Nexxt Spine

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Surgical Technique Guide

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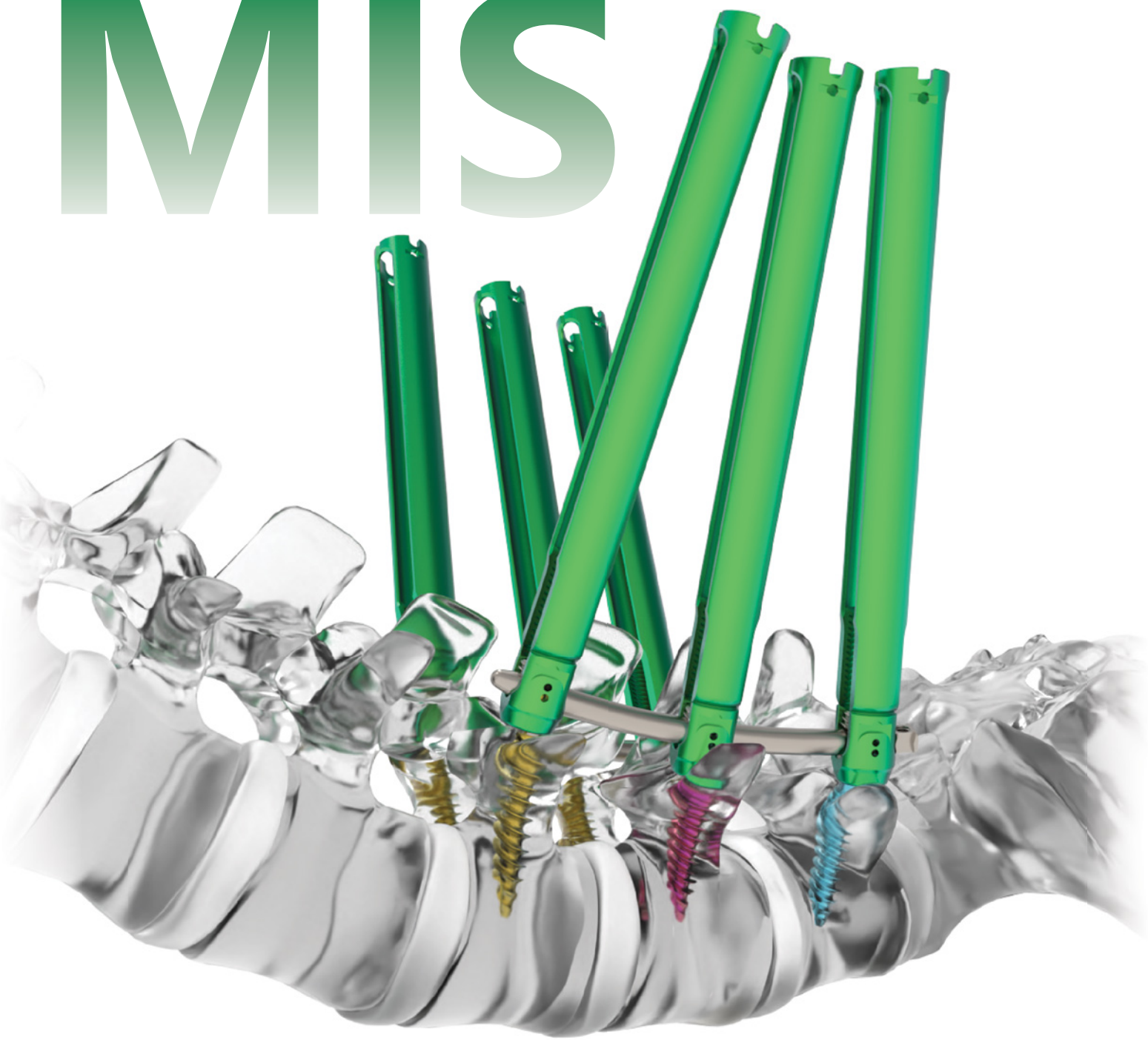

INERTIA CONNEXX®
MINIMALLY INVASIVE

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71-051, Rev E

Table of Contents

INERTIA CONNEXX® MINIMALLY INVASIVE MODULAR PEDICLE SCREW SYSTEM

The INERTIA CONNEXX® Minimally Invasive Modular Pedicle Screw System is a modular comprehensive system for posterior thoracolumbar stabilization, designed to ensure ease of use and intraoperative flexibility through a customizable solution for degenerative, deformity, and tumor/trauma applications via a percutaneous or mini-open (Wiltse) approach using cannulated Pedicle Screws, Set Screws, and guided Rod placement.

INERTIA CONNEXX® enhances efficiency through a modular platform, dual Rod diameter capabilities to tailor construct stiffness, and provide variable solutions for minimally invasive procedures, while providing the surgeon multiple extended tower lengths to match patient anatomy and limit bulk in the working corridor.

INERTIA CONNEXX® has been designed and evolved from valuable feedback from our surgeon development team, and Nexxt Spine would like to take the opportunity to thank them for their contributions and efforts to make the INERTIA CONNEXX® Minimally Invasive Modular Pedicle Screw System one of the most versatile systems for posterior thoracolumbar fixation and stabilization.

Indications for Use

GENERAL DESCRIPTION

The INERTIA CONNEXX® Modular Pedicle Screw System consists of Rods, pedicle screws and Set Screws. Rods are available in either straight or pre-contoured (curved) forms in a variety of lengths. Pedicle screws are available in modular polyaxial or non-modular uniplanar designs having double lead standard or cortical/cancellous thread forms in a variety of diameter-length combinations. Set screws are used to fasten the Rod and Pedicle Screw. All implant components are manufactured from titanium alloy (Ti-6AL-4V ELI) per ASTM F136.

INDICATIONS

The INERTIA CONNEXX® Modular Pedicle Screw System is intended for immobilization and stabilization of the posterior non-cervical spine (T1-S2/Ilium) in skeletally mature patients as an adjunct to fusion for the following indications: degenerative disc disease (defined as back pain of discogenic origin with degeneration of the disc confirmed by history and radiographic studies), spondylolisthesis, trauma (i.e., fracture or dislocation), spinal stenosis, curvatures (i.e., scoliosis, kyphosis, or lordosis), tumor, pseudarthrosis, and/or failed previous fusion.

When used for posterior non-cervical Pedicle Screw fixation in pediatric patients, the INERTIA CONNEXX® Modular Pedicle Screw System implants are indicated as an adjunct to fusion to treat adolescent idiopathic scoliosis. The INERTIA CONNEXX® Pedicle Screw is to be used with autograft and/or allograft. Pediatric Pedicle Screw fixation is limited to a posterior approach

CONTRAINDICATIONS

Use of the INERTIA CONNEXX® System and spinal fixation surgery are contraindicated when there was recent or local active infection near or at the site of the proposed implantation. Any conditions that preclude the possibility of fusion are relative contraindications. These include but are not limited to: cancer, fever, mental illness, alcoholism or drug abuse, osteoporosis or osteopenia, neurotrophic diseases, obesity, pregnancy and foreign body sensitivity. Biological factors such as smoking, use of nonsteroidal anti-inflammatory agents, the use of anticoagulants, etc. all have a negative effect on bony union. Contraindications may be relative or absolute and must be carefully weighed against the patient's entire evaluation. See also the WARNINGS, PRECAUTIONS AND POTENTIAL RISKS sections of this insert.

IMPORTANT NOTE TO OPERATING SURGEON PRECAUTION

The implantation of Pedicle Screw spinal systems should be performed only by experienced spinal surgeons with specific training in the use of this Pedicle Screw Spinal System because this is a technically demanding procedure presenting a risk of serious injury to the patient.

The INERTIA CONNEXX® Modular Pedicle Screw System is designed to provide biomechanical stabilization as an adjunct to fusion in skeletally mature patients. Spinal fixation should only be undertaken after the surgeon has had hands on training in this method of spinal fixation and has become thoroughly knowledgeable about spinal anatomy and biomechanics. A surgical technique is available for instructions on the important aspects of this surgical procedure and can be requested from Nexxt Spine LLC at the address or phone number above.

Preoperative instructions to the patient are essential. The patient should be made aware of the limitations of the implant and potential adverse effects of the surgery. The patient should be instructed to limit postoperative activity, as this will reduce the risk of bent, broken or loose implant components. The patient must be made aware that implant components may bend, break or loosen even though restrictions in activity are followed.

Postoperative evaluation of the fusion and implant status is necessary. The surgeon may remove the implant once a solid fusion is obtained. The patient must be informed of the potential of this secondary surgical procedure and the associated risks.

CLEANING/REPROCESSING OF NEXXT SPINE SURGICAL INSTRUMENTS

All implants and instruments must first be cleaned using established hospital methods before sterilization and introduction into a sterile surgical field. Refer to the Nexxt Spine Reprocessing Instructions for Reusable Instruments document available at www.NexxtSpine.com/Resources/Indications-For-Use or by calling 317-436-7801 for a copy of the detailed cleaning instructions.

STERILIZATION

The INERTIA CONNEXX® Modular Pedicle Screw System implants can be supplied sterile or nonsterile. All sterile products are labeled "STERILE" and supplied in protective sterile barrier packaging. Do not use sterile products if the packaging has been damaged or previously opened. Do not re-sterilize or autoclave sterile implants. If not specifically labeled sterile, components are nonsterile.

Nonsterile components are supplied clean and not sterile. All implants and instruments should be cleaned and sterilized prior to surgery. Prior to sterilization, verify that all instruments are in their open and unlocked position within the instrument tray(s). AORN recommended practices for in hospital sterilization should be followed. The use of an FDA cleared sterilization wrap is recommended.

Sterilization testing of components has shown the following recommendations for sterilization are effective to an SAL of 10-6:

Method:	Steam
Cycle:	Prevaccum
Temperature:	270°F (132°C)
Exposure Time:	4 minutes
Drying Time:	60 minutes

NOTE: Instruments that may have been exposed to Creutzfeldt-Jakob disease (CJD) should be treated according to the hospital's prior decontamination protocol. Nexxt Spine recommends contacting the Center for Disease Control and the World Health Organization for the most recent information on CJD transmission and deactivation.

Warnings and Precautions

1. The safety and effectiveness of this device has not been established for use as part of a growing Rod construct. This device is only intended to be used when definitive fusion is being performed at all instrumented levels.

2. The use of Pedicle Screw fixation in the pediatric population may present additional risks when patients are of smaller stature and skeletally immature. Pediatric patients may have smaller spinal structures (pedicle diameter or length) that may preclude the use of pedicle screws or increase the risk of Pedicle Screw malpositioning and neurological or vascular injury. Patients who are not skeletally mature undergoing spinal fusion procedures may have reduced longitudinal spinal growth, or may be at risk for rotational spinal deformities (the "crankshaft phenomenon") due to continued differential growth of the anterior spine.
Other adverse events related to Pedicle Screw fixation, such as screw or Rod bending, breakage, or loosening, may also occur in pediatric patients, and pediatric patients may be at increased risk for device-related injury because of their smaller stature.

3. The implantation of Pedicle Screw spinal systems in pediatric patients should be performed only by experienced spinal surgeons with specific training in the use of this Pedicle Screw Spinal System in pediatric patients because this is a technically demanding procedure presenting a risk of serious injury to the patient. Preoperative and operating procedures, including knowledge of surgical techniques, good reduction, and proper selection and placement of the implants are important considerations in the successful utilization of the system in pediatric patients.
The selection of the proper size, shape and design of the implant for each patient is crucial to the safe use of this device in pediatric patients.

4. The safety and effectiveness of Pedicle Screw spinal systems have been established only for spinal conditions with significant mechanical instability or deformity requiring fusion with instrumentation. These conditions are significant mechanical instability or deformity of the thoracic, lumbar, and sacral spine secondary to severe spondylolisthesis (grades 3 and 4) of the L5-S1 vertebra, degenerative spondylolisthesis with objective evidence of neurological impairment, fracture, dislocation, scoliosis, kyphosis, spinal tumor, and failed previous fusion (pseudarthrosis). The safety and effectiveness of these devices for any other conditions are unknown.

5. PATIENT SELECTION. Proper patient selection is critical to the success of the procedure. Only patients who satisfy the criteria set forth under the INDICATIONS section of this document AND who do not have any of the conditions set forth under the CONTRAINDICATIONS section of this document should be considered for spinal fixation surgery using the INERTIA CONNEXX® System. In addition, patients who smoke have been shown to have an increased incidence of pseudarthrosis. Based upon the fatigue testing results, the physician/surgeon should consider the levels of implantation, patient weight, patient activity level, other patient conditions, etc. which may impact the performance of the system.

6. PATIENT EDUCATION. Preoperative instructions to the patient are essential. The patient should be made aware of the limitations of the implant and potential risks of the surgery. The patient should be instructed to limit postoperative activity, as this will reduce the risk of bent, broken or loose implant components. The patient must be made aware that implant components may bend, break or loosen even though restrictions in activity are followed.

7. HANDLING. Implant components should be handled and stored appropriately to protect them from unintentional damage. The surgeon should avoid introducing notches or scratches into the Rod or screw surfaces as these may induce premature failure of the component. Excessive reverse bending of Rods can cause metal stressing resulting in a lower fatigue life for the Rod.

8. IMPLANT SELECTION. The INERTIA CONNEXX® System components are available in a variety of sizes to ensure proper fit of the implanted device. The potential for the success of the fusion is increased by selecting the correct size of the implant. These devices are not intended to be used as the sole support for the spine.

9. INSTRUMENT USAGE INERTIA CONNEXX® System instruments are to be used for implantation of the INERTIA CONNEXX® System components. Failure to use the dedicated instruments may compromise the integrity of the implanted device. Care should be taken to ensure that the correct component-specific instruments are used properly. Failure to do so may compromise the integrity of the implanted device and lead to premature device failure and subsequent patient injury.

10. MR ENVIRONMENT The INERTIA CONNEXX® System has not been evaluated for safety and compatibility in the MR environment. The INERTIA® System has not been tested for heating migration or image artifact in the MR environment. The safety of the INERTIA® System in the MR environment is unknown. Scanning a patient who has this device may result in patient injury.

