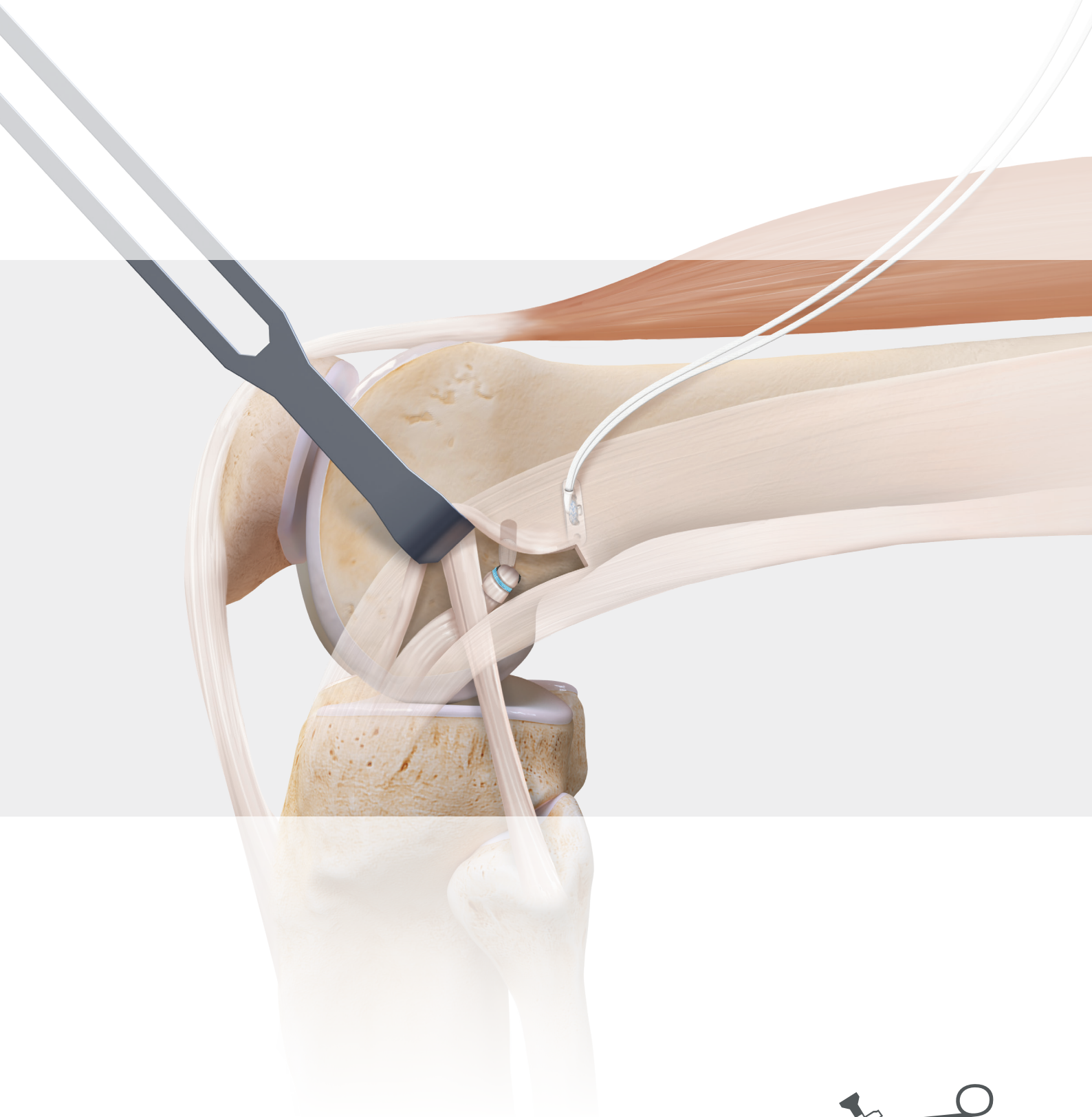


IT Band Tenodesis With the Double Knotless Knee FiberTak[®] Anchor

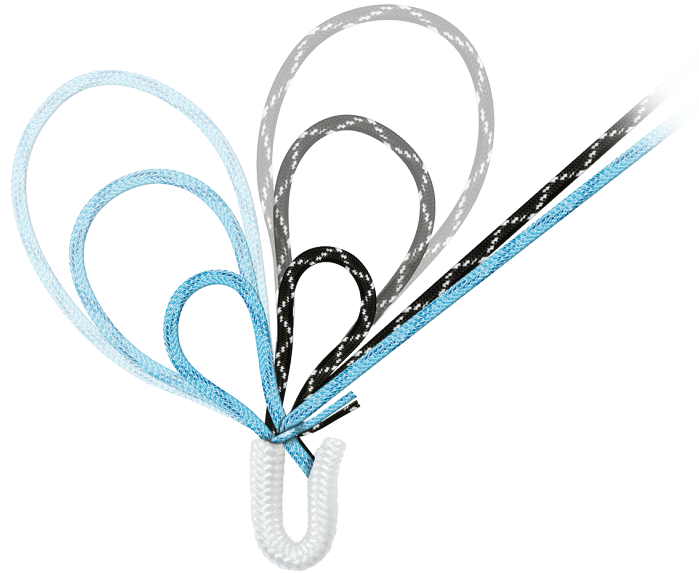
Surgical Technique



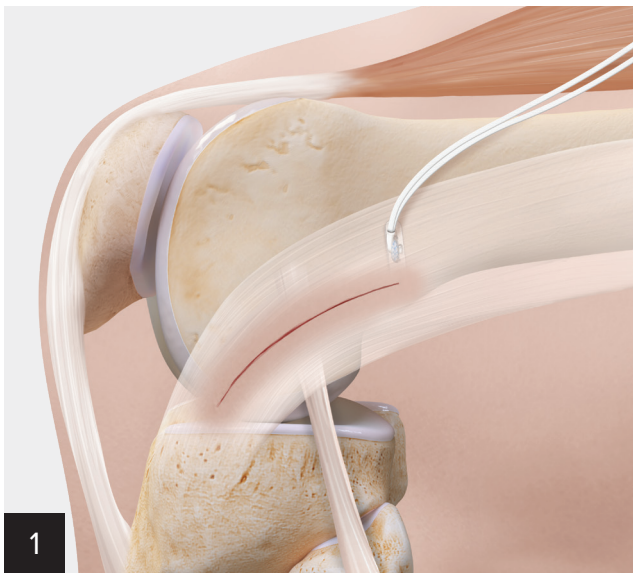
Iliotibial Band Tenodesis Introduction

The Double Knotless Knee FiberTak® iliotibial band (ITB) tenodesis technique offers several distinct advantages when compared to other techniques for lateral extra-articular augmentation.

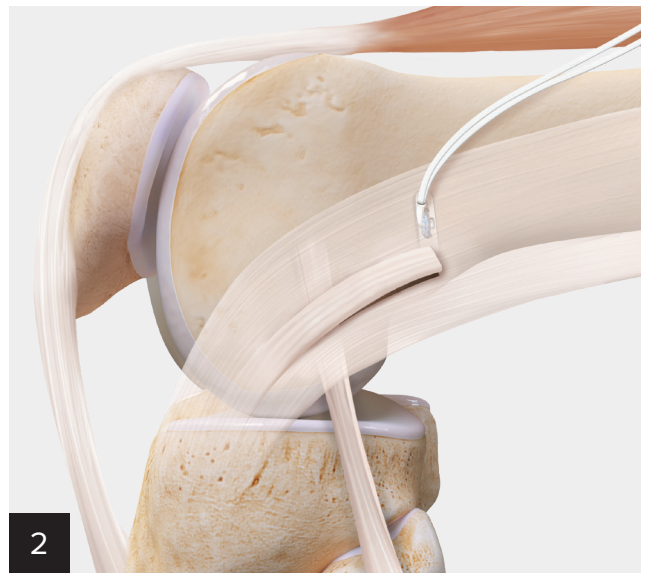
- **Simple:** Quick, easy, and reproducible technique
- **Safe:** Reduced risk of converging the ACL femoral tunnel as anchor sets just below the cortex and damaging ACL graft as with traditional drilling techniques due to self-punching anchor technique; lower risk of graft laceration as described with interference screw techniques¹
- **Low Profile:** No prominent or additional hardware, such as staples, that may lead to pain, discomfort, or hardware removal¹
- **Preserves Anatomy:** No need to ream a socket using onlay technique, which also minimizes the length of the graft required
- **Titratable Graft Tensioning:** Provisionally tension and incrementally retension the graft after checking for isometry and no overconstraint



