

## Case Report

# TRAGO-ANGLE INCISION – A BLEND OF COSMESIS AND ACCESSIBILITY.

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### ABSTRACT

Incision for any surgery should maintain an equilibrium between accessibility and aesthetics. Traditional incisions for superficial parotidectomy often lead to scarring, excessive intraoperative bleeding, and possible facial/greater auricular nerve damage. Hereby proposing a modified incision for superficial parotid tumours which has greater aesthetic outcome with adequate exposure.

### Introduction

An incision is the mainstay of any surgical procedure. Time spent on placing a proper incision is never wasted. A multitude of incisions are described in literature like Lazy 'S' incision, facelift incision, periauricular incision, preauricular incision. None of them maintains the equilibrium between accessibility and good aesthetic outcome and has their own disadvantages.

The most commonly used incision for superficial parotidectomy is the Lazy 'S' incision described by Blair in the year 1918<sup>1</sup>. It consists of a preauricular incision with a submandibular extension in a slight 'S' shape curve. The incision can provide adequate exposure of the entire parotid gland; the major disadvantage is that of post operative scar<sup>2</sup>.

Appiani in 1967<sup>3</sup> described about the Facelift incision in which the preauricular incision was extended

retroauricularly in the occipital direction. It provided superior aesthetic outcome as compared to the Blair's incision, but offered limited surgical exposure, and hence was reserved for smaller sized tumours<sup>2</sup>.

In the periauricular approach, a preauricular incision is extended, encircling the ear lobe, till the mastoid process. The incision provided adequate exposure and good aesthetic result, but few temporary complications, like, damage to Greater auricular nerve and Facial nerve, inflammation of the temporomandibular joint, transient Frey's syndrome were reported<sup>4</sup>.

### TECHNIQUE

We are reporting a modified preauricular approach for superficial parotidectomy. The incision starts immediately inferior to the tragus. It continues inferiorly, almost parallel to the posterior border of ramus of the mandible, extending about 0.5 cm inferior

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to the angle of mandible (Fig. 1, Fig. 2). Skin and subcutaneous tissue is dissected using blade and cautery



Fig. 1: Depicts pre-incision skin marking.



Fig. 2: Depicts the extent of skin incision.

till the parotido massetric fascia. The dissection now proceeds anterosuperiorly and anteroinferiorly till the well encapsulated tumor mass is identified (Fig. 3). Subsequently the tumor mass is dissected free of superficial lobe of parotid gland and delivered without any inadvertent damage to the facial nerve.

Since the incision is given on skin creases along the langers lines, very minimal post-operative scar is visible (Fig. 4). Intra-operatively it provides excellent exposure, with minimal haemorrhage and no facial or greater auricular nerve damage.

#### CONCLUSION

The modified approach provides adequate exposure for manipulation of the lesion, without compromising on cosmesis. It also overcomes the disadvantages of the other incisions like excessive bleeding, facial/ greater auricular nerve damage or excessive scarring. Thus for surgical removal of any superficial lesion in the

parotid gland, this can be the standard incision in practise.



Fig. 3 Depicts adequately exposed well encapsulated superficial parotid lobe tumour



Fig. 4: Shows post-operative scar after 2 weeks.

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