The information contained in this document is intended for healthcare professionals only.
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GMRS Proximal Femoral Surgical Protocol

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Introduction
The GM RS Proximal Femoral Components are based on over a decade of clinical history. The neck length has been increased to improve range of motion and better meet the needs of various patient anatomies. The GM RS Proximal Femoral Components are fully compatible with all Stryker Cobalt-Chrome V40 femoral heads. GM RS is not indicated for use with any ceramic head. The components continue to be available in two configurations, standard and trochanteric, but are now also available in neutral, left and right anteverted orientations.
The stem options for the GM RS Proximal Femoral Replacement are unrivaled and are now available in both cemented and press-fit stem options. The cemented stems are available in six configurations: straight, curved and long curved, each type with or without extra-cortical porous-coated body sections. The press-fit stems are available in three configurations: straight fluted, curved and long curved.
Description of the Proximal Femoral Global Modular Replacement System

Proximal Femoral Components
The proximal femoral components are available in two styles, standard and trochanteric. The components are also available in three different configurations, neutral, left and right, for use with curved stems that may dictate the orientation of the component based on the anatomy of the femur. The left and right components incorporate 15° of anteversion. All components have a replacement length of 70mm, which is measured to the center of the standard length (zero offset) femoral head. The components accept Stryker femoral head implants with the 5°40’ taper (V40 femoral heads). The proximal femoral components have a 135° neck angle and fixation holes to reattach the abductor mechanism.

Extension Pieces
The extension pieces are used to extend the replacement length, and are available in 30mm through 80mm lengths in 10mm increments and 100mm through 220mm lengths in 20mm increments. This component features a male and a female taper to attach a stem to the proximal femoral component. The body segments have an overall diameter of 26mm. The extension pieces can be stacked to achieve the desired reconstruction length.
**Stem Components**

**Cemented Stems**

The cemented stems are available in two styles. The first style incorporates an extra-cortical porous-coated section with a 40mm replacement length. The stems are also available without the porous-coated section with a 11mm replacement length. The stems are available in the following diameters: 11, 13, 15 and 17mm. The cemented stems are available in both straight and curved configurations. They have a stem length of 127mm in both straight and curved configurations and have a stem length of 203mm in the curved configuration only. Optional cement centralizers are available for the 127mm long cemented stems. The cemented stems are manufactured from forged cobalt-chrome.

**Press-fit Stems**

The press-fit stems are available in three styles: straight fluted (125mm stem length), bowed (150mm stem length) and long bowed (200mm stem length). The press-fit stems have a 11mm replacement length. The stems are made of titanium alloy with titanium plasma spray. The proximal 3cm of the stem is coated with PureFix hydroxyapatite (HA). The stems are available in diameters 11-19mm in 1mm increments.

**Trial Components**

The implant system is complemented with a complete set of trial components. The trial components are replicas of their corresponding implants; however, they have non-locking trunnions. The metal trials are satin-finished so that they can easily be distinguished from the prosthesis. The extension piece trials are made of plastic. The 30mm extension piece trial can be mated with the trial cemented stems without the extra-cortical porous coating to trial for the cemented stems with the extra-cortical porous coating.
GMRS
Proximal Femoral Surgical Protocol

**Indications**

The Modular Replacement Systems are intended for use in patients requiring extensive reconstruction of the hip joint and or knee joint, including knee fusions, necessitated by extensive bone loss due to trauma. Failed previous prosthesis and/or tumor resection.

**Contraindications**

A. As related to Bone Tumors:
Not all bone tumors may be treated successfully by segmented resection. Any condition on that may have already resulted in either local or distant spread of the tumor may be a contraindication. Examples of such conditions include:

1. Pathological fractures;
2. Overt infection;
3. Inopportune placement of biopsy incision: and,
4. Rapid disease progression beyond a respectable margin.

Each patient must therefore be individualized and carefully evaluated by appropriate staging techniques prior to consideration of segmental replacement.

