ReUnion® RSA
Reverse Shoulder Arthroplasty System
Operative technique
ReUnion RSA
Reverse Shoulder Arthroplasty System

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This publication sets forth detailed recommended procedures for using Stryker devices and instruments. It offers guidance that you should heed, but, as with any such technical guide, each surgeon must consider the particular needs of each patient and make appropriate adjustments when and as required. A workshop training is recommended prior to performing your first surgery.

All non-sterile devices must be cleaned and sterilized before use. Follow the instructions provided in our cleaning and sterilization guide (L24002000). Multi-component instruments must be disassembled for cleaning. Please refer to the corresponding assembly/disassembly instructions. Please remember that the compatibility of different product systems have not been tested unless specified otherwise in the product labeling.

See package insert (Instruction for Use V15197, V15198, V15199, V15200 & V15201) for a complete list of potential adverse effects, contraindications, warnings and precautions. The surgeon must discuss all relevant risks including the finite lifetime of the device with the patient when necessary.

This document is intended to be used by healthcare professionals only.
Description and indications

**Description**

The ReUnion Reverse Shoulder is a system of components intended for total shoulder replacement in a reverse shoulder configuration. The system is comprised of a humeral cup, humeral insert, glenosphere, glenoid baseplate, and screws. This system is used with components from the following system:

- ReUnion Total Shoulder Arthroplasty (TSA) System (K103835)

Consult package label for accessory information.

**Indications**

The ReUnion RSA Shoulder System is intended for primary, fracture, or revision of total Shoulder replacement. The patient’s joint must be anatomically and structurally suited to receive the selected implant(s), and a functional deltoid muscle is necessary to use the device. The patient’s joint must have gross rotator cuff deficiency, a functional deltoid muscle and be anatomically and structurally suited to receive the selected implant(s).

- Painful, disabling joint disease of the shoulder resulting from: degenerative arthritis or rheumatoid arthritis.
- Proximal humeral fracture.
- Revision of previously failed shoulder joint replacement.
- Glenoid Baseplate components are intended for cementless use with the addition of screw fixation. The Humeral Stem components are intended for both cemented and cementless use.

*(the following is applicable for US only)*

In the case of revision, when ReUnion TSA humeral stems are well fixed, the system is indicated for conversion to a reverse shoulder arthroplasty. In conjunction with ReUnion RSA humeral and glenoid components, ReUnion TSA humeral stems can be converted from a hemi or total shoulder arthroplasty to a reverse shoulder arthroplasty, as well as revised from an existing reverse shoulder arthroplasty to a secondary reverse shoulder arthroplasty, in treatment of a grossly deficient rotator cuff with severe arthropathy or previously failed joint replacement with a grossly deficient rotator cuff. The patient must have a functional deltoid muscle, and be anatomically and structurally suited to receive the implant(s).
**Contraindications**

- Any active or suspected latent infection in or about the shoulder joint.

- Any mental or neuromuscular disorder which would create an unacceptable risk of prosthesis instability, prosthesis fixation failure, or complications in postoperative care.

- Bone stock compromised by disease, infection or prior implantation which cannot provide adequate support and/or fixation to the prosthesis.

- Skeletal immaturity.

- Patients whose anticipated activities would impose high stresses on the prosthesis and its fixation.

- Obesity. An overweight or obese patient can produce loads on the prosthesis which can lead to failure of fixation of the device or to failure of the device itself.

See package insert for warnings, precautions, adverse effects and other essential product information.

**Precautions**

The ReUnion RSA has not been evaluated for safety and compatibility in the Magnetic Resonance (MR) environment. It has not been tested for heating, migration, or image artifact in the MR environment. The safety of ReUnion RSA in the MR environment is unknown. Scanning a patient who has this device may result in patient injury.

**Warnings**

See package insert (Instruction for Use V15197, V15198, V15199, V15200 & V15201) for a complete list of warnings.

**Patient counseling**

Surgeons should discuss all relevant contraindications, adverse effects and the need for post-implantation protection with their patients.
Surgical technique
Surgical technique

**Patient positioning**
For standard shoulder arthroplasty, the patient is positioned in a semi-Fowler’s (beach chair) position. The torso is inclined 30° to 45° and the legs are padded and bent. The patient’s shoulder is brought to the edge of the table to allow full extension of the arm, thus affording exposure of the humeral shaft. A bolster may be placed beneath the involved scapula to improve exposure of the articular surface.

![Figure 1](image1)

The head is stabilized to avoid movement during the procedure. It is recommended that anesthesia be brought to the contralateral side of the table to allow full access to the surgical field.

**Tech tip:**
Consideration may be given to a commercially available beach chair positioner.

![Figure 2](image2)
Surgical technique

**Surgical approach**
For most cases, an extended delto-pectoral incision will be adequate to allow exposure to all involved structures. This begins 3-4cm medial to the acromioclavicular joint coursing distally over the coracoid process and along the delto-pectoral interval. You will note that the cephalic vein is medial to the coracoid.

The incision is then taken down through subcutaneous tissue to the delto-pectoral interval. The cephalic vein is identified and usually taken laterally with the deltoid to preserve the lateral perforators.
Surgical technique

**Pectoralis major tendon release**

A self-retaining or Richardson type retractor may be placed beneath the pectoralis medially and the deltoid laterally. The conjoined tendons, as they originate from the coracoid process, are identified and the interval deep to the tendons and superficial to the subscapularis is carefully developed by finger dissection. The medial retractor can be repositioned in this interval, respecting the musculocutaneous nerve and other neurovascular structures medially.

A blunt retractor is then passed superiorly beneath the coracoacromial ligament and acromion and superficial to the rotator cuff tendons. This allows additional exposure of the rotator interval and the anterior capsule.
Subscapularis tendon release (capsulotomy)

Prior to performing the anterior capsulotomy for exposure, the surgeon should determine the amount of passive external rotation available given the degree of soft tissue contracture or bony deformity.

In most cases, a full thickness capsulotomy releasing both subscapularis and capsule simultaneously may be performed for exposure.

The vertical limb of the capsulotomy begins 1.5cm-2cm medial to the biceps tendon. This runs from the rotator interval, superiorly to the inferior margin of the subscapularis tendon distally.

A horizontal limb, both superiorly and inferiorly, is then created and traction sutures are placed.

Tech tip:
Placement of traction sutures in the tendon aids in its release.

In most cases of arthritis of the glenohumeral joint, osteophytic spurring on the inferior portion of the humeral head will result in capsular shortening, loss of external rotation, and will necessitate release to allow exposure of the humeral head.

This is best accomplished by placing a retractor within the capsule at the inferior margin of the humeral head, externally rotating the arm, adducting and releasing that capsule intra-articularly, thus avoiding injury to the extracapsular axillary nerve. This step is critical in gaining exposure.

Tech tip:
A constant understanding of the location of the axillary nerve is critical during exposure.
Surgical technique

**Removal of osteophytes**

With the capsulotomy complete, the humeral head can be dislocated with external rotation and a pull from behind the proximal arm, delivering the humerus anterior and lateral.

Osteophytes are removed inferiorly and anteriorly to determine the level of head resection, and to define the anatomic neck and articular margins.

The humeral resection may be performed using either an intramedullary or extramedullary resection guide. Both methods are described below.

This step is critical in determining the orientation of the humeral head in relation to the glenoid. Furthermore, the extent of osteophytes, loose bodies, and humeral head deformation needs to be determined preoperatively with templating and radiographic studies.
In most cases, the humeral component should be set in approximately 30° of retroversion. There are a number of techniques that may be employed to achieve this retroversion. By flexing the elbow 90° and externally rotating the arm 30°, the humeral head cut is made straight on, thereby achieving 30° of retroversion.

