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Dr. Thomas Kreibich on the primary stability of the
TrabecuLink Femoral and Tibial Cones

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LINK Trabeculink Femoral and Tibial Cones provide solid anchorage in at least two of three zones,* serving to reinforce meta- and diaphyseal bone defects or bone loss and thus stabilize in the distal femur and proximal tibia. Dr. Thomas Kreibich talks about his experience with the use of FlexiCones in practice in this interview.

Dr. Kreibich, you have been using LINK FlexiCones for complex knee revisions since the beginning of 2020. Why?

If you reduce large defect zones in the meta- and diaphyseal area with bone graft, this usually does not lead to good results in the long term. This is due to reduced rotational stability and the fact that the prosthesis cannot be securely anchored in the newly created bone bed. With the FlexiCones, we reduce the defect zone in both the dia- and metaphysis and thus increase the degree of coupling. Because of this form-fit, the femoral component is well grasped by the FlexiCones.

Do you ever use several FlexiCones at the same time?

If the defect in the different levels is very pronounced, I place two FlexiCones on top of each other to increase the anchoring potential for the new prosthesis to be cemented.

For which indications have you used the FlexiCones so far?

They were large knee revisions with multiple previous surgeries, especially in patients who already had a knee revision once due to sepsis and in whom the femur was significantly altered due to type II and type III bone defects.

What do you think is special about the FlexiCones from LINK?

Firstly, it is very good that the 3-zone FlexiCones are precisely tailored to LINK implants. This results in a high form-fit



Septic replacement of a knee prosthesis: restoration with LINK Endo-Model and LINK FlexiCones: 2-zone Trabeculink Femoral Cone (femoral), half Trabeculink Tibial and proximal Femoral Cone (tibial).

right from the start. What I particularly like about LINK FlexiCones is that they can be adapted to the defects better than the somewhat rigid, thicker-walled models that we have mainly used up to now.

Do you see a difference between a stem that is precisely adapted to the medullary canal and a FlexiCone that is anchored without cement but contains cement inside to fix the standard stem?

Absolutely. The interface between the cone and the bone makes the defect smaller. But in the same way, the FlexiCone improves the cement anchorage with the stem-anchored knee prosthesis on its inside. I see an advantage in the



ABOUT

Dr. Thomas Kreibich is Head of the ENDO-Klinik location in Wuppertal, Germany.

fact that with relatively conventional, stem-anchored LINK implants and the FlexiCones, a good result can be achieved. This shortens the operating time and is good for the patients.

The LINK FlexiCones are elastic. How do you rate this aspect?

I see the flexibility due to the thin-walled design as an advantage because, on the one hand, it significantly reduces the risk of fracture or fissure during implantation in the remaining femur. On the other hand, the FlexiCones adapt better to the defect situation than rigid models. It is then no longer necessary to trim the bone in order to place a rigid cone.

You are planning a FlexiCones study with ten patients. What is it about?

We will follow the patients we have operated on with this procedure for two to three years, take regular X-ray diagnostics and compare the images with the postoperative images to assess the stability of the FlexiCones.

You use the FlexiCones for revision surgeries with larger bone defects. Are they also suitable for primary implantations?

That is certainly possible. We had an elderly lady with very pronounced osteopenia who initially required a stem-anchored implant due to bone density reduction. In this case we did additional reinforcement with a FlexiCone.

How do you proceed with a revision if the bone no longer contains any cancellous bone?

In such bone glades, we remove the loosening membrane, practically just cleaning out soft layers from the inside bone. Then we drive the FlexiCone into this corticated bone. Since there are no large stress peaks as with rigid cones, there is also no great risk of fissure.

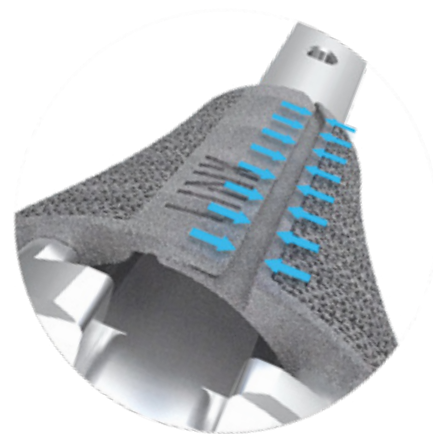
The intention in the development of the FlexiCones was that the force is applied in the meta- and diaphyseal area, so that no more loosening occurs. How do you rate this aspect?

What we can already say is that the primary stability of the cones in the bone is fantastic and we have much higher primary stability in the cement anchorage due to the internal structure of the cones. These two points are extreme advantages, especially in burnt-out knee revisions. After all, we know that even with scarfed prostheses after septic revisions, the femoral and tibial components of the stem often show signs of loosening after only a few years. I hope to see no more of these effects, because the FlexiCones from LINK are a big step forward for advanced revision arthroplasty.

Dr. Kreibich, thank you for the interview.



Stable anchorage: TrabeuLink FlexiCones stabilize prosthesis anchorage in meta- and diaphyseal bone defects; they are compatible with the entire LINK Endo-Model Knee Family.



Elastic design: TrabeuLink FlexiCones with spring effect ensure easy intrasurgical positioning and high primary stability.

* R. Morgan-Jones, S. I. S. Oussedik, H. Graichen, F. S. Haddad: Zonal fixation in revision total knee arthroplasty, *The Bone & Joint Journal*, Vol. 97-B, No. 2, February 2015