B. As related to Failed Previous Prosthesis and Trauma:

1. Any active or suspected latent infection in or about the operative joint.
2. Any mental or neuromuscular disorder which would create an unacceptable risk of prosthesis instability, prosthesis fixation failure, or complication in postoperative care.
3. Bone stock compromised by disease, infection or prior implantation, which cannot provide adequate support and fixation of the prosthesis.
4. HA coated stems are contraindicated in situations where bone stock is inadequate to support press for application.

See Package Insert for warnings, precautions, adverse effects and other essential product information.
GMRS Proximal Femoral Surgical Protocol

Global Modular Replacement System
Proximal Femoral Resection for
Large Segmental Replacements

This publication sets forth detailed recommended procedures for using Stryker Orthopaedics devices and instruments. It offers guidance that you should heed, but, as with any such technical guide, each surgeon must consider the particular needs of each patient and make appropriate adjustments when and as required.
Surgical Protocol

Measuring Resection Length

Pre-operative planning is imperative to determine the appropriate resection location and is typically measured from the tip of the greater trochanter. The proximal femoral template can be used to guide the resection to a level that can be reproduced by the available implants (Figure 1). The template has markings on both sides, which indicate the resection lengths for the various constructs. The lateral side of the template has markings, which indicate the resection lengths for an assembly including a stem with the porous-coated section. The medial side of the template has markings, which indicate the resection lengths for an assembly including a stem without the porous-coated section. The numbers (30, 40, 50, etc.) indicate the available extension piece lengths that can be inserted in between the stem and the proximal femoral component to achieve the desired resection length. If the desired resection length best lines up with the ‘N’ on the template, no extension piece is used, i.e., either stem style is assembled directly to the proximal femoral component. A 1/8” diameter drill can be inserted into the center of the femoral head. The template can then be placed over the drill pin to evaluate femoral head offset in addition to resection length. Once the desired resection length is determined, the anterior cortex of the femur is marked with a bovie or similar device to indicate the resection level.

Marking Anterior Aspect of Femur

A longitudinal line representing the anterior point on the femur should now be marked distal to the resection level to aid in rotational orientation of the prosthesis (Figure 2). A guide to the placement of this mark is the linea aspera on the posterior aspect of the femur. The anterior mark should be a line formed at the intersection of a sagittal plane passing anteriorly through the linea aspera and the anterior cortex of the femur.
Femoral Osteotomy
The remaining soft-tissue attachments around the femur are transected. A malleable retractor is placed medially to the femoral shaft to prevent inadvertent injury to the soft-tissue structures. An oscillating saw or other cutting device is used for the osteotomy (Figure 3). The cut should be at a right angle to the shaft. It is important not to distract the extremity following removal of the proximal femur in order to avoid placing tension on the sciatic nerve and the femoral vessels.

SURGICAL TIP: It is preferable to resect the femur a millimeter or two proximal to the marked resection level. This will allow the face reamer (see Figure 4) to plane accurately up to the mark at a 90° angle.

Dislocation of Hip
The hip is dislocated either anteriorly or posteriorly, depending on the approach used.

Cemented Stems
Preparation of the Femur
A flexible guide wire is inserted into the femoral canal. Flexible reamers are utilized to widen the canal to the appropriate diameter. To permit an adequate cement mantle, the canal should be reamed to 2mm larger than the selected stem of the prosthesis. A facing reamer is used to plane the osteotomy site so as to ensure direct contact and accurate seating of the prosthesis upon the cortices. The correct facing reamer size is selected for the chosen stem to prepare the osteotomy site for the radius on the stem at the stem/seat junction (Figure 4).
Preparation of the Femur (continued)
The chosen cemented stem trial is placed in the reamed femur to facilitate ease of insertion and appropriate cement mantle. If there is any difficulty, continue reaming until the trial fits freely in the canal, or reassess stem size. It is extremely important to verify the close apposition of the seat of the cemented stem trial to the proximal femoral cortex. Optional cement centralizers are available for the 127mm long cemented stems. The last size flexible reamer used corresponds to the diameter of the distal centralizer necessary for correct positioning of the stem tip.

