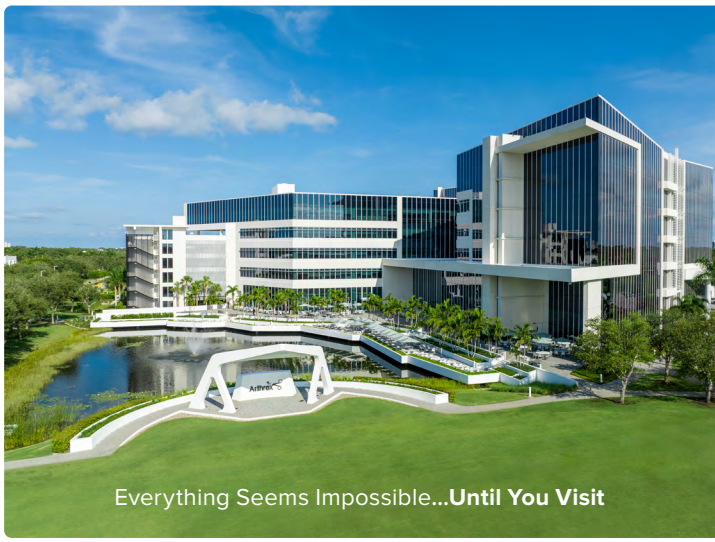
Arthrex Presents:

Breakthroughs in Trauma Innovation

OTA 2026



The Arthrex Trauma portfolio continues to evolve, delivering innovative products that support our mission of Helping Surgeons Treat Their Patients Better®. Through breakthroughs in upper and lower extremity trauma, we remain committed to providing surgeons with dynamic products designed to enhance patient care and procedural efficiency. Our dedication to medical education remains steadfast, with over 10 Trauma corporate courses available in the next year for a variety of training levels. We invite you to learn more about our course offerings and experience the Arthrex Destination Difference at our Naples, Florida, global headquarters.

This year, we introduced the NEW Syndesmosis TightRope® PRO implant and FibuLock® PRO fibular nail. We have preserved the proven biomechanical performance and clinical efficiency of these products, while enhancing workflow integration and select implant improvements to seamlessly incorporate them into your practice. Arthrex Trauma is also excited to showcase the NEW Variable Angle Proximal Tibial Plating System, Radial Head Replacement System, and anatomic proximal humeral plate alongside flagship innovations such as our trochanteric nail telescoping lag screw system with optional Trochanteric Biologic Augmentation System during the exhibit and workshops.

We are excited about the future as these breakthrough products join our innovative long bone nailing platform featuring the market's only left-threaded telescoping lag screw, minimally invasive soft-tissue fixation technologies, and a comprehensive Orthobiologics portfolio designed to enhance patient healing outcomes. We invite you to stop by our booth, Exhibit #409, as we are offering the hands-on 3DAnatomy™ Surgical Skills Suite showcasing these innovative products.



Michael Karnes
Director, Product Management
Foot & Ankle and Trauma

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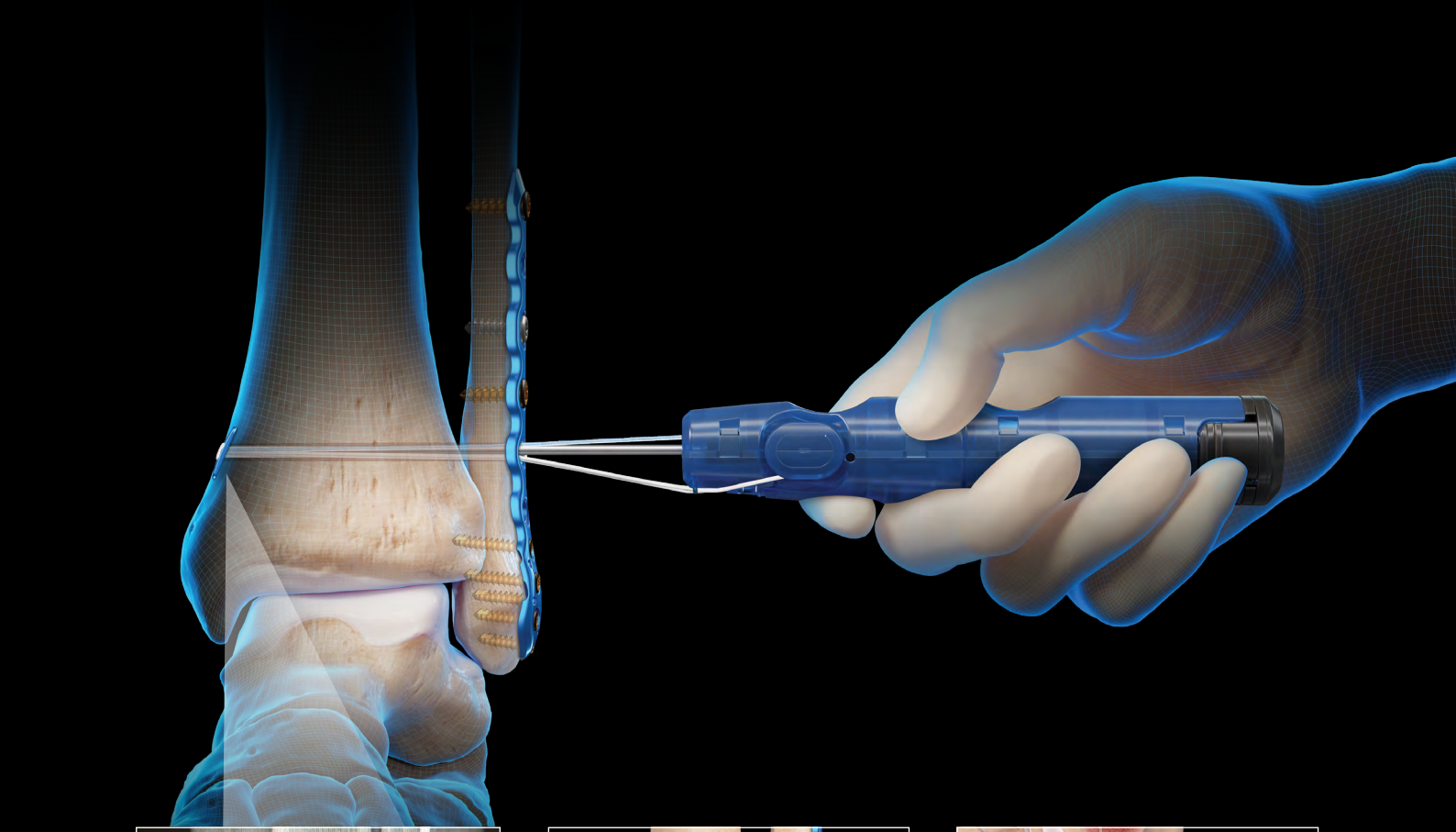
03	FibuLock® PRO Fibular Nail and Syndesmosis TightRope® PRO Implant
06	A Kitchen Sink Case
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11	Arthrex VA Proximal Tibial Plating System
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Arthrex®

Syndesmosis TightRope® PRO

Clinically proven knotless construct[1] with smaller drill tunnels and lower-profile buttons

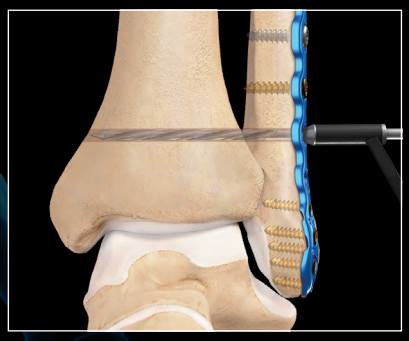
Expanding on the 20+ years of TightRope clinical efficacy, the TightRope PRO system features multiple upgrades to improve consistency and reproducibility.





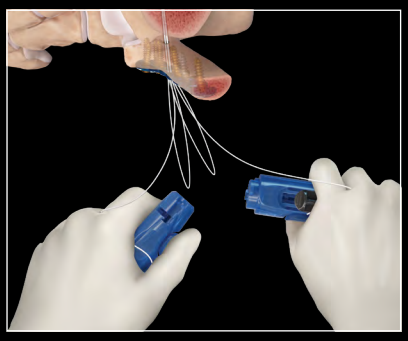
Lower-Profile Medial and Lateral Buttons

Decreases prominence and material



Smaller, 3.2 mm Drill

25% reduction in bone tunnel size



Integrated Tensioning Handles

Reduces surgical steps with streamlined suture management

Reference
1. Sanders D, et al. *J Orthop Trauma.* 2019;33(11):531-537. doi:10.1097/BOT.0000000000001559

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Going PRO Spotlight

FibuLock® PRO Fibular Nail and Syndesmosis TightRope® PRO Implant



Derek Donnegan, MD

What led you to adopt fibular nailing into your practice?
For me it started with the patients who kept me up at night after surgery—high-energy mechanism and the patient on the thin edge of a compromised soft-tissue envelope. In an unstable ankle fracture, those patients need stability, but a traditional lateral plate asks a lot of skin that often can't deliver, and wound breakdown or symptomatic hardware can turn a routine fracture into a limb-threatening problem. Fibular nailing gave me a way to get stable, load-sharing fixation through a small incision with minimal periosteal stripping—respecting the soft tissues instead of fighting them.

I started using the FibuLock nail in 2023. My entry point was the comminuted Weber C fibula fracture in a high-energy injury—the pattern where a lateral plate stresses an already-traumatized soft-tissue envelope, and where holding length, alignment, and rotation is the whole ballgame. The nail let me be soft-tissue–friendly and reliably maintain that reduction, and once I saw it deliver in those cases, I was sold.

How have fibular nailing and your applications evolved?
It started with those comminuted, high-energy Weber C patterns, but as my comfort and my outcomes grew, my applications broadened to include simpler fracture patterns as well. What really drives the decision now is the patient in front of me, especially the ones where I'm worried about the soft-tissue envelope or the bone quality. In those patients, the nail has moved from a bailout to a planned, first-line choice, regardless of how simple or complex the pattern looks on the X-ray.

What percentage of ankle fractures do you nail?
At this point I'm nailing roughly 60% of the fibulas I fix—and that number has climbed steadily as the technology and my comfort with it have grown.

What are your "must-nail" applications?
There are two patterns, for me, where nailing has become the default rather than the exception. The first is the comminuted Weber C fibula fracture, where an intramedullary construct holds length, alignment, and rotation better than a plate fighting through a traumatized soft-tissue envelope. The second is the fibula fracture in combination with an ipsilateral tibia fracture, where the nail gives me stable fixation without adding another demanding incision to a limb that's already had a lot done to it.

What makes the FibuLock PRO fibular nail your go-to implant for fibular nailing?
For me it comes down to control of the reduction and the quality of the distal fixation. The pull-to-length instrumentation lets me restore and hold length, alignment, and rotation intraoperatively under live fluoroscopy, and that's exactly the part of the reduction that's often hardest to get right with other constructs. On top of that, the distal end is where the FibuLock PRO nail really separates itself: up to four low-profile distal screw options let me tailor the construct to the fracture and get solid, customizable purchase distally, without the hardware prominence that can drive irritation and removal. The talon expansion adds intramedullary fixation on top of all of that, but it's the length control and the distal screw options that make the system behave predictably case to case and earn it a place as my workhorse.

How does the FibuLock PRO fibular nail elevate this procedure and build on the FibuLock legacy?
The PRO keeps everything that made the original work and sharpens the parts that matter most intraoperatively. It's built on the same clinically successful fundamentals, with 12% more talon expansion for even stronger canal fixation. The distal fixation options expand meaningfully—up to four distal screws and three syndesmotic options—so I can tailor the construct to the fracture instead of forcing the fracture to the implant. The zero-profile construct with headless interlocking screws addresses the prominence complaints that drive hardware removal. And the pull-to-length instrumentation lets me dial in length, alignment, and rotation under fluoroscopy in real time, with modular instruments and a longer 275 mm cannulated nail that extends my reach to more proximal fibula fractures.

What is the biggest advantage of the new system?
It's hard to name just one, because the advantages compound. The ability to reliably get length is at the top—that's the reduction problem the system solves best. On top of that, the lower-profile screws and the expanded distal screw options let me tailor the construct to the fracture and cut down on the prominence that drives hardware irritation. And the lower-profile jig that comes on and off easily makes the whole case smoother and faster intraoperatively. Together, that combination makes the PRO feel like more than an incremental improvement.

What adoption hurdles do you hear from peers, and what would you say to surgeons hesitant to nail routinely?
The hesitation I hear most is comfort with an indirect reduction—surgeons trained to open, reduce, and plate under direct vision can feel like they're giving up control. Close behind are questions about managing the syndesmosis through a nail and the usual "I've always plated and my results are fine."

I tell them to start where the decision is easy. Take the at-risk soft-tissue patient—the case where a plate genuinely worries you—and let the nail earn your trust there. The instrumentation on the PRO does the heavy lifting: pull-to-length restores length and rotation predictably, and the integrated syndesmotic options eliminate the tradeoff between a nail and proper syndesmotic fixation. The learning curve is real but short, and it's concentrated on the cases with the biggest payoff.

What excites you about the future of ankle fracture treatment?
The whole field is moving toward doing more while disturbing less—smaller incisions, less soft-tissue insult, earlier weight-bearing*, and improved. Fibular nailing sits right at that intersection, and as it integrates cleanly with advances like the Syndesmosis TightRope® PRO implant, I think we're heading toward a world where stable, soft-tissue–friendly fixation with a functional early recovery is the expectation, not the exception.

Case Highlights From My Practice

CASE 1

All-Percutaneous FibuLock® PRO Nail With Syndesmosis TightRope PRO Implant
Minimally invasive (MIS)—entirely percutaneous nailing

Patient
A 38-year-old woman presented with an unstable left ankle fracture.

Injury and fracture pattern
Distal fibula fracture and small posterior malleolar fracture with associated syndesmotic instability, confirmed on intraoperative stress examination.

Why I chose fibular nailing
I wanted stable fixation of both the fibula and the syndesmosis without a formal lateral incision. An entirely percutaneous approach let me respect the soft-tissue envelope while restoring length, alignment, and rotation, and the low-profile construct minimizes the hardware prominence patients feel over the distal fibula.

Construct and technique
FibuLock® PRO fibular nail placed percutaneously with distal interlocking fixation, and a Syndesmosis TightRope PRO implant for the syndesmotic injury. Reduction was confirmed under fluoroscopy with a stress examination.

