

MANUFACTURING GUIDELINES



SYME PROSTHESIS WITH “MEDIAL WINDOW”

Physical Rehabilitation Programme



ICRC



ICRC

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Table of contents

Foreword	2
Objectives of these <i>Guidelines</i>	3
Introduction	4
1. Raw materials and components	5
2. Thermoforming the soft liner	7
3. Aligning the heavy-duty nut and moulding	9
4. Thermoforming the PP socket	12
5. Assembly and machining	14
6. Welding and cosmetic finish	18
7. Final product	21

Foreword

The ICRC's polypropylene technology

Since its inception in 1979, the ICRC's Physical Rehabilitation Programme has promoted the use of technology that is appropriate to the specific contexts in which the organization operates, i.e. countries affected by war and low-income or developing countries.

The technology must also be adapted to the needs of the physically disabled in the countries concerned.

Therefore:

- The devices/components that are made using this technology must be durable, comfortable, and easy for patients to use and maintain
- The technology has to be simple and easy for technicians to put into practice and the devices/components easy to repair
- The technology must be standardized and the devices/components compatible with the climate in different regions of the world
- The technology must be inexpensive but modern and consistent with internationally accepted standards
- The technology must be easily available

The choice of technology is of great importance for promoting sustainable physical rehabilitation services.

For all these reasons, the ICRC decided to develop its own technology instead of buying ready-made orthopaedic components, which are generally too expensive and unsuited to the contexts in which the organization works. The materials used in the ICRC's prosthetic and orthotic (P&O) devices cost less than those used in devices assembled from ready-made components.

When the ICRC launched its physical rehabilitation programmes in 1979, locally available materials such as wood, leather and metal were used, and orthopaedic components were manufactured locally. In the early 1990s, the ICRC began to standardize the techniques used in its various projects around the world, not only for the sake of consistency, but also and more importantly, to improve the quality of services for patients.

Polypropylene was first used – to manufacture prosthetic sockets – in the ICRC's projects in 1988. The first polypropylene knee joint was produced in Cambodia in 1991; other components, such as various alignment systems, were first developed in Colombia, and gradually refined. At the same time, a more durable prosthetic foot, made initially of polypropylene and ethylene vinyl acetate (EVA), and now of polypropylene and polyurethane, replaced the traditional wooden/rubber foot.

In 1998, after careful consideration, it was decided to scale down local component production in order to focus on patient care and on the training of personnel at country level.

Objectives of these *Guidelines*

The ICRC's *Manufacturing Guidelines* are designed to provide the information necessary for producing high-quality assistive devices.

Their main aims are as follows:

- To promote and enhance standardization of ICRC polypropylene technology
- To provide support for training in the use of this technology
- To promote good practices

This is the latest in a series of efforts by the ICRC to ensure that patients have access to high-quality services.

ICRC

Assistance Division/Health Unit

Physical Rehabilitation Programme

Introduction

This manual describes a method of manufacturing a ***polypropylene Syme prosthesis with long-stump foot***, using the polypropylene technology employed in ICRC projects throughout the world.

The casting, rectification and alignment methods used correspond to international prosthetic and orthotic (P&O) standards and are therefore not described in the ICRC's *Manufacturing Guidelines*.

- PP 4 mm (Low-activity patient)
- PP 5 mm (Active patient)
- EVA 3 mm
- EVA 6 mm
- 25 mm Velcro strap with return loop



Syme foot and heavy-duty nut including conical disc

1. Long-stump foot, complete with heavy-duty nut
2. Conical disc

Part code

Foot kit

OCPOFOOTERLS (size) L

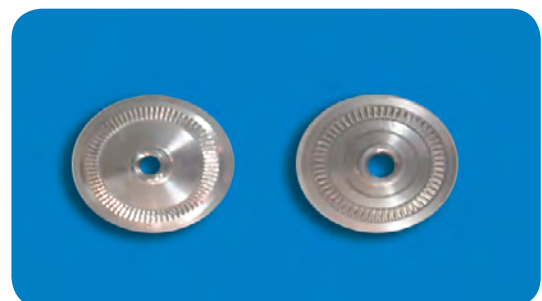


Heavy-duty nut

OCPOMODUTFCB – 8 mm (Low-activity patient)

OCPOMODUTFCC – 10 mm (Active patient)