Bipolar Head Sizing
A trial Centrax or UHR Bipolar femoral head prosthesis is chosen, based on the measurement taken from the femoral head that has been resected. The trial is utilized to test the “suction” fit of the head in the acetabulum. Full seating of the trial should be checked. It is important to pull the remaining capsular structures over the attempted head reduction to try to recreate the suction fit. The trial should however still move freely in the acetabulum.

**NOTE:** It is suggested that the detailed Surgical Technique for the Centrax or UHR Bipolar system be reviewed. If an acetabular component is being implanted, then the appropriate surgical technique should be reviewed.

Trial Reduction
The purpose of the trial reduction is to determine the ease of insertion of the femoral prosthesis and bipolar components prior to cementing, and to determine whether the length of the prosthesis is appropriate. If the prosthesis is too long, too much tension will be placed upon the neurovascular structures. If it is too short, stability can be compromised. The parts that must be assembled to articulate the proximal femoral trial include: the cemented stem trial, extension piece trial (when needed based on resection length), proximal femoral trial, femoral head trial, and bipolar head trial. Place the appropriate head trial on the proximal femoral trial. The femoral heads are available in multiple neck offset options. Choose the option which re-establishes leg length and joint stability. The assembled trial prosthesis is then placed into the femoral canal. Assemble the Centrax or UHR Bipolar trial onto the appropriate head trial; then reduce into the acetabulum (Figure 5).
Assembly of the Prosthesis (Cemented)
The femoral prosthesis consists of the cemented stem, extension piece (when needed based on the length of the reconstruction), the proximal femoral segment, and the femoral head. Check that the correct sizes of all components have been chosen before assembly. If necessary, it is acceptable to join two extension pieces to make up the necessary length.

When assembling a 127mm long cemented stem, the instruments used for the assembly of the prosthesis are the impaction tube, appropriate size impaction tube insert, 5-in-1 impactor and mallet.

NOTE: Before joining any of the tapers, make sure the male and female components are completely clean and dry.
Assembly of the Prosthesis (Cemented) (continued)

The cemented stem and extension piece are assembled first. The impaction tube insert corresponding to the stem diameter is assembled with the impaction tube base (Figure 6).

The cemented stem is placed into the impaction tube, and the extension piece body is mated with it (Figure 7). The femoral/tibial hole of the 5-in-1 impactor is placed over the taper of the extension piece (Figure 8), and impacted with several swift blows of the mallet to lock the tapers. Next, the proximal femoral component is inserted onto the extension piece and the shoulder of the proximal femoral component is impacted by placing the 5-in-1 impactor against it and impacting with several swift blows of the mallet (Figure 9).
Assembly of the Prosthesis (Cemented) (continued)

When assembling a 203mm long curved cemented stem, the instruments used for the assembly of the prosthesis are the impaction tube, appropriate size impaction tube insert, impaction support block and mallet (optional). The proximal femoral component is inserted into the impaction block. The extension piece, if required, is then inserted into the proximal femoral component and the cemented stem is either inserted into the extension piece or proximal femoral component. The impaction tube insert corresponding to the stem diameter is assembled with the impaction tube base and inserted over the stem.

The construct can be impacted together by either sliding the impaction tube over the stem as a slap hammer (Figure 10) or the impaction tube can be placed flush against the seat of the stem and impacted with several swift blows of the mallet (Figure 11). The appropriate femoral head is then impacted onto the proximal femoral trunnion. The Centrax or UHR Bipolar is placed onto the femoral head.
Implantation and Orientation of the Femoral Prosthesis

The femoral canal is thoroughly irrigated. A cement plug can be placed at the appropriate depth if the distal tip is still in the diaphysis. This depth is checked by inserting the trial femoral stem to verify complete seating. The femoral canal is again irrigated and dried. The soft-tissues, especially those that are near the neurovascular structures, are protected and packed off with wet lap pads. Surgical Simplex P bone cement is then mixed and injected into the canal to ensure complete filling of the canal. Some cement is then placed around the stem of the prosthesis.

