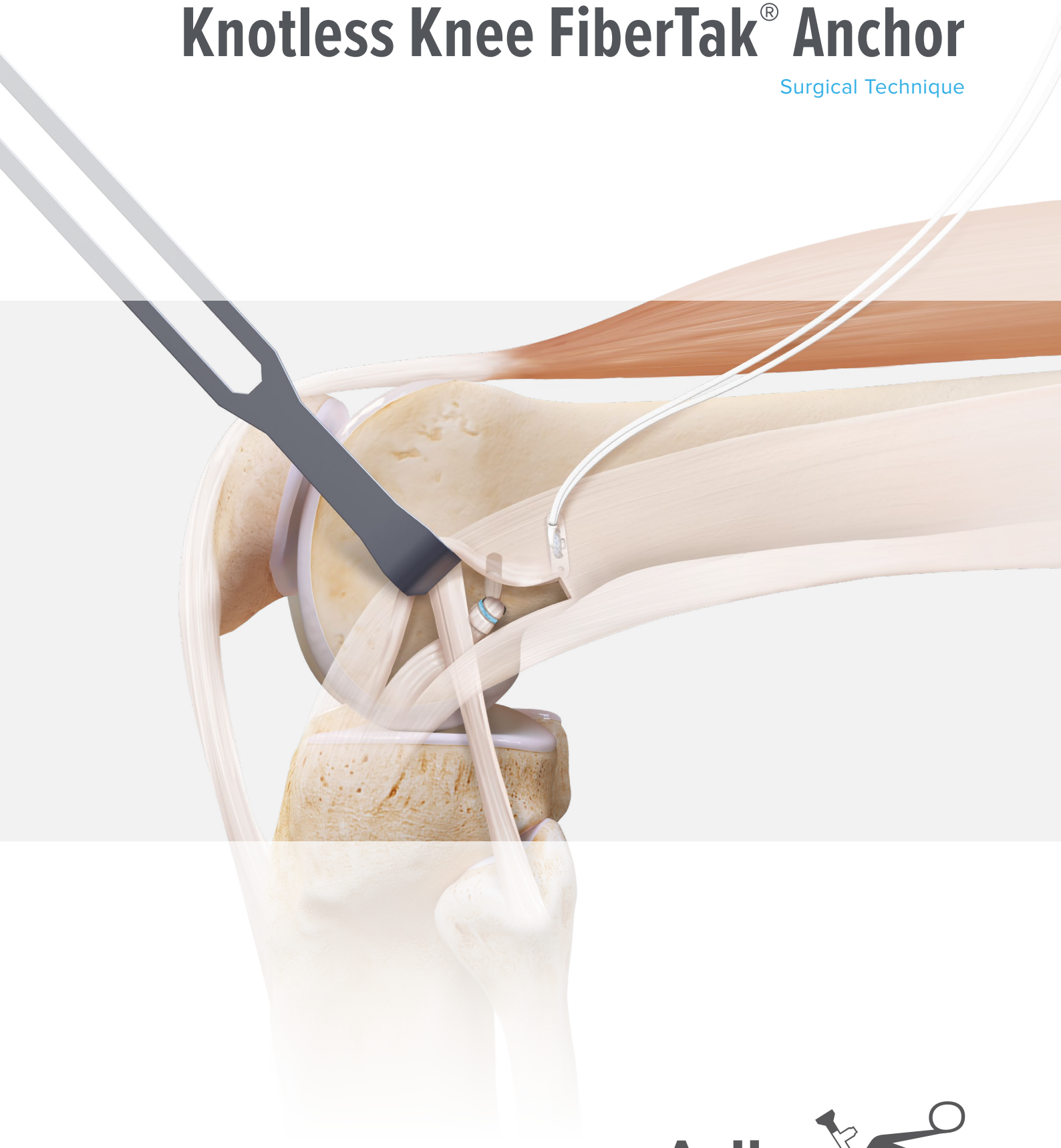
Lateral Extra-Articular Tenodesis With the Double Knotless Knee FiberTak® Anchor

