

**The information contained in this document
is intended for healthcare professionals only.**

SOLAR[®] Radial Head

FOR USE IN RADIAL HEAD
ARTHROPLASTY ASSOCIATED WITH

- COMMINUTED FRACTURES
- RHEUMATOID DISEASE
- POST-TRAUMATIC DISEASE

CEMENTED COMPONENT DESIGNED
FOR HIGHER DEMAND PATIENTS.

SUPERIOR WEAR CHARACTERISTICS
DUE TO CoCr MATERIAL

HELPS RESTORE PROPER
JOINT FUNCTION

DESIGNED TO PREVENT PROXIMAL
MIGRATION OF THE RADIUS DUE TO
HEAD REMOVAL

5 SIZES TO ACCOMMODATE
SURGICAL PATIENT POPULATION



RADIAL HEAD ENDO PROSTHESIS

Implant Catalog No.	Size (diameter/thickness)	Trial Catalog No.
6948-0-508	Small, 8MM	6948-5-208
6948-0-511	Small, 11MM	6948-5-211
6948-0-609	Medium, 9MM	6948-5-309
6948-0-612	Medium, 12MM	6948-5-312
6948-0-615	Medium, 15MM	6948-5-315

Solar Radial Head Prosthesis Surgical Technique

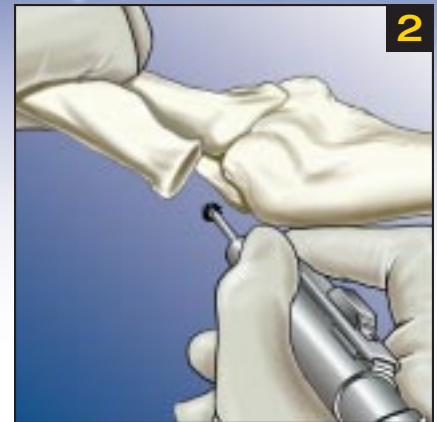
The approach is made through a dorsolateral incision. The radiohumeral joint is then exposed between the anconeus and extensor carpi ulnaris muscles, carefully preserving the motor branch of the radial nerve (posterior interosseous nerve) that passes at the radial neck. Blunt retractors are then used to gain exposure of the radial head at the epiphyseal-metaphyseal junction.



The annular and collateral ligaments are then located and preserved.

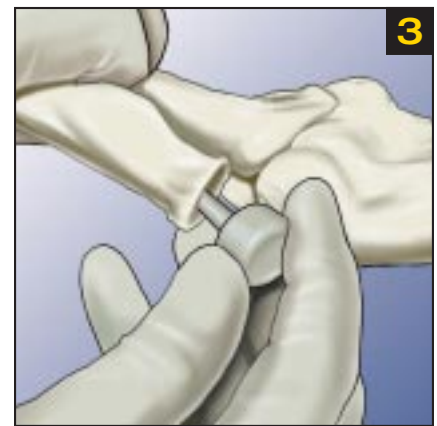
Synovectomy of the anterolateral and posterior aspects of the elbow joint may be performed at the same time. All excrescencies and marginal osteophytes can now be trimmed. (FIGURE 1)

The intramedullary canal of the radius is shaped to accept the stem of the implant using a curette, burr or small rasp. Bone resection preparation should be as conservative as possible. (FIGURE 2)

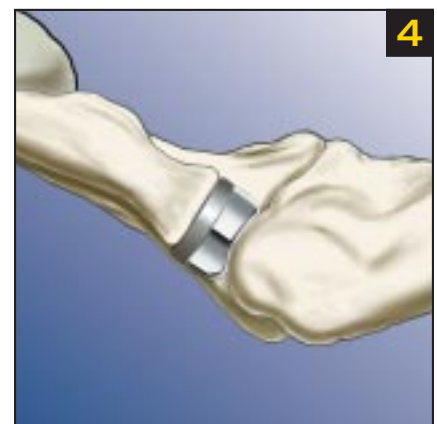


Note: The top of the intramedullary canal must be slightly counterbored with a burr to obtain clearance for the fluted portion (directly under the bearing head) of the implant.

A trial implant that best replicates the amount of proximal radius to be removed is inserted into the prepared canal and the joint reduced. Good contact of the trial head with the capitellum and smooth rotation through full ROM should be noted on passive flexion and rotation of the forearm. (FIGURE 3)



The trial implant is then removed and the joint is thoroughly irrigated with saline solution. The canal is gently filled with PMMA bone cement using the finger-packing method. The implant is then inserted into the canal. Use gentle impaction with a blunt instrument if necessary. Excess cement is then removed. (FIGURE 4)



The capsule, ligaments and the anconeus and extensor carpi ulnaris muscles are sutured in layers. An incision drain is inserted, if desired, and the facial layers are closed. With the elbow in 90° of flexion, a bulky conforming dressing is applied including a posterior plaster splint.

If there are any symptoms of ulnar nerve entrapment, or if there is significant synovitis about the medial epicondyle, a synovectomy of the medial aspect of the elbow is performed. The ulnar nerve can be transposed anteriorly as necessary and the medial collateral ligament should be resutured if incised.

(Surgical Technique authored by Gregory Hicken, MD)

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