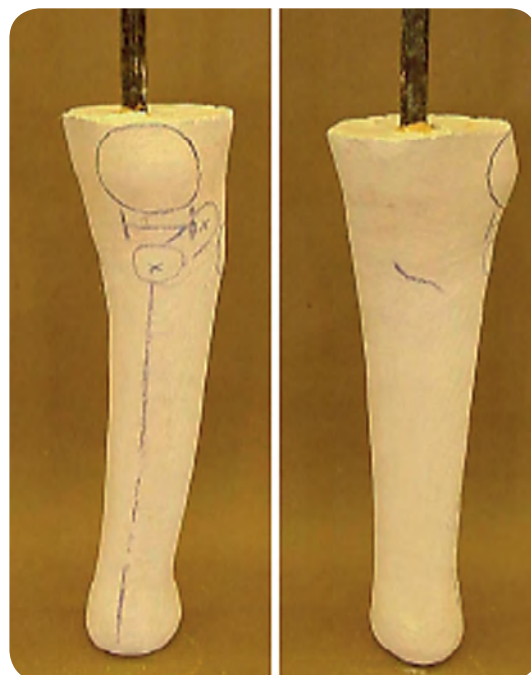
Installed before draping



Modified positive plaster model

Step 1

Alternative weight-bearing surfaces for a Syme amputation are similar to those of a PTB socket when the distal end bearing is compromised



Step 2

Cut 6 mm EVA sheet to conform to the shape of the positive mould with distal end cap

Skive the lateral edges and distal end (1 cm in from edge to zero at the edge)



Skive distal end to zero (1 cm from the edge)

Apply contact adhesive to skived edges



Heat the EVA sheet until it is malleable

Create a conical liner by neatly aligning and gluing the skived edges together



Prepare the positive mould with talcum powder

Heat the cone at 120° C and drape over the positive mould; make sure the seam is in the centre of the popliteal area



Cover the mould with a plastic bag and apply the vacuum

Allow the EVA to cool

After the EVA has cooled down, remove the plastic bag



Apply contact adhesive to the skived edges of the distal end and prepare a cap (for the distal end)

Allow it to dry, and heat in the oven



Heat the cap until malleable and apply it to the distal end of the positive mould; maintain constant pressure



Grind the excess EVA to produce a smooth finish

Ensure the distal end has no seams and that it has an even finish, as the distal surface is weight-bearing



3

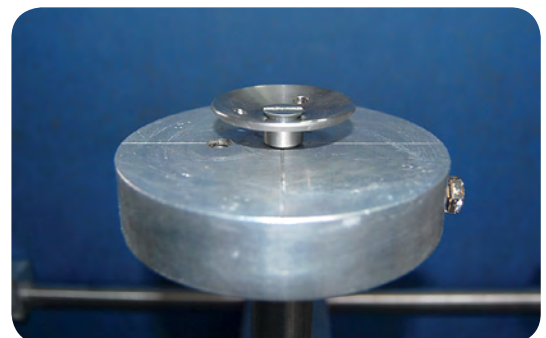
ALIGNING THE HEAVY-DUTY NUT AND MOULDING

Step 3

Fix the heavy-duty nut to the jig with a 6 mm counter sunk bolt



Install the heavy-duty nut in the centre of the jig

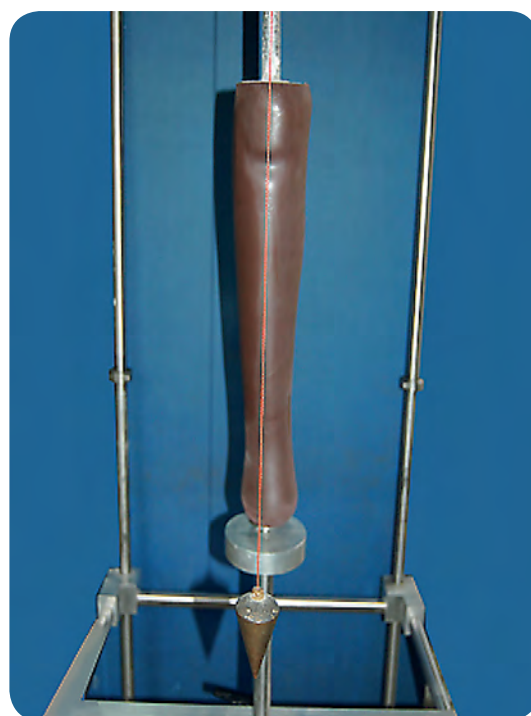


Use a standard alignment jig to make certain that the heavy-duty nut is properly aligned