Surgical Technique

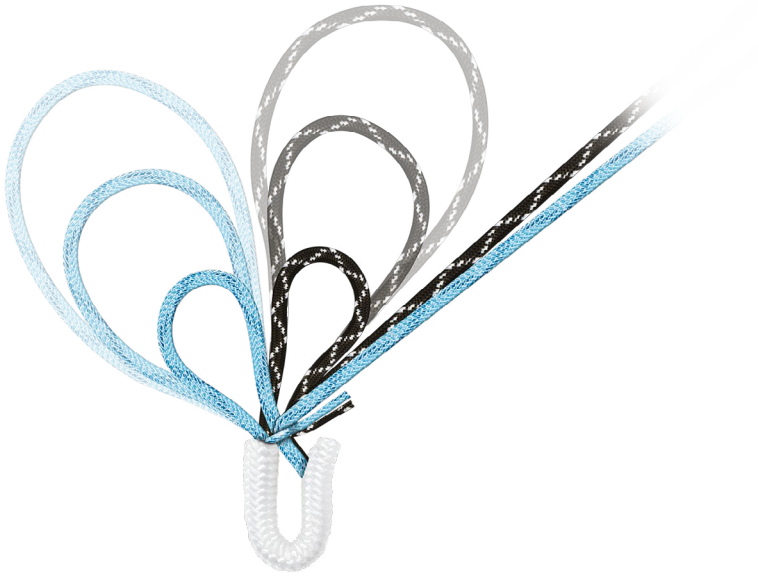


Arthrex®

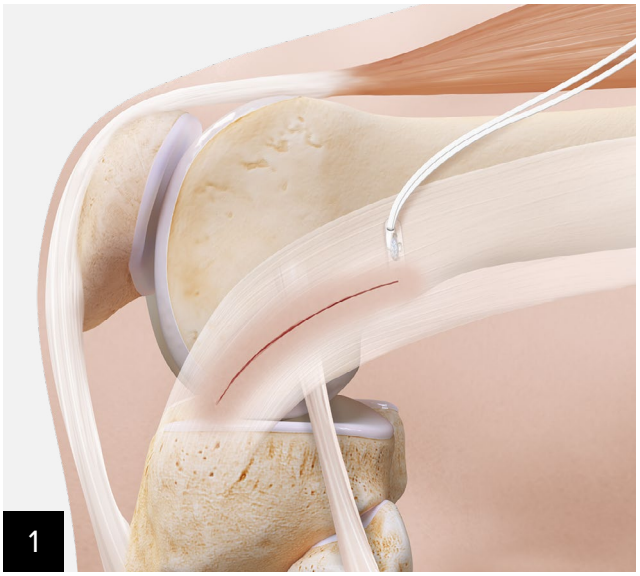
Lateral Extra-Articular Tenodesis: Introduction

The Double Knotless Knee FiberTak® lateral extra-articular tenodesis (LET) technique offers several distinct advantages when compared to other techniques for lateral extra-articular augmentation.

- **Simple:** Quick, easy, and reproducible technique
- **Safe:** Reduced risk of converging the ACL femoral tunnel as the anchor sets just below the cortex; reduced risk of damaging the ACL graft as with traditional drilling techniques due to the self-punching anchor technique; lower risk of graft laceration as described with interference screw techniques[1]
- **Low Profile:** No prominent or additional hardware, such as staples, that can lead to pain, discomfort, or hardware removal[1]
- **Preserves Anatomy:** No need to ream a socket using onlay technique, which also minimizes the length of the graft required
- **Titratable Graft Tensioning:** Provisionally tension and incrementally retension the graft after checking for isometry and no overconstraint



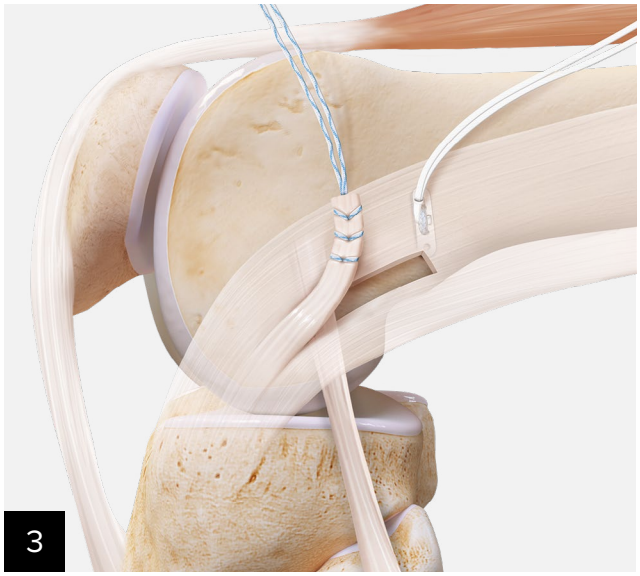
Lateral Extra-Articular Tenodesis Surgical Technique



