CONFORMIS

CORDERA™ HIP SYSTEM

SURGICAL TECHNIQUE GUIDE

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Introduction

The Conformis Cordera Hip System is a cementless, primary total hip replacement system composed of femoral and acetabular components. The femoral component consists of a standard monoblock femoral stem body and neck, which mates with a standard femoral head. The acetabular component consists of a standard size shell with standard screw hole placement, a mating polyethylene liner, and cancellous screws. The acetabular component is designed for cementless use; initial implant fixation is achieved through press-fit design.

Cordera hip system

Surgeon Design Team

The Cordera Hip System Surgical Technique was developed in collaboration with:

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Pre-operative Planning

Determination of Leg Length Discrepancy

Perform a clinical evaluation in conjunction with a radiographic analysis to determine preoperative leg length discrepancy, and use both to determine intraoperative leg length management.

Acetabular Cup Sizing and Position

Acetabular sizing determination is made using the A/P radiograph of the hip. Determine the optimal position for the acetabular component and estimate the size using template overlays. The acetabular teardrop can be referenced as the interior margin of the acetabular reconstruction. The goal in cementless acetabular fixation is to optimize position and bone contact. Once this is determined, mark the intended center of rotation of the bearing surface on the A/P radiograph.

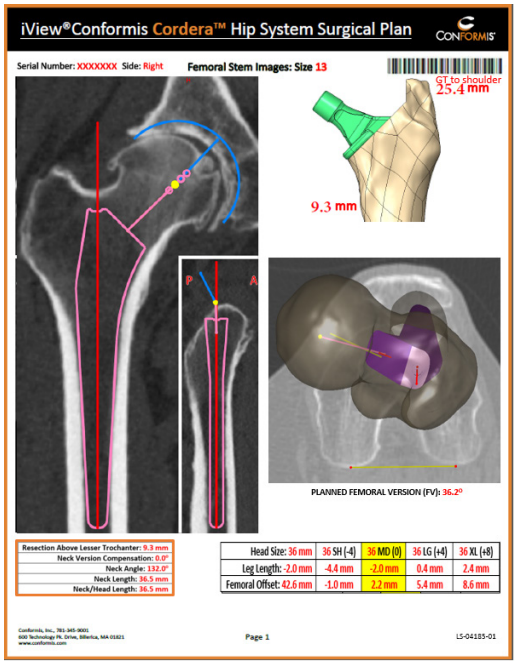
Femoral Stem Selection

Select the template size that fits the proximal femur and manages leg length. The femoral template should be in line with the long axis of the femur, and the neck resection line drawn at the point where the selected stem provides the desired amount of leg length.

SURGICAL TECHNIQUE

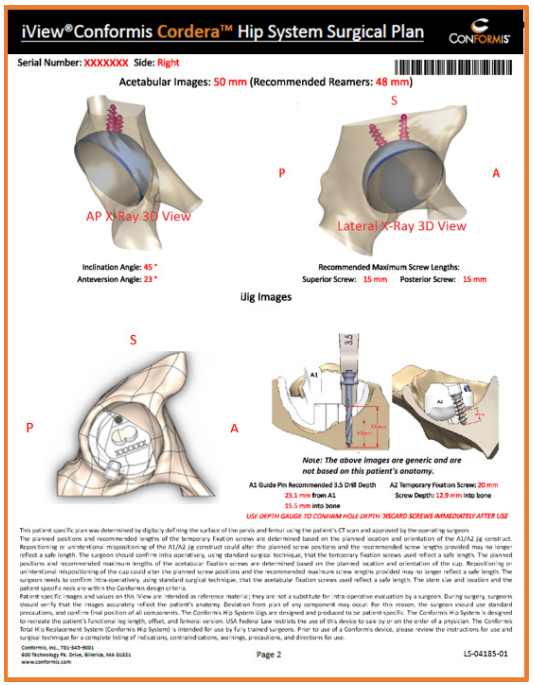
WITH IVIEW & IJIGS

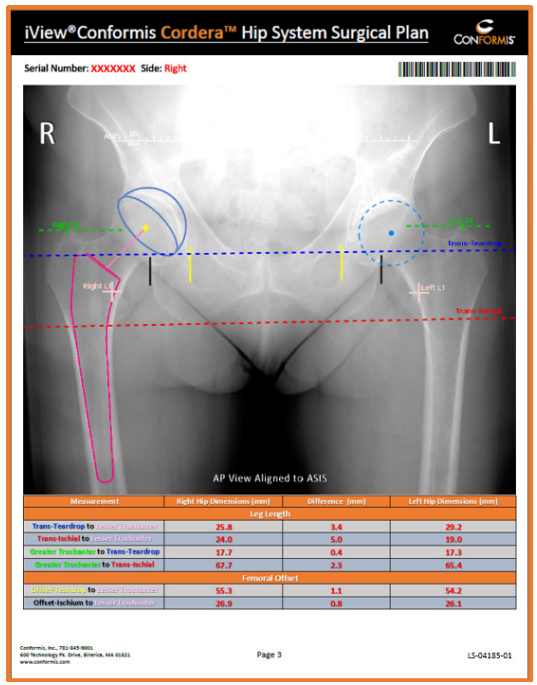
iView Overview



iView® patient-specific planning images are included with each implant and are also available preoperatively from Conformis. The images provide patient-specific dimensional information and final implant positioning.

iView® patient-specific planning images are intended as reference material and not a substitute for intra-operative evaluation by a surgeon. During surgery, physicians should verify that the images provided accurately reflect the patient's anatomy and evaluate the hip for range of motion and stability.





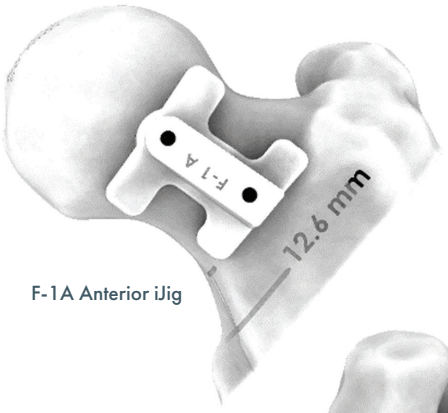
hip

Step 1 EXPOSURE AND NECK RESECTION

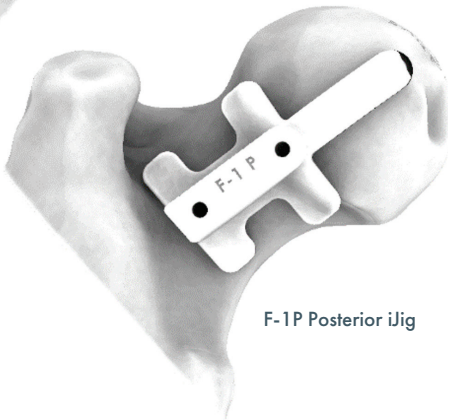
1 The serial number is noted on the iView and engraved on each iJig. Before beginning the case, confirm that the serial number is correct and matches across all components.

2 Utilizing the Cordera Hip System, total hip replacement surgery can be performed through either a posterior or anterior approach.

3 Adequately expose the acetabulum and proximal femur.



F-1A Anterior iJig



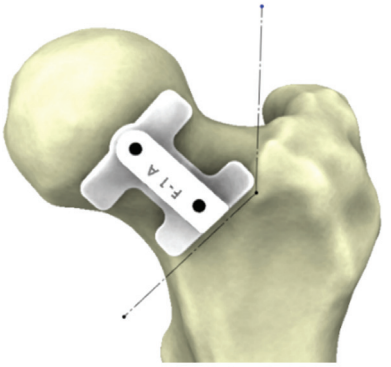
F-1P Posterior iJig

4 Select the anterior or posterior version of the F1 iJig corresponding to the surgical approach being used. The iJig is marked "F-1 A" for the anterior approach, and "F-1 P" for the posterior approach. Note the femoral head model has the outline of both iJig positions. Place the appropriate F1 iJig on the femoral head model as a guide to demonstrate the patient's anatomy. Rotate the femur to expose the femoral neck for insertion and placement of the F1 iJig.

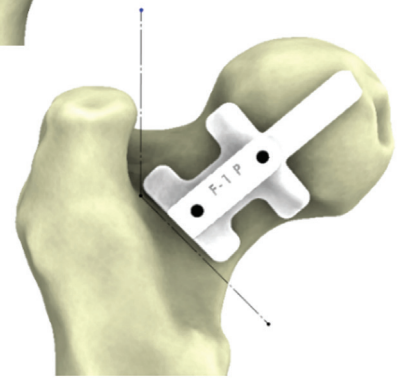
5 The contoured surface of the F1 iJig matches the patient's femoral neck and will feel stable when it is in the correct position. Ensure all cartilage and soft tissue is removed as necessary to allow the iJig to lay in direct apposition to bone. Adjust it on the neck until it is stable against the bone.

