MRH Knee System
Modular Peg Baseplate
Surgical Protocol

Using Monogram® IM
Revision Instruments
**Modular Rotating Hinge Knee System**
**Using Monogram® IM Revision Instruments**

Mr C R Howie FRCS  
Consultant Orthopaedic Surgeon  
Princess Margaret Rose Orthopaedic Hospital  
Edinburgh

Mr I M Pinder FRCS  
Consultant Orthopaedic Surgeon  
Freeman Hospital  
Newcastle upon Tyne

Mr D J Weir FRCS  
Consultant Orthopaedic Surgeon  
Freeman Hospital  
Newcastle upon Tyne

Dr Sam Nasser, M.D.  
Associate Professor  
Department of Orthopaedic Surgery  
Wayne State University School of Medicine  
Detroit, Michigan

Stryker also recognises the contribution of the following surgeons who assisted in the evaluation and development of the Monogram IM Revision Instruments:  
J V Bono, MD; K A Krakow, MD; L S Borden, MD; E T Habermann, MD; A K Hedley, MD; D S Hungerford, MD.

---

**The Modular Rotating Hinge Knee System**

The system has been designed for knees with severe joint destruction and/or ligament instability where a condylar style implant is not thought appropriate. While the hinge mechanism has been designed for those knees in which the soft tissue envelope is compromised, where possible the collateral ligaments should be preserved to enhance the longevity of the device.

In the revision situation, severe bone deficit may be encountered. Where this is symmetrical, the defect may be made up by thicker implants. However, it is not uncommon to require an asymmetrical augment medially or laterally. The Modular Rotating Hinge prosthesis has a selection of femoral and tibial augments which can be attached to the device after suitable bone preparation using intramedullary instrumentation.

This device provides considerable restraint, and it is recommended that a minimum stem length of 80mm is used. Due to the design modularity, this device can be used with cemented and two styles of Press-fit stems in a variety of diameters, lengths and offsets, thus maximizing surgical options.

---

**Surgical Technique**

The surgeon should utilize his/her normal technique for mobilizing the knee prior to implant surgery. If necessary, the medial or lateral collateral ligaments and quadriceps mechanism should be mobilized while preserving the soft tissue envelope to maintain tension in the capsule ligament system. Insertion of a rotating hinge does not compensate for inadequate soft tissue release. Tissue tightness may also result in poor access and secondary malalignment.

Prior to definitive implant insertion, trial reduction should be carried out to ensure correction of alignment and stability with estimation of the range of motion.

Occasionally, particularly in staged reconstruction for infection, the femoral component may require down-sizing or placement posteriorly to reduce tension to allow soft tissue closure.
Implant Overview

The implant system comprises:
- 5 sizes of left and right femoral component (XS, S, M, L, XL)
- 4 sizes tibial baseplate (XS, S, M, L)
- 5 thicknesses of DURATION® Stabilized Polyethylene tibial inserts.
- Variety of patellar sizes and styles
- Tibial Augmentation; 5mm and 10mm blocks and angled wedges
- Femoral Augmentation; 10mm distal blocks
- Stem Extender options to address a variety of approaches for IM fixation;
  - Diameters 10mm-23mm in lengths 80mm and 155mm.
  - Cobalt-chromium Cemented, Cobalt-chromium Press-fit, and Titanium Fluted Press-fit Stem Extenders
  - Stem interchangeability minimizes O.R. inventory; one set works with both femoral and tibial components.
  - 4mm Offset Stem Adapter option for optimal positioning of femoral component.
Modular Rotating Hinge Surgical Protocol

Alignment Rationale

The Modular Rotating Hinge femoral and tibial components are positioned at 90° to the coronal and sagittal planes, with alignment references taken from the intramedullary (IM) canal.

The Monogram® IM Revision Instruments provide for the sizing, alignment and positioning of the bone cuts and preparation for stem extenders and augmentation blocks.

By referencing and maintaining fixation in the IM canal, Monogram IM Revision Instruments provide a stable construct for reliable and accurate bone preparation and implant placement.

Options are also provided for extramedullary alignment to be used where intramedullary referencing is not possible, for example where the canal is severely bowed.

Resection Length

The Modular Rotating Hinge Knee offers a wide range of assembly options with 5 thicknesses of Duration® Stabilized polyethylene tibial inserts and an array of femoral and tibial augmentation blocks.