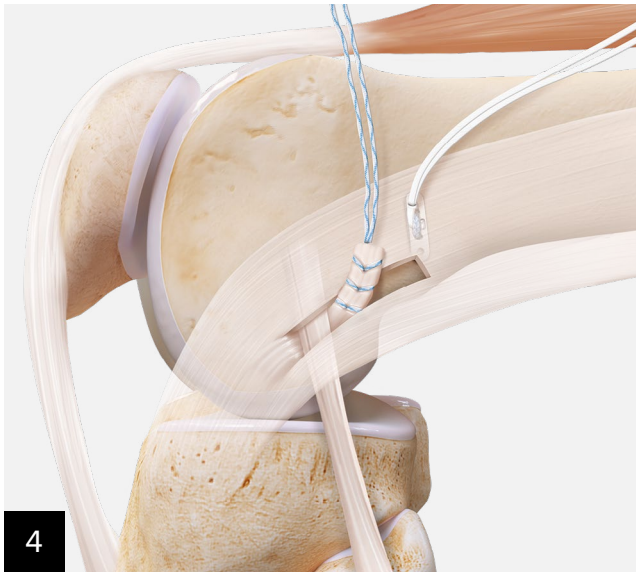
Perform a lateral extra-articular (LET) approach by making a 4 cm incision starting just proximal to Gerdy's tubercle and extending to the lateral femoral epicondyle. Expose and identify the iliotibial band (ITB) and leave it intact distally at Gerdy's tubercle.

Obtain a distally based ITB graft measuring 10 mm × 60 mm to 80 mm. Avoid the proximal and distal Kaplan fibers posteriorly. These fibers provide anterolateral knee rotatory stability and should be preserved.

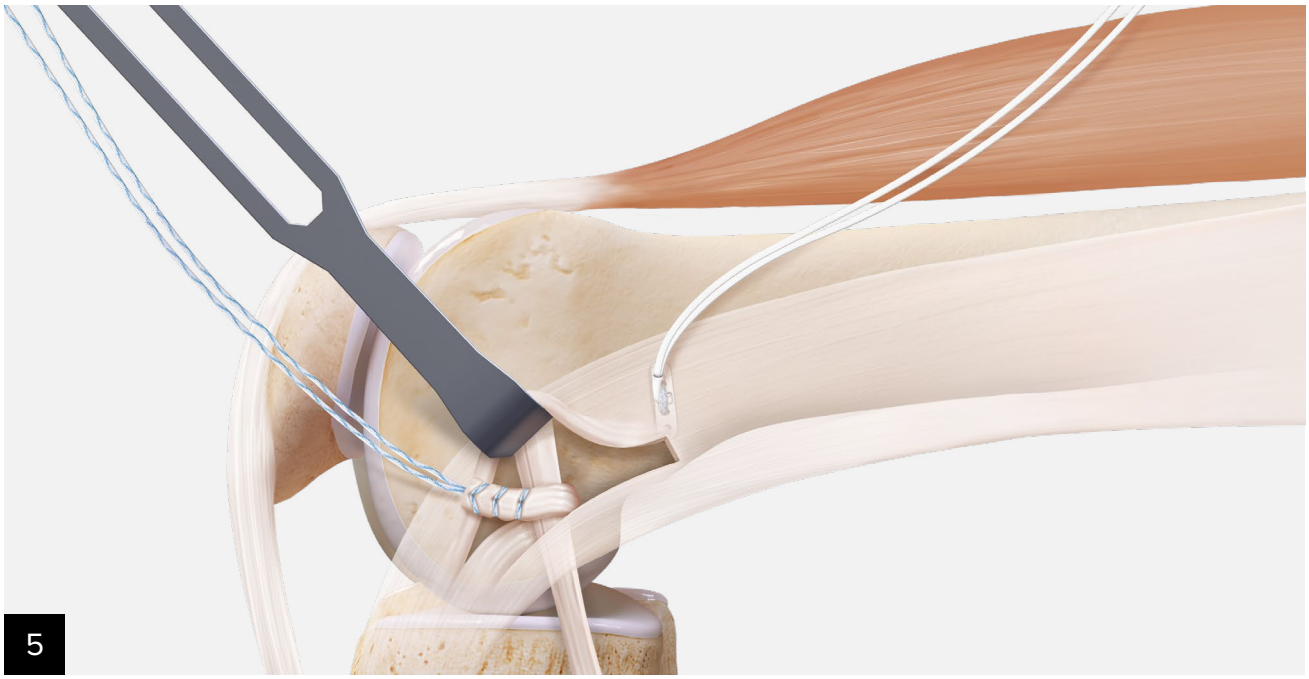
Note: Identify the lateral collateral ligament (LCL).