TECHNIQUE TIPS

- Internally and externally rotating the femur may help with insertion and location of the F1 iJig in small incisions.
- Comparing the appearance in the patient to the markings on the femoral head model provides visual feedback.



F-1A Anterior iJig

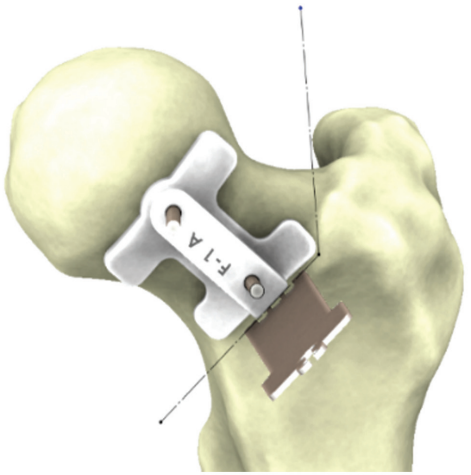


F-1P Posterior iJig

6 Place two short 3 mm headless pins through the two divergent holes in the iJig. The pins will lock the iJig in place during resection of the femoral head. Verify that the iJig is fully seated against the femoral neck.

TECHNIQUE TIP

The F1 iJig will not slide off over the pins, since they are divergent to keep it locked in place. At least one of the pins must be removed prior to removing the F1 iJig after the resection is complete.



7 Using an oscillating or reciprocating saw, perform a femoral neck osteotomy by first cutting adjacent to the distal surface of the F1 iJig, parallel to the nearest pin (use the flat bottom of the F1 iJig as a guide for the parallel position). Perform a vertical cut, if needed, with the saw or an osteotome.

TECHNIQUE TIP

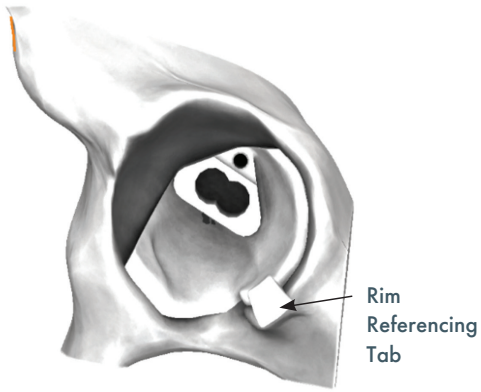
When making the neck resection, align the saw blade axis parallel to the pin closest to the saw blade and flush against the bottom of the F1 iJig.

8 Using the pin puller, remove the pins from the iJig and remove the iJig from the femoral neck. Remove the femoral head and neck from the incision. Once the femoral head is removed, place it into the Anterior and Posterior Resection Indicator Model and confirm the neck resection in all planes. It is important the neck resection be flush for collared stems. A slightly divergent neck resection is allowable for non-collared stems.

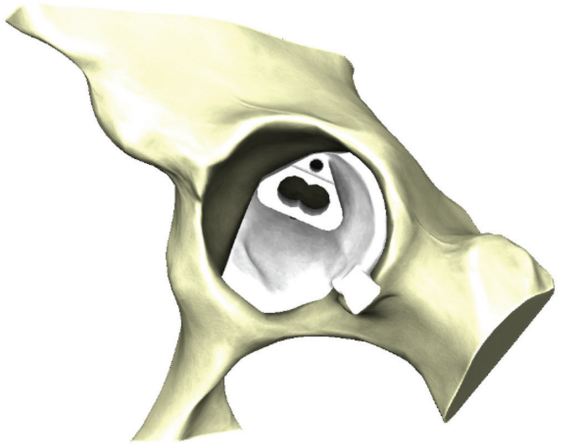
TECHNIQUE TIPS

- The resected head may not fit tightly in the Anterior and Posterior Resection Indicator model. This is due to the model being designed to subchondral bone. For a closer fit, remove any remaining cartilage and soft tissue. Use it as a guide only for the level of the neck resection.
- If you wish to confirm head size, measure the diameter of the resected head with calipers. The measured head diameter should be approximately 4mm smaller than the Cup size on the iView.

Step 2 ACETABULAR PREPARATION



A-1 iJig in Acetabulum
Bone Model



A-1 iJig in
Acetabulum

9 Place the A1 iJig in the acetabular bone model to identify the location of the iJig within the anatomy. Remove labrum, cartilage, and soft tissue as needed to ensure the iJig seats directly on subchondral bone. Do not remove osteophytes from the rim of the acetabulum, as they are accounted for in the contour of the patient specific iJig and may provide additional stability.

TECHNIQUE TIPS

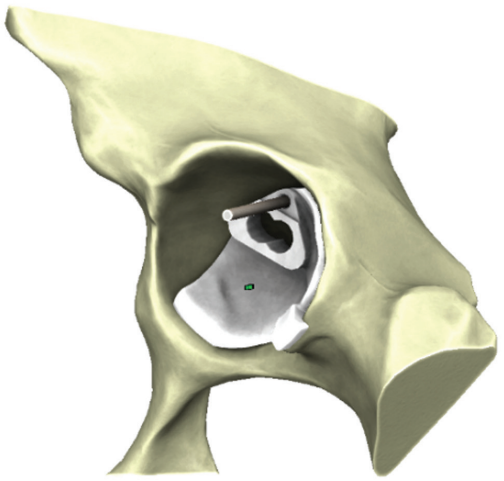
- In the case Conformis is unable to design acetabular jigs, the acetabulum should be prepared with standard full basket reamers using standard reaming protocol. The final reamer should be 2mm smaller than the cup size.
- In the case the surgeon does not utilize the acetabular jigs, proceed to Step 18.

CAUTION: Use of the full hemispherical acetabular reamer may invalidate the Cordera™ Hip System surgical plan. The ability to achieve the planned leg length and offset as well as acetabular cup position and orientation may be impacted.

10 Place the A1 iJig into the opening of the acetabulum. The rim-referencing tab of the iJig will be oriented to reference the posterior edge of the rim by the transverse acetabular ligament. Insert the iJig into the acetabulum and orient the iJig within the socket until it has reached stable positioning. When in the correct position, the notch on the inferior edge should fit flush against acetabular edge.

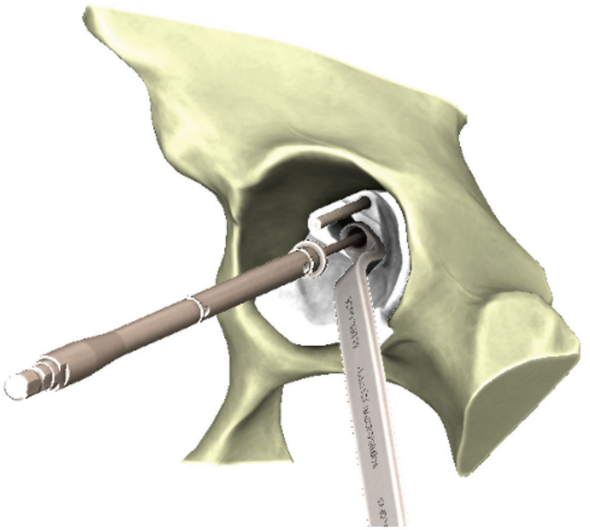
TECHNIQUE TIPS

- First place the A1 iJig into the acetabular bone model. This gives a visual reference to placement of A1 in the patient's acetabulum. Bring the model close to the incision site for a visual confirmation of placement.
- Retention of osteophytes during placement of the A1 iJig may provide additional stability as they are accounted for in the iJig design.
- If osteophytes are removed from the rim prior to placement of the A1 iJig, it will still seat at the correct location in the acetabulum.



