Arthrex Presents:

Breakthroughs in Foot and Ankle Technology

AOFAS Winter 2026

Welcome to the 2026 AOFAS Winter Meeting in beautiful Napa Valley, CA! We're excited to join you in celebrating innovation and collaboration in foot and ankle surgery.

This year's meeting marks a significant milestone—the highly anticipated launch of Syndesmosis TightRope® PRO, a next-generation solution that redefines the treatment of syndesmotic injuries. Be among the first to experience this breakthrough implant through hands-on demonstrations featuring our 3DAnatomy™ models.

Beyond TightRope PRO, we invite you to explore our comprehensive portfolio of innovative solutions, including the DualCompression hindfoot fusion nail, MIS FiberTak® Achilles SpeedBridge™ repair system, FibuLock® fibular nail, DynaNite™ nitinol product line, and our extensive Orthobiologics offerings to support patient care for every case.

At Arthrex, education is at the heart of everything we do. Our robust Medical Education program provides hands-on training, interactive courses, and cutting-edge resources designed to empower surgeons worldwide. Join us as we continue to advance surgical innovation, medical education, and patient outcomes together.

Michael Karnes
Director, Product Management

Arthrex®

Syndesmosis TightRope® PRO

New Product Launch

The Foot & Ankle and Trauma team is excited to announce the launch of the latest generation in syndesmotic fixation:

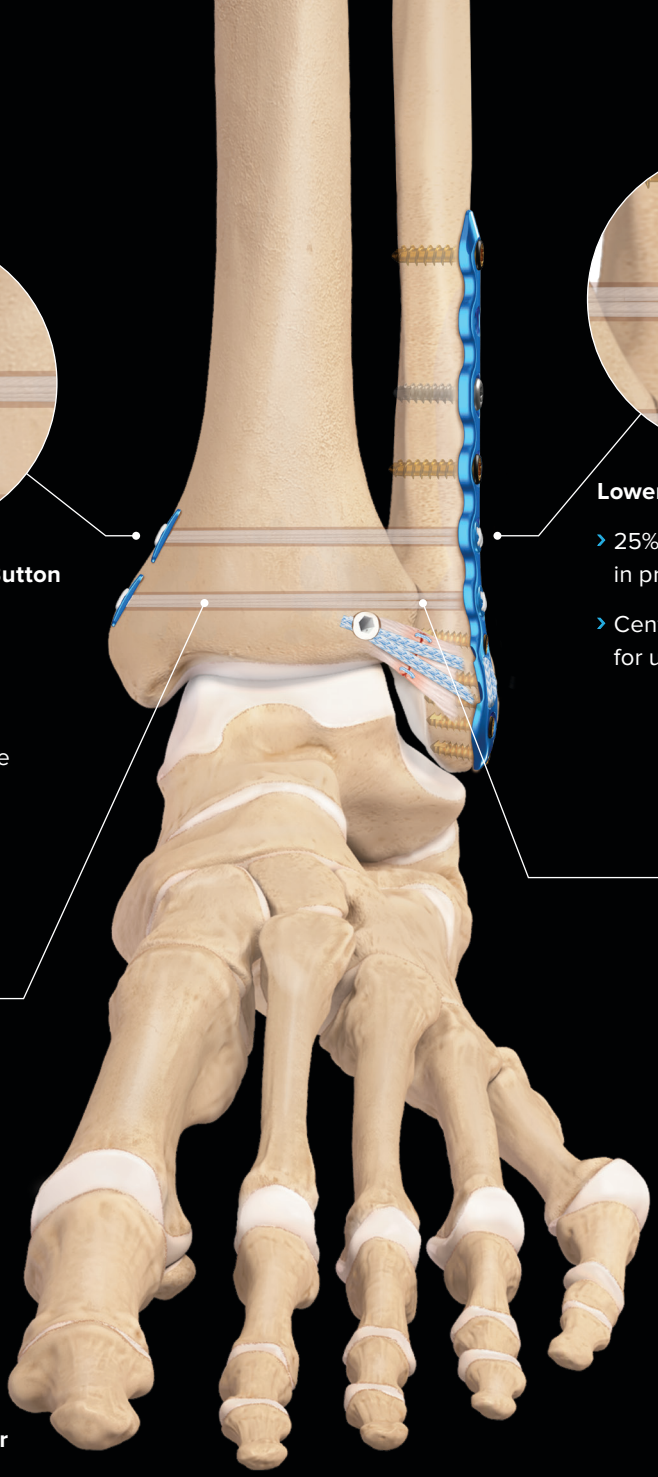
The Syndesmosis TightRope PRO

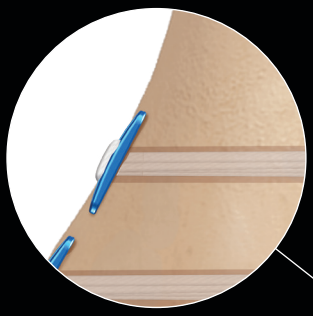
Arthrex pioneered dynamic syndesmotic fixation 20 years ago, and the TightRope PRO builds on that legacy by leveraging the clinical success of the current iterations and incorporating advancements that increase usability, simplicity, and consistency.