**NOTE:** If a stem centralizer is not being used, plug the distal hole in the stem with bone cement. Failure to plug the hole may lead to increased porosity of the cement at the stem tip, where peak stress occur in the cement and may initiate cracks in the cement at the stem tip.

The orientation of the prosthesis is critical. As a guide to appropriate anteversion, align the rotational alignment mark on the femoral stem segment with the rotational reference mark previously made on the anterior cortex of the femur, and antevert the prosthesis 10° to 15°. The linea aspera can also be used as a guide. Construct an imaginary sagittal plane that passes directly anterior, originating from the linea aspera. If implanting a curved stem with an anteverted proximal femoral component, the assembly will not need to be rotated since the anteversion is built into the proximal femoral component. The prosthesis is then inserted into the femoral canal at the proper anteversion until the stem seat is flush with the host bone at the osteotomy site (**Figure 12**). Excess cement is removed from around the prosthesis. Care is taken to prevent cement from getting into the porous-coated area on the stem. The prosthesis is firmly held in place while the cement cures.

**CAUTION:** The prosthesis should be slowly inserted into the canal. Rapid insertion can pressurize the canal and can lead to a fat embolism which can be fatal immediately or in the post-operative period. The anesthesiologist should be alerted and prepared for this possible event.
Therefore, the surgeon may choose to additionally flexible ream 1mm to 2mm greater than the diameter of the intended stem or the surgeon may choose to implant a stem 1mm to 2mm smaller than the diameter of the final flexible reamer if cortical wall thickness is of concern. However, under-reaming is recommended by 0.5mm smaller than the stem size selected for implantation to ensure a press-fit of the stem depending on bone quality and surgeon preference and/or requirements. The stem trials can be used as a guide for selecting stem size and verifying complete seating of the implant. Note that the stem trials are 1.25mm smaller than the stem to be implanted. (i.e. Trial engraved 15mm is actually 14mm in diameter for trialing for a 15.25mm stem in a canal reamed to 14.5mm). Once a stem diameter is determined, the appropriate size facing reamer should be used to prepare the osteotomy to ensure direct contact and accurate seating of the prosthesis upon the cortices (Figure 14).

Flexible reamers should always be used with a guide wire for guidance and removal in the event the reamer becomes lodged.

NOTE: The GMRS Press-fit stems may not be appropriate for all resection levels. Extremely long or very short resections, where the majority of the stem length exists in the proximal or distal metaphysis, may not obtain a sufficient press-fit. The press-fit stem must be engaged in sufficient bone stock to support the device.

Press-fit Stems

NOTE:
The GMRS Press-fit stems may not be appropriate for all resection levels. Extremely long or very short resections, where the majority of the stem length exists in the proximal or distal metaphysis, may not obtain a sufficient press-fit. The press-fit stem must be engaged in sufficient bone stock to support the device.

Preparation for the 150mm and 200mm Bowed Press-fit Stems

Preparation of the Femur

Flexible reamers are used to prepare the intramedullary canal to accept the anteriorly bowed press-fit stems. To determine the appropriate size flexible reamer, it is necessary to know the stem diameter planned for preoperatively. Select the diameter of a flexible reamer starting with a size at least one to two millimeters smaller than the templated size. Use flexible reamers that are available in 0.5mm increments only. Progressively ream under power until resistance and cortical chatter is encountered (Figure 13). If good cortical contact is not achieved with initial reaming, increase the reamer diameter in 0.5mm increments until cortical contact is achieved. Ream until the desired stem length depth groove aligns with the femoral resection and the axial center of the canal. Mismatch of the implant curvature with the prepared canal may prevent the prosthesis from fully seating.
Trial Reduction
The appropriate size bowed press-fit stem trial should be assembled to the appropriate length extension piece trial, if required, and the proximal femoral trial. Recreation of leg length can now be verified, soft tissue tension elevated and circulation checked. The pulses are palpated distally. If the pulse is diminished, a shorter prosthesis is required. This will necessitate modifying the length of the prosthesis or removing additional bone from the femur. Range of motion of the hip joint is tested with the capsule pulled over the femoral head component. The prosthesis should be stable in flexion, adduction, and internal rotation. Fine-tuning of the prosthetic length can be performed with the selection of femoral head neck lengths available. As a guide to rotational orientation, align the rotational alignment mark on the stem trial with the rotational reference mark previously made on the anterior cortex of the femur (Figure 15). The linea aspera can also be used as a guide. The anteverted proximal femoral trials may need to be used since the orientation of the component may be dictated by the anatomy of the femur. If the evaluation identifies a rotation different than that already marked, an additional mark should be made or the rotation should be noted relative to the existing mark.

