Aviator™
Anterior Cervical Plating System
Surgical Technique

- Visual and Tactile Confirmation
- Increased Angulation
- Simplified Instrumentation
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System Overview

The Aviator™ anterior cervical plating system offers a unique double screw locking mechanism, a high degree of screw angulation and simplified instrumentation.

The primary screw locking mechanism is a spring-loaded bar, which is designed to automatically lock over the screw heads. Rotation of the blocker locks the spring bar in place and allows for additional visual and tactile feedback that the screws are locked.

This system provides variable angle screws that offer 20° of screw angulation and allow semi-constrained bone screw fixation. The screws are designed with a square head to facilitate engagement with the instrumentation and to reduce chance of stripping.

Instrument options further enhance surgical technique versatility by matching surgeon preference regarding approach and screw pathway preparation.

The Aviator™ plate is made of Titanium Alloy (Ti-6Al-4V) and is 2.5mm thick and 17.4mm wide.

The lordotic curve, or radius of curvature, in the sagittal plane is 190mm for one- and two-level plates, and 390mm for three- and four-level plates. The plate also features 25mm of curvature in the axial plane for matching of the patient’s anatomy. The large graft-viewing windows allow for visualization of the endplates to aid in graft positioning.
Screw Types

The Aviator™ system features variable angle bone screws that utilize a spherical head allowing increased angulation against the plate.

Screws are offered as self-tapping, which feature a cutting flute and a less aggressive screw tip, and self-drilling, which have been designed with a sharp tip for insertion without prior drilling.

Screw Sizes

Aviator™ screws are available in 4.0mm and 4.35mm diameters and are color-coded for easy identification.

Screw Angulation

Cephalad/Caudal Angulation In-situ

Variable screws have a wide range of variability in their degree of cephalad/caudal orientation.

Middle holes: 0° neutral with +/- 10° of variability
End holes: +2° to +20°

Medial/Lateral Convergence In-situ

When screws are inserted into the plate they can have the following degrees of convergence beneath the plate.

End holes: 6° neutral with +/- 5° of variability
Middle holes: 6° neutral with +/- 5° of variability
Patient Positioning and Exposure

Patient is placed in a supine position with the head turned slightly away from the side of the approach. For one- or two-level procedures, a transverse incision parallel to the skin creases of the neck is recommended. For longer level procedures, one can choose to do a transverse or oblique incision placed along the anterior border of the sternocleidomastoid. The left side is preferred, as the more constant course of the recurrent laryngeal nerve on this side potentially minimizes the risk of its injury. After blunt dissection through the various tissue layers, the anterior cervical spine is gently exposed.

The implantation of the anterior cervical plate follows a discectomy or a corpectomy, including an appropriate interbody/bone graft insertion.

Care should be taken to remove any bony anatomy or osteophytes which would inhibit the Aviator™ plate from sitting flat against the bone.
Implant Selection and Preparation

The sizing of Aviator™ plates is measured from the center of the cephalad hole to the center of the caudal hole. Using the Caliper, measure the distance between the center points of the appropriate vertebrae and select the corresponding plate. In cases in which the measured distance falls between two sizes, it is usually recommended that the smaller size be used. A plate that is too long may interfere with the adjacent disc space. Regardless of the plate size selected, the screws must be inserted with the correct amount of screw angulation. A Plate Holder is available to hold the plate next to the vertebral column to confirm size selection.

Hold the Plate Holder at the bend and attach to the narrow sides of the plate. Squeeze the Plate Holder until it clicks one time to lock to the plate. Squeeze the Plate Holder a second time to release the plate from the Plate Holder.
The Aviator™ plate has been designed with a slight sagittal and axial bend for matching of a patient’s anatomy. If additional sagittal plate contouring is necessary, the Plate Bender may be used.

The Plate Bender has two sides: (+) which will increase lordosis and (-) which will decrease lordosis. Position the plate face-up to increase lordosis or face-down to decrease lordosis. Insert the plate on the appropriate side of the Plate Bender so that the axial curve of the plate matches the curve in the slot. The plate should fit between the two notches on either side of the slot, so that bending only occurs in the graft windows. Bend plates incrementally to help match patient anatomy.

Note: Do not bend plates over the screw holes or the spring bar.

Note: Due to the notch sensitivity of titanium, the plate must never be unbent or reverted to its original shape once it has been contoured.