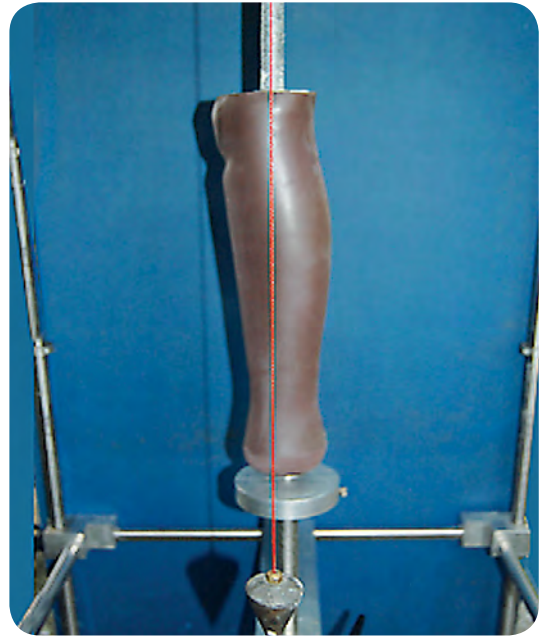
Coronal plane

Align the centre of the knee with the medial aspect of the foot, with tibial adduction in accordance with P&O standards



Sagittal plane

Align the centre of the knee in flexion, in accordance with P&O standards and 10 mm anterior to the centre of the heavy-duty nut



Mark the outline of the heavy-duty nut to maintain the alignment when fixing it with a self-tapping screw



Secure the heavy-duty nut with a self-tapping screw (4 mm x 30 mm)

The mould is now ready for draping



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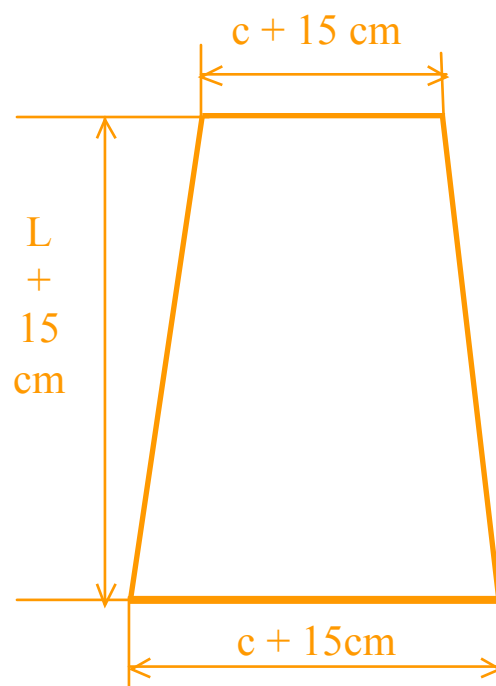
THERMOFORMING THE PP SOCKET

Step 4

Prepare a PP sheet (4 mm or 5 mm according to patient requirements) for thermoforming the socket



For the dimensions of the PP sheet, add 15 cm to the length and width

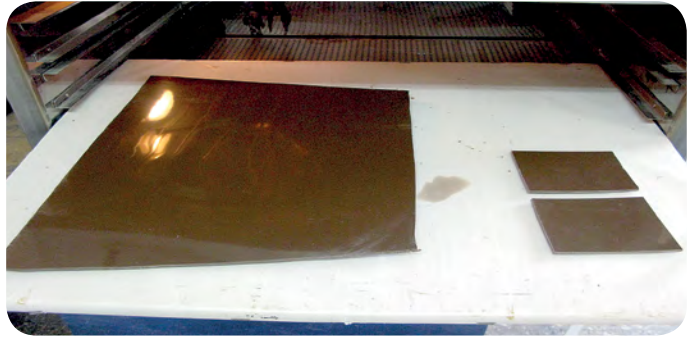


Prepare 2 more squares of PP
(5 mm x 100 mm x 100 mm) to add to
the distal end of the socket during the
thermoforming process

Place the small square pieces in the oven with
the large sheet of PP, as shown on the right

Place the PP sheet in the oven at 180° C

Drape the PP and cut off excess material



Keep the vacuum on until the plastic
cools down and has regained its matt
appearance



Add 10 mm of hot PP (square shapes
of the same width as the mould)

