

Optimizing Burn Outcomes: Evidence-Based Use of Fish-Skin Grafts in Modern Practice

Faculty

Rajiv Sood, MD, FACS, FABA

Chief, Plastic Surgery and Burn Reconstruction
JMS Burn Centers
Augusta, Georgia

Ram Velamuri, MD, FACS, MS, DNB

Medical Director, Tampa General Regional Burn Center
Associate Professor, USF Morsani College of Medicine
Tampa, Florida

Michael Van Vliet, MD, FACS

Medical Director, Burn and Plastic Surgery Center
Blake Hospital
Bradenton, Florida

Faculty Disclosures

- **Rajiv Sood, MD, FACS, FABA:** Advisory Board—Kerecis, Avita, Smith & Nephew
- **Ram Velamuri, MD, FACS, MS, DNB:** Consultant—Kerecis; Speakers Bureau—Avita, Exsurco Medical
- **Michael Van Vliet, MD, FACS,** has nothing to disclose in relation to this activity

*This CME activity includes brand names for participant clarity purposes only.
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Program Information

- This program is provided by HMP Education, an HMP Global company
- HMP Education acknowledges Kerecis LLC for their (financial/in-kind) support of this accredited medical education activity

Learning Objectives

- Assess the role of advanced dermal substrates, including fish-skin grafts, in optimizing wound beds and promoting tissue regeneration
- Interpret key clinical outcomes, including time to closure, graft take, infection rates, and length of stay
- Apply evidence-based patient selection and graft bed preparation techniques to improve integration and outcomes
- Incorporate novel biologic products into OR and burn unit workflows to enhance efficiency and patient care
- Identify limitations and complications, and implement strategies to manage graft failure and infection

WOUNDS

A Compendium of Clinical Research and Practice

Intact Fish Skin Graft vs Synthetic Dermal Substitutes for Acute Burn Injuries

Rajiv Sood, MD, FACS, FABA

Disclosures

- This study was funded by Kerecis (Coloplast)
- Rajiv Sood has served as a consultant to Kerecis
- BData Inc. received funding for data extraction and analysis
- Frameshift (Copenhagen) received funding for independent statistical analysis
- BData and Frameshift performed all analyses independently
- Sponsor had no access to patient-level data

Background

- Dermal regeneration products are used to prepare wound beds prior to STSG
- All work by providing a scaffold allowing cellular and vascular ingrowth to manage the wound bed
- Differ in the material composition, integration speeds, pore size, and biological complexity
- Synthetic/biosynthetic scaffolds (collagen/GAG matrix, polyurethane foam) require a 14-35-day integration period before autografting
- Intact fish skin graft is a biologically-derived dermal regeneration graft that is fully incorporated in 7-10 days without a barrier layer
- No large-scale registry comparison between these product categories has been performed
- Each additional hospital day increases exposure to nosocomial infection, VTE, deconditioning, and costs (\$4000-\$6000/day)



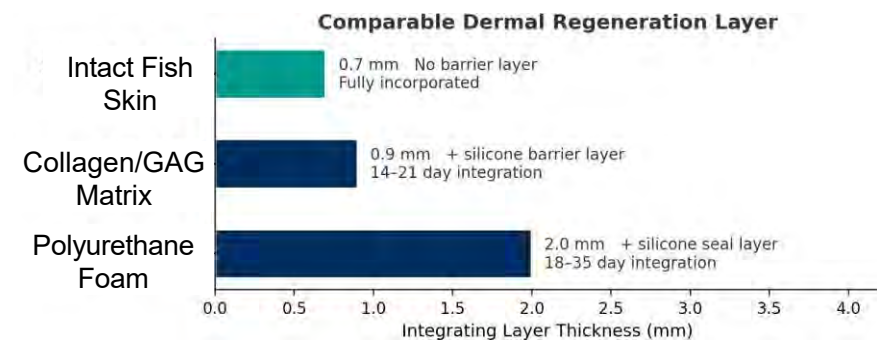
Intact Fish Skin



Polyurethane Foam



Collagen/GAG Matrix



Biologically-Derived Dermal Regeneration Graft

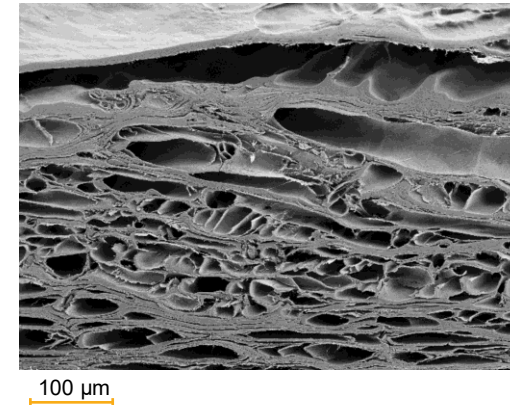
Benefits

- Not temporary wound coverage
- Intact skin architecture + chemical complexity with fatty acids from North Atlantic cod (Gadus morhua)
- Fully incorporated into the wound bed without a removable barrier layer
- Single-stage application – no second surgery to remove an outer membrane

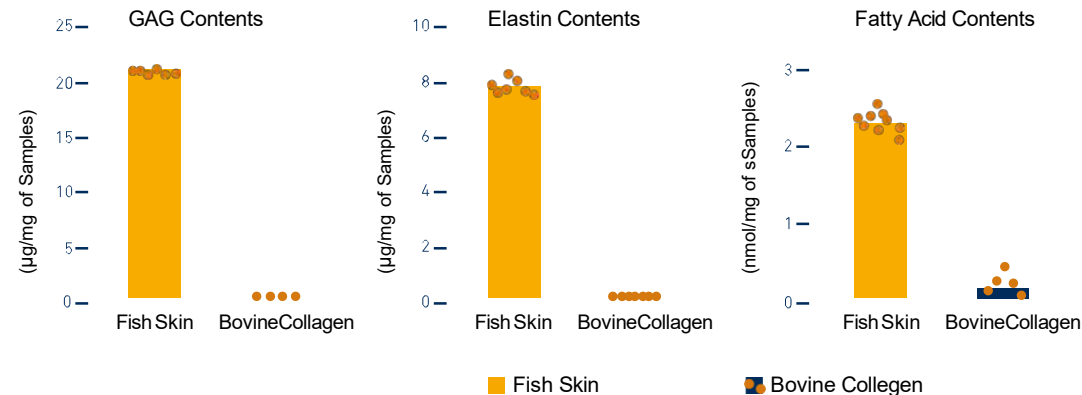
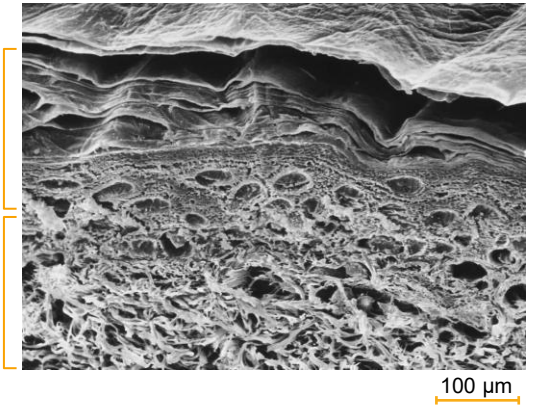
Indications for use

- Partial- and full-thickness wounds
- Trauma wounds (including second-degree burns)
- Surgical wounds (donor sites/grafts, post-Mohs surgery, post-laser surgery, podiatric, wound dehiscence)

Fish Skin



Human Skin



	Human Skin	Fish Skin
Collagen	✓	✓
Elastin	✓	✓
Fibronectin	✓	✓
Proteoglycans	✓	✓
Glycans	✓	✓
Lipid	✓	✓

Magnusson S, et al. *Mil Med.* 2017;182:383-388. Baldursson BT, et al. *Int J Low Extrem Wounds.* 2015;14. Magnusson S, et al. *Laeknabladid.* 2015;101:567-573. Alam K, et al. *Mil Med.* 2019;184(suppl 1):16-20. Pujji O, et al. *BMJ Mil Health.* 2018;164:358-359. Shupp JW, et al. *Fish Skin Compared to Cadaver Skin as a Temporary Covering for Full Thickness Burns: An Early Feasibility Trial.* Presented at: AMUS Annual Meeting; 2020. Badois N, et al. *J Wound Care.* 2019;28:624-628. Kirsner RS, et al. *Wound Repair Regen.* 2020;28:75-80. Lullove EJ, et al. *Wounds.* 2021. Wallner C, et al. *J Burn Care Res.* 2021;42(suppl 1):125-126. Stone R, et al. *J Burn Care Res.* 2018;39:S234-S235. Stone R 2nd, et al. *Int J Mol Sci.* 2021;22(4):1590. Magnusson S, et al. *Today's Wound Clinic.* 2016;10(5). Lantis JC, et al. Presented at: Symposium on Advanced Wound Care Fall Meeting; 2017. Wang Y, et al. *Adv Drug Deliv Rev.* 2018;123:3-17.

Published Burn Evidence for Intact Fish Skin Graft

Category	N	Lead Reference	Key Findings	Evidence Level
Deep Partial-Thickness Burns	6	Heitzmann et al., Burns 2025	Accelerated closure vs Suprathel; reduced STSG need; Ongoing RCT on autograft reductions (NCT07326657)	RCT + comparative
Full-Thickness	3	Hassouba et al., JBCR 2025	13.9 vs 29.1 days to graftable bed vs synthetic (P<.001)	Non-inferiority + cohort
Donor Site Management	2	Yoon et al., Int J Biol Macromol 2022	Superior cellular ingrowth vs bovine collagen; effective coverage with reduced pain	Comparative + case series
Mixed Depth/General Burn	3	Staubach et al., J Clin Med 2024	Safety across adult and pediatric; favorable 2-yr scar outcomes in children	Case series + comparative
Military/Complex Trauma	4	Reda et al., Mil Med 2023	Feasible in austere/field settings; effective against MDR-infected wounds	Case series
Preclinical/Mechanism	5	Kamolz et al., Burns 2021	α-SMA, neovascularization, IL-10, SPM; KereDerm formation (Sood, 2025)	Animal + in vitro
Systematic Reviews	6	El Araby et al., J Clin Med 2025	Consistent: faster healing, less pain; all call for larger comparative trials	Meta-level

29 publications on burn-related topics have been published. All systematic reviews identified the need for a large comparative trial. RCT = randomized controlled trial; MDR = multidrug resistance; α-SMA = alpha smooth muscle actin; SPM = specialized pro-resolving mediator. Sood R, et al. Presented at: ABA 2026; April 14-17, 2026; Orlando, Florida.

Study Design: Acute Burns Requiring Dermal Regeneration + STSG

- ABA Burn Care Quality Platform – largest U.S. burn registry (12,492 autograft patients, 80 centers)
- Adult patients (≥ 18 yo) with acute burn requiring STSG
- Pure-product cohort: Single dermal substitute during index hospitalization
- IFSG arm: Intact fish skin graft only
- SSS arm: Collagen/GAG matrix or polyurethane foam only
- 1:4 propensity score matching (KNN on logit)
- Covariates: Age, sex, TBSA, burn severity, inhalation, trauma
- Primary endpoint: Hospital LOS
- Secondary endpoint: Sepsis, graft loss, VTE, HAPI

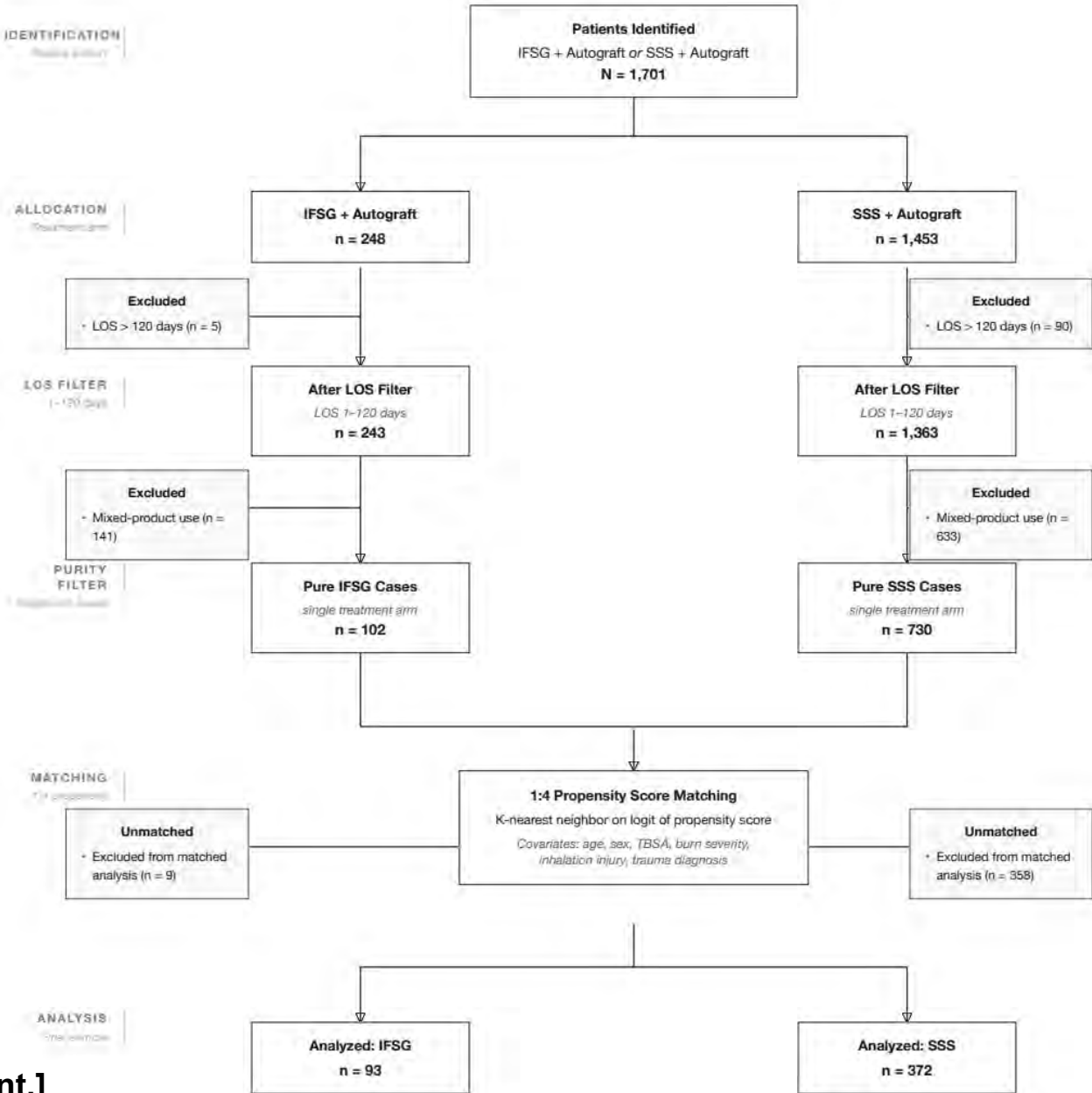
IFSG = intact fish skin graft; SSS = synthetic/biosynthetic dermal substitutes; KNN = k-nearest neighbors; TBSA = total body surface area; LOS = length of stay; HAPI = hospital-acquired pressure injury.

Sood R, et al. Presented at: ABA 2026; April 14-17, 2026; Orlando, Florida. Sood R, et al. *MedRxiv*. 2026:2026.04.14.26350896. [Epub ahead of print.]

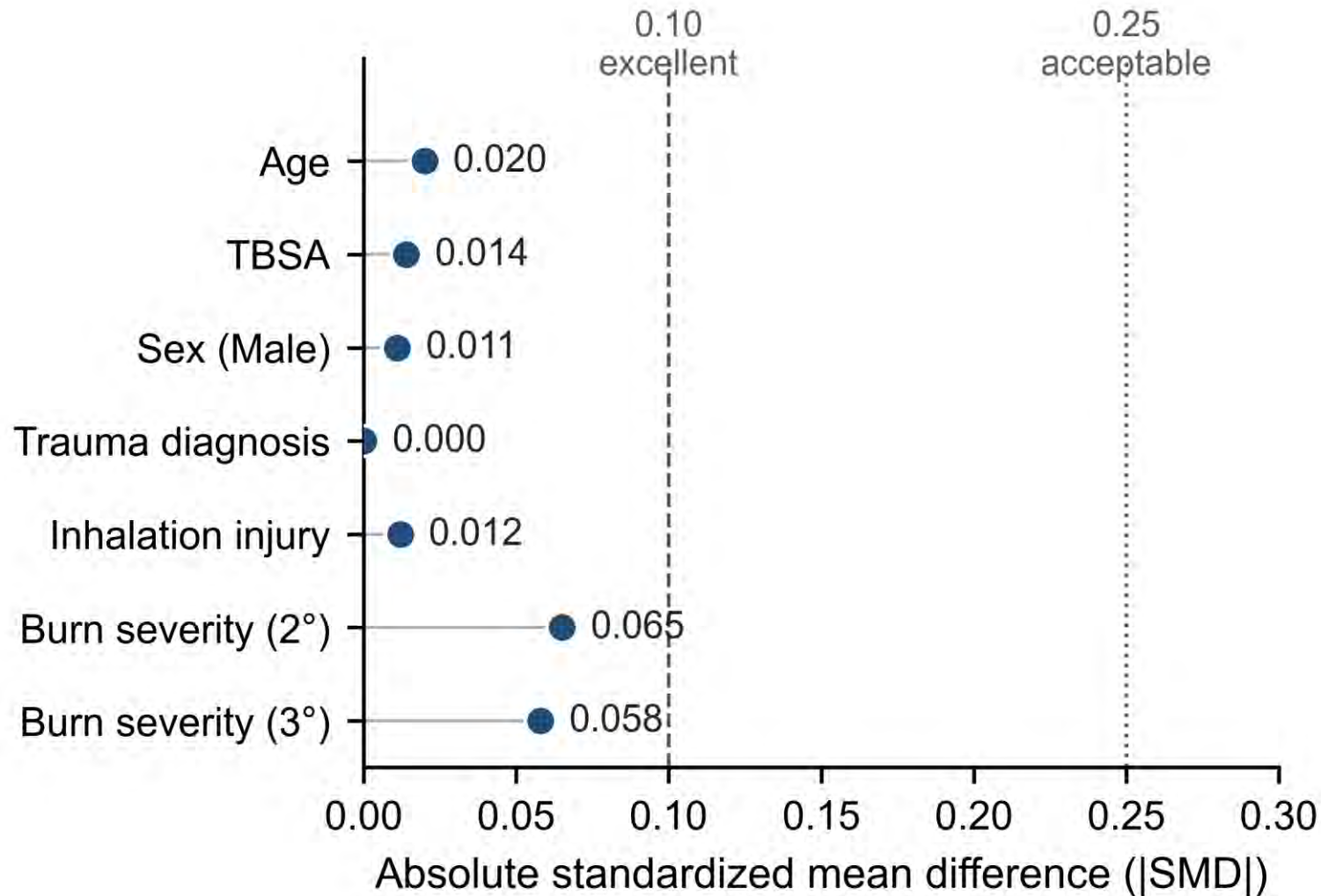
Patient Flow (Consort)

