



US007867280B2

(12) **United States Patent**  
**Goble et al.**

(10) **Patent No.:** **US 7,867,280 B2**  
(45) **Date of Patent:** **Jan. 11, 2011**

(54) **METHODS FOR MOUNTING AND USING TETHERED JOINT BEARING IMPLANTS**

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(\* ) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 1190 days.

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(21) Appl. No.: **10/901,935**

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(22) Filed: **Jul. 28, 2004**

(65) **Prior Publication Data**

(Continued)

US 2006/0009774 A1 Jan. 12, 2006

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**Related U.S. Application Data**

Restriction Requirement mailed Jul. 2, 2007 in U.S. Appl. No. 10/935,941.

(60) Provisional application No. 60/586,706, filed on Jul. 9, 2004.

(Continued)

(51) **Int. Cl.**  
**A61F 2/38** (2006.01)

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*Assistant Examiner*—David Comstock  
(74) *Attorney, Agent, or Firm*—Baker & Daniels LLP

(52) **U.S. Cl.** ..... **623/20.32**; 623/20.14; 606/304

(58) **Field of Classification Search** ..... 606/300, 606/301, 304, 321, 74, 80, 85, 96, 103, 104, 606/151; 623/20.15, 23.44, 20.3, 20.33, 623/20.34, 20.36, 23.27, 20.14, 20.32  
See application file for complete search history.

(57) **ABSTRACT**

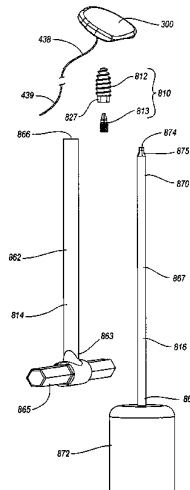
A method includes the acts of sliding a first end of a flexible first line through a channel in a first bone anchor. A portion of the first line is connected to an implant having a top articular surface and an opposing bone apposition surface. The first line extending between the implant and the first bone anchor is then tensioned. While the tensioning force is maintained on the first line, the first line is secured to the first bone anchor.

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**27 Claims, 60 Drawing Sheets**



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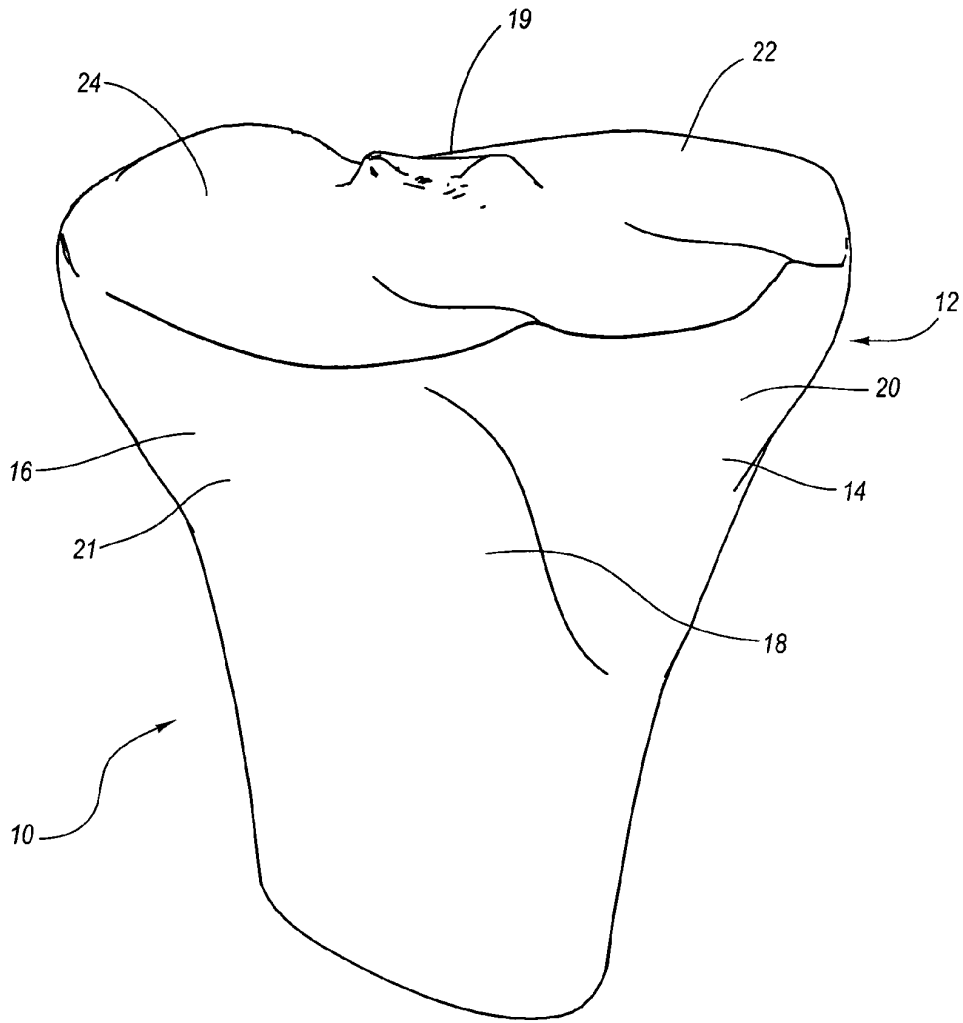
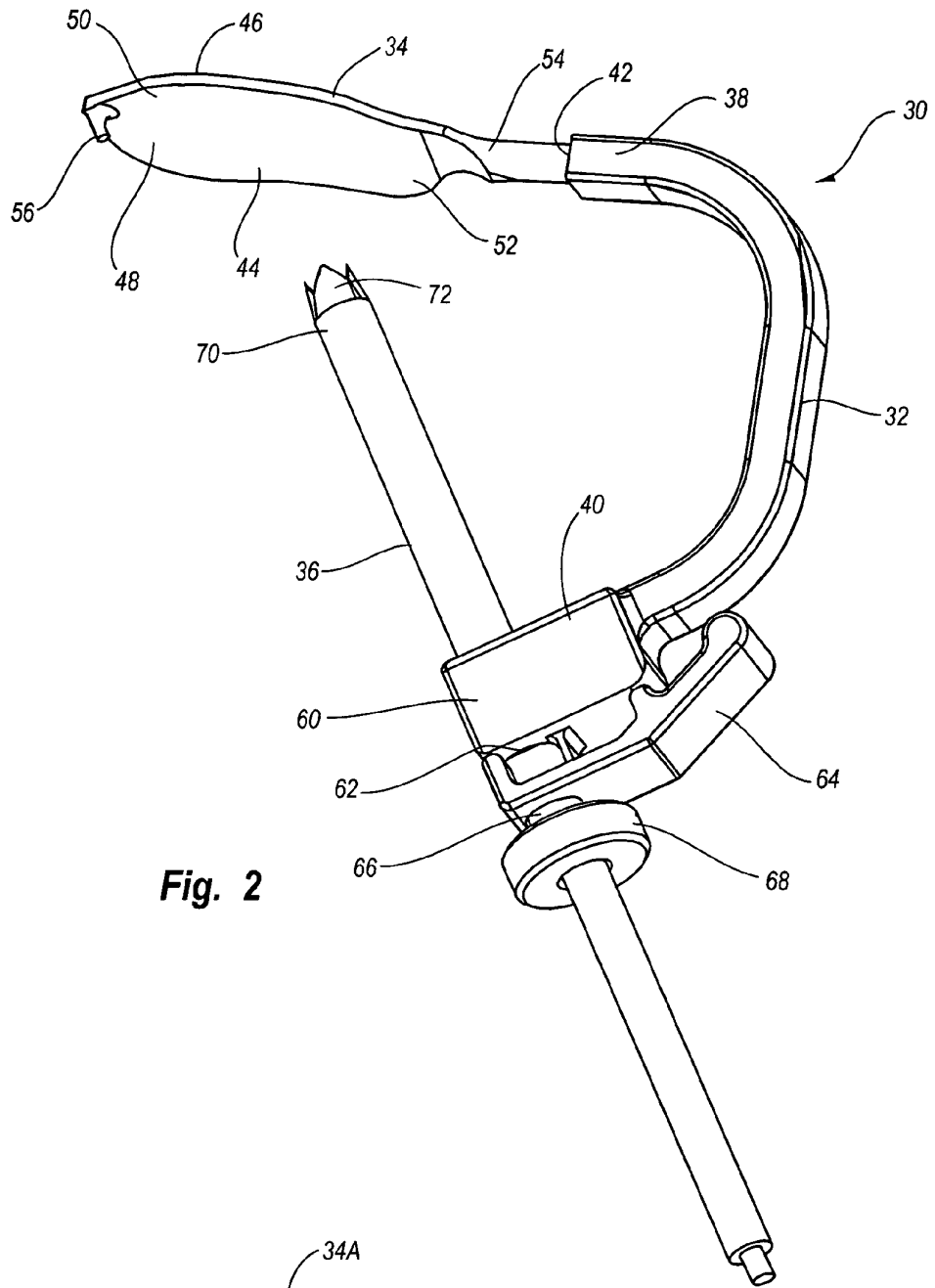
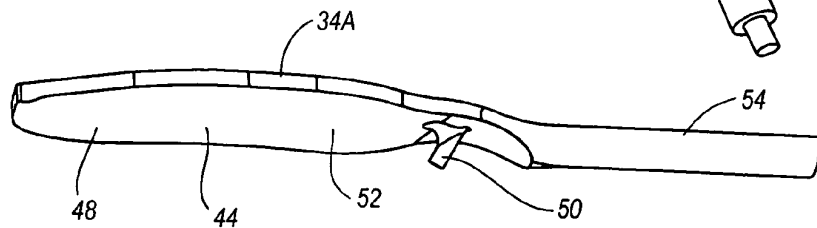


Fig. 1



**Fig. 2**



**Fig. 2A**

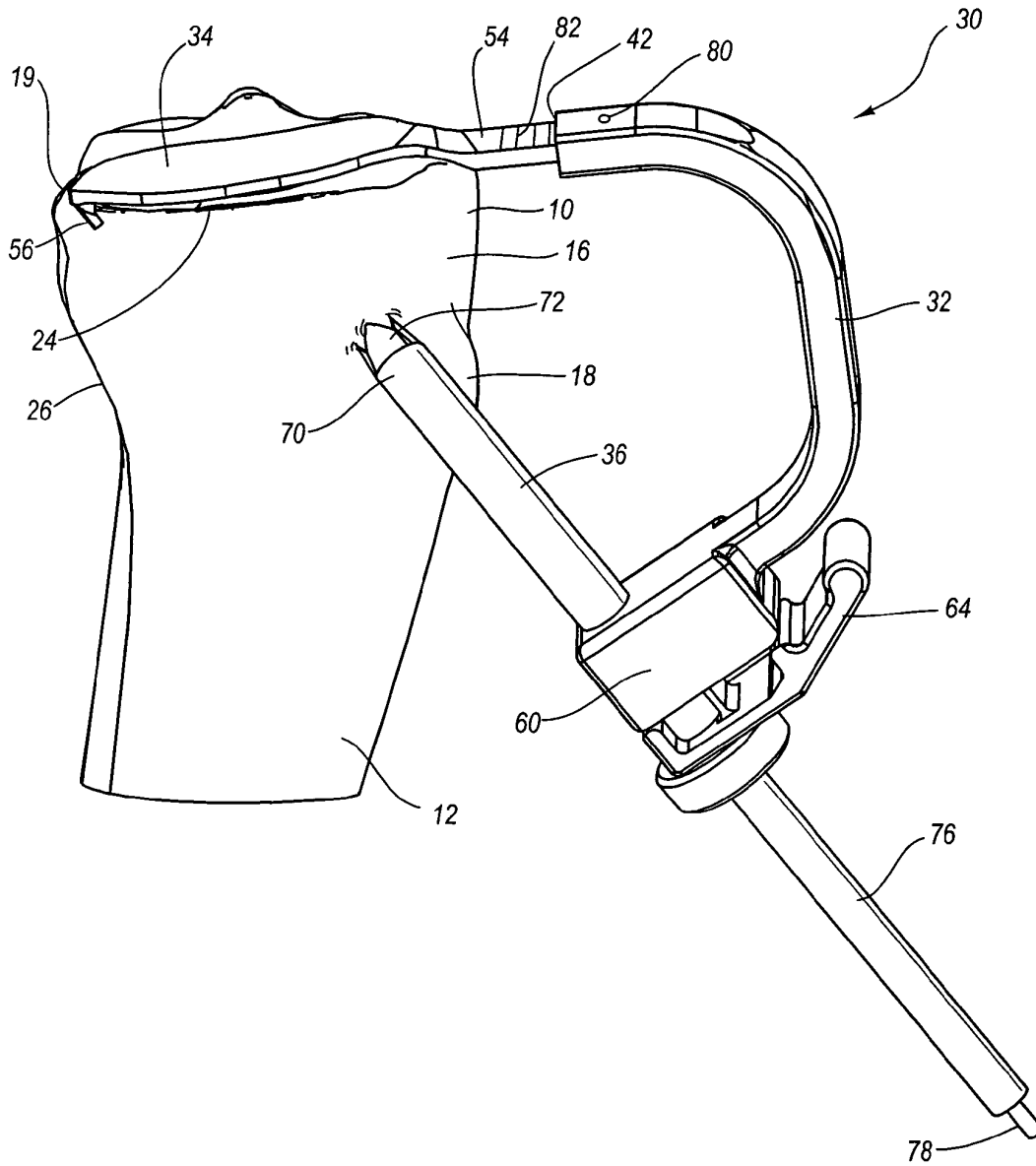


Fig. 3

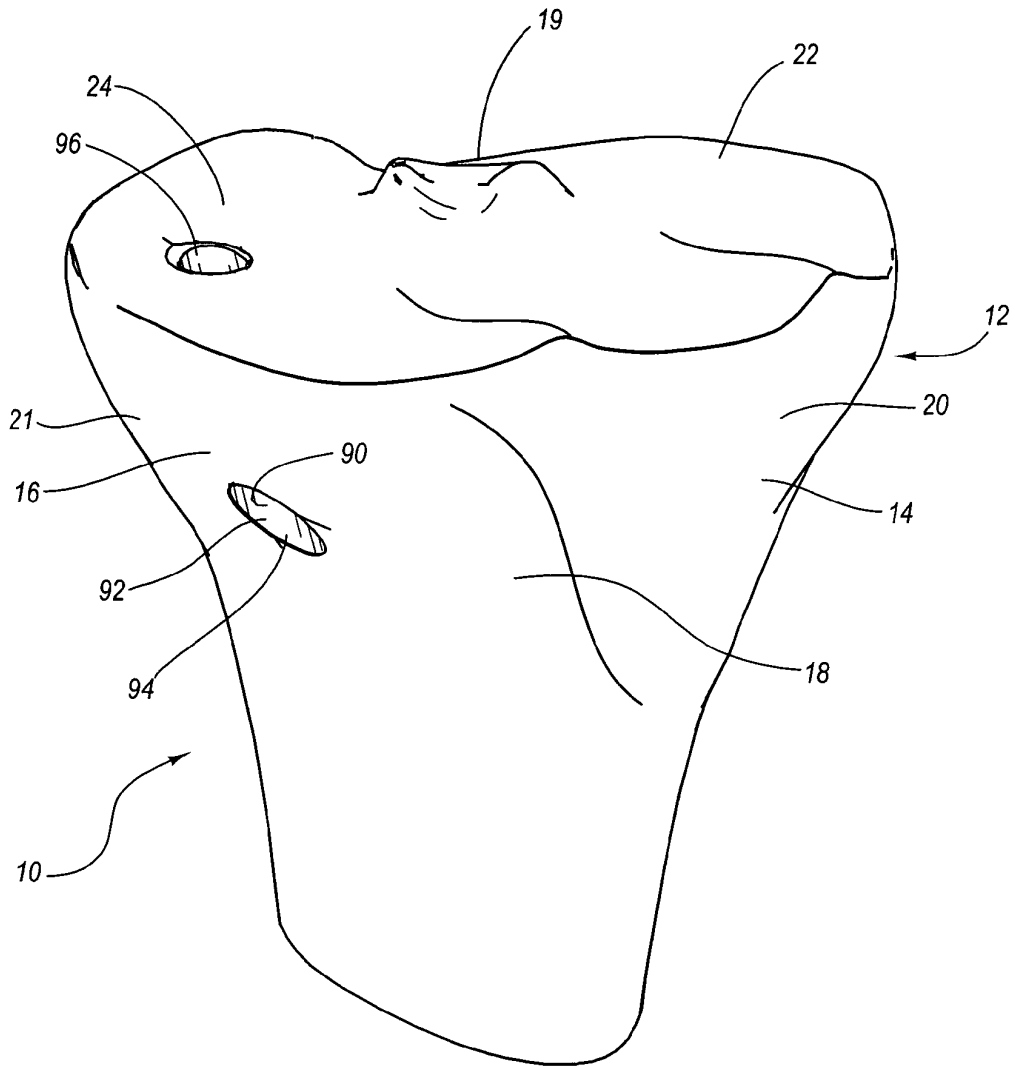


Fig. 4

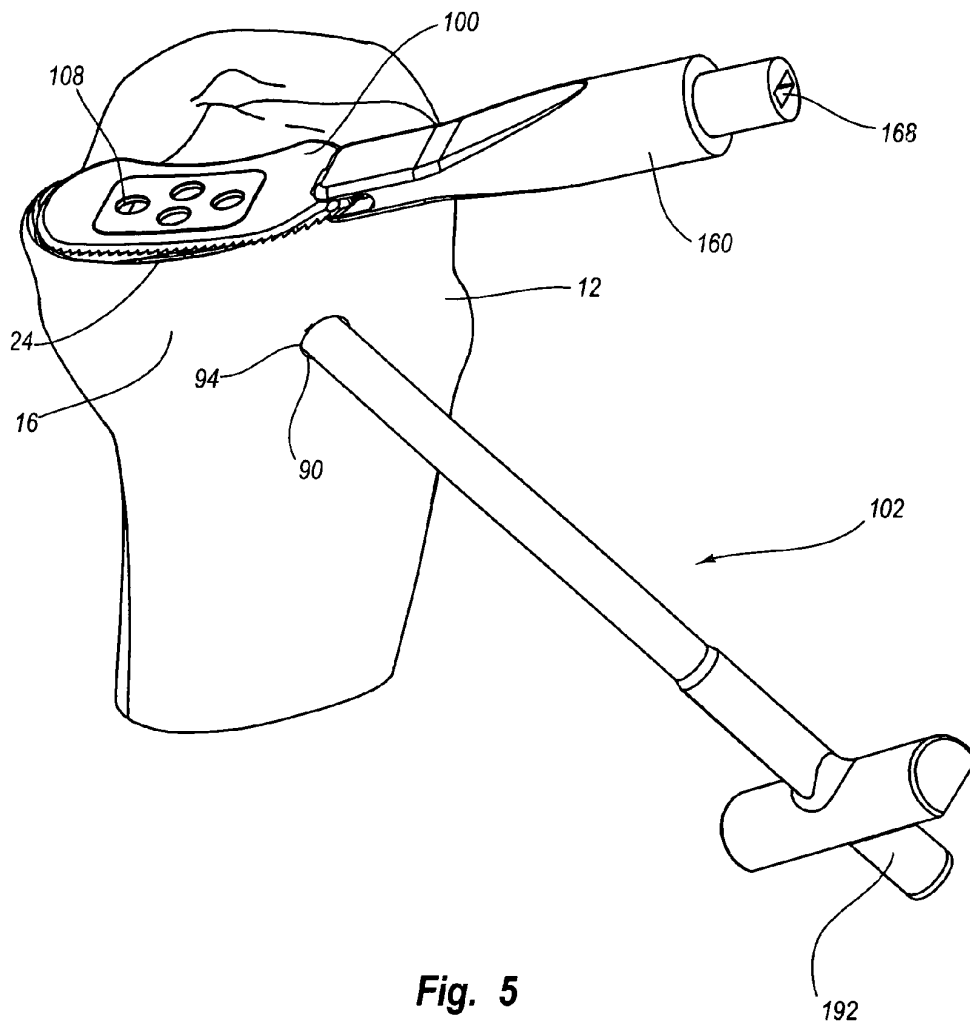


Fig. 5

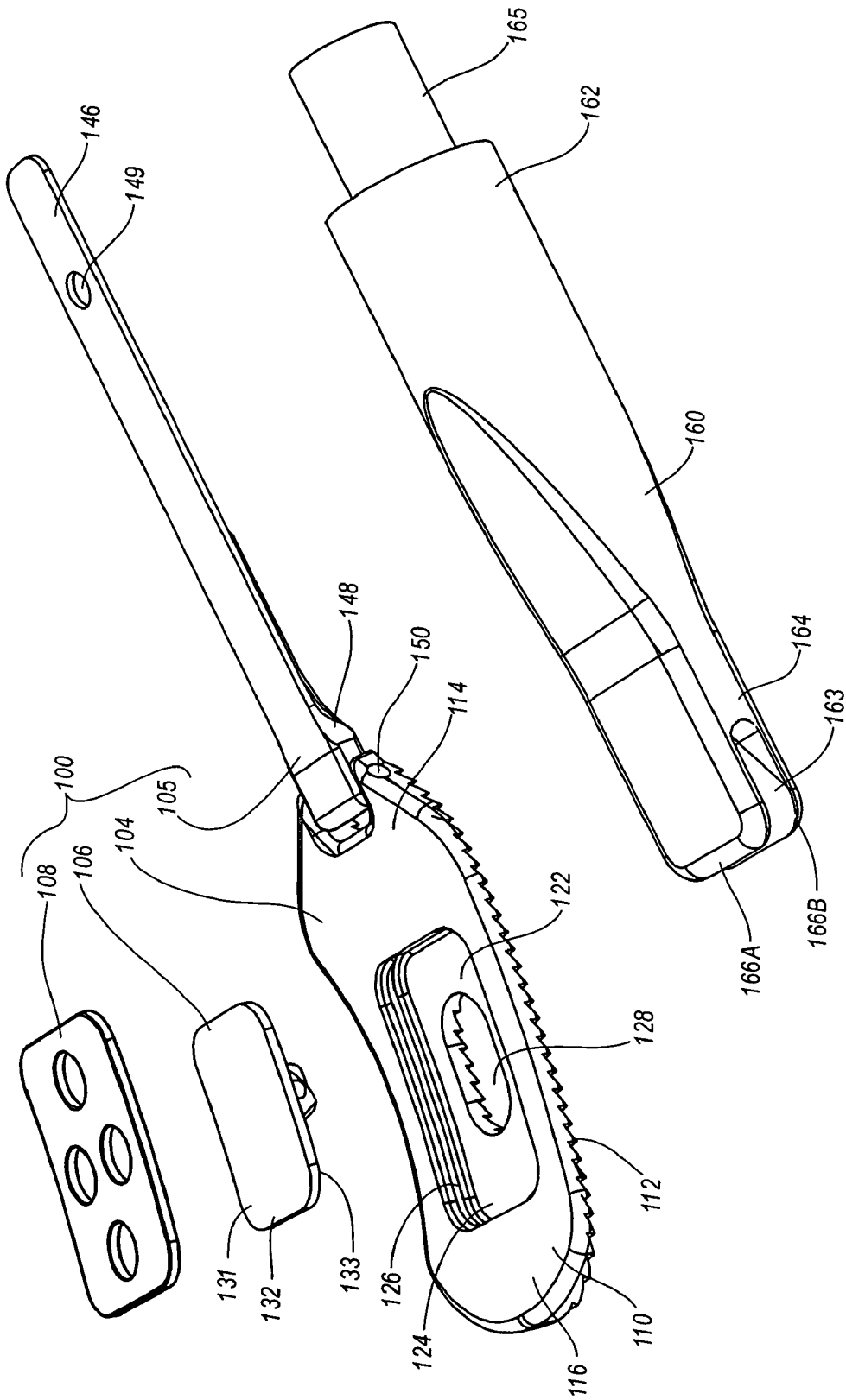


Fig. 6



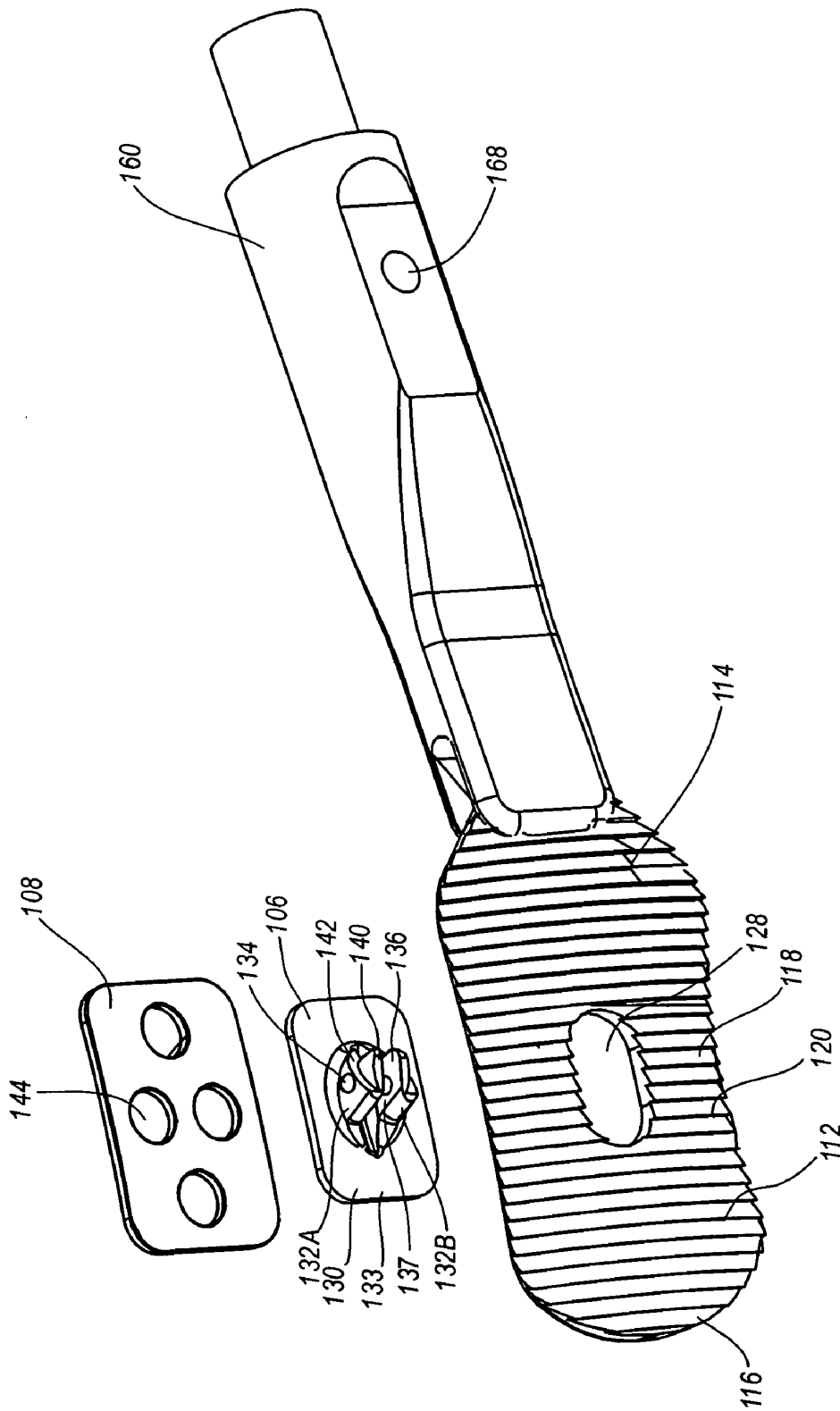


Fig. 7

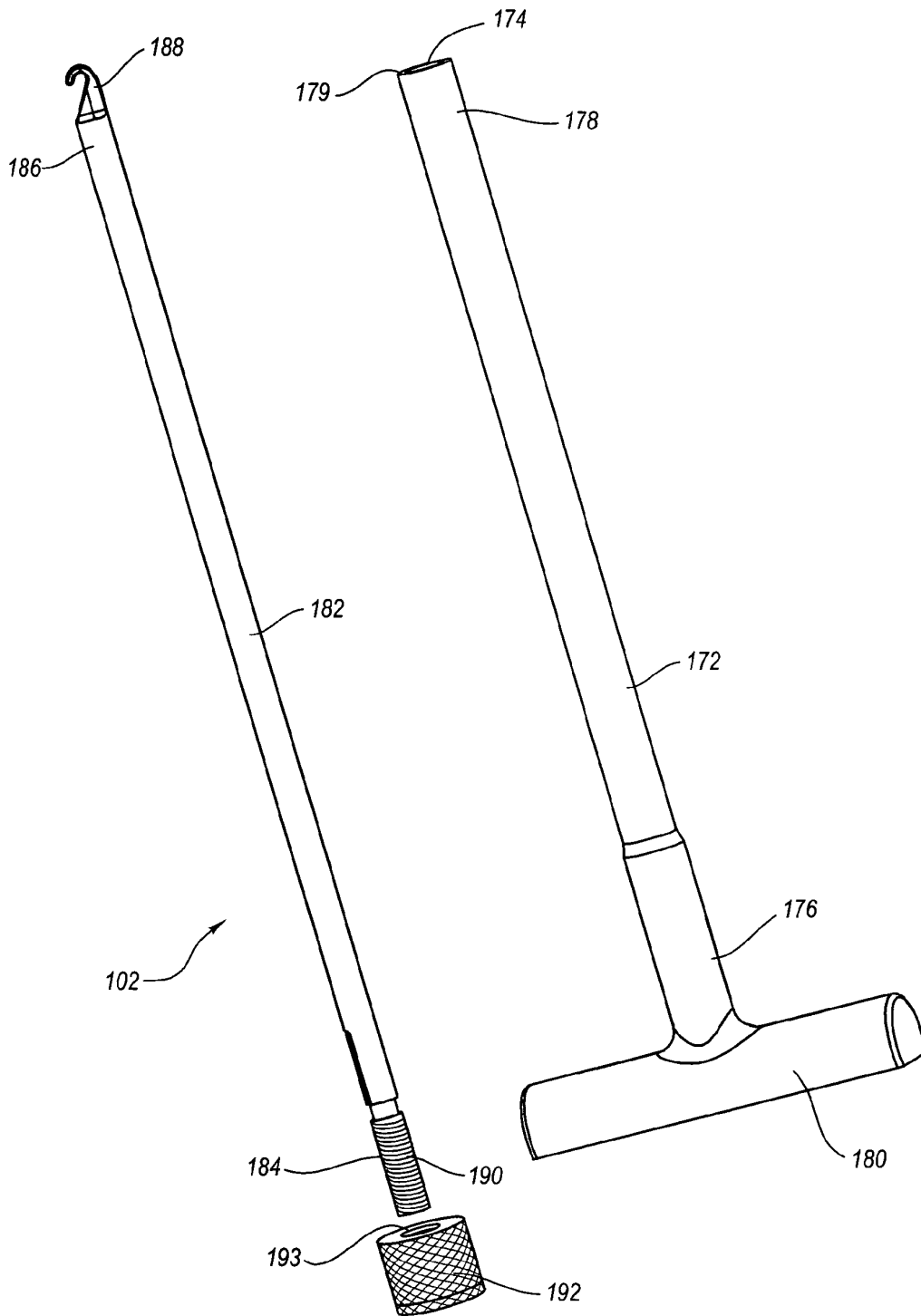
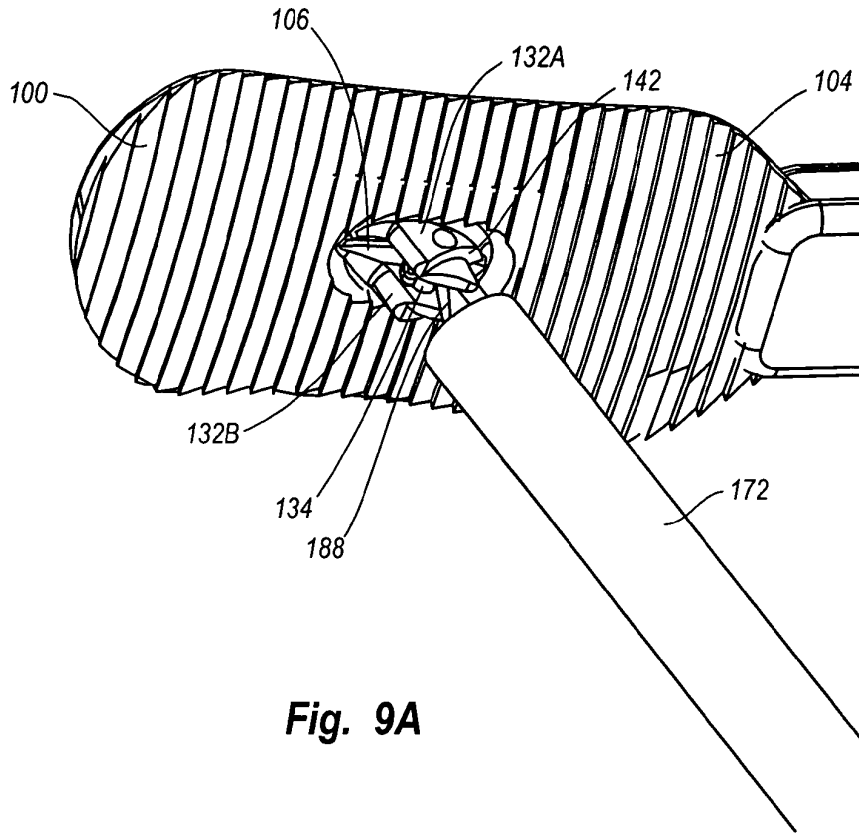
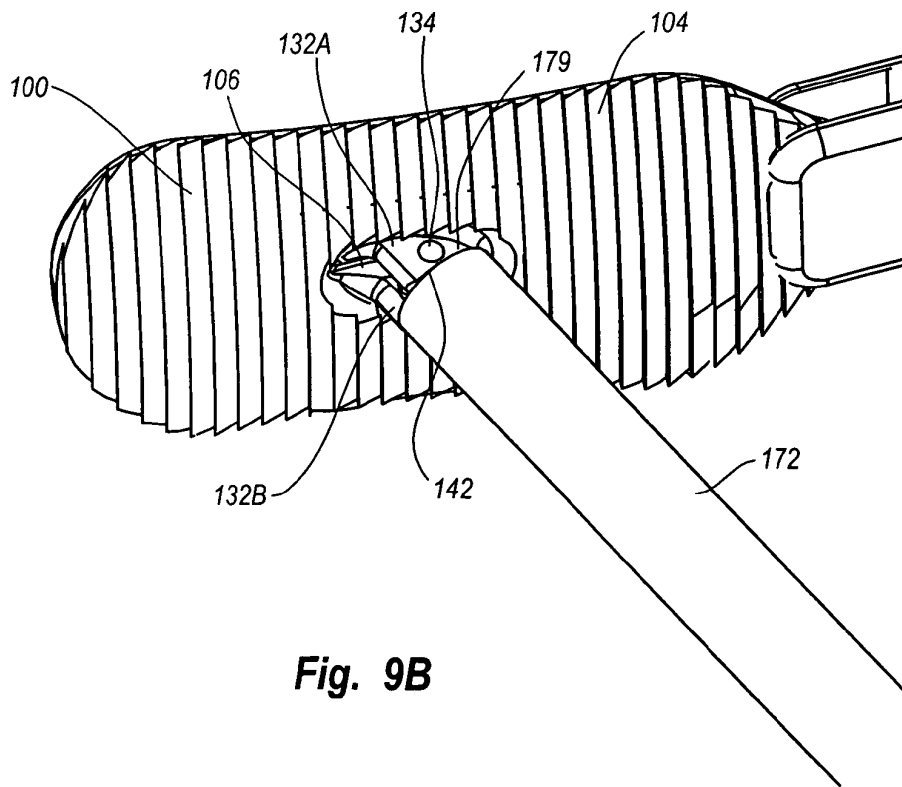