> *“It’s thinner, faster, with a lower soft-tissue profile, allowing a true one-person operation that delivers the same stability as prior TightRope designs.”*
>
> **Anish R. Kadakia, MD**

Designed to improve on the most trusted, market-leading syndesmotic device, the TightRope PRO features several key improvements on the lateral-based TightRope XP:

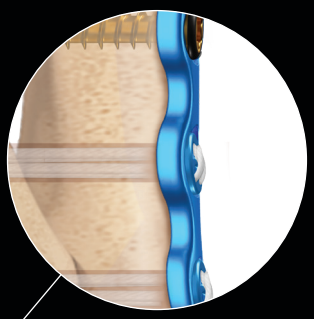
- Reduced medial and lateral button prominence
- Self-centering lateral button
- Less-invasive 3.2 mm drill tunnel
- Increased intraoperative flexibility for implant placement
- Integrated tensioning handles
- Auto-reduction suture for consistent suture management





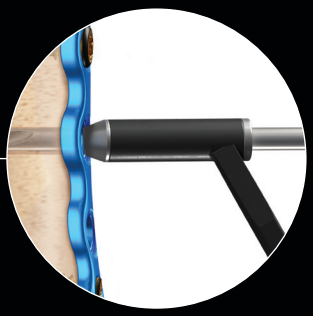
Lower-Profile Medial Button

- 25% less material
- Increased surface area on bone
- Identical suture bridge to TightRope® XP



Lower-Profile Lateral Button

- 25% decrease in prominence
- Centering feature for use with plates



3.2 mm Drill and Drill Guide

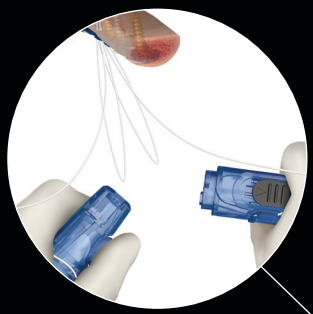
- 25% reduction in bone tunnel size
- 50% increase in drill trajectory options
- Protects plates and TightRope suture

Clinically Proven Knotless Construct

- #5 UHMWPE knotless suture
- Leverages 40+ clinical studies[1]

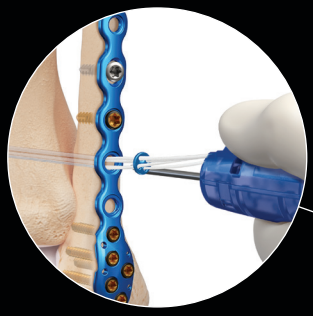
Optional Washer

Increases the medial or lateral footprint for poor bone quality



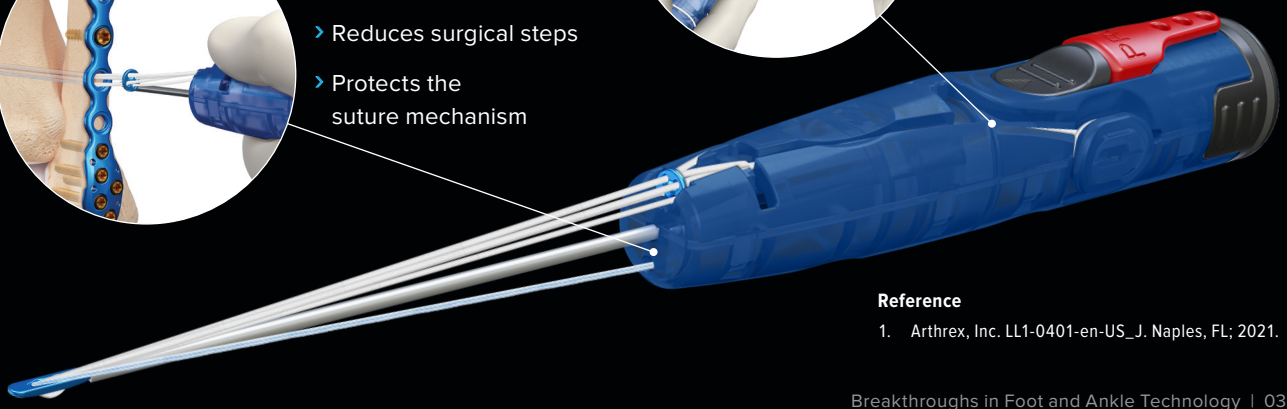
Integrated Tensioning Handles

- Reduces surgical steps
- Improves consistency and reproducibility



Auto-Reducing Lateral Button

- Reduces surgical steps
- Protects the suture mechanism



Reference

1. Arthrex, Inc. LL1-0401-en-US_J. Naples, FL; 2021.

Case Review

Role of Lapidus in My Minimally Invasive Bunionectomy Practice

Patrick Maloney, MD

As you've transitioned toward bunionectomy using a minimally invasive surgery (MIS) approach, what role does the Lapidus procedure still play in your practice?
My bunion practice has shifted from 30% open chevron, 40% scarf, and 30% Lapidus to now 90% MIS bunionectomy and 10% mini-open Lapidus.

Lapidus continues to play a role for patients with marked instability or hypermobility at the 1st TMT joint, as well as in cases of symptomatic arthritis at that joint.

Many consider 1st TMT instability as the root cause of hallux valgus—and MIS bunionectomy techniques aim to address this by "locking out" the TMT joint— how do you clinically decide between performing a Lapidus vs a bunionectomy? Is it purely based on severity and hypermobility, or are there other biomechanical or patient-specific factors that guide your choice?
The decision is primarily guided by a thorough physical exam.