Figure 1. Patient Flow Diagram (CONSORT)

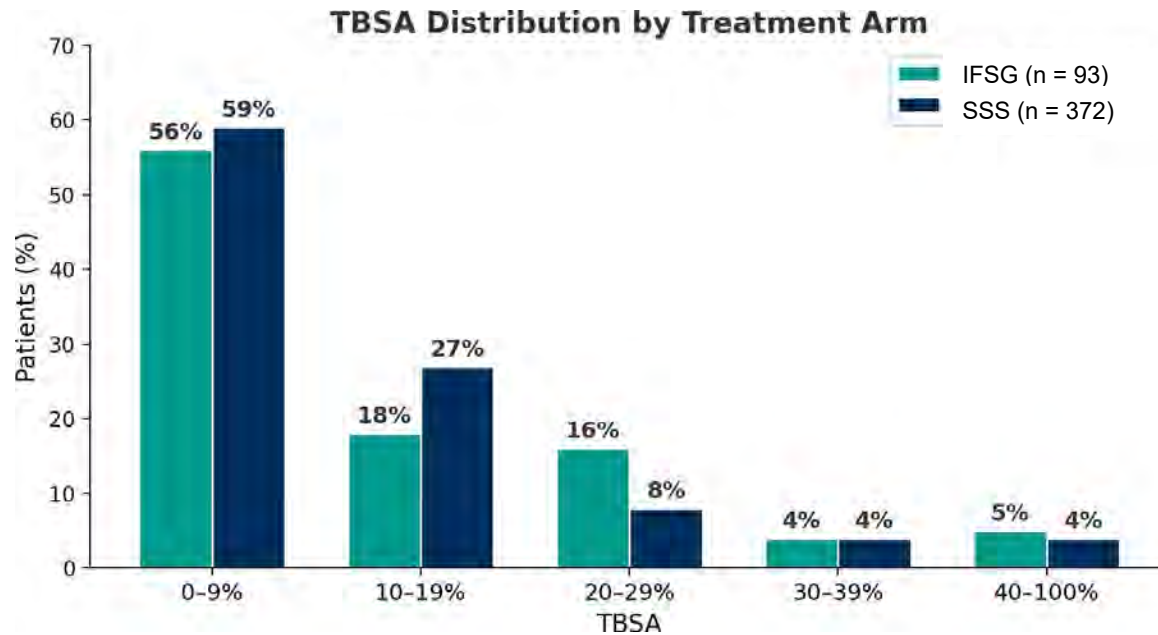
Cohort derivation and 1:4 propensity-score matched analysis sample



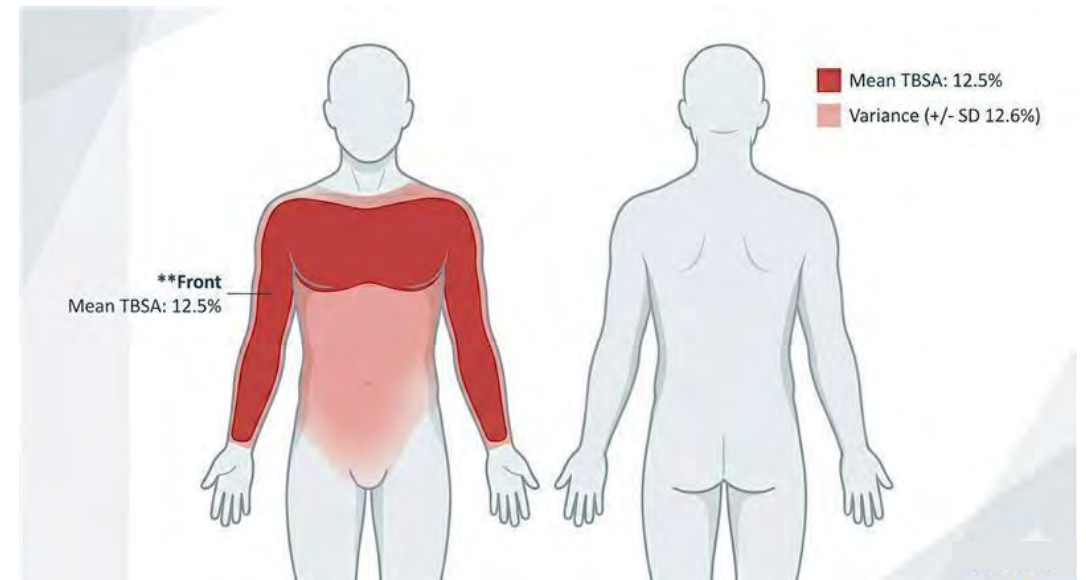
Post-Match Covariate Balance



TBSA Distribution by Treatment Arm

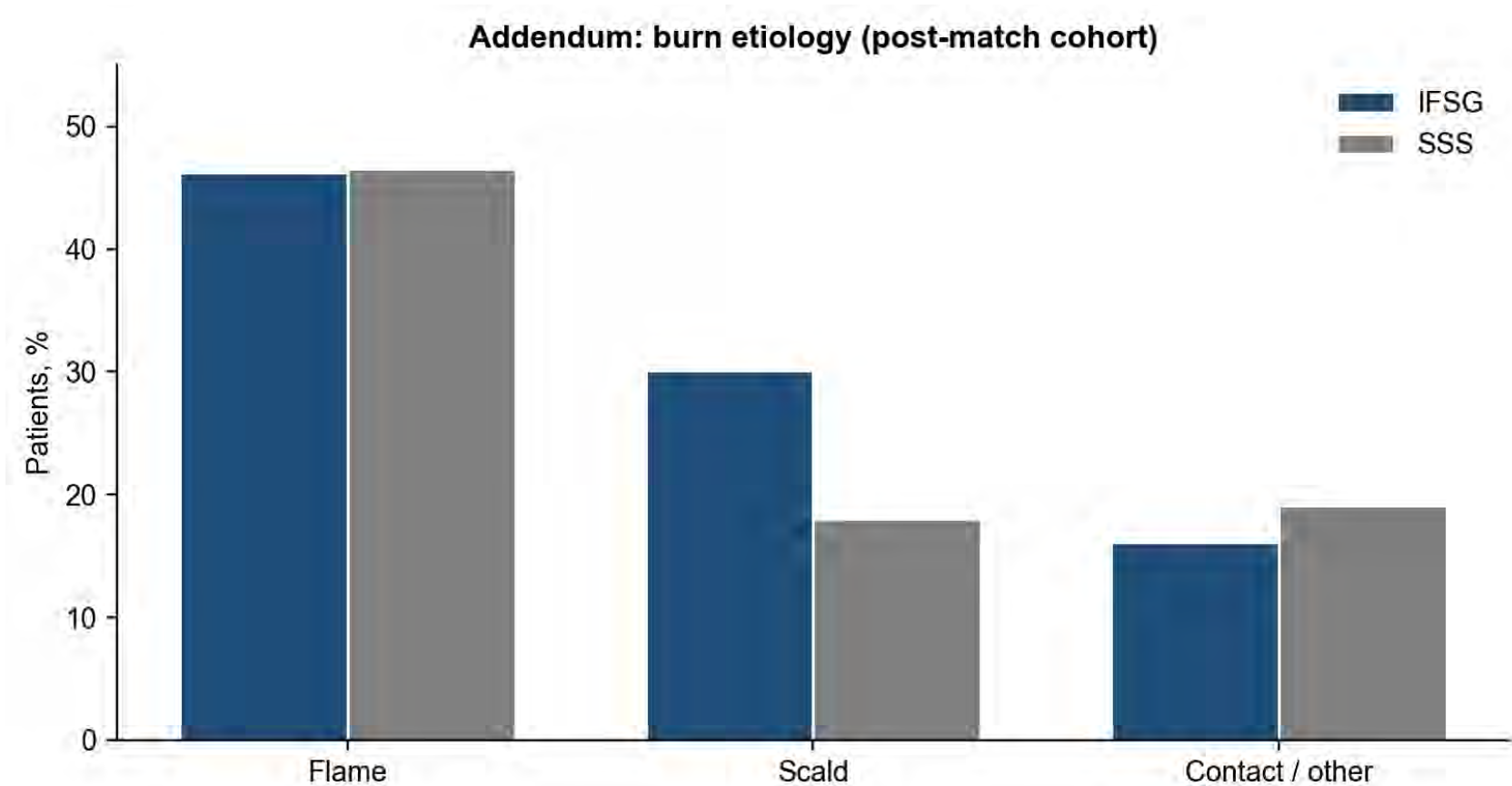


Similar distribution across arms: Majority of patients (53-59%) had burns <10% TBSA. Predominantly medium-sized burns, few patients had ≥40% TBSA.

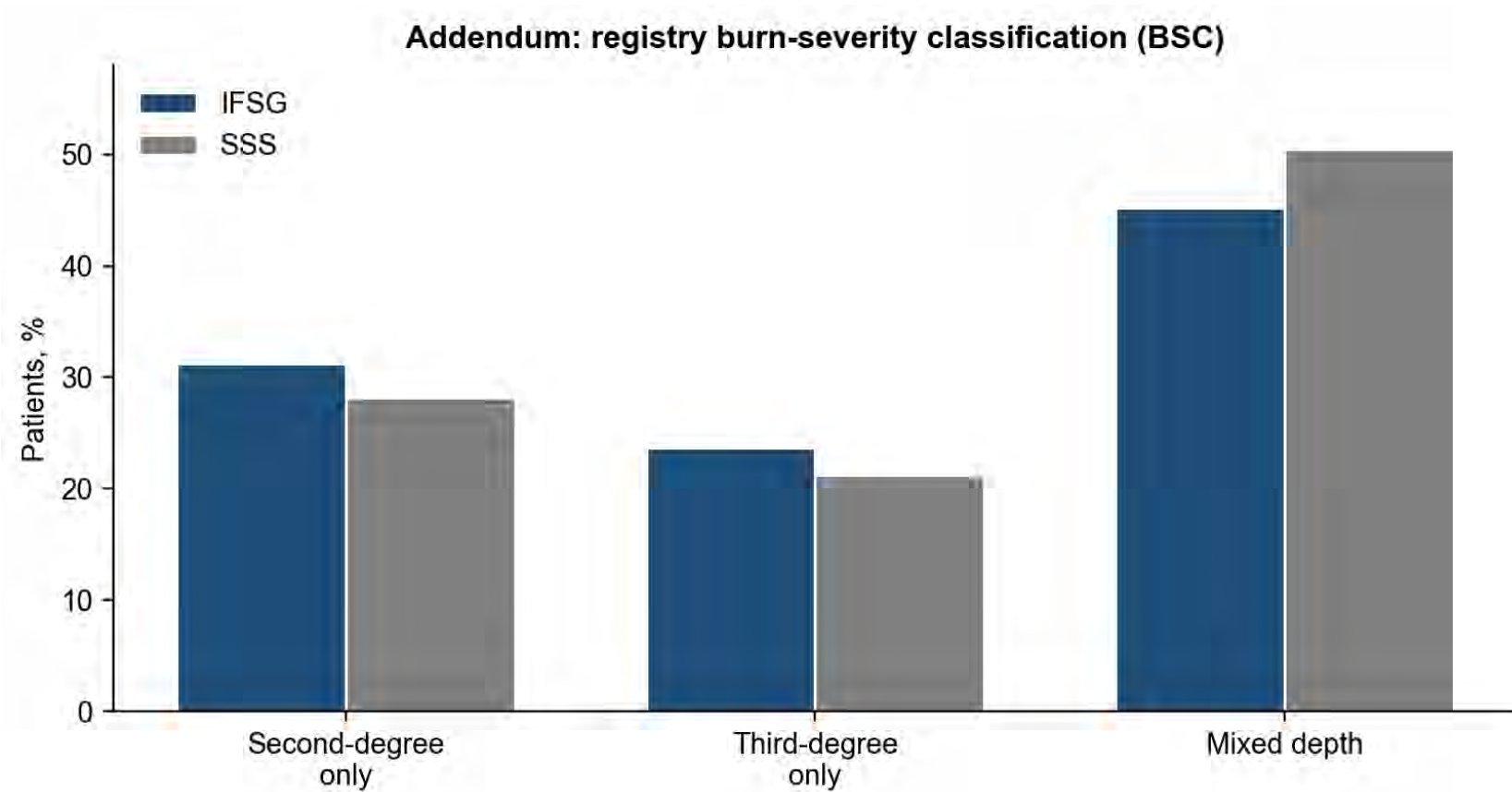


Study predominantly included small- to medium-sized burns where single-cycle STSG grafting was possible.

Burn Etiology



Burn Depth (BSC)

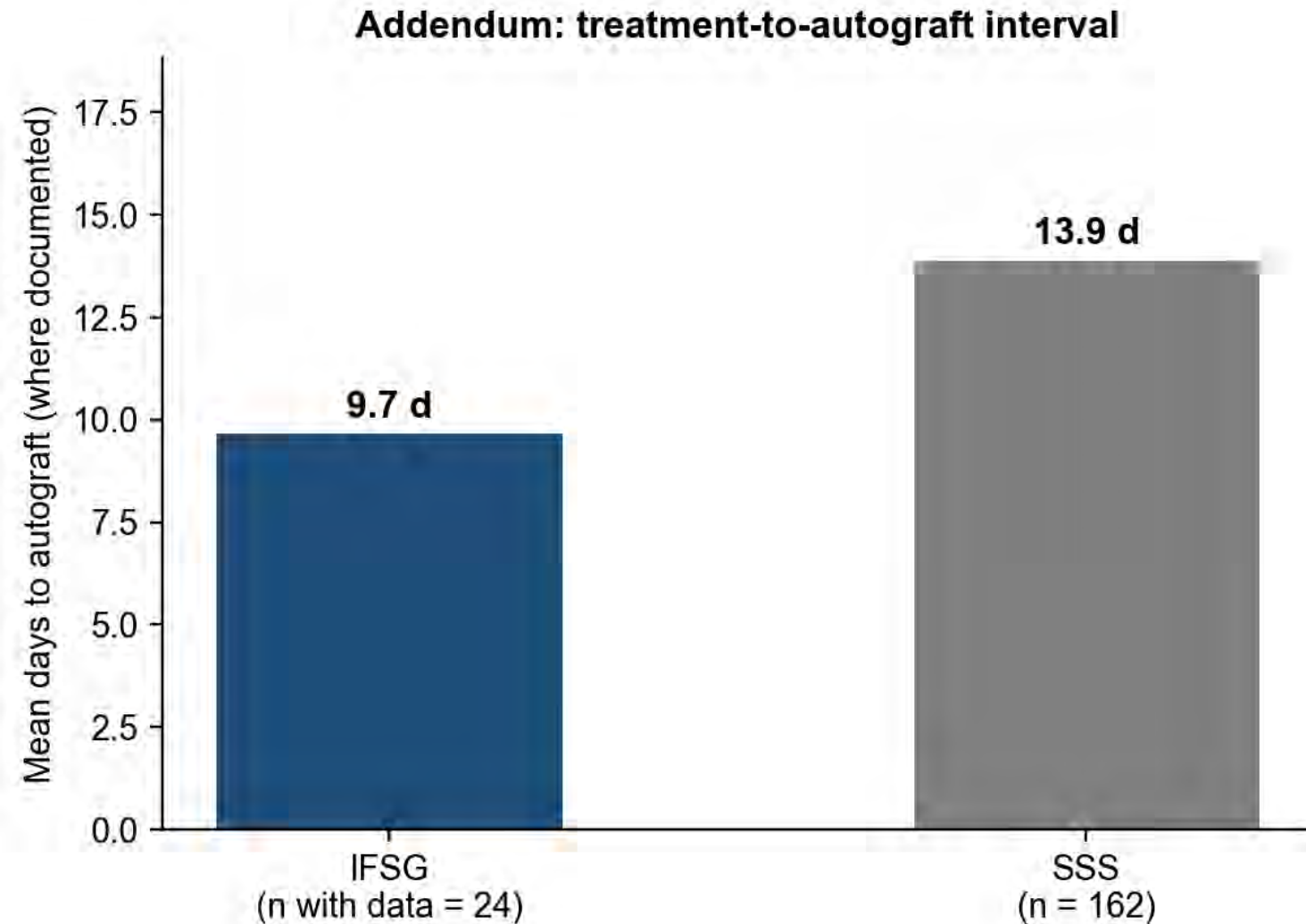


K11b two-arm analysis.

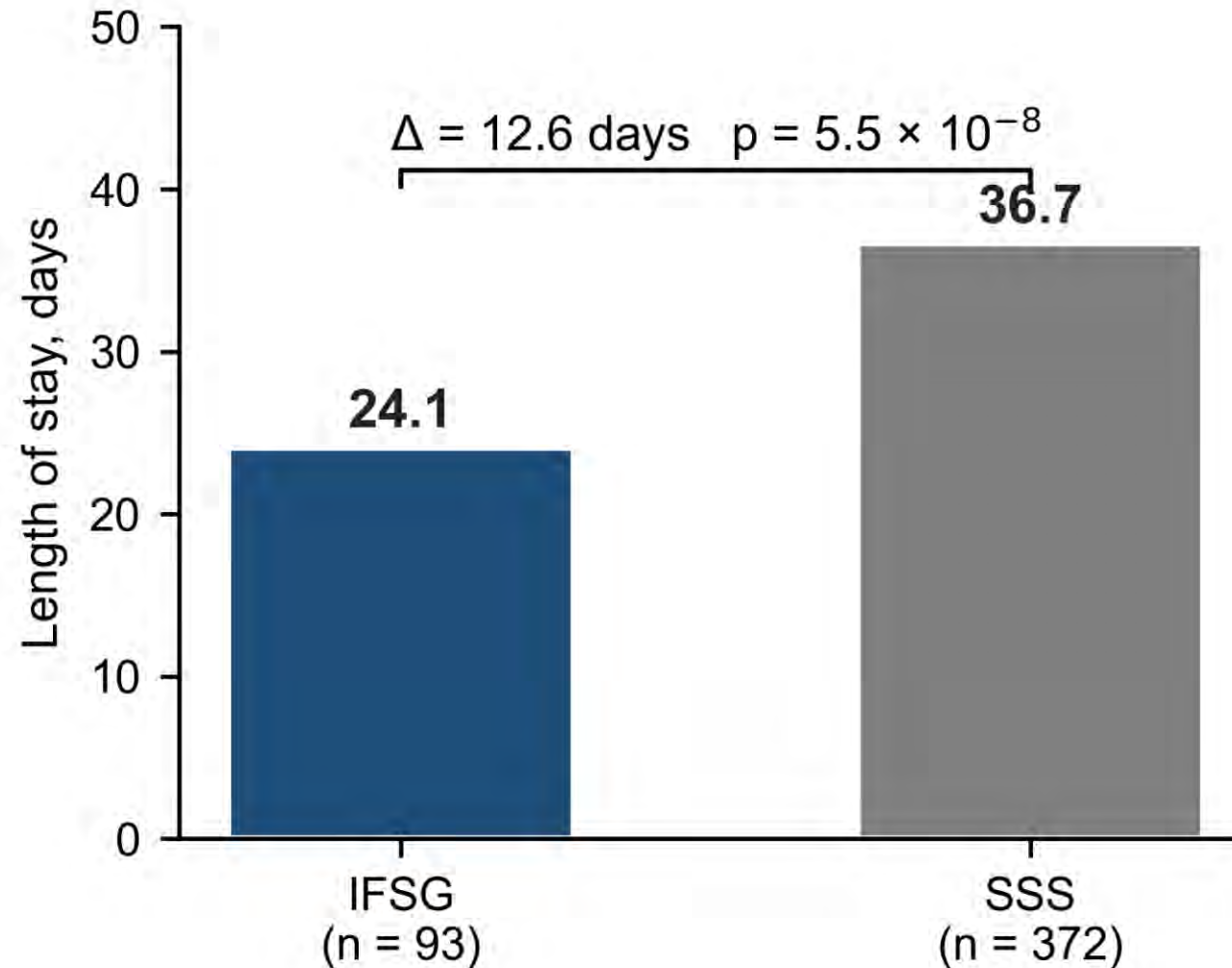
BSC = burn-severity classification.

