Disclaimer
The technique description herein is made available to the healthcare professional to illustrate a suggested method for the procedure. In the final analysis, the preferred method is that which addresses the needs of the specific patient. For more product, health and safety information, review the package inserts for each device.

For additional health and safety information, review the package inserts included in each LEGION® Total Knee System product.
Introduction

The LEGION® Total Knee System has been designed to offer orthopaedic surgeons solutions to address a range of intraoperative situations. Proper implant function is dependant on an accurate surgical technique. The ORTHOMATCH™ Universal Instrumentation system is designed to be used with LEGION TKS to provide an easy to use system intended to facilitate an accurate and reproducible surgical outcome. The system is designed to accommodate either a minimally invasive or standard surgical incision and exposure.

While it is the designers’ objective to develop accurate, easy-to-use instrumentation, each surgeon must evaluate the appropriateness of the following technique based on his or her medical training, experience and the specific patient clinical evaluation.
Indications and Contra-indications

Indications
The general principles of good patient selection and sound surgical judgment apply
to the total knee procedure. Preoperative planning and meticulous surgical technique
are essential to achieve optimum results. Considerations of anatomic loading, soft-
tissue condition, and component placement are critical to minimize a variety of
postoperative complications.

Indications for Total Knee Replacement:
1. Rheumatoid arthritis.
2. Post-traumatic arthritis, osteoarthritis, or degenerative arthritis.
3. Failed osteotomies, unicondylar replacement, or total knee replacement.
4. Posterior stabilized knee systems are designed for use in patients in primary and revision
surgery, where the anterior and posterior cruciate ligaments are incompetent and the collateral
ligaments remain intact.
5. Constrained knee systems are designed for use in patients in primary and revision surgery,
where the posterior cruciate ligament and one or both of the collateral ligaments (i.e. medial
collateral and/or lateral collateral ligament) are incompetent.
6. Hinge knee systems are designed for use in patients in primary and revision surgery, where
the posterior cruciate ligament and one or both of the collateral ligaments (i.e. medial collateral
and/or lateral collateral ligament) are absent or incompetent.

Contra-indications:
1. Cases where there is poor bone stock which would make the procedure unjustifiable.
2. Active, local infection or previous intra-articular infections.
3. Mental or neurologic conditions that tend to pre-empt the patient's ability or willingness to
restrict activities.
4. Neuropathic (Charcot) joint.
5. Conditions that tend to place increased loads on implants such as age, weight, and activity
level, which are incompatible with a satisfactory long-term result.
6. Collateral ligament insufficiency (except in cases where a constrained knee system is indicat-
ed and used).
7. Skeletal immaturity.
8. Use of a supracondylar nail through intercondylar notch of PROFIX primary femoral compo-
nents.
9. Use of slotted femoral and tibial stems without adequate bone support.
10. Anterior cruciate ligament insufficiency when using the JOURNEY II XR tibial base and inserts.
11. Incomplete or deficient soft tissue surrounding the knee.
12. Use of a suprapatellar tibial nail through cruciate notch of JOURNEY II XR tibial base.

Disclaimer
This surgical technique is provided for educational and informational purposes only.
Smith & Nephew does not provide medical advice and it is not intended to serve
as such. It is the responsibility of the treating physician to determine and utilize the
appropriate products and techniques according to their own clinical judgment for
each of their patients. For more information on the products in this surgical technique,
including indications for use, contraindications, effects, precautions and warnings,
please consult the LEGION Total Knee System’ Instructions for Use (IFU).
Preoperative planning

On a full lower limb radiological view determine the angle between the anatomical and the mechanical axes. This measurement will be used intraoperatively to select the appropriate valgus angle so that correct limb alignment is restored. (Beware of misleading angles in knees with a flexion contracture or rotated lower extremities.)

Note: Many surgeons prefer to simply select a standard angle for the distal femoral cut (ie, 5°, 6° or 7°) based on the patient and surgical experience.

Recommended sawblade
1.35 Sawblade
Cutting thickness and blade thickness is 0.053” or 1.35mm.

M = Mechanical Axis
A = Anatomical Axis
T = Transverse Axis
V = Vertical Axis
1. Open the femoral canal with the 9.5mm Intramedullary Drill. The drill has a 12mm step to open the entry point further (Figure 1).

