

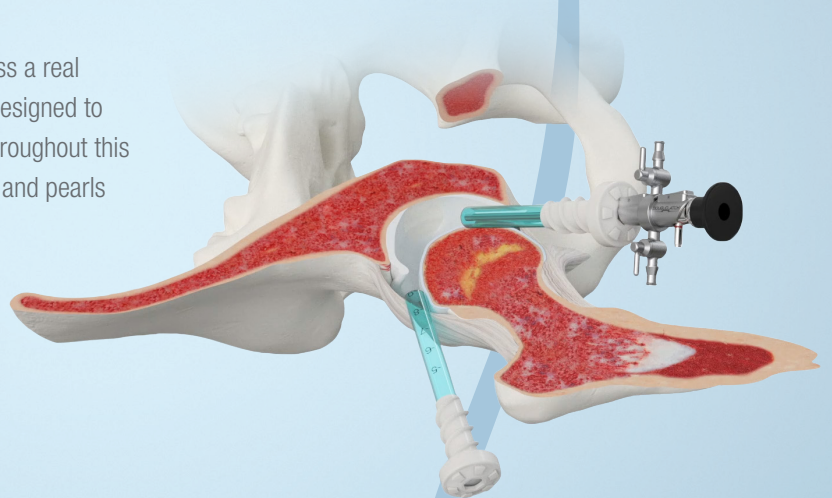
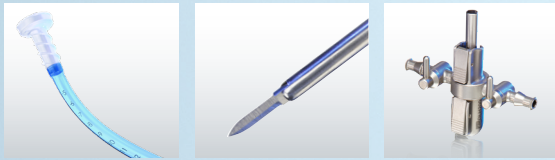


## Hip Access Made EZ

### A Written Technique Guide featuring the Paradigm™ Hip System

Designed by some of the world's leading hip surgeons, the Paradigm™ Hip System is a complete portfolio of products constructed with safety in mind, to provide surgeons with simple and reproducible solutions for arthroscopic hip repairs.

The anatomy of the hip joint makes easy and effective access a real challenge, until now. Paradigm's access instruments were designed to safely simplify this process and reduce procedural steps. Throughout this technique guide, we will address several tried-and-true tips and pearls gained from extensive experience in the operating room.



#### Technique featured by

**Tony Andrade, MB BS, FRCS (Tr and Orth)**

Consultant Orthopaedic Surgeon

Circle Reading Hospital, United Kingdom

**Thomas H. Wuerz, MD, MSc, MS, FAAOS**

Board Certified Orthopedic Surgeon

Boston Sports and Shoulder Center and New England Baptist Hospital

Boston, MA, USA

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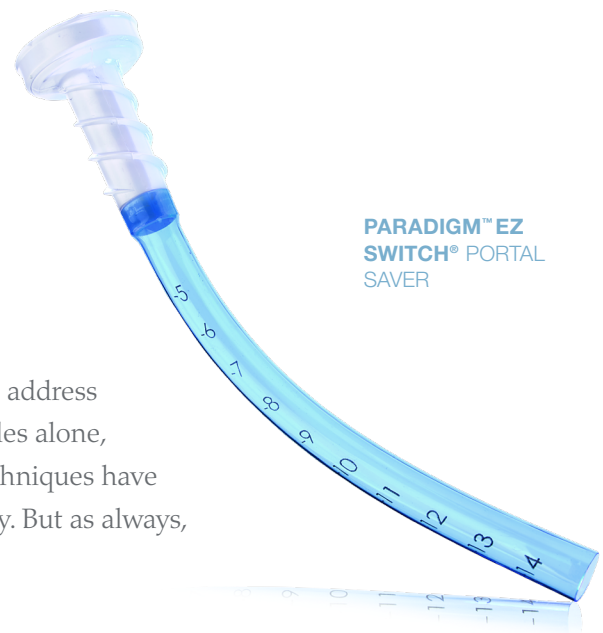
# Gaining Access to the Hip Joint Using the Paradigm™ Hip System

Authored by Tony Andrade, FRCS (Tr and Orth) and Thomas Wuerz, MD

*Hip Arthroscopy can be an effective method of treatment for a variety of hip conditions including but not limited to femoroacetabular impingement and labral tears.*

Just as in other areas of orthopedic surgery, techniques to address hip pathologies develop and evolve. In the last two decades alone, advancements in minimally invasive and arthroscopic techniques have improved our ability to treat patients effectively and safely. But as always, there is still work to be done.

