**Splint Bone Removal**

The second and fourth metacarpal bones, or splint bones, are attached to the abaxial surface of the medial and

lateral proximal sesamoids by fibrous bands.49 Thus, frequent hyperextension of the fetlock that results in stretching of these bands may be a predisposing factor for fracture of the splint bones.49 Fracture generally occurs at the most distal third of the splint bone.

**Indication**

Indicated when these bones are fractured.

**Surgical Preparation**

General anesthesia is recommended for this operation. The horse is placed in either lateral recumbency with the affected splint bone uppermost or dorsal recumbency with the injured leg suspended. The latter method has advantages when more than one splint is to be operated on, and it achieves natural hemostasis during the surgical procedure.

**Procedure**

A variable-length incision is made directly over the splint bone, extending from approximately 1 cm distal to the distal extremity of the splint bone to approximately 2 cm proximal to the proposed site of amputation. The subcutaneous fascia is incised along the same line as the incision, through the periosteum. The periosteum is elevated off the affected part of the splint bone. The distal end of the splint bone is undermined with the aid of sharp dissection and is freed from surrounding fascia. Then the end is grasped firmly with forceps. With further sharp dissection, the splint bone is separated from its attachments to the third metacarpal or metatarsal bone. Some of the attachments to the third metacarpal or metatarsal bone may need to be severed with the aid of a chisel. The splint bone should be amputated above the fracture site or the area of infection. The proximal end of the splint bone should be tapered to avoid leaving a sharp edge and any loose fragments removed or flushed out of the surgical site. The periosteum should be sharply excised to reduce the chances of periosteal proliferation. If infection is present, unhealthy scar tissue must be excised with sharp dissection, and all sequestra removed. Any bleeding should be controlled at this time. Following removal of the splint bone, the subcutaneous tissue should be closed with a synthetic absorbable suture. Considerable dead space may result from removal of the bone, especially if much bony and fibrous tissue reaction was present. A good pressure bandage is often adequate to reduce dead space. Only in rare instances is an ingress-egress system of flushing indicated. The skin should be closed with a monofilament nonabsorbable suture using a simple interrupted pattern. The incision is covered with an antimicrobial dressing and is placed under a pressure bandage.

**Post Op**

Tetanus prophylaxis is administered. Antibiotics are used in cases of acute (active) osteitis or osteomyelitis, although with appropriate preoperative wound management and thorough wound debridement, the infection usually resolves without the need for preoperative antimicrobial therapy. The limb should be kept under a pressure bandage for 3–4 weeks. Change the bandage in the first 1–2 days postoperatively. After that time, pressure bandages are changed every 5–7 days, or sooner if needed. If drains are in place, they should generally be removed the second or third postoperative day. Skin sutures should be removed 10–14 days after surgery.

**Complications**

Suspensory desmitis

**Prognosis**

Limited for return to athletics.