Mediflex®

FAQ GUIDE

UNIVERSAL ROUND BAR™ RETRACTION SYSTEMS

How does URB compare to Omni-Tract®? Are the systems/components fully interchangeable, or are there specific compatibility differences reps should know?	The URB system competes 1:1 across all procedures where the systems can be applicable. Both systems utilize round bar style blades and snap clamps attaching to round bar frames through a variety of mounting hardware, including field posts, post couplers, and horizontal connectors. Mediflex® blades and snap clamps are interchangeable with Omni-Tract® and will fit onto their frames. Their frames can be attached to Mediflex® frames with our 69613 post coupler; however, Mediflex® frame cannot be adapted to the Omni-Tract® field post. Mediflex® uniquely offers its new StrongArm™ Plus setup for one-piece frame procedures. These include abdominal and pelvic procedures.
What are the clinical advantages of URB vs. Omni-Tract®, especially around independent arm adjustability versus the single-lever lock found on many Omni-Tract® setups?	During initial setup, our frame typically requires only one person, whereas theirs often requires two due to the nature of their frame. Many times during surgery, the surgeon will need to reposition blades or the frame. With Mediflex®'s independent tightening mechanism, the surgeon can easily reposition one side of the frame without needing to stabilize the other side of the frame.
What is the typical price difference between URB and comparable Omni-Tract®/Thompson systems?	• Mediflex® is generally 30-50% less expensive than Thompson • Mediflex is generally 10-15% less expensive than Omni-Tract®
Do we directly compete with Thompson specialty kits (e.g., cervical, spine/procedure-specific)?	We compete with Thompson in what is known as soft-tissue procedures. This does not include spinal, cardiac or orthopedics. We are well suited to offer comparable solutions for all other specialties.

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How does URB compare to Thompson? Should reps cross-reference replacement parts for existing Thompson sets, or position URB as a clinically equivalent full-system alternative (not part-for-part swap)?

The URB is a functional equivalent to a Thompson system.

While there is some interchangeability between the systems' components, it is best not to make this a key focal point when competing with them, as it can get complicated.

Unless they need standalone snap clamps or one-piece blades, their systems are designed differently, despite serving the same intended purpose.

Doctors tell us that our field posts create a more rigid setup because we use a 1-inch diameter bar, whereas they use a ½-inch bar. Setup is quicker with all of our blades being a one-piece design.

Since our URB frame utilizes three unique positioning mechanisms, only one person is required for setup.

The most notable difference is that our system is typically 30–50% less expensive than theirs.

Thompson's strongest areas of focus are transplant, spinal, and neuro, with limited focus in MIS. Most of our customers are in MIS and prefer a brand that presents solutions for all of their cases.

Historically, we've been able to compete very well against Thompson, except for surgeons who were particularly focused on the snap clamp twist ratchet used for lifting the rib cage in upper GI and transplant surgery.

Since launching our new one-piece snap clamp twist ratchet, we've seen a significant increase in success evaluations when compared with Thompson.

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How should reps frame surgeon preferences and training backgrounds?	Historically, we saw that Bookwalter users tended to focus on abdominal, lower abdominal, and pelvic procedures. This meant that general, colorectal, GYN, and urology surgeons trained mostly on these systems.
a. When approaching a surgeon who has been trained on a different style of system, would they interested in changing?	Thompson's focus has been primarily on upper GI and transplant procedures, as these are longer cases where setup time is not an issue. It is very rare for surgeons who train on one system to switch to another later in their careers. While we encourage you to explain the benefits and differences of the systems, it is usually better to give them what they are used to rather than create a new learning curve for systems that are functionally the same.
b. If trained on Bookwalter, are they likely going to want to use a Thompson or URB?	We have yet to see this unless they have shifted their procedural focus from general surgery to HBP surgery. These surgeons are trained on a system that is low-profile, quick to set up, and does not interfere with their positioning.
c. Why do some surgeons prefer bilateral set ups?	For transplant procedures, adequate rib cage retraction and costal margin retraction are essential due to the nature of the incision and the need to access several anatomical areas. This is also ideal for upper GI surgeries and oncologic procedures such as HIPEC (chemotherapy).
What is the correct way to close a snap clamp as sometimes it can be difficult for doctors with smaller hands?	The best way to close the snap clamp is to close it in line with the blade shaft, using the bottom of the shaft for leverage.Over time, the clamps will loosen, becoming easier to close. They are designed to have a long shelf life by using specially coated washers without relying on springs.

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Based on our promotions, we encountered that surgeons called these sets "Thompson" as a generic name. With this, what specific innovations or differentiations, advantages of our URB & bilateral sets over Thompson sets?	The Thompson generic name was synonymous with Liver Transplant for many years and was their main focus of business. Since they do not have a brand name for their product line(s), most customers refer to the kit as "the Thompson." Many surgeons refer to our products as "the Mediflex®," but this can refer to any number of our solutions across all specialties we market to.
In government hospitals, we found that some Pakistan- and China-made brands of general surgical instruments also offer the same Thompson design, including KLS Martin, which many of these brands bundle with their general instrumentation sets. What approaches or strategies could we try if other brands bundled?	Mediflex® partners should focus on where the doctors' needs lie. Most doctors perform the majority of their cases minimally invasive, with a smaller percentage performed as open surgery. Mediflex® has solutions for both open and MIS surgery and should leverage both when marketing our offering. Surgeons who need good visualization and a stable operating site require this for both open and MIS cases.
Do we offer custom blades and/or radiolucent blade options? If yes, what lead times should we quote?	While custom blades can be offered, Mediflex® has expanded its blade offering to over 200 Roundbar blades and 200 Bookler® blades that can be used with their respective snap clamps. We have worked diligently over the year to expand our offering and believe we now cover approximately 95% of market demand.
Why would a surgeon prefer detachable blades (clinically) and how would you discuss?	Most surgeons trained on round-bar–style systems are accustomed to swivel blades that do not lock. They were taught that the swivel allowed the anatomy and tissue to be retracted in a more "natural way." The locking feature tends to be more important in smaller, more acute incisions, such as cardiac, spinal, or orthopedic procedures.

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