Flexor tendon grafting is rarely performed primarily, but rather several weeks or months after injury. This procedure often follows a failed primary repair or an undiagnosed injury. Primary repair may not be indicated. These includes skeletal instability, segmented tendon lacerations, tendon substance loss, pulleys and sheath destruction, skin loss, and wound infection. A one stage tendon graft is possible only if the tendon bed is in a good condition. A supple digit with full or nearly full passive motion is an absolute prerequisite **(Mihael, 1986)**.

Contraindications to flexor tendon grafting include; stiff joint, adherent extensor tendons and loss of A_2 and/or A_4 pulley, so the grafting should be delayed until the tissue have been softened and the joints are supple **(Paul, 1987)**.

The source of tendon grafts in descending frequency of preference are the palmaris longus, the plantaris and the long extensors of the middle three toes **(White, 1960)**.

Exploration of a failed primary repair or a failed tendon graft may reveal a ruptured repair or adhesions restricting motion. When the latter are encountered, tenolysis can significantly improve function.

Tenolysis of adherent flexor tendons is found to be necessary in approximately 25 percent of all digits that have undergone primary flexor tendon repair in zone II **(Whitaker, 1977)**.