The activL® Artificial Disc: a next-generation motion-preserving implant for chronic lumbar discogenic pain

James J Yue1
Rolando Garcia Jr2
Larry E Miller3
1Department of Orthopaedic Surgery, Yale School of Medicine, New Haven, CT, 2Orthopedic Care Center, Miami, FL, 3Miller Scientific Consulting, Inc., Asheville, NC, USA

Abstract: Degeneration of the lumbar intervertebral discs is a leading cause of chronic low back pain in adults. Treatment options for patients with chronic lumbar discogenic pain unresponsive to conservative management include total disc replacement (TDR) or lumbar fusion. Until recently, only two lumbar TDRs had been approved by the US Food and Drug Administration — the Charité Artificial Disc in 2004 and the ProDisc-L Total Disc Replacement in 2006. In June 2015, a next-generation lumbar TDR received Food and Drug Administration approval — the activL® Artificial Disc (Aesculap Implant Systems). Compared to previous-generation lumbar TDRs, the activL® Artificial Disc incorporates specific design enhancements that result in a more precise anatomical match and allow a range of motion that better mimics the healthy spine. The results of mechanical and clinical studies demonstrate that the activL® Artificial Disc results in improved mechanical and clinical outcomes versus earlier-generation artificial discs and compares favorably to lumbar fusion. The purpose of this report is to describe the activL® Artificial Disc including implant characteristics, intended use, surgical technique, postoperative care, mechanical testing, and clinical experience to date.

Keywords: activL® Artificial Disc, artificial disc, degenerative disc disease, discogenic, implant, lumbar, motion preservation, pain

Introduction
Degeneration of the lumbar intervertebral discs is a leading cause of chronic low back pain in adults1 and responsible for 62 million annual physician visits in the US.2 Internal disc disruption is identified in 42% of patients reporting persistent low back symptoms.3,4 Most patients with definitive imaging evidence of disc degeneration coupled with chronic low back pain have a poor prognosis for recovery with conservative management alone.5–8 When comprehensive multimodal conservative treatment options have been exhausted, lumbar fusion or total disc replacement (TDR) may be considered to alleviate chronic discogenic pain.

The goal of lumbar fusion is to eliminate motion and instability at the painful motion segment, which may relieve discogenic pain. However, fusion is associated with a 10%–15% risk of reoperation within 5 years9,10 and a 30%–80% risk of adjacent level disease due to increased stress at the adjacent segment.11,12 Additionally, since patients undergoing fusion for lumbar degenerative disc disease (DDD) are notably younger than the typical spine patient,1 the risk of future complications must be carefully considered since revision surgery is technically demanding, associated with greater surgical risk, and results in mixed clinical success.
TDR is an alternative to spinal fusion in well-selected patients with chronic symptomatic lumbar DDD. The basic premise of TDR is to eliminate pain and improve function by eliminating the painful disc and restoring disc height while preserving segmental range of motion which may lower risk of adjacent segment degeneration. Numerous meta-analyses of randomized controlled studies have shown that TDR yields comparable or superior outcomes versus lumbar fusion through 2 years.\textsuperscript{13–16} Additionally, the long-term risk of adjacent segment degeneration is lower with TDR\textsuperscript{17} since functional movement is preserved, not obliterated, as with spinal fusion.

Until recently, only two lumbar TDRs had been approved by the US Food and Drug Administration (FDA) – the Charité Artificial Disc (DePuy Spine, Raynham, MA, USA) in 2004\textsuperscript{18} and the ProDisc-L Total Disc Replacement (Synthes Spine, West Chester, PA, USA) in 2006.\textsuperscript{19} The Charité disc was subsequently removed from the market in 2012. In June 2015, a next-generation lumbar TDR received FDA approval – the activL\textsuperscript{®} Artificial Disc (Aesculap Implant Systems, Center Valley, PA, USA).\textsuperscript{20} Compared to previous-generation lumbar TDRs, the activL\textsuperscript{®} Artificial Disc incorporates specific design enhancements that result in a more precise anatomic match and allow a range of motion that better mimics the healthy spine. The purpose of this report is to describe the activL\textsuperscript{®} Artificial Disc including implant characteristics, intended use, surgical technique, postoperative care, mechanical testing, and clinical experience to date.

