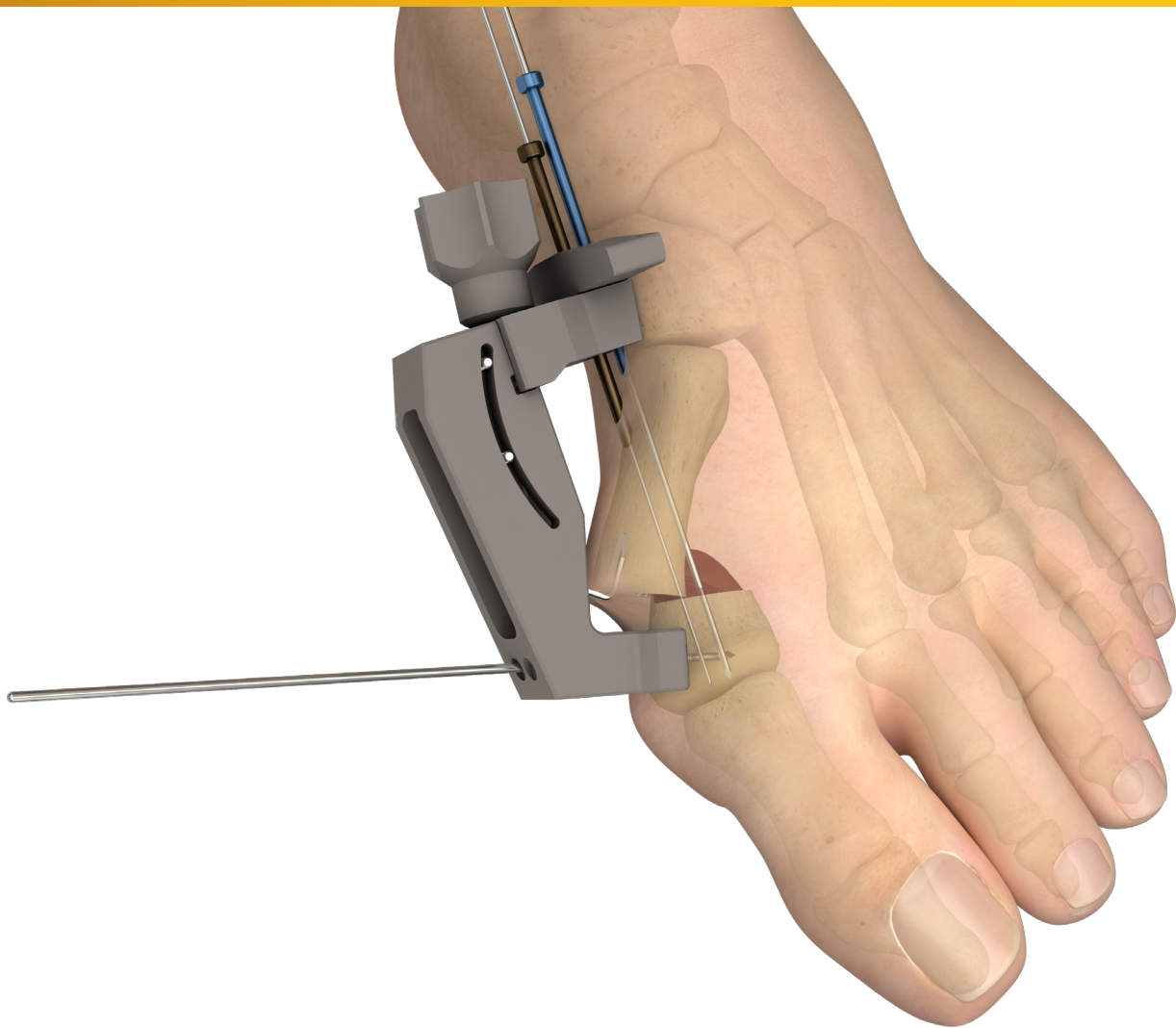


PROstep™ MICA® SOLO

Tips and tricks



Trajectory Cartridges (Figure 1)

- These all have roughly the same entry point at the proximal-medial corner of the metatarsal
- The total angular span from the medial to the lateral Cartridge is 5°. So if you start with the Central cartridge, you can change the angle to be 2.5° more medial or 2.5° more lateral
- The total distance span at the met head from the medial to the lateral Cartridge depends on the length of the metatarsal, but on average it is around 6mm. So if you start with the Central cartridge, you can adjust the target location in the met head 3mm medially or 3mm laterally

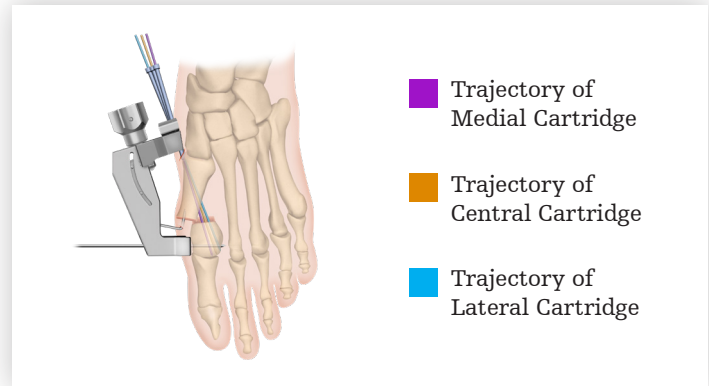


Figure 1

Adjustment Knob

- Once the medial cortex is fully engaged by the metal hook and shifting begins, a single additional turn of the Adjustment Knob causes between 1 and 1.5mm of shift
- The “percent shift” fully depends on the width of the patient’s metatarsal, but if we assume ~20mm width at the osteotomy site, then a full turn of the Knob causes 5%-7% more shift.