BData/ABA Burn Care Quality Platform; 2026.

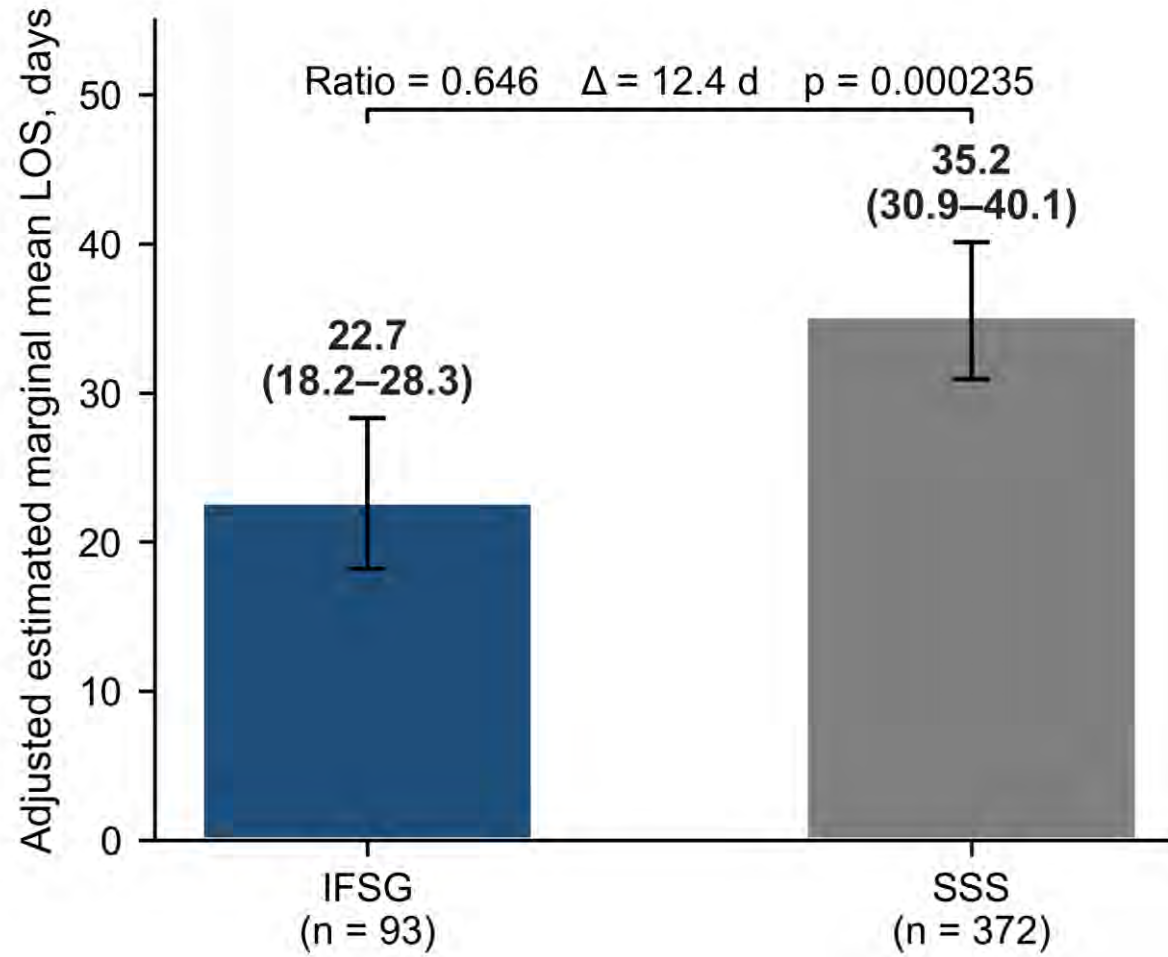
RESULTS: Treatment to Autograft



RESULTS: Unadjusted Length of Stay



RESULTS: GLMM: Adjusted LOS (EMM)

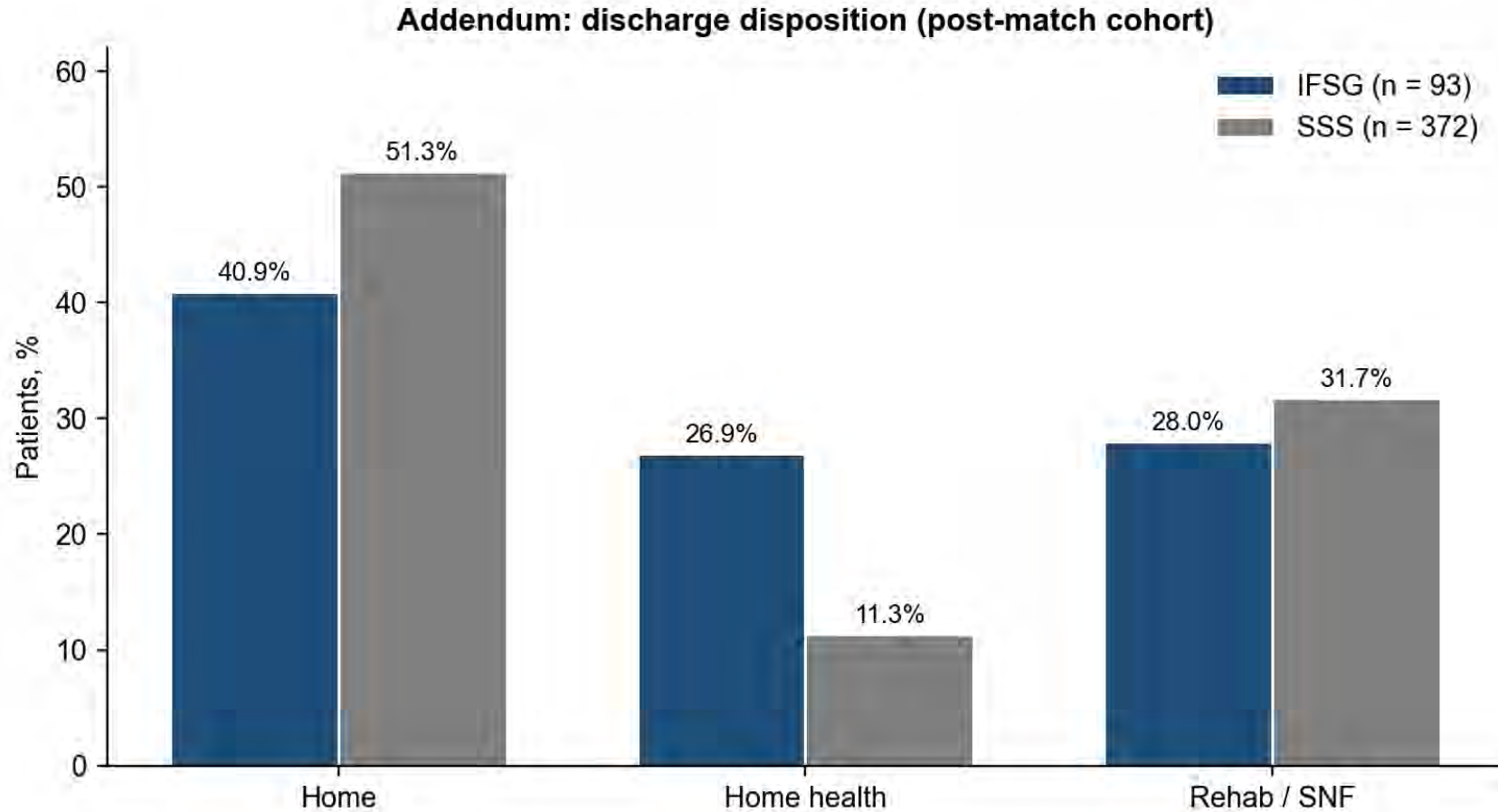


K11b two-arm analysis.

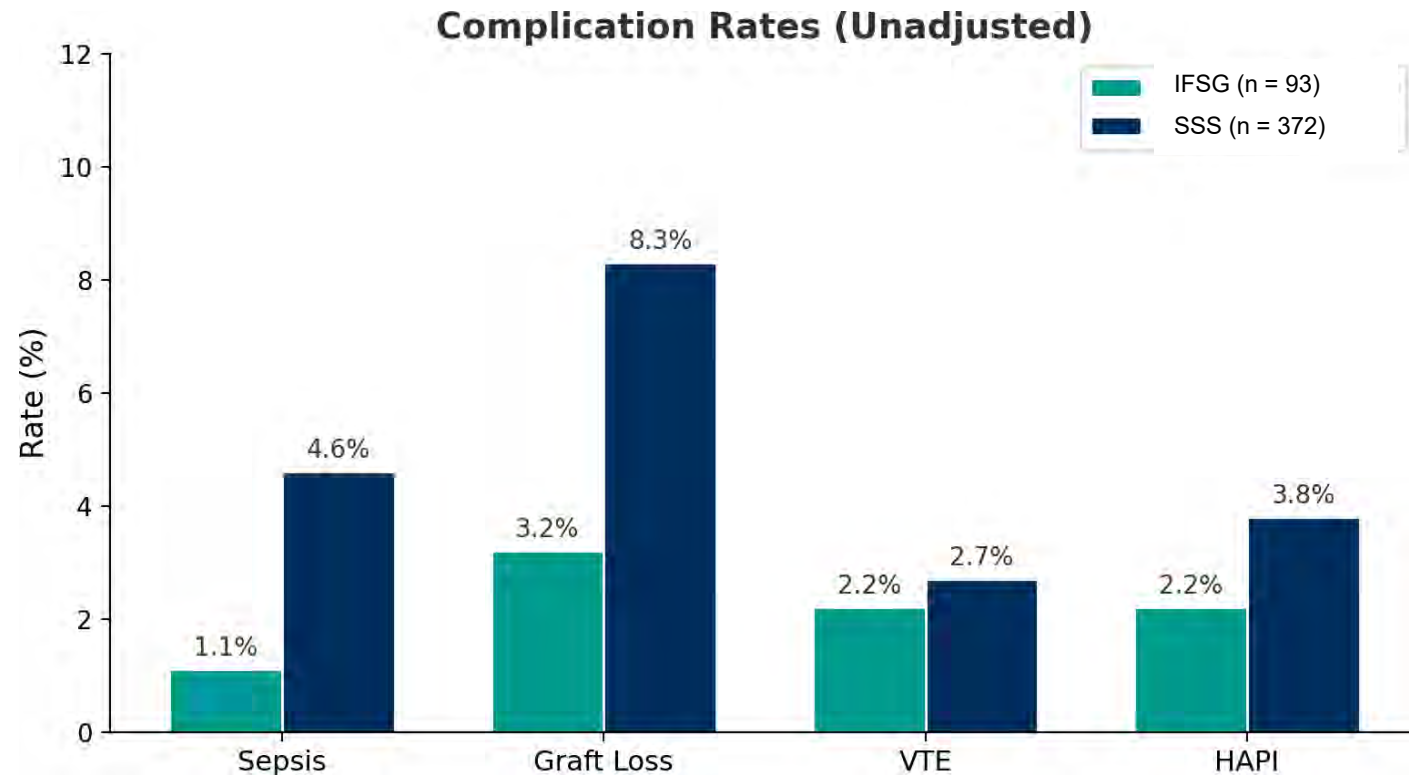
GLMM = generalized linear mixed model; EMM = estimated marginal mean.

BData/ABA Burn Care Quality Platform; 2026.

Discharge Disposition

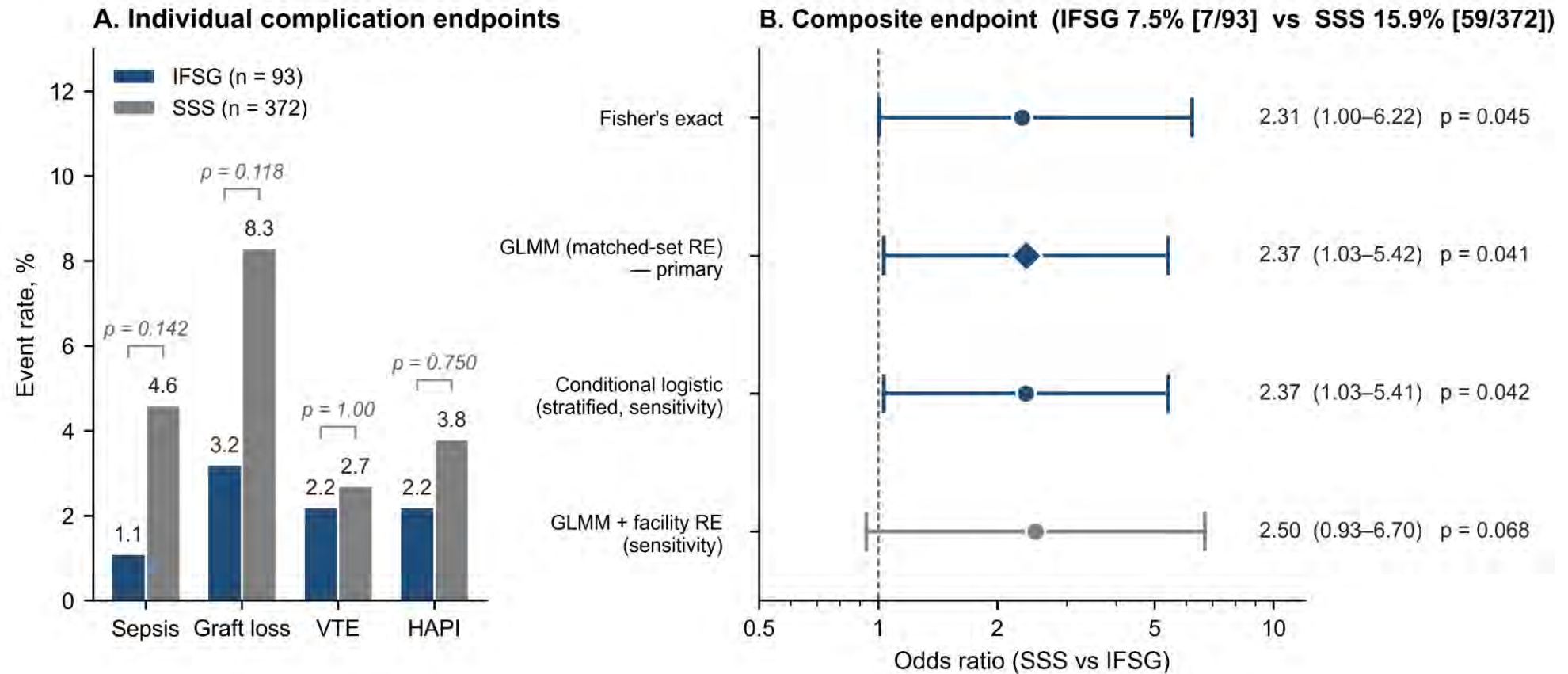


Secondary Outcomes: Complication Rates



All four endpoints numerically lower in IFSG arm. Fisher's exact p-values: Sepsis 0.142, Graft Loss 0.118, VTE 1.000, HAPI 0.750.

Complications



K11b two-arm analysis.

RE = random effect.

BData/ABA Burn Care Quality Platform; 2026.

Clinical Implications

For burns requiring STSG with adequate donor sites

- 1. Minimal risk**
 - All four complication endpoints (sepsis, graft loss, VTE, HAPI) numerically lower than synthetic alternatives in the largest comparative dataset available
- 2. Optimal speed**
 - 34% shorter LOS, consistent with independently reported wound-bed preparation timelines (Hassouba, et al., $P < .001$)
- 3. Exploratory autograft-sparing potential**
 - In mixed-depth burns (45-51% of this cohort), biologically active graft may achieve closure of deep partial components without STSG, ongoing RCT (NCT07326657)
- 4. Reduced cost burden**
 - Each avoided hospital day: \$4000-\$8800 in burn center costs; 12.6-day reduction = \$50,000–\$110,000 per patient episode

Limitations

- Retrospective registry design—cannot establish causation
- Whole-patient data, not wound-level specificity
- Cohort predominantly medium-sized burns (median TBSA ~10-12%); extremely large burns requiring CEA or donor-site reharvesting were underrepresented
 - LOS advantage may be attenuated in that subgroup; insufficient data for large-burn subanalysis
- Unmeasured confounders despite propensity score matching
- Cannot capture long-term outcomes (scar quality, contracture)
- Discharge to home health suggests some wound care shifted to outpatient setting—potential bias in LOS comparison
- Single-country data (U.S. ABA registry)
- Prospective RCT warranted for definitive evidence

CEA = cultured epithelial autograft.

Hassouba M, et al. *J Burn Care Res.* 2025;46(S1):S140. National Institutes of Health, National Library of Medicine (NIH). Accessed June 22, 2026.

<https://clinicaltrials.gov/study/NCT07326657>. Jain A, et al. *J Burn Care Res.* 2026;47(S1):S199. Sood R, et al. Presented at: ABA 2026; April 14-17, 2026; Orlando, Florida.

Where Do These Findings Apply?