ITB Tenodesis Surgical Technique

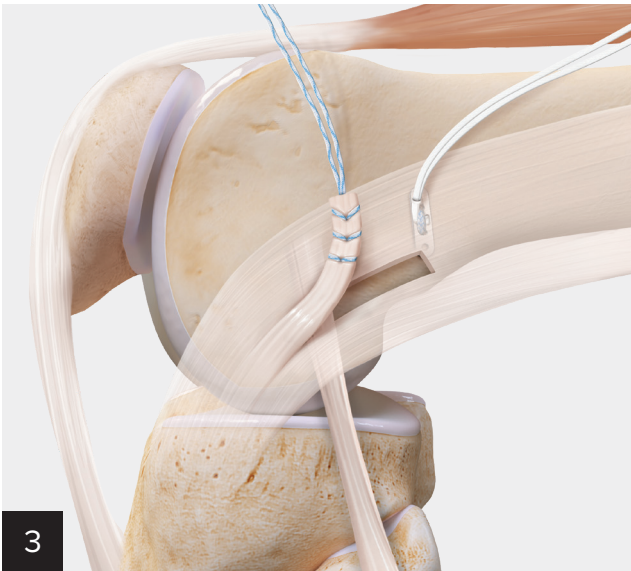


Perform a lateral extra-articular approach by making a 4 cm incision starting just proximal to Gerdy's tubercle and extending to the lateral femoral epicondyle. Expose and identify the ITB and leave it intact distally at Gerdy's tubercle.

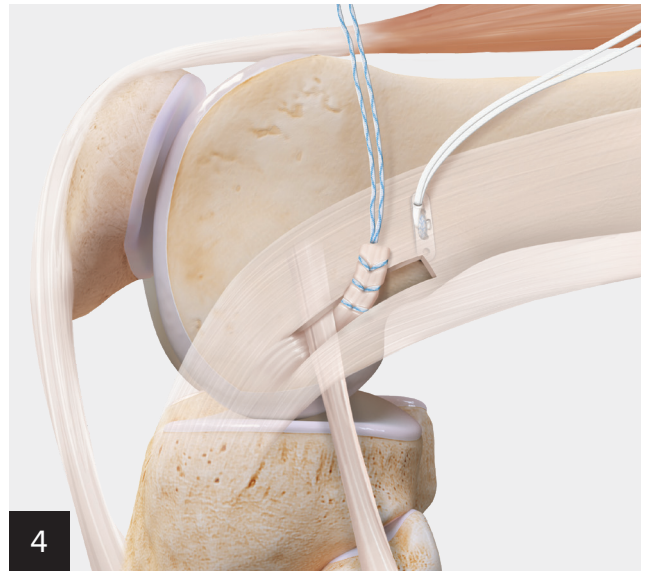


Obtain a distally based ITB graft measuring 10 mm × 60 mm to 80 mm. Avoid the proximal and distal Kaplan fibers posteriorly. These fibers provide anterolateral knee rotatory stability and should be preserved.

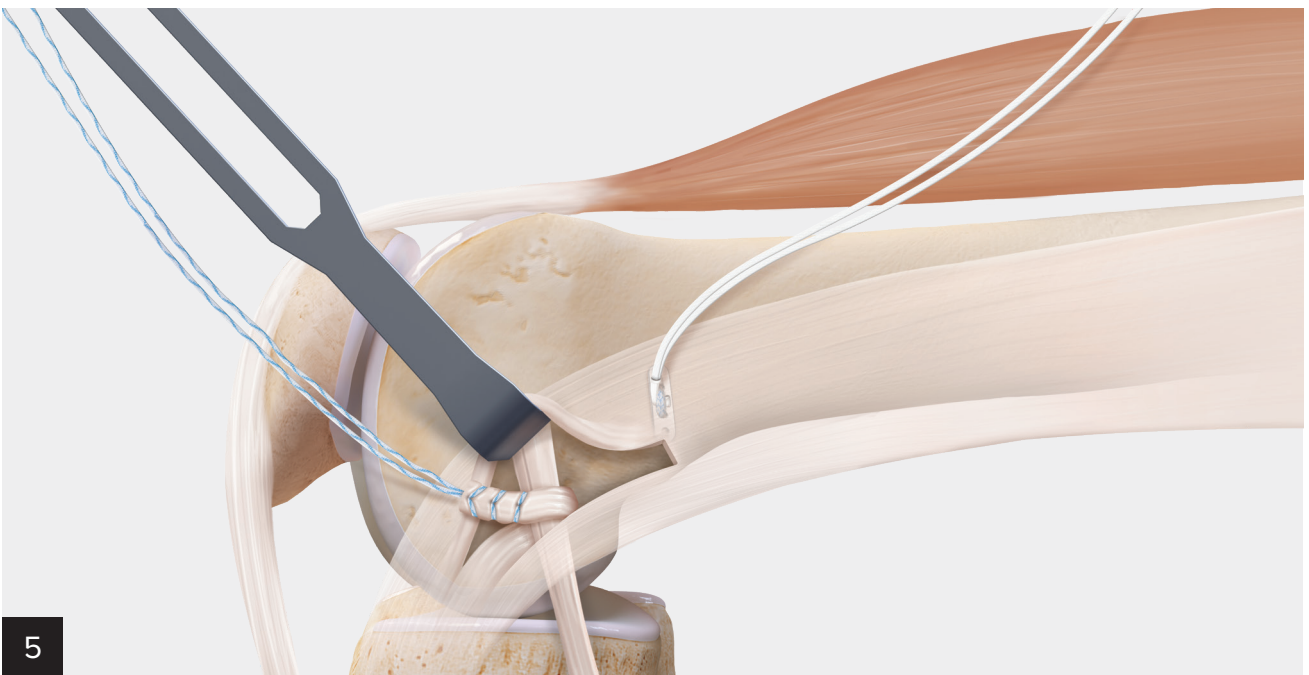
Note: Identify the lateral collateral ligament (LCL).