2. Assemble the Valgus Alignment Guide with the Valgus Bushing (5°, 6° or 7°) (Figure 2a). Position the right or left mark facing upwards to match the correct side (hand) of the knee. These choices should be based on preoperative planning and assessment of valgus angle.

3. Slide the T-Handle rod through the Valgus Bushing and in to the femoral canal until the assembled Valgus Alignment Guide (Figure 2b) touches at least one of the distal femoral condyles.

4. Connect the Universal Cutting Block to the Valgus Alignment Guide with the “F” mark facing upwards (Figure 2c) and allow the cutting block to sit in a neutral position within the trochlea.

5. Use Trocar Pins to secure the Distal Femoral Cutting Block to the anterior femur through the two holes marked “0” (Figure 3).
6. Once the universal cutting block is secured with pins, remove pins from Valgus Alignment Guide and slide the Valgus Alignment Guide anteriorly to fully remove it. Then remove the T-Handle and Valgus Bushing from the Intra-medullary canal.

7. Extend the knee fully and insert drop rod guide assembly in to the blade slot of the Universal Cutting Block to check Hip Knee Mechanical Axis (HKA) before resection (Figure 4).

8. By sliding the Resection Check Guide (angel wing) into the slot of the Universal Cutting Block assess the bone resection level before performing the resection. The Universal Cutting Block pinned through the “0” holes will resect 9.5mm from the prominent condyle of the femur (Figure 5).

9. If additional bone removal is desired, the Universal Cutting block can be shifted superiorly by removing it from the pins and reinserting it onto the “+2” pin holes. This will result in a 11.5mm distal resection (Figure 6).
10. Once resection level and alignment are determined, insert a third pin into the angled pin hole to secure the Universal Cutting Block in position (Figure 7).

11. Resect the distal femur using an oscillating saw (Figure 8).

12. Once resection complete then remove pins and the Universal Cutting Block from the femoral bone and remove the cut bones from the distal condyles.
1. Assemble the 3° Cut Block Connector and Tibial Spiked Fixation Rod to the Extramedullary Tibial Alignment Guide and Ankle clamp (Figure 9).

2. Connect the Universal Cutting Block to the 3° Cut Block Connector with the “T” mark facing outwards. This can be attached either centrally or medially depending on preference.

3. Place the Ankle Clamp around the patient’s ankle distally, and proximally impact the posterior spike of the Tibial Spiked Fixation Rod into the ACL footprint to secure assembly (Figure 10).
4. Align the Extramedullary Tibial Alignment Guide parallel to the Tibial Axis in the coronal and sagittal planes. Rotate the assembly to the medial one-third of the tibial tubercle and impact the anterior spike of the up rod (Figure 10 and 10a).

Note: 3-5° of slope is built into the articular insert (depending on which insert is chosen) and 3° of posterior slope is built into the Cut Block Connector.

5. Attach the Tibial Stylus to the Universal Cutting Block by inserting the foot of the Tibial Stylus into the cutting slot of the Universal Cutting Block (Figure 11).

6. Adjust the resection level by lowering the Universal Cutting Block until the Tibial Stylus touches the low point on the less affected side of the tibia. The Tibial Stylus can be adjusted for 2mm (affected side) or 9mm (less affected side) tibial resection by reversing its position in the cutting slot of the Universal Cutting Block.

7. Pin the Universal Cutting Block to the tibia by inserting pins first through the central holes; then the medial hole (Figure 11a).
8. Check the posterior slope and resection plane with Resection Check (angel wing) (Figure 11b).

9. Remove the extramedullary Tibial Alignment Guide assembly by loosening the thumbscrews and then using the slaphammer to remove the Spiked Rod superiority while the Universal Cutting Block remains in position with secured pins. The Ankle Clamp and 3° Cut Block Connector can also be removed.

10. Insert Drop Rod Guide assembly into the blade slot of the Universal Cutting Block in Mid line of proximal tibia to check mechanical axis alignment (Figure 12).

11. Resect the proximal tibia using an oscillating saw (Figure 13).
12. Remove the Universal Cutting Block from the bone and clean up the proximal tibial surface (Figure 13a).

**Note:** When a Posterior Stabilised implant is chosen, if it has not already been removed, excise completely the entire PCL attachment from the femoral intracondylar notch with either a cautery or scalpel to prevent it from affecting the assessment.

