Arthrex #1 in the Minds of Foot & Ankle Surgeons!

Our mission at Arthrex is to help surgeons treat their patients better. The recent report from PearlDiver Consulting Group highlights the job we are doing. They conducted a large independent survey of US orthopaedic surgeons and podiatrists regarding their product and manufacturer preferences. The results below demonstrate the favorable brand perception that Arthrex has created with foot & ankle surgeons. We would like to thank you, our customers, for ranking us #1.

Surgeons were asked, “Which company selling foot & ankle surgical products do you believe to be the market leader,” and the most common answer was Arthrex.

US Market Leader in Foot and Ankle

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<thead>
<tr>
<th></th>
<th>Arthrex</th>
<th>Competitor A</th>
<th>Competitor B</th>
<th>Competitor C</th>
<th>Competitor D</th>
<th>Competitor E</th>
<th>Competitor F</th>
<th>Competitor G</th>
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<tr>
<td>Percent</td>
<td>0%</td>
<td>5%</td>
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The report goes on to detail the specific examples of where Arthrex is making a difference in the foot & ankle market. From offering innovative product solutions to providing the best overall service, our customers ranked us #1 each time.

- Most innovative foot & ankle (F&A) product line — Arthrex
- Most committed company to F&A for now and long term — Arthrex
- Most comprehensive offering of products for F&A surgeons — Arthrex
- Most commonly mentioned F&A supplier — Arthrex
- Best overall service from the F&A sales force — Arthrex
- Best product/procedure training for F&A procedures — Arthrex

As a private company, Arthrex is driven to provide better surgical solutions for our customers, not for stockholders. Your vote of confidence in us energizes and confirms we are helping you treat your patients better. Rest assured that your continued support will excite constant improvement in what we do moving forward. Thank you again for your confidence in us and your support of Arthrex Inc.

Pete Denove
Director, Distal Extremities Product Management
Arthrex Inc.
Pdenove@Arthrex.com

Compression FT

Arthrex introduces the titanium headless compression screw, Compression FT, used for intra-articular and extra-articular fractures and nonunions of small bones and small bone fragments, arthrodesis, and osteotomies. The Compression FT (fully threaded) Screws come in 2.5 Micro, 3.5 Mini, and 4.0 Standard. The variable stepped thread pitch, headless design allows for simplified insertion, provides compression, and reduces the risk of profile complications. With the titanium headless compression screws, the surgeons achieve zero-profile, stable fixation in many of the common fracture, fusion and osteotomy sites throughout the body.

5th Metatarsal Fracture System

The newly released 5th Metatarsal Fracture System is a comprehensive, uniquely designed screw and plate system that gives surgeons a variety of options to efficiently and effectively treat complex fifth metatarsal fractures.

- Solid 4.5, 5.5 and 6.0 mm screws
- Unique anatomic hook screws
- Unique anatomic hook plate

Features Product

5th Metatarsal Fracture System

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Q. What compelled you to use the TightRope on elite athletes with syndesmotic injuries?

A. Several factors, but first and foremost, I was never satisfied with the delayed weight-bearing status after traditional transosseous screw fixation of the syndesmosis. After any major injury, an athlete’s first question is when can I return to play? Our traditional short-term and long-term outcome measures of ankle fracture surgery all apply to the elite athlete but return to play time is extremely important as well.

A. Second, the elite athlete, especially a skilled player position, needs a loaded range of ankle dorsiflexion of more than 20 degrees. The TightRope allows for more physiological motion at the distal tibiofibular joint. As a result of earlier weight-bearing and more normal joint kinematics, more ankle dorsiflexion range-of-motion is generally achieved. This is important for elite athletic performance.

Q. When utilizing the TightRope, what features have you found most valuable?

A. First, I think you have to evaluate all implants on performance. The TightRope has allowed me to achieve immediate rotational stability of the ankle and lets me push earlier weight-bearing.

A. Second, the implant has to be surgeon friendly from a technical standpoint. Insertion of the TightRope is quick, reproducible, and without any major technical problems.

Q. We sometimes hear “I always use screws for syndesmosis injuries.” What would be your response to those conversations?

A. I think anytime you use the term “always” in medicine you can be setting yourself up for potential failure. Single or double three and four cortices metal screws is, and has been for the last two decades, the gold standard treatment of displaced syndesmosis injuries. The problems associated with this technique however are numerous. Postoperative CT scans confirm malalignment of the syndesmosis in up to 50 percent of cases. Immediate weight-bearing is usually discouraged with the screws in place and screw breakage rates, if not removed, are also significant. Even though screws are still the gold standard, I think we must, at minimum, rethink our overall treatment strategy for these difficult ankle fracture patterns with syndesmotic injury. The TightRope has opened my eyes to a better understanding of the injury patterns seen and a treatment strategy that is more anatomically based.

Q. Can you describe your return-to-play factor with the TightRope compared to screws?

A. Every case, from a rehabilitation standpoint, has to be individualized. With my current surgical treatment of these injuries, which includes TightRope fixation of the syndesmosis and repair of the anterior inferior tibiofibular ligament, I am able to accelerate the rehabilitation and return-to-play timeline in a minimum 3 – 4 weeks. I can push the early postoperative rehabilitation protocol because I do not leave the operating room until I have achieved enough rotational stability to allow immediate weight loading.

Q. What is your rehabilitation protocol with the TightRope?

A. I follow a fairly simple rehabilitation protocol using my intraoperative assessment of fixation stability, pain, swelling, and range-of-motion as a guide to progression. The first two weeks, the patient is in a well-padded splint to maximize antswelling and early soft tissue healing. They are on crutches 30 – 50 lbs partial weight-bearing. At two weeks, after suture removal, I place them in a pneumatic CAM Walker boot, begin range-of-motion and use of a stationary bicycle. Weight-bearing is allowed as comfort permits, with most athletes being full weight-bearing by four weeks. At four weeks, if they have greater than 10 degrees of dorsiflexion and are full weight-bearing, they start progressive resistive exercises and running in an aquatreadmill with the water at chest level. More aggressive proprioceptive exercises and transition into a standard AFO occurs at around eight weeks. Flat inline running at 10 weeks and full agility and sports specific activities at 12 – 14 weeks. This program can be accelerated if immediate rotational stability is achieved in the operating room. Depending on fixation and stability on the medial side of the ankle, specifically the deep deltoid, this program, especially weight-bearing maybe need to be delayed 3 – 4 weeks.

