

EPF™ Xpress

Endoscopic Plantar Fasciotomy

Operative technique



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This publication sets forth detailed recommended procedures for using Stryker devices and instruments.

It offers guidance that you should heed, but, as with any such technical guide, each surgeon must consider the particular needs of each patient and make appropriate adjustments when and as required.

A workshop training is recommended prior to first surgery.

Please remember that the compatibility of different product systems have not been tested unless specified otherwise in the product labeling.

For additional information please refer to the instructions for use (IFU), Ref. V15207 with each instrument. The surgeon must discuss all relevant risks, including the finite lifetime of the device, with the patient, when necessary.

Introduction

The EPF Xpress system is designed for the treatment of plantar fasciosis. The EPF Xpress system is a minimally invasive surgical technique for chronic plantar fasciitis (fasciosis).

Operative technique

Step 1

Plan your medial skin incision portal.

Using thumb, palpate the calcaneal tubercle or exostosis.

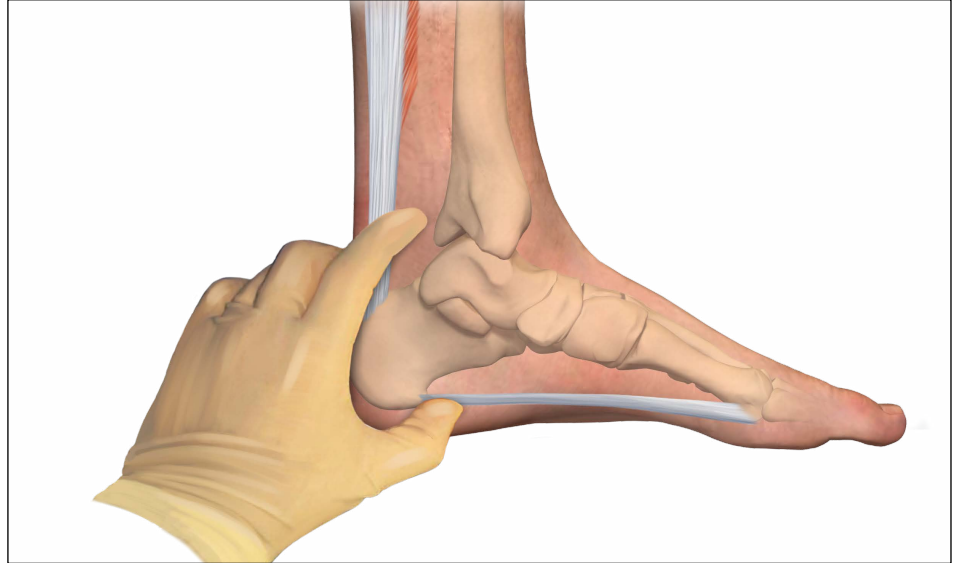


Figure 1

Step 2

A vertical skin marking is made 1-3mm distal of the tubercle.

Using a ruler, measure dorsal 17mm from the patient's plantar aspect. Make a horizontal mark bisecting vertical marking. This represents a focal point for medial portal incision.

A 5mm superficial incision is made at this location with a #15 blade.

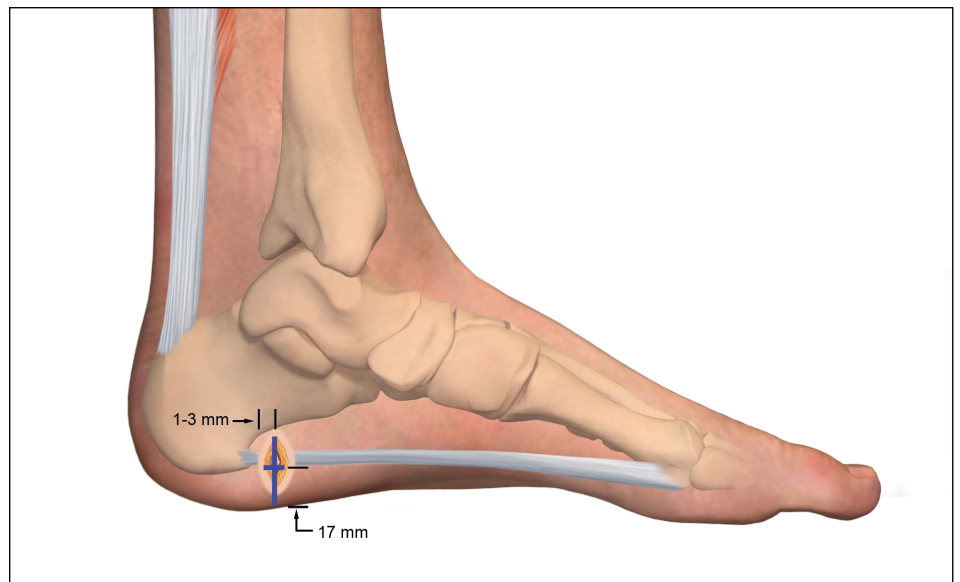


Figure 2

Step 3

Using small blunt dissecting scissors, separate the subcutaneous fat creating a portal.



Figure 3

Step 4

Introduce the fascial elevator into the incision palpating the medial aspect of the plantar fascia.

Advance the elevator across the interior aspect of the fascia, tenting the lateral aspect and creating a channel for introduction of the obturator/cannula.

Remove the fascial elevator applying gentle dorsal pressure. The fascial elevator will "drop-off" the medial investment of the fascia when exiting the medial portal. This confirms that the fascial elevator is inferior to the fascia.



Figure 4

Step 5

Introduce the obturator/cannula assembly in a similar manner.