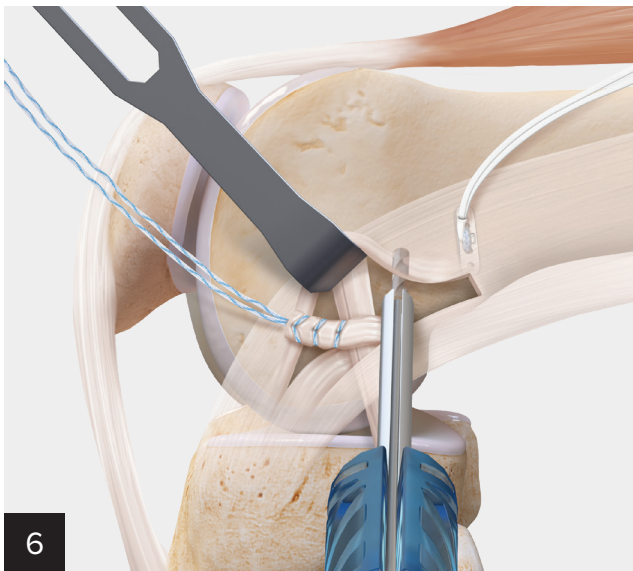
Whipstitch the proximal ITB graft with a FiberLoop® SutureTape.



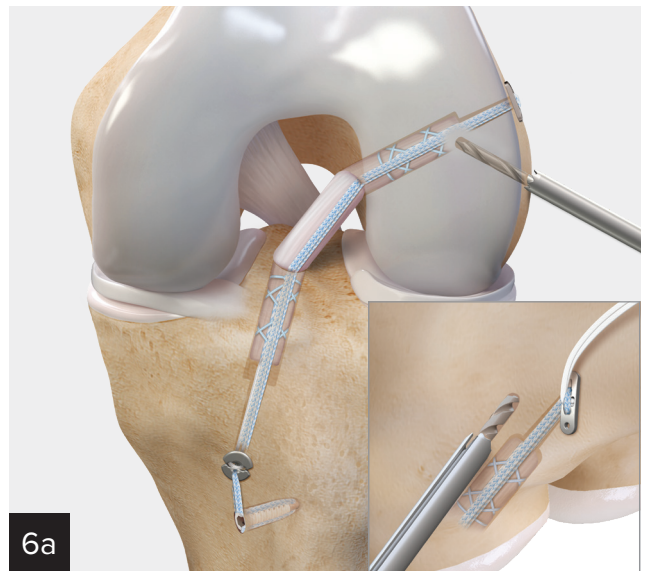
Pass the ITB graft deep (medial) to the LCL. Alternatively, some surgeons prefer to pass the graft over the LCL.



