

Why an **Oxford** Partial Knee?

Key Points & Clinical Rationale

When assessing the choice of partial or total knee arthroplasty, it is important to understand the benefits of each option. Clinical evidence in published literature suggests that there are several potential clinical benefits with choosing a partial knee: long term results, early return to function,* more natural motion,* and reproducible technique.



The Oxford Partial Knee is intended for use in individuals with osteoarthritis or avascular necrosis limited to the medial compartment of the knee and is intended to be implanted with bone cement.

Long-term Oxford Partial Knee Results

Kaplan Meier Survivorship

- 94.0% at minimum 15 year postoperative based on 675 knees⁸⁻¹⁰
- 91.0% at minimum 20 year postoperative based on 11 knees⁸

*As compared to total knee replacement.

With over 35 years' clinical experience, the Oxford Partial Knee is the most widely used¹ and proven partial knee system in the world.

- A multi-center study found that Oxford PKR patients were 1.8 times more likely to report that their knee felt normal and 2.7 times more satisfied with their ability to perform activities of daily living compared to TKA patients.²
- A survey³ showed that Oxford partial knee patients are happier with their knee replacements than total knee patients
- A multi-centre study demonstrated decreased morbidity and complications of PKA compared to TKA^{4**}
- Proven⁵, safe and reproducible technique¹
- Better functionality^{6**} and more natural motion⁷ compared to TKA
- Best-in-class continuous education program

Early Return to Function

Quicker Return to Low-impact Sports (bowl, dance, golf, cycle) than TKA¹¹

- Return to Sport was 96.7% in UKA vs. 63.6% in TKA
- Quicker Return to Sporting Activity after surgery: 3.6 months in the UKA group, and 4.1 months in the TKA group
- Less Pain during Sporting Activity: 24.1% reported pain in the UKA group and 42.9% in the TKA group

Quicker Recovery than TKA¹² (56 knees in 48 patients)

- Hospital Stay: 1.4 days to Discharge in UKA vs. 2.2 days in TKA (p <.05)
- Range of Motion at Discharge: 77° in UKA vs. 67° in TKA. (p <.05)
- Walking Distance at Discharge: 56.69 metres in UKA vs. 41.76 metres TKA (p <.05)

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More Natural Motion in Mobile vs. Fixed Partial Knees¹³

Closer approximation to normal knee kinematics

- Larger and more consistent tibial internal rotation ($p < .05$ in Mobile Bearing Oxford PKA vs. fixed bearing PKA at 90 degrees flexion)
- More consistent anterior/posterior translation of the medial femoral condyle ($p < .05$ in Mobile Bearing Oxford PKA vs. fixed bearing PKA at 90 degrees flexion)
- More consistent anterior/posterior translation of contact point ($p < .05$ in Mobile Bearing Oxford PKA vs. fixed bearing PKA at 90 degrees flexion)

Reproducible Technique¹⁴

Microplasty Instrumentation

- Provides surgeons with the tools to allow for precise and accurate results for each patient
- Spherical mill and spigots provide a simplified approach to balancing the flexion and extension gaps with precise 1 mm incremental bone removal
- The Femoral Drill Guide linked to the IM rod provides for accurate and reproducible alignment
- The Femoral Instrumentation has been shown to be more accurate and reproducible than Phase 3 Instrumentation

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Biomet does not practice medicine and does not recommend any particular orthopaedic implant or surgical technique and is not responsible for the kind of treatment selected for a specific patient. The surgeon who performs any implant procedure is responsible for determining and utilizing the appropriate techniques for implanting prosthesis in each individual patient.

The Oxford knee is contraindicated in patients with ligamentous insufficiency, osteoporosis, infection, rheumatoid disease, tibial plateau fracture, or marked bone loss. For full prescribing information, see the packet insert or Biomet's website.

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One Surgeon. One Patient.

References

**Not all partial knees in this study were Oxford knees

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