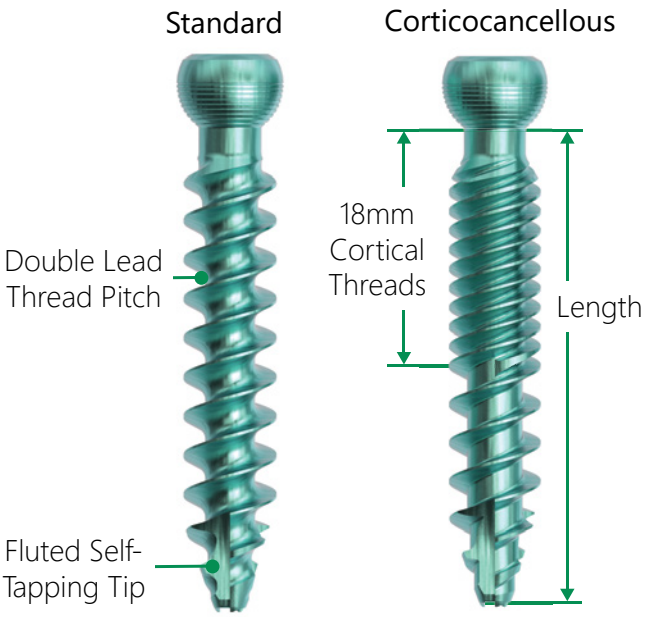
11. MIXED METALS. The INERTIA CONNEXX® System is available in titanium alloy. It is imperative that this metal does not come into contact in vivo with other dissimilar metals. Accelerated corrosion may occur when two dissimilar metals are used together when building a construct.

12. SINGLE USE ONLY. These devices are provided as single use only implants and are not to be reused or reimplanted regardless of an apparent undamaged condition.

13. DELAYED UNION OR NONUNION. The INERTIA CONNEXX® System is designed to assist in providing an adequate biomechanical environment for fusion. It is not intended to be and must not be used as the sole support for the spine. If a delayed union or nonunion occurs the implant may fail due to metal fatigue. Patients should be fully informed of the risk of implant failure.

PRODUCT SPECS & FEATURES

Modular Shanks - Ti-6Al-4V ELI per ASTM F136



- Fully compatible with INERTIA CONNEXX® product portfolio to accommodate a variety of minimally invasive, open, mid-line, and hybrid techniques.
- Standardized T25 drive feature for all Shanks and Set Screws to reduce instrument need.

Modular Shank Sizing

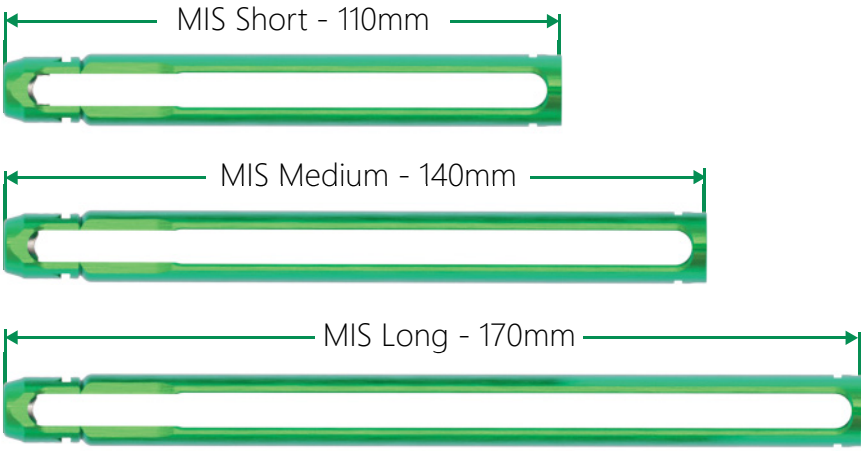
Ø5.0-11.5mm x 20-120mm

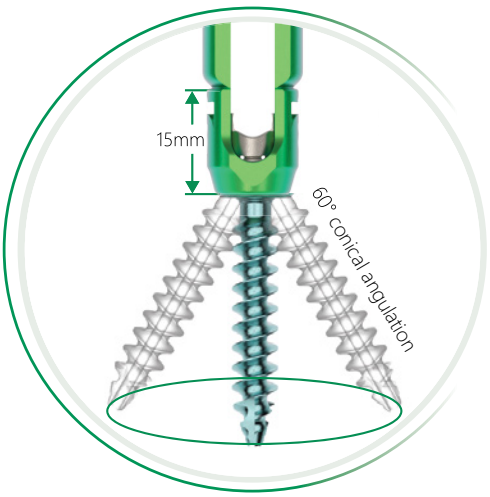
Cannulated Standard

Cannulated Corticocancellous

Housings

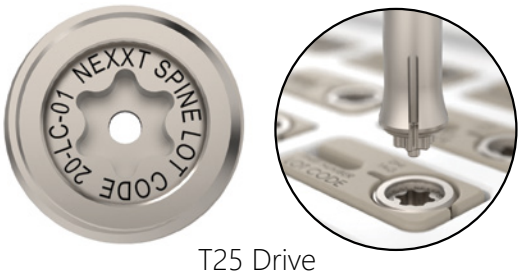
- Patented Rod Retention tabs securely hold rod during preliminary placement with audible click.
- All Housings are fully compatible with all Shanks except preassembled Uniplanar Housings.
- All MIS Extended Tabs provide 20mm of internal, Set Screw driven reduction.





Set Screws - Ti-6Al-4V ELI per ASTM F136

- "Click On" attachment feature securely mates driver to Set Screw.
- Set screw will automatically disengage from driver when locked at correct depth and compressing on Rod.



T25 Drive

Spine Rods - Ti-6Al-4V ELI per ASTM F136

Curved Ø5.5mm x 40-150mm Straight Ø5.5mm x 200-400mm

- Spine Rods are available in Bullet Tip and Pre-Bent.
- Ambidirectional attachment allows lordotic or kyphotic orientation to match patient anatomy

Implant Traceability

- All Modular Shanks, Set Screws, and Standard Housings include a Removable Tracking Tag marked with lot code information and UDI to simplify tracking of implants.
- Modular Extended Tabs include a UDI, part number, and lot code etched onto the surface.

NOTE:
Removable Tracking Tags are not an implant and should be disposed or provided to hospital materials management for tracking purposes if appropriate.

Some implant dimensions may be only available By Request.
Contact **Info@NexxtSpine.com** for full implant availability.

SURGICAL STEPS

The surgical technique shown in this document is for illustrative and demonstrative purposes only. The technique actually employed will always depend upon the medical judgment of the surgeon exercised before and during surgery as to the best mode of treatment for each patient. Please see Instructions for Use for the complete list of indications, warnings, precautions, and other important information concerning the use and guidance of the INERTIA CONNEXX® Minimally Invasive Modular Pedicle Screw System.

1. PATIENT POSITIONING

Place the patient on the operating table in a prone position (Figure 1.1). Prepare and drape in a conventional manner that will allow for implant placement and anatomical marking. The fluoroscope should have easy access to the surgical field for both A/P and lateral views.

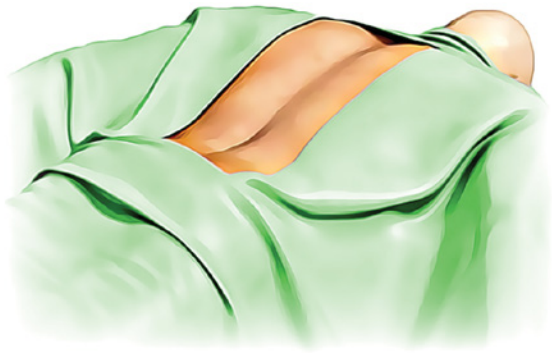


Figure 1.1
Position patient in a traditional manner as deemed by the surgeon

Patient's position should be checked radiographically to determine the direction of the pedicles relative to the horizontal plane, as well verifying that the pedicles are symmetrical to each other with the spinous process centered between them (Figure 1.2). The superior endplate should be parallel and be visualized as a crisp solid line with no obliquity.

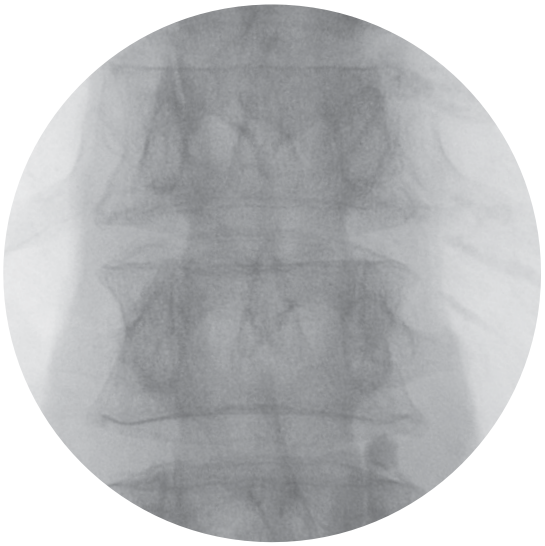


Figure 1.2
Symmetrical pedicles and centered spinous process

2. INCISION PLANNING

Fluoroscopically locate the pedicle's lateral border by placing a K-Wire in a cephalad/caudal orientation on the skin.

With a sterile pen, mark a vertical line "A", on the skin. Position the K-Wire perpendicular to "A" and with a slightly superior bias over the pedicle. Confirm fluoroscopically and mark with a horizontal line on the skin, line "B". Repeat marking line "B" for each vertebral body to be instrumented, first ensuring to reposition the C-arm for proper A/P view of each level. The intersection of lines "A" and "B" marks the optimal pedicle entry (Figure 2.1).

Due to the depth of soft tissue and muscle, draw a second vertical line 2cm–3cm lateral to line "A." This is line "C", and delineates the incision site (Figure 2.2). An oblique view directly down the pedicle can also be utilized to identify the ideal skin entry point.

Note: *Greater obesity requires greater lateral distance.*

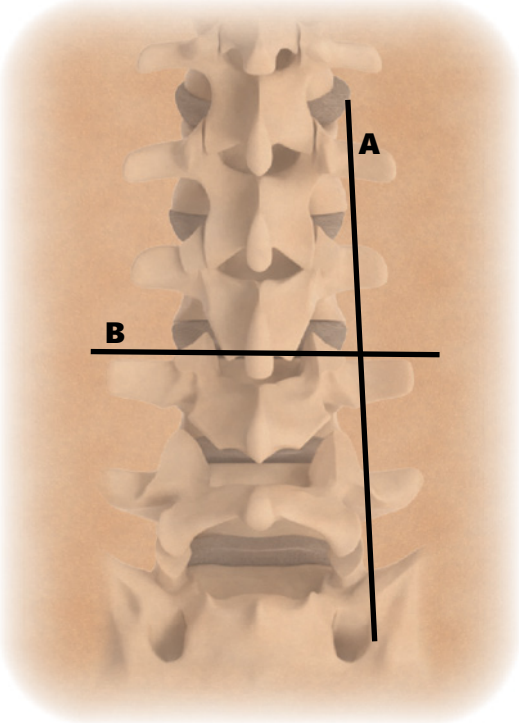


Figure 2.1
Marking lines 'A' and 'B' intersect for pedicle entry point

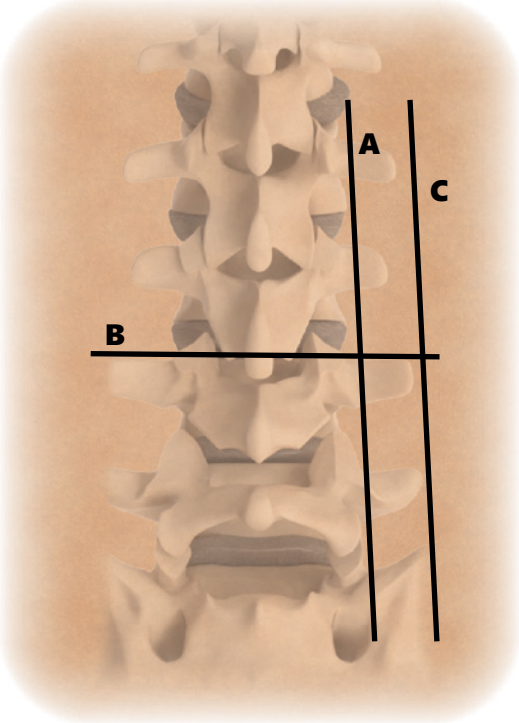


Figure 2.2
Marking line 'C' and 'B' intersect for incision point

3. PEDICLE ACCESS AND APPROACH

Create a 2cm long vertical skin incision through the fascia at the previous noted intersection of the "B" and "C" skin markings if percutaneous Rod placement technique is to be employed. This will be the entry point for the Pedicle (Jamshidi) Targeting Needle.

Utilizing A/P fluoroscopy, advance Pedicle Targeting Needle through incision to appropriate pedicle (Figure 3.1).

NOTE: *If "mini-open" (modified Wiltse approach) Rod placement is desired, make a 3.0cm incision connecting the pedicles. Incise the skin and the facial layer. Use blunt dissection to locate the pedicle entry point.*

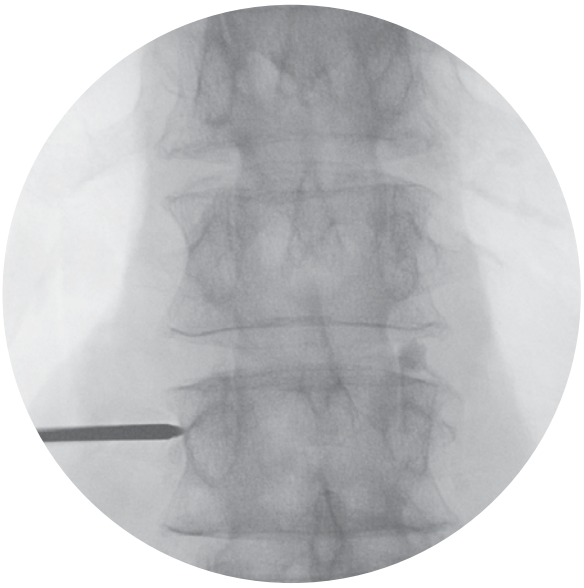


Figure 3.1
Confirming instrument position before plunge

Insert the Pedicle Targeting Needle through the incision. Using A/P fluoroscopy, confirm the Pedicle Targeting Needle position at the lateral border of the pedicle.

Using a mallet, advance the Pedicle Targeting Needle slightly to dock it into the bone and stabilize. Reference a lateral fluoroscopic image to confirm that the cephalad/caudal trajectory matches the pedicular anatomy (Figure 3.2).