Arthroscopic surgery of the hip presents unique challenges because of the difficulty to access the joint space with minimal visualization. “While increasingly recognized as an effective procedure for the treatment of femoroacetabular impingement and related hip disorders, hip arthroscopy is considered a technically challenging procedure whose learning curve is not well defined.”<sup>1</sup> It can take an experienced surgeon years to feel proficient in their hip arthroscopy skills, dependent on factors such as the opportunity to train or volume of cases in their practice. But challenging as it may be, the appeal of training to be a hip arthroscopist prevails, as shown in the number of hip arthroscopies performed annually which grew 600% between 2006 and 2010<sup>2</sup> and continues to be one of the highest growing areas in Orthopedic Surgery. ■



<sup>1</sup>Nawabi, Danyal H. et al. “Learning curve for hip arthroscopy steeper than expected.” Journal of Hip Preservation Surgery vol. 3, Suppl 1 hnw030.007. 14 Sep. 2016, doi:10.1093/jhps/hnw030.007

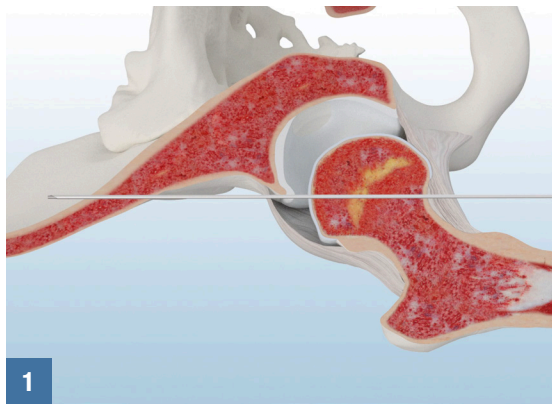
<sup>2</sup>Bozic KJ, Chan V, Valone FH 3rd, Feeley BT, Vail TP. Trends in hip arthroscopy utilization in the United States. J Arthroplasty. 2013 Sep;28(8 Suppl):140-3. doi: 10.1016/j.arth.2013.02.039. Epub 2013 Aug 1. PMID: 23916639





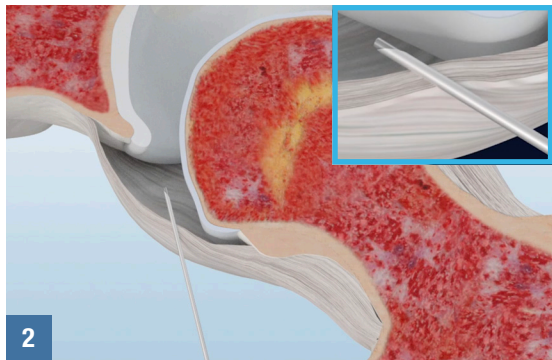
## ACCESSING THE HIP JOINT

Access into the hip joint is typically gained by inserting a spinal needle, then dilating wide enough to fit a scope sheath and/or metal sled or cannula. In order to minimize iatrogenic damage, the spinal needle must be appropriately sited to gain access through the capsule into the joint.

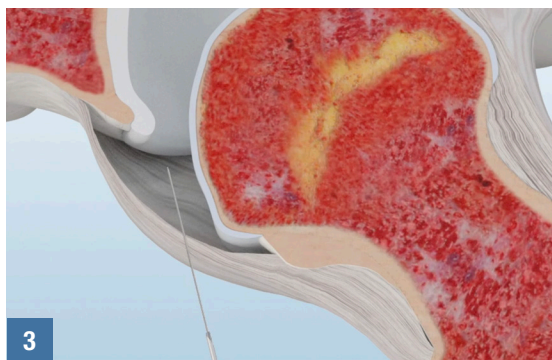


**STEP 1:** After adequate traction of the joint has been established and confirmed fluoroscopically, access to the joint can be considered. Under fluoroscopic guidance and using CONMED's Paradigm® Tactile Needle, insert the needle as described in the section above titled Portal Placement. The tip of the needle should aim towards the top of the cotyloid fossa.

**NOTE:** You can utilize the nub at the handle of the needle to reiterate which direction the beveled tip of the needle is facing in the joint. The sharp tip of the needle should be furthest away from the femoral head to minimize scuffing.