The minimum resection length is 27mm, the maximum including full augmentation options is 61mm.
Femoral Canal Preparation

A Stem Extender of at least 80mm should be used on the Femoral and Tibial Components for Modular Rotating Hinge procedures.

The medullary canal must be reamed in order to accommodate the new implant. Fluted reamers, available in diameters 8-23mm, are sequentially advanced into the canal until the tip of the appropriate depth gauge reaches the level of the most prominent bony aspect of the distal femur (Figure 1).

Note: Reamer Depth Gauges for femoral preparation are available in two lengths for neutral stems and two lengths for offset stems. 80mm and 155mm refer to the depth required to properly seat the implant with the respective 80mm and 155mm length Stem Extender.

Figure 2 gives an example of depth gauge marking, and how it relates to preparation of the medullary canal for a given combination of implants.

Technical Hint: In situations where Press-fit Stem diameters of 14mm or less are being used, it is necessary to ream the medullary canal of the distal femur with a 15mm reamer to at least 40mm. This reaming provides the necessary clearance to fully seat the cutting guide tower instrument and the "stem boss" portion of the stemmed femoral component.

It is strongly recommended that intramedullary reaming be performed manually to avoid bone perforation and/or fracture.
**Modular Rotating Hinge**

**Fig 3a**
![Modular Rotating Hinge](image)

**Fig 3b**
![Modular Rotating Hinge](image)

**Femoral Distal Resection**

After preparing the medullary canal, the corresponding diameter stem trial is selected and attached to the resection guide tower.

The assembly is inserted into the canal until the reference mark on the resection guide tower is aligned with the most prominent bony aspect of the distal femur. This position will allow a 2mm distal femoral "clear up" cut to be made.

The appropriate left or right femoral collar may be attached to the tower to assist in setting the final depth and rotation of the instrument (Figure 3a).

**Technical Hint:** To impact and extract the assembly in and out of the medullary canal, the T-Handle Impactor Extractor can be utilized (Figure 3b).

The 6° Valgus Femoral Resection Guide is assembled onto the tower, slid down to touch the anterior femur and secured using the cam-lock mechanism (Figure 4a).

Further fixation to the femur can be achieved by adding 1/8" (3.2mm) drills through the guide. A pin may also be inserted obliquely into the "X" drill hole to provide additional stability.

With the Femoral Resection Guide securely fixed to the stem assembly for enhanced stability, the 2mm "clear up" cut is performed using the slot marked "N" for neutral.

If Distal Femoral Augments are required, the 10mm cutting guide slots are used.

**Note:** If a further resection is required, the cutting guide can be re-positioned referencening the pins placed on the distal femur through the 2mm or 4mm pin holes on the resection guide. If this is done, the medullary canal should be reamed a further 2mm or 4mm in order to ensure the implant will be fully seated.

**Technical Hint:** Before fixing the resection guide with 1/8" drills, alignment can be verified by referencing the position of the femoral head with the extramedullary rod inserted through the "N" hole on the alignment handle, attached to the Femoral Resection Guide (Figure 4b). The position of the femoral head is determined from pre-operative X-ray templating.
**Tibial Preparation**

Fluted reamers, available in diameters 8-23mm are sequentially advanced into the medullary canal until the tip of the Tibial Reamer Depth Gauge reaches the level of the most prominent bony aspect of the proximal tibia (Figure 5a).

Note: Reamer Depth Gauges for tibial preparation are available in two lengths. 80mm and 155mm refer to the depth required to properly seat the implant with the respective 80mm and 155mm length Stem Extender.

After preparing the medullary canal, the corresponding diameter stem trial is selected and attached to the resection guide tower. The tibial collar is attached to the tower to assist in setting the final depth and rotation of the instrument (Figure 5b). The assembly is inserted into the canal until the tibial collar contacts the most prominent bony aspect of the proximal tibia. This position should allow a 2mm proximal tibial "clean up" cut to be made.

**Technical Hint:** To impact and extract the assembly in and out of the medullary canal, the T-Handle Impactor Extractor can be utilized.

The Tibial Resection Guide (making a Neutral-Neutral cut relative to the mechanical axis) is assembled onto the tower, slid down to touch the anterior tibia and secured using the cam-lock mechanism (Figure 6).

Fixation to the tibia can be achieved by adding 1/8" (3.2mm) drills through the guide. A pin may also be inserted obliquely into the "X" drill hole to provide additional stability.

With the assembled construct stabilized, the 2mm "clean up" cut is performed through the slot on the guide while the stem assembly is still in place, providing enhanced stability.

