Surgical Technique

JOURNEY® UNI
Unicompartmental Knee System

JOURNEY® PFJ
Patellofemoral Joint System

JOURNEY UNI and JOURNEY PFJ combined
preoperative planning and surgical technique
JOURNEY® UNI and JOURNEY PFJ combination preoperative planning and surgical technique

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Nota Bene
The technique description herein is made available to the healthcare professional to illustrate the authors’ suggested treatment for the uncomplicated procedure. In the final analysis, the preferred treatment is that which addresses the needs of the patient. Additional JOURNEY Active Knee Solutions surgical technique brochures are available for the other JOURNEY Components.
Preoperative planning

When addressing isolated OA disease of the medial or lateral condyle and the patellofemoral joint, consider using the JOURNEY™ Unicompartmental and JOURNEY Patellofemoral devices in combination. Radiographic preoperative planning is recommended in order to optimize implant sizing/positioning and to ensure that there is no impingement between the two implants or with any surrounding tissue or ligaments. Radiographic preoperative planning allows the surgeon to determine whether segmental devices or a total knee system would be the optimal treatment for each patient prior to surgery:

- Take standing, weight-bearing A/P and lateral radiographs of the knee, as well as a skyline radiograph of the patella.

- Optionally, the surgeon can request a non-weight bearing, valgus-stressed A/P radiograph, showing the leg in correct alignment. This view will help assess the amount of resection and implant construction necessary (if any) to correctly align the limb.
**Unicondylar implant sizing**

The size of the JOURNEY® Unicompartmental femoral implant is estimated by comparing the lateral radiograph of the femur with the implant templates. The template size which most closely matches the profile of the femur on the distal and posterior aspects is chosen. Tibial templates are also available to approximate the size and thickness of components that will be needed for surgery.

The images to the right illustrate the sizing criteria for three different UNI femoral implants on the same femur:

- **Size 3** is slightly undersized. It may be considered as functional, but not optimal.
- **Size 5** is oversized, with both posterior and anterior over hang.
- **Size 4** has an optimal fit to the articular surface, has good coverage and no over hang.

Part numbers for digital templates:
- **JOURNEY UNI femoral**: 7128-1472
- **JOURNEY UNI tibia**: 7128-1783
- **JOURNEY PFJ**: 7128-1544

**Femoral component dimensions (mm)**

<table>
<thead>
<tr>
<th>Size</th>
<th>AP</th>
<th>HT</th>
<th>ML</th>
<th>DM</th>
<th>PM</th>
</tr>
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<td>1</td>
<td>40</td>
<td>31</td>
<td>19</td>
<td>5.5</td>
<td>5.5</td>
</tr>
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<td>58</td>
<td>42</td>
<td>25</td>
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</tbody>
</table>
Unicondylar implant sizing/positioning

The size and M/L position of the JOURNEY® Unicompartmental implant is estimated by comparing the A/P radiograph of the femur with the implant templates. The template size that best fits the M/L width of the femoral condyle should be chosen. Tibial templates are also available to approximate the size and thickness of components that will be needed for surgery. In this example, size 4 provides the optimal M/L fit.
**Patellofemoral implant sizing/positioning**

Once the JOURNEY™ UNI femoral implant has been sized and positioned, next determine the size and position of the patellofemoral implant. The primary method for determining the appropriate size of the patellofemoral implant is assessing the M/L width of the implant relative to the M/L width of the femur. The best size will fully cover the anterior surface without overhang. Avoiding overhang is more important than complete coverage. Proximal-distal coverage is less critical. Leaving a small portion of cancellous bone uncovered should not compromise the result. Note: When positioning the patellofemoral X-Ray template, the surgeon should keep in mind that all sizes of the JOURNEY™ Patellofemoral implant are positioned centrally with respect to the trochlear groove.

**Note:** Preoperative radiographic planning will assist the surgeon in determining size and placement. However, actual size may change once the anterior cortex of the femur has been resected in order to optimize implant coverage. When assessing the size and position of the JOURNEY Patellofemoral implant in combination with the JOURNEY Unicompartmental implant, both templates will need to be viewed simultaneously. This will allow the surgeon to determine preoperatively if the JOURNEY UNI femoral implant and the JOURNEY PFJ implant can be implanted without implant – implant or implant – ligament impingement.