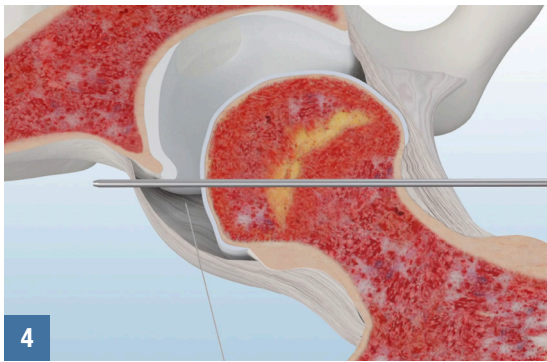
**STEP 2:** Upon entering the joint space, the surgeon should feel a tactile confirmation that empty space has been encountered. With resulting loss of the negative intra-articular pressure, an air arthrogram should be visible. According to surgeon preference, either fluid (saline) or air can be injected into the joint at this stage, to achieve better joint dilatation.



**STEP 3:** Insert a guidewire through the Tactile Needle, and then remove the needle, leaving the guidewire in the joint. The tip of the guidewire should be in the lunate fossa confirming intra-articular position. The guidewire should be seen close to the femoral head but not be obscured by it under fluoroscopic imaging for ideal position.

**NOTE:** The Tactile Needle does not have a stylet and is cannulated to accommodate a guide wire.

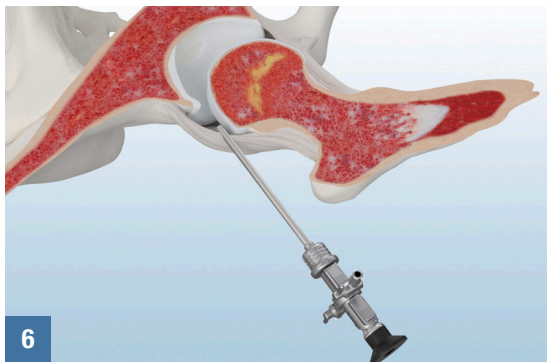
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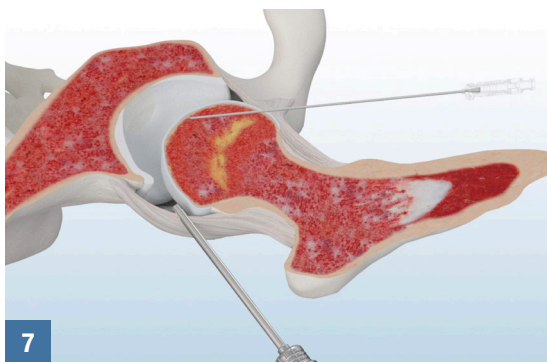
**STEP 4:** Insert a cannulated switching stick over the guidewire whilst retracting it a short distance to make sure the guidewire does not break. Then remove the guidewire.