**Note:** If a further resection is required, the cutting guide can be re-positioned referencing the pins placed on the proximal tibia through the 2mm or 4mm pin holes on the resection guide. If this is done, the medullary canal should be reamed a further 2mm or 4mm in order to ensure the implant will be fully seated.

**Technical Hint:** Before fixing the resection guide with 1/8" (3.2mm) drills, alignment can be verified referencing the center of the ankle with the extremedullary rod inserted through the "NT" hole on the alignment handle, attached to the Tibial Resection Guide (Figure 6).
**Extension Gap Assessment**

A Spacer Block can be used to assess the extension gap, but not the size of the final flexion gap as the posterior cut has not been made.

Select the appropriate thickness Spacer Block and place it into the joint gap with the knee in full extension (Figure 7a).

Modular 5mm and 10mm Half Spacers can be attached to the appropriate faces of the Spacer block to compensate for bone loss in order to carry out soft tissue evaluation (Figure 7b).

*Technical Hint: The position of the patella is a helpful indicator in deciding where to locate the position of the femoral and tibial implants. The distal femur can be built up with 10mm augmentation blocks. The proximal tibia can be built up with the 5 and 10mm augmentation blocks and/or thicker tibial insert spacers.*

**Femoral Sizing**

In addition to pre-operative templating, femoral sizing can be accomplished using the femoral sizing template, by placing the posterior aspect of the template in the intercondylar notch to enable the internal cuts profile to seat flush against the bone (Figure 8a).

The handle of the template also provides markings that correspond to the M/L width of the implant (Figure 8b).

To accurately locate the template using the fixed stem position of the implant as the A/P reference point, replace the resection guide tower and trial stem in the femur, and position the sizing template so that the etched line marked "N" ("neutral" stem position) is coincident with the center line of the guide tower and the medullary canal. If an anterior gap is present, reposition the sizing template posteriorly so the engraved line marked "4mm" is coincident with the center line of the guide tower and reassess the fit of the template in this "4mm offset stem" position.

Repeat this process with a different size template if necessary to determine the best size femoral component and whether a 4mm offset stem is required.
Intramedullary Alignment

The appropriate left or right 6° Valgus Stem Adapter is assembled to the selected size Femoral A/P Chamfer Resection Guide and set to the "N" line on the resection block if no offset is to be used. If the 4mm posterior offset is to be used, the Valgus Stem Adapter should be locked at the "4" line.

The Trial Stem Extender is then attached (Figure 9b), and inserted into the canal until the Resection Guide rests against the cut distal femur (Figure 9a).

If a 10mm distal augment cut has been made on the femur, as detailed in Figure 4a, a magnetic 10mm Resection Guide Spacer should be attached to the Femoral Resection Guide (Figure 10b).

Option: An 8mm IM Rod can be used to reference the medullary canal, if the 8mm IM Rod Valgus Adapter is attached to the Femoral Resection Guide (Figure 9c).

Femoral Sizing and Resection

Femoral sizing can be verified using the Sizing Indicator, referencing the anterior cortex, as indicated (Figure 10a).

If it is desirable at this stage to change the position of the Resection Guide to Neutral or 4mm posterior offset, this can be done by releasing the Locking Knob on the Valgus Adapter one half turn and sliding the Resection Guide to its new position. Then tighten the Locking Knob.

Correct internal/external rotation of the Femoral Resection Guide can be achieved by setting the Resection Guide parallel to the transepicondylar axis. The Resection Guide can then be fixed using 1/8" (3.2mm) drills or pins.

The anterior femoral cut may now be made using a .050" (1.27mm) oscillating sawblade through the most anterior slot on the guide.

Technical Hint: The tabs on the posterior aspect of the Femoral Resection Guide represent the external profile of the posterior condyles of the Femoral Component. With the knee in flexion, the correct rotation of the Femoral Resection Guide can also be assessed by referencing the spacer block between the resected tibial surface and the posterior condyle tabs on the Resection Guide to ensure a parallel flexion gap (Figure 10a).
The Anterior Shim Plate can be attached to the Femoral Resection Guide to provide stability for the Resection Guide assembly during the anterior and posterior chamfer resections (Figure 11).

*Technical Hint: A narrow oscillating saw blade of less than 1” (25mm) is recommended for the chamfer cuts.

Option: If IM referencing is not used, the Anterior Shim Plate can be attached to the Femoral Resection Guide to reference the existing anterior cut. Care should be taken in checking that the original anterior cut is not malrotated.