**Superior-lateral approach**

The skin incision is made along the lateral edge of the acromion or made in a lateral direction. Following subcutaneous dissection, the anterior and middle deltoid muscle portions opposite the lateral margin of the acromion are separated using blunt dissection. The dissection starts at the level of the AC joint, 5-7mm posterior to the tip of the acromion, and extends straight laterally down into the deltoid muscle. It should not extend more than 4cm from the external aspect of the acromion in order to preserve the axillary nerve which is located at the turning fold of the subacromial bursa.

When the subacromial bursa is visible, gentle longitudinal traction in line with the limb allows a retractor to be placed in the subacromial space. The humeral head is dislocated and the proximal humerus will protrude through the rotator cuff defect. Exposure may be optimized, if necessary, by releasing the anterior border and the rest of the superior cuff.
Humeral head resection and canal reaming
Humeral head resection and canal reaming

Instructions for extramedullary (EM) resection guide

Once the margin of the articular surface is determined, the extramedullary humeral resection guide should be placed on the anterior aspect, parallel to the long axis of the humeral shaft.

Adjust the cutting block to the proper angular stop, left or right and verify that the resection block is fully against the stop, prior to tightening the locking knob.

Note:
The correct height is determined superior-laterally by the attachment of the supraspinatus tendon.

Tech tip:
The cut should be at the margin of the cuff attachment, removing the articular surface, but preserving the tendon attachment. Care should be taken to protect the biceps tendon and rotator cuff insertion with a small Hohman, Bennett or Crego retractor during head resection.

Accurate retroversion of the cut will remove all of the articular surface posteriorly, but preserve the posterior capsule and cuff attachments.
Humeral head resection and canal reaming

Prior to headless pin insertion, ensure that the arm is in proper retroversion using the 30° version rod and setting the arm in correct retroversion.

The version rod should align with the patient’s forearm.

When the correct retroversion has been determined, pin the external humeral resection guide to the humeral shaft using the headless pins inserted at slightly diverging angles.

If desired, mark the angle of the resection at a height appropriate for the desired head resection.

The angle of resection (135°) is marked and the humeral cut is initiated.

**Note:**
Remove the version rod prior to initiating resection.

**Warning:**
Do not use the version rod to rotate the assembly.
Humeral head resection and canal reaming

Once pinned in place, the knob can be loosened and the vertical shaft of the EM cutting guide can be removed to improve access for making the resection.

Place the oscillating saw blade along the flat surface of the guide and complete the humeral head resection.

**Notes:**
- A sagittal sawblade that has a width of ⅛” (12mm) or less is desirable.
- Ensure that the blade is oscillating prior to coming in contact with bone.
- Inspect sawblade for any defects prior to utilization.

The guide can be removed and the cut completed freehand or refined with a rongeur; any residual osteophytes, especially posteriorly, should be resected using an osteotome.

The resected head should be saved for later comparison and sizing of the modular humeral head options, as well as a source for bone graft.

**Note:**
- The saw blade should remain flush against the resection plane of the resection guide prior to initiating the humeral head resection.

Once the cut has been completed, remove the headless pins using the headless pin removal tool and then the cutting block.
Humeral head resection and canal reaming

Retractors are placed beneath the rotator cuff tissue superiorly and medially to provide adequate exposure of the canal for reaming. Reaming begins with bullet-tip fluted cylindrical reamers.

Placement should be somewhat lateral and just posterior to the bicipital groove. This will allow for appropriate position within the canal.

Reaming should be performed manually using the quick release ratcheting T-handle and be progressive in size (i.e. 7mm, 8mm, 9mm, etc) until friction is felt as the reamer contacts cortical bone.

**Tech tip:**
*It is important not to let the coracoid / conjoined tendon crowd posterior humeral metaphysis and force your canal entry too anterior.*
Humeral head resection and canal reaming

For a press-fit stem with the head resected, the reamer should be inserted to the top of the cutting teeth (Figure 20, green arrow).

If the humeral head has not already been resected and/or a cemented stem with cement restrictor is going to be utilized, the reamer should be inserted to the depth of the first line above the cutting teeth (Figure 20, blue arrow).

If a long stem prosthesis is indicated, reaming depth is to the second line positioned near the top of the reamer shaft (Figure 20, red arrow).

Notes:
These engraved marks are only present on reamer sizes 8 and above.
The last reamer size used will match the distal size of the broach to be used.

Warning:
The slotted mallet should not be utilized to strike the underside of the ratcheting T-handle for extraction or removal of the starter awl or cylindrical reamers.
Humeral head resection and canal reaming

Instructions for intramedullary (IM) resection guide

Assemble the 6mm starter awl and the ratcheting T-handle. Place the tip of the starter awl in line with the long axis of the humerus and bore a pilot hole through the humeral head along the long axis.

Placement should be somewhat lateral and just posterior to the bicipital groove. This will allow for appropriate valgus position within the canal.

The entry point is made posterior to the bicipital groove, relatively lateral on the head’s articular surface and just medial to the rotator cuff attachment. Using a mallet, lightly tap the awl into the canal.

The starter awl can be impacted through the humeral head starting position using the mallet to impact on the metal pad of the T-handle.

Note:
The T-handle can be placed into three different positions marked on the collar near the silicone handle. These positions are marked as “R” for REVERSE, “L” for LOCKED, and “F” for FORWARD. The user should align the white arrow marker with the appropriate directional setting during use.

Manually insert the starter awl until the larger diameter portion (positive stop) above the cutting teeth is located just above the humeral head.

Tech tip:
It is important not to let the coracoid / conjoined tendon crowd posterior humeral metaphysis and force your canal entry too anterior.

Once the entry point has been made through the humeral canal, remove the 6mm starter awl and begin to ream the humeral canal with the fluted cylindrical humeral reamers.
Retractors are placed beneath the rotator cuff tissue superiorly and medially to provide adequate exposure of the canal for reaming. A Darrach retractor along the posterior humerus can lever against the coracoid, exposing the entire humeral metaphysis. Reaming begins with bullet-tip fluted cylindrical reamers.

Reaming should be performed manually using the quick release ratcheting T-handle and be progressive in size (i.e. 7mm, 8mm, 9mm, etc) until friction is felt as the reamer contacts cortical bone.

When cortical contact is achieved, detach the ratcheting T-handle and leave the last reamer used within the humeral canal.

**Notes:**
These engraved marks are only present on reamer sizes 8 and above.

The last reamer size used will match the distal size of the broach to be used.

**Warning:**
The slotted mallet should not be utilized to strike the underside of the ratcheting T-handle for extraction or removal of the starter awl or cylindrical reamers.

When utilizing the IM resection guide or whenever utilizing a cement restrictor, the fluted cylindrical reamers should be inserted to the first line above the cutting teeth (Figure 24, blue arrow).

If a long stem prosthesis is to be utilized, reaming depth is to the second line positioned near the top of the reamer shaft (Figure 24, red arrow).
Humeral head resection and canal reaming

Make sure that the clamp tower can be assembled correctly by aligning the engrave arrow on the clamp tower to the engraved arrow on the cylindrical reamer.

**Note:**
The starter awl and all of the cylindrical reamers have the “D” shaped cross section marked by a large arrow, to mate with the large arrow marked IM resection guide’s clamp tower.

Once aligned, depress the cantilever arm of the clamp tower and slide it down over the shaft of the starter awl until the clamp tower comes in contact with the humeral head.

Assemble the IM resection guide to the resection guide block by depressing the superior plunger on the resection guide and attaching the resection guide block.

Make sure to correctly orient the IM resection guide to the correct side of the resection guide block as noted by the L or R markings on each of the instruments.
Humeral head resection and canal reaming

Slide the IM resection guide and resection block assembly onto the clamp tower making sure the orientation is correct by visualizing the markings L or R.

The cantilever arm should be used for macro height adjustments, while the fine adjustment wheel located just below the superior plunger should be utilized for micro height adjustments.

Prior to headless pin insertion, ensure the arm is properly retroverted. Align the forearm with the 30° version rod.