Fig. 8



**Fig. 9A**



**Fig. 9B**

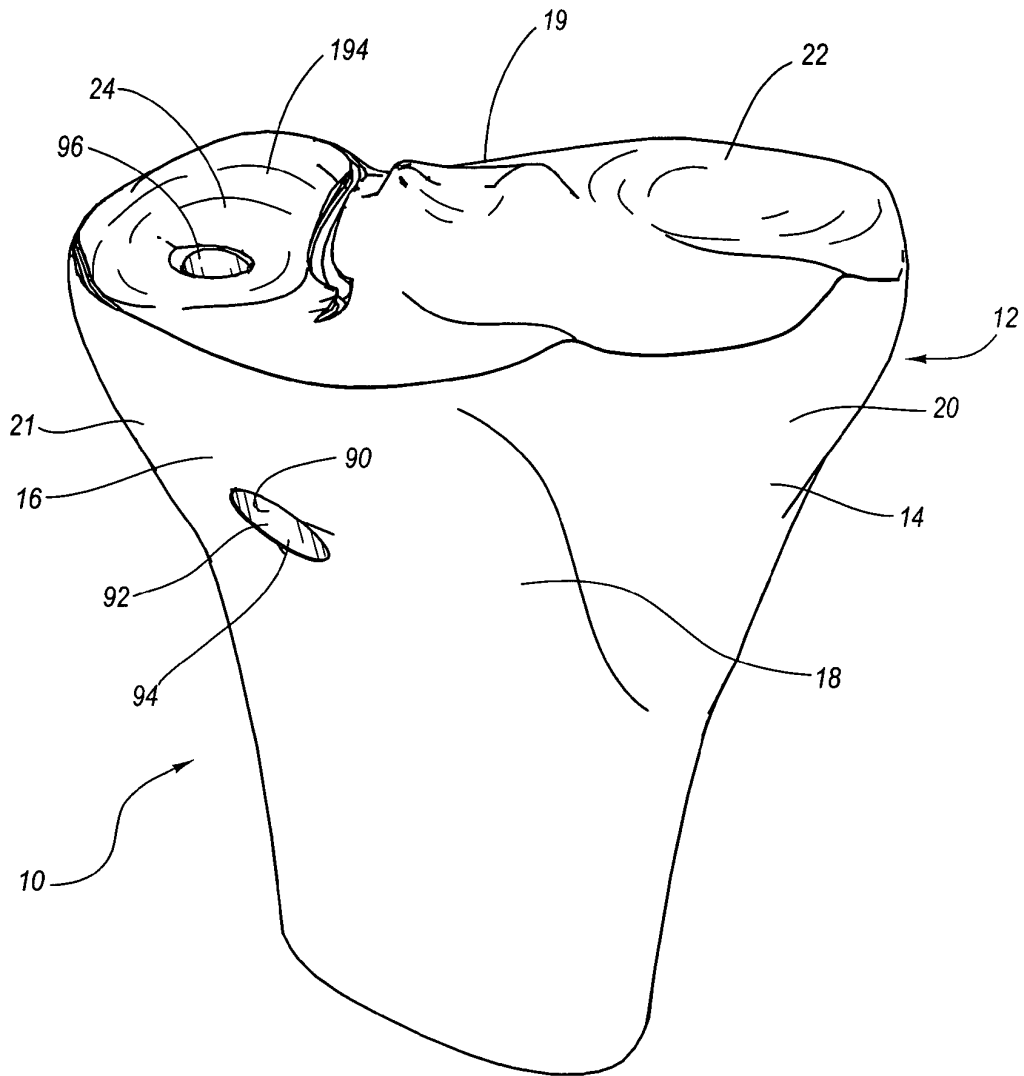


Fig. 10

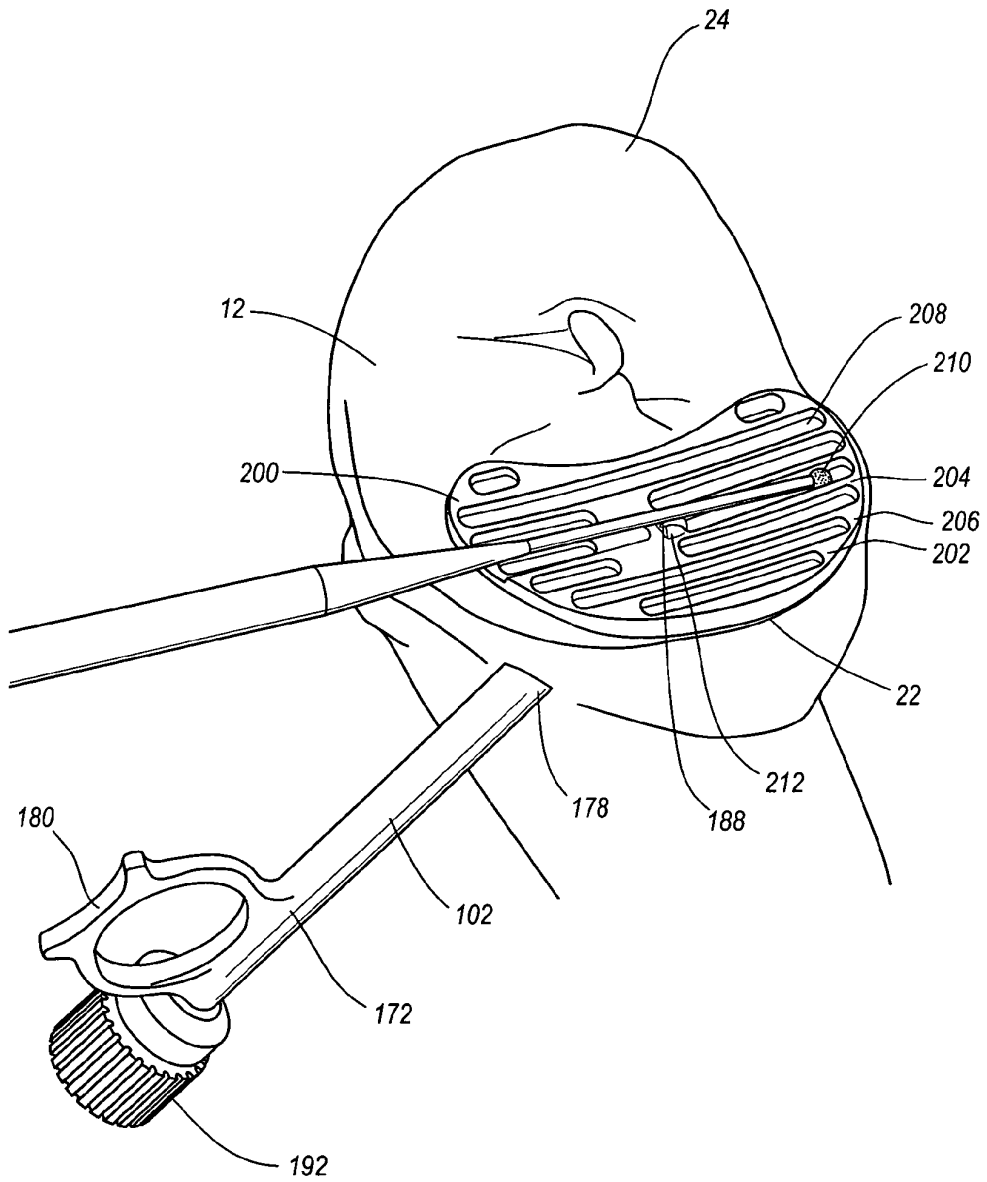


Fig. 11

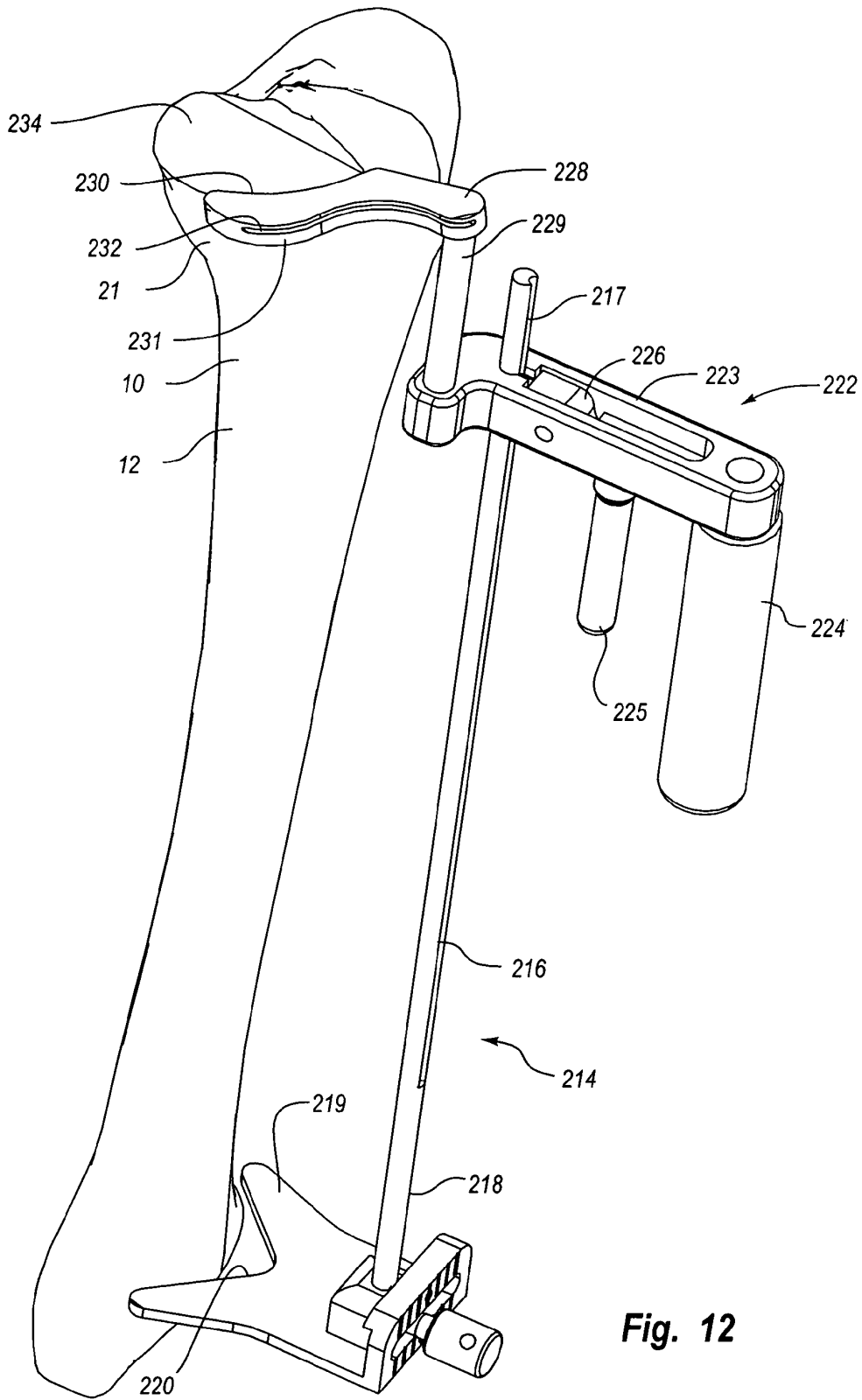


Fig. 12

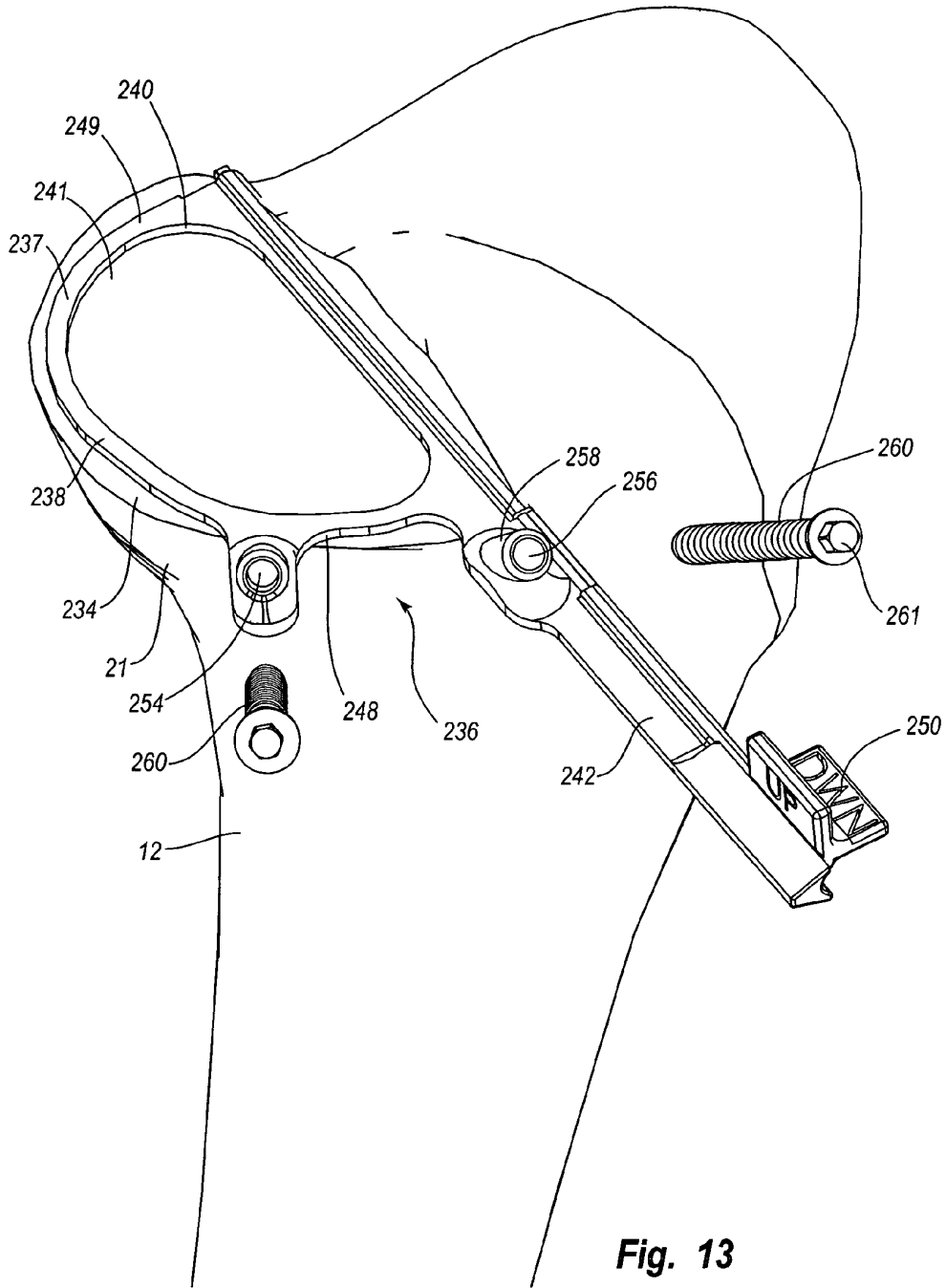
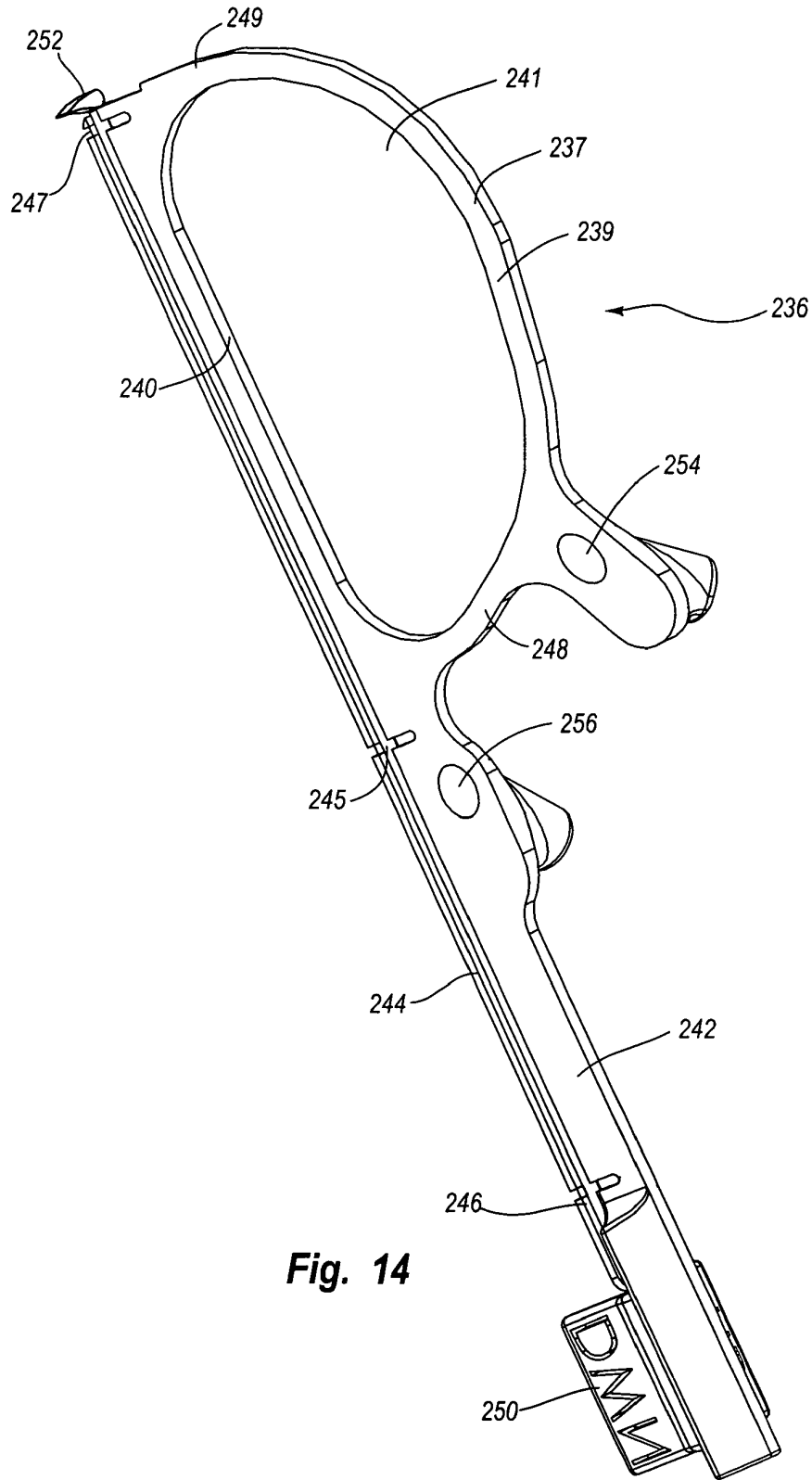


Fig. 13



**Fig. 14**



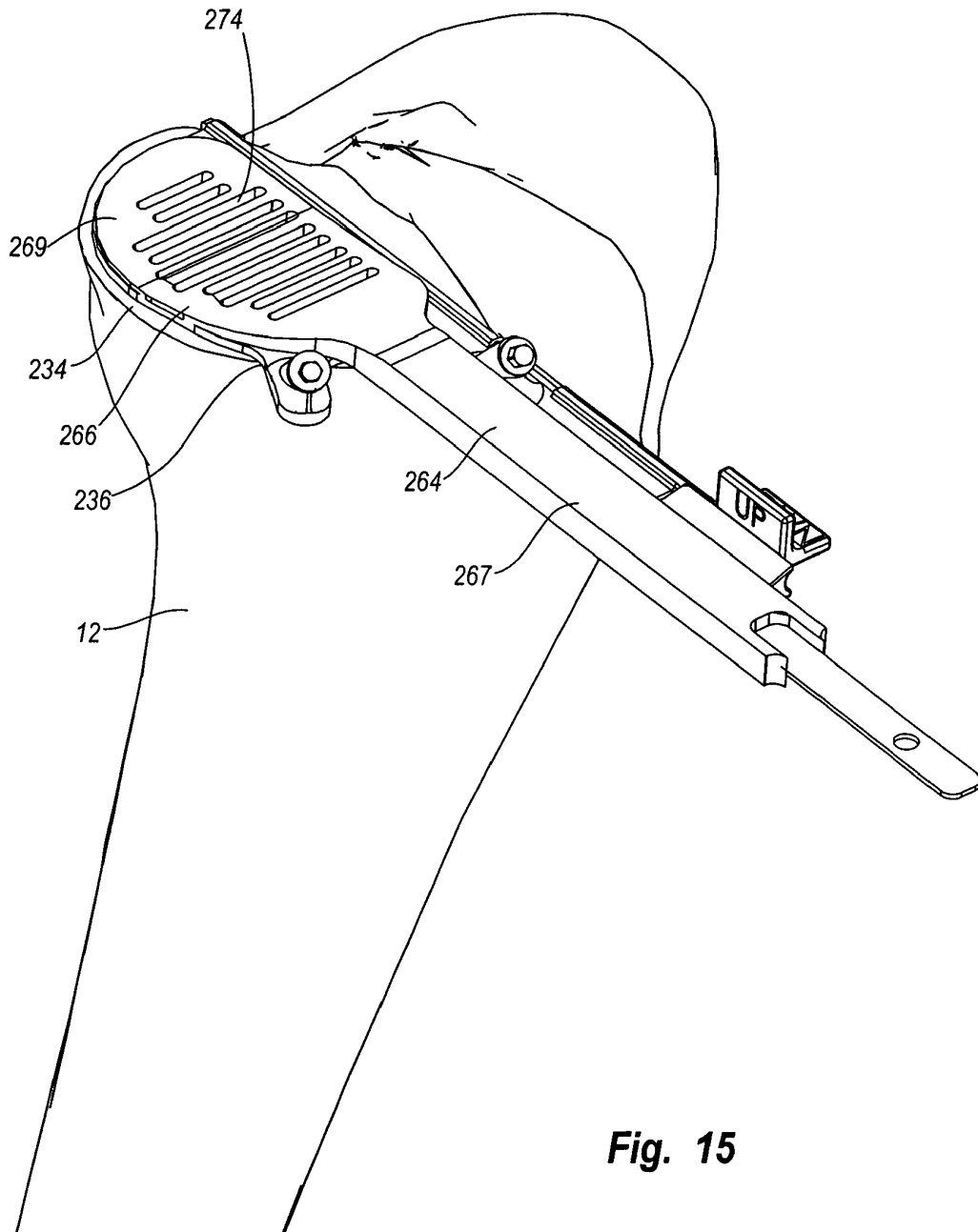
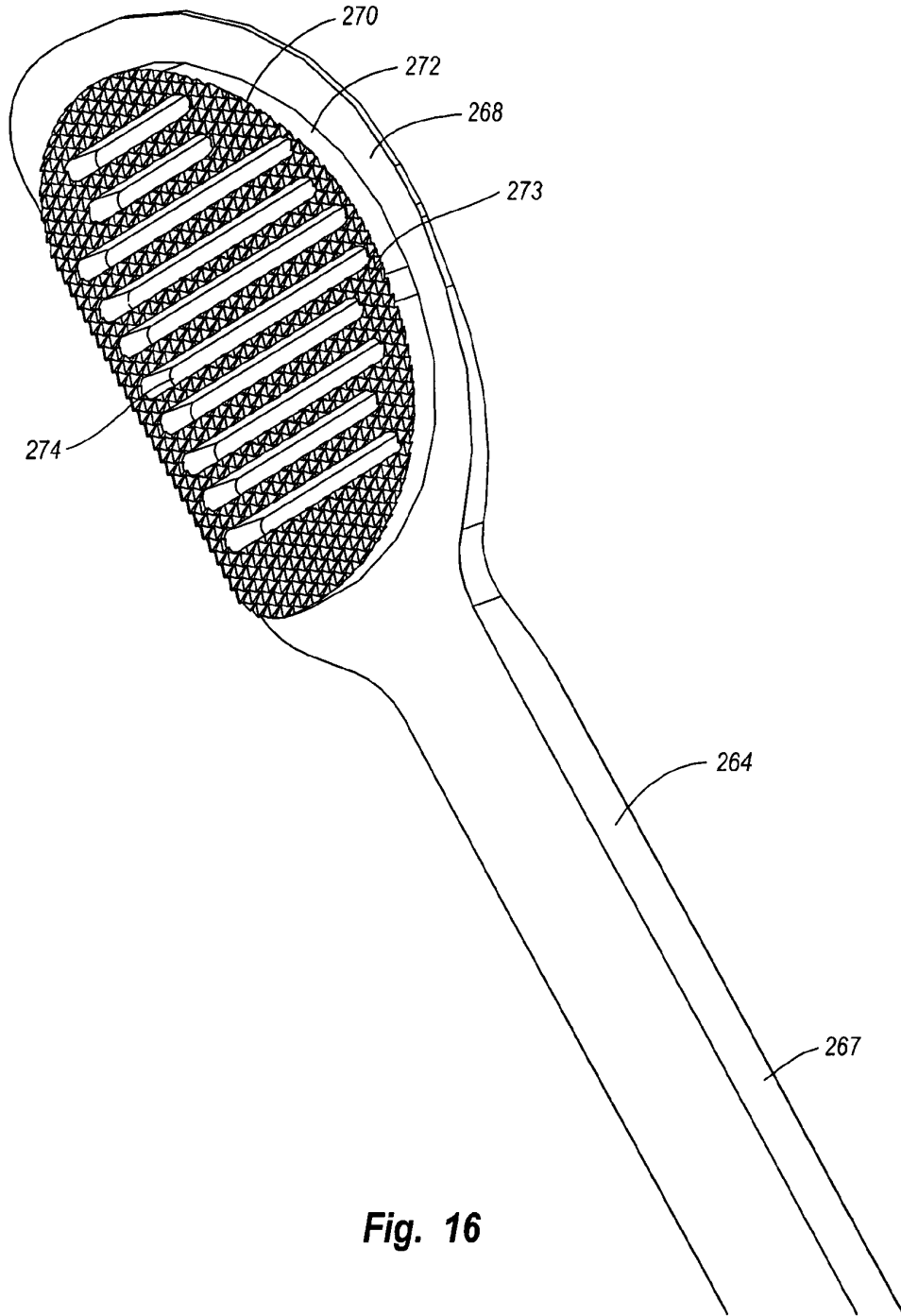


Fig. 15



**Fig. 16**

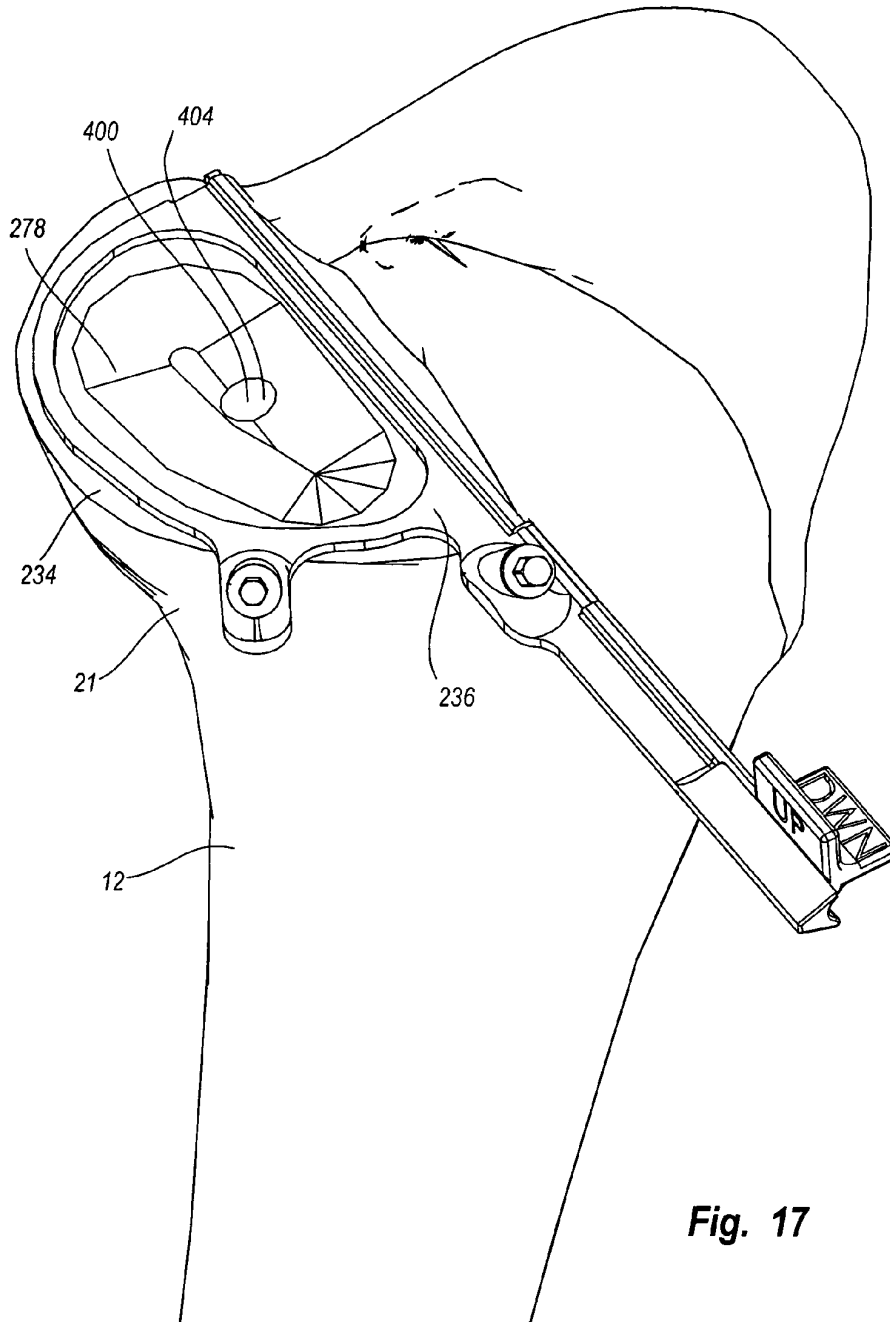
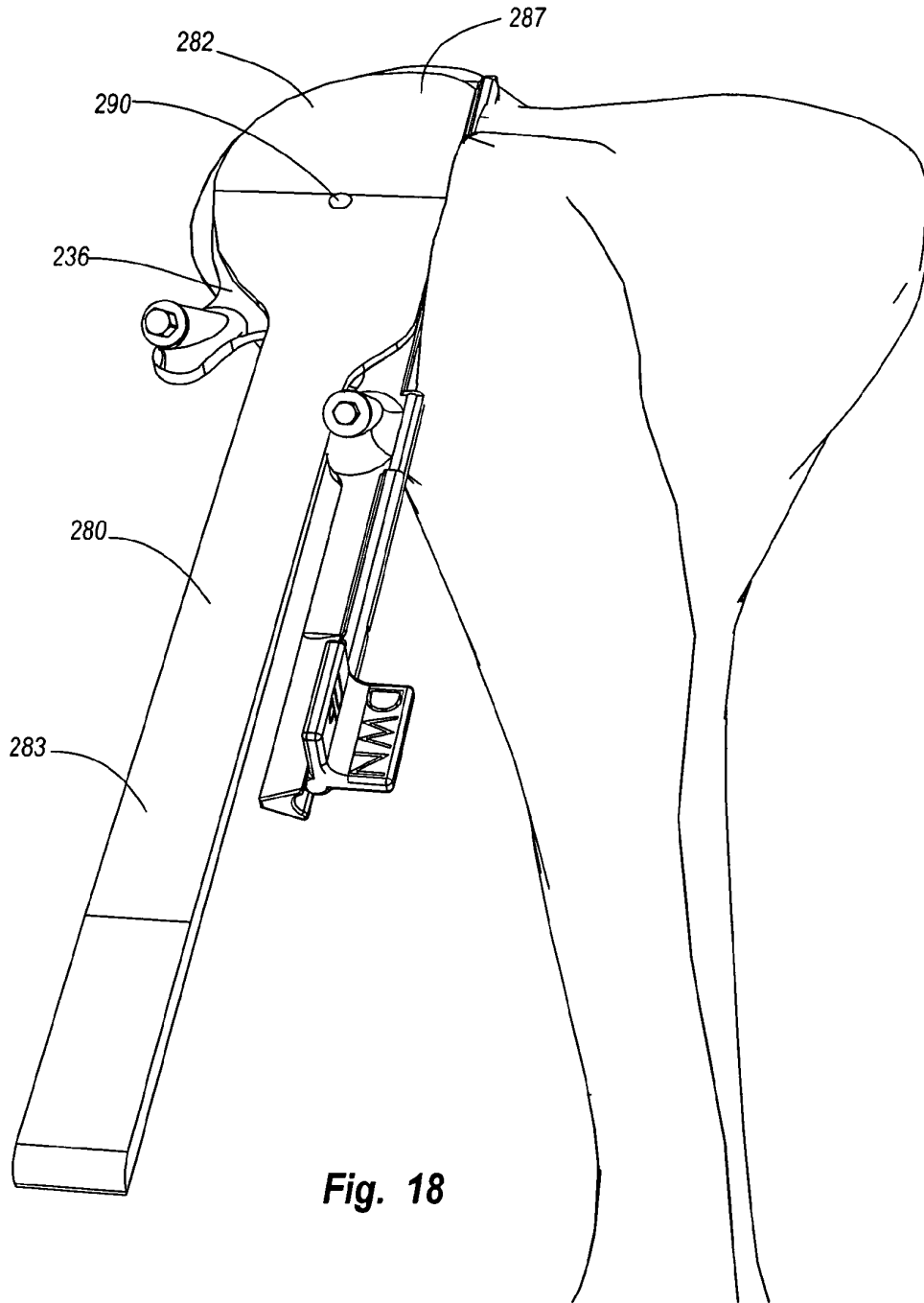
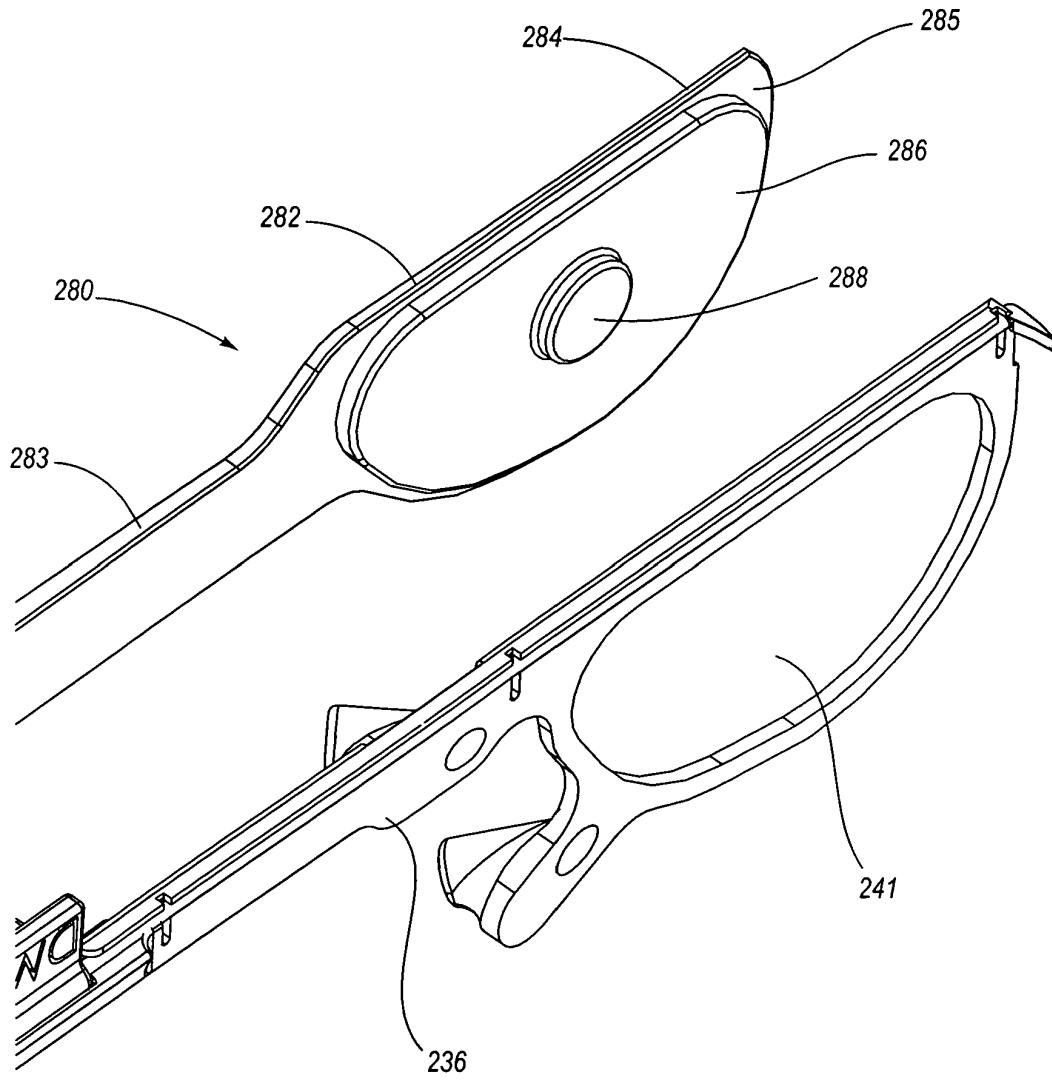


Fig. 17





**Fig. 19**

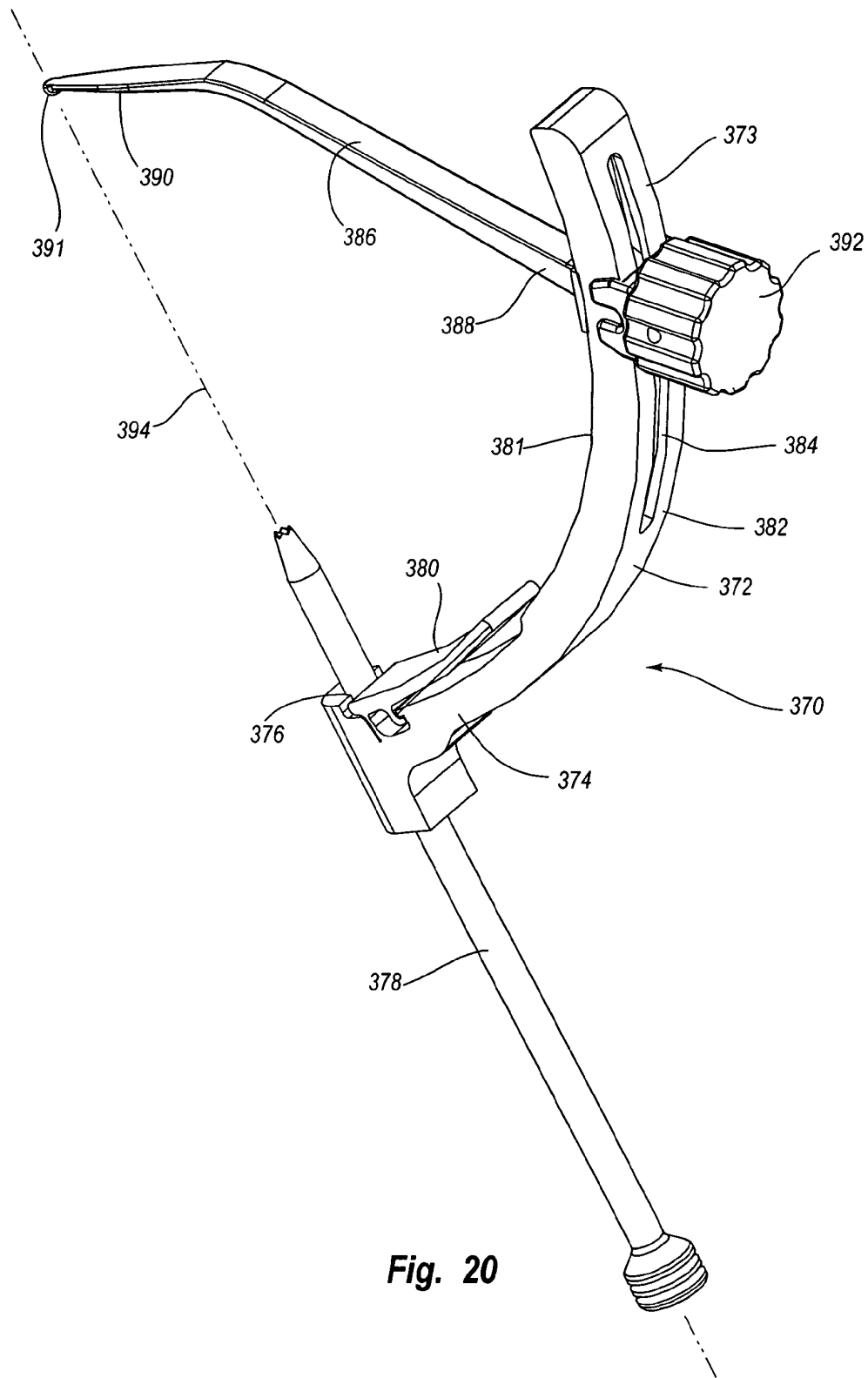


Fig. 20

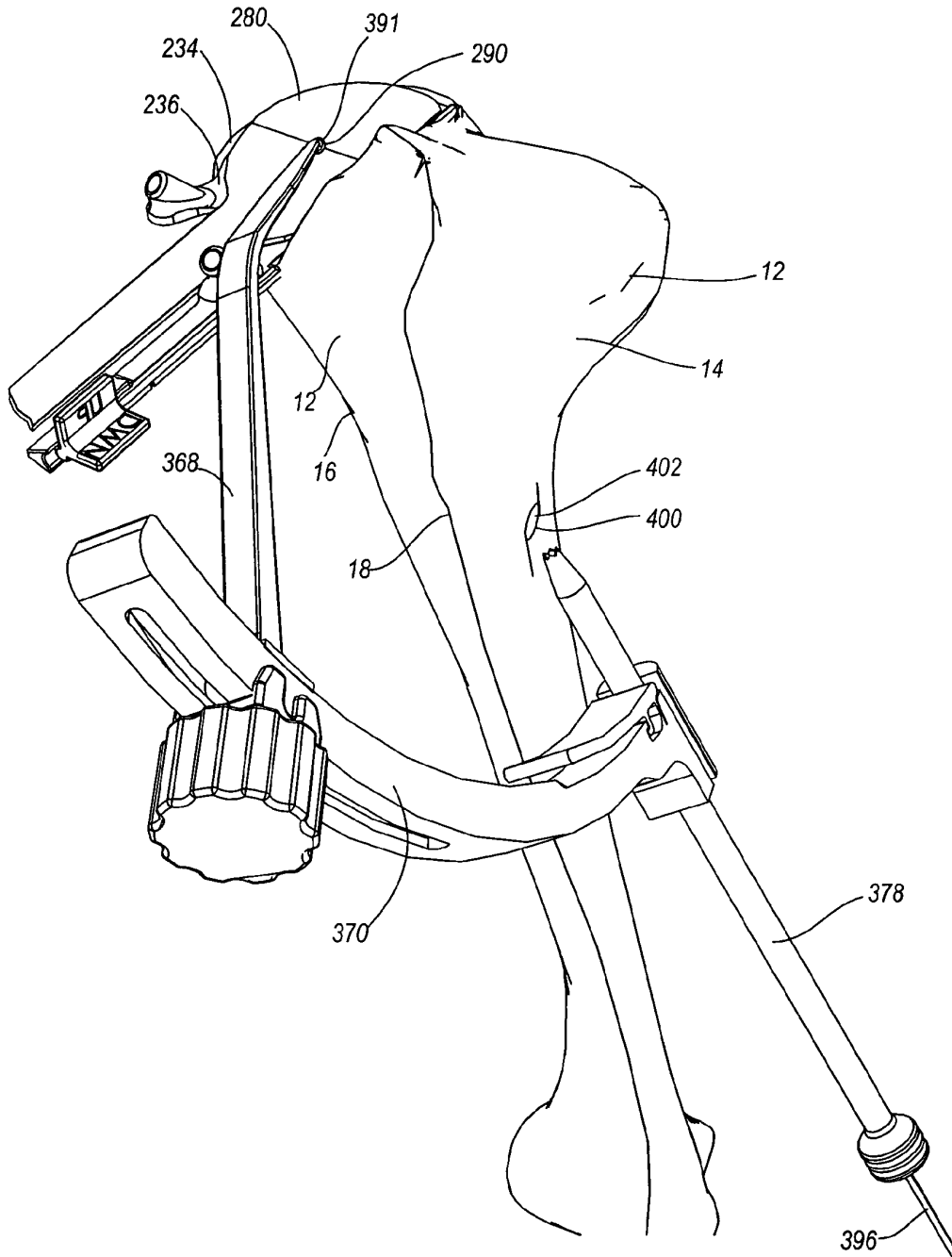


Fig. 21

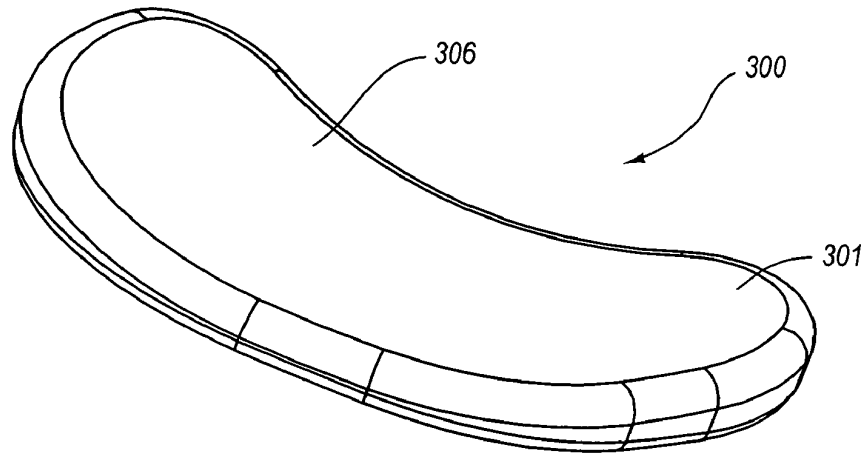


Fig. 22A

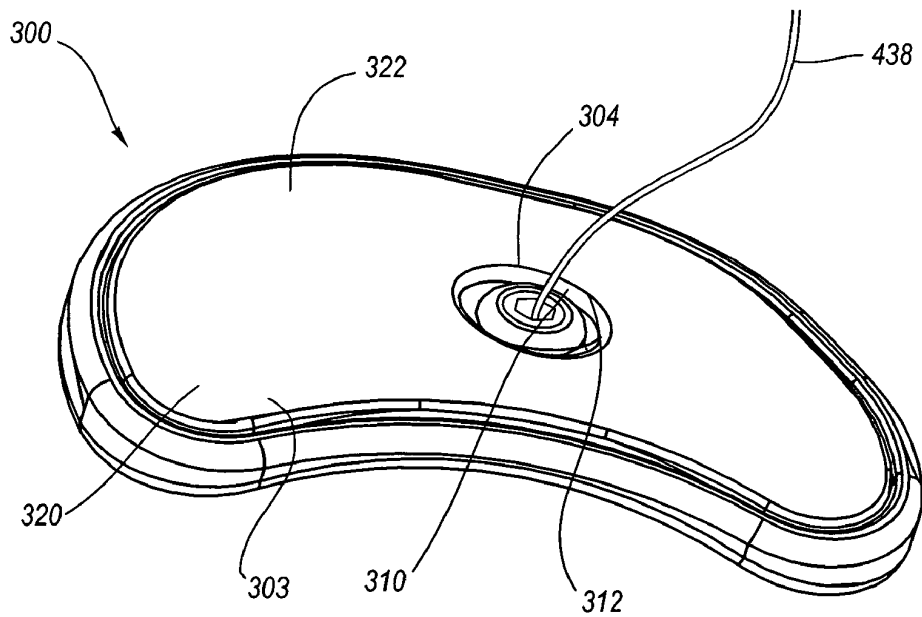
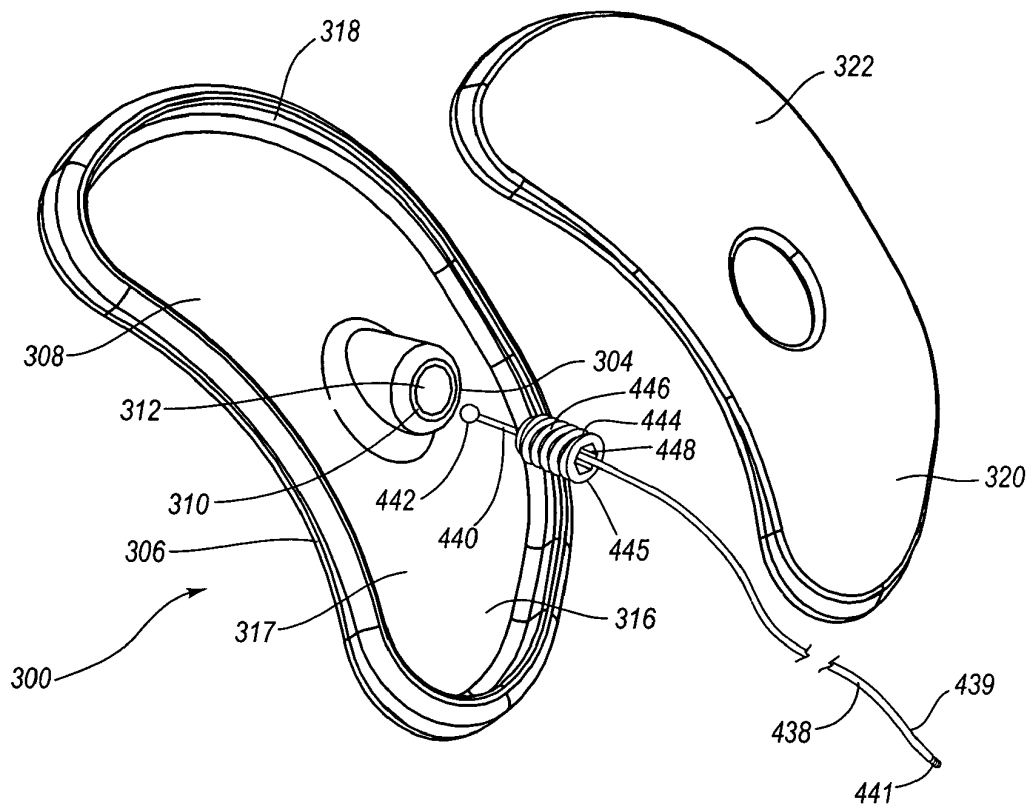
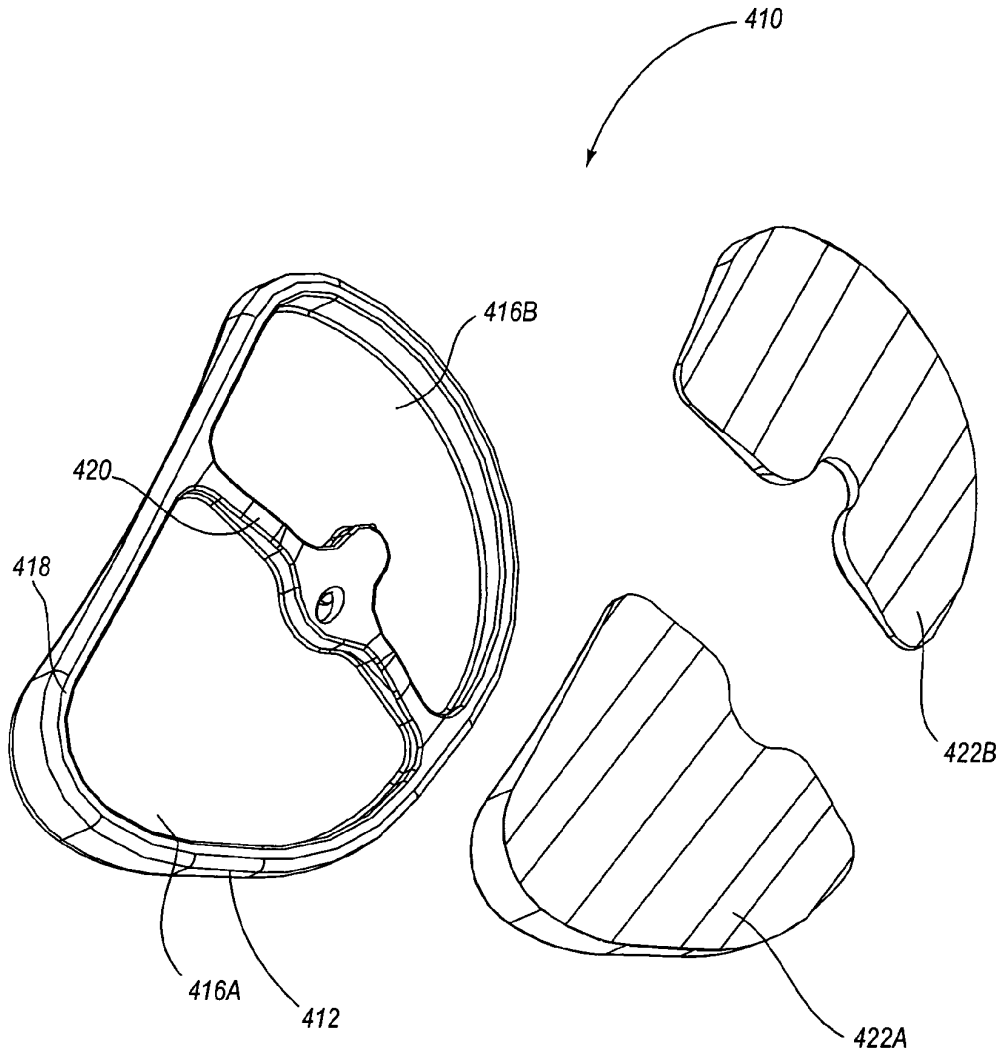