Offset Stem Preparation

If the 4mm Offset Stem Adapter Implant is being used it is necessary to ream the femur to prepare for the new posterior position of the Femoral Component Stem Boss and Offset Adapter (Figure 12a).

Remove the Trial Stem Extender and Valgus Adapter and assemble the Femoral Offset Reamer through the Reamer Bushing (Figure 12b). Attach the Bushing to the Femoral Resection Guide and ream to the “Offset” reamer depth marking.

Note: If a straight stem with a diameter of 14mm or less is used on the Femoral Component, the Offset Reamer and Reamer Bushing should be used to the “Boss” reamer depth marking (Figure 12c) to prepare the distal femur for the stem boss of the femoral component.

If the 8mm IM Rod has been used for IM referencing (shown in Figure 9c), stem reaming should be completed at this stage for at least an 80mm length stem.
Select the size of Tibial Template which best matches the cut proximal tibia without overhanging the cortex.

Use the Stem Extender Rod, attached to a Trial Stem Extender, through the Alignment Reamer Guide and Neutral Bushing to center the Template with the Stem construct in the canal (Figure 13).

With the knee in full flexion, and the Alignment Handle attached to the Template, an Alignment Pin is placed through the “NT” hole positions of the Handle to verify alignment. The tibial tubercle will normally be positioned just lateral to the pin which should be centered distally over the center of the ankle.

When alignment is correct, the Template is secured with Headed Nails or pins through holes located anteriorly and posteriorly on the template.

Then ream the Stem Boss using the Stem Boss Bushing and Stem Boss Reamer to the "Boss" depth marking (Figure 14a).

The Peg Reamer is placed through the peg holes on both sides of the Tibial Peg Drill Guide, to prepare for the 10mm or 20mm anti-rotation pegs on the underside of the Tibial Baseplate. The Peg Drill is at the correct depth when the witness line on the drill is level with the top surface of the Peg Drill Guide (Figure 14b).
With the Tibial Template in position, the Augment Drill Guide is secured to the anterior face of the Template by tightening the Locking Knob. Two 1/8” (3.2mm) drill pins are inserted into the outermost holes of the drill guide (Figure 15). For smaller bones, use the innermost holes.

The Augment Drill Guide is then removed from the Tibial Template, leaving the drill pins in place.

The appropriate augment is selected, based upon the nature of the bony tibial defect or deficiency. Once the depth of the defect is determined, the appropriate cutting surface of the Augment Resection Guide is slid onto the drill pins and advanced towards the defect.

When the Augment Resection Guide is correctly positioned, the flat surface on top of the guide will be level with the resected proximal tibia. The sawblade is then laid on the cutting surface of the jig, and the transverse cut performed (Figure 16a).

**Note:** The Half Augment Resection Guide should be positioned using the correct component size drill holes (see inset diagram Figure 16b). For a 5mm or 10mm half spacer, the sagittal cut should be marked out referencing the appropriate trial.

The Full Angled Wedge Resection Guide should be positioned such that the wedge cut intersects the medial and lateral cortices to ensure optimal bone coverage by the implant. The Full Wedge Resection Guide can be moved proximally by repositioning it through the 2, 4, 6, 8 and 10 holes to optimise the resection run-out.
Tibial Preparation: Primary Option

It is possible to prepare the tibia for a Modular Rotating Hinge Tibial Baseplate using the Monogram® primary tibial instruments.

Select the size of Tibial Template which best matches the cut proximal tibia without overhanging the cortex.

With the knee in full extension, and the Alignment Handle attached to the Template, an Alignment Pin is placed through the "NT" hole position of the handle to verify alignment (Figure 17). The tibial tubercle will normally be positioned just lateral to the pin which should be centered distally over the centre of the ankle.

When alignment is correct, the Template is secured with Headed Nails or pins through holes located anteriorly on the Template.

Tibial Stem Reaming

The Tibial Reamer Guide can be used to ream the canal for the Tibial Baseplate "Stem Boss" using the Stem Boss Reamer. If the medullary canal has not been prepared for at least an 80mm Stem Extender as described on page 3, then this should also be done at this stage using the appropriate diameter reamer.

The Tibial Reamer Guide is placed onto the Tibial Template and the distal Locking Knob is tightened, securing the assembly (Figure 18).

With the bushing in place, ream to the appropriate depth, indicated by the markings on the Reamer shaft.