- Four femoral sizes with asymmetric components (left and right)
- Uses GENESIS™ II round resurfacing or biconvex patella (do not use the JOURNEY Bi-Cruciate Stabilized patellar implants with the JOURNEY PFJ)
- PFJ reimbursement code is 27438
- Designing surgeons are John Newman, FRCS; William B. Smith, MD; Jeffrey R. Dugas, MD; and E. Lyle Cain, MD

**JOURNEY PFJ femoral component sizes**

<table>
<thead>
<tr>
<th></th>
<th>AP</th>
<th>ML</th>
<th>HT</th>
</tr>
</thead>
<tbody>
<tr>
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<td>37</td>
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<tr>
<td>Small</td>
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<tr>
<td>Medium</td>
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</tr>
<tr>
<td>Large</td>
<td>28</td>
<td>49</td>
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</table>
Unicondylar implant sizing/positioning

JOURNEY® PFJ Size SML
Slightly undersized

JOURNEY PFJ Size LRG
Slightly oversized, slight lateral overhang

JOURNEY PFJ Size MED
Optimal, complete coverage and no overhang
Implant coordination

Once the correct size and position of JOURNEY® UNI and JOURNEY PFJ implants have been determined separately, assess how the implants will fit on the bone in combination by using the X-Ray. Specifically, assess the templates A/P positioning by using both implant templates simultaneously on the M/L film:

- Position the JOURNEY UNI femoral X-Ray template to the X-Ray of the femur.
- Keeping the JOURNEY Unicompartmental femoral template on the X-Ray, position the JOURNEY patellofemoral template on the X-Ray.
Once the correct position of unicompartmental and patellofemoral implant have been determined in the M/L film, assess position on the A/P view. Assess the M/L positioning by using both implant templates simultaneously on the A/P view:

- Position the JOURNEY® UNI femoral X-Ray template to the X-Ray of the femur.

The devices can be implanted in combination to address bi-compartmental disease of the medial or lateral condyle and the patellofemoral joint if there is:
- No implant – implant impingement
- No implant – ligament impingement
JOURNEY™ PFJ System

For orthopaedic surgeons who prefer to use a partial knee implant system for the treatment of isolated patellofemoral disease, the JOURNEY PFJ offers the next generation of implant design, wear reduction, and market-leading ease of use and instrumentation.

JOURNEY PFJ fast facts

- Four femoral sizes with asymmetric components (left and right)
- Uses GENESIS™ II round resurfacing or biconvex patella (do not use the JOURNEY Bi-Cruciate Stabilized patellar implants or oval patellas with the JOURNEY PFJ)
- PFJ reimbursement code is 27438
- Designing surgeons are John Newman, FRCS; William B Smith, MD; Jeffrey R. Dugas, MD; and E. Lyle Cain, MD

JOURNEY PFJ femoral component sizes

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</tr>
<tr>
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<td>49</td>
<td>45</td>
</tr>
</tbody>
</table>
Femoral component

- **Asymmetric**: The implant mimics the distal condyle's normal, anatomic shape by following a 10° A/P angle. This allows the left medial component to be used on the right lateral condyle, and the right medial component to be used on the left lateral condyle.

- **Anatomic**: The implant comes in seven sizes in order to customize the fit to the patient. The shape of the sagittal J-curve is the result of extensive testing to optimize function throughout the flexion arc. The anatomic anterior mesial bevel is a design feature that further optimizes the shape by ensuring smooth patellar tracking in deep flexion.

- **Bone interface**: Three planar resections and two peg holes provide a uniform, congruent cement interface. The pegs significantly diverge from the posterior planar resection, and the posterior peg is long enough to aid in placing the component in small spaces for final implantation. The entire mating surface, including the pegs, is grit-blasted to enhance cement fixation.

- **Versatility**: Sizes 3, 4, 5, 6 and 7 all feature the exact same planar resections and peg hole locations. Once these preparations have been made, the 3 – 7 trials are interchangeable, and can be up- and down-sized until a decision is made for the final implant choice. Sizes 1 and 2 are also interchangeable, with slightly different cuts and peg locations than 3 – 7. Sizes 3 – 7 typically are used for 80% or more of uni cases.

Tibial component

- **Asymmetric**: The left medial component can be used on the right lateral tibia, and the right medial component can be used on the left lateral tibia.

- **Flexibility**: the implant comes in six sizes, and the poly thickness increases in single millimeter increments from 8 – 11mm to allow for fine-tuning the fit.* The all-poly version and the metal-backed version have the same instrumentation, allowing for easy intraoperative choice. The all-poly version also has a thin 7mm option. The same tibial system is used in JOURNEY cases, so intraoperative options are increased.

- **Unconstrained kinematics**: when coupling a curved femoral component on a flat articular surface, unconstrained kinematics can be achieved. The JOURNEY UNI system is an ACL/PCL conserving device that lacks constraint, so the native ligaments can control the movement of the knee.

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*12 and 14mm options are available through InVentures.
Tibia cut first method summary

**Step 1**
Assemble the extramedullary tibial guide and place on tibia. Set tibial resection depth, posterior slope and sagittal alignment. Pin the tibial cutting block.

**Step 2**
Resect the proximal tibia.

**Step 3**
Insert a gap stick into the flexion/extension space and balance the knee.

**Step 4**
Assemble the distal cutting block and appropriate tibial trial insert. Align block with drop rod assembly.

**Step 5**
Pin the distal cutting block to the femur. Resect the distal femur.

**Step 6**
Size the femur using the 2-in-1 femoral cutting block. Position the 2-in-1 femoral cutting block and pin it to the distal femur. Drill the peg holes and resect the femur.

