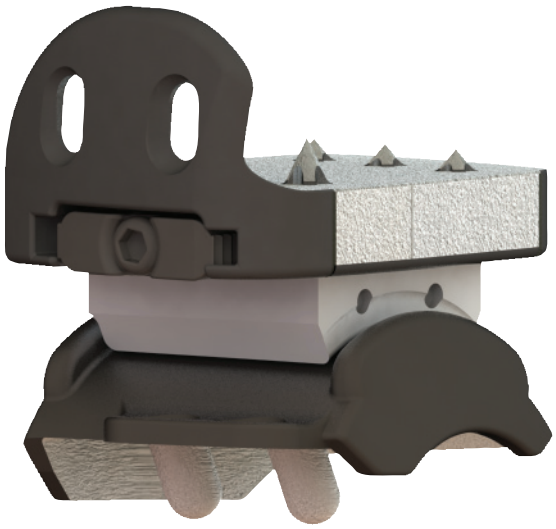
SURGICAL TECHNIQUE

Table of Contents

Hintermann Series H2®
Total Ankle Replacement Prosthesis

1. Description

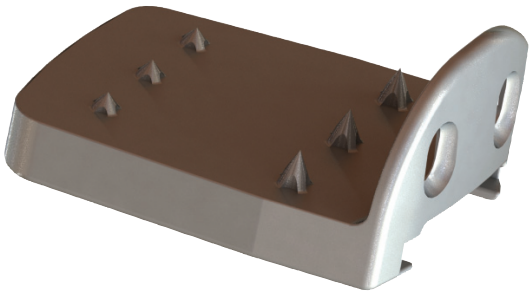
- **The Hintermann Series H2® Total Ankle Replacement Prosthesis** is a semi-constrained design that:
  - resurfaces the tibia and talus by minimal bone resection
  - incorporates a constrained inlay
  - integrates adjustable inlay orientation relative to tibial axis
- The anatomical shape of the unique design of the Hintermann H2 Total Ankle Replacement Prosthesis is designed to provide:
  - high intrinsic stability
  - low contact stresses to the bone
  - low ligament stress
  - minimal wear
- **Outside US market:** Ti/HaP spray coating on both tibial and talar bone contacting surfaces
- **US market:** Plasma spray coating on both tibial and talar bone contacting surfaces



2. Technical Features

2.1 Tibial Component

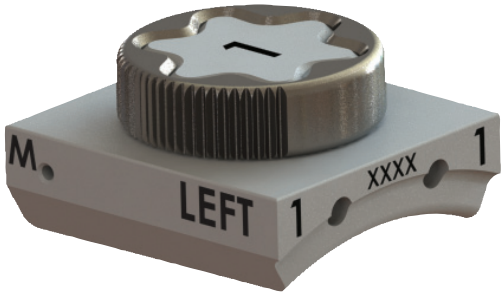
- Anatomical shape for minimal contact stress to the bone
- Minimal bone resection required
- Low profile anterior shield designed:
  – to provide rotational stability of tibial component
  – to prevent scarring and bone formation that may hinder joint motion
- Titanium peaks designed for anchoring in subchondral bone toward increasing stability in translation and rotation



Tibial Component Sizes
Sizes: 2, 3, 4, 5, 6

2.2 PE Inlay

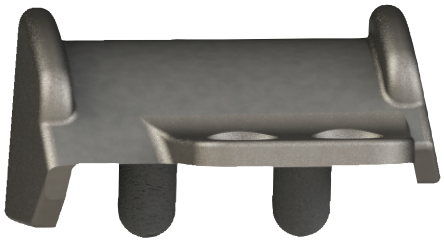
- Ultra-high molecular weight polyethylene, UHMWPE
- High congruency with the metal surfaces of both tibial and talar components
- Free sagittal plane motion on conically-shaped talar surface
- Large contact area with both tibial and talar components designed to provide:
  – low contact stresses
  – minimal wear
  – intrinsic stability against eversion-inversion forces
- X-ray markers (titanium alloy Ti6Al4V)



PE Inlay Sizes
Sizes: 1, 2, 3, 4, 5, 6
Thicknesses: 5mm, 6mm, 7mm, 9mm
Offsets: neutral, anterior, posterior

2.3 Talar Component

- Anatomical shape (conical surface) designed:
  – to allow physiological talar motion
  – to minimize medial ligament stress
- Minimal bone resection required
- Anterior pegs designed to improve sagittal stability and positioning
- Medial and lateral rims designed to guide movement of the PE inlay
- Anterior shield designed to prevent ingrowth of osteophytes



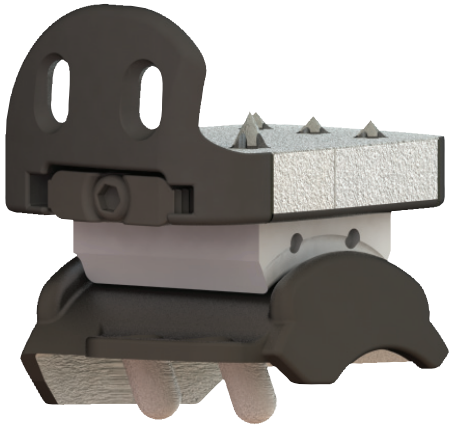
Talar Component Sizes
Sizes: 1, 2, 3, 4, 5, 6

3. Materials

3.1 Introduction

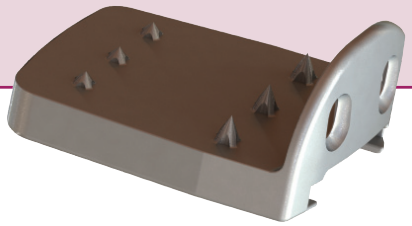
The Hintermann Series H2® Total Ankle Replacement Prosthesis is composed of:

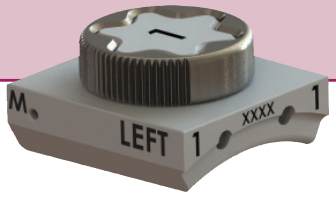
- Talar component - Cobalt chromium alloy (containing up to 1% nickel)
- Tibia component - Titanium alloy
- Poly inlays - UHMWPE with Ti radiographic markers



3.2 Materials

Talar Component	Tibial Assembly	PE Inlay
Cobalt chromium alloy (CoCr) ISO 5832-4 & ASTM F75 **Double Coated (outside US market):** Ti/HaP coated **Single Coated (US market):** Plasma Ti coated	Titanium alloy Ti6Al4V **Double Coated (outside US market):** Tray: Ti alloy ASTM F136/Ti/HaP coated Slide: Ti alloy ASTM F136/ PEEK (ASTM F2026-16) **Single Coated (US market):** Tray: Ti alloy ASTM F136/Plasma Ti coated Slide: Ti alloy ASTM F136/ PEEK (ASTM F2026-16)	UHMW polyethylene ISO 5834-2 & ASTM F648





Indications

The Hintermann Series H2® Total Ankle Replacement (Hintermann Series H2) System is designed to treat ankle arthritis through replacement of the ankle joint with a prosthesis, thereby reducing pain, restoring alignment, replacing flexion and extension movement in the ankle joint, and allowing for movement at the replaced joint.

The Hintermann Series H2 is indicated as a total ankle replacement in primary or revision surgery of ankle joints damaged by:

- Systemic arthritis of the ankle (e.g., rheumatoid arthritis, hemochromatosis)
- Primary arthritis (e.g., degenerative disease)
- Secondary arthritis (e.g., post-traumatic, avascular necrosis provided sufficient talus remains to support implant)

The Hintermann Series H2 is also indicated for patients with a failed previous ankle surgery and for revision surgeries following failed total ankle replacement or non-union/mal-union of ankle arthrodesis, provided sufficient bone stock is present.

NOTE: In the United States, this device is intended for cemented use only.

Contraindications

Relative Contraindications:

- Severe osteoporosis
- Immunosuppressive therapy
- High demanding sport activities (e.g., contact sports, jumping)

Absolute Contraindications:

- Sepsis
- Infection sequelae
- Systemic infection, fever, and/or local inflammation
- Complete talar necrosis
- Insufficient quantity of bone stock or poor skin coverage around the ankle joint that would make the procedure unjustifiable
- Persisting skin lesion
- Important ligament laxity
- Severe osteoporosis
- Ankle arthrodesis with malleolar exeresis
- Neuromuscular or mental disorders which might jeopardize fixation and postoperative care
- Neurobiologic diseases
- Nonfunctional lower limb muscles
- Complete loss of ankle collateral ligament
- Charcot arthropathy
- Elevation of WBC count
- Distant foci of infection from genitourinary, pulmonary, skin and other sites, dental focus infection which may cause hematogenous spread to the implant site
- Bone immaturity
- Patient pregnancy
- Recent infection
- Avascular necrosis of the talus/tibia > 1/2
- Diabetic syndrome with peripheral polyneuropathy/ Charcot arthropathy
- Suspected or documented metal allergy or intolerance
- Severe misalignment (e.g., varus misalignment >30°; valgus misalignment >15°)*
- Severe instability*

* If not surgically correctable.

Surgical Technique

Developed with the cooperation of Prof. Beat Hintermann, Liestal - Switzerland.

DT MedTech, LLC, as the manufacturer of this device, does not practice medicine and does not recommend this, or any other surgical technique, for use on a specific patient. The surgeon who performs any implant procedure is responsible for determining and using the appropriate techniques for implanting the device in each patient.

1. Positioning of the Patient

- The patient is positioned with the affected foot on the edge of the table.
- The affected foot is maintained on a block to facilitate treatment of associated problems (e.g., subtalar arthrodesis, ligament reconstruction, and tendon transfer).
- The ipsilateral back is lifted until a strictly upward position of the foot is obtained.

2. Surgical Approach

- An anterior longitudinal incision of 10 to 12 cm in length is made to expose the retinaculum.
- The retinaculum is dissected along the lateral border of the anterior tibial tendon and the anterior aspect of the distal tibia is exposed.
- While the soft tissue mantel is dissected with the periosteum from the bone, attention is paid to the neurovascular bundle that runs behind the long extensor hallucis tendon.
- Arthrotomy is made and hooks are inserted to carefully keep the soft tissue mantle away. A self-retaining distractor may be helpful; attention must be paid, however, that no tension is applied to the skin.
- Osteophytes on tibia are removed, particularly on antero-lateral aspect.
- Osteophytes on talar neck and anterior aspect of medial malleolus are also removed.
- The fibula can usually not be fully visualized at this stage.

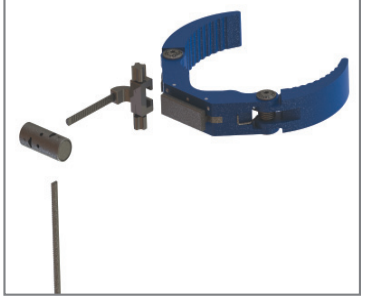
3. Positioning of the Tibial Cutting Block

3.1 Preparation

a. The tibial cutting block (309753 and 309773), the tibial rod (309615), the tibial positioning V (309625), alignment rod connector (309620), and translation block (309630) are assembled before positioning on the patient. The distal cutting block (309773) is fixed with central thumb screw in a most superior position to allow vertical adjustment.

b. The proximal end of the tibial positioning V (309625) is adjusted to the tibial tuberosity while its arms are held open and then closed.

3.1-a



Attention must be paid not to expose the fibular head to compression (risk of nerve injury).

3.1-a

c. Proximal neutral position of the tibial rod is obtained while the translation block (309630) is positioned on the middle of the sliding rail of the tibial positioning V (309625).

d. The distal tibial cutting block (309773) is positioned on the center of the distal tibial metaphysis and fixed by two shoulder pins (309604, 309605, 309606, 309664, 309665, or 309666).

3.2 Settings

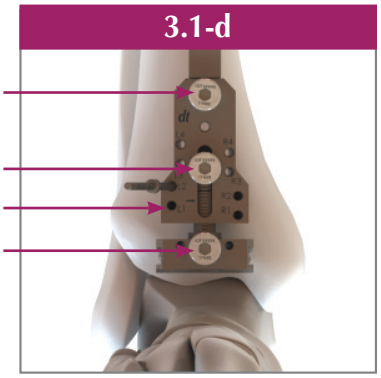
For proper positioning, the following adjustments must be made:

3.1-a

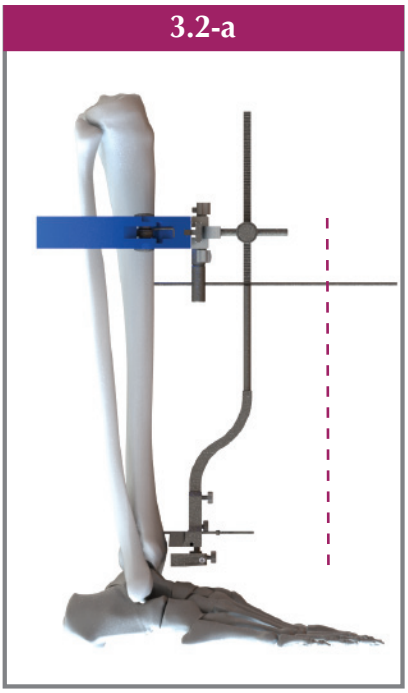
a. Sagittal plane
The rod must be positioned parallel with the anterior border of the tibia.

b. Frontal (coronal) plane
The tibial rod must be placed in the center of the tibia: proximally, it is projected onto the tibial tuberosity, and distally, it is projected onto the center of the distal tibia.