Stem Implantation
Once the appropriate size stem has been selected, the implant can be assembled to the Command stem inserter by threading the instrument into the end of the male taper of the implant (Figure 16). As the inserter is threaded into the implant it is important to align the key on the end of the inserter with the slot in the end of the male taper of the stem. The knob should be hand tightened until the instrument is fully seated within the countersink of the implant (Figure 17).
Stem Implantation (continued)

With the bow of the implant aligned in the same plane as the bow of the femur and the alignment mark of the implant in-line with the mark determined during trial reduction, the implant can be gradually impacted into the femur using the mallet (Figure 18). As the implant enters the femur and resistance increases, impaction may need to be halted temporarily to allow the cortices to relax. After a brief pause, impaction can be re-initiated until another segment of the stem enters the femur. Impaction may again need to be halted and the process repeated until the stem is fully seated. Orientation and rotation of the implant using the alignment mark must be monitored during the entire insertion process. The handle on the inserter can be used to guide or rotate the implant during insertion.

The progression of the press-fit stem into the canal should be monitored and should be consistent for each impact of the mallet. If the stem progression decreases significantly with each impact of the mallet, this may be an indicator that the stem is becoming lodged and may not be able to be fully seated. If too much resistance is encountered, the stem may need to be removed from the femur via impaction on the inserter or by removing the inserter and using the McReynolds slap hammer (Figure 19). The canal can then be reamed up by 0.5mm using the flexible reamers. Mismatch of the implant curvature to the femoral curvature may require repeating this process until the canal is reamed as much as 2mm larger than the stem diameter to be implanted.

**NOTE:** Much caution should be taken to prevent fracturing or splitting the femur. Prophylactic cabling may be required prior to impacting the stem to prevent fracture of the femur.

Proceed to page 22 for assembly of the press-fit prosthesis.
Preparation for the 125mm Straight Fluted Press-fit Stems

Preparation of the Femur

Designated press-fit trial/reamers are provided for the preparation of these stems. These trial/reamers are available in 0.5mm sizes and step in 1mm increments (i.e. 10.5, 11.5, etc.). To determine the appropriate size trial/reamer, it is necessary to know the stem diameter planned for preoperatively. Select the diameter of a trial/reamer starting with a size at least one and a half to two and a half millimeters smaller than the templated size, if possible. Insert the trial/reamer into the reamer driver and progressively ream under power until resistance and cortical chatter is encountered (Figure 20). If good cortical contact is not achieved with initial reaming, increase the reamer diameter in 1mm increments until cortical contact is achieved. These reamers/trials prepare the canal 0.75mm undersize from the stem diameter to be implanted because the implants are typically 0.25mm larger than their labeled size. The final diameter trial/reamer chosen should be inserted fully such that it also face reams the osteotomy to ensure direct contact and accurate seating of the prosthesis upon the cortices. This final diameter trial/reamer is disconnected from the power and left in the intramedullary canal as the trial stem.