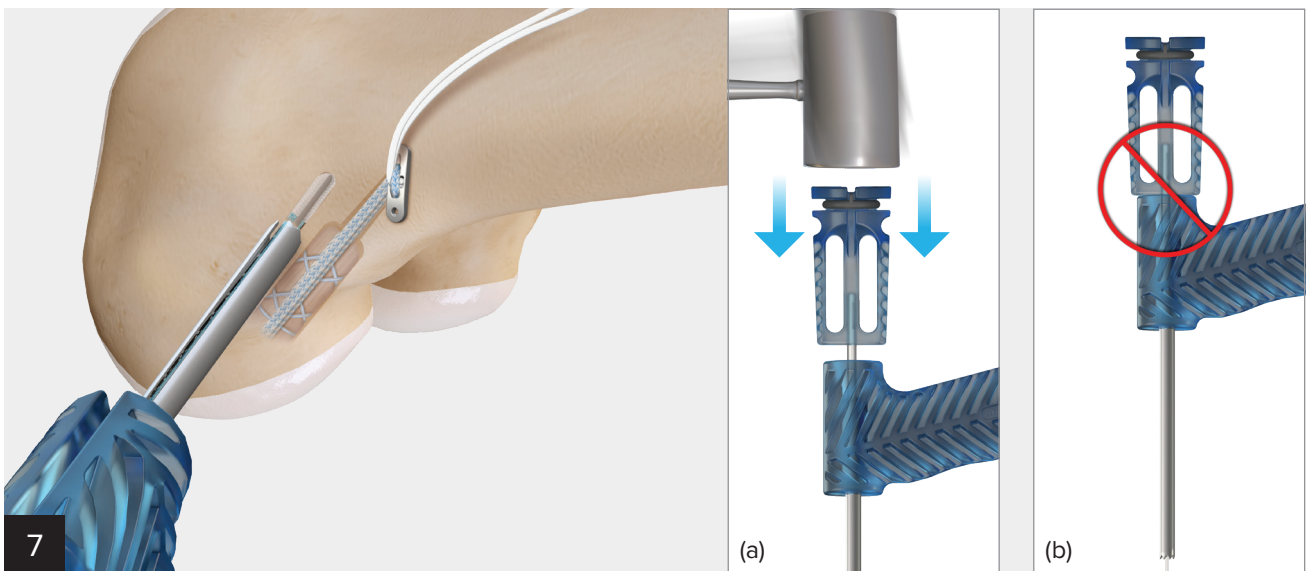
Identify the fixation site posterior and proximal to the femoral origin of the LCL.



6
Direct the FiberTak® drill guide anteriorly and proximally, taking care to avoid the femoral socket of the ACL reconstruction. The anchor can be inserted by self-punching, drilling a pilot hole, or using the awl to punch a pilot hole.

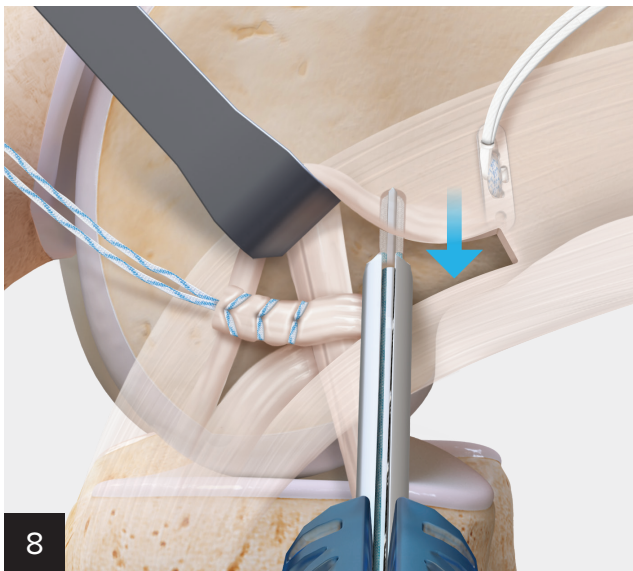


6a
If hard bone is expected, use a 2.6 FiberTak fluted drill to prepare a pilot hole.



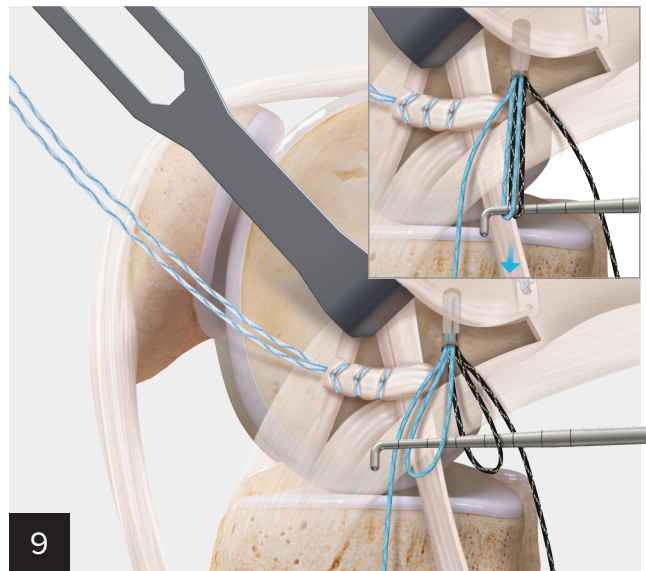
7
Insert the knotless FiberTak soft anchor through the drill guide and mallet the inserter down to the back of the guide handle (a).

Note: Do not continue to impact the driver once the anchor inserter handle reaches the back of the guide handle. This could inadvertently advance the tip of the guide into bone, compromising the cortex and potentially impacting fixation strength (b).