Q. When you spoke at the 2014 NFL Combine about ankle, injuries what excited the audience?

A. Foot & ankle injuries are a huge problem in the NFL. The number of player days missed, secondary to high ankle sprains and ankle fractures is tremendous. I think any treatment advances that allow earlier player return is looked on with excitement. High ankle sprains are another big impact area. There is potential for the TightRope and InternalBrace™ Ligament Augmentation Repair to have a role in the higher-grades of ankle sprain injuries. The current difficulty is identifying which injuries, in which player positions and at what time in season would benefit from surgical intervention.
### 2013 Orthopaedic Trauma Association Paper Presentation

Prospective randomized multicenter trial comparing a static implant and a dynamic implant (TightRope) in the surgical treatment of ankle syndesmosis rupture.

**2013 Orthopaedic Trauma Association Paper Presentation**

**PURPOSE:** To compare the functional results of TightRope versus 3.5 mm quadricortical screw.

**METHODS:** Prospective randomized double-blinded, controlled trial

70 patients (5 centers) with an acute syndesmotic rupture, stabilized either with TightRope (n=34) or quadricortical screw (n=36).

<table>
<thead>
<tr>
<th>Screws (36 patients)</th>
<th>TightRope (34 patients)</th>
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<tbody>
<tr>
<td>Implant failure 37%</td>
<td>Implant failure 0%</td>
</tr>
<tr>
<td>Loss of reduction 12%</td>
<td>Loss of reduction 0%</td>
</tr>
<tr>
<td>Lower plantar range-of-motion</td>
<td>Higher plantar range-of-motion</td>
</tr>
<tr>
<td>Lower AOFAS scores</td>
<td>Higher AOFAS scores</td>
</tr>
<tr>
<td>Slower return to previous activity</td>
<td>Quicker return to previous activity</td>
</tr>
</tbody>
</table>

**CONCLUSION:** “TightRope gives better outcomes without breakage or loss of reduction and re-operation.”

Pelet S, Lafortune M, Belzile E, Glazebrook M, Bédard L, van Bekerom M. Prospective Randomized Multicentric Trial Comparing a Static Implant and a Dynamic Implant in the Surgical Treatment of Ankle Syndesmosis Rupture.

### AJSM Article

Fixation of Ankle Syndesmotic Injuries: Comparison of TightRope Fixation and Syndesmotic Screw Fixation for Accuracy of Syndesmotic Reduction (CT scan)

<table>
<thead>
<tr>
<th>Screws (23 patients)</th>
<th>TightRope (23 patients)</th>
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</thead>
<tbody>
<tr>
<td>22% malreduction</td>
<td>0% malreduction</td>
</tr>
<tr>
<td>Less accurate under CT scan</td>
<td>More accurate under CT scan</td>
</tr>
<tr>
<td>Late diastasis occurred</td>
<td>Late diastasis avoided because implant remained</td>
</tr>
</tbody>
</table>

**CONCLUSION:**

“TightRope provides a more accurate method of syndesmotic stabilization and eliminates the need for a second procedure for routine removal.”

Q. Why have Brostroms been considered the gold standard when some of the literature indicates that patients have to step down in their activities?

Dr. Clanton: The Maffulli article in AJSM is one of the only articles that includes a long-term outcomes analysis of the Brostrom procedure and suggests such a reduction in activity (42%). Most other studies, which look at shorter term results, generally have reported success rates ranging from 85 – 95% with the Brostrom procedure or with the Gould modification of this procedure.

Dr. Ellington: I would not call it a complication, but could be considered a failure. Patients want their instability corrected. The Brostrom does this well; however, if patients have improved stability yet cannot return to their previous level of activity/function, then the gold standard seems “tarnished”.

Q. What compelled you to use the InternalBrace construct to augment your Brostroms?

Dr. Clanton: After hearing Dr. Gordon Mackay’s presentation on the InternalBrace concept, we performed biomechanical testing that confirmed the improved strength of the augmentation. This was recently published in the February issue of The American Journal of Sports Medicine.

Dr. Ellington: I needed an augment (because of the stated failures above). I traditionally used the Evans procedure (split transfer of the brevis to the fibula). I never really liked this…it wasn’t anatomic, it sacrificed a tendon and you can make patients too tight. I decided to first use it in my work comp and revision Brostroms and when I experienced great success in these patients (more difficult patients) I was surprised actually. From there, I have now adopted to using InternalBrace in all my cases.

In my opinion, we should always be vigilant for methods by which we can improve the results of what we do for our patients.”

Q. We often hear “I never met a Brostrom that needed augmentation” OR “My Brostroms all do fine.” Knowing the clinical value, what would be your response to those conversations?

Dr. Clanton: The Brostrom procedure has been an excellent procedure over the short-term, but does not work in all situations. For example, it is not appropriate for patients who are reinjured and have instability following prior ankle reconstructions. I also do not favor the Brostrom technique in patients who are hyperflexible. In my opinion, we should always be vigilant for methods by which we can improve the results of what we do for our patients.

Dr. Ellington: The literature doesn’t support such claims and once I thought the same. These patients rarely come back after initial follow-up. However, I strongly believe that although their instability has improved, some are not happy with their outcome because of inability to return to previous level. These patients likely choose not to return to see their doctor.

Q. It is understood that this procedure is relatively new with limited, long-term clinical follow-up. Can you comment on the outcomes and your experience with your patients you have treated? Please explain the difference between standard Brostrom repair and those that have InternalBrace?

Dr. Clanton: While the procedure is relatively new for the ankle, it has been used in other areas such as the shoulder and for the Achilles tendon with good results and few negative outcomes.