MAJORITY OF SURGICAL BURN PATIENTS

Deep partial-thickness → full-thickness, single-cycle STSG (<40% TBSA)

- LOS driven by speed of wound-bed preparation
- IFSG: 24.1 vs 36.7 days (34% reduction)
- All complication rates numerically lower
- Potential to avoid autograft in deep partial and mixed depth components
- ~89% of burn center surgical admissions

LARGE BURNS (40-60% TBSA)

Donor-site reharvesting required; staged closure

- LOS advantage likely attenuated—bottleneck shifts to donor-site healing or other injuries (inhalation injury, etc.)
- Safety profile remains relevant (sepsis 1.1% vs 4.6%)
- Not enough evidence that either product would be superior in this range
- Exploratory if IFSG can reduce autograft need in mixed depth burns

MASSIVE BURNS (>60% TBSA)

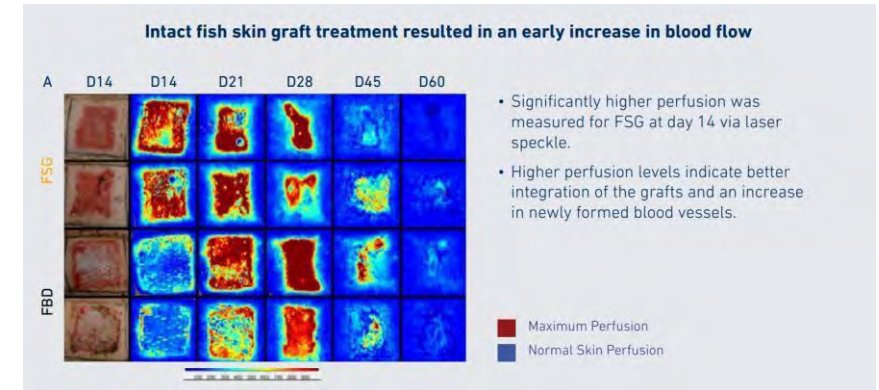
CEA/Meek grafting/allograft cycling

- LOS determined by factors beyond single-product integration
- IFSG adjunctive alongside CEA; exploratory to reduce autograft requirement
- Insufficient data for subgroup analysis in current study

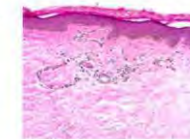
“But How Does It Work?”

Mechanism of Action: What We Know

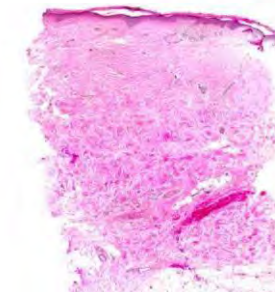
- Organized neovascularization with early α -SMA expression (vascularization) and resolution by day 21 (less fibrotic contraction)
- Manages the wound healing transition from inflammation to proliferation
- Formation of “keratinocyte-ready dermis”—a vascularized neodermis supporting STSG take or direct epithelialization
- Biologically-driven integration timeline rather than mechanically constrained degradation kinetics



IFSG +
STSG
1 year
follow up



Dermal – Epidermal Junction
Developed Rete ridges



Dermal structure
Natural “basket-weave” pattern
Multiple distinct layers visible
Well distributed vascular structures
Characteristic of normal dermis

LOS: Outpatient Management

Initial Exam Post-Injury Day 10: Contour Fill

- 8% TBSA full-thickness burn with black, green, and yellow burn eschar with erythemic wound borders

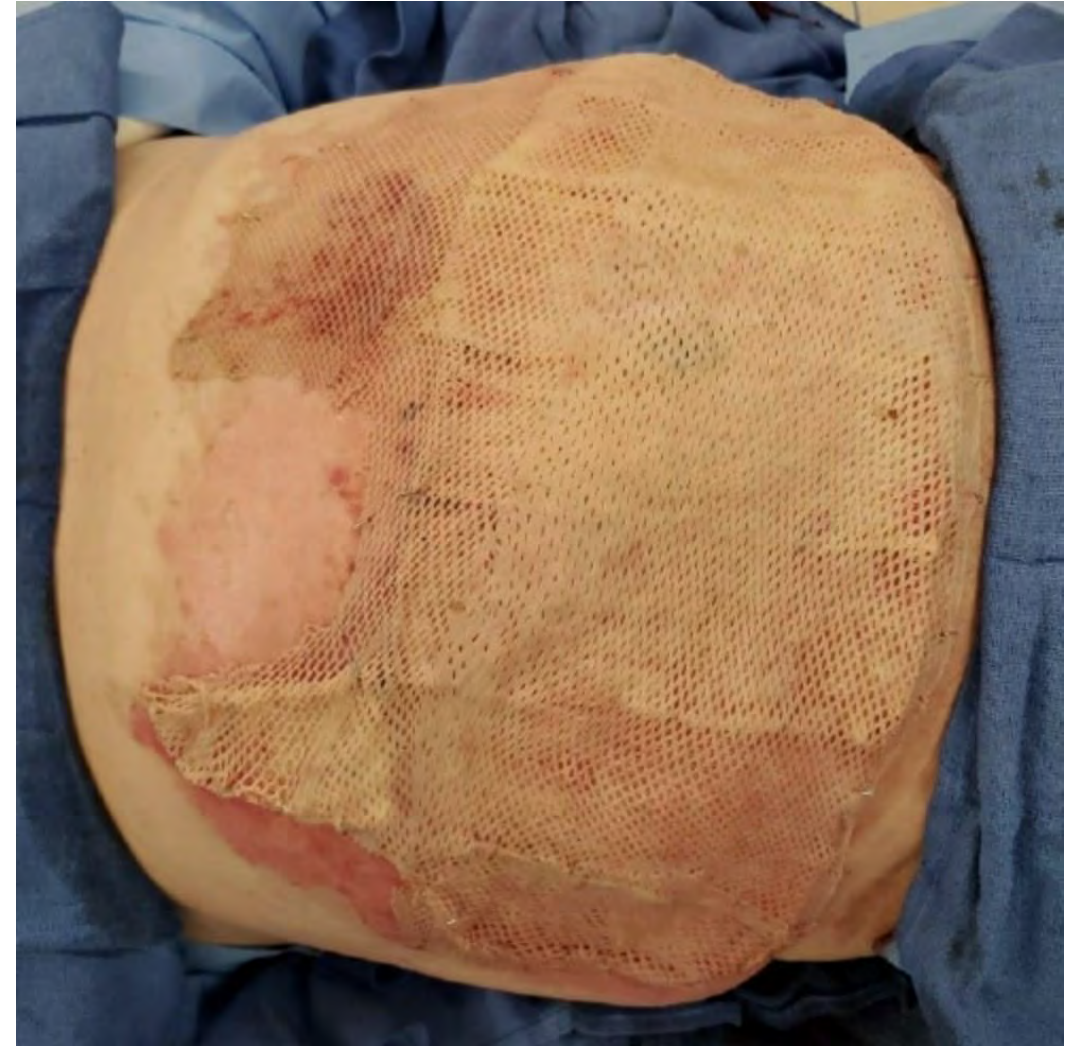
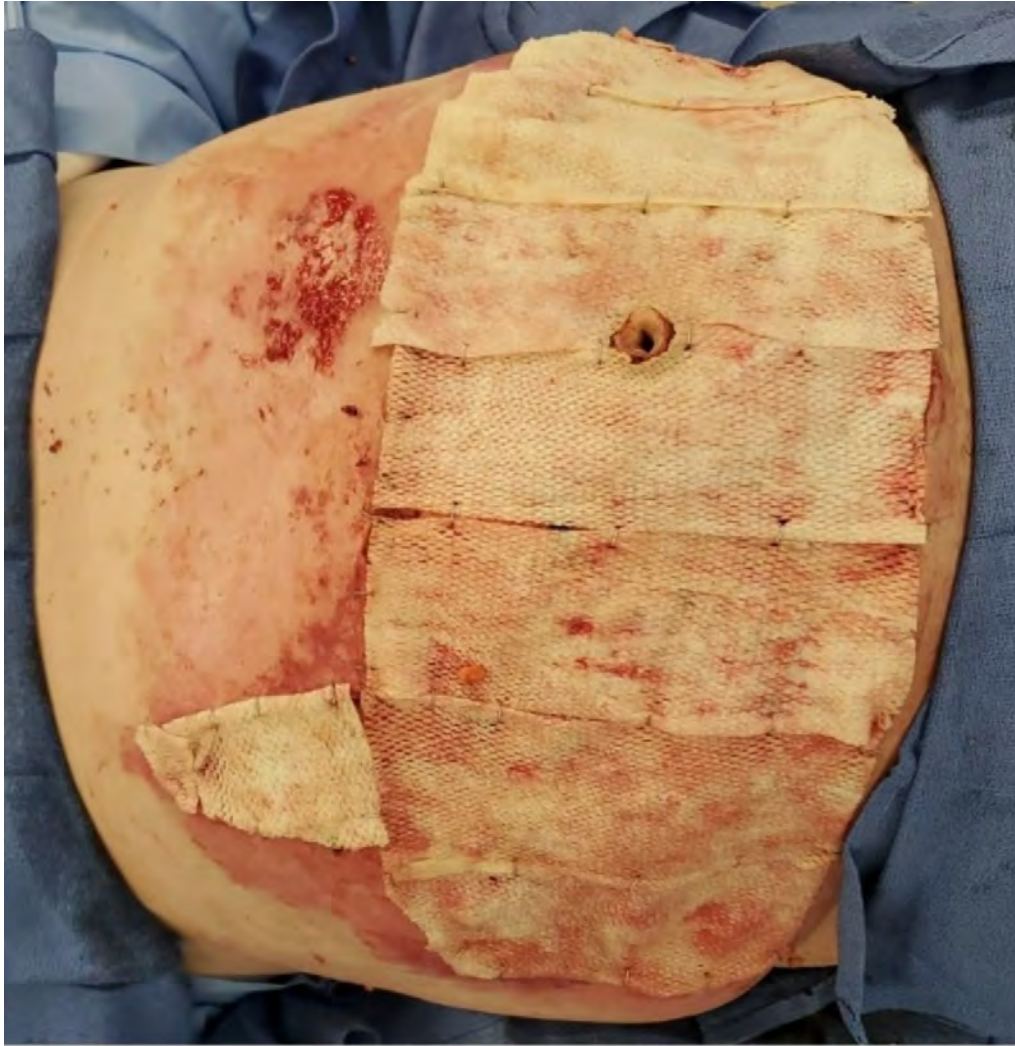


Initial Excision

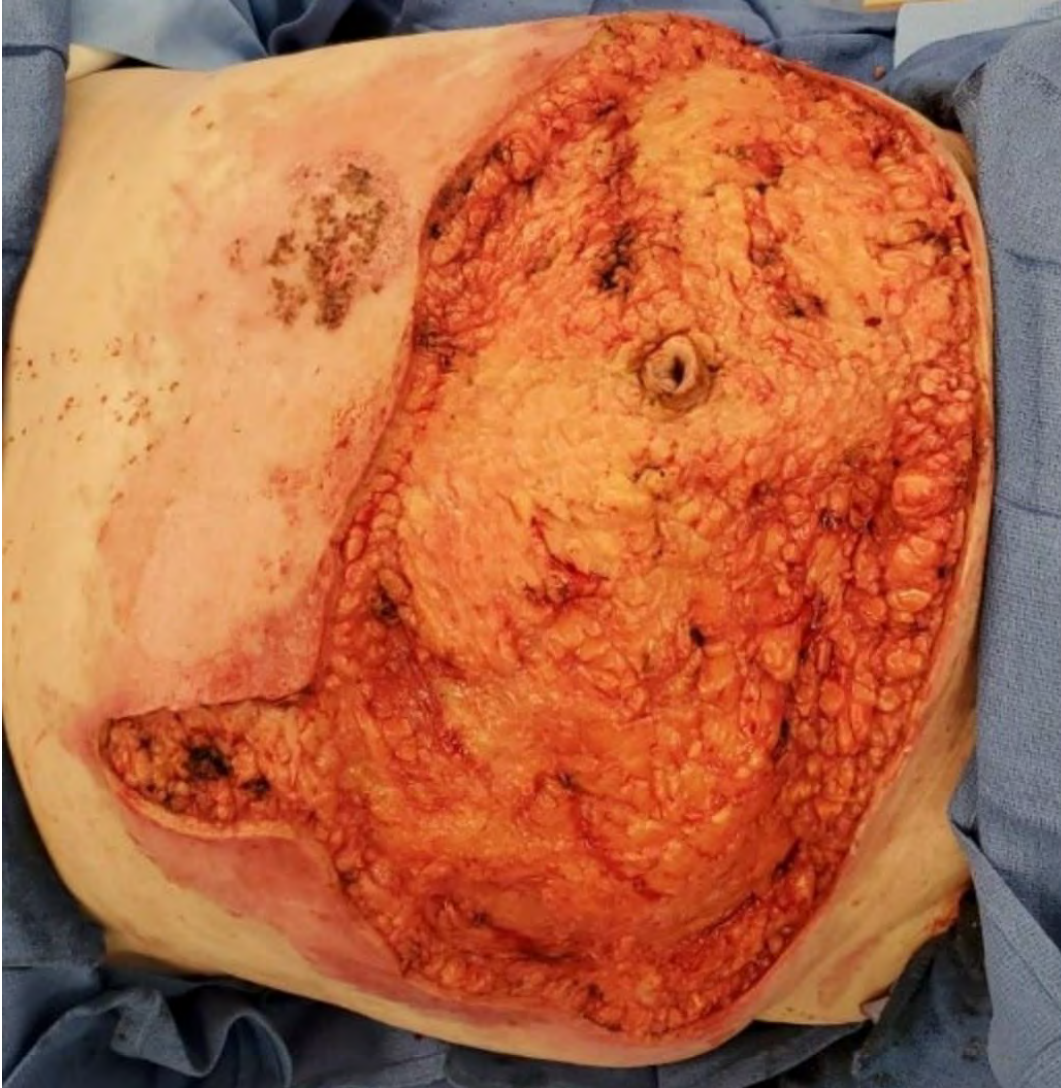
Date of Wound Picture:	Post-injury day 11
Size and Product Applied:	IFSG 7x20 cm meshed 2:1
Wound Measurement:	22 x 55 x 3 + 10 x 8 x 2
Debrided:	Bovie excision
Brief Description:	Under general anesthesia the wound bed was prepared to healthy subcutaneous fat was identified
Wound Treatments:	Allograft sandwich technique Dressed in veil, silver nitrate wring out cotton woven gauze, dry cotton woven gauze and tape



IFSG Initial Application



Initial Excision Compared to Final Prep



Autografting

- Autografted meshed using 3:1 ratio
- Sprayed with epidermal cells
- Dressed in synthetic membrane burn dressing, non-adhesive oil emulsion dressing, silver nitrate wring out, dry cotton woven gauze, and tape
- Admitted for 24 hrs for IV pain control



Treatment Outcome

**Date of Wound
Healed/Closed:**

Post-op day 34/23/14

**Total Number of
IFSG
Applications:**

Two

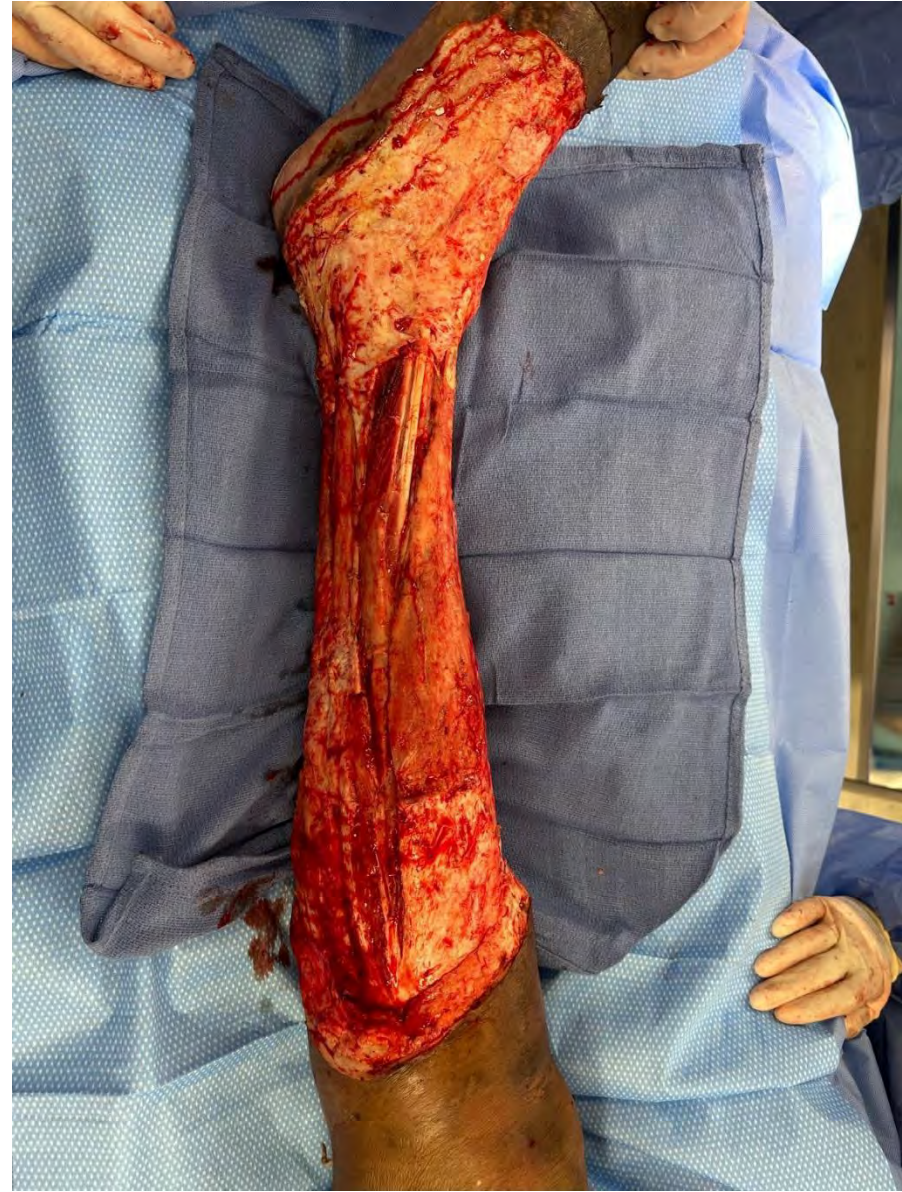
**Description of
Treatment and
Outcome:**

Graft with 99% take

- Dressing stayed intact with
outers changed once in the clinic
(primary layer dry stayed intact as it
was drying well) secondary dressing
replaced in silver nitrate wring out, dry
cotton woven gauze and tape









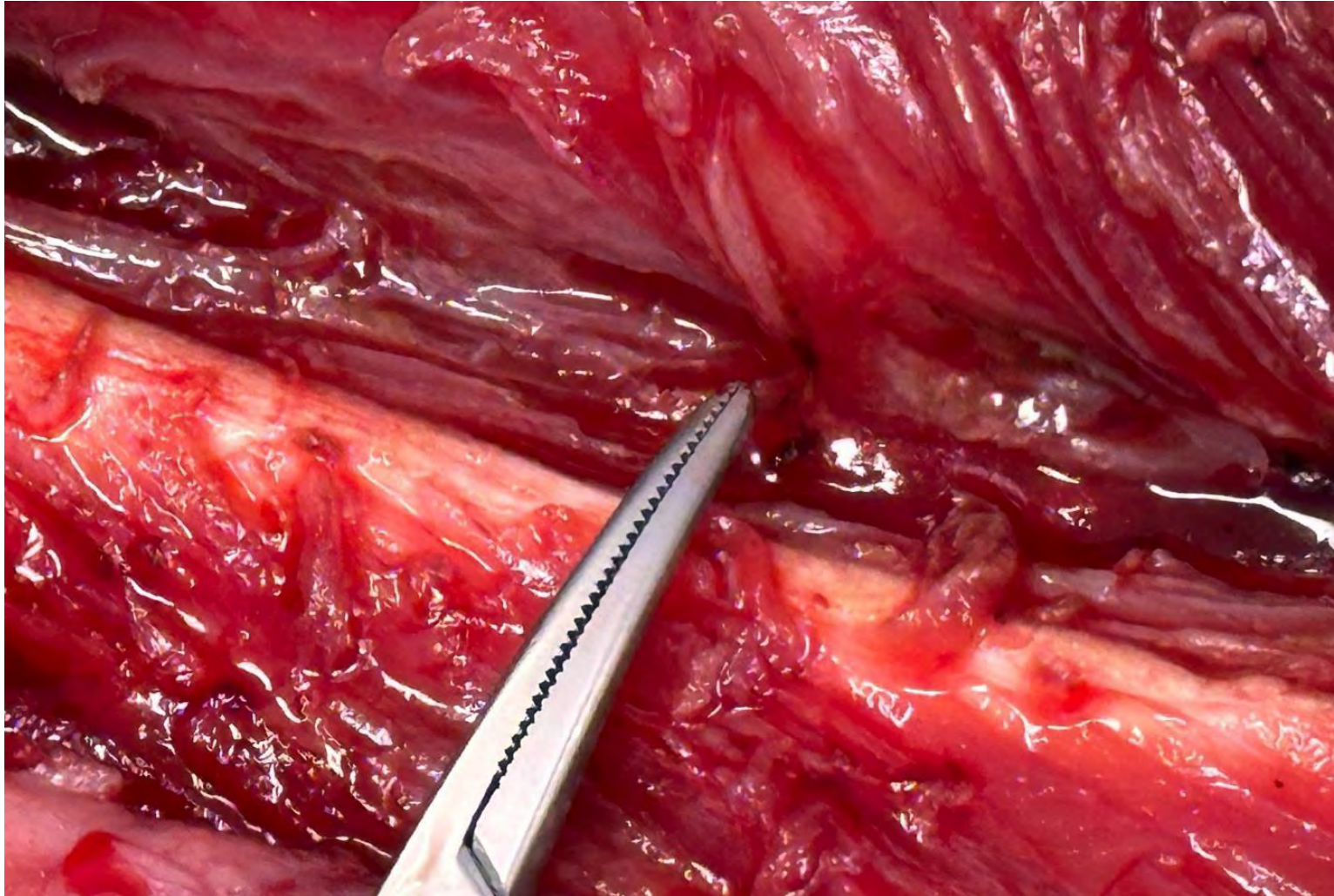








Tibialis Anterior Flap





Sood R, et al. *J Burn Care Rehabil.* 2003;24(6):386-391.

