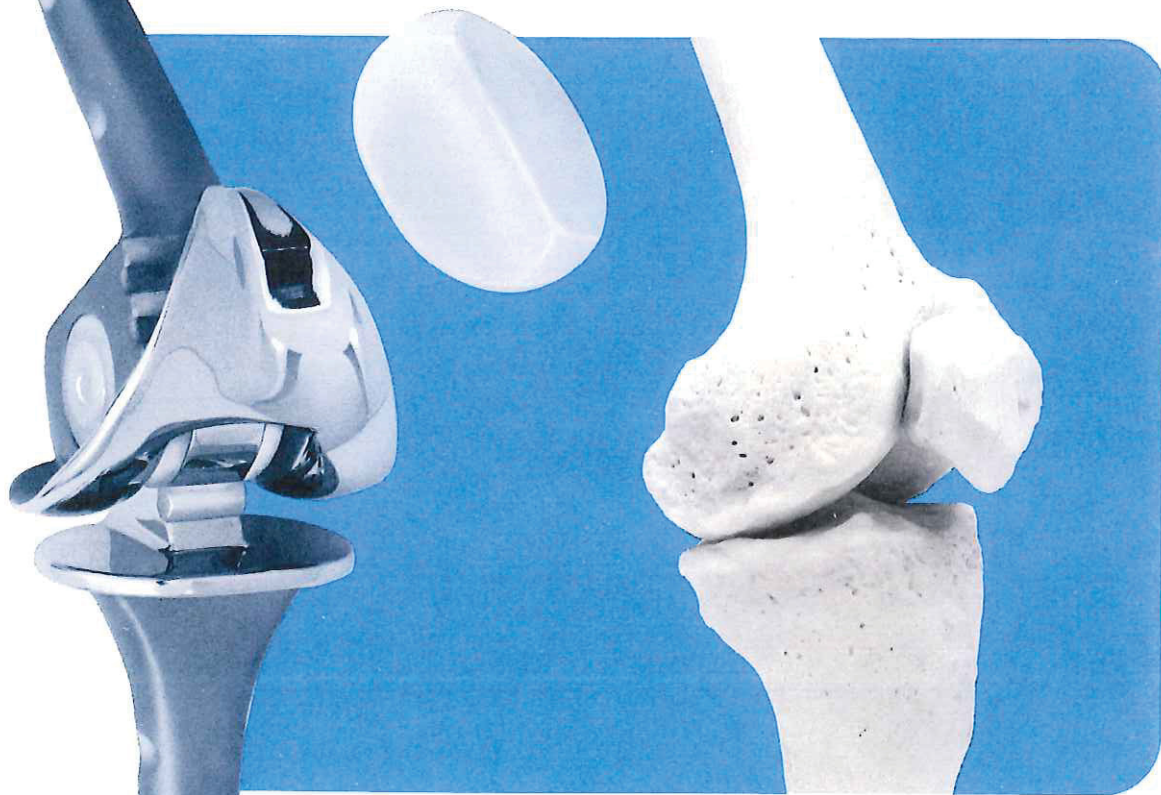


Richards Intracondylar Knee



Another Alternative

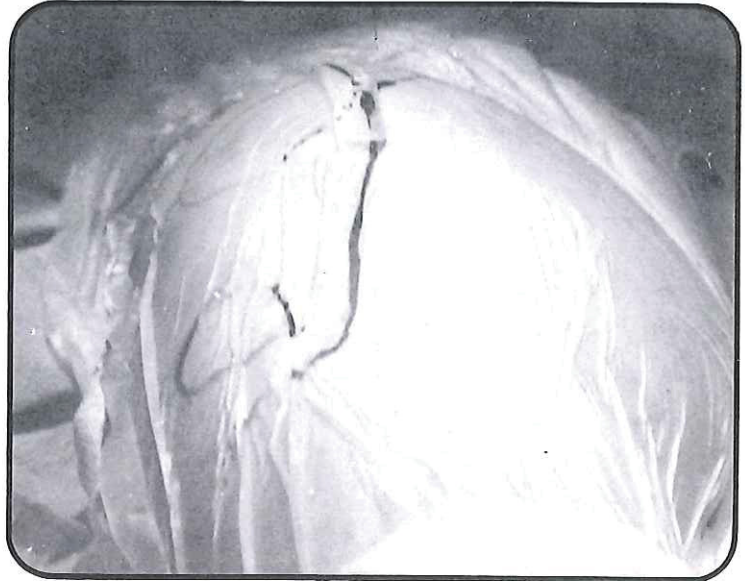
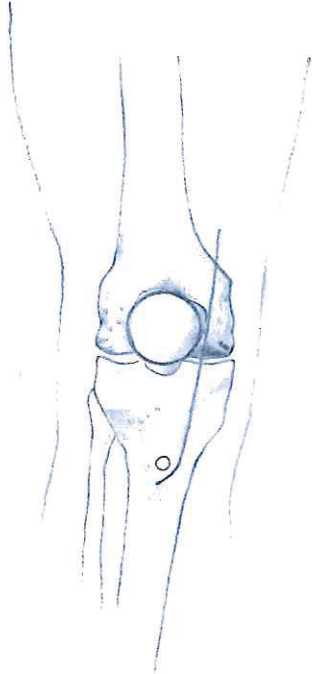