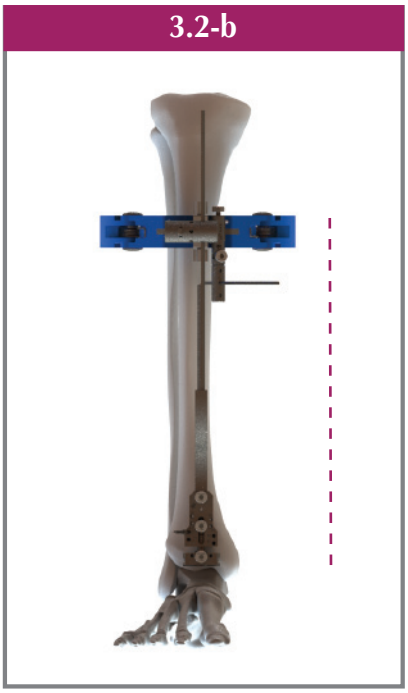
3.1-d



3.2-a



3.2-b



c. Optional Pin Outrigger

The Optional Pin Outrigger (309725): May be attached to tibial positioning V (309625) rail for additional stability. The pin outrigger can be oriented in the proximal or distal direction on either side of the translation block (309630). One screw is used to lock the translation of the pin outrigger relative to the tibial positioning V rail. The other is used to lock the motion of the pin outrigger head. Screws may be tightened with screwdriver (309645). The three holes are present to give multiple pin placement options. One 2.5 mm K-wire (309225 or 309226) is sufficient for fixation.

3.2-c

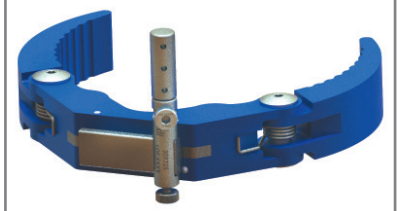
d. Vertical adjustment

- The distal tibial cutting block (309773) is moved proximally until the desired resection height is achieved. As a general rule, a resection of approximately 2 mm to 3 mm from the apex of the tibial plafond is desired.
- Tighten the central screw with screwdriver (309645).

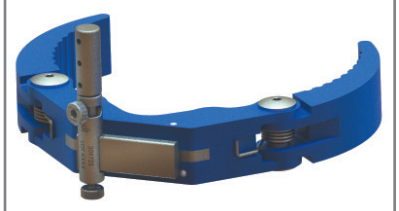
3.2-c

3.2-c

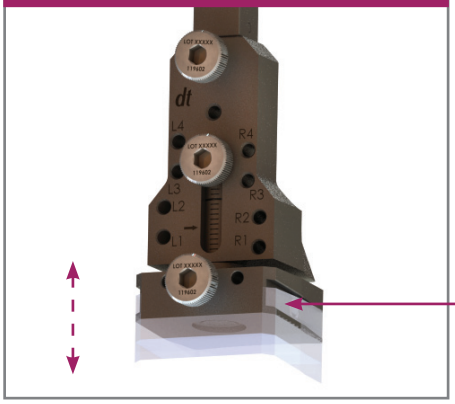
3.2-c



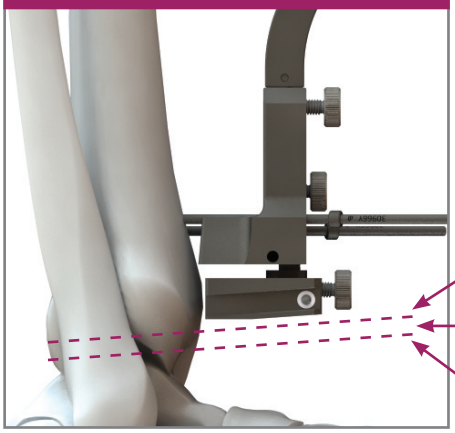
3.2-c



3.2-d



3.2-d

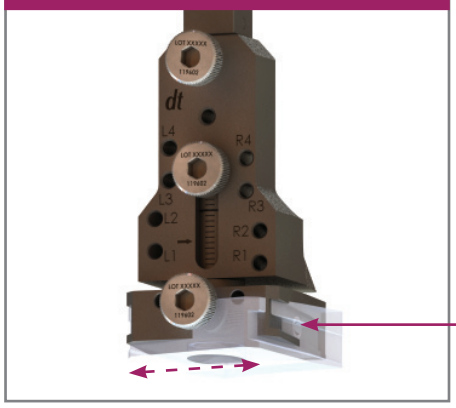


NOTE: In varus ankles, thicker tibial resection is usually needed. Whereas, in valgus ankles, and/or in presence of high joint laxity, less bone resection is advised.

e. Rotational setting

- If necessary, the distal tibial cutting block (309773) may be rotated to get a parallel position of its medial surface to the medial surface of the talus; this helps prevent damaging the medial malleolus with the saw blade during resection.
- Tighten the inferior screw with screwdriver (309645).

3.2-e

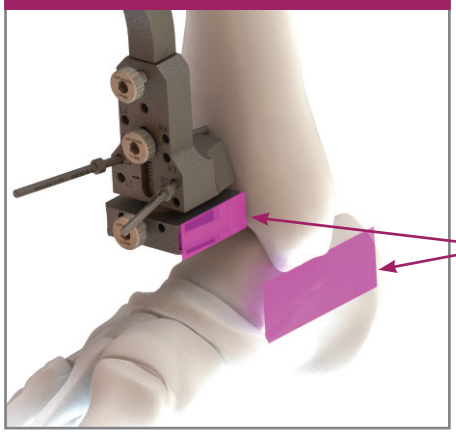


4. Tibial Resection

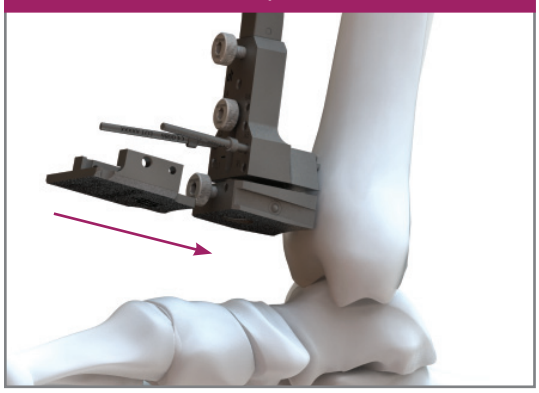
4.1 Positioning of the Tibial Cutting Guide

- The tibial cutting guide is selected depending on the size of the tibia. Three cutting guide sizes (SMALL– 309637, MEDIUM – 309636, and LARGE – 309635) are available. Typically, the medium guide is used to protect the lateral and the medial malleoli. The large guide should be used only for very large ankles. Special attention must be paid to the malleoli when using the saw blade.
- The guide is fixed in the slots of the cutting block creating a window in which the saw blade will be captured. The width of the window limits the excursion of the saw blade, thereby helping to protect the malleoli from being damaged.

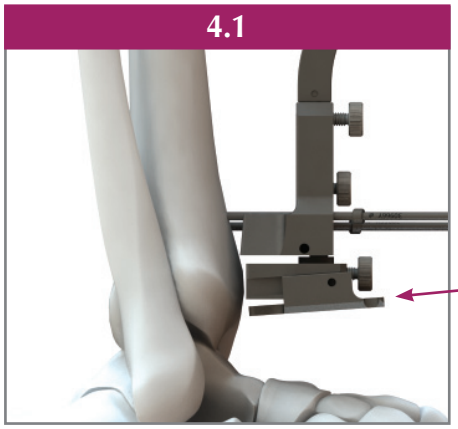
3.2-e



4.1



4.1



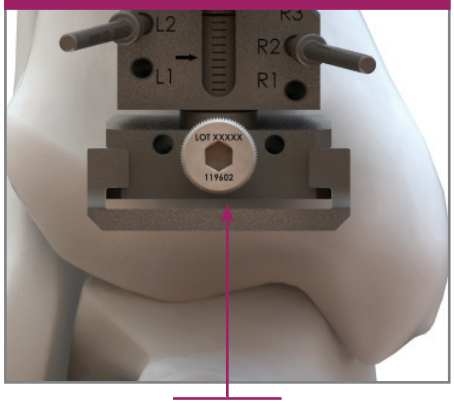
Attention should be paid to the proper contact of the tibial cutting block with the anterior surface of the tibia.

4.2 First Cut

- The tibial resection is performed with the appropriate saw blade (listed below), inserted into the window of the tibial cutting block.

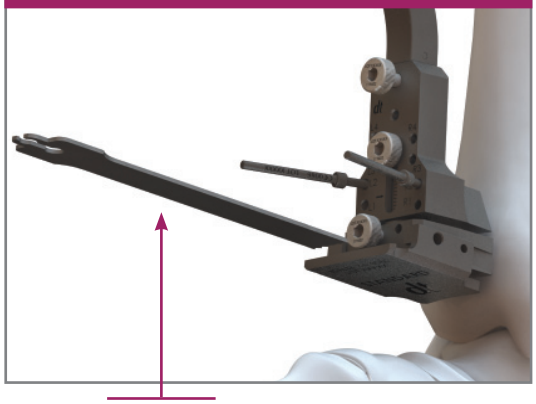
Make sure that the saw blade is perfectly in an antero-posterior position to avoid any damage to the malleoli.

4.2



Saw Blade Window

4.2



Saw Blade

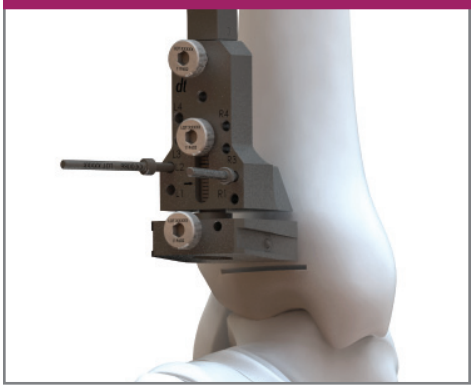
Several attachments are available for Hintermann Series™ saw blades	
Aesculap® attachment (309622)	
AO Synthes® attachment (309623)	
Stryker® 6 attachment (309624)	
Conmed Linvatec® attachment (309627)	
Stryker® attachment (309626)	

4.3 Opening of the Joint

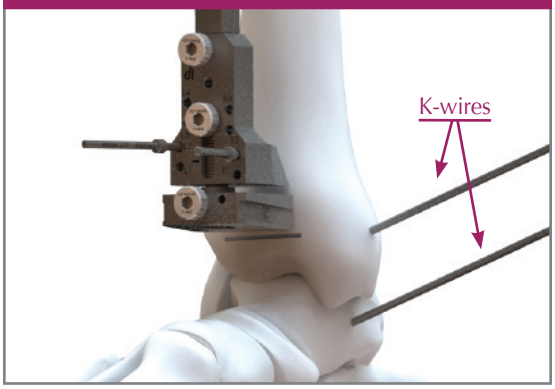
- The tibial cutting guide is removed, and the Hintermann Series™ distractor (119664) is mounted with provided 2.4 mm K-wire (309225 or 309226) to the antero-medial aspect of the distal tibia and the antero-medial talar neck, respectively.

K-wires should be placed in such a position that they do not hinder further preparation of the talus.

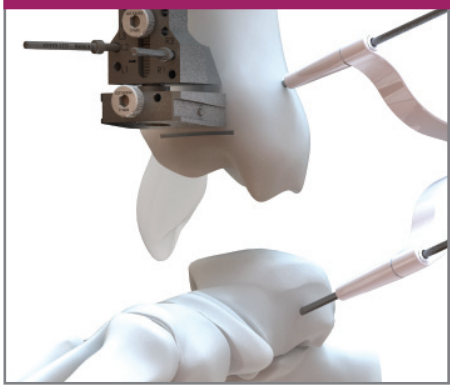
4.3



4.3



4.3



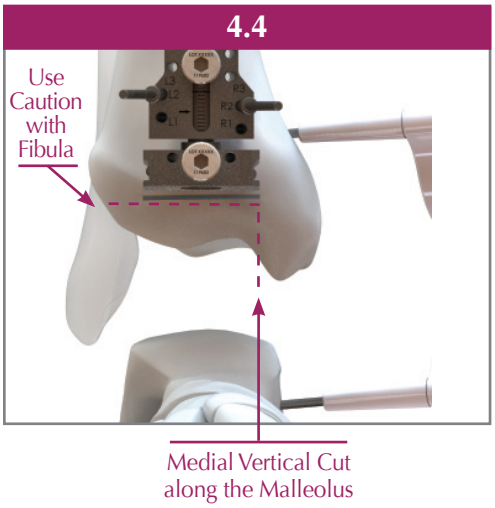
- Obtained distraction provides further visualization of the tibiotalar joint and facilitates the removal of the posterior resected bone and tissue fragments. K-wires may be cut to limit interference.