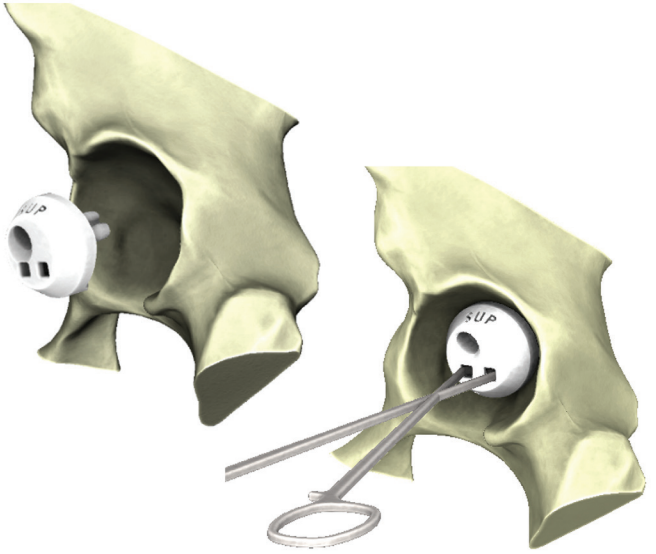
11 Use the short 3.5 mm flex drill and 3.5 mm end of the drill guide to drill through the smaller hole on the A1 iJig, and place a pin by hand to hold the A1 iJig in place. The recommended depth of the hole from the top of the A1 iJig as well as the depth of penetration into bone are stated on the surgical iView. Use the depth gauge to assess whether the recommended drilling depth has been achieved.

Use caution to not drill through the medial wall of the pelvis as the drill bit is extended.



12 Drill two pilot holes through the A1 iJig using the 5.5 mm flexible drill bit and corresponding end of the double-ended drill guide. These two holes will be used for securing the pegs of the A2 iJig. The A1 iJig 5.5 mm holes have a built in depth stop.

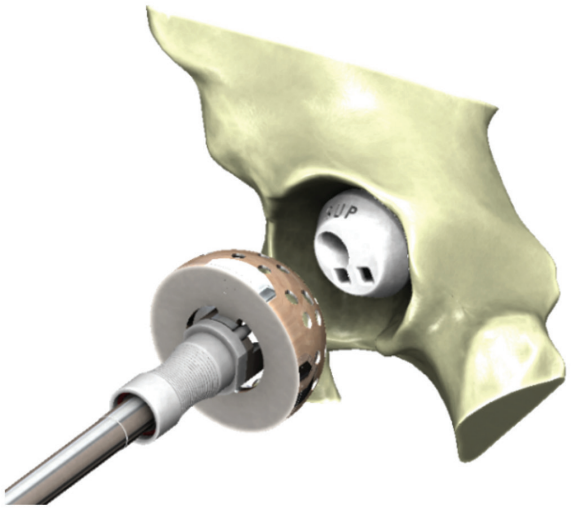
Use caution to not drill through the medial wall of the pelvis as the drill bit is extended.



13 Remove the A1 iJig and pin from the acetabulum. Inspect and ensure the bone bridge is removed between the 5.5mm drill holes. Choose one of the two A2 iJigs provided. One is designed to meet the plan (labeled "PLAN") for reamer depth, and the other (labeled "+2") deepens the reaming by an additional 2 mm. Insert the chosen A2 iJig into the acetabulum, inserting the pegs on the back of the iJig into the two drilled 5.5 mm holes. The two small holes on the iJig can be grasped with a Kocher clamp, to help aid with insertion into the incision. Press to ensure the A2 iJig is seated tightly and securely on the acetabulum floor. It is recommended to secure the A2 iJig with a screw using the 3.5 mm drill bit and drill guide.

TECHNIQUE TIPS

- The back side of the A2 and A2+2 iJigs is patient-specific. Once that patient-specific bone is removed, these iJigs will not have the correct referencing.
- After reaming is completed with the Stage 1 and Stage 2 reamers, you must not use either of the A2 iJigs again to guide the ream. The referencing will have been removed and this results in a risk of reaming too deeply.



14 Due to the specifics of sizing of the reamers and the cup, **the appropriate reamer size is 2 mm smaller than the cup.** Insert the Stage 1 acetabular reamer over the A2 iJig. Ream until the handle is seated on top of the A2 iJig. The A2 iJig acts as a depth stop for the reamer.

Note: there is no need for consecutive size reaming. This system reams directly to size.

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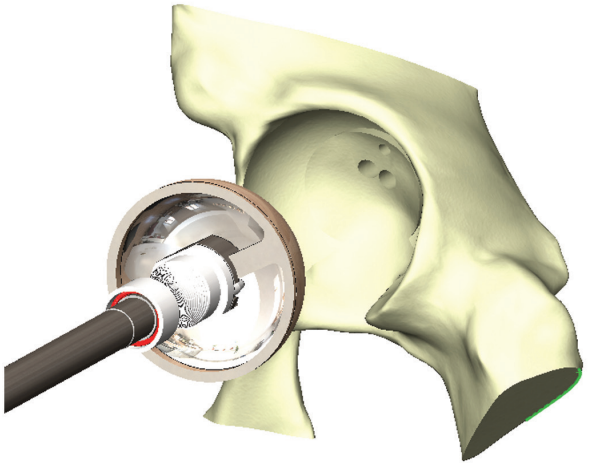
15 Remove the A2 iJig using a Kocher or similar instrument.



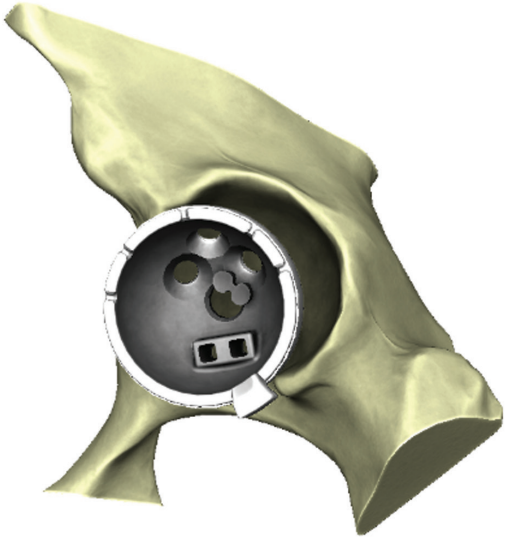
16 Using the provided stage 2 reamer that is 2 mm smaller than the planned cup size, ream away the remaining central bone that was under the A2 iJig in the acetabular floor. The stage 2 reaming process may leave loose tissue obscuring the triangular hole pattern. After reaming, ensure that all three holes in the triangular pattern are visible.

Note: Remember, after reaming is completed with the Stage 2 reamer, you cannot use the A2 iJig again to guide the ream. The referencing will have been removed and this results in a risk of reaming too deeply.

TECHNIQUE TIPS

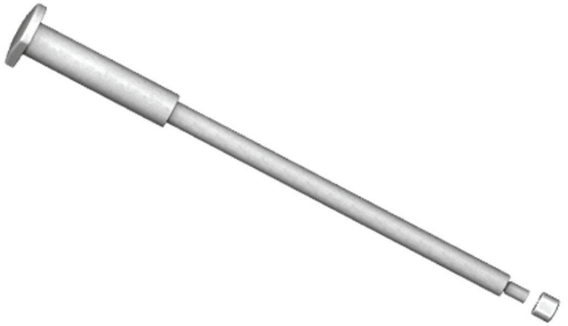
- If the surgeon feels the need to medialize the cup further, standard reamers can be used.
- A full hemispherical acetabular reamer is available for use if the surgeon's medical judgment deems appropriate. However, the full hemispherical acetabular reamer is NOT intended for use with the Cordera Hip System acetabular iJigs. The final reamer size should be 2 mm smaller than the planned cup size.

CAUTION: Use of the full hemispherical acetabular reamer may invalidate the Cordera Hip System surgical plan. The ability to achieve the planned leg length and offset as well as acetabular cup position and orientation may be impacted.

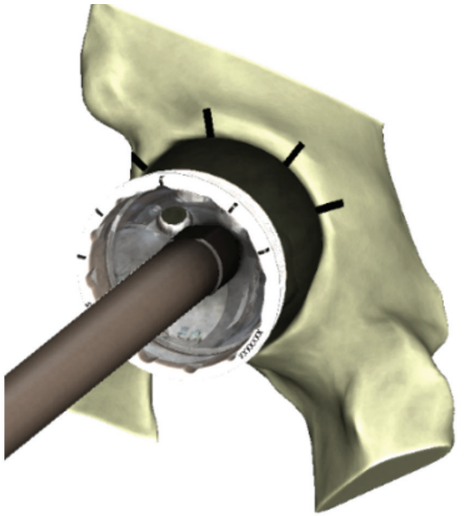


17 The A3 cup placement iJig is provided to seat into the dual drilled holes to represent the final placement of the planned cup and is intentionally undersized. Similar to the A1 iJig, the A3 iJig features a tab to reference the posterior rim of the notch. This iJig has acetabular rim markings that align with cup laser marks. Additionally, there are 3 central holes representing the screw holes in the cup. Use a marker or cautery to mark the indentations representing the laser mark locations on the rim of the cup, the position of the cup along the rim of the bony edge or the screw hole locations. Remove the iJig and proceed with the cup insertion step.