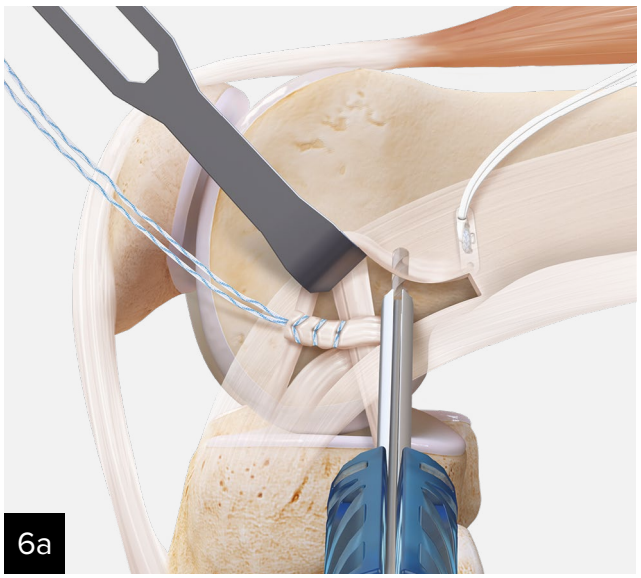
Whipstitch the proximal ITB graft with a FiberLoop® SutureTape.



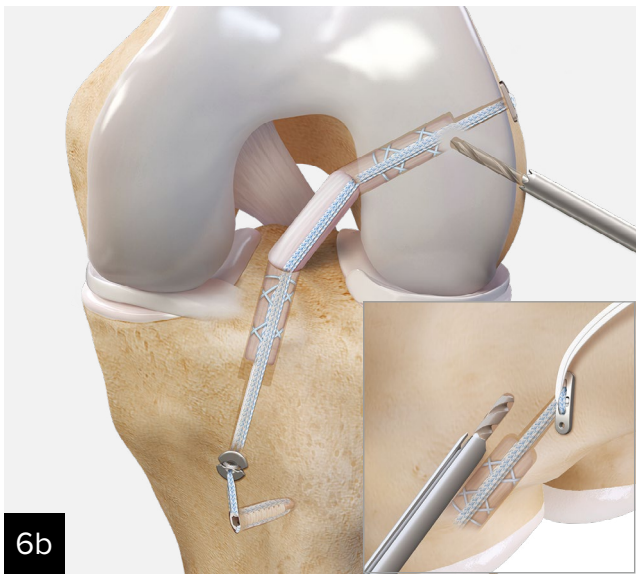
Pass the ITB graft deep (medial) to the LCL. Alternatively, some surgeons prefer to pass the graft over the LCL.