To remove the plate from the Plate Bender, hold the plate in one hand while releasing the handle with the other hand.

Temporary Fixation Pins are available to hold the plate during screw hole preparation. Load the Temporary Fixation Pin onto the Temporary Fixation Pin Inserter by pulling up the sleeve of the inserter. Position the pin in the center of the screw hole. Apply slight downward pressure while threading the pin into the screw hole. When fully inserted, the pin can penetrate the bone up to 9.5mm. Placement of two pins diagonally from each other is recommended for stabilization of the plate on the anterior vertebral column. Remove the Temporary Fixation Pins after the plate is sufficiently stabilized with screws.

Note: Excessive pivoting or angulation on the Temporary Fixation Pin Inserter should be avoided, as it can cause fracturing of the Temporary Fixation Pins. Temporary Fixation Pins are recommended for single-use only.*

* The Aviator™ Temporary Fixation Pins are made of titanium alloy (Ti-6Al-4V) implantable-grade material.
Plate blockers should be in the unlocked position before attempting to prepare the screw hole.

If self-tapping screws are selected, use the Single Barrel Drill Guide to guide the appropriate Drill Bit. If self-drilling screws are used, use either the Punch Awl or a Drill Bit and the Single Barrel Drill Guide to center and direct the pathway of the screw.

Drilling Technique

Drill Bits, which are available in 2.5mm diameter and four sizes (10, 12, 14, 16mm), corresponding to the screw lengths, provide a positive stop for accurate drilling depth in combination with any of the guides. A Tap is available in one pre-set depth (10mm). To create the screw thread pattern, rotate the Tap until it contacts the plate.

The Drill Bit and Tap can each be attached to the Quick Release Handle.
The **Variable Single Barrel Drill Guide** is designed to direct the screw trajectory within the range to ensure optimal functioning of the spring bar.

The tip of the **Variable Single Barrel Drill Guide** has a spherical shape which allows it to angulate on the plate within the allowed range:

**Sagittal plane**
- Middle holes: 0° neutral with +/- 10° variability
- End holes: +2° to +20°

**Axial Plane**
- 6° neutral with +/- 5° of variability

Position the bone screws within the recommended range of angulation to ensure secure locking of the screws within the plate.

**Note:** The drill guide must be engaged securely to the plate prior to screw hole preparation.

The drill guide directs the **Drill Bit** to prepare the screw pathway. The drill guide provides a positive “snap” when inserted into the screw hole in the plate. A slight downward pressure should be applied to the drill guide to keep it in the correct position during drilling.

The drill guide needs to be removed for tapping and/or screw insertion. To disengage, rock the drill guide slightly while lifting the instrument from the plate. Forcing the drill guide straight into or out of the screw hole should be avoided.

**Caution:** Do not apply cantilever loads while the drill is engaged in the bone.
**Punch Awl Technique**

As an alternative to the drill guide, the **Punch Awl** may be used to center and direct the pathway of the self-drilling screws. When fully deployed, the **Punch Awl** can penetrate up to 8mm of bone.

The **Variable Punch Awl Sleeve** is threaded onto the **Punch Awl** shaft and is designed to seat into the screw hole of the plate, and to provide the **Punch Awl** the correct range of angulation for variable screws.

**Note:** Do not use the **Punch Awl** without a **Punch Awl Sleeve**.

The awl should be in the locked position so as to avoid prematurely engaging the awl tip into the bone. The button is positioned in the bottom key hole of the collar when in the locked position.

With the **Punch Awl Sleeve** assembled to the **Punch Awl** shaft, the **Punch Awl** will snap into the screw hole in the same manner as the **Variable Single Barrel Drill Guide**. Position the awl for the desired screw trajectory. Depress the button to unlock the tip, and then apply downward pressure to penetrate the bone. A slight rocking motion facilitates disassembly. Rotate the awl while applying upward force to remove.

**Caution:** Do not apply cantilever loads while the **Punch Awl** is engaged in the bone.

Press the sleeve button again to return the awl sleeve to the locked position prior to engaging the awl into an additional screw hole.

**Note:** Using the **Punch Awl** is strongly recommended when self-drilling screws are used, as it helps to provide an optimal screw trajectory.