Fig. 22B





**Fig. 22C**



**Fig. 23A**

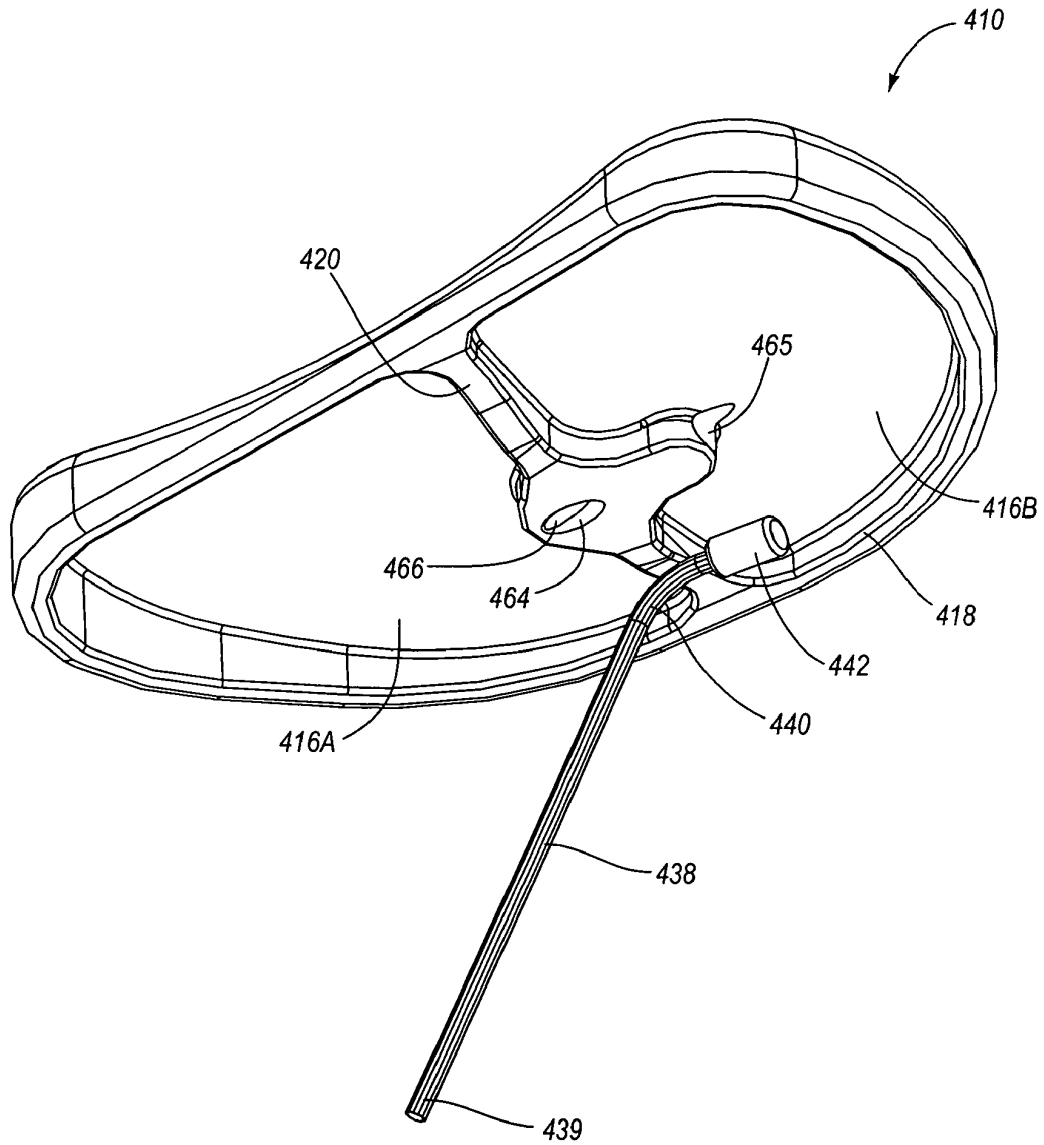
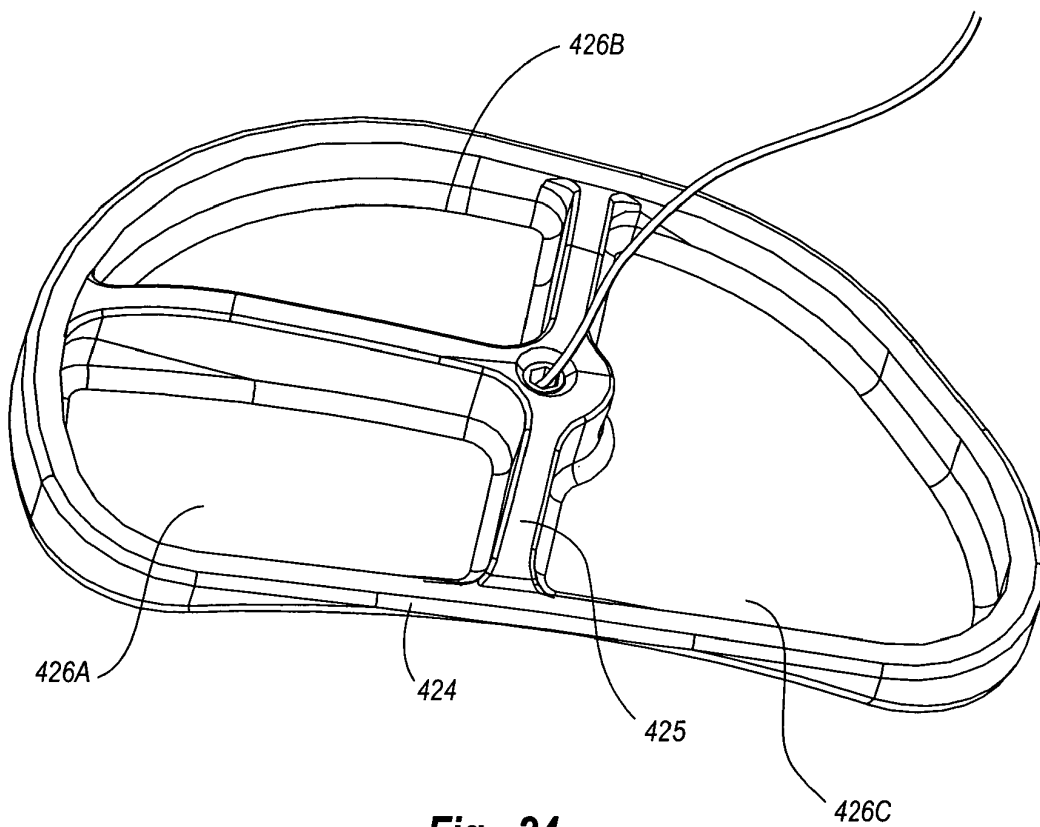
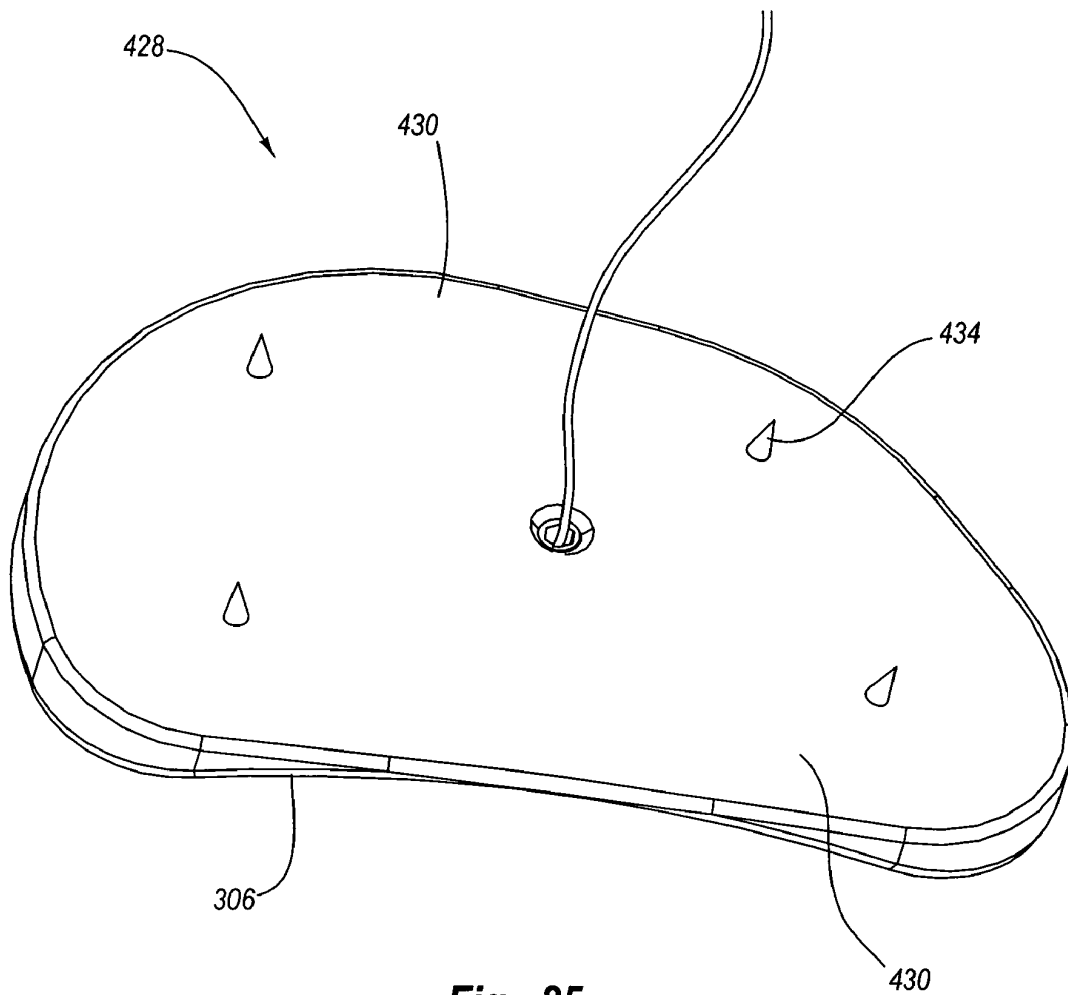


Fig. 23B



**Fig. 24**



**Fig. 25**

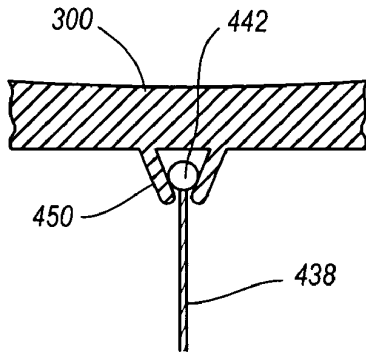


Fig. 26

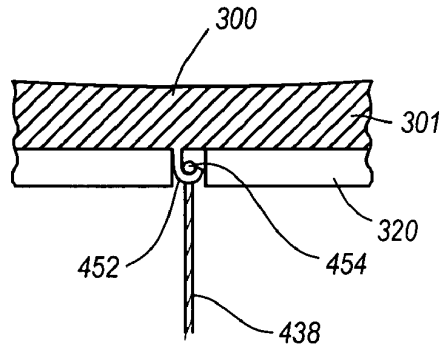


Fig. 27

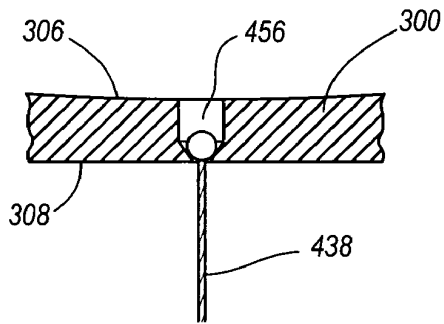


Fig. 28

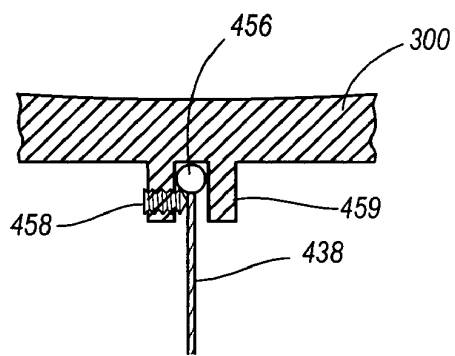


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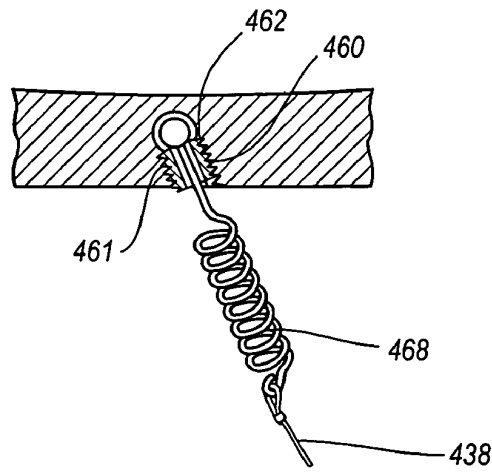
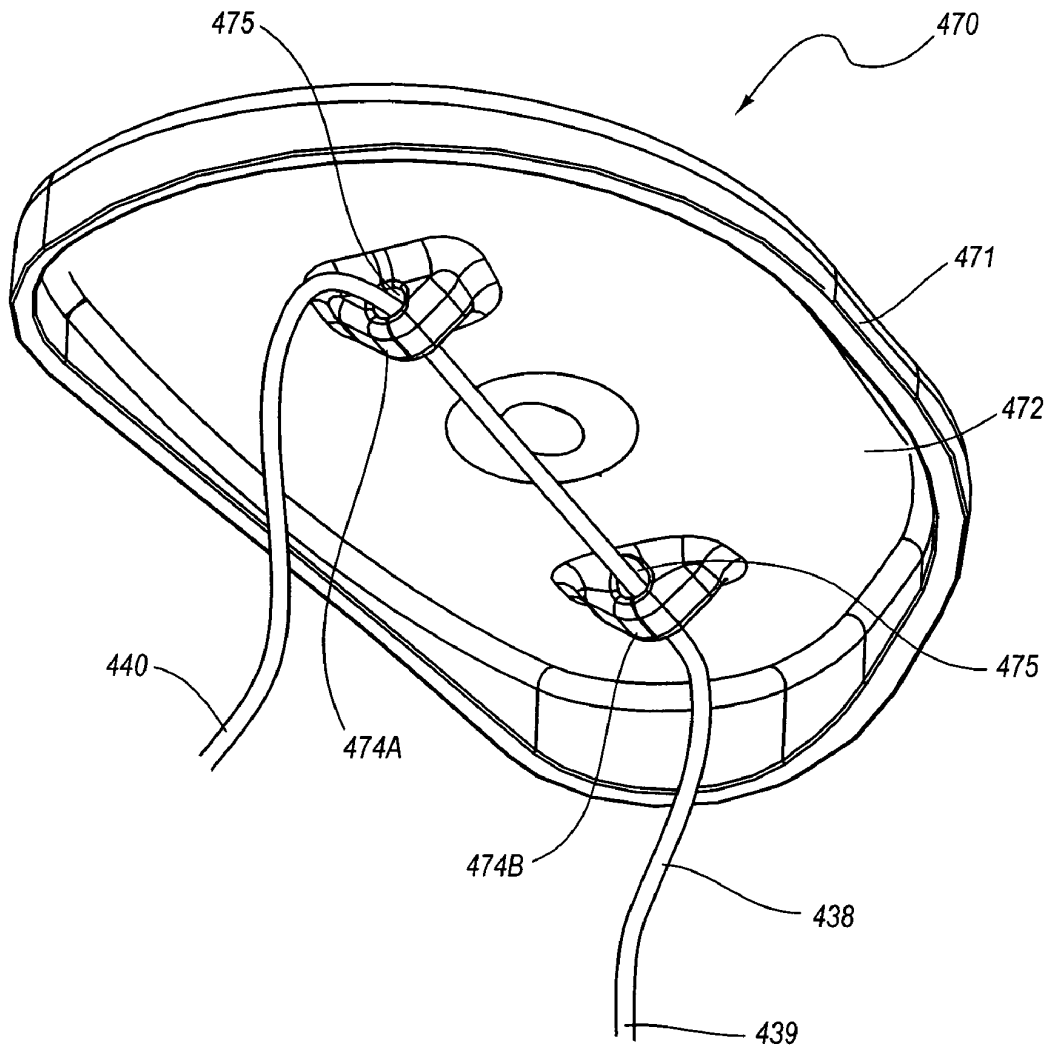
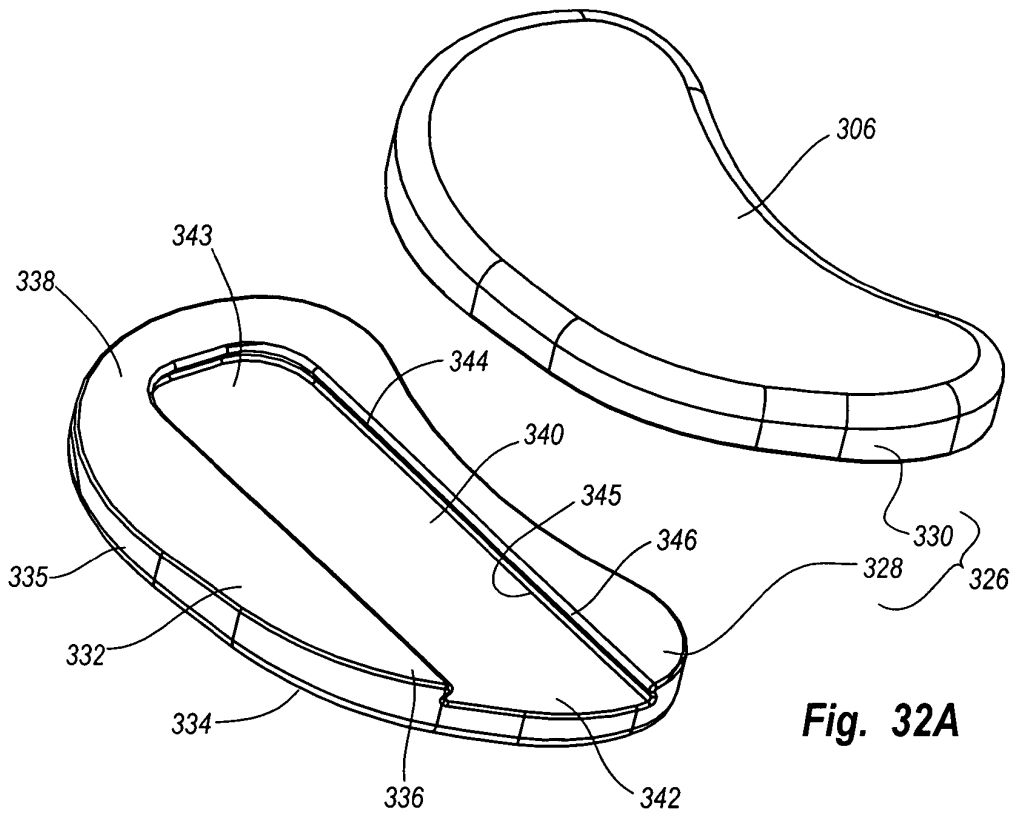


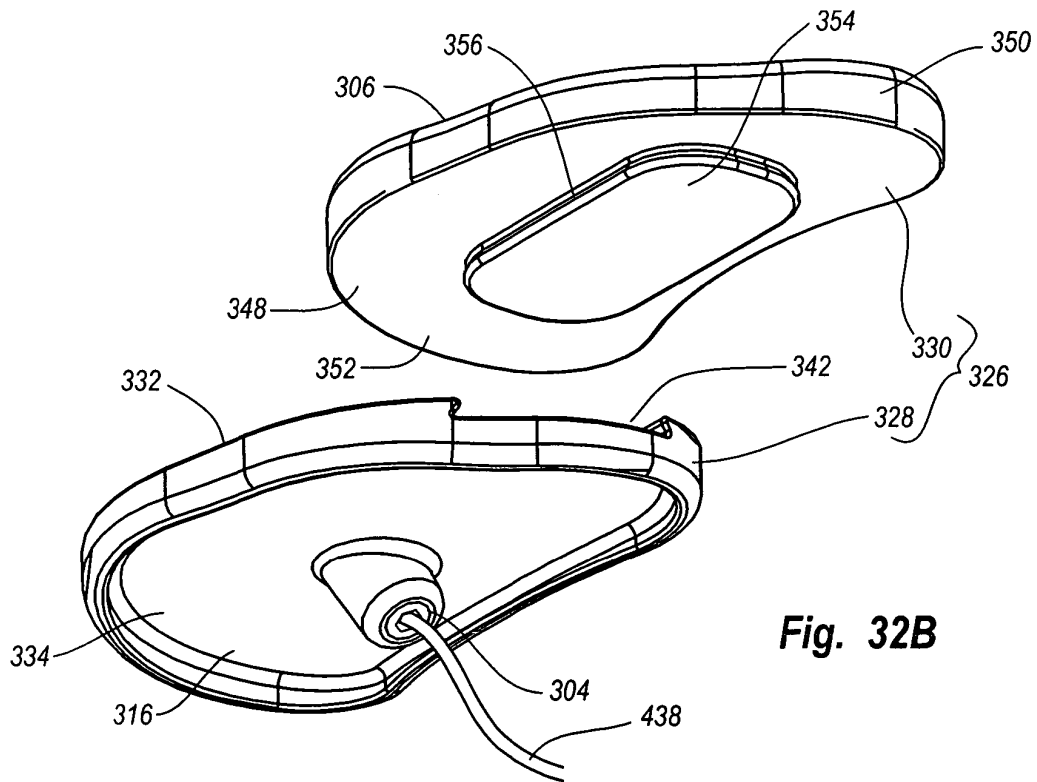
Fig. 30



**Fig. 31**

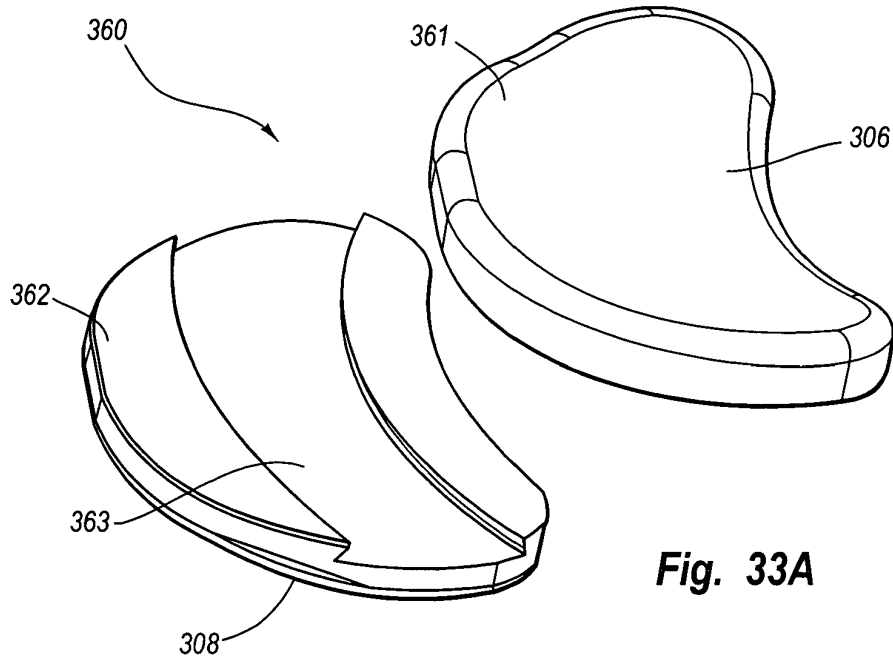


**Fig. 32A**

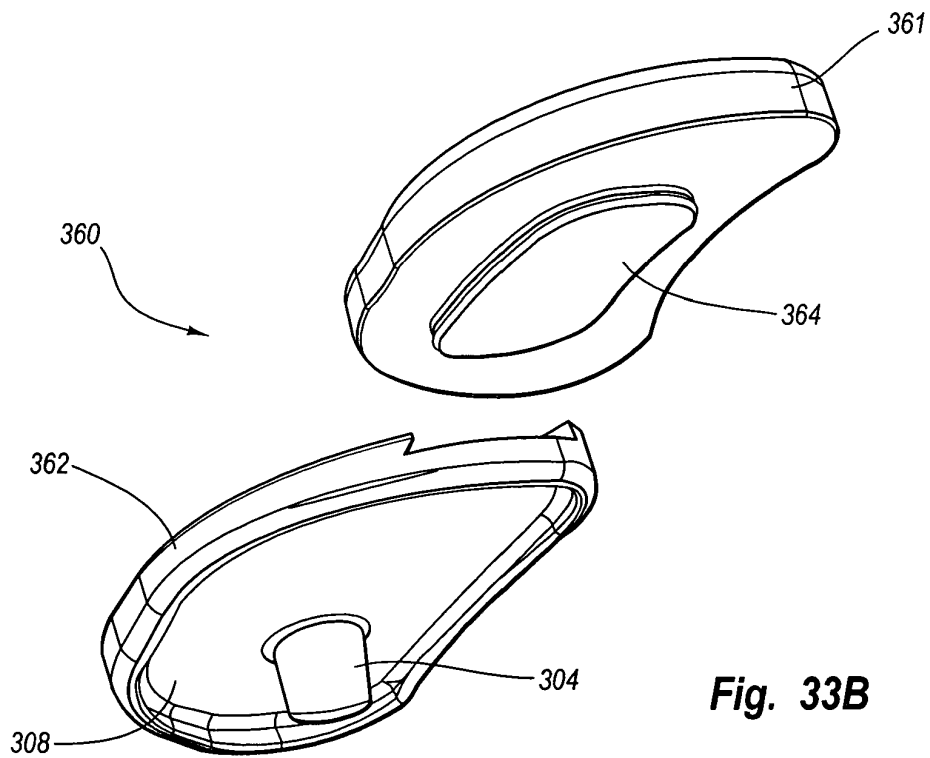


**Fig. 32B**

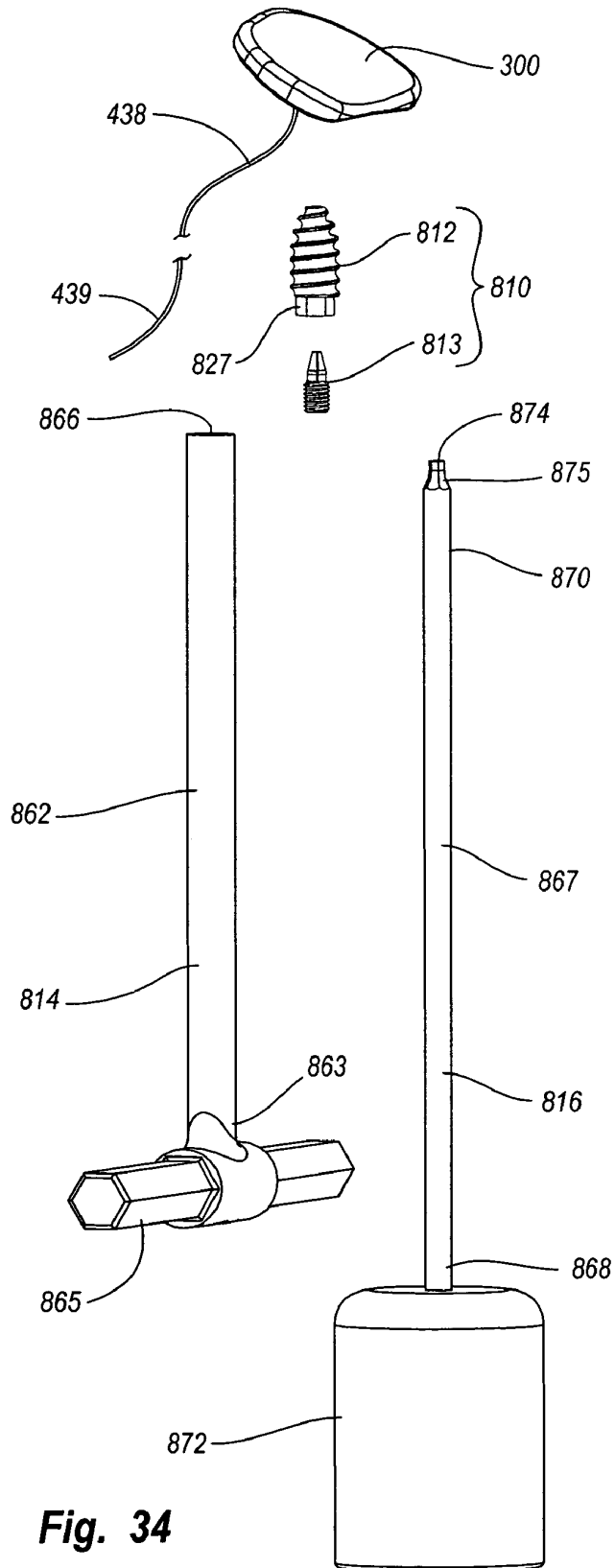




**Fig. 33A**



**Fig. 33B**



**Fig. 34**

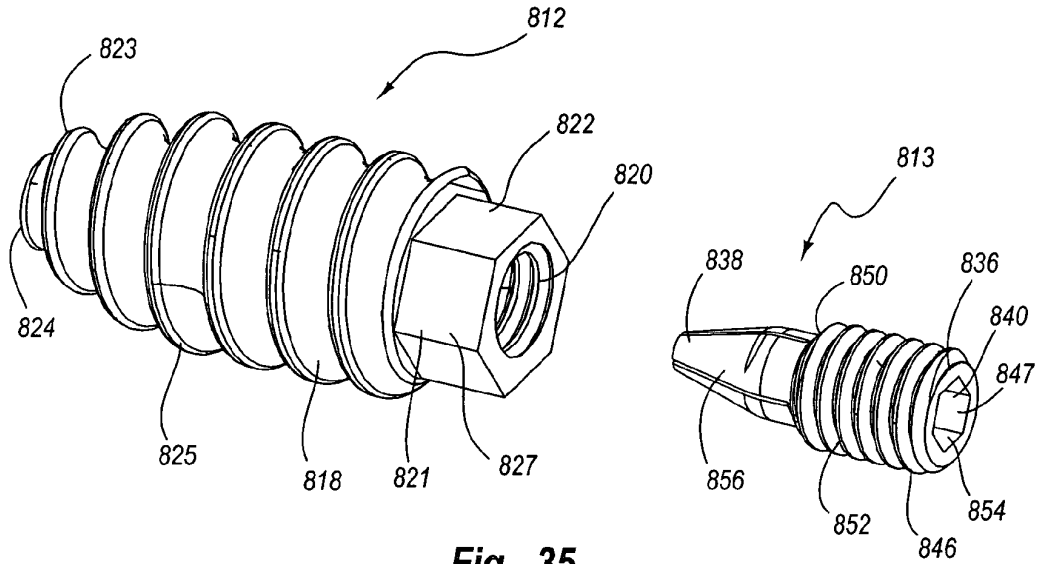


Fig. 35

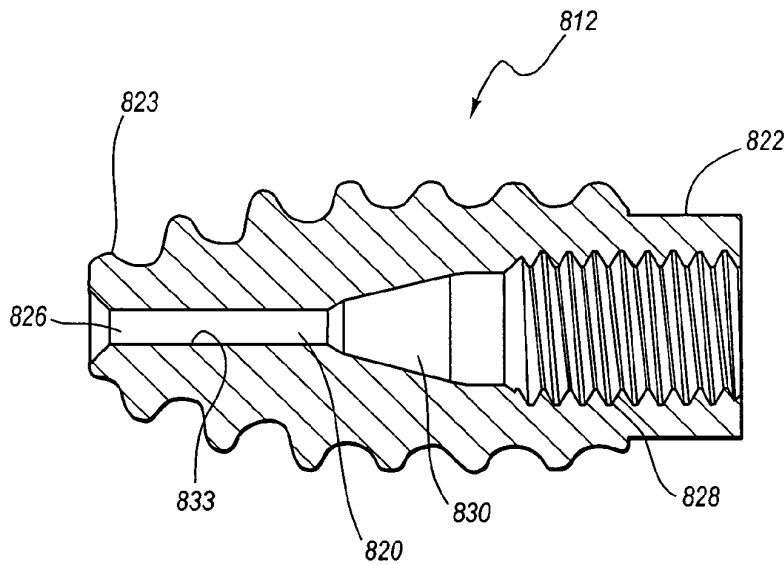
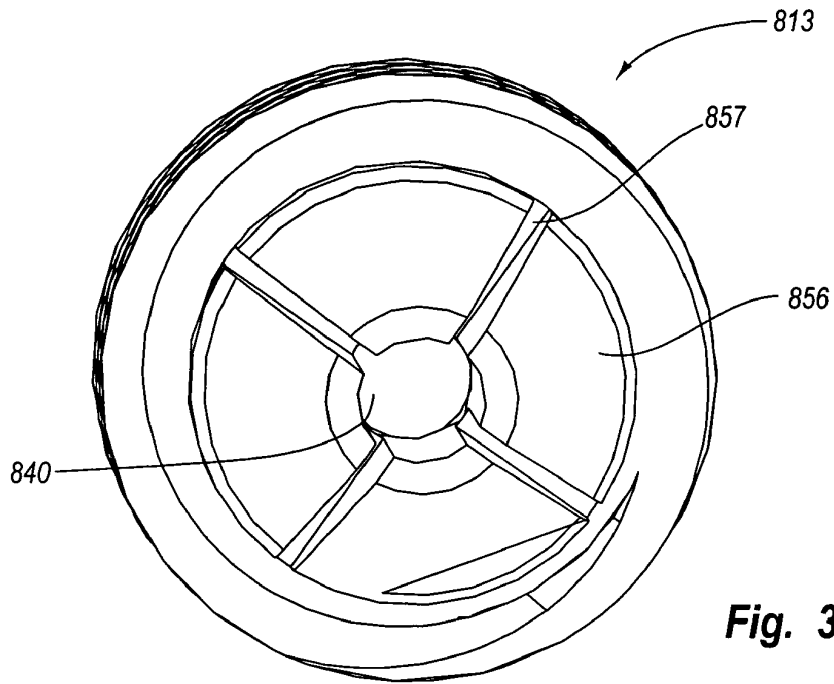
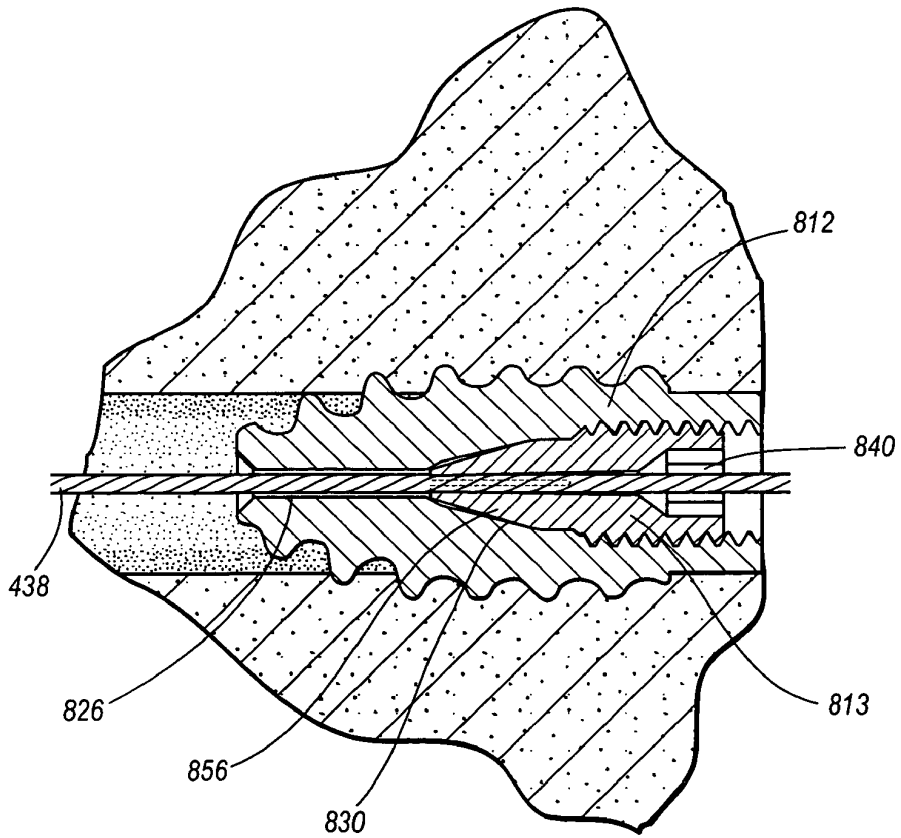