Dr. Ellington: I have used InternalBrace on around 25 patients, most with long-term follow-up. Without a doubt, they have increased stability.

Q. What have been the most positive effects of the InternalBrace for your patients?

Dr. Clanton: In my patients, the most positive aspect of the InternalBrace has been less worry (for the patient and me).

Dr. Ellington: Confidence in the ankle.

Q. Surgeons often speak of clinical studies before trying something new. Why try the InternalBrace now? What are the minimum expectations you have?

Dr. Clanton: Fortunately, there are now biomechanical studies that support the use of the InternalBrace and there are individuals such as Drs. Mackay, Coetzee, Gates, Vora, and Ellington who have extensive experience with the technique in the lateral ankle as well as other locations.

Dr. Ellington: It should be tried because the standard Brostrom has solid evidence that it is not as good as we think. The minimum expectations are no additional complications from using the InternalBrace, easy application of the system.

Q. What are the technique pearls you have learned and can pass along?

Dr. Clanton: It is important to follow the recommendations for exactly how to perform the technique, and to understand the anatomy and biomechanical function that one wishes to restore. It is certainly possible to place the augmentation in an incorrect position and overconstrain the joint. Dr. Mackay’s technique of keeping a hemostat under the FiberTape™ during the insertion of the second SwiveLock seems to help in avoiding this.

Dr. Ellington: The talus is a hard bone. When I tap the talus, I leave the tap in while I insert the system into the fibula. This allows the talus to “stretch” a little, making the placement of the talus implant a little easier.

Q. In simple terms, explain your surgical technique.

Dr. Clanton: I perform the Brostrom procedure and augment it with the InternalBrace placed over the top of the ATFL arm of the Brostrom.

Dr. Ellington: I repair my ATFL with 3.0 suture anchor. Then drill and tap (leave tap in) the talus. Next I drill and tap the fibula. I place the fibular side, line up the talus side (making mark a on FiberTape with surgical marker). I remove talus tap, place talus implant, with hemostat under and with the ankle in slight plantarflexion and inversion to prevent overtightening.
Q. Have you considered InternalBrace for other indications (Spring Ligament, Deltoid Ligament, and/or Lateral Ankle with Arthroplasty)?

Dr. Clanton: I have used the InternalBrace in all of those situations and it has been very effective.

Dr. Ellington: Yes, I have done three for spring ligament.

**Intra-op:** I place one limb plantar to dorsal with the FDL and the other dorsal to plantar. I hold the foot in slight plantarflexion/inv as I tension. Placing the calcaneus tunnel is verified first by finding the sustentaculum tali directly, then confirming by placing a small guide wire and checking a lateral and axial heel view. Then I remove the wire and drill.

**Post-op:** Awesome corrections. Fully weight-bearing—radiographic parameters much better than those without spring ligament repair. I now do on all flatfoot reconstruction. I’m starting to believe that this could replace the need for a lateral column lengthening (Evans) in some cases. It really improves talonavicular uncoverage.

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**Ultimate Failure (Newton)*

<table>
<thead>
<tr>
<th></th>
<th>Native ATFL</th>
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<tbody>
<tr>
<td></td>
<td>250</td>
</tr>
<tr>
<td>Brooman w/anchors</td>
<td>150</td>
</tr>
<tr>
<td>Brooman w/anchors &amp; InternalBrace</td>
<td>100</td>
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</table>

Q. Why do you prefer the percutaneous approach to Achilles tendon repair?
A. Percutaneous Achilles repair enhances outcomes in two ways. Firstly, percutaneous repair is associated with a lower complication rate. Secondly, I firmly believe that, by less violation of the soft tissue envelope, a percutaneous repair leads to a better organized, stronger tendon and quicker healing.

Q. Is a percutaneous repair strong enough to allow for early weight-bearing and mobility?
A. Numerous bench studies have shown superiority of percutaneous repair when compared to Krackow technique in terms of strength-to-failure and tendon lengthening prior to failure. Our own clinical study demonstrated no failures of repair two years after percutaneous technique even with immediate weight-bearing and an accelerated rehabilitation program.*

Q. Describe the evolution of your approach to percutaneous Achilles tendon repair.
A. I was trained to do an open repair and was usually satisfied with the results. Occasionally, however, I would encounter wound complications and/or pain and disability due to tendon adhesions and chronic swelling. I began percutaneous repair using a modification of the Kakuchi technique, retrieving the sutures in an intrasynovial fashion using a crochet hook. I immediately noticed an improvement in patient satisfaction with regards to pain and return to activity.

With the release of the Arthrex PARS system, locked sutures are possible, a feature that I feel enhances repair strength and prevents suture creep and subsequent tendon lengthening.

Lately, I have been using a knotless PARS technique, with traditional percutaneous suture passage proximally with anchoring of the sutures into the heel (through the distal Achilles stump) directly into the calcaneus. This technique further minimizes soft tissue dissection and enhances repair strength. In addition, local irritation from bulky suture knots is obviated.

Q. What are the benefits of the Arthrex PARS system?
A. Economical: nondisposable jig, the only cost is for the sutures and needles
   Ergonomic: contoured handle facilitates jig placement
   Anatomic: wide paddles ensure tendon capture by sutures
   Efficient: colored sutures enhance suture management

Q. With the knotless technique, how do you ensure apposition of the tendon ends after repair?
A. Regardless of the position of the tendon ends, the tendon will heal. If the tendon ends are far apart, scar will bridge the intervening defect. The goal, therefore, is not tendon apposition, the goal is restoration of appropriate length of the musculotendinous unit. This is best effected by draping the uninjured extremity into the sterile field and reproducing appropriate resting tension.

When using the crochet hook method, I would mildly over-tighten the repair, assuming suture creep and subsequent lengthening. With the locked suture of the PARS or the Knotless-PARS repair, I try to avoid over-tightening as I feel that suture creep and late lengthening is unlikely.

