Oxford® Partial Knee

A Definitive Implant

With over 35 year’s clinical experience, the Oxford® Partial Knee is the most widely used¹ and proven partial knee system in the world.

- A multi-center study² 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**

- 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 TKA⁴

- Proven⁵, safe and reproducible technique¹

- Better functionality⁶ and more natural motion⁷ compared to TKA

- Best-in-class continuous education program

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¹ Not all partial knees in this study were Oxford knees

² Adjusted odds ratio controlled for gender, age, minority, income, and center, p<0.05, multivariate analysis
Femoral Component

- Conforming, spherical design minimizes contact stress throughout entire range of motion
- Curved inner geometry for minimal bone removal

Mobile Meniscal Bearing

- Only true mobile meniscal bearing knee system approved for use in the U.S.
- Mobile bearing designed to remain fully congruent with femoral component throughout entire range of motion
- Increased wear resistance with ArCom® Direct Compression Molded polyethylene

Clinical Survivorship

92.4% at 10 Years
94.0% at 15 Years
91.0% at 20 Years

The most widely used and clinically proven partial knee system in the world.
The long-term clinical performance of the Oxford® Partial Knee is supported by world-wide clinical studies. The Oxford® Partial Knee has comparable, if not better, long-term survivorship results than competitive total knee arthroplasties. It is the only partial knee replacement that rivals the clinical heritage of total knee replacements.
### Overview of Oxford® Unicompartmental Knee Arthroplasty