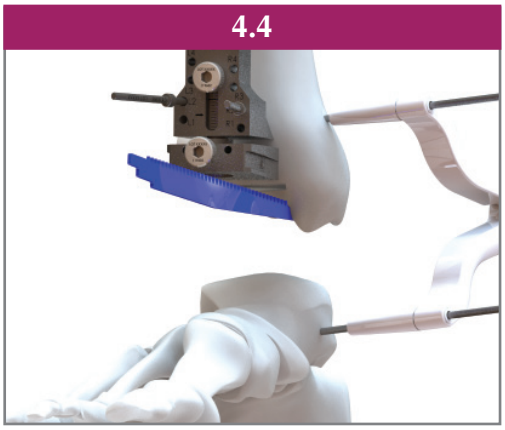
4.4 Finalization

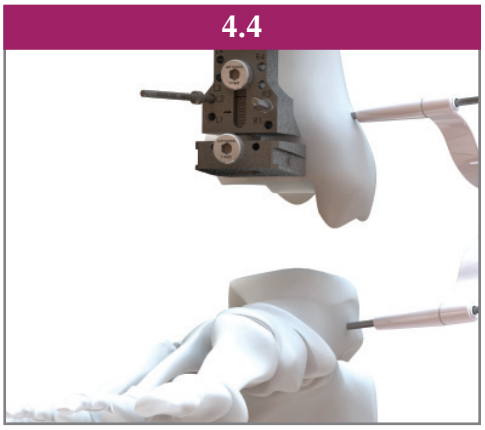
- Once the tibial cut is made, a reciprocating saw may be used to finalize the cuts, particularly for the vertical cut on medial side.

Attention should be paid so not to insert the saw blade too deeply into the joint as the tibial nerve might be at risk because the bone of the distal tibia is particularly hard postero-medially. An osteotome should be used with caution. The malleolus can fracture easily!

- While the distal part of the tibia is being resected, emphasis should be given to achieve a properly edge-shaped cut (90°) along the medial malleolus. This will allow insertion of the tibial component properly along the medial malleolus.
- In most cases, bone remains on the lateral side of the tibia. The horizontal cut is carefully completed with the oscillating saw until the fibula becomes completely visible.
- The resected bone is removed using a rongeur. Some bone and capsular tissue on the posterior aspect of the joint might be left in place at this stage of surgery. These are more easily removed once the talar cuts are performed, provided they do not hinder insertion of the talar cutting block.







5. Talar Resection

If there is not enough bone stock left for shaping the contours as described in this section (e.g., insufficient bone stock as a result of severe flattened deformity of the talar dome, revision of a prior total ankle replacement or arthrodesis, removal of large cystic or necrotic bone or multiple cuts to talus intraoperatively), the Flat Cut Talar Component would be used. Refer to Section 14 for instructions for implanting the Flat Cut Talar Component utilizing the Flat Cut Talar Cut Block, Flat Cut Talar Trials, and the Flat Cut Talar Component.

5.1 Insertion of the Block

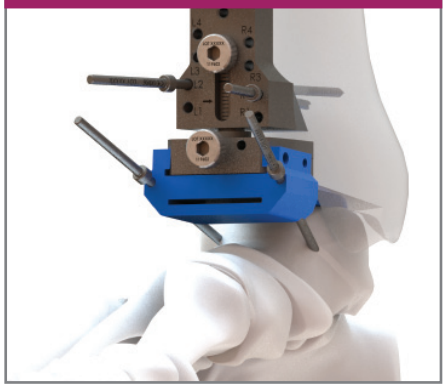
- The talar cutting block (309655, 309656, or 309657) is inserted into the corresponding slots of the tibial cutting block (309773) until it has been fixed by the detent.
- The central screw is unlocked and the distal tibial cutting block is translated as distally as possible until the collateral ligaments are tightened. Re-tighten the screw.
- Once central screw is locked, the distractor is removed, leaving the K-wires in place.

5.2 Fixation of the Block

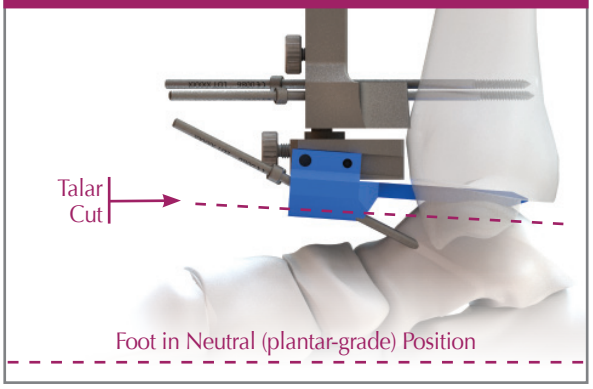
- While the foot is held in its neutral (plantar-grade) position, 2 pins (309605 or 309665) are inserted medially and laterally to secure the talar cut guide to the talus.
- Alignment of the hindfoot and flexion position of the foot are checked visually. If proper foot position is not achieved, the pins must be removed and the procedure should be repeated.

5.2

5.2



5.2

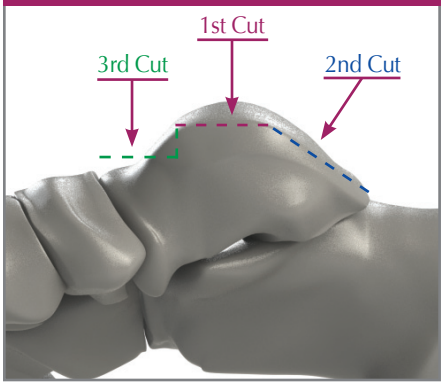


NOTE: To achieve neutral foot position, it may be helpful to take the heel with one hand, and the forefoot with the other hand. If there are any osteophytes left on talar neck that hinder, they must be removed.

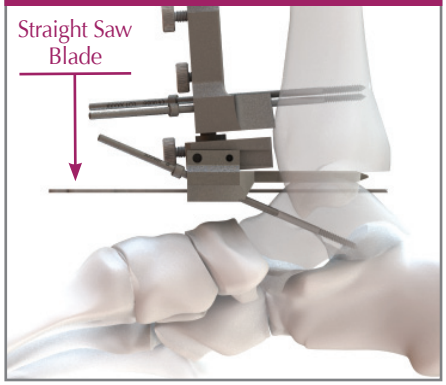
5.3 Superior Cut

- The resection of the talar dome is performed with the oscillating saw. The saw blade is inserted through the slot of the talar cutting block (309655, 309656, or 309657) to affect the cut.

5.3



5.3

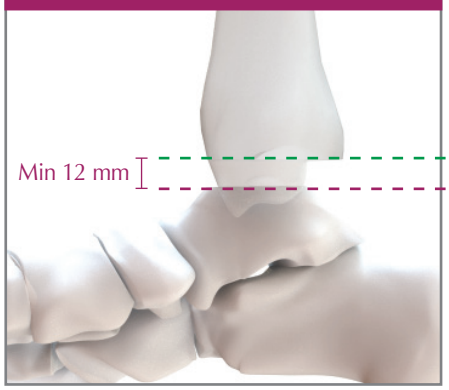


Several attachments are available for Hintermann Series™ saw blades

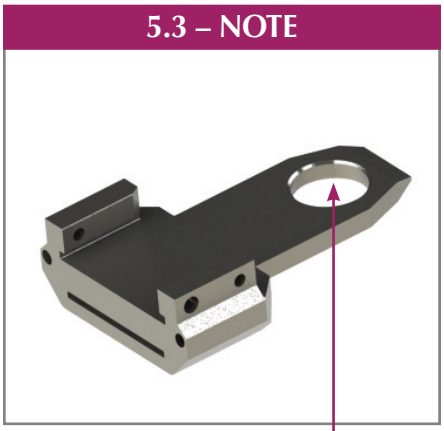
Aesculap® attachment (309622)	
AO Synthes® attachment (309623)	
Stryker® 6 attachment (309624)	
Conmed Linvatec® attachment (309627)	
Stryker® attachment (309626)	

5.3

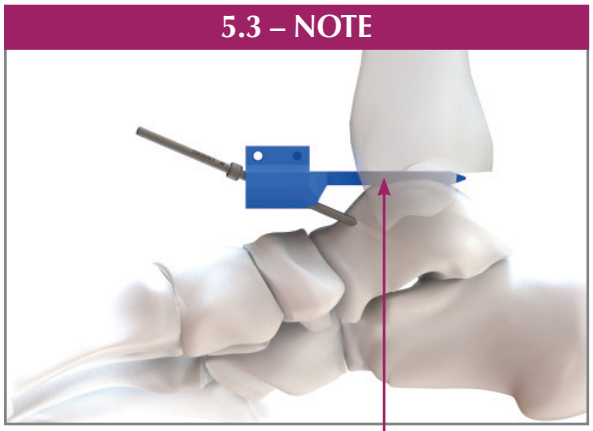
5.3



5.3 – NOTE



5.3 – NOTE



■ ***NOTE: If necessary, depth of the talar cut can be verified by removing the tibial resection block, distracting and visualizing the saw blade through the window or by fluoroscopy (lateral view).***

5.4 Assessment of the Implant Size

- The tibial depth gauge (309607) is used to determine the size of tibial implant.
- The gauge is inserted with the appropriate face (right/left) against the tibial surface and the posterior edge is hooked on the posterior border of the tibia. The size to be selected can be read from the scale on depth gauge, located on its upper side (tibia side).

NOTE: If the anterior border of the tibia is between two marks, the biggest size should be selected between both. The anterior tibia might be shaped to the indicated mark to allow appropriate positioning of the tibial component (e.g., no medial or lateral gapping that may irritate soft tissues). The talar size should be within 1 size of tibial component (e.g., if tibial component size is 2, talar component size must be 1, 2, or 3).

5.4

5.5 Posterior and Collateral Cuts

- The appropriate size of the talar cutting guide* and talar cut guide handle (309380) is selected based on tibial measurement.
- The selected talar cutting guide is placed on the flat surface of the talus maintaining the hooks carefully positioned on the posterior aspect of the talus; the resection guide becomes in proper contact to the resection surface of the talus.
- The following bony margins around the guide should be visualized as follows:
  – medial side: 2 mm margin for cuts
  – lateral side: 1 to 3 mm margin (1 to 2 posterior, 2 - 3 anterior)

NOTE: If margins are larger or smaller than indicated above, the surgeon chooses a size up or down, ensuring that the size is matched to the tibial implant size plus/minus one size.

- While the foot is brought to a neutral position, the handle of the cutting guide should meet the second ray.

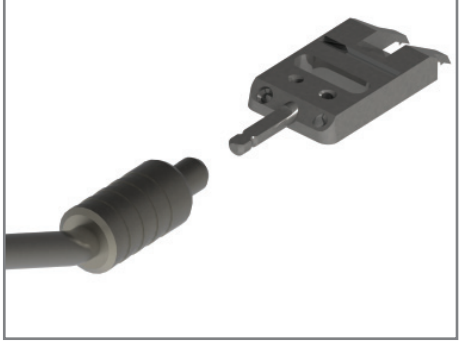
* 329360 to 329366 for the right foot/329370 to 329376 for the left foot

NOTE: In case of osteophytes or thick cartilage layer left on posterior talus, a chisel may be used. The tibial impactor (119751) may also be used to get the cutting guide fitted firmly to the talar resection surface.

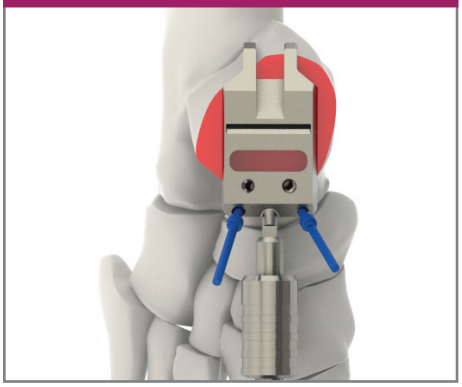
- 2 to 4 pins are used for fixation of the cutting guide to the talus.

NOTE: The number and length of pins may be selected per the quality of bone to obtain an appropriate fixation. If necessary, the position of the cutting guide can be checked by fluoroscopy (e.g., proper fit of hooks on posterior aspect of talus and cutting guide on resection surface); the posterior peaks on the flat talar horizontal surface indicates the center of the talar component with regards to its antero-posterior position.

