

# Maylard's incision: how to make an easy incision for complex pelvic abdominal surgery

Elías Ortiz Molina,<sup>1</sup> Begona Díaz de la Noval,<sup>2</sup> M<sup>a</sup> José Rodríguez Suárez,<sup>2</sup> Rafael Hernández Pailos,<sup>1</sup> Fiamma García Sánchez,<sup>1</sup> Javier García González<sup>1</sup>

<sup>1</sup>Gynecology and Obstetrics, Hospital la Mancha Centro, Alcázar de San Juan, Spain  
<sup>2</sup>Gynecology and Obstetrics, Hospital Universitario Central de Asturias, Oviedo, Spain

## Correspondence to

Dr Javier García González, Gynecology and Obstetrics, Hospital la Mancha Centro, Alcázar de San Juan 13600, Spain; jigg192021@gmail.com

Video has been presented at the 35th training meeting of the Spanish Society of Gynecology and Obstetrics.

Accepted 10 October 2019  
Published Online First 23 October 2019



© IGCS and ESGO 2020. No commercial re-use. See rights and permissions. Published by BMJ.

**To cite:** Ortiz Molina E, Díaz de la Noval B, Rodríguez Suárez M<sup>a</sup>J, et al. *Int J Gynecol Cancer* 2020;**30**:154–155.

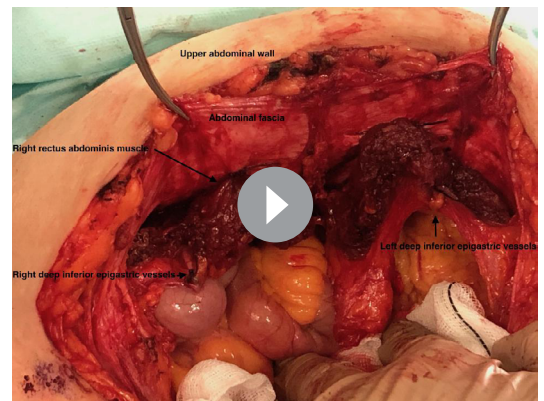
The video aims to show the Maylard technique, an extended transverse incision characterized by bilateral ligation of the deep inferior epigastric vessels and transection of the anterior rectus abdominis muscles.<sup>1</sup> It is an easy and advantageous alternative to mid-line laparotomy.<sup>1,2</sup>

The procedure is as follows as shown in [Video 1](#): (1) a transverse skin incision is made at least 4 cm above the symphysis pubis and extended laterally until 3 cm from the anterior superior iliac spines, (2) the subcutaneous tissue and the abdominal fascia are opened with lateral extension up to the external edge of the rectus abdominis muscles, (3) the inferior epigastric vessels are located, ligated, and cut, (4) the rectus abdominis muscles are sectioned between the fingers using an electrocautery device, (5) incision of the transversalis fascia and blunt opening of the parietal peritoneum is carried out, (6) after the surgical procedure, the cut edge of the muscle is secured to the fascia using a delayed-absorbable 'U' suture, (7) the parietal peritoneum is not closed, (8) the rectus abdominis muscles do not need approximation.

We mobilize the rectus muscles from the sheet even though the original technique suggested that this should not be done in order to prevent retraction.<sup>2</sup> We made this change for better control of the epigastric vessels in case of damage and for teaching purposes. Retraction is prevented with the above-mentioned U-shaped stitches.

Maylard's incision is a standardized and easily learned procedure. It provides adequate exposure of the abdominal, pelvic, and retro-peritoneal cavities with the advantages of transverse incisions—namely, less hernia formation, low complication rate, and cosmetic results.<sup>1–3</sup> In obese patients, it decreases the risk of post-operative complications. If the laparoscopic approach is not possible, it is a sound choice. In women with cervical cancer, as in the Laparoscopic Approach to Carcinoma of the Cervix Trial,<sup>4</sup> Maylard's incision could be a good option.

Some papers have compared Maylard and Pfannenstiel incisions without finding remarkable differences.<sup>3</sup> However, for a complex surgery, Pfannenstiel is not the best incision because of its limited exposure of the pelvic anatomy.



**Video 1** The Maylard incision in gynecologic surgery.

We conclude that, unless a mid-line laparotomy is indicated, the Maylard incision is preferable when optimal exposure to the pelvis is required.<sup>1</sup> Hands-on training should be encouraged.

**Contributors** EOM, RHP: performed surgery, edited the video; BDN: wrote the abstract with support from MJRS, reviewed the literature, analyzed and interpreted the data; MJRS: wrote the abstract, reviewed the literature and drafted the manuscript; FGS: reviewed the literature, wrote the abstract with support from JGG; JGG: conceptualization, surgeon in charge, patient recruitment and supervision. All authors approved the published version. All authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** None declared.

**Patient consent for publication** Not required.

**Ethics approval** The local institutional review board was consulted; approval for this article was not required.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** There are no data in this work.

## REFERENCES

- Helmkamp BF, Krebs HB. The Maylard incision in gynecologic surgery. *Am J Obstet Gynecol* 1990;**163**:1554–7.
- Maylard AE. Direction of abdominal incision. *Br Med J* 1907;**2**:895–901.

- 3 Ghanbari Z, Baratali BH, Foroughifar T, *et al.* Pfannenstiel versus Maylard incision for gynecologic surgery: a randomized, double-blind controlled trial. *Taiwan J Obstet Gynecol* 2009;48:120–3.
- 4 Ramírez PT, Frumovitz M, Pareja R, *et al.* Minimally invasive versus abdominal radical hysterectomy for cervical cancer. *N Engl J Med* 2018;379:1895–904.