**Prosthesis characteristics**

The activL\textsuperscript{®} Artificial Disc is a next-generation biomimetic implant that incorporates several innovative features not found in previous-generation lumbar TDRs that are intended to accommodate a wider range of anatomic variations and more accurately replicate the kinematic patterns of the human lumbar spine. The activL\textsuperscript{®} Artificial Disc consists of two metal endplates and one polyethylene inlay (Figure 1). The superior and inferior endplates consist of a cobalt chromium alloy with a Plasmapore\textsuperscript{TM} CaP surface coating, composed of titanium and a microscopic dicalcium phosphate overcoating. Each endplate incorporates three anterior horizontal spikes that ensure secure initial fixation. For lumbosacral arthroplasty, an optional inferior endplate design is available for patients with an ovoid S1 footprint (Figure 2). The S1 endplate has rounded posterior edges and can be placed close to the posterior rim of S1 without the endplate edges protruding into the spinal canal. In some cases, this may allow the surgeon to use a larger size compared to the standard endplate shape, thereby reducing the risk of subsidence and

![Figure 1 activL\textsuperscript{®} Artificial Disc.](https://www.dovepress.com/)

**Note:** Top left, activL\textsuperscript{®} Artificial Disc. Disc components include spike cobalt chromium endplate with an ultra-high molecular weight polyethylene inlay; top right, implant assembly; bottom, implant insertion tool.
The activL® Artificial Disc is designed to provide pain relief by replicating natural disc motion. It features an ultra-high molecular weight polyethylene core and a fixed center of rotation that restrains a physiological range of motion. In device failures. The ProDisc-L disc utilizes a fixed center translation restraint resulted in abnormal kinetics and early posterior edges, which was the ideal implant size for 87% of TDR that offers an 8.5 mm total device height (measured inlay component).

Table 1 Available configurations of activL® Artificial Disc and ProDisc-L Total Disc Replacement

<table>
<thead>
<tr>
<th>Device component</th>
<th>AP width (mm)</th>
<th>Lateral width (mm)</th>
<th>Angle (degrees)</th>
<th>Height (mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>activL® Artificial Disc</td>
<td>26, 28, 30, 33</td>
<td>31, 34.5, 39, 40</td>
<td>0, 5</td>
<td>8.5, 10, 12, 14</td>
</tr>
<tr>
<td>ProDisc-L</td>
<td>27, 30</td>
<td>34.5, 39</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>activL® Artificial Disc</td>
<td>26, 28, 30, 33</td>
<td>31, 34.5, 39, 40</td>
<td>6, 11</td>
<td>10, 12, 14</td>
</tr>
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<td>ProDisc-L</td>
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<td>–</td>
<td>–</td>
</tr>
<tr>
<td>ProDisc-L</td>
<td>27, 30</td>
<td>34.5, 39</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>activL® Artificial Disc</td>
<td>21</td>
<td>21</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>ProDisc-L</td>
<td>26, 29</td>
<td>23, 25</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

contrast, the semiconstrained ultra high molecular weight polyethylene core of the activL® Artificial Disc supports translation only in the anteroposterior direction to more closely replicate natural physiological motion, potentially minimizing biomechanical stress at the facet joint and adjacent levels.

**Intended use**

The success of any lumbar TDR procedure is highly dependent on proper patient selection. The activL® Artificial Disc is intended for treatment of skeletally mature adults with single-level symptomatic DDD at L4–L5 or L5–S1 who have failed at least 6 months of nonoperative treatment. The main contraindications to use include active infection, osteoporosis or osteopenia, allergy or sensitivity to implant materials, isolated lumbar or chronic radiculopathy, disc extrusion with sequestration, myelopathy, spinal stenosis, spinal deformity, spondylolisthesis grade II to IV, vertebral body pathology at the affected level, facet ankyloses or facet joint degeneration, disc height <3 mm, symptoms attributable to more than one level, abdominal pathology that would preclude an anterior retroperitoneal approach, and involved vertebral endplate <31 mm medial–lateral and/or <26 mm anteroposterior. Clinical findings should closely correlate with radiologic imaging findings from magnetic resonance imaging, standing plain X-ray studies, discography, or computed tomography in order to correctly identify the lumbar disc as the primary pain generator.

