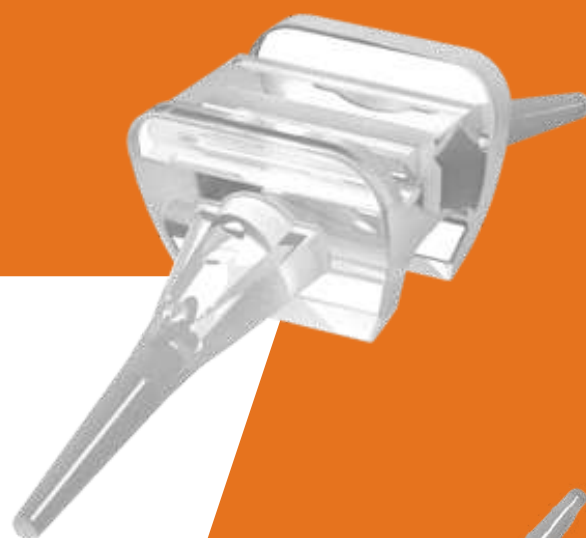




Digitalis PIP

PROXIMAL
INTERPHALANGEAL
JOINT ARTHROPLASTY





CLINICAL INDICATIONS

- Osteoarthritis
- Rheumatoid arthritis
- Joint surfaces destroyed following traumatic events
- Ankylosed joints or with limited range of motion
- Non-functional joint due to inadequate bony alignment

SURGICAL TECHNIQUE GUIDE

This document details the recommended surgical technique for the PIP DIGITALIS, specifically designed for the correction of bone deformities of the hand joints.

It serves as an educational resource to support qualified surgeons in ensuring the safe and effective application of the system. The following guidelines are provided for reference purposes only.

It remains the sole responsibility of the operating surgeon to determine the appropriateness of each procedure based on their professional clinical judgment and experience.

For comprehensive information regarding indications, contraindications, warnings, and precautions, please consult the official Instructions for Use (IFU) provided with the device.

INSTRUMENTATION

DDGI000001B

Digitalis instruments sterilization box (empty)



DDGI203000

Digitalis Handle



DDGI201003

Multisize Trial MCP

DDGI201004

Multisize Trial PIP



DDGI201001

Digitalis MCP Reamer

DDGI201002

Digitalis PIP Reamer



DDGI202001

Digitalis MCP Rasp

DDGI202002

Digitalis PIP Rasp



DDGI201013

Silicon MCP Trial size 1

DDGI201023

Silicon MCP Trial size 2

DDGI201033

Silicon MCP Trial size 3

DDGI201043

Silicon MCP Trial size 4

DDGI201053

Silicon MCP Trial size 5



DDGI201014

Silicon PIP Trial size 1

DDGI201024

Silicon PIP Trial size 2

DDGI201034

Silicon PIP Trial size 3

DDGI201044

Silicon PIP Trial size 4



DORSAL APPROACH

ARTICULATION EXPOSURE

Make a gradual curved dorsal incision above the interphalangeal joint (PIP). Extend the dissection to the extensor tendon bundle. An approach with dorsal incision of the extensor tendon, elevation of the extensor tendon and its central part is recommended. Remove all periarticular osteophytes. The collateral ligament insertions may or may not be preserved, depending on the degree of contracture present.



ARTICULAR SURFACES OSTEOTOMY

Protecting the tendon and soft tissues in general with retractors, use a micro-oscillating saw to resect the head of the proximal phalanx and the base of the medial phalanx. Remove any osteophytes or sharp spurs from the joint.



SIZE CHOICE



Starting with the smallest size, insert the multi-size trial located inside the instrument kit supplied with the device, test it and choose the one that best fits anatomically inside the joint.

PREPARATION OF THE MEDULLARY CANALS

Manually locate the medullary canals of the proximal and medial phalanges using a tip. Once the canal has been located, insert the reamer mounted on the appropriate handle. Proceed into the medullary canal until reaching the depth corresponding to the size chosen and/or identified in the previous step, clearly indicated on the reamer. Then use the rasp to complete the preparation of the medullary canals (it does not matter whether you start with the proximal or medial phalanx first), taking care to keep the upper edge and the lateral and medial edges of the rasp parallel to the corresponding edges of the relevant bone portions. To avoid rotation during broaching, use a forward-backward scraping method. Advance until you reach the depth corresponding to the selected size, clearly indicated on the rasp.

NOTE: The key on the PIP multi-size trial can be used to tighten and/or loosen the reamer and rasp on the handle.



TRIAL SPACER AND FINAL IMPLANT

Insert the test spacer ● corresponding to the selected size and verify that the spacer fits perfectly on the surface of the resected bone planes, checking the mobility, alignment and stability of the implant. Insert the final implant.



WOUND CLOSURE



Close the extender block with a 4.0 absorbable suture and proceed with careful suturing of the skin tissue.

CAUTION: In order to obtain sufficient exposure of the joint in difficult cases, it may be necessary to cut the collateral ligament on one side of the proximal phalanx. In this case, repair the collateral ligament using non-absorbable 4.0 monofilament sutures. If necessary, place a drain and close the skin with a conforming dressing, keeping the PIP joint in a very slight flexion of 10-20 degrees.

Post-operative care: Bandage the finger and keep it in the rest position for 3-4 weeks, before starting the rehabilitation treatment.

Removal: If the implant needs to be removed, make a gradual curved dorsal incision above the affected joint (proceeding medially to the extensor tendon) and perform a full-thickness capsulotomy. Remove the silicone component using a needle holder and perform an implant revision or arthrodesis procedure depending on the most appropriate clinical indication for the case. Re-suture capsule and patient's skin.



D I S T R I B U T E D B Y :



**Digitalis
Brochure**

BRM EXTREMITIES Srl

Via Lorenzo Mascheroni 29
20145 Milano (MI) Italy
T +39 02 89415508
brm-extremities.com

Headquarter

Via Privata ai Campi 7
23862 Civate (LC) Italy
T +39 0341 1693087
info@brm-extremities.com

TC-04A-002-B-EN-Rev00