NOTE: *The surgeon can locate the transverse process with the distal tip of the Pedicle Targeting Needle and walk the distal tip medial until the distal tip is located lateral to the center of the pedicle.*

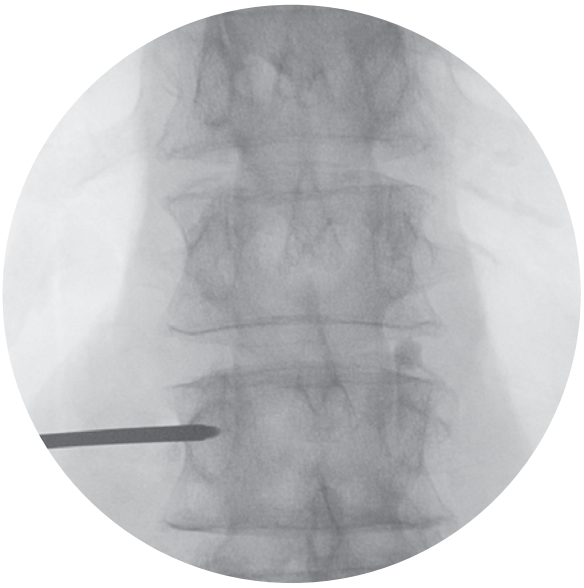


Figure 3.2
Pedicle Targeting Needle plunged and stylet still inserted

4. K-WIRE INSERTION

Continue advancing the Pedicle Targeting Needle under A/P fluoroscopy. As the tip of the needle approaches the middle of the Pedicle Targeting Needle, it should be approximately one third into the vertebral body when viewed on a lateral image. Advance the Pedicle Targeting Needle to the desired depth, but no further than half the depth of the vertebral body.

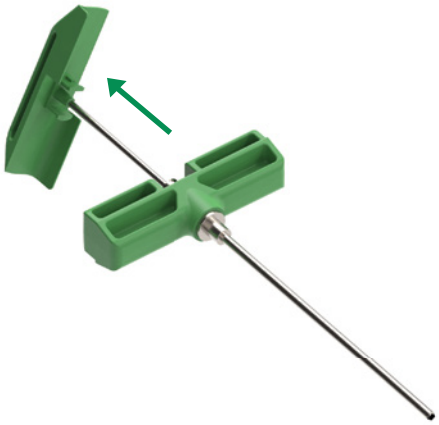


Figure 4.1
Removing inner stylet by rotating and pulling

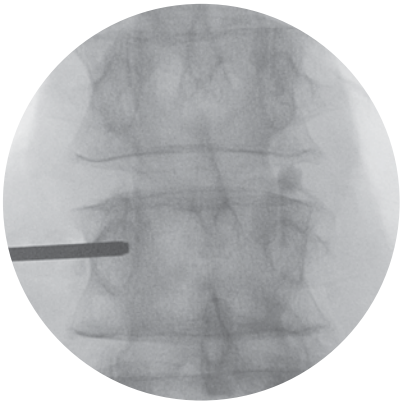


Figure 4.2
Pedicle Targeting Needle plunged and stylet removed

Remove the inner stylet of the Pedicle Targeting Needle by turning the top handle 90° to the cannula handle (Figure 4.1). Carefully advance the K-Wire past the tip of the Pedicle Targeting Needle and firmly into cancellous bone (Figure 4.2). Ideal placement of the K-Wire tip is approximately two-thirds of the depth of the vertebral body. Remove the Pedicle Targeting Needle while maintaining the position of the Guidewire (Figure 4.3).

NOTE: *K-Wire markings should be visible (on proximal body) when advancing through the Pedicle Targeting Needle, as the markings and proximal end of Dilator 1 will be used to determine screw length.*

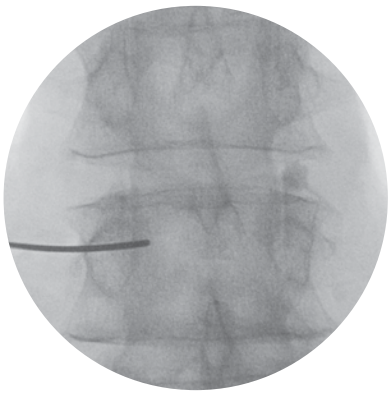


Figure 4.3
K-Wire inserted and needle removed

4. K-WIRE INSERTION (cont.)

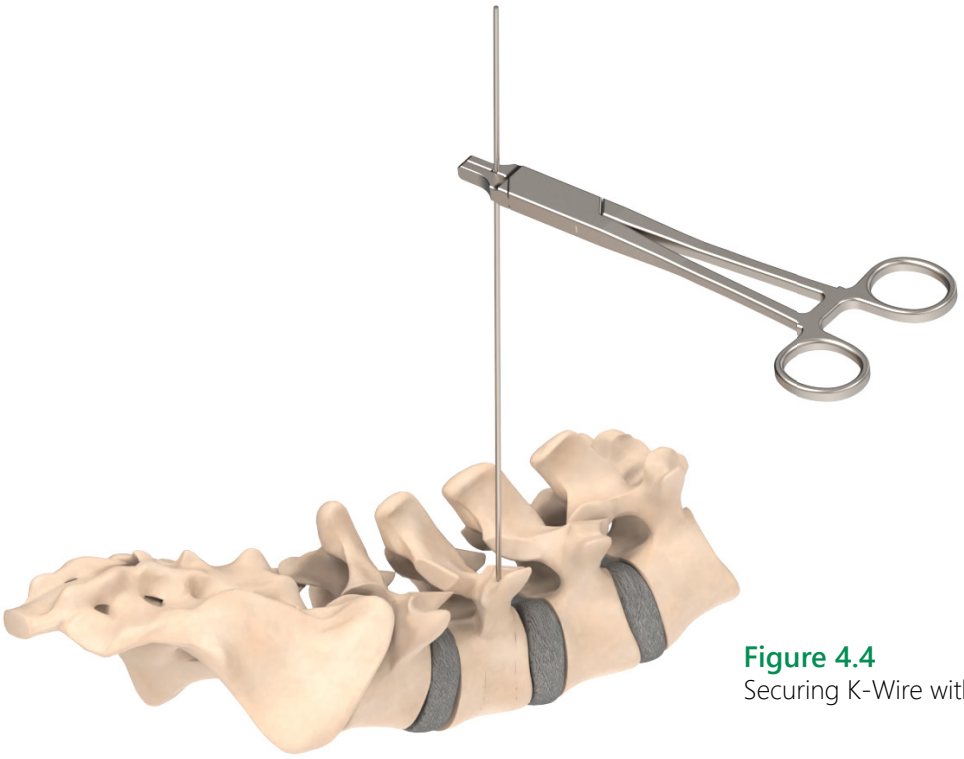


Figure 4.4
Securing K-Wire within anatomy

Remove Pedicle Targeting Needle while securing K-Wire and ensuring it stays secured within patient anatomy (Figure 4.4).

Repeat these steps for all pedicles that are intended for screw placement.

NOTE: *Do not advance or remove the K-Wire while placing instruments over the K-Wire during the procedure. Bending of the K-Wire should be avoided as it could cause a kink and/or break.*

NOTE: *K-Wire advancement should be monitored using fluoroscopy. Failure to do so may cause the K-Wire, or part of it, to advance through the bone and into a location that may cause damage to underlying structures.*

5. DILATOR PLACEMENT

Insert Dilator 1 over the K-Wire and twist the dilator back and forth while advancing down the K-Wire until it docks against posterior boney elements (Figure 5.1). Verify that the Dilator is placed firmly against the bone by utilizing lateral fluoroscopy.

NOTE: *Dilators 2 and 3 are fabricated from radiopaque plastic which has been designed to show on fluoroscopy the distal tip location in relation to the posterior boney elements. Dilator 1 is aluminum.*

NOTE: *Use lateral fluoroscopy to properly manage the K-Wire during pedicle preparation to confirm placement and avoid anterior advancement of the K-Wire.*

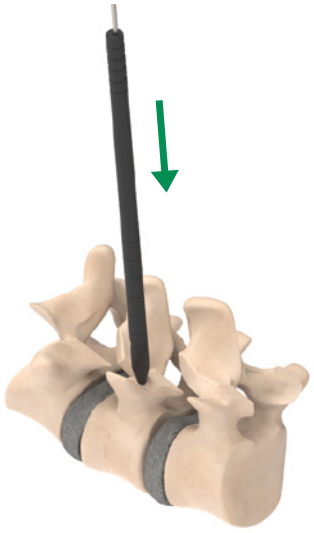


Figure 5.1
Dilator 1 inserted over K-Wire

Guide Dilator 2 over the K-Wire, then over Dilator 1. Advance Dilator 2 through the soft tissue until it is seated against the pedicle (Figure 5.2).

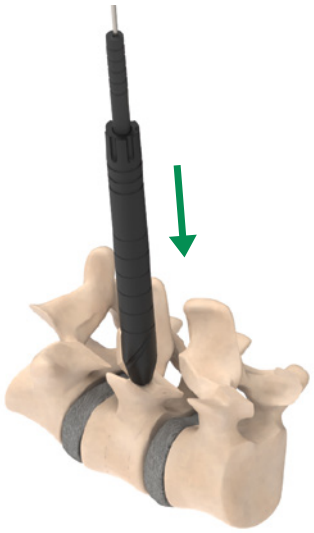


Figure 5.2
Dilator 2 inserted over Dilator 1

Guide Dilator 3 over the Guidewire, then over Dilator 2. Advance Dilator 3 through the soft tissue until it is seated against the pedicle (Figure 5.3).

NOTE: *The Dilator Pusher Handle can be utilized to assist full seating of the Dilator 2 and 3*

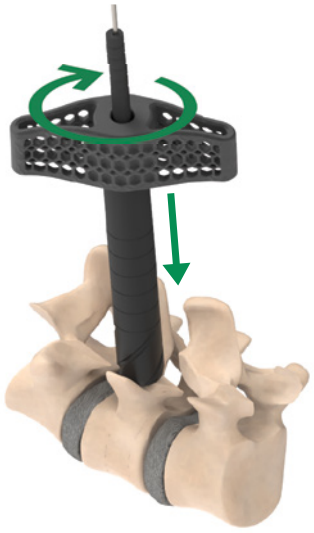


Figure 5.3
Dilator 3 inserted over Dilator 2 with help of Dilator Pusher Handle

6. PEDICLE TAPPING AND PREPARATION

Prior to preparing the pedicle for Extended Tab Screw Assembly placement, remove Dilator 1, leaving the Guidewire, Dilator 2, and Dilator 3 in position.

NOTE: *Dilator 2 provides the working corridor for the Tap and optional 9mm Bone Awl. (Figure 6.1) Dilator 3 provides the working corridor for the Extended Tab Screw Assembly (Figure 6.2).*

Figure 6.1
Dilators 2-3 are a window for Taps

Figure 6.2
Dilator 3 is a window for Extended Tabs

Select the preferred Ratcheting Handle, and attach to an appropriately sized Tap by inserting the proximal end of the Tap into the distal end of the handle. Compress the spring loaded quick-connect ring of the handle to assemble (Figure 6.3).

Figure 6.3
Ratcheting T-handle attachment process onto Tap

6. PEDICLE TAPPING AND PREPARATION (cont.)

Set the ratchet to the preferred drive position. Guide the Tap and Ratcheting Handle over the K-Wire into Dilator 2, then advance until it is seated against the pedicle. Rotate clockwise until the desired tapping depth has been achieved. Confirm placement using fluoroscopy.

NOTE: *The thread length of all Taps is 30mm and can be used as a reference when determining screw length (Figure 6.4).*

Figure 6.4
Tap with depth laser markings

CAUTION: Use lateral fluoroscopy to properly manage the K-Wire during pedicle preparation to confirm proper placement and avoid anterior advancement of the K-Wire (Figure 6.5)

NOTE: *Taps are designed to be line-to-line with corresponding Shank diameter.*

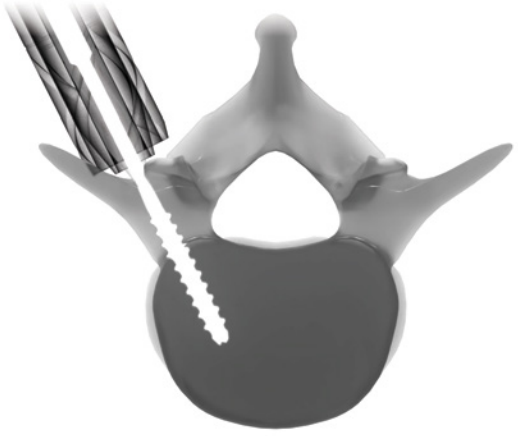
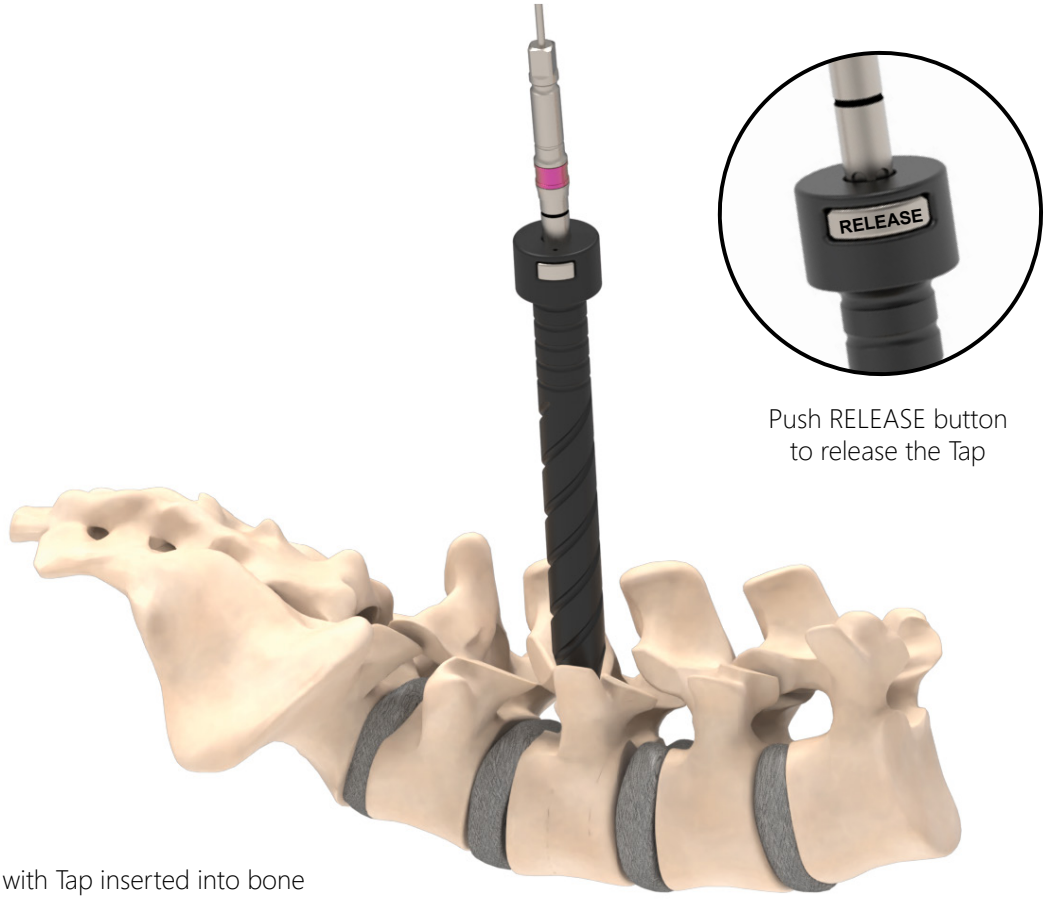


Figure 6.5
Tap with 10mm thread window feature encased in pedicle

7. INTEGRATED TAP-DILATOR (OPTIONAL)



Push RELEASE button
to release the Tap

Figure 7.1
Tap Dilator with Tap inserted into bone

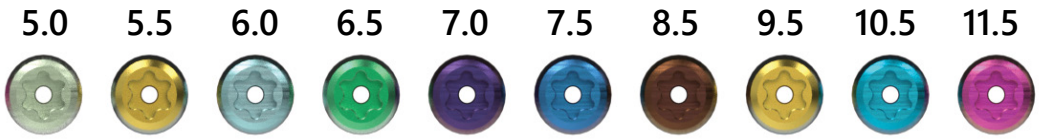
Insert Tap with assembled handle into the Tap Dilator. The Tap Dilator will automatically click and secure the Tap when inserted to engaging depth. Insert Tap and Tap Dilator assembly over K-Wire and into surgical site (Figure 7.1). Firmly press Tap down onto patient bone. Confirm full seating with lateral fluoroscopy. Press the Release button and apply downward pressure to begin tapping to desired depth.