**Step 7**
Assemble the tibial hook sizer and tibial sizer. Size the tibia.

**Step 8**
Assemble the femoral trial on to the distal femur, insert the tibial base trial onto the proximal tibia and insert the appropriate thickness of tibial insert trials into the tibial trial base. Perform a trial range of motion.

**Step 9**
Punch for tibial implant lugs.

**Step 10**
Cement the femoral and tibial implants in place using the lugs to locate the position and orientation.

Using the tibial styli

- Some surgeons prefer to simply place an angel wing in the cutting slot in order to locate the tibial transverse cut.
- If it is preferred to use a stylus in order to measure the resection, two double-ended styli are offered to measure 2, 4, 6 or 8 millimeters of resection.
- Evaluate the degree of deformity during preoperative planning, as this will aid in determining which stylus to use.
- If significant deformity is present, consider the 2-4 stylus in order to minimize the tibial resection.
- If deformity is minimal, consider the 6-8 stylus, because the thinnest metal backed tibia is 8 millimeters (total thickness, baseplate plus insert) and overstuffing the joint is to be avoided.
Tibial preparation

Instrument assembly

1. Remove the long screw from the ankle clamp.
   • Insert the ankle clamp into the hole of the EM alignment tube and insert the long screw into the ankle clamp. Lock the EM alignment tube to the ankle clamp using the cam.
   • Insert the selected rod, spiked or non-spiked, into the hole of the tibial cutting block.
   • Insert the rod into the proximal end of the EM alignment tube. Lock the EM alignment tube to the rod using the cam.
   • Place the extramedullary tibial ankle clamp around the ankle and align the EM guide parallel to the tibial axis in the sagittal and coronal planes, then adjust in the sagittal plane to account for the desired posterior tibial slope.

Note: The tibial cutting block has a neutral slope. If posterior slope is desired, the extramedullary guide easily allows this.
2. **Option 1 – Spiked fixation rod**
- Impact the posterior spike to secure the rod to the tibial plateau.
- Rotate the extramedullary alignment guide assembly to the medial one-third of the tibial tubercle and adjust the ankle guide for desired posterior slope.
- Impact the anterior spike of the spiked rod.

**Option 2 – Non-spiked fixation rod**
- Temporarily secure the tibial cutting block to the non-spiked rod using the gold thumb screw.
- Lock in place using the gold cam.

*Note: The hex driver may be used to tighten the gold thumb screw if desired.*

3. **Tibial resection depth**
- Insert the paddle of the tibial stylus into the slot of the tibial cutting block.
- There are two double sided tibial styli that allow for resection depths of 2mm, 4mm, 6mm, and 8mm.
- Lower the tibial cutting block with the stylus to the lowest point on the tibial plateau.
- Lock the tibial cutting block using the gold thumb screw.
4. Sagittal resection alignment

- Care should be taken for proper rotation of the cut. Tendency is to internally rotate the vertical cut due to poor exposure next to the tendon (often fat pad is in the way). A good rule of thumb is the saw blade should be parallel to the lateral wall of the medial femoral condyle.
- The tibial cutting block allows for further M/L positioning after the depth has been set.
- To lock the M/L position once attained, use the hex driver to lock the screw located in the tibial cutting block.

Tip: A sagittal saw blade or resection check placed through the vertical slot of the cutting block will aid in the M/L position as well as rotation alignment.

Note: The medial sagittal cut should be made just medial to the insertion point of the ACL in the tibial spine in order to maximize the size of the tibial base.

5. Intersection pin

- Insert the quick connect drill or pin at the intersection of the two tibial resection slots.
- Care should be taken to not damage the posterior vascular structures by inserting the drill or pin too far.
- Leave the drill or pin in place for resection.

Note: The drill or pin aids in the prevention of over-resection.

Tip: If using the non-spiked fixation rod, the oblique distal pin should be used for added fixation if required.

Hex screwdriver 7401-2441  Quick connect pin 7401-2904  Quick connect 1/8” drill 7401-2905
6. Tibial resections

Perform the sagittal and transverse resections.

**Recommended oscillating blades**

<table>
<thead>
<tr>
<th>Cat No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7151-2905</td>
<td>Stryker 2000 1/2&quot; straight</td>
</tr>
<tr>
<td>7151-2906</td>
<td>Old Stryker 2000 1/2&quot; straight</td>
</tr>
<tr>
<td>7151-2907</td>
<td>Amsco Hall 1/2&quot; straight</td>
</tr>
<tr>
<td>7151-2908</td>
<td>3M 1/2&quot; straight</td>
</tr>
</tbody>
</table>

*Or any 0.053” or 1.35mm thick blade

**Recommended reciprocating saw blades**

<table>
<thead>
<tr>
<th>Cat No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7144-1570</td>
<td>Stryker reciprocating saw blade double-sided</td>
</tr>
<tr>
<td>7144-1573</td>
<td>Stryker reciprocating saw blade single-sided</td>
</tr>
<tr>
<td>7144-1574</td>
<td>Amsco Hall reciprocating saw blade single-sided</td>
</tr>
</tbody>
</table>

**.047” or 1.19mm for double-sided blades
.039” or 1.00mm for single-sided blades

**Optimal tibial cut**

As shown, the sagittal cut should be made just medial to the ACL attachment point on the tibial spine in order to maximize the size of the tibial base.