Q. What is your post-op protocol following Knotless-PARS repair?
A. Immediately postoperatively, patients are placed in a short leg cast in gravity equinus. On post-op day 3 – 5 they are placed in a CAM Walker with a modular Achilles wedge. PT starts day 5 – 7 with progressive ROM, strengthening, and proprioceptive exercises. The CAM Walker is removed at week 8 and activity as tolerated is allowed at week 12. My detailed protocol can be accessed by scanning the QR code below.

Q. What do you see in the future of Achilles repairs?
A. The Midsubstance Achilles SpeedBridge is a big advancement in tendon repairs and is based upon the Internal Brace concept popularized by Gordon Mackay and Arthrex. By restoring appropriate soft tissue length/tension in a stable fashion, we can appropriately stress the repaired soft tissue (in this case, Achilles tendon). Early motion allows for avoidance of “cast disease” and results in a better organized tendon with improved strength and flexibility.

In the future, we will learn to harness the body’s own mechanisms to improve healing. Preliminary results in an animal suggest enhanced healing of Achilles repairs with application of bone marrow aspirate concentrate. As we become more efficient in concentrating and activating the patient’s native stem cells, the speed and quality of tendon healing will dramatically improve.

* Reference:
Q. What type of fracture pattern/injury did your patient have?
A. My patient highlighted this month is a Welterweight UFC fighter who sustained a severe fracture while competing in the octagon. He sustained a closed high ankle fracture with a syndesmosis rupture. He was taken to the operating room for urgent open reduction and internal fixation. At the onset, it was our goal to get him back into the ring as quickly as possible and return him to his pre-injury level of competition.

Q. Considering you were treating a high-impact athlete, what type of implant were you looking for and why did you choose Arthrex?
A. We were looking to provide stable internal fixation. We used the Arthrex one-third tublar plate and the TightRope device to stabilize the syndesmosis.

Q. Was there anything unexpected during the case and did you have the implant and instrument selection you needed?
A. I felt it was imperative to have multiple implant options during the case, should there be anything unexpected and that is exactly why I chose the Arthrex system. The set includes basic plates like one-third tubular plates and straight plates but also distal fibular anatomic plates as well as medial and lateral hook plate options. The screw selection is extremely comprehensive as well with everything from a 2.7 mm locking to 4.0 mm cannulated screws.

Not only do I have a vast implant selection but the set has all the instruments I could need including Lobster Claws, pointed Reduction Forceps, dental picks and even a new syndesmosis clamp giving me full confidence I have all the tools necessary for a great case.

I also will typically have BioCartilage in the room available in case we note a large osteochondral defect. In the high-impact athlete, I now perform an arthroscopy on these severe ankle fractures to evaluate the syndesmosis, as well as examine for chondral injuries.

Q. What is your response to those who might be concerned about using the TightRope on an elite or high-impact athlete?
A. There is increasing evidence and confidence with treating these athletes with a TightRope rather than screw fixation. In fact, many players with similar injuries in the NFL have returned to play with a TightRope in place. Placement of the TightRope at the time of the initial procedure obviates the need for an additional hardware removal procedure and may return the athlete to his sport more quickly. For those surgeons who remain skeptical, placement of one screw with a TightRope may offer a compromise with screw removal around week eight.

Q. The Arthrex Ankle Fracture System has only been available since 2010. Was there a learning curve in dealing with a new system for you or your operating room staff?
A. There really is no learning curve other than familiarizing yourself with the tray and the various plate constructs and instruments. Everything is color-coded in the set, making it very easy and straightforward for my operating room staff.

Q. What is your postoperative protocol after using the TightRope with an associated ankle fracture?
A. The ankle fracture typically dictates the postop protocol here. In this case, we treated him initially with a splint and then advanced him to a cast for a few weeks. Following this, he was placed into a CAM boot at the four week mark and allowed to begin active range-of-motion exercises. He was advanced to full weight-bearing at six weeks out from surgery and started formal physical therapy at that time. He was placed into an ankle brace and shoe at ten weeks from surgery and continued to advance his activity in physical therapy. He returned to training four months after surgery with a full release.
Q. What is the newest trend in Brostrom Repair Techniques for your practice?
A. For the past several years I have been performing the ArthroBrostrom on my patients with chronic lateral ankle instability with ATFL and CFL tears. This is a fast procedure, minimally invasive and allows patients to rehab and get back to activities much quicker than a traditional open procedure.

Q. What are the benefits of the ArthroBrostrom procedure?
A. I am able to address simultaneous intra-articular pathology at the same time as repairing the ATFL ligament. In the past, an arthroscopic debridement of the ankle joint was done in a majority of patients with chronic lateral ankle instability and then an open Modified Brostrom was done. With this procedure, we are able to do all of this arthroscopically.

The ArthroBrostrom has allowed me to cut down my OR time considerably compared with the traditional open Modified Brostrom in which I would scope before the open repair. Furthermore, being able to address simultaneous joint pathology arthroscopically and perform an ATFL repair at the same time is a significant improvement compared to the open technique. In almost 200 cases, my patients have done just as well subjectively and clinically compared to the open technique.

My patients have very little swelling, discomfort and are able to begin physical therapy in less than four weeks after the procedure.

Q. How does this repair construct compare to current standard repair options?
A. I actually have authored a paper that will be published in the Journal of Foot and Ankle Surgery later this year on this topic. A retrospective study of 62 patients was done comparing the “All-Inside” Arthroscopic Brostrom and a traditional open Modified Brostrom. Thirty-two patients received an open Brostrom-Gould procedure and 30 an All-Inside Brostrom procedure. The two groups were compared preoperatively with AOFAS ankle-hindfoot scoring system and a Visual Analog Score (VAS) for pain. Postoperatively AOFAS, Karlsson Peterson and VAS scores were compared. The mean follow-up for the Brostrom-Gould group is 3.7 years (1.3 to 5.3 years), the All-Inside Brostrom group 1.3 years (0.7 to 1.7 years). Our review shows that the minimally invasive arthroscopic technique using bone anchors for lateral ankle stabilization is comparable to the traditional open Brostrom-Gould.