CAUTION: The Dilator 3 is not designed to sequentially dilate with the Tap Dilator.

8. EXTENDED TAB SCREW PREP

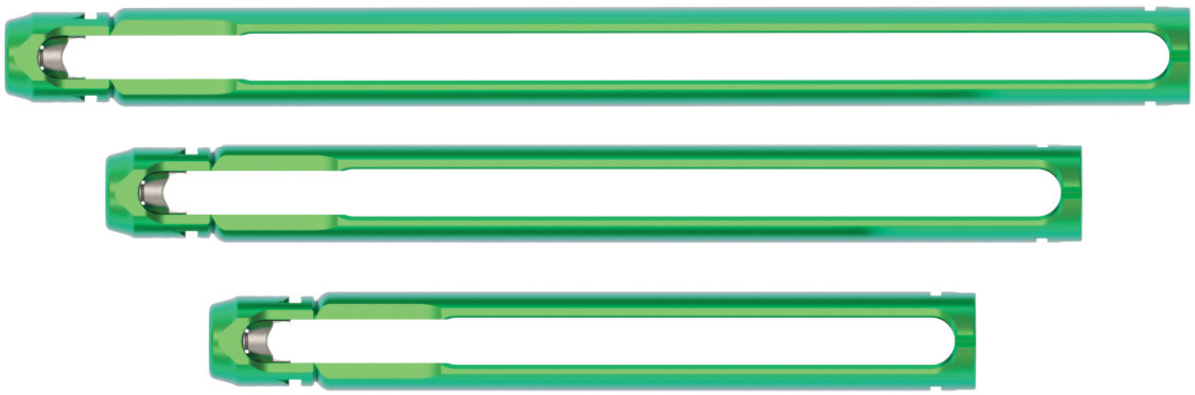
Once the pedicle has been prepared, select the preferred Shank diameter and length per the pathology's requirements. Shank length may be determined by the caddy in which they reside whereas the Shank diameter may be determined via unique anodization colors (Figure 8.1). To verify Shank diameter and length, use the measurement features integrated into the Shank caddies.

Figure 8.1 - Cannulated Ømm by Color



There are three Extended Tab lengths to accommodate different patient pathologies. Generally, the Short 110mm Extended Tabs are used for the thoracic region, or patients with a low physical habitus, with the Medium 140mm and Long 170mm Extended Tabs are for the lumbar spine (Figure 8.2).

Figure 8.2 - MIS Extended Tabs



NOTE: *It may be preferred in longer constructs to use the longer Extended Tabs to reach the anterolisthesed segment of a spondylolisthesis. It is ideal to have approximately 50% of the Extended Tabs above the surface of the skin.*

NOTE: *Short and Medium Extended Tabs should not be utilized if skin level noted on Dilator 2 or 3 is noted at 70mm or higher.*

8. EXTENDED TAB SCREW PREP (cont)

Attach the appropriate Extended Tab onto the Shank's spherical ball geometry by applying a downward force to provisionally connect the two components.

Utilizing the Housing Assembly Tool, place the provisionally assembled Shank and Extended Tab into the tool. The elongated Rod of the instrument should sit in the saddle of the Extended Tab, while the distal portion of the Extended Tab is seated in the mating "cup" (Figure 8.3). Ensure that the Shank is not captured, and is free to rotate and toggle before final seating. Compress the handles of the instrument until the alignment arrows are fully pointing toward each other to fully seat and secure the components together (Figure 8.4).

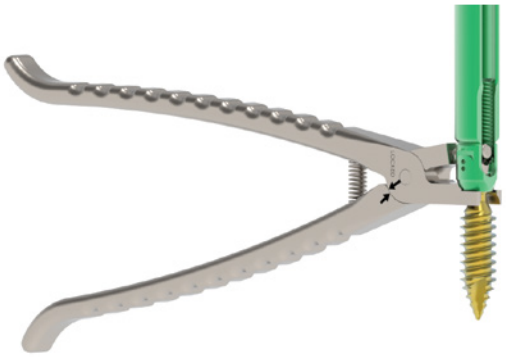


Figure 8.3
Example of instrument with implant mated

TIP: After locking the components, surgeon should pull the Shank downward and rotate slightly to confirm that components have been securely connected. The surgeon can also verify the implant has been appropriately locked by visualizing the silver cap position within the Extended Tab. Visually confirm the components are securely locked (Figure 8.5).

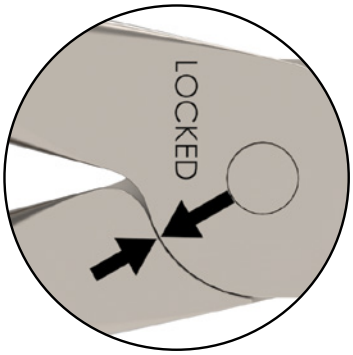


Figure 8.4
Marked arrows pointing toward each other indicate secure lock

Figure 8.5
Cap in the unlocked and locked position

NOTE: *Extended Tabs are single use and cannot be reused once locked.*

9. EXTENDED TAB SCREW INSERTION

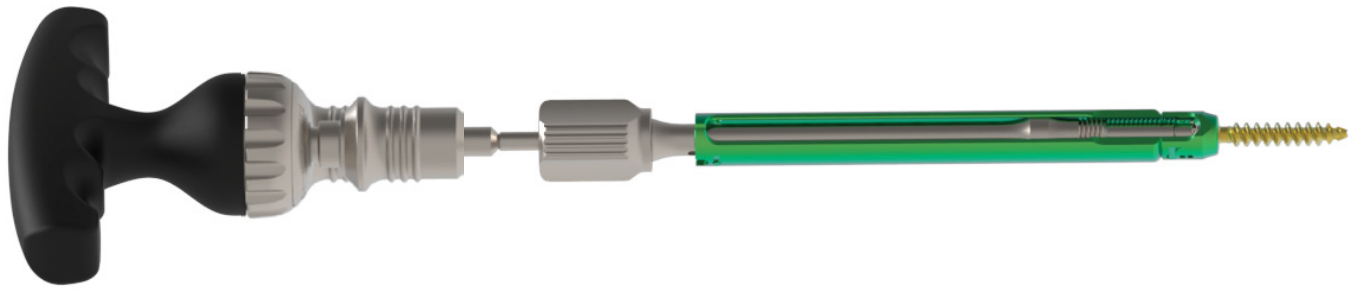


Figure 9.1
Assembled Screw Inserter with T-Handle, Extended Tab, and Shank

Select the preferred Ratcheting Handle, and attach to the Cannulated Screw Inserter by inserting the proximal end of the Cannulated Screw Inserter into the distal end of the handle. Compress the spring loaded quick-connect ring of the handle to assemble. Set the ratchet to the preferred drive position.

Insert the Cannulated Screw Inserter assembly into the screw assembly and engage the T25 distal tip with the mating feature of the Shank. Rotate the assembly knob on the Cannulated Screw Inserter in a clockwise direction to assemble the instrument to the screw assembly (Figure 9.1). Confirm the screw assembly is firmly attached and that there is no toggle of the Shank. Do not over tighten.

9. EXTENDED TAB SCREW INSERTION (cont.)

Remove Dilator 2, then guide the Extended Tab Assembly over the K-Wire and down Dilator 3 until the distal tip of the implant assembly makes contact with the bone.

Rotate the assembled Cannulated Screw Inserter clockwise until the desired depth of the Shank is achieved (Figure 9.2).

Verify via lateral fluoroscopy during screw insertion to verify trajectory and implant placement depth (Figure 9.3).

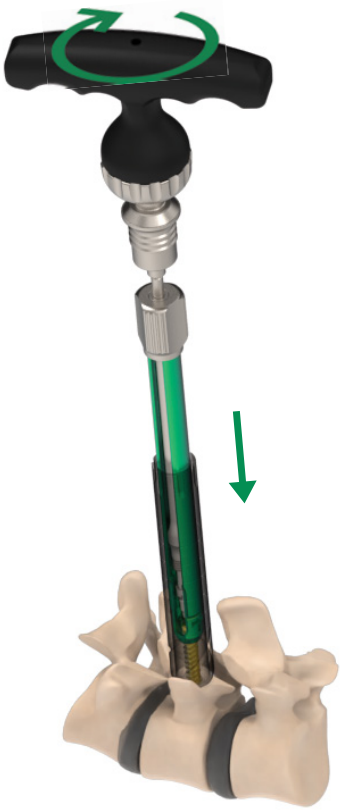


Figure 9.2
Rotating assembly clockwise down K-Wire until Shank depth achieved

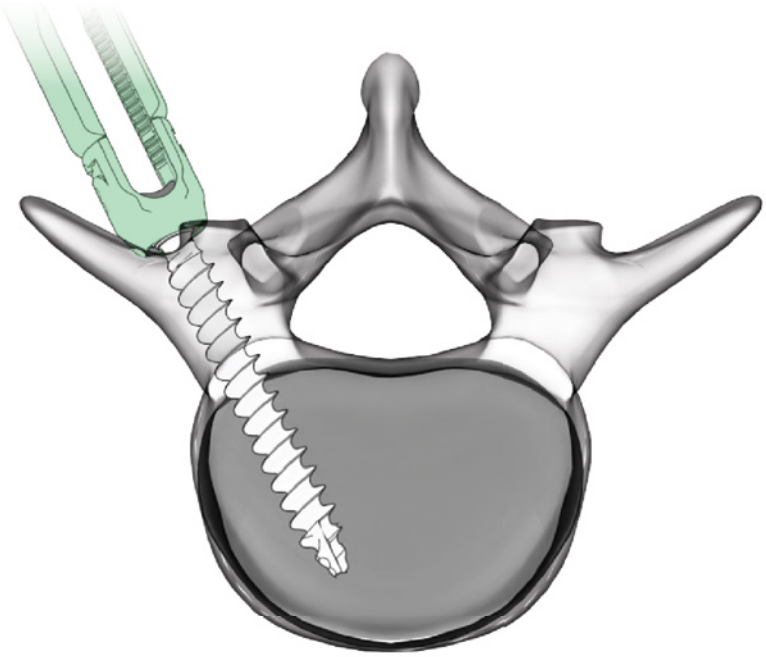


Figure 9.3
Example assembly driven into the pedicle body

9. EXTENDED TAB SCREW INSERTION (cont.)

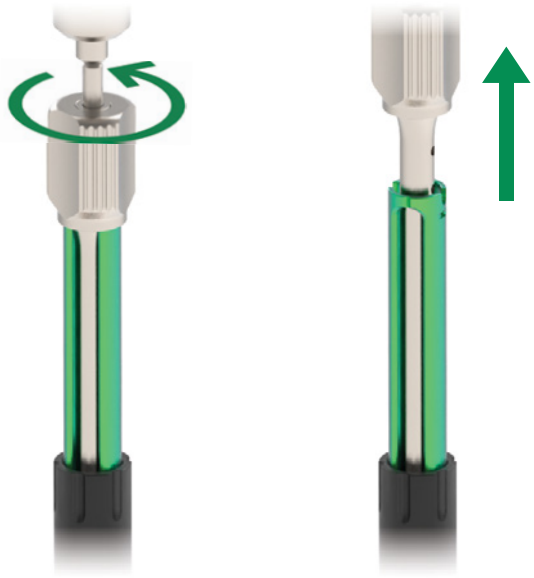


Figure 9.4
Rotate lower knob counter-clockwise to release instrument from Shank

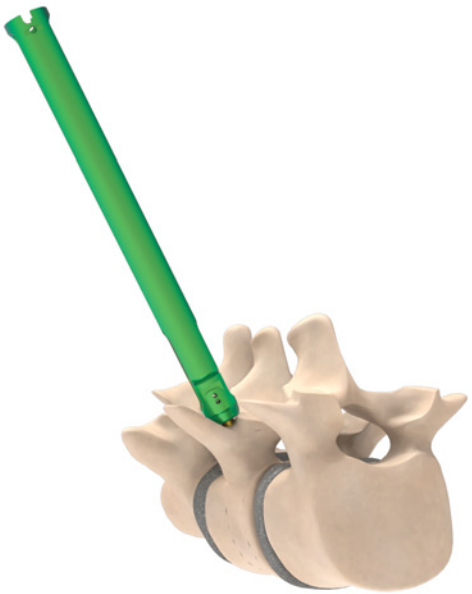


Figure 9.5
Shank assembly with Screw Inserter and Dilator removed

After final placement and verification of screw placement disassemble the Cannulated Screw Inserter from the Extended Tab by rotating the knob counterclockwise. Pull upward on the instrument while managing the K-Wire, to remove from the placed screw assembly (Figure 9.4). The Final Driver can be utilized after removal of the Cannulated Screw Inserter to easily advance or withdraw the implanted screw assembly.

Manually remove the K-Wire and Dilator 3 (Figure 9.5).

Place the remaining screws per a similar technique.