Following screw hole preparation, select the appropriate screw and confirm its length using the **Screw Depth Gauge** in the screw tray. The screw size indicates the actual amount of screw purchase in the bone below the bottom surface of the plate (i.e. a 14mm screw protrudes 14mm below the plate, while the screw head is contained within the screw hole).
Bone Screw Insertion

Screws may be placed using either the Retaining Screwdriver or the Quick Turn Screwdriver.

The Retaining Screwdriver features a square drive with a split tip to hold the screw head securely. Using the screw tray to load the screws, depress the square screwdriver tip into the recessed square of the screw head.

Drive the bone screws until they are past the spring bar, which is designed to flex away from the screw as it progresses into the bone.

Inserting the screws sequentially at opposite corners of the plate, working toward the center of the plate, helps keep the plate flat against the bone.

Screws are fully seated once the spring bar has returned to its original position and covers the screw head. Gently pull back on the screwdriver to release the screw after insertion.

Screws may also be inserted using the Quick Turn Screwdriver. To load the screws, ensure the Quick Turn Screwdriver is fully seated into the square drive of the bone screws, and tighten the Draw Rod until resistance is felt. This is designed to be approximately five to seven turns. Do not over-tighten the Draw Rod.

To remove the Quick Turn Screwdriver, unthread the Draw Rod completely, and gently remove the screwdriver from the bone screw.

Note: The Draw Rod is used with both the Quick Turn Screwdriver and the Rescue Driver.
Locking the Screws

When screws are fully inserted within the allowed range of angulation, the spring bar can then expand over the screw head.

Once the spring bar is positioned over the screw heads, the blocker should be rotated to secure the spring bar over the screws. Using the Solid Screwdriver Shaft, rotate the blocker clockwise 180° until the blocker tab is facing between the screw heads. Tension will begin to be felt as the tab reaches the locked position. This must be done for each level of screws on the plate.

**Note:** As the blocker is rotated, the spring bar may advance further over the screw heads to its final position.

Locking is confirmed when the gold tab on the blocker is aligned with the groove located between the two screws.

**Note:** If excessive force is applied, the blocker can rotate past the groove. If this occurs, rotate the blocker counterclockwise so that it realigns with the groove.

**Note:** Be sure to confirm that both screws are below the spring bar before attempting to tighten a blocker.

**Note:** If the blocker cannot be rotated 180°, the bone screws have not been driven far enough below the spring bar and need to be driven further.

**Tip:** While any of the screwdrivers can be used to lock the blocker, the Solid Screwdriver Shaft is optimized for ease of attachment.

Screw must be below the spring bar before locking the blocker.
The **Rescue Driver** allows for removal of bone screws in a previously locked plate. The square tip of the **Rescue Driver** allows for a rigid attachment to the screw, while the protruding foot deflects the spring bar away from the screw to facilitate removal.

The **Draw Rod** or inner shaft threads into the screw head providing a rigid attachment to the screw and ensuring that the **Rescue Driver** sits flat on the screw so that the foot can engage the spring bar.

To begin removal of the screw, unlock the blocker using either the **Solid Screwdriver Shaft** or the square head of the **Rescue Driver**. Rotate the blocker 180° counterclockwise until you feel a positive stop. This will unlock the spring bar and allow it to move.

**Note:** The blockers must be unlocked before attempting to back out a screw which has been seated underneath a spring bar.

Insert the shaft of the **Rescue Driver** into the screw head with the protruding foot facing 180° away from the spring bar.

**Tip:** The groove along the shaft of the driver aligns with the rounded foot and can be used to assist in proper positioning of the **Rescue Driver**.
Align the **Rescue Driver** with the screw trajectory to seat the square head of the driver into the screw head. Ensure that the driver is fully seated into the screw head before inserting the draw rod. Maintaining alignment, thread the draw rod until it is finger tight (approximately 10-12 turns).

**Note:** The **Draw Rod** must be threaded completely before attempting to extract the screw. If you do not feel the Draw Rod tighten, remove the Rescue Driver and reposition it so that the square head of the Rescue Driver is fully seated in the screw head.

**Caution:** If the Rescue Driver is not properly seated while attempting to back out the screw, the spring bar may deform to allow the screw to pass.

Rotate the **Rescue Driver** counterclockwise so that the rounded foot deflects the spring bar away from the screw head, as the screw is simultaneously being backed out of the bone.