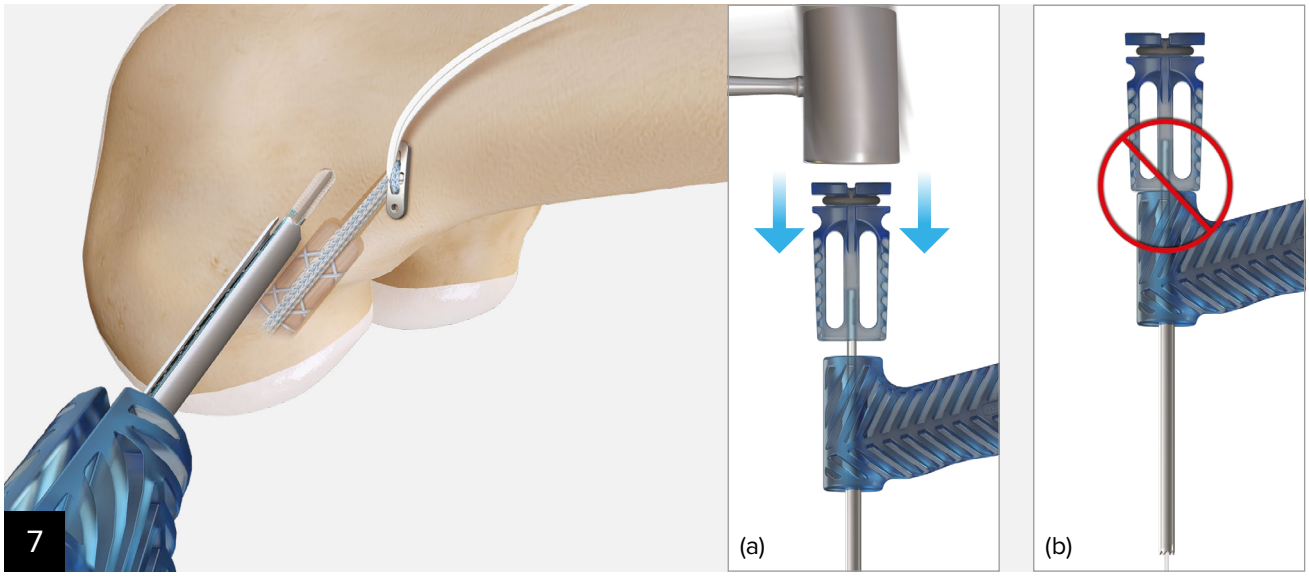
Identify the fixation site posterior and proximal to the femoral origin of the LCL.



Direct the FiberTak® drill guide anteriorly and proximally, taking care to avoid the femoral socket of the ACL reconstruction. The anchor can be inserted by self-punching, drilling a pilot hole, or using the awl to punch a pilot hole.

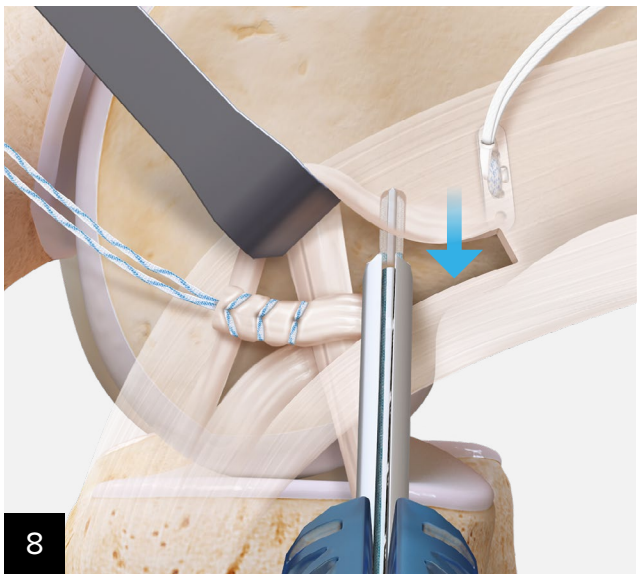


If hard bone is expected, use a 2.6 FiberTak fluted drill to prepare a pilot hole.

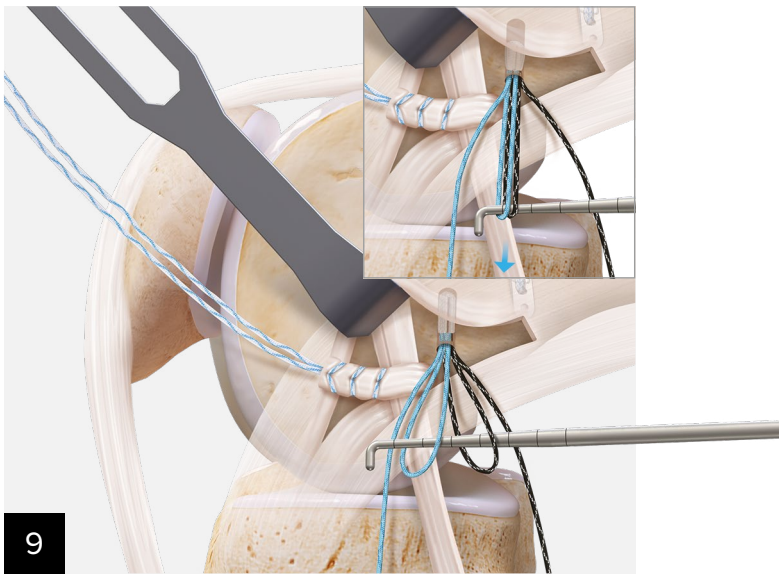


Insert the knotless FiberTak soft anchor through the drill guide and mallet the inserter down to the back of the guide handle **(a)**.