NOTE: *If excessive bone growth on the anterior face of the facet is noted on fluoroscopy which may inhibit seating of the Extended Tab, or bleeding bone required for posterior lateral fusion, the Decorticating Tool can be placed down Dilator 3 over the K-Wire and rotated by hand to remove bone. The Decorticating Tool can be assembled to any of the static or ratcheting cannulated handles for use. It is not recommended to use the Decorticating Tool with power or to remove excessive bone as this may weaken the bone-Shank interface.*

10. ROD PREPARATION

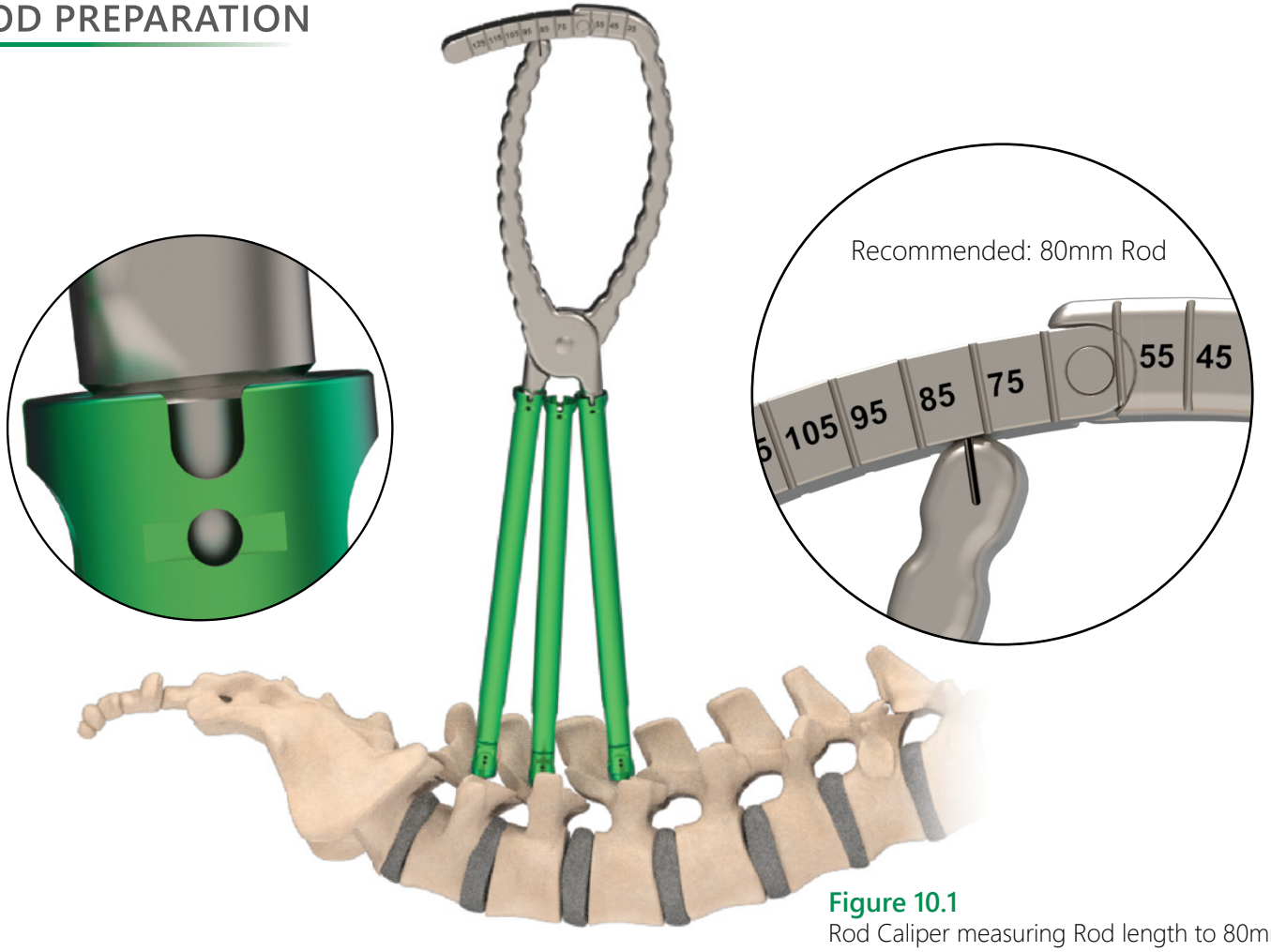


Figure 10.1
Rod Caliper measuring Rod length to 80mm

The INERTIA CONNEXX® Modular Screw System offers multiple Rod diameters, lengths, and materials. Surgeons should select the Rod that is appropriate for their patient's needs.

The Rod Caliper should be utilized to determine the length of Rod needed for the final construct. Insert the arms of the Rod Caliper into the proximal ends of the inferior and superior Extended Tabs, and advance the arms down until fully seated (Figure 10.1). Surgeon can utilize lateral fluoroscopy to verify placement of Rod Caliper as well. It may be necessary to angle the Rod Caliper cephalad and caudal to fully seat the distal end of the measurement tool into the Extended Tabs.

NOTE: *The length noted on the Rod Caliper is the true length of the Rod required. No additional length is needed to allow for overhang of the Extended Tabs for full Set Screw seating. (E.g., 50mm indication = select a 50mm Rod).*

10. ROD PREPARATION (cont.)

NOTE: *Full seating of the Rod Caliper is confirmed when the laser markings at the top of the arms are positioned at the top of both Extended Tabs. For Medium Tabs please utilize the dashed line for verification.*

Figure 10.2
French Rod bender

If patient anatomy requires additional lordosis greater than normal lordotic MIS Rods, use the French Rod Bender to prepare and contour the Rods with progressive bends until obtaining a shape appropriate for the construct (Figure 10.2). Pre-contoured Rods simplify the initial approximation without inducing additional stress into the Rod.

NOTE: *If any additional Rod contouring is performed, Rod length will differ from Rod measurement due to change in curvature. Excessive or repeated bending of Rods may reduce strength and result in construct failure.*

11. ROD INSERTION

The Fascial Wand may be used prior to Rod insertion to create a pathway for passing the Rod through the slots of the Extended Tabs. Pass the Fascial Wand through the most cranial Extended Tab or incision, then advance it through each Extended Tab until the most caudal Extended Tab has been reached (Figure 11.1).

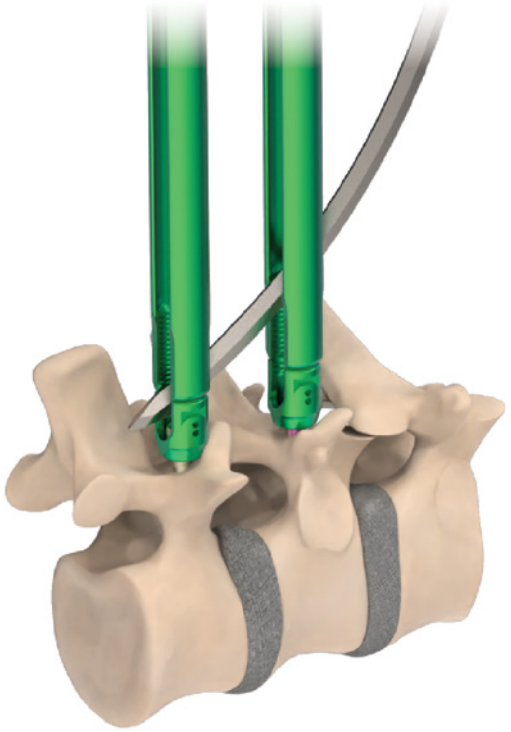


Figure 11.1
Fascial Wand advancing through first Extended Tab

NOTE: *Before using the Fascial Wand for Rod placement, utilize the Housing Alignment Tool to ensure that all of the slots in the Extended Tabs align and do not encumber the passing of the Rod (Figure 11.2).*

Figure 11.2
Housing Alignment tool rotates the openings of the Extended Tabs to face each other

11. ROD INSERTION (cont.)

Select the appropriate length Rod as determined by the Rod Caliper and remove from the Rod Caddy. Insert the distal tip of the MIS Rod Inserter into the mating recess of the Rod and rotate threaded knob clockwise to secure distal thread of MIS Rod Inserter to Rod (Figure 11.3).

NOTE: *The Rod can be placed in the MIS Rod Inserter in both a lordotic curvature, or reversed for kyphotic curvature, depending on patient's anatomy.*

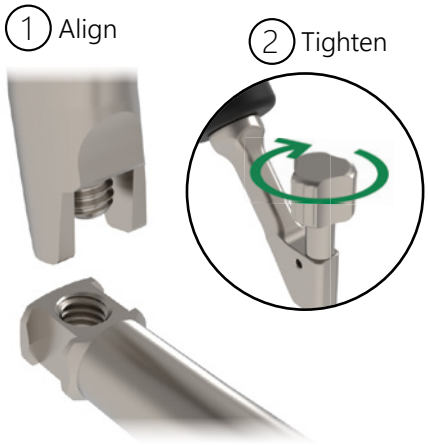


Figure 11.3
Assembly process to attach MIS Rod

Introduce the MIS Rod Inserter in a cranial to caudal orientation with the handle facing in the cranial direction.

Insert the pointed end of the Rod into the most cranial Extended Tab Rod slot opening until it passes below the fascia and into the Extended Tab.

The MIS Rod Inserter will be almost parallel to the patient during this phase of Rod passage. When the distal tip of the Rod enters the distal part of the Extended Tab, begin to rotate the MIS Rod Inserter handle which will push the Rod through each of the remaining Extended Tabs. (Figure 11.4).

Figure 11.4
Rod Inserter can be lifted straight up after insertion

11. ROD INSERTION (cont.)

OPTIONAL ROD PLACEMENT – MINI OPEN:

The Mini-Open or Wiltse Rod Holder can be utilized if the surgical approach allows for the use of the instrument. With the distal tips of the instrument open, attach and clamp to the mid portion of the selected Rod. The instrument will allow for dropping between the Extended Tabs (Figure 11.5)

Figure 11.5
Wiltse Rod Holder inserting Rod between Extended Tabs

OPTIONAL ROD CONFIRMATION:

Use the Rod Confirmation instrument to ensure Rod is properly placed within screws. Indicator lines on the instrument will show if no Rod is present, Rod is present and requires "XXmm" of reduction but can be captured with a Set Screw as the Extended Tabs has 20mm of built in reduction, and if the Rod is present but will require a secondary instrument to persuade the Rod down (Figure 11.6).

NOTE: The instrument provides Rod confirmation for the Long (170mm) and Medium (140mm) Housing. Verification of Rod placement in the Short (110mm) should be done with visual confirmation.

Figure 11.6
Each side corresponds to a size of the Extended Tab

12. SET SCREW INSERTION

Insert the distal end of the Tactile Set Screw Inserter into a Set Screw (Figure 12.1) The Tactile Set Screw inserter has been designed to capture the Set Screw and automatically release once the Set Screw has been fully seated onto the Rod (Figure 12.3).

NOTE: *Removable Tracking Tags are not an implant and should be disposed or provided to hospital materials management for tracking purposes if appropriate.*

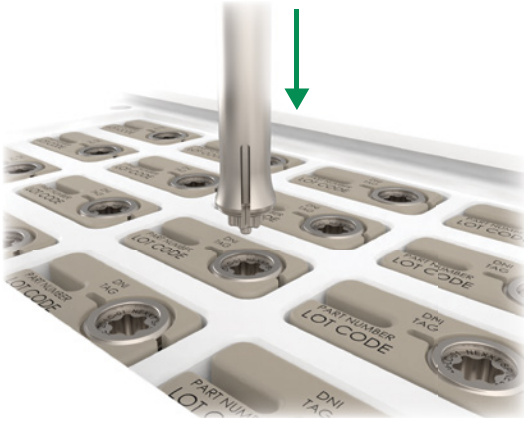


Figure 12.1
Tactile Set Screw Inserter "Click On" from the caddy

Align the Tactile Set Screw Inserter with the assembled Housing and introduce the Set Screw. Turn the Set Screw until it comes into contact with the Rod (Figure 12.2). Do not final tighten. Repeat this procedure for inserting all Set Screws.

NOTE: *Set Screw insertion requires minimal effort to seat within the Extended Tab. Do not force placement as this may damage the threads of the Set Screw. If the Set Screw is difficult to rotate, the Rod may not be seated properly and Rod reduction or contouring may be required.*

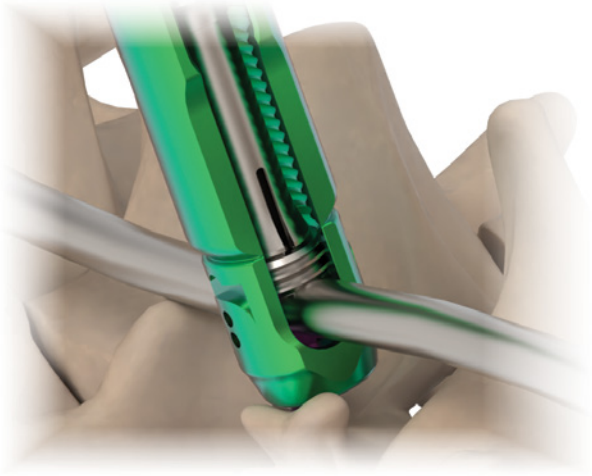


Figure 12.2
Rotating the Tactile Set Screw Inserter until compression on Rod automatically releases Set Screw

Figure 12.3
Set Screw automatically dissociates when securely tightened

13. ROD REDUCTION

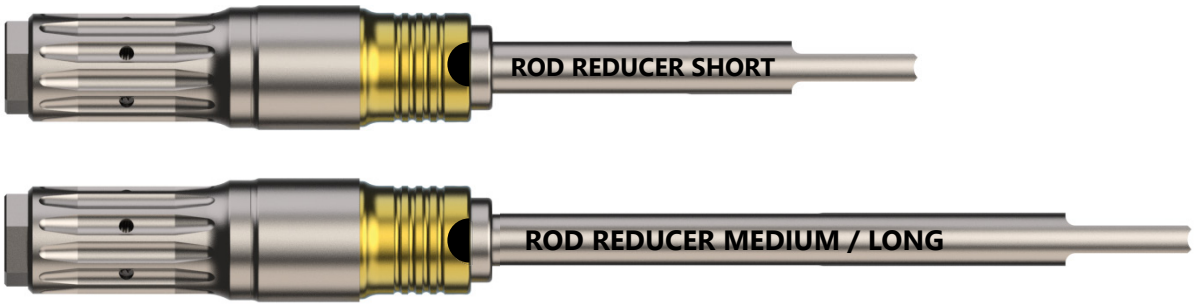


Figure 13.1
MIS Tower Reducers - Short and M/L

Reduction greater than 20mm requires the use of a MIS Tower Reducer. There are two MIS Tower Reducers to match the length of the Extended Tabs. Each MIS Tower Reducer is laser etched with the Extended Tab length(s) supported by the reducer (Figure 13.1). An example of this is the MIS Tower Reducer - Short must be used with Short Extended Tabs.