I try to stabilize the medial cuneiform with one hand at the level of the tibialis anterior insertion. Then I use the other hand to translate and rotate the 1st metatarsal base. I would equate this analysis to a clearly positive anterior drawer exam in someone with ankle instability.

Radiographic findings also play a key role—evidence of joint subluxation on AP or lateral views, along with significant plantar gapping, strongly supports the indication for a Lapidus procedure. With minor evidence of instability, such as slight plantar gapping, MIS bunionectomy can still be done, as you can be confident to retension the TMT capsule with the MIS shift.

The importance of de-rotation of the capital fragment and getting the sesamoids reduced is well recognized in the Lapidus procedure. How do you approach sesamoid correction with MIS bunionectomy, and how critical do you think it is for long-term success?
Proper alignment of the 1st metatarsal head over the sesamoids is essential in any hallux valgus correction. MIS techniques make this achievable by allowing the capital fragment to be both translated and rotated after completing the osteotomy.

However, after your correction, if the lateral sesamoid position is not perfect, a lateral release does not significantly alter patient outcomes.

I opt to do lateral release as the last step with MIS bunionectomy correction if there is still significant contracture of the lateral capsule following fragment shift.

Champions of MIS bunionectomy often claim faster and easier recovery for their patients compared to Lapidus. Based on your experience, how do patient outcomes and expectations actually compare?
MIS bunionectomy generally offers faster recovery and earlier weight-bearing compared to Lapidus, with patients often returning to normal activities sooner and reporting less pain.[1]

Short-term functional outcomes tend to be better with MIS, although long-term results are similar for both procedures. MIS also has lower rates of nonunion and hardware complications, while Lapidus has higher fusion-related risks.

While there are no longer-term studies (ie, 10+ years) on recurrence rates after MIS bunionectomy, I anticipate a lower recurrence risk with MIS bunionectomy. In a 5-year follow-up study, Lam et al determined a radiographic recurrence rate of 7.7%.[2]

MIS bunionectomy is known to have a steep learning curve. What are the top 3 pieces of advice for a surgeon?

- Prioritize precise wire and screw placement. Ensure the lateral screw exits through intact proximal cortex approximately 1 cm proximal to the osteotomy. Poor placement compromises stability and correction.
- Use fluoroscopy liberally. When in doubt, take additional images. Continuous visualization of burr position during the osteotomy will build confidence and prevent inadvertent cortical breaches.
- Verify reduction before fixation. Confirm the capital fragment is well aligned on both AP and lateral views prior to screw insertion. Always center the metatarsal head over the sesamoid complex to maintain proper biomechanics.

References

1. Lewis TL, Lau B, Alkhalfan Y, et al. Fourth-generation minimally invasive hallux valgus surgery with metaphyseal extra-articular transverse and Akin osteotomy (META): 12 month clinical and radiologic results. *Foot Ankle Int.* 2023;44(3):178-191. doi:10.1177/10711007231152491
2. Lewis TL, Robinson PW, Ray R, et al. Five-year follow-up of third-generation percutaneous chevron and Akin osteotomies (PECA) for hallux valgus. *Foot Ankle Int.* 2023;44(2):104-117. doi:10.1177/10711007221146195

Case Review

Minimally Invasive vs Open Insertional Achilles Repair

Jorge I. Acevedo, MD

This is a case example of a patient who received surgical treatment on both feet for insertional Achilles pathology. In 2019, the right foot was treated using a traditional open approach, with a midline incision and central tendon split. The tendon was then repaired back to bone using the 4.75 mm Achilles SpeedBridge™ system. In October 2025, the left foot was treated through an MIS approach using the MIS FiberTak® Achilles SpeedBridge system with knotless rip-stop.

The patient describes his MIS repair as “light-years better than the open one in terms of recovery. It’s been awesome. I was unable to put weight on the open side for 2 months but was able to bear weight immediately on the MIS side. I was at the gym 6 days after surgery.”

I have been using the minimally invasive surgery (MIS) Achilles repair technique for 5 years, including the last 2 years with the MIS FiberTak Achilles SpeedBridge kit.

Insertional Achilles pathology is a common problem I see in my practice. Many patients fail nonoperative management and opt for surgery. The traditional open approach works well, but I am always concerned about the prospect of wound issues, prolonged pain and swelling, and the issue with returning to regular shoe wear.

The MIS procedure has resulted in significantly fewer wound complications, and the immediate weight-bearing is a huge plus. I use arthroscopy as an adjunct because I believe it provides improved irrigation as well as direct vision of bony and tendon debridement using a combination of the MIS burr and shaver.

Right side: open Achilles repair (2019)

Left side: MIS Achilles repair (8 weeks ago)

Preoperative x-rays

Postoperative x-rays (MIS SpeedBridge repair)

Scientific Update

Ankle Instability

Anish R. Kadakia, MD

Broström With Augmentation Markedly Improves Ankle Stability Measured by the Cumberland Ankle Instability Tool Compared With Broström Without Augmentation
Steven M Hadley Jr , Rachel Bergman, Sarah J. Westvold, Tanya Kukreja, Ryan Filler, Anish R. Kadakia

J Am Acad Orthop Surg. Published online November 11, 2025. doi:10.5435/JAAOS-D-25-00717

What is the focus of this study?
No ankle instability study has previously directly evaluated the benefit of nonaugmented vs augmented with *Internal*Brace™ repair measured using the Cumberland Ankle Instability Tool (CAIT). Additionally, we wanted to see if the severity of preoperative instability affects outcome and whether augmentation offers superior outcomes with more severe instability.