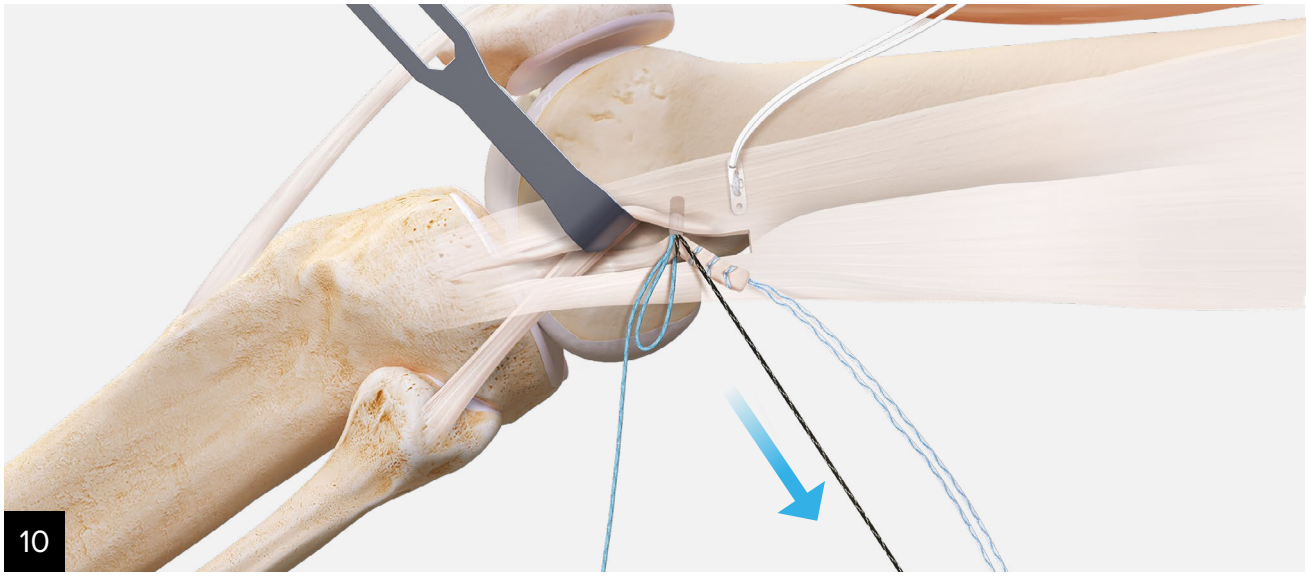
Note: Do not continue to impact the driver once the anchor inserter handle reaches the back of the guide handle. This could inadvertently advance the tip of the guide into bone, compromising the cortex and potentially impacting fixation strength (b).



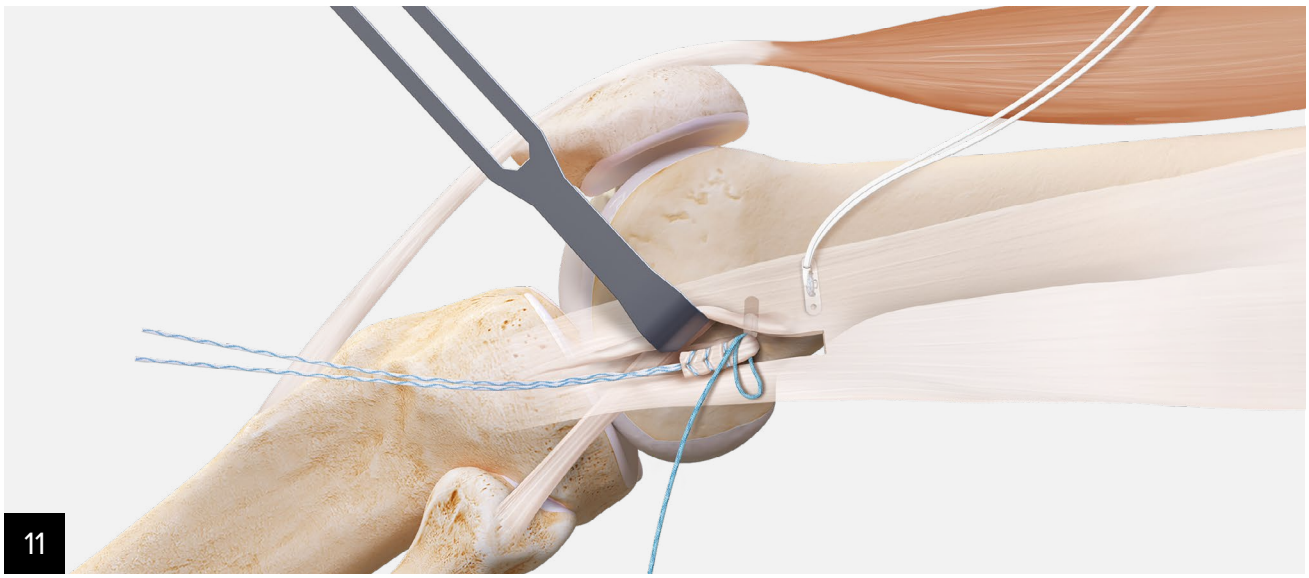
Pull the black suture-release tab, uncoil the sutures, and pull back the anchor handle to remove the inserter.