Insert the chosen MIS Tower Reducer while lining up the black laser-marked arch on the gold knob with the rod slot. Push the MIS Tower Reducer down (axially) until the spring clips of the instrument engage with the proximal features of the Extended Tab, and confirm engagement by pulling (axially) up on the instrument or by verifying the presense of a black indicator ring at the proximal end of the gold sleeve. Pulling up on gold sleeve will release the MIS Reducer (Figure 13.2).

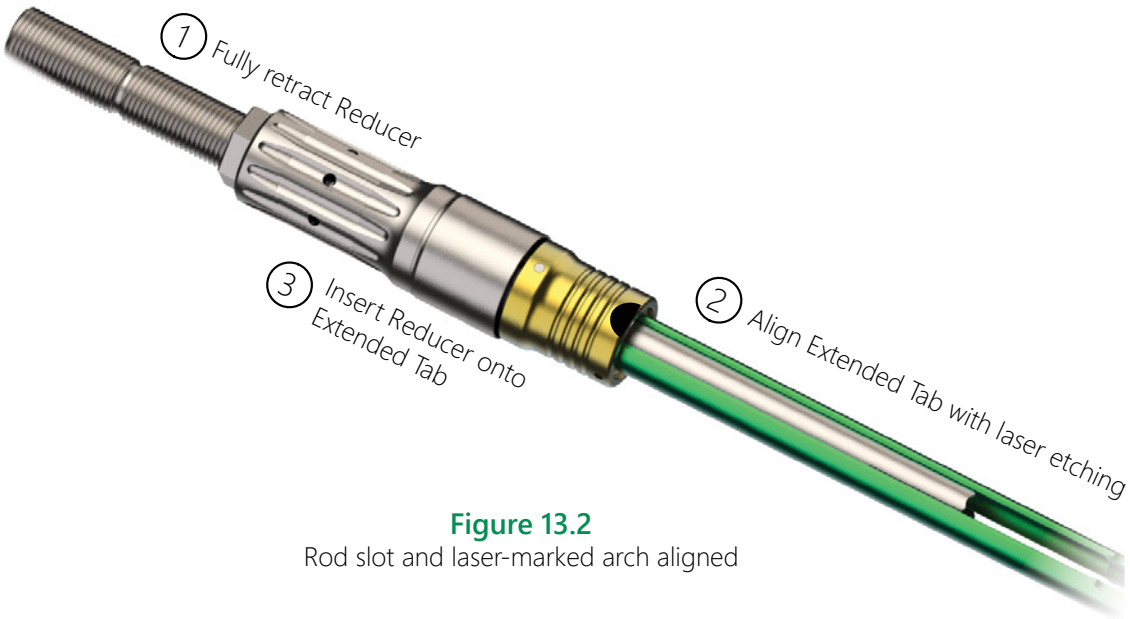


Figure 13.2
Rod slot and laser-marked arch aligned

13. ROD REDUCTION (cont.)

Rotate the reduction knob clockwise to reduce the rod (Figure 13.3). The Reducer Deep Socket or Reducer T-Handle can be utilized if additional force is required to obtain full reduction.

When the Rod is sufficiently reduced, introduce Set Screw using the Tactile Set Screw Inserter and thread into the Extended Tab. (Figure 13.4)

If final tightening through Reducer is required, utilize the Final Driver - Universal and follow instructions for Final Tightening in Step 15: Final Tightening, except without utilizing counter-torque instruments.

NOTE: *The Set Screw Inserter - MIS Tower and Final Driver - MIS Tower are not compatible with reduction instruments.*

To remove MIS Tower Reducer, rotate reduction knob counterclockwise several turns to remove load on the reduction mechanism. Pull upwards on the gold sleeve and pull the instrument out of the Extended Tab (Figure 13.5).

NOTE: *Reduce the middle levels and inferior/superior levels of a long construct simultaneously for easier Rod seating.*

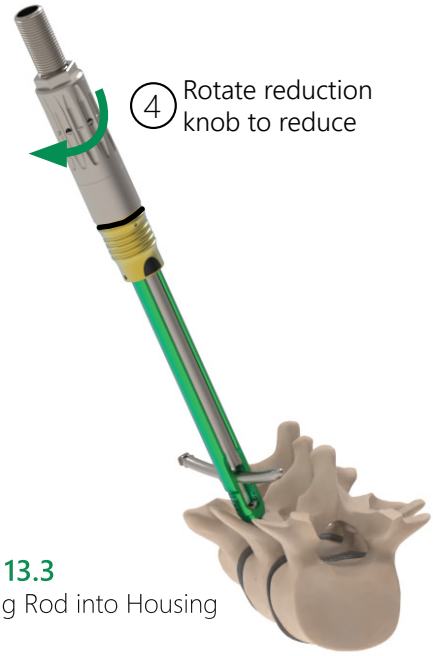


Figure 13.3
Reducing Rod into Housing

Figure 13.4
Tightening Set Screw through Rod Reducer

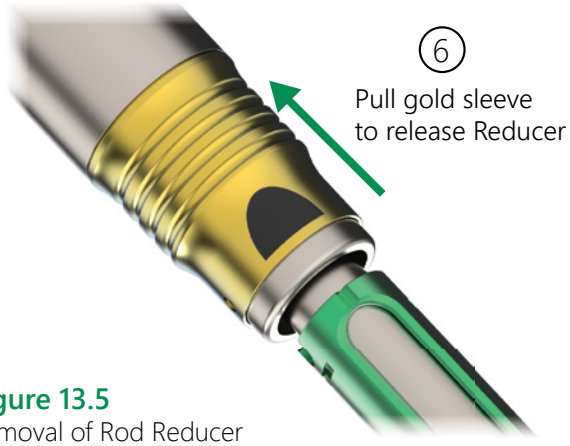


Figure 13.5
Removal of Rod Reducer

14. MIS COMPRESSOR AND DISTRACTOR

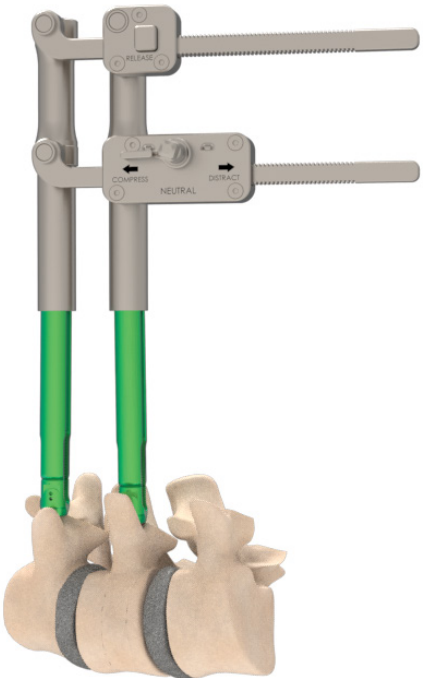
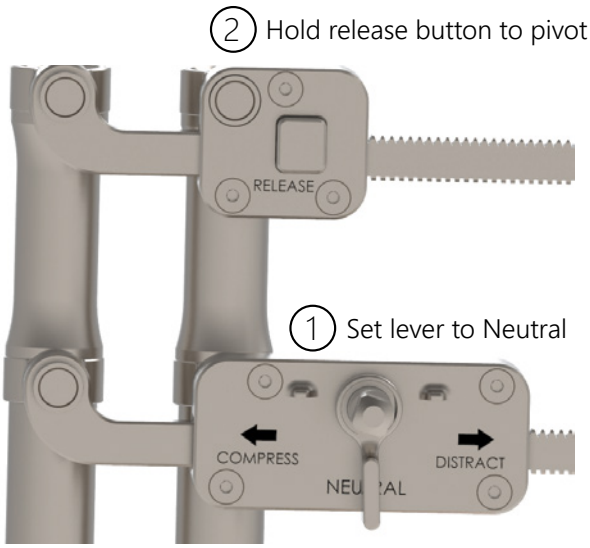


Figure 14.1
MIS Compressor and Distractor assembly attached to Extended Tabs



TO LOAD

Figure 14.2
Instructions on loading onto Housings

If compression or distraction is desired, provisionally tighten a Set Screw on one side of the motion segment, leaving the adjacent Set Screw loose to allow movement along the Rod. The MIS Compression/Distraction Rack does not require assembly and comes pre-assembled for use in surgery.
Slide the MIS Compressor Distractor guides over the sequential Extended Tabs. (Figure 14.1). Ensure that the lower fulcrum switch is placed in "NEUTRAL" before assembly to the Extended Tabs. (Figure 14.2).

NOTE: *The Set Screw Inserter - MIS Tower and Final Driver - MIS Tower are not compatible with the Compressor Distractor. Utilize the Tacticle Set Screw Inserter and the Final Driver - Universal for Set Screw interaction.*

NOTE: *MIS Compressor/Distractor provides a stop feature when placing the instrument on the Extended Tabs, as well as a visualization window to ensure that the instrument is fully seated on both Extended Tabs.*

Surgeon can set the upper fulcrum point position, depending on Extended Tabs spacing by depressing the button which will allow the MIS Compressor Distractor to slide freely. Release the button to set the final position.

14. MIS COMPRESSOR AND DISTRACTOR (cont.)

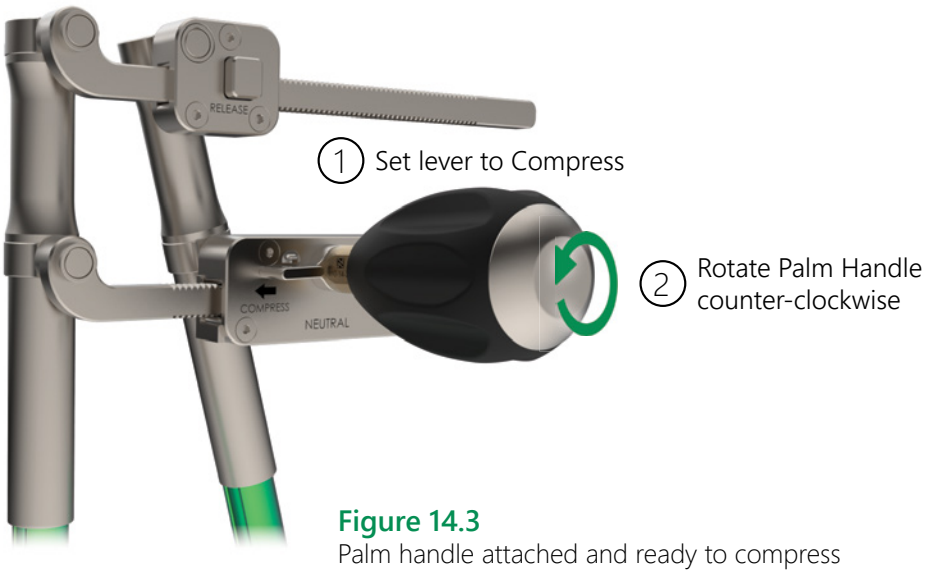


Figure 14.3
Palm handle attached and ready to compress

TO COMPRESS

Begin with the guide tubes slightly "toed in" to each other at the top of the rack to establish the pivot point. Slide the bottom fulcrum switch to "COMPRESS" and verify that the upper fulcrum is secured in place (Figure 14.3).

Attach the ¼ Square Acorn Handle to the mating knob on the lower fulcrum and rotate the handle counterclockwise.

When appropriate compression has been achieved, insert Tactile Set Screw Driver into the tube and provisionally tighten. Place the lower fulcrum switch into the "NEUTRAL" position and remove from Extended Tabs.

Final tighten provisionally tightened Set Screw per STEP 15: Final Tightening.

14. MIS COMPRESSOR AND DISTRACTOR (cont.)

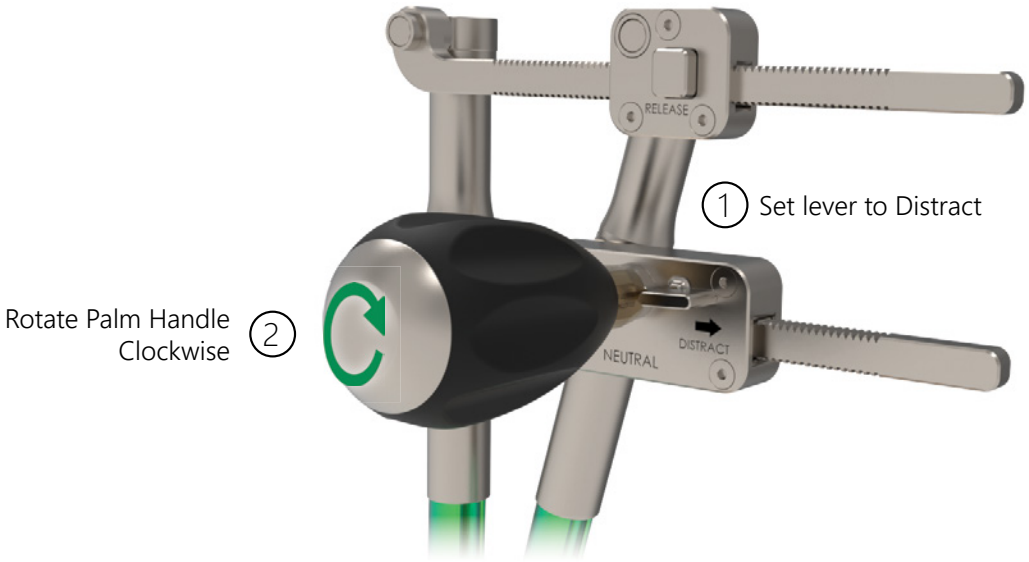


Figure 14.4
Palm handle attached and ready to Distract

TO DISTRACT

Begin with the guide tubes slightly "toed out" to each other at the top of the rack to establish the pivot point. Slide the bottom fulcrum switch to "DISTRACT" and verify that the upper fulcrum is secured in place (Figure 14.4).

Attach the ¼ Square Acorn Handle to the mating knob on the lower fulcrum and rotate the handle clockwise.

When appropriate distraction has been achieved, insert Tactile Set Screw Driver into the tube and provisionally tighten. Place the lower fulcrum switch into the "NEUTRAL" position and remove from Extended Tabs.

Final tighten provisionally tightened Set Screw per STEP 15: Final Tightening.