Q. Are there any important surgical pearls to keep in mind for this procedure?
A. Standard debridement of the joint is performed with close attention to the lateral gutter and anterior fibula. I also like to use the Arthrex noninvasive Ankle Distractor and would recommend placing the foot at least six inches above the operating table to allow easy manipulation of the Micro SutureLasso while passing the sutures.
Achilles SpeedBridge Surgical Tips and Pearls

Insertional Calcific Achilles Tendinosis is a painful and frequently disabling condition. While most patients with insertional Achilles tendinosis can be managed nonoperatively, those patients who do not respond to conservative treatment may require decompression and debridement of the diseased tendon.

The Arthrex Achilles SpeedBridge is a novel concept in Achilles reattachment following debridement. While standard anchor fixation of the tendon creates only a single point of compression directly over the anchor, the SpeedBridge enables an hourglass pattern of FiberTape suture to be laid over the distal end of the tendon in a completely knotless manner. This four anchor construct enables a greater area of compression for the Achilles tendon on the calcaneus, improving stability.

Step 1: The Haglund’s prominence is removed using a micro-sagittal saw and osteotome. Care is taken to chamfer off the medial and lateral sides of the calcaneus so as not to leave a prominence that is palpable under the skin, creating difficulties with footwear.

Step 2: The two 4.75 mm BioComposite SwiveLock loaded with FiberTape, one blue and one white/black, are inserted in the proximal holes. The eyelet should be placed completely in the drill hole until the anchor body makes contact with the bone. Hold the thumbpad steady and rotate the driver handle in a clockwise direction until the anchor body is flush with the bone.

Note: To remove the driver, unwind the #2 FiberWire tip retention suture that holds the PEEK tip in place during anchor insertion. This suture may be incorporated into the repair or discarded.

Step 3: Pass the needle attached to the FiberTape through the Achilles tendon on each side.

Step 4: After cutting the swedged portion on each proximal anchor, retrieve one FiberTape tail from each proximal anchor (one blue and one white/black) and preload them through the distal SwiveLock C eyelet. Adjust tension of the FiberTape and insert the BioComposite SwiveLock C into the prepared distal bone socket until the anchor body contacts bone. Do not attempt to adjust tension while the eyelet is in the hole. Make sure the anchor is flush to the bone prior to removing the handle.

Step 5: Cut the tails on the distal row flush to the anchor, resulting in the final knotless repair.

Note: Two #2 FiberWire sutures may be used to provide additional fixation to the distal tendon.

Pull-out Strength Comparison

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<tr>
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<th>Arthrex</th>
<th>Competitor</th>
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<tr>
<td>4.75 mm Bio-SwiveLock C w/FiberTape</td>
<td>56.9</td>
<td></td>
</tr>
<tr>
<td>Mitek Versablk®</td>
<td>34.1</td>
<td></td>
</tr>
<tr>
<td>Arthrex SpeedScrew®</td>
<td>30.6</td>
<td></td>
</tr>
<tr>
<td>Arthrex Opus Magnum®</td>
<td>27.5</td>
<td></td>
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<tr>
<td>4.5 mm Linvatec PopLok®</td>
<td>21.6</td>
<td></td>
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<tr>
<td>Smith &amp; Nephew Footprint PK®</td>
<td>19.3</td>
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Dr. Ellington’s first impression of Arthrex CPR system was that it was unnecessary. Although, treating patients who have elevated toes and crossover toes deformities is difficult and there was not a good way to treat this pathology, Dr. Ellington felt the way he trained was sufficient though the clinical outcomes are unpredictable.

Dr. Ellington discusses how in his past treatments of second MTP instability, he used K-wires to pin the second MTP joint in hopes that the toe would scar in at the appropriate position, right tension and ultimately not crossover or elevate. After many patients treated he experienced challenges based on the unpredictability of the surgery. Even though the surgery seemed to go well, the clinical outcomes were often times suboptimal.

This concern led Dr. Ellington to take a closer look at the Arthrex CPR system. A patient with severe deformity came to Dr. Ellington to seek treatment (severe hallux valgus with underlying arthritis, second MTP dislocation and crossover toe, severe hammertoe). The CPR system was easier and more straightforward than he originally thought, though there was a learning curve, but intraoperatively was most impressed with clinical alignment of the toe and the stability of the second MTP joint. In surgery, he had confidence that the second MTP joint was stable. This patient was closely followed with multiple postoperative visits. She will be having her other foot treated as she has similar deformities.
**CASE REVIEW**

**Lisfranc ORIF vs Primary Arthrodesis**

**Treatment Considerations for Acute Midfoot Lisfranc Injuries: Bridge Plating and Primary Arthrodesis Techniques**

Current treatment considerations for acute traumatic lisfranc injuries require individualized assessment of the “personality” of the injury pattern. Recognition of the bony versus soft tissue component of the injury allows the ability to plan appropriate surgical intervention. Below are two cases with significantly different “personalities” treated with distinctly different implant strategies.

**Case 1**

Traditional open reduction and internal fixation techniques require absolute anatomic reduction of the tarsal metatarsal articulations. Current techniques place heightened focus on use of implant constructs that minimize injury to the respective articular services to maintain fixation. Bridge plate fixation is an elegant method of fixation of bony and soft tissue components in Lisfranc injuries. The lack of intra-articular violation limits further iatrogenic development of midfoot arthrosis.

Case 1 demonstrates a 47-year-old female status post motor vehicle accident with acute ligamentous and bony Lisfranc injury. The frequent bony component of communition of the second metatarsal base requiring spanning fixation is present in this case. The Arthrex complete foot plating system is comprised of anatomically-specific plates that are ideal for such indications. The cloverleaf screw cluster in the proximal end of the plates allows for maximal fixation in the respective cuneiform and the distal plate extension allows the ability to reduce and bypass the zone of communition of the second metatarsal base fracture. The anatomic plates demonstrated spanning the first and third tarsometatarsal joints provide rigid fixation, while eliminating iatrogenic joint penetration. The plate construct is generally removed at 3 – 4 months status post injury. At the time of hardware removal a Mini TightRope is often placed from the healed base of the second metatarsal to medial cuneiform to prevent late diastasis.