Remove the white retention suture from the preconverted loops. Place a probe through both loops of the anchor and apply gentle tension to set the anchor.

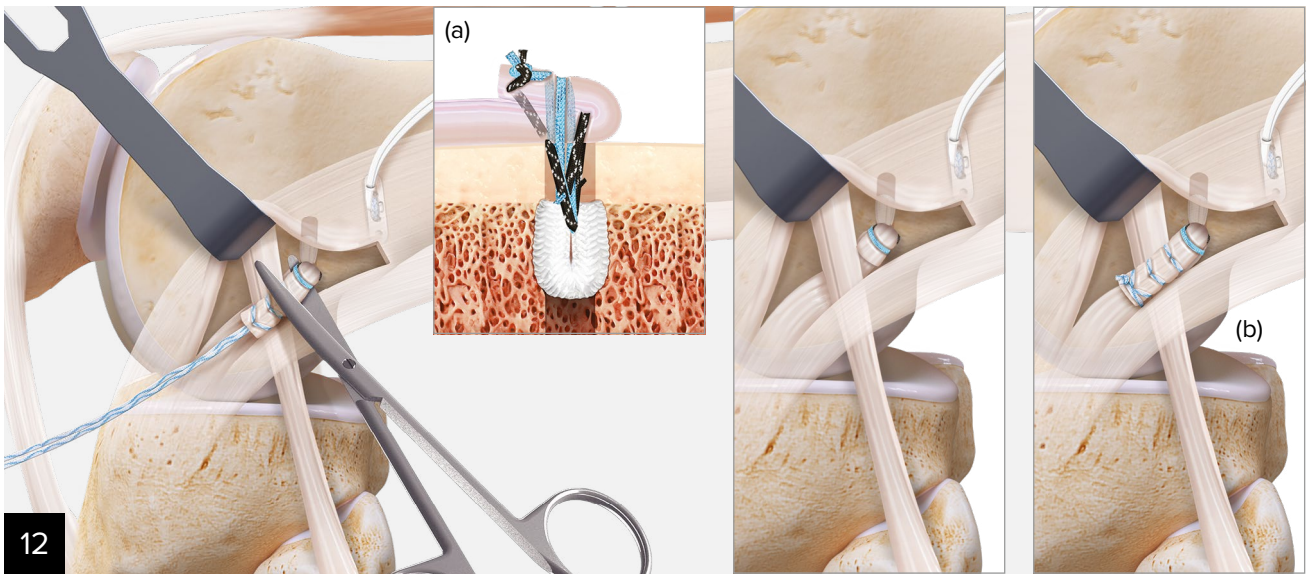


Pull the graft through both loops and use the black tensioning strand to begin cinching the black repair loop down around the graft.