13. Extend the knee to 0 degree to check mechanical axis alignment and extension gap balance. Check alignment and balance with the appropriate Spacer Block and Rod. Balance ligaments in standard fashion (Figure 14).

**Note:** If the extension gap is too tight for a 9mm spacer, and the distal resection is through the deepest portion of the trochlear groove, resect additional tibia.
The ORTHOMATCH™ Femoral Sizer allows for external rotation to be set from 0-9° based on surgeon preference and patient anatomy. Rotational alignment may be checked by aligning the A/P axis (Whiteside’s Line) with the vertical marks on the sizing guide or by ensuring that the “EPI” lines on the face of the guide are parallel with the epicondylar axis. Once rotation is set the guide can be locked by turning the Quick Connect Handle.

The sizing guide can be used for either posterior referencing or anteriorly referencing by utilizing either the “Anterior Reference” or “Posterior Reference” holes. These holes correlate with similar holes on the A/P Resection blocks.

The Femoral size is indicated on either side of the femoral housing of the sizer. In addition, the Femoral Stylus is marked with sizing correlating with the femoral flange length / anterior sawblade exit point.
Sizing steps are as follows:

**Optional:** Mark the AP and epicondylar axis on the femur (Figure 15).

a. Place sizing guide onto resected distal femur
b. Pin guide through fixation holes to provide stability
c. Select desired femoral external rotation 0-9deg
d. Note indicated size – if between sizes see surgical step 7 below for more detail
e. Select Anterior or Posterior referencing
f. Pin either anterior or posterior referencing holes with trocar pins
g. Leave pins in place for femoral cutting block

1. Place the Femoral Sizer flush to the resected distal femur by using the Quick Connect Handle to ensure both the posterior paddles of the Femoral Sizer are in contact with the underside of the posterior condyles (Figure 16).

2. Secure the guide to the bone through the two pin holes located at the bottom of the sizing guide (Figure 16a).
3. It is important to use the distal femoral anatomic landmarks (AP axis and Epicondylar Axis) of the knee to guide external rotation and to ensure optimized sizing, ligament balance and patella tracking.

The sizing guide is commonly set at 3°. However, certain patient groups have higher external rotation of the femur, which correlates to a greater degree of tibia vara. In these patients more external rotation of the femoral component should be considered (Figure 16b).

**Note:** Ensure that the appropriate side is chosen when setting external rotation, i.e., “L” for left and “R” for right.

4. Once the desired external rotational is set, lock the sizing guide by rotating the central knob clockwise with the Quick Connect Handle.

5. In order to determine femoral size, position the stylus tip just lateral of the anterior trochlear sulcus and slide the Femoral Sizer housing down until the stylus touches the anterior cortex. The size is indicated against the laser marked “SZ” (Figure 16c).
6. Slide the Femoral Stylus backward or forward so that
the size indicated on the Femoral Stylus matches the
size indicated on the Femoral Sizer. The point at which
the Femoral Stylus contacts the bone marks the peak of
the femoral anterior flange (Figure 16d).

7. If between sizes, it is recommended to use the
following protocol depending on preferred referencing
technique.

**Posterior referencing**
Choose the next larger size (i.e., upsize) to reduce the
risk of anterior notching

**Anterior referencing**
Choose the next smaller size (i.e., downsize) to avoid
overstuffing the flexion space

**Note:** The average difference between sizes of the
LEGION™ femoral implant is 3mm.

8. Once implant size and external rotation are determined
place two pins in the appropriate anterior OR posterior
referencing pin holes (not both). Remove the Femoral
Sizer by sliding it off the secured trocar pins, leaving
the pins in situ (Figure 16e and 16f).
1. Select the appropriate size A/P Resection Block and place it over the pins through the appropriate anterior or posterior referencing holes. Ensure that the cutting block is flush with the resected distal femur. Once secure remove the anterior or posterior referencing pins from the block (Figure 17).

2. In order to secure the block there are additional fixation holes medially and laterally as well as a central pin hole.

3. Prior to bone resection, insert the Resection Check (angel wing) into the anterior blade slot of the A/P Resection Block to check the plane of the resection and to avoid any chance for notching (Figure 17a).

**Note:** Component size can also be estimated by the M-L dimension of the cutting block at the condylar and junctional region. The cutting block M-L width corresponds to the Standard size (not Narrow) LEGION® femoral component.