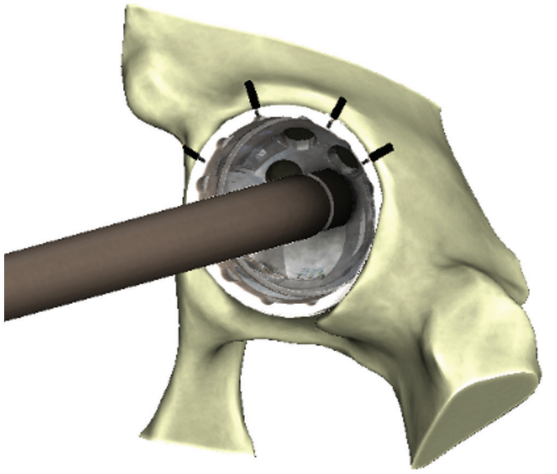
Step 3 IMPLANT ACETABULAR CUP



18 Attach the cup impactor tip onto the distal end of the cup impactor. Thread the cup impactor into the acetabular cup.



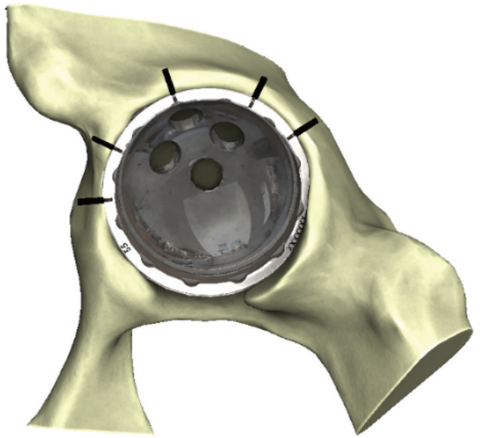
19 Place the cup in the exposure and rotate it until the laser marks on the rim of the cup are aligned with the marks previously made on the acetabular rim.



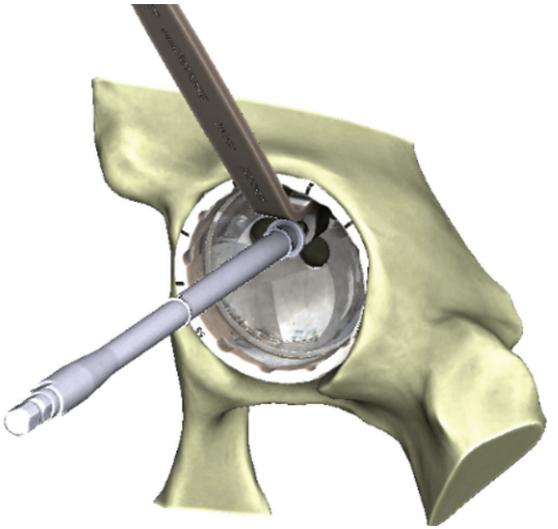
20 Impact with firm mallet blows until the cup is fully seated.

TECHNIQUE TIP

- Use the acetabular bone model with the cup simulation iJig to confirm visually the cup in relation to the acetabular rim. This can be achieved by placing the model with the cup next to the incision to verify inclination and anteversion of the pre-operative plan.

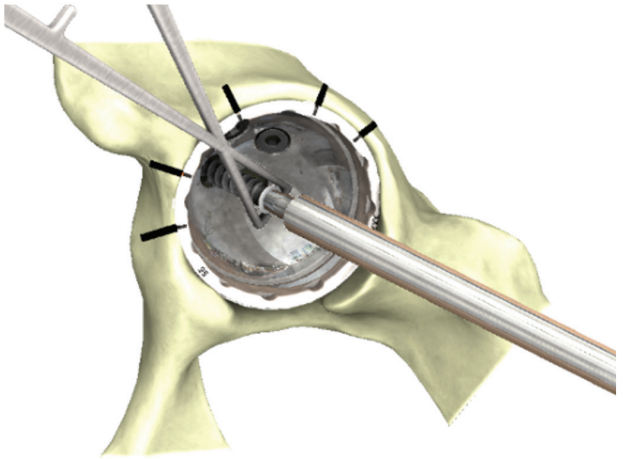


21 Unthread the impactor from the cup and remove it from the incision.



22 If use of screws is preferred, use the 3.5 mm flexible drill bit and drill guide (the short 3.5 mm drill for screws ≤ 25 mm, use the long 3.5 mm drill for screws > 25 mm length), to prepare pilot holes for the acetabular screws, using caution to not drill through the opposite cortex of the ilium. Use the depth gauge to measure the depth of each hole.

Note: The iView plans for the two most posterior screw holes. Usage of the most anterior screw hole is not guided or planned and may be used at the surgeon's discretion.



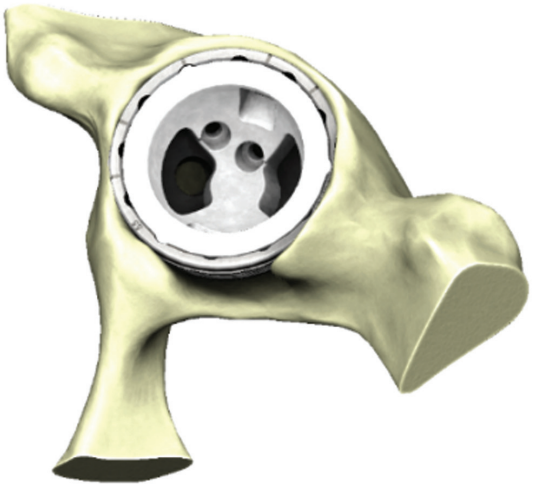
23 Use the flexible or straight screwdriver, and screw holding forceps to place screws of appropriate lengths according to each measured hole depth, and drive until tight.

Note: Ensure that all screws are fully seated and are not protruding into the cup, as this could prevent the liner from locking.

TECHNIQUE TIPS

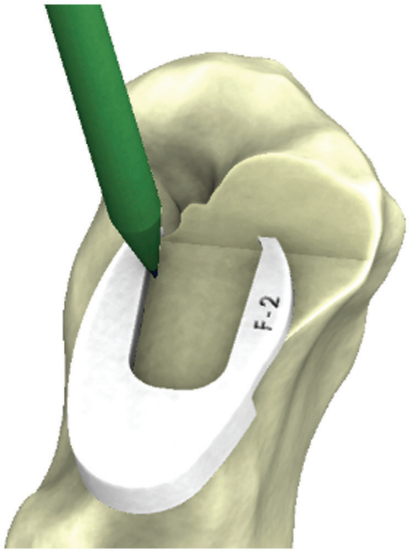
- The screw lengths communicated in the iView represent the longest screw that could be pre-operatively confirmed to safely sit within the ilium.

Caution: The planned positions and recommended maximum lengths of the acetabular fixation screws are determined based on the planned location and orientation of the cup. Repositioning or unintentional mis-positioning of the cup could alter the planned screw positions and the recommended maximum screw lengths provided may no longer reflect a safe length. Confirm intra-operatively, using standard surgical technique, that the acetabular fixation screws used reflect a safe length.



24 Place the trial liner in the acetabular cup.

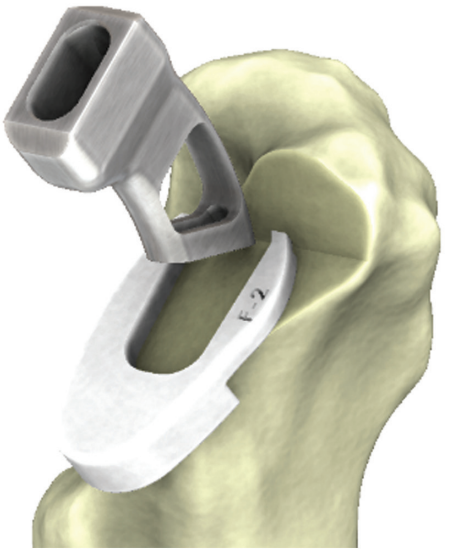
Step 4 FEMORAL PREPARATION



25 Place the F2 iJig flush against the resected neck surface and against the remaining medial neck. The medial wall of the F2 iJig overhangs the calcar and is contoured to match the patient's bone. Rotate the iJig anteriorly and posteriorly until it is stable against the medial neck. It may be necessary to remove additional bone from the greater trochanter to allow proper iJig placement. Note: The most lateral portion of the F2 iJig cutout indicates the planned lateral shoulder of the implant.

