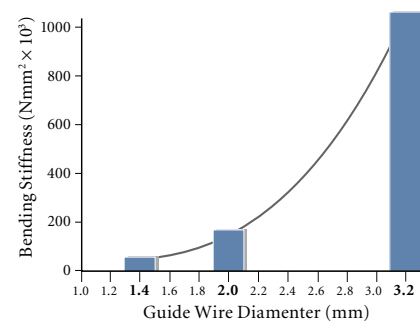


Features & Benefits

Large Diameter guide wire: 3.2mm

- Provides greater bending stiffness
- To reduce deflection.
 - To ensure more precise screw placement.
 - To minimise the risk of pushing the guide wire further into the bone than desired.

Chart 1: Bending stiffness vs Diameter***



Modular Case design

- Easy access to the instruments, thus simplifying the procedure.
- Available in a "Minimal" or "Complete" configuration, to help optimize inventory management and meet different user needs.



Complete Set

Minimal Set

Elastosil® Handles

Elastosil® handles provide enhanced surgeon grip.



Complete cannulated screws system

Screw Range - Titanium and Steel					
	4.0mm	5.0mm	6.5mm	6.5mm	8.0mm
Partially Threaded					
Thread Length	1/3rd Thread	1/3rd Thread	20mm	40mm	25mm
Screw Length	14–50mm* 55–70mm**	20–50mm* 55–80mm**	40–120mm**	55–120mm**	40–120mm**
Fully Threaded					
Screw Length	10–50mm*	20–50mm* 55–70mm**	30–120 mm**	30–120mm**	40–120mm**
Guide Wire	Ø1.4mm	Ø2.0mm	Ø3.2mm	Ø3.2mm	Ø3.2mm

* 2mm increments ** 5mm increments *** Data on file at Stryker

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Osteosynthesis

Asnis™ III

Ø 6.5 & 8mm

Hip Fracture



Features & Benefits

The Asnis™ III Cannulated Screw Systems Systems have been designed to optimise surgical outcomes while simplifying procedures. The systems incorporate several features intended to enhance screw placement, insertion and removal.



Low Profile Screw Head
Reduced potential for soft-tissue irritation

Material Choice
Titanium Alloy (TAV)
Increased CT and MRI compatibility
Anodizing Type II minimises fretting, increases fatigue strength and notch resistance*

Stainless Steel (316LVM)
Compatibility with current steel systems
Proven clinical history

Packaging Choice
Implants available both sterile and non-sterile packed

Shaft and Core Diameter Equal
For improved strength

Thread Choice
Implants available with both partial and fully threaded options

Reverse Cutting Flute
To facilitate removal

Self-drilling / tapping design
Efficient cutting tip design to improve operating efficiency

Large diameter Guide Wires
To provide most precise screw placement
Threaded tip engages bone for optimal enhanced purchase

* Data on file at Stryker

General Information

Garden Classification: The most commonly used classification for intracapsular Hip Fractures

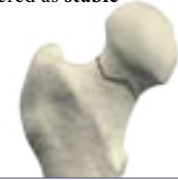
Garden I

- Incomplete Fx
- Stable



Garden II

- Complete but not displaced Fx
- Considered as **stable**



Garden III

- Complete & partially displaced subcapital Fx
- **Unstable**

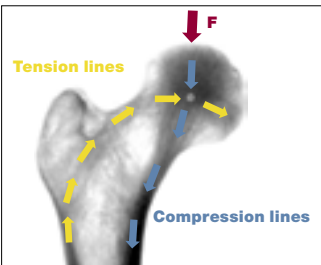


Garden IV

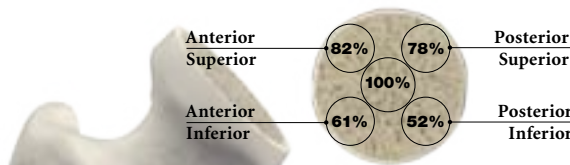
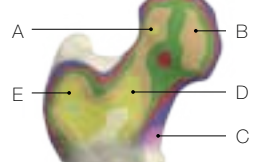
- Complete & fully displaced Fx
- **Unstable**



Density of trabecular bone in the femoral head



YIELD STRENGTH DISTRIBUTION*
The greatest yield strength is found in areas B and C.



“Screw thread fixation in the head is dependent on the density of the trabecular bone. Screw threads placed in the middle and superior head have superior holding power to those in an inferior position”**.

* Stryker Osteosynthesis Science&Technology Department - “Positioning the lag screw”
** Cannulated Screw Fixation - Book ISBN 0-387-94463-X (Springer) - STANLEY E. ASNIS & RICHARD F. KYLE

Main Indication

Intracapsular Hip Fracture



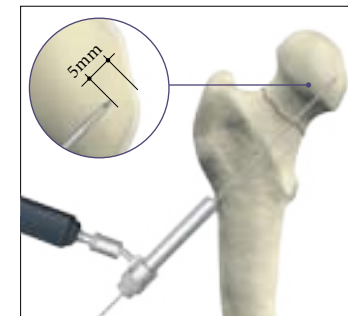
The patient is placed in a supine position on a fracture table

Displaced fracture have to be reduced first.

A straight lateral incision is made, starting at the flare of the greater trochanter and extending distally. The Fascia Lata and vastus lateralis are then split in line with the incision.

Step 1: Guide Wire Insertion

In the AP view, using image intensification, the most inferior guide wire is passed just above the calcar, into the inferior femoral head.



In the lateral view, this guide wire should stay in the mid-line of the femoral head and neck.

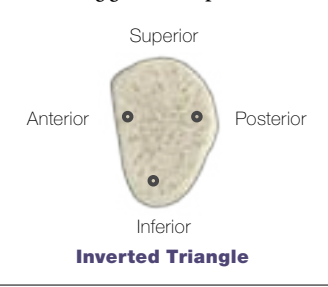
Anteversion must be checked.

In the case of dense cortical bone, the lateral femoral cortex can be opened with a 3.2mm drill bit.

Drill guides for single, parallel, or multiple screw positioning options



Cross section of the femoral neck showing guide wire placement.



Step 2: Screw length measurement

Performed with the direct reading depth gauge. This measurement will place the screw at the tip of the guide wire.

If “in-between” sizes, use the shorter length. If compression is needed, consider the length of expected compression and choose an appropriately shorter screw.



Step 3: Screw placement

A cannulated screw is placed over each guide wire using the cannulated screwdriver.

A self-drilling, self-tapping screw tip readily allows bone penetration.



Step 4: Verifying Final Position

The final position of the screws is verified using image intensification (AP / Lateral views). Guide wires are removed. The incision is closed.



Please note: Guide wires are single use.

Make sure to discard all used guide wires.

Step 5: Screw Removal

Be sure to use the Asnis™ III solid screwdriver to remove Asnis™ III screws.

Never use a worn, damaged or cannulated screwdriver. The screw reverse cutting flutes may facilitate the re-cutting of the femoral cortex “from inside out” to allow for the passage of the threads.

This flyer displays selected key points and is not substitute for the full operative technique manual.

Other Indications