**AP translations**

Should any fine adjustment be required at this stage, then an option is to use the anterior OR posterior referencing Translation Blocks. These are designed to allow fine adjustment of the A/P position of the femoral cutting block.

To use the translation block remove the trochar pins, placing the spikes on the back of the block into the same location holes used for the A/P cutting block, and then re-drill pins in the new position. It is useful to mark the original pin track holes with a marking pen in order to properly identify the new holes. Care must be taken when using these Translation Blocks as any translation of the cutting block may affect both the posterior flexion space and patello-femoral joint space.
4. Complete the anterior, posterior and chamfer cuts with an oscillating saw. The block is designed to allow for angling of the sawblade during the cuts (Figure 17b).

**Note:** To maintain block stability, the anterior chamfer cut should be completed last.

5. Once all resection cuts are complete, remove the A/P Resection Block and remaining pins from the bone (Figure 18).

6. Ensure the knee is flexed to 90 degrees to check flexion gap balance using the appropriate Spacer Block and Rod. There should be 1-2mm of laxity laterally only. The objective is to have equal flexion and extension spaces (Figure 18a and 18b).

**Note:** Surgical tips to achieve optimal flexion:
- Avoid posterior impingement of femoral component by ensuring adequate size and correct posterior condylar offset
- Use a curved/offset osteotome to remove any posterior osteophytes
- Correctly balance the flexion gap
- Prevent overhang of the femoral and tibial components
- Ensure optimal tibial slope taking into consideration slope built in instruments and implants and the patient’s anatomy
- Beware of the neurovascular structures at the posterior aspect of the knee joint
- For the Posterior Stabilised option, excise the entire PCL attachment from the femoral intercondylar notch with either a cautery or scalpel as the PCL has been shown to constrain flexion assessment
Component trialing - Posterior Stabilized resection

1. Flex the knee to 90° and insert the appropriate sized femoral trial using the femoral trial impactor.

**Note:** To avoid the trial slipping into flexion, the Trial Femoral Impactor can also be used as a Notch Impactor by rotating it 180 degrees and impacting the anterior femoral notch area (Figure 19).

2. The Femoral trial should be both fully seated and flush with the lateral cortex avoiding excessive overhang on either side of the bone. If overhang is present a Narrow implant can be selected, indicated by the laser markings either side of the trial.

**Note:** It is important also to assess the fit of the trial in the trochlea and trochlea junction area to avoid any overhang.

**Note:** The LEGION™ Femoral Trials can be used to trial for both LEGION Posterior Stabilized (PS) and Cruciate Retaining (CR) implants. For PS implants, proceed to step 3. For CR implants, proceed to page 29, step 1 (Component trialing - Cruciate Retaining resection).

3. Secure the Femoral Trial to the bone using two short headed pins in the anterior flange (Figure 20).

4. Insert the appropriate sized housing collet (size 1-2 or 3-8) to the trial femoral component by sliding the housing collet from anterior to posterior in the provided slot.

4a. Then slide the appropriate sized Collet Guide into the housing from anterior to posterior (Figure 21).
5. Assemble the PS Housing Reamer by attaching the housing reamer dome and the PS reamer sleeve to the reamer shaft. Ream through the PS Housing Collet in both anterior and posterior positions until the depth stop of the Reamer contacts the PS Housing Collet (Figure 21a).

6. Attach the Modular PS Box Chisel to the Modular Handle and impact through the Collet Guide until flush with the Collet. The Chisel should be used anteriorly and then posteriorly to ensure that the full length of the PS box is prepared. Remove any remaining bone debris within the box preparation area.

7. Select the appropriate sized femoral trial PS Cam Module (matching the Femoral Trial size selected). Insert the arms of the femoral trial PS Cam Module into the anterior aspect of the Femoral Trial box and push posteriorly until seated (Figure 21b).
8. Place the appropriate size and desired thickness Articular Insert Trial onto the Tibial Trial. For an Insert thickness greater than 9mm select the appropriate shim. Attach the Quick Connect Handle to the Tibial Trial and insert the assembly into the knee (Figure 22).

*Note:* The recommended technique is to flex the knee to 120°, push in the insert as far as possible and bring the leg out into full extension.