**Warnings:**

*The version rod is not intended to be a load bearing instrument.*

*Do not use the version rod to rotate the assembly or the awl/reamer.*

It is recommended that the resection level be confirmed by sliding the bladerunner instrument through the cutting block’s captured cutting slot and assessing the planned thickness and plane of resection.
Humeral head resection and canal reaming

When the level of the humeral head resection is confirmed. Pin the humeral IM cutting block to the humerus using the provided headless pins, to secure the resection block to the bone.

Using the pin driver attachment or pin collet, drive two (2) straight pins, perpendicular to the resection guide block, into place.

With the humeral resection guide block pinned to the humerus with two (2) straight pins, remove the version rod and then depress the plunger on the IM Resection Guide Assembly (Fig. 31, blue arrow).

Pull the IM Resection Guide Assembly and fluted cylindrical reamer from the humeral canal in one piece, leaving only the cutting block behind (Fig. 31, red arrow).

With only the humeral cutting block in place drive the third and final cross pin into the humeral cutting block to secure it in place prior to starting the humeral resection.

**Note:**
Hole marked as “X” is for insertion of the cross-pin.
Humeral head resection and canal reaming

With all three (3) headless pins in place, position the saw blade through the cutting slot for a captured cut.

Notes:
A sagittal sawblade that has a width of ½" (12mm) or less is desirable.
Ensure that the blade is oscillating prior to coming in contact with bone.
Inspect sawblade for any defects prior to utilization.

Alternatively, place the saw blade directly on the resection block for an open cut.

Warning:
To avoid cutting through the posterior capsule, stop the oscillating blade just short of the capsule and complete the cut with an osteotome.
Humeral head resection and canal reaming

Once the cut has been completed, remove the headless pins using the headless pin removal tool and then the cutting block.

**Tech tips:**
*Care should be taken to protect the biceps tendon and rotator cuff insertion with a small Hohman or Crego retractor during head resection.*

*The correct cut should remove all of the articular surfaces at the margins of the capsule and rotator cuff attachments superior and posterior. Those soft tissue attachments must be preserved.*

**Humeral head resection and canal reaming (superior-lateral approach)**

Assemble the 6mm starter awl and the ratcheting T-handle [Figure 37] and place the tip of the starter awl in line with the long axis of the humerus to bore a pilot hole through the humeral head along the long axis of the humeral shaft.

Placement should be somewhat lateral and just posterior to the bicipital groove. This will allow for appropriate neutral position within the canal.

The entry point is made posterior to the bicipital groove, relatively lateral on the head’s articular surface and just medial to the rotator cuff attachment site. Using a mallet, lightly tap the awl into the canal.

The starter awl can be impacted through the humeral head starting position using the mallet to impact on the metal pad of the T-handle.

**Note:**
The T-handle can be placed into three different positions marked on the collar near the silicone handle. These positions are marked as “R” for REVERSE, “L” for LOCKED, and “F” for FORWARD. The user should align the white arrow marker with the appropriate directional setting during use.
Humeral head resection and canal reaming

Manually insert the starter awl until the larger diameter portion (positive stop) above the cutting teeth is located just above the humeral head.

**Tech Tip:**
**It is important not to let the coracoid / conjoined tendon crowd the posterior humeral metaphysis and force your canal entry too anterior. The IM entry point should be slightly (2mm) posterior.**

Once the entry point has been made through the humeral canal, remove the 6mm starter awl, and begin to ream the humeral canal with the fluted cylindrical humeral reamers.

Retractors are placed beneath the rotator cuff tissue superiorly and medially to provide adequate exposure of the canal for reaming. A Darrach retractor along the posterior humerus can lever against the coracoid, exposing the entire humeral metaphysis. Reaming begins with bullet-tip fluted cylindrical humeral reamers.

Reaming should be performed manually using the quick release ratcheting T-handle and be progressive in size (i.e. 7mm, 8mm, 9mm, etc) until friction is felt as the reamer contacts cortical bone.

When cortical contact is achieved, detach the ratcheting T-handle and leave the last reamer used within the humeral canal.

**Warning:**
The slotted mallet should not be utilized to strike the underside of the ratcheting T-handle for extraction or removal of the starter awl or cylindrical reamers.

**Note:**
The last reamer size used will match the distal size of the broach to be used.

When utilizing the intramedullary (IM) resection guide or whenever utilizing a cement restrictor, the fluted cylindrical humeral reamers should be inserted to the first line above the cutting teeth [Figure 39, blue arrow].

If a long stem prosthesis is to be utilized, reaming depth is to the second line positioned near the top of the reamer shaft [Figure 39, red arrow].
Humeral head resection and canal reaming

Make sure that the clamp tower can be assembled correctly by aligning the engraved arrow on the clamp tower to the engraved arrow on the cylindrical reamer [Figure 40].

**Note:**
The starter awl and all of the cylindrical reamers have the “D” shape cross section marked by a large arrow, to mate with the large arrow marked IM resection guide’s clamp tower [Figure 40].

Once aligned, depress the cantilever arm of the clamp tower (red arrow) and slide it down over the shaft of the starter awl (blue arrow) until the clamp tower comes in contact with the humeral head [Figure 41].

Assemble the IM resection guide to the superior resection guide block by depressing the plunger on the IM resection guide (blue arrow) and attaching the superior resection guide block (red arrow) [Figure 42].

Make sure to correctly orient the IM resection guide to the desired side of the superior resection guide block. L or R markings on the IM guide should match the L or R markings on the resection guide block.
Humeral head resection and canal reaming

Slide the IM resection guide and superior resection block assembly onto the clamp tower [Figure 43].

The cantilever arm should be used for macro height adjustments, while the fine adjustment wheel located just below the superior plunger should be utilized for micro height adjustments.

Ensure the guide is in proper retroversion by using the version rod and aligning the forearm in the desired retroversion.

**Note:**
Threaded version rod holes are at 30° of retroversion.

**Warning:**
The version rod is not intended to be a load bearing instrument.

Do not use the version rod like a breaker bar to attempt to rotate the IM resection assembly.

**Note:**
Although marked with L/R markings for left and right orientation to each other, the IM resection guide and superior resection block assembly can be used in either orientation for left or right shoulders, regardless of markings.

It is recommended that the resection level be confirmed by sliding the bladerunner instrument through the cutting block’s captured cutting slot and assessing the planned thickness and plane of resection [Figure 44].

When the level of the humeral head resection is confirmed, pin the superior resection guide block to the humerus using the provided headless pins.

Using the headless pin driver attachment or pin collet, drive two (2) straight pins into the resection guide block.

With the superior humeral resection guide block pinned to the humerus with two (2) straight pins, depress the plunger (blue arrow) then pull the resection guide assembly and starter awl/reamer from the IM canal in one piece (red arrow), leaving only the superior resection block behind.
Humeral head resection and canal reaming

With only the superior humeral resection block in place, drive the third and final cross pin into the superior humeral resection block to secure it in place prior to starting the humeral resection.

Place the saw blade through the captured cutting slot and begin to make the superior-lateral humeral head cut.

Once the cut has been completed, remove the headless pins using the headless pin removal tool and then the superior humeral resection block.
Humeral preparation
Humeral preparation

Broaching the humerus
Upon completion of humeral canal reaming, select a humeral broach that is at least 4mm smaller than the size of the last reamer used.