What were the main findings from this study?
We found that patients who underwent *Internal*Brace ligament augmentation had significantly higher postoperative CAIT scores compared with nonaugmented patients, denoting superior stability. When we adjusted for preoperative instability, the more severe the instability, the greater the difference in outcomes. This implies that with significant objective and subjective instability, the *Internal*Brace procedure is crucial to providing a stable ankle.

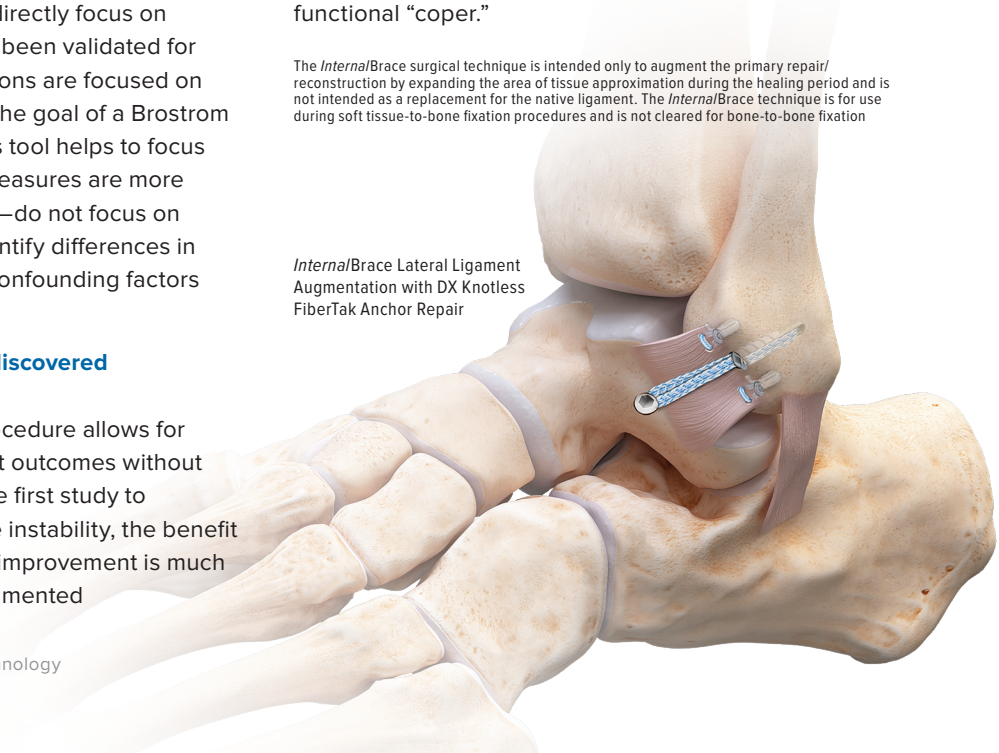
How does the CAIT differ from other measures?
Other functional measures do not directly focus on stability of the ankle. The CAIT has been validated for ankle instability specifically. Questions are focused on stability in various situations. With the goal of a Brostrom being to provide ankle stability, this tool helps to focus on this aspect specifically. Other measures are more general and—although very useful—do not focus on stability and may not be able to identify differences in populations because of the other confounding factors being measured.

What additional information was discovered with this study?
We knew that the *Internal*Brace procedure allows for a faster rehab, resulting in excellent outcomes without adding complications, but this is the first study to determine that the more severe the instability, the benefit is not only significant but the delta improvement is much greater when comparing to nonaugmented Brostrom repairs. Given that the CAIT score focuses on instability, this study shows use of the *Internal*Brace procedure reproducibly eliminates or significantly decreases mechanical and functional instability, which is the primary complaint that drives patients to seek treatment for this condition. Although a nonaugmented Brostrom repair was shown to improve function, the use of *Internal*Brace ligament augmentation significantly improved stability, with a smaller standard deviation.

Given that the more severe the instability before surgery, the more value *Internal*Brace repair offers, the implication is that if there is significant mechanical instability, augmentation may be the preferred method of treatment.

Over this study's period, how has using *Internal*Brace ligament augmentation helped evolve your treatment paradigm for ankle instability patients?
Based on these findings, the use of the *Internal*Brace procedure among myself and my colleagues is now the standard of how we treat all instability. We will continue to follow these patients and potentially conduct a prospective study to evaluate the outcomes. Looking objectively at our data, *Internal*Brace ligament augmentation repair resulted in the outcome we are trying to achieve more reliably than without augmentation. That outcome is a functionally stable ankle for the patient, giving them the best chance to return to their preinjury lifestyle without becoming a functional "coper."