**Sub-optimal tibial cut**

As shown, if the sagittal cut is made medial to the tibial spine, it prevents maximization of the size of the tibial implant which could lead to lateralizing the femoral component which may not be desirable. If this occurs, the recommendation would be to redo the sagittal cut just medial to the ACL attachment point on the tibial spine in order to maximize the size of the tibial base.

If the sagittal blade flexes, it can result in an uneven cut along the tibial spine and will prevent sizing the tibia accurately. If this occurs, redo the sagittal cut using the saw or using the Bone Rasp as shown in the next step.
7. Fine tuning tibial resections

- The bone rasp may be used to clean up the resections, including the corner.
- The bone rasp has teeth along three faces of the instrument.
- In the event that bone removal is necessary on the sagittal resection but not the transverse, the rasp may be turned upside-down as shown.

Bone rasp
7144-1351
Joint balancing

8. Checking gap balance

- Place the appropriate gap stick into the flexion/extension space between the femur and resected tibia to balance the joint.

- The thickness of gap stick that balances the joint in flexion and extension will determine the thickness of tibial insert poly to be used in conjunction with the distal cutting block as well as implant trialing and implantation.

- Typically when extension is balanced, flexion will be tight due to distal condyle disease.

Note: Gap stick thicknesses are: 7mm, 8mm, 9mm, 10mm and 11mm. These are the thicknesses currently offered in the JOURNEY® UNI tibial inserts. The 7mm option is only available in the all poly option, not the metal backed tibia.

Tip: Many surgeons advise to check the extension gap in 10° – 20° of flexion to account for the screw-home mechanism.

Fine tuning

- The bone rasp can be used to fine-tune the gap balancing by removing 1 or 2mm of cartilage off of either the posterior or distal condyle as appropriate (see gap balancing chart on the next page).

- The joint should be balanced in flexion and extension.

Tip: Many surgeons consider a 2mm flexion and extension gap when valgus stress is applied to a medial uni to be a good rule of thumb. Some accept a slightly larger gap in flexion when using a fixed bearing tibia. The tibial insert handle is 1.5mm and can be used to help assess laxity.
# 9. Gap balancing, after tibial cut

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Flexion Gap</th>
<th>Extension Gap</th>
<th>Next step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Good</td>
<td>Good</td>
<td>Remove equal thickness distal and posterior femoral bone. The distal and 2-in-1 cutting blocks are designed to do this. Rule of thumb is a 2mm gap upon valgus stress in a medial uni.</td>
</tr>
<tr>
<td>2</td>
<td>Good</td>
<td>Tight</td>
<td>Use bone rasp to remove 1mm to 2mm of cartilage from the distal condyle prior to femoral resections, or recut the tibia with less or no slope and accept modest flexion laxity since the cruciate ligaments are intact.</td>
</tr>
<tr>
<td>3</td>
<td>Good</td>
<td>Loose</td>
<td>Consider removing less distal femoral bone with the 4.5mm distal block in order to build up the extension gap but not the flexion gap.</td>
</tr>
<tr>
<td>4</td>
<td>Tight</td>
<td>Good</td>
<td>Use bone rasp to remove 1mm to 2mm of cartilage from the posterior condyle prior to femoral resections.</td>
</tr>
<tr>
<td>5</td>
<td>Tight</td>
<td>Tight</td>
<td>Remove more proximal tibia, assess if scenario one can be achieved with the gap sticks.</td>
</tr>
<tr>
<td>6</td>
<td>Tight</td>
<td>Loose</td>
<td>Can be challenging. Often in ACL deficient knees/lateral unis where the wear pattern is more posterior than distal. In the chronic ACL deficient knee, PCL contracture can occur, resulting in excessive rollback. The wear pattern can effectively create more slope, and it is common to under-resect, leading to relative overstuffing of the posterior space. In these cases you tend to get more fixed medial contracture (vs. correctable) but still have some anteromedial cartilage so the joint is tighter in flexion. Solutions include resecting less distal femur with the 4.5mm block, rasping 1 – 2mm of cartilage from the posterior condyle in order to shift the femoral component anteriorly, and increasing the tibial slope.</td>
</tr>
<tr>
<td>7</td>
<td>Loose</td>
<td>Good</td>
<td>Carefully examine the degree of laxity in flexion. Many uni surgeons agree that with fixed bearing tibias, modest laxity in flexion (slightly greater than the 2mm rule of thumb) can be acceptable. The cruciate ligaments are retained, and more normal kinematics are still achieved. If flexion is deemed unacceptably loose, one option is to remove less posterior bone by allowing a space between the posterior paddle of the 2-in-1 cutting block before pinning so that less than 6.5mm of posterior bone is removed. Another is to remove more distal bone and increase the thickness of tibial poly.</td>
</tr>
<tr>
<td>8</td>
<td>Loose</td>
<td>Tight</td>
<td>Extremely rare. UKA might not be indicated. Options are similar to scenario 7 but harder to address.</td>
</tr>
<tr>
<td>9</td>
<td>Loose</td>
<td>Loose</td>
<td>Trial with the next mm increment of gap stick, assess if scenario one can be achieved with thicker poly. The poly increases in small, 1 mm increments, so balancing can be fine-tuned.</td>
</tr>
</tbody>
</table>

## Optional

The drop rod can be used with the gap sticks to check A/P slope and varus/valgus of the tibial resection and overall limb alignment.

