**Rigidfix™ Cross Pin System**

The Mitek Rigidfix ACL Cross Pin System is an innovative fixation method for ST grafts on both, the femoral and tibial sides during ACL reconstruction. The absorbable Cross Pins provide a secure fixation and facilitate a 360 degree bone-to-graft interface.

- **High fixation stability**
  - High pull out strength. The Cross Pin fixation facilitates a 100% bone-to-graft interface which leads to a quick and safe 360 degree in healing process of the graft.

- **Easy to use system – improved handling**
  - The operative technique ensures a higher level of reproducibility and reduces the risk of complications.

- **Secure location of the cross pins**
  - Cross Pin fixation is performed accurately in the bone tunnels – always positioned at the same location. This virtually eliminates fixation tolerances, injures to the graft and potential loosening of the fixation device.

- **Improved biomechanics**
  - The ability to achieve ‘close to the joint’ fixation, minimises any graft elongation and tunnel widening.

- **Absorbable implants**
  - No artificial material will remain permanently in the bone. Secure fixation performance is also ensured during the absorption period.

**INDICATIONS**
The MITEK RIGIDfix™ 3.3 mm ST Cross Pin Kit is intended for femoral and tibial fixation.

**CONTRAINDICATIONS**
1. Pathological conditions of bone, such as cyclic changes or severe osteopenia, which would impair secure cross pin fixation.
2. Pathological conditions in the soft tissue graft to be attached that would impair secure fixation with the cross pins.
3. Foreign body reactions to the absorbable implant material.

**PRECAUTIONS**
1. Surgeons should not attempt clinical use of MITEK RIGIDfix™ 3.3 mm ST Cross Pin kit before reviewing the instructions for use and rehearsing the installation procedure in skills laboratory.
2. Slit the small and / or large sleeves against the inner diameter of each sleeve.
3. The Mitek RIGIDfix™ Cross pin kit should only be used with the Mitek RIGIDfix™ 3.3 mm ST Cross Pin Kit.

**WARNINGS**
- Inspect all instruments for damage before use. DO NOT attempt to repair a damaged instrument.
- Pathologists and Pathology groups have shown to cause some minor migration to a small percentage of patients.

**CAUTION**
- Federal law (USA) restricts this device to sale by or on the order of a physician.

For more information, call your Mitek representative at 1-800-382-4682 or visit us at www.mitek.com. Mitek Worldwide, a Division of ETHICON, Inc., 60 Glacier Drive, Westwood, Massachusetts 02090

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http://www.jnjgateway.com

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**RIGIDFIX™ ABSORBABLE CROSS-PINS FOR SOFT TISSUE ACL-RECONSTRUCTION**
Tendon harvest

To harvest the soft tissue graft for ACL reconstruction, slightly different techniques for different types of tendon are common practice. The following describes one way to harvest semitendinous (semi-t) and gracilis tendons. Make a longitudinal or oblique incision approximately 2 cm medial to the tibial tubercle, almost directly beneath the medial patellar tendon. The top part of the incision is made on the semitendinous (semi-t) and gracilis tendons. After the incision is made, the fat and gasserian-like tissue are dissected from the sartorius fascia, which is flat and overlies the tendons. A #13 blade is used to incise the sartorius tendon along its fiber. Note that only the tendons are incised. A window is completed to view the gracilis and sartorius tendons.

which can be seen every- ly the insertion of the MCL (Fig. A). The gracilis is narrower in width and is more slender and apparent than the semi-t. Unlike the semi-t, the gracilis generally has no inferior or superior connections at its insertion. The semi-t can be identified by its generally robust nature and its attachments. These must be separated prior to harvesting or the graft may be prematurely cut during harvesting. A finger run around the semi-t to semi-t, the gracilis to gracilis, and, finally, the semi-t to the gracilis, across the front and back to create a secure bundle. This bundle is the part of the graft that will be inserted into the femoral bone tunnel. Mark the graft at 30 mm from the distal end for later reference when placing it into the bone tunnel.

Suture as for the femoral tunnel to the top of the femoral bone tunnel. Mark the graft at 30 mm from the distal end for later reference when placing it into the bone tunnel.

To prepare the semi-t portion of the graft, the distance from the top of the femoral tunnel to the top of the tunnel is required to be measured, as described later in the procedure. Refer to this recorded measurement and whip stitch the graft beginning at this measurement and whip stitch distally for a total of 30mm. Using the same technique and type of suture as for the femoral preparation (Fig. C).

It is essential to ensure that the stripper is not sharp and that all connections to the tendon have been severed. After one or both tendons are harvested, they are prepared on the preparation board.

The semi-t and gracilis tendons

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The semi-t and gracilis tendons can be prepared for implantation, on the graft board. Whip stitch the ends of the grafts. A #2 needle should hold adequately. Fold the two grafts over a C#15 RIBBON SUTURE (Fig. 7).

To prepare the semi-t portion of the graft, whip stitch the looped-over part of the graft (Fig. D). Specifically, whip stitch the semi-t to semi-t, the gracilis to gracilis, and, finally, the semi-t to the gracilis, across the front and back to create a secure bundle. This bundle is the part of the graft that will be inserted into the femoral bone tunnel. Mark the graft at 30 mm from the distal end for later reference when placing it into the bone tunnel.

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