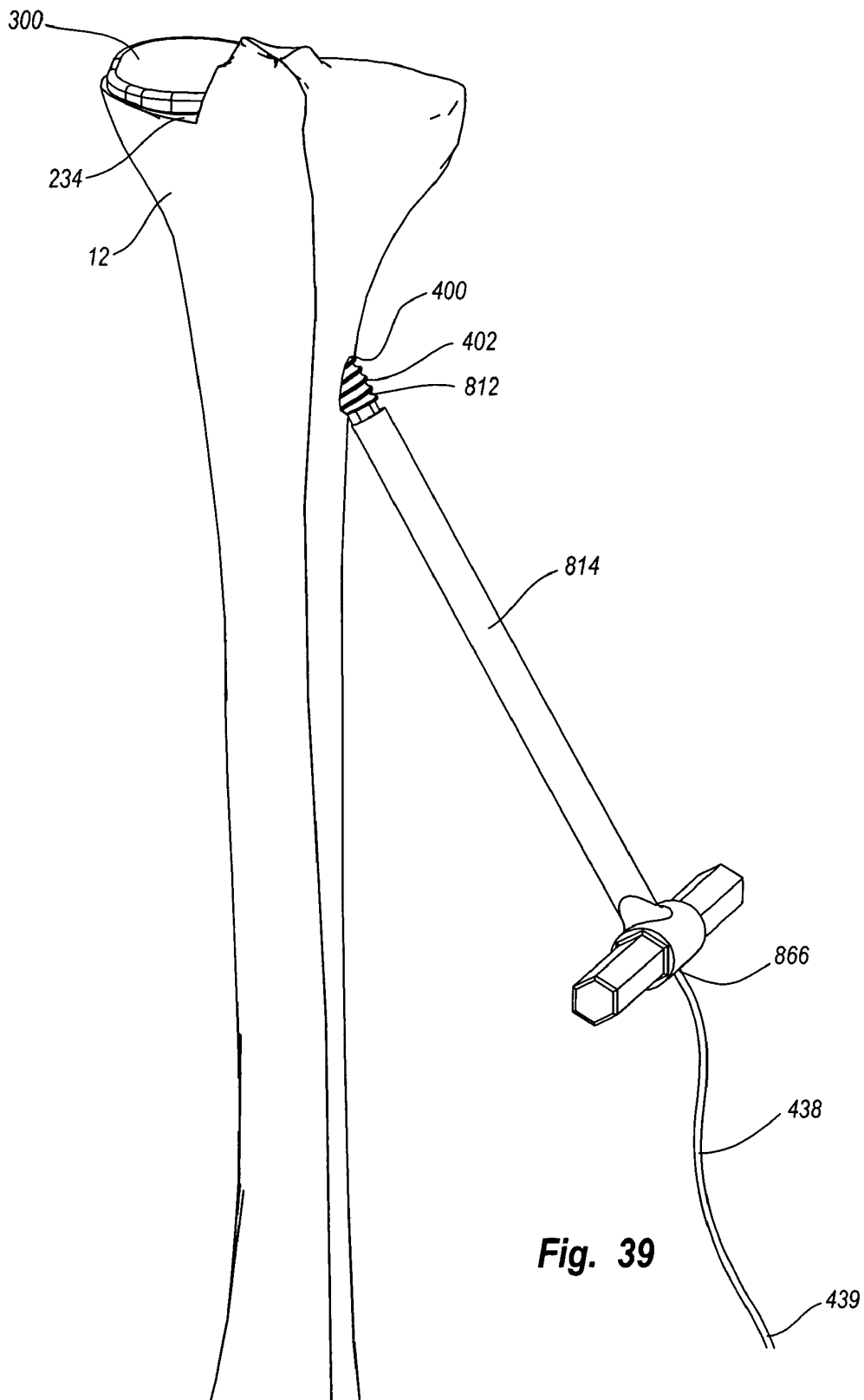
Fig. 36



**Fig. 37**



**Fig. 38**



**Fig. 39**

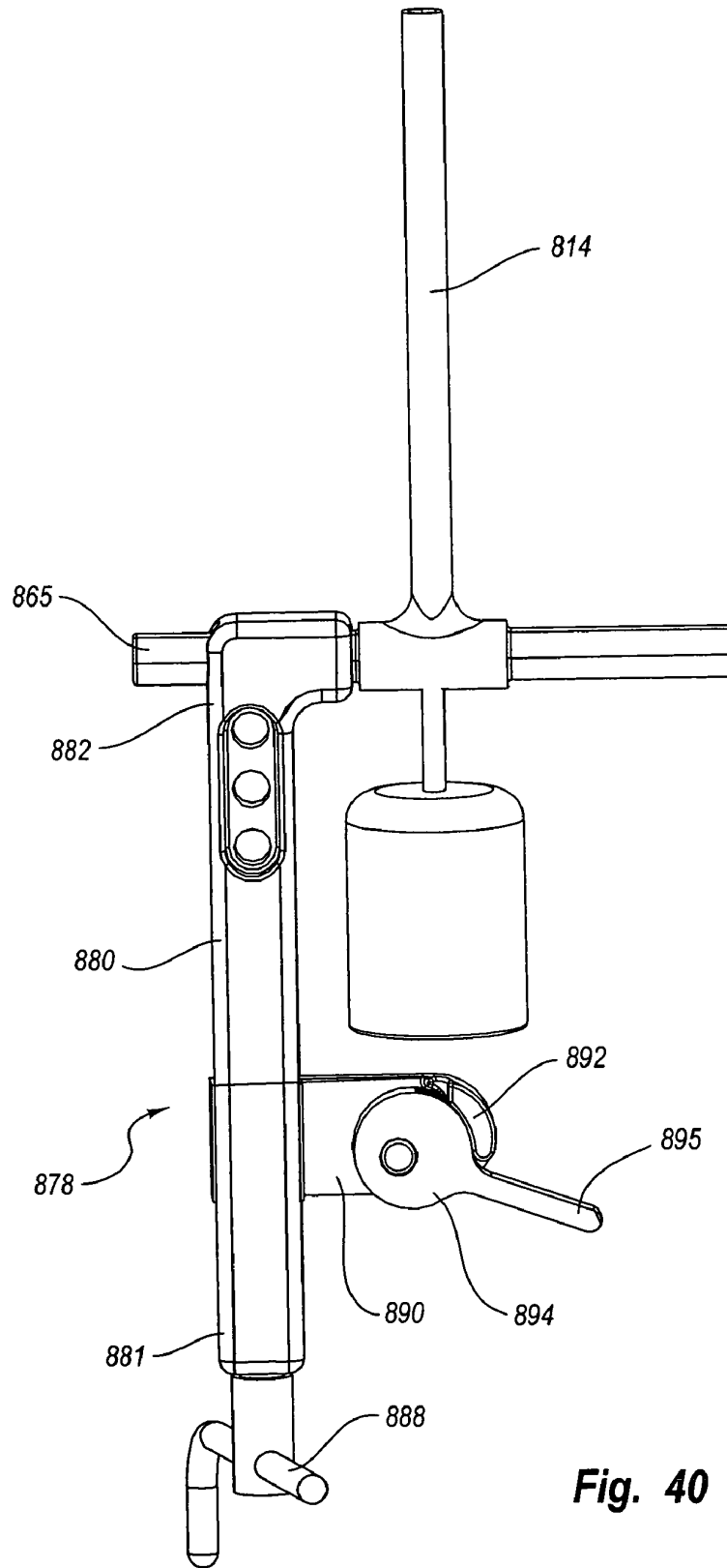
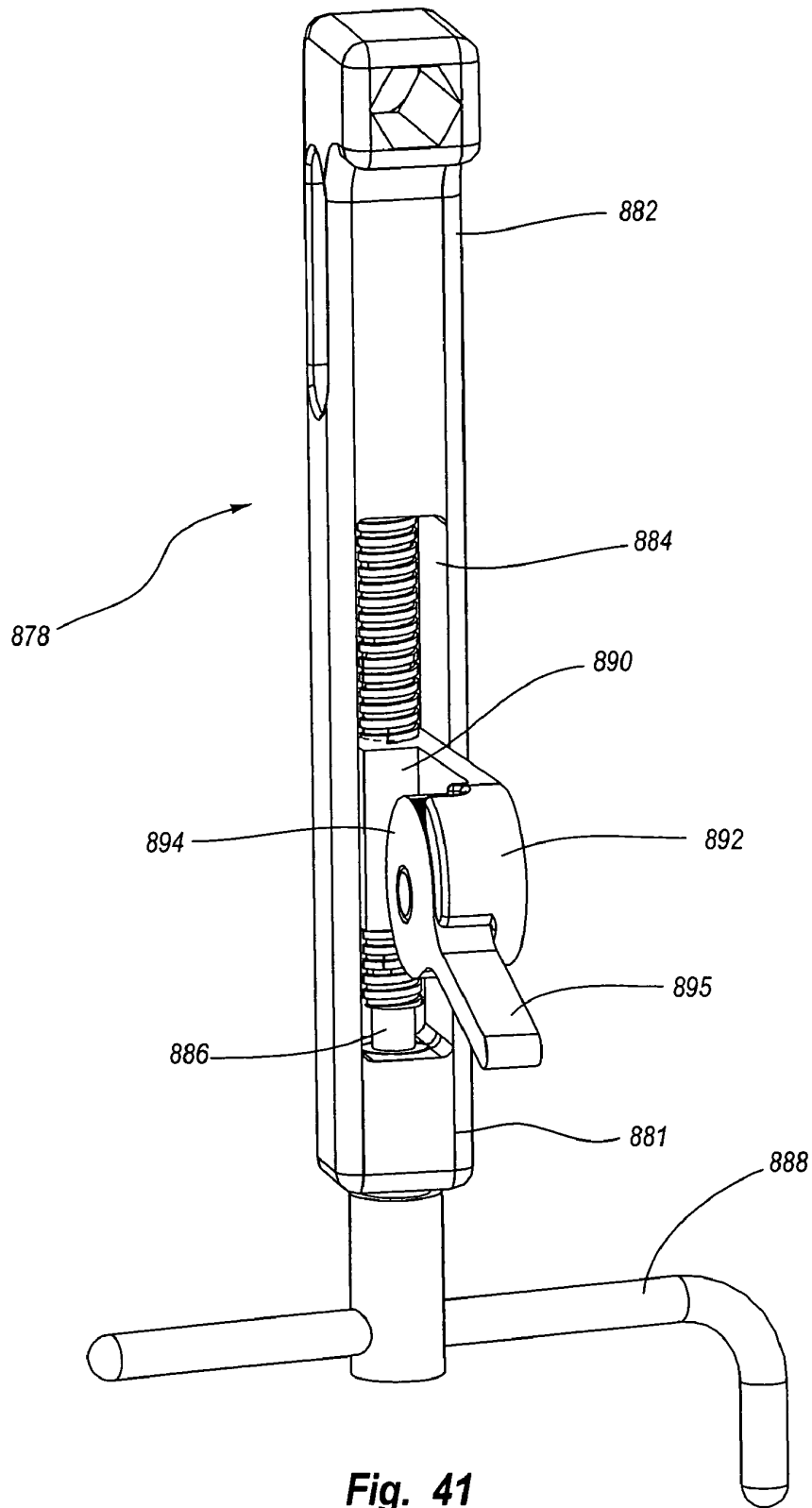


Fig. 40



**Fig. 41**

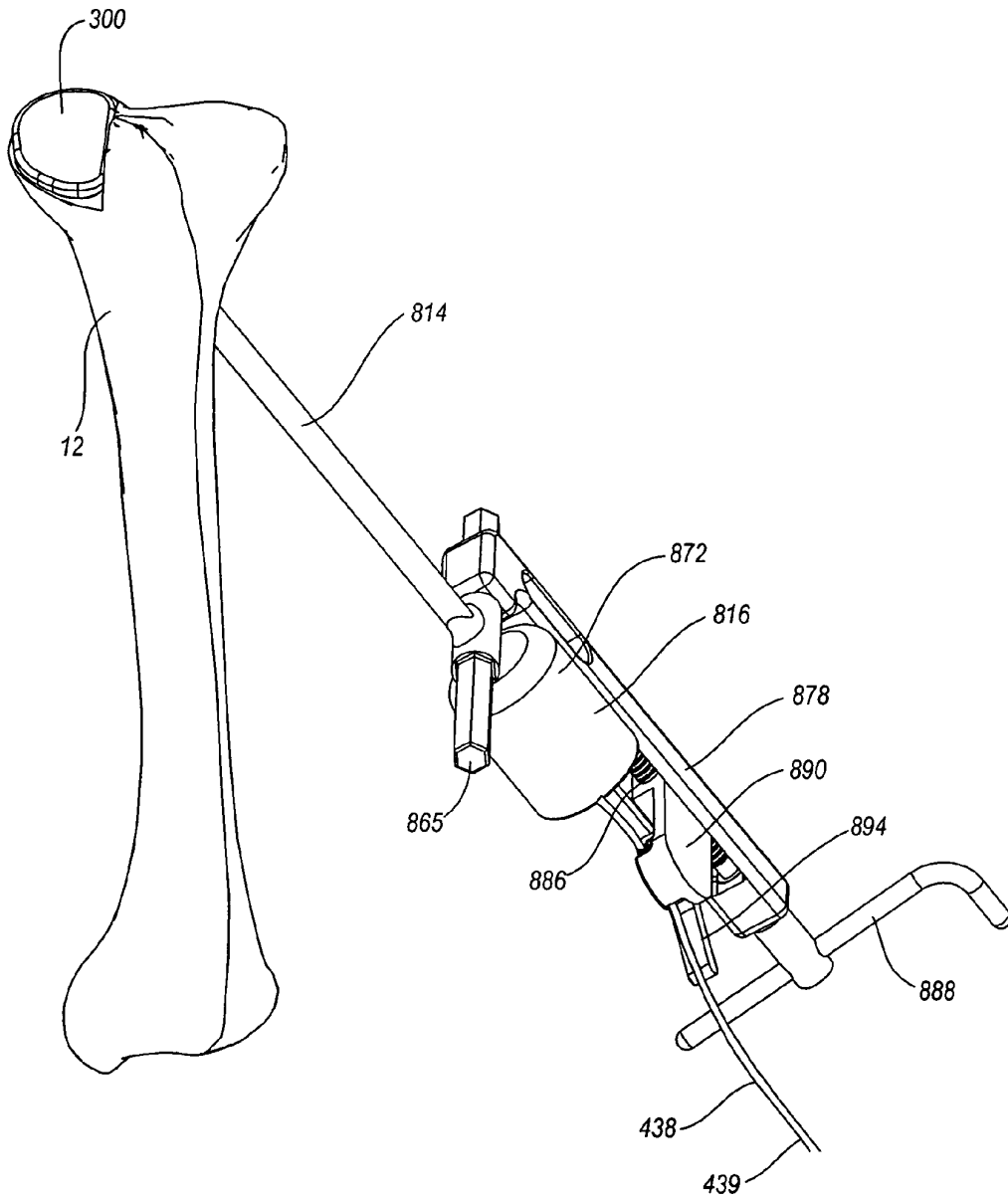


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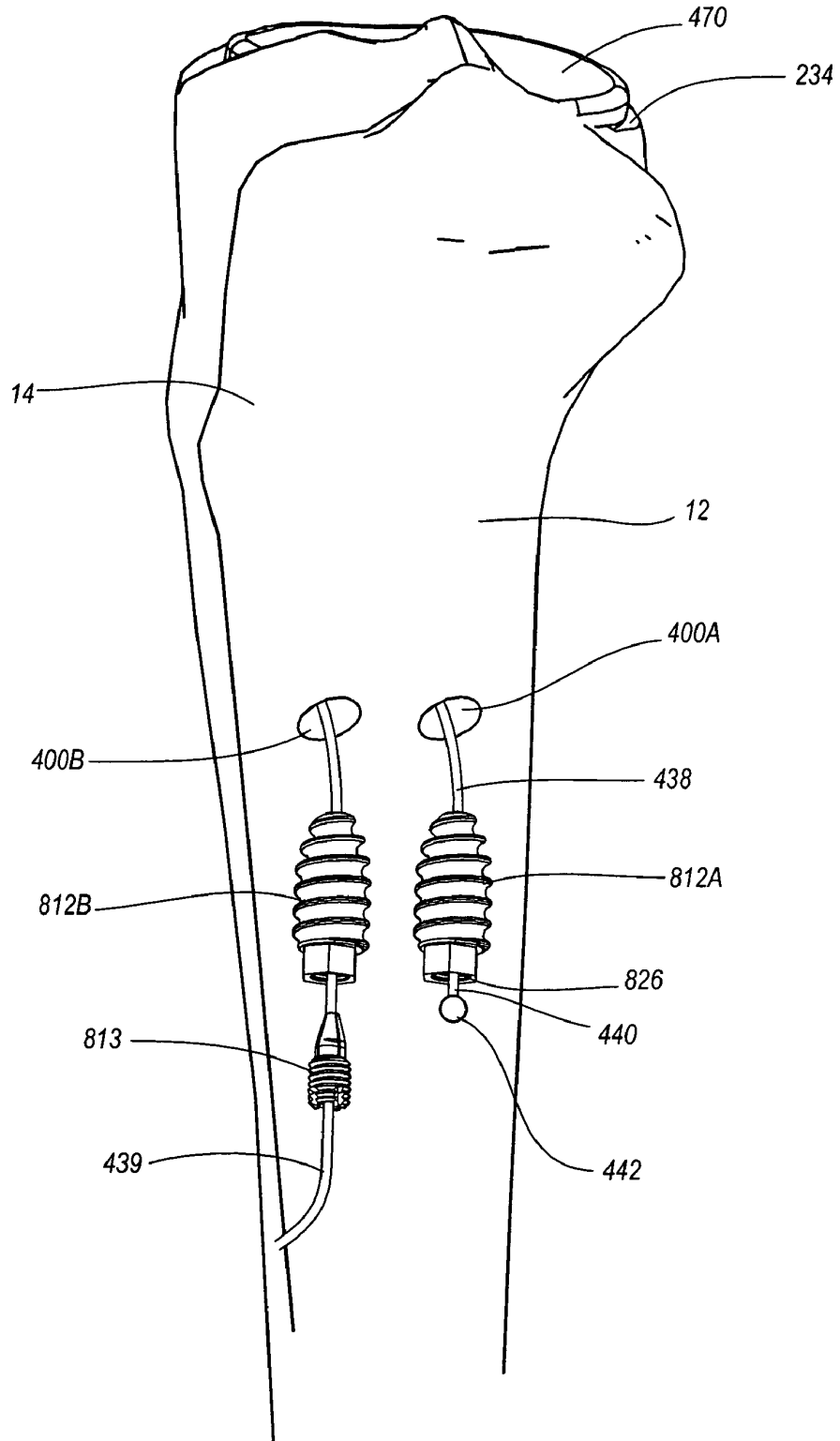


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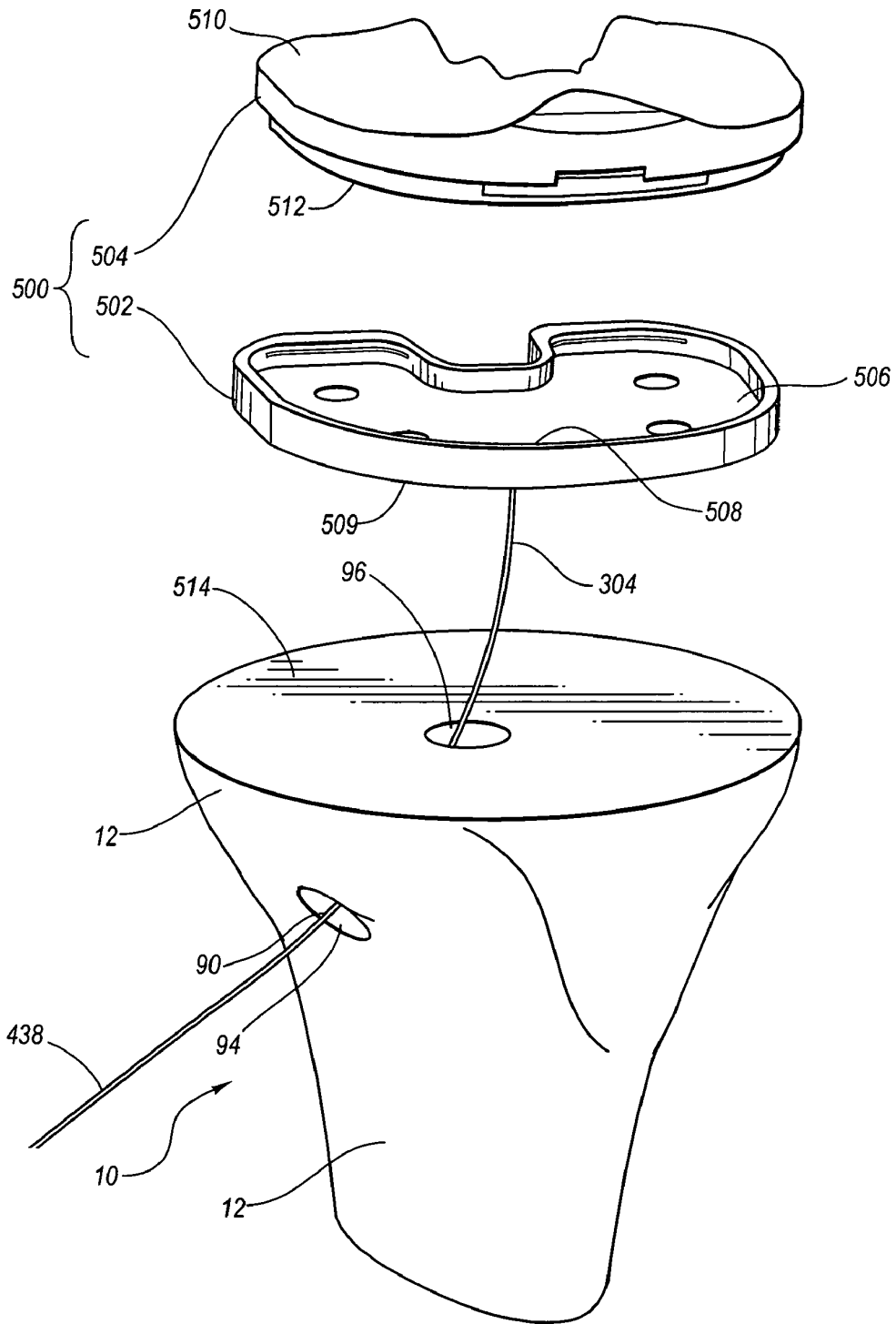


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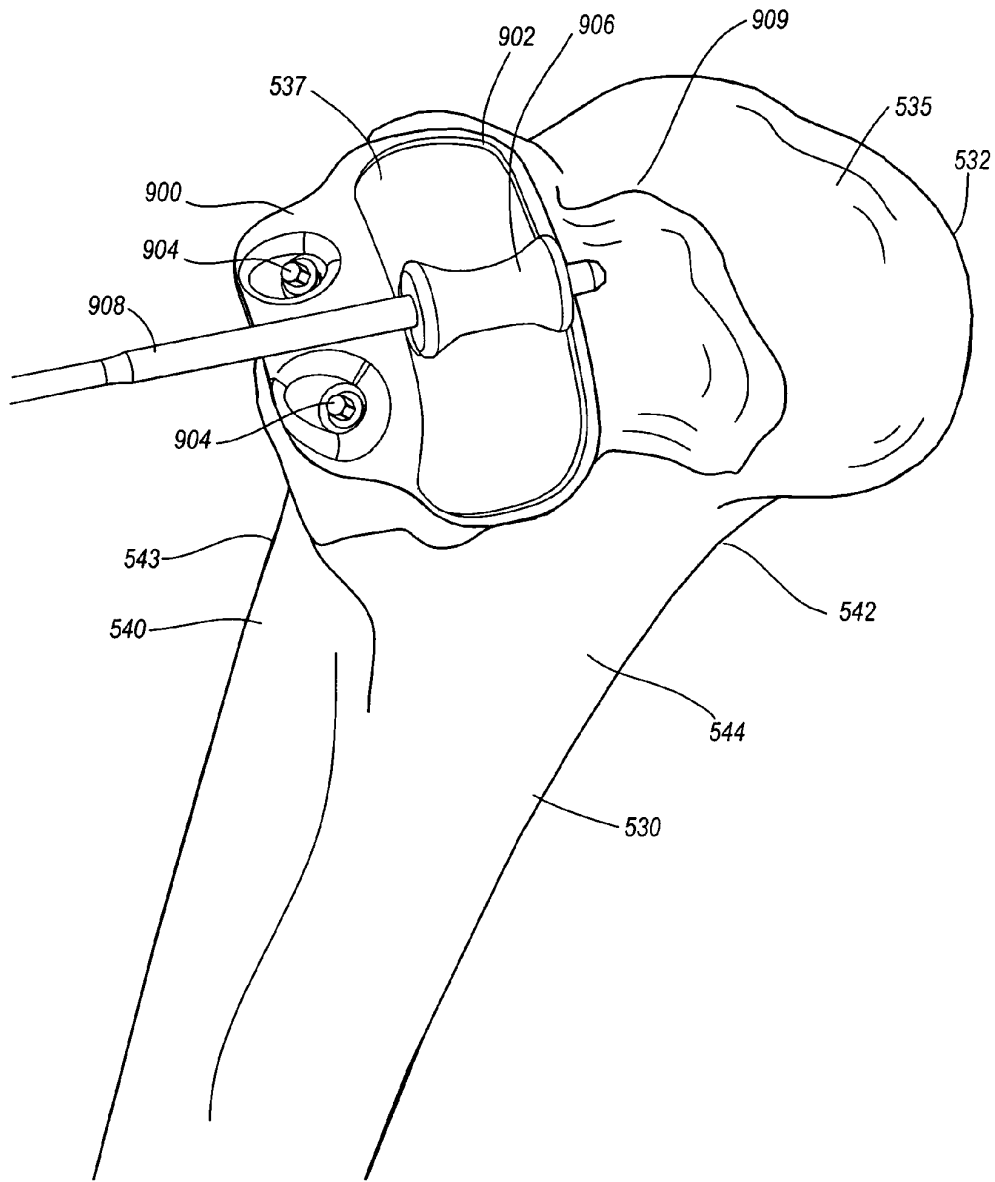


Fig. 45

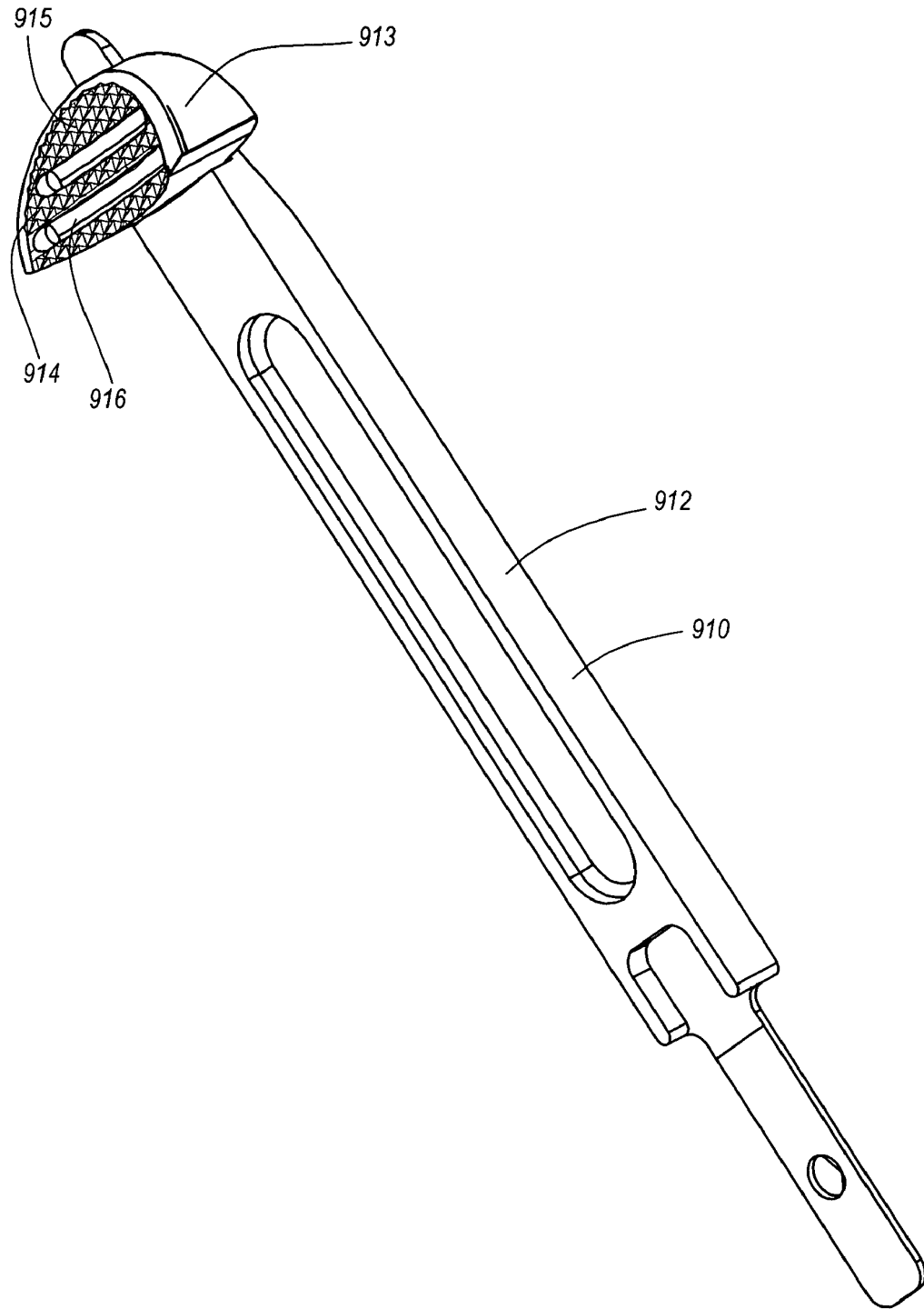
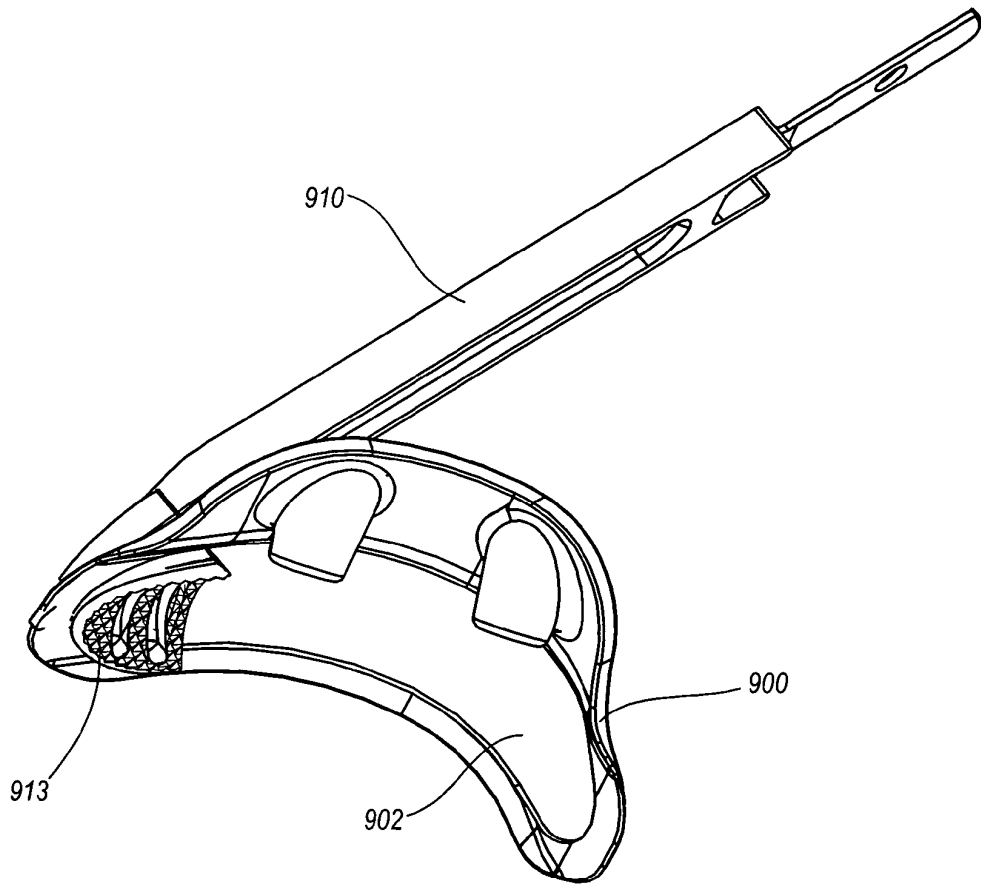


Fig. 46



**Fig. 47**

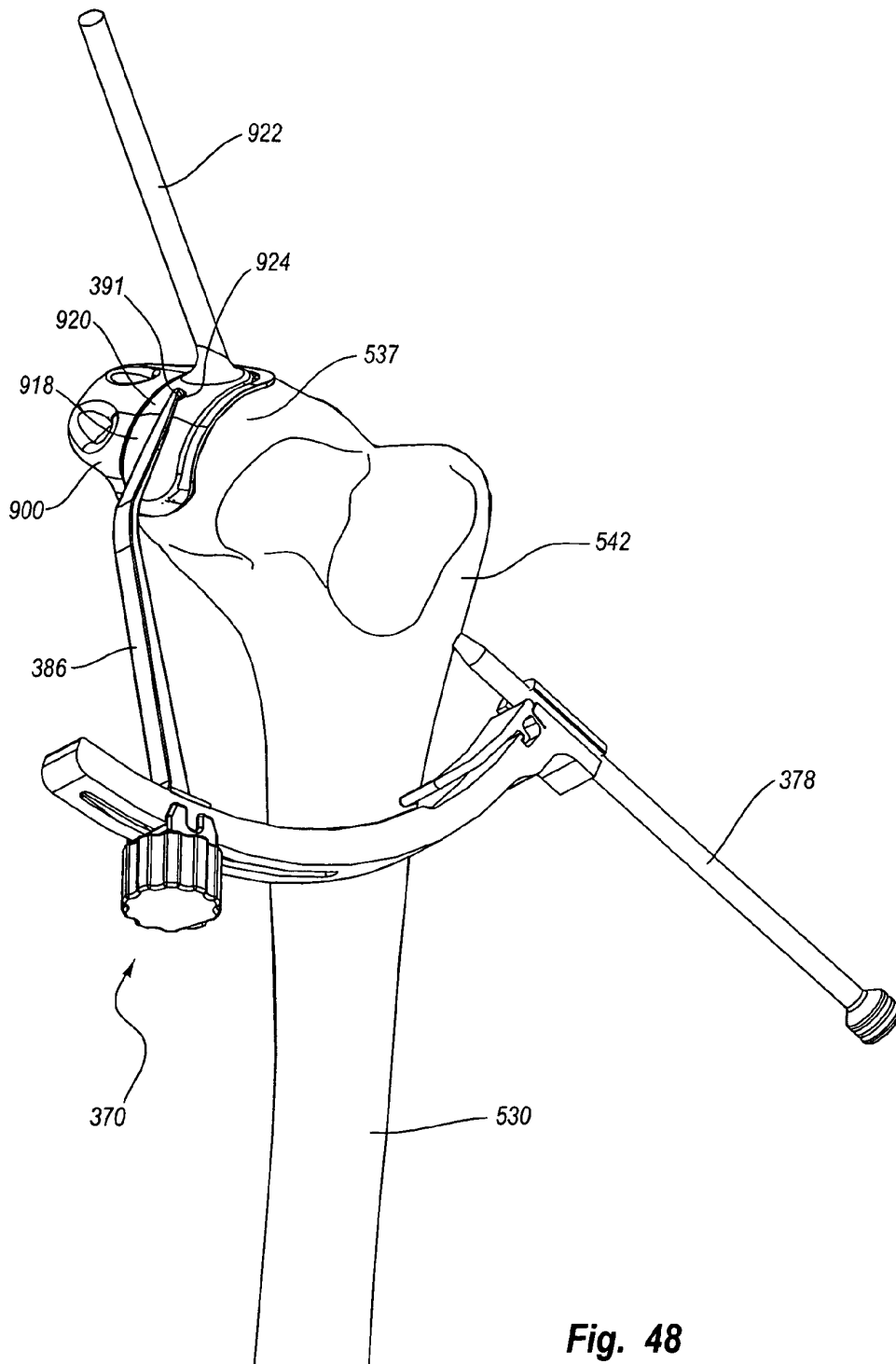
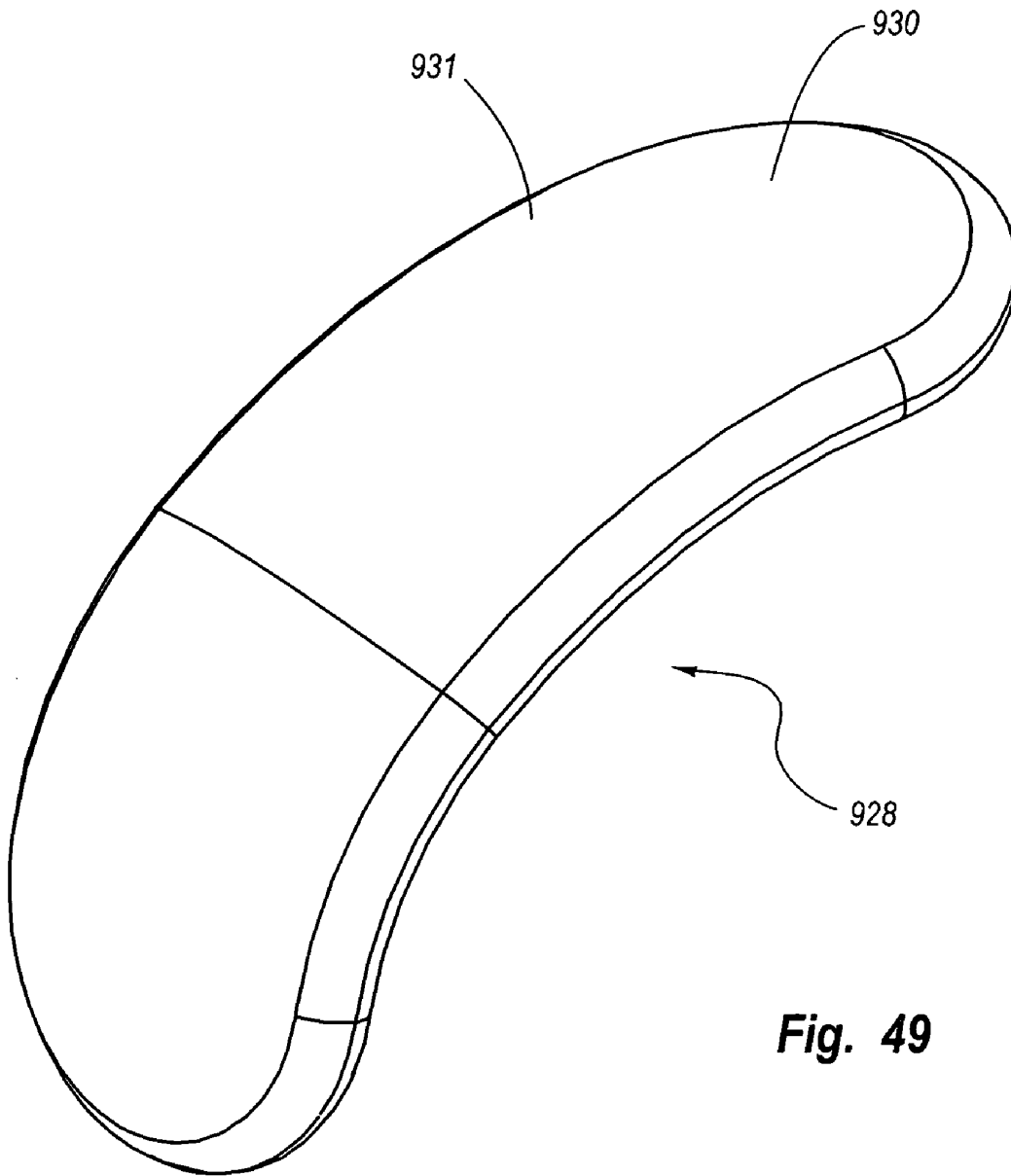
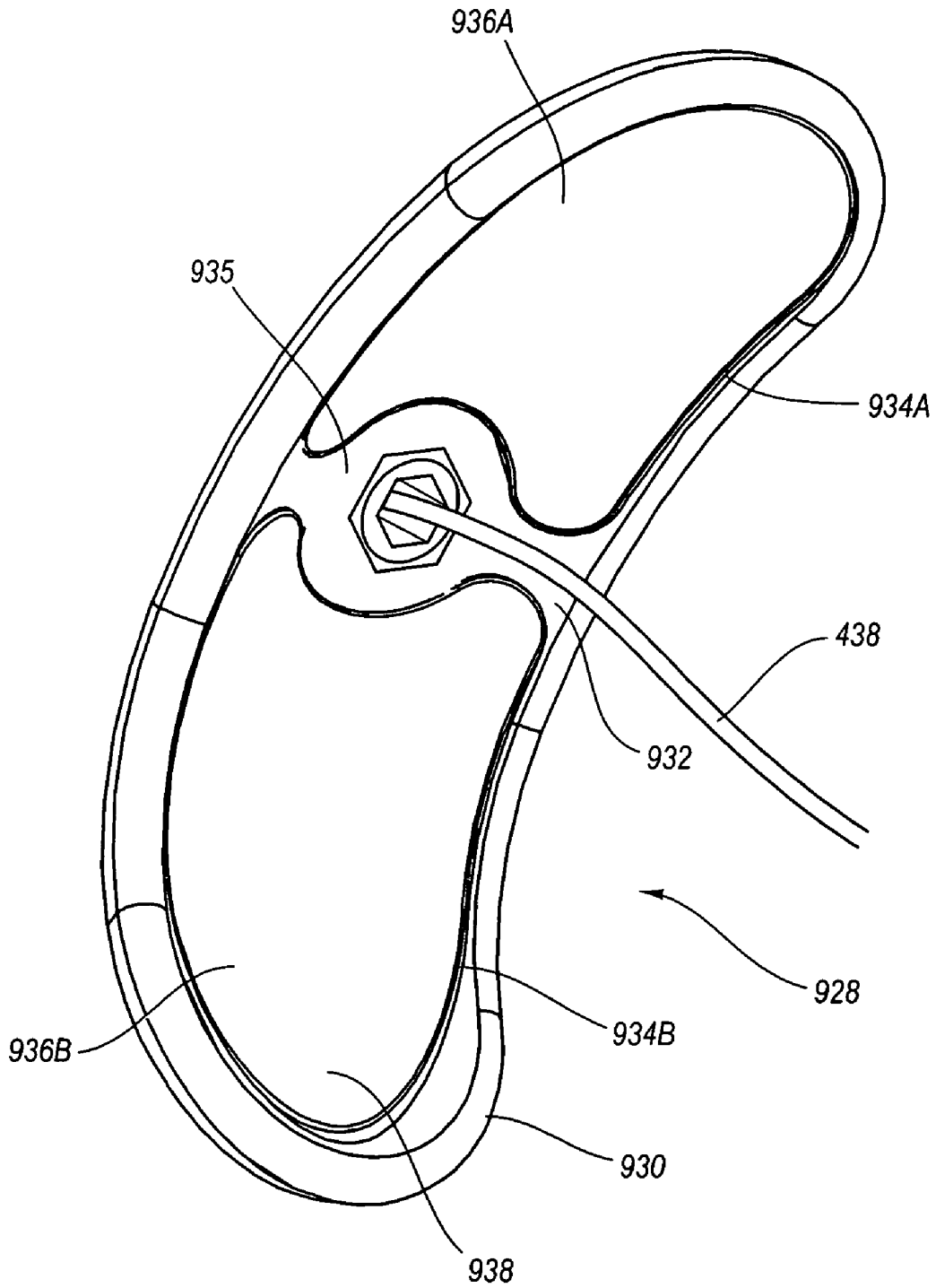


