Bone - Prosthesis Junction for Active Tendon Implants: A Biomechanical Comparison of Two Fixation Techniques

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**INTRODUCTION**

End-to-end repair of damaged tendon is not possible in many instances of injury. Staged flexor tendon reconstruction has been proven to be a valuable method of addressing complex flexor tendon injuries when the alignment presents late, has failed primary repair, or the injury mandates it (1). Silicone implants have been used for two-stage flexor tendon reconstructions with reports of long-term use as active implants (2,3). Implants have been reported functional approximately one year post-surgery with some in use up to 25 years after reconstruction (4). This suggests the potential of the implant serving as a permanent prosthesis. The biomechanical strength of two proximal juncture methods using a commercially available active tendon implant has been studied with a reported mean ultimate failure load of 220N (5). Biomechanical investigation of distal fixation has yet to be studied, but combined with the proximal results could lead to changes in two-stage flexor tendon reconstruction protocols allowing for earlier active range of motion, delayed Stage II surgeries, and perhaps permanent implantation.

**Purpose:** This study investigates two distal fixation techniques, Screw versus Knot fixation, using an active tendon implant in a canine model.

**METHODS**

- Cadaveric canine middle phalanges in matched fashion from 3rd and 4th toes of 14 forepaws.
- Clean and cord ends of tendon implant (Model ATPC Hunter Active Tendon Implant, Wright Medical Technology, Inc., Arlington, TN) applied (6) alternately to matched 3rd and 4th phalanges
- Screw: clean and attached with 2.0mm bicortical screw (TriMed, Inc., Santa Clara, CA)
- Knot: cords through 2.0mm transverse bone tunnel and wrapped dorsal to volar around bone then tied in surgeon’s knot
- Two 1.6mm K-wires through bone distal to fixation in U-shape for load application
- Bone painted white for contrast; one black mark on bone; two black marks on implant
- Constructs mounted via custom-designed clamp in a biaxial servohydraulic testing machine (Model 1321, Instron Corp., Canton, MA) retrofitted with TestMax™ II digital controller (MTS Corp., Eden Prairie, MN) (Figure 1)
- Constructs were loaded 2 and 50 N at 0.192 Hz for 500 cycles then load-to-failure at 20mm/min (5)
- Video recording started, every 100 cycles, at end of cycling, and for entire failure test; digitally processed (NIH ImageJ freeware, Bethesda, MD) for stretch between distal bone and rod black marks (5) for digital image processing.

**RESULTS**

- No constructs failed during cycling
- Cyclic stretch between bone and distal rod not detected different from 0 for Screw constructs (p=0.54); but significantly greater after 1st cycle, 500th cycle, and 500th vs 1st cycle for Knot constructs (p=0.001) (Figure 2)
- Significantly greater stiffness for Screw construct vs Knot (p=0.001) during load to failure (Figure 3a)
- Significantly more stretch at peak load for Knot construct than Screw (p=0.001) (Figure 3b)
- No significant difference detected between Screw and Knot peak loads (p=0.234) (Figure 3c)
- 11 out of 14 (79%) of Screw constructs failed during failure testing, with few failing at bone tunnel resulting in intraarticular fractures
- 10 out of 14 (71%) Knot constructs failed at bone tunnel but with cords fraying at bone-cord interface
- Peak load excluded from analysis for 1 Screw construct which failed in bone at K-wire without failure of Screw fixation

**DISCUSSION**

Problematic flexor tendon injuries are often treated with staged flexor tendon reconstruction (1). The silicone implant has been used passively (1) but also as an active tendon implant (3,4,7) in the hopes of functional outgrowth and surgery allowing earlier resumption of normal activities. Implant biomechanical characteristics must be understood to ensure repair survival during loads associated with normal activities. Implants must survive forces up to 9N during passive finger movement and 35N with active flexion (6), and up to 120N during firm tip pinch of the index finger (9). Two types of proximal tenodesis attachments for the implant have been shown to exceed these values by surviving average loads generated by normal activities.

The current study investigated bony attachment methods using a Screw or a Knot. The majority of the Screw constructs failed with the screw pulling through the bone and creating an intraarticular fracture suggesting that bone would have to be repaired in addition to Stage II tendon grafting. In contrast, the Knot construct cords failed leaving little damage to the bone during cycling or load-to-failure testing. However, both the Screw and Knot methods survived average loads greater than 340N suggesting that the proximal tenodesis attachment would be more likely to fail first. Thus, distal bony failure might not occur for the Screw at these lower loads.

The higher failure loads at distal and proximal ends of the implant than those required for normal activities suggests survival under early active motion. This should be considered in rehabilitation protocols following stage I reconstruction. Further, the potential use of the implant as a permanent tendon prosthesis may be considered. When using the Knot method of distal attachment, stretching of the Knot construct was greater than the Screw which should be accounted for during implantation.

**Significance:** This study suggests that tenodesis and bony connections of tendon implants can survive loads typical of active rehabilitation protocols with failure likely occurring at the tendinous attachment. Potential use of the implant as a permanent prosthesis is suggested and should be investigated further.

**REFERENCES**

3) Bader KF, Curton JW. Arch Surg. 1968;97:406-411
4) Ketchum LD. J Hand Surg Am. 2000;25:731-733

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