Compress the distal addition as soon as
excess PP has been removed

This should be done while the draped
plastic is still hot



The result of adding the plastic on to the
distal end of the mould can be seen in
the adjacent photograph

Make sure that the two parts, i.e. the
socket and the 10 mm addition, form
a secure weld



Step 5

Grind the extra PP added to the distal end

If the socket is to be built directly on to the foot, round the distal end

If the socket is to be assembled with the oval disc, flatten the disc end

Do not grind the socket

**Machine the distal end to reveal the countersunk screw**

Once you have revealed the countersunk screw you can remove it, knowing that you have approx. 8 mm of PP added on to the distal end



When considering the adjustability – length and alignment – of the prosthesis (for dynamic gait), you have two options, which are listed below

- ▶ Make sure that the shape of the distal end matches the concavity of the foot
- ▶ For the convex disc assembly, make sure that the distal end is flat and perpendicular to the shaft of the tibia



Convex/Concave finish



Flat finish with convex disc



Without oval disc

- ▶ Advantages: Less risk of leg-length discrepancy
- ▶ Disadvantages: Fewer adjustments, i.e. only AP tilting possible



With oval disc

- ▶ Advantages: More adjustment available in tilt and shift
- ▶ Disadvantages: Prosthesis approx. 10 mm longer (risk of leg-length discrepancy)



Use an oscillating saw to cut the medial window in the device

The small radius (indicated by the red arrow) of the modified cutting disc allows you to cut tight corners and ensures smooth and even curves

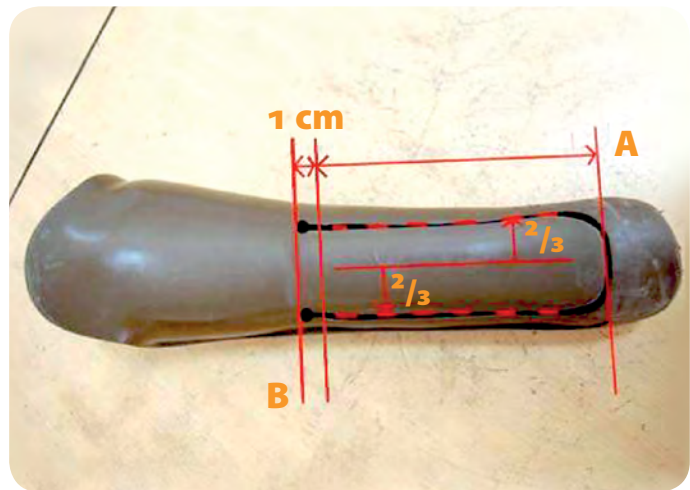


Measuring and cutting the suspension window

Cut the medial window from the largest malleoli measurement (A) to 1 cm above, at the same circumference (B)

Drill a 10 mm hole at the proximal end of the window to prevent the PP from cracking

Width measurements are: $\frac{2}{3}$ of the width from the centre of the device



CAUTION

Do not machine the window in the socket, as the gap between the socket and the cutout window will increase and eventually reduce the pressure applied for suspension; it will also spoil the finish. Ideally, you should deburr and smooth the edges without using the router.

Fix a Velcro strap with return loop above the apex of the medial malleolus to secure the medial window and maintain pressure for suspension



Step 6

Once the dynamic alignment is optimal, fasten the foot anchor bolt securely

Make sure the alignment remains correct before welding

Prepare the welding surfaces with a soldering iron



Weld the components with the PP rod so that the foot is firmly attached to the socket

**Cosmetic finishing**

Prepare the socket for the cosmetic cover

Apply contact adhesive in the gap between foot and socket



Fill the gap between the socket and the foot with EVA

Apply adhesive to both sides of the EVA

Heat the EVA before inserting it into the gap to ensure that it fills the gap completely



Make sure the EVA is evenly compressed into all voids



Grind the EVA filler flush with the foot and the PP



CAUTION

Do not grind the PP, as it will leave unsightly marks on the prosthesis and result in a poor cosmetic finish.

Use a smaller drum sander/cone: it is better for shaping and will not damage either the PP or the foot



If the shape of the filling is satisfactory, cover with a 3 mm EVA strip

Skive the edges of the cover strip to ensure a neat, flush finish

Find the centre on the anterior aspect and wrap the finishing EVA cover around the shaped EVA filling so that the ends meet in the centre of the posterior



Trim the excess material for a neat finish
Polish out scuff-marks on the PP



The prosthesis is ready for delivery



MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.



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