5.5

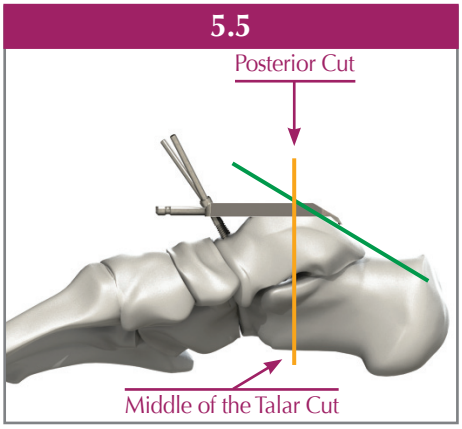


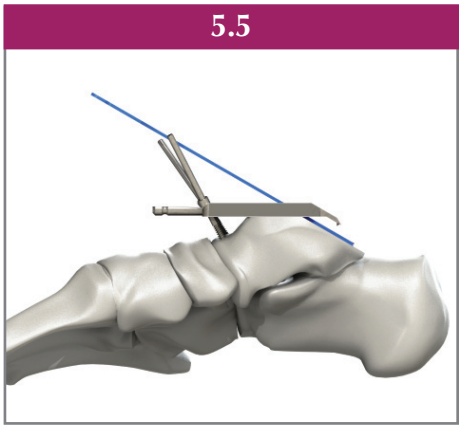
5.5



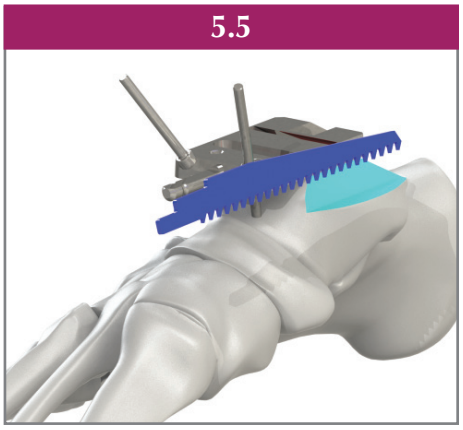
5.5

- The handle should be removed once the resection block is firmly fixed to the talus by pins.
- The posterior cut is made through the posterior slot using the oscillating saw blade
- Medial and lateral cuts are made using a reciprocating saw, paying attention that the saw blade strictly follows the cutting guide.
  – Medial size: approximately 6 mm deep
  – Lateral size: approximately 8 mm deep



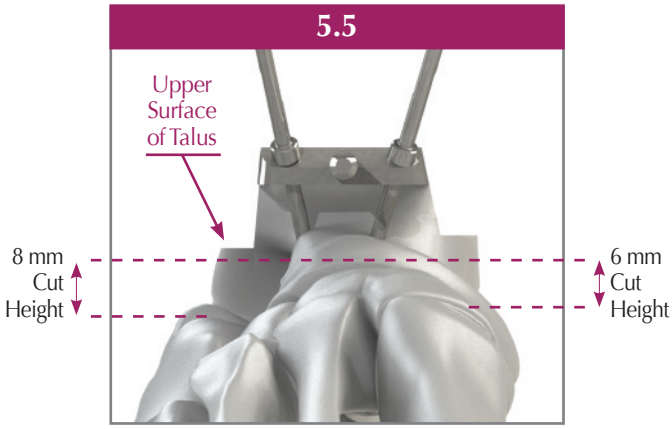


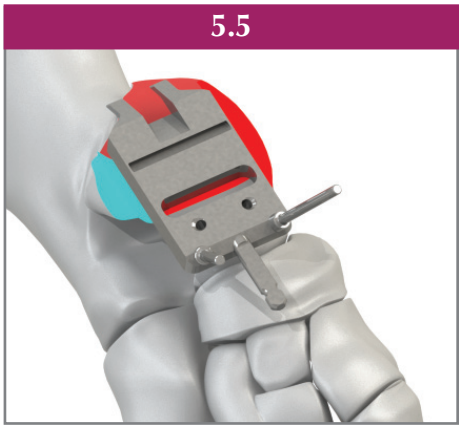
NOTE: If necessary, a chisel may be used to finish the cut at its medial and lateral borders. In order to make further talar trial impaction easier, it may be helpful to slightly resurface the postero-lateral corner of the talus, per the cutting guide.



- The resected bone is removed with a rongeur.
- Remaining bony and capsular structures on posterior aspect are carefully removed.

NOTE: A chisel is used to mobilize the medial and lateral resections of the talus if necessary (e.g., hard bone), the posterior corner of collateral cuts may be softened with a chisel or rongeur to allow proper insertion of the talar trial.





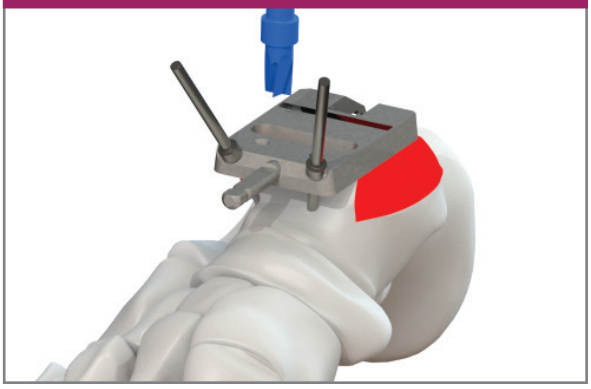
5.6 Anterior Cut

- The talar reamer (diam. 6 mm, 309200) is used to make the anterior cut through the slot, and the created step is squared with a rongeur.

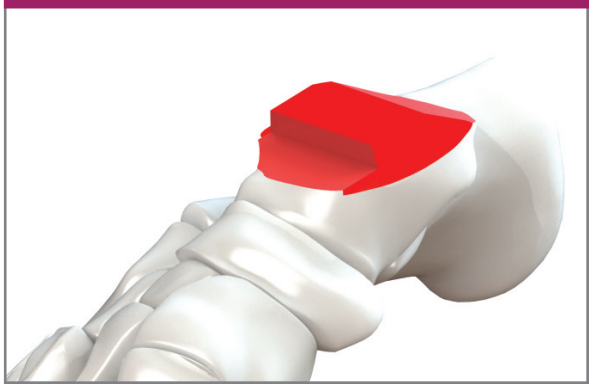
Attention should be paid to keep the reamer perpendicular to the slot and to go as deep as possible as allowed by the end-stop. The flange of the reamer should sit properly and perfectly perpendicular to the cutting guide.

NOTE: In case of hard bone, more than one lateral movement should be performed.

5.6



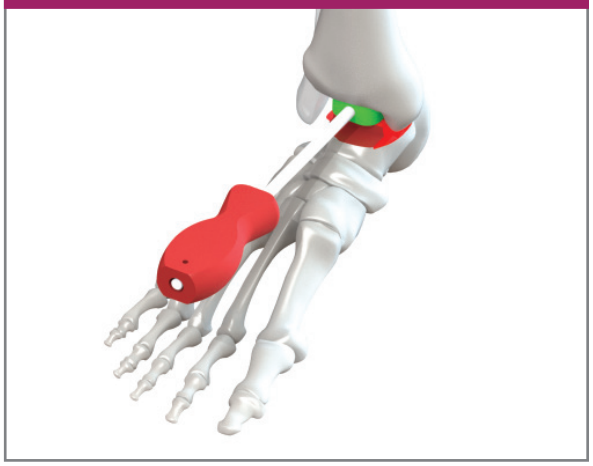
5.6



6. Checking of the Cuts, Alignment, and Stability

- After having removed the Hintermann Series™ distractor (119664), the spacer handle (309670, 309671, or 309672), representing the thickness of the tibial and talar components and the thinnest 5 mm inlay, is inserted into the created joint space. While the foot is held in neutral flexion position, it allows to check the following points:

6.0



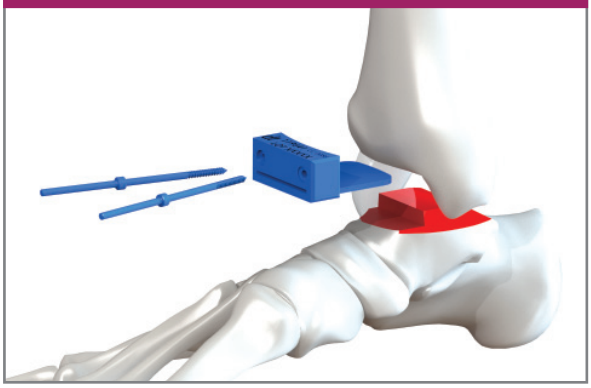
Three Cases:

1. **If insufficient quantity of bone has been resected.**
   If the spacer cannot be properly inserted into the joint space, and if there is no obvious contracture of the remaining posterior capsular, additional bony resection might be considered. In most instances, such additional resection should be done on tibial side. The tibial cutting block is repositioned using the same fixation holes for the pins. The distal resection block is moved proximally as desired and a new cut is performed with the saw blade. Alternately, the 2 mm tibial cutting guide (119641) can be used on the tibial cut to remove 2 mm of bone.

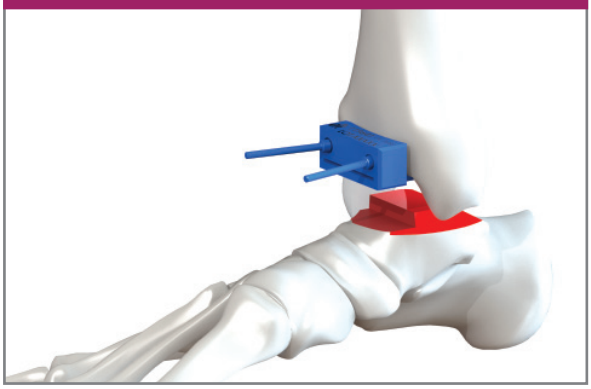
2. **If the achieved alignment is inappropriate.**
   If the alignment is not appropriate, and if an associated deformity of the foot itself (e.g., varus, valgus heel) can be excluded, a corrective cut should be considered. In most instances, the resection should be done on tibial side. The desired angular correction on tibial resection cutting is made, and the tibial cutting block is repositioned using other fixation holes for the pins. The distal resection block is moved proximally or distally to match with the height of the original cut, such as with an angular bony resection.

3. **If the medial and lateral stability are inappropriate.**
   If the ankle is not stable on both sides, the use of a thicker inlay might be advised. If the ankle is not stable on one side, a release of the contro-lateral ligaments and/or ligament reconstruction on affected side should be considered. Ligament reconstruction is best performed once the definitive implants have been inserted, and if there is still an obvious instability.

6.0



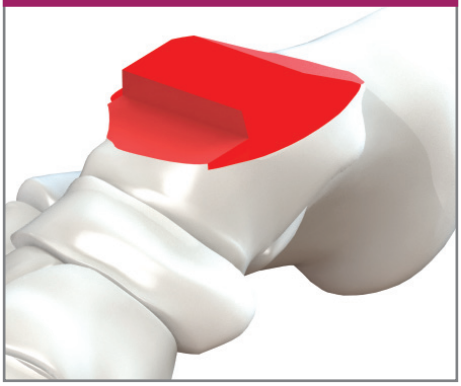
6.0



7. Final Bone Prep

- On medial and lateral sides, the cuts are finalized using a chisel to make an almost horizontal (anterior to posterior, parallel to the floor) cut along the base of the cuts previously performed. This will avoid extended loss of bone stock and potential damage of the vascular supply of the talus.
- The medial and lateral gutters are cleaned using a rongeur.
- The remaining bone and capsule of the posterior compartment are removed.

7.0



NOTE: To achieve full dorsiflexion, the posterior capsule should be removed completely until fat tissue and tendon structures are visible.

NOTE: If using flat-cut talar component, talus will appear flat at this step if Section 14 was used.

8. Insertion of Trial Components

8.1 Talar Trial

- The selected talar trial (309680-309686 for right side/309690-309696 for left side) is inserted using the specific impactor (309699). The window on the posterior aspect of the trial allows verification of proper fit to the posterior resected surface of the talus.

NOTE: If using flat-cut talar component, flat-cut trial is not shown in the images, but is placed on talus in a manner similar to what is shown in Image 8.1.

Care must be taken to avoid posterior displacement of the trial component while impacting. If proper seating of the component cannot be achieved, the medial and/or lateral gutters must be cleaned again. In most instances, remaining bone after inappropriate resection may be the cause.

8.2 Tibial Trial

- The tibial trial (129682-129686 for right side/129692-120696 for left side), as selected before, is inserted.

NOTE: If remaining osteophytes on lateral side avoid proper contact of the shield of the component and/or if close contact along the medial malleolus cannot be achieved while the tibial shield is fitted against the anterior border of the tibia, removal of the osteophytes and/or smoothening of the anterolateral tibia is advised.

NOTE: If using flat-cut talar component, flat-cut trial is not shown in the images, but same principles are used to check fit of components relative to one another.

Attention should be paid to approximate tibial component against the medial malleolus.