Introduction of the Pusher Assembly (Figures 2, 3, 4)

- If the osteotomy site is tight, the Straight Elevator may be used as a “shoehorn” to help insert the hook
- Prior to throwing the anchoring wire into the met head:
 - Verify that the hook is fully seated proximally into the shaft fragment. If the 2mm pin is pointing at the MTP joint, or the distal block seems too distal, the hook is probably not fully seated proximally into the shaft fragment as shown to the right. Need to ensure the metal hook is flush against the bone corner.
 - Hold the hallux in extra varus (slightly more than you would with a manual MICA procedure)
 - If desired, hold the hallux in adequate supination to reposition sesamoids



Figure 2

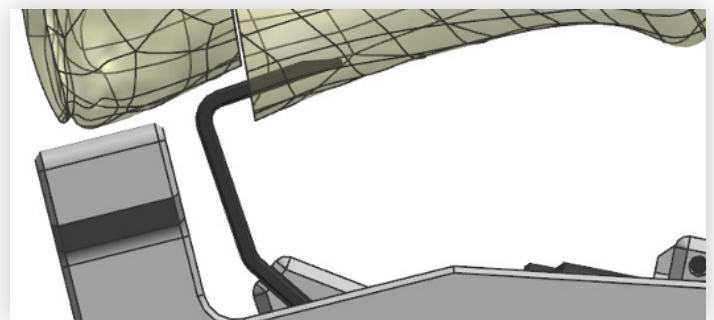


Figure 3



Figure 4

Guide alignment (Figure 5)

- Ensure the guide is aligned with the long axis of the metatarsal. Verify in lateral view. The proximal end must be sufficiently dorsal on the foot.
- The wires target for where the hook and pushing wedge are. If the hook is falling plantarly into the plantar arm of the osteotomy in the proximal fragment canal, there is potential for wires to be placed more plantar than desired.



Figure 5

Driving the Fixation Wires (Figure 6)

- Ensure the Wire Sleeves are directly touching bone with the chamfer clocked towards the bone prior to throwing the fixation wires
- “Peck drill” to avoid skiving off the shaft fragment lateral cortex
- The 1.4mm Wire Sleeve can be used a second time sequentially if a second 1.4mm wire is preferred for the medial wire throw after the lateral throw is complete
- If the IM hook is in the way of the medial wire throw:
 1. Proceed with drilling and placing the lateral screw
 2. Remove the Guide and use a Trajectory Cartridge with Wire Sleeves as a parallel guide to throw the medial wire
- After depthing, wires may be advanced through the foot and tagged with a hemostat on the far side to avoid pulling them out with the drills
- Once the lateral screw engages with the head fragment, the anchoring wire can be partially pulled back if it is in the way of the screw
- When throwing the 1.4mm wire through the Corner Removal Guide (Recontouring Guide), push the guide laterally into the foot for a more lateral pilot hole, and distally for a more medial pilot hole

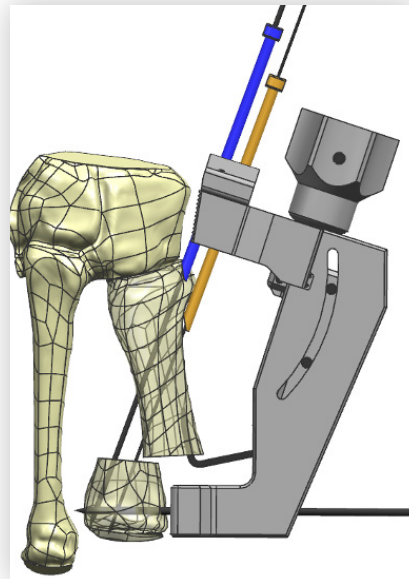


Figure 6

Other (Figure 7)

- For very small feet, the standard trajectory may begin too proximal
 - Manually pull the proximal end away from the foot
 - Insert the 1.4mm Wire Sleeve to contact the metatarsal corner
 - The Sleeve will now support the proximal end of the device

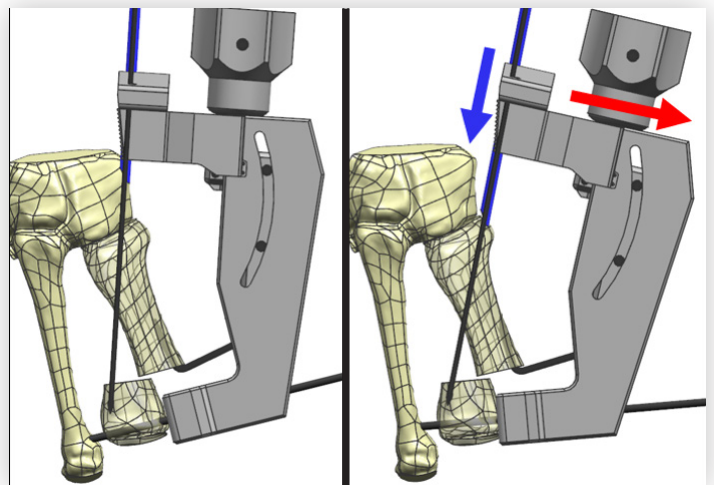


Figure 7

Foot & Ankle

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