* Deepen the incision through subcutaneous tissue and antebrachial fascia on the same line.
* The transverse branch of the cephalic vein may, or may not, require ligation if it interfered with the approach. Retract the cephalic vein caudally.
* Expose the lateral wall of flexor carpi radialis tendon sheath and incise medial wall to expose tendon.
* Retract flexor carpi radialis caudally, with self-retracting retractors, and expose the medial wall of sheath which adheres to the superior check ligament.
* Visualize and palpate proximal check ligament.
* There are 2 parts to the ligament:
  + The transverse group of fibers which are more superficial are cut first, allowing the oblique fibers to be visualized.
  + The less taut oblique fibers are more difficult to transect. A small incision is made in the middle of the oblique part and Kelly forceps passed through and underneath it to assist in the transection of the fibers.
* Elevation of the oblique part of the ligament using forceps assists in cutting the fibers in a proximal direction and avoids the *reti carpi* vessels.
* At the proximal part of the incision identify and avoid the nutrient artery of the SDF tendon.
* After the proximal part is severed, transect the ligament in a distal direction. At the most distal part of the ligament transection may cause entry into the carpal sheath, however this is usually not a problem.
* Complete severance of the ligament is confirmed by palpation, there being no attachment between the radius and ligament. The radial head of the deep digital flexor tendon is visualized in the upper and central parts of the incision.