The locking mechanism of the Aviator™ system has been tested to ensure that a screw inserted into a previously used screw hole will be securely locked.* The spring bar can be locked and unlocked for the implantation of a rescue screw. However, repeated screw insertion through the plate should be avoided as its function may have been compromised. A maximum of two bone screw insertions is recommended for any level within a plate.

**Note:** If an implant is suspected damaged or defective, e.g. the spring bar is deformed, it must be replaced.

*Data on file at Stryker Spine (Ref. DHF0000015820).
### Implants

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Aviator™ Anterior Cervical Plating System

IMPORTANT PRODUCT INFORMATION FOR STRYKER SPINE AVIATOR™ ANTerior CERVical Plating System
NON STERILE PRODUCT

DESCRIPTION
The Stryker Spine Aviator™ Anterior Cervical Plating (ACP) System consists of bone plates that are available in a variety of sizes, in order to help accommodate individual patient physiology and pathology and to help facilitate anterior stabilization of the cervical spine. The Aviator™ plates are intended to be used with the Aviator™ bone screws. The Aviator™ ACP System is intended for unilateral fixation.

MATERIAL
The components of the Aviator™ ACP System are manufactured out of Titanium alloy as defined in the ISO 5832-3 and ASTM F136 standards.

INDICATIONS
The Aviator™ Anterior Cervical Plating System is intended for anterior intervertebral screw fixation of the cervical spine at levels C2-T1. The system is indicated for temporary stabilization of the anterior spine during the development of cervical spine fusions in patients with the following indications:

• Degenerative Disc Disease (as defined by neck pain of discogenic origin with degeneration of the disc confirmed by patient history and radiographic studies)
• Trauma (including fractures)
• Tumors
• Deformities or curvatures (including kyphosis, lordosis, or scoliosis)
• Pseudarthrosis
• Failed previous fusion
• Decompression of the spinal cord following total or partial cervical vertebrectomy
• Spondylolisthesis
• Spinal lolisthesis

WARNING: This device is not approved or intended for screw attachment to the posterior elements (pedicles) of the cervical, thoracic or lumbar spine.

CAUTION
Based on the fatigue testing results, the physician/surgeon must consider the levels of implantation, patient weight, patient activity level, other patient conditions, etc. which may impact on the performance of the system.

GENERAL CONDITIONS OF USE
Before clinical use, the surgeon must thoroughly understand all aspects of the surgical procedure and limitations of the spinal device. Knowledge of surgical techniques, proper reduction, selection and placement of implants, and pre- and post-operative patient management are considerations essential to a successful surgical outcome. Consult the medical literature for information regarding proper surgical techniques, precautions, and potential adverse effects associated with spinal fixation surgery.

Do not substitute another manufacturer’s device for any component of the Aviator™ ACP System. Any such use will negate the responsibility of Stryker Spine for the performance of the resulting mixed component implant.

Do not mix metals (i.e. Titanium based devices with stainless steel items). Some corrosion occurs on all implanted metals and alloys. Contact of dissimilar metals, however, may accelerate corrosion. Corrosion may accelerate fatigue fracture of implants, and cause metal compounds to be released into the body.

ANATOMICAL LIMITATIONS
• The Aviator™ ACP System is intended for use in the cervical spine only. However, as with any orthopaedic implant, even when an implant’s design does not expressly contraindicate its placement in a particular area, the surgeon may encounter certain patient physiologies which impose their own unique anatomic limitations.
• Anterior cervical plates are designed for use in the cervical region of the spine only and must not be used below T1.

CONTRA-INDICATIONS
• Marked local inflammation.
• Any mental or neuromuscular disorder which would create an unacceptable risk of fixation failure or complications in postoperative care.
• Bone stock compromised by disease, infection or prior implantation which cannot provide adequate support and/or fixation to the devices.
• Bony abnormalities preventing safe screw fixation.
• Open wounds.
• Rapid joint disease, bone absorption, osteopenia, osteomalacia, and/or osteoporosis. Osteoporosis or osteopenia are relative contraindications, since this condition may limit the degree of obtainable correction and/or the amount of mechanical fixation.
• Metal sensitivity, documented or suspected.
• Pregnancy.
• Anytime implant utilization would interfere with anatomical structures or physiological performance.
• Inadequate tissue coverage over the operative site.