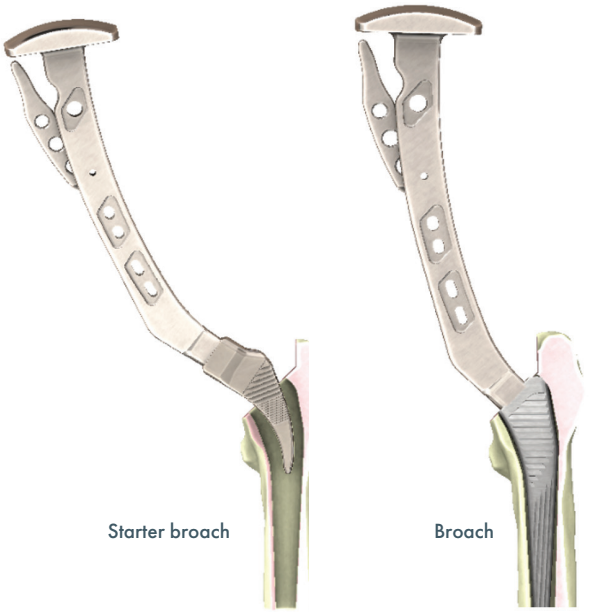
TECHNIQUE TIP

- Use a marking pen to draw the inner dimensions of the F2 iJig onto the bone surface to be used as a reference.



26 Use the box osteotome for initial entry into the canal where indicated by the lateral aspect of the F2 iJig. This iJig communicates placement of the femoral stem into the planned location and orientation. Remove the F2 iJig and set aside.

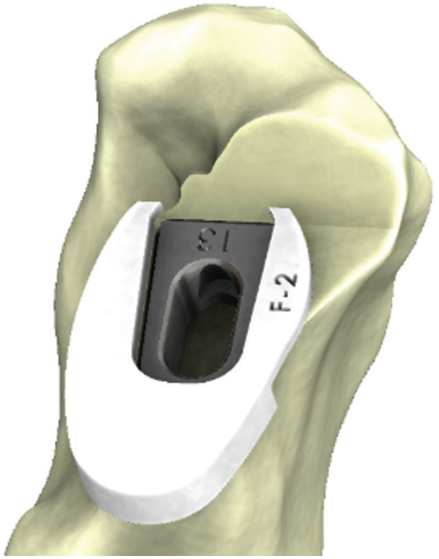
27 Use the canal finder and/or the rat tail to further open the femoral canal, maintaining a neutral alignment with the canal axis to avoid a varus or valgus trajectory.



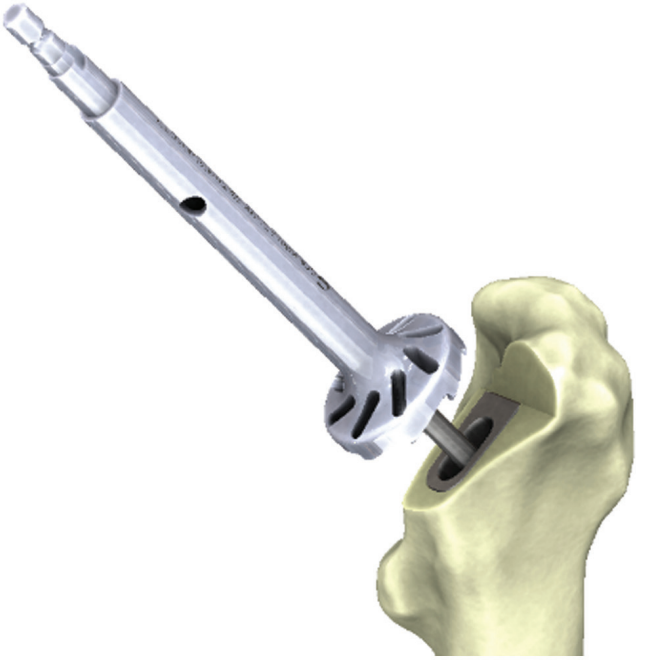
28 Beginning with the smallest broach, progressively broach the femoral canal to the size determined during pre-operative planning. Both straight or offset broach handles are available.

TECHNIQUE TIPS

- The face of the broach corresponds to the resection level; therefore, the broach should be impacted until the face is flush with the resection level.
- Note that the broaches compact cancellous bone in all areas except the proximal lateral side of broach. In this area a diamond tooth pattern is used so that the broaches can be used as a rasp to lateralize the femur.

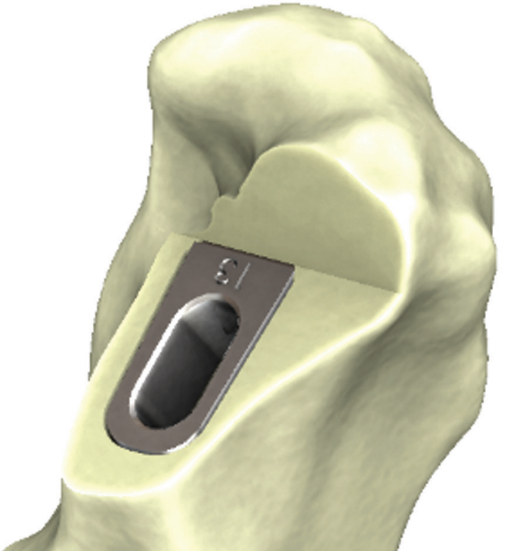


29 The F2 iJig can be reinserted and used to assess stem version after broaching. The lateral portion of the F2 iJig can be snapped off for this step. When the broach is fully seated, the broach face will be flush with the resection plane.



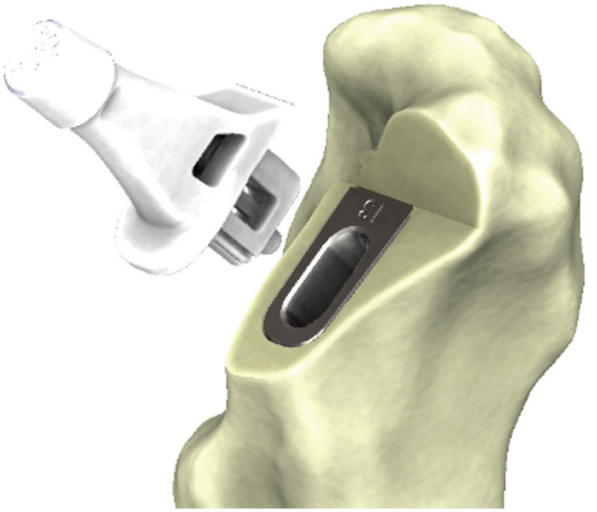
30 If desired, a calcar planer is supplied to shape the bone around the bone-broach interface. Screw the calcar planer post into the inserted broach. Place the calcar planer over the post and plane until the desired bone interface is obtained.

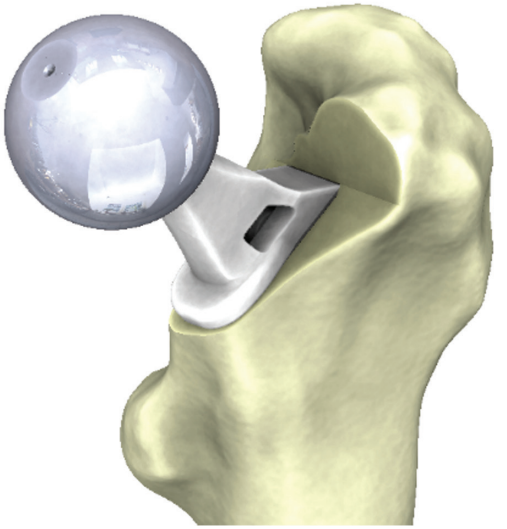
Note: if you countersink the broach below the planned neck resection level and plane down, this will effectively shorten the leg by the depth of countersinking.



31 Leave the final broach size corresponding to the implant size in the femoral canal.

Step 5 TRIAL REDUCTION





32 If not already in place, position the trial liner into the cup.

33 Place the appropriate trial neck into the broach (an audible click or snap may be felt when in place). The trial neck that matches the planned Cordera™ stem is provided with the iJig kit.