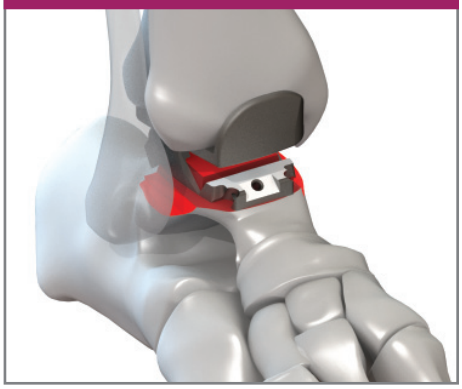
8.3 Trial Verification

- It is highly recommended to use fluoroscopy to check the position of implant trials with foot held in neutral position, particularly:

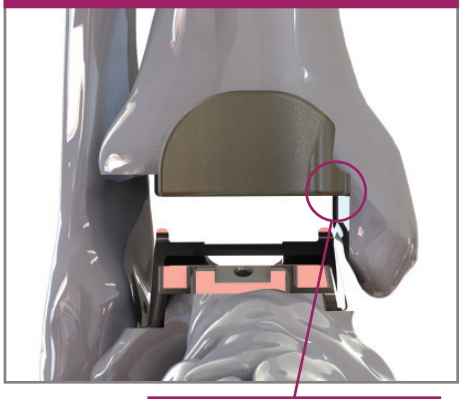
  a. Appropriate length of tibial component, i.e., its posterior border should be aligned with the posterior aspect of the tibia, thereby the tibial surface is fully covered.

8.1

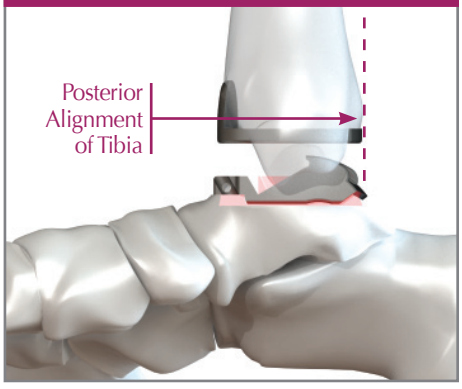
8.2



8.2



8.3-a

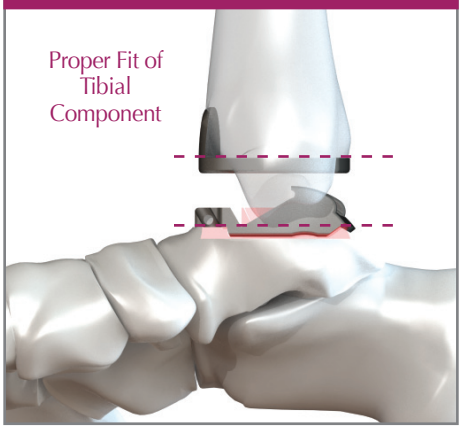


b. Proper fit of tibial and talar components to the prepared bone surface and parallel to each other.

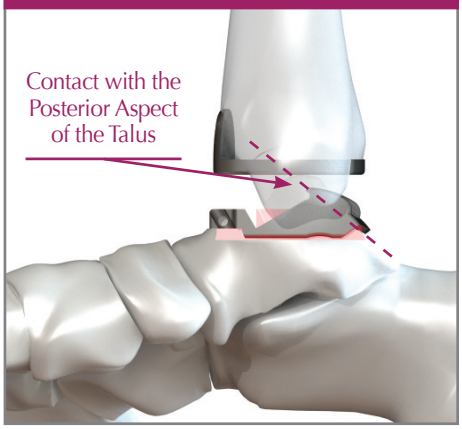
c. Proper fit of the posterior edge of talar component to the posterior surface of the talus.

- ***NOTE: If using flat-cut talar component, flat-cut trial is not shown in the images 8.3-a, 8.3-b and 8.3-c, but same principles are used to check fit of components relative to one another.***

8.3-b



8.3-c



9. Anterior Cut of the Talus

- If proper position of the talar trial has been achieved, resection of the anterior surface of the talus is performed with the oscillating saw using a feathering technique.
- The Hintermann Series™ distractor is again used to distract the joint for visualization.

- ***NOTE: If using flat-cut talar component, Section 11 is not needed.***

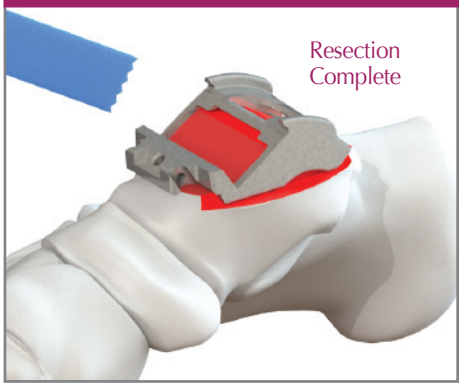
9.0

10. Drilling of the Peg Holes

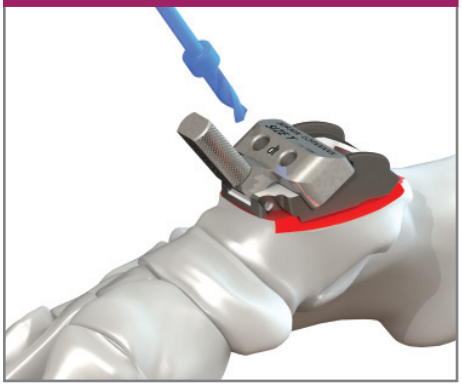
- The talar drilling guide (same size as the talar trials: 309301-309306) is fixed to the talar trial.
- Using the guide, 2 holes are drilled with the 4.5 mm peg drill (309309) until the shoulder of the peg drill meets the drill guide surface.
- The assembly is then removed.

- ***NOTE: If using flat-cut talar component, talar drilling guide is not needed. Instead, holes in flat-cut talar trial are used to drill peg holes. 4.5 mm peg drill (309369) is used instead of 309309.***

9.0



10.0



10.0

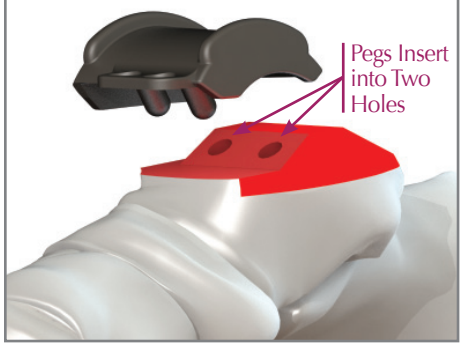
11. Implant Insertion

- After removing the Hintermann Series™ Distractor, the definitive implants are inserted as follows:

11.1 Talar Component

- Bone cement is applied to the inferior faces of the talar component per cement manufacturer's instructions.
- The talar component is implanted by hand such that the pegs can readily insert into the 2 holes. The implant is impacted using a mallet and the talar impactor (119609) to ensure a proper fit of the component to the bone.

11.1



11.1

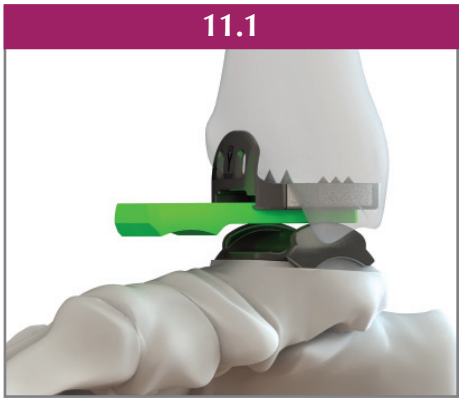
11.1

11.2 Tibial Component

- Bone cement is applied to the superior face and the posterior face of the anterior shield of the tibial component per cement manufacturer's instructions.
- The tibial component is inserted along the medial malleolus until proper fit to the anterior border of the tibia is achieved.
- The implant is impacted using a mallet and the tibial impactor (119751) to ensure a proper fit of the component to the bone.

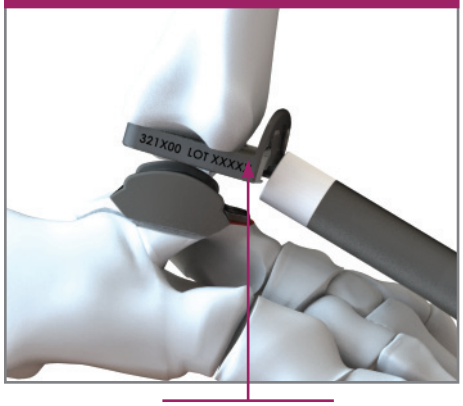
In order to obtain good contact between the tibial cut and the tibial component on the entire surface, the impactor handle should be in an oblique position regarding the tibial component axis.

11.1



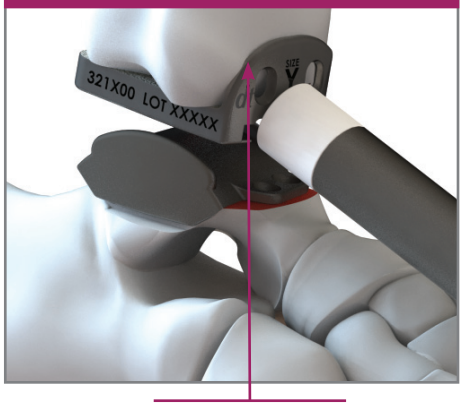
NOTE: To avoid any contact between the metallic surfaces, retrograde insertion on the trial inlay is advised. Trial inlay may also be used to help fully seat posterior aspect of tibial tray. When inserted, axial pressure to heel may be applied to push up on tibial tray. Check with fluoroscopy, if necessary.

11.2



Prior to Impaction

11.2



Impaction Complete

11.3 Trial Inlay

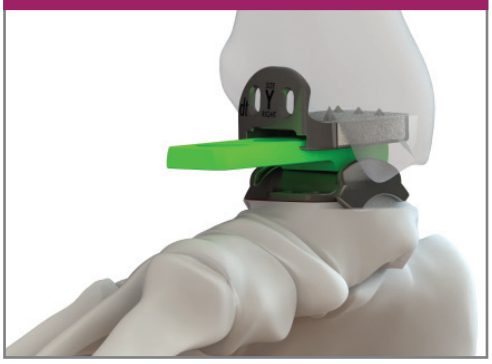
- The 5 mm trial inlay (119665) is inserted. If sufficient soft tissue tension cannot be achieved, the 6 mm, 7 mm, or 9 mm trial inlays (119666/119667/119669) can be used which would correspond to the implant thickness chosen to complete the implantation.

11.4 Trial Inlay Offset

- The Trial inlay offset measurement tool (326002-326006), included in the packaging with the tibial component, is inserted between the tibial and talar components to verify the relative anterior/posterior position of the talar and tibial implants.
- In order to determine the relative (anterior/posterior) position of the Talar and Tibial Component and to choose the appropriate PE Inlay (neutral, anterior, posterior), lateral fluoroscopy of the joint should first be taken with the foot in maximal dorsiflexion, before taking the measurement.
- The following letters are used on the tool to indicate offset measurement:

A Anterior position
N Neutral position
P Posterior position

11.3



11.4

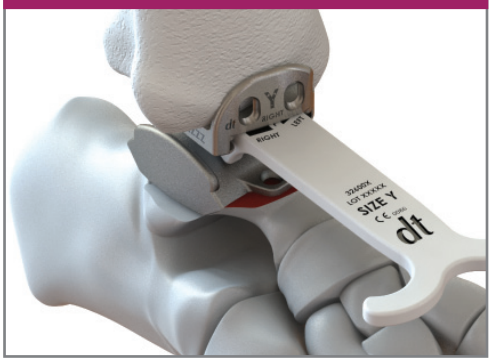
11.4

Anterior (A) position

11.4

Neutral (N) position

11.4



Posterior (P) position

11.5 Inlay

- The inlay (size matched to the talar component) is selected and inserted by hand. The teeth of the metallic ring must face anteriorly toward the surgeon. The 'M' marking on the implant should be realized medially.

The contact surface on the talus is conical. This creates difference between the load bearing radii on medial and lateral aspects of the talus. The anterior facing teeth of the ring are necessary for locking the poly implant.

Proper insertion of the inlay is mandatory! If teeth are not facing anteriorly and 'M' marking is not medial, the poly has been placed or chosen incorrectly.

11.6 Slide Insertion

- Manually insert the tibial slide until it seats into the tibial implant. The rails of the tibial implant are designed to only accept the tibial slide in a single orientation.

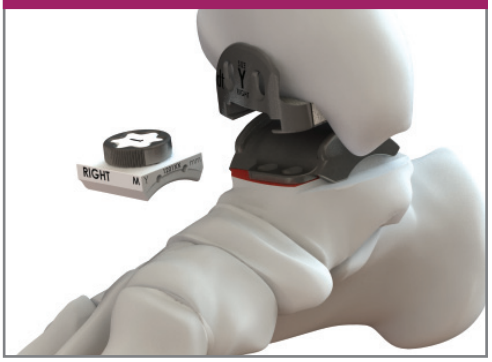
11.7 Verification

- It is highly recommended to verify the position of the implants by fluoroscopy in A/P and lateral positions. Note that poly inlays contain two radiographic markers which can be seen fluoroscopically indicating the alignment of the poly implant relative to the tibial and talar implants.