**Case 2**

For primarily soft tissue Lisfranc injuries, particularly when high energy, open reduction internal fixation techniques may be suboptimal and in such scenarios primary arthrodesis may offer a more appropriate solution.

Case 2 demonstrates a 64-year-old male status motorcycle accident with mainly ligamentous injury pattern with marked anatomical displacement. As with ORIF techniques, anatomic realignment of the tarsal metatarsal relationships is critical. Cartilage removal and joint preparation with fixation constructs optimizing compression allow for improved likelihood of union. The Arthrex Double Compression Plate construct has biomechanically demonstrated improved compression ability as compared to alternative compression staple plate devices. Optional locking and nonlocking fixation on one side of the planned arthrodesis site allows versatility in fixation options. On the other side of the arthrodesis site, the compression initially is obtained by traditional compression plating principles. This compression is further maximized via the staple arms of the plate for maximal compression fixation. The multiple geometric plate constructs and lengths allow for optimization of fixation for multiple anatomic areas of the foot and ankle including the transverse tarsal joints as demonstrated in this case example of primary arthrodesis of the first, second, and third tarsometatarsal joints.
Calcaneal Fracture System

The new Calcaneal Fracture System is the most comprehensive solution for calcaneal fracture fixation, featuring calcaneal fracture-specific instrumentation such as 5 mm Schanz Pins, Plate Cutter, Keyless Chuck, and elevators. Implants include low profile 1.35 mm titanium locking plates that are designed to minimize soft tissue irritation. The plates accept a full range of screws from 3.5 mm nonlocking, 3.5 mm locking, 3.5 mm variable angle locking (+/-15°), and 4.0 mm cancellous screws. The perimeter plates are available in four sizes with left and right designs. The percutaneous plates include five different designs including specific left and right plates. All of these features give the surgeon the tools to address all classifications of calcaneal fractures.

Syndesmosis Clamp

Arthrex is pleased to announce the addition of the Syndesmosis Clamp that can be added to the Arthrex Ankle Fracture Set. Dr. Clanton stated, “There has been a need for a specific clamp for the ankle and the syndesmosis for a long time. Typical clamps that are readily available have either been too small and pinch the skin badly or too large and are better suited for pelvis fractures. I am happy to see that Arthrex has recognized the need and responded.”
NEW PRODUCTS

5th Metatarsal Fracture System
The only system that offers both screw and plating options for fifth metatarsal fractures in one comprehensive set.

Jones Fracture Screws
Strength – solid robust 4.5, 5.5 and 6.0 mm screws
Multiple lengths – 40 to 65 mm offering more options for the surgeon
Cannulated drills and taps – fast and reproducible results
Specific instrumentation – designed to get the “high and inside” position with ergonomic guides, longer Guidewires, easy to read instruments and laser lined drill/taps
Small low profile head – less soft tissue irritation

5th Metatarsal Hook Plate
Revision or complex fracture – when a screw may no longer be an option
Anatomic plate – low profile universal plate designed with hooks to capture the base of the fifth Metatarsal
Variable angle locking – increase the strength of the plating construct with 2.4 mm locking screws
Specific instrumentation – ergonomic tamp, color-coded instruments, laser-marked drills and Plate Cutter to be used to remove hooks if needed

Longer Distal Fibular Plates - Sterile
The Distal Fibular Plates are an essential component to the plates within the ankle fracture system. As a result, 10-, 12- and 14-hole lengths are now available for more complex ankle fractures. The designs of the plates remain consistent with the shorter lengths and contain 2.7 mm locking or 3.0 mm cancellous screws distally, 3.5 mm locking or non-locking or 4.0 mm cancellous screws in the shaft, chamfers for the TightRope button and scallops for contourability. An aluminum template for these longer plates can be added to any ankle fracture tray to aid implant selection as longer plates are sterile packed.
NEW PRODUCTS

Compression FT

Features and Benefits:

• **Variable Stepped Thread Pitch** – The screw tip’s wider thread pitch enters the bone faster than trailing threads, gradually compressing the fragments as the screw is advanced.

• **Headless** – The titanium screws can be implanted intra-articularly and extra-articularly with minimal risk of impingement or soft tissue irritation.

• **Self-drilling and Self-tapping** – Two sets of cutting flutes facilitate insertion.

• **Multiple Size Options** – The screws are available in 2.5, 3.5 and 4.0.

• **Cannulation** – Assists in accurate placement for both percutaneous and open indications.

• **Improved Driver Engagement** – Hexalobe recess in 3.5 and 4.0 Compression FT Screws provide improved torque transmission. Note: 2.5 screw has 1.5 mm hex driver.

• Available in titanium alloy.

Proximal Interphalangeal Fusion

• Reverse angled barbs to maintain fixation and compression on both sides of the fusion site.

• Simple all-inside technique.

• PEEK material which is nonabsorbable and radiolucent.

• PEEK implant allows surgeon to cut or revise as needed.

• Multiple diameter implant options with straight and 10 degree angles for anatomic fusion.

• Disposable implant kit for convenience.

*Product not cleared by the FDA, for sale in the United States.*
Tenodesis Conversion Lock

The amazingly versatile tenodesis line just added another weapon to its arsenal. Arthrex is excited to announce the release of the new Tenodesis Conversion Lock Implant System.

The Tenodesis Conversion Lock Implant System is designed to turn any regular tenodesis screw into a SwiveLock in a matter of seconds. This simple snap-and-go system will save time at the back table. Simply load the correct Tenodesis Screw onto your driver, snap on the attachable PEEK eyelet and you are ready to do anything from an FHL/FDL tendon transfer, lateral ankle reconstruction, open proximal biceps tenodesis, MPFL reconstruction, single-row Achilles reconstruction with FiberTape and more.