The Peg Drill is placed through the peg holes on both sides of the Tibial Reamer Guide, to prepare for the 10mm or 20mm anti-rotation pegs on the underside of the Tibial Baseplate. The Peg Drill is at the correct depth when the witness line on the drill is level with the recessed surface of the Reamer Guide peg drill holes (Figure 18).

Technical Hint: The Alignment Handle can be attached to the Anterior face of the Tibial Reamer Guide to enable an extramedullary alignment check before reaming.
Trialing

On completion of the femoral and tibial bone preparation a trial reduction should then be performed to confirm that appropriate motion, stability and patellar tracking have been achieved.

The Trial Femoral Component (1) and Trial Tibial Baseplate (2) can be fitted with the appropriate Trial Augments and Trial Stem Extenders before being placed onto the prepared bones. If a 4mm offset adapter is to be used, this can be attached to the femoral component in the same way as the implant, as detailed on pages 16 and 17.

Place the appropriate thickness Trial Tibial Insert (3) onto the Trial Tibial Baseplate and drop in the appropriate Trial Tibial Rotating Component (4).

Insert the Trial Axle (5) into the bore of the Trial Femoral Component until the groove lines up with the intercondylar gap between the condyles. Engage the Trial Axle down into the “snap-fit” hinge on the Trial Rotating Component (4).

Femoral Implant Assembly

The implant Femoral Spacers are attached by screw fixation to the distal condylar area of the femoral component. The Torque Wrench is attached to the Distal Locking Screw Adapter. A locking torque of 60 - 80 in/lbs is applied to the screw head in order to lock the Spacer and Femoral Component together (Figure 20b).

To attach a Press-fit Stem Extender to the implant, hand tighten the stem into the Femoral Stem Boss as far as possible. Attach the Stem Socket Wrench to the Torque Wrench, insert the male hex tip of the wrench into the hex recess on the Stem Extender and tighten to 120 in/lbs – 180 in/lbs (Figure 20a).

Option: If using a 155mm Titanium Fluted Stem Extender, tighten to 120 in/lbs with the Tri-fluted Stem Wrench, illustrated in Figure 23b.

If using a Cemented Stem Extender, hand tighten the Stem into the Femoral Stem Boss as far as possible. The Combination Wrench is then used to fully tighten.

Note: A Stem Extender of at least 80mm should be used on the Femoral Components for Modular Rotating Hinge procedures.
Femoral Offset Stem Assembly

**STEP 1**

Turn the jam nut along the threaded stud until it contacts the offset adapter body (Figure 21a). Screw the offset adapter into the boss of the femoral component implant until it is fully seated. Tighten the stem extender into the adapter by hand as far as possible.

**STEP 2**

Slide the Trial Axle into the Femoral Component implant and drop the Offset Fixture onto the axle between the condyles (Figure 22b). Tighten the locking knob by hand until it sits firmly against the stem boss of the femoral component implant (Figure 22a).

**STEP 3**

Turn the offset adapter body counter-clockwise until the stem is anterior to the boss of the femoral component (Figure 22a). **DO NOT EXCEED ONE FULL TURN.**
Modular Rotating Hinge

STEP 4

Attach the counter wrench to the appropriate left or right positioning rail on the offset locking jig and engage the offset adapter body. Using the stem wrench (hex tip (Figure 23a) or tri-fluted (Figure 23b) and torque wrench, tighten the stem extender to the adapter body to a torque value of 120 in/lbs – 180 in/lbs (Figure 23a).

STEP 5

Attach the jam nut wrench to the torque wrench. Engage the jam nut with the torque wrench assembly while holding the counter wrench and tighten to 120 in/lbs – 180 in/lbs (Figure 24).

Note: Orient the square drive adapter, tri-fluted stem wrench and jam nut wrench with the long axis of the torque wrench.
Tibial Stem Implant Assembly

To attach a Press-fit Stem Extender to the implant, hand tighten the stem into the Tibial Stem Boss as far as possible. Attach the Stem Socket Wrench to the Torque Wrench, insert the male hex tip of the wrench into the hex recess on the Stem Extender and tighten to 120in/lbs – 180in/lbs (Figure 25a and 25b).

Note: A Stem Extender of at least 80mm should be used on the Tibial Components for Modular Rotating Hinge procedures.

Option: If Cemented Stem Extenders are to be used, hand tighten the stem into the Tibial Stem Boss as far as possible. The Combination Wrench and Counter Wrench are then used to fully tighten.

