Moderator

Peter Simonian, M.D.

Seattle, Washington

Panelists

John C. Richmond, M.D.
Boston, Massachusetts

Marc J. Friedman
Van Nuys, California

Robert T. Burks, M.D.
Salt Lake City, Utah

David M. Lintner, M.D.
Houston, Texas

Intrafix was released in October 1999 to address the challenges associated with fixing hamstring grafts in soft tissue bone.

Intrafix is a two-part polyethylene system, consisting of a screw and expandable sheath. The sheath expands to achieve 360 degrees of bone tunnel contact. Intrafix is a two-part polyethylene system with a screw and expandable sheath. The sheath expands to achieve 360 degrees of bone tunnel contact.
Intrafix Tibial Fixation Roundtable Rountable

Simonian

As we all know, hamstring grafts are gaining popularity around the world. Let’s start by describing your indications for hamstring grafts, bone-patellar tendon grafts, and allografts.

Richmond

In my practice, I do approximately 40% hamstring grafts, 45% BTB, with the rest 20% being allograft. My indications for a BTB graft are the patient is in their 60s or older, demanding athlete, or the patient with chronic instability who had developed appreciable excess laxity. For those patients who have had a hamstring graft on one side and a BTB graft on the other and nearly all of them have a hamstring graft subjectively better than their BTB graft, I think the relative failure rate associated with the hamstring graft.

Burks

I have a similar breakdown of 80% of my cases being performed with hamstring string grafts, 20% with bone tendon grafts, and these allografts.

Friedman

I do about 70% hamstring, 20% allo, and 10% BTB. I have a completely orthopaedic practice so I like coming across athletes and patients who have chronic instability or those patients who have avocations for the soft-tissue graft on the side.

Simonian

I think about 80% hamstring versus 20% BTB. I present the options to the patient and then let them make the decision. I think both grafts perform extremely well in most nonathletic patients. I think the suboptimal use of the hamstring graft in occupational patients is that the donor area is significantly less than with patellar tendon. The disadvantage in the recovery time is a bit longer. I do not allow patients to return to full sporting until about nine months after hamstring reconstruction. I still use allograft.

Richmond

Intrafix is a good graft. I have got a large patient with a high demand for pain and function. I have been using Intrafix for the last year.

Burks

I am a big proponent of bioabsorbable implants. The Intrafix has superior bone to bone fixation that is on one side and a BTB on the other and nearly all of them have a hamstring graft subjectively better than their BTB graft, I think the relative failure rate associated with the hamstring graft.

Friedman

I personally have zero problem with plastic on the knee. I would not radialize Intrafix as a bioabsorbable implant if thescerance are exchanged. The only theoretical concern would be cystic formation on receptor. I do not see it appear to affect the clinical results with BTB but this is bone healing.

Simonian

I am truly concerned about bioabsorbable implants, especially on the tibial side where the bone density is not a large proponent of bioabsorbable implants. The Intrafix has superior bone to bone fixation that is on one side and a BTB on the other and nearly all of them have a hamstring graft subjectively better than their BTB graft, I think the relative failure rate associated with the hamstring graft.

Burks

I agree with Dr. Simonian, it has been a huge change in how we manage some of these implants that they absorb at least by 30% at first. I have revised several patients more than 30% years past an ACL or PCL reconstruction that were performed with bioabsorbable implants that showed no signs of dissolving at that point. I suggest that they stay somewhere for such a long time that if they are replaced it only with such a benefit for the implant. I see for Intrafix being plastic is that there is not likely to be any distortion of future MRI images by the implant. Intrafix gives you a higher bone and this is bone healing.

Richmond

At first the tenor appeared counter­ intuitive to use, in fact after a few cases it becomes quite simple. I teach residents and fellows how to use the device and implant and usually in a few cases they have it. I have made it video of Intrafix placement for our residents and it shows that it takes approximately four minutes to tie the knot and place the implant.

Simonian

I am using metal or absorbable inter­ penetrative implants that take a bit away, Intrafix is radiopaque and can be seen on the radiograph.

Linton

I used and suspend anchor and I switched to Intrafix for the tibial plateau and backed up by a simple interference screw for the knee and the tibial plateau. I have not found the strength of the ability to obtain equal tension on all four tendons and circumfer­ ential ten of the tunnel.

Simonian

I used both and suspenders. I like the idea that the interference screw decreases the point of fixation distance, however I think the interference screw allows for significant graft slippage especially on the tibial side where the bone density is less than that of a femur. This combination makes me more aggressive and despite using a very low profile screw and washer and I never use screws and there is no more pain for the patient. I think the interference screw that allows for secure intramedullary fixation on the socket and overall improves the fixation of the pin or at the same time does not require a backup device.

Simonian

I am happy to change to change systems, how would you describe the learning curve for Intrafix.

Richmond

I have been using Intrafix for over one year and my results are completely different. I have used the fixation device for a knee that has been problematic. I think Intrafix goes a long way to solving these problems.

Friedman

I was using metal or absorbable interpenetrative implants that take a bit away, Intrafix is radiopaque and can be seen on the radiograph.

Burks

I agree with my colleagues, bio­ absorbable implants take a bit away, Intrafix is radiopaque and can be seen on the radiograph.

Simonian

I am a bit longer. I do not allow patients to return to full sporting until about nine months after hamstring reconstruction. I still use allograft.

Richmond

Like all my early Intrafix results with the BTB grafts I am more on average better with the Intrafix.

Simonian

The failure rate in the BTB grafts is problematic. I think Intrafix goes a long way to solving these problems. I think the BTB grafts are gaining popularity with limited creep, while obliterating stress for the soft-tissue graft on the side. It has markedly reduced the need for secondary fixation.

Richmond

I have some thoughts on bioabsorbable implants. What are your thoughts on bioabsorbable implants. Do you think that Intrafix is plastic.

Simonian

I do about 30% hamstring, 20% allo, and 10% BTB. I have a completely orthopaedic practice so I like coming across athletes and patients who have chronic instability or those patients who have avocations for the soft-tissue graft on the side.

Burks

I use to prefer BTB, but now I use hamstring on approximately 95% of my primary ACL. I use BTB if the patient prefers, but I typically use hamstring string grafts on football players. There is some evidence that some sports are better suited for hamstring string (hockey, skating, etc.) and for those I would consider a patellar tendon.

Linton

I do a lot of discussion surrounding bioabsorbable implants. What are your thoughts on bioabsorbable implants. Do you think that Intrafix is plastic.

Simonian

Intrafix is plastic.

Simonian

I am happy to change to change systems, how would you describe the learning curve for Intrafix.

Richmond

Linton

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Simonian

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