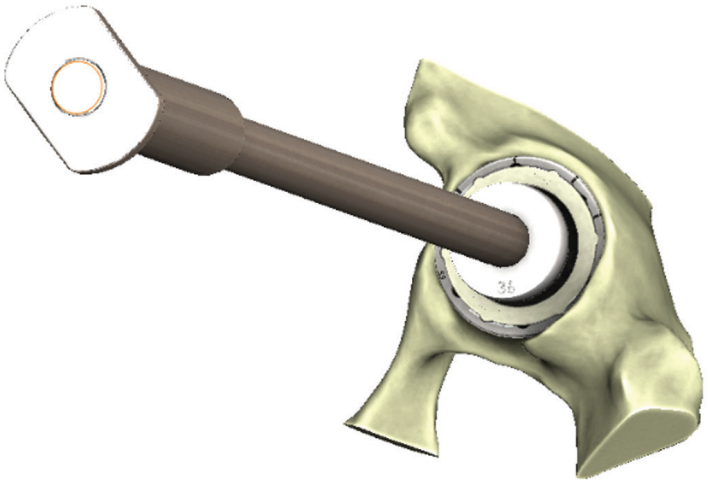
Note: the trial neck features a small peg that sits in the threaded hole of the broach. This threaded hole is off-center so it will fit in only one direction.

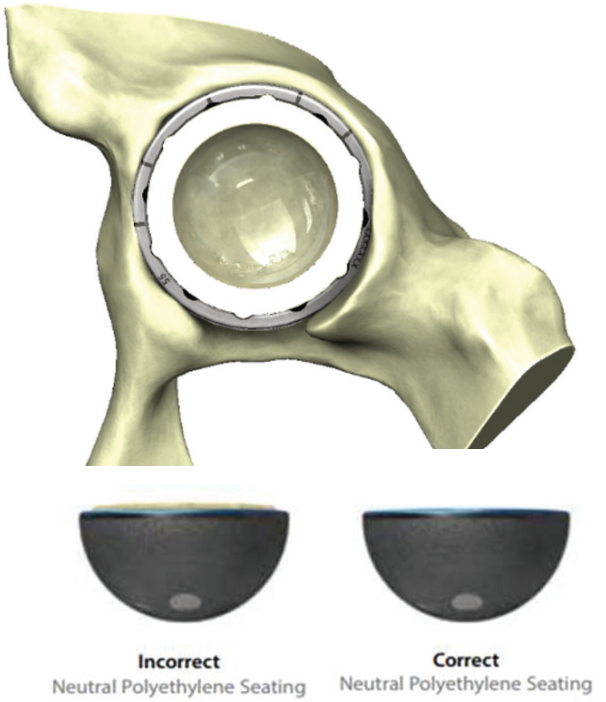
34 Place the planned trial head onto the taper of the trial neck.

35 Reduce the hip into the trial liner.

36 Check leg length and stability through a full range of motion.

Step 6 FINAL IMPLANTATION

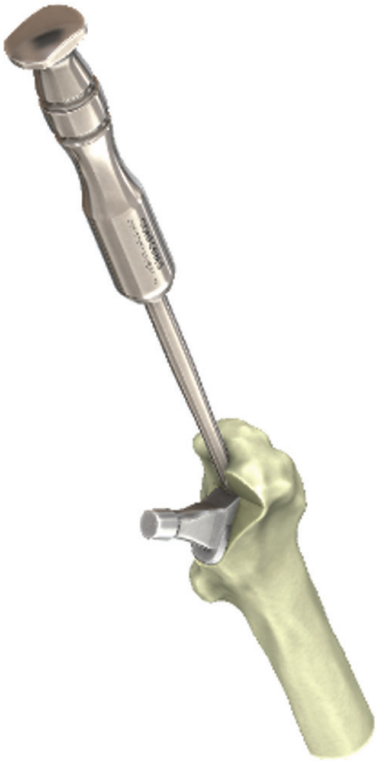




37 Remove all trials and the broach from the femoral canal. Do not irrigate or dry the femoral canal, as this will help to preserve the compacted cancellous bone.

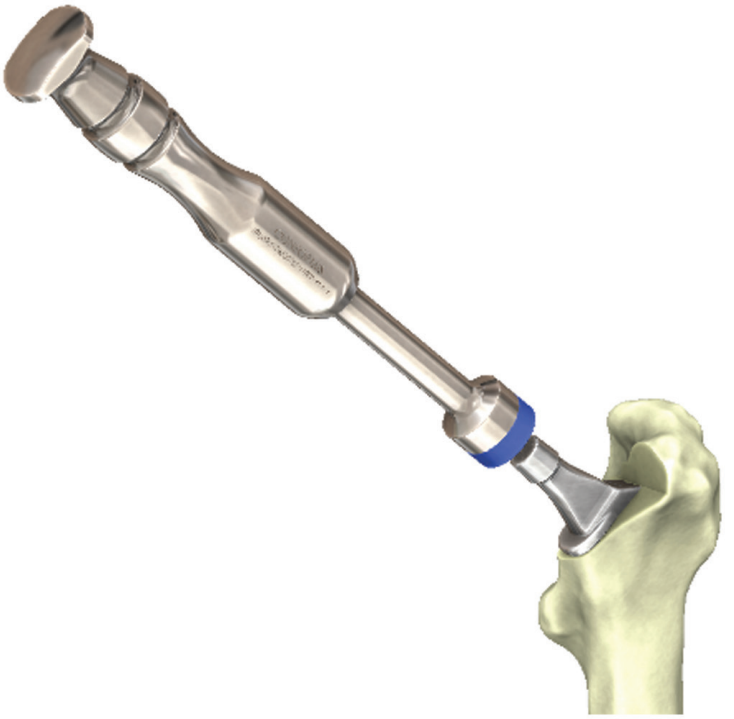
38 Place the acetabular liner into the cup with the anti-rotation scallops aligned in the cup. Care must be taken that there is no soft tissue between the liner and cup, as this may prevent the liner from seating properly and locking into the cup. Seat it using the liner impactor with firm mallet blows in the direction of cup axis.

39 Confirm that the face of the liner is flush with the face of the cup to ensure that it is fully seated.



40 Manually place the stem into the broached femoral canal. Using either the straight or offset impactor handle, set the impactor into the lateral shoulder of the femoral stem and impact along the axis of the stem until it is fully seated. The HA coating should sit level with the femoral neck resection.

41 If desired, place the trial head onto the stem taper and confirm the range of motion and leg length with the final implants. Remove the trial head.



42 Clean the taper of all blood and fat. Place the femoral head on the stem taper. Seat the taper using the head impactor and firm mallet blows in the direction of the neck axis.

TECHNIQUE TIPS

- Ensure that all mating surfaces are free of soft tissue, clean and dry prior to placing the liner inside the cup and impacting the head onto the stem.
- Lower impaction forces used to seat the head on the stem taper may contribute to fretting corrosion of CoCr heads at the taper interface. Therefore, it is important to firmly impact the head onto the stem taper.

43 Reduce the hip and do a final check of stability, range of motion and leg length.

44 Close the incision.

SURGICAL TECHNIQUE

WITHOUT IVIEW & IJIGS

The Cordera hip replacement surgery can be performed through either a posterior or anterior approach.

Exposure and Neck Resection

1. Adequately expose the acetabulum and proximal femur.

2. Using an oscillating or reciprocating saw, perform a femoral neck osteotomy. The recommended angle of resection is 45°. The resection of the neck can be performed with one or two cuts, depending on surgeon preference.

3. Remove the femoral head and neck from the incision.

Acetabular Preparation and Implantation

4. Make sure that the acetabulum is fully exposed and remove soft tissue to visualize the acetabular rim. Using standard full hemispherical reamers, progressively ream the acetabulum until bleeding subchondral bone is reached and the templated position has been achieved; progress until the reaming size is 2 mm smaller than the planned hemispherical cup size.

5. The planned acetabular cup implant is then inserted with an acetabular inserter. Use of C-Arm imaging can be used to monitor and adjust position and progressive seating of the prosthesis.

6. Following final seating of the acetabular shell, optional cancellous screw fixation may be accomplished, if desired. To insert screws, the drill and drill guide are used to drill single or multiple drill holes through the shell screw holes. The depth gauge is provided to determine the appropriate length of screw for each hole. Ensure each screw is fully seated with the screw heads counter sunk below the level of the inner surface of the shell implant to prevent impingement of the liner and ensure optimal liner seating within the shell implant.

7. Select the appropriate acetabular liner for the Acetabular shell and planned head diameter. Ensure the inside surface of the implant shell is dry and cleared of any soft tissue debris and position the liner in the shell by hand. The liner is impacted by placing the liner impactor head, which is packaged with the liner implant, into the liner. The cup impactor tip is then inserted into the opening of the liner impactor head. Seat it using the liner impactor with firm mallet blows in the direction of cup axis.

Femoral Preparation and Implantation

8. Use the box osteotome for initial entry into the canal in a posterolateral direction.

9. Use the canal finder to further open the femoral canal, maintaining a neutral alignment with the canal axis to avoid a varus or valgus trajectory. Optional use of the Femoral Rasp or Starter Broach may assist with preparing the femoral canal.