Richards Intracondylar Knee

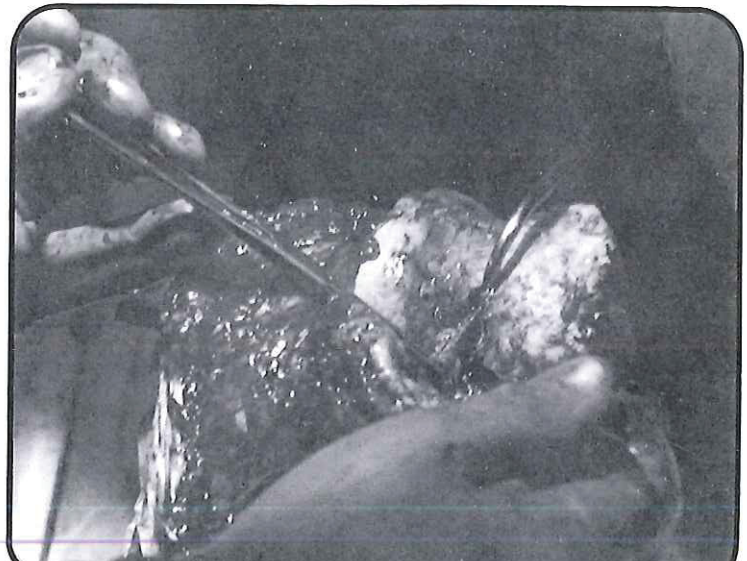
Technique as described by Charles O. Bechtol, M.D., Los Angeles, California



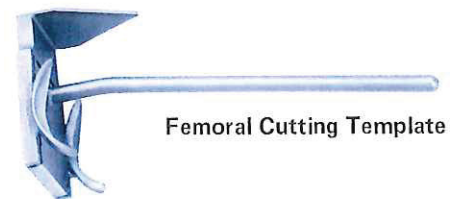
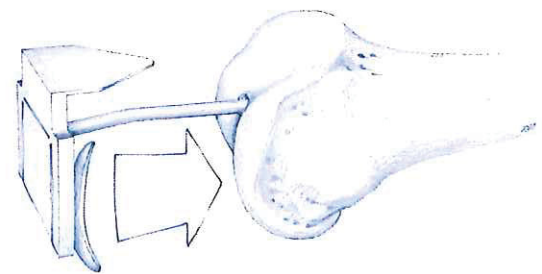
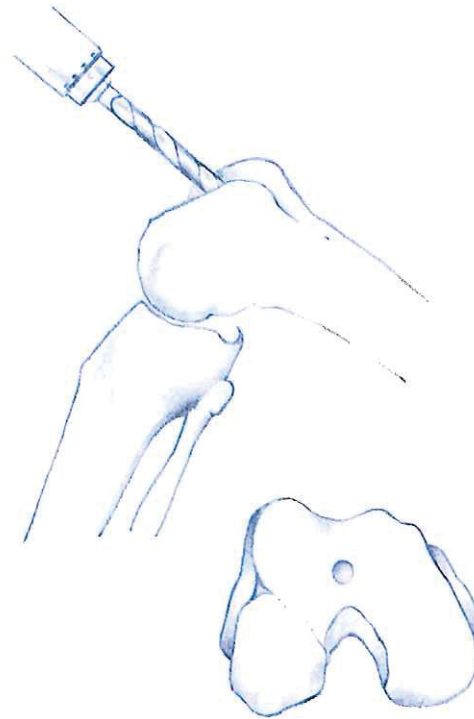
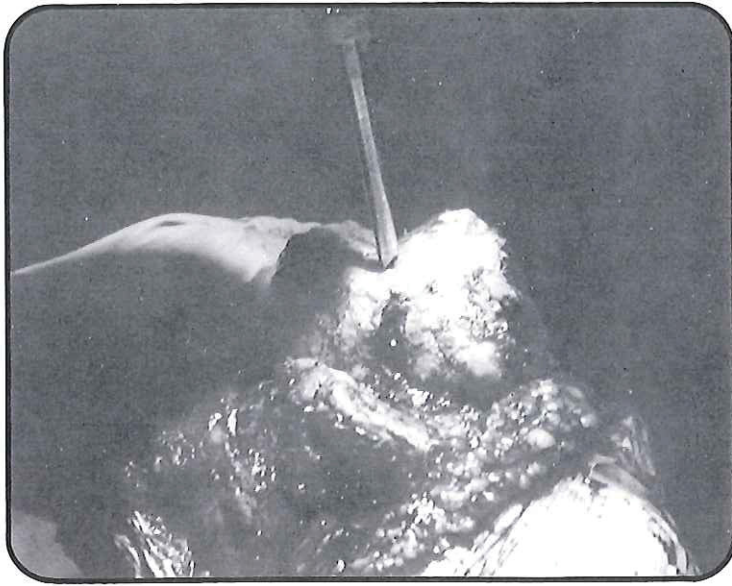
1. After routine skin preparation, the leg is draped in the usual manner. If a tourniquet is used, the leg is exsanguinated with a Tourniwrap™; with the knee in 60° to 90° flexion, the tourniquet is inflated. A median para-patellar incision is recommended.