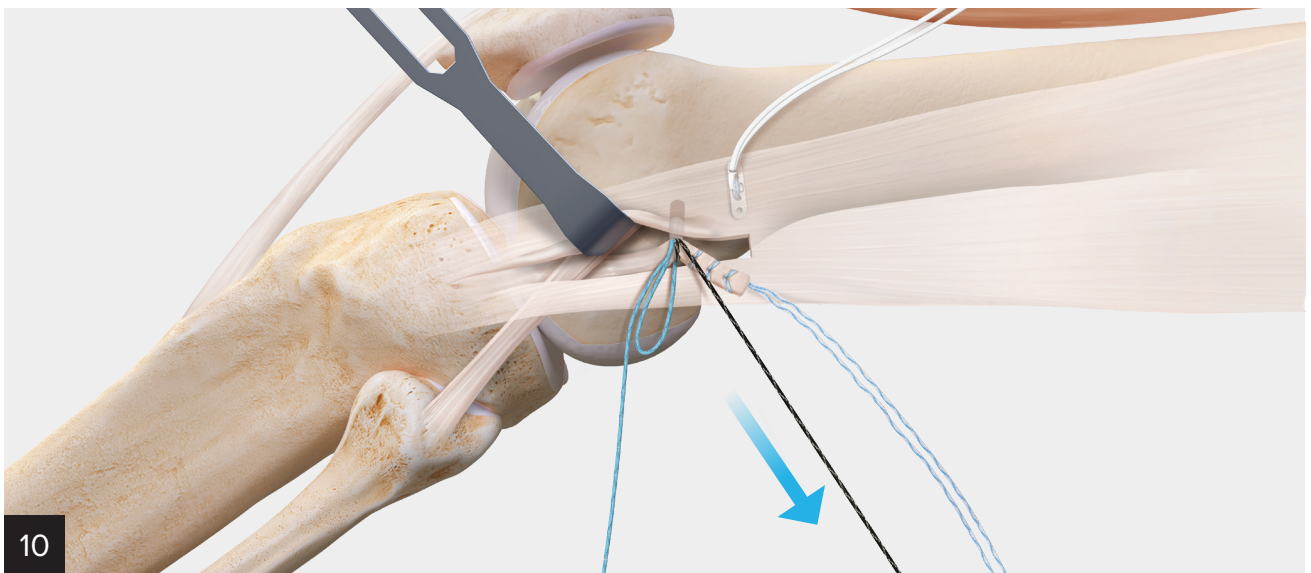
8

Pull the black suture-release tab, uncoil the sutures, and pull back the anchor handle to remove the inserter.



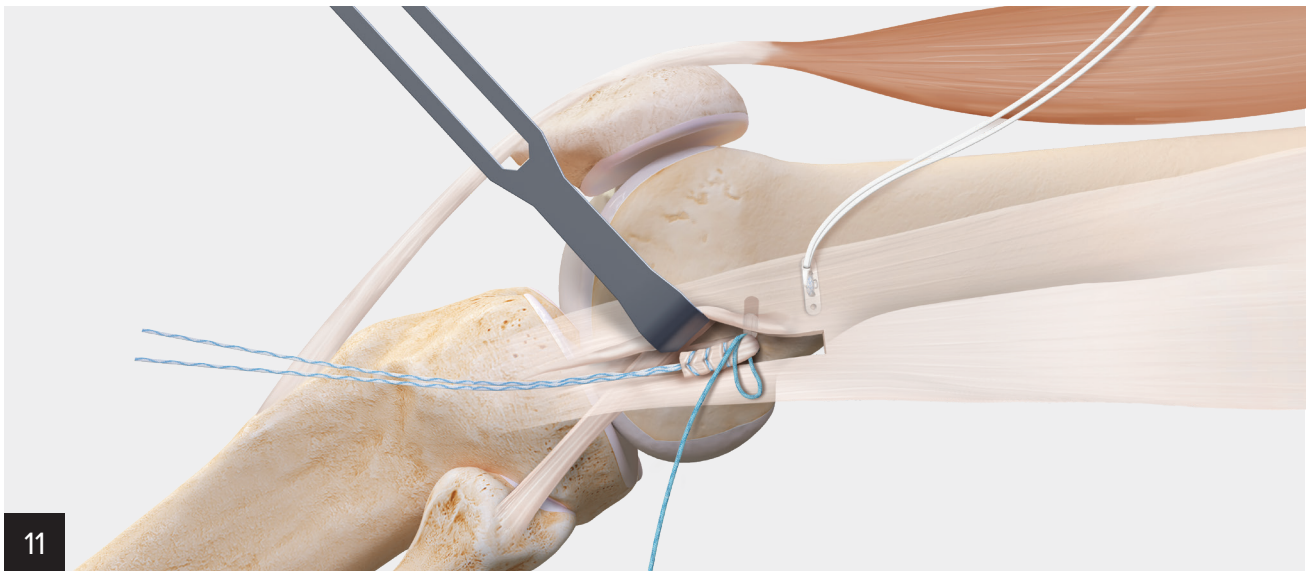
9

Remove the white retention suture from the preconverted loops. Place a probe through both loops of the anchor and apply gentle tension to set the anchor.