9. Perform trial range of motion and assess laxity and balance. The knee should drop passively into full extension. Under varus/valgus stress, there should be approximately 1-2mm of gapping both medially and laterally throughout the range-of-motion. There should be no increase in resistance as the knee flexes from 0° to 90°. If the knee is too tight, try a thinner insert or resect more tibia.

*Note:* Under full varus or valgus stress, the gapping should be at least the width of a cautery tip (~2mm).

10. Long leg alignment can also be assessed by bringing the leg into full extension and passing the alignment rods through the Quick Connect Handle.

11. Use a cautery to mark the location of the laser marked lines on the anterior surface of the tibia to reference the baseplate rotation (Figure 22a).

*Note:* In most cases, rotational alignment of the tibial baseplate is based upon best fit and coverage. However, medial third of the tibial tubercle is a useful guide to define rotation.
1. Once the trial assessment is complete and final implant size determined remove the Insert Trial and, if necessary, the femoral trial (Figure 23).

2. Re-assess the tibial coverage, size and rotation required and pin the Tibial Trial baseplate in place using two short headed pins (Figure 24).

3. Using the 11mm Tibial Drill, drill through the central canal of the Tibial Trial (Figure 24a).
4. Select the appropriate Modular Fin Punch, attach it to the Modular Handle and prepare the keel. Keel punch through the baseplate (Figure 24b). To remove the keel punch, disengage the Modular Handle and then use the slap hammer to remove from the bone (Figure 24).

**Note:** An alternative method to setting tibial rotation is to use the Tibia Trial Bullet. This can be used once the central canal has been prepared but before the keel preparation. With the Tibial Trial not pinned to the tibial surface, insert the bullet into the prepared canal, insert a 9mm trial Articular Surface and the appropriate Femoral trial. Assess baseplate rotation and use a cautery to mark correct position. Then pin and prepare keel as described above.
1. Rotate the patella to 90°. Trim tissue surrounding the patella using electrocautery.

2. Use a rongeur to remove osteophytes and reduce the patella to its true size. The electrocautery should also be used to release soft tissue attachments to the estimated level of resection.

3. Measure patellar thickness with the patellar calipers (Figure 25).

   **Note:** The LEGION™ Total Knee System is compatible with the GENESIS™ II patella. The GENESIS II Resurfacing Patella is 9mm thick for all sizes.

4. Subtract 9mm from this measured thickness. This is the amount of bone that will remain after resection (Figure 25a).

5. Set the Patella Resection guide for the amount of bone that should remain after resection. The guide is set at this level by turning the knurled knob (Figure 25a).

**For example:**

- **A.** Measure the overall thickness of the patella with the Patellar Caliper. For this example, the patella measures 25mm.
- **B.** Subtract the thickness of the The GENESIS II Resurfacing Patellar Component. In this example, 9mm (25mm - 9mm = 16mm). The guide should be set at 16mm.
6. Cut the patella through the dedicated saw guide (Figure 25b).

7. Select the appropriate diameter Resurfacing Patella Drill Guide and place it onto the Patella. Align Patella Drill Guide to the resected patella.

8. Use the Patella Peg Drill to drill for the three peg holes through the Patella Drill Guide until the drill bottoms out in the guide (Figure 25c).
9. Remove the Patella Reamer Guide and Drill Guide from the patella. Place the Resurfacing Patellar Trial onto the resected patella. Use the Patella Caliper to reassess the patella thickness (Figure 25d and 25e).

10. Revert back the patella onto the femoral trial to check patella-femoral articulation by flexing and extending the knee several times.

Figure 25d

Figure 25e
1. Maximally flex the knee and place a thin bent Hohmann retractor laterally and medially and an Aufranc retractor posteriorly to sublux the tibia forward (Figure 26).

2. Apply generous amounts of cement to the dry underside of the baseplate, keel and onto the proximal tibia and keel prep hole (Figure 26).

3. Use the Tibial Implant Impactor on the Modular Handle and Mallet to fully seat the Tibial Baseplate Component onto the proximal tibia. Remove excess cement (Figure 26a).
4. Flex the knee to 90° keeping the thin bent Hohmann laterally and removing the Aufranc retractor. Mix and prepare bone cement for femoral component and distal femur. Apply cement to the femoral component or prepared bone, based on the surgeon’s preference (Figure 26b).

**Note:** Care should be taken to avoid excess cement on the posterior aspect of the femur and femoral component. Excess cement that extrudes posteriorly can be difficult to remove.