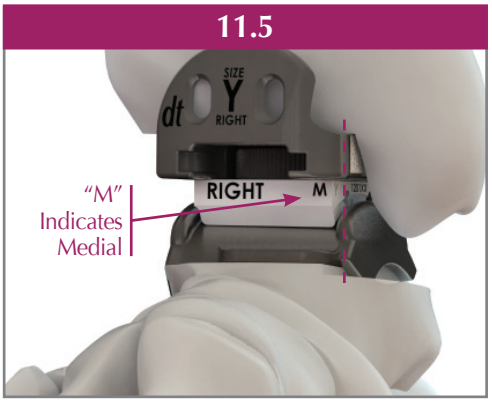
Obtaining accurate rotation of the tibial polyethylene is critical to the ultimate alignment and wear characteristics of the H2 device and needs to be meticulously ascertained by the surgeon prior to definitively fixing the rotation with the Tibial Slide Device. Careful assessment of the tray orientation through multiple trials of flexion and extension throughout a full range of motion will be necessary to avoid inappropriate rotation and subsequent adverse edge loading of the polyethylene.

NOTE: After the insertion of the final components and the PE inlay, and with the spacer in place, it can then be determined whether or not additional surgeries might be necessary in order to obtain a more balanced ankle.

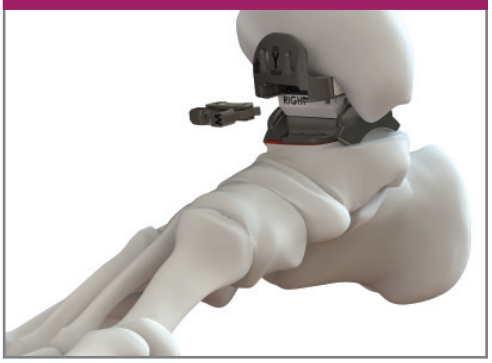
11.5



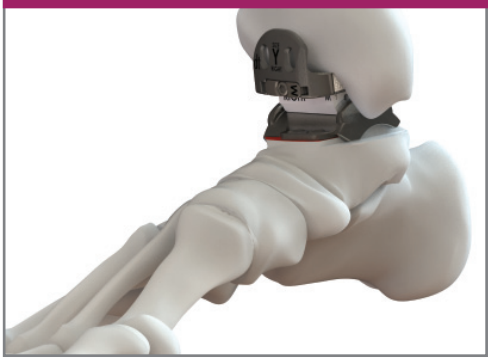
11.5



11.6



11.6



11.8 Locking Poly Inlay

- With the implants in place, while visually observing the congruency of the implants, the ankle should be flexed to its maximum allowable range of motion to provide for the poly implant to find its anatomic position which accommodates the relative rotation of the talar component to the tibial component.
- Once the range of motion evaluation is complete, the foot is returned to its plantar grade position.
- The poly inlay is locked in place utilizing the torque limiting Tibial Slide Screwdriver (329645). The screwdriver inserted into the tibial slide screw and is turned clockwise until the clutch mechanism disengages at its predetermined torque level.

11.8

- After locking the poly inlay, the ankle should be flexed to its maximum allowable range of motion while observing congruency of the implants and proper tensioning of the joint.

While the foot is moved in dorsiflexion with sufficient force, remaining soft tissue contracture on posterior aspect of the ankle should be released. Proper soft tissue balancing is critical to implant function.

- In order to confirm the relative A/P and rotational orientation of the implant construct, lateral and A/P radiographs of the joint should be taken.

NOTE: Fluoroscopy also allows detection of any remaining bony fragments or osteophytes that could be a potential source of pain or motion limitation.

12.0

12. Wound Closure

- Insertion of a drain is recommended.
- Wound closure is obtained by suture of the tendon sheath and retinaculum, respectively, and the skin.
- Careful dressing is made to avoid any pressure to the skin.
- A splint is used to keep the foot in neutral (plantar-grade) position.

13. Postoperative Care *(Recommended by Prof. B. Hintermann; Liestal, Switzerland)*

- Dressing and splint are removed and changed after 2 days.
- When the wound condition is dry and proper, typically 2 to 4 days after surgery, the foot is placed in a stabilizing cast or walker to protect the ankle against eversion, inversion, and plantar flexion movements for 6 weeks.
- Weight bearing is tolerated. Full weight bearing may be achieved as early as 1 week postoperatively.
- A rehabilitation program should be started for the foot and ankle after cast or walker removal, including stretching and strengthening of the triceps surae.
- The first clinical and radiological evaluation is made at 6 weeks to verify wound status, osteointegration, and position of the implants.
- It is recommended that the patient should be advised to wear a compression stocking to avoid extremity swelling for an additional 4 to 6 months.

14. Flat Cut Talar Implant

14.1 Fixation of the Block

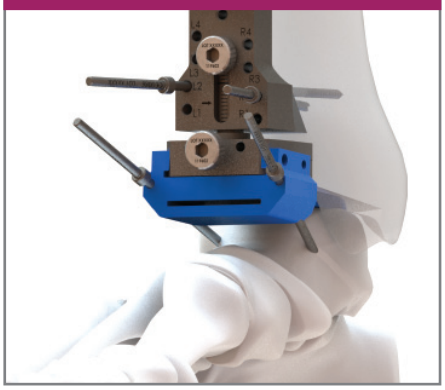
- The Flat Cut Talar cutting block (309658) is inserted into the corresponding slots of the tibial cutting block (309773) until it has been fixed by the detent.
- While the foot is held in neutral position, 2 pins (309605 or 309665) are inserted medially and laterally.
- Alignment of the hindfoot and flexion position of the foot are checked visually. If proper foot position is not achieved, the pins must be removed and the procedure should be done again.

NOTE: To achieve neutral foot position, it might be helpful to take the heel with one hand and the forefoot with the other hand. If there are any osteophytes left on talar neck that hinder, they must be removed.

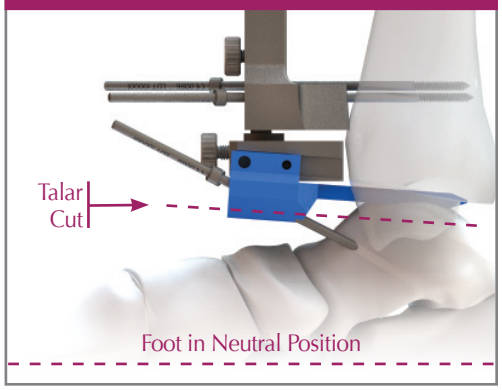
NOTE: If there is substantial bone loss of the talus, the talus should be held in its desired position to the tibia while holding the Hintermann distractor that tensions the ligaments. Then a free-hand flat cut is made parallel to the tibial resection surface for minimal resection of additional bone on the talar side.

14.1

14.1



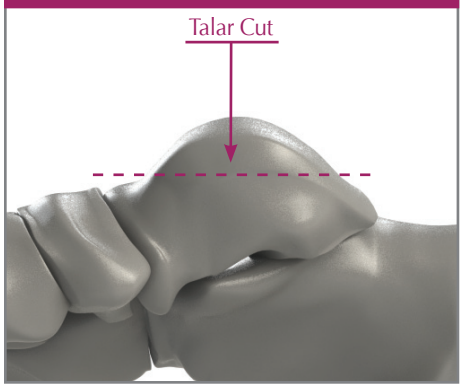
14.1



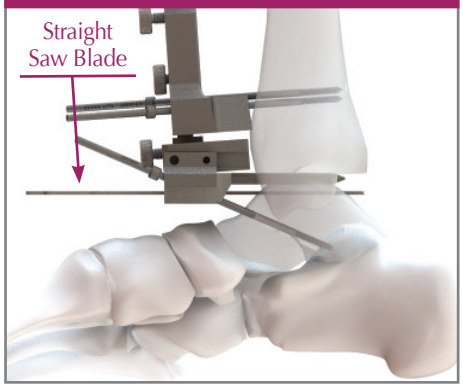
14.2 Superior Cut

- The resection of the talar dome is performed with the oscillating saw. Saw blade is inserted through the window of the talar cutting block (309658) to guide and affect the cut and protect the malleoli.

14.2



14.2

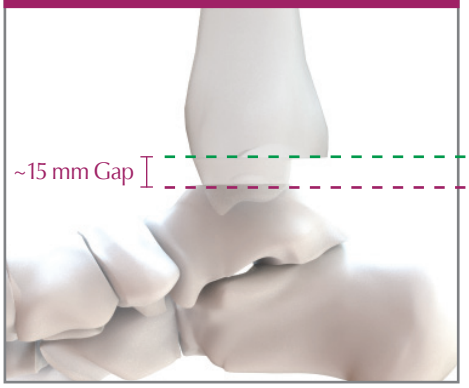


Several attachments are available for Hintermann Series™ saw blades

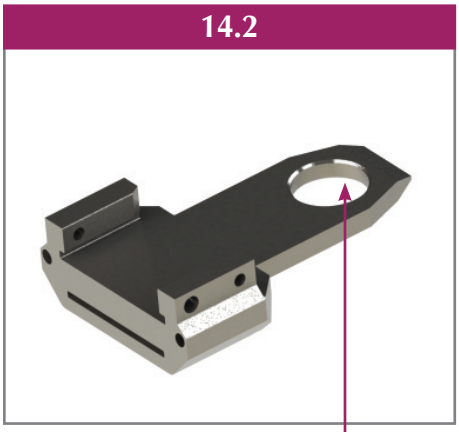
Aesculap® attachment (309622)	
AO Synthes® attachment (309623)	
Stryker® 6 attachment (309624)	
Conmed Linvatec® attachment (309627)	
Stryker® attachment (309626)	

14.2

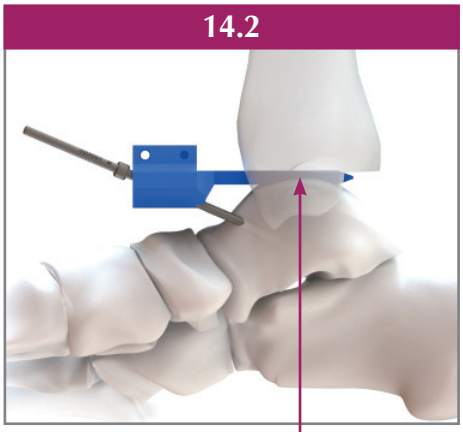
14.2



14.2



14.2



■ ***NOTE: If necessary, depth of the talar cut can be verified by removing the tibial resection block, distracting and visualizing the saw blade through the window or by fluoroscopy (lateral view).***

14.3 Assessment of the Implant Size

- The tibial depth gauge (309607) is used to determine the size of tibial implant.
- The gauge is inserted with the appropriate face (right/left) against the tibial surface and the posterior edge is hooked on the posterior border of the tibia. The size to be selected can be read from the scale depth gauge, located on its upper side (tibia side).

■ ***NOTE: If the anterior border of the tibia is between two marks, the biggest size should be selected between both. The anterior tibia might be shaped to the indicated mark to allow appropriate positioning of the tibial component (e.g., no medial or lateral gapping that may irritate soft tissues). The talar size should be within 1 size of tibial component (e.g., if tibial component size is 2, talar component size must be 1, 2, or 3).***

14.3

14.4 Collateral Cuts

- The appropriate size of the talar cutting guide* and talar cut guide handle (309380) is selected based on tibial measurement. The resection block is used for reference only for the medial and lateral cuts and should not be used for posterior and anterior shaping of the talus.
- The selected talar cutting guide is placed on the flat surface of the talus maintaining the hooks carefully positioned on the posterior aspect of the talus; the resection guide becomes in proper contact to the resection surface of the talus.
- The following bony margins around the guide should be visualized as follows:

  – medial side: 3 mm margin for cuts

  – lateral side: 2 to 4 mm margin (2 to 3 posterior, 3 to 4 anterior)

NOTE: If margins are larger or smaller than indicated above, the surgeon chooses a size up or down, ensuring that the size is matched to the tibial implant size plus/minus one size.

- While the foot is brought to a neutral position, the handle of the cutting guide should meet the second ray.

*329360 to 329366 for the right foot / 329370 to 329376 for the left foot

NOTE: In case of osteophytes or thick cartilage layer left on posterior talus, a chisel may be used. The tibial impactor (119751) may also be used to get the cutting guide fitted firmly to the talar resection surface.

- 2 to 4 pins are used for fixation of the cutting guide to the talus.

NOTE: Number and length of pins may be selected per the quality of bone to obtain an appropriate fixation. If necessary, the position of the cutting guide can be checked by fluoroscopy (e.g., proper fit of hooks on posterior aspect of talus and cutting guide on resection surface); the posterior peaks on the flat talar horizontal surface indicates the center of the talar component with regards to its antero-posterior position.