15. FINAL TIGHTENING

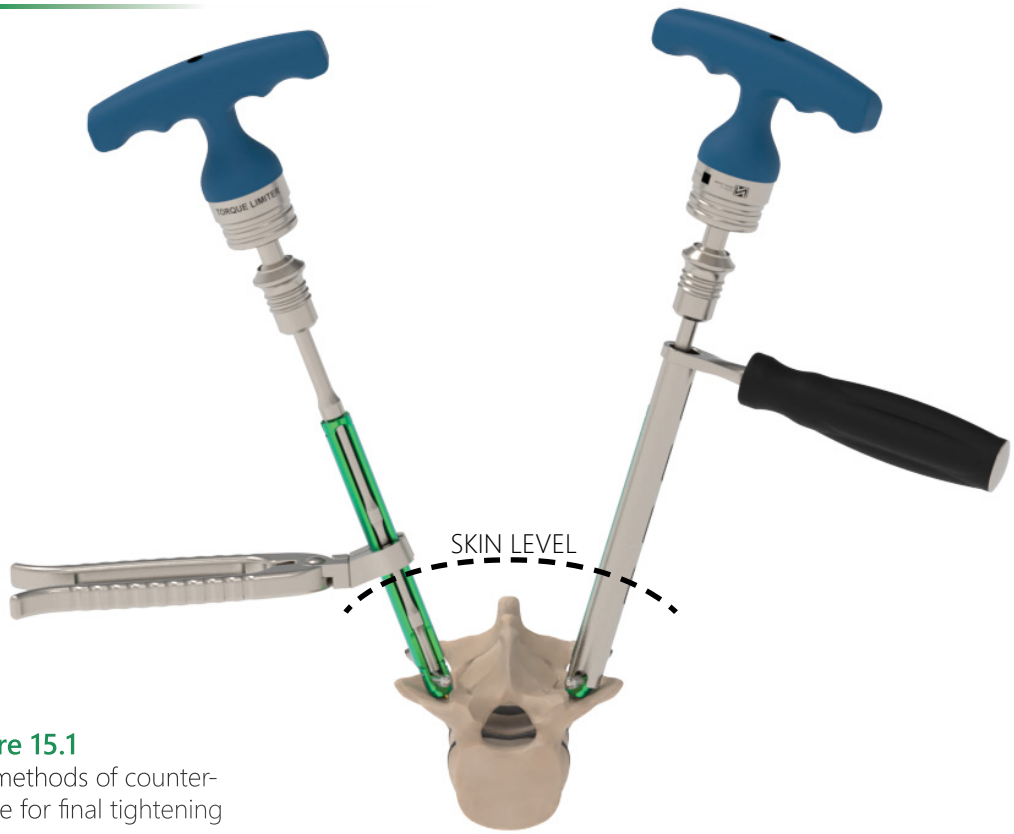


Figure 15.1
Two methods of counter-torque for final tightening

All Set Screws must be tightened to a torque of 90 in-lbs. to affect a secure construct.

Attach the 90 in-lbs. Torque Limiting Handle to the Final Set Screw Driver. Slide the Counter-torque over the Extended Tab until the instrument bottoms out and rests on the Rod (Figure 15.1). Alternatively, utilize the Angled Counter Torque by clamping onto the exterior of the Extended Tab as close to the skin level as possible.

Insert the Final Set Screw Driver through the Counter-torque and seat securely into the Extended Tab. Turn the Torque Limiting Handle clockwise until the breakaway torque is reached. Final tightening is achieved when the Torque Limiting Handle audibly clicks. Repeat on each Set Screw.

NOTE: *Ensure the Rod is placed appropriately and has adequate overhang prior to final tightening. Ensure that all levels on the construct are fully reduced and Set Screws are delivered prior to final tightening.*

WARNING: Do not final tighten construct without the Counter-torque instrument as this may cause the Extended Tabs to deform and prematurely disassociate the Housing.

16. TAB REMOVAL

After construct is final tightened, insert the Tab Removal Tool into desired screw with handle orientated medial/lateral and the clipping jaws engaged with proximal end of Extended Tabs (Figure 16.1, 16.2). Apply squeezing pressure until proximal ring separates (Figure 16.3). Apply medial/lateral force to remove the Extended Tab from the Housing. Repeat on alternate side of construct.

Figure 16.1
The MIS Tab Remover

NOTE: *After separating proximal Extended Tab connection, maintain squeeze pressure to retain one Extended Tab after medial/lateral motion. Release Extended Tab from Tab Removal Tool by relaxing squeeze pressure.*

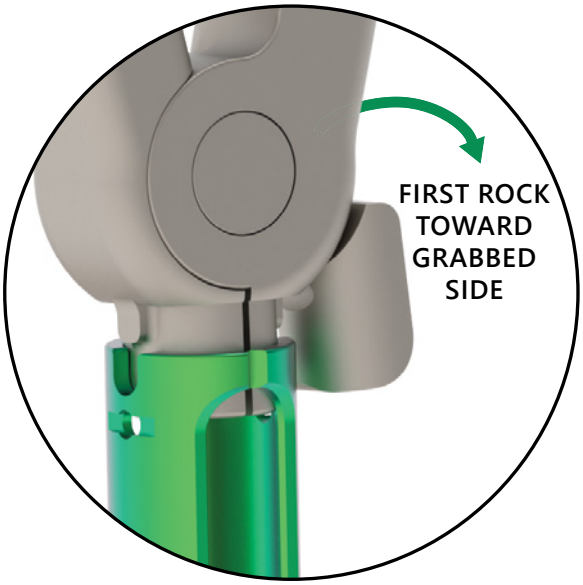


Figure 16.2
MIS Tab Remover Tool seats in notch of Extended Tab

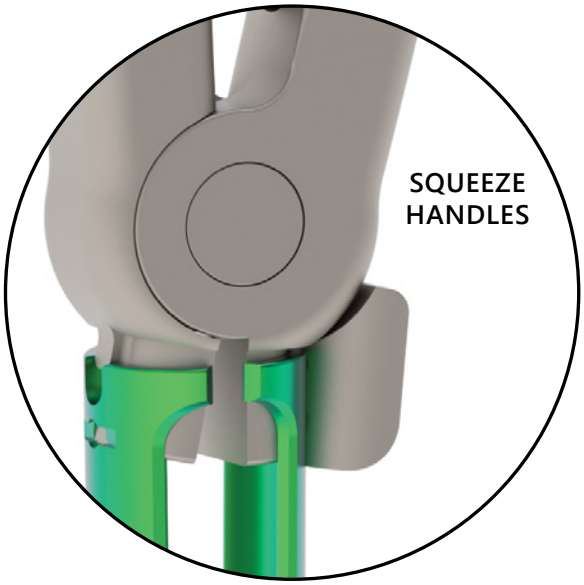


Figure 16.3
Squeeze handles to seperate proximal ring on Extended Tab

17. RESCUE TOWER PROCEDURE

If the Extended Tabs prematurely disassociates during the procedure, the OPEN Rod Reducer may be used as a Rescue Tower.

Push Dilator 3 over the Housing to clear a path for the Rescue Tower Guide Rod.

Insert the Rescue Tower Guide Rod down Dilator 3 and onto the Housing by aligning the top of the instrument with the Housing as shown. (Figure 17.1). Push down and thread instrument after mating. Remove Dilator 3 (Figure 17.2).

Figure 17.1
The instrument top is designed to reflect the orientation of the Housing

Slide a fully retracted Open Reducer down the Rescue Tower Guide Rod until the Open Reducer connects with the Housing. Remove the Rescue Tower Guide Rod and resume the procedure with the standard Tactile Set Screw Driver.

① Dilator 3 used to gain access to Housing

② Rescue Tower Guide Rod inserted onto Housing

③ **Open** Reducer mates with Housing as Rescue Tower

Figure 17.2
Rescue Procedure

IMPLANT PART NUMBERS

Parts designated with * are OPTIONAL ORDER. Green cells indicate Standard Order.

MIS Curved Rods

Standard P/N	Description
Ø5.5mm x XXXmm Curved Rod	
20-RC55-035*	Ø5.5mm x 35mm
20-RC55-040	Ø5.5mm x 40mm
20-RC55-045	Ø5.5mm x 45mm
20-RC55-050	Ø5.5mm x 50mm
20-RC55-055	Ø5.5mm x 55mm
20-RC55-060	Ø5.5mm x 60mm
20-RC55-065	Ø5.5mm x 65mm
20-RC55-070	Ø5.5mm x 70mm
20-RC55-075	Ø5.5mm x 75mm
20-RC55-080	Ø5.5mm x 80mm
20-RC55-085*	Ø5.5mm x 85mm
20-RC55-090	Ø5.5mm x 90mm
20-RC55-095*	Ø5.5mm x 95mm
20-RC55-100	Ø5.5mm x 100mm
20-RC55-105*	Ø5.5mm x 105mm
20-RC55-110	Ø5.5mm x 110mm
20-RC55-115*	Ø5.5mm x 115mm
20-RC55-120	Ø5.5mm x 120mm
20-RC55-125*	Ø5.5mm x 125mm
20-RC55-130*	Ø5.5mm x 130mm
20-RC55-135*	Ø5.5mm x 135mm
20-RC55-140*	Ø5.5mm x 140mm
20-RC55-145*	Ø5.5mm x 145mm
20-RC55-150*	Ø5.5mm x 150mm

MIS Straight Rods

Standard P/N	Description
Ø5.5mm x XXXmm Straight Rod	
20-RS55-200*	Ø5.5mm x 200mm
20-RS55-220*	Ø5.5mm x 220mm
20-RS55-250*	Ø5.5mm x 250mm
20-RS55-300*	Ø5.5mm x 300mm
20-RS55-400*	Ø5.5mm x 400mm

Extended Tabs

Standard P/N	Description
20-ETL-01	Extended Tab L 170mm
20-ETM-01	Extended Tab M 140mm
20-ETS-01	Extended Tab S 110mm

Set Screw

Standard P/N	Description
20-LC-01	Set Screw

*White cells indicate By Request.
Contact Info@NexxtSpine.com
for full SKU offering

Green rows indicate Standard Order

Cannulated Shanks

Standard P/N	Description
Ø5.0mm x XXmm Shanks	
20-SCS-5020*	Ø5.0mm x 20mm
20-SCS-5025*	Ø5.0mm x 25mm
20-SCS-5030*	Ø5.0mm x 30mm
20-SCS-5035*	Ø5.0mm x 35mm
20-SCS-5040*	Ø5.0mm x 40mm
20-SCS-5045*	Ø5.0mm x 45mm
20-SCS-5050*	Ø5.0mm x 50mm
20-SCS-5055*	Ø5.0mm x 55mm
20-SCS-5060*	Ø5.0mm x 60mm
20-SCS-5065*	Ø5.0mm x 65mm
20-SCS-5070*	Ø5.0mm x 70mm
20-SCS-5075*	Ø5.0mm x 75mm
20-SCS-5080*	Ø5.0mm x 80mm

Standard P/N	Description
Ø5.5mm x XXmm Shanks	
20-SCS-5520*	Ø5.5mm x 20mm
20-SCS-5525*	Ø5.5mm x 25mm
20-SCS-5530	Ø5.5mm x 30mm
20-SCS-5535	Ø5.5mm x 35mm
20-SCS-5540	Ø5.5mm x 40mm
20-SCS-5545	Ø5.5mm x 45mm
20-SCS-5550	Ø5.5mm x 50mm
20-SCS-5555*	Ø5.5mm x 55mm
20-SCS-5560*	Ø5.5mm x 60mm
20-SCS-5565*	Ø5.5mm x 65mm
20-SCS-5570*	Ø5.5mm x 70mm
20-SCS-5575*	Ø5.5mm x 75mm
20-SCS-5580*	Ø5.5mm x 80mm

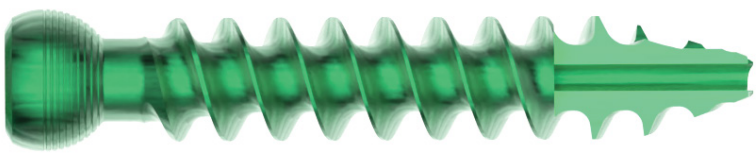
Standard P/N	Description
Ø6.0mm x XXmm Shanks	
20-SCS-6020*	Ø6.0mm x 20mm
20-SCS-6025*	Ø6.0mm x 25mm
20-SCS-6030*	Ø6.0mm x 30mm
20-SCS-6035*	Ø6.0mm x 35mm
20-SCS-6040*	Ø6.0mm x 40mm
20-SCS-6045*	Ø6.0mm x 45mm
20-SCS-6050*	Ø6.0mm x 50mm
20-SCS-6055*	Ø6.0mm x 55mm
20-SCS-6060*	Ø6.0mm x 60mm
20-SCS-6065*	Ø6.0mm x 65mm
20-SCS-6070*	Ø6.0mm x 70mm
20-SCS-6075*	Ø6.0mm x 75mm
20-SCS-6080*	Ø6.0mm x 80mm

Standard P/N	Description
Ø6.5mm x XXmm Shanks	
20-SCS-6520*	Ø6.5mm x 20mm
20-SCS-6525*	Ø6.5mm x 25mm
20-SCS-6530*	Ø6.5mm x 30mm
20-SCS-6535	Ø6.5mm x 35mm
20-SCS-6540	Ø6.5mm x 40mm
20-SCS-6545	Ø6.5mm x 45mm
20-SCS-6550	Ø6.5mm x 50mm
20-SCS-6555	Ø6.5mm x 55mm
20-SCS-6560*	Ø6.5mm x 60mm
20-SCS-6565*	Ø6.5mm x 65mm
20-SCS-6570*	Ø6.5mm x 70mm
20-SCS-6575*	Ø6.5mm x 75mm
20-SCS-6580*	Ø6.5mm x 80mm
20-SCS-6585*	Ø6.5mm x 85mm
20-SCS-6590*	Ø6.5mm x 90mm
20-SCS-6595*	Ø6.5mm x 95mm
20-SCS-65100*	Ø6.5mm x 100mm

Standard P/N	Description
Ø7.0mm x XXmm Shanks	
20-SCS-7020*	Ø7.0mm x 20mm
20-SCS-7025*	Ø7.0mm x 25mm
20-SCS-7030*	Ø7.0mm x 30mm
20-SCS-7035*	Ø7.0mm x 35mm
20-SCS-7040*	Ø7.0mm x 40mm
20-SCS-7045*	Ø7.0mm x 45mm
20-SCS-7050*	Ø7.0mm x 50mm
20-SCS-7055*	Ø7.0mm x 55mm
20-SCS-7060*	Ø7.0mm x 60mm
20-SCS-7065*	Ø7.0mm x 65mm
20-SCS-7070*	Ø7.0mm x 70mm
20-SCS-7075*	Ø7.0mm x 75mm
20-SCS-7080*	Ø7.0mm x 80mm
20-SCS-7085*	Ø7.0mm x 85mm
20-SCS-7090*	Ø7.0mm x 90mm
20-SCS-7095*	Ø7.0mm x 95mm
20-SCS-70100*	Ø7.0mm x 100mm