10. Beginning with the smallest broach, progressively broach the femoral canal until stability is obtained, which should agree to the size determined during pre-operative planning.

> **Note:** in Dorr A femurs, reaming the diaphysis allows for better fit of the stem into compacted bone.

11. Leave the final broach size corresponding to the implant size in the femoral canal. If desired, used the calcar planar to plane the bone flush to the broach face.

12. Using the final broach, the surgeon has the option to trial the final construct with the desired trial neck and a trial femoral head. The trial necks are sterile packed separately. Place the trial neck into the broach and the trial head on the trial neck taper and reduce. Perform range of motion (ROM) and leg length measurements. Denote the selected neck angle and length, and the selected head size and length.

    Using the markings on the trial neck, verify that the appropriate trial neck is being used:

    For broach sizes 10, 11, 12, and 13, only the following trial necks may be used:
    -127°, 29mm
    -127°, 36.5mm
    -132°, 29mm
    -132°, 36.5mm

    For broach sizes 14, 15, and 16, only the following trial necks may be used:
    -127°, 29mm
    -127°, 36.5mm

13. Remove the broach from the femoral canal.

> **Note:** Do not irrigate or dry the femoral canal. This will help to preserve the compacted cancellous bone.

14. Manually place the stem into the broached femoral canal. Set the impactor into the lateral shoulder of the femoral stem and impact along the axis of the stem until it stops or desired level is reached.

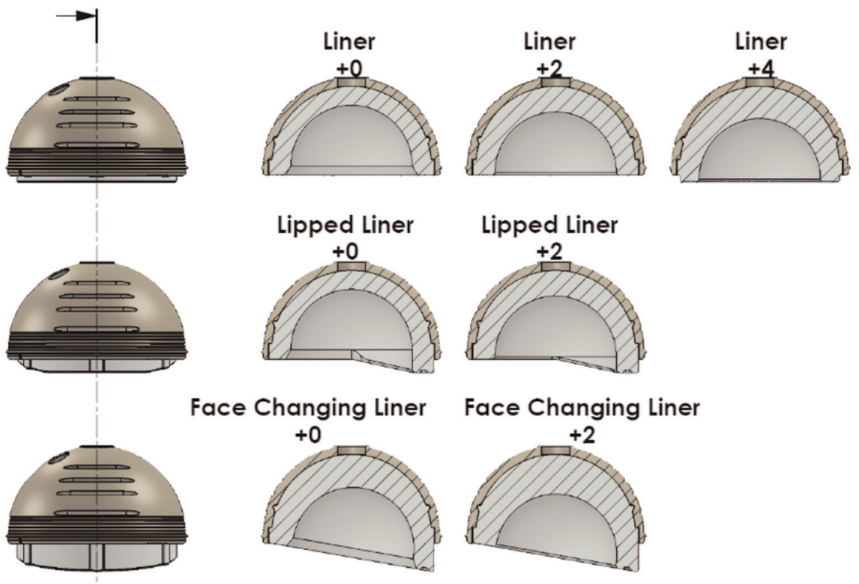
Final Trialing

15. Place the trial head onto the stem taper and reduce. Perform range of motion (ROM) and leg length measurements. Denote selected head size and length.

Head Insertion

16. For final head insertion, clean and dry the stem taper carefully. Place the femoral head onto the taper and lightly tap it (especially if a ceramic head is used) using the head impactor. Ensure bearing surfaces are clean and finally reduce the hip.

Liner Compatibility and Thicknesses



	FEMORAL HEADS						
	CO CR Heads			DELTA Heads			
Diameter	28 mm	32 mm	36 mm	28 mm	32 mm	36 mm	40 mm
Short	✓	✓	✓	✓	✓	✓	✓
Medium	✓	✓	✓	✓	✓	✓	✓
Long	✓	✓	✓	✓	✓	✓	✓
X-Long	✓	✓	✓	–	✓	✓	✓

Standard:
The case is planned to a +2 liner. Also available in sizes 0 and +4 mm.

Lipped (4mm):
The lip style liner supplied in 0 and +2 mm.

Face Changing (10 degree):
The FC liner supplied in 0 and +2 mm.

Cup	Cup	46-49 mm			50-53 mm			54-57 mm			58-63 mm			64-66 mm		
	Group	B			C			D			E			F		
Liner	Head	28	32		32	36		36			36			36		
	Offset	+0	+2	+4	+0	+2	+4	+0	+2	+4	+0	+2	+4	+0	+2	+4
Thickness	45°	5.6	5.0	6.3	5.6	5.0	6.3	5.6	7.0	8.3	7.6	9.0	10.3	10.6	12.0	13.3
	Apex	5.6	5.6	7.6	5.6	5.6	7.6	5.6	7.6	9.6	7.6	9.6	11.6	10.6	12.6	14.6
Ceramic Only																
Liner	Head								40			40			40	
	Offset								+2	+4	+0	+2	+4	+0	+2	+4
Thickness	45°								5.0	6.3	5.6	7.0	8.3	8.6	10.0	11.3
	Apex								5.6	7.6	5.6	7.6	9.6	8.6	10.6	12.6

Intended Use

The Cordera Hip System may be used with iJigs designed from a patient's pre-operative CT scan, which must include certain necessary landmarks that are clearly identifiable.

The Cordera Hip System is indicated for use in skeletally mature individuals undergoing hip replacement surgery due to:

- A severely painful and/or disabled joint from osteoarthritis, traumatic arthritis, rheumatoid arthritis, avascular necrosis, or congenital hip dysplasia.
- Treatment of non-displaced non-unions of the hip, femoral neck fracture, and trochanteric fractures of the proximal femur with head involvement, unmanageable by other techniques.
- Revision procedures for failed previous hip surgery (excluding situations where hardware is present).

The Cordera Hip System includes standard hip replacement components and if selected, may use patient-specific single-use instrumentation.

The Cordera Hip System implants are intended for cementless fixation using an anterior or posterior surgical technique.

Contraindications

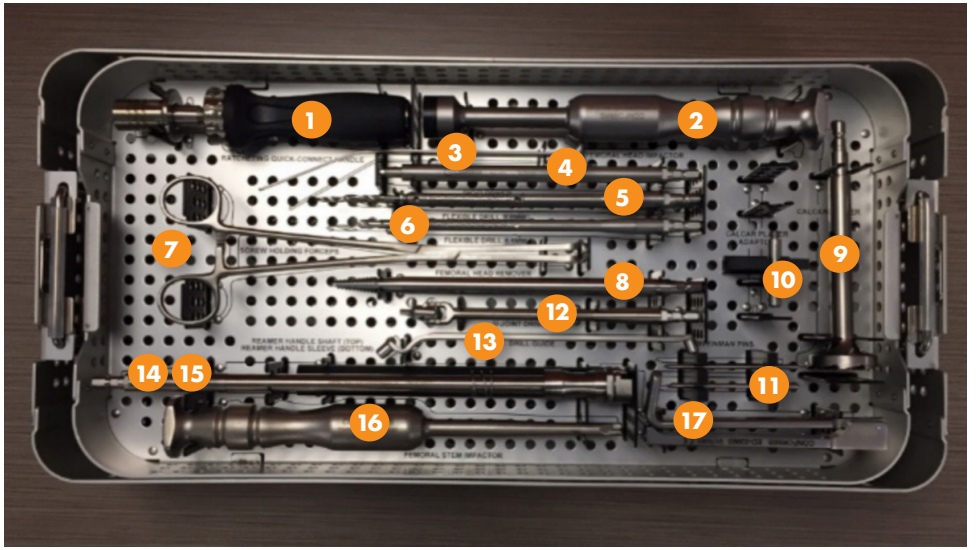
The following conditions are contraindications for total hip replacement:

- Active or recent local or systemic infection.
- Loss of musculature, neuromuscular compromise or vascular deficiency in the affected limb rendering the procedure unjustified.
- Poor bone quality, such as osteoporosis, where, in the surgeon's opinion, there could be considerable migration of the prosthesis or a significant chance of fracture of the femoral shaft and/or the lack of adequate bone to support the implant(s).
- Charcot's or Paget's disease.
- Ceramic heads are contraindicated in revision surgery when the femoral stem is well fixed and is not being replaced.
- Poor quality femoral bone stock which may compromise the proximal fixation of the femoral stem.
- Any disease, ligamentous or severe muscle laxity or inadequate soft tissue coverage which may compromise the normal healing process or function of the implant.
- Pathological conditions, neuromuscular disorders or mental conditions whereby the risks associated with these conditions outweigh the benefits to be derived.
- Metal sensitivity