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<td>5569-C-2011</td>
<td>13 mm</td>
<td>13 mm</td>
<td>11 mm</td>
</tr>
<tr>
<td>5569-C-2011</td>
<td>13 mm</td>
<td>13 mm</td>
<td>11 mm</td>
</tr>
<tr>
<td>5569-C-2012</td>
<td>14 mm</td>
<td>14 mm</td>
<td>12 mm</td>
</tr>
<tr>
<td>5569-C-2012L</td>
<td>14 mm</td>
<td>14 mm</td>
<td>12 mm</td>
</tr>
<tr>
<td>5569-C-2013</td>
<td>15 mm</td>
<td>15 mm</td>
<td>13 mm</td>
</tr>
<tr>
<td>5569-C-2014</td>
<td>16 mm</td>
<td>16 mm</td>
<td>14 mm</td>
</tr>
<tr>
<td>5569-C-2015</td>
<td>17 mm</td>
<td>17 mm</td>
<td>15 mm</td>
</tr>
</tbody>
</table>

**Warning:**
Do not use the broach handle/stem inserter for removal of a well fixed or cemented humeral stem.
Humeral preparation

Ensure the broach handle/stem inserter is in proper retroversion by threading in the version rod and aligning the patient’s forearm with the version rod.

**Warnings:**

The version rod is not intended to be a load bearing instrument.

Do not use the version rod like a breaker bar and attempt to rotate the broach handle to adjust the version.

The version rod must be removed prior to striking the underside of the impaction pad to avoid damaging the version rod during evaluation.

Attach the broach to the broach handle/stem inserter by making sure the locking pin is engaged and the broach is drawn onto the alignment pin while closing the handle.

The broach and broach handle/stem inserter will lock together via the handle on the medial side of the broach handle. It can be disengaged by releasing the same handle.

**Note:**

Prior to impaction, ensure that handle is closed and firmly grasped during mallet blows.
**Humeral preparation**

Impact the broach along the long axis of the humerus. The broach is fully seated when the superior face of the broach is sitting flush to the resection surface of the humerus.

Sequentially broach the humeral canal until the last humeral broach size used matches the diameter of the final cylindrical reamer used.

**Caution:**
Avoid excessive impaction of a well fixed broach as this may lead to fracture of the humerus.

**Warning:**
Do not use a humeral broach larger than the last cylindrical reamer used without first reaming up to the appropriate diameter if increased proximal fit is desired.

**Note:**
When removing the humeral broaches using the broach handle, make sure that upward mallet blows are placed on the strike pad.

The final broach utilized should be left in place as a trial and modular head and/or neck trials can be evaluated.
Humeral preparation

**Osteotomy evaluation and calcar planing**
Assess the planer’s relationship to the resected plane. If the angle diverges, then the calcar planer shall be utilized to finalize the plane, providing an optimum resection for the fixed head configuration (Figure 52).

If required, select the appropriate size calcar planer (see table below) to refine the resected surface.

Insert the calcar planer into the ratcheting T-handle and then insert the calcar planer’s guide post into the mating surface on the humeral broach (Figure 52, inset).

<table>
<thead>
<tr>
<th>Humeral head size</th>
<th>Calcar planer</th>
</tr>
</thead>
<tbody>
<tr>
<td>40, 44, 48</td>
<td>Small</td>
</tr>
<tr>
<td>52, 56</td>
<td>Large</td>
</tr>
</tbody>
</table>

**Warning:**
Do not use the calcar planers under power. They are intended for manual use only.

The angle of the calcar planer, when correctly placed into the broach, will be perpendicular to the standard neck angle of 135°.

Apply axial pressure onto the ratcheting T-handle and carefully refine the resected humeral surface.

**Note:**
To cut, depress the spring loaded shaft until a positive stop is reached.
Humeral preparation

**Humeral protector plate**

Upon completion of the humeral head resection and calcar planing, place the appropriate sized humeral resection protector plate onto the resected humeral surface.

This will protect the humerus during retraction, for glenoid preparation.

**Notes:**

The long pin of the calcar plate should be utilized in rotating and positioning the plate on the resected surface.

The humeral protector plate may not fully seat if the broach is not fully seated.

**Warning:**

Make sure not to damage the cortical bone around the perimeter of the resection of the humerus.
Glenoid preparation
Glenoid preparation

Placement of the pilot wire

Place the glenoid baseplate centering guide onto the face of the glenoid so that the inferior most portion of guide is aligned with the inferior most portion of the glenoid itself and the “SUPERIOR” marking can easily be seen superiorly [Figure 55 inset].

Tech tip:
The outer diameter of the glenoid baseplate centering guide matches the outer diameter (28mm) of the glenoid baseplate implant. A 10° inferior tilt has been built into the glenoid baseplate centering guide.

Insert the calibrated 3.2mm pilot wire into the glenoid using the included pin driver or a pin collet at the desired position and depth, ensuring the pin engages the medial cortical wall.

Ideally, the 3.2mm pilot wire should be placed into the best possible bone stock, keeping in mind that eccentric glenospheres are included in the ReUnion RSA System and can be positioned in any direction [See Table Below].

<table>
<thead>
<tr>
<th>Glenosphere</th>
<th>32</th>
<th>36</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral offset (mm)</td>
<td>+2, +6</td>
<td>+2, +6</td>
<td>+2, +6</td>
</tr>
<tr>
<td>Eccentricity (mm)</td>
<td>0</td>
<td>0, +2</td>
<td>0, +2, +4</td>
</tr>
</tbody>
</table>

Warning:
The calibrated 3.2mm pilot wire is a SINGLE USE ONLY instrument.

Measuring depth of pilot wire

The depth of the pilot wire can be measured by aligning the calibrated markings on the 3.2mm pilot wire [Figure 57 inset] with the flat surface of the glenoid baseplate centering guide [Figure 57].

Tech tip:
The 3.2mm pilot wire has calibrated markings that correspond to the lengths of center screws available in the system (24, 28, 32, 36, 40, and 44mm).
Glenoid preparation

Reaming and planing the glenoid

Select the appropriately sized glenoid reamer/planar and assemble it to the cannulated straight reamer driver via a hex shaped quick connect feature [Figure 58].

<table>
<thead>
<tr>
<th>Glenoid reamer/planar</th>
<th>32</th>
<th>36</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diameter (mm)</td>
<td>32</td>
<td>36</td>
<td>40</td>
</tr>
</tbody>
</table>

**Note:**
All of the glenoid reamer/planars have the same radius of curvature; as long as the soft tissue permits, any of the reamer/planars can be used to prepare the glenoid implants.

**Tech tip:**
If the user is uncertain at this step which glenosphere size will be utilized, it is recommended that the largest size glenoid reamer/planar be used that the patient’s anatomy will accommodate.

**Note:**
The glenoid reamer/planars are designed to ream the glenoid face and plane the outer edge to receive the glenoid baseplate and glenosphere implants.

**Caution:**
During reaming, make sure to use the power instruments in “REAM” mode or be sure to utilize reamer specific attachments for proper RPM and torque settings.

With the calibrated 3.2mm pilot wire in place, position the glenoid reamer/planar over the top of the 3.2mm pilot wire and begin to ream the glenoid face utilizing a pulsing method [Figure 60].

**Caution:**
To ensure accuracy in reaming, apply power prior to the reamer/planar making contact with the lateral surface of the glenoid.
Glenoid preparation

Pulse ream the glenoid to the desired level, ensuring that the medial geometry of the glenoid baseplate is completely reamed and contained inside the glenoid.

**Tech tip:**
*Due to the included 10° inferior tilt in the glenoid baseplate centering guide, inferior reaming should be evident first. Superior reaming should then follow.*

It is critical that the glenoid is adequately reamed to ensure complete seating of the glenoid baseplate. Ream to expose subchondral bone. Continue reaming to expose the subchondral bone on the inferior 50% of the prepared glenoid until bleeding bone is exposed and the entire circumference of the glenoid reamer/planar has made contact with the glenoid face.

**Caution:**
*There is no stop on the glenoid reamer, so continual attention to reaming depth is important. A full awareness of the patient’s existing glenoid deformity/version prior to reaming is necessary to determine the amount of correction necessary for effective glenoid implantation.*

**Note:**
*Confirm there is adequate soft tissue clearance within the envelope of the reamer/planar to ensure glenosphere to baseplate taper lock.*

If using an eccentric glenosphere [See table below], after standard glenoid reaming has been completed, be sure to use the included eccentric glenoid planar [Figure 62] to ensure the eccentric glenosphere can be properly seated to the glenoid baseplate without any interference from the backside of the glenosphere.