2. After dissection and joint debridement, the knee is flexed to 90°. All osteophytes on the tibia, femur and patella should be removed. The medial and lateral collateral ligaments should be divided at their origin from the femur. The cruciate ligaments should be divided. This allows improved exposure of both tibial and femoral surfaces. The capsule must be freed laterally and posteriorly to allow good mobility of both femur and tibia.

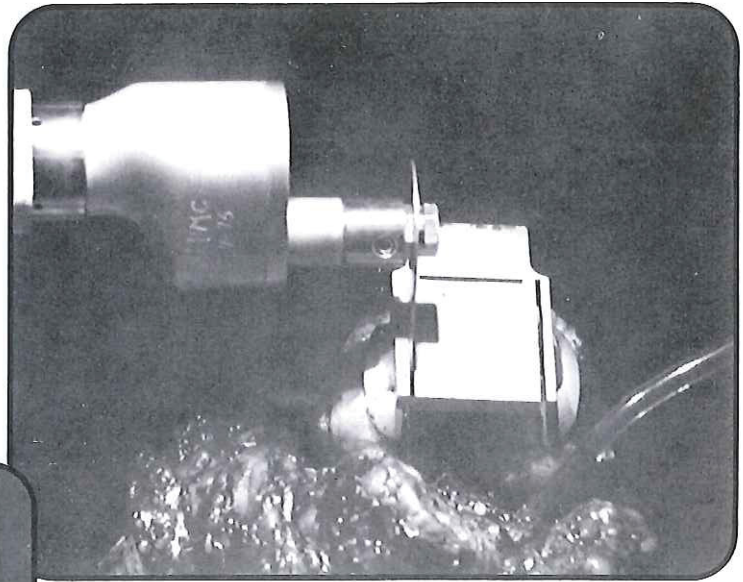
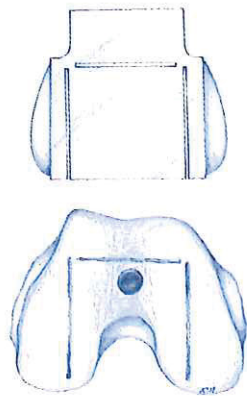


3. A 5/16'' diameter hole is drilled directly up into the femoral shaft through the central patellar facet of the femur.



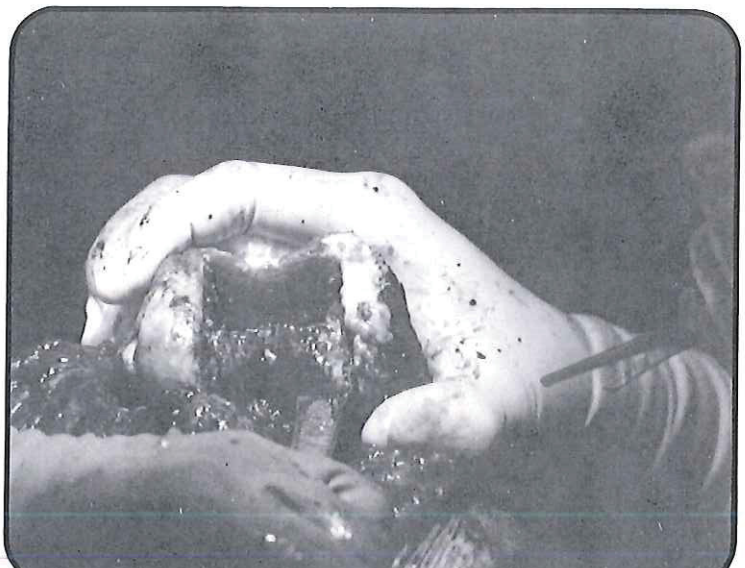
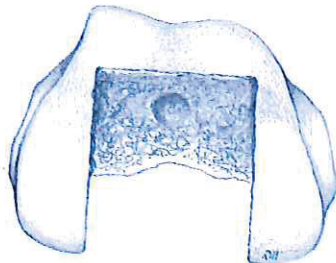
4. The Femoral Cutting Guide is inserted completely into the hole with the V-shaped portion of the guide positioned anteriorly on the femur.

5. The Femoral Cutting Guide has cutting slots to guide a power saw or thin-bladed osteotome. The slots are spaced apart the same width as the femoral component.



6. Once the initial cuts have been made, the Femoral Cutting Guide is removed and the cuts are completed. The saw blade should be kept cool with saline.

7. It is necessary to remove the posterior cortex layer of the femoral condyles the same width as the guiding cuts.



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