Fig. 48



**Fig. 49**



**Fig. 50**



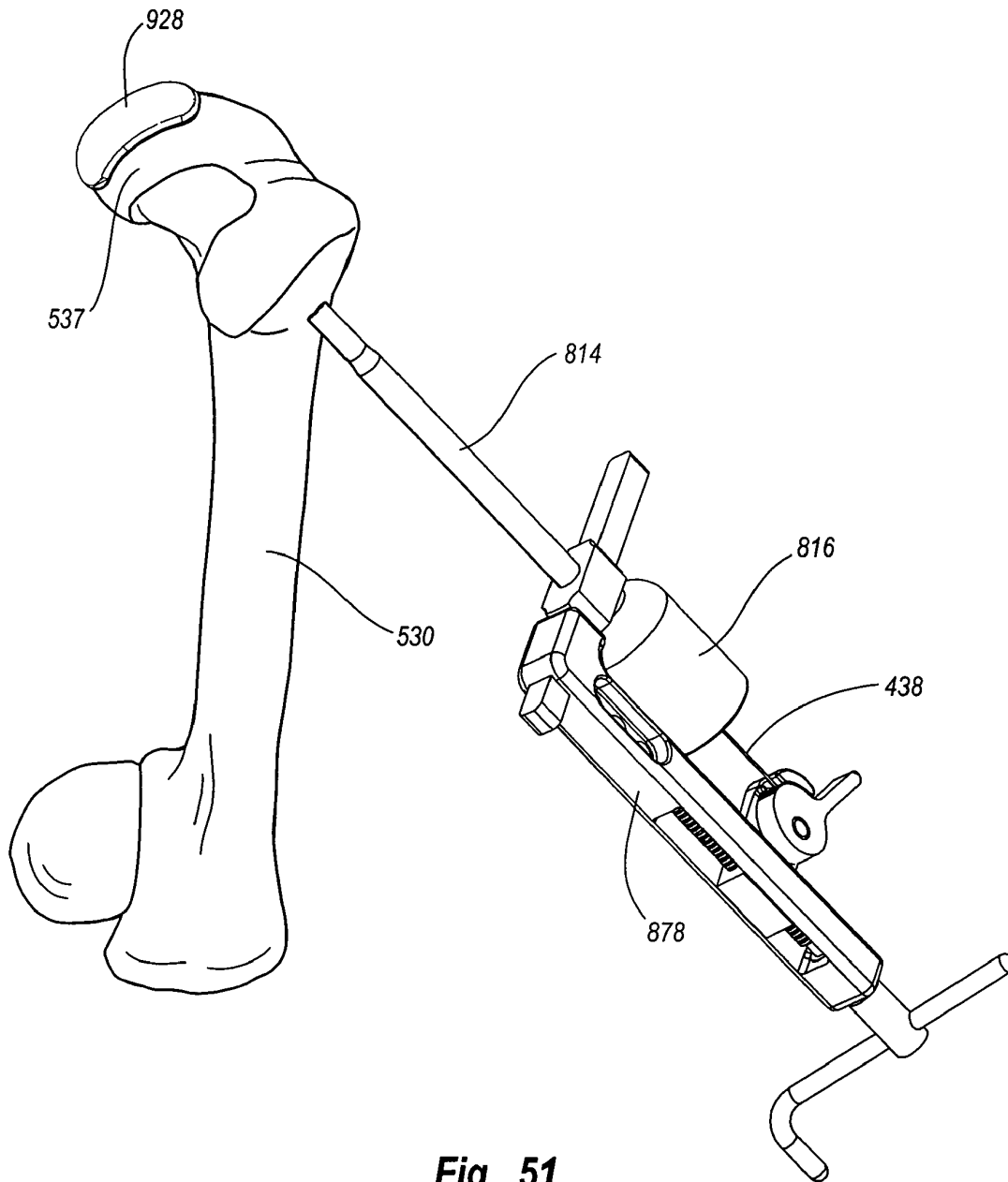


Fig. 51

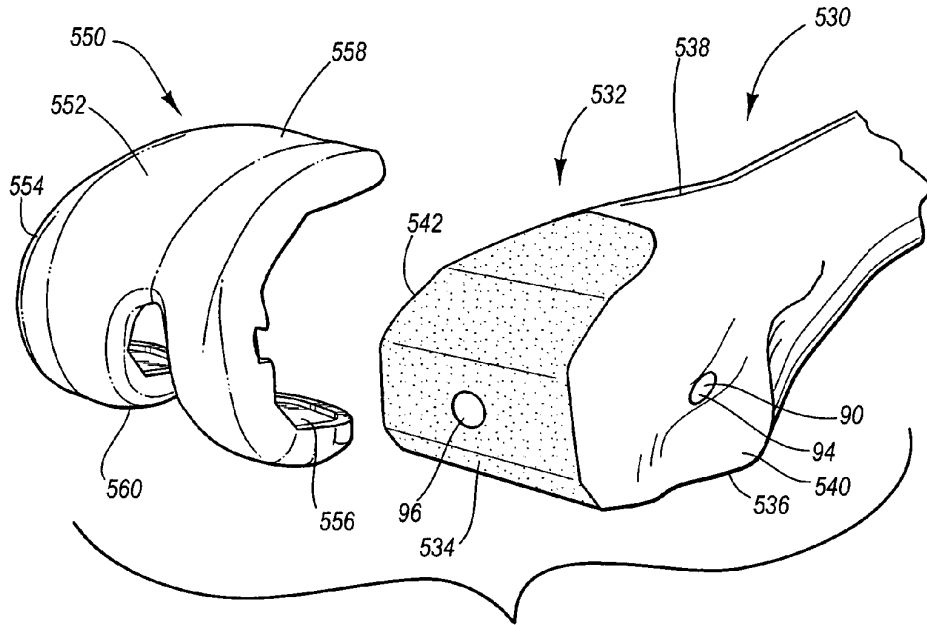


Fig. 52

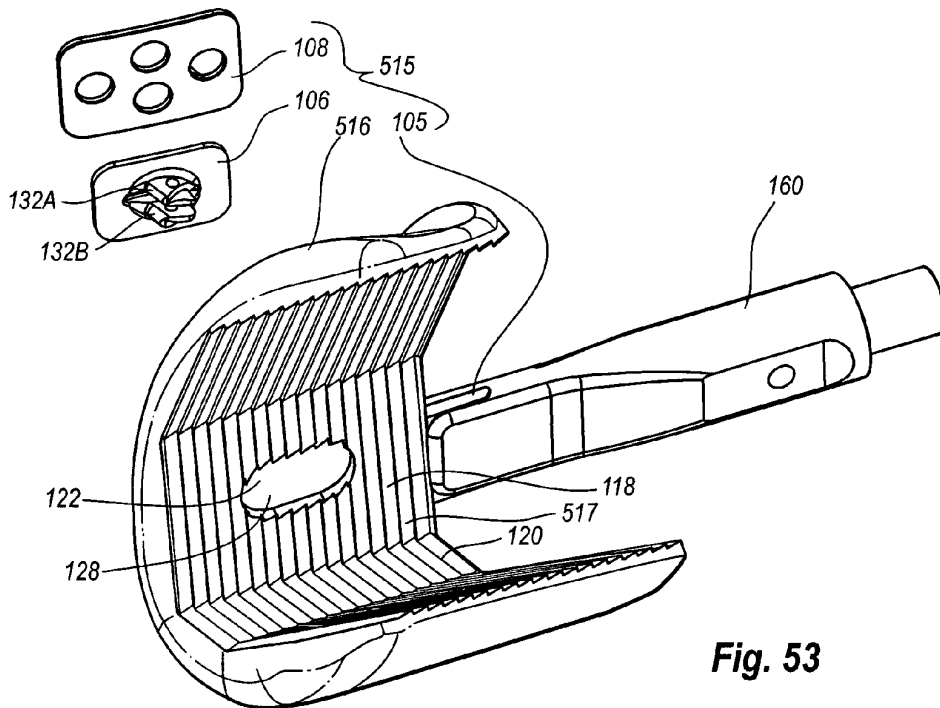


Fig. 53

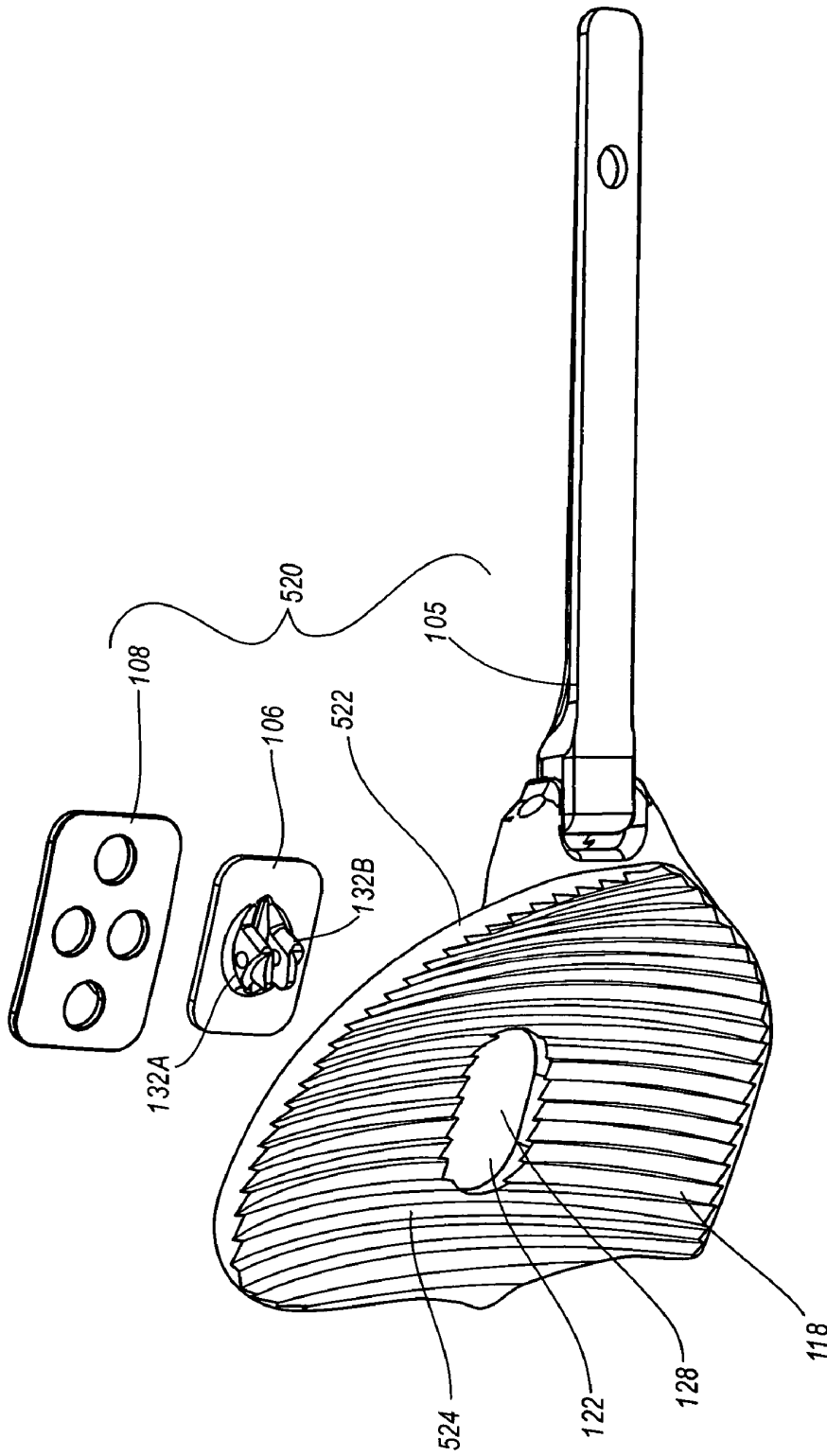


Fig. 54

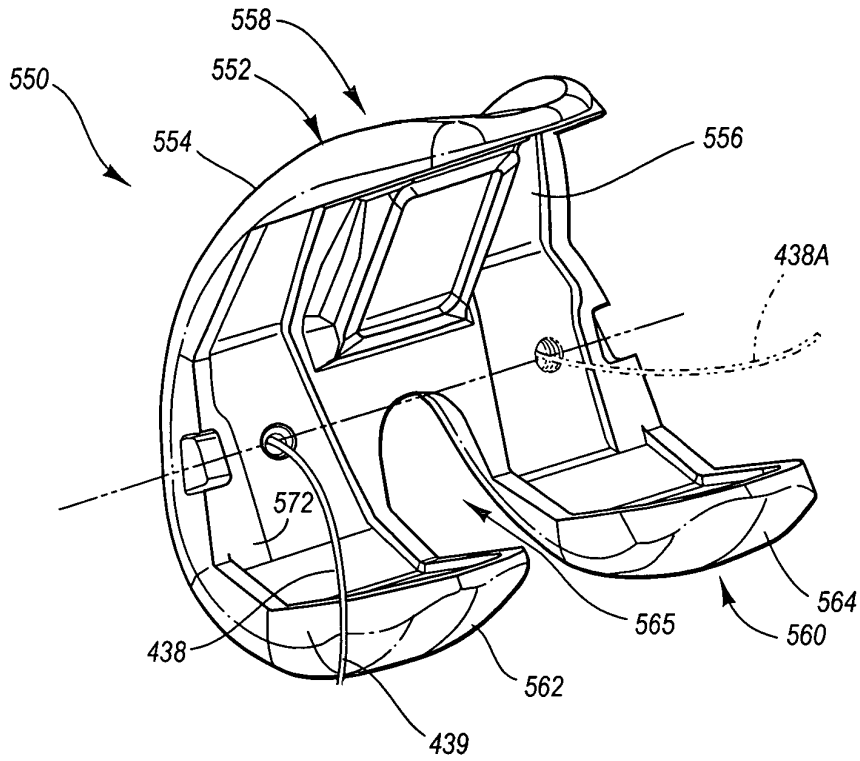


Fig. 55

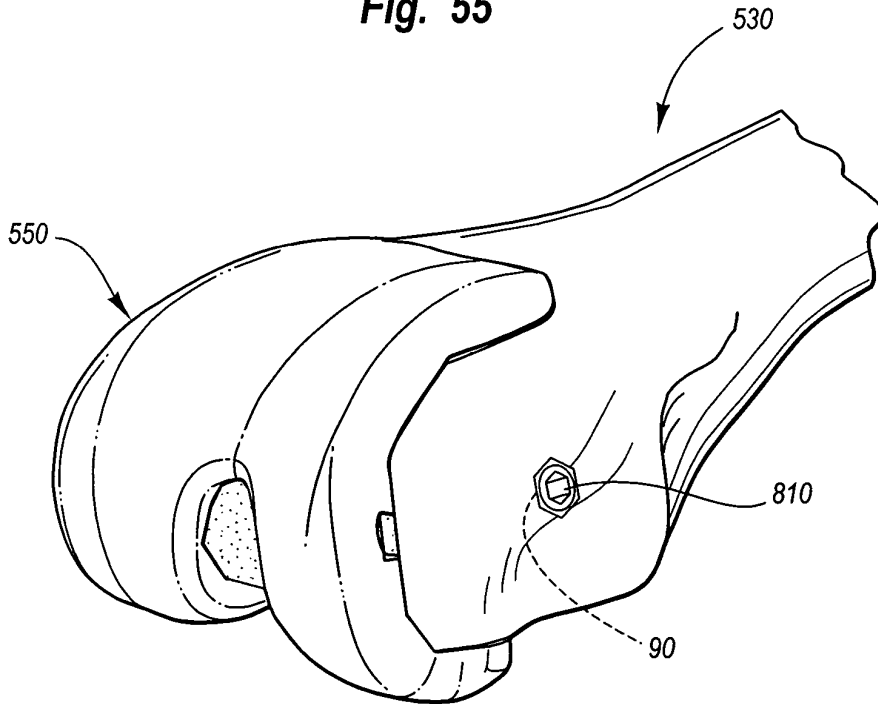


Fig. 56

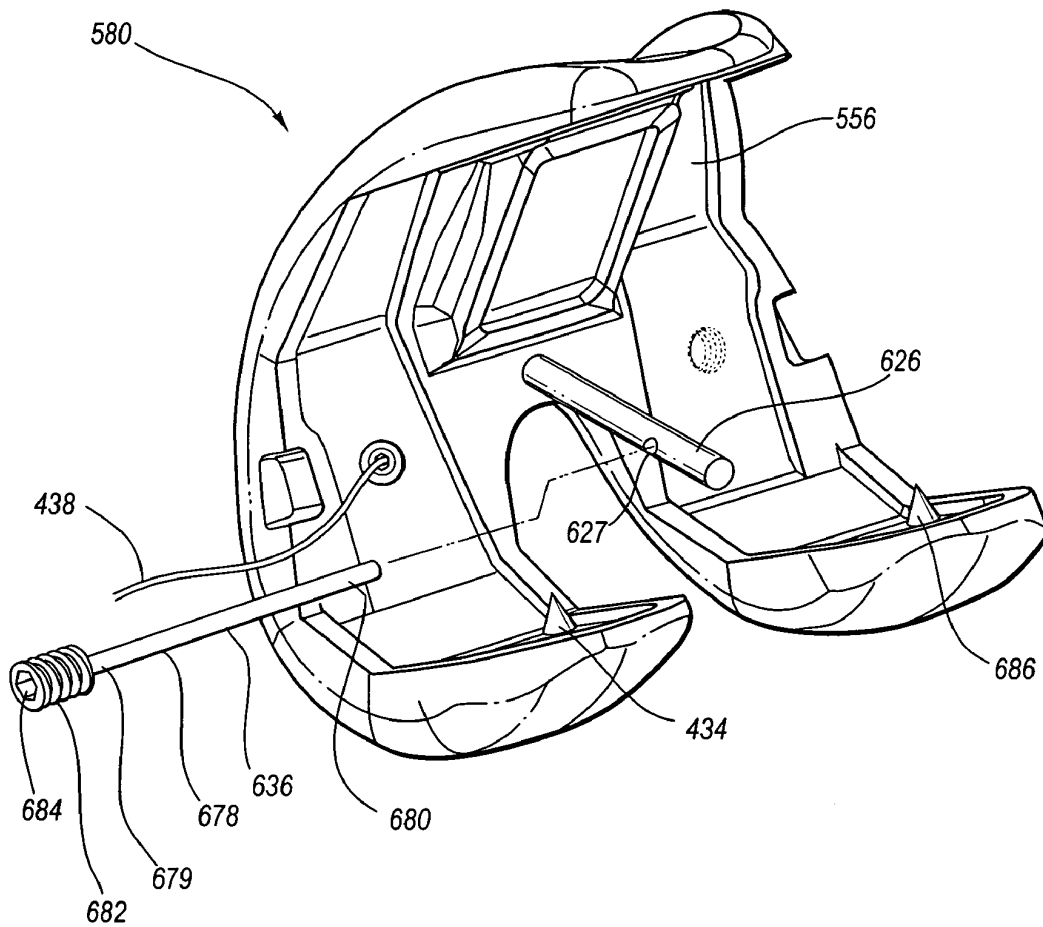


Fig. 57

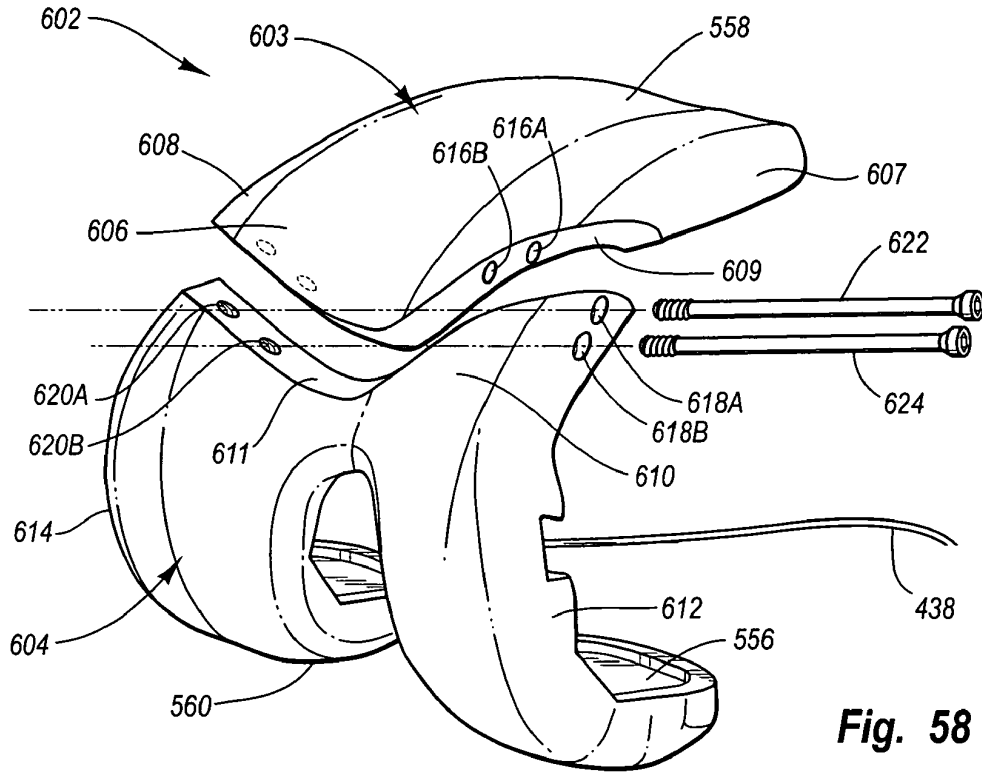


Fig. 58

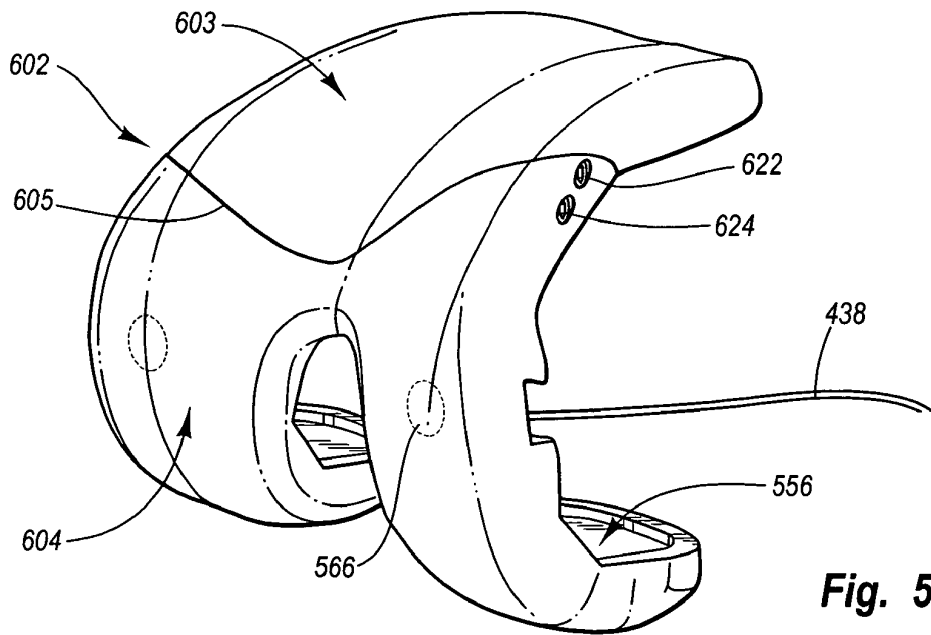


Fig. 59

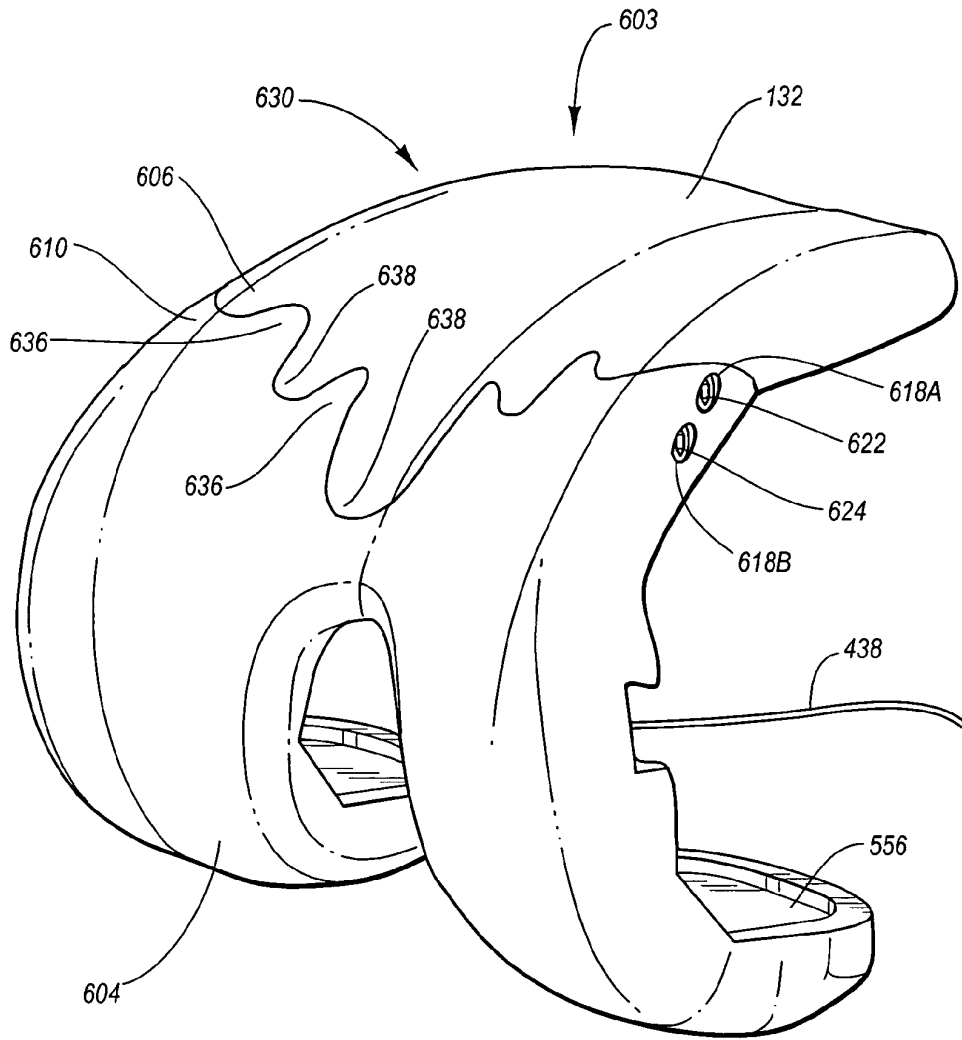
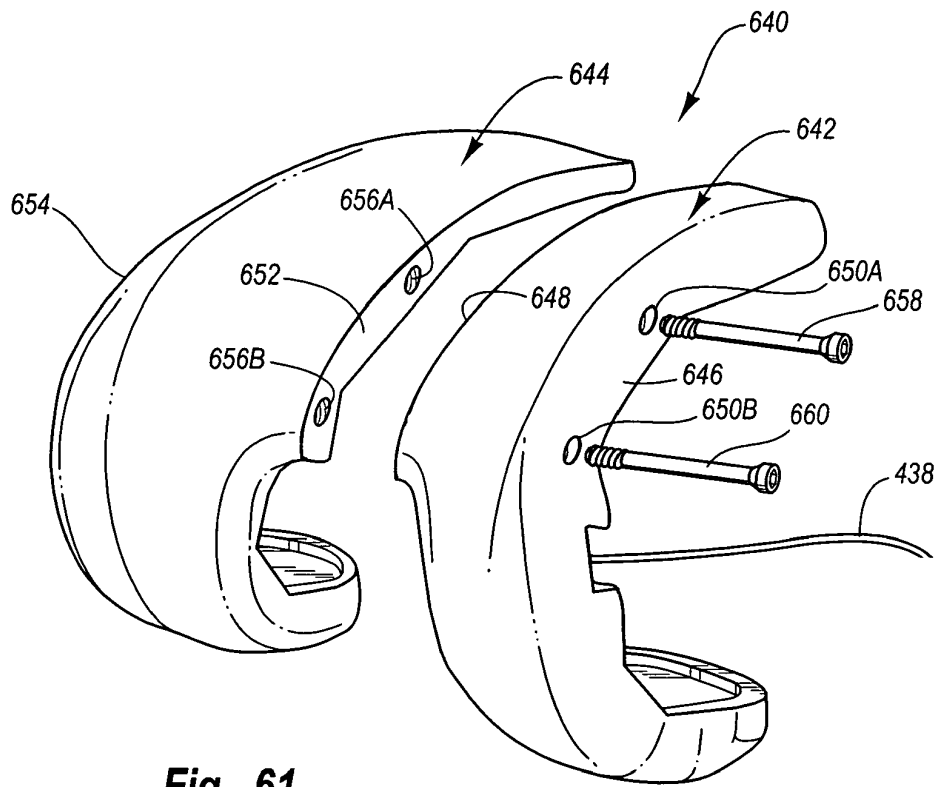
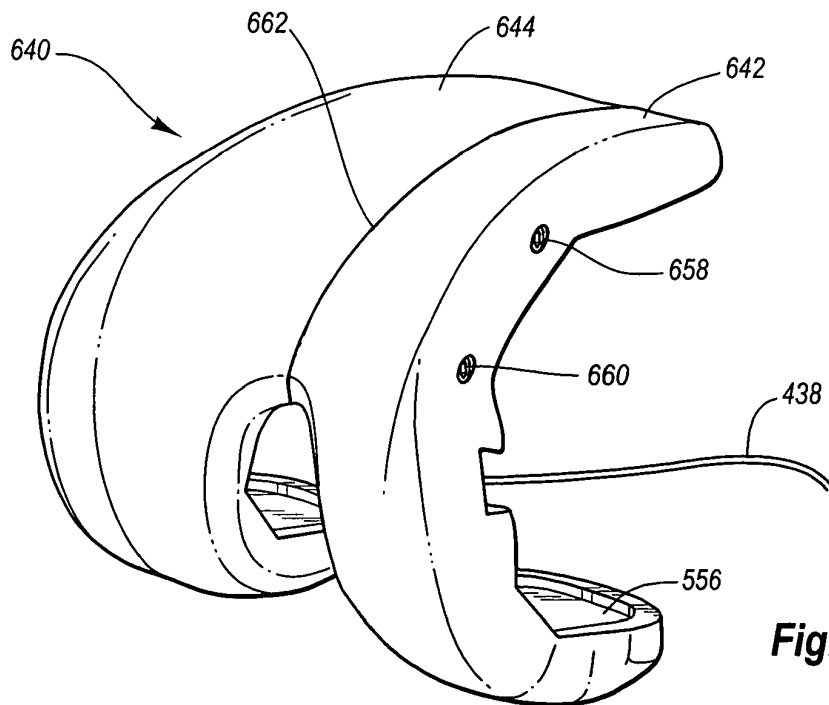


Fig. 60



**Fig. 61**



**Fig. 62**



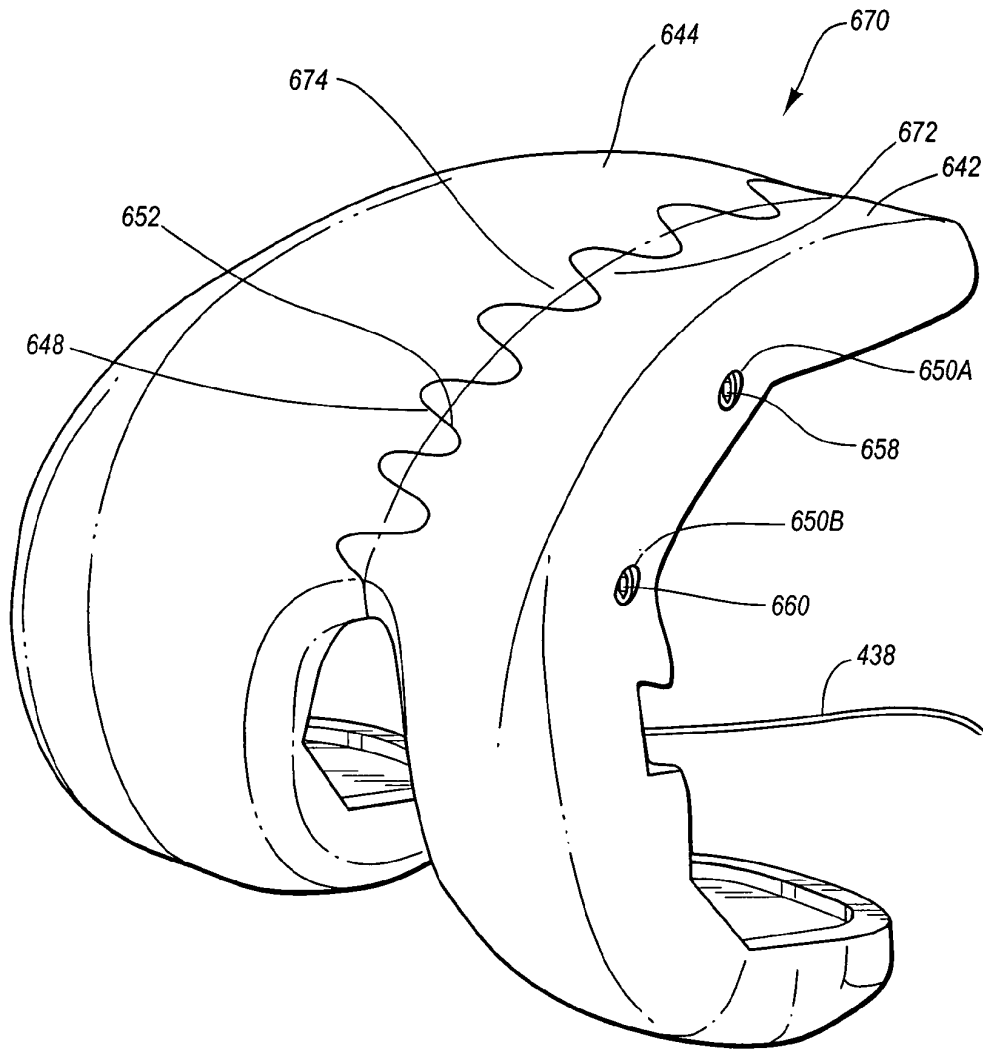
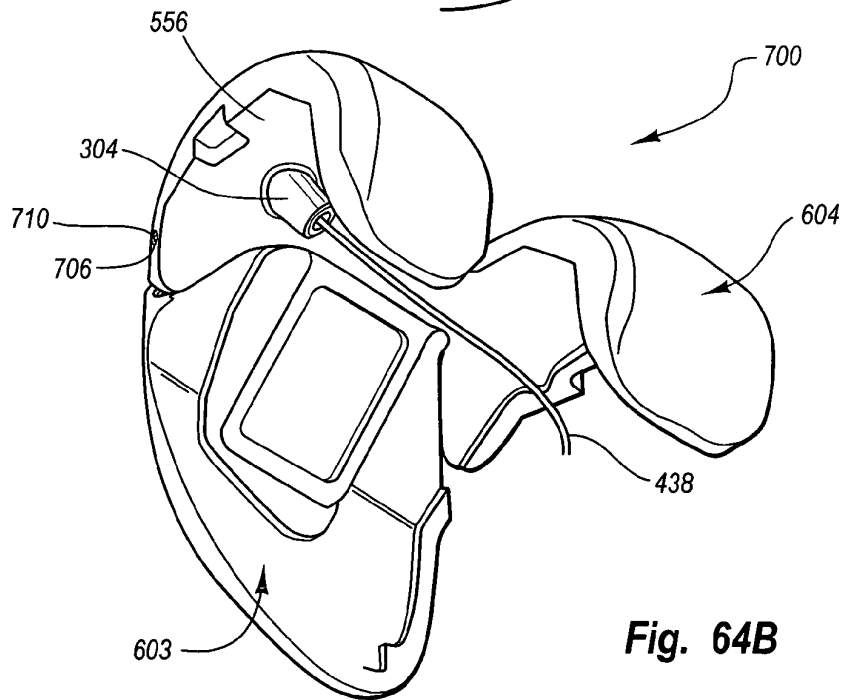
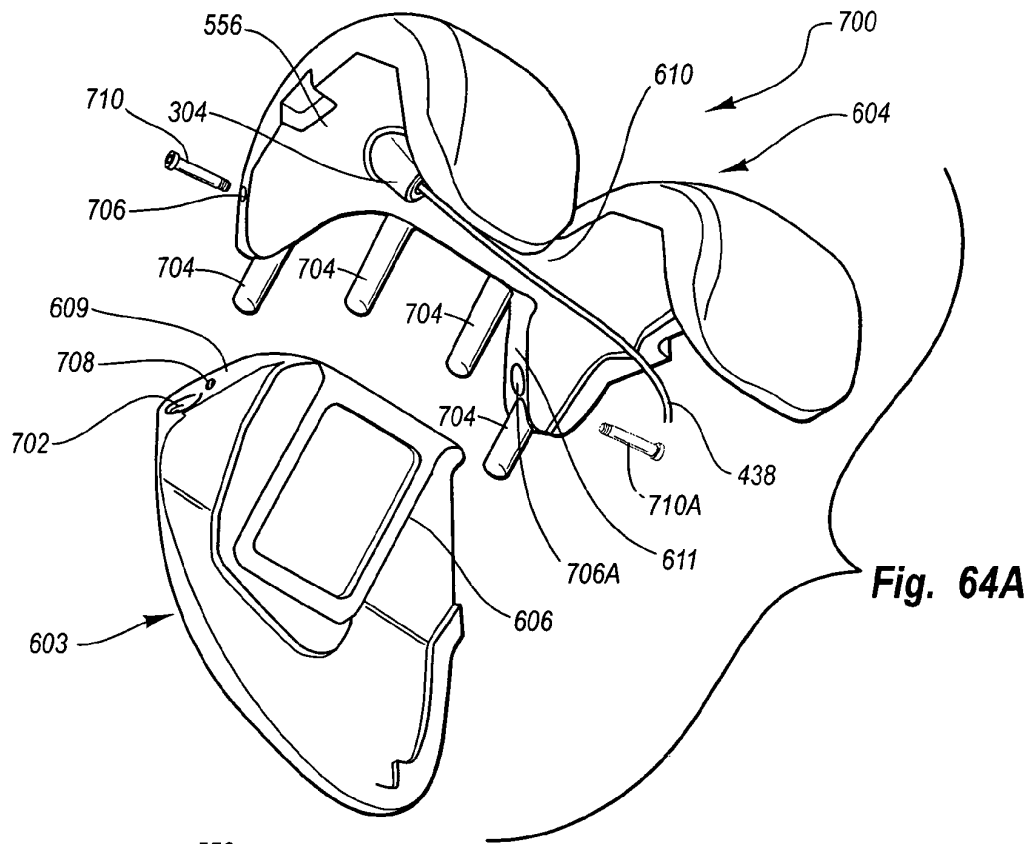