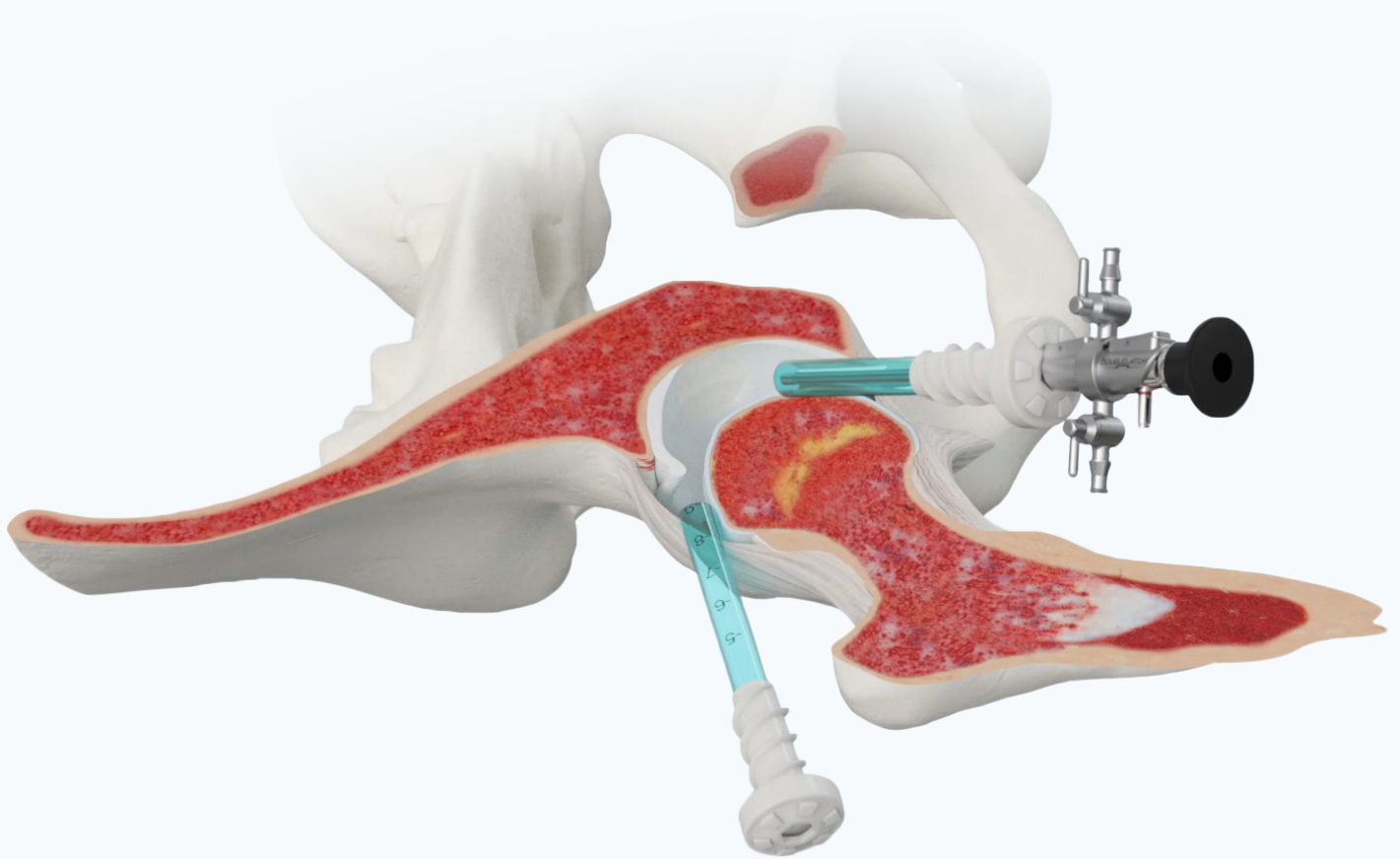
**STEP 5:** According to surgeon preference, utilize the CONMED dilator(s) until the portal is effectively dilated and ready for scope insertion.



**STEP 6:** Introduce the CONMED DoubleLatch® Bridge System and remove the switching stick. Visualization is now established.



**STEP 7:** For the second portal, insert the needle to pierce the capsule and enter joint space under direct visualization. Repeat steps two through six to establish subsequent portals.

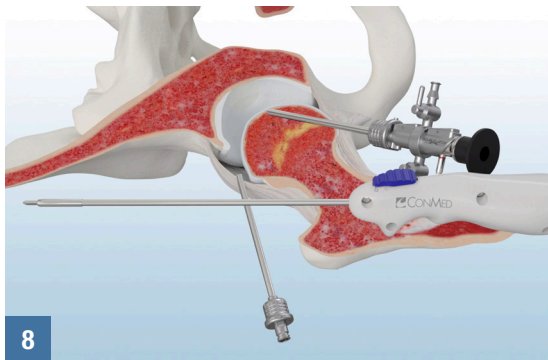


*There is now easy access into both portals  
using the Paradigm™ EZ Switch® System.*

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## CAPSULOTOMY

Once portal access is achieved, some form of capsulotomy is usually required to allow better visualization and maneuverability within the joint. There are different methods and techniques for opening the capsule. Some result in a larger capsulotomy for the widest maneuverability, while others aim for a minimal capsulotomy to preserve the structural integrity and reduce iatrogenic damage. Regardless of technique, it is important to note that proper capsular management is critical to the success of the procedure and the patient's recovery post op.

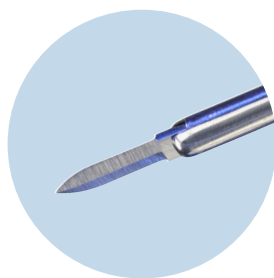
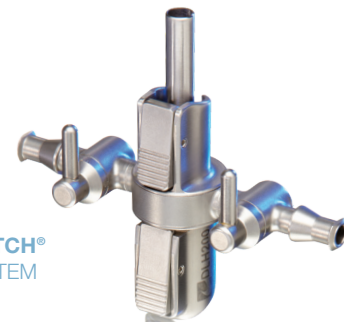


**STEP 8:** Insert the Paradigm® Retractable Blade into the Anterolateral Portal, leaving the arthroscope in the Mid-Anterior Portal for visualization. The distal end of the handle on the Retractable Blade can screw into the metal cannula, providing additional control and column strength while cutting.