Result
Post-op radiographs show an anatomically reduced fibula and syndesmosis with a restored, congruent mortise and a low-profile, headless construct.

CASE 2

Mini-Open, Clamp-Assisted FibuLock PRO Nail With Syndesmosis TightRope PRO Implant
Mini-open—percutaneous nail with clamp-assisted reduction

Patient
A 46-year-old woman presented with an unstable left ankle fracture with syndesmotic widening.

Injury and fracture pattern:
Ankle fracture dislocation with distal fibula fracture and small posterior malleolar fracture with syndesmotic widening and instability.

Why I chose fibular nailing
This pattern benefited from direct reduction control, so I used a mini-open incision to place a reduction clamp for anatomic reduction of the fibula and fixed it with a percutaneous nail. This gave me the reduction precision of an open approach with a smaller soft-tissue footprint than a full lateral plate, and the TightRope PRO implant handled the syndesmosis through the same low-profile construct.

Construct and technique
Mini-open, clamp-assisted reduction of the fibula, FibuLock PRO nail with distal interlocking fixation, and a Syndesmosis TightRope PRO implant. Length, alignment, and rotation were confirmed fluoroscopically.

Result
Post-op radiographs show a well-reduced fibula with a restored mortise and syndesmotic reduction, achieved through a soft-tissue-friendly, low-profile construct.

Case 1: Pre-op Imaging



Case 1: Post-op Imaging



Case 2: Pre-op Imaging



Case 2: Post-op Imaging



* Postoperative management is patient-specific and dependent on the treating professional's assessment. Individual results will vary and not all patients will experience the same postoperative activity level or outcomes.

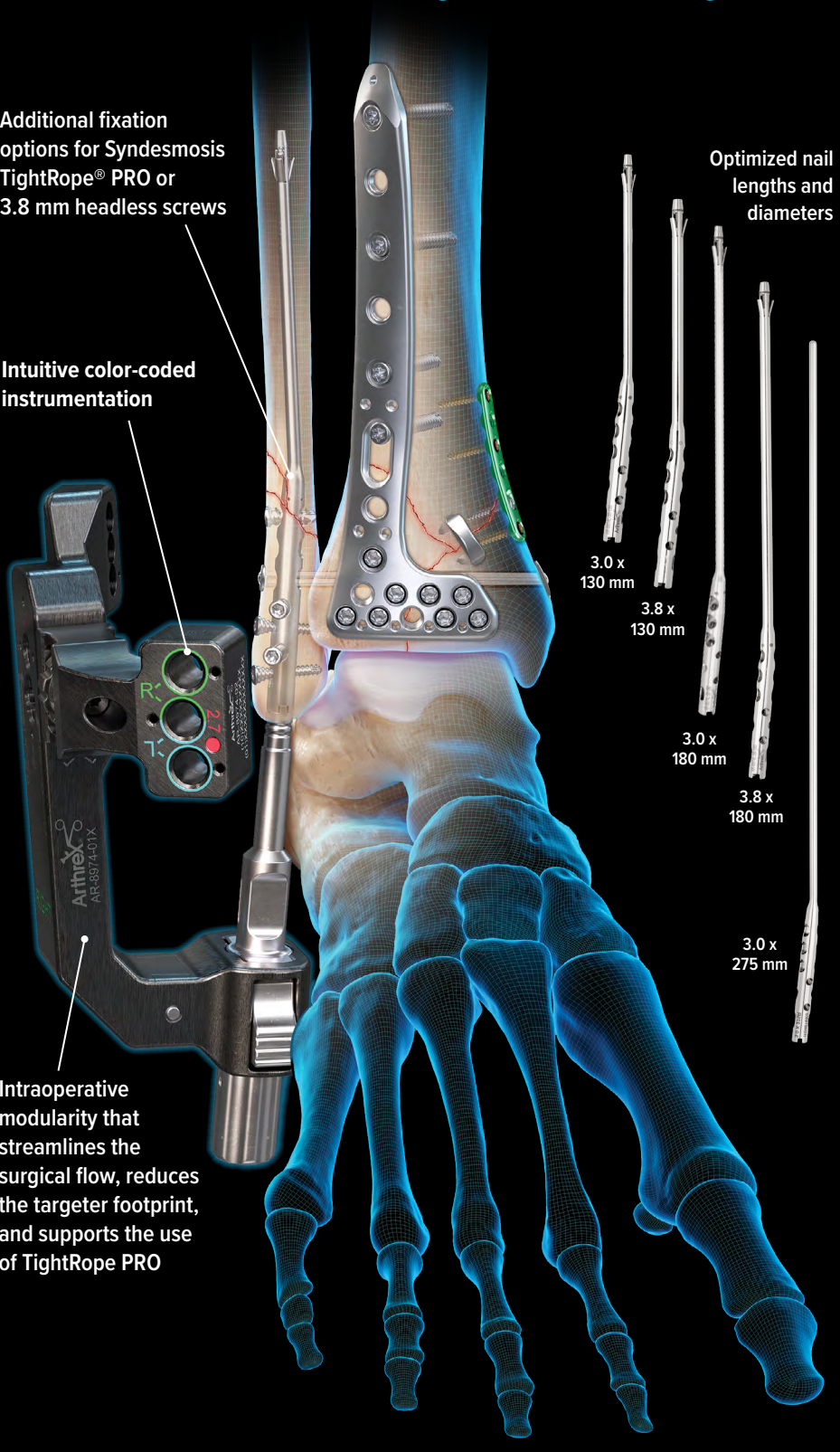
FibuLock® PRO

Arthrex Innovation—Advancing Fibular IM Nailing

Additional fixation options for Syndesmosis TightRope® PRO or 3.8 mm headless screws

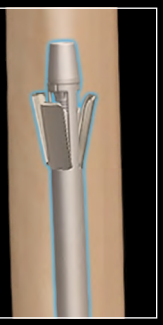
Intuitive color-coded instrumentation

Intraoperative modularity that streamlines the surgical flow, reduces the targeter footprint, and supports the use of TightRope PRO



Optimized nail lengths and diameters

FibuLock PRO talons deploy up to 12% wider[1]



Intraoperative length, alignment, and rotation adjustment



4 distal interlocking headless cortical screws



Optional 2- and 3-hole lateral buttress plates



Arthrex®

Reference
1. Arthrex, Inc. Data on file (APT-06396). Naples, FL; 2024.

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Arthrex Ankle Fracture Continuum of Care

A Kitchen Sink Case



William Harvin, MD

Patient

- 33-year-old female
- Right trimalleolar ankle fracture-dislocation
- Radiographs and CT demonstrated a closed trimalleolar ankle fracture with a Haraguchi type 2 posterior malleolar fracture.
- Significant swelling and posterolateral blisters, she was initially treated with closed reduction and splinting.

Planning

For most supination-external rotation ankle fractures with a moderate-sized posterior malleolar fracture, particularly when there is posterior ankle displacement, my typical treatment is fixation of all malleolar components via a posterolateral approach in the prone position supplemented with a small anteromedial approach for the medial malleolus. My typical sequence is ORIF of the lateral malleolar fracture with 2.0 mm lag screws, followed by ORIF of the posterior malleolar fracture with mini fragment or posterior malleolar plate buttress fixation, return to the fibular fracture for antiglide plating, and finally ORIF of the medial malleolus with lag screw fixation or another construct as dictated by the fracture pattern. My goal is anatomic restoration of the ankle mortise and syndesmosis with a sufficiently stable construct to permit early progression of weight-bearing after an appropriate period of soft-tissue rest, generally 2 to 3 weeks.

In this case, two factors caused me to modify my standard algorithm. First, the patient had resolving blisters over the posterolateral ankle, making my usual posterolateral approach less desirable. Second, the Haraguchi type 2 posterior malleolar fracture involves both the posterolateral and posteromedial ankle. In my experience, adequately buttressing both components contributes to a stable construct that permits early weight-bearing. Neglecting the posteromedial component can result in posteromedial ankle instability.

Posterior Malleolar Fixation—Mini Fragment + Titanium Ankle Fracture Plate

Due to the soft-tissue condition and fracture morphology, I elected to perform posterior fixation through a posteromedial approach in the prone position. The posteromedial fragment was reduced first followed by the posterolateral fragment. Provisional K-wires were inserted. Since the posterior fragments were relatively small, I selected a 2.7 mm T-plate from the Arthrex Mini Fragment System. The 2.7 mm system provided a relatively low-profile construct while still allowing multiple screw trajectories and plate configurations. The system includes a broad range of 2.0, 2.4, and 2.7 mm plates, including T-plates and wide T-plates, allowing the implant to be selected based on the individual fracture morphology rather than forcing the fracture into a predetermined plate design. In this case, the width of the 2.7 mm T-plate allowed me to span and buttress both posterior fracture components with a single plate. However, after fixation I felt that the posteromedial fragment was not quite adequately buttressed, so I supplemented the construct with a dedicated posteromedial distal tibia plate. I generally try to avoid placing a plate within the posterior tibial tendon (PTT) groove. The Arthrex posteromedial distal tibia plate is particularly useful for this fracture pattern because it has a tapered profile intended to minimize soft-tissue irritation, particularly in regards to the PTT.



Lateral Malleolar Fixation—FibuLock® PRO Nail

The lateral malleolar fracture was minimally displaced, so rather than a more extensile approach needed for traditional plate fixation, I used a small direct lateral approach centered over the fracture. The fracture was reduced and held with a pointed reduction clamp. Retrograde nailing was performed with the FibuLock PRO nail. After completing fixation, the pointed clamp was removed, and there was still some instability at the fracture. Therefore, I supplemented with cerclage.

Why and When I Nail

Fibular nailing has become an increasingly important part of my practice. While I still predominantly use plate fixation, there are several applications in which I find intramedullary fixation particularly attractive. The first is the comminuted fibular fractures in which maintaining length and rotation can be challenging with minimally invasive plating. The second is a patient in whom

minimizing additional soft-tissue dissection is particularly important. These situations may include patients with significant traumatic soft-tissue injury, fracture blisters, compromised skin, or elderly patients with limited soft-tissue tolerance.

The new FibuLock® PRO nail provides several features that are particularly useful in these situations. Two improvements from the first-generation implant stand out. First, the FibuLock PRO implant has the ability to obtain and maintain fibular length during nail insertion. In comminuted fractures, passage of an intramedullary device can otherwise result in shortening or rotation of the fibula. The PRO system incorporates an integrated pull-to-length technique that allows the surgeon to restore and maintain length and rotation before final deployment of the proximal fixation. Arthrex also increased the opening width of the proximal talons compared with the original FibuLock design, providing improved proximal fixation and rotational control. Second, the PRO system has three syndesmotic options, which can simplify syndesmotic implant insertion around multiple tibial implants.

Medial Malleolar Fixation

I then flexed the knee to 90° and performed a small anteromedial approach. After reduction, the medial malleolar fracture demonstrated a shearing tendency with lag screw fixation alone. I therefore removed the lag screws, added a 2.7 mm Mini Fragment System antiglide plate and then reinserted the lag screws.

Again, the Arthrex Mini Fragment System is particularly useful for this type of fixation because the 2.7 mm plates provide a low-profile option in relatively subcutaneous locations. Their low-profile heads make it possible to place a plate directly over lag screws without creating excessive implant prominence. Independent lag screws allow for interfragmentary compression while adding a plate provides antiglide or neutralization without creating a substantially bulky construct.

Syndesmotic Stabilization

Finally, the ankle was stressed under fluoroscopy to assess syndesmotic stability. The instability was subtle. Although one could reasonably debate whether fixation was necessary, given the complexity of the injury and my goal of creating a construct stable enough for early rehabilitation, I elected to stabilize the syndesmosis with a TightRope® PRO implant.

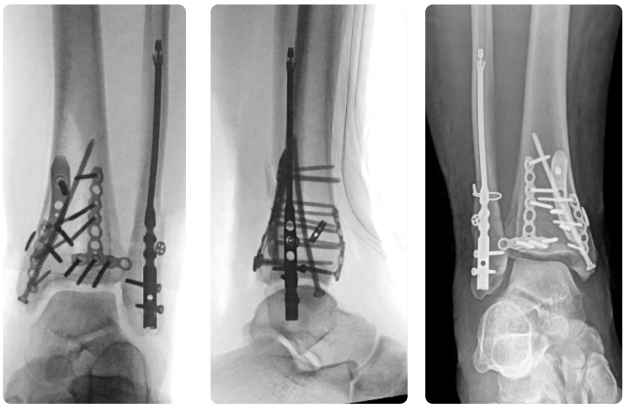
The TightRope platform provides a useful alternative to traditional rigid syndesmotic screw fixation. Rather than rigidly locking the distal tibia and fibula together, the suture-button construct permits controlled physiologic motion of the syndesmosis following reduction. The newest TightRope PRO system further reduces the implant profile and incorporates a smaller 3.2 mm drill tunnel, integrated tensioning handles, and a self-centering lateral button. These features are particularly attractive in the ankle, where soft-tissue coverage is limited and minimizing implant prominence is desirable.

In this case, the TightRope PRO implant provided a relatively low-profile method of augmenting the syndesmosis without adding another rigid screw across the distal tibiofibular joint.

Final Construct

At completion of the procedure, the ankle mortise was restored with anatomic reduction of all malleolar fracture components and the syndesmosis.

This case demonstrates the comprehensive Arthrex foot and ankle portfolio. The value of these systems is less about any individual implant and more about the ability to build a patient-specific construct around the fracture morphology and associated soft-tissue injuries. In this patient, the combination of fragment-specific, low-profile fixation, minimally invasive fibular nailing, and dynamic syndesmotic stabilization allowed me to address a complex trimalleolar fracture while avoiding the compromised posterolateral soft tissues.

