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Roper-Hall Magnetic Implant Instruction Sheet



Caution – M.R.I. Scanners should not be used on patients who have the magnetic implants.

This device is only to be used by a suitably trained and qualified Physician under normal operating room conditions.

Sterilisation.

Sterile Devices - Supplied ready for use. Sterilised by Ethylene Oxide to EN550. **Do not autoclave.** Do not use if it is out of date, if the packaging has been damaged, pierced or is wet.

STERILE	
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IMPORTANT - Storage Instructions:

This device contains a magnet. In order to ensure the magnet integrity is not compromised the device should be stored away from steel shelving and other ferro magnetic materials, (an area liable to create a high level of demagnetisation is a metal workbench). The device should also be kept away from excessive heat. Check suitability of magnetic properties before implantation.

Instructions For Use And Warnings:

This information is supplied in addition to the surgeons own training program.

To be used after enucleation of the eye. The magnetic implant provides a secure holding and provides improved movement for the external prosthesis, it also helps to improve the cosmetic appearance of the eye after enucleation.

Check magnetic properties before surgery commences.

The implant is to be introduced into the muscle cone and the four rectus muscles brought into the tunnels; they are then sutured in a cruciate form (internal to external and superior to inferior) with mattress sutures. The implant should be placed so it is facing forward or slightly nasally at the time the mattress sutures are tied. Finally cross-bracing sutures are placed to fill the central depression with tissue and to help keep the device in position. If the individual muscles are looped round the bridge over the tunnels and secured to their own bellies, there is a danger of displacement if one muscle slips, there is less integration of movement and the Conjunctiva may give way from lack of nutrition, covering as it would, a fairly large area of smooth acrylic. It is important that the Recti are separated for 1.5cms behind the insertions to allow the Conjunctiva and Tenon's Capsule to be closed without tension. A purse-string suture is advisable and this should be allowed to remain about 14 days until a scar has formed.

Patient Selection:

Not to be used on eyes with malignant melanoma or other intra-ocular neoplasm when extra-ocular extension is suspected on preoperative evaluation or at the time of surgery; the presence of frank infection of the globe or orbit; and aged and infirm patients, when the extra operative and anaesthetic time cannot be justified.

Warnings:

Occasionally excessive bleeding may prevent insertion, a small piece of gelatin or haemostatic sponge is usually very effective in controlling a persistent ooze.

Care should be taken to ensure that Conjunctival covering is adequate and that the pressure does not cause erosion of the Conjunctiva.

A wheel rotation of the prosthesis may take place as the limit of movement is reached, the prosthesis adapting its position to the available Conjunctiva.

Sagging of the lower lid is more frequent than with simple enucleation, but re-examination after one year normally shows an improvement of lid position, probably from improved muscle tone. The sagging can be corrected by the Kuhnt-Szymanowski operation or a similar procedure. This operation has the added advantage of achieving a normal lid sulcus and can be expected to give an appreciable increase in movement by holding the eye in more direct contact with the implant.

With the presence of movement there is also an increased tendency for spontaneous extrusion of the artificial eye.

Residual problems of lower lid droop and a deep upper lid sulcus remain common to this as well as other more recent orbital implants.