14.4

14.4

14.4

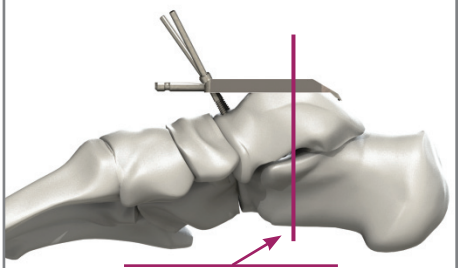
- The handle should be removed once the resection block is firmly fixed to the talus by pins.
- Medial and lateral cuts are performed using a reciprocating saw, paying attention that the saw blade strictly follows the cutting guide.
  - Medial side: approximately 3 mm deep
  - Lateral side: approximately 5 mm deep

NOTE: If necessary, a chisel may be used to finish the cut at its medial and lateral borders. In order to make further talar trial impaction easier, it may be helpful to slightly resurface the postero-lateral corner of the talus, per the cutting guide.

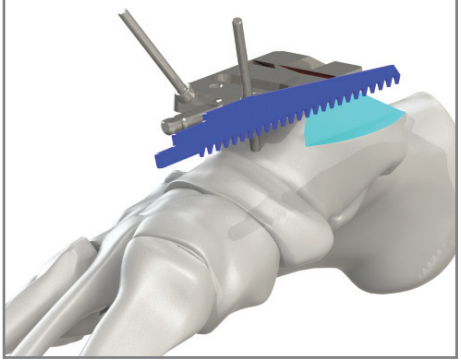
- The resected bone is removed with a rongeur.
- Remaining bony and capsular structures on posterior aspect are carefully excised.

NOTE: A chisel is used to mobilize the medial and lateral resections of the talus if necessary (e.g., hard bone), the posterior corner of collateral cuts might be softened with a chisel or rongeur to allow proper insertion of the talar trial.

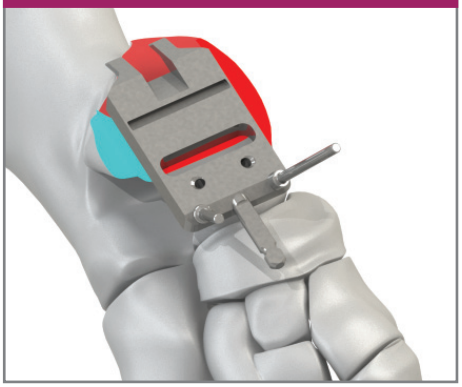
14.4



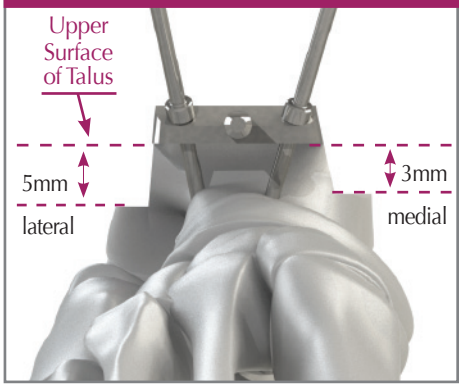
14.4



14.4



14.4



(Right Foot Shown)

[Return to Section 6 to continue Surgical Technique]

References

Container: Instruments

Reference	Description
399900	Instrument Case
including	
399950	Lid
399920	Upper Layer
399910	Pin Caddy

Container: Trials

Reference	Description
399901	Trials Case
including	
399951	Lid

Hintermann Series™ Total Ankle Replacement Prosthesis Instrument List:

Instrument Case (Lower Layer)	
119309	Pin Tamp
119664	Hintermann Distractor
309615	Tibial Rod
309620	Rod Connector
309625	Tibial Positioning V
309630	Translation Block
309645	Screwdriver 3.5 mm Hex
309725	Pin Outrigger
309753	Tibial Cutting Block - Proximal
309773	Tibial Cutting Block - Distal
Instrument Case (Upper Layer)	
119609	Talar Impactor
119641	Tibial 2 mm Cut Guide
119751	Tibial Impactor
309600	Cortical Screw Screwdriver
309635	Tibial Cut Guide- Large
309636	Tibial Cut Guide - Medium
309637	Tibial Cut Guide - Small
309653	Parallel Pliers
309655	Talar Cut Block - Large
309656	Talar Cut Block - Medium
309657	Talar Cut Block - Small
309658	Talar Cut Block – Flat Cut
309670	Spacer 12 mm
309671	Spacer 15 mm
309672	Spacer 18 mm
309699	Talar Trial Impactor
329360	Talar Cut Guide Right Size 0
329361	Talar Cut Guide Right Size 1
329362	Talar Cut Guide Right Size 2
329363	Talar Cut Guide Right Size 3
329364	Talar Cut Guide Right Size 4
329365	Talar Cut Guide Right Size 5
329366	Talar Cut Guide Right Size 6
329370	Talar Cut Guide Left Size 0
329371	Talar Cut Guide Left Size 1
329372	Talar Cut Guide Left Size 2
329373	Talar Cut Guide Left Size 3
329374	Talar Cut Guide Left Size 4
329375	Talar Cut Guide Left Size 5
329376	Talar Cut Guide Left Size 6
309380	Talar Cut Guide Handle
329645	Tibial Slide Screwdriver
997035	Straight Chisel
Instrument Case (Pin Caddy)	
119602	M4 x 0.7 Thumb Screw
309116	K-wire 1 sharp 1 blunt ø 1.6 mm L 150 mm
309117	K-wire 1 sharp 1 blunt ø 1.6 mm L 150 mm Threaded
309200	Talar Reamer ø 6 mm
309309	Talar Peg Drill ø 4.5 mm
309369	Talar Peg Drill ø 4.5 mm [Long]
309225	K-wire 1 sharp 1 blunt ø 2.4 mm L 230 mm
309226	K-wire 1 sharp 1 blunt ø 2.4 mm L 230 mm Threaded
309604	Pins L 30 mm, Non-Threaded
309605	Pins L 70 mm, Non-Threaded
309606	Pins L 45 mm, Non-Threaded
309611	ø 2.4 Drill
309664	Pins L 30 mm, Threaded
309665	Pins L 70 mm, Threaded
309666	Pins L 45 mm, Threaded

Please consult with DT MedTech International Limited for availability in territories outside the USA.

Hintermann Series™ Total Ankle Replacement Prosthesis Instrument List – Continued

Trial Case	
119631	Tibial Spacer 4 mm
119632	Tibial Spacer 8 mm
119665	Trail Inlays Thickness 5 mm
119666	Trail Inlays Thickness 6 mm
119667	Trail Inlays Thickness 7 mm
119669	Trail Inlays Thickness 9 mm
119790	Flat Cut Talar Trial, Right, Size 1
119791	Flat Cut Talar Trial, Right, Size 2
119792	Flat Cut Talar Trial, Right, Size 3
119793	Flat Cut Talar Trial, Right, Size 4
119794	Flat Cut Talar Trial, Right, Size 5
119795	Flat Cut Talar Trial, Left, Size 1
119796	Flat Cut Talar Trial, Left, Size 2
119797	Flat Cut Talar Trial, Left, Size 3
119798	Flat Cut Talar Trial, Left, Size 4
119799	Flat Cut Talar Trial, Left, Size 5
129680	Tibial Trial, Right, Size 0
129681	Tibial Trial, Right, Size 1
129682	Tibial Trial, Right, Size 2
129683	Tibial Trial, Right, Size 3
129684	Tibial Trial, Right, Size 4
129685	Tibial Trial, Right, Size 5
129686	Tibial Trial, Right, Size 6
129690	Tibial Trial, Left, Size 0
129691	Tibial Trial, Left, Size 1
129692	Tibial Trial, Left, Size 2
129693	Tibial Trial, Left, Size 3
129694	Tibial Trial, Left, Size 4
129695	Tibial Trial, Left, Size 5
129696	Tibial Trial, Left, Size 6
309300	Talar Drill Guide Assembly - Size 0
309301	Talar Drill Guide Assembly - Size 1
309302	Talar Drill Guide Assembly - Size 2
309303	Talar Drill Guide Assembly - Size 3
309304	Talar Drill Guide Assembly - Size 4
309305	Talar Drill Guide Assembly - Size 5
309306	Talar Drill Guide Assembly - Size 6
309607	Tibial Depth Gauge
309680	Talar Trial, Right, Size 0
309681	Talar Trial, Right, Size 1
309682	Talar Trial, Right, Size 2
309683	Talar Trial, Right, Size 3
309684	Talar Trial, Right, Size 4
309685	Talar Trial, Right, Size 5
309686	Talar Trial, Right, Size 6
309690	Talar Trial, Left, Size 0
309691	Talar Trial, Left, Size 1
309692	Talar Trial, Left, Size 2
309693	Talar Trial, Left, Size 3
309694	Talar Trial, Left, Size 4
309695	Talar Trial, Left, Size 5
309696	Talar Trial, Left, Size 6
326002	H2 Offset Measurement Tool Size 2
326003	H2 Offset Measurement Tool Size 3
326004	H2 Offset Measurement Tool Size 4
326005	H2 Offset Measurement Tool Size 5
326006	H2 Offset Measurement Tool Size 6

Hintermann Series™ Tibial Components (with included locking mechanisms)*

(US Market: Single-Coat / Outside US Market: Double-Coat)

Single-Coat Reference	*Double-Coat* Reference	Description
421002	321002	H2 Tibial Tray Size 2 - Right (7 mm)
421022	321022	H2 Tibial Tray Size 2 - Right (9.5 mm)
421032	321032	H2 Tibial Tray Size 2 - Right (12 mm)
422002	322002	H2 Tibial Tray Size 2 - Left (7 mm)
422022	322022	H2 Tibial Tray Size 2 - Left (9.5 mm)
422032	322032	H2 Tibial Tray Size 2 - Left (12 mm)
421003	321003	H2 Tibial Tray Size 3 - Right (7 mm)
421023	321023	H2 Tibial Tray Size 3 - Right (9.5 mm)
421033	321033	H2 Tibial Tray Size 3 - Right (12 mm)
422003	322003	H2 Tibial Tray Size 3 - Left (7 mm)
422023	322023	H2 Tibial Tray Size 3 - Left (9.5 mm)
422033	322033	H2 Tibial Tray Size 3 - Left (12 mm)
421004	321004	H2 Tibial Tray Size 4 - Right (7 mm)
421024	321024	H2 Tibial Tray Size 4 - Right (9.5 mm)
421034	321034	H2 Tibial Tray Size 4 - Right (12 mm)

Single-Coat Reference	*Double-Coat* Reference	Description
422004	322004	H2 Tibial Tray Size 4 - Left (7 mm)
422024	322024	H2 Tibial Tray Size 4 - Left (9.5 mm)
422034	322034	H2 Tibial Tray Size 4 - Left (12 mm)
421005	321005	H2 Tibial Tray Size 5 - Right (7 mm)
421025	321025	H2 Tibial Tray Size 5 - Right (9.5 mm)
421035	321035	H2 Tibial Tray Size 5 - Right (12 mm)
422005	322005	H2 Tibial Tray Size 5 - Left (7 mm)
422025	322025	H2 Tibial Tray Size 5 - Left (9.5 mm)
422035	322035	H2 Tibial Tray Size 5 - Left (12 mm)
421006	321006	H2 Tibial Tray Size 6 - Right (7 mm)
421026	321026	H2 Tibial Tray Size 6 - Right (9.5 mm)
421036	321036	H2 Tibial Tray Size 6 - Right (12 mm)
422006	322006	H2 Tibial Tray Size 6 - Left (7 mm)
422026	322026	H2 Tibial Tray Size 6 - Left (9.5 mm)
422036	322036	H2 Tibial Tray Size 6 - Left (12 mm)