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



*Internal*Brace Lateral Ligament Augmentation with DX Knotless FiberTak Anchor Repair

Case Review

DualCompression Hindfoot Nail

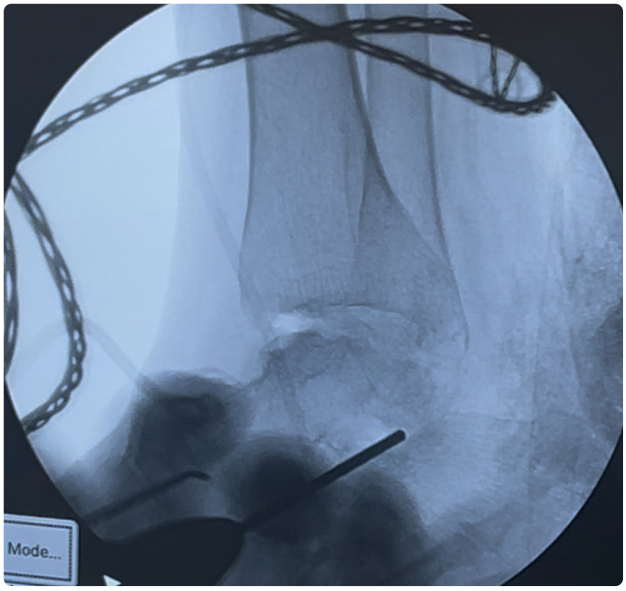
David J. Heinsch, MD

Surgical Technique

The procedure began with percutaneous Achilles tendon lengthening (TAL) to allow passive correction of the hindfoot deformity through increased laxity.

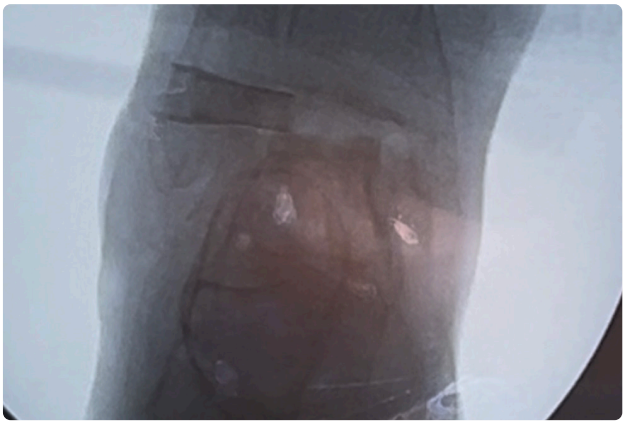
Next, we isolated the subtalar joint on fluoroscopy. A small stab incision was made in the sinus tarsi, and the MIS Sayre elevator was used to free the joint. A 3 × 30 mm Shannon burr was then used to clear the cartilage, ensuring complete joint access and preparation under fluoroscopy. A wedge burr was used to remove the subchondral plate.

The tibiotalar joint was prepped using a transmalleolar approach. The anterior ankle joint was prepared first, followed by the posterior aspect. Progress was monitored using a C-arm on the AP and lateral projections. Care was taken to prep in quadrants to ensure complete joint access. Again, cartilage was removed with the Shannon burr and the subchondral plate was morselized using the wedge burr.



The talonavicular joint was then prepped using a supplemental anterolateral portal. After joint preparation was complete, the residual medial tubercle was resected using a wedge burr under fluoroscopic guidance.

Next, 10 cc of ArthroCell™ Plus was prepared and injected via the graft gun through the percutaneous portals.



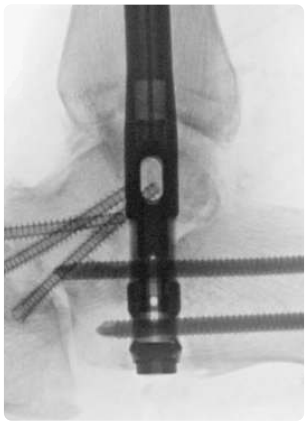
Delivery of ArthroCell Plus using the Graft Gun

Finally, the hindfoot was reduced and fixated with the DualCompression hindfoot nail and three 5.0 mm headless compression screws.

Case Review

DualCompression Hindfoot Nail (Cont.)

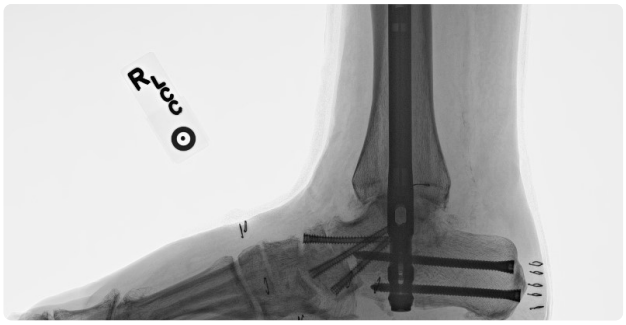
David J. Heinsch, MD



Q&A: What are the benefits of the Arthrex DualCompression hindfoot nail?

I have found the DualCompression hindfoot nail to have many advantages. Any conversation must start with its thoughtful design, which provides industry-leading ease of instrumentation. The aiming arm and the spade-tip drill make drilling the interlocks reliable and reproducible, while the long-axis calcaneal screws provide the opportunity for improved stability even in compromised bone. It also provides the option for isolated talar fixation for a third point of distal fixation if desired. Further, it is the only nail on the market that provides sustained dynamic compression with the ease of a conventional aiming arm and instrumentation.

New application of nitinol technology allows for both immediate and prolonged compression through the nitinol core. You can gain up to 10 mm of compression across both the tibiotalar and subtalar joints, achieving immediate in-line mechanical and sustained compression. Also, the nail can be locked both statically or dynamically at the proximal extent to allow for additional compression over time.



Q&A: Are you augmenting these cases with biologics?