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**Extramedullary alignment rod**

**JOURNEY™ UNI gap stick**

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**114861**

**7401-3474**
Femoral preparation

10. Instrument assembly

Choose the appropriate size and hand distal cutting block required to make the distal resection (the options are 4.5mm and 6.5mm).

Note: The 4.5 mm distal resection block should only be used in situations where you are trying to build up the extension gap, but not the flexion gap, by taking less distal femoral bone. This situation arises after the tibial cut and before the femoral cut, where the extension gap is loose and the flexion gap is not. See the previous page for a more detailed explanation in scenario 3 and 6.

Locate the tibial trial insert that will allow maximum coverage of the resected tibial plateau and is the identical thickness of the gap stick used to balance the joint in flexion and extension (e.g., 8mm gap stick = 8mm trial insert).

Invert the tibial trial insert so that the groove is facing upward.

Insert the tibial trial insert onto the lower rail of the distal cutting block.

- Insert the drop rod assembly into the distal block.
- Assemble the drop rod by screwing the two ends together while capturing the flange of the drop rod slot closest to the midline of the knee.
  or
- Assemble the drop rod by screwing the two ends together and insert into the drop rod hole closest to the midline of the knee.

11. Extramedullary alignment

- Insert the distal block and tibial insert trial assembly into the extension space.
- Assess the M/L placement of the distal block in order to avoid pinning into the trochlear groove.
- Use the drop rod assembly to ensure the distal resection is made perpendicular to the femoral axis. To accomplish this, it may be necessary to slightly flex the knee to compensate for posterior tibial slope.

Note: A vertical line has been marked onto the top and anterior faces of the block to help assess block alignment prior to pinning.
12. Distal resection

- Use the drop rod assembly to ensure the distal resection is made perpendicular to the femur. To accomplish this, it may be necessary to slightly flex the knee to compensate for posterior tibial slope.

- Assess block position.

- Pin the Distal Block to the femur.

- Resect the distal femur.

JOURNEY™ UNI distal block
7401-3442

JOURNEY UNI tibial trial
7143-6133

65mm Rimless speed pin
7500-9338
13. Checking gap balance:
Insert the thick end of the same gap stick previously used to balance the joint in extension bullet point:
The thick end of the gap stick represents the total thickness of the selected poly insert, tibial baseplate and distal femoral condyle implant.

Note: Femoral implant sizes 1 and 2 are 1mm thinner in the posterior and distal condylar thickness dimensions than sizes 3-7 (sizes 1 and 2 are 5.5mm and sizes 3-7 are 6.5mm). When trialing with a size 1 or 2 femur, it is possible for gap balancing with the gap stick to be perfect after the tibial and femoral cuts, and then have 1mm of laxity in flexion and extension. If the patient is very small and has the potential for a size 1 or 2, ensure that your initial tibial cut does not require the largest insert thickness of 11mm.

14. Femoral block sizing, positioning and fixation
• The size of block is determined by optimizing the coverage of the distal resection without overhang and positioning to the posterior condyle.
• The anterior edge of the block should not go beyond the anterior edge of the distal resection but should be 1mm to 1.5mm posterior of the edge.
• The M/L position of the 2-in-1 femoral block is obtained by locating it to give optimal coverage of the distal resection and positioning to the posterior condyle.

Note: To assist in component positioning, the blocks have the same footprint as the implants.
Tip: The A/P cuts and peg hole location are the same for sizes 3, 4, 5, 6, and 7. Once cuts are made and peg holes drilled, up- or down-sizing is still available.
Tip: The A/P cuts and peg hole location are the same for sizes 1 and 2. Once cuts are made and peg holes drilled, up- or down-sizing is still available between these two sizes. If between sizes 2 and 3; size 2 should be selected.
Note: There is a laser-etched line down the middle of the block to assist with M/L positioning.
Tip: Use the JOURNEY™ UNI 2-in-1 block QC handle to assist in cutting block positioning.
15. **Anterior pin and toggle**
- Ensure that the 2-in-1 block is flush to the distal resection and posterior condyle once the optimal position has been achieved.
- Insert a headed pin into anterior pin hole.
- Finalize rotation of the block.

