

Commander Cage Set

iSpine

Commander cervical cages are designed primarily for restoring height of the intervertebral disc space after resection of the disc. It is intended for use in ACDF procedures in patients with uni or multi-level instabilities between C2-C7 discs.

The implants are made of PEEK (Poly-ether-ether-ketone) polymer.

The radiopaque marker is made of tantalum: Ta and self-stabilizing fin is made of Ti6Al4V Titanium Alloy.

Commander cages are available in four different footprint options and five different heights to accommodate varying patient anatomy.

Sizes available:					
12mm x 15mm x	4.5mm	5.3mm	6.1mm	6.9mm	7.7mm
12mm x 17mm x	4.5mm	5.3mm	6.1mm	6.9mm	7.7mm
14mm x 17mm x	4.5mm	5.3mm	6.1mm	6.9mm	7.7mm
14mm x 19mm x	4.5mm	5.3mm	6.1mm	6.9mm	7.7mm



- *Anatomic contoured fit for optimized stability contributing to a successful fusion*
- *The low profile cage has a lordotic angle of 2.8 (degrees) for sagittal alignment*
- *An auto static fin gives immediate stability*
- *Anti-back out teeth also act as additional stabilizers*
- *Tantalum marker at 2mm to posterior edge*
- *Two large graft windows to maximise the bone fusion rate*

PEEK – Bone-implant interface is improved due to an elasticity modulus (GPa) closer to cancellous bone. This ensures continuity in the mechanical properties throughout the level involved.

Impactor allows central insertion by maintaining a strong grip. Security pin enables an accurate orientation allowing a simple, controlled insertion.



Surgical Technique

Exposure and discectomy:

The patient is placed in the supine position

An anterior approach to the cervical spine is used through a right or left cervicotomy.

The anterior aspect of the vertebral bodies cephalad and caudal to the segment involved are exposed.

The longus colli muscles are bluntly dissected from deep adherence and then retracted laterally.

The surgeon incises the annulus with a scalpel and completely excises the disc by means of a pituitary rongeur until the posterior longitudinal ligament is reached.

End plate preparation:

After decompressing the spinal cord and nerve roots, the surgeon prepares the endplates using a curette without damaging the underlying cortical bone.

Cage size selection

A trial is mounted onto the trial cage holder.

Select the smallest trial cage height for which proper stability is obtained. To test this stability distraction is momentarily relaxed. The position can be verified fluoroscopically thanks to a radiodense marker.

Optional: the depth of the endplate may be measured using the depth gauge also available in the set.

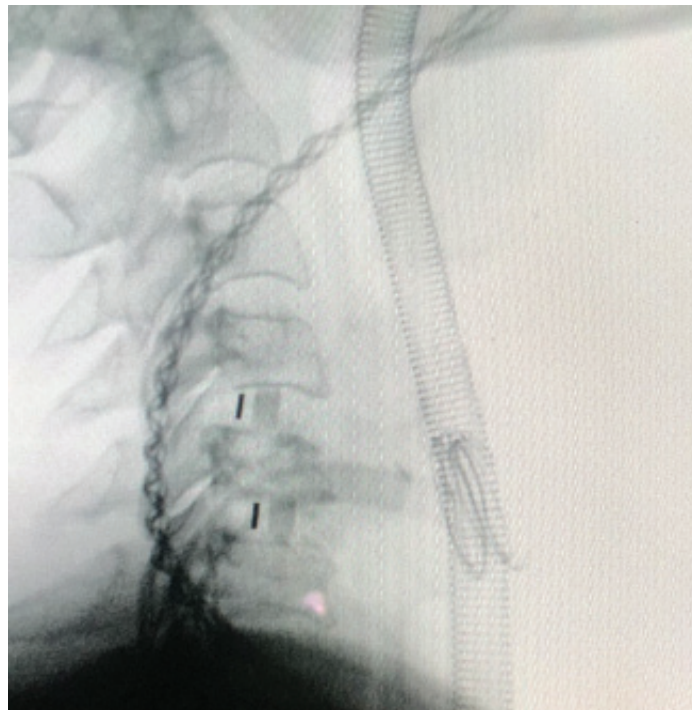
Cage preparation and insertion

The chosen cage is mounted onto the inserter making sure that the positioning knob is aligned in the hole besides the threads in the cage. The cage is then filled with DBMX bone paste or bone graft.

A cranial/caudal indication close to the handle facilitates proper positioning of the cage. The cage is impacted using the impactor while distraction of the interbody space is maintained in such a manner that minimal resistance is felt during insertion.

The impactor comes with a stop for maximal safety during cage insertion. When the impactor has been withdrawn the implant position may be adjusted using the final impactor. Carefully place the distal extremity of the final impactor in the threaded hole of the cage before striking it.

Slight compression of the cage is applied before removing the distractor.



Above: lateral x-ray with commander cage

Instrument Log

1 Cage inserter



2 Depth guage



3 Double-sided curette



4 Tamp



5 Mallet



6 Trial inserters



7 Trials



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