Trial Reduction and Flute Preparation

The stabilization handle or a wrench can be used to rotate the trial/reamer counter-clockwise until the rotational alignment mark aligns with the mark previously made on the anterior cortex. An extension piece trial, if required, and the proximal femoral trial are then assembled onto the trial/reamer (Figure 21). Recreation of leg length can now be verified and circulation checked. The pulses are palpated distally. If the pulse is diminished, a shorter prosthesis is required. This will necessitate modifying the length of the prosthesis or removing additional bone from the femur. Range of motion of the hip joint is tested with the capsule pulled over the femoral head component. The prosthesis should be stable in flexion, adduction, and internal rotation. Fine-tuning of the prosthetic length can be performed with the selection of femoral head neck lengths available. If the evaluation identifies a rotation different than that already marked, an additional mark should be made or the rotation should be noted relative to the existing mark.
Trial Reduction and Flute Preparation (continued)

Once the rotation is determined, the extension piece trial, if required, and proximal femoral trial are removed from the trial/reamer leaving the trial/reamer at its orientation within the canal. The stabilization handle is inserted through the elongated hole perpendicular to the flats of the trial/reamer and held to prevent rotation of the trial/reamer during flute preparation. While holding the stabilization handle, the headless pin driver is used under power to insert the first flute drill through any one of the holes in the trunnion of the trial/reamer (Figure 22). This first drill is left in place to lock the rotation of the trial/reamer.

Additional flute drills are inserted into the remaining holes leaving each drill in place once it reaches its depth stop (Figure 23). Once all four drills have been inserted, each drill and the trial/reamer can be removed using the pin puller.

If the intramedullary canal has been reamed up using the 17.5 or 18.5mm trial/reamer, then the trial/reamer must be removed upon completion of the trial reduction and the appropriate size drill guide inserted and the flutes prepared using the drills and stabilization handle in the same manner mentioned above (Figure 24).
Stem Implantation
Once the appropriate size stem has been selected, the implant can be assembled to the Command stem inserter by threading the instrument into the end of the male taper of the implant (Figure 25). As the inserter is threaded into the implant it is important to align the key on the end of the inserter with the slot in the end of the stem. The knob should be hand tightened until the instrument is fully seated within the countersink of the implant (inset Figure 25).

With the alignment mark of the implant in-line with the mark determined during trial reduction and aligning the flutes with their respective preparation, the implant can be gradually impacted into the femur using a surgical mallet (Figure 26). As the implant enters the femur and resistance increases, impaction may need to be halted temporarily to allow the cortices to relax. After a brief pause, impaction can be re-initiated until another segment of the stem enters the femur. Impaction may again need to be halted and the process repeated until the stem is fully seated. Orientation and rotation of the implant using the alignment mark must be monitored during the entire insertion process. The handle on the inserter can be used to guide or rotate the implant during insertion.
Stem Implantation (continued)

The progression of the press-fit stem into the canal should be monitored and should be consistent for each impact of the mallet. If the stem progression decreases significantly with each impact of the mallet, this may be an indicator that the stem is becoming lodged and may not be able to be fully seated. If too much resistance is encountered, the stem may need to be removed from the canal via impaction on the inserter or by removing the inserter and using the McReynolds slap hammer (Figure 27). The canal can then be reamed up by 0.5mm using the full size reamers (Figure 28). A curette may be needed to remove any bone chips inserted into the four prepared flutes after additional reaming. Reaming up by more than 0.5mm should not be required.

**NOTE:** Much caution should be taken to prevent fracturing or splitting the bone. Prophylactic cabling may be required prior to impacting the stem to prevent fracture of the bone.
Assembly of the Prosthesis (Press-fit)
Once the stem is fully seated, the extension piece, if required, and the appropriate proximal femoral component, neutral, left or right, can be impacted onto the implanted stem using the 5-in-1 impactor and a mallet (Figure 29). Each component should be impacted onto the stem sequentially; first, the extension piece, if required, and then the proximal femoral component (Figure 30). This will ensure a better taper lock at each taper junction rather than assembling all of the components and impacting on the end of the construct.

**OPTION:** The entire implant construct including the press-fit stem can be assembled on the back table using the impaction support block. The Command stem inserter can be assembled into the proximal shoulder of the proximal femoral component (Figure 31). The assembly can then be impacted into the femur as a construct.
GMRS Proximal Femoral
Surgical Protocol

Appendices
APPENDIX I

Taper Disassembly
Should it be necessary to disengage an assembled taper joint, a taper separator is provided. The taper separator utilizes the mechanical advantage of a wedge(s) and lever arm to overcome the locking forces of the tapers and separator components. It is important that the separator be positioned so that the wedge(s) does not act against the anti-rotation tabs of the implants. The correct orientation is in an anterior-to-posterior direction. The implants are designed to withstand the forces generated by the separator in this direction. Placement of the separator wedges against the anti-rotation tabs may damage them, making disengagement difficult. The separator may be used via three different methods.