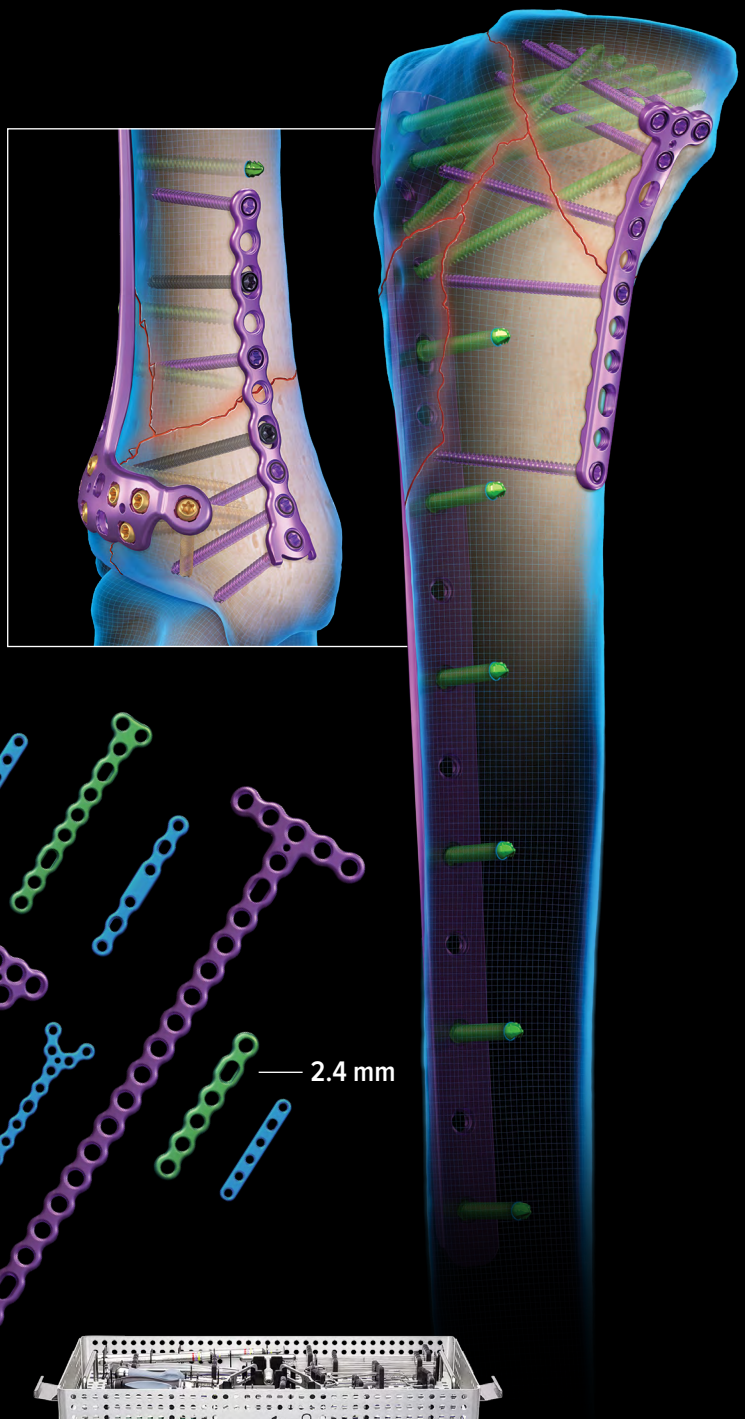


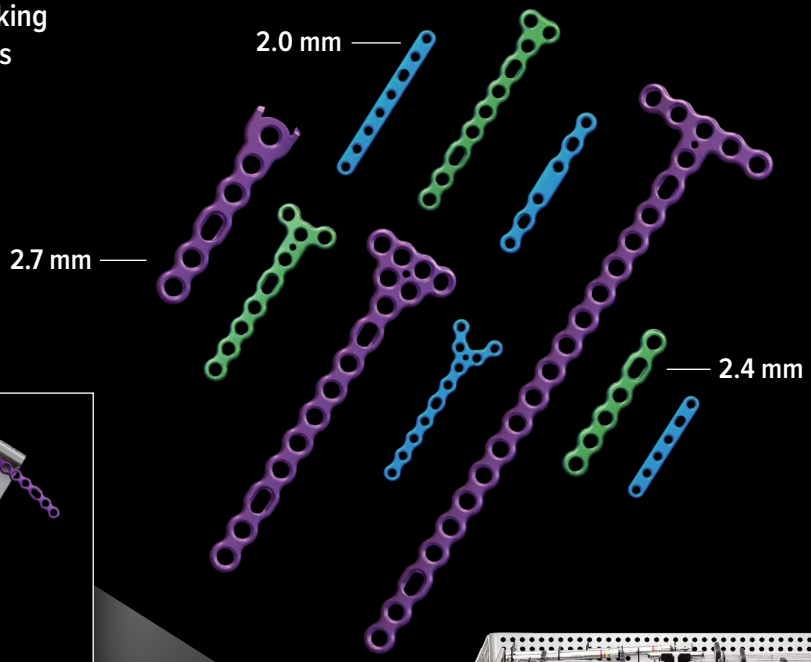
Arthrex Mini Fragment System

Aiding in the reduction and fixation of small and long bone trauma

The Mini Fragment System offers screw and plate options in 2.0 mm, 2.4 mm, and 2.7 mm sizes.

- 60 different plate sizes and styles fit a multitude of trauma needs
- Screw lengths range from 6 mm to 80 mm and are compatible with KreuLock™ locking compression screws







Comprehensive Bending and Cutting Options



Mini Fragment Tray

Arthrex®

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Product Highlight

JumpStart® Pin Site Dressing Kit for External Fixation



JumpStart antimicrobial wound dressing is an advanced dressing for the management of surgical incision sites. Microcell batteries made of elemental silver and zinc generate an electrical current when activated by conductive fluids. These microcell batteries create microcurrents to support the body's natural electrical healing process and to provide antimicrobial protection to assist with wound healing.





Reduce the Risk of Pin Tract Infection With JumpStart® External Fixator Pin Site Dressing Kit

- Three-component pin site wound dressing kit
- Wraps easily around 4 mm, 5 mm, and 6 mm fixation pins
- Fits flush around pins without gapping or tenting
- Excellent absorption speed, wicking, and moisture retention
- Fixation clip is easy to grasp and slide down pin
- Maintains placement of the dressing in situ

Complications from PTI may include[2,4,5]:

- Delayed bone union
- Joint or fracture site contamination
- Pin loosening, which may lead to loss of fixation, loss of alignment, and/or frame instability
- Vessel or nerve damage
- Pain and limited patient function
- Abandoning external fixator treatment
- Osteomyelitis

> **Pin-tract infection (PTI) is the most commonly expected problem... when using external fixation[1]**

> **Complications could be devastating if it leads to the failure of the bone-pin interface[2]**

27.4%
Composite rate of PTI in patients of all ages with external fixation[3]

4%
Incidence of deep-tissue infections and osteomyelitis[4]

JumpStart dressings have been shown to be effective against *Staphylococcus aureus*, the most common cause of PTI[5,6]

Better with BIO™

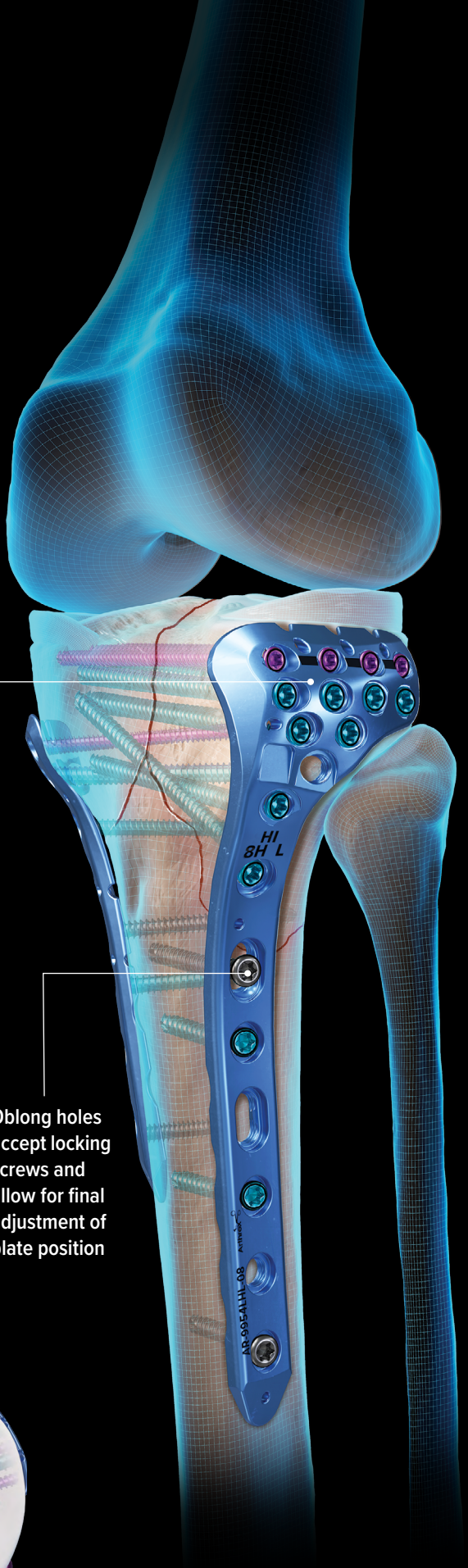
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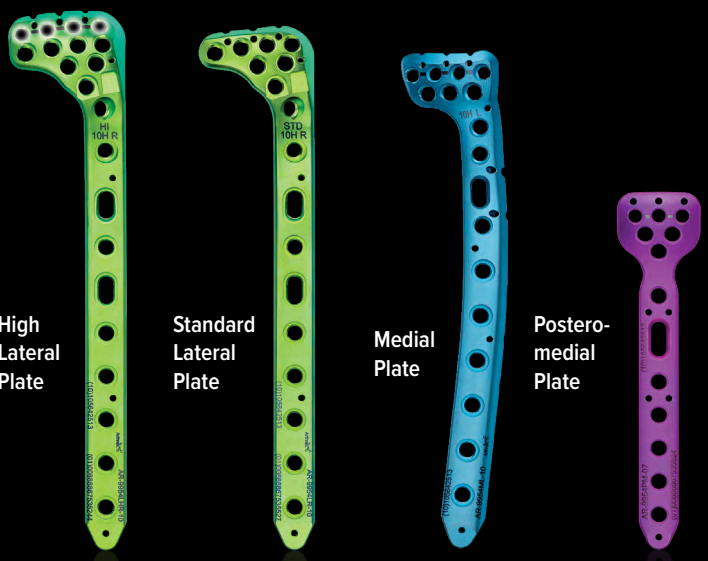
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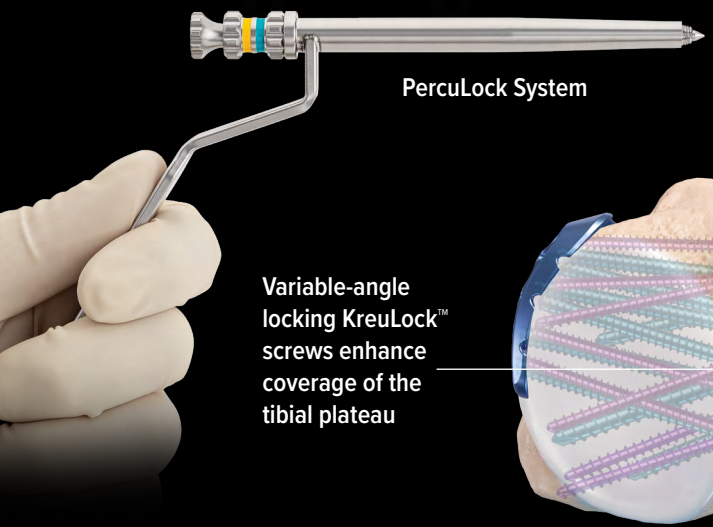
Arthrex Variable Angle (VA) Proximal Tibia Plating System

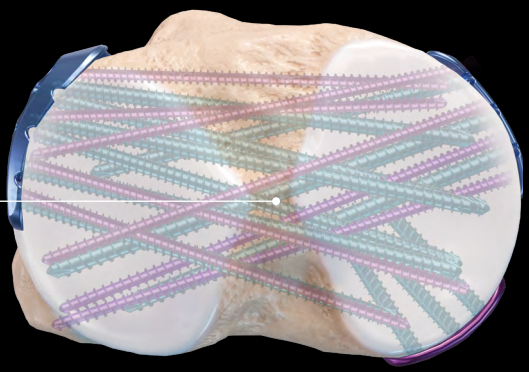
Versatile, anatomically contoured plates for all proximal tibia fractures

- Comprehensive system with 4 anatomic plate styles
- Cortical and variable-angle locking screws up to 80 mm by 2 mm increments
- Suture holes easily incorporate soft-tissue repair
- PercuLock™ system allows for minimally invasive percutaneous screw insertion









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Feature Article

Arthrex VA Proximal Tibial Plating System



John Munz, MD

Fractures of the tibial plateau can be challenging injuries in which surgeons must provide anatomical reduction of the articular surface, maintenance of alignment, and stable fixation to optimize surgical outcomes. Plating solutions for these injuries initially were nonanatomical plates with nonlocking screws applied in a buttressing mode. Difficulties in applying these plates revolved around contour, fit, and plate prominence. With nonlocking screws, issues with screw toggle and failure led to loss of reduction with the inability to maintain angular stability, especially in osteoporotic bone. Although the principles of fracture fixation remain the same, plates have now evolved to anatomical plates with angular stable locking screws to address different fracture patterns involving the knee. Limitations of current devices on the market include plate fit, type, and sizes of screws available for fixation and limited instrumentation to facilitate ease of insertion.

Why and how does this new Arthrex system represent a significant advancement in treatment?

The Arthrex VA Proximal Tibial Plating System offers advancements in the number and types of plates to address all fracture patterns about the proximal tibia. For lateral plating options, standard and high versions offer unique solutions for lateral condyle injuries. The high-version plate provides a subchondral fit to allow rafting screws immediately beneath the articular surface, eliminating the need for separate rim plate fixation. The anatomic medial plate and posteromedial plate provide solutions for the medial condyle depending on the fracture exit points. The direct medial plate follows the natural contour of the tibia in both coronal and sagittal planes. For coronal plane fractures exiting the posterior tibia, the posteromedial plate allows buttressing and contour ability for accurate plate placement. The types and sizes of screws available provide surgeons with a complete armamentarium for fracture fixation. Screw design offers both nominal and variable-angle technology for surgeons as well as a full complement of screw lengths and diameters. The instrumentation allows for ease of insertion and eliminates challenging steps when applying implants. The drill guides are all color-coded to match the corresponding drills for the different screws available. This set offers surgeons the complete package, maximizing plate design, function, and fit. The instrumentation is intuitive for the surgical team for seamless integration in the operating room.

How will the new system influence your approach?