**Note: H2 Tibial Locking Mechanisms are packaged with appropriate Tibial Component*

Hintermann Series™ H2 PE Inlays

Right PE Inlays		Left PE Inlays	
Reference	Description	Reference	Description
321105	H2 PE Inlay Size 1 - Right – 5 mm/Neutral	322105	H2 PE Inlay Size 1 - Left – 5 mm/Neutral
321106	H2 PE Inlay Size 1 - Right – 6 mm/Neutral	322106	H2 PE Inlay Size 1 - Left – 6 mm/Neutral
321107	H2 PE Inlay Size 1 - Right – 7 mm/Neutral	322107	H2 PE Inlay Size 1 - Left – 7 mm/Neutral
321109	H2 PE Inlay Size 1 - Right – 9 mm/Neutral	322109	H2 PE Inlay Size 1 - Left – 9 mm/Neutral
321115	H2 PE Inlay Size 1 - Right – 5 mm/Anterior	322125	H2 PE Inlay Size 1 - Left – 5 mm/Posterior
321116	H2 PE Inlay Size 1 - Right – 6 mm/Anterior	322126	H2 PE Inlay Size 1 - Left – 6 mm/Posterior
321117	H2 PE Inlay Size 1 - Right – 7 mm/Anterior	322127	H2 PE Inlay Size 1 - Left – 7 mm/Posterior
321119	H2 PE Inlay Size 1 - Right – 9 mm/Anterior	322129	H2 PE Inlay Size 1 - Left – 9 mm/Posterior
321125	H2 PE Inlay Size 1 - Right – 5 mm/Posterior	322115	H2 PE Inlay Size 1 - Left – 5 mm/Anterior
321126	H2 PE Inlay Size 1 - Right – 6 mm/Posterior	322116	H2 PE Inlay Size 1 - Left – 6 mm/Anterior
321127	H2 PE Inlay Size 1 - Right – 7 mm/Posterior	322117	H2 PE Inlay Size 1 - Left – 7 mm/Anterior
321129	H2 PE Inlay Size 1 - Right – 9 mm/Posterior	322119	H2 PE Inlay Size 1 - Left – 9 mm/Anterior
321205	H2 PE Inlay Size 2 - Right – 5 mm/Neutral	322205	H2 PE Inlay Size 2 - Left – 5 mm/Neutral
321206	H2 PE Inlay Size 2 - Right – 6 mm/Neutral	322206	H2 PE Inlay Size 2 - Left – 6 mm/Neutral
321207	H2 PE Inlay Size 2 - Right – 7 mm/Neutral	322207	H2 PE Inlay Size 2 - Left – 7 mm/Neutral
321209	H2 PE Inlay Size 2 - Right – 9 mm/Neutral	322209	H2 PE Inlay Size 2 - Left – 9 mm/Neutral
321215	H2 PE Inlay Size 2 - Right – 5 mm/Anterior	322225	H2 PE Inlay Size 2 - Left – 5 mm/Posterior

Hintermann Series™ H2 PE Inlays – Continued

Right PE Inlays		Left PE Inlays	
Reference	**Description**	**Reference**	**Description**
321216	H2 PE Inlay Size 2 - Right – 6 mm/Anterior	322226	H2 PE Inlay Size 2 - Left – 6 mm/Posterior
321217	H2 PE Inlay Size 2 - Right – 7 mm/Anterior	322227	H2 PE Inlay Size 2 - Left – 7 mm/Posterior
321219	H2 PE Inlay Size 2 - Right – 9 mm/Anterior	322229	H2 PE Inlay Size 2 - Left – 9 mm/Posterior
321225	H2 PE Inlay Size 2 - Right – 5 mm/Posterior	322215	H2 PE Inlay Size 2 - Left – 5 mm/Anterior
321226	H2 PE Inlay Size 2 - Right – 6 mm/Posterior	322216	H2 PE Inlay Size 2 - Left – 6 mm/Anterior
321227	H2 PE Inlay Size 2 - Right – 7 mm/Posterior	322217	H2 PE Inlay Size 2 - Left – 7 mm/Anterior
321229	H2 PE Inlay Size 2 - Right – 9 mm/Posterior	322219	H2 PE Inlay Size 2 - Left – 9 mm/Anterior
321305	H2 PE Inlay Size 3 - Right – 5 mm/Neutral	322305	H2 PE Inlay Size 3 - Left – 5 mm/Neutral
321306	H2 PE Inlay Size 3 - Right – 6 mm/Neutral	322306	H2 PE Inlay Size 3 - Left – 6 mm/Neutral
321307	H2 PE Inlay Size 3 - Right – 7 mm/Neutral	322307	H2 PE Inlay Size 3 - Left – 7 mm/Neutral
321309	H2 PE Inlay Size 3 - Right – 9 mm/Neutral	322309	H2 PE Inlay Size 3 - Left – 9 mm/Neutral
321315	H2 PE Inlay Size 3 - Right – 5 mm/Anterior	322325	H2 PE Inlay Size 3 - Left – 5 mm/Posterior
321316	H2 PE Inlay Size 3 - Right – 6 mm/Anterior	322326	H2 PE Inlay Size 3 - Left – 6 mm/Posterior
321317	H2 PE Inlay Size 3 - Right – 7 mm/Anterior	322327	H2 PE Inlay Size 3 - Left – 7 mm/Posterior
321319	H2 PE Inlay Size 3 - Right – 9 mm/Anterior	322329	H2 PE Inlay Size 3 - Left – 9 mm/Posterior
321325	H2 PE Inlay Size 3 - Right – 5 mm/Posterior	322315	H2 PE Inlay Size 3 - Left – 5 mm/Anterior
321326	H2 PE Inlay Size 3 - Right – 6 mm/Posterior	322316	H2 PE Inlay Size 3 - Left – 6 mm/Anterior
321327	H2 PE Inlay Size 3 - Right – 7 mm/Posterior	322317	H2 PE Inlay Size 3 - Left – 7 mm/Anterior
321329	H2 PE Inlay Size 3 - Right – 9 mm/Posterior	322319	H2 PE Inlay Size 3 - Left – 9 mm/Anterior
321405	H2 PE Inlay Size 4 - Right – 5 mm/Neutral	322405	H2 PE Inlay Size 4 - Left – 5 mm/Neutral
321406	H2 PE Inlay Size 4 - Right – 6 mm/Neutral	322406	H2 PE Inlay Size 4 - Left – 6 mm/Neutral
321407	H2 PE Inlay Size 4 - Right – 7 mm/Neutral	322407	H2 PE Inlay Size 4 - Left – 7 mm/Neutral
321409	H2 PE Inlay Size 4 - Right – 9 mm/Neutral	322409	H2 PE Inlay Size 4 - Left – 9 mm/Neutral
321415	H2 PE Inlay Size 4 - Right – 5 mm/Anterior	322425	H2 PE Inlay Size 4 - Left – 5 mm/Posterior
321416	H2 PE Inlay Size 4 - Right – 6 mm/Anterior	322426	H2 PE Inlay Size 4 - Left – 6 mmc/Posterior
321417	H2 PE Inlay Size 4 - Right – 7 mm/Anterior	322427	H2 PE Inlay Size 4 - Left – 7 mm/Posterior
321419	H2 PE Inlay Size 4 - Right – 9 mm/Anterior	322429	H2 PE Inlay Size 4 - Left – 9 mm/Posterior
321425	H2 PE Inlay Size 4 - Right – 5 mm/Posterior	322415	H2 PE Inlay Size 4 - Left – 5 mm/Anterior
321426	H2 PE Inlay Size 4 - Right – 6 mm/Posterior	322416	H2 PE Inlay Size 4 - Left – 6 mm/Anterior
321427	H2 PE Inlay Size 4 - Right – 7 mm/Posterior	322417	H2 PE Inlay Size 4 - Left – 7 mm/Anterior
321429	H2 PE Inlay Size 4 - Right – 9 mm/Posterior	322419	H2 PE Inlay Size 4 - Left – 9 mm/Anterior
321505	H2 PE Inlay Size 5 - Right – 5 mm/Neutral	322505	H2 PE Inlay Size 5 - Left – 5 mm/Neutral
321506	H2 PE Inlay Size 5 - Right – 6 mm/Neutral	322506	H2 PE Inlay Size 5 - Left – 6 mm/Neutral
321507	H2 PE Inlay Size 5 - Right – 7 mm/Neutral	322507	H2 PE Inlay Size 5 - Left – 7 mm/Neutral
321509	H2 PE Inlay Size 5 - Right – 9 mm/Neutral	322509	H2 PE Inlay Size 5 - Left – 9 mm/Neutral
321515	H2 PE Inlay Size 5 - Right – 5 mm/Anterior	322525	H2 PE Inlay Size 5 - Left – 5 mm/Posterior
321516	H2 PE Inlay Size 5 - Right – 6 mm/Anterior	322526	H2 PE Inlay Size 5 - Left – 6 mm/Posterior

Hintermann Series™ H2 PE Inlays – Continued

Right PE Inlays		Left PE Inlays	
Reference	**Description**	**Reference**	**Description**
321517	H2 PE Inlay Size 5 - Right – 7 mm / Anterior	322527	H2 PE Inlay Size 5 - Left – 7 mm / Posterior
321519	H2 PE Inlay Size 5 - Right – 9 mm / Anterior	322529	H2 PE Inlay Size 5 - Left – 9 mm / Posterior
321525	H2 PE Inlay Size 5 - Right – 5 mm / Posterior	322515	H2 PE Inlay Size 5 - Left – 5 mm / Anterior
321526	H2 PE Inlay Size 5 - Right – 6 mm / Posterior	322516	H2 PE Inlay Size 5 - Left – 6 mm / Anterior
321527	H2 PE Inlay Size 5 - Right – 7 mm / Posterior	322517	H2 PE Inlay Size 5 - Left – 7 mm / Anterior
321529	H2 PE Inlay Size 5 - Right – 9 mm / Posterior	322519	H2 PE Inlay Size 5 - Left – 9 mm / Anterior
321605	H2 PE Inlay Size 6 - Right – 5 mm / Neutral	322605	H2 PE Inlay Size 6 - Left – 5 mm / Neutral
321606	H2 PE Inlay Size 6 - Right – 6 mm / Neutral	322606	H2 PE Inlay Size 6 - Left – 6 mm / Neutral
321607	H2 PE Inlay Size 6 - Right – 7 mm / Neutral	322607	H2 PE Inlay Size 6 - Left – 7 mm / Neutral
321609	H2 PE Inlay Size 6 - Right – 9 mm / Neutral	322609	H2 PE Inlay Size 6 - Left – 9 mm / Neutral
321615	H2 PE Inlay Size 6 - Right – 5 mm / Anterior	322625	H2 PE Inlay Size 6 - Left – 5 mm / Posterior
321616	H2 PE Inlay Size 6 - Right – 6 mm / Anterior	322626	H2 PE Inlay Size 6 - Left – 6 mm / Posterior
321617	H2 PE Inlay Size 6 - Right – 7 mm / Anterior	322627	H2 PE Inlay Size 6 - Left – 7 mm / Posterior
321619	H2 PE Inlay Size 6 - Right – 9 mm / Anterior	322629	H2 PE Inlay Size 6 - Left – 9 mm / Posterior
321625	H2 PE Inlay Size 6 - Right – 5 mm / Posterior	322615	H2 PE Inlay Size 6 - Left – 5 mm / Anterior
321626	H2 PE Inlay Size 6 - Right – 6 mm / Posterior	322616	H2 PE Inlay Size 6 - Left – 6 mm / Anterior
321627	H2 PE Inlay Size 6 - Right – 7 mm / Posterior	322617	H2 PE Inlay Size 6 - Left – 7 mm / Anterior
321629	H2 PE Inlay Size 6 - Right – 9 mm / Posterior	322619	H2 PE Inlay Size 6 - Left – 9 mm / Anterior

Hintermann Series™ Talar Components)

(US Market: Single-Coat / Outside US Market: Double-Coat)

Single-Coat **Regular Component**	*Double-Coat* **Regular Component**	**Description**	*Single-Coat* **Flat Cut Component**	*Double-Coat* **Flat Cut Component**	**Description**
401110	301110	Right – Size 0			
401111	301111	Right – Size 1	401121	301121	Right – Size 1
401112	301112	Right – Size 2	401122	301122	Right – Size 2
401113	301113	Right – Size 3	401123	301123	Right – Size 3
401114	301114	Right – Size 4	401124	301124	Right – Size 4
401115	301115	Right – Size 5	401125	301125	Right – Size 5
401116	301116	Right – Size 6			
402110	302110	Left – Size 0			
402111	302111	Left – Size 1	402121	302121	Left – Size 1
402112	302112	Left – Size 2	402122	302122	Left – Size 2
402113	302113	Left – Size 3	402123	302123	Left – Size 3
402114	302114	Left – Size 4	402124	302124	Left – Size 4
402115	302115	Left – Size 5	402125	302125	Left – Size 5
402116	302116	Left – Size 6			

DT MedTech, LLC

Corporate Offices:

110 West Road | Suite 227 | Baltimore, MD USA 21204

Phone: (US) **410.427.0003** *(OUS)* **+1 410 427 0003**

Fax: (US) **410.494.0515** *(OUS)* **+1 410 494 0515**

Email: **info@dtmedtech.com**

Website: **dtmedtech.com**

DT MedTech International Limited

Customer Service:

Phone: **+31 73 303 2537**

Email: **CustomerService@DTMedTech.com**

Manufacturer:
DT MedTech, LLC
110 West Road, Suite 227
Baltimore, MD 21204
The United States of America
(US) **410.427.0003**
(OUS) **+1 410 427 0003**

EU Authorized Rep:
Healthlink Europe BV
De Tweeling 20-22
5215 MC's-Hertogenbosch
The Netherlands
+31 73 303 2537

USA Authorized Rep:
HealthLink Europe & International
211 E. Six Forks Road
Suite 209 A-B
Raleigh, NC 27609
1-800-781-8926 919-783-4142

CE 0086

Please consult with DT MedTech International Limited for availability in Territories outside the USA.