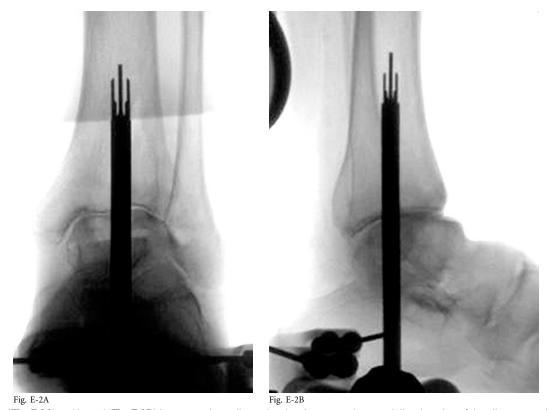
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Cadaveric dissection of the posterior aspect of the hindfoot, after placement of the alignment rod, showing the exiting location of the intramedullary guide (red arrow) anterior to the posterior facet (asterisk) of the subtalar joint (Fig. E-1A) and the corresponding location of the guide in the center of the talus (Fig. E-1B).

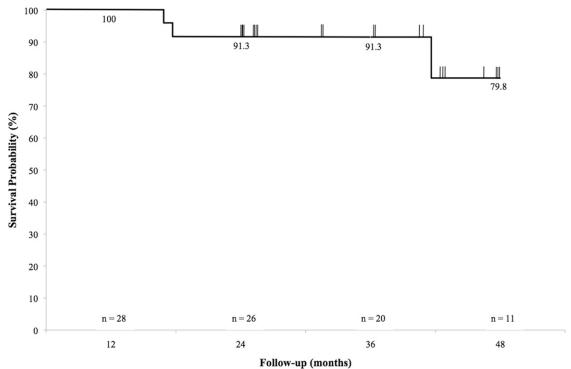
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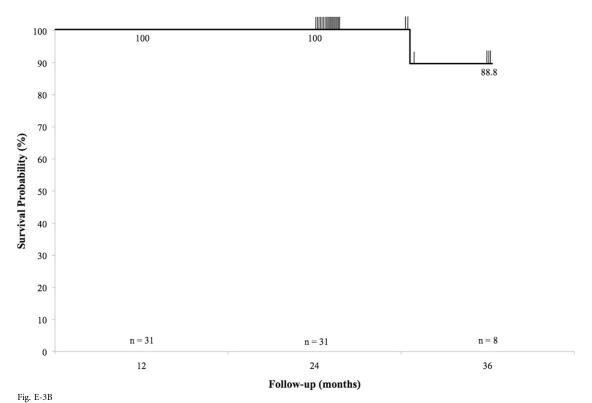
Anteroposterior (Fig. E-2A) and lateral (Fig. E-2B) intraoperative radiographs showing correct intramedullary location of the alignment guide in relation to the subtalar and tibiotalar joints.

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Kaplan-Meier survival curve showing an estimated survival rate of 91.3% at two years for the twenty-eight INBONE I implants (**Fig. E-3A**) compared with 100% at two years for the thirty-one INBONE II implants (**Fig. E-3B**).

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Fig. E-4A Fig. E-4B



Fig. E-4C

Figs. E-4A through 4-F An INBONE II total ankle arthroplasty (in a patient who had previously undergone subtalar arthrodesis) that required revision. Fig. E-4A and 4-B Mortise and lateral weight-bearing radiographs demonstrating talar component loosening and posterolateral subluxation at three years postoperatively; the tibial component was well fixed.

Figs. E-4C and E-4D Weight-bearing mortise and lateral radiographs made after revision of the talar component to another INBONE II talar implant, along with removal of subtalar hardware and concurrent talonavicular arthrodesis, showing thorough gutter debridement with neutral coronal and sagittal ankle alignment and no evidence of further implant migration.

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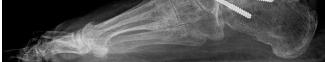






Fig. E-4F

Fig. E-4E Functional lateral radiograph with the ankle in maximal dorsiflexion showing 11° of clinical dorsiflexion and 7° of dorsiflexion through the prosthesis. Fig. E-4F Functional lateral radiograph with the ankle in maximal plantar flexion showing 15  $^{\circ}$  of clinical plantar flexion and  $9^{\circ}$  of plantar flexion through the prosthesis.