**Standard Surgical Procedure**

* A 10 cm longitudinal skin incision extending from the level of the centre of the chestnut towards the medial distal malleolus of the radius, over the tendon of the flexor carpi radialis, and between the cephalic vein and the caudal border of the radius
* 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 interferes 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
* Visualise and palpate proximal check ligament
* There are 2 parts of the ligament:
  + The transverse group of fibres which are more superficial are cut first, allowing the oblique fibres to be visualised.
  + The less taut oblique fibres 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 fibres
* 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 visualised in the upper and central parts of the incision
* The incision in the flexor carpi radialis sheath is closed with simple interrupted or continuous sutures of 2 or 3 metric synthetic absorbable material
* The antebrachial fascia and subcutaneous layers are closed with simple continuous sutures of 2 metric synthetic absorbable material. The skin is closed with skin staples or simple interrupted sutures of 2 or 3 metric non-absorbable material

Diagram, engineering drawing

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