5. Place the Femoral Implant onto the femur and use the Modular Femoral Impactor to fully seat the implant. Remove excess cement. Extend the knee to remove cement anteriorly without retracting the proximal soft tissue (Figure 26c).

**Note:** Similar to the Femoral Trial Impactor, the Femoral Implant Impactor can be used to impact into the femoral notch as well as on to the distal surface of the component by rotating 180 degrees. This can be used to prevent the component from tilting into flexion during impaction.
6. Place the appropriate size Insert Trial onto the Tibial Implant and extend the leg to pressurize the cement. Remove any additional excess cement (Figure 26d).

7. Apply bone cement to the patella. Place the patellar implant onto the patella and clamp into the bone. Remove excess cement (Figure 26e).

8. Select the correct Articular Insert Implant with the appropriate thickness.

9. Clear any debris from the locking mechanism of the Tibial Implant and slide the Articular Insert Implant into the Tibial Implant engaging the locking mechanism. Begin insertion in flexion and extend the leg to engage the locking mechanism.
10. The Articular insert is locked into position using the Modular Tibial Impactor. This should be done when the leg is flexed to around 20-30 degrees and by impacting on the anterior surface of the insert (Figure 26f).

Note: To check insert is fully seated, perform a visual examination on each side of the insert slot. This area will have no visible gap.

11. Check fixation and close.

Figure 26f
Component trialing - 
Cruciate Retaining resection

The LEGION® platform is also available for use with a cruciate retaining procedure.

Component trialing
1. For cruciate retaining femorals, after completing step 3 of the component trialing, prepare the femoral lug holes through the femoral trial with the femoral lug punch.

2. Place the appropriate size and desired thickness Articular Insert Trial onto the Tibial Trial. For Insert thicknesses greater than 9mm select the appropriate shim. Attach the Quick Connect Handle to the Tibial Trial and insert the assembly into the knee.

Note: The recommended technique is to flex the knee to 120°, push in the insert as far as possible and bring the leg out into full extension.

3. Perform trial range of motion and assess laxity and balance. The knee should drop passively into full extension. Under varus/valgus stress, there should be approximately 1-2mm of gapping both medially and laterally throughout the range-of-motion. There should be no increase in resistance as the knee flexes from 0º to 90º. If the knee is too tight, try a thinner insert or resect more tibia.

Note: Under full varus or valgus stress, the gapping should be at least the width of a cautery tip (~2mm).

4. Long leg alignment can also be assessed by bringing the leg into full extension and passing the alignment rods through the Quick Connect Handle.

5. Use a cautery to mark the location of the laser marked lines on the anterior surface of the tibia to reference the baseplate rotation.

Note: In most cases, rotational alignment of the tibial baseplate is based upon best fit and coverage. However, medial third of the tibial tubercle is a useful guide to define rotation.

Implantation and closure
1. Flex the knee to 90° keeping the thin bent Hohmann laterally and removing the Aufranc retractor. Mix and prepare bone cement for femoral component and distal femur. Apply cement to the femoral component or prepared bone, based on the surgeon's preference.

Note: Care should be taken to avoid excess cement on the posterior aspect of the femur and femoral component. Excess cement that extrudes posteriorly can be difficult to remove.

2. Place the Femoral Implant onto the femur and use the Modular Femoral Impactor to fully seat the implant. Remove excess cement. Extend the knee to remove cement anteriorly without retracting the proximal soft tissue.

Note: Similar to the Femoral Trial Impactor, the Femoral Implant Impactor can be used to impact into the femoral notch as well as on to the distal surface of the component by rotating through 180 degrees. This can be used to prevent the component tilting into flexion during impaction.

3. Place the appropriate size Insert Trial onto the Tibial Implant and extend the leg to pressurize the cement. Remove any additional excess cement.

4. Clear any debris from the locking mechanism of the Tibial Implant and slide the Articular Insert Implant into the Tibial Implant engaging the locking mechanism. Begin insertion in flexion and extend the leg to engage the locking mechanism.

5. The Articular insert is locked into position using the Modular Tibial Impactor. This is best done when the leg is flexed to around 20-30 degrees and impacting on the anterior surface of the insert.

Note: To check insert is fully seated, perform a visual examination on each side of the insert slot. This area will have no visible gap.

Check fixation and close.