The Tenodesis Conversion Lock kit comes with four attachable PEEK eyelets, as well as a 7-inch working length FiberTape and a suture loader.

BioComposite Tenodesis Screw and Disposable Driver

To make life simple in the operating room, Arthrex has released a 5.5 mm BioComposite Tenodesis Screw and Disposable Driver with a preloaded #2 suture loop. Simply open up the screw and driver, capture the end of the tendon with the suture loop and insert into the predrilled bone tunnel.

InternalBrace Deltoit Reconstruction using Tenodesis Conversion Lock
Lateral Ankle Reconstruction

The Lateral Ankle Reconstruction Implant System delivers the gold standard interference screw fixation that surgeons have counted on for the past 11 years. By using a free tendon graft to recreate the ATFL and CFL ligaments, surgeons are able to achieve a reproducible, rigid, anatomic reconstruction for patients with continued ligament laxity or after a failed primary Brostrom repair.

The all-in-one implant kit includes all of the necessary implants and instrumentation to perform this procedure. As a result, this aids in reduced OR inventory and sterilization costs. Designed to be used in conjunction with our presutured and sized allograft, Arthrex is now your one-stop shop for Lateral Ankle Reconstruction.

Lateral Ankle Graft

The Presutured Lateral Ankle Tendon is a preassembled, presized, sterile allograft tendon for use with the Lateral Ankle Reconstruction Implant System. It achieves an anatomic reconstruction of the anterior talofibular and calcaneofibular ligaments with simple tensioning and rigid fixation. This presutured tendon was precisely assembled according to Arthrex specifications by highly trained tissue technicians to ensure that the tendon meets the requirements of the Lateral Ankle Reconstruction technique.

Allograft Ordering information:

Allografts are ordered separately through our tissue partners, JRF or LifeNet Health.

JRF Orders: 877-255-6727
JRF Part Number: LAF01

LifeNet Health Orders: 888-847-7831
LifeNet Health Part Number: FPSST
ANCHOR SPOTLIGHT

Mini Bio-PushLock – AR-8825B
Mini PEEK PushLock – AR-8825P
Mini Bio-SutureTak – AR-1322BNF
Small Joint Bio-SutureTak – AR-8934BNF

2.2 x 4 mm Micro Corkscrew FT
2.7 x 7 mm Mini Corkscrew FT
2.5 x 10 mm Corkscrew FT
2.5 x 12 mm Corkscrew
5 x 15 mm Corkscrew
2.4 x 7.5 mm FASTak

Titanium Anchors

2.4 x 8 mm Micro SutureTak
3 x 14 mm Small Joint SutureTak
2.4 x 8.5 mm Mini SutureTak
2.4 x 6.5 mm Micro SutureTak

5.5 x 15 mm Bio-Corkscrew FT
2.5 x 8 mm Bio-PushLock

Non-Absorbable Anchors

2.5 x 8 mm PEEK PushLock

Pull-out Strength in 30 lb/ft³ (lbf) Ultimate Load:*

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*Data on file

Absorbable Anchors

Micro Bio-SutureTak – AR-1320BNF

Absorbable Anchors

Titanium Anchors

Micro QUICKANCHOR® with 2-0 ETHIBOND®
Micro QUICKANCHOR® with 3-0 ETHIBOND®
MICROFIX QUICKANCHOR® Plus
MINILOK QUICKANCHOR® Plus

2.2 x 4 mm Micro Corkscrew FT
2.7 x 7 mm Mini Corkscrew FT
2.5 x 10 mm Corkscrew FT
2.5 x 12 mm Corkscrew
5 x 15 mm Corkscrew
2.4 x 7.5 mm FASTak
NEW PRODUCTS

Double Compression Plates

The Double Compression Plate System is a revolutionary fixation construct that allows maximal surgical compression across fusion sites. The hallmark of this novel design is the biomechanically improved compression achieved using the unique double-compression mechanism. Initial compression is achieved using standard compression hole principles. Additional, secondary compression is achieved through the bridge “arms” of the plate construct. This double-compression mechanism allows the surgeon maximal compression potential with direct visual and tactile controlled feedback.

The plating system’s unique bridge thickness and geometry allow for low profile contour with biomechanically improved fatigue rigidity. The flexibility of locking and nonlocking compression hole options and multiple geometric plate configurations allow the surgeon the opportunity to optimize fixation while maximizing the advantages of the nonlocking compression hole mechanism.

The fixation system’s simplicity, ease-of-use, and multiple plate configurations allow universal applicability. These indications are inclusive of but not limited to talonavicular, calcaneocuboid, transverse tarsometatarsal, forefoot, and hindfoot arthrodesis sites.

The improved overall compression achieved with the double-compression mechanism allows for the maximal potential for bone-to-bone opposition, which is known to be the most critical factor in overall construct stability. Clinically, this can translate to improved fusion rates for simple and complex arthrodesis throughout the foot and ankle.

- 20, 25, 30 mm lengths
- 2-hole, 3-hole, two types of 4-hole
- Plates are stainless steel
- Use 3.5 mm locking and nonlocking stainless steel screws
- Compression slot on one side of the plate
- 1.75 mm thick and very strong since inner arms are not as long as similar plates but still obtain more compression due to the oblong compression slot
- 14 lbs of compression gained with the oblong compression slot
- Gain an additional 7 lbs of compression with distraction of inner arms
- Bridge is not as wide as other plates since compression is achieved with the oblong slot
- Versatility of placing the locking screw end of plate in osteoporotic or compromised bone segment

Medial Column Fusion Plate

The new Medial Column Contoured Plates are uniquely designed for the medial architecture of the foot. The plates can be used for the complicated Charcot arthropathy case or for the revision triple arthrodesis. It is also perfectly contoured for the patient needing an arthrodesis with extensive osteoarthritis of the midfoot, including the naviculo-cuneiform joints and tarsometatarsal joints. The dorsal and plantar tabs on the plate can be bent to form a cage-like structure for the medial column of the foot, or they can be resected if not necessary. Each tab includes the possibility of placing locking screws into a section of bone in multiple planes. This can be complimented by eccentric compression slots in the middle of the plate to individually compress each section of the arthrodesis. The distal portion of the plate can be resected if not necessary and the oblique compression slots can be used eccentrically or with an oblique compression screw providing a lag effect. All the features of this plate combine to help the surgeon fuse multiple joints at once in a very efficient and stable manner.
Ankle Arthroscopy

The Ankle Arthroscopy Instrument Set was designed specifically for the foot & ankle surgeon to provide a comprehensive solution for ankle arthroscopy. This complete set of instruments includes ring-handled graspers and punches, curettes, osteotomes, elevators and Chondral Picks for the daily work of the ankle arthroscopist.