Fig. 63



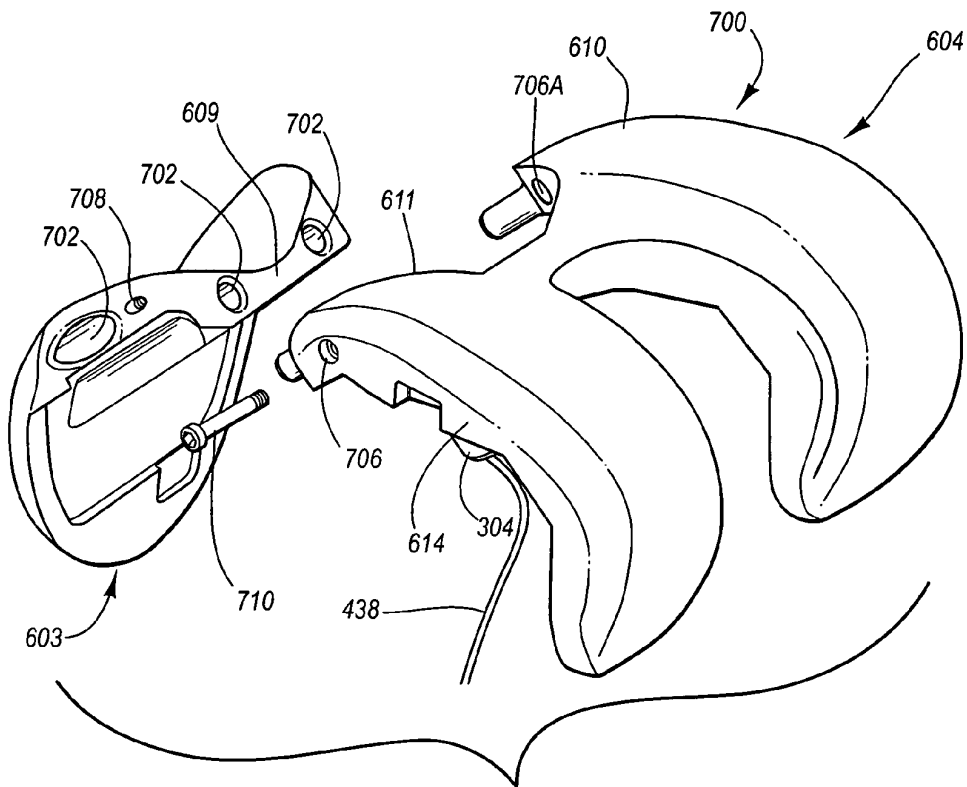


Fig. 64C

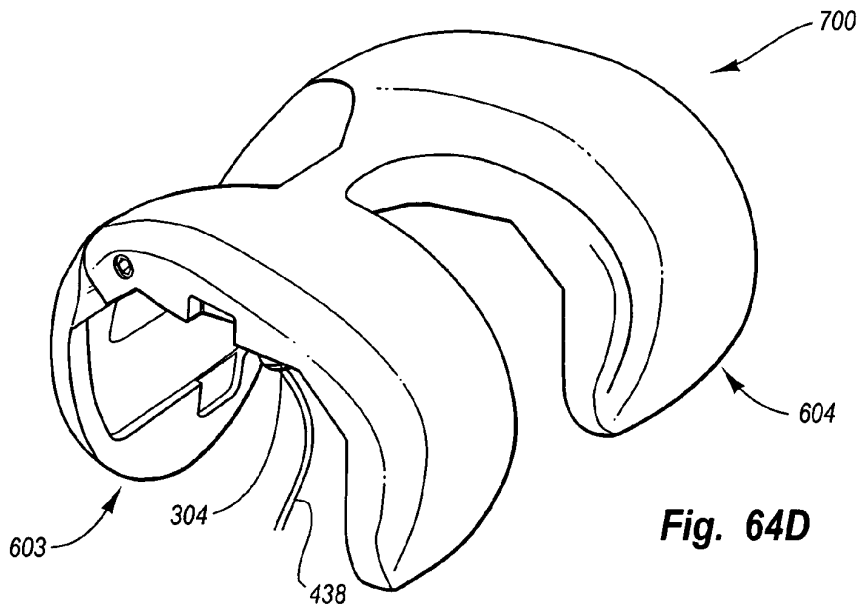
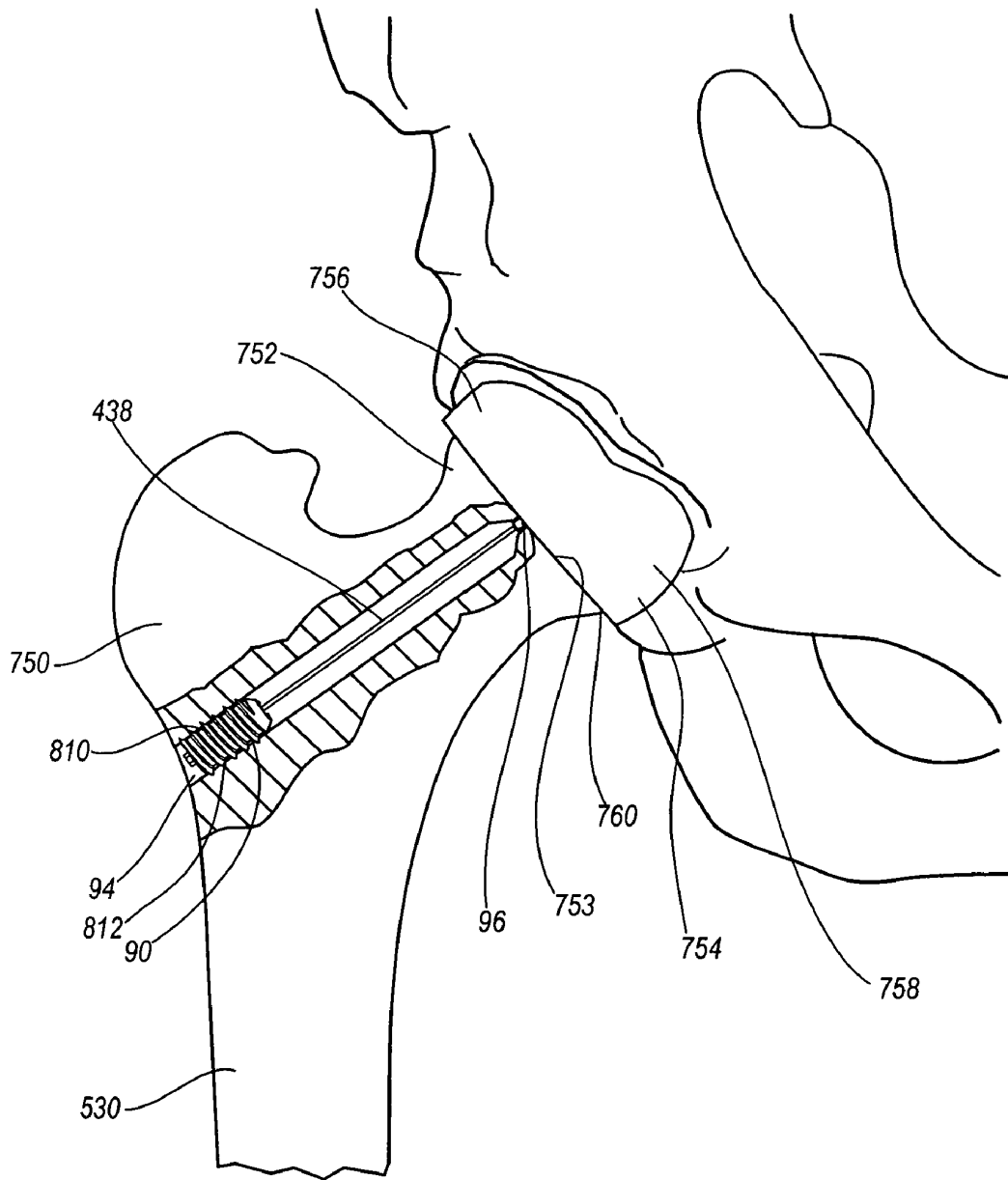
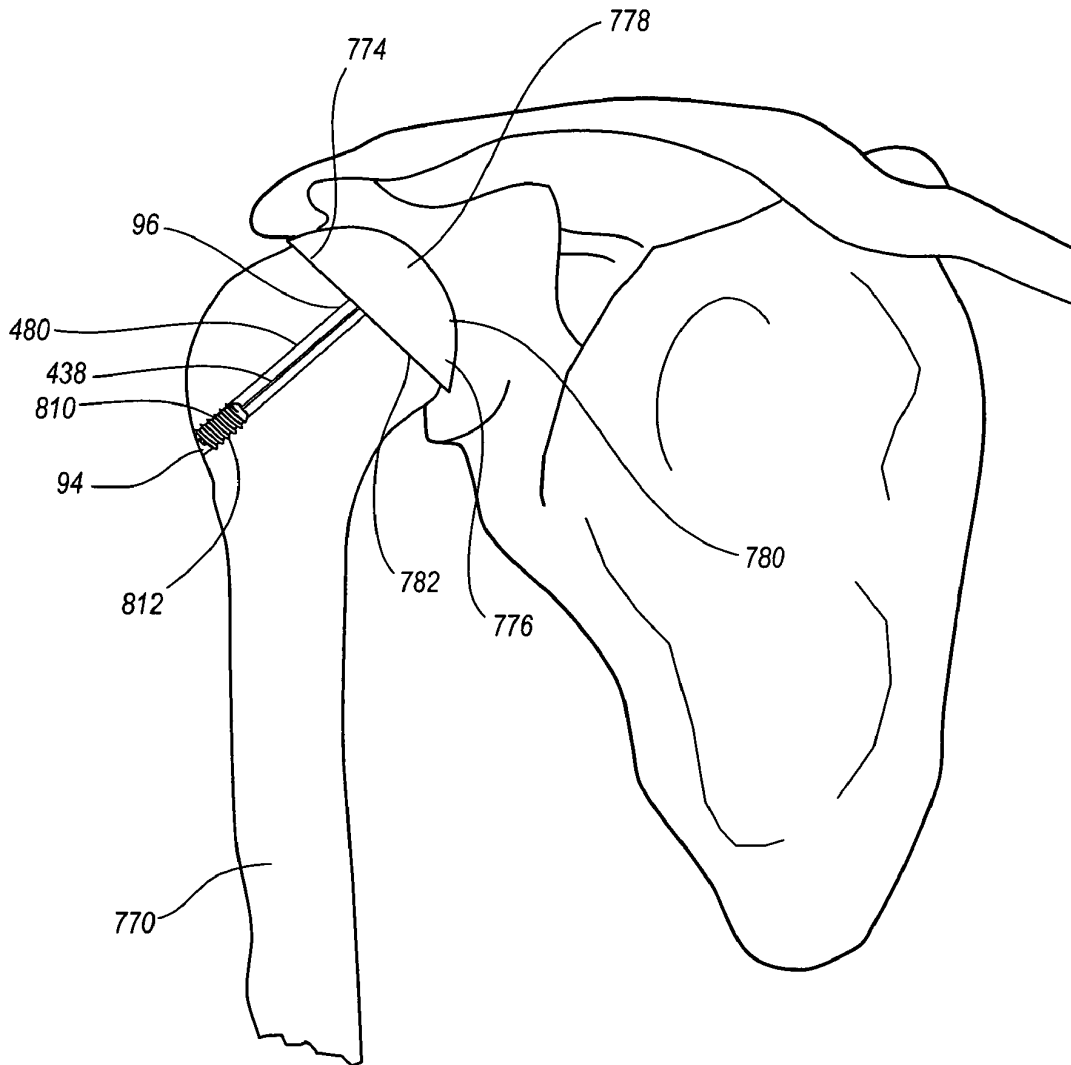


Fig. 64D



**Fig. 65**



**Fig. 66**

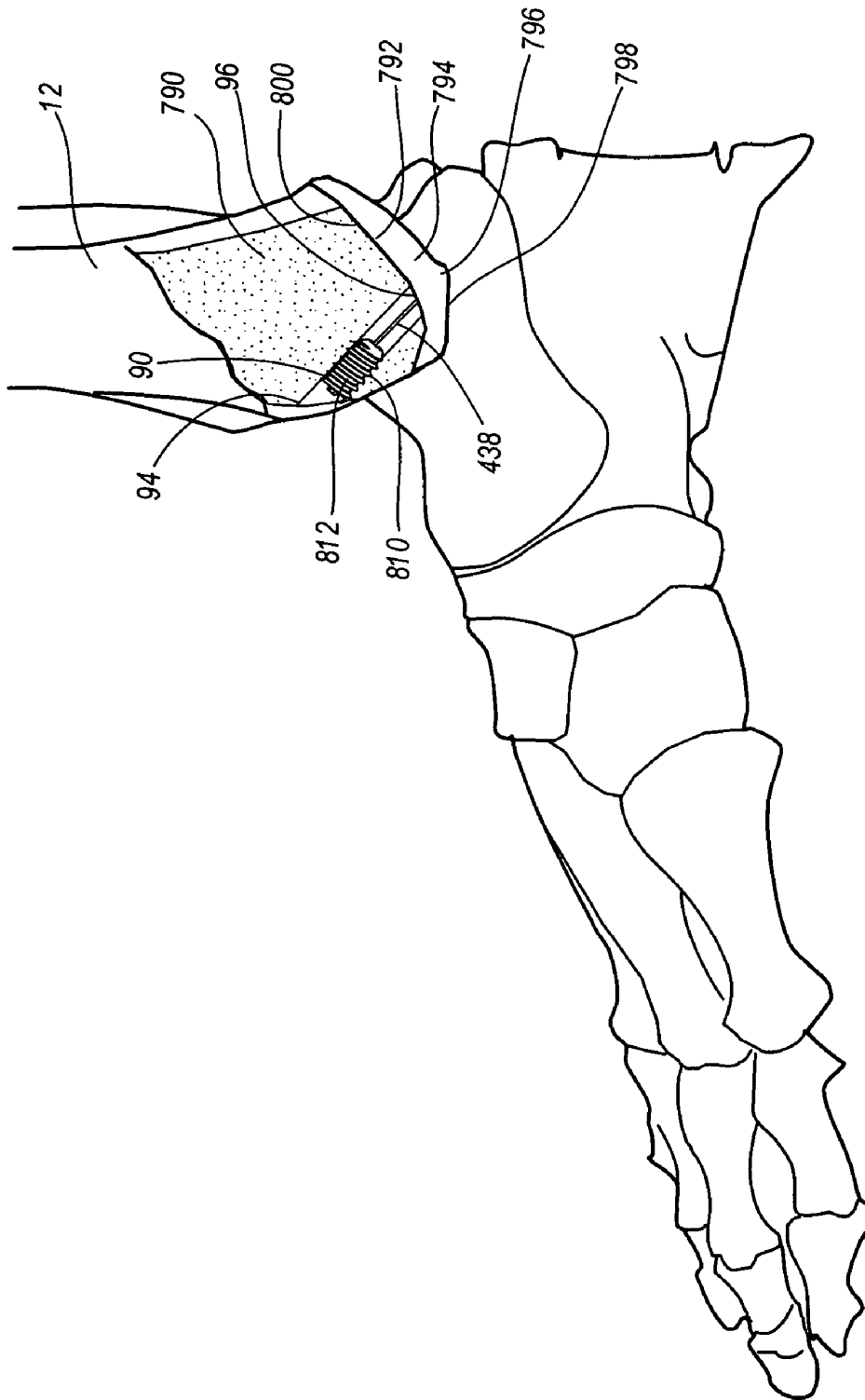


Fig. 67

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## METHODS FOR MOUNTING AND USING TETHERED JOINT BEARING IMPLANTS

### CROSS-REFERENCE TO RELATED APPLICATIONS

This application claims priority to U.S. Provisional Patent Application Ser. No. 60/586,706, filed Jul. 9, 2004, which is incorporated herein by specific reference.

### BACKGROUND OF THE INVENTION

#### 1. The Field of the Invention

The present invention relates to methods for mounting tethered implants on a natural or resected articulation surface of an orthopedic joint of a patient.

#### 2. The Relevant Technology

The human body has a variety of movable orthopedic joints such as the knee joint, hip joint, shoulder joint, and the like. These joints are formed by the intersection of two bones. The intersecting end of each bone has smooth articular surface that is comprised of cartilage. As a result of injury, wear, arthritis, disease or other causes, it is occasionally necessary to replace all or part of an orthopedic joint with an artificial implant. This procedure is referred to as a joint replacement or arthroplasty. For example, a total knee arthroplasty comprises cutting off or resecting the articular surfaces at both the distal end of the femur and the proximal end of the tibia. Complementary artificial implants are then mounted on the distal end of the femur and the proximal end of the tibia. Where only a portion of a joint is damaged, a partial joint arthroplasty can be performed. In this procedure, one or more artificial implants replace only a portion of a joint.

Although joint replacement is now a common procedure that has met with popular success, conventional implants and related mounting techniques have significant shortcomings. One significant drawback of many joint replacements is the extended and painful patient recovery. For example, a traditional knee replacement requires an open procedure wherein a relatively large incision is made which severs a portion of the muscle bounding the femur. The large incision is made so as to fully expose the respective ends of the femur and tibia.

This exposure is necessary when using conventional techniques to resect the femur and tibia and to mount the implants. For example, some conventional tibial implants are screwed directly into the resected end face of the tibia. Mounting such screws requires exposure of the resected end face. In yet other embodiments, the implants are formed with posts projecting therefrom. The posts are received within sockets formed on the resected end face of the tibia and femur. Again, forming of the sockets and inserting the posts into the sockets requires substantially full exposure of the resected end face of the tibia and femur.

In general, the more invasive the surgery, the more painful, difficult, and time consuming the patient recovery. This is largely due to the significant amount of scar tissue produced by the incision and resection of various soft tissues. Furthermore, such open and invasive surgeries have a greater risk of infection.

Another problem with conventional joint implants and related techniques for mounting is that it can be difficult to fit, adjust, and/or exchange different implants during the fitting stage. That is, implants come in a variety of different sizes, shapes, and configurations. During the joint replacement procedure, the surgeon may often test a variety of different sized implants to determine the best fit and alignment. As conventional implants are screwed into or pounded onto the bone

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during placement, the fitting, adjustment, and/or replacement of different conventional implants can be difficult and potentially damaging to the bone. Likewise, it can often be difficult to replace worn or damaged implants.

Accordingly, what is needed are implants and related methods and systems for preparing an articular surface of a joint and mounting an implant thereat which minimizes the length of incision, the amount of bone resection, and/or the impact on soft tissue. What is also needed are implants and related methods and systems which enable easier fitting, alignment, testing and/or replacement of implants.

### BRIEF DESCRIPTION OF THE DRAWINGS

Various embodiments of the present invention will now be discussed with reference to the appended drawings. It is appreciated that these drawings depict only typical embodiments of the invention and are therefore not to be considered limiting of its scope.

FIG. 1 is a perspective view of the proximal end of a tibia; FIG. 2 is a perspective view of a guide assembly for forming a tunnel on the proximal end of the tibia shown in FIG. 1;

FIG. 2A is a perspective view of an alternative template used with the guide assembly shown in FIG. 2;

FIG. 3 is a perspective view showing the guide assembly in FIG. 2 mounted on the tibia of FIG. 1;

FIG. 4 is a perspective view of the tibia shown in FIG. 1 having a tunnel formed thereon;

FIG. 5 is a perspective view of a rasp assembly resecting the tibia of FIG. 4;

FIG. 6 is a top perspective view of the rasp assembly shown in FIG. 5;

FIG. 7 is a bottom perspective view of the rasp assembly shown in FIG. 6;

FIG. 8 is an exploded perspective view of the retention rod shown in FIG. 5;

FIGS. 9A and 9B are perspective views of the retention rod shown in FIG. 8 being mounted to the rasp assembly shown in FIG. 5;

FIG. 10 is a perspective view of the tibia shown in FIG. 4 having a recess formed thereon;

FIG. 11 is a perspective view of a cutting template being mounted on the tibia shown in FIG. 4;

FIG. 12 is a perspective view of a tibial cutting guide positioned against a tibia;

FIG. 13 is a perspective view of a guide template mounted on a resected surface of the tibia shown in FIG. 12;

FIG. 14 is a bottom perspective view of the guide template shown in FIG. 13;

FIG. 15 is a perspective view of a rasp mounted on the guide template shown in FIG. 13;

FIG. 16 is a bottom perspective view of the rasp shown in FIG. 15;

FIG. 17 is a perspective view of the tibia shown in FIG. 13 after the rasp is removed;

FIG. 18 is a perspective view of a centering template mounted on the guide template shown in FIG. 17;

FIG. 19 is a bottom perspective view of the centering template and guide template shown in FIG. 18;

FIG. 20 is a perspective view of a tunnel guide;

FIG. 21 is a perspective view of the tunnel guide of FIG. 20 mounted on the centering template and tibia shown in FIG. 18;

FIG. 22A is a top perspective view of a condylar implant; FIG. 22B is a bottom perspective view of the condylar implant shown in FIG. 22A;

FIG. 22C is an exploded perspective view of the condylar implant shown in FIG. 22B;

FIG. 23A is an exploded perspective view of an alternative embodiment of a condylar implant having two pockets;

FIG. 23B is a bottom perspective view of the implant shown in FIG. 23A with a line for connecting thereto;

FIG. 24 is a bottom perspective view of another alternative embodiment of a condylar implant having three pockets;

FIG. 25 is a perspective view of a unitary condylar implant having spikes formed thereon;

FIG. 26 is a cross sectional side view showing a wire attached to an implant by crimping;

FIG. 27 is a cross sectional side view showing a wire attached to an implant by looping around a hook;

FIG. 28 is a cross sectional side view showing a wire attached to an implant by passing through a constricted opening in the implant;

FIG. 29 is a cross sectional side view showing a wire attached to an implant by a set screw;

FIG. 30 is a cross sectional side view showing a wire attached to an implant by a barbed retainer;

FIG. 31 is a bottom perspective view of an alternative embodiment of an implant having a line slidably connected thereto;

FIG. 32A is a top exploded perspective view of a two piece condylar implant having a linear track;

FIG. 32B is bottom exploded perspective view of the condylar implant shown in FIG. 32A;

FIG. 33A is a top exploded perspective view of a two piece condylar implant having a curved track;

FIG. 33B is bottom exploded perspective view of the condylar implant shown in FIG. 33A;

FIG. 34 is an exploded view of an anchor assembly for securing a condylar implant to a tibia;

FIG. 35 is an enlarged perspective view of the anchor assembly shown in FIG. 34 including a bone anchor and a lock;

FIG. 36 is a cross sectional side view of the bone anchor shown in FIG. 35;

FIG. 37 is an elevated front view of the lock shown in FIG. 35;

FIG. 38 is a cross sectional side view of the assembled anchor assembly shown in FIG. 35 having a line extending therethrough;

FIG. 39 is a perspective view of an implant mounted on a tibia with the anchor assembly of FIG. 38 being mounted to the tibia;

FIG. 40 is an elevated front view of a tensioner;

FIG. 41 is an elevated side view of the tensioner shown in FIG. 40;

FIG. 42 is a perspective view of the tensioner shown in FIGS. 40 and 41 coupled with the mounted anchor assembly shown in FIG. 39;

FIG. 43 is a perspective view of a system used to secure the implant shown in FIG. 31 to the tibia;

FIG. 44 is an exploded perspective view of an inventive full tibia implant for mounting on the proximal end of a tibia;

FIG. 45 is a perspective view of a guide template mounted on a medial condyle of a femur and a milling head disposed within an opening of the guide template;

FIG. 46 is a perspective view of a rasp that is selectively used with the guide template shown in FIG. 45;

FIG. 47 is a perspective view of the rasp shown in FIG. 46 being used with the guide template of FIG. 45;

FIG. 48 is a perspective view of the femur shown in FIG. 45 with a centering template mounted on the guide template and a tunneling guide seated on the centering template;

FIG. 49 is a top perspective view of a femoral condylar implant;

FIG. 50 is a bottom perspective view of the femoral condylar implant shown in FIG. 49 having a line connected thereto;

FIG. 51 is a perspective view of the system shown in FIG. 42 being used to secure the femoral condylar implant of FIG. 49 to the femur;

FIG. 52 is a perspective view of an inventive femoral implant for mounting on the distal end of a resected femur;

FIG. 53 is a perspective view of a femoral rasp assembly for resecting the distal end of a femur;

FIG. 54 is a perspective view of an alternative embodiment of a femoral rasp assembly for resecting the distal end of a femur;

FIG. 55 is an inside perspective view of the femoral implant shown in FIG. 52;

FIG. 56 is a perspective view of the femoral implant shown in FIG. 55 mounted to the femur shown in FIG. 52;

FIG. 57 is a perspective view of an alternative embodiment of the femoral implant;

FIG. 58 is a perspective view of a laterally bisected, two-piece femoral implant in a disassemble state;

FIG. 59 is a perspective view of the implant shown in FIG. 58 in an assembled state;

FIG. 60 is a perspective view of an alternative embodiment of the implant shown in FIGS. 58 and 59;

FIG. 61 is a perspective view of a longitudinally bisected, two-piece femoral implant in a disassemble state;

FIG. 62 is a perspective view of the implant shown in FIG. 61 in an assembled state;

FIG. 63 is a perspective view of an alternative embodiment of the implant shown in FIGS. 61 and 62;

FIGS. 64A-D are perspective views of another alternative embodiment of a laterally bisected, two-piece femoral implant;

FIG. 65 is a partial cross sectional side view of an inventive implant mounted on the proximal end of a femur;

FIG. 66 is a partial cross sectional side view of an inventive implant mounted on the proximal end of a humerus; and

FIG. 67 is a partial cross sectional side view of an inventive implant mounted on the distal end of a tibia.

#### DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENTS

The present invention relates to methods and apparatus for preparing an articulation surface of an orthopedic joint to receive an implant, implants for mounting at an articulation surface of an orthopedic joint, anchoring systems for securing an implant at an articulation surface of an orthopedic joint, and related methods and instruments. As used in the specification and appended claims, the terms "articulation surface" and "natural articulation surface" are broadly intended to include all natural articular surfaces of a bone forming a portion of an orthopedic joint and all articulation wear surfaces of a bone forming a portion of an orthopedic joint which are produced as a result of wear, trauma, disease, or other causes which remove all or a portion of the natural articular surface.

The implants, anchoring systems, instruments, and methods of the present invention can be used in combination to mount an inventive implant or can be used separately or in combinations with other conventional implants, anchoring systems, instruments and/or methods. It is appreciated that the implants, anchoring systems, instruments, and methods of the present invention can be used for mounting an implant on virtually any articulation surface of any orthopedic joint in a



human or other mammal. By way of example and not by limitation, the implants, anchoring systems, instruments, and methods of the present invention can be used in association with resurfacing an articulation surface of a knee joint, ankle joint, hip joint, shoulder joint, elbow joint, wrist joint, interphalangeal joint, or other joints. As such, the implants can be mounted on the proximal end and distal end of the femur, tibia, humerus, radius, and ulna, and on the articular surfaces of the scapula, pelvis, bones within the foot and hand, and other bone articular surfaces. Likewise, the implants, anchoring systems, instruments, and methods of the present invention can be used in facilitating a partial joint arthroplasty or a total joint arthroplasty.

In one embodiment, the implants, anchoring systems, instruments, and/or methods of the present invention are designed so that an articulation surface of a joint can be prepared and an implant mounted thereon using procedures that are minimally invasive. As a result, recovery time is significantly improved while the damage to soft tissue is decreased and the risk of infection minimized. Also in one embodiment of the present invention, the implants, anchoring systems, instruments, and/or methods are designed so that the implant can be selectively adjusted, tightened, and/or loosened after the implant is positioned on the articulation surface. This ability allows for greater ease in adjustment and fitting of an implant at the time of initial placement and for greater ease in replacement of an implant.

Set forth below are several embodiments of the present invention used in association with preparing an articulation surface at a proximal end of a tibia and mounting a condylar implant at the proximal end of the tibia. It is again noted that these embodiments are only given by way of example and that one skilled in the art based on the teaching provided herein would be able to use corresponding implants, methods, and instruments to prepare and/or mount an implant on other joint articulation surfaces.

Depicted in FIG. 1 is a proximal end 10 of a tibia 12. Proximal end 10 has a lateral side 14 and a medial side 16 which each extend between an anterior side 18 and a posterior side 19. Proximal end 10 further comprises a lateral condyle 20 and a medial condyle 21. Lateral condyle 20 terminates proximally at a lateral facet 22 of a superior articular surface of tibia 12 while medial condyle 21 terminates proximally at medial facet 24 of a superior articular surface of tibia 12.

Although tibia 12 shown in FIG. 1 is from a left leg, it is appreciated that the tibia of the right leg has a complimentary configuration and that the methods and apparatus of this specific example are equally applicable thereto. Furthermore, the methods and apparatus of this example are primarily illustrated in association with medial condyle 21 of tibia 12. It is also appreciated that the methods and apparatus can be used in association with lateral condyle 20.

In one embodiment, to facilitate mounting of a condylar implant on medial condyle 21, conventional arthroscopic procedures are used to resect the posterior portion of the medial meniscus. Once the posterior portion of the medial meniscus is removed, a vertical or horizontal incision, generally in a range between about 2 cm to about 6 cm, is formed over the anterior side of the medial meniscus. Following retraction of the surrounding tissue, the anterior side of the medial meniscus is resected. A coarse rasp is then inserted between the medial condyle of the femur and medial condyle 21 of tibia 12. The rasp is used to remove approximately 1-2 mm of articular cartilage on medial facet 24 of tibia 12. Removal of the meniscus and the articular cartilage provides increased access to medial facet 24 of tibia 12.

Depicted in FIG. 2 is one embodiment of a guide assembly 30 which is now used for forming a tunnel through a portion of tibia 12. As discussed below in greater detail, the tunnel can be used for preparing tibia 12 for a condylar implant and/or securing a condylar implant to tibia 12. In general, guide assembly 30 includes a substantially U-shaped guide brace 32 having a template 34 and a tubular guide sleeve 36 mounted on opposing ends thereof. More specifically, guide brace 32 has a first end 38 and an opposing second end 40. Recessed in first end 38 is a socket 42.

Template 34 comprises a low profile base plate 44 having a top surface 46 and an opposing bottom surface 48 which each extend between a first end 50 and an opposing second end 52. Although not required, in one embodiment bottom surface 48 has a configuration generally complementary to medial facet 24 of the superior articular surface of tibia 12. Base plate 44 typically has a maximum thickness extending between surfaces 46 and 48 in a range between about 1 mm to about 4 mm. Projecting from second 52 of base plate 44 is a stem 54. Stem 54 is configured to be slidably received within socket 42 of guide brace 32. A catch 56 downwardly extends from bottom surface 48 of base plate 44 at first end 50. As depicted, catch 56 has the configuration of a narrow finger. In other embodiments, catch 56 can comprise an elongated ridge or other configurations.

Formed on second end 40 of guide brace 32 is an enlarged housing 60 having a passage 62 extending therethrough. A resiliently flexible clamp arm 64 is mounted to housing 60. An aperture 66 extends through clamp arm 64 in general alignment with passage 62.

Tubular guide sleeve 36 slidably extends through passage 62 and aperture 66. Guide sleeve 36 has a proximal end 68 and an opposing distal end 70. A plurality of sharpened teeth 72 are formed at distal end 70. By pressing clamp arm 64 toward housing 60, passage 62 and aperture 66 are aligned allowing guide sleeve 36 to freely slide within passage 62 and aperture 66 to a desired location. As clamp arm 64 is released, clamp arm 64 resiliently biases away from housing 60 so as to bind guide sleeve 36, thereby securing guide sleeve 36 in the desired location. In alternative embodiments, it is appreciated that clamp arm 64 can be replaced with a set screw, clamp, or a variety of other types of fasteners that can be used to selectively secure guide sleeve 36 to second end 40 of guide brace 32.

During use, as depicted in FIG. 3, template 34 is slid over medial facet 24 of tibia 12, i.e., the articulation surface, so that catch 56 catches on posterior side 19 of tibia 12. Catch 56 thus facilitates proper positioning of template 34 and also helps to retain template 34 on medial facet 24. It is appreciated that the size and shape of the lateral and medial facets of the superior articular surfaces of the tibia varies between different patients. As such, the present invention comprises a plurality of alternative templates 34 which are configured for placement on one of the lateral and medial facet and which each have a different configuration. As such a number of the alternative templates 34 can be initially test fitted to determine one that has a best fit for a particular patient.

For example, depicted in FIG. 2A is one alternative template 34A that is smaller than template 34. Like elements between templates 34 and 34A are identified by like reference characters. In further contrast to template 34, template 34A has a catch 56A downwardly extending from second end 52 of base plate 44. Catch 56A thus biases against anterior side 18 or medial side 16 of tibia 12 to help properly position template 34A. In yet other embodiments, in contrast to positioning the projection on one of the opposing ends of base plate 44, the projection can be positioned along one of the opposing sides

of base plate 44 so as to bias against lateral side 14 (when used on lateral facet 22) or bias against medial side 16 of tibia 12.

Once template 34 is selected and properly positioned on medial facet 24, tubular guide sleeve 36 is advanced within housing 60 so that teeth 72 at distal end 70 bias against medial side 16 of proximal end 10 of tibia 12. As such, tubular guide sleeve 36 biases against tibia 12 at a location spaced apart from the articulation surface of medial facet 24. Guide sleeve 36 is then secured in place by releasing clamp arm 64. By securing guide sleeve 36 against tibia 12, guide assembly 30 is clamped onto tibia 12. In one alternative embodiment, guide sleeve 36 can be biased against anterior side 18 of tibia 12.

Next, a tubular drill sleeve 76 is inserted into tubular guide sleeve 36. Positioned within drill sleeve 76 is a guide wire 78. Using drill sleeve 76 as a guide, guide wire 78 is drilled through tibia 12 until guide wire 78 reaches template 34, thereby forming a guide tunnel. In part, template 34 functions as a shield to prevent guide wire 78 and/or other drill tools from accidentally contacting and damaging the femur. In other embodiments, a hole or recess is formed on template 34. Guide wire 78 can be passed through or into the hole or recess to ensure complete formation of the tunnel on medial facet 24.

Once the guide tunnel is formed, guide wire 78 and drill sleeve 76 are removed from guide sleeve 60. A larger drill tool, not shown, such as a larger guide wire, drill bit, or the like is then passed through guide sleeve 60 and drilled through tibia 12 along the guide tunnel to form a final tunnel 90 (FIG. 4) through tibia 12. It is appreciated that any number of progressively larger drill tools can be used. In alternative embodiments guide wire 78 and drill sleeve 76 can be eliminated. A single larger drill tool can then be used to form tunnel 90 in a single pass. Using a sequence of larger drill tools, however, helps ensure proper placement of tunnel 90 and facilitates forming the opening of the tunnel adjacent to template 34.

As discussed below in greater detail, the angular orientation of tunnel 90 is typically held constant and is based on the configuration of the implant. However, depending on the amount of bone needed to be resected for mounting the condylar implant, it may be necessary to shift the position of tunnel 90 posterior or anterior. Shifting the position of tunnel 90 posterior-anterior is accomplished by selectively moving stem 54 of template 34 further into or further out of socket 42 of guide brace 32. Once template 34 and guide brace 32 are positioned at their relative positions, a set screw 80 is tightened so as to secure template 34 and guide brace 32 together. Predefined markings 82 are formed on stem 54 to help define the relative positioning between template 34 and guide brace 32.

Once tunnel 90 is formed, guide assembly 30 is removed so as to produce tibia 12 shown in FIG. 4. As depicted, tunnel 90 has an interior surface 92 that extends from a first end 94 to an opposing end second end 96. First end 94 is formed on medial side 16 of proximal end 10 of tibia 12. Second end 96 is formed on medial facet 24 of tibia 12. Expressed in other terms, second end 96 of tunnel 90 is formed on a section of an articulation surface, i.e., medial facet 24, while first end 94 is at a location on tibia 12 that is spaced apart from the articulation surface. Although tunnel 90 can be any desired size, in one embodiment tunnel 90 has a diameter in a range between about 5 mm to about 10 mm.

Using the above discussed methods and instruments, tunnel 90 is formed by procedures that are minimally invasive to the patient. As discussed below in greater detail, once tunnel 90 is formed, tunnel 90 can then be used to assist in the resection of medial facet 24 and/or the mounting of a condylar

implant on the resected medial facet 24. Furthermore, by using tunnel 90 the resection of medial facet 24 and the mounting of the condylar implant can also be performed using procedures that are minimally invasive.

Although not required, in one embodiment as mentioned above, tunnel 90 is used in the resection of tibia 12 for preparing tibia 12 to receive a condylar implant. The resection of tibia 12 can be accomplished using a number of different procedures. For example, as depicted in FIG. 5, in one embodiment a rasp assembly 100 is used in association with a retention rod 102 to facilitate resection of tibia 12.

As depicted in FIG. 6, rasp assembly 100 comprises a rasp body 104 having a pivot arm 105 mounted thereon, a rasp guide 106, and a cover plate 108. More specifically, as depicted in FIGS. 6 and 7, rasp body 104 has a top surface 110 and an opposing bottom surface 112 that each extend between a proximal end 114 and an opposing distal end 116. Transversely extending across bottom surface 112 are a plurality of ridges 118 that each terminate at a sharpened cutting edge 120. It is appreciated that ridges 118 and cutting edges 120 can be at any desired orientation or combination of different orientation that facilitate cutting. Bottom surface 112 is configured such that reciprocating movement of bottom surface 112 on tibia 12 produces a recess on tibia 12 that can receive a desired implant. Recessed on top surface 110 of rasp body 104 is a guide slot 122. Guide slot 122 is bounded by a floor 124 and a sidewall 126 upstanding from floor 124. Extending through floor 124 to bottom surface 112 is an opening 128.

Rasp guide 106 comprises a slide plate 130 having a top surface 131 and an opposing bottom surface 133. Downwardly projecting from bottom surface 133 are a pair of spaced apart forks 132A and 132B with a pin 134 extending therebetween. Forks 132A and B have facing interior surfaces 136 which bound a gap 137 and have opposing exterior surfaces 138. Forks 132A and B terminate at a free terminus 140. Exterior surface 138 of each fork 132A and B is recessed at terminus 140 such that a sloping shoulder 142 is formed on each fork 132A and B.

Rasp guide 106 is received within guide slot 122 so that forks 132A and B project through opening 128. Rasp guide 106 is slightly smaller than guide slot 122 such that forks 132A and B are free to reciprocate within opening 128 as slide plate 130 reciprocates within guide slot 122. As shown in FIG. 5, cover plate 108 is secured within guide slot 122 so as to retain rasp guide 106 within guide slot 122. Cover plate 108 can be mounted using conventional techniques such as welding, press fit, and the like. Holes 144 are formed through cover plate 108 to prevent unwanted build-up of resected bone particles within guide slot 122.

As depicted in FIG. 6, pivot arm 105 has a proximal end 146 and an opposing distal end 148. A set hole 149 extends through pivot arm 105 toward proximal end 146. Distal end 148 of arm 105 is hingedly mounted to proximal end 114 of rasp body 104 by a pin 150.

In one embodiment, an insertion handle 160 is used to place rasp body 104 over medial facet 24 of tibia 12. Insertion handle 160 has a proximal end 162 and an opposing distal end 164. A post 165 is formed a proximal end 162. Post 165 is adapted to receive an extension handle if desired. A pair of spaced apart lips 166A and B project from distal end 164 and bound a slot 163. A channel 168 (FIG. 5) longitudinally extends through insertion handle 160 so as to communicate with slot 163. Channel 168 is configured to receive pivot arm 105 when rasp body 104 is received within slot 163.

During use, pivot arm 105 is slid into channel 165 from between lips 166A and B. Lips 166A and B are then advanced to extend above and below proximal end 114 of rasp body

104. A set screw 168 (FIG. 7) is then advanced into insertion handle 160 so as to extend through set hole 149 on pivot arm 105. In this configuration insertion handle 160 rigidly supports rasp body 104 so as to prevent hinged movement of rasp body 104 during insertion.

Turning to FIG. 8, retention rod 102 comprises a tubular set rod 172 bounding a channel 174 extending from a proximal end 176 to an opposing distal end 178. Distal end 178 terminates at a distal end face 179. A handle 180 outwardly projects from proximal end 176 to facilitating grasping retention rod 102.

Retention rod 102 further comprises a hook rod 182. Hook rod 182 has a proximal end 184 and an opposing distal end 186. Projecting from distal end 186 is a hook 188. Threads 190 are formed on proximal end 184. A knob 192 is also provided having a threaded port 193. Threads 190 on hook rod 182 are configured to mate with threaded port 193 of knob 192. Hook rod 182 is received within channel 174 of set rod 172 such that knob 192 biases against handle 180 and hook 188 extends beyond distal end face 179. In this configuration, rotation of knob 192 relative to hook rod 182 causes hook 188 to extend or retract relative to set rod 172.

During operation, as depicted in FIG. 5, rasp assembly 100 is mounted on medial facet 24 of tibia 12. Rasp assembly 100 is positioned using the rigidly mounted insertion handle 160, as discussed above, such that forks 132A and B (FIG. 7) are aligned with the second end 96 of tunnel 90. Once rasp assembly 100 is positioned, retention rod 102 is advanced within tunnel 90 from first end 94. As depicted in FIG. 9A, knob 192 is rotated so that hook 188 extends beyond set rod 172. With hook 188 freely exposed, hook 188 is hooked over pin 134 extending between forks 132A and B.

As depicted in FIG. 9B, once hook 188 has captured pin 134, knob 192 is rotated so as to advance set rod 172 toward hook 188. Set rod 172 is advanced until distal end face 179 of set rod 172 biases against shoulders 142 of forks 132A and B. Shoulders 142 are sloped such that end face 179 can sit flush against shoulder 142 while set rod 172 retains its orientation within tunnel 90. In this configuration, retention rod 102 is securely fixed to rasp guide 106.

Once retention rod 102 is secured to rasp assembly 100, insertion handle 160 is removed from pivot arm 105. A reciprocal driver, such as a reciprocal saw, not shown, is then connected to pivot arm 105. While holding rasp guide 106 substantially stationary by holding onto retention rod 102, the reciprocal driver rapidly reciprocates rasp body 104 so that cutting edges 120 resect medial facet 24 of tibia 12. In one embodiment, rasp body 104 reciprocates along a length in a range between about 1 mm to about 4 mm. Other dimensions can also be used.