10

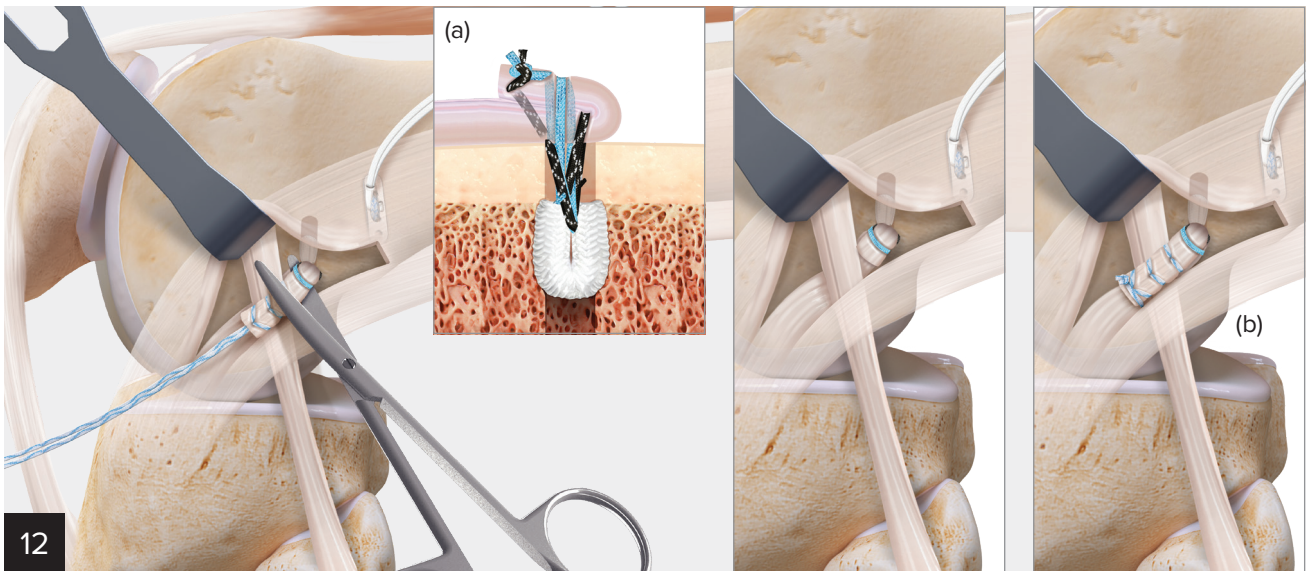
Pull the graft through both loops and use the black tensing strand to begin cinching the black repair loop down around the graft.



11

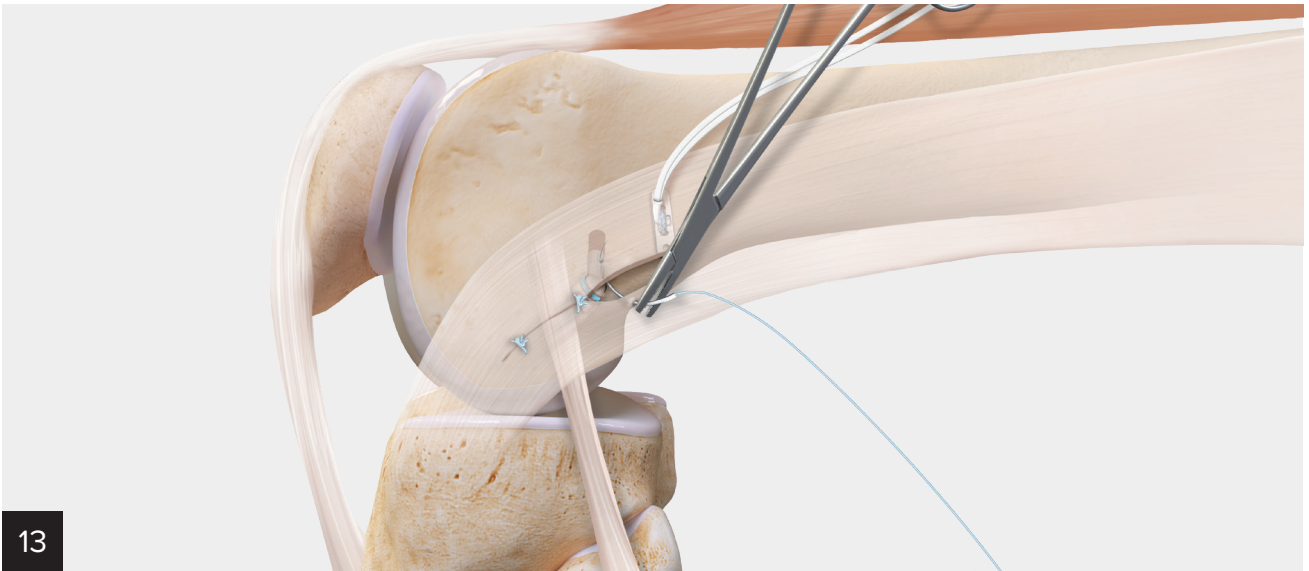
Set the leg to the preferred position, typically neutral rotation and 30° of flexion, and provisionally tension the first loop construct. Check internal rotation after tensioning to make sure there is no overconstraint. The isometry of the tenodesis can be confirmed by moving the leg through full range of motion. Additional tension can be applied by pulling the black tensioning suture if desired.