I augment all my fusion cases with ArthroCell™ Plus or Angel® bone marrow aspirate concentrate (BMAC). The availability of biologics with added regenerative potential can prevent nonunion or delayed union in these big fusion cases. I prefer ArthroCell Plus for older patients (>65 years) or patients who may have impaired physiology leading to lower stem cell viability in their bone marrow. ArthroCell Plus has viable cells in an osteoconductive scaffold to promote solid fusion. Also, it has easy handling characteristics and is simple to prepare on the back table by thawing. It can be applied using the Arthrex Graft Gun, and is compatible with both open and minimally invasive surgery.

Arthrex also offers a variety of allograft void fillers that are osteoinductive and osteoconductive, as well as the tools for harvesting BMAC and the OsteoAuger™ device for surgeons who want to use autologous bone for their fusion patients.

ArthroCell Plus Allograft

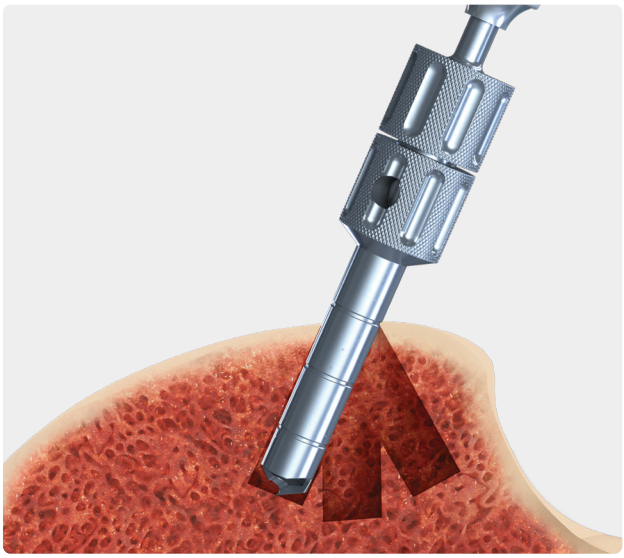
Case Review

DualCompression Hindfoot Nail (Cont.)

David J. Heinsch, MD

Q&A: What other Arthrex innovations have served to improve outcomes in these tough cases?
For challenging cases like these hindfoot fusions, I like to use the Arthrex minimally invasive surgery (MIS) handpiece and burrs. I have transitioned to mostly MIS joint prep for all fusions at this point. I feel the burrs have greatly improved my joint prep by making it faster, more biologically friendly, and more complete. In early implementation of MIS joint prep, I began by using the burrs through smaller versions of my typical open incisions. Initially, I wanted to still see the joint to ensure adequate preparations. After gaining a good feel for the technology, I was able to transition to all-percutaneous preparation. The newer burrs in 3 × 30 mm and 4 × 15 mm allow for a more aggressive approach and a larger preparation area.

I have also adapted the Arthrex graft gun for use in foot and ankle surgery as an MIS graft delivery device to get ArthroCell™ Plus into joints through small incisions. Together, these tools allow me to perform fusions through small incisions, expanding my ability to safely perform fusions for deformity correction, even in patients who have questionable soft tissue or compromised biology, by allowing large fusions without large incisions or extensive stripping.



OsteoAuger™ Bone Graft Harvesting System

Case Review

DynaNite® Nitinol Staples

Andrew R. Hsu, MD

Case Presentation

A 27-year-old female with a history of multiple sclerosis was involved in a high-speed motor vehicle accident, sustaining a right foot Lisfranc fracture-dislocation with lateral subluxation of the midfoot across the tarsometatarsal (TMT) joints. The patient was married with two young children and employed as a waitress. She required an early return to weight-bearing given her social and work needs. She presented with diffuse midfoot pain and swelling without fracture blisters.

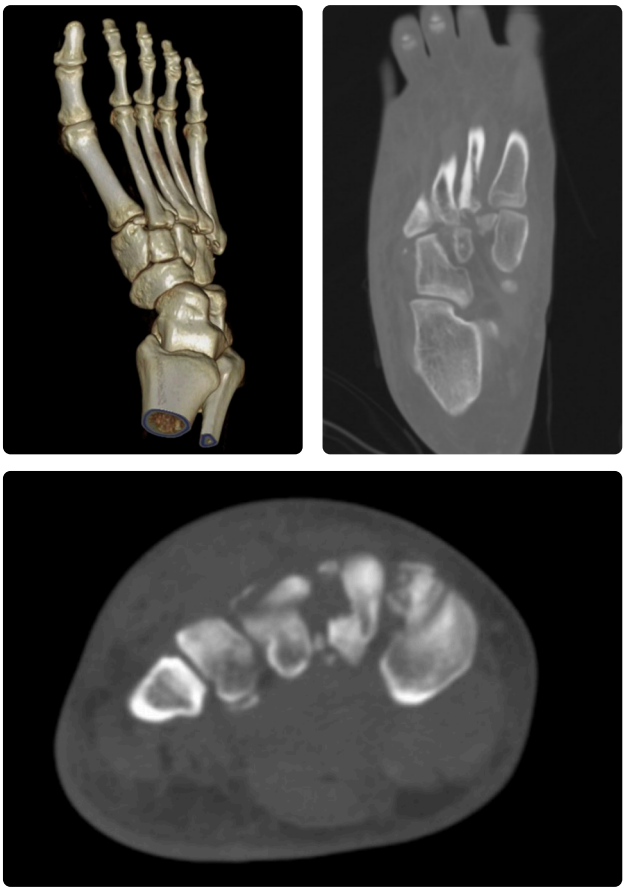
Pre-op X-Rays

Preoperative x-rays show comminuted fracture of the proximal base of the 2nd metatarsal with extension to the TMT joint. There is lateral subluxation of the 1st and 2nd proximal metatarsal bases at the TMT joints with widening of the Lisfranc interval.