Once the tip of the obturator is palpated on the lateral aspect, make a small vertical incision over the tip so the obturator can pass through the soft tissue.

Remove obturator.

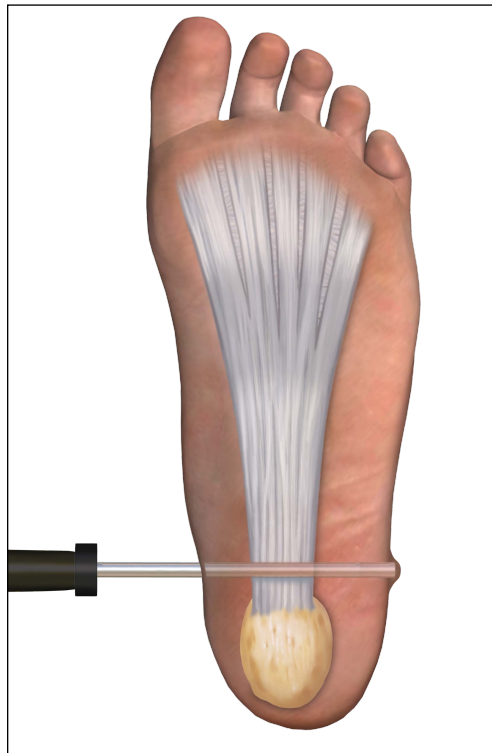


Figure 5

Step 6

Introduce a 4.0mm, 30 degree beveled scope in the medial portal and the hook blade in the lateral portal. Advance hook blade medially across the fascia engaging the medial bland edge.

The double banded cannula marking represents approximately where the medial fascia release begins and the single marking represents the location the fascia release should be stopped.

Withdraw the hook blade laterally, transecting the medial 1/3 of the plantar fascia. Release any remaining fascia fibers.

Visualization of the intrinsic muscle belly beneath the fascia will confirm a complete release.

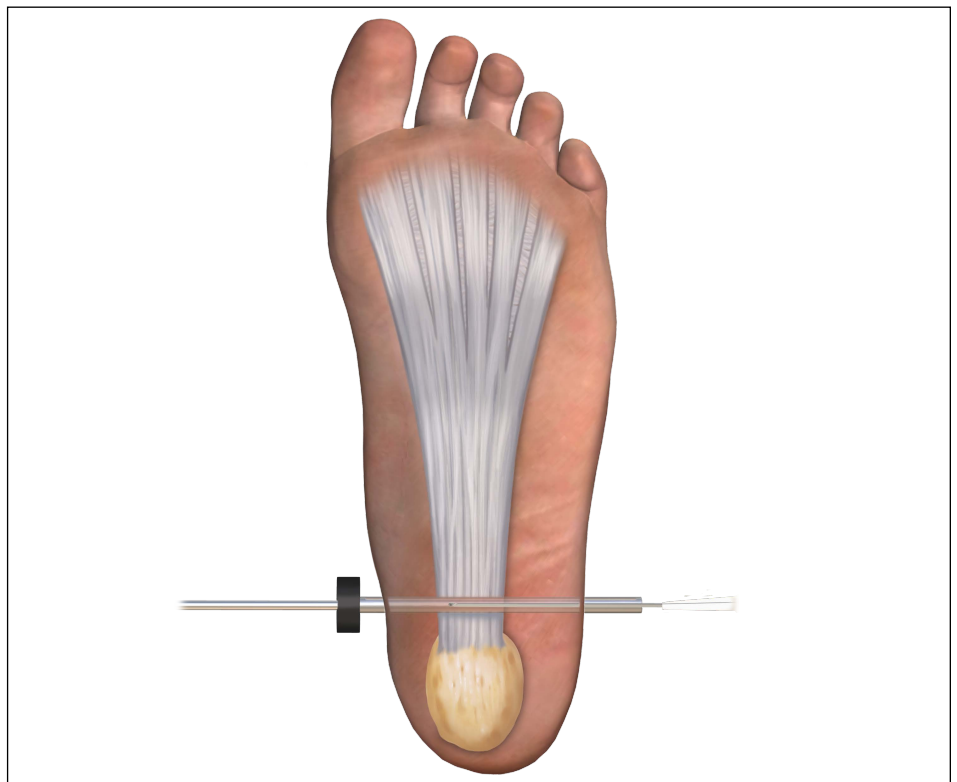


Figure 6

Step 7

Medial 1/3 fascia released.

Skin closure is achieved with simple interrupted 5-0 nylon or prolene.

3cc of 0.5% Marcaine plain, and 1cc of dexamethasone phosphate are then placed into the surgical site.

Wrap the foot in a small compressive gauze dressing then place in a surgical shoe.



Figure 7

Post operative management

Patients may remove the dressing the next morning after surgery and shower regularly, but are prohibited from immersing the foot, until one week after sutures are removed. Sutures are removed 10-14 days after surgery.

Patients should apply a bandage and wear a comfortable regular shoe. If the patient cannot tolerate a regular shoe, they can continue in a surgical shoe.

Patients should not be on their foot in regular shoes more than 5 minutes per hour during the first 4-6 weeks, or once the fascia has healed. If they require more time on their feet, it is recommended they wear a cast boot.

Patients are encouraged to begin gentle stretching the day after surgery.

Patients are also counseled to avoid stair climbing, time on ladders and other stressful activity until 8 weeks post op.

Running and high impact sports are to be avoided for 8-12 weeks, based on how the patient is progressing.

Foot & Ankle

This document is intended solely for the use of healthcare professionals. 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 a Stryker product. A surgeon must always refer to the package insert, product label and/or instructions for use, including the instructions for Cleaning and Sterilization (if applicable), 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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