The Arthrex VA Proximal Tibial Plating System allows fragment-specific fixation while respecting local soft tissues to allow surgeons to address the fracture pattern as well as repair soft-tissue injuries. This allows surgeons to provide anatomical reduction and stable fixation, while supporting early active range of motion. The precise fit of the plates provides better options for difficult fractures as well as the ability to preserve and augment soft tissues.

Case Highlights From My Practice

CASE 1

A 38-year-old male had an isolated status post fall down stairs. The Arthrex high lateral plate was used and provided an anatomic proximal fit to the lateral plateau, allowed for smaller 2.7 mm screw placement directly under the articular surface.





What sets our system apart from others?
The Arthrex VA Proximal Tibial Plating System is differentiated by offering plates with precise fit while still allowing contouring to accommodate differences in patient osteology. Other plating systems include anatomic plates but are limited by poor fit and rigidity, thus making application less than ideal. Another differentiating factor is the complement of screws including variable-angle as well as nominal-angle screws. This is coupled with the ability to use KreuLock ™ technology to an advantage. The instrumentation is also an added benefit to the system. The PercuLock™ system facilitates percutaneous screw insertion without adding wasted steps to the workflow. This allows more precise screw placement while using fluoroscopy. Multiple different drill guides and soft-tissue protection sleeves are also available to accommodate different surgical needs and preferences.

Top 3 surgical tips for a successful case and outcome?

1. **Reduction Priorities:** Obtaining and maintaining an anatomical articular reduction, maintenance of axial and rotational alignment, restoration of condylar width, and obtaining knee stability are paramount.
2. **Addressing Bone Voids:** Knowing what you will use to fill a void, whether it is allograft (BoneSync™ fillers) or a synthetic product (Quickset™ cement) is important. The Arthrex Biologic options provide multiple solutions for these voids and are important to address in the surgical reconstruction.
3. **Management of Soft Tissues:** Managing meniscal pathology and ligamentous injury is important to optimize outcomes. The full complement of Arthrex repair techniques should be used to address these injuries. Plate design allows seamless incorporation of suture repairs into final constructs.

In your practice, what are important postoperative considerations for optimal outcomes?
The Arthrex VA Proximal Tibial Plating System equips surgeons with the ability to provide stable fixation and address soft tissues to allow early range of motion to prevent stiffness and improve functional outcomes.

How this system improves upon previous plating solutions?
This system improves on previous plating solutions in many areas. First, true anatomic plate design. Other systems tout anatomic fit, but this does not translate for most patients. Also, having a plating system with soft tissues in mind provides options for soft-tissue repair and augmentation. The design took feedback from high-volume surgeons who are commonly tackling these complex injuries to address the current limitations of other plating systems. Every instrument in the set is well thought out to maximize efficiency while reducing implant application challenges. This system lets surgeons prioritize what matters, especially obtaining and maintaining reductions, while optimizing outcomes.

Any final comments about the system as a whole?
The Arthrex VA Proximal Tibial Plating System is pragmatic and easy to use, offering precision engineering and intuitive instrumentation to provide surgeons game-changing solutions for complex proximal tibial injuries in my practice.

CASE 2

A 42-year-old male had an isolated injury of status post fall from an electric scooter. Following external fixation, I was able to use the Arthrex VA Proximal Tibial Plating System. The medial plate provided an anatomic proximal fit to the medial plateau alongside soft-tissue repair holes for MCL/pes anserine repairs as needed.



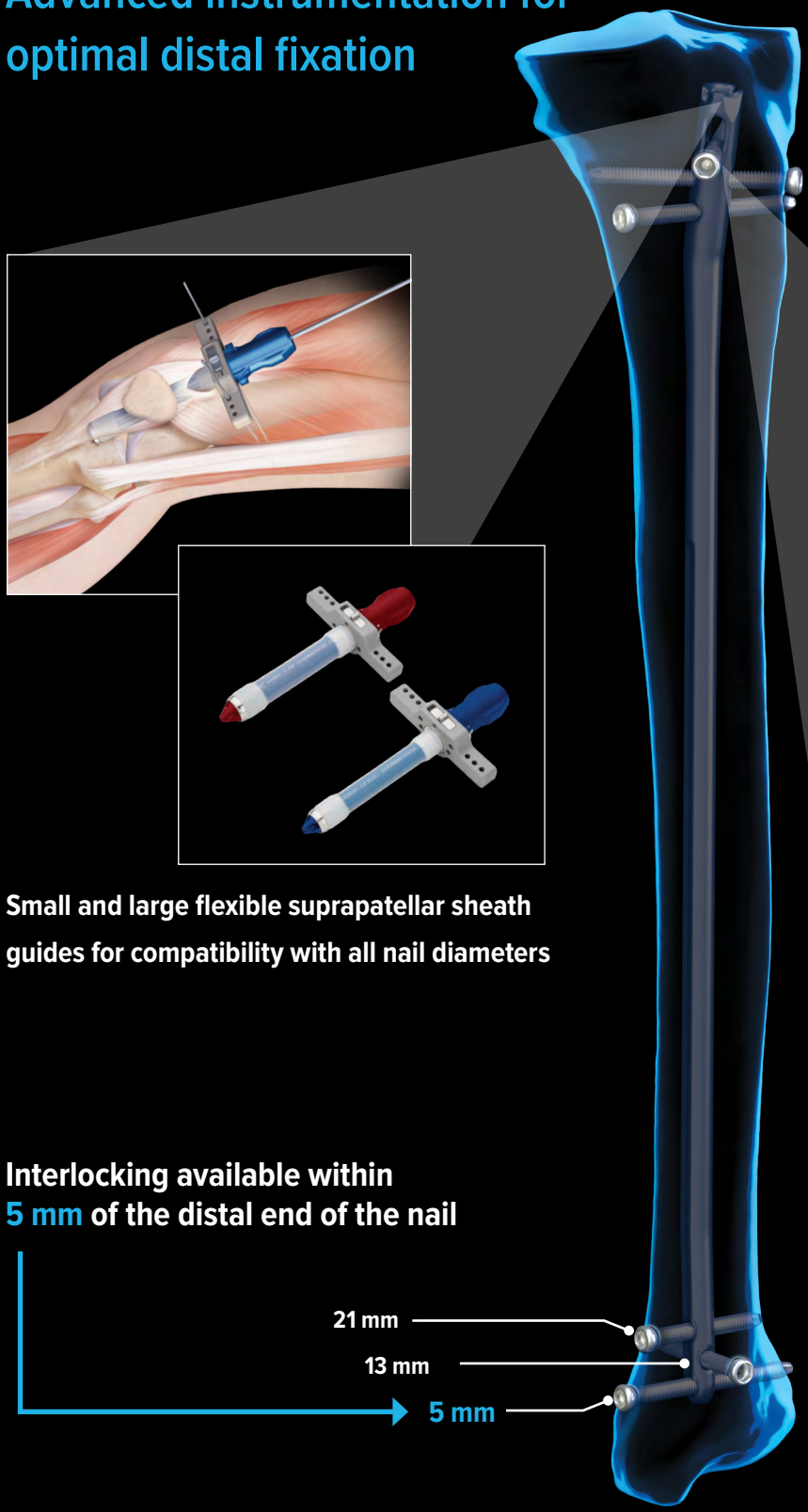






Tibial Nail System

Advanced instrumentation for optimal distal fixation



Statically locked threaded screw holes and 1 slot for fracture dynamization

Small and large flexible suprapatellar sheath guides for compatibility with all nail diameters



Up to 8 mm of intraoperative compression[1]

Interlocking available within 5 mm of the distal end of the nail

21 mm

13 mm

5 mm

Reference

1. Advanced Orthopaedic Solutions, Inc. AOS tibial nail. FDA 510(k) premarket notification. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm?ID=K070444.

Arthrex®

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When You Treat Hip Fractures… Think Arthrex

The Arthrex trochanteric nail is a next-generation hip nail that addresses the shortcomings of current systems, such as lag screw irritation, workflow inefficiencies, and loss of rotational reduction.



Left-Threaded Telescoping Lag Screw

Unique to Arthrex, the left-threaded telescoping lag screw incorporates a reverse thread form allowing for counterclockwise insertion. In the presence of rotational instability, the use of this lag screw option may prevent loss of reduction during insertion in left-sided hip fractures.



Three Innovative Implant Offerings

- Short nail, long nail, and the unique extended short (ES) nail
- ES nail combines the mechanical advantages of a long nail with the ease of a short nail
- Anti-rotation screw option available for all three nails





Better with BIO™

Streamlined Biologic Augmentation

Designed to deliver bone graft material uniformly around the lag screw, the Arthrex Trochanteric Nail Augmentation System streamlines the application of various flowable bone grafts in a single kit.

Arthrex®

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Femoral Fracture Case Roundtables

Arthrex Antegrade Femoral Nail, Arthrex Retrograde Femoral Nail, and Arthrex Trochanteric Nail

CASE 1



Alexander M. Crespo, MD

Patient
68-year-old | Fall down stairs

Injury and fracture pattern
Sagittal-plane intra-articular split with comminuted metaphysis

Highlights
The intra-articular fracture was reduced under direct visualization and compressed with Arthrex Mini Fragment screws positioned outside the nail path. Length, alignment, and rotation were restored, then provisionally maintained with 2.7 mm Mini Fragment plates. A reamed Arthrex retrograde intramedullary nail was inserted and statically locked using robust 6.5 mm screws.

Key product features that helped with this case:

- **6.5 mm cancellous bolts:** Designed for distal fixation purchase in osteoporotic bone, with a larger diameter that supports bending strength and fatigue resistance
- **4 threaded distal holes:** Provide angular stability and help prevent screw back-out through threaded screw-to-nail interfaces
- **Posterior condyle targeting:** Provides additional trajectories to support distal fragment control
- **Up to 7 mm axial compression:** Enables controlled compression at the oblong hole when fracture morphology permits
- **Threaded nut + washer:** Provides an option to compress selected intra-articular fracture patterns
- **Mini Fragment integration:** Allows independent articular reduction and provisional alignment to remain clear of the nail path

Pre-op Images



Post-op Images



CASE 2



John Munz, MD

Patient
55-year-old | High-speed motorcycle collision

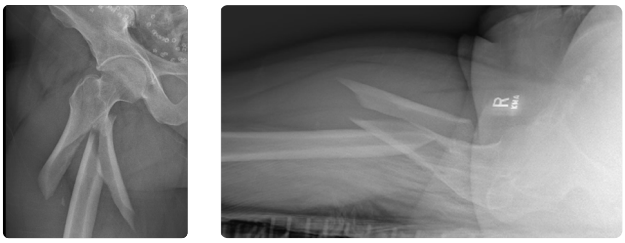
Injury and fracture pattern
Closed injury, High-energy multifragmentary proximal femur fracture

Highlights
This multi-fragmentary fracture presented challenges for restoration of length, alignment, and rotation secondary to the amount of fracture displacement. Gross length was restored using traction, and the fracture was openly reduced with the assistance of clamps and maintained with FiberTape® Cerclage to allow nail placement. Following nail placement, many options were available for proximal fixation. A configuration of two reconstruction screws and a single transverse screw was used to fully secure the proximal component.

Key product features that helped with this case:

- **Flexible proximal locking:** Multiple proximal locking options that can be tailored for fixation of the proximal segment depending on fracture configuration
- **Screw options:** Offer different diameters and screw types to provide intraoperative fixation flexibility
- **FiberTape Cerclage:** Provides a low-profile adjunct for reduction and fragment containment during nail passage

Pre-op Images



Post-op Images



CASE 3



John D. Adams, MD

Patient

49-year-old | Motor vehicle accident

Injury and fracture pattern

Combined intertrochanteric fracture and comminuted segmental femoral shaft fracture

Highlights

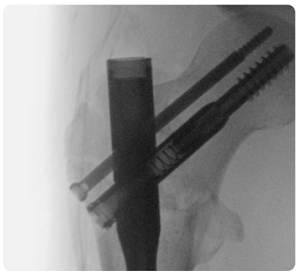
The intertrochanteric component was first addressed with provisional reduction of the head and neck segment. The Trochanteric Nail System allowed me to readily use an anti-rotation screw for additional proximal rotational control alongside the telescoping lag screw, which implores a self-contained and controlled collapse. The femoral shaft component was brought out to length utilizing traction and rotationally assessed through the nail's featured anteversion and contralateral limb comparison.

Key product features that helped with this case:

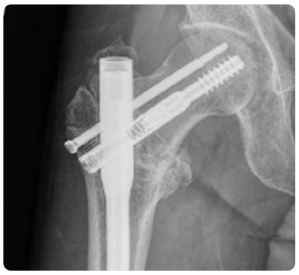
- **Anti-rotation screw:** Provides additional proximal rotational control and is readily available within the surgical workflow
- **Telescoping lag screw:** Enables self-contained, controlled fracture collapse
- **Lateralized workflow:** Allows locking through the inserter and use of captured distal screws



Preoperative Imaging



Proximal Intraoperative



Postoperative View



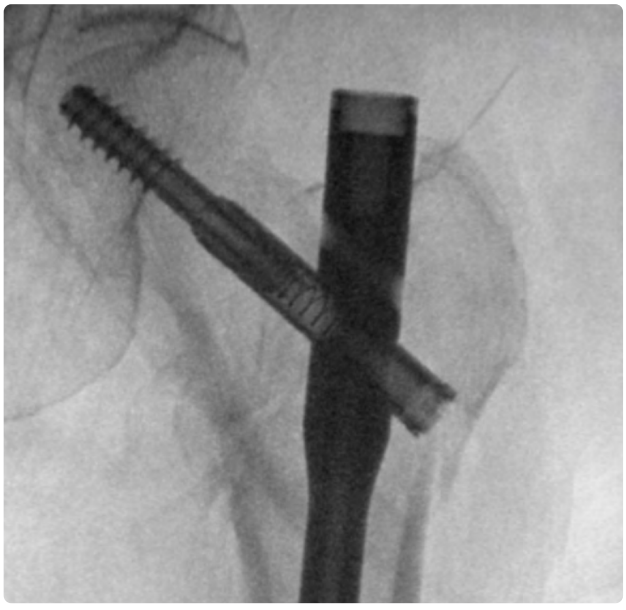
AP Shaft Follow-Up

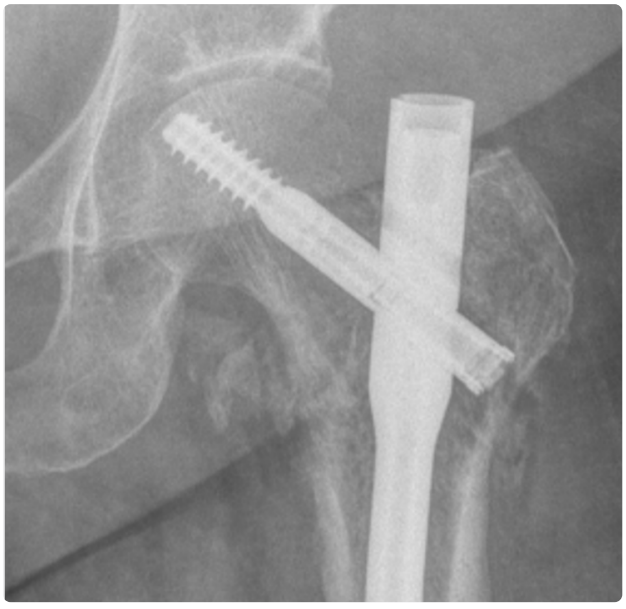


Lateral Shaft Follow-Up

Telescoping Lag Screw Technology: In Action

Whether selecting the long, short, or ES nail, portfolio flexibility with the Arthrex Trochanteric Nail System gives way to selecting the optimal construct for the patient and fracture. The telescoping lag screw technology is available for each construct, providing a self-contained collapse to prevent lateral lag screw irritation.





