Technique

* The animal is sedated with an appropriate dose of an appropriate injectable anaesthetic agent in order to facilitate greater ease of operation e.g. detomidine HCl, butorphanol
* A local anaesthetic is introduced to conduct a block that would desensitize the area during the operation e.g. lidocaine
* The caudomedial aspect of the cannon region is clipped as best as possible in order to decrease the risk of microbial infection during the procedure.
* Clean the clipped area with an appropriate antiseptic/antibacterial agent e.g. povidone-iodine, chlorhexidine.
* The method of approach for the procedure is chosen, which would be between the mid-metacarpal approach and the mid-pastern approach. \*\*
* A 2-3” incision is made on the lateral aspect of the affected limb in line with the deep digital flexor tendon (DDFT).
* The dorsal and palmar edges of the DDFT are palpated and two tunnels are made with a curved haemostat, one between the superficial and deep digital flexors tendons and the other between the DDFT and the neuromuscular bundle, which also communicates with the suspensory ligament. The haemostat should be palpable on the medial aspect of the metacarpal region.
* Inserted into each of these two tunnels are broad-blade butter knives or haemostats to be used as retractors. They are then turned to point each other in a V formation, isolating lifting the tendon out of the incision.
* A scalpel (preferably #10) is used to laterally transect the tendon between the butter knives/haemostats.
* The hoof of the horse is then extended in order to ensure thorough transection of the tendon.
* The sheath incised to conduct the procedure is closed using absorbable in a simple continuous pattern. The skin wound is closed using non-absorbable suture material in a pattern of the surgeon’s choice.

\*\* The mid-metacarpal approach is safer since there is no need to enter any synovial structures, reducing the degree of intra-surgical trauma. Furthermore, it has been found that soft tissue attachments distal to the tenotomy site and proximal to the digital sheath is slightly more stable if performed in the mid-metacarpal region than the mid-pastern region.

Additionally, in the event that another tenotomy needs to be done in the same horse, it would be much more feasible in the mid-pastern region if it was done in the mid-metacarpal region first. If it was the other way around, the adhesions in the mid-pastern region would increase the difficulty and affect the results of the mid-metacarpal tenotomy.