Gaurav Khanna, MD; Bruce A. Levy, MD


<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>n</th>
<th>Age (years)</th>
<th>Disease</th>
<th>Knee Score</th>
<th>Follow-up (y)</th>
<th>% Survivorship (y)</th>
<th>Mode of Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goodfellow et al</td>
<td>1988</td>
<td>103</td>
<td>70 (range: 54–86)</td>
<td>Medial or lateral OA</td>
<td>None Given</td>
<td>3 (2–5)</td>
<td>91.0</td>
<td>9 revisions (5 component loosening, 3 bearing dislocation, 1 disease progression)</td>
</tr>
<tr>
<td>Carr et al</td>
<td>1993</td>
<td>121</td>
<td>69 (range: 57–81)</td>
<td>Medial OA</td>
<td>40.1 (OKS)</td>
<td>3.8</td>
<td>99.0</td>
<td>1 revision (component loosening)</td>
</tr>
<tr>
<td>Murray et al</td>
<td>1998</td>
<td>143</td>
<td>71 (range: 35–91)</td>
<td>Anteromedial OA</td>
<td>None Given</td>
<td>7.6 (6–14)</td>
<td>98.0 (10)</td>
<td>5 revisions (2 component loosening, 2 lateral OA, 1 unexplained pain)</td>
</tr>
<tr>
<td>Vorlat et al</td>
<td>2000</td>
<td>41 (3 lateral)</td>
<td>62 (range: 46–84)</td>
<td>Medial or lateral OA</td>
<td>87.0 (HSS)</td>
<td>5 (2–8)</td>
<td>93.0</td>
<td>3 revisions (2 lateral OA, 1 component malalignment)</td>
</tr>
<tr>
<td>Svard et al</td>
<td>2001</td>
<td>124</td>
<td>70 (range: 51–86)</td>
<td>Anteromedial OA</td>
<td>None Given</td>
<td>12.5 (10.1–15.6)</td>
<td>95.0 (10)</td>
<td>6 revisions (3 bearing dislocation, 2 component loosening, 1 infection)</td>
</tr>
<tr>
<td>Emerson et al</td>
<td>2002</td>
<td>50</td>
<td>63 (range: 38–85)</td>
<td>Medial OA</td>
<td>92 (AKS)</td>
<td>6.8 (2–13)</td>
<td>93.0 (10)</td>
<td>7 revisions (4 lateral OA, 1 bearing impingement, 1 inflammatory arthritis, 1 component loosening)</td>
</tr>
<tr>
<td>Keys et al</td>
<td>2004</td>
<td>40</td>
<td>68 (range: 0–90)</td>
<td>Medial OA</td>
<td>None Given</td>
<td>7.5 (6–10)</td>
<td>100 (10)</td>
<td>None</td>
</tr>
<tr>
<td>Rajasekhar et al</td>
<td>2004</td>
<td>135</td>
<td>71 (range: 53–88)</td>
<td>Medial OA</td>
<td>92.2 (AKS)</td>
<td>5.8 (2–12)</td>
<td>94.0 (10)</td>
<td>5 revisions (2 component loosening, 1 component loosening/bearing dislocation, 1 bearing dislocation, 1 unexplained pain)</td>
</tr>
<tr>
<td>Langdon et al</td>
<td>2005</td>
<td>29</td>
<td>71 (46–85)</td>
<td>AVN</td>
<td>38.0 (OKS)</td>
<td>5.2 (1–13)</td>
<td>100 (10)</td>
<td>None</td>
</tr>
<tr>
<td>Price et al</td>
<td>2005</td>
<td>52</td>
<td>pts &lt;60: 56 (range: 35–60)</td>
<td>Medial OA</td>
<td>94.0 (HSS)</td>
<td>10</td>
<td>91.0 (10)</td>
<td>4 revisions (2 lateral OA, 1 component loosening, 1 bearing fracture)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>512</td>
<td>pts &gt;60: 71 (range: 60–95)</td>
<td>Medial OA</td>
<td>86.0 (HSS)</td>
<td>10</td>
<td>96.0 (10)</td>
<td>20 revisions (8 lateral OA, 5 component loosening, 3 deep infection, 3 bearing dislocation, 1 unexplained pain)</td>
</tr>
<tr>
<td>Verdonk et al</td>
<td>2005</td>
<td>97 (10 lateral)</td>
<td>61 (range: 46–84)</td>
<td>Medial or lateral OA</td>
<td>None Given</td>
<td>6.8 (2–14)</td>
<td>86.0</td>
<td>14 revisions (5 component loosening, 3 bearing dislocation, 3 lateral OA, 2 unexplained pain, 1 suprapatellar femur fracture)</td>
</tr>
<tr>
<td>Price et al</td>
<td>2005</td>
<td>439</td>
<td>70 (range: 49–95)</td>
<td>Medial OA</td>
<td>86.0 (HSS)</td>
<td>15</td>
<td>93.1 (15)</td>
<td>23 revisions (7 lateral OA, 5 component loosening, 5 bearing dislocation, 2 infection, 2 unexplained pain, 1 component loosening/bearing dislocation, 1 bearing fracture)</td>
</tr>
<tr>
<td>Vorlat et al</td>
<td>2006</td>
<td>149</td>
<td>66 (range: 46–89)</td>
<td>Medial OA</td>
<td>None Given</td>
<td>5.5 (1–10)</td>
<td>84.0 (10)</td>
<td>24 revisions (9 lateral OA, 6 component loosening, 4 bearing dislocation, 2 bearing fracture, 1 tibial subsidence, 1 instability, 1 unknown)</td>
</tr>
<tr>
<td>Kort et al</td>
<td>2006</td>
<td>46</td>
<td>56 (range: 43–60)</td>
<td>Medial OA</td>
<td>90.5 (AKS)</td>
<td>(2–6)</td>
<td>96.0</td>
<td>2 revisions (1 tibial loosening/ femoral malalignment, 1 femoral malalignment)</td>
</tr>
<tr>
<td>Luscombe et al</td>
<td>2006</td>
<td>78</td>
<td>63 (range: 41–79)</td>
<td>Medial OA</td>
<td>38.3 (OKS)</td>
<td>2</td>
<td>95.0</td>
<td>4 revisions (1 unexplained pain, 1 deep infection, 1 component loosening, 1 bearing dislocation)</td>
</tr>
<tr>
<td>Pandit et al</td>
<td>2006</td>
<td>888</td>
<td>66 (range: 33–89)</td>
<td>Anteromedial OA, Secondary OA, Osteonecrosis</td>
<td>None Given</td>
<td>5.9 (0.5–22)</td>
<td>98 (10) 91 (20)</td>
<td>29 revisions (10 lateral arthrosis, 9 component loosening, 5 infection, 2 bearing dislocations, 3 unexplained pain)</td>
</tr>
<tr>
<td>Price and Svard</td>
<td>2010</td>
<td>682</td>
<td>69.7 (range: 48–94)</td>
<td>Anteromedial OA, Secondary OA, Osteonecrosis</td>
<td>None Given</td>
<td>5.9 (0.5–22)</td>
<td>98 (10) 91 (20)</td>
<td>29 revisions (10 lateral arthrosis, 9 component loosening, 5 infection, 2 bearing dislocations, 3 unexplained pain)</td>
</tr>
</tbody>
</table>

**Abbreviations:** AKS=American Knee Score, AVN=Avascular Necrosis, HSS=Hospital for Special Surgery, OA=Osteoarthritis, and OKS=Oxford Knee Score.
The Oxford® System continues to advance partial knee arthroplasty with Microplasty® Instrumentation. This instrumentation platform includes innovative tools to help the surgeon with accuracy and reproducibility.
Uniting Precision with Efficiency

The Oxford® Knee coupled with 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
- Minimal incision to avoid quadriceps disruption
- Size specific femoral instrumentation for precise 1 mm incremental bone removal
References

1. Data on file
2. A Minimalist Approach for Compartment Pathology: Uni, Bi or Tri, Spring CCJCR 2013, Michael Berend, M.D. Presentation #32.

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