INFERIOR CHECK LIGAMENT DESMOTOMY

**PROCEDURE**

The ligament may be approached from the lateral or medial aspect of the limb; with bilateral contractural deformity, this allows both surgical procedures to be performed without turning the foal on the table. However, because soft tissue proliferation is often encountered postoperatively, it is generally preferred to perform the procedure from the lateral side. A medial soft-tissue proliferation can be mistaken for a proliferation of the medial vestigial metacarpal bone and considered a blemish. Additionally, the check ligament is more easily identified from the lateral approach.

**Surgical Technique**

A 3–4-cm incision is made over the cranial border of the Deep Digital Flexor (DDF) tendon centred at the junction of the proximal one-third and distal two-thirds of the cannon bone. The position of the incision is illustrated in Figure 9.3*A,* and the relevant anatomy is illustrated in Figure 9.3*B*. Following the skin incision, the loose connective tissue over the flexor tendons is dissected bluntly and the paratenon is incised (Figure 9.3*C*). The superficial and deep flexor tendons must be identified, but they need not be dissected from each other. Blunt dissection is directed cranial to expose the inferior check ligament, and a cleavage plane is identified between the proximal part of the DDF tendon and the inferior check ligament. This cleavage plane is used to separate the check ligament from the DDF tendon (Figure 9.3*D*). Forceps are inserted between the check ligament and the DDF tendon to separate the structures; then the check ligament is lifted from the incision and is incised with a scalpel (Figure 9.3*E*). Remove a 1-cm segment of the check ligament. This surgical manipulation sometimes disrupts the synovial sheath of the carpal canal, the distal extremity of which extends most of the way down inside the cleavage plane.

This event seems to be of little consequence, however. The foot of the patient is then extended manually. The ends of the check ligament become separated, and complete severance of all parts of the check ligament can be ascertained. The paratenon and superficial fascia are closed in a single layer with simple continuous sutures of synthetic, absorbable material. The skin is closed with non-absorbable sutures in a suture pattern of the surgeon’s choice.

NOTE: The figures mentioned are inserted as a .JPEG file in the same section of the Cmap.