Telescoping Lag Screw
Self-contained controlled collapse

Product Highlight

Arthrex Platelet-Rich Plasma Processing Solutions

Arthrex offers a comprehensive lineup of distinctive platelet-rich plasma (PRP) processing solutions, including the Angel® concentrated platelet-rich plasma (cPRP) system, the Arthrex ACP® double-syringe system, and the ACP Max™ system. Each system offers the unique benefit of creating a PRP formulation to meet your procedural needs.

Angel System
Customize and automate your PRP formulations with a single touch. The Angel system can process 40 to 180 mL of whole blood (WB) or bone marrow aspirate (BMA).

Learn More

Arthrex ACP Double-Syringe System
Conveniently process up to 15 mL of WB for quick and safe PRP preparation.

Learn More

ACP Max PRP System
Effectively produce a PRP solution with up to 12× increase in platelet concentration from 30, 60, or 90 mL of WB.[1-3]

Learn More



Arthrex Bone Marrow Recovery and Processing Solutions

Featuring a unique design that facilitates precise depth and directional control, the **Vortex™ threaded recovery needle** allows users to reposition the tip easily and accurately within the bone to optimize bone marrow aspiration.

BMA harvested with the Vortex needle can be further processed with the Angel system to concentrate platelets and nucleated progenitor cells.

Learn More



Available in both 8 ga and 13 ga open- and closed-tip options

Better with BIO™

References

1. Arthrex, Inc. Data on file (APT-5368). Naples, FL; 2021.
2. Arthrex, Inc. Data on file (APT-5535). Naples, FL; 2022.
3. Arthrex, Inc. Data on file (APT-5756). Naples, FL; 2022.

Roundtable Feature Article

DynaNite® Staples in Trauma Surgery and Next Generation Advancements in DynaNite® Staple Technology



Erik Kubiak, MD



Andrea Attenasio, DO

The DynaNite staple line offers excellent fixation options, while focusing on providing continuous compression across the fracture or fusion site. With 20 different bridge lengths and widths, Arthrex's comprehensive staple portfolio provides versatility by design to aid in quick and efficient fracture reduction without the hassle of applying and navigating through clamps or drilling and measuring for screws.

What led you to begin using DynaNite staples?
For many years, we relied on traditional fixation methods such as lag screws and mini plates, along with reduction and fixation techniques focused on obtaining and maintaining fracture reduction. Those principles hold true for many fracture patterns, but certain transverse or butterfly fracture patterns can be more challenging, as they are not always amenable to lag screw fixation and can gap when a plate is applied. These fracture patterns are what first led me to see the efficacy and benefits of DynaNite staples. They served as an initial fixation solution to maintain continued compression of these transverse fractures, where a lag screw would not have worked.

DynaNite staples are a product that may not be encountered in early residency or fellowship training, but once seen, their use makes sense from a workflow efficiency standpoint and the ability to provide sustained compression.

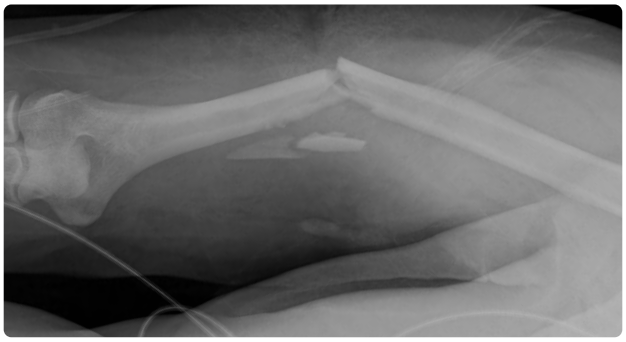
What unique treatment challenges do DynaNite staples help solve, compared to traditional fixation and reduction options?
When thinking of these staples, compression is a top feature that comes to mind. Historically, we relied on lag screws and mini plates to hold things in place—to achieve fixation—but when you want anatomic reduction and primary bone healing, that's where having an option that provides compression is key.

In addition to the constant compression, in certain cases, it is hard to get appropriate anatomic access and placement of a plate or lag screw. DynaNite staples can be easier to position when anatomy limits access for application of a lag screw.

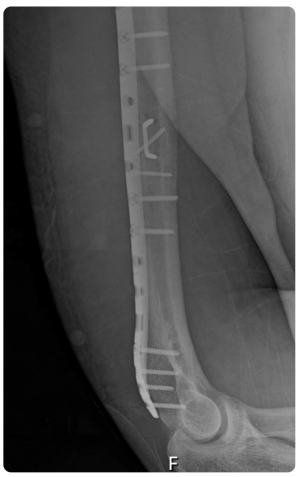
I often think of cases where a reduction clamp is used, and once the hardware is placed, you wish you could just leave the clamp there. DynaNite staples provide a unique benefit: they achieve the efficacy of clamping down the fracture for enhanced reduction, but can be left in place to also provide the continuous compression needed for primary healing.

What are some of the most common cases you have used DynaNite staples for in your practice?
Most commonly, places where the bony anatomy can be hard to achieve an anatomic plate fit or there is a fracture pattern where a lag screw may not be best, such as the humerus.

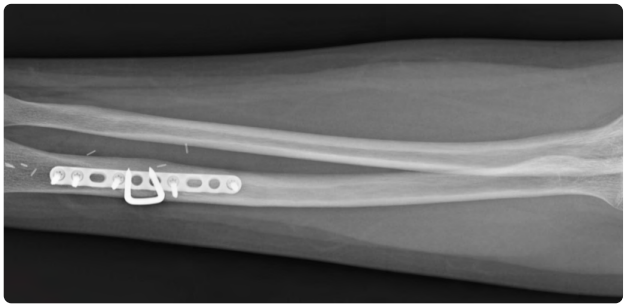
For example, in this motor vehicle crash patient, there was an open right humeral shaft fracture. The DynaNite staple helped reduce and secure the fragment and, paired with the Arthrex Elbow Fracture Plating System, provided an efficient fixation solution.







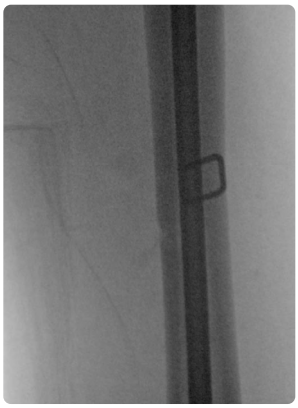




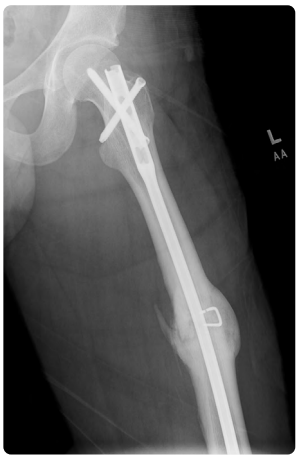
In another case involving a patient who sustained a distal radius fracture in a bicycle accident, the DynaNite staple worked effectively alongside the plating construct and aided in reduction and compression of this smaller bony anatomy to aid in further supporting primary bone healing.

DynaNite staples also provide fracture management efficiency when using intramedullary nails, bringing compression to the fracture site. Here it is an excellent tool to help hold preliminary reduction of your fracture site while you place your intramedullary nail while also providing compression to support healing.









During this case, in which Dr. Kubiak was operating without surgical assistance, the DynaNite staple held the fracture reduced, allowing him to move forward with the rest of the case.

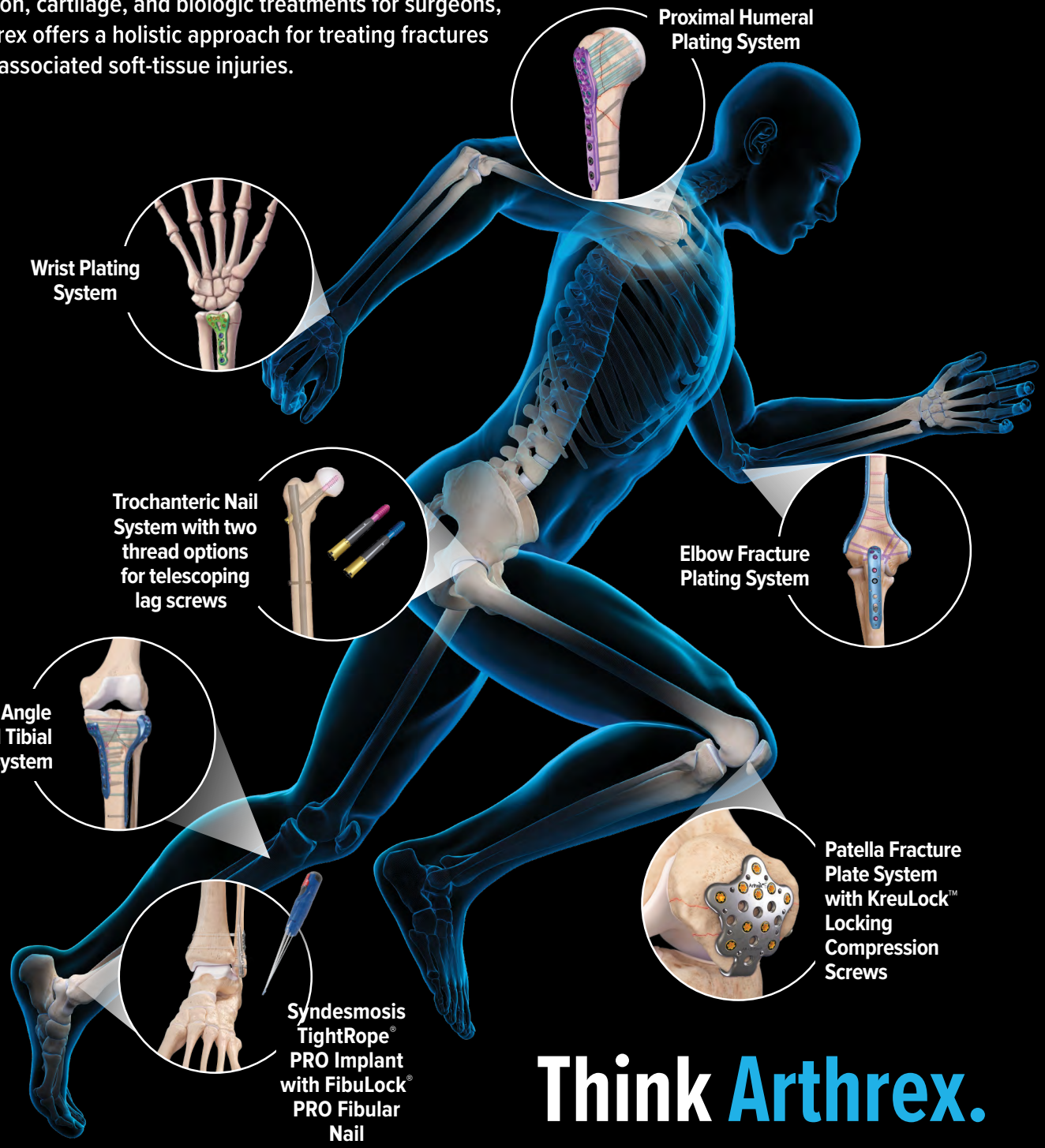
The Next Generation in DynaNite® Staples for Trauma

The new DynaNite Reduction staple* is the first nitinol staple designed specifically for fracture reduction in the trauma setting. The novel staple design prioritizes enhanced reduction with a low-profile implant. The instrumentation has been designed specifically for traumatologists to streamline workflow and allow for implantation of the staple in deep working spaces while respecting the surrounding soft tissue and bony anatomy.



When You Treat Fractures . . .

With more than 6000 products for bone, ligament, tendon, cartilage, and biologic treatments for surgeons, Arthrex offers a holistic approach for treating fractures and associated soft-tissue injuries.



Think Arthrex.

Arthrex

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The *Internal*Brace surgical technique is intended only to augment the primary repair/reconstruction by expanding the area of tissue approximation during the healing period and is not intended as a replacement for the native ligament. The *Internal*Brace technique is for use during soft tissue-to-bone fixation procedures and is not cleared for bone-to-bone fixation.

Product Spotlight

Arthrex Elbow Trauma Portfolio



Elbow Fracture Plating System

Arthrex now offers a comprehensive portfolio for managing complex elbow trauma, including both the Elbow Fracture Plating System and the Arthrex Radial Head Replacement System. This portfolio integrates rigid bony stabilization with soft-tissue anchors, FiberTape® Cerclage, and biologic solutions to support fixation, stability, and healing throughout the elbow fracture treatment continuum.