Titanium Tri-Fluted Stem Option:

When using a 155mm Titanium Fluted Stem Extender, the Tri-Fluted Stem Wrench Adapter must be used to apply the final torque to the implant. This adapter is attached to the Torque Wrench and slid into the slots of the Stem until it has bottomed out on the implant. The Stem must be tightened to the final locking torque of 120in/lbs – 180in/lbs (Figure 26).
The implant Tibial Spacers are attached by screw fixation to the underside of the baseplate with a screw or 10mm augment peg. The Torque Wrench is attached to the Distal Locking Screw Adapter. A locking torque of 60 - 80 in/lbs is applied to the screw or peg head in order to lock the Spacer and Tibial Component together (Figure 27).

The Modular Peg Baseplate has 10mm Pegs attached as standard (20mm Pegs can be added). These should be removed in the case of a tibial augment being used.

The Tibial Impactor Extractor (Figure 28) is used to impact the Tibial Baseplate to its full depth, ensuring the Modular Pegs engage in the prepared bone.
**Femoral Implantation**

The implant Femoral Component Assembly is attached to the Femoral Impactor Extractor, guided onto the femur and impacted flush (Figure 29).

With the Femoral Component and Tibial Baseplate implanted, it is possible to use the Trial Axle (1) with the Trial Rotating Component (2) and Trial Tibial Insert Spacer (3) to verify that the appropriate motion, stability and patellar tracking have been achieved. With the knee in full extension this also assists in loading the femoral and tibial baseplate components while the cement is curing to provide an optimal bond between implant and bone.
**Final Implant Assembly**

To complete the assembly of the final implant components, insert the Tibial Sleeve into the Tibial Baseplate until it is flush with the surface.

There are two sizes of Tibial Insert Spacer, XS/S and M/L, which fit with the corresponding Tibial Baseplates. They both come in 5 different thicknesses of 10mm, 13mm, 16mm, 20mm and 24mm.

Snap in the appropriate thickness Tibial Spacer, chosen at the trialing stage and drop in the Tibial Rotating Component.

**Option:** An additional Tibial Rotating component with 3mm posterior offset is available for Large and Extra Large Femoral components. This component offsets the Femoral component posteriorly, relative to the tibial stem, a further 3mm to enable optimal patellar tracking.
Insert the two Femoral Bushings into the Femoral Component so that the flanges are inside the intercondylar cut out (Figure 33).

Line up the Tibial Rotating Component with the holes of the Femoral Component Bushings and slide the implant Axle into the assembly until the "recess" in the Axle can be seen through the Tibial Rotating Component from the front. Twist the Axle so that the "recess" is inferior. The grooves on the end of the axle which engage into the Axle Introducer Handle are a helpful indicator in aligning the Axle.

With the Axle correctly oriented the Bumper can now be inserted. This should be impacted into the Tibial Rotating Component until it is flush with the hinge housing and has cleared the "snap-fit" lip on the Tibial Rotating Component.

*Note:* With the Bumper inserted the axle should **not be further rotated**.

*Option:* The Bumper implant is available in two options, neutral and 3° flexion.
### Implant Listing