**Surgical technique**

The patient is placed on a fluoroscopic imaging table in a supine position. Fluoroscopic views are obtained so that with the C-arm in zero degree rotation (anteroposterior view) of the spine, the spinous process is equidistant from the medial pedicle edges. On the lateral view, the anterior and posterior vertebral body cortices should be easily identifiable. A standard anterior retroperitoneal approach to the lower lumbar spine is utilized. Once the anterior disc has been exposed and the appropriate level of dissection verified, the midpoint of the disc space is marked under fluoroscopic imaging. A complete discectomy and mobilization are then performed. Special
care should be taken to preserve the subchondral bone. The entire posterior longitudinal ligament does not need to be removed unless removal of extruded disc material or greater intervertebral disc mobilization is required.

After endplate preparation and disc space mobilization are complete, implant trialing is performed. Disc and plate size height and lordotic angles should be reconfirmed. Under anteroposterior and lateral X-ray views, trial plates are inserted to confirm correct device sizing. The largest possible endplate coverage should be chosen in all cases. Care must be exercised to avoid placing the plates too deeply. The disc space is distracted to a point where the implant will be held firmly in place – the height measurement is then observed on the distractor. Next, the implant is assembled and attached to the inserter. During implantation, it is imperative that the artificial disc does not deviate from a central position. Unlike other lumbar TDRs that require the endplates to be inserted first followed by disc space distraction to seat the core, the activL® Artificial Disc is inserted en bloc which lowers the risk of overdistraction and reduces operative time. Finally, the position of the implant is confirmed under fluoroscopy and the inserter is disconnected from the implant. The set contains an impactor which can be utilized to manipulate the individual endplates posteriorly following insertion.

**Postoperative care**

Patients are generally permitted to ambulate on the day of surgery, as tolerated, with an elastic bandage or lumbosacral orthosis to support the abdominal musculature. Patients are advised to avoid hyperextension for 3 weeks. Lumbar stabilization therapy can typically be initiated 2 to 4 weeks following surgery. Aerobic walking is emphasized for the first six postoperative weeks after which progressive resistance exercise may be undertaken. Median time to return to work following implant with the activL® Artificial Disc is 68 days, which compares favorably to ProDisc-L (median 97 days).

Patients are typically allowed to return to nonstrenuous activities by 6 weeks and normal activities by 3 months.

**Mechanical testing**

The activL® Artificial Disc has been extensively tested in nonclinical studies. Where applicable, the International Organization for Standardization and American Society for Testing and Materials standards for testing artificial discs were followed using finished discs. Device testing included worst-case modes and loading conditions that were anticipated in an in vivo environment. A summary of these tests is provided below.

**Static endplate expulsion**

Five activL® Artificial Disc endplates were inserted onto custom grade 15 polycarbonate urethane foam blocks with a 1 mm thickness of grade 80 foam on the surface to simulate the denser bone of the endplate. Under a 450 N axial load, shear loading was applied to the endplate at 5 mm/minute and the force necessary to dislodge the endplates was measured. The acceptance criteria for this test was at least 400 N, which is the maximum shear force encountered in the lumbar spine. The maximum shear force measured was 1,259±60 N. For comparison, the maximum shear force required to dislodge ProDisc-L endplates was 933 N under identical testing conditions.

**Subsidence**

Five activL® Artificial Disc endplates were compressed into custom grade 15 polycarbonate urethane foam blocks with a 1 mm thickness of grade 80 foam on the surface to simulate the denser bone of the endplate. The load was applied at 0.1 mm/minute and the maximum subsidence load was measured. The acceptance criteria for this test was a subsidence load ≥3,400 N, the maximum in vivo axial force. The maximum observed subsidence load was 5,761±391 N.