Pre-op CT

Preoperative CT scan shows comminuted intra-articular fractures involving the proximal bases of the 2nd, 3rd, and 4th metatarsals with multiple fracture fragments in the TMT joints. There is a small cortical fracture at the distal dorsal aspect of the medial cuneiform.

Widening of the Lisfranc interval with lateral subluxation of the midfoot was again seen.



Decision-Making

Given the patient's age, functional needs, and degree of fracture comminution across her midfoot extending into the TMT joints with lateral subluxation, the decision was made to pursue a primary midfoot ORIF with fusion.

To minimize hardware irritation from multiple plates and screws across the midfoot, multiple DynaNite staples were used across the 1st, 2nd, and 3rd TMT joints with additional fixation across the Lisfranc interval using a dual-incision approach.

Case Review

DynaNite® Nitinol Staples (Cont.)

Andrew R. Hsu, MD

Surgical Technique

One skin incision was placed dorsal medial over the 1st TMT joint to allow for 90°-90°–oriented DynaNite staple insertion with another incision spaced between the bases of the 2nd and 3rd TMT joints to allow for joint preparation and fixation. Additional DynaNite staples were placed for fixation and compression across the 2nd and 3rd TMT joints.

All joints were prepared for fusion using osteotomes and curettes with AlloSync™ Pure mixed with bone marrow concentrate prepared using the Angel® system inserted into the joint spaces to assist with fusion.

Post-op

The patient was made non–weight-bearing to the right lower extremity in a splint for 2 weeks to allow her incisions to heal. After suture removal at 2 weeks, she began range-of-motion exercises to the right foot and ankle from weeks 2-4 with initiation of early weight-bearing 4 weeks postoperatively. She progressed to weight-bearing in a tall CAM boot from weeks 4-8 with a return to regular shoe wear at 8 weeks. She was able to return to work at 3 months (x-rays below) with evidence of fusion across her midfoot without any hardware irritation or need for secondary procedures.

Final Thoughts

DynaNite staples are an ideal implant for primary midfoot ORIF and fusion as they allow for individualized sterile size selection based on patient anatomy with multiple size options, low-profile fixation to minimize hardware irritation, and continuous compression to enhance bony fusion.

Staples can be placed through significantly smaller skin incisions as they can be inserted individually without the need for plate contouring across multiple joints.

DynaNite Staple

Case Review

Progressive Flatfoot Deformity After Ankle ORIF

David Jaffe, MD

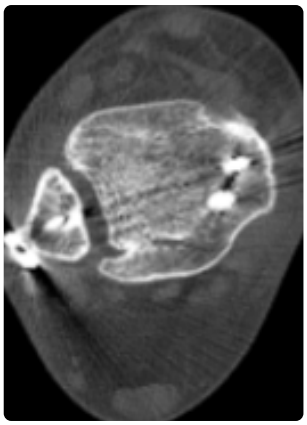
Patient Presentation

A patient in her fifth decade presented with complaints of balance and gait instability, without focal foot pain. She had a history of bimalleolar ankle fractures sustained 2 years previously. Despite an extended course of conservative management, including orthotics and bracing, symptoms persisted without improvement.

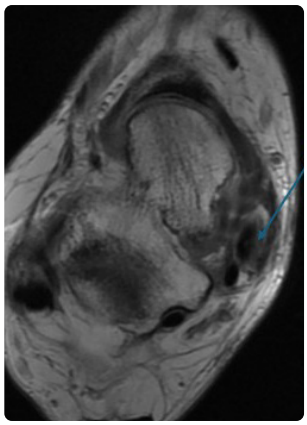
Physical Examination

Ankle range of motion was full and painless.

- No significant swelling. Mild tenderness localized to the subfibular region; no tenderness over the posterior tibial tendon.
- Hindfoot alignment demonstrated a flexible, severe pes planovalgus deformity on the affected side.



Ankle CT



Ankle MRI

Diagnostic Imaging

CT demonstrated a healed posterior malleolar fracture with intact syndesmotic alignment and no evidence of widening or asymmetry to explain the valgus hindfoot collapse. Ankle MRI demonstrated mild posterior tibial tendon tendinosis without split tear, preserved hindfoot joints, and incidental naviculocuneiform arthritis.

Pre-op

Case Review

Progressive Flatfoot Deformity After Ankle ORIF (Cont.)

David Jaffe, MD

Surgical Considerations

Triple Arthrodesis

› Corrects the deformity and stabilizes the foot, but a fusion may be excessive as the patient lacks pain and arthritis.

Calcaneal Osteotomy With FDL Transfer

› Soft-tissue reconstruction with a medial displacement calcaneal osteotomy (MDCO) could correct the deformity, but given no medial pain and intact PTT, this could be overly intensive.

My Surgical Solution

MDCO-Evans-Cotton

I elected to perform a joint-sparing corrective double calcaneal osteotomy using AlloSync™ allograft wedges to realign the deformity while preserving hindfoot motion.

