

Translation of the original report of Dr. J. Walpert M.D. (Clinic Fleetinsel Hamburg):

First clinical evaluation of absorbable MetaToe EndoSorb implants in Clinic Fleetinsel Hamburg

Since October 2007 I use the MetaToe EndoSorb implants to correct malpositions of the forefoot. The whole observation period (10/22/2007 - July 2010) 170 patients were treated with the absorbable MetaToe EndoSorb implant. Exemplarily, all patients which have been treated with MetaToe™ EndoSorb in 2009 by Dr. Walpert were evaluated for this report.

In 2009, 60 patients (53 female and 7 male) were treated with a total number of 73 MetaToe EndoSorb implants. Basic indication was the correction of the small toe alignment, almost exclusive for the hammertoe correction. In 55 cases a Hallux Valgus correction has been performed at the same time. In 18 cases there was only the treatment of the small toes (2nd toe -5th toes) done. Multitreatment at two of the small toes was done 7-times and treatment at three toes at the same time was done once. In nine cases a slide-osteotomy of the middle-foot bones (big toe) was done in combination with a MetaToe EndoSorb implant.

Out of 60 patients 52 (86%) could be included in this evaluation. The follow-up examination of the remaining 8 patients was done by the family doctor or the office orthopedic doctor. These patients live not in the vicinity of Hamburg so that they couldn't attend the follow-up examination in Fleetinsel Hamburg because of logistical obstacle. These patients have been asked to call if there are any complications. No difficulties were reported postoperatively for these 8 patients, who have been contacted sporadically but not all of them by phone call.

The 52 patients came for follow-up examination routinely 14 days postoperatively to change bandage. 5-6 weeks postoperatively an x-ray control and a final change of bandage were done. Out of the 52 patients no infection in operating field (small toes) was observed. An antibiotic treatment has not been indicated. In one case a secondary infection of the small toes occurred due to an infection of operated big toe area. The follow-up examination showed no further complications. 3 patients (8%) showed a wound healing hold-up. All the three patients were undergone a simultaneous multisurgery with the involvement of Great Toe. Swelling of the treated small toe was observed in 26% (14 patients), all healed.

No further complication like screw breakage, slide of treated bone parts was observed. Delayed healing and so on was not occurred.

Allergic reactions, foreign body reaction or sterile sinus formation as described in literature, was not occur in observation period as well as in 2007 up to today (2010).

During operative treatment there were no abnormal complications concerning to the MetaToe EndoSorb material.

After two and a half years practical knowledge with the MetaToe EndoSorb implant, I am convinced that for the intended use the MetaToe EndoSorb implant is at least as suitable and robust as the previously used resorbable Hammertoe implant made by another manufacturer. The strength of the MetaToe EndoSorb implant is absolutely sufficient for the intended use. In clinical use it is conspicuous that the MetaToe EndoSorb material is less brittle compared to the previously used implant. Thus, intraoperative shortening of the implant is possible without splitting. The thread geometry of the implant provides a safe stability of the osteotomy.

After more than 150 implantations, the effectiveness and safety of the MetaToe EndoSorb implant has clearly proved to have the ability for the intended use.

I am using the MetaToe EndoSorb implant increasingly in my clinical daily routine.

Dr. med. J. Walpert