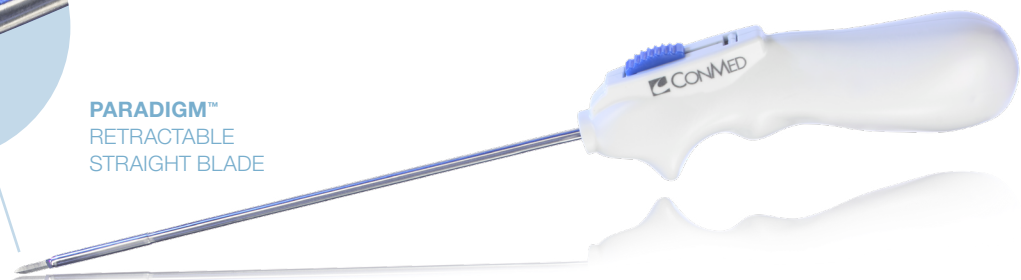
**NOTE:** Starting the capsulotomy in the ALP allows confirmation that the labrum is not being penetrated.



**STEP 9:** Once soft tissue is cleared, push forward on the retractable lever to expose the blade in the joint.



PARADIGM™  
RETRACTABLE  
STRAIGHT BLADE









**TIPS &  
TRICKS****MANAGING FLUID WHILE USING EZ SWITCH®**

The EZ Switch was designed without an outflow port, to reduce overall working length resulting in ideal instrument management. If outflow is desired, a dual port scope sheath may be utilized. If field of view becomes disrupted during the arthroscopy, and a dual port scope sheath is unavailable, you may insert a sled or slotted cannula, or device with suction, into the EZ Switch and allow fluid to escape until the field of view is clear.

**UTILIZING EZ SWITCH® THROUGH VARYING CAPSULOTOMY TECHNIQUES****MINIMAL CAPSULTOMY**

Ensure you have enough working room within your capsulotomy for the EZ Switch. Depending on the size of the capsulotomy, this may require adding 2-3mm in length to provide adequate access through the capsule.

If the EZ Switch portal saver backs out slightly during the arthroscopy, even if the threads are still engaged, be sure to reinsert the obturator before screwing the threads back in. This will prevent any kinking or twisting of the flexible body during reinsertion.

**STEP 18:** Repeat steps 14 through 17 to insert the second EZ Switch® Portal Saver into the next portal.

**NOTE:** Should you consider a T-Shaped Capsulotomy, then you may need to reposition your AL portal. To do this, remove the EZ Switch® and reposition the reference tool and repeat steps 16 and 17.

**REINSERTING EZ SWITCH® DURING THE PROCEDURE**

If at any point during the procedure you need to regain your portal or if fluid causes the EZ Switch to back out slightly, insert the obturator back into the EZ Switch portal saver and screw the threads back in for maximum grip, as outlined in steps 16 and 17.

**T-SHAPED CAPSULTOMY**

If you are utilizing a T-Shaped Capsulotomy, then you may need to reposition your portals during the arthroscopy. To do this, remove the EZ Switch, reposition the reference tool and follow the instructions for inserting the EZ Switch as outlined in steps 16 and 17.17.

## ORDERING INFORMATION

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To order any of our Paradigm™ Hip System products, please call CONMED Customer Service at: (US) 1-866-4CONMED

### PARADIGM™ HIP SYSTEM

Paradigm™ EZ Switch® System..... PEZS01A  
Paradigm™ Access Kit and  
EZ Switch™ System .....PEZS02A  
Paradigm™ Tactile Access Kit  
and EZ Switch® System..... PEZS03A  
Paradigm™ EZ Switch®  
Portal Saver ..... PEZS04  
Paradigm™ Retractable Hook Blade ..... PRBH  
Paradigm™ Retractable Straight Blade ..... PRBS

For more information about our entire Paradigm Hip System or DoubleLatch Bridge System, please visit <https://www.conmed.com/en/products/orthopedics/hip/>



## Hip Access Made EZ featuring the Paradigm™ Hip System

CONMED Corporation  
11311 Concept Blvd.  
Largo, Florida 33773

Toll Free: 1-866-4CONMED  
International: 727-214-3000  
[www.CONMED.com](http://www.CONMED.com)

This material provides information regarding how to use CONMED medical devices and instruments in surgical procedures. It is not medical advice and each surgeon should use their own professional judgment before using to treat a particular patient. Surgeons should be trained in the use of such devices before surgery and should always refer to the product labeling including the Instructions for Use before using any medical device.

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