Elbow Fracture Features and Benefits

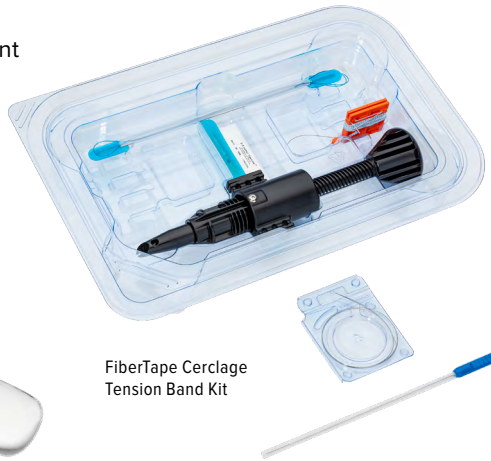
- 180° and 90°-90° distal humerus plating constructs
- Anatomic and low-profile design
- KreuLock™ screw technology for the elbow
- All plate screw holes accommodate 2.7 mm or 3.5 mm shaft hybrid screws
- Removable screw tabs allow for extra fixation

Radial Head Features and Benefits

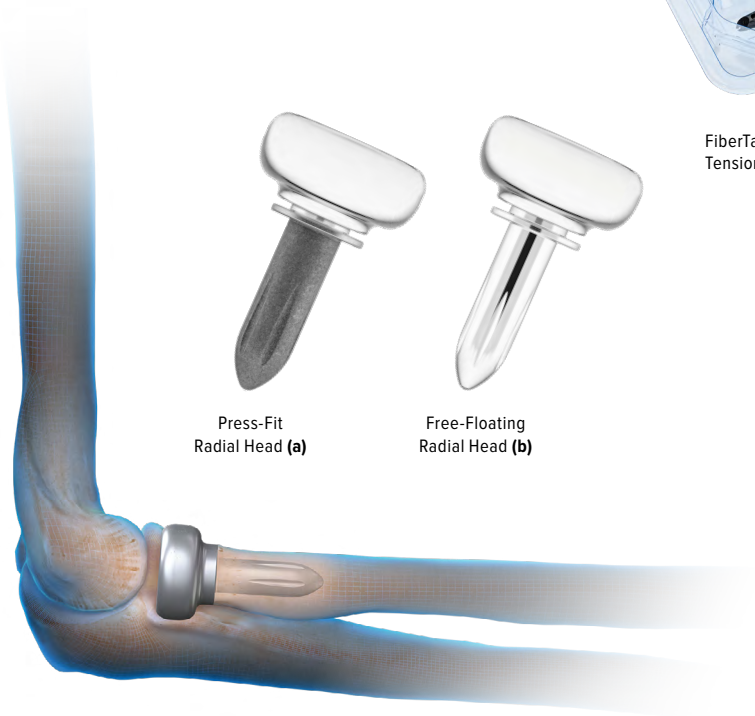
- Press-fit and free-floating stem options
- Nonanatomic, spherical heads
- Side-loading trial stem and heads for ease of placement
- Head-to-stem junction accomplished by Morse taper impaction
- Efficient and intuitive instrumentation



PEEK SwiveLock® Anchor

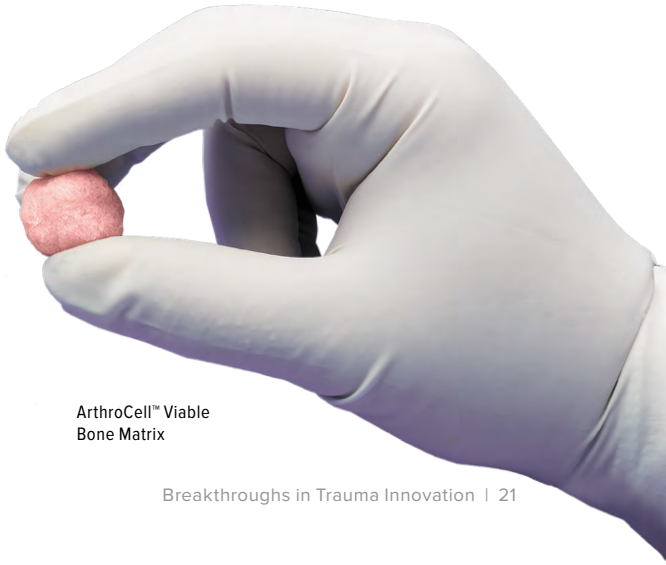


FiberTape Cerclage Tension Band Kit



Press-Fit Radial Head **(a)**

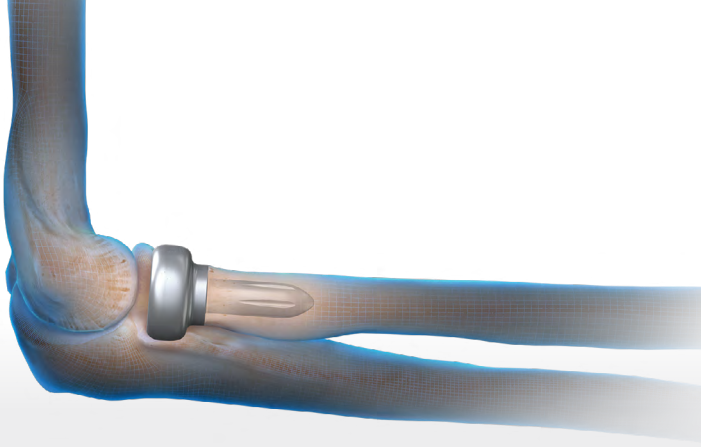
Free-Floating Radial Head **(b)**



ArthroCell™ Viable Bone Matrix

New Product Highlight

Arthrex Radial Head Replacement System



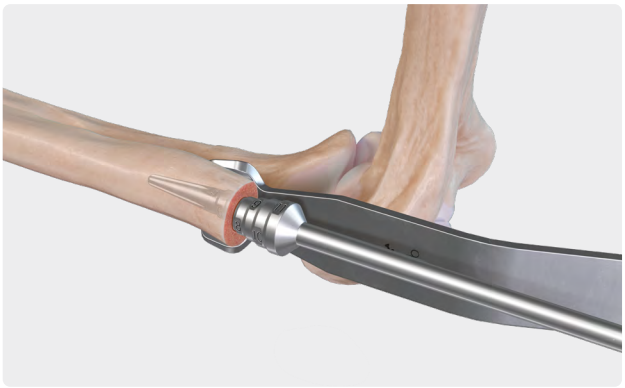
Arthrex provides a comprehensive portfolio for managing elbow fractures, including Compression FT cannulated screws, the Elbow Plating System, soft-tissue fixation solutions, and arthroplasty. The Arthrex Radial Head Replacement System combines a circular, nonanatomic head with the choice of either a smooth, free-floating stem or a grit-blasted, press-fit stem. Radial head sizes range from 18 to 28 mm in diameter and stem sizes range from 5 to 11 mm in diameter.



Free-Floating and Press-Fit Stem Options
The Radial Head Replacement System features two different stem options. The smooth, free-floating stem allows for slight movement within the intramedullary space, while the press-fit stem provides rigid fixation.



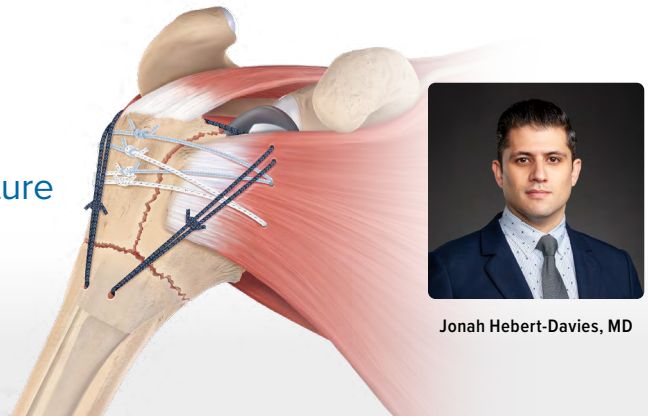
Side-Loading Trial Heads
Side-loading trials enable reproducible and simplified trialing. The trial stem is shorter than the implant itself, for easier trial placement and removal.



Efficient and Intuitive Instrumentation
The shoehorn elevator facilitates axial alignment of the radial shaft for canal preparation and implant insertion. Dedicated removal tools simplify revision procedures, including tools to disengage the Morse taper and a threaded stem extractor that allows for controlled removal of the stem when needed.

Tips and Pearls

Reverse Shoulder Arthroplasty for Fracture



Jonah Hebert-Davies, MD

The evolution of reverse shoulder arthroplasty for treating proximal humerus fractures has accelerated over the past decade. Multiple recent studies[1,2] have shown improved outcomes compared to open reduction internal fixation (ORIF), and incorporating these findings into everyday practice helps us give our patients the best possible results.

Earlier Decision-Making

A key change is deciding on arthroplasty sooner. When discussing nonoperative management versus surgery, stress the importance of timing: "in my practice, I aim to operate within 4 weeks of the fracture in efforts to lower complication rates and improve outcomes."

Implant Selection

Surgeons have increasingly shifted from the traditional Grammont-style prosthesis to a 135° anatomic stem. While the Univers Revers™ system accommodates either option, several studies now demonstrate superior implant survivorship and functional results with the 135° design.[1,3,4]

Tuberosity Fixation

To optimize motion and patient-reported scores, the standard of care for 3- and 4-part fractures should include fixation of all tuberosities. The FxBridge™ kit has streamlined this step in my practice, making the procedure simpler, reproducible, and efficient. Over the past 10 years, it has been the single greatest contributor to surgical efficiency for me. The robust fixation of the system also lets my patients begin range-of-motion exercises earlier, leading to high tuberosity-healing rates with minimal stiffness.







FxBridge™ Tuberosity Repair System

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1. O'Sullivan J, Lädermann A, Parsons BO, et al. A systematic review of tuberosity healing and outcomes following reverse shoulder arthroplasty for fracture according to humeral inclination of the prosthesis. *J Shoulder Elbow Surg.* 2020;29(9):1938-1949. doi:10.1016/j.jse.2020.03.032
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4. Jo O, Borbas P, Grubhofer F, et al. Prosthesis designs and tuberosity fixation techniques in reverse total shoulder arthroplasty: influence on tuberosity healing in proximal humerus fractures. *J Clin Med.* 2021;10(18):4146. doi:10.3390/jcm10184146

Q&A Article Spotlight

Arthrex Proximal Humeral Plating System



Mark Gage, MD

What design features in the Arthrex Proximal Humeral Plating System stand out the most to you?
This system brings fixation of the proximal humerus to a new level. The increased number of fixation points at the critical inferior head component of the proximal humerus and the multitude of 3.5 mm and 4.5 mm screw options facilitate its application to a number of clinical scenarios. Additionally, the integrated suture-based cerclage system can be very helpful for soft-tissue incorporation and metaphyseal fracture reconstruction.

The Arthrex Proximal Humeral Plating System uses KreuLock™ locking compression screws. What has been your experience with the screws and what value do you attribute to their use around the proximal humerus?
The KreuLock screw design imparts compression as the screw is advanced into a locked position. The application of these screws in the humeral head can be helpful when reconstructing and compressing the greater and/or lesser tuberosity fragments to the head/neck component and saves me steps during the reconstruction.

What do you like most about the instrumentation that accompanies the plate system?
The backpack screw guide is easily applied and removed with a central screw and the drop-in drill guide for locking screws is seamless. The whirly bird function is helpful when performing a plate-assisted reduction in the varus-impacted pattern. Lastly, I find the addition of long instruments—sleeves and drills—to be very helpful, particularly when working with patients with more soft tissue.

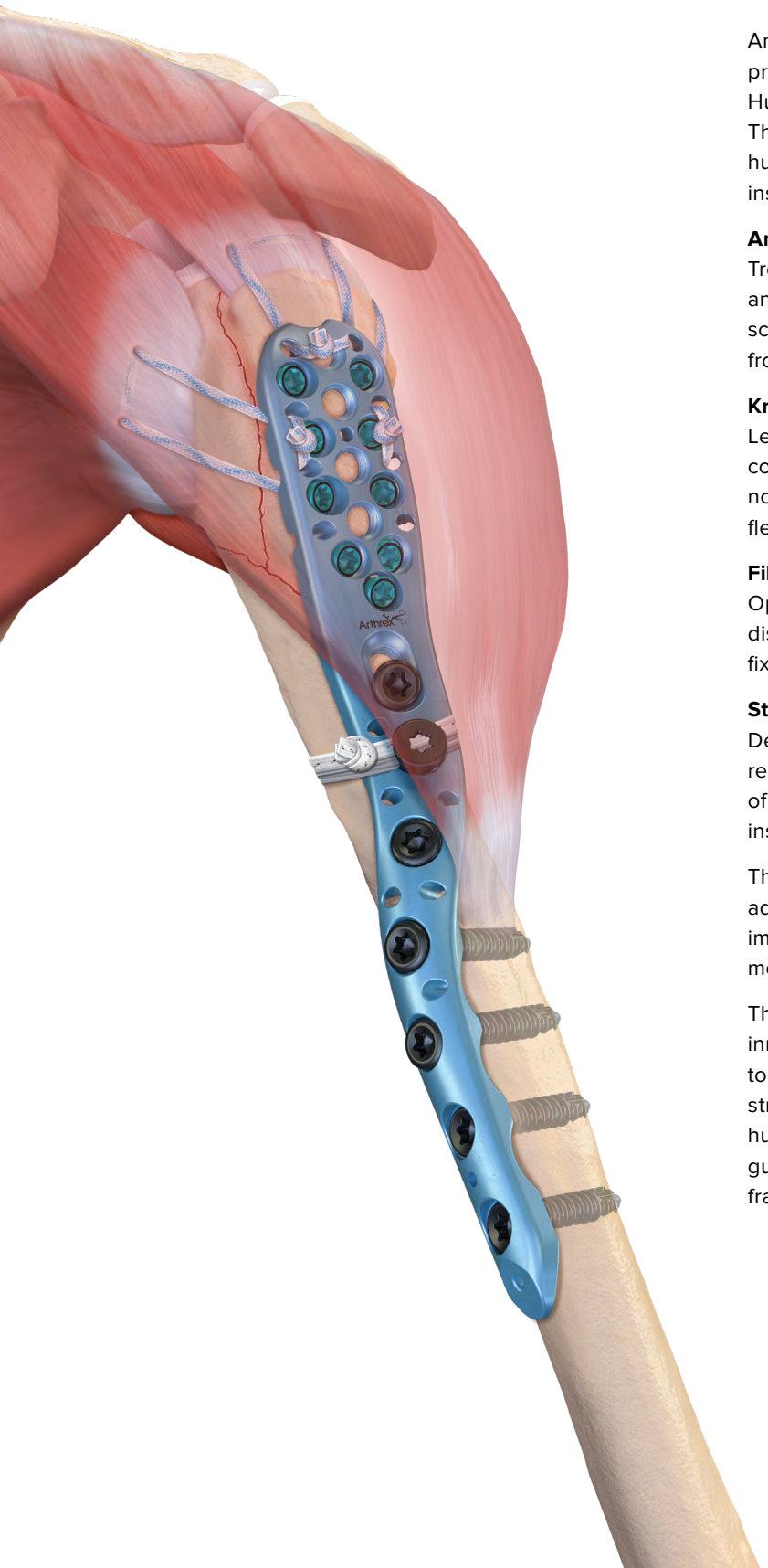
How has the ability to easily incorporate the FiberTape® Cerclage button within the plate impacted your fixation and treatment strategy?
I think at times there is a comminuted metaphyseal component that is best handled with cerclage fixation. Further, this fracture pattern is often associated with the pectoralis tendon insertion point. The FiberTape Cerclage button uniquely allows for suture-based fixation that can both incorporate surrounding soft tissues such as the pectoralis tendon and provide osseous stability.