Other medical or surgical conditions which would preclude the potential benefit of surgery, such as congenital abnormalities, immunosuppressive disease, elevation of sedimentation rate unexplained by other diseases, elevation of white blood count (WBC), or marked left shift in the WBC differential count.

These contra-indications can be relative or absolute and must be taken into account by the physician when making his/her decision. The above list is not exhaustive.

INFORMATION FOR PATIENT
The surgeon must discuss all physical and psychological limitations inherent to the use of the device with the patient. This includes the rehabilitation regimen, physical therapy, and wearing an appropriate orthosis as prescribed by the physician. Particular discussion must be directed to the issues of premature weightbearing, activity levels, and the necessity for periodic medical follow-up.

The surgeon must warn the patient of the surgical risks and made aware of possible adverse effects. The surgeon must warn the patient that the device cannot and does not replicate the flexibility, strength, reliability or durability of normal healthy bone, that the implant can break or become damaged as a result of strenuous activity or trauma, and that the device may need to be replaced in the future. If the patient is involved in an occupation or activity which applies inordinate stress upon the implant (e.g., substantial walking, running, lifting, or muscle strain) the surgeon must advise the patient that resultant forces can cause failure of the device. Patients who smoke have been shown to have an increased incidence of non-unions. Such patients must be advised of this fact and warned of the potential consequences. For diseased patients with degenerative disease, the progression of degenerative disease may be so advanced at the time of implantation that it may substantially decrease the expected useful life of the appliance. In such cases, orthopaedic devices may be considered only as a delaying technique or to provide temporary relief.

PRE-OPERATIVE PRECAUTIONS
The surgical indication and the choice of implants must take into account certain important criteria such as:

• Patients involved in an occupation or activity which applies inordinate stress upon the implant (e.g., substantial walking, running, lifting, or muscle strain) may be at increased risk for failure of the fusion and/or the device.
Aviator™ Anterior Cervical Plating System

• Surgeons must instruct patients in detail about the limitations of the implants, including, but not limited to, the impact of excessive loading through patient weight or activity, and be taught to govern their activities accordingly. The procedure will not restore function to the level expected with a normal, healthy spine, and surgeons should counsel patients not to have unrealistic functional expectations.

• A condition of senility, mental illness, chemical dependence or alcoholism. These conditions among others may cause the patients to ignore certain necessary limitations and precautions in the use of the implant, leading to failure and other complications.

• Foreign body sensitivity. Where material sensitivity is suspected appropriate tests must be made prior to material implantation.

• Patients who smoke have been shown to have an increased incidence of non-unions. Such patients must be advised of this fact and warned of the potential consequences.

• Care must be taken to protect the components from being marred, nicked, or notched as a result of contact with metal or abrasive objects. Alterations will produce defects in surface finish and internal stresses which may become the focal point for eventual breakage of the implant.

THE CHOICE OF IMPLANTS
The choice of proper shape, size and design of the implant for each patient is crucial to the success of the surgery. The surgeon is responsible for this choice which depends on each patient.

The size and shape of the bone structures determine the size, shape and type of the implants. Once implanted, the implants are subjected to stresses and strains. These repeated stresses on the implants must be taken into consideration by the surgeon at the time of the choice of the implant, during implantation as well as in the post-operative follow-up period. Indeed, the stresses and strains on the implants may cause metal fatigue or fracture or deformation of the implants, before the bone graft has become completely consolidated. This may result in further side effects or necessitate the early removal of the osteosynthesis device.

INTRA-OPERATIVE PRECAUTIONS
• The insertion of the implants must be carried out using instruments designed and provided for this purpose and in accordance with the specific implantation instructions for each implant. Those detailed instructions are provided in the surgical technique brochure supplied by Stryker Spine.
• Discard all damaged or mishandled implants.

• Stryker Spine implants must not be reshaped, unless otherwise indicated in the surgical technique instructions. When implants need to be bent, the bending must be carried out gradually using the appropriate instruments, provided by Stryker Spine. The use of inappropriate instruments may result in scratches, notches, and sharp bending, causing the breakage of the implants. Improper seating of the implant may result in implant failure.
• Never reuse an implant, even though it may appear undamaged.
• Do not mix metals.