<table>
<thead>
<tr>
<th>Description</th>
<th>Size</th>
<th>Implant Cat. No.</th>
<th>Trial Cat. No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femoral Component</td>
<td>Extra-Small</td>
<td>6481-1-100</td>
<td>6481-1-300</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Small</td>
<td>6481-1-110</td>
<td>6481-1-310</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium</td>
<td>6481-1-120</td>
<td>6481-1-320</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Large</td>
<td>6481-1-130</td>
<td>6481-1-330</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Extra-Large</td>
<td>6481-1-140</td>
<td>6481-1-340</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Extra-Small</td>
<td>6481-3-100</td>
<td>6481-3-400</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Small</td>
<td>6481-3-101</td>
<td>6481-3-401</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium</td>
<td>6481-3-102</td>
<td>6481-3-402</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Large</td>
<td>6481-3-103</td>
<td>6481-3-403</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Extra-Small/Small</td>
<td>6481-3-210</td>
<td>6481-3-510</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Small</td>
<td>6481-3-213</td>
<td>6481-3-513</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium/Large</td>
<td>6481-3-220</td>
<td>6481-3-520</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Large</td>
<td>6481-3-224</td>
<td>6481-3-524</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium/Large</td>
<td>6481-3-310</td>
<td>6481-3-610</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium/Large</td>
<td>6481-3-313</td>
<td>6481-3-613</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium/Large</td>
<td>6481-3-316</td>
<td>6481-3-616</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium/Large</td>
<td>6481-3-320</td>
<td>6481-3-620</td>
</tr>
<tr>
<td>Femoral Component</td>
<td>Medium/Large</td>
<td>6481-3-324</td>
<td>6481-3-624</td>
</tr>
<tr>
<td>Femoral Block, Distal 10mm</td>
<td>Extra-Small</td>
<td>6481-1-200</td>
<td></td>
</tr>
<tr>
<td>Femoral Block, Distal 10mm</td>
<td>Small</td>
<td>6481-1-210</td>
<td></td>
</tr>
<tr>
<td>Femoral Block, Distal 10mm</td>
<td>Medium</td>
<td>6481-1-220</td>
<td></td>
</tr>
<tr>
<td>Femoral Block, Distal 10mm</td>
<td>Large</td>
<td>6481-1-230</td>
<td></td>
</tr>
<tr>
<td>Femoral Block, Distal 10mm</td>
<td>Extra-Large</td>
<td>6481-1-240</td>
<td></td>
</tr>
<tr>
<td>Femoral Block, Distal 10mm</td>
<td>(All sizes)</td>
<td>6481-1-400</td>
<td></td>
</tr>
<tr>
<td>Tibial Rotating Component</td>
<td>Extra Small-Extra Large</td>
<td>6481-2-100</td>
<td>6481-3-500</td>
</tr>
<tr>
<td>Tibial Rotating Component</td>
<td>Large - Extra Large</td>
<td>6481-2-101</td>
<td>6481-3-600</td>
</tr>
<tr>
<td>Femoral bushing (1 per pack)</td>
<td>All Sizes</td>
<td>6481-2-110</td>
<td></td>
</tr>
<tr>
<td>Tibial Sleeve</td>
<td>All Sizes</td>
<td>6481-2-140</td>
<td></td>
</tr>
<tr>
<td>Bumper Insert - Neutral</td>
<td>All Sizes</td>
<td>6481-2-130</td>
<td></td>
</tr>
<tr>
<td>Bumper Insert, 3 Degrees</td>
<td>All Sizes</td>
<td>6481-2-133</td>
<td></td>
</tr>
<tr>
<td>Axle</td>
<td>All Sizes</td>
<td>6481-2-120</td>
<td>6481-2-220</td>
</tr>
<tr>
<td>Offset Adapter 4mm (including Jam Nut)</td>
<td>6478-6-490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trial Offset Adapter 4mm (not including Jam Nut)</td>
<td>——</td>
<td>6778-6-490</td>
<td></td>
</tr>
<tr>
<td>Jam Nut Trial</td>
<td>——</td>
<td>6778-6-485</td>
<td></td>
</tr>
</tbody>
</table>
### Implant Listing