Prior to pilot wire removal, take note of and record the depth/length of the pilot wire as measured in a previous step.

<table>
<thead>
<tr>
<th>Glenosphere</th>
<th>32</th>
<th>36</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral offset (mm)</td>
<td>+2, +6</td>
<td>+2, +6</td>
<td>+2, +6</td>
</tr>
<tr>
<td>Eccentricity (mm)</td>
<td>0</td>
<td>0, +2</td>
<td>0, +2, +4</td>
</tr>
</tbody>
</table>
Measuring depth/length for center screw

Glenoid baseplate center screw length selection may be determined using the following methods:

1. With the calibrated 3.2mm pilot wire in place, read the corresponding depth marking on the pilot wire [Figure 63] relative to the face of the glenoid baseplate centering guide [Figure 63].

2. If the 3.2mm pilot wire is removed, place the depth gauge into the prepared center screw hole and read the corresponding measurement from the depth gauge [Figure 63].

Remove the glenoid reamer/planar and/or glenoid planar and then remove the 3.2mm pilot wire using the pin collet or headless pin removal instrument.

When utilizing the depth gauge be sure to engage the far cortex with the hook of the depth gauge and place the tip of the instrument against the glenoid face before reading the measurement [Figure 64 inset].

Caution:
During assembly of the depth gauge be sure not to pinch or impinge surgical glove between sub-assemblies.

When removing the depth gauge be sure to disengage the bone hook from the far cortex prior to removal of the instrument in order to prevent fractures and damage to the depth gauge’s tip.

Tech tip:
It is important to prepare and select a center screw length that engages the far cortex to ensure optimal compression and fixation.

Note:
Center screw: Ø 6.5mm screw, lengths 24-44mm (4mm increments).

Tech tip:
Due to variations in patient morphology, depth measurements should be taken at multiple points to ensure the longest, most appropriate measurement is obtained.
Glenoid preparation

**Baseplate and center screw placement**

Insert the inner barrel of the baseplate holder into the outer handle.

While pressing down on the end of the inner barrel, tighten the knob at the end of the baseplate holder [Figure 65] to prepare the instrument to receive the glenoid baseplate implant.

With the inner barrel fully seated and tightened down into the outer barrel, squeeze the sides of the baseplate holder [Figure 66] and place the 28mm glenoid baseplate implant onto the retention pins by aligning them with two (2) of the peripheral screw holes. Release the sides of the baseplate holder to actively retain the glenoid baseplate.

The glenoid baseplate should now be securely fixed to the baseplate holder.
Glenoid preparation

Assemble the center screw T25 driver to the 4-sided ratcheting handle [Figure 67].

Once assembled, the center screw T25 driver should be securely engaged into the 4-sided handle and ready for use.

**Tech tip:**
The tip of the T25 driver is tapered slightly, providing self-retention of the screw to the driver.

The intent of center screw placement should be to compress the glenoid baseplate onto the face of the glenoid and achieve a bi-cortical lock.

**Note:**
It is important to prepare and select a center screw length that engages the far cortex to ensure optimal compression and fixation.

**Tech tip:**
A correctly seated center screw will provide the best baseplate compression and fixation. This will also ensure the correct seating of the glenosphere to the glenoid baseplate.

Taking note of the measurements taken either with the calibrated guide pin or the depth gauge, select the appropriate length screw and verify its length with the screw identification tool built into the case/tray [Figure 68].

Place the selected center screw into the opening on the end of the baseplate holder and allow it to slide down into position on top of the glenoid baseplate [Figure 69].

**Tech tip:**
The selected center screw may also be loaded onto the center screw T25 driver prior to insertion into the baseplate holder.
Glenoid preparation

Align screw and handle along pilot wire trajectory per Figures 70 and 71.

Rotate the glenoid baseplate so that the inferior screw can be aimed toward the scapular neck. The superior screw should be aimed towards the base of the coracoid process superiorly (long axis of the glenoid bone) or the best available bone stock [Figure 71].

Insert the tip of the center screw into the hole that has been bored with the 3.2mm pilot wire.

Apply an axial force towards the face of the glenoid [Figure 72] while holding the baseplate holder firmly in place to prevent rotation of the glenoid baseplate.

With the center screw T25 driver securely attached to the center screw within the baseplate holder, begin to tighten down the center screw into the glenoid fossa.

**Warning:**
*It is important to ensure the screw driver and screw are parallel with each other and the tip of the T25 driver is fully engaged in the screw head.*

*The screws and drivers should only be manually driven and never used under power.*

*Deviation from this technique may lead to stripping of the driver and screw interface.*

When fully seated, the glenoid baseplate should sit flush with the glenoid face and the scapula should rotate slightly when attempting to tighten the center screw further onto the glenoid face.

**Tech tip:**
*If the glenoid baseplate does not compress when using the selected screw, double check the measurement using the depth gauge and ensure that the far cortex can be captured using the appropriate length screw.*

**Caution:**
*Once the center screw is fully seated in the baseplate, do not over-tighten the center screw.*
Glenoid preparation

**Warning:**
Once the center screw is locked into position DO NOT turn the glenoid baseplate handle to reposition or rotate the baseplate [Figure 73].

Remove the baseplate holder from the now locked glenoid baseplate by loosening the knob in a counter clockwise direction [Figure 74].

After the center screw has been properly locked into position on the glenoid baseplate, a visual inspection of the glenoid baseplate should be performed to confirm there are no gaps between the reamed surface and the glenoid baseplate.

**Note:**
After removing the baseplate holder, double check the center screw is fully seated with the T25 driver.

**Tech tip:**
A correctly seated center screw will provide the best glenoid baseplate compression and fixation. This will also ensure the correct seating of the glenosphere to the glenoid baseplate.
Glenoid preparation

**Preparation for peripheral screw placement**

**Inferior screw**
Place the variable angle peripheral drill guide into the glenoid baseplate’s inferior hole. The drill guide can be angled up to a maximum angle of ±15° but should always be engaged fully in the glenoid baseplate hole.

If possible, palpate the scapular neck and aim into the best possible bone, as close to the lateral border of the scapula as permitted.

**Note:**
The locking peripheral screws are designed to allow a maximum angulation of up to ±15° for optimal screw placement.

Peripheral screws: Ø 4.5mm screw, lengths 16-52mm (4mm increments).

**Tech tip:**
A separate fixed angled drill guide is included and can be utilized to place peripheral screws in a perpendicular configuration to the glenoid baseplate.

While firmly holding the peripheral drill guide against the glenoid baseplate, begin drilling through the subchondral bone to the desired optimal depth using the 3.1mm drill bit.

**Tech tip:**
Axial pressure should be maintained on the drill guide throughout the entire drilling process to ensure proper seating of the drill guide to the baseplate.

Redirect and re-drill as needed to achieve optimal peripheral screw trajectory and bone purchase.

**Caution:**
Care must be taken during the drilling process in order to preserve as much bone as possible for screw purchase.
Glenoid preparation

Once the far cortex has been perforated take note of the depth by aligning the laser marked ring on the drill bit with the markings on the face of the guide [Figure 78].

The depth gauge can also be utilized to verify peripheral screw length by placing the depth gauge directly into and flush against the glenoid baseplate and engaging the far cortex with the depth gauge’s hook.

**Caution:**
When removing the depth gauge be sure to disengage the bone hook from the far cortex prior to removal of the instrument in order to prevent fractures and damage to the depth gauge’s tip or damage to the glenoid baseplate.

**Caution:**
During drilling, make sure to use the power instruments in “DRILL” mode or be sure to utilize drill specific attachments for proper RPM and torque settings.