Standard P/N	Description
Ø7.5mm x XXmm Shanks	
20-SCS-7520*	Ø7.5mm x 20mm
20-SCS-7525*	Ø7.5mm x 25mm
20-SCS-7530*	Ø7.5mm x 30mm
20-SCS-7535	Ø7.5mm x 35mm
20-SCS-7540	Ø7.5mm x 40mm
20-SCS-7545	Ø7.5mm x 45mm
20-SCS-7550	Ø7.5mm x 50mm
20-SCS-7555	Ø7.5mm x 55mm
20-SCS-7560*	Ø7.5mm x 60mm
20-SCS-7565*	Ø7.5mm x 65mm
20-SCS-7570*	Ø7.5mm x 70mm
20-SCS-7575*	Ø7.5mm x 75mm
20-SCS-7580*	Ø7.5mm x 80mm
20-SCS-7585*	Ø7.5mm x 85mm
20-SCS-7590*	Ø7.5mm x 90mm
20-SCS-7595*	Ø7.5mm x 95mm
20-SCS-75100*	Ø7.5mm x 100mm

Standard P/N	Description
Ø8.5mm x XXmm Shanks	
20-SCS-8540*	Ø8.5mm x 40mm
20-SCS-8545*	Ø8.5mm x 45mm
20-SCS-8550*	Ø8.5mm x 50mm
20-SCS-8555*	Ø8.5mm x 55mm
20-SCS-8560*	Ø8.5mm x 60mm
20-SCS-8565*	Ø8.5mm x 65mm
20-SCS-8570*	Ø8.5mm x 70mm
20-SCS-8575*	Ø8.5mm x 75mm
20-SCS-8580*	Ø8.5mm x 80mm
20-SCS-8585*	Ø8.5mm x 85mm
20-SCS-8590*	Ø8.5mm x 90mm
20-SCS-8595*	Ø8.5mm x 95mm
20-SCS-85100*	Ø8.5mm x 100mm
20-SCS-85105*	Ø8.5mm x 105mm
20-SCS-85110*	Ø8.5mm x 110mm
20-SCS-85115*	Ø8.5mm x 115mm
20-SCS-85120*	Ø8.5mm x 120mm



Shank shown in partial cross section to illustrate cannula

Cannulated Corticocancellous

Standard P/N	Description
Ø5.0mm x XXmm Shanks	
20-SCC-5025*	Ø5.0mm x 25mm
20-SCC-5030*	Ø5.0mm x 30mm
20-SCC-5035*	Ø5.0mm x 35mm
20-SCC-5040*	Ø5.0mm x 40mm
20-SCC-5045*	Ø5.0mm x 45mm
20-SCC-5050*	Ø5.0mm x 50mm
20-SCC-5055*	Ø5.0mm x 55mm
20-SCC-5060*	Ø5.0mm x 60mm
20-SCC-5065*	Ø5.0mm x 65mm
20-SCC-5070*	Ø5.0mm x 70mm
20-SCC-5075*	Ø5.0mm x 75mm
20-SCC-5080*	Ø5.0mm x 80mm

Standard P/N	Description
Ø5.5mm x XXmm Shanks	
20-SCC-5525*	Ø5.5mm x 25mm
20-SCC-5530*	Ø5.5mm x 30mm
20-SCC-5535*	Ø5.5mm x 35mm
20-SCC-5540*	Ø5.5mm x 40mm
20-SCC-5545*	Ø5.5mm x 45mm
20-SCC-5550*	Ø5.5mm x 50mm
20-SCC-5555*	Ø5.5mm x 55mm
20-SCC-5560*	Ø5.5mm x 60mm
20-SCC-5565*	Ø5.5mm x 65mm
20-SCC-5570*	Ø5.5mm x 70mm
20-SCC-5575*	Ø5.5mm x 75mm
20-SCC-5580*	Ø5.5mm x 80mm

Standard P/N	Description
Ø6.0mm x XXmm Shanks	
20-SCC-6025*	Ø6.0mm x 25mm
20-SCC-6030*	Ø6.0mm x 30mm
20-SCC-6035*	Ø6.0mm x 35mm
20-SCC-6040*	Ø6.0mm x 40mm
20-SCC-6045*	Ø6.0mm x 45mm
20-SCC-6050*	Ø6.0mm x 50mm
20-SCC-6055*	Ø6.0mm x 55mm
20-SCC-6060*	Ø6.0mm x 60mm
20-SCC-6065*	Ø6.0mm x 65mm
20-SCC-6070*	Ø6.0mm x 70mm
20-SCC-6075*	Ø6.0mm x 75mm
20-SCC-6080*	Ø6.0mm x 80mm

Standard P/N	Description
Ø6.5mm x XXmm Shanks	
20-SCC-6525*	Ø6.5mm x 25mm
20-SCC-6530*	Ø6.5mm x 30mm
20-SCC-6535*	Ø6.5mm x 35mm
20-SCC-6540*	Ø6.5mm x 40mm
20-SCC-6545*	Ø6.5mm x 45mm
20-SCC-6550*	Ø6.5mm x 50mm
20-SCC-6555*	Ø6.5mm x 55mm
20-SCC-6560*	Ø6.5mm x 60mm
20-SCC-6565*	Ø6.5mm x 65mm
20-SCC-6570*	Ø6.5mm x 70mm
20-SCC-6575*	Ø6.5mm x 75mm
20-SCC-6580*	Ø6.5mm x 80mm
20-SCC-6585*	Ø6.5mm x 85mm
20-SCC-6590*	Ø6.5mm x 90mm
20-SCC-6595*	Ø6.5mm x 95mm
20-SCC-65100*	Ø6.5mm x 100mm

Standard P/N	Description
Ø7.0mm x XXmm Shanks	
20-SCC-7025*	Ø7.0mm x 25mm
20-SCC-7030*	Ø7.0mm x 30mm
20-SCC-7035*	Ø7.0mm x 35mm
20-SCC-7040*	Ø7.0mm x 40mm
20-SCC-7045*	Ø7.0mm x 45mm
20-SCC-7050*	Ø7.0mm x 50mm
20-SCC-7055*	Ø7.0mm x 55mm
20-SCC-7060*	Ø7.0mm x 60mm
20-SCC-7065*	Ø7.0mm x 65mm
20-SCC-7070*	Ø7.0mm x 70mm
20-SCC-7075*	Ø7.0mm x 75mm
20-SCC-7080*	Ø7.0mm x 80mm
20-SCC-7085*	Ø7.0mm x 85mm
20-SCC-7090*	Ø7.0mm x 90mm
20-SCC-7095*	Ø7.0mm x 95mm
20-SCC-70100*	Ø7.0mm x 100mm

Standard P/N	Description
Ø7.5mm x XXmm Shanks	
20-SCC-7525*	Ø7.5mm x 25mm
20-SCC-7530*	Ø7.5mm x 30mm
20-SCC-7535*	Ø7.5mm x 35mm
20-SCC-7540*	Ø7.5mm x 40mm
20-SCC-7545*	Ø7.5mm x 45mm
20-SCC-7550*	Ø7.5mm x 50mm
20-SCC-7555*	Ø7.5mm x 55mm
20-SCC-7560*	Ø7.5mm x 60mm
20-SCC-7565*	Ø7.5mm x 65mm
20-SCC-7570*	Ø7.5mm x 70mm
20-SCC-7575*	Ø7.5mm x 75mm
20-SCC-7580*	Ø7.5mm x 80mm
20-SCC-7585*	Ø7.5mm x 85mm
20-SCC-7590*	Ø7.5mm x 90mm
20-SCC-7595*	Ø7.5mm x 95mm
20-SCC-75100*	Ø7.5mm x 100mm

Standard P/N	Description
Ø8.5mm x XXmm Shanks	
20-SCC-8540*	Ø8.5mm x 40mm
20-SCC-8545*	Ø8.5mm x 45mm
20-SCC-8550*	Ø8.5mm x 50mm
20-SCC-8555*	Ø8.5mm x 55mm
20-SCC-8560*	Ø8.5mm x 60mm
20-SCC-8565*	Ø8.5mm x 65mm
20-SCC-8570*	Ø8.5mm x 70mm
20-SCC-8575*	Ø8.5mm x 75mm
20-SCC-8580*	Ø8.5mm x 80mm
20-SCC-8585*	Ø8.5mm x 85mm
20-SCC-8590*	Ø8.5mm x 90mm
20-SCC-8595*	Ø8.5mm x 95mm
20-SCC-85100*	Ø8.5mm x 100mm
20-SCC-85105*	Ø8.5mm x 105mm
20-SCC-85110*	Ø8.5mm x 110mm
20-SCC-85115*	Ø8.5mm x 115mm
20-SCC-85120*	Ø8.5mm x 120mm

Shank shown in partial cross section to illustrate cannula

INSTRUMENT PART NUMBERS

Tactile Set Screw Inserter

Standard P/N	Description
I20-10-13	Tactile Set Screw Inserter
I20-10-12*	Dual End Set Screw Inserter

Set Screw Inserter - MIS Tower

Standard P/N	Description
I20-10-16	Set Screw Inserter - MIS Tower

Jamshidi Needle

Standard P/N	Description
RAN-1115N	Jamshidi Needle

Rod Confirmation

Standard P/N	Description
I20-16-05	Rod Confirmation

Reducer T Handle

Standard P/N	Description
I20-10-07*	Reducer T-Handle

Final Driver - Universal

Standard P/N	Description
I20-10-11	Final Driver - Universal

Rescue Tower Guide Rod

Standard P/N	Description
I20-21-01	Rescue Tower Guide Rod

Tap Dilator

Standard P/N	Description
I20-14-25*	Tap Dilator

Final Driver - MIS Tower

Standard P/N	Description
I20-10-17	Final Driver - MIS Tower

Reusable Targeting Needle

Standard P/N	Description
I20-14-37*	Targeting Needle Cannula
I20-14-38*	Inner Shaft - Awl
I20-14-39*	Inner Shaft - Beveled Awl

Cannulated Decorticating Tool

Standard P/N	Description
I20-14-32	Decorticating Tool
I20-14-40	Decorticator Cleaner

Axial 1/4" SQ Ratcheting Handle

Standard P/N	Description
I10-01-26*	Axial Ratchet 1/4 SQR

Cannulated Taps

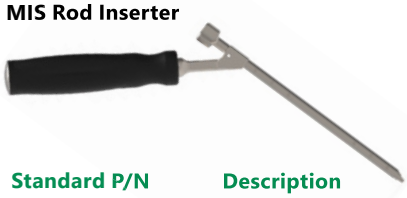
Standard P/N	Description
I20-14-45	4.5mm Cann. Tap
I20-14-55	5.5mm Cann. Tap
I20-14-65	6.5mm Cann. Tap
I20-14-75	7.5mm Cann. Tap

Dilator Set

Standard P/N	Description
I20-14-10	Dilator 1
I20-14-20	Dilator 2
I20-14-30	Dilator 3

INSTRUMENT PART NUMBERS (cont)

MIS Rod Inserter



Standard P/N	Description
I20-16-06	MIS Rod Inserter

MIS Rod Inserter Release Tool

Standard P/N	Description
I20-16-09	MIS Rod Inserter Release Tool

Rod Measuring Caliper

Standard P/N	Description
I20-16-04	MIS Rod Measuring Caliper

Cannulated Screw Inserter

Standard P/N	Description
I20-16-01	Cannulated Screw Inserter

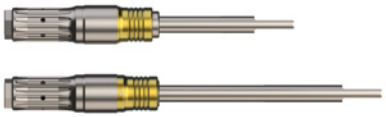
Reducer Deep Socket

Standard P/N	Description
I20-18-02	Reducer Deep Socket

Housing Assembly Tool

Standard P/N	Description
I20-16-08	Housing Assembly Tool

MIS Tower Reducers



Standard P/N	Description
I20-18-04	MIS Tower Reducer Short
I20-18-05	MIS Tower Reducer M/L

OPEN Inline Reducer (Used as Rescue)

Standard P/N	Description
I20-10-05	Inline Reducer

Compressor/Distractor

Standard P/N	Description
I20-18-03	MIS Compressor Distractor

Tower Turner

Standard P/N	Description
I20-16-03	Tower Turner

90LB Square Handle

Standard P/N	Description
I10-01-11	Torque Limiting, 90lb, 1/4" Square

Ratcheting T-Handle

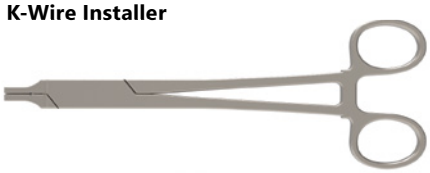
Standard P/N	Description
I10-01-77	Cannulated Ratcheting T-Handle, 1/4" Square

INSTRUMENT PART NUMBERS (cont)

Rod Holder

Standard P/N	Description
I10-08-06	Rod Holder

K-Wire Installer



Standard P/N	Description
I10-14-01	K-Wire Installer

K-Wire

Standard P/N	Description
I10-14-196	K Wire - Trocar Thrd.
I10-14-197 *	K Wire - Blunt Thrd.

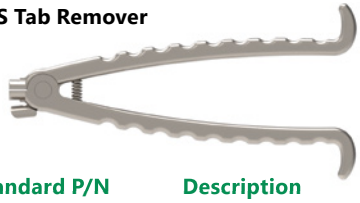
Angled Counter Torque

Standard P/N	Description
I20-20-07	Angled Counter Torque

MIS Counter Torque

Standard P/N	Description
I20-20-02	MIS Counter Torque

MIS Tab Remover



Standard P/N	Description
I20-20-06	Tab Remover

Dilator Pusher

Standard P/N	Description
I20-14-33	Dilator Pusher

5.5mm Rod Bender

Standard P/N	Description
I10-30-15	5.5mm Rod Bender

1/4" Square Adapter

Standard P/N	Description
I92-20-03*	1/4" Square Adapter

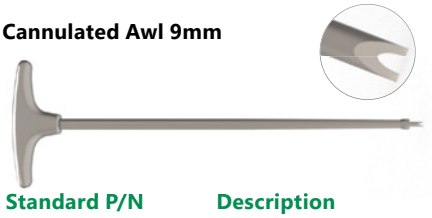
Fascial Wand

Standard P/N	Description
I20-16-02	Fascial Wand

Pear Handle 1/4" Square

Standard P/N	Description
I10-14-37	Quick 1/4" SQ Pear

Cannulated Awl 9mm



Standard P/N	Description
I10-14-02*	9mm Cannulated Awl

*White cells indicate By Request. Contact Info@NexxtSpine.com for full SKU offering

Green rows indicate Standard Order

COMPATIBLE NEXXT MATRIXX® SYSTEMS

Lateral + STRUXXURE® L

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TLIF

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71-051, Rev E