#### Monogram®

**Total Knee Instruments**

#### Press-fit Implant Listings

<table>
<thead>
<tr>
<th>Tibial Augmentation</th>
<th>Size</th>
<th>Left Implant</th>
<th>Left Trial</th>
<th>Right Implant</th>
<th>Right Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half Flat Wedge 5mm</td>
<td>Extra-Small</td>
<td>6476-0-130</td>
<td>6776-0-130</td>
<td>6476-0-140</td>
<td>6776-0-140</td>
</tr>
<tr>
<td>Half Flat Wedge 5mm</td>
<td>Small</td>
<td>6476-1-130</td>
<td>6776-1-130</td>
<td>6476-1-140</td>
<td>6776-1-140</td>
</tr>
<tr>
<td>Half Flat Wedge 5mm</td>
<td>Medium</td>
<td>6476-3-130</td>
<td>6776-3-130</td>
<td>6476-3-140</td>
<td>6776-3-140</td>
</tr>
<tr>
<td>Half Flat Wedge 5mm</td>
<td>Large</td>
<td>6476-5-130</td>
<td>6776-5-130</td>
<td>6476-5-140</td>
<td>6776-5-140</td>
</tr>
<tr>
<td>Half Flat Wedge 10mm</td>
<td>Extra-Small</td>
<td>6476-0-110</td>
<td>6776-0-110</td>
<td>6476-0-120</td>
<td>6776-0-120</td>
</tr>
<tr>
<td>Half Flat Wedge 10mm</td>
<td>Small</td>
<td>6476-1-110</td>
<td>6776-1-110</td>
<td>6476-1-120</td>
<td>6776-1-120</td>
</tr>
<tr>
<td>Half Flat Wedge 10mm</td>
<td>Medium</td>
<td>6476-3-110</td>
<td>6776-3-110</td>
<td>6476-3-120</td>
<td>6776-3-120</td>
</tr>
<tr>
<td>Half Flat Wedge 10mm</td>
<td>Large</td>
<td>6476-5-110</td>
<td>6776-5-110</td>
<td>6476-5-120</td>
<td>6776-5-120</td>
</tr>
<tr>
<td>Half Angled Wedge</td>
<td>Extra-Small</td>
<td>6478-6-100</td>
<td>6776-0-160</td>
<td>6478-6-100</td>
<td>6776-0-160</td>
</tr>
<tr>
<td>Half Angled Wedge</td>
<td>Small</td>
<td>6478-6-110</td>
<td>6776-1-160</td>
<td>6478-6-110</td>
<td>6776-1-160</td>
</tr>
<tr>
<td>Half Angled Wedge</td>
<td>Medium</td>
<td>6478-6-120</td>
<td>6776-3-160</td>
<td>6478-6-120</td>
<td>6776-3-160</td>
</tr>
<tr>
<td>Half Angled Wedge</td>
<td>Large</td>
<td>6478-6-135</td>
<td>6776-5-160</td>
<td>6478-6-135</td>
<td>6776-5-135</td>
</tr>
<tr>
<td>Full Angled Wedge</td>
<td>Extra-Small</td>
<td>6478-6-160</td>
<td>6776-0-150</td>
<td>6478-6-150</td>
<td>6776-0-150</td>
</tr>
<tr>
<td>Full Angled Wedge</td>
<td>Small</td>
<td>6478-6-170</td>
<td>6776-1-150</td>
<td>6478-6-170</td>
<td>6776-1-150</td>
</tr>
<tr>
<td>Full Angled Wedge</td>
<td>Medium</td>
<td>6478-6-180</td>
<td>6776-3-150</td>
<td>6478-6-180</td>
<td>6776-3-150</td>
</tr>
<tr>
<td>Full Angled Wedge</td>
<td>Large</td>
<td>6478-6-190</td>
<td>6776-5-150</td>
<td>6478-6-190</td>
<td>6776-5-150</td>
</tr>
</tbody>
</table>

#### Tibial Augmentation

<table>
<thead>
<tr>
<th>Size</th>
<th>Left Implant</th>
<th>Left Trial</th>
<th>Right Implant</th>
<th>Right Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra-Small</td>
<td>6476-0-100</td>
<td>6776-0-100</td>
<td>6476-0-100</td>
<td>6776-0-100</td>
</tr>
<tr>
<td>Small</td>
<td>6476-1-100</td>
<td>6776-1-100</td>
<td>6476-1-100</td>
<td>6776-1-100</td>
</tr>
<tr>
<td>Medium</td>
<td>6476-3-100</td>
<td>6776-3-100</td>
<td>6476-3-100</td>
<td>6776-3-100</td>
</tr>
<tr>
<td>Large</td>
<td>6476-5-100</td>
<td>6776-5-100</td>
<td>6476-5-100</td>
<td>6776-5-100</td>
</tr>
</tbody>
</table>

#### Cemented Implant Listings

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10mm x 80mm</td>
<td>6476-8-260</td>
<td>6778-7-060</td>
<td>6476-8-270</td>
<td>6778-7-065</td>
</tr>
<tr>
<td>11mm x 80mm</td>
<td>6476-8-260</td>
<td>6778-7-060</td>
<td>6476-8-270</td>
<td>6778-7-065</td>
</tr>
<tr>
<td>155mm</td>
<td>6476-8-260</td>
<td>6778-7-060</td>
<td>6476-8-270</td>
<td>6778-7-065</td>
</tr>
</tbody>
</table>
This document is intended solely for the use of healthcare professionals. The information presented in this brochure is intended to demonstrate the breadth of Stryker product offerings. Always refer to the package insert, product label and/or user instructions before using any Stryker product. Products may not be available in all markets. Product availability is subject to the regulatory or medical practices that govern individual markets. Please contact your Stryker representative if you have questions about the availability of Stryker products in your area.

Products referenced with ™ designation are trademarks of Stryker. Products referenced with ® designation are registered trademarks of Stryker.