16. **Second and third pin**
- Insert the medial outboard pin.
- Insert the lateral distal pin. – optional

**Tip:** Adequate fixation can be possible without inserting the medial outboard pin when the Alignment peg is used.

**Note:** When positioning the 2-in-1 block, keep in mind that the footprint is the same as the corresponding implant.

**Note:** You do not want the block or the implant to overhang off the most anterior part of the distal cut.

**Note:** If there is 1 – 2mm of uncovered anterior bone between the anterior edge of the implant and the perimeter of the resection, this is acceptable.
17. Femoral peg hole preparation

- Drill the anterior peg hole.

- Insert the alignment peg into the prepared anterior peg hole.

- Drill the posterior peg hole.
18. Resect the posterior condyle.

Note: The posterior cut is a flexed cut at 105° from the distal cut, allowing for optimal bone coverage in flexion while maintaining the 6.5mm thickness.

- Remove the alignment peg and resect the posterior chamfer.

Note: The posterior paddle serves as a blade stop when the posterior chamfer cut is being made.

- Remove pins and block.
**Instrument assembly**

- Insert the JOURNEY® UNI tibial hook sizer into the appropriate JOURNEY UNI tibial sizer.

**19. Sizing the tibia**

- Insert the tibial sizer assembly into the joint.
- Pull the assembly anteriorly until the posterior hook engages the posterior cortex.
- The tibial sizer should completely cover the resected tibial plateau without overhang.

Note: The hook sizer can be used to size the tibia without the tibial sizer.
20. **Trial reduction and final preparation**

- Insert the tibial base trial onto the proximal tibia.
- Assemble the appropriate size femoral trial onto the distal femur.
- Insert the appropriate thickness and size of the tibial insert trial into the tibial baseplate trial.
- Perform a trial range of motion.
- Check to make sure the femur sits in the middle of the tibia both in flexion and extension. This is to prevent edge loading. The laser etched line on the block in step 14 will likely ensure centering of the component. This is a final check.

**Tip:** The tibial base trials have small spikes to prevent movement during trialing.

**Note:** Femoral sizes 3 - 7 share same cuts and peg locations so size adjustments can be made if needed.

**Remove femoral trial**

- Punch for the tibial pegs using the tibial punch in the appropriate size.

**Note:** Before cementing the final implants, prepare the patella femoral joint with the JOURNEY® UNI trials in place.
Patellofemoral preparation

Preoperative note: If replacing the patella, use GENESIS™ II biconvex or round resurfacing implant. Do not use the JOURNEY™ BCS Total Knee Patellar Component.

21. Maneuver patella out of the joint space without evertion. Place the Offset EM Alignment Rod on the anterior femur. The rod goes underneath the quad, on top of the femur, and serves as a guide to ensure that the intramedullary rod is inserted parallel, not breaching the femoral cortex.

At this point, you can free-hand a parallel opening in the canal, or use the "L" shaped drill guide in step 3. The opening needs to be high in the canal, not centered.

Drill IM canal pilot hole

22. Using the EM Alignment Rod for visual alignment of flexion, open the femoral canal with the 4.75mm drill. The "L" shaped IM drill guide (shown at right) can be used as an aid in placement and ensuring creation of an opening that is parallel to the canal.

Insert IM rod

23. Attach the 4.7mm IM Rod to the T-Handle inserter. Place the 4.7mm IM Rod into the opening hole until it stops at the depth stop. Double-check A-P alignment with EM Alignment Rod.
24. **Connect cutting guide to IM rod**

Slide the Anterior Cutting Guide onto IM Rod from the medial side until a “click” is heard.

**Tip:** Some surgeons, even with a medial incision on a left knee, have preferred the right anterior cutting guide. This is perfectly acceptable; the same anterior cut can be achieved with either guide.

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25. **Cutting guide rotational alignment**

**Method 1: Tibial referencing**

25. Draw the AP Axis along the trochlear groove using a cautery or a marking pen. There are both femoral and tibial referencing methods. Tibial referencing is considered the primary method, with the femoral referencing as a secondary check.

25a. Attach the tibiofemoral alignment ankle clamp to the ankle, and align the vertical rod with the tibial shaft. Flex the knee to 90°.

Clinical studies support determining the femoral component rotation by referencing a line perpendicular to the longitudinal tibial shaft axis.
Cutting guide rotational alignment

25b. Align the platform on the top of the alignment guide with the bottom face of the Anterior Cutting Guide. The platform should be flush or nearly flush with the bottom of the anterior cutting guide. In proper alignment, there is typically less than 1° or 2° of difference between the femoral and tibial referencing.

25c. When pinning the guide, a pin driver may be desired. Select two or three of the five holes for optimal fixation. One of the holes chosen needs to be the outrigger pinhole. Please see Step Eight for more detail on pinning the Anterior Cutting Guide.

25d. A shorter pin is included in the set for the medial outrigger.
Cutting guide rotational alignment

Method 2: A/P Axis/Epicondilar Axis Visualization

25e. Attach the Quick Connect Handle to the pocket on top of the Anterior Cutting Guide by depressing the gold button on the handle.

25f. Slide the long axis of the Alignment T-Bar through one of the holes in the quick connect handle all the way until it snaps on around the quick connect handle.