How has the system overall helped you achieve stable fixation in challenging fracture patterns?
This system has maximized the screw options and points of fixation throughout the construct for the proximal humerus. The 4.5 mm screws are helpful in patients with proximal-third shaft fractures and particularly in polytrauma or larger patients where early mobilization and upper-extremity weight-bearing is a priority. I have found this system to be helpful in the ability to incorporate adjacent soft tissues to augment the osseous reconstruction. This is particularly helpful in achieving stable fixation in elderly and osteoporotic patients. Incorporating the rotator cuff in tuberosity fractures and the deltoid insertion and pectoralis tendon for complex metaphyseal fractures is very helpful in fixation augmentation and facilitating earlier motion for these patients. The abundant suture holes throughout the plate work well as anchor points for both the proximal cuff and more distal deltoid and pectoralis tendon repair.



New Product Highlight

Anatomic Proximal Humeral Plating System



Arthrex is proud to announce the launch of anatomic proximal humeral plates, an extension of the Proximal Humeral Plating System and lateral plate offerings. The anatomic plates are anatomically contoured to the humeral shaft to avoid the deltoid and pectoralis major insertions for use with a deltopectoral approach.

Anatomic Design for Complex Fractures
Treat a wide range of proximal humeral fracture patterns and patient anatomies with 13 variable-angle locking screws and 7 plate lengths, left- and right-specific, from 92-265 mm.

KreuLock™ Compatibility
Leverage proven KreuLock technology with the comprehensive screw portfolio including locking and nonlocking options for secure fixation and intraoperative flexibility.

FiberTape® Cerclage Button Integration
Optional cerclage buttons thread directly into any distal screw hole and are designed to help maximize fixation stability.

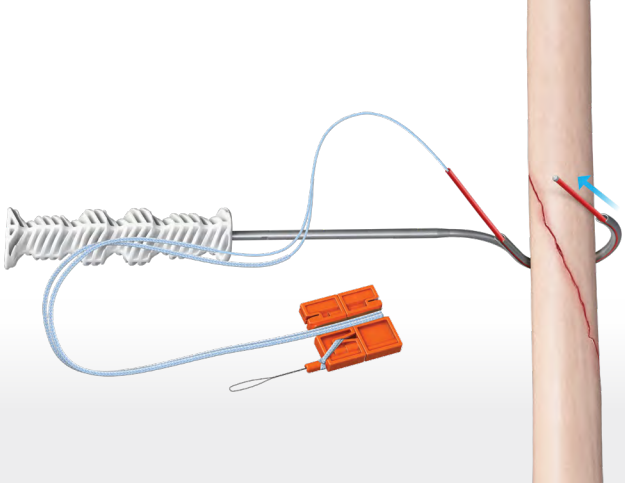
Streamlined Instrumentation
Designed to simplify the surgical workflow and reduce turnover time with a 2-tray system consisting of the Proximal Humeral Plating System and general instrument trays.

The Anatomic Proximal Humeral Plating System addresses unique challenges with precision-engineered implants that offer stability without compromising mobility, helping patients return to function faster.

This launch further reinforces Arthrex dedication to innovation in trauma care, providing surgeons with tools that combine clinical versatility and biomechanical strength. With the launch of the anatomic proximal humeral plates, Arthrex continues to build on a platform guided by patient-centric solutions in upper-extremity fracture management.

Product Spotlight

QuickPass™ FiberTape® Cerclage System



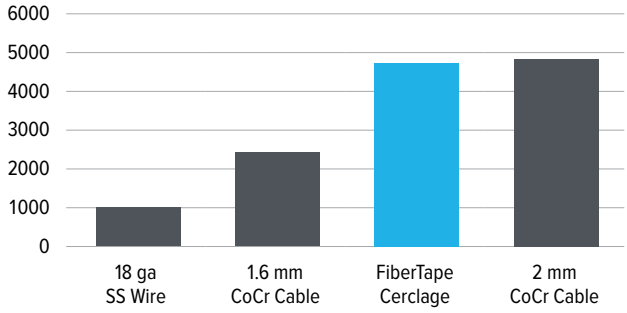
FiberTape Cerclage, composed of UHMWPE and polyester braid, is an all-suture alternative to the metal cables and wires traditionally used for circumferential fracture management in the upper and lower extremities.

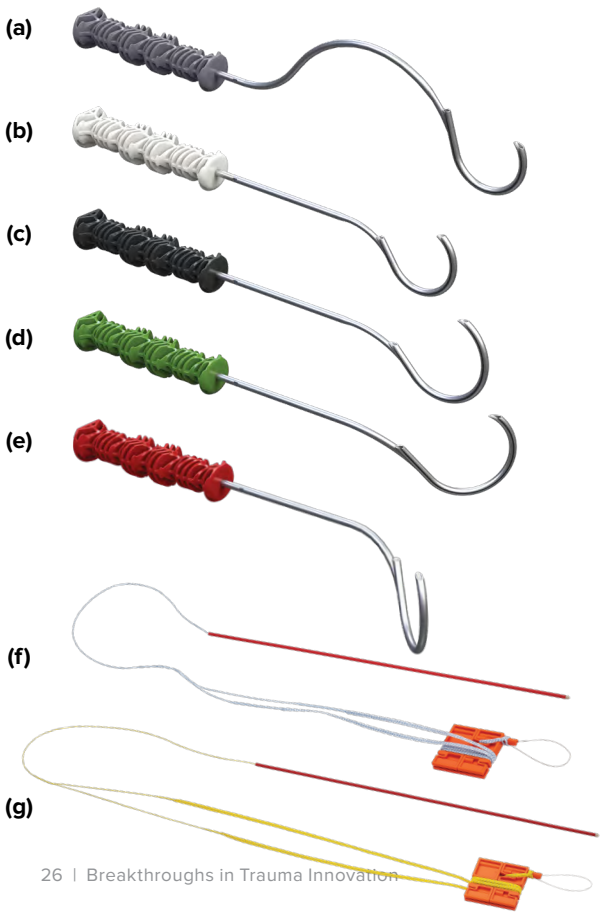
The QuickPass FiberTape Cerclage system builds on the trusted performance of the original FiberTape Cerclage system by introducing unique instrumentation designed to make suture passage faster and more efficient. Implant options include either FiberTape or Radiopaque FiberTape Cerclage QuickPass tubes and cannulated, slotted FiberTape Cerclage QuickPass suture passers. The QuickPass tube used in conjunction with the cannulated, slotted hooks enables the suture to be passed around the bone twice, without the need for a separate shuttle suture.

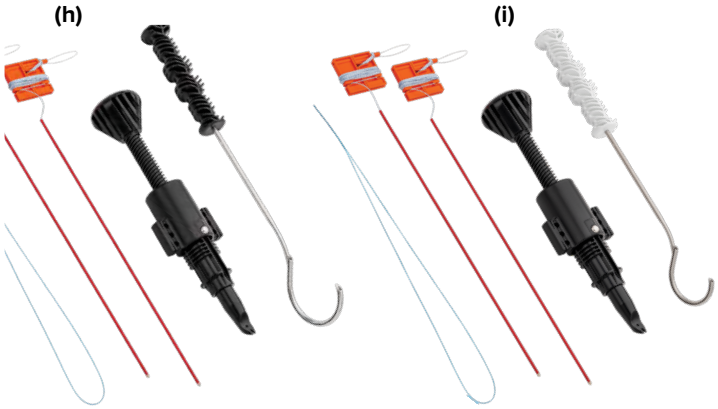
Advantages of Suture-Based Cerclage

- Broad footprint compression
- Low-profile construct
- High ultimate-load strength
- No sharp ends or broken wires that could potentially harm surgeons or patients
- No concerns about metal mismatch with adjacent implants
- No migration of metallic debris or risk of metallosis

Ultimate Load (N)[1-3]







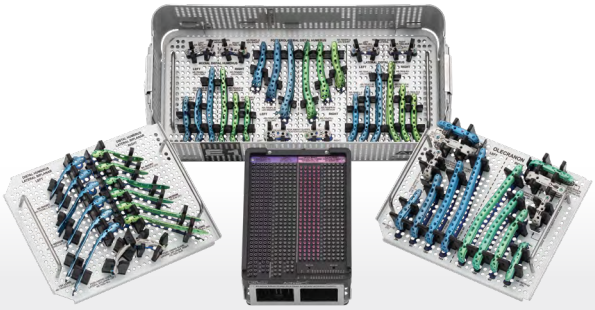
FiberTape Cerclage QuickPass Passer, curved **(a)**
FiberTape Cerclage QuickPass Passer, medium **(b)**
FiberTape Cerclage QuickPass Passer, large **(c)**
FiberTape Cerclage QuickPass Passer, left offset **(d)**
FiberTape Cerclage QuickPass Passer, right offset **(e)**
FiberTape Cerclage with QuickPass Tube **(f)**
Radiopaque FiberTape Cerclage with QuickPass Tube **(g)**
FiberTape Cerclage with QuickPass System (large passer) **(h)**
FiberTape Cerclage with QuickPass System (medium passer) **(i)**

References

1. Arthrex, Inc. Data on file (APT 3197). Naples, FL; 2017.
2. Arthrex, Inc. Data on file (APT 04426). Naples, FL; 2019.
3. Arthrex, Inc. Data on file (APT 4577). Naples, FL; 2020.

Case Q&A

Elbow Fracture Plating





Jonah Hebert-Davies, MD

What product features in the Arthrex Elbow Plating System stand out the most to you?
I think the best part about the Elbow Plating System is the flexibility it provides. With so many options for fixation, plates, and screws, it really allows for the treatment of all fractures around the elbow. It also integrates well with the Mini Fragment System to further expand our ability to care for the most complex fractures. Additionally, the fit of the plates is noticeably better than other systems I've used in the past.

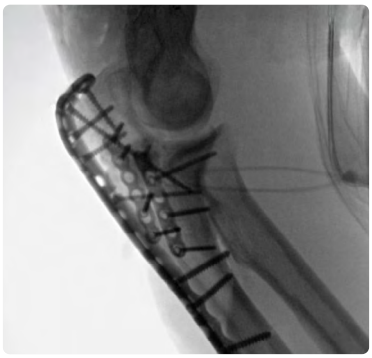
Arthrex has the full elbow portfolio in terms of soft tissue, biologics, and plating. How has that helped strengthen your treatment options for your patients?
Bad fractures around the elbow typically include soft-tissue injury to the ligaments and tendons. The ability to have comprehensive treatment across one company is extremely beneficial.

The Arthrex Elbow Plating System uses KreuLock™ locking compression screws. What has been your experience with the screws and what value do you attribute to their use around the elbow?
Specifically in distal humerus fractures, there is a need for compression at the joint as well as angle-stable fixation. The KreuLock screws allow me to achieve both with a single implant. This can avoid the unnecessary step of compressing with a nonlocking screw and then swapping the screw out for a locking screw, reducing the risk of soft-tissue injury.

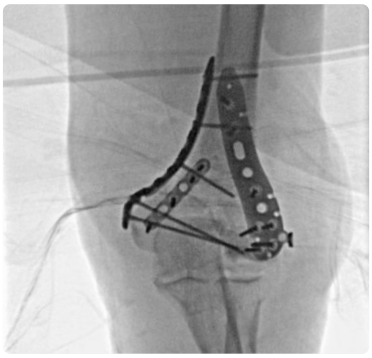
Let's talk about the evolution of tension bands and how you have used FiberTape® Cerclage in your practice.
FiberTape Cerclage has become the only form of cerclage I use since its release. It is extremely useful, easy to use, and provides great stability that doesn't loosen once you tension it. I use it in spiral humeral shaft fractures, or to support periprosthetic fracture fixation where limited bone is available for screw fixation.

What do you like about the Arthrex extra-articular plate?
The extra-articular plate is an important part of the elbow system. We are seeing more patients with periprosthetic fractures that need extra-long fixation to protect the bone, and this plate provides the length needed to span the humerus. Also, for isolated distal-third humeral shaft fractures, combining the plate with a mini-fragment plate allows for greater construct stability, which in turn allows patients to do more sooner.

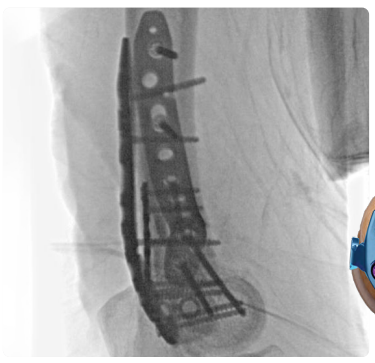
Do you like using the tab fixation options?
Absolutely, especially the ability to use the lateral tabs on the posterolateral plate for distal fixation. They give me the best of both worlds by combining the advantages of posterior and lateral fixation while providing more secure fixation distally. Having orthogonal screws options means I can still put the plate in a soft-tissue–friendly position while maximizing fixation for specific fracture patterns, such as coronal shears fractures.