**Warning:**
The 3.1mm drill bit is a SINGLE USE ONLY instrument.

Do not use the drill bit outside of the provided peripheral drill guides during peripheral screw preparation.
Peripheral screw placement

The intent of peripheral screw placement should be to engage the maximum amount of good quality bone stock available with the appropriate length screws.

Taking note of the measurements taken either with the peripheral drill guide or the depth gauge, select the appropriate length screw and verify its length with the screw identification tool built into the case/tray [Figure 79].

Assemble the peripheral screw T25 driver to the 4-sided ratcheting handle and engage onto the selected inferior peripheral screw.

**Note:**
Make sure the peripheral screw is taper locked to the peripheral screw T25 driver before handling the assembly.

Place the selected inferior peripheral screw into the glenoid baseplate and begin to manually tighten the peripheral screw.

The head of the peripheral screw should be below the level of the surface of the baseplate when it is fully engaged and locked in place.

**Warning:**
It is important to ensure the screw driver and screw are parallel with each other and fully engaged as you insert the screws.

The screws and drivers should only be manually driven and never used under power.

Deviation from this technique may lead to stripping of the driver and screw interface. Once the screws are fully seated in the baseplate, do not over-tighten.

Repeat above steps for opposing superior screw and then the anterior and posterior screws.

**Tech tip:**
The required minimum number of screws shall be no less than two (2) peripheral screws (superior and inferior) and one (1) center screw.

When possible, four (4) peripheral and one (1) center screw should be used.
Glenoid preparation

Glenosphere trialing
Select the appropriately sized glenosphere trial [see table below] and determine the eccentricity and lateral offset required for optimum glenosphere placement and ROM.

<table>
<thead>
<tr>
<th>Glenosphere</th>
<th>32</th>
<th>36</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral offset (mm)</td>
<td>+2, +6</td>
<td>+2, +6</td>
<td>+2, +6</td>
</tr>
<tr>
<td>Eccentricity (mm)</td>
<td>0</td>
<td>0, +2</td>
<td>0, +2, +4</td>
</tr>
</tbody>
</table>

Grasp the glenosphere trials using the glenoid holder instrument [Figure 83] and place the glenosphere trial onto the glenoid baseplate, making sure that the glenosphere trial is completely bottomed out onto the glenoid baseplate.

It is possible to orient the glenosphere eccentricity in any direction including anterior/posterior, which may help with extreme instability. Glenosphere trials are marked with an arrow and “ECC” marking to show the orientation of the eccentricity [Figure 84].

Tech tip:
An eccentric glenosphere placed inferiorly provides the best opportunity to minimize the possibility of scapular notching.

The definitive glenosphere implant can be inserted now or the user can move on to insert the humeral trials and place the definitive glenosphere implant at the conclusion of trialing.

Note:
The glenoid holder will be required to remove the glenosphere trial from the glenoid baseplate.
Humeral cup
Insert trialing
Humeral cup/insert trialing

**Optional utilization of humeral cup trial adaptors**

(Humeral cup trial adaptors are available in the US only)

Humeral cup trials sit flush to the face of the Humeral broaches and cemented humeral stems [Figure 85 left]. In cemented applications, the morse taper adjoining the humeral cup implant with the humeral stem implant adds a nominal thickness of approximately 1.5mm [Figure 85 Right].

**Note:**

Humeral cup trial adaptors are only applicable to cemented humeral stem applications.

For this reason, single-use/sterile humeral cup trial adaptors are available for optional utilization with ReUnion RSA humeral cup trials. Utilization of the trial adaptors will account for the additional nominal 1.5mm gap introduced by the morse taper.

Humeral cup trial adaptors mate with ReUnion RSA humeral cup trials and expanding cup trials. To determine the size of the humeral cup trial, please refer to the “humeral cup/insert trialing” section.

Place the flat side of the humeral cup trial adaptor on the bottom face of the selected humeral cup trial assembly. The longer straight pin on the humeral cup trial fits through the smaller circular hole surrounded by cutouts, while the oblong pin fits through the corresponding oblong hole in the adaptor.

**Note:**

There should be no gap between the bottom face of the humeral cup trial and the top side of the humeral cup trial adaptor.
Humeral cup/insert trialing

With the shorter oblong pin on the humeral cup trial oriented superiorly and the longer straight pin oriented inferiorly, place the assembled components on the humeral broach or ReUnion TSA cemented humeral stem.

Continue trialing the ReUnion RSA humeral cup trial assemblies as described in the “humeral cup/insert trialing” section.

If an alternate humeral cup trial is desired, remove the humeral cup trial adaptor from the previous humeral cup trial and assemble it to the new trial as previously described.

Tech tip:
The forked removal tool can aid in humeral cup trial adaptor removal. See the “humeral cup trial adaptor disassembly” section.

Humeral cup/insert trialing

The ReUnion RSA shoulder system has 3 methods of humeral cup/insert trialing available.

1. Expanding humeral cup trial and expanding humeral trial insert.

2. Sliding humeral cup trial and humeral insert trial

3. Traditional humeral cup implant and humeral insert trial

All three methods are intended to provide accurate assessment of deltoid tension for optimal range of motion and joint stability.
Humeral cup/insert trialing

Expanding humeral trial

<table>
<thead>
<tr>
<th>Expanding humeral cup trials</th>
<th>Humeral construct size range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (Sizes 32, 36, and 40)</td>
<td>12mm - 18mm (2mm incr.)</td>
</tr>
<tr>
<td>Large (Sizes 32, 36, and 40)</td>
<td>16mm - 22mm (2mm incr.)</td>
</tr>
</tbody>
</table>

Select the appropriately sized expanding insert trial [see table above]. Both small and large insert trials are color coded to match the three different diameters of glenospheres.

Tech tip:
Select a small insert trial if you anticipate a tighter joint; select a large insert trial if you anticipate a looser joint.

Constrained X3 humeral inserts are available and capture more of the glenosphere. The polyethylene walls are higher than standard bearings, but do not add any additional joint space.

Note:
The metal expandable humeral cup trials only come in one size, but are able replicate both 4 and 10mm humeral cup options.

Insert the selected expanding insert trial into the expanding humeral cup trial and rotate clockwise until it is in its collapsed state [Figure 90].

Place the assembled trial on the humeral broach by placing the long straight pin on the inferior hole perpendicular to the resection plane. Reduce (relocate) the joint with the trial fully collapsed to facilitate the reduction maneuver.

Note:
If utilization of the optional humeral cup trial adaptor is desired, follow instructions for attachment to expanding humeral cup trial prior to placement on the humeral broach/cemented humeral stem.

Perform an initial reduction with the collapsed trial, making sure to minimize the amount of tension on the deltoid.

As the trial is expanded and tension placed on the deltoid, the markings will correspond to the humeral cup and humeral insert thicknesses.
Humeral cup/insert trialing

In the example provided in Figure 91 and 92, a 8mm thick X3 humeral insert would be used with a 10mm thick humeral cup, in a left (L) shoulder.

**Note:**
The top number represents the humeral insert thickness (mm). The bottom numbers (4 and 10) represent the humeral cup thickness (mm). The L or R represent which side shoulder is being trialed.

Using the unthreaded portion of the version rod, expand the expanding insert trial until the entire construct begins to apply tension to the deltoid.

Progressively expand the trial with the shoulder reduced by turning the expanding trial counterclockwise. Each turn will increase the thickness of the construct by 2mm.

**Warning:**
Do not overly tension the deltoid as this may cause damage to bone and soft tissue.

The trial reduction should show very limited distraction (1mm or less). In cases of extreme instability, constrained humeral bearings are available.

Constrained X3 humeral inserts capture more of the glenosphere and have polyethylene walls which are higher than the standard X3 humeral insert implants, but do not add any additional joint space.

If the appropriate amount of tension is achieved for optimal range of motion, the component size markings on the lateral aspect of the expanding trial construct should be recorded for final prosthesis selection.

Prior to removal, the expanding trial should be compressed back to its original state, releasing the tension from the deltoid so that the instrument can be removed easily.

