TECHNICAL NOTE

Modification to 'modified Blair incision (cervicomastoidofacial)' incision

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Introduction

The Surgical approaches for parotidectomies vary based on the histopathology of the tumours, the location of the tumour in the gland and exclusively on the surgeon's preference. The excision of the parotid pathologies was carried out with different incisions but, the most popular approach for the parotidectomy remains the 'Cervicomastoidofacial incision' or synonymously known 'modified Blair incision. Incisions for parotidectomies are evolved throughout a century based on the principle of 'optimum access with maximum cosmesis' at different levels of parotidectomies [1, 2, 3].

The Blair incision or the 'Lazy S' incision was first introduced in 1912. This has provided excellent access for surgeries of partial and superficial parotidectomies for several decades. A noticeable scar with poor cosmetic outcome produced by the 'Lazy S' incision was identified as the major drawback of the incision. Bailey in 1941 introduced a modification to the Blair incision with an intention of exposing the whole parotid gland for better exposure to extensive tumours and currently known as the 'Modified Blair incision'. Modified Blair incision is currently the widely employed incision for parotidectomies and contains a preauricular 'Lazy S' approach together with the submandibular or cervical extension. "Modified Blair incision' does not promote the reconstruction of the parotid surface, which can lead to an apparent deformation of the contour around the corner of the mandible after larger tumours have been resected. This has been described in the literature as a disadvantage of the approach [1, 2, 3].

Surgical technique

The preauricular lazy S incision consists of two arms namely the preauricular segment and the lazy S extension behind the ear lobe. Traditionally the two arms are linked under the earlobe with a curved incision. Once the flap is raised and the tumour is exposed the ear lobe is pulled superiorly with the aid of a suture hooked on the lobe for better exposure of the parotid tail and the superior view of the surgical site. If the excised tumour is significantly large, the resulting deformation in the surgical site may confuse the surgeon on the repositioning of the earlobe to its exact position. Further, bridging the preauricular and retro auricular extensions under the edge of the earlobe may enhance the risk of infections.

Therefore authors suggest two modifications to the incision with their experience at Morriston Hospital to minimize the surgical hazards. Instead of the preauricular and retro auricular extensions of the incision connected just under the ear lobe (crease) authors suggest connecting them 3-5mm inferior on the cervical skin (Still under the shadow of the ear lobe, thus no compromised aesthetics). Further, the incisions are connected in the 90^0 angles pointing inferiorly (Figure 1a – Proposed modification, Figure 1b – Postoperative image of healing surgical site).

Figure 1a: Modification to the traditional cervicomastoidofacial incision

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Figure 1b : Post operative images of healing surgical site of 6 weeks

Discussion

The more concerned complications pertaining to the incisions of parotidectomy are the unesthetic scars, unesthetic repositioning of the earlobe and incision-related infections [1, 2].

The suggested modification facilitates more aesthetic repositioning of the earlobe following large tumour excisions providing a landmark (Rather than a curved incision). Further suturing the flap becomes easier in the area as sutures are placed on the cervical skin rather directly on the earlobe. The approach minimizes the risk of infections, favouring the aesthetically pleasing scar allowing a clean surgical site.

Conclusion

Based on the authors' experience the proposed surgical modification to the cervicomastoidofacial incision has resulted in pleasing outcomes with minimal incision-related complications. Thus, the authors believe the modification would aid in improving clinical outcomes.

Ethics approval

Not applicable

Informed consent

Obtained

Competing interests

None

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