Final Result



Sepsis/Infection

Case #1: Necrotizing Soft Tissue Infection with IFSG

- 50-year-old male admitted for NF/NSTI
- Required 7 surgeries
 - 4 surgical excisions
 - 5th surgery – fish xenografting/NPWT
 - Closed with STSG on 7th surgery
- LOS: 34 days







Post-application day #3



Post-application day #10



Post-STSG day #7

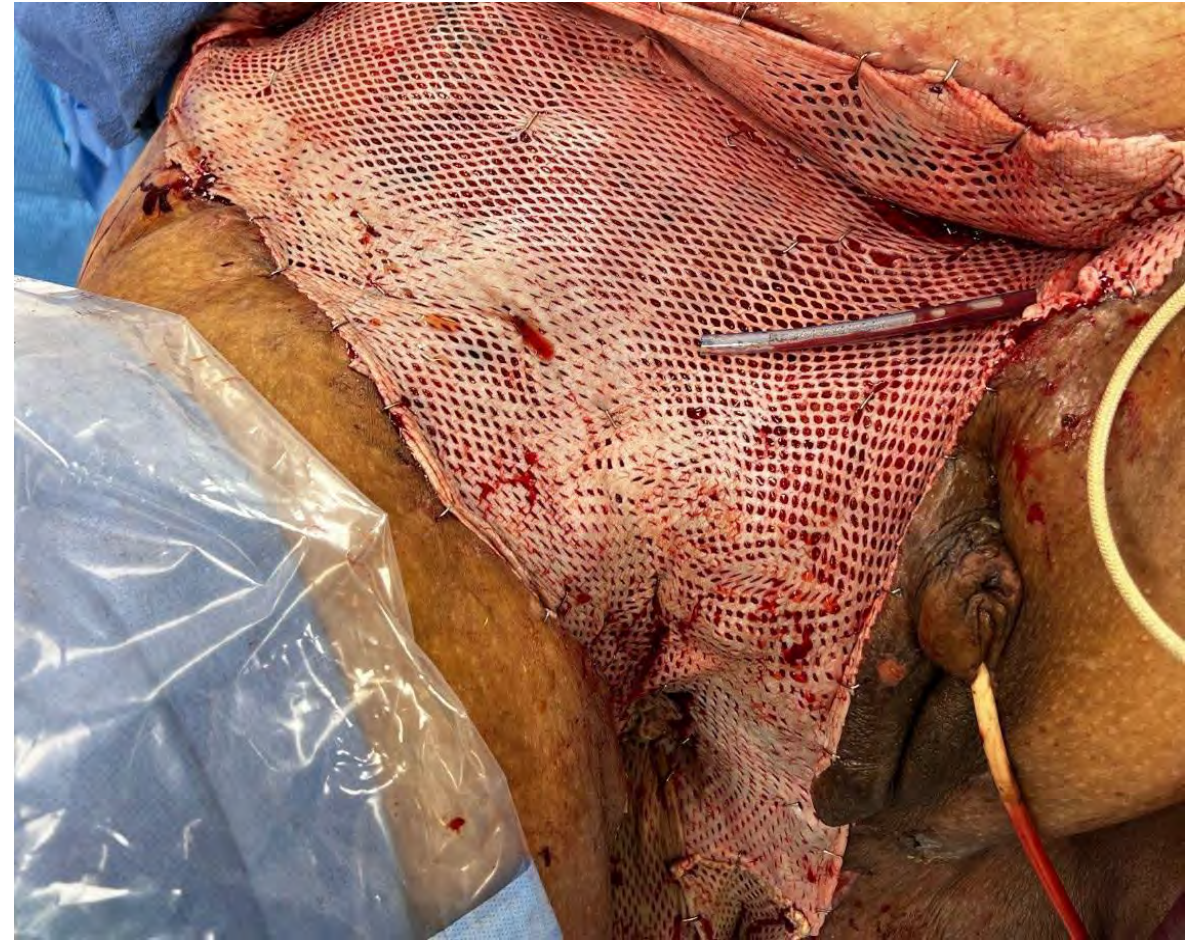


1-month follow-up

Case #2



Case #2: Necrotizing Soft Tissue Infection – Abdomen and Perineum

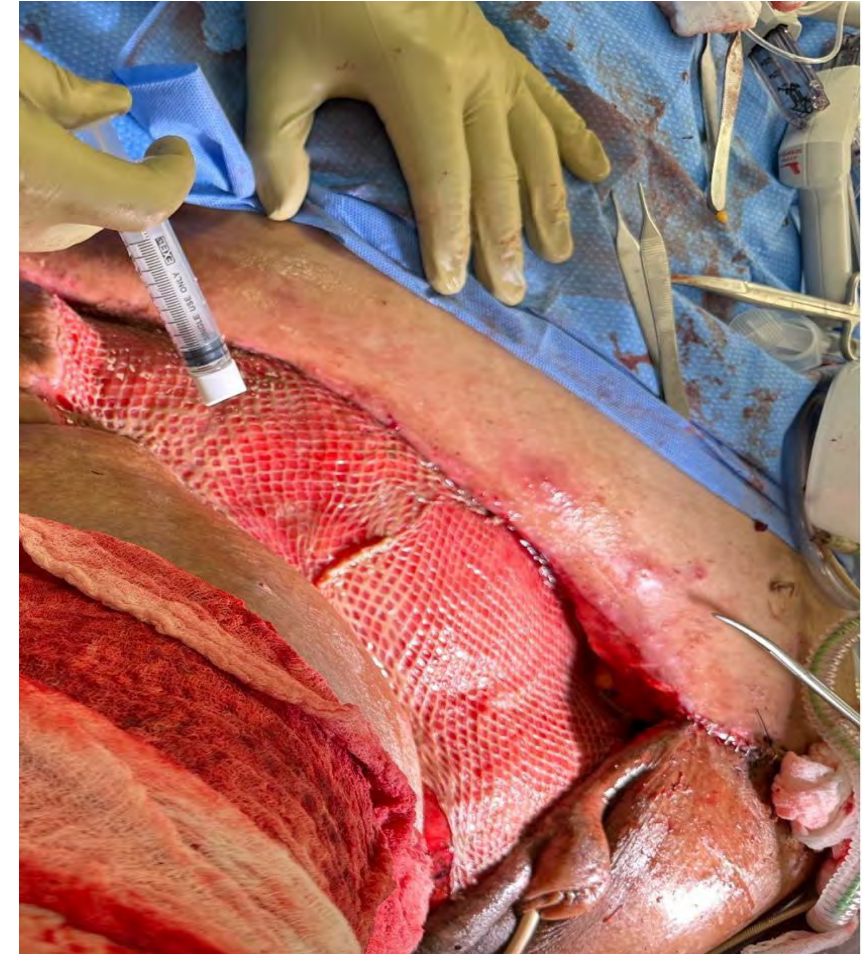


Post-debridement with application of cadaveric tissue

Case #2: Necrotizing Soft Tissue Infection – Abdomen and Perineum



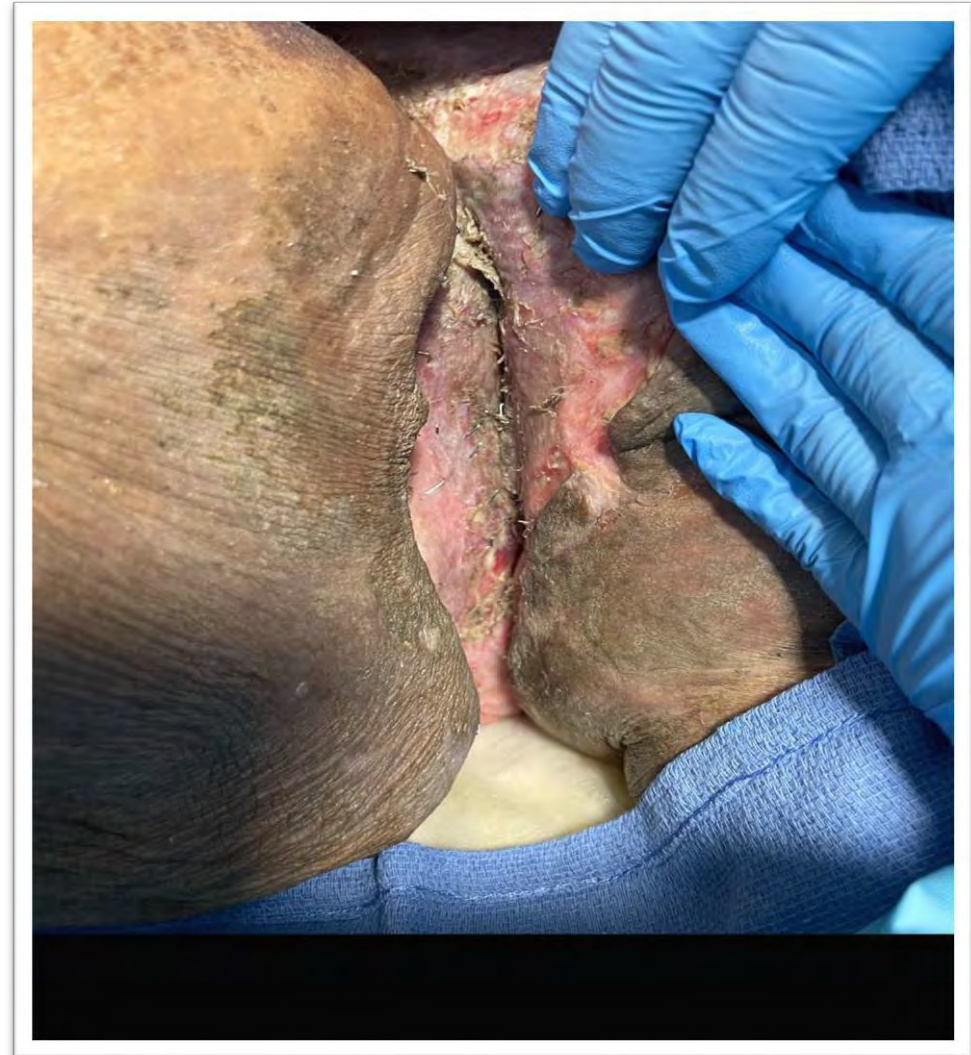
Wound bed granulated



Application of autologous
cell harvesting device



Case #2: Necrotizing Soft Tissue Infection – Abdomen and Perineum



Conclusions

In 93 + 372 propensity-matched burn patients from 61 ABA centers

- IFSG associated with 12.6-day shorter LOS (24.1 vs 36.7 days, 34% reduction)
- All complication rates numerically lower in IFSG arm (sepsis, graft loss, VTE, HAPI)
- Shorter hospitalization was NOT at the expense of graft take or safety
- IFSG functions as a dermal regeneration graft comparable to synthetic scaffolds, but with a biologically accelerated integration timeline

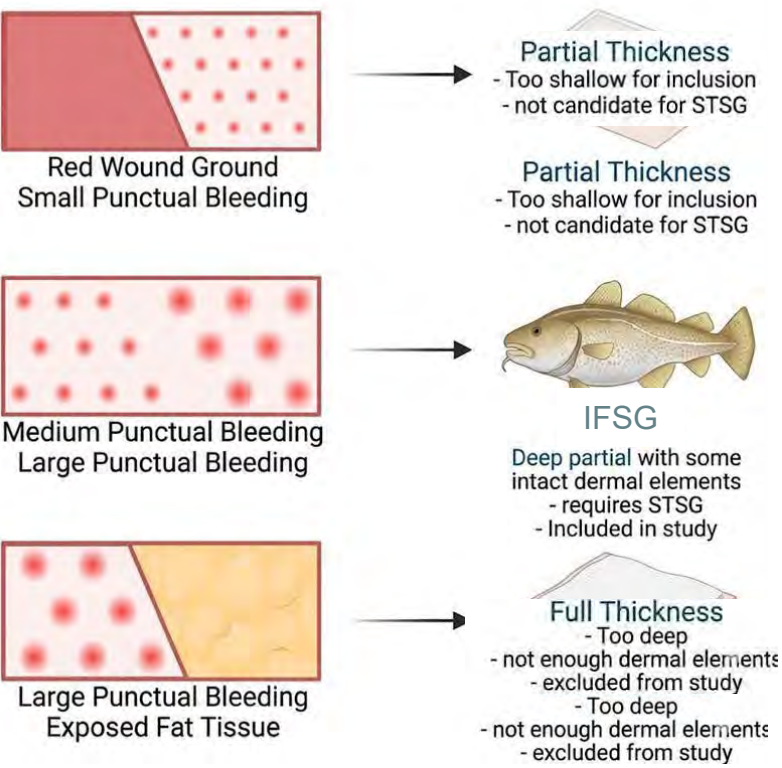
**Open-Label, Controlled, Randomized,
Multicenter Study Evaluating Intact Fish Skin
Graft in Promoting Autologous Skin Tissue
Regeneration of Deep Partial-Thickness Burns:**

The LOGI Study

KS-1040

Study Protocol

Study Design	Open-Label, Controlled, Randomized, Multicenter Study
Device(s)	Kerecis GraftGuide® Intact Fish Skin Graft
Study Objective(s)	The objective of this study is to assess the efficacy of a single application of IFSG in the treatment of complex skin defects caused by thermal burns that contain intact dermal elements for which surgical excision and autografting are clinically indicated.
Performance Objective(s)	The primary performance objective of the study is to evaluate the difference in autografting requirements for deep partial thickness wounds treated with IFSG compared to those treated with the standard protocol for autografting at 1 month.
Secondary Objective(s)	The secondary performance objectives of the study include evaluation of additional performance endpoints including wound durability, pain and cosmesis. Biopsies from patients for histology and immunohistology
Patient Population	Participants in the study will be available from the investigator's patient population who are indicated to receive autografts.
Number of Patients	Screen approximately 120, to obtain between 65 and 75 enrolled subjects
Number of Sites	Up to 12 sites in the United States.
Duration of study participant participation	12 months



Graphical Abstract

Intact Fish Skin vs Synthetic Dermal Substitutes: Impact on Hospital Length of Stay

Methods

Adult acute burn patients
(n = 465)

- 93 IFSG vs 372 SSS



ABA Burn Care Quality Platform

- 49 verified burn centers



Propensity score-matched (1:4)

- Matched on: age, TBSA, burn severity, inhalation injury, trauma



Treatment Groups

- IFSG (Kerecis® GraftGuide®)
- SSS (Integra® DRT, NovoSorb® BTM)



Outcomes

- Primary: hospital LOS
- Secondary: composite complications



Findings

LOS (adjusted)

22.7 vs. 35.2 days

12.4 days

~35%

Composite
Complications

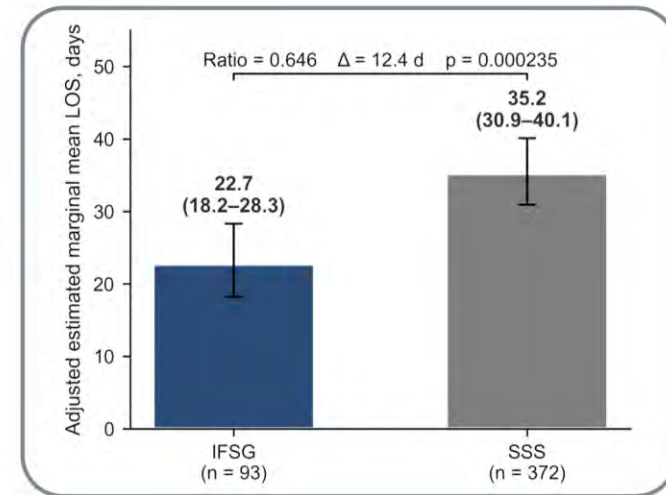
(sepsis, graft loss, VTE, HAPI)

7.5% vs. 15.9%

Lower in IFSG

OR 2.37

(P = 0.041)



Conclusion:

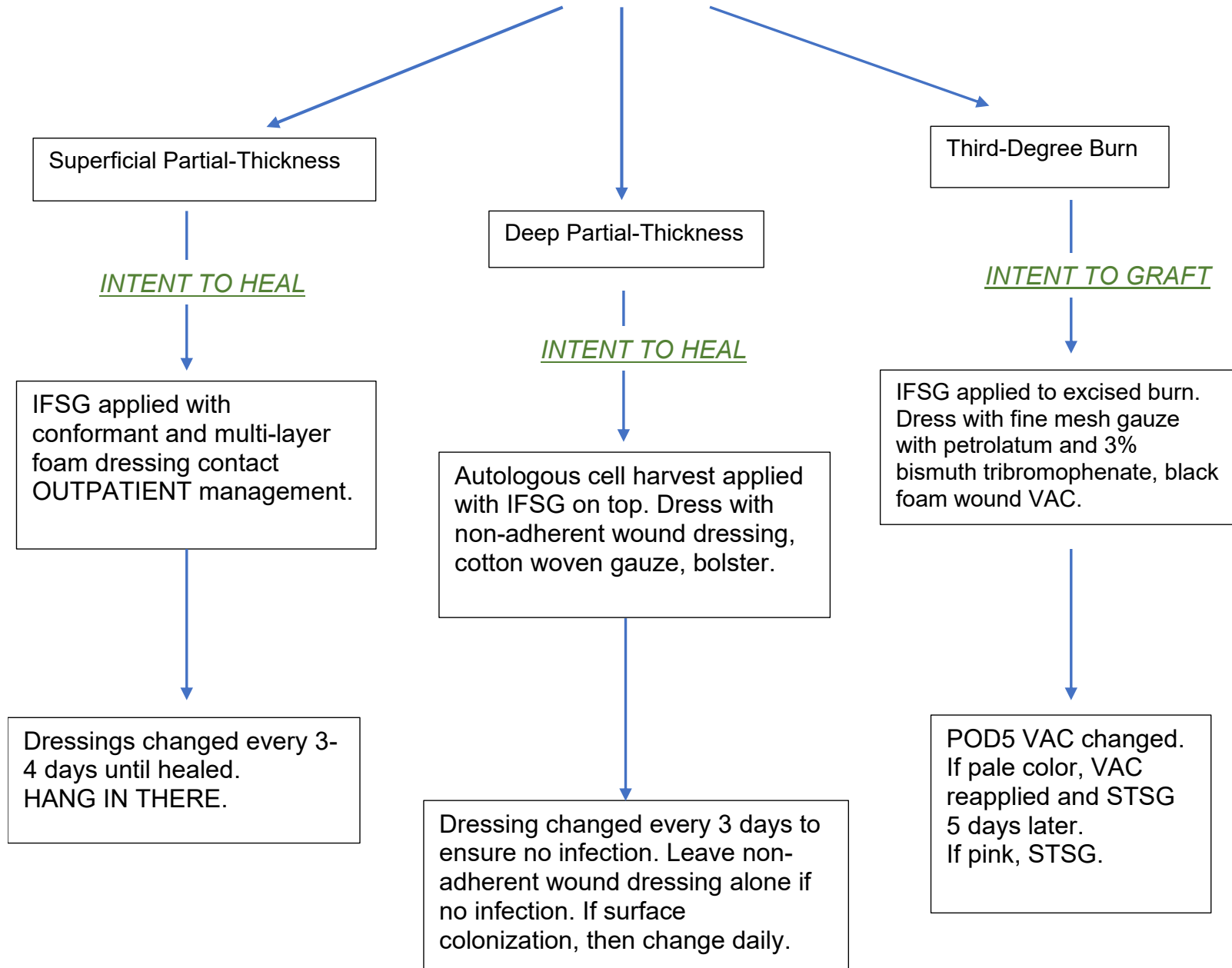
IFSG was associated with **shorter hospitalization** and **lower complication rates** compared with synthetic/biosynthetic dermal substitutes in a propensity-matched burn cohort.

Improving Integration and Outcomes

Michael Van Vliet, MD, FACS

Healing a Burn without STSG

Burn Injury



Patient 1

- 79-year-old male
- Propane explosion, 13% TBSA
- Thin skin, desiring no STSG



Post-injury
day 1, about
12 hours
after injury



































POD5
dressing
change,
reapplication
one area















POD10 dressing
change bedside



















Patient 2

- 38-year-old male
- Gasoline explosion, 6% TBSA
- Young guy, desiring no STSG





Debridement and IFSG





POD3



POD6





Advanced Gelling Fiber Wound Dressing

Patient 1

- 45-year-old male
- 23% TBSA burn, mixed deep partial-thickness and full-thickness burn





























POD5









POD8



POD14









Patient 2

- 25-year-old male
- Deep partial-thickness burn to abdomen, back, and bilateral upper extremities







POD5





POD10

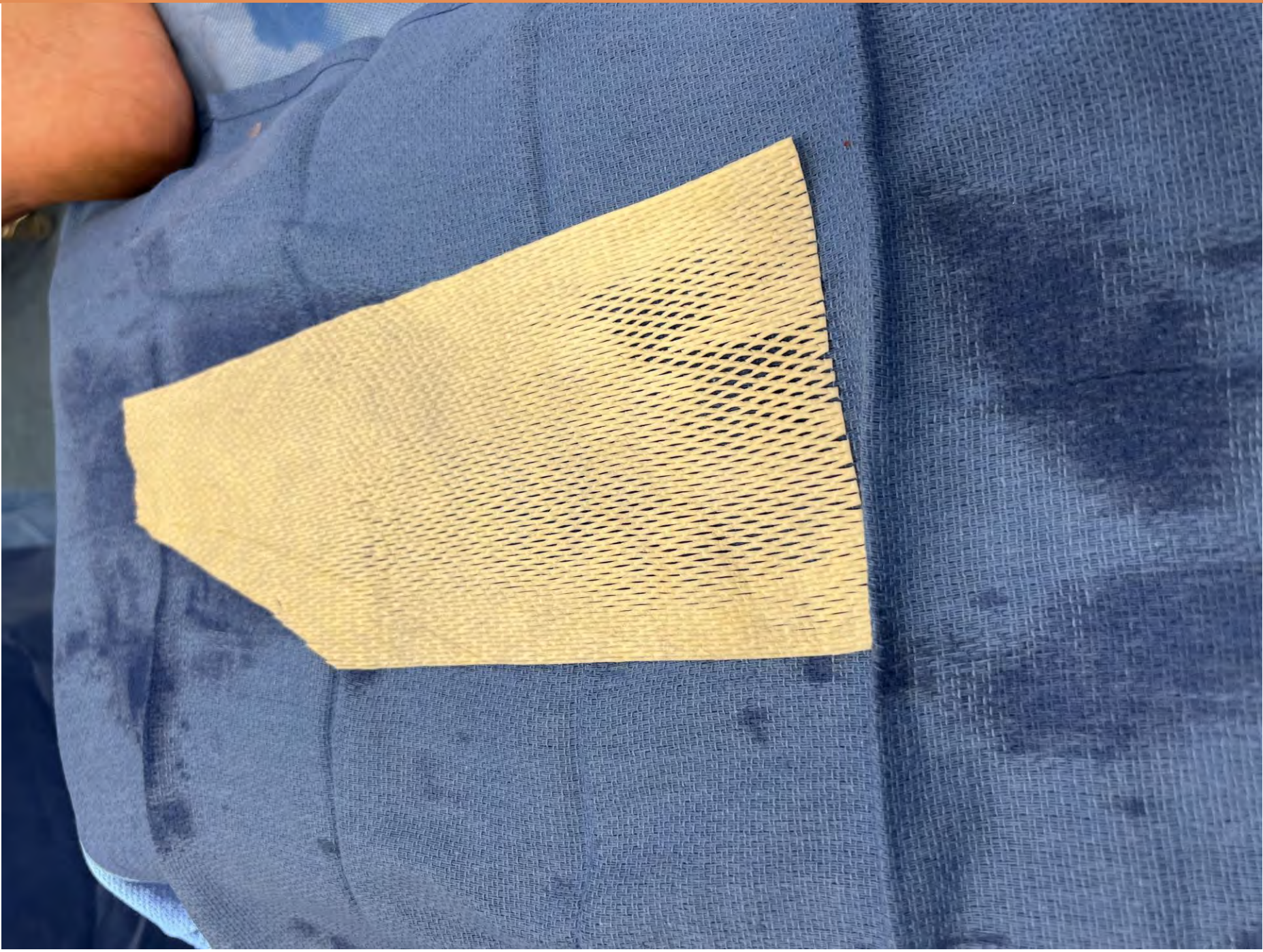


Patient 3

- 21-year-old male
- Right leg burn, deep partial-thickness







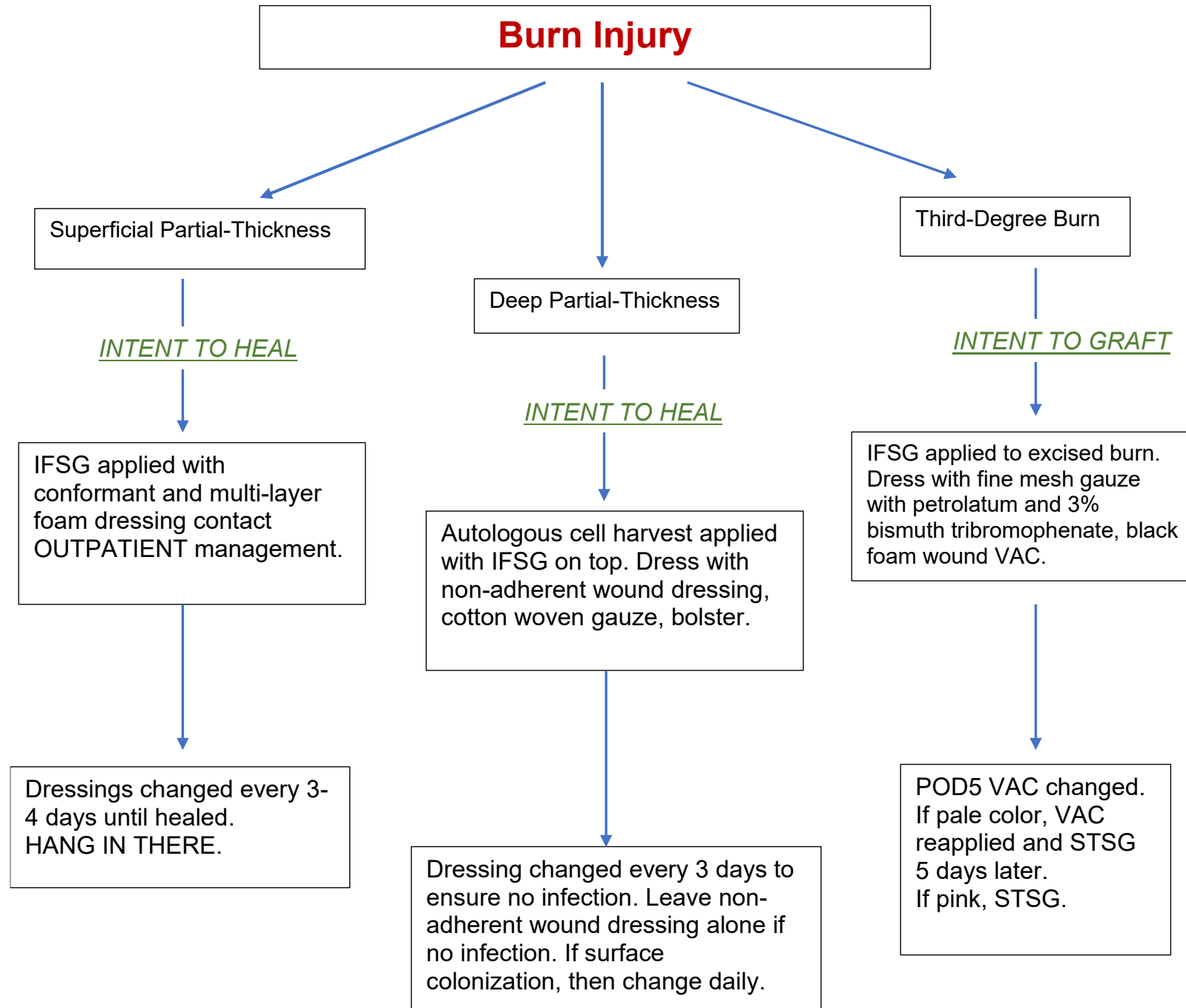








IFSG Base with Autologous Cell Harvesting



Patient 1

- 44-year-old female
- 48% TBSA, third-degree burn after a house fire
- Patient excised and placed in allograft
- Allograft exchanged for IFSG with NPWT
- 2 weeks after IFSG application, patient undergoes autologous cell harvesting

s/p excision
and allograft,
post-injury
day 7.
Prepping for
re-excision
and IFSG.











Beds
prepped





IFSG
applied.
Post-
injury
day 7











VAC
change 5
days
after
IFSG
applied









Post-IFSG
application
day 10.
Bed ready
for
autologous
cell
harvesting





















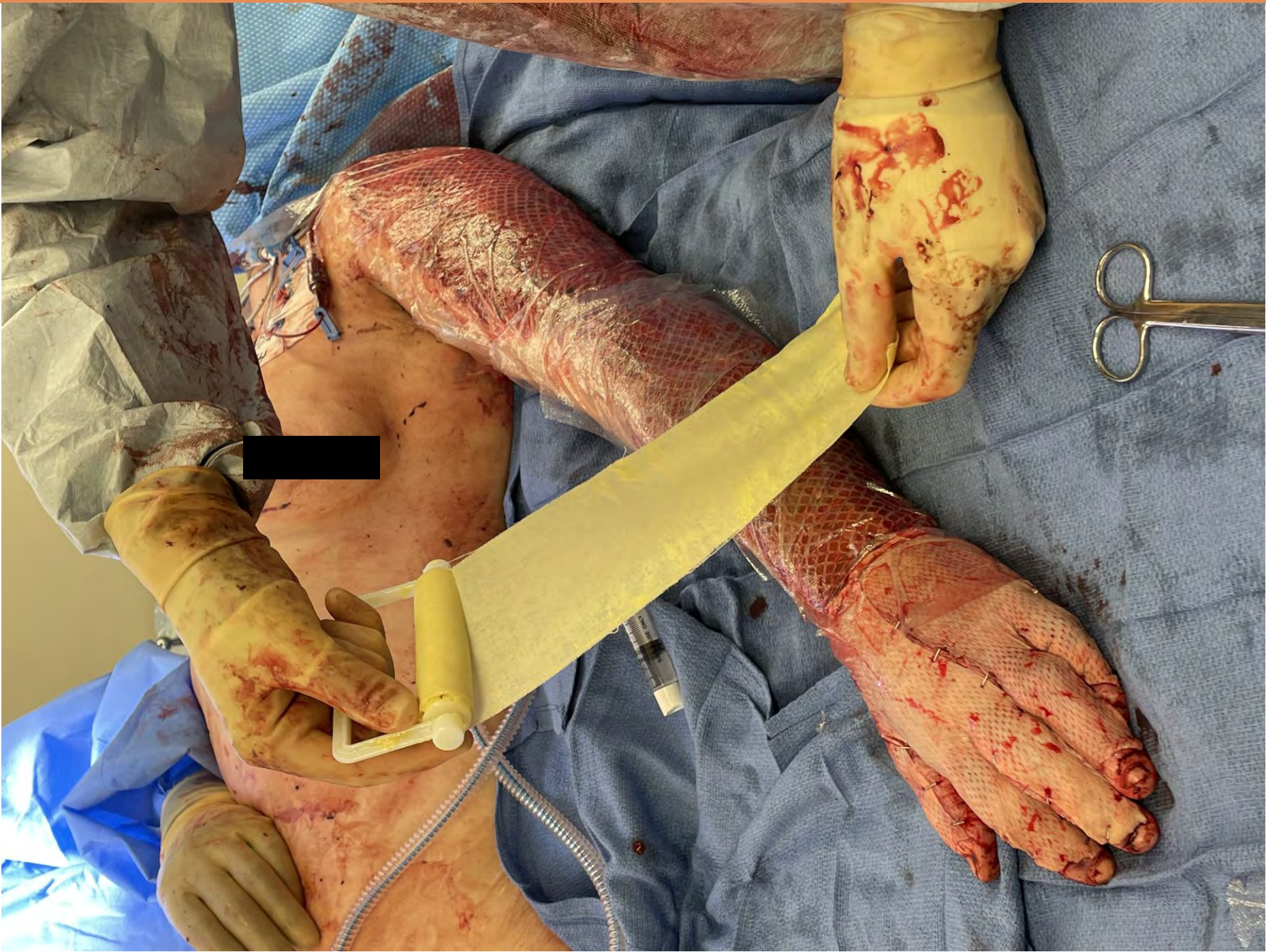


















7 days after
autologous
cell harvest
applied to
IFSG base
(VAC
removed)