In one embodiment bottom surface 112 of rasp body 104 is slightly arched so as to be convex. By having pivot arm 105 hingedly attached to rasp body 104, rasp body 104 is free to reciprocate along the arched path. The hinged attachment also helps to minimize binding of rasp body 104. In alternative embodiments, arm 105 can be rigidly attached to rasp body 104.

In one embodiment of the present invention means are provided for removably engaging retention rod 102 with rasp body 104 such that rasp body 104 can be selectively reciprocated without substantial movement of retention rod 102. By way of example and not by limitation, one embodiment of the means comprises rasp guide 106 slidably mounted on rasp body 104 and hook 188 mounted on retention rod 102. In alternative embodiments it is appreciated that a variety of different structures can accomplish the same function. For example, pin 134 and hook 188 can be replaced with a

threaded connection, bayonet connection, or any number of other conventional connections which allows retention rod 102 to engage with rasp guide 106.

It is also appreciated that rasp guide 106 can be mounted on rasp body 104 in a variety of different ways. For example, opening 128 can extend through rasp body 104 without the formation of guide slot 122. In this embodiment slide plate 130 can be positioned directly on top surface 110 of rasp body 104 while forks 132A and B extend through opening 128. In yet another alternative, guide slot 122 can be formed on bottom surface 112 of rasp body 104. Cover plate 108 can be formed having opening 128 extending therethrough and cutting edges 120 formed on a bottom surface thereof. Slide plate 130 can be positioned within the guide slot 122 so that when cover plate 108 is secured over guide slot 122, forks 132A and B extend through opening 128 formed on cover plate 108.

It is also appreciated that retention rod 102 can have a variety of different configurations. For example, in alternative embodiments set rod 172 can be eliminated. As such, retention rod 102 can simply comprise hook rod 182. Furthermore, as discussed above, hook 188 can be replaced with a variety of different types of connectors.

Once medial facet 24 has been sufficiently resected by rasp body 104, rasp assembly 100 and retention rod 102 are removed. The resected bone particles are removed by conventional flushing and suction. As depicted in FIG. 10, tibia 12 now has a resected recess 194 formed on medial facet 24.

It is appreciated that the resection of tibia 12 can be accomplished using a variety of different techniques. For example, in one alternative depicted in FIG. 11, the resection of tibia 12 is accomplished by cutting through an area bounded by a cutting template 200. Cutting template 200 comprises a plate 202 having a top surface 204 and an opposing bottom surface 206. In the embodiment depicted cutting template 200 is configured to rest on lateral facet 22 of tibia 12. Of course, cutting template 200 can also be designed for resting on medial facet 24.

Extending between opposing surfaces 204 and 206 are a plurality of guide spaces 208. Guide spaces 208 are formed so that when cutting template 200 is positioned, guide spaces 208 are positioned over at least a portion of the facet to be resected. In the embodiment depicted, guide spaces 208 have the configuration of an elongated channel. As will be discussed below in greater detail, the channels facilitate guided receipt of a cutting burr 210 which is used to selectively remove the unwanted bone. In alternative embodiments, depending on the type and size of tool used to remove the bone, guide spaces 208 can come in a variety of different sizes, shapes, and orientations.

In one embodiment, although not required or shown, a second cutting template is provided having guide spaces extending therethrough. In the second cutting template, the guide spaces are aligned so as to bound the area of the facet to be resected which was blocked by plate 202 of cutting template 200. As a result, by sequentially using both cutting templates, all or at least a greater proportion of the bone can be removed by cutting burr 210. Additional cutting templates can also be used.

Cutting template 200 is used in association with retention rod 102 as previously discussed. In the embodiment depicted, handle 180 has a different configuration. During use, cutting template 200 is positioned over lateral facet 22. Distal end 178 of set rod 172 is advanced through tunnel 90 so that hook 188 of hook rod 182 projects out of set rod 172. Hook 188 is passed through a guide space 208 and then pulled back onto top surface 204 of plate 202. A rib 212 upwardly projects from

plate 202 adjacent to guide space 208. Hook 188 is hooked over rib 212 so as to improve the engagement between hook 188 and cutting template 200.

Once hook 188 is engaged to cutting template 200, knob 192 is rotated so as to bias set rod 172 against bottom surface 206 of template 200. As a result, retention rod 102 is securely clamped to cutting template 200. Accordingly, by pulling retention rod 102, cutting template 200 is securely held in place on lateral facet 22. Cutting burr 210 or some other form of drill bit is then advanced into and along each of guide spaces 208 so as to resect the portion of the bone directly below guide space 208. As previously discussed, in one embodiment cutting template 200 can be removed and replaced with a second template. Burr 100 can then be passed through guide spaces of the second template to remove further bone that was covered by cutting template 200.

In other alternatives, it is appreciated that once cutting template 200 is removed, the remaining bone portion can be removed by sight and feel without the use of a template. In yet other embodiments, depending on the type and amount of bone needed to be resected, a single template can be rotated or shifted on lateral facet 22 so that the single template is used to remove the desired bone.

In one embodiment of the present invention, means are provided for removably engaging retention rod 102 to cutting template 200 so that retention rod 102 secures cutting template 200 to the lateral or medial facet of tibia 12 when retention rod 102 is received within tunnel 90 of tibia 12. By way of example and not by limitation, one embodiment of such means comprises hook 188 and guide space 208 which enables hook 188 to engage with cutting template 200.

The present invention also envisions that there are a variety of other structures that can accomplish the same function. For example, the same structures and techniques as discussed above for securing retention rod 102 to rasp assembly 100 can also be used with cutting template 200. That is, in one alternative forks 132A and B with pin 134 can be mounted on bottom surface 206 of plate 202. Other connections such as threaded connection, bayonet connections, and the like can also be used.

The present invention envisions still other instruments and methods that can be used to resect medial condyle 21. For example, depicted in FIG. 12 is a guide 214. Guide 214 comprises rod 216 having an upper end 217 and an opposing lower end 218. Adjustably mounted on lower end 218 of rod 216 is a brace 219 having a v-shaped notch 220. Notch 220 is configured so that brace 219 can be securely held against the distal end of tibia 12. Adjustably mounted at the upper end of rod 216 is an adjustment mechanism 222. Adjustment mechanism 222 comprises an elongated body 223 having rod 216 slidably extending therethrough. A handle 224 and an adjacent trigger 225 are each connected to body 223. Trigger 225 is connected to a cam 226 which is spring biased against rod 216. As such, by retracting trigger 225, cam 226 is pulled back and adjustment mechanism 222 can freely slide along rod 216. Once trigger 225 is released, cam 226 is spring biased against rod 216, thereby securing adjustment mechanism 222 in place.

A cutting guide 228 is connected to body 223 by a post 229. Alternatively, cutting guide 228 can be directly connected to body 223. Cutting guide 228 has an inside face 230 and an opposing outside face 231. An elongated slot 232 extends between faces 230 and 231. Inside face 230 is contoured so as to closely fit against the anterior side of medial condyle 21.

During use, guide 214 is positioned against tibia 12 as shown in FIG. 12. An operator uses handle 224 to bias guide 214 against tibia 12 so that guide 214 is securely held in

position. Once positioned, a blade on an oscillating saw (not shown) is advanced through slot 232 in cutting guide 228. Using slot 232 as a guide, the blade on the oscillating saw is advanced anterior to posterior through the medial condyle 21 so as to form resected surface 234. The saw blade also cuts through the medial side of medial condyle 21. Cutting guide 228 is positioned so that the saw blade removes the articular cartilage of medial condyle 21. Thus, in one embodiment cutting guide 228 is positioned so that slot 232 is positioned at a distance typically in a range between 1 mm to about 4 mm below medial facet 24. Other dimensions can also be used.

Once the blade from the oscillating saw is removed, guide 214 is also removed. A reciprocating sagittal saw is then used to cut from the top surface of medial facet 24 down to resected surface 234 along the lateral edge of resected surface 234. The fully separated cut bone piece can then be removed from tibia 12 as shown in FIG. 12. It is appreciated that the medial meniscus can be removed prior to resection of medial condyle 21, as previously discussed, or can simply be removed concurrently with the above discussed resection of medial condyle. In yet other embodiments, it is appreciated that resected surface 234 can be formed through the use of an electric burr, mill, bone chisel, bone chipper or the like. The above resection process can be used in combination with the rasping process previously discussed. That is, either before or after forming tunnel 90, the oscillating saw or other tool can initially be used to remove the articular cartilage before rasping. The option has the benefit of easy removal of the articular cartilage which can be difficult to remove by rasping. Furthermore, the total amount of material to be removed by rasping is reduced. In addition, the above resection process provides a planar surface on the tibia which is more convenient to work with when forming a pocket for the implant.

As mentioned above, in one embodiment resected surface 234 is a further resected to form a contoured pocket in which the implant can be mounted. By way of example, depicted in FIGS. 13 and 14 is a guide template 236. Guide template 236 comprises a body 237 having a top surface 238 and an opposing bottom surface 239. Although not required, in the embodiment depicted, surfaces 238 and 239 are each substantially flat and form a thickness extending therebetween which is typically in a range between about 0.5 mm to about 4 mm. Body 237 has an interior surface 240 which encircles an opening 241 extending between surfaces 238 and 239.

Opening 241 has an area that corresponds to the size of the implant. Thus, opening 241 can be any size or shape depending on the size and shape of implant to be used. In the embodiment depicted, opening 241 has an elongated configuration and typically has an area greater than about 2 cm<sup>2</sup> and more commonly greater than 3 cm<sup>2</sup>. Again, other sizes and shapes can be used. Furthermore, in alternative embodiments, body 237 need not completely encircle opening 241. For example, a section of body 237 bounding opening 241 can be eliminated.

Body 237 has an anterior side 248 and an opposing posterior side 249. Projecting from anterior side 248 is an elongated handle 242. Extending along bottom surface 239 of body 237 and handle 242 is a recessed channel 244. Rotatably disposed within channel 244 is a shaft 245. Shaft 245 has a first end 246 disposed at the free end of handle 244 and an opposing second end 247 disposed at posterior side 249 of body 237. A handle 250 is connected to first end 247 of shaft 245. Handle 250 enables the user to easily rotate shaft 245 by selective movement of handle 250. Outwardly projecting from second end 247 of shaft 245 is a catch 252. By selective rotation of shaft 245, catch 252 can be selective moved between a first position wherein catch 252 is disposed in the

same plane as body 237 and a second position, as shown in FIG. 14, wherein catch 252 orthogonally projects below bottom surface 239 of body 237.

During use, catch 252 is initially oriented in the first position. Body 237 can then be easily slid anterior to posterior along resected surface 234. Catch 252 can then be rotated to the second position such that catch 252 catches on the posterior side of tibia 12. Catch 252 can thus be used to facilitate proper placement and stabilization of guide template 236 on resected surface 234. Once guide template 236 is positioned, it is checked for proper fit. That is, body 237 should extend complementarily around the perimeter edge of resected surface 234. If not, guide template 236 is replaced with a guide template of different size and/or shape. In this regard, a plurality of guide templates 236 are provided having different sizes to fit patients of different size. It is also appreciated that guide template 236 can be configured to be adjustable in size and/or shape.

Although not required, in one embodiment means are provided for securing body 237 to tibia 12. By way of example and not by limitation, a first hole 254 and a second hole 256 are formed at two-spaced apart locations along or adjacent to anterior side 248 of body 237. The holes can also be formed on handle 242. A tubular sleeve 258 encircles and upwardly projects at an angle from each of holes 254 and 256. In part, sleeves 258 function as a guide but are not required. A pair of screws 260 are provided each having an enlarged head 261.

Once guide template 236 is appropriately positioned, screws 260 are advanced through corresponding holes 254 and 256 so as to screw into the anterior side of tibia 12. As a result of using two-spaced apart screws 260, guide template 236 is secured in place so as to prevent unwanted sliding or rotation. In alternative embodiments, a single hole and screw can be used or three or more holes and corresponding screws can be used. Furthermore, in contrast to using screws, other types of fasteners such as barbs, spikes, expansion bolts, staples, clamps, or the like can be used to secure body 237 to tibia 12.

Turning to FIG. 15, once guide template 236 is secured in position, a rasp 264 is positioned on guide template 236. As depicted in FIGS. 15 and 16, rasp 264 comprises a head 266 having an elongated handle 267 projecting therefrom. Head 266 includes an inside face 268 and an opposing outside face 269. Projecting from inside face 268 is a cutting mount 270. Counting mount 270 comprises a base 272 projecting from inside face 268 and a plurality of cutting teeth formed on base 272. Cutting mount 270 has a configuration smaller than opening 241 on guide template 236 such that cutting mount 270 can be received within opening 241 as shown in FIG. 15 and can be reciprocated back and forth therein.

In one embodiment, cutting mount 270 reciprocally slides back and forth within opening 241 along a distance in a range between about 3 mm to 15 mm. Other dimensions can also be used. Cutting mount 270 also has a thickness which is greater than the thickness of body 237 of guide template 236. As a result, cutting teeth 237 ride against resected surface 234 when cutting mount 270 is received within opening 241. During the reciprocating movement, guide template 236 functions as a guide for rasp 264 so that only the bone bounded within opening 241 can be removed.

Furthermore, in the embodiment depicted cutting mount 270 is smaller than head 266 such that an openly exposed portion of inside face 268 encircles cutting mount 270. Head 266 has an outer perimeter generally corresponding to the outer perimeter of body 237 of guide plate 236 such that head 266 extends over body 237 when cutting mount 270 is received within opening 241. As such, as cutting mount 270 is

reciprocated within opening 241, cutting teeth 273 cut away at the bone bounded within opening 241. The bone is continually cut away until head 266 biases against body 237, thereby precluding further advancement of cutting mount 270 into opening 241. To enable the cut bone particles to escape from opening 241, a plurality of open channels 274 extend through cutting mount 270 and head 266.

It is appreciated that rasp 264 can come in a variety of alternative configurations. For example, instead of having base 272 extend from head 266, cutting teeth 273 could be elongated so as to extend directly from head 266. Likewise, it is not necessary that head 266 outwardly project on all sides of cutting mount 270 so as to overlay guide plate 236. Rather, discrete spaced apart sections of head 266 can be adapted to overlay guide plate 236. In still other embodiments, head 266 can have the same perimeter dimensions as cutting mount 270. In this embodiment, handle 267 would still overlay guide template 236. It is likewise appreciated that the size and arrangement of channels 274 and cutting teeth 273 can be modified in a variety of different configurations.

In one embodiment, cutting mount 270 has a rounded bottom surface that outwardly curves front to back and side to side. As a result, as depicted in FIG. 17, once rasp 264 is removed, a rounded pocket 278 is formed on resected surface 234. It is appreciated that cutting mount 270 can have a variety of different configurations so as to form pocket 278 of a corresponding shape. As will be discussed below in greater detail, pocket 278 is configured to provide a best fit for mounting the implant. In alternative embodiments where the bottom of the implant is substantially flat, rasp 264 need not be required in that resected surface 234 can be positioned at the desired level to receive the implant. Alternatively, rasp 264 can be formed so that cutting mount 270 has a substantially flat face. In yet other embodiments, cutting mount 270 can be configured to form grooves, channels, slots or the like to fit corresponding projections extending from the implant.

Once the bone surface is prepared to receive the implant, a tunnel 400 is formed intersecting with pocket 278 so that the implant can be mounted. Guide assembly 30, as previously discussed with regard to FIGS. 2 and 3, can be used to form tunnel 400 either before or after the formation of pocket 278 in the same way that tunnel 90 was formed.

In an alternative method, a centering template 280 is mounted on guide template 236. As depicted in FIGS. 18 and 19, centering template 280 comprises a mounting plate 282 having an elongated handle 283 projecting therefrom. Mounting plate 282 comprises an upper plate 284 having an inside face 285. Projecting from inside face 285 is a boss 286. Boss 286 has a configuration complimentary to opening 241 of guide template 236. Furthermore, boss 286 is slightly smaller than inside face 285 of upper plate 284. As a result, when boss 286 is received within opening 241, as shown in FIG. 18, upper plate 284 extends over a portion of guide plate 236. This coupling provides a fixed positioning of centering template 280 relative to guide template 236. Projecting from boss 286 is a contact boss 288. Contact boss 288 is positioned so as to be located over the intended opening for tunnel 400. This location is typically at the center of resected surface 234. Other locations, however, can also be used. As will be discussed below in greater detail, contact boss 288 acts in part as a stop for the drill forming tunnel 400 within tibia 12 so that the drill does not damage the femur.

As depicted in FIG. 18, formed on outside face 287 of upper plate 284 in vertical alignment with contact boss 288 is a centering indent 290. As discussed below in greater detail, centering indent 290 is used in association with a tunnel guide for positioning the placement of tunnel 400.

Depicted in FIG. 20 is one embodiment of a tunnel guide 370 incorporating features of the present invention. Tunnel guide 370 comprises a brace 372 having an inside face 382 and an opposing outside face 383 that each extend between a first end 373 and an opposing second end 374. Second end 374 has a channel 376 extending therethrough. Sideably disposed within channel 376 is a tubular guide sleeve 378. A clamp arm 380 is coupled with brace 372 and resiliently biases against guide sleeve 378. As such, by depressing clamp arm 380, guide sleeve 378 can be selectively slide to a desired location and then secured in position by release of clamp arm 380. An elongated slot 384 extends along the length of brace 372 at first end 373 and extends between inside face 381 and outside face 382.

Tunnel guide 370 further comprises an elongated alignment arm 386 having a first end 388 slidably disposed within slot 384 and an opposing second end 390. Second end 390 terminates at a rounded tip 391. An adjustment knob 392 threadedly engages first end 388 of alignment arm to brace 372. Rotation of adjustment knob 392 in a first direction allows second end of alignment arm 386 to freely slide along slot 384. By rotating adjustment knob 392 in the opposing direction, alignment arm 386 is rigidly clamped to brace 372. It is noted that guide sleeve 378 has a central longitudinal axis 394 extending therethrough. Tunnel guide 370 is configured such that independent of the placement of alignment arm 386 along slot 384, axis 394 is always aligned with tip 391.

As depicted in FIG. 21, during operation tip 391 of alignment arm 386 is received within indent 290 of centering template 280. Because guide sleeve 378 is always aligned with tip 391, the surgeon is now free to bias the distal end of guide sleeve 378 at any location on tibia 12 for which tunnel guide 370 can be adjusted. It is understood that tunnel 400 will extend through tibia 12 between the location where the distal end of guide sleeve 378 is positioned and pocket 278 formed on resected surface 234. The surgeon is thus free to select the best location on tibia 12 for forming the tunnel. Such selection can take into consideration the area of best bone quality and the desired length and position for tunnel 400. In the present embodiment, where the implant is being mounted on the medial condyle 21, guide sleeve 378 is shown being biased against lateral side 14 of tibia 12. In alternative embodiments, it is also appreciated that guide sleeve 378 can be biased against anterior side 18 or medial side 16 of tibia 12.

Once guide sleeve 378 is biased against tibia 12, a guide wire 396 is passed through guide sleeve 378 and then drilled through tibia 12 until guide wire 396 contacts boss 288 (FIG. 19). As a result, a tunnel 400 is formed having a first end 402 located at a position spaced apart from resected surface 234 and a second end 404 (FIG. 17) which extends through pocket 278 on resected surface 234. As discussed below in greater detail, tunnel 400 receives a flexible line that is mounted to the implant. In one embodiment, passing the flexible line through tunnel 400 requires tunnel 400 to have a diameter typically in a range between 1 mm to about 3 mm. Of course, larger diameters can also be used. Accordingly, depending on the desired size for tunnel 400, guide wire 396 can be used to independently form tunnel 400. Alternatively, a tubular drill sleeve can be positioned over guide wire 396 to enlarge tunnel 400. Alternatively, guide wire 396 can be removed and a larger drill can be passed through the preliminary tunnel formed by the guide wire 396 to form the final tunnel 400.

As will be discussed below in greater detail, a bone anchor is secured within first end 402 of tunnel 400. The bone anchor requires a larger opening than what is necessarily needed for the line to pass through tunnel 400. Accordingly, where the tunnel 400 is minimized to limit bone removal, first end 402

of tunnel 400 is counter bored with a larger drill so as to enable proper placement of the bone anchor. In one embodiment, tunnel 400 can be counter sunk so as to have a diameter in a range between about 4 mm to 8 mm. Again, other dimensions can also be used.

Once tunnel 400 is formed, tunnel guide 370, centering template 280, and guide template 236 are removed from tibia 12. Accordingly, by using any of the aforementioned methods and/or combinations thereof, a resected medial condyle having a tunnel coupled therewith, is now ready to receive an implant.

Depicted in FIGS. 22A-22C is one embodiment of a condylar implant 300 incorporating features of the present invention. The term "condylar implant" is broadly intended to include implants that can replace all or a portion of a condyle of a tibia. The condylar implant can also replace all or a portion of the articulation surface of the condyle. Accordingly, while the depicted embodiments show one conventional size and configuration for a condylar implant, in alternative embodiments the condylar implant can be larger to replace more of the tibia or can be smaller to replace only a section of a condyle of a tibia. In such alternatives, the condylar implant can have a variety of different configurations.

In general, condylar implant 300 has a top articular surface 306 and an opposing bone apposition surface 303. In one embodiment, top articular surface 306 has a generally concave contour so as to mate with a corresponding femoral condyle. Alternatively, articular surface 306 can be substantially flat. Bone apposition surface 303 has a generally convex contour that curves front to back and side to side and that is configured to mate with pocket 278 on resected surface 234 (FIG. 17). As a result of contouring bone apposition surface 303, implant 300 can be formed having a low profile configuration with a generally uniform thickness along the length thereof. This uniform thickness provides uniform strength for implant 300. Furthermore, by contouring implant 300 to fit within pocket 278, the stability of mounted implant 300 is increased so as to prevent unwanted movement of implant relative to tibia 12.

In alternative embodiments, bone apposition surface 303 can be substantially flat. As a result, implant 300 can be mounted directly on flat resected surface 234. In this embodiment, however, contouring of articular surface 306 would result in the opposing ends of implant 300 being thicker than the middle. Again, however, depending on the size of the patient and the portion of the bone being replaced, implant 300 can have an array of different sizes and configurations.

As depicted in FIG. 22C, implant 300 comprises a body 301 and an inlay 320. Body 301 has top articular surface 306 and an opposing bottom surface 308. A pocket 316 is recessed on bottom surface 308. Pocket 316 is bounded by a floor 317 and a sidewall 318 upstanding around the perimeter thereof. A stem 304 projects from floor 317 and is completely encircled by pocket 316. Body 301 is typically comprised of a metal such as chromium, cobalt, titanium, or the like and alloys thereof but can also be made of ceramics, plastics, or other materials. Body 301 can also be comprised of layers or sections of different materials. In one embodiment, body 301 has a maximum thickness typically in a range between about 2 mm to about 10 mm. Other dimensions can also be used depending on the amount that the tibial condyle is resected or worn away.

Inlay 320 is secured within pocket 316 of body 301 so as to encircle stem 304. Inlay 320 is comprised of a porous bone ingrowth material such as porous tantalum. Other conventional porous bone ingrowth materials can also be used. Inlay 320 is secured within pocket 316 using conventional tech-

niques such as press fit, welding, adhesive, sintering, and the like. Inlay 320 can also be mechanically connected to body 301 such as by screws, fasteners, rivets, or the like. In alternative embodiments, pocket 316 can be eliminated and inlay 320 can be secured to the bottom surface of body 301 using various techniques. Inlay 320 has an exposed bottom surface 322 that, as discussed above, can be arched, substantially flat, or can have any other desired configuration. In this embodiment, bottom surface 322 of inlay 320 comprises substantially all of bone apposition surface 303 of base plate 301.

In contrast to having a single pocket 316 in which a single inlay 320 is positioned, it is appreciated that body 301 can be formed having a plurality of pockets each adapted to receive a separate inlay. For example, depicted in FIGS. 23A and B is an alternative embodiment of an implant 410 comprising a body 412 having a bottom surface 414. Bottom surface 414 is formed with two pockets 416A and B which are partially bounded by a perimeter sidewall 418 and are separated by a central bridge 420. Each pocket 416A and B is adapted to receive a corresponding inlay 422A and B. In this embodiment, the bone apposition surface includes not only the bottom surface of inlays 422A and B but also the bottom surface of bridge 420 and perimeter sidewall 418.

Similarly, depicted in FIG. 24 is an alternative embodiment of a body 424 for an implant. Body 424 has a bottom surface 424 with three separate pockets 426A, B, and C. Each of the pockets 426 is adapted to receive a separate inlay. The bridges formed between the separate pockets provide increased structural support for the implant and, as will be discussed below in greater detail, provide a structure on which the flexible line can be attached.

In still other embodiments, it is appreciated that the inlay of porous bone ingrowth material can be eliminated. In this embodiment, the condylar implant can comprise a single integral member. For example, depicted in FIG. 25 is an alternative embodiment of a condylar implant 428. Implant 428 is formed as a single integral body 430 having top articular surface 306 and an opposing bottom surface 430 which also functions as the bone apposition surface. To facilitate secure attachment of implant 428 to tibia 12, a plurality of spikes 434 are formed on bottom surface 430. It is appreciated that in all of the embodiments herein that spikes, fins, or other forms of projections can also be formed projecting from bottom surface of the implant. Such projections can be separated from or encircled by the porous bone ingrowth inlay. The projections can also be formed on the porous bone ingrowth inlay. Such projections can penetrate into the tibia or be received within slots formed on the tibia to help prevent unwanted movement of the implant.

As previously mentioned, flexible line is used to secure the implants to tibia 12. As used in the specification and append claims, the term "line" is broadly intended to include wire, cable, cord, suture, braided line, combinations thereof or any other type of flexible filament. The line can be made of metal, alloys, synthetics, composites, or any other desired material. In one embodiment of the present invention the line comprises braided filaments of a cobalt chrome alloy having a diameter in a range between about 0.25 mm to about 5 mm with about 0.5 mm to about 3 mm being more common and about 0.5 mm to about 2 mm being most common. Other dimensions can also be used. The line can be of any desired length.

In one embodiment, the line can also be defined in that for an unsupported length of line of 4 cm, the line has substantially no compressive strength. In yet other embodiments, for an unsupported length of line of 4 cm, the line fails under buckling when an axial compressive load of 0.25 N, 1 N, 2 N,

5 N, 20 N, or 50 N is applied. That is, different lines can be used that fail under different loads. Stiffer lines can also be used.

It is also appreciated that the line can be static or resiliently stretchable. In one embodiment where the line is resiliently stretchable, the line can be comprised of a material have shape memory of pseudo elastic properties. One example of such a material is a nickel titanium alloy sold under the name Nitinol. In yet other embodiment, it is appreciated that sections of the line could be replaced with a spring member such as a coiled spring or rubber or bungee type member.

Returning to FIGS. 22B and C, an elongated line 438 is provided having a first end 439 and an opposing second end 440. First end 439 terminates at a tip 441 that is sealed so as to have and maintain a smooth uniform diameter. Second end 440 terminates at an enlarged rounded head 442. In alternative embodiments, second end 440 can have the same configuration as first end 439 or can have an enlarged head of any desired configuration.

In one embodiment of the present invention, means are provided for connecting flexible line 438 to implant 300. By way of example and not by limitation, stem 304 is provided with a threaded socket 312. Slidably disposed on line 438 is a tubular retainer 444. Retainer 444 comprises a body 445 having one or more helical threads 446 mounted on the exterior surface thereof. Threads 446 are configured to engage with threaded socket 312. A channel 448 longitudinally extends through body 445. Channel 448 constricts toward the distal end of body 445 so that the channel 448 thereat is larger than the diameter of line 438 but smaller than the diameter of head 442. The proximal end of channel 448 is enlarged and has a polygonal transverse cross section. As a result, first end 439 of line 438 can be passed through channel 448 of body 445 distal to proximal. Line 438 can then be pulled through retainer 444 until head 442 is stopped by the constricted section of channel 448. The first end of line 438 can then be advanced through a central channel in a tubular driver (not shown) having a free end adapted to fit within channel 448 of retainer 444 at the proximal end thereof. The driver can thus be used to screw retainer 444 into threaded socket 312, thereby securing line 438 to implant 300.

Depicted in FIG. 23B is another embodiment of the means for connecting a line to an implant. In this embodiment a passage 464 extends through bridge 420. Passage 464 has an entrance 465 formed on a side wall of bridge 420 and an exit 466 formed on a bottom surface of bridge 420. Again, passage 464 constricts as it extends from entrance 465 to exit 466. Line 438 is shown having an enlarged substantially cylindrical head 442 formed on second end 440. Head 442 is larger than the constricted portion of passage 464. Head 442 can be crimped, welded, or otherwise formed on line 438. Head 442 can also be integrally formed with line 438. During assembly, first end 439 of line 438 is passed through passage 464 from entrance 465 to exit 466. Line 438 is advanced through passage 464 until head 442 is captured and securely retained within constricted passage 464. Inlays 422A and B can then be positioned within pockets 416A and B. In yet other embodiments, rather than constricting passage 464, it is appreciated that head 442 can be wedge shaped so that head 442 is captured within passage 464.

Depicted in FIGS. 26-31 are a variety of still other embodiments of the means for connecting a line to an implant. Specifically, depicted in FIG. 26 is a stem 450 mounted to implant 300 which can be selectively crimped so as to catch head 442 within stem 450. In one embodiment this can be accomplished by forming slots along stem 450. Depicted in FIG. 27, a hook 452 is formed projecting from the bottom

surface of body 301 of implant 300. In contrast to having head 442, a loop 454 is formed at the second end of line 438. Loop 454 is looped around hook 452. Inlay 320 is then mounted on the bottom surface of body 301 so as to prevent loop 454 from accidentally sliding off of hook 452.

Depicted in FIG. 28, a channel 456 can be formed extending through implant 300 from top surface 306 to bottom surface 308. Channel 456 is enlarged at top surface 306 so as to receive head 442 of line 438 but constricts toward bottom surface 308 so as to capture head 442 within channel 456. The opening to channel 456 on top surface 306 can be rounded to prevent unwanted wear on the femoral condyle. In other embodiments, a plug can be inserted within channel 456 so as to occlude the opening to channel 456. In still another alternative, instead of forming the opening to channel 456 on top surface 306, a constricted slot can be formed that inwardly extends from the side of implant 300.

Depicted in FIG. 29, a set screw 458 is screwed into the side of a tubular stem 459 to capture head 456 therein. Finally, depicted in FIG. 30, rather than having a threaded retainer 444 as discussed above, a tubular retainer 460 can be provided with outwardly projecting barbs 461. Retainer 460 can simply be pushed into a socket 462 having threads or barbs thereon so that retainer 460 is captured therein. It is also noted that in FIG. 30 line 438 is shown comprising a resiliently stretchable spring 468. It is appreciated the spring 468 can be directly connected to the implant or disposed along line 438. Spring 468 can also come a variety of different shapes and sizes and be made from different materials. As will be discussed below in greater detail, spring 468 helps maintain the desired tension force on line 438 so that the implant is securely held in position.

In the embodiment depicted in FIG. 31, an implant 470 has a body 471 with a bottom surface 472. A pair of spaced apart projections 474A and B project from bottom surface 472. A passage 475 extends through each projection 474A and B. Line 438 is passed through each passage 475 so that line 438 is slidably connected to implant 470 with both ends 439 and 440 of line 438 being freely disposed. As will be discussed below in greater detail, in this embodiment both ends 439 and 440 of line 438 are separately connected to the bone. Since line 438 is slidably connected to implant 470, this embodiment functions like a pulley in that a tensioning force applied to one end of line 438 is magnified as it passes through the passages 474. As such, greater force can be used to secure the implant without increasing the load on line 438.

Furthermore, by connecting line 438 to implant 470 at two spaced apart locations, the implant is secured in a more stable configuration that prevents unwanted sliding or rotation on the bone. In other embodiments, it is appreciated that line 438 can be connected to only a single projection 474. It is also appreciated that a first line can be connected to projection 474A while a second line is connected to projection 474B. In like manner, it is appreciated that in all embodiment disclosed herein, two or more discrete lines can be connected two each of the implants using any of the methods disclosed herein. It is also appreciated that there are still a large number of other ways in which line 438 can be secured to an implant. For example, the line can be welded, press fit, or attached by a variety of different types of fasteners such as bolts, rivets, or clamps.

Depicted in FIGS. 32A and B is another alternative embodiment of a condylar implant 326. Like elements between condylar implants 300 and 326 are identified by like reference characters. In contrast to condylar implant 300 which is fixed and rigid, condylar implant 326 is mobile. Specifically, in condylar implant 326 the body comprises a

lower bearing plate 328 from which the flexible line projects and an upper bearing plate 330 that is slidably mounted on lower bearing plate 328.

Lower bearing plate 328 has a top surface 332 and an opposing bottom surface 334 with a perimeter edge 335 extending therebetween. Pocket 316 is formed on bottom surface 334 to receive inlay 320. In this embodiment, stem 304 is shown elongated and at an angle. If desired, stem 304 can be formed long enough so that it extends directly into the tunnel formed on the tibia. Likewise, stem 304 can be oriented at any angle to correspond with the tunnel. Top surface 332 is substantially flat or inwardly arched and extends between an anterior end 336 and a posterior end 338. A track 340 is recessed on top surface 332. Track 340 has an open mouth extending through perimeter edge 335 at anterior end 336 and longitudinally extends toward posterior end 338. Track 340 is bounded by a substantially flat floor 343 having a sidewall 344 upstanding therefrom. Sidewall 344 comprises a recess groove 345 which extends along floor 343 and an outwardly projecting lip 346 which projects along top surface 332. As such, the opposing sidewalls 344 of track 340 form a mortis.

Upper bearing plate 330 comprises top articular surface 306 and a bottom surface 348 which each extend between an anterior end 350 and an opposing posterior end 352. Bottom surface 348 has a configuration substantially congruent to top surface 332 of lower bearing plate 328. Projecting from bottom surface 348 is an elongated key 354 which extends from toward anterior end 350 to toward posterior end 352. Key 354 has a sidewall 356 that is substantially complementary to sidewall 344 of track 340 such that key 354 forms a tenon that can slide into track 340 from mouth 342. In this position key 354 can freely slide along track 340 but is prevented from vertically separating from track 340.

During use, upper bearing plate 330 can slide posterior-anterior on lower bearing plate 328 as the femoral condyle rotates on top articular surface 306. This ability of upper bearing plate 330 to slide minimizes high stress points between the femoral condyle and upper bearing plate, thereby minimizing wear. Furthermore, because bearing plates 328 and 330 slide against each other on congruent surfaces, both of bearing plates 328 and 330 can be comprised of metal without producing undue wear. In other embodiments, bearing plates 328 and 330 can be comprised of plastics, ceramics, or composites of different materials. In addition, bearing plates 328 and 330 can be made of the same or different materials.

Although key 354 and track 340 are shown as being linear, in alternative embodiments they can be congruently curved to more naturally correspond to the bending movement of the knee. For example, depicted in FIGS. 33A and B is another alternative embodiment of a condylar implant 360 which includes an upper bearing plate 361 and a lower bearing plate 362. In this embodiment, lower bearing plate 362 includes a track 363 that is curved along the length thereof. Upper bearing plate 361 includes an elongated key 364 having a curve complementary to track 363 such that key 364 can freely slide within track 363. As previously discussed, key 364 and track 363 can also be arched or curved in a vertical plane.

Depicted in FIG. 34 is one embodiment of an anchor assembly 810 used to secure condylar implant 300 to tibia 12. Anchor assembly 810 comprises a bone anchor 812 that operably connects with a lock 813. As discussed below in greater detail, bone anchor 812 is selectively placed by a first drive driver 814 while lock 813 is selectively placed by a second driver 816.



Turning to FIG. 35, bone anchor **812** comprises a tubular body **818** having a substantially cylindrical configuration. Body **818** includes an interior surface **820** and an exterior surface **821** that each extend between a proximal end **822** and an opposing distal end **823**. Distal end **823** tapers to a reduced nose **824**. Formed at proximal end **822** is an engaging head **827** having an exterior surface with a transverse cross section that is polygonal or any other non-round configuration. As a result, first driver **814** can connect with engaging head **827** to selectively rotate bone anchor **812**. Encircling and radially outwardly projecting from exterior surface **821** are one or more helical threads **825**. Threads **825** can be conventional or self-tapping and extend radially outward beyond the outer perimeter of engaging head **827**. In alternative embodiments, threads **825** can be replaced by ridges, barbs, or other bone engaging structures used in conventional bone anchors. Bone anchor **825** can be formed of a biocompatible metal, a bioabsorbable polymer, a bioactive ceramic, or any other desired material.

As depicted in FIG. 36, interior surface **820** bounds a channel **826** longitudinally extending through bone anchor **812**. Extending proximal to distal, interior surface **820** comprises a threaded portion **828**, a frustoconical tapered portion **830**, and a constricted cylindrical portion **833**.

Returning to FIG. 35, in the embodiment depicted, lock **813** comprises a collet. In general, lock **813** has a proximal end **836**, an opposing distal end **838**, and a channel **840** extending therebetween. More specifically, lock **813** comprises a tubular body **846** extending from proximal end **836** to a second end **850**. Encircling and radially, outwardly projecting from body **846** are one or more helical threads **854**. Threads **854** are configured to engage with threaded portion **828** of bone anchor **812**. At least a portion of channel **840** extending through body **846** is bounded by an interior surface **847** having a polygonal or other non-circular transverse cross section so that second driver **816** (FIG. 34) can be secured therein for selective rotation of lock **813**.

Projecting from second end **850** of body **846** are a plurality of flexible fingers **856**. As depicted in FIG. 37, four fingers **856** are provided with each finger **856** being separated by a slot **857** extending along the length of fingers **856**. In alternative embodiments, two or more fingers **856** can be used. The distal end of each finger **856** is radially, inwardly tapered.

As depicted in FIG. 38, during operation lock **813** is partially screwed into proximal end **822** of bone anchor **812**. In this position, with fingers **856** unflexed, line **438** is passed through channels **826** and **840**. As discussed below in greater detail, when it is desired to secure line **438** relative to bone anchor, lock **813** is advanced further into bone anchor **812** until tightly secured therein. In so doing, fingers **856** of lock **813** bias against tapered portion **830** of bone anchor **812** which causes fingers **856** to radially, inwardly constrict and securely engage line **438**. In this position, line **438** is prevented from being pulled in either direction. However, line **438** can again be freely moved by simply unscrewing lock **813** from within bone anchor **812** so that fingers **856** are able to freely, outwardly flex.

Returning to FIG. 34, first driver **814** comprises a tubular shaft **862** having a proximal end **863** and an opposing distal end **864**. A handle **865** is formed at proximal end **863**. A passage **866** extends through shaft **862** and handle **865** so that line **438** can pass completely through first driver **814**. Passage **866** at distal end **864** has an interior surface that is complementary to the exterior surface of engaging head **827** of bone anchor **812**. As such, first driver **814** can be selectively coupled with bone anchor **812** for selective rotation of bone anchor **812**.

Second driver **816** also comprises a tubular shaft **867** having a proximal end, **868** and an opposing distal end **870**. A tubular handle **872** is mounted proximal end **868**. As such, a passage **874** extends the length of second driver **816** so that line **438** can extend completely therethrough. Distal end **870** of shaft **867** terminates at a tip **875**. Tip **875** has a configuration complementary to channel **840** at proximal end **836** of lock **813**. As such, second driver **816** can be selectively coupled with lock **813** for selective rotation of lock **813**.

Turning to FIG. 39, to facilitate mounting of condylar implant **300**, with the second end of line **438** connected to implant **300**, first end **439** of line **438** is passed through tunnel **400** from second end **404** (FIG. 17) to first end **402**. In one embodiment this is accomplished by passing an instrument up through tunnel **400** from first end **402** to second end **404**. The instrument is then used to grab first end **439** of line **438** and pull it down through tunnel **400**. Other techniques can also be used.

Line **438** is continually pulled through tunnel **400** to remove all slack. With the slack removed, condylar implant **300** is slid onto resected surface **234** so as to fit within pocket **278**. Here it is noted that because condylar implant **300** has a relatively low profile, condylar implant **300** can be easily passed through the relatively small incision that was originally formed over the medial meniscus. This is in contrast to other conventional procedures where larger incisions must be made to either allow placement of an implant having a large stem that is embedded within the bone for securing or to provide access room to enable securing the implant by passing screws down through the top of at least a portion of the implant.

Once implant **300** is positioned, bone anchor **812** is fed onto line **438**. Specifically, with lock **813** partially inserted into bone anchor **812**, as discussed above with reference to FIG. 38, first end **439** of line **438** is passed distal to proximal through channels **826** and **840** of bone anchor **812** and lock **813**. First end **439** of line **438** then is passed distal to proximal through passage **866** of first driver **814** so that first driver **814** can removably couple with bone anchor **812**. It is appreciated that the above steps can be performed in a variety of different sequences. For example, line **428** can be passed through bone anchor **812** and lock **813** separately before they are connected together.

First driver **814** is then used to screw bone anchor **812**, having lock **813** therein, into first end **402** of tunnel **400**. Bone anchor **812** is advanced until proximal end **822** passes into tibia **12**. In one embodiment, a tap, not shown, is used to initially thread the interior surface of tunnel **400** at first end **402**. Alternatively, bone anchor **812** can be self-tapping.

Next, a tensioner **878** is used to tension line **438**. As depicted in FIGS. 40 and 41, tensioner **878** comprises a frame **880** having a proximal end **881** and an opposing distal end **882**. Distal end **882** removably connects to handle **865** of first driver **814**. A channel **884** is formed within a portion of frame **880**. Rotatably disposed within channel **884** is a threaded shaft **886**. A portion of shaft **886** extends beyond proximal end **881** and has a handle **888** connected thereto. Mounted on threaded shaft **886** within channel **884** is a clamp arm **890**. Clamp arm **890** is mounted such that rotation of shaft **886** by rotation of handle **888** causes clamp arm **890** to selectively advance along shaft **886** depending on the direction of rotation.

