

# Cochlear™ Baha® DermaLock™ Surgical Procedure

For detailed instructions, consult the Cochlear Baha DermaLock Surgery Guide.

## STEP 1 Prepare the site

- A** • Identify the implant site with the indicator for Baha, generally 50-55 mm from the ear canal and in line with the top of the pinna.
- B** • Mark the incision, generally 20-30 mm long, following the direction of the hair line. Mark the implant site 10 mm posterior to the incision line. Some methylene blue may be applied on a needle to mark the bone to facilitate identification of implant site after opening the incision.
- C** • Measure the tissue thickness before local anesthesia is injected
  - A thin (27 gauge/0.4 mm) hypodermic needle, a clamp and a ruler may be used. Inject local anesthesia. The amount of injection should be limited for minimal distortion of tissue thickness. If surgery is performed under general anesthesia, 1-2 ml of local anesthesia is generally sufficient.

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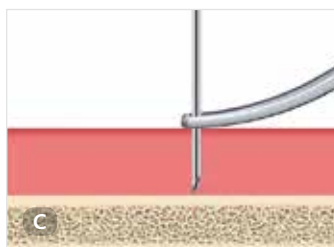
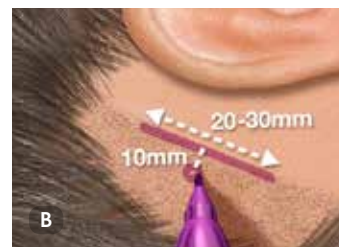
**NOTE:** Ensure not to depress the tissue when measuring.

- Select the appropriate abutment length based on the measured tissue thickness. See the table for suggested abutment selection guide.

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**NOTE:** When in doubt, select the longer abutment.

- The coating is intended to be in contact with the tissue. In a few patients, the coating may be slightly visible. This will not impact the outcome.



Approximate tissue thickness (mm)	Abutment length (mm)
3 or less	6
4-5	8
6-7	10
8-9	12
10-11	14
<b>D</b> 12 or more	14 with soft tissue thinning



## STEP 2 Make the incision

- F** • Use a scalpel to make an incision down to the periosteum.
- G** • Open up the incision using a self retaining retractor. Make a cruciate incision (6 x 6 mm square) in the periosteum to expose enough bone for the implant flange and raise the edges with the raspatorium.

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**NOTE:** The use of cautery, particularly monopolar, should be minimized where possible.



## STEP 3 Drill with the guide drill

- H** • Use the drill indicator and abundant irrigation during all drilling procedures.
  - Begin drilling with the guide drill with 3 mm spacer (2000 rpm).
  - Move the burr up and down to ensure visual inspection and that coolant reaches the tip of the drill.
  - Check the bottom of the hole repeatedly for bone.
- I** • If there is adequate bone thickness, remove the white spacer and continue drilling to a depth of 4 mm.



## STEP 4 Drill with the widening drill

- J** • Widen the hole with the relevant widening drill (2000 rpm).
  - Move the widening drill up and down during drilling to ensure that coolant reaches the tip of the drill.
- K** • Create a small countersink in the bone. The widening drill is designed to allow early recognition when countersinking is complete.



## STEP 5 Place the implant and abutment

- L** • Pick up the implant and abutment using the abutment inserter.
- M** • Place the implant without irrigation until the first threads of the implant are well within the bone. Once the implant is in the bone, continue with irrigation. If unsure about the bone quality, start the torque low and increase if needed.

Bone quality	Suggested torque
Compact bone	40-50 Ncm



## STEP 6 Close and suture

- N** • Use a biopsy punch Ø 5 mm to punch a hole in the skin next to the incision, exactly over the abutment.

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**NOTE:** Avoid stretching the skin and ensure that the sutures do not pull the skin in an unnatural way. Increased tension in the skin, and the resulting push/pull forces, could lead to discomfort around the abutment.

- O** • Ensure that the skin edges around the abutment do not create an unwanted pocket around the abutment.
  - Carefully ease the skin over the abutment.
  - Suture the incision. The sutures should stabilise both the skin and the underlying tissue during the healing.



## STEP 7 Attach the healing cap

- P** • Apply a thin, low or non-adherent dressing and attach the healing cap with plug.
- Remove the dressing, sutures and healing cap 10-14 days post-op. If not healed, apply a new dressing and a new healing cap.

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**NOTE:** Avoid using a thick dressing underneath the healing cap, as this may cause unwanted compression of the soft tissue during healing. In order to obtain a good seal between the hydroxyapatite-coating and the full thickness of the surrounding tissue, a stress-free interface without tissue compression should be maintained at all times, especially during the healing phase. Avoid using ribbon gauze.



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