**Static compression shear**

Five activL® Artificial Disc endplates were tested under static compression-shear (10° angle) in saline at 37°C at a rate of 50 N/s until failure. The acceptance criteria for this test was a value =5,500 N, which is equivalent to the fracture load of the L5 vertebral body. The mean yield load of the specimens was 6,626±272 N.

**Dynamic compression shear**

Five activL® Artificial Disc specimens were tested under compression shear loads (10° angle) in saline at 37°C using a sinusoidal wave form with R=10 at 5 Hz until 10 million cycles or failure. The acceptance criteria for this test was a value ≥3,400 N, the maximum in vivo axial force. Four activL® Artificial Disc specimens completed 10 million cycles at 4,000 N with no failure. In contrast, when subjected to the same test conditions, the ProDisc-L specimen suffered a fractured inferior endplate at 4,000 N.

**Creep characterization**

Six activL® Artificial Disc specimens with the tallest (14 mm) and six with the shortest (8.5 mm) ultra-high-molecular-weight polyethylene inlays were loaded in compression shear (10° angle) in saline at 37°C using the following sequential
The activL® Artificial Disc has been in commercial use in Europe since 2005, with nearly 8,000 discs implanted to date. The commercial experience has been favorable with only four device explants, one device migration, and no device expulsions reported during this time.

Early clinical experience with the activL® Artificial Disc included an unpublished multicenter prospective study conducted in Germany in 2005. At 6 months postsurgery, back pain decreased 51%, Oswestry Disability Index (ODI) scores decreased 39%, and employment increased from 61% to 87%. Another unpublished European multicenter study treated 50 patients with the activL® Artificial Disc and reported an 87% reduction in pain severity and a 92% reduction in ODI at 1 year. A subsequent study reported that segmental motion preservation was superior with activL® Artificial Disc versus fusion in patients with single-level lumbar DDD. Based on these favorable initial results, an FDA-investigational device exemption (IDE) trial of the activL® Artificial Disc was initiated in 2007.

The FDA-IDE study of the activL® Artificial Disc was a prospective, multicenter, randomized, single-blind, controlled study (ClinicalTrials.gov NCT00589797). Eligible patients reported lumbar pain due to a radiographically confirmed diagnosis of DDD at either L4–L5 or L5–S1 despite at least 6 months of nonsurgical management. Patients were randomly allocated (2:1) to activL® Artificial Disc (n=218) or Control (n=106), consisting of ProDisc-L or Charité based on surgeon preference. The overall treatment success rate at 2 years with activL® Artificial Disc was superior to the Control group (P=0.02). Patients treated with the activL® Artificial Disc also had higher rates of radiographic success (59% vs 43%, P<0.01) and ODI success (75% vs 66%,
adverse event; SAE, serious adverse event; SDRE, serious device-related event.

Abbreviations: activL® Artificial Disc versus ProDisc-L or Charité.

Figure 5 Incidence of complications in a randomized controlled trial comparing activL® Artificial Disc to control total disc replacements (ProDisc-L or Charité). Abbreviations: DRAE, device-related adverse event; PRAE, procedure-related adverse event; SAE, serious adverse event; SDRE, serious device-related event.

Figure 6 Changes in back pain severity over 6-year mean follow-up with activL® Artificial Disc versus ProDisc-L. Abbreviation: VAS, visual analog scale.

Changes in back pain severity over 6-year mean follow-up with activL® Artificial Disc versus ProDisc-L (P=0.04) (Figure 7). Serious device-related complication rates were 10% for activL® Artificial Disc and 45% for ProDisc-L (P=0.03), with lumbar/leg pain (6.9% vs 15.1%) and implant subsidence (1.4% vs 1.9%) most commonly reported. Reoperation rates at the index level were 5% for activL® Artificial Disc and 27% for ProDisc-L (P=0.11).

Additional long-term studies with the activL® Artificial Disc are underway to further characterize the durability of treatment effect. A 7-year postapproval study with 376 patients is ongoing with the objective to evaluate the long-term safety and effectiveness of the activL® Artificial Disc compared to ProDisc-L or Charité. Representative 7-year
follow-up imaging from this series is presented in Figure 8. A 10-year global safety study is also planned that will characterize adverse events and complaints in patients where the activL® Artificial Disc is used as intended. The main outcomes of this study will include reoperations, heterotopic ossification, device malfunction, and device removals as well as analysis of all device explants.