10 days
after
autologous
cell
harvest
applied to
IFSG base







2 ½ weeks
after
autologous
cell harvest
applied and
STSG











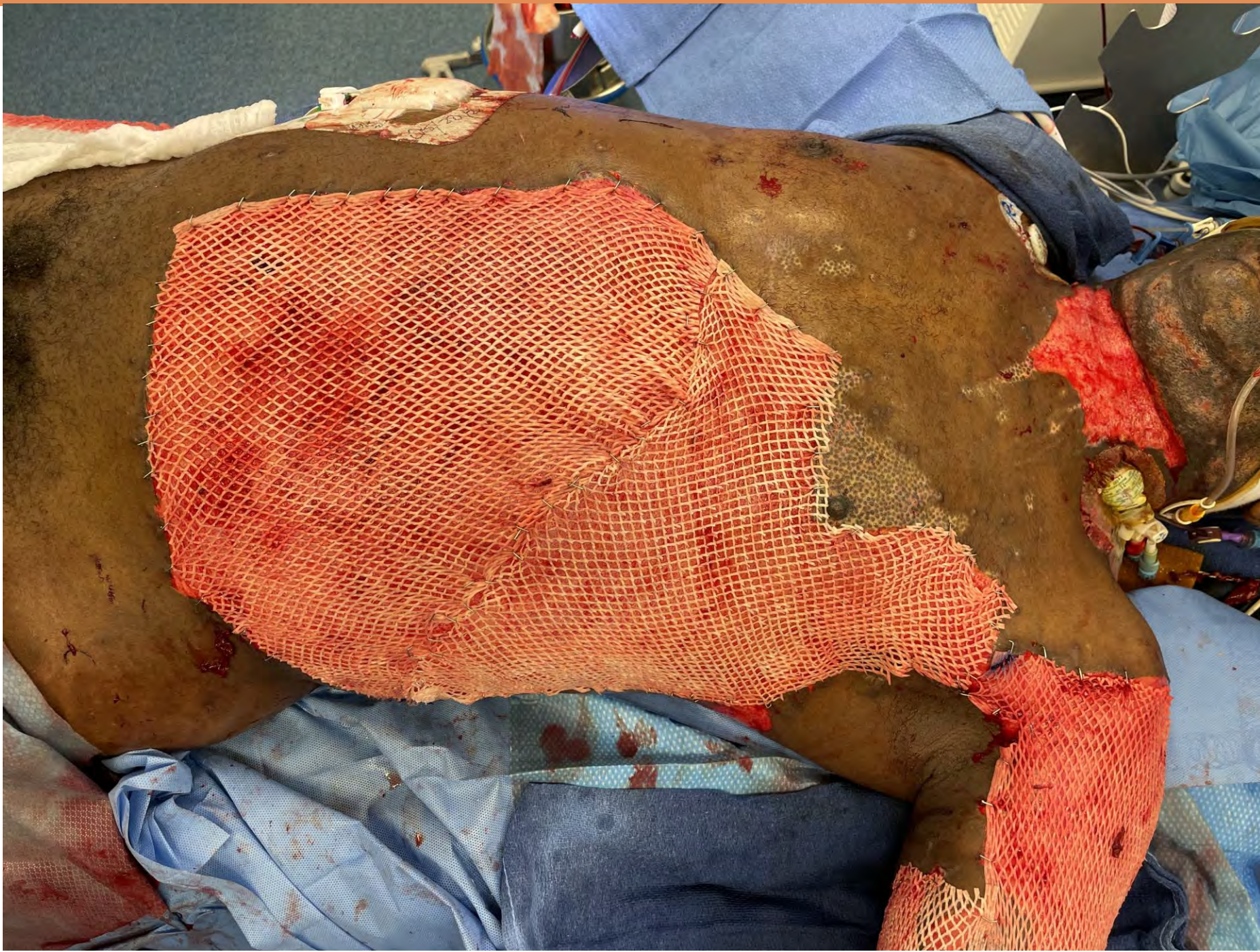
Patient 2

- 38-year-old male
- Burned with hydrogen peroxide







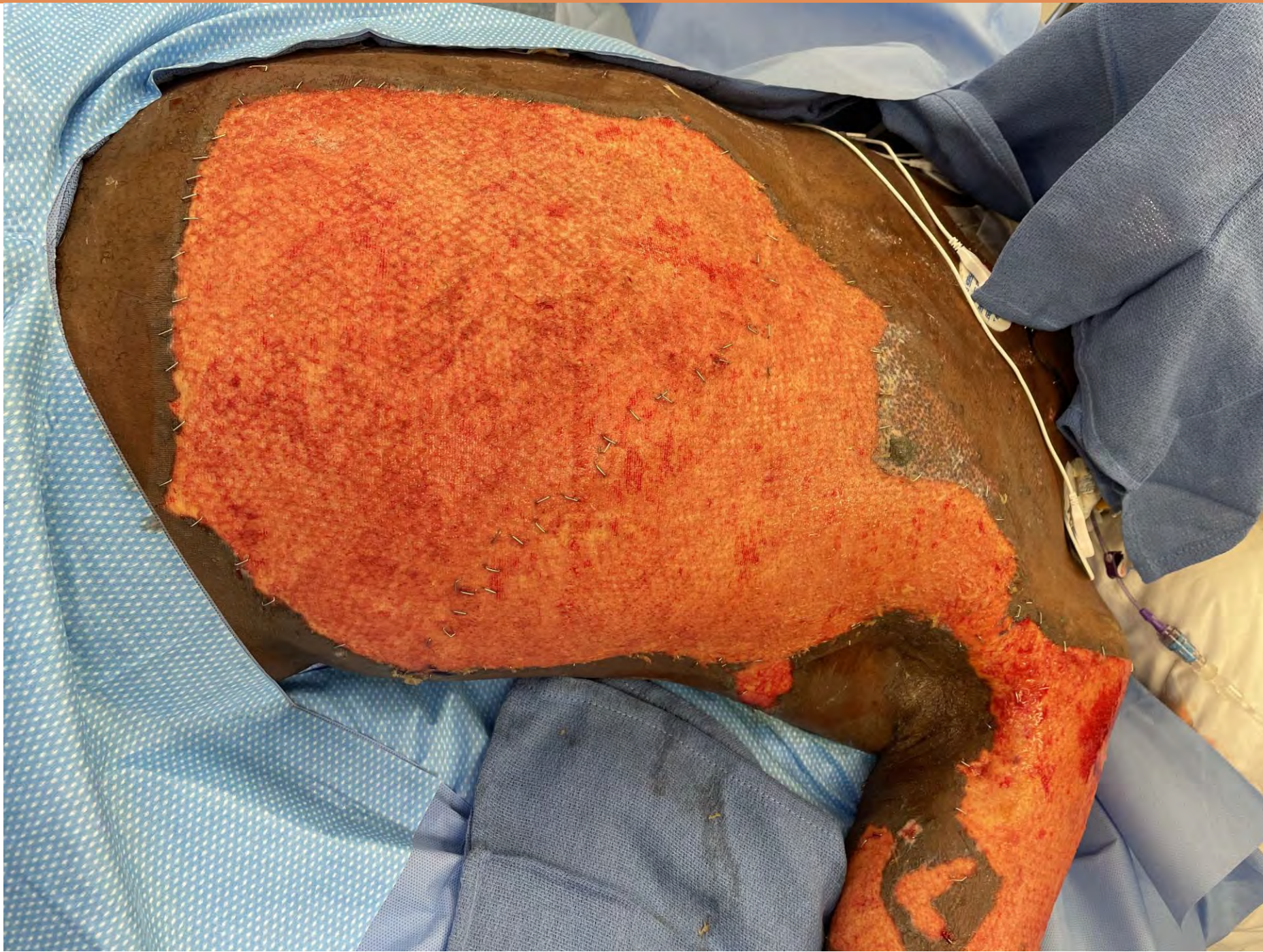


IFSG
applied





POD5







POD10



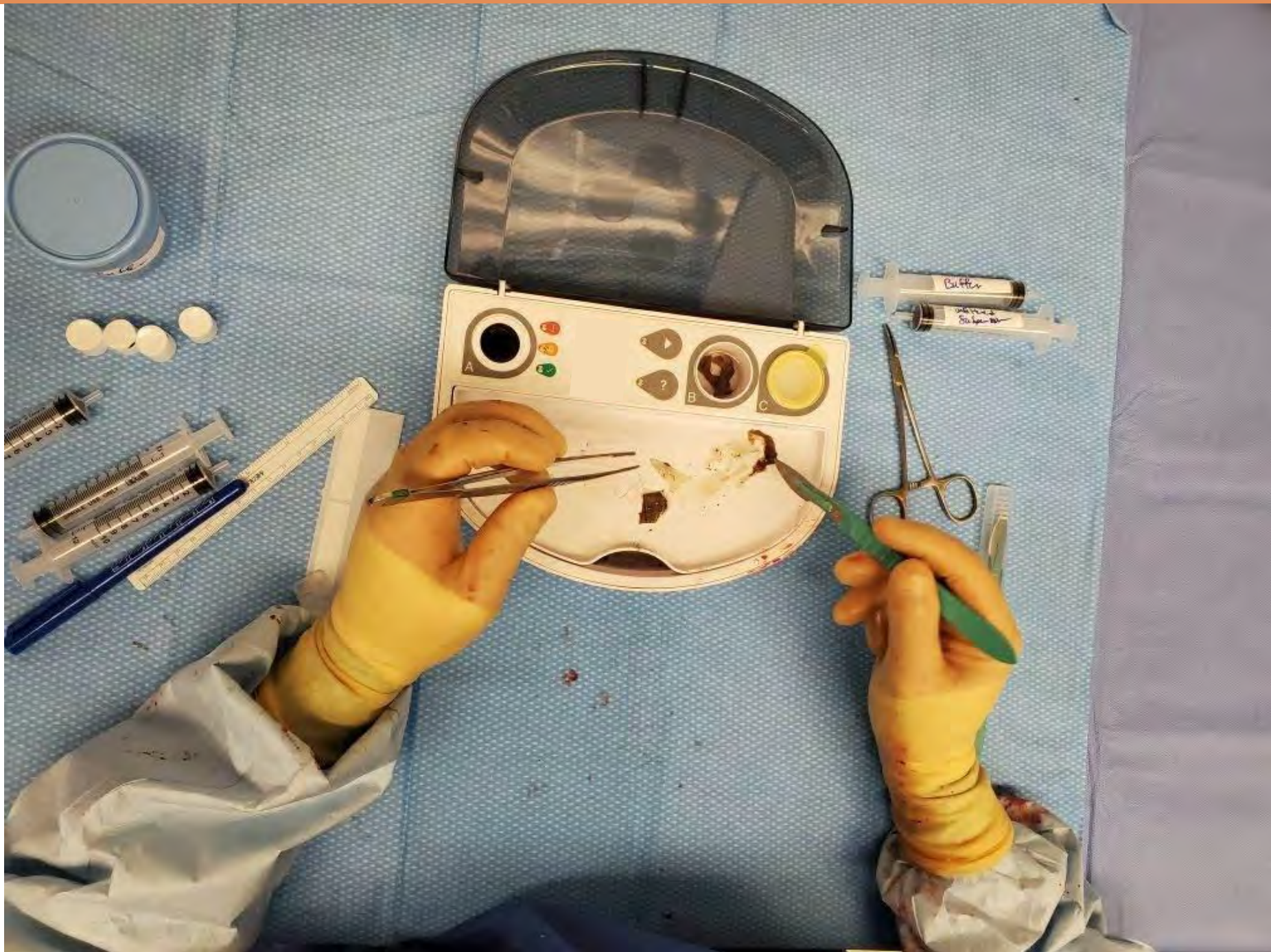




STSG
applied







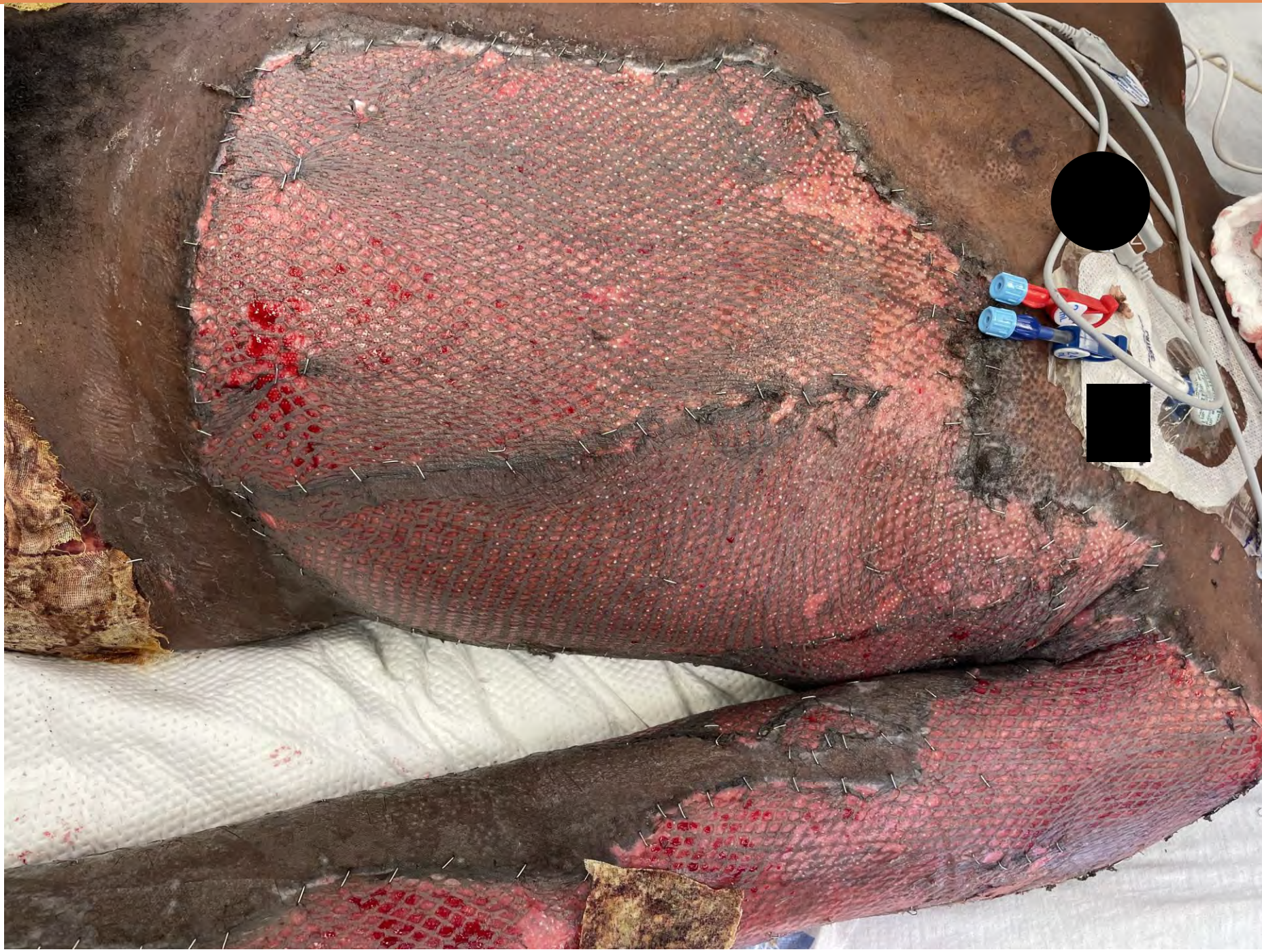
Autologous
cell
harvesting
performed



Autologous
cell harvest
applied to
STSG



Post-skin
graft day 5







Post-skin
graft day 6



Post-skin
graft day 7



Patient 3

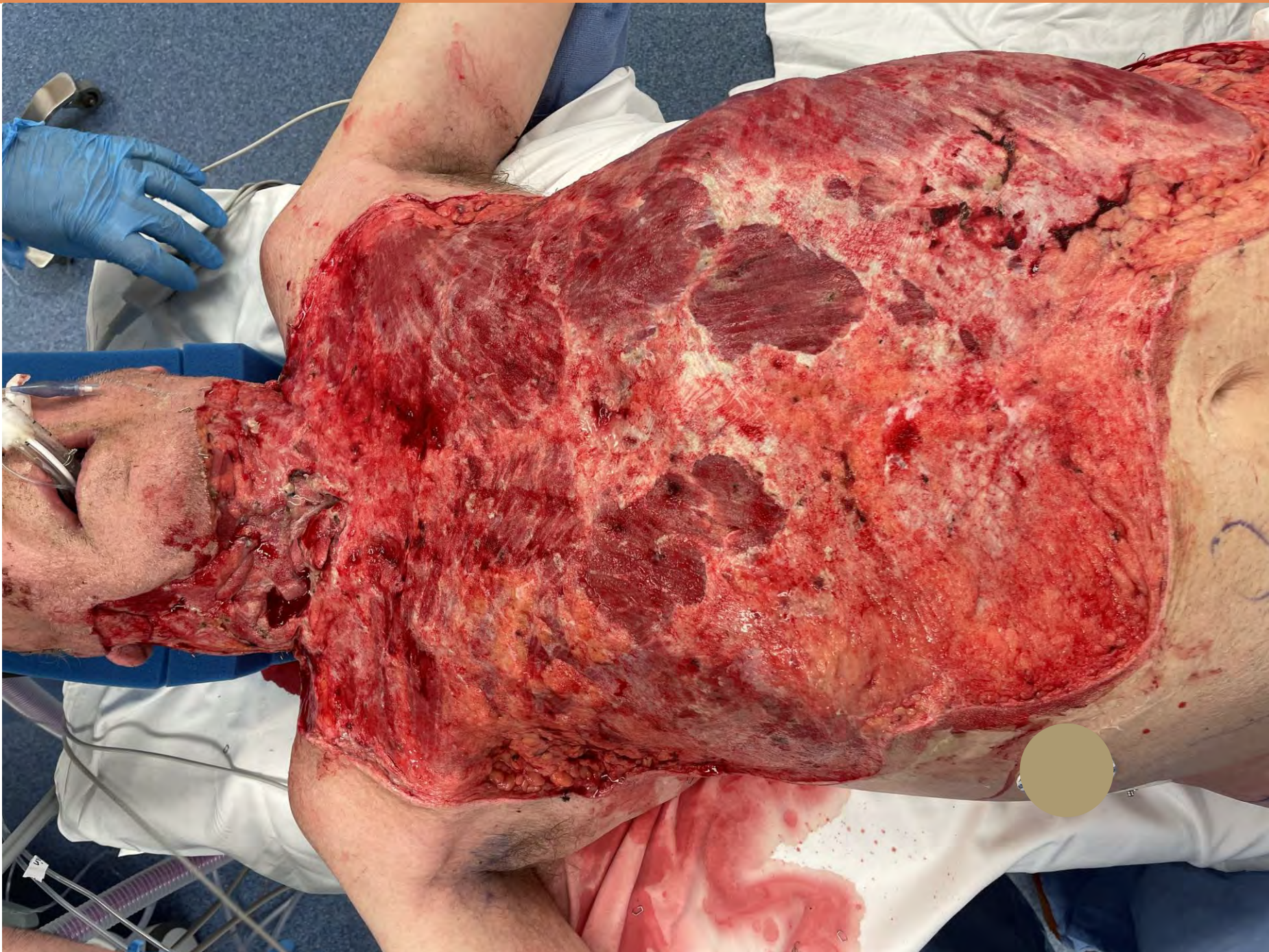
- 71-year-old male
- Necrotizing fasciitis from tooth abscess