Reflect the graft distally, pulling it through the blue loop, and pull the blue tensioning suture, making sure to place the cinching loop distal to the first loop, to complete the FiberStaple™ construct.



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The remaining length of graft can be cut 1 cm distal to the construct. Alternatively, the tensioning strands can be passed back through the graft to reinforce the construct **(a)** or the excess ITB autograft can be passed over the LCL and sutured into itself using the SutureTape **(b)**.



Repair the ITB defect with SutureTape.

Note: Final ACL graft tensioning can be performed and the tensioning strands cut to complete the ACL reconstruction.

Ordering Information

Product description	Item number
Double-Loaded Knotless Knee FiberTak® soft anchor	AR-3740SP
Disposable Drill Guide Kit, Knee FiberTak anchors	AR-3710
Reusable 2.6 Punch Knee FiberTak anchors	AR-3714
FiberLoop® SutureTape, 1.3 mm, 20 in loop (white/blue) w/ straight needle	AR-7534
TigerLoop™ 1.3 mm SutureTape, white/black, looped w/ needle	AR-7534T
FiberLoop SutureTape, 0.9 mm, 20 in loop (white/blue) w/ straight needle	AR-7524
0.9 mm SutureTape, 38 in, white/black, w/ straight needle	AR-7547T
0.9 mm SutureTape loop, 20 in, white/blue, w/ straight needle	AR-7524
0.9 mm SutureTape, 38 in, white/blue, w/ two ½ circle, 36.6 mm curved tapered needles	AR-7571-02

1.3 mm SutureTape, 38 in, white/blue, w/ 2 straight diamond-point needles, 64.8 mm	AR-7546-02
1.3 mm SutureTape, 38 in, black/white, w/ 2 straight diamond-point needles, 64.8 mm	AR-7546TT-02
1.3 mm SutureTape, 38 in, white/blue, w/ two ½ circle, 26.5 mm curved, tapered needles	AR-7505
1.3 mm SutureTape, 38 in, black/white, w/ two ½ circle, 26.5 mm curved tapered needles	AR-7505TT-02
1.3 mm SutureTape, 38 in, white/blue, w/ two ½, curved tapered 36.6 mm needles	AR-7531-02
FiberSnare® suture, blue/white stripe, w/ 2 in loop	AR-7209SNL
FiberSnare suture, black/white, w/ 2 in loop	AR-7209SNT

Products advertised in this brochure / surgical technique guide may not be available in all countries. For information on availability, please contact Arthrex Customer Service or your local Arthrex representative.

Reference

1. Muller B, Willinge GJA, Zijl JAC. Minimally invasive modified Lemaire tenodesis. *Arthrosc Tech.* 2020;10(1):e29-e36. doi:10.1016/j.eats.2020.09.006



This description of technique is provided as an educational tool and clinical aid to assist properly licensed medical professionals in the usage of specific Arthrex products. As part of this professional usage, the medical professional must use their professional judgment in making any final determinations in product usage and technique. In doing so, the medical professional should rely on their own training and experience, and should conduct a thorough review of pertinent medical literature and the product's directions for use. Postoperative management is patient-specific and dependent on the treating professional's assessment. Individual results will vary and not all patients will experience the same postoperative activity level and/or outcomes.



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