Magnetic Resonance (MR) Environment

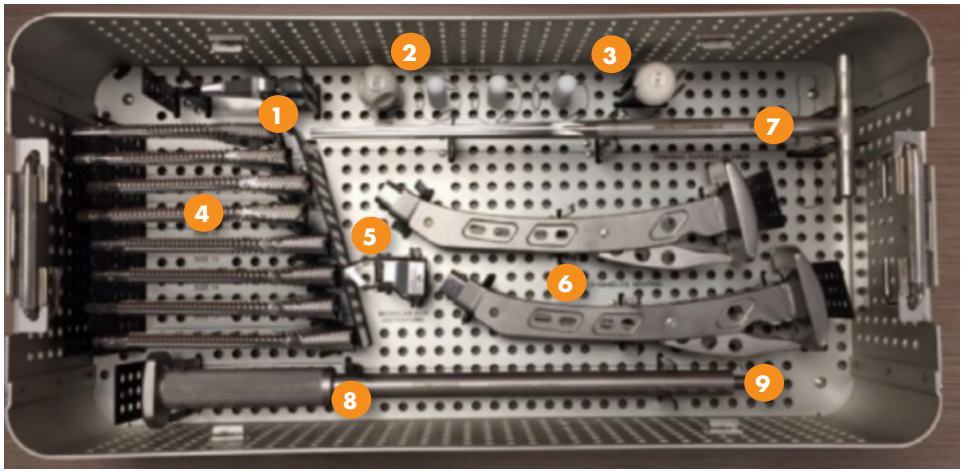
The Cordera Hip System has not been evaluated for safety and compatibility in the MR environment. It has not been tested for heating, migration, or image artifact in the MR environment. The safety of the Cordera Hip System in the MR environment is unknown. Scanning a patient who has this device may result in patient injury.

Instrumentation



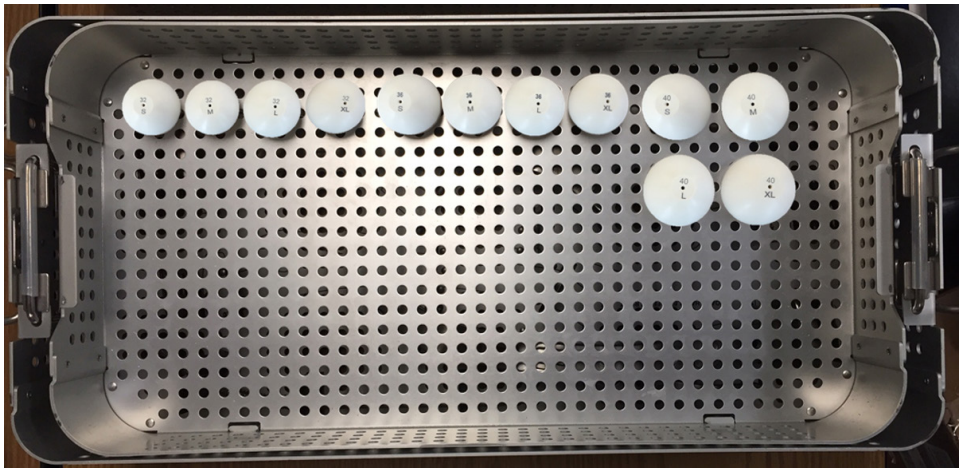
Primary Tray — Top:

1. Ratcheting Quick-Connect Handle
2. Femoral Head Impactor
3. Depth Gauge
4. Rigid Driver
5. Flexible Drill, 3.5MM
6. Flexible Drill, 5.5MM
7. Screw Holding Forceps
8. Femoral Head Remover
9. Calcar Planer
10. Calcar Planer Adaptor
11. Steinman Pins
12. U-Joint Driver
13. Drill Guide – Double Ended
14. Reamer Handle Shaft (Top)
15. Reamer Handle Sleeve (Bottom)
16. Femoral Stem Impactor
17. Pin Puller



Primary Tray Base

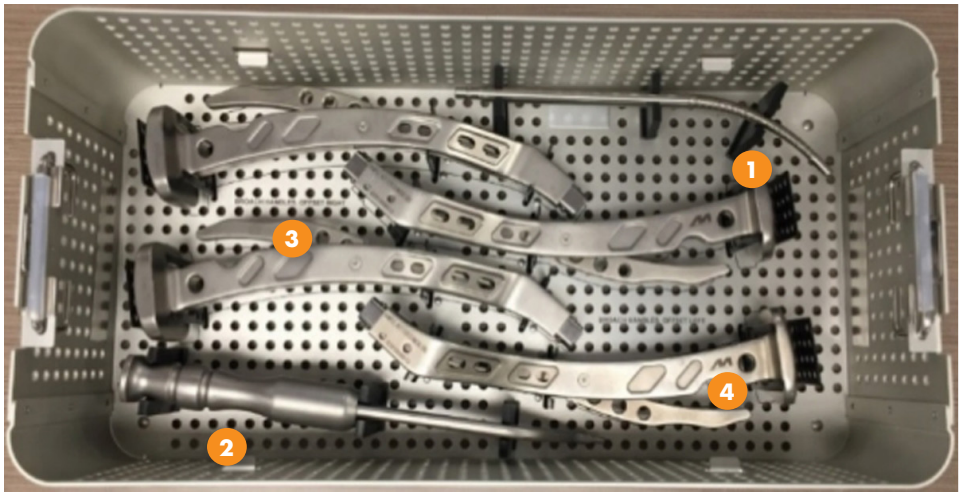
1. Starter Broach
2. Trial Head, 28mm S, M, L
3. Trial Head, 28mm XL
4. Femoral Broaches
   (Labeled as Size 9, Size 10, Size 11, Size 12, Size, 13, Size 14, Size 15, Size 16)
5. Modular Box Osteotome
6. Broach Handles, Neutral
7. Femoral Tapered Reamer
8. Cup Impactor
9. Cup Impactor Tip, Titanium



Auxiliary Tray Top:

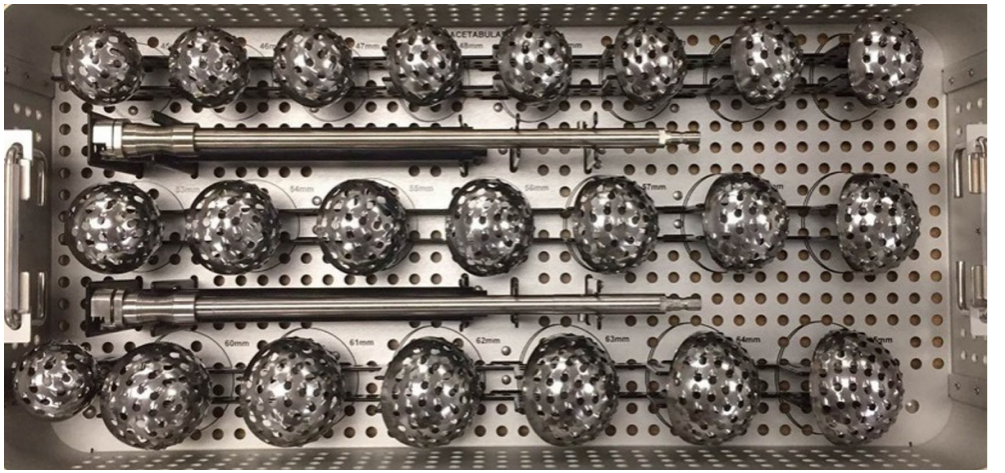
Femoral Head Trials labeled as:

1. Ø32mm SH
2. Ø32mm MD
3. Ø32mm L
4. Ø32mm XL
5. Ø36mm SH
6. Ø36mm MD
7. Ø36mm L
8. Ø36mm XL
9. Ø40mm SH
10. Ø40mm MD
11. Ø40mm L
12. Ø40mm XL



Auxiliary Tray Base:

1. Femoral Rasp
2. Offset Stem Impactor
3. Broach Handles, Offset Righ
4. Broach Handles, Offset Left



Full Basket Reamer Tray:

1. Size 44 – 65 mm
2. Reamer handle

www.conformis.com

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600 Technology Pk. Drive, 4th Floor
Billerica, MA 01821
Phone: 781-345-9001
Fax: 781-345-0147

Caution: Federal law restricts this device to sale by or on the order of a physician. Prior to use of a Conformis device, please review the instructions for use and surgical technique for a complete listing of indications, contraindications, warnings, precautions, and directions for use.

MK-03213 AD 8/20