This approach offers several advantages:

› preserves motion

› protects the adjacent midfoot joints

› avoids excessive stress through the deltoid

› avoids reliance on the medial soft-tissue reconstruction in the absence of PTT tear/pain

Graft Options

AlloSync Allograft Wedges

Dense cancellous AlloSync allograft wedges offer a balance between structural support and a favorable resorption profile relative to tricortical or metal wedges. However, resorption can lead to loss of correction if incorporation is not achieved in a timely manner.

Lack of living cells can be mitigated by adding bone marrow aspirate or autologous blood products.

Internal fixation with hardware may hold the graft in place while healing, but may also result in graft fracture or graft collapse, and could lead to hardware irritation.

BioSync® Metal Wedges

With metal wedges, the implant will maintain height and length, but the adjacent joints may be overloaded, resulting in stiffness and joint stress.

Potential future revision can be complicated with graft removal, void filling, and planning fixation.

First-Year Post-op Images

Q&A

BioCartilage® Allograft Use for Talus

Mark Drakos, MD

How do you evaluate your osteochondritis dissecans (OCD) lesions prior to surgical intervention?

I use x-ray and MRI primarily. I rarely use CT, except for large cystic lesions.

What are your indications for using BioCartilage allograft on these lesions?

I use it for any ankle cartilage injury. Typically, I will avoid using it in large lesions (>150 mm^2) or cystic lesions. I also like adding in bone marrow concentrate (BMC) for the cellular components.

What is your preferred surgical technique for your OCD and BioCartilage allograft cases?

I typically employ all arthroscopic methods for these patients. I start by retrieving bone marrow from the anterior superior iliac crest to spin down to BMC. For significant bone defects (>1 cm in depth) or bone voids left by subchondral cysts or necrotic bone, I graft from either the iliac crest or calcaneus to initially pack the void before adding the BMC–BioCartilage mixture on top. I arthroscopically debride the lesion to remove any scar tissue, osteophytes, and loose fragments. Then, before introducing the BioCartilage allograft, I remove fluid from the joint using a spinal needle and vacuum suction. Next, I insert the BMC–BioCartilage mixture using the arthroscopic cannula from the kit and pack it down using a Freer elevator.

What benefit do you see in using BioCartilage allograft vs microfracture only?

Our study published in *Foot and Ankle International* (2021) showed that when BioCartilage matrix is applied to lesions, it has a lower failure rate.[1] As a consequence, I have not done any microfractures in over 10 years. In addition, we found that with the addition of BMC to BioCartilage allograft when treating OCDs vs isolated microfractures, patients had significantly better scores for the defect Infill, Integration, and Signal MOCART subcategories.

How has this changed your patient outcomes over the last 10 years?

They have improved markedly over that time, and the reduced failure rate is consistent at <5%. We are doing a 5-year follow-up study now to show the improved benefits overtime with the use of BioCartilage allograft.

Reference

1. Drakos MC, Eble SK, Cabe TN, et al. Comparison of functional and radiographic outcomes of talar osteochondral lesions repaired with micronized allogenic cartilage extracellular matrix and bone marrow aspirate concentrate vs microfracture. *Foot Ankle Int*. 2021;42(7):841-850. doi:10.1177/1071100720983266

Foot and Ankle Medical Education

Course Schedule

Upcoming Medical Education Events

Date	Course Name	Location
January 23, 2026	Western Foot and Ankle Minimally Invasive Surgery Course	Englewood, CO
January 24, 2026	Western Foot and Ankle Minimally Invasive Surgery Course	Englewood, CO
February 9, 2026	Foot and Ankle Minimally Invasive Surgery Course	Naples, FL
February 13, 2026	Team Physician Controversies	Naples, FL
March 9, 2026	Novel Approaches to Hindfoot Surgery	Naples, FL
March 20-21, 2026	Foot and Ankle Team Physician Controversies	Naples, FL
June 12, 2026	Western Foot and Ankle Minimally Invasive Surgery Course	Englewood, CO
June 13, 2026	Western Foot and Ankle Minimally Invasive Surgery Course	Englewood, CO
July 13, 2026	Foot and Ankle Minimally Invasive Surgery Course	Naples, FL
July 30, 2026	MIS Course	San Diego, CA
July 31-August 1, 2026	Western Foot and Ankle Summit	San Diego, CA
September 21, 2026	Foot and Ankle Minimally Invasive Surgery Course	Naples, FL
October 2-3, 2026	Getting It Right: Novel Approaches to Hindfoot Surgery	Naples, FL
October 19, 2026	Foot and Ankle Minimally Invasive Surgery Course	Naples, FL
October 30-31, 2026	Controversies in Foot and Ankle Surgery	Naples, FL
November 16, 2026	Foot and Ankle Minimally Invasive Surgery Course	Naples, FL

Learn more about the Arthrex Medical Education Experience

The views expressed in this newsletter reflect the experience and opinions of the presenting surgeons and do not necessarily reflect those of Arthrex, Inc.

This description of technique is provided as an educational tool and clinical aid to assist properly licensed medical professionals in the usage of specific Arthrex products. As part of this professional usage, the medical professional must use their professional judgment in making any final determinations in product usage and technique. In doing so, the medical professional should rely on their own training and experience and should conduct a thorough review of pertinent medical literature and the product's directions for use. 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.

Products may not be available in all markets because product availability is subject to the regulatory or medical practices in individual markets. Please contact your Arthrex representative if you have questions about availability of products in your area.

Arthrex manufacturer, authorized representative, and importer information (Arthrex eIFUs)

US patent information

arthrex.com