Dorsal Olecranon and Mini CFS Plates



Medial, Posterolateral, and Mini CFS Plates

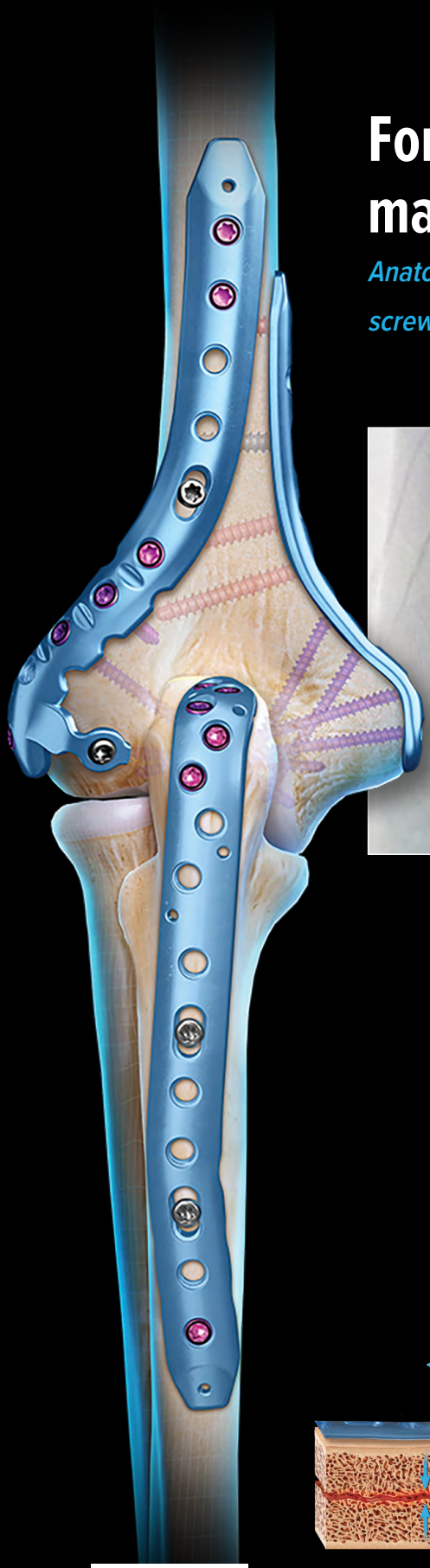


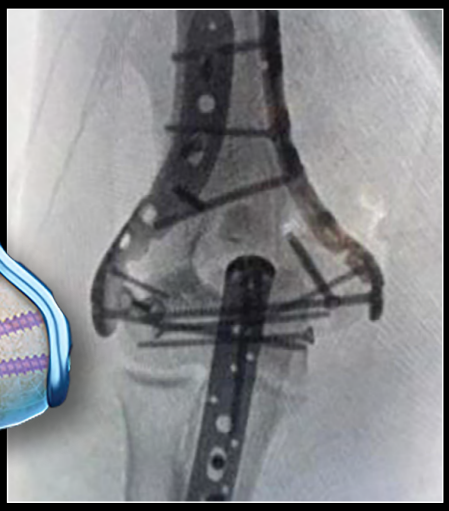
Medial and Posterolateral Plates



For the most advanced elbow fracture management...Think Arthrex

Anatomic contoured plates with variable-angle KreuLock™ compression screws provide secure, uncompromising fixation



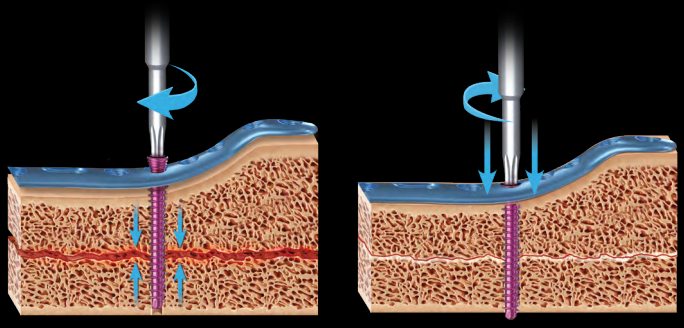


The Elbow Fracture Plating System

- Anatomically precise, contoured plates
- 90° and 180° plating options
- 2.7 mm and 3.5 mm hybrid screws powered by patented KreuLock locking compression screws
- Removable screw tabs for supplementary fixation and enhanced stability



Lateral | Posterolateral | Lateral Biplanar | Medial | Dorsal Olecranon | Extra-Articular



KreuLock Locking Compression Screws

Engineered to deliver dual compression—thread pitch design actively draws bone fragments together for optimal stability while also securely anchoring the plate to bone[1,2]

Explore innovations for upper extremity trauma from Arthrex

References

1. Arthrex, Inc. Data on file (APT-04100). Naples, FL;2020.
2. Arthrex, Inc. Data on file (APT-04120). Naples, FL;2020.

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Case Review

Humeral Plating With FiberTape® Cerclage



E. Patrick Murray, MD

Presentation

The patient was a 34-year-old right-hand-dominant man who worked as a store clerk. He sustained a comminuted humerus fracture after being involved in a head-on motor vehicle collision at approximately 50 miles per hour. The CT scan demonstrated the extent of the comminution in the humeral shaft. There was only 1.5 cm of intact medullary canal distally before the olecranon fossa. I felt that there was not sufficient bone stock distally for an intramedullary nail construct, so I chose to approach this fracture with a plate construct. The posterior plate did not provide sufficient length before the axillary nerve limited the exposure, so a dual-plate construct was performed with overlap of the anterior and





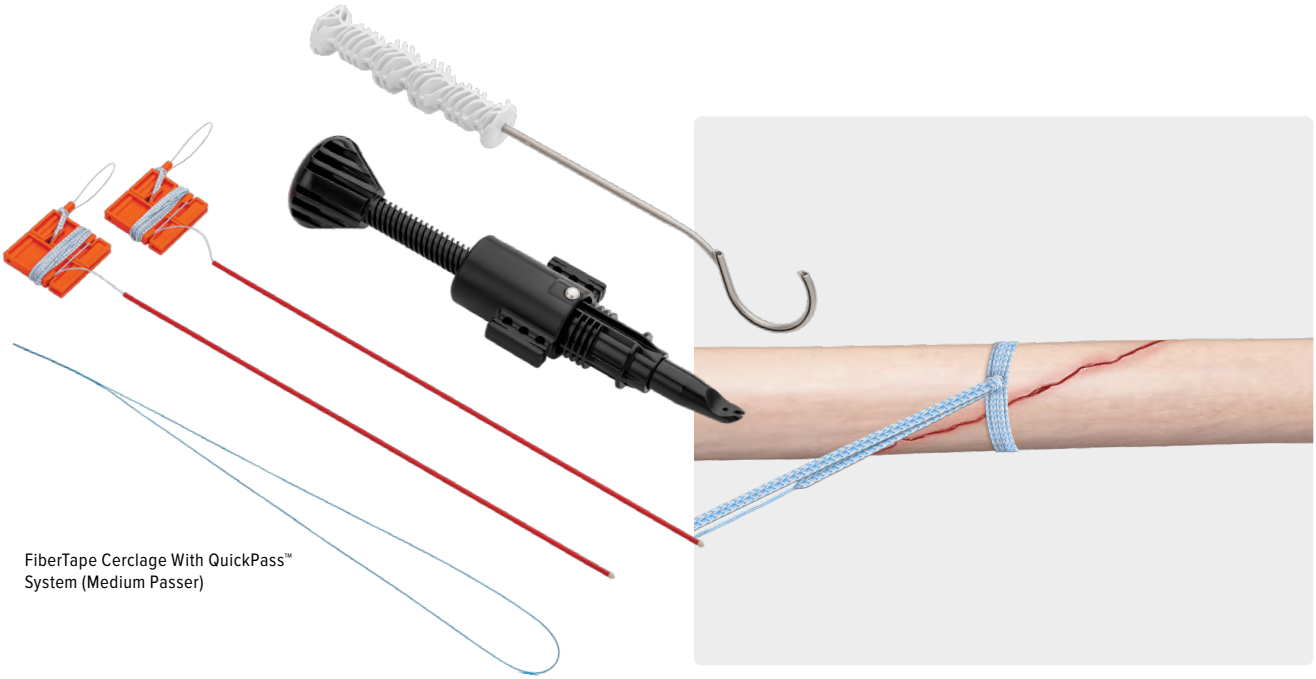


posterior plates.

The extra-articular distal humerus plate and FiberTape® Cerclage have become a great combination in our toolbox to use when addressing complicated, long bone trauma. Can you describe this case and how using all these products together worked well?
The FiberTape Cerclage system has been a very useful tool in the treatment of long bone fractures. I have found them to be helpful when trying to reduce the fracture and the cerclage is an easy way to maintain provisional fixation, especially in the setting of segmental fractures that otherwise would require multiple clamps. The cerclage can be tensioned by hand as the fragments are aligned. The FiberTape Cerclage will provide enough friction that it will hold its position and reduce the fracture but can still be loosened if the fracture reduction needs to be adjusted. Once the provisional reduction is established, the FiberTape Cerclage can be tensioned to generate compression across the fracture, and the knot is locked into place with a series of half-hitch suture knots. In this case, I used a combination of FiberTape Cerclage and lag screws to control the various comminuted fracture fragments.

How easy was it to combine plating with cerclage?
Combining FiberTape Cerclage and plating is extremely easy. The only technical consideration is to make sure the knot stack is set to the side of the anticipated plate position on the bone. I will oftentimes provisionally lay the plate on the bone prior to final tensioning of the FiberTape Cerclage to ensure the knot is sufficiently out of the way. The FiberTape suture itself is very low profile, and the plate can lay directly on top of the FiberTape suture without a significant gap between plate and bone.

How did the extra-articular plate contour down to bone?
The extra-articular plate is very well designed and nicely matches the contour of the humerus. In this case, the only additional contouring required was at the proximal end of the construct to account for the flare of the proximal humerus in the metaphyseal region, just distal to the axillary nerve. I have found these plates to rarely need any additional contouring in my experience.

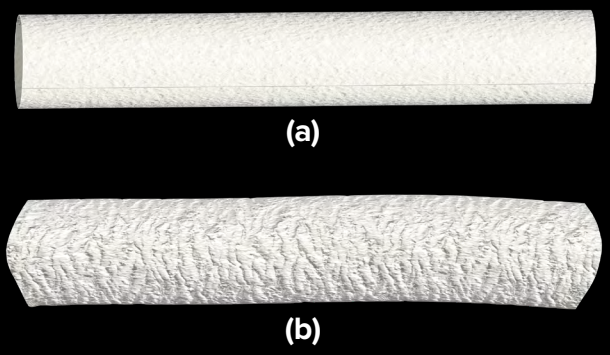


FiberTape Cerclage With QuickPass™ System (Medium Passer)

Arthrex Nerve Wrap and Nerve Conduit

Nerve Repair in the Upper and Lower Extremities

Arthrex Nerve Wrap and Nerve Conduit are designed to guide axon regeneration across short gaps using a resorbable, biocompatible, and semipermeable structure made from bovine type I collagen. Available in various sizes and shelf-stable for easy storage, these solutions provide reliable support for nerve repair procedures.

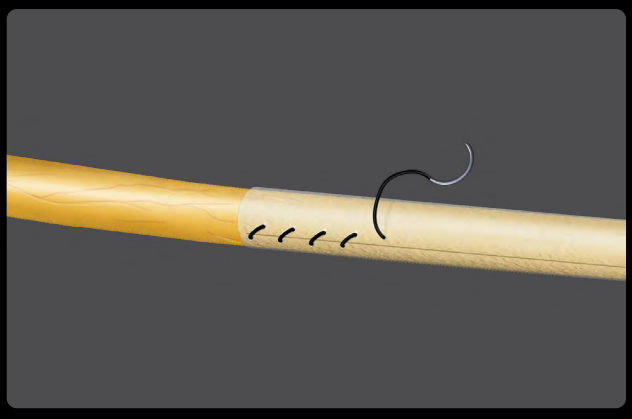


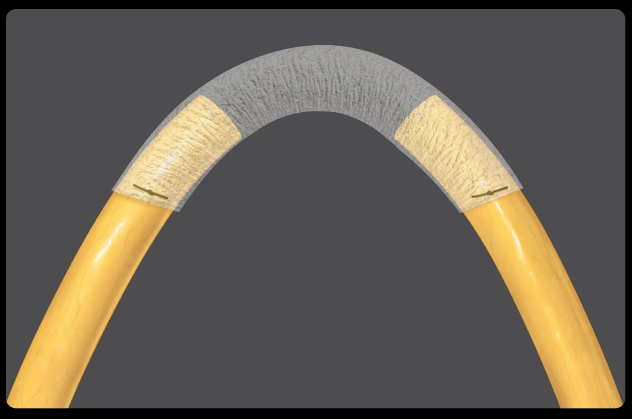
Arthrex Nerve Wrap (a)

- Indicated for crush or compression nerve injuries
- Self-curling memory

Arthrex Nerve Conduit (b)

- Indicated for severed nerve injuries up to 1.5 cm
- Flexible and kink-resistant





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Trauma and Extremities Medical Education

Experience the Arthrex Destination Difference

Educational Dedication for Trauma Fellows
Arthrex believes Trauma Fellows represent a unique population with distinct educational needs. Between strong local agency trainings and numerous corporate Medical Education offerings, Arthrex focuses on advancing surgical confidence and patient care.

The Arthrex Trauma Fellowship Forum is a differentiated education event designed to engage fellows in key areas where Arthrex provides meaningful value. The program features in-depth education on scapula fractures, including interactive live demonstrations followed by a cadaveric lab. Fellows also gain experience with reverse total shoulder arthroplasty for fracture, incorporating techniques for glenoid augmentation, Virtual Implant Planning™ software, and the FxBridge™ tuberosity repair system. Led by expert faculty, small group case discussions focus on polytrauma management and revision surgery.

Along with their full year of program educational opportunities, fellows leave the Arthrex Trauma Fellowship Forum confident in managing less common procedures and better equipped to deliver advanced patient care. Arthrex looks forward to welcoming you to Naples, Florida, April 2-3, 2027.

Arthrex Trauma Medical Education Courses

2026		
October 2-3	On-Call With Arthrex Trauma	Naples, FL
November 6-7	Elite Foot and Ankle Trauma	Naples, FL
December 5	Western Master Class: Complex Traumatic Hand	Naples, FL
2027		
January 8-9	Elite Upper Extremity Trauma	Naples, FL
February 5-6	Western Trauma PA/NP Course	Denver, CO
March 19-20	REVISIONS Foot and Ankle Summit	Naples, FL
March 20	Western Master Class: Complex Traumatic Hand	Naples, FL
April 9-10	On-Call With Arthrex Trauma	Naples, FL

Trauma Resident and Fellows Education

Date	Course Name	Location
2026		
December 11-12	Approaching Fellowship: Arthrex Trauma Prep Course	Naples, FL
2027		
April 2-3	Trauma Fellowship Forum	Naples, FL





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