**Note:**
If optional humeral cup trial adaptor is being utilized, ensure that it is properly detached from the humeral cup trial assembly/humeral broach and is not left in the wound.
Humeral cup/insert trialing

**Sliding humeral cup trial and humeral trial insert**

<table>
<thead>
<tr>
<th>Humeral trials</th>
<th>Humeral construct size range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sizes 32, 36, and 40</td>
<td>8mm - 22mm (2mm incr.)</td>
</tr>
</tbody>
</table>

Select the appropriately sized humeral cup trial and humeral insert trial [see table above].

Engage the humeral insert trial into the humeral cup trial by sliding the insert into position and turning it by hand or using the non-threaded end of the version rod to “lock” the trial insert into place [Figure 96].

**Note:**
If utilization of the optional humeral cup trial adaptor is desired, follow instructions for attachment to humeral cup trial prior to placement on humeral broach.

Place the assembled humeral cup trial and humeral insert trial onto the humeral broach in preparation for a trial reduction by placing the long straight pin on the inferior hole perpendicular to the resection plane.

Perform an initial trial reduction to determine the appropriate amount of tension on the deltoid for optimal stability and range of motion.

The trial reduction should show very limited distraction (1mm or less). In cases of extreme instability, constrained X3 humeral inserts are available.

**Tech tip:**
Constrained X3 humeral inserts are available and capture more of the glenosphere. The polyethylene walls are higher than standard bearings, but do not add any additional joint space.

**Warning:**
Do not overly tension the deltoid as this may cause damage to bone and soft tissue.
Humeral cup/insert trialing

If the appropriate amount of tension is achieved for optimal stability and range of motion, distract the humeral insert trial and humeral cup trial by first rotating the humeral insert trial from a “locked” position to an “unlocked” position by using the non-threaded end of the version rod [Figure 97].

To distract the humeral trial components, place the arm in slight abduction and external rotation to align the trial components with the glenosphere/glenoid.

Distract the trial implant by translating the humerus and humeral cup trial anteriorly until the humeral cup trial is free of the humeral insert trial.

The humeral insert trial shall remain engaged to the glenosphere and can then be removed separately.

**Note:**
If optional humeral cup trial adaptor is being utilized, ensure that it is properly detached from the humeral cup trial assembly/humeral broach and is not left in the wound.
Humeral cup/insert trialing

Traditional humeral trialing (humeral trial insert and humeral cup implant)

<table>
<thead>
<tr>
<th>Humeral cup trials</th>
<th>Humeral construct size range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sizes 32, 36, and 40</td>
<td>8mm - 22mm (2mm incr.)</td>
</tr>
</tbody>
</table>

With the definitive humeral cup locked to the humeral stem, placed the selected humeral insert trial into the definitive humeral cup and reduce the joint [Figure 98].

If the appropriate amount of tension is achieved for optimal stability and range of motion, distract the joint and extract the humeral insert trial from the definitive humeral cup.

Component size selection

The ReUnion RSA Reverse Shoulder System comes with a large range of implant sizes to accommodate all ranges of glenohumeral instability and/or rotator cuff deficiency.

Note:
For assemblies of 14mm and 16mm, it is recommended to use the thicker metal humeral cup component versus a thicker X3 humeral insert.
Final implant insertion
0945 ReUnion RSA -proof 3
Final implant insertion

Glenosphere placement

Engage the desired definitive glenosphere on the glenosphere holder/impactor and place the glenosphere onto the glenoid baseplate [Figure 100].

If using an eccentric glenosphere, use the eccentric alignment mark on the glenosphere impactor tip and align it to the laser mark on the underside of the eccentric glenosphere to place the glenosphere in the optimum orientation as trialed.

Note:
Confirm there is adequate soft tissue clearance within the envelope of the baseplate to ensure glenosphere to baseplate taper lock.

Caution:
Constrained X3 humeral inserts are available and capture more of the glenosphere. The polyethylene walls are higher than standard bearings, but do not add any additional joint space.

Prior to impaction, make sure the glenosphere and baseplate tapers are aligned and that there are no protruding bone ledges or interposed soft tissue that may impede full seating of the glenosphere.

Definitively seat the glenosphere by placing several sharp blows on the glenosphere holder/impactor. A set screw is not needed to attach the glenosphere to the glenoid baseplate.

The design of the morse taper provides a secure mode of fixation. Check the glenosphere handle to make sure the taper is fully seated after impaction by gently toggling in all directions.

If the morse taper has not been engaged, toggling of the handle will disengage the glenosphere from the baseplate.

Note:
It is critical to ensure that all tapers are clean, dry and clear of any debris or damage prior to assembling the glenosphere to the glenoid baseplate.
Final implant insertion

To detach the glenosphere holder/impactor from the glenosphere after it has been impacted in place, unthread the instrument counter-clockwise until it is free [Figure 101].

After the removal of the glenosphere holder/impactor, inspect the glenosphere for placement and clean the articulating surface of all debris.

**Humeral cup and insert assembly**

**press-fit stem application**

Place the definitive humeral cup implant into the humeral assembly block.

Position the definitive X3 humeral insert on top of the definitive humeral cup.

Attach the appropriately sized humeral insert impactor tip to the universal impactor adaptor and attach the assembly to the 4-Sided handle.

While holding the humeral assembly block steady, impact the definitive X3 humeral insert into the definitive humeral cup using several sharp blows of the mallet [Figure 103 inset].

The assembled definitive humeral cup and X3 humeral insert are now locked and ready to be inserted onto the definitive humeral stem.

**Note:**

Optional humeral cup trials are limited to cemented humeral stem applications and should not be utilized in press-fit applications.

It is critical to ensure that all tapers are clean, dry and clear of any debris or damage prior to assembling the humeral cup to the stem.

Place the humeral cup and X3 humeral insert assembly onto the taper of the humeral stem [Figure 103].

The humeral stem should not be fully seated as to allow space for a sufficient taper lock of the humeral cup and X3 humeral insert assembly to the humeral stem.

Several sharp mallet blows are used to seat the humeral cup and X3 humeral insert assembly until the backside of the humeral cup is flush to the resection. Be sure the angle of the driver is in line with the axis of the trunnion (90° to humeral cup face) [Figure 105].
Final implant insertion

**Warning:**
Excessive impaction on a properly seated humeral stem may potentially cause a fracture of the medial calcar or humeral shaft.

Reduce the joint and assess the final range of motion. The final reduction should show very limited distraction (1mm or less).

Impingement should not be present in either adduction or abduction. If impingement occurs in abduction, a greater tuberosity osteotomy or tuberoplasty may be necessary.

**Note:**
Attention must be paid to version of the implant.

With either cemented or press-fit application, expanding humeral trials or humeral trial cups may be again used to evaluate adequacy of range of motion, soft tissue tensioning and to check for impingement.

When trialing off of the proud press-fit stem, care should be taken to assess the anticipated final seating height.

**Options for cemented stem application**

For cemented stems, the ReUnion RSA has three options for definitive component placement [see table below].

**Caution:**
If the humeral resection plane is compromised, it may prevent the humeral cup from sitting appropriately flush to the resection plane, potentially affecting humeral component version.

In this event, option 3 (see table below) must be used.