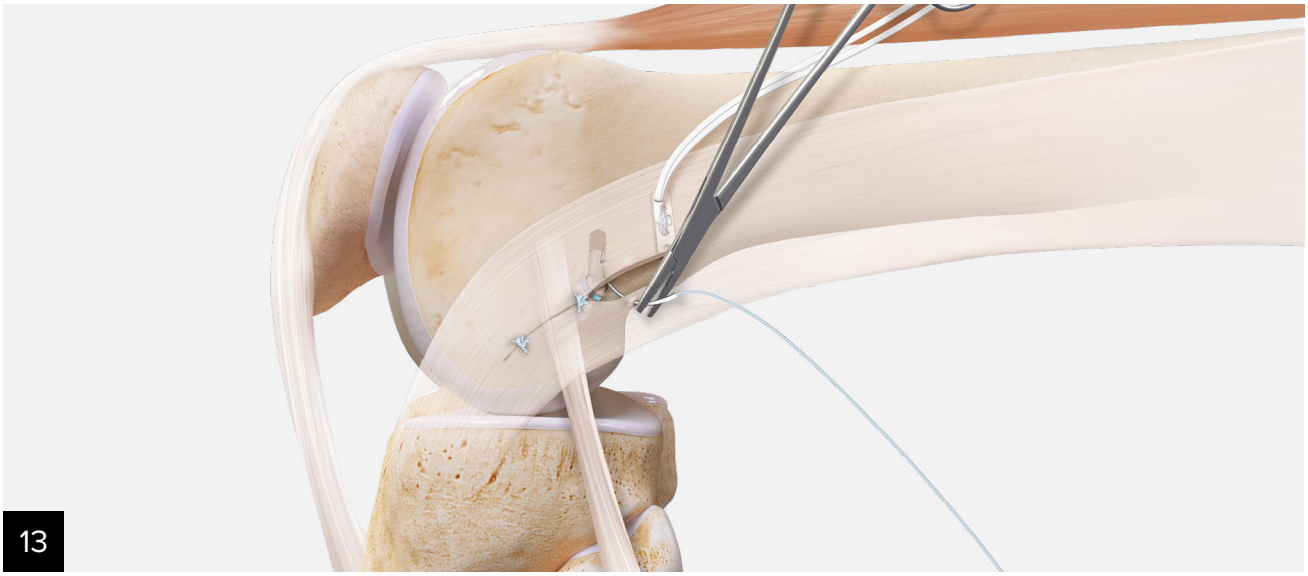


Set the leg to the preferred position, typically neutral rotation and 30° of flexion, and provisionally tension the first loop construct. Check internal rotation after tensioning to make sure there is no overconstraint. The isometry of the tenodesis can be confirmed by moving the leg through full range of motion. Additional tension can be applied by pulling the black tensioning suture if desired.

Reflect the graft distally, pulling it through the blue loop, and pull the blue tensioning suture, making sure to place the cinching loop distal to the first loop, to complete the FiberStaple™ construct.



The remaining length of graft can be cut 1 cm distal to the construct. Alternatively, the tensioning strands can be passed back through the graft to reinforce the construct **(a)** or the excess ITB autograft can be passed over the LCL and sutured into itself using the SutureTape **(b)**.



13

Repair the ITB defect with SutureTape.

Note: Final ACL graft tensioning can be performed and the tensioning strands cut to complete the ACL reconstruction.

Ordering Information

Product Description	Item Number
Double Knotless Knee FiberTak® soft anchor	AR-**3740SP**
Knee FiberTak disposable drill guide kit	AR-**3710**
2.7 mm Knee FiberTak disposable hard-bone drill	AR-**3712-27**
2.8 mm Knee FiberTak disposable hard-bone drill	AR-**3712-28**
2.9 mm Knee FiberTak disposable hard-bone drill	AR-**3712-29**
3 mm Knee FiberTak disposable hard-bone drill	AR-**3712-30**
2.6 mm Knee FiberTak reusable punch	AR-**3714**
FiberLoop® SutureTape, 1.3 mm, 20 in loop (white/blue) w/ straight needle	AR-**7534**
TigerLoop™ 1.3 mm SutureTape, white/black, looped w/ needle	AR-**7534T**
FiberLoop SutureTape, 0.9 mm, 20 in loop (white/blue) w/ straight needle	AR-**7524**
0.9 mm SutureTape, 38 in, white/black, w/ straight needle	AR-**7547T**
FiberSnare® suture, blue/white stripe, w/ 2 in loop	AR-**7209SNL**
FiberSnare suture, black/white, w/ 2 in loop	AR-**7209SNT**

Products advertised in this brochure / surgical technique guide may not be available in all countries. For information on availability, please contact Arthrex Customer Service or your local Arthrex representative.

Reference

1. Muller B, Willinge GJA, Zijl JAC. Minimally invasive modified Lemaire tenodesis. *Arthrosc Tech.* 2020;10(1):e29-e36. doi:10.1016/j.eats.2020.09.006

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

US patent information

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