Overall, mid- to long-term data with the activL® Artificial Disc demonstrate outcomes that are at least comparable and, in some cases, superior versus previous-generation artificial lumbar discs. Additionally, patient outcomes with activL® Artificial Disc compare favorably to lumbar fusion. An analysis of the 2-year activL® Artificial Disc IDE data compared to 2-year outcomes from randomized controlled trials of TDR versus lumbar fusion31–36 shows lower back pain severity, lower ODI scores, and lower reoperation rates compared to other TDRs and fusion (Figures 9–11).

**Discussion**

Since the last lumbar TDR approval in the US, nearly a decade passed until the activL® Artificial Disc received FDA approval in 2015. Despite early enthusiasm following approval of the first lumbar TDRs, utilization rates have remained low over the last 10 years,37 which may be attributable to lack of TDR selection, strict indications for use, challenging instrumentation, mixed clinical outcomes, and reimbursement challenges. With recent advances in TDR technology and further refinements to patient eligibility criteria, TDR utilization may increase, particularly given that clinical outcomes with the activL® Artificial Disc demonstrate that next-generation lumbar TDRs perform better.
than their previous-generation counterparts. As more lumbar TDRs become available and favorable long-term (>10 years) data continue to accumulate,38–40 this technology may become a mainstay in the physician’s armamentarium of therapeutic options of lumbar DDD.

Although the specific contributors to long-term treatment success with the activL® Artificial Disc have yet to be identified, the introduction of incremental device sizing and replication of physiological range of motion allow the artificial disc to closely mimic the anatomy and function of a healthy intervertebral disc. The range of available device configurations and ability for translational movement are not available in other TDRs. The influence of specific device-related characteristics on patient outcomes deserves further study.

Aside from implant characteristics, appropriate patient selection is arguably the most important factor in determining TDR treatment success.41 At one point in life, almost every individual will suffer an episode of low back pain of sufficient severity to disrupt normal daily activities, including work and recreation.42 Careful differential diagnosis to identify the lumbar disc as the primary pain generator is mandatory. Once a diagnosis of single-level symptomatic lumbar DDD is made, careful attention must be given to potential contraindications to TDR. Patients over 55 years have a higher risk of TDR contraindications, most commonly due to concomitant spinal stenosis, facet arthrosis, high-grade spondylolisthesis, and osteopenia.43 Therefore, although the benefits of TDR are generally comparable between older and younger patients,44 TDR eligibility is higher in the younger population. Lumbar TDR may also be more attractive from the patient’s perspective compared to fusion since recovery from surgery is quicker. Additionally, implant with the activL® Artificial Disc does not interfere with future surgical options if necessary. Specific positioning and revisions instruments are available that allow for anterior implant translation, removal and replacement of the polyethylene inlay, or complete removal of the implant. Given this, an appropriate continuum of care for the patient with single-level lumbar DDD would begin with nonsurgical treatment and, in patients who fail conservative measures, TDR represents the next therapeutic step in eligible patients, with lumbar fusion as the last resort. Given the superiority of control TDRs versus fusion in previous reports14–17,45 and the favorable outcomes of activL® Artificial Disc versus control TDRs in FDA-IDE study, the benefits of the activL® Artificial Disc over fusion surgery can be inferred, thereby providing additional support for this proposed treatment pathway in patients with chronic lumbar discogenic pain.

In conclusion, the next-generation activL® Artificial Disc is a promising new therapeutic option for patients with single-level lumbar DDD unresponsive to nonsurgical management. Randomized controlled trials confirm improved mid-term effectiveness of this artificial disc compared to earlier-generation TDRs as well as favorable outcomes versus lumbar fusion. Additional safety and effectiveness data are anxiously awaited to confirm long-term treatment durability of the activL® Artificial Disc.

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Disclosure

The authors report no conflicts of interest in this work.

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