The incision is made using a disposable CK2 microsurgical blade (SybronEndo). With the smaller size of this blade, accurate incisions can be made that have a cleaner cut than those of the much larger BP #15 or BP #15S blades. As the incision is being made, the operator needs to visualise the suturing process. Sometimes just a small variation in the design of the incision can make a significant difference to easier and less traumatic closure of the surgical flap. In general, the operator is working with relatively healthy tissue and no attempt should be made to remove or alter the periodontium. This is especially applicable when making a full sulcular flap.

All flaps are full thickness and the incision must be complete, so that there is no inadvertent tearing upon retraction of the flap. The split thickness flap is to be avoided, as it is the most traumatic and healing is compromised. The periosteum does not survive the flap reflection procedure. It has been postulated that depolymerised periosteal collagen plays a role in rapid reattachment of the flapped tissues to cortical bone.

In general, all flaps should be extended, at a minimum, to the apical microsurgery—Part II: Incision and atraumatic flap elevation

Dr. John J. Stropko, USA
The mplcular flap
This design is routinely used in all posterior quadrants. The full sulcular flap should be used in the anterior if there is a thin zone of attached gingival tissue, or if there is a concern about the possibility of dehiscence over the mesial of the second tooth anterior to the apex of the root being surgised. This flap design is effective, successful and affordable, and swelling arises from impingement of the tissue during the retraction process.

The Leubke-Ochsenbein or muco-gingival flap
This flap is used only when there is an adequate amount of attached gingival tissue present and the periodontal probing is within normal limits. The incision design should be scalloping in nature and generally follow the architecture of the teeth, which allows for easy repositioning upon completion of the apical microsurgical procedures (Fig. 5).

All releasing incisions are made parallel to the long axis of the teeth. This is important because the blood supply to the zone is also parallel to the long axis. If a wide-base flap is made, the blood supply to the tissue adjacent to the flap will be compromised and healing may not be predictable or uneventful.

The reflection of the flap accomplished using the Molt, Rud-
dle or O chrono (Syrhymo) periosteal elevators. The working end of the instrument is gen-