In addition to the standard instrumentation, this unique set is available with the optional GPS Targeting System to pinpoint exact K-wire placement which aids in percutaneous cannulated screw insertion or retrograde drilling of osteochondral lesions.

Intended to be used in conjunction with our Ankle Arthroscopy Set, the noninvasive ankle distractor is designed to provide ankle distraction in a simple and effective manner. With the large tensioning wheel, fine traction can be easily increased or decreased during diagnostic or surgical arthroscopy procedures. The easy-to-use Clark Rail Adapter makes attachment and rough tension of the device simple and hassle free. A complete arthroscopy setup is achieved when used in conjunction with the Small Joint Limb Holder and ankle strap.

The Arthroscopic Ankle Distraction Strap is made of strong nylon strapping material with soft, nonslip foam pads for patient comfort and secure hold. This one-size-fits-all device offers effective traction and grip, which gives the surgeon a distinct advantage over current distraction options.

ArthroBrostrom

In keeping with Arthrex’s commitment to minimally invasive surgery, the all-arthroscopic lateral ankle repair kit or ArthroBrostrom Kit is setting new standards. This kit comes with all the necessary implants and accessories to perform a modified Brostrom repair arthroscopically. With reduced patient morbidity and equivalent overall repair construct to open techniques, the ArthroBrostrom Kit provides a powerful repair construct to treat this common pathology, while preventing a large surgical incision.
2013 and 2014 continue to be very exciting times for Medical Education in Distal Extremities and Orthopaedic Trauma. Last August we offered the largest version of our Foot & Ankle courses – the Advanced Ankle Instability, Arthroscopy and Sports Injuries Course in San Francisco. Eighty surgeons had the opportunity to rotate between Arthroscopic and open technique wetlab stations learning new techniques.

We also participated in cadaver workshops with AOFAS and ACFAS. At the AOFAS Summer Meeting we had a very good response to our “Advances in Ankle Instability and the InternalBrace™ Ligament Augmentation Repair Technology”. At the ACFAS 2014 Meeting the focus was on Tendon and Ligament Repair/Reconstruction, and was the perfect arena to practice basic and advanced tenodesis blind-tunnel fixation and internal bracing for ligament augmentations.

Arthrex was chosen as the top Foot & Ankle company by a number of orthopaedic and podiatry surgeons in the Pearl Diver Consulting Group survey. Having been selected as the organization providing the best product/procedure training is a reflection of our passion for surgeon education. At Arthrex, from our President down, we believe surgeon education is of paramount importance to help surgeons treat patients better and we will keep raising the bar in future events.

Last year Arthrex trained more than 10,000 surgeon visitors through our cadaveric surgical skill facilities. In addition to Jamie Bradshaw, PA-C , and myself, we now added Gianpietro Zampogna, M.D., Frank Grimaldi, PA-C and Michelle Chargot, M.D. as Clinical Specialists. This increase in manpower will be essential as we continue to host even more single-day lab opportunities working one on one with the clinical specialist or the ability of holding multiple Foot & Ankle courses at the same time.

We have four unique upcoming educational opportunities right around the corner. June 27 – 28th we will participate in ArthroParis, part of the ArthroSeries and Arthrex’s largest international educational events. World renowned international Faculty will assemble to teach over 250 orthopedic surgeons from around the world on minimally invasive and arthroscopic Foot & Ankle and Wrist Surgery. This meeting includes lecture presentations, live cadaveric demonstrations and product fair to show the latest products. August 15 – 16th, we head to Seattle, WA for the West Coast Advanced Ankle Instability and Sports Injuries Symposium. This will be a great opportunity for surgeons to hear from their peers on the latest Arthrex innovations and have hands on experience within our wetlab stations. September 6th, we offer OrthoBiologics Solutions to Enhance Outcomes in Surgery of the Foot and Ankle, course. A great Faculty has been assembled to discuss the latest on Autologous Conditioned Plasma, and BioCartilage in OCD lesions among other topics with the ability to practice the main core of our surgical techniques for sports injuries. On September 13th we are at our corporate lab in Vail for our Foot and Ankle Course featuring techniques related to forefoot, midfoot, hindfoot and sports injuries.

I want to take this opportunity to thank our surgeon customers who attended our educational events and all of our DX Consultants and Surgeon Instructors for such an amazing job on the podium and in the lab. Special thanks to our Lab Services team, they are the best in the business and critical to the success of our educational events.

Felix Riano, MD
Medical Education Manager
Distal Extremities and Orthopaedic Trauma
## 2014 Course Schedule

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<th>Course and Symposium</th>
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<td>Foot &amp; Ankle Masters Course</td>
<td>5/10</td>
<td>Manhattan, NY</td>
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<td>Podiatry Fellows Symposium</td>
<td>5/22 – 23</td>
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Podiatry Fellows Symposium 2013

Foot & Ankle Fellows Course 2014
The What’s New at Arthrex weekly surgeon email provides exclusive access to the very latest orthopaedic innovations at Arthrex before they are officially released on our website.

It includes premier surgical technique videos, animations, presentations and related science utilizing emerging technology and techniques.

Receive your weekly email update on What’s New at Arthrex by scanning the QR code or visiting the following URL.

http://cptr.it/DEXWNSE