On table
after
excision,
VAC
applied



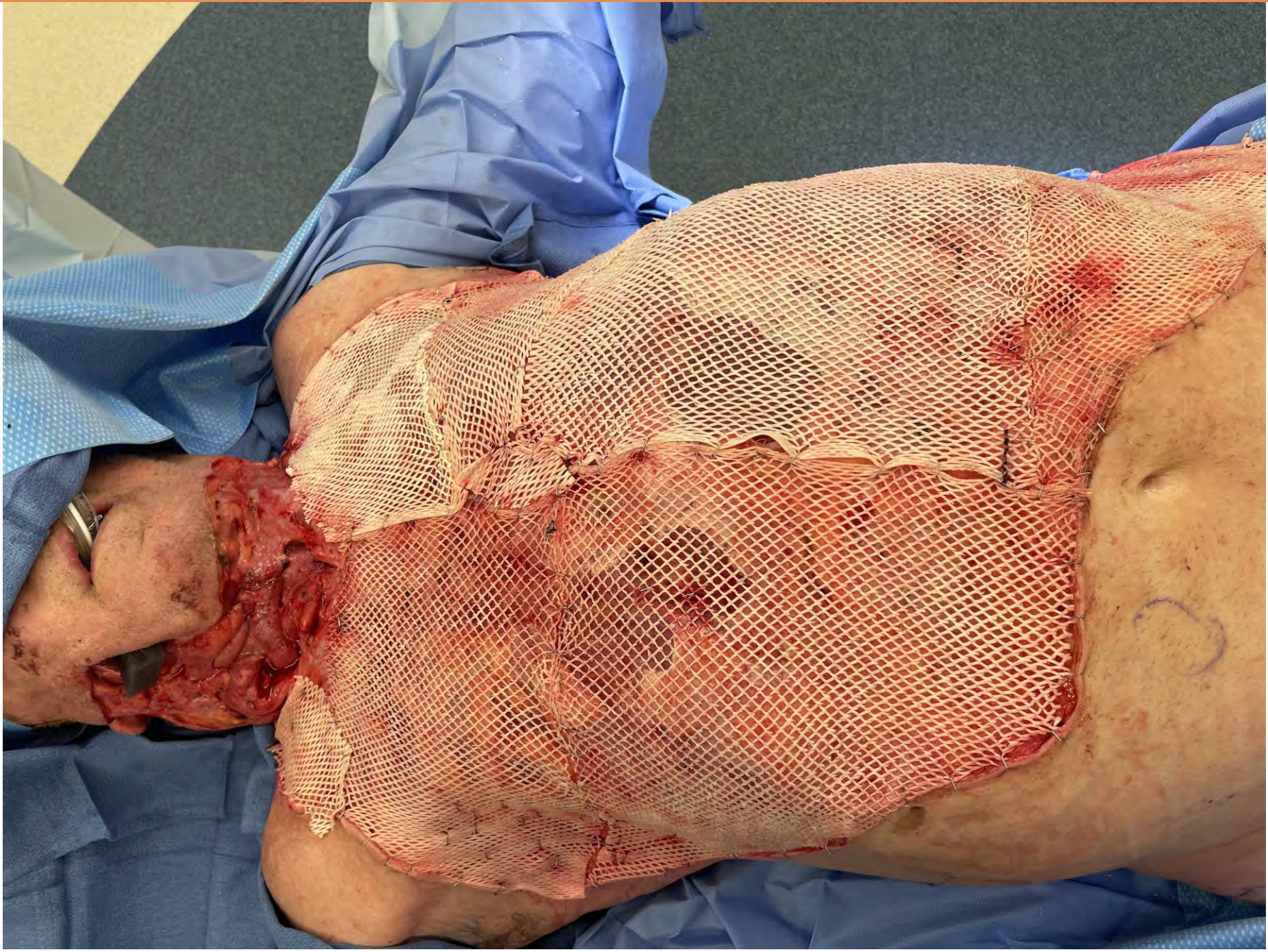


POD2 after
VAC
removed,
reapplied



POD4 after
initial
excision

IFSG
applied





POD5
after IFSG
applied





POD10
after IFSG
applied



POD15

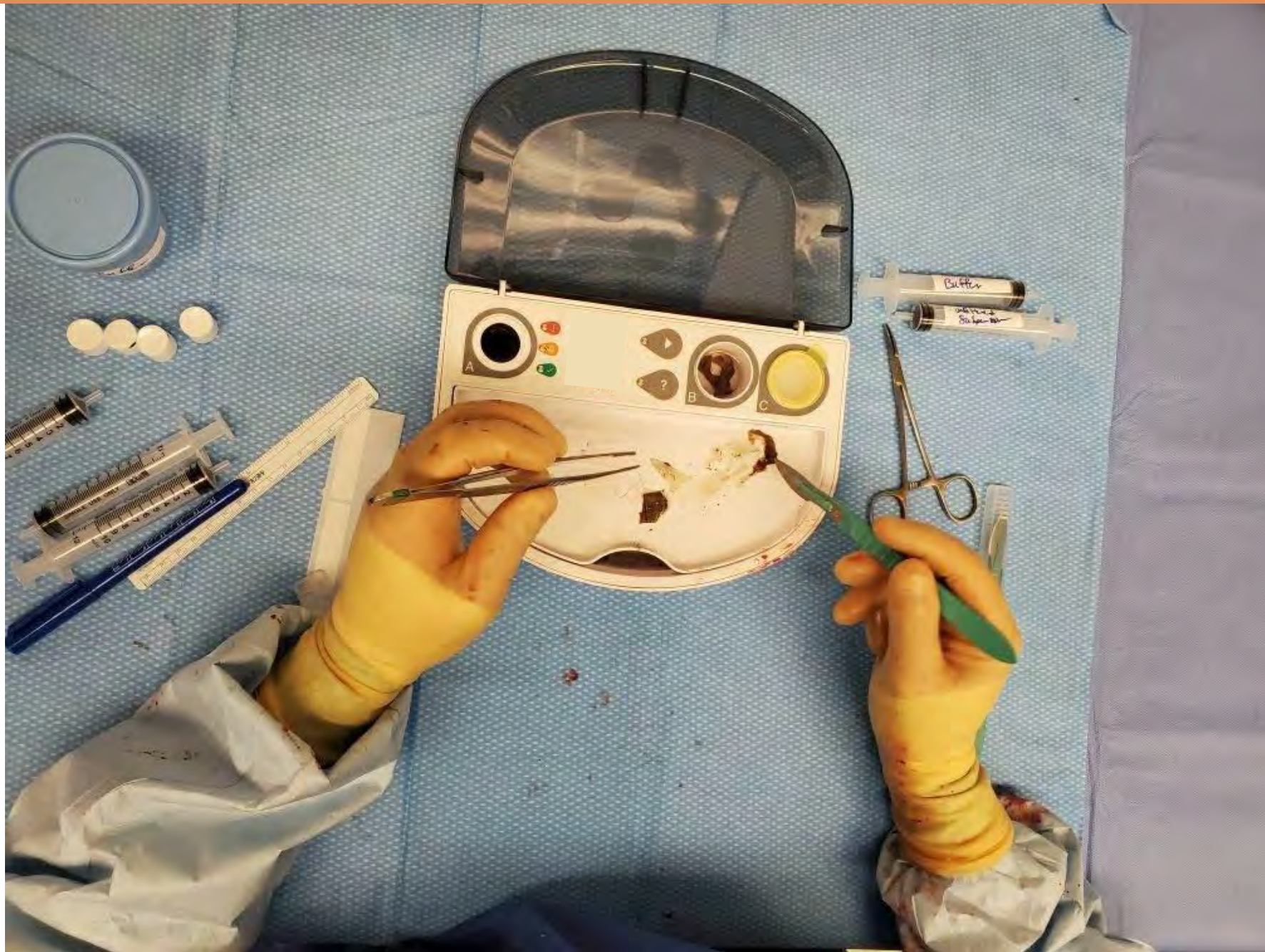


POD20,
STSG
applied
with
autologous
cell
harvest









Autologous
cell
harvesting
performed





POD25/5
from
takedown
of STSG





Optimizing Burn Outcomes Using Skin Substitutes

Ram Velamuri, MD, FACS, MS, DNB

Ideal Skin Substitute

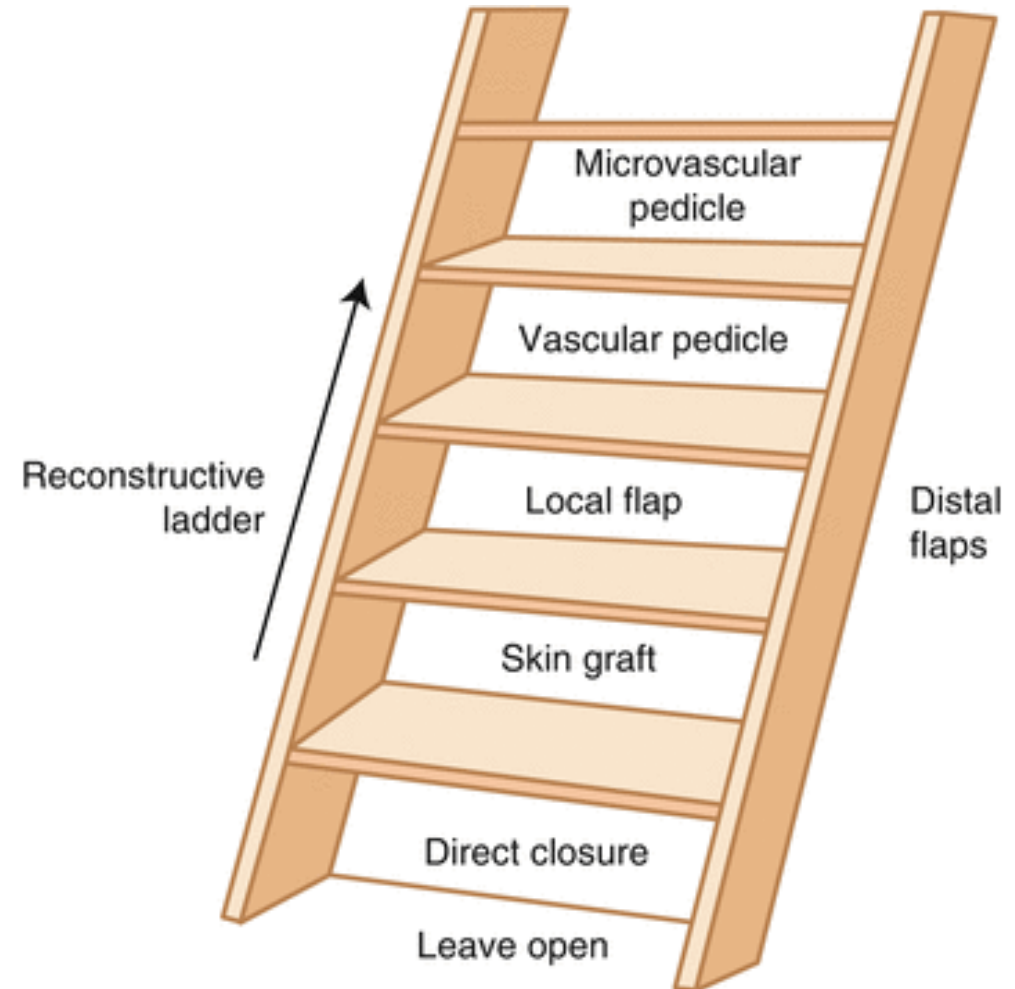
- Safety – safe/non-toxic/sterile
- Adherence
- Moisture control (porosity is recommended without compromising moisture)
- Infection
- Physical adaptability (stretch/flexible)
- Pain management
- Transparency
- Stability (long shelf life at room temperature is desirable)
- Cost-effective
- Ease of application

Skin Substitutes Commonly Used

- Biobrane™
- Integra
- PriMatrix®
- AlloDerm
- MatriDerm®
- PermeaDerm®
- Kerecis
- NovoSorb® BTM
- Apligraf®
- Dermagraft®
- SUPRATHEL®
- Cohealyx®



Reconstructive Ladder



Focus on the Wound

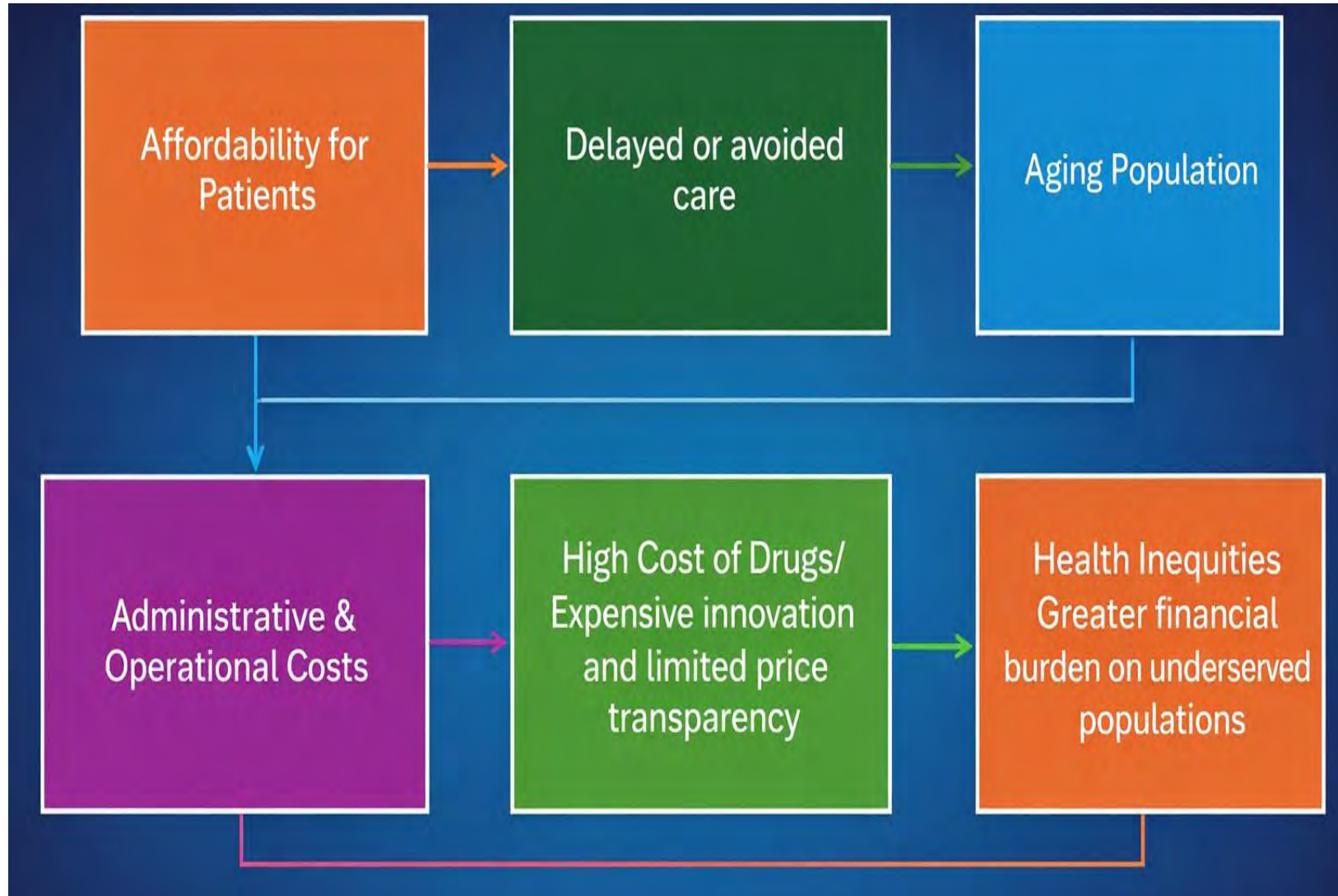
Complex wound → Debridement → Optimization of comorbid factors

Surgical reconstruction (flaps vs grafts)

Full-thickness wounds? No local or free flap options? Not ready for immediate grafts?

??? How to build tissue faster? LOS?

Things to Consider – Healthcare Costs



Why Shorter Hospital Stays Matter for Burn Patients



Lower risk of complications: Reduced hospital-acquired infections (eg, sepsis, pneumonia)



Improved physical recovery: Earlier mobilization and faster return to daily activities



Better psychological outcomes: Less stress, anxiety, and sleep disruption



Enhanced patient satisfaction



More efficient use of burn unit resources: Beds available for new or more severe cases

Skin Substitutes: Limitations and Complications

- Incomplete integration or failure of skin substitute adherence
- Infection beneath or around the grafted area can impair healing
- Limited vascularization may reduce graft survival
- High cost and variable availability of advanced skin substitutes
- Risk of delayed wound closure, scarring, and repeated procedures
- Patient factors (diabetes, ischemia, malnutrition, smoking) increase failure risk

Management Strategies for Graft Failure and Infection

- Careful wound bed preparation and debridement before application
- Optimize patient factors and control underlying comorbidities
- Use aseptic technique and appropriate antimicrobial measures
- Monitor closely for signs of infection, necrosis, or poor integration
- Early culture-guided antibiotic therapy when infection is suspected
- Reapplication of skin substitute, adjunctive therapies, or surgical revision when required

Acellular Fish Skin Graft

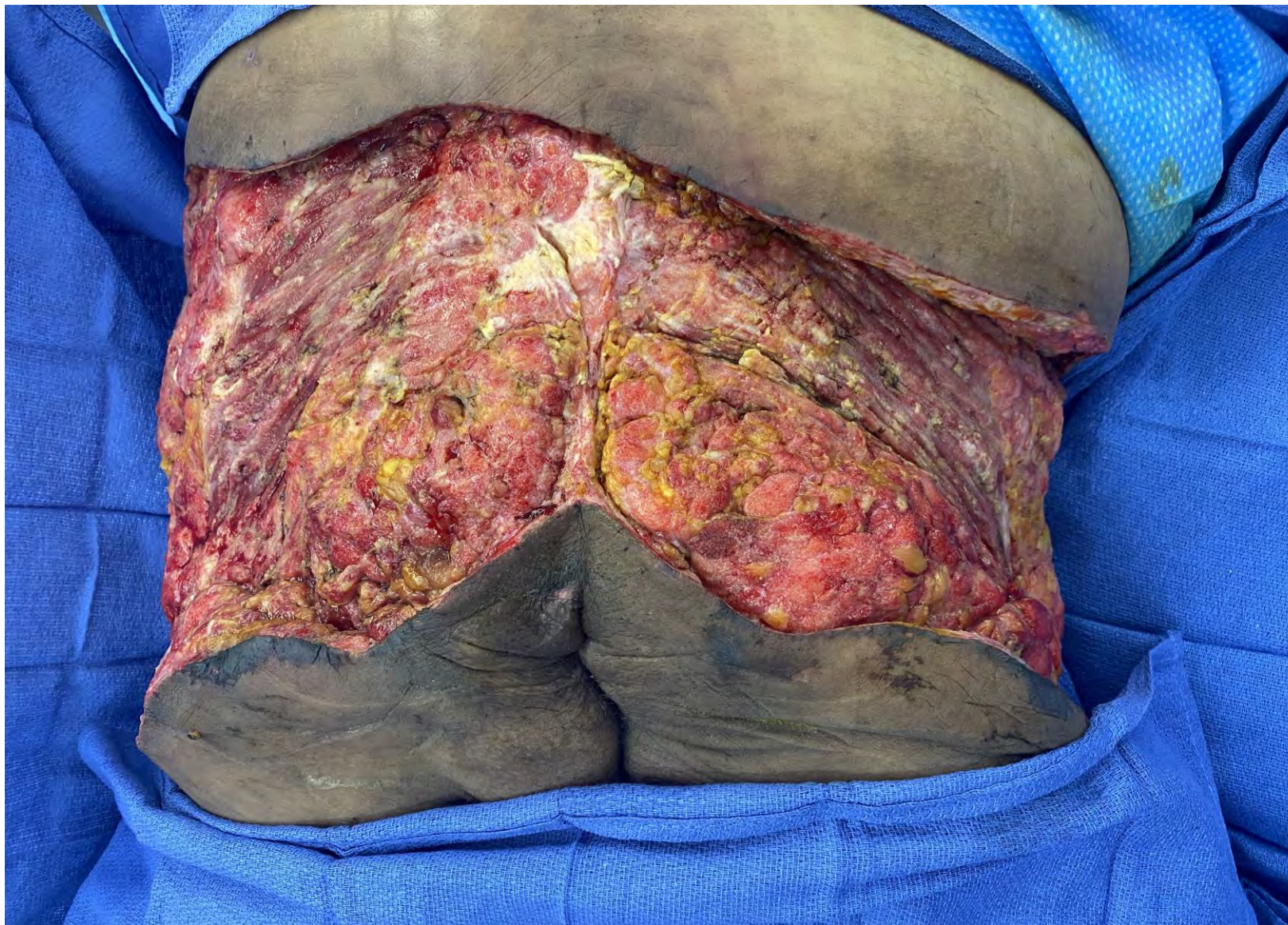
Case #1: 54-Year-Old Transgender Female s/p Silicone Injections to Lower Back/Buttocks and BLE



s/p = status-post; BLE = bilateral lower extremities.









2 Weeks Post-Application



1 Week Post-STSG



STSG = split-thickness skin graft.