<table>
<thead>
<tr>
<th>Method of assembly</th>
<th>Trialing Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stem + Cup + X3 insert (back table)</td>
<td>Expanding, sliding, traditional</td>
</tr>
<tr>
<td>2. Stem + Cup (back table), X3 insert (in-vivo)</td>
<td>Expanding, sliding, traditional</td>
</tr>
<tr>
<td>3. Stem, Cup, X3 insert (in-vivo individually)</td>
<td>Traditional</td>
</tr>
</tbody>
</table>
Final implant insertion

**Option 1: Complete back table assembly and monoblock insertion**

**Caution:**
*Prior to monoblock insertion into the cement mantle, surgeon must inspect the resection plane to ensure the humeral cup can be seated flush to the resection.*

1. Place the definitive humeral cup implant into the humeral assembly block.
2. Position the definitive X3 humeral insert on top of the definitive humeral cup [Figure 108].
3. Attach the appropriately sized humeral insert impactor tip to the universal impactor adaptor and attach the assembly to the 4-Sided handle.
4. While holding the humeral assembly block steady, impact the definitive X3 humeral insert into the definitive humeral cup using several sharp blows of the mallet [Figure 108 inset].
5. The assembled definitive humeral cup and X3 humeral insert are now locked and ready to be inserted onto the definitive humeral stem.
6. Place the definitive humeral stem into the correct position on the marked humeral assembly block.
7. While holding the humeral assembly block steady, impact the humeral cup and X3 humeral insert assembly into the humeral stem using several sharp blows to lock the assembly. Be sure the angle of the driver is in line with the axis of the trunnion (90° to humeral cup face).
8. The monoblock assembly (humeral stem, humeral cup, and X3 humeral insert) is now ready to be inserted into the cement mantle.
9. Insert the monoblock assembly into the cement mantle. Surgeon must ensure that the back surface of the humeral cup is flush to the resection plane [Figure 110].
10. Reduce the joint and assess the final range of motion. The final reduction should show very limited distraction (1mm or less).
11. Impingement should not be present in either adduction or abduction. If impingement occurs in abduction, a greater tuberosity osteotomy or tuberoplasty may be necessary.

*Figure 108*

*Figure 109*

*Figure 110*
Final implant insertion

Option 2: Back table assembly of the humeral cup and cemented stem

Caution:
Prior to monoblock insertion into the cement mantle, surgeon must inspect the resection plane to ensure the humeral cup can be seated flush to the resection.

Place the definitive humeral stem into the correct position on the marked humeral assembly block.

Position the definitive humeral cup onto the definitive humeral stem.

Attach the universal impactor tip to the universal impactor adaptor and attach the assembly to the 4-Sided handle.

While holding the humeral assembly block steady, impact the humeral cup into the humeral stem using several sharp blows to lock the humeral cup into the humeral stem. Be sure the angle of the driver is in line with the axis of the trunnion (90° to humeral cup face).

The monoblock assembly (humeral stem and humeral cup) is now ready to be inserted into the cement mantle.

Insert the monoblock assembly into the cement mantle. Surgeon must ensure that the back surface of the humeral cup is flush to the resection plane [Figure 112].

Place the definitive X3 humeral insert selected during trialing onto the humeral cup.

Attach the appropriately sized humeral insert impactor tip to the 4-sided handle.

Apply several sharp mallet blows to lock the X3 humeral insert to the humeral cup. Be sure the angle of the driver is in line with the axis of the trunnion (90° to humeral cup face).

Reduce the joint and assess the final range of motion. The final reduction should show very limited distraction (1mm or less).

Impingement should not be present in either adduction or abduction. If impingement occurs in abduction, a greater tuberosity osteotomy or tuberoplasty may be necessary.
Final implant insertion

Option 3: In-vivo individual assembly of cemented humeral stem, humeral cup, and X3 humeral insert

**Note:**
If optional humeral cup trial adaptor is being utilized, ensure that it is disassembled and removed prior to impacting the humeral cup implant.

**Caution:**
If optional humeral cup trial adaptor is being utilized, ensure that it is properly detached from the humeral cup trial/cemented humeral stem and is not left in the wound.

Place the definitive humeral cup implant onto the cemented humeral stem [See Figure 114].

Attach the universal impactor tip to the universal impactor adaptor and attach the assembly to the 4-sided handle.

Impact the humeral cup into the humeral stem using several sharp blows to lock the humeral cup into the humeral stem. Be sure the angle of the driver is in line with the axis of the trunnion (90° to humeral cup face) [Figure 115].

Place the X3 humeral insert onto the humeral cup.

Attach the appropriately sized humeral insert impactor tip to the 4-sided handle.

Several sharp mallet blows are used to seat the X3 humeral insert into the humeral cup. Be sure the angle of the driver is in line with the axis of the trunnion (90° to humeral cup face).

Reduce the joint and assess the final range of motion. The final reduction should show very limited distraction (1mm or less).

Impingement should not be present in either adduction or abduction. If impingement occurs in abduction, a greater tuberosity osteotomy or tuberoplasty may be necessary.
Implant removal

Humeral stem removal

**Warning:**
Do not use the broach handle/stem inserter for removal of a well fixed or cemented humeral stem.

Utilize the humeral stem removal tool and McReynolds slap hammer to remove the humeral stem from the humeral canal.

Attach the humeral stem extractor to the humeral stem by inserting the guide post into proximal hole of the stem. Engage the clamping arm into trunnion, then tighten the knob.

Depending on the integrity of the cement mantle or degree of humeral stem ingrowth, humeral shaft osteotomies and other techniques described in the peer reviewed literature may be justified.

Thread the McReynolds slap hammer attachment to the humeral stem extractor and apply upward thrusts in line with the long axis of the humerus and well fixed humeral stem.

**Warning:**
Do not apply cantilever loads while sliding the hammer to remove the stem as this may cause a fracture of the humerus.
Implant removal

**Humeral poly insert removal**
Dislocate the glenohumeral joint so that the X3 humeral insert is exposed.

Use the 3.1mm drill bit and drill a pilot hole into the X3 humeral insert at an oblique angle.

Drive the 3.1mm drill bit to the flat bottom surface of the humeral cup away from the sides and the locking features of the X3 humeral insert.

Assemble the polyethylene removal tool to the 4-sided handle and introduce the tip of the polyethylene removal tool into the prepared pilot hole at the same oblique angle.

Drive the polyethylene removal tool into the X3 humeral insert until the insert disassociates from the humeral cup.

**Note:**
*After the X3 humeral insert has been removed, make sure that the joint space is completely clean and clear of any and all debris and polyethylene particles.*

**Humeral cup removal**
Attach the forked removal tool to the 4-sided handle and slide the forked removal tool under the humeral cup.

Align the forked removal tool to the neck of the humeral cup and lightly tap the forked removal tool in with a mallet to mechanically disassociate the humeral cup from the humeral stem.

If the humeral cup is in direct contact with the bone, the surgeon may need to create a small window along the edge of the resection to obtain access for insertion of the fork.
Implant removal

Glenosphere removal
With the glenohumeral construct distracted and the glenosphere fully exposed. Introduce the glenosphere jackscrew into the threaded hole at the top of the glenosphere.

Utilizing the center screw T25 driver, begin to thread in the glenosphere jackscrew until the glenosphere distracts completely from the glenoid baseplate.
Instrument disassembly

Disassembly of glenoid reamer/planar

The recommended method to disassemble the glenoid reamer/planars from the cannulated straight reamer driver is by utilizing the glenoid holder to grasp around the circumference of the glenoid reamer/planar.

By holding the reamer/planar face as shown [Figure 125] with the glenoid holder, pull the glenoid reamer/planar face away from cannulated straight reamer driver in an axial direction to disengage the quick connect feature.

Warning:
Do not toggle the glenoid reamer/planar during disassembly as this has the potential to compromise the fit of the quick connect mechanism [Figure 125 inset].
Instrument disassembly

If attempting to remove the glenoid reamer/planar without use of the glenoid holder, it is recommended the user utilize gauze or another material to protect their hands from blades of the reamer.

Humeral cup trial adaptor disassembly

Attach the forked removal tool to the 4-sided ratcheting handle.

Slide the forked removal tool between the humeral cup trial and the humeral cup trial adaptor. Ensure that the flat side of the forked removal tool faces the bottom side of the humeral cup trial and the ramped side faces the humeral cup trial adaptor.

Carefully disassemble the humeral cup trial adaptor from the humeral cup trial.
Notes:
Notes:
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