Positioned on clamp arm **890** is a stop plate **892**. An eccentrically mounted cam **894** is rotatably mounted to clamp arm **890** and is spring biased against stop plate **892**. A handle **895** projects from cam **894**. Depressing handle **895** causes cam **894** to rotate away from stop plate **892**. Line **438** can then be

placed between cam **894** and stop plate **892**. When handle **895** is released, cam **894** spring biases against stop plate **892** causing line **438** to be secured therebetween. Because cam **894** is eccentrically mounted, the more tension on line **438** toward first driver **814**, the greater the force applied by cam **894** to secure line **438** in place.

Turning to FIG. **42**, once bone anchor **812** has been mounted to tibia **12**, first end **439** of line **438** is passed distal to proximal through passage **874** in second driver **816**. Proximal end **870** of second driver **816** is then advanced proximal to distal through passage **866** of first driver **814**. Second driver **816** is advanced until distal tip **875** couples with lock **813**. Next, tensioner **878** is connected with handle **865** of first driver **814**. Line **438** extending from second driver **816** is then connected to clamp arm **890** by cam **894** as discussed above. Handle **888** of tensioner **878** is then rotated so that clamp arm **890** is moved along threaded shaft **886** away from second driver **816**. In so doing, a tension force is applied to line **438**. A force measuring device, such as a transducer, can be coupled with tensioner **878** for measuring the tension force applied to line **438**. In turn, the tension force on line **438** is the same force used to bias implant **300** against tibia **12**. When a sufficient tension force is applied to line **438**, handle **872** of second driver **872** is rotated, thereby causing lock **813** to secure line **438** within bone anchor **812**. In one embodiment, the tension force applied to line **438** is in a range between about 25 pounds (110 N) to about 300 pounds (1,335 N) with about 150 pounds (670 N) to about 250 pounds (1,110 N) being more common. Other forces can also be applied.

Once lock **813** is secured in place, tensioner **878**, second driver **816** and first driver **814** are removed. One of the unique features of this embodiment of the present invention is that should the surgeon wish to make some modification to the implant or related anchor system, lock **813** can simply be loosened using second driver **816** to allow the desired movement or adjustment. The above process can then be repeated to resecure implant **300** in place. Once properly position and secured, line **438** is severed just proximal of lock **813**. Even after line **438** is severed, however, further tension can be applied to line **438** by backing bone anchor **812** back toward first end **402** of tunnel **400** using first driver **814**. Closing procedures for the tissue are then performed.

It is appreciated that the same above process can be used for securing implant **300** to tibia **12** using tunnel **90** as shown in FIG. **10**. Furthermore, a first tunnel **90** can be formed for use in resecting tibia **12** following which a second tunnel **400** can be formed for placement of line **438** and anchor assembly **810**. It is likewise appreciated that many of the mounting steps can be modified or performed in an alternative order. For example, in one method condylar implant can be positioned on resected surface **234** prior to having line **438** connected thereto. As previously discussed with regard to FIG. **22**, a driver can then be used to secure line **438** to implant **300** by passing retainer **444** through tunnel **400** from first end **402** to second end **404** where retainer is then screwed into implant **300**, thereby securing line **438** to implant **300**.

In one embodiment of the present invention means are also provided for securing line **438** to bone anchor **812**. One example of such means comprises lock **813**. In alternative embodiments lock **813** can have a variety of different configurations or be replaced with a variety of different structures. For example, any number of different wedges, cleats, or cams can be placed in bone anchor **812** so that line **438** can be pulled one way through bone anchor **812** but is prevented from being pulled back. In yet other embodiments, once line **438** is tensioned, a lock can be crimped or otherwise secured to line **438**. The lock would then bias against bone anchor **812**

to prevent line **438** from being pulling back through bone anchor **812**. Examples of various locks which can be used are disclosed in U.S. Pat. No. 5,702,397, issued Dec. 30, 1997 and U.S. patent application Ser. No. 09/970,559, filed Oct. 3, 2001. The bone anchors with related line locking structures disclosed in U.S. Pat. No. 5,702,397 and application Ser. No. 09/970,559 are incorporated herein by specific reference.

Depicted in FIG. **43** is one embodiment of a system used for mounting implant **470** as previously discussed with regard to FIG. **31**. In this embodiment, two tunnels **400A** and **400B** extend from lateral side **14** of tibia **12** to resected surface **234**. Tunnels **400A** and **B** can be formed having parallel alignment or any desired angle. Furthermore, tunnels **400A** and **B** can be formed by moving tunnel guide **370** (FIGS. **20** and **21**) to two locations at which the tunnels are drilled or tunnel guide **370** can be formed having two adjacent guide sleeves **378** mounted on the brace **372**. Each tunnel guide **370** can then be used for forming corresponding tunnels **400A** and **B**.

To secure implant **470** to tibia **12**, first end **439** of line **438** is passed proximal to distal through channel **826** in first bone anchor **812A**. First end **439** is then passed up through first tunnel **400A**, through passages **475** on implant **470** (FIG. **31**), down through second tunnel **400B**, and finally through second bone anchor **812B** and lock **813**. First driver **814** is used to drive bone anchors **812A** and **B** into corresponding tunnels **400A** and **B**. Line **438** is pulled down through second tunnel **400B** so as to remove the slack therefrom. In so doing, enlarged head **442** on second end **440** of line **438** is advanced into first bone anchor **812A** where head **442** is securely wedged within tapered portion **830** of channel **826** (FIG. **36**). With second end **440** of line **438** secured to bone anchor **812A**, the same process previously discussed with regard to FIG. **42** is used tension line **438** and secure line **438** to second bone anchor **812** using lock **813**.

It is appreciated that first bone anchor **812A** can be replaced with a variety of alternative structures that prevent second end **440** of line **438** from being pulled through first tunnel **400A**. For example, the first bone anchor can simply comprise an enlarged washer that captures enlarged head **442** but is too big to pass through tunnel **400A**. In yet other embodiment, the first bone anchor can simply comprise an enlarged tubular wedge that wedges into tunnel **400A** but cannot pass therethrough. In still other embodiments, line **438** can be formed without enlarged head **442**. In this embodiment, lock **813** or other wedging or locking type structure can be used to secure second end **440** of line **438** to the first bone anchor. Where two separate lines **438** are connected to an implant, each line is extended through a corresponding tunnel. The process discussed with regard to FIG. **42** is then separately performed for each separate line.

By using the above discussed implants and anchor assemblies with the corresponding methods and instruments, it is appreciated that the implants can be securely mounted to tibia **12** using procedures that are minimally invasive. Furthermore, because the implants are only secured in place after they are positioned on the proximal end of the tibia, the surgeon can easily switch out different sizes of implants when trying to determine an appropriate fit. Likewise, because the anchoring assemblies are operated through the first end of the tunnel which is remote from the implant, the inventive anchoring assemblies enable the surgeon to easily adjust the placement of the implant during initial positioning and to subsequently remove the implant should a replacement be required at a later date.

Furthermore, as a result of using a flexible line to secure the implants, the surgeon can select the best location for forming the tunnel and mounting the bone anchor at the time of the

operation. That is, the surgeon is not limited to forming the tunnel at a predefined location based on structural limitations imposed by the implant. In addition, because the line can be relatively small, the size of the required tunnel can be minimized, thereby minimizing the amount of bone that needs to be removed when forming the tunnel. Replacement of a worn or damaged implant is also relatively easily achieved by cutting the line.

Because the inventive implants, anchor assemblies, tissue preparation instruments, and corresponding methods each produce independently unique benefits, it is appreciated that these various features can be used independently with other conventional apparatus and techniques. For example, in one embodiment a larger incisions can be made at the knee of a patient and the proximal end of tibia 12 resected using conventional resection techniques. In this embodiment, tunnel 90 and/or 400 can be formed either before or after the resection of tibia 12. Once the tibia is resected and the tunnel formed, the above procedure can then be used to secure condylar implant 300. In another alternative, tunnel 90 can be formed and tibia 12 resected as discussed above. However, once tibia 12 is resected, a conventional implant can be mounted on tibia 12 using conventional techniques.

The above discussed embodiments relate to mounting a condylar implant on tibia 12. As previously mentioned, however, the present invention can also be used to mount other types of implants on other articulation surface so as to achieve one or more of the same benefits. For example, depicted in FIG. 44 is a full tibial implant 500. Tibial implant 500 comprises a tray 502 and a bearing plate 504. Tray 502 has a top surface 506 and an opposing bone apposition surface 509. Top surface 506 bounds a pocket 508 which is configured to receive and lock bearing plate 504. Bearing plate 504 has a top articular surface 510 and a bottom surface 512 which is selectively snap fit within pocket 508 of tray 502.

In one embodiment, tray 502 is comprised of metal while bearing plate 504 is comprised of a polymeric material. It is noted that bearing plate 504 and tray 502, as discussed above, are well known in the art and can be replaced with a variety of other conventional bearing plates 504 and trays 502 used in full tibial implants. The distinction over the prior art, however, is that tray 502 has been modified so that line 438, as previously discussed, is connected to tray 502 so as to project from bone apposition surface 509.

As also depicted in FIG. 44, proximal end 10 of tibia 12 has been uniformly resected so as to form a resected articulation surface in the form of a tibial plateau 514. Tunnel 90 includes second end 96 formed on tibial plateau 514 and first end 94 spaced apart from tibial plateau 514. Tibia 12 can be resected to form tibial plateau 514 by using any of the methods or combination of methods disclosed herein or by using other conventional techniques. For example, tunnel 90 can be formed using the method disclosed for forming tunnel 400. Depending on the method used, tunnel 90 can be formed before or after resection of tibia 12.

Once tibia 12 is resected, line 438 is passed through tunnel 90 and tray 502 is positioned on tibial plateau 514 so that the location where line 438 connects with tray 502 aligns with second end 96 of tunnel 90. One of the above discussed anchor assemblies is then used to secure tray 502 to tibia 12. Bearing plate 504 can be secured to tray 502 either before or after securing tray 502 to tibia 12.

It is appreciated that the various alternatives discussed above with regard to how line 438 can be mounted to tray 502 and the number and position of inlays are also applicable to tray 502. Furthermore, to help prevent unwanted movement of tray 502, resected surface 514 can be contoured with a

pocket of which bone apposition surface 509 has a complementary configuration. Likewise, any number of spikes, fins, or projections can be formed so as to project from bone apposition surface 509.

Features of the present invention can also be used for mounting a femoral implant on the distal end of a femur. Like elements between different embodiments are identified by like reference characters. For example, depicted in FIG. 43 is a distal end 532 of a femur 530 having a medial side 540 and a lateral side 542 that extend between an anterior side 538 and a posterior side 536. Distal end 532 of femur 530 terminates at a lateral condyle 535 and a medial condyle 537.

Mounted on medial condyle 537 is a guide template 900. Guide template bounds an elongated opening 902 that extends therethrough and which is configured to closely fit over a predefined portion of an articulation surface of medial condyle 537. Opening 902 bounds the area where the bone is to be resected and a condylar implant mounted. Guide template is curved and comes in a variety of different sizes and shapes so that a proper fit can be made on medial condyle 537. Once a proper sized and fitting guide template 900 is positioned, guide template 900 is secured in place by spaced apart screws 904 that are screwed through screw holes in guide template 900 and into the medial side of femur 530. It is appreciated that the various alternatives as discussed above with regard to guide template 236 are also applicable to guide template 900.

In one embodiment, a milling head 906 is used to facilitate resection of medial condyle 537 bounded by guide template. Milling head 906 has a substantially hour-glass configuration and has an elongated handle 908 projecting from one side and a stem 909 projecting from the other. Milling head 906 is positioned within opening 902 in a medial-lateral orientation with handle 908 projecting from medial side 540 of femur 530. In this orientation, milling head 906 is rapidly rotated and then selectively moved within opening 902 anterior-posterior. This movement is guided by the sides of guide template 900 bounding opening 902. Milling head 906 grinds away the bone bounded within opening 902 until handle 908 and stem 909 rest against guide template 900, thereby preventing milling head 906 from descending further into the bone.

Because guide template 900 is curved anterior-posterior, the milled pocket formed by milling head 906 is outwardly arched anterior-posterior. Likewise, because milling head 906 is curved lateral-medial, the milled pocket is also outwardly arched lateral-medial. As such, the recessed pocket produced by milling head 906 is arched anterior-posterior and lateral-medial. Again, this pocket configuration enables the formation of a low profile implant having substantially uniform thickness and strength. Furthermore, the pocket formation produces a stable platform for the implant having a complementary configuration. In alternative embodiments, it is again appreciated that milling head 906 can have a variety of different configurations.

As depicted in FIGS. 46 and 47, a rasp 910 can be used to form rounded ends for the recessed pocket. Rasp 910 comprises an elongated handle 912 having a cutting mount 913 mounted on the end thereof. Cutting mount 913 has a generally semi-circular transverse cross section with a concave bearing face 914. Formed on bearing face 914 are a plurality of cutting teeth 915. Extending through cutting mount are a plurality of slots through which bone fragments can be removed. Cutting mount 913 is configured to be reciprocally moved within the opposing ends of opening 902 of guide template 900 so as to form rounded ends on the pocket formed to receive the implant.

Once the recessed pocket is finished, a centering template **918** is mounted within the recessed pocket that is still bounded by guide template **900**. As depicted in FIG. **48**, centering template **918** comprises a mounting plate **920** having a handle **922** projecting therefrom. Mounting plate **920** has substantially the same size and contouring as opening **902** of guide template **900**. As such, mounting plate **920** is substantially fixed when received within opening **902**. Formed on an upper surface of mounting plate **920** is a centering indent **924**. When mounting plate **920** is positioned within opening **902**, indent **924** is located above the location where tunnel **400** is to enter the recessed pocket formed on medial condyle **547**.

Once centering template **918** is positioned, tunnel guide **370** (as previously discussed with regard to FIGS. **20** and **21**) is mounted on femur **530** to facilitate the formation of tunnel **400**. Specifically, tip **391** of alignment arm **386** is positioned on indent **924** of centering template **918** while guide sleeve **378** is biased against lateral side **542** of femur **530**. Again, guide sleeve **378** can be positioned at any optimal location on femur **530** for the formation of tunnel **400**. After the tunnel guide **370** is positioned, a guide wire and/or other drilling structures used to form tunnel **400** through femur **530** using guide sleeve **378** as a guide. This is substantially the same process as previously discussed with regard to FIG. **21**.

In one alternative embodiment, centering template **918** and tunnel guide **370** can be eliminated. That is, tunnel **400** can be drilled starting at the recessed pocket and extending to the lateral or medial side of the femur. Because it is less critical where tunnel exits on the lateral or medial side, tunnel guide **370** is not required but could, if desired, still be used. This process could also be used on the tibial side.

Once tunnel **400** is formed, tunnel guide **370**, centering template **918**, and guide template **900** are removed from femur **530**. A femoral condylar implant **928** is then positioned within the recessed pocket. As depicted in FIGS. **49** and **50**, in one embodiment femoral condylar implant **928** comprises a body **930** having a curved articular surface **931** and an opposing bottom surface **932**. A pair of pockets **934 A** and **934 B** are formed on bottom surface **932** and are separated by a bridge **935**. Disposed within each pocket **934 A** and **934 B** is an inlay **936 A** and **936 B** of porous bone ingrowth material. Bridge **935** and inlays **936 A** and **936 B** substantially comprise a bone apposition surface **938**. Bone apposition surface has a configuration complementary to the formation of the recessed pocket formed on medial condyle **537**. Connected to bridge **935** is line **438**. It is appreciated that the various alternatives as previously discussed with regard to the tibial condylar implants and the methods for connecting line **438** thereto are also applicable to femoral condylar implant **928**.

Finally, turning to FIG. **51**, femoral condylar implant **928** is secured to femur **530** using anchor assembly **810** (FIG. **35**) and the instruments and techniques as previously discussed with regard to FIGS. **34-43**. The same alternatives as previously discussed with regard to FIGS. **34-43** are also applicable to the attachment of femoral condylar implant **928**. For example, two separate tunnels can be formed on femur **530** that intersect with the recessed pocket on medial condyle **537**. Opposing ends of a single line **438** slidably connected to implant **928** can be passed through the separate tunnels and secured with corresponding bone anchors. Alternatively, two separate and discrete lines **438** can be connected to femoral condylar implant **928**, each line being disposed in a separate tunnel.

The present invention can also be used in mounting a total femoral implant. For example, depicted in FIG. **52**, the articulation surface at distal end **532** of femur **530**, notably the

femoral medial condyle and lateral condyle, have been resected so as to form a resected articulation surface **534**. Tunnel **90** is formed on femur **530**. Second end **96** of tunnel **90** extends through resected articulation surface **534** while first end **94** of tunnel **90** is formed on medial side **540** at a location spaced apart from resected articulation surface **534**. Tunnel **90** can be bored through femur **530** at an oblique angle  $\alpha$ , as reflected in FIG. **30**. In one embodiment the angle  $\alpha$  is in a range between about  $15^\circ$  to about  $50^\circ$  with about  $20^\circ$  to about  $40^\circ$  being more common. Other angles can also be used. Tunnel **90** can be bored by making an incision in the skin adjacent femur **530**, properly orienting a tubular alignment guide, then boring tunnel **90** with a drill through the alignment guide. In one embodiment tunnel **90** can be formed using a modified guide assembly similar to guide assembly **30** as previously discussed. Tunnel **90** can also be formed using the same types of methods and tools used to form tunnel **400**.

Resected articulation surface **534** can be formed using the present invention or other conventional resecting techniques. For example, depicted in FIG. **53** is a femoral rasp assembly **515** which has components similar to rasp assembly **100** previously discussed with regard to FIGS. **6-9**. Femoral rasp assembly **515** comprises a substantially U-shaped rasp body **516**, pivot arm **105**, rasp guide **106**, and cover plate **108**.

Insertion handle **160** is shown removably disposed over pivot arm **105** and, if desired, can be used to initially place rasp assembly **515** on femur **530**. Rasp body **516** has a substantially concave cutting surface **517** having a plurality of ridges **118** formed thereon. Ridges **118** each terminate at sharpened cutting edge **120**. It is appreciated that ridges **118** and cutting edges **120** can be at any desired orientation or combination of different orientations that facilitate cutting.

As with rasp assembly **100**, extending through rasp body **516** is guide slot **122** and opening **128**. Rasp guide **106** is received within guide slot **122** so that forks **132A-B** pass through opening **128**. Cover plate **108** secures rasp guide **106** within guide slot **122**.

During operation, rasp assembly **515** is mounted on the distal end of femur **530** such that forks **132A** and **132B** of rasp guide **106** are aligned with second end **96** of tunnel **90**. Once rasp assembly **515** is positioned, retention rod **102** (FIGS. **8** and **9**) is advanced within tunnel **90** from first end **94** and connected to rasp guide **106** as previously discussed.

Once retention rod **102** is secured to rasp assembly **515**, insertion handle **160** is removed and a reciprocal driver, such as a reciprocal saw, is connected to pivot arm **105**. While holding rasp guide **106** substantially stationary by holding onto retention rod **102**, the reciprocal driver rapidly reciprocates rasp body **516** so that cutting edges **120** resect the distal end of femur **530**. In the embodiment depicted, rasp body **516** is only designed to resect the medial side of the distal end of femur **530**. A complementary rasp assembly can then be used to resect the lateral side of the distal end of femur **530** using a second tunnel **90** extending through lateral side **542** of femur **530**, thereby forming resected articulation surface **534**.

In yet other embodiments, it is appreciated that multiple different rasp assemblies with one or more different tunnels can be used to resect femur **530** or a single rasp assembly can be configured to simultaneously resect the entire distal end of femur **530**. For example, depicted in FIG. **54** is another embodiment of a femoral rasp assembly **520**. Rasp assembly **520** comprises an arched rasp body **522**, pivot arm **105**, rasp guide **106**, and cover plate **108**. Rasp body **522** has a substantially concave cutting surface **524** having a plurality of ridges **118** formed thereon. As with rasp body **516**, extending through rasp body **522** is guide slot **122** and opening **128**. Rasp guide **106** is received within guide slot **122** so that forks

132A-B pass through opening 128. Cover plate 108 secures rasp guide 106 within guide slot 122.

Rasp body 522 is configured to primarily resect the anterior surface at the distal end of femur 530. As such, a corresponding tunnel 90 can be used on femur 530 to ensure proper placement of rasp body 522 during resection. A complementary rasp body is then be used to resect the remainder of the distal end of femur 530. For example, depicted in FIGS. 58-64 are alternative embodiments of two piece femoral implants. Corresponding two piece rasp bodies can be formed to resect the corresponding surfaces that receive the pieces of the femoral implants.

Furthermore, it is also appreciated that although resected articulation surface 534 is shown having a plurality of planar faces, in alternative embodiments the one or more rasp assemblies can be configured so as to produce resected articulation surface 534 having a continuous smooth arched surface or combinations of different surfaces.

In other embodiments, it is appreciated that the various rasps can be used without the formation of tunnels or the use of retention rods. That is, the rasps can simply be biased against the bone. Likewise, by using guides similar to guide 214 depicted in FIG. 12, an oscillating or reciprocating saw can be used to form the resected surfaces depicted in FIG. 52. In yet other embodiments, a combination of sawing and rasping can be used to form the desired resected surface.

In one embodiment of the present invention, a femoral implant 550 is provided incorporating features of the present invention. As depicted in FIGS. 52 and 55, femoral implant 550 comprises a substantially U-shaped body 552 having an articular surface 554 and an opposing bone apposition surface 556 which each extend between an anterior end 558 and a posterior end 560. Articular surface 554 is configured to mate with a tibia or tibial implant while bone apposition surface 556 is configured to mate with resected articulation surface 534 of femur 530.

More specifically, body 552 of femoral implant 550 comprises a substantially U-shaped medial condyle 562 and a substantially U-shaped lateral condyle 564. Condyles 562 and 564 are connected together at anterior end 558 but are spaced apart at posterior end 560 so that an elongated slot 565 is formed thereat. Mounted to femoral implant 550 so as to project from bone apposition surface 556 of medial condyle 562 is line 438. During use, first end 439 of line 438 is passed through tunnel 90 from second end 96 to first end 94. Femoral implant 550 is then positioned on resected articulation surface 534 so that the position where line 438 connects with femoral implant 550 is aligned with second end 96 of tunnel 90. Here it is appreciated that because there are no posts projecting from bone apposition surface 556, femoral implant 550 can be slide on to resected articulation surface 534 lateral to medial or medial to lateral through a medial or lateral incision on the knee of the patient. As a result, it is not necessary to openly expose distal end 532 of femur 530 during placement of femoral implant 550. As depicted in FIG. 56, once femoral implant 550 is positioned, anchor assembly 810 or alternatives thereto, is used to secure femoral implant 550 to femur 530.

In one alternative embodiment depicted in FIG. 55, a second line 438A can be connected to femoral implant 550 so as to project from bone apposition surface 556 of lateral condyle 564. By passing second line 438A through a second tunnel on the lateral side of femur 530, a second anchor assembly can be used to further secure femoral implant 550 to femur 530. Alternatively, second line 438A and the second anchor assembly can be used instead of the first line 438 and corresponding anchor assembly 810. In yet another alternative, a

single line 438 can be slidably mounted to femoral implant 550 with opposing ends of the line being secured within separate tunnels.

Depicted in FIG. 57 is an alternative embodiment of a femoral implant 580 incorporating features of the present invention. Again, like elements of different embodiments are identified by like reference characters. In contrast to bone apposition surface 556 being substantially flat, an elongated post 626 is formed projecting from bone apposition surface 556. An opening 627 extends through the side of post 626. An elongated pin 678 has a proximal end 679 and an opposing distal end 680. An enlarged threaded head 682 is formed at proximal end 679. A polygonal socket 684 is formed on an end face of head 682 to receive a driver. A first bore is formed on resected surface 534 (FIG. 52) of femur 530 to receive post 626. Either before or after femoral implant 580 is positioned on resected surface 534 with line 438 extending through tunnel 90, a second bore is formed into or through femur 530 lateral to medial or medial to lateral so that the second bore is aligned with opening 627 in post 626. Pin 678 is then advanced into the second bore so that pin 678 passes through opening 627 of post 626. Pin 678 is then secured in place by screwing threaded head 682 of post 626 into the femur. Post 626 thus helps to prevent any unwanted movement of femoral implant 580. As also depicted in FIG. 57, spikes 686 project from bone apposition surface 556. It is appreciated that any number of spikes, fins, or other forms of projections can be formed on bone apposition surface 556 and can be used in conjunction with or independent of post 626.

In one embodiment, in addition to using anchor assembly 810 to attach the femoral implant to the femur 530, a bone cement can be employed to further enhance the adhesion of the femoral implant to resected femur 530. The bone cement can be applied before and/or during mounting of the femoral implant. For example, the femoral implant can be partially attached and then a syringe or other form of delivery tube used to inject bone cement between the femoral implant and femur 530. In addition, a porous or fibrous material, such as a wire mesh, may be attached to bone apposition surface 556 of the femoral implant to thereby foster bone growth between the femoral implant and resected femur 530 and/or to provide surface area for attaching the bone cement between the femoral implant and resected femur 530. In one embodiment, one or more pockets can be formed on bone apposition surface 556. An inlay of porous bone ingrowth material, such as previously discussed with regard to inlay 320, can be secured within the pockets.

Depicted in FIGS. 58-64 are connectible two-piece femoral implants incorporating features of the present invention. The implants can be used in knee arthroplasty wherein the two parts are independently slid in from the medial or lateral side of the knee through an incision and then connected and mounted onto resected articulation surface 534 of femur 530. A coupling member, such as a bolt, screw, pin, or the like, can be used to attach one part of the femoral implant to the other. Optionally, one part may be mounted on resected articulation surface 534 followed by the other part being connected thereto. One or more lines 438 connected to the femoral implant is used in conjunction with a corresponding anchor assembly 810 or alternative thereof, as discussed above, to connect the femoral implant to femur 530. Because the smaller parts of the two-piece femoral implant can be sequentially inserted through an incision, the required incision can be smaller than required for unitary implants.

FIG. 58 is a perspective view of a two-piece femoral implant 602 in a divided state while FIG. 59 is a perspective view of femoral implant 602 shown in an assembled state. In

one embodiment, femoral implant **602** can be designated as “end use” in that the entire structure is configured to be permanently mounted onto the resected articulation surface during a resurfacing procedure and is designed for permanent daily use by a patient.

Femoral implant **602** is centrally divided lateral to medial and comprises a patellar condyle **603**, which includes anterior end **558**, and a tibial condyle **604**, which includes posterior end **560**. Patellar condyle **603** includes at a substantially V-shaped posterior end **606**. Posterior end **606** terminates at an end face **609** that extends between a medial side **607** and a lateral side **608** of patellar condyle **603**. A pair of spaced apart linear passageways **616A-B** transversely extend through posterior end **606** of patellar condyle **603** so as to enter and exit through end face **609**.

Tibial condyle **604** terminates at a V-notched anterior end **610** that is complementary to V-shaped posterior end **606** of patellar condyle **603**. Anterior end **610** terminates at an end face **611** that also extends between a medial side **612** and lateral side **614** of tibial condyle **604**. A pair of spaced apart passageways **618A-B** transversely extend through anterior end **610** of tibial condyle **604** between medial side **612** and end face **611**. A pair of threaded sockets **620A-B** are formed on end face **611** toward lateral side **614** in alignment with passageways **618A-B**.

When patellar condyle **603** and tibial condyle **604** are mated, a joint line **605** is formed at the intersection. In one embodiment, joint line **605** is positioned so that it corresponds to the location of the sulcus of femur **530** when femoral implant **602** is mounted on femur **530**. In the mated position, passageways **616A-B**, passageways **618A-B**, and sockets **620A-B** are aligned. As a result, bolts **622** and **624** having threaded ends can be passed through passageways **616A-B**, **618A-B** and screwed into sockets **620A-B** so as to securely connect patellar condyle **603** and tibial condyle **604**. It is appreciated that bolts **622** and **624** can be replaced with a variety of other structures to connect patellar condyle **603** and tibial condyle **604**.

Femoral implant **602** further comprises line **438** connected to patellar condyle **603** and/or tibial condyle **604**. Again, by extending the one or more lines **438** through a corresponding tunnel on the femur, anchor assembly **810** or an alternative thereto can be used to secure the lines **438** and thus femoral implant **602** to femur **530** as discussed in the above embodiments.

Depicted in FIG. **60** is a femoral implant **630** that is substantially the same as femoral implant **602**. The only difference is that interlocking teeth **636** and **638** are formed along posterior end **606** of patellar condyle **603** and anterior end **610** of tibial condyle **604**, respectively. Interlocking teeth **636** and **638** provide greater engagement and stability between patellar condyle **603** and tibial condyle **604**.

Depicted in FIGS. **61** and **62** is another alternative embodiment of a two-piece femoral implant **640**. Femoral implant **640** is centrally divided anterior to posterior so as to comprise a substantially U-shaped medial condyle **642** and a substantially U-shaped lateral condyle **644**. Medial condyle **642** has a medial side face **646** and a lateral side face **648**. A pair of spaced apart passageways **650A-B** transversely extend through medial condyle **642** between side faces **646** and **648**.

Lateral condyle **644** also has a medial side face **652** and a lateral side face **654**. A pair of spaced apart threaded sockets **656A-B** are formed on medial face **652** of lateral condyle **644**. When condyles **642** and **644** are mated, a joint line **662** is formed at the intersection. In one embodiment, joint line **662** is positioned so that it corresponds to the location of the trochlear groove of femur **530** when femoral implant **640** is

mounted on femur **530**. In the mated position, passageways **650A-B** are aligned with threaded sockets **656A-B**. As a result, fasteners **658** and **660** each having a threaded end can be selectively passed through passageways **650A-B** and screwed into sockets **656A-B** so as to secure condyles **642** and **644** together. Again, line **438** is mounted to medial condyle **642** and/or lateral condyle **644** to facilitate attachment of femoral implant **640** to femur **530**.

Depicted in FIG. **63** is a femoral implant **670** that is substantially the same as femoral implant **640**. The only difference is that a plurality of interlocking teeth **672** and **674** are formed along lateral side face **648** of medial condyle **642** and medial side face **652** of lateral condyle **644**, respectively. Interlocking teeth **672** and **674** provide greater engagement and stability between medial condyle **642** and lateral condyle **644**.

Depicted in FIGS. **64A-D** is another embodiment of a two-piece femoral implant **700** incorporating features of the present invention. Femoral implant **700** is substantially similar to implant **602** discussed above with regard to FIGS. **58** and **59**. As such, like elements are identified by like reference characters. In contrast to implant **602**, a plurality of spaced apart holes **702** are formed on end face **609** of posterior end **606** of patellar condyle **603**. A plurality of spaced apart pegs **704** project from end face **611** of anterior end **610** of tibial condyle **604**. Pegs **704** are formed complementary to holes **702** such that when patellar condyle **603** and tibial condyle **604** are mated together, pegs **704** are received within holes **702** so as to rigidly hold condyles **603** and **604** together.

In contrast to having a pair of bolts transversely extending across patellar condyle **603** in femoral implant **602**, femoral implant **700** comprises a passageway **706** that extends from lateral side **614** of tibial condyle **604** to end face **611** at anterior end **610** of tibial condyle **604**. A threaded socket **708** is formed on end face **609** of posterior end **606** of patellar condyle **603**. When condyles **603** and **604** are mated, passageway **706** and socket **708** are aligned. A bolt **710** having a threaded end is passed through passageway **706** and screwed into socket **708** so as to secure condyles **603** and **604** together. In one alternative, a complementary passageway **706A** and socket **708A** can also be formed on the medial side of condyles **603** and **604** to provide further engagement by a bolt **710A**.

Although not required, in the embodiment depicted line **438** is shown connected to a stem projecting from bone apposition surface **556**. Alternatively, one or more lines **438** can connect directly to bone apposition surface **556**.

Depicted in FIGS. **65-67** are still other examples of inventive implants mounted on resected articulation surfaces of other orthopedic joints. For example, depicted in FIG. **65** is femur **530** having a proximal end **750** that would normally terminate at a femoral head **752** having an articulation surface. In the depicted drawing, femoral head **752** has been resected to form a resected articulation surface **753**. In each of the embodiments depicted in FIGS. **65-67**, it is appreciated that the resected articulation surface can be formed using conventional techniques or by using a modified version of one or more of the methods disclosed herein in combination with forming a tunnel.

A proximal femoral implant **754** is shown mounted on resected articulation surface **753**. Implant **754** comprises a body **756** having an articular surface **758** and an opposing bone apposition surface **760**. Articular surface **758** engages with the acetabular socket while bone apposition surface **760** biases against resected articulation surface **753**.

Tunnel **90** is formed on femur **530** using any desired technique. Second end **96** of tunnel **90** is formed on resected

articulation surface **753** while first end **94** of tunnel **90** is formed on the shaft of femur **530** at a location spaced apart from resected articulation surface **753**. A line **438** is mounted to implant **754** and projects from bone apposition surface **760**. Line **438** is passed through tunnel **90** and is secured therein using anchor assembly **810** or an alternative thereto. Anchor assembly **810** and line **438** thus combine to secure implant **754** to femur **530**.

Depicted in FIG. **66** is a humerus **770** having a proximal end **772** that would normally terminate at a humerus head having an articulation surface. In the depicted drawing, the humerus head has been resected to form a resected articulation surface **774**. A proximal humerus implant **776** is shown mounted on resected articulation surface **774**. Implant **776** comprises a body **778** having an articular surface **780** and an opposing bone apposition surface **782**. Articular surface **780** engages with the scapula while bone apposition surface **782** biases against resected articulation surface **774**.

Tunnel **90** is formed on humerus **770**. Second end **96** of tunnel **90** is formed on resected articulation surface **774** while first end **94** of tunnel **90** is formed on the shaft of humerus **770** at a location spaced apart from resected articulation surface **774**. A line **438** is connected to implant **776** so as to project from bone apposition surface **782** of implant **776**. Anchor assembly **810** is disposed within tunnel **90** and is coupled with implant **776** through line **438** so as to secure implant **776** to humerus **770**.

Depicted in FIG. **67** is tibia **12** having a distal end **790** that would normally terminate at an articulation surface such as the inferior articular surface and the malleolar articular surface. In the depicted drawing, distal end **790** of tibia **12** has been resected to form a resected articulation surface **792**. A distal tibial implant **794** is shown mounted to resected articulation surface **792**. Implant **794** comprises a body **796** having an articular surface **798** and an opposing bone apposition surface **800**. Articular surface **798** engages with the talus or an implant thereat while bone apposition surface **800** biases against resected articulation surface **792**.

Tunnel **90** is formed on tibia **12**. Second end **96** of tunnel **90** is formed on resected articulation surface **798** while first end **94** of tunnel **90** is formed on tibia **12** at a location proximally spaced apart from resected articulation surface **792**. Line **438** is connected to implant **794** so as to project from bone apposition surface **800**. Line **438** is disposed within tunnel **90** and connected to anchor assembly **810** so as to secure implant **794** to tibia **12**.

Set forth above are several different embodiments of the present invention. It is appreciated that the different features of the different embodiments can be mixed and matched to produce a variety of other embodiments within the scope of the present invention. By way of example and not by limitation, each of the different implants can be made with or without an inlay of porous bone ingrowth material on the bone apposition surface; each different implant can have one or more different lines that are connected in one or more different ways; and each different implant can be made as an integral body or two or more separate parts. For example, each implant can comprise a metal tray that is mounted to the bone and a plastic bearing plate that is mounted to the tray. It is likewise appreciated that the different methods steps for the different embodiments can also be mixed and matched and used with other techniques. Finally, it is again noted that the implants described herein are only by way of example and not by limitation. The present invention can also be used in association with resurfacing articulation surfaces of other orthopedic joints.

Finally, the above embodiments primarily discuss mounting implants on resected articulation surfaces. On occasion, however, a sufficient portion of a natural articulation surface has been worn down or otherwise removed by events other than surgical resection so that it is not necessary to resect the wear surface which is still functioning as a natural articulation surface. On these occasions, it is envisioned that the implant can be mounted directly on the worn natural articulation surface with minimal or no surgical resection of the articulation surface.

The present invention may be embodied in other specific forms without departing from its spirit or essential characteristics. The described embodiments are to be considered in all respects only as illustrative and not restrictive. The scope of the invention is, therefore, indicated by the appended claims rather than by the foregoing description. All changes which come within the meaning and range of equivalency of the claims are to be embraced within their scope.

What is claimed is:

1. A method comprising:

passing a first end of a flexible line through a channel in a bone anchor and through a channel of a first driver removably coupled in a force transferring relationship with the bone anchor to drive the bone anchor;

removably coupling a portion of the line passed through the first driver to a line tensioner by attaching the line to a line attachment point movably disposed on the line tensioner;

removably coupling the line tensioner with the first driver; moving the line attachment point with respect to the line tensioner to apply a tensioning force to the line;

advancing a collet into the bone anchor while the tensioning force is maintained on the line, the collet at least partially encircling the line and having a plurality of flexible arms that radially, inwardly constrict to engage the line when the collet is advanced into the bone anchor; and

after the step including applying tensioning force to the line, decoupling the first driver from the bone anchor.

2. A method as recited in claim 1, wherein the first driver is a tubular member, the channel thereof extending along a central longitudinal axis thereof.

3. A method as recited in claim 1, further comprising removably coupling a second driver to the collet, the second driver having a channel through which the line extends.

4. A method as recited in claim 3, wherein at least a portion of the second driver is disposed within the channel of the first driver.

5. A method as recited in claim 1, wherein the collet is at least partially disposed within the channel of the bone anchor prior to passing the proximal end of the flexible line through the channel in the bone anchor.

6. A method as recited in claim 1, wherein the collet is positioned within the channel of the bone anchor after the proximal end of the flexible line is passed through the channel in the bone anchor.

7. A method as recited in claim 1, further comprising securing a second end of the line to an implant.

8. A method as recited in claim 7, wherein the implant has a top articular surface and an opposing bone apposition surface, the implant being configured to replace a portion of an articulation surface of a joint of a patient.

9. A method as recited in claim 1, further comprising slidably connecting an implant to the line at a location between the first end of the line and an opposing second end of the line.

10. A method as recited in claim 1, wherein advancing the collet into the bone anchor comprises screwing the collet into the bone anchor.

11. A method for mounting an implant at an orthopedic joint, the method comprising the acts of:

forming a first tunnel through a bone, the first tunnel having an open second end on a natural or resected articulation surface of the bone and an open first end at a location on the bone spaced apart from the natural or resected articulation surface;

passing a first end of a flexible first line through the first tunnel, the first line being connected to an implant having a bone apposition surface;

positioning the bone apposition surface of the implant over the natural or resected articulation surface of the bone; and

securing at least a portion of the first line within the first tunnel by:

passing the first end of the first line through a channel in a bone anchor; and

screwing the bone anchor into the tunnel so that one or more threads projecting from an exterior surface of the bone anchor engage with the bone bounding the first tunnel so as to secure the bone anchor within the first tunnel.

12. A method as recited in claim 11, wherein the act of forming the first tunnel comprises:

biasing a tubular guide sleeve against the location on the bone that is spaced apart from the natural or resected articulating surface; and

passing a drill tool through the guide sleeve and into the bone so that the drill tool exits the bone on the natural or resected articulating surface.

13. A method as recited in claim 11, wherein the act of forming the first tunnel through the bone comprises forming the tunnel through the proximal end or distal end of a femur, tibia, humerus, radius, or ulna.

14. A method as recited in claim 11, wherein the implant comprises a body having an articular surface and the opposing bone apposition surface, a stem projecting from the bone apposition surface, the method further comprising positioning the implant on the natural or resected articulating surface so that at least a portion of the stem is received within the second end of the first tunnel.

15. A method as recited in claim 14, further comprising advancing a cross pin through the bone and into an opening formed on a side of the stem.

16. A method as recited in claim 11, wherein the implant comprises a top articular surface.

17. A method as recited in claim 11, further comprising mounting an articular surface to the implant.

18. A method as recited in claim 11, further comprising securing a portion of the first line within the channel of the bone anchor.

19. A method as recited in claim 18, wherein securing the portion of the first line within the channel of the bone anchor comprises positioning or manipulating a lock at least partially disposed within the channel of the bone anchor so that the first line is secured within the bone anchor.

20. A method as recited in claim 18, further comprising: passing the first end of the first line through a collet; and the act of securing the portion of the first line within the channel of the bone anchor comprises advancing the collet into the channel of the bone anchor, the collet having a plurality of flexible arms that radially, inwardly constrict to engage the first line when the collet is advanced into the bone anchor.

21. A method as recited in claim 20, further comprising tensioning the first line extending between the implant and the bone anchor prior to advancing the collet into the channel of the bone anchor.

22. A method as recited in claim 20, further comprising severing the first line proximal of the bone anchor after the collet is advanced into the channel of the bone anchor.

23. A method as recited in claim 18, further comprising backing the bone anchor back toward the first end of the first tunnel after securing a portion of the first line within the channel of the bone anchor.

24. A method as recited in claim 11, further comprising: forming a second tunnel through the bone, the second tunnel having an open second end on a natural or resected articulation surface of the bone and an open first end at a location on the bone spaced apart from the natural or resected articulation surface; and positioning a second end of the first line within the second tunnel, the implant being slidably mounted on the first line between the first end and the opposing second end.

25. A method as recited in claim 24, further comprising securing the second end of the first line to the bone.

26. A method as recited in claim 11, further comprising: forming a second tunnel through the bone, the second tunnel having an open second end on a natural or resected articulation surface of the bone and an open first end at a location on the bone spaced apart from the natural or resected articulation surface; and passing a flexible second line through the second tunnel, the second line being connected to the implant.

27. A method as recited in claim 26, further comprising securing at least a portion of the second line within the second tunnel.

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