POST-OPERATIVE PRECAUTIONS
Physician instructions regarding full weight-bearing activities must be complied with until maturation of the fusion mass is confirmed. Failure to comply with physician instructions may result in failure of the implant, the fusion, or both.

SIDE EFFECTS
Include but are not limited to:
• Late bone fusion or no visible fusion mass and pseudarthrosis;
• Peripheral neuropathies, nerve damage, heterotopic bone formation and neurovascular compromise, including paralysis;
• Superficial or deep-set infection and inflammatory phenomena;
• Allergic reactions to the implanted materials although uncommon can occur;
• Metal sensitivity of allergic reactions to a foreign body have been reported, possibly leading to tumor formation;
• Decrease in bone density due to stress shielding;
• Neurological and spinal dura mater lesions from surgical trauma;
• Dural leak requiring surgical repair;
• Asymptomatic presence of microparticles may be observed around the implants as a result of interaction between the components as well as between the component and bone (i.e. wear);
• Cessation of growth of the fused portion of the spine;
• Loss of proper spinal curvature, correction, height and/or reduction;
• Pain, discomfort, or abnormal sensations due to the presence of the device;
• Early loosening may result from inadequate initial fixation, latent infection, premature loading of the device or trauma. Late loosening may result from trauma, infection, biological complications or mechanical problems, with the subsequent possibility of bone erosion, or pain.
• Serious complications may occur with any spinal surgery. These complications include, but are not limited to,
genitourinary disorders; gastrointestinal disorders; vascular disorders, including thrombus; bronchopulmonary disorders, including emboli; bursitis, hemorrhage, myocardial infarction, infection, paralysis or death.
• Inappropriate or improper surgical placement of this device may cause distraction or stress shielding of the graft or fusion mass. This may contribute to failure of an adequate fusion mass to form.
• Intraoperative fissure, fracture, or perforation of the spine can occur due to implantation of the components. Postoperative fracture of bone graft or the intervertebral body above or below the level of surgery can occur due to trauma, the presence of defects, or poor bone stock.

Adverse effects may necessitate reoperation.

REMOVAL
• Stryker Spine devices are indicated for treatment of fracture or stabilization of a surgical site during the normal bone consolidation process. After this period, the presence of the device is no longer strictly required and its removal can be planned. Removal may also be necessary as a result of the above mentioned adverse effects.
• Removal of an ACP System may require special instruments to disengage the implant from the vertebrae. Appropriate recommendations are provided in the Surgical Technique brochure.
• Any decision by a physician to remove the internal fixation device must take into consideration such factors as the risk to the patient of the additional surgical procedure as well as the difficulty of removal.

PACKAGING
• The implants are delivered in packages; these must be intact at the time of receipt.
• The systems are sometimes supplied as a complete set: implants and instruments are arranged on trays and placed in specially designed storage boxes.

FURTHER INFORMATION
A surgical technique brochure is available on request through your Stryker agent or directly from Stryker Spine. Users with brochures that are over two years old at the time of surgery are advised to ask for an updated version.

CAUTION
Federal law (U.S.A.) restricts this device to sale by or on the order of a licensed physician.
COMPLAINTS

Any health professional having a complaint or grounds for dissatisfaction relating to the quality of the product, its identity, its durability, its reliability, safety, effectiveness and / or its performance, should notify STRYKER Spine or its representative. Moreover, if a device has malfunctioned, or is suspected of having malfunctioned, STRYKER Spine or its representative must be advised immediately. If a STRYKER Spine product has ever worked improperly and could have caused or contributed to the death of or serious injury to a patient, the distributor or STRYKER Spine must be informed as soon as possible by telephone, fax or in writing.

For all complaints, please give the name and reference along with the batch number of the component(s), your name and address and an exhaustive description of the event to help STRYKER Spine understand the causes of the complaint.

For further information or complaints, please contact:

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A surgeon must always rely on his or her own professional clinical judgment when deciding whether to use a particular product when treating a particular patient. Stryker does not dispense medical advice and recommends that surgeons be trained in the use of any particular product before using it in surgery.

The information presented is intended to demonstrate the breadth of Stryker product offerings. A surgeon must always refer to the package insert, product label and/or instructions for use before using any Stryker product. Products may not be available in all markets because product availability is subject to the regulatory and/or medical practices in individual markets. Please contact your Stryker representative if you have questions about the availability of Stryker products in your area.

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