Method 1
The wedges are initially advanced by hand to bring them in contact with the implant at the joint to be disengaged. The wedges are advanced by turning the nut in a clockwise direction, until resistance is felt (Figure 35). The wedges are then further advanced, using the wrench end of the 5-in-1 impactor provided, until the tapers disengage.

Method 2
The wedges of the separator are advanced until they are sufficiently tight against the taper junction to be separated using the wrench end of the 5-in-1 impactor. A mallet can then be used to impact the chisel component of the separator. The separator is designed to allow the nut and chisel to travel a small distance when impacted to ease separation.

Method 3
The separator can be disassembled and the chisel component of the assembly can be used by itself to separate a taper junction (Figure 36). The chisel is inserted anteriorly at the location to be separated and impacted with a mallet until separation is achieved.

NOTE: Caution should be taken when disengaging any taper-locked joint. The high forces that hold a taper-locked joint together may result in a sudden and forceful action upon disengagement along the axis of the tapers.
APPENDIX II

Reconstruction of Hip Capsule and Abductor Mechanism

Once the permanent prosthesis is in place, the remaining hip capsule and abductors are reconstructed to ensure a stable prosthesis. The hip capsule is then sutured together. A 3mm Dacron™ tape is wrapped around the inferior portion of the capsule, forming a noose around the femoral neck. This is to provide immediate stability. The capsule can be reinforced by rotating the external rotator muscles proximally, and suturing them to the repaired capsule. The remaining psoas muscle can be rotated anteriorly to close and reinforce the capsular repair (Figure 37).

Reconstruction of Abductor Mechanism

If the entire bone has been resected, including the greater trochanter, the remaining abductors maybe brought down to the holes in the proximal femur with 3mm tape. The vastus lateralis can now be rotated proximally to overlie the abductor muscle fixation. Soft-tissue closure of the vastus lateralis to the abductor muscles is performed. The remaining muscles are sutured to the vastus lateralis anteriorly and the hamstrings posteriorly (Figure 38).
GMRS Proximal Femoral
Surgical Protocol

Implant Listing and
Resection Length Overview Chart
## Implant Listing

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<td>Extension Piece</td>
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<tr>
<th>Description</th>
<th>Diameter</th>
<th>Straight Stem with porous coated body section</th>
<th>Bowed Stem without porous coated body section</th>
<th>Long Bowed Stem with porous coated body section</th>
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</thead>
<tbody>
<tr>
<td>Cemented Stem</td>
<td>11mm</td>
<td>6485-3-011</td>
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<td>6485-3-311</td>
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<tr>
<td>Cemented Stem</td>
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<tr>
<td>Cemented Stem</td>
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<td>6485-3-715</td>
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<tr>
<td>Cemented Stem</td>
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<td>6485-3-017</td>
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<th>Diameter</th>
<th>Straight Fluted 125mm Length</th>
<th>Bowed 150mm Length</th>
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<td>Press-fit Stem</td>
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<td>Press-fit Stem</td>
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<td>Press-fit Stem</td>
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### Proximal Femur Resection Lengths

**Proximal Femoral Replacement Length with Neutral (zero offset) Head = 70mm**

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<tr>
<th>Extension Piece Length</th>
<th>Femoral Head</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Head Offset &gt; -4</td>
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<tr>
<td></td>
<td>Lateral Offset &gt; 31</td>
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### Proximal Femur Resection Lengths

**Proximal Femoral Replacement Length with Neutral (zero offset) Head = 70mm**

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<td>200mm</td>
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A surgeon must always rely on his or her own professional clinical judgment when deciding to use which products and/or techniques on individual patients. Stryker is not dispensing medical advice and recommends that surgeons be trained in orthopaedic surgeries before performing any surgeries.

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