Visualize anterior cut

25g. Using the T-Bar as a visual guide, align the Anterior Cutting Guide in 0°-3° of external rotation. A second quick connect handle can be attached to the medial part of the cutting guide to stabilize while pinning.
Visualize anterior cut

25h. If you are satisfied with the alignment at this point, you can choose to go ahead and pin the guide. Pinning guidelines are in step 8. Tibial referencing is a secondary check, detailed on the next page.

26. Pin the Anterior Cutting Guide using the headed pins provided in the set. It is helpful to pre-drill the pin holes to prevent twisting of the guide when impacting the pins into place. Two to three pins, one of which is inserted in the medial outrigger pinhole, are sufficient to assure stability.
27. **Set depth and resect anterior femur**

Place the Anterior Cutting Guide with the sizing stylus referenced off of the low point of the center of the trochlea on the anterior aspect of the femur. Turn knob to adjust height. Height may also be checked with the Resection Check (angel wing) in the cutting slot. When proper height is reached, use the hex driver to tighten the set screw and lock the cutting guide in place. Resect the anterior femur.

**Note:** the adjustable nature of this guide allows you to undercut and then shave down sequentially to make every resection ideal.

28. **Position drill guide**

- Size the femur by placing the appropriate drill guide onto the femur and judging the fit. If desired, a Quick Connect handle can be placed in the drill guide.
- Using a cautery, mark the location of the laser mark on the top of the drill guide.
- Drill preparation holes for the reamer guide through the proximal two holes marked with bull's-eyes and pin in place with headless pins.
- Mark the intercondylar region with a cautery or marking pen.
- Remove the Drill Guide by sliding over the pins. Leave the pins in place.
29. **Secure reamer guide**

- Place the reamer guide onto the cut surface, sliding the guide over the pins into the slots in the reamer guide until the tip of the guide touches the intercondylar region and can not slide any further.

- Removing a small amount of bone or cartilage from the notch can sometimes help to fully seat the reamer guide.

- Align the laser line on the center of the anterior surface with the appropriate (L or R) cautery mark made in Step Ten.

- Assure that the reamer guide sits flush against the anterior cut surface.

- Pin one additional headed short pin in one of the open holes to secure the device.

- Place one pin into the trochlear region through the distal portion of the resection guide. There are three holes to choose from, but only one hole can be selected.

- Placement of the reamer guide will decide how much or little trochlea bone is removed.

- Keeping the tip out of the notch will prevent going too deep with the first reamer and will allow the deeper reamers to be used in the event more depth is needed.
30. **Choose reamer depth**

Attach the Yellow Reamer Sleeve to the reamer shaft as shown. Attach the reamer to the drill. In most cases, the yellow sleeve will be all that is required to achieve adequate depth. Use your depth gauges often to avoid over reaming. Over reaming may make the patella jump as it changes from one surface to the other. The darker the sleeve, the deeper you ream.

Order of reamer sleeves:
- **Yellow** = standard
- **Green** = +1mm
- **Blue** = +2mm
- Darker is deeper.

31. **Ream troclear bone**

Place the round reamer tip into the round depression in the reamer guide and ream the troclear region from medial to lateral and back. Using a small amount of force to keep the reamer in contact with bone, ream up to but not touching the cautery/marker lines that denote the outer boundary of the implant that were made in step 10.

**Tip:** Instead of immediately going back and forth across the reamer guide, some surgeons prefer to bring the reamer directly towards the guide in a straight line until the sleeve reaches the guide, and then begin the side to side motion. This technique can facilitate reaming and let the surgeon focus on resurfacing just to the tide marks.
**Note:** You only have to ream to the mark, not to the sides of the guide.

Reaming is complete once the sleeve maintains contact with the guide throughout the range of motion to the edges of the intended implantation site. In many cases, you will only need the first sleeve to achieve the necessary depth for a smooth transition zone.

32. **Assess reamed depth**

When the yellow reamer sleeve will not allow any further reaming depth, remove the reamer from the guide and place the Trochlear Depth Gauge into the reamed region to judge the reaming depth. If more bone removal is necessary, the Green +1mm sleeve or Blue +2mm sleeve may be used to increase the depth and width of the reamed area. In most cases, the yellow sleeve will be sufficient. Check reaming depth each time with the Trochlear Depth Gauge before switching to a more aggressive reamer sleeve.
33. When reaming is complete, place the drill guide onto the femur. If necessary, the Putti Rasp may be used to fine tune the component fit.

33a. If desired, pins can be inserted through the laser etched smaller holes to stabilize the guide. If it is preferred to avoid these pins, alignment pegs may be used. These are exactly the same depth as the implant pegs, so no unnecessary pinholes are created.

33b. Use the Peg Drill to drill the first peg hole in the top of the implant. The suggested order is top, bottom, then both sides.

33c. Once drilled, insert an Alignment Peg in the hole to stabilize the guide.
**Drill peg holes**

33d. Repeat the drill and fill process in the bottom hole.
   Drill the bottom hole with the Peg Drill.

33e. Insert another Alignment Peg, leaving the top Alignment Peg in place as well.

**Drill peg holes**

33f. Drill the third hole.

33g. Drill the fourth hole.
34. **Patellofemoral trialing**

- Place femoral trial. Begin by inserting the distal/posterior hole and lever the trial into place, using light taps on the impactor to seat the component.
  - In most cases, the bone will be soft enough to lever the trial in place. With hard or eburnated bone, it may be necessary to open up the inferior portion of the top three holes with a drill in order to seat the component.
  - This design fits tightly. Take care when removing the trial. Start by lifting the proximal end.

- Prepare patella with same technique and instruments as a standard GENESIS™ II Total Knee Replacement.
  - Do not use the JOURNEY® BCS Total Knee Patellar Component.
Resurfacing patellar preparation

The surgeon can choose from a free hand cutting technique with towel clips or if desired he or she can choose one of the following instrumented techniques.

34a. Method 1: Resection guide technique

- Measure the overall thickness of the patella with the patellar calipers.
- Subtract from this number the thickness of the GENESIS™ II round resurfacing patellar component – 9mm.
- The guide is set at the amount of bone that needs to remain after cutting the patella – ie the difference between the original patellar thickness and 9mm. The guide is set at this level by turning the knurled knob.
- Cut the patella through the full dedicated saw guides.
- Drill for the three pegs, insert the resurfacing patellar trial and remeasure.
  - The overall thickness should be equivalent to the original thickness.  
  
  **Note:** The reaming technique described for the biconvex patella can be used as well. The only differences in technique are to use the red resurfacing depth gauge, resurfacing reamers and the resurfacing drill guides.
34b. **Method 2: Insert Technique**

**Instrument assembly:** Determine the appropriate diameter patellar implant and select the correctly sized patellar reamer collet and slide it into place on the patellar reamer guide.

- Attach the patellar reamer guide to the patella. Tighten the patellar reamer guide on the patella.
- Use the patellar calipers to measure the thickness of the patella.
Instrument assembly: Attach the blue Patellar Depth Gauge to the Reamer Guide. Attach the matching sized Patellar Reamer Dome and Patellar Depth Stop to the Patellar Reamer Shaft. Lower the assembly through the Patellar Reamer Guide until the Reamer Dome contacts the patella.

- Swing the Patellar Depth Gauge around so that the “claw” surrounds the Patellar Reamer Shaft.
- Lower the Patellar Depth Stop by pushing the gold button until it contacts the Patellar Depth Gauge. The Patellar Depth Stop will automatically lock in place (bottom image).
- Remove the depth gauge.

- Ream the patella until the depth stop engages the patellar reamer guide. Often in these cases, the patella will be very thin (10-18mm). In those cases, stop well short of the measured resection and remove minimal patellar bone. A shallow rim is all that is required for the inset and you may save 6-8mm of patella for the future.
- Place the patella trial button onto the prepared patella.
- Perform a trial range of motion with the trial components in place.
35. **Final UNI implantation**

- Thoroughly clean the femur and tibia.
- Ensure implants are completely dry.
- Cement the femoral and tibial implants in place using the pegs to locate the position and orientation.
- To pressurize the cement, a Tibial Insert Trial of the appropriate size may be placed in the Tibial Base Implant during this time. Note: Care should be taken to avoid excess cement on the posterior aspect of the femur and femoral component. Excess cement that extrudes posteriorly is difficult to remove.
36. Insertion of the articular insert

- Thoroughly clean the Tibial Base Implant making sure that no debris is present in the locking area or on the mesial rail.
- Ensure there is no protrusion of the vertical wall of the tibia impeding the insert from aligning properly (utilize rasp on vertical wall if required)
- Slide the tibial insert at a shallow angle along the A/P spine posterior ensuring the insert doesn't impinge on the vertical tibial eminence until the insert will not go further.
- Once insert is positioned and aligned as far posteriorly as possible apply a posteriorly directed and distal force with thumb/finger pressure until the anterior lock portion of the insert engages the tibial base.
- If necessary, the tibial impactor may be used to seat the insert with the aid of a mallet using a gentle tap.
- If the insert does not immediately lock with finger pressure, ensure the insert is properly aligned in the baseplate by pushing the insert from the outside toward the tibial spine with finger pressure.

This gap is normal and allows for the insertion of an extraction tool, if required.
37. **Final PFJ implantation**

- Ensure implants are completely dry.
- Cement the patellofemoral implant in place using the pegs to locate the position and orientation.
- Begin by inserting the distal/posterior hole and lever the implant into place, using light taps on the impactor to seat the component.
- Assemble the Patellar Cement Clamp to the Patellar Reamer Guide.
- Apply bone cement to the reamed patella.
- Place the patellar implant onto the prepared patella.
- Clamp the patellar implant into the bone and remove the extruded cement.

38. **Completion**

- Irrigate the components thoroughly, perform routine closure and wound management.
**Tray layouts**

7142-2378 - JOURNEY® UNI tray 1

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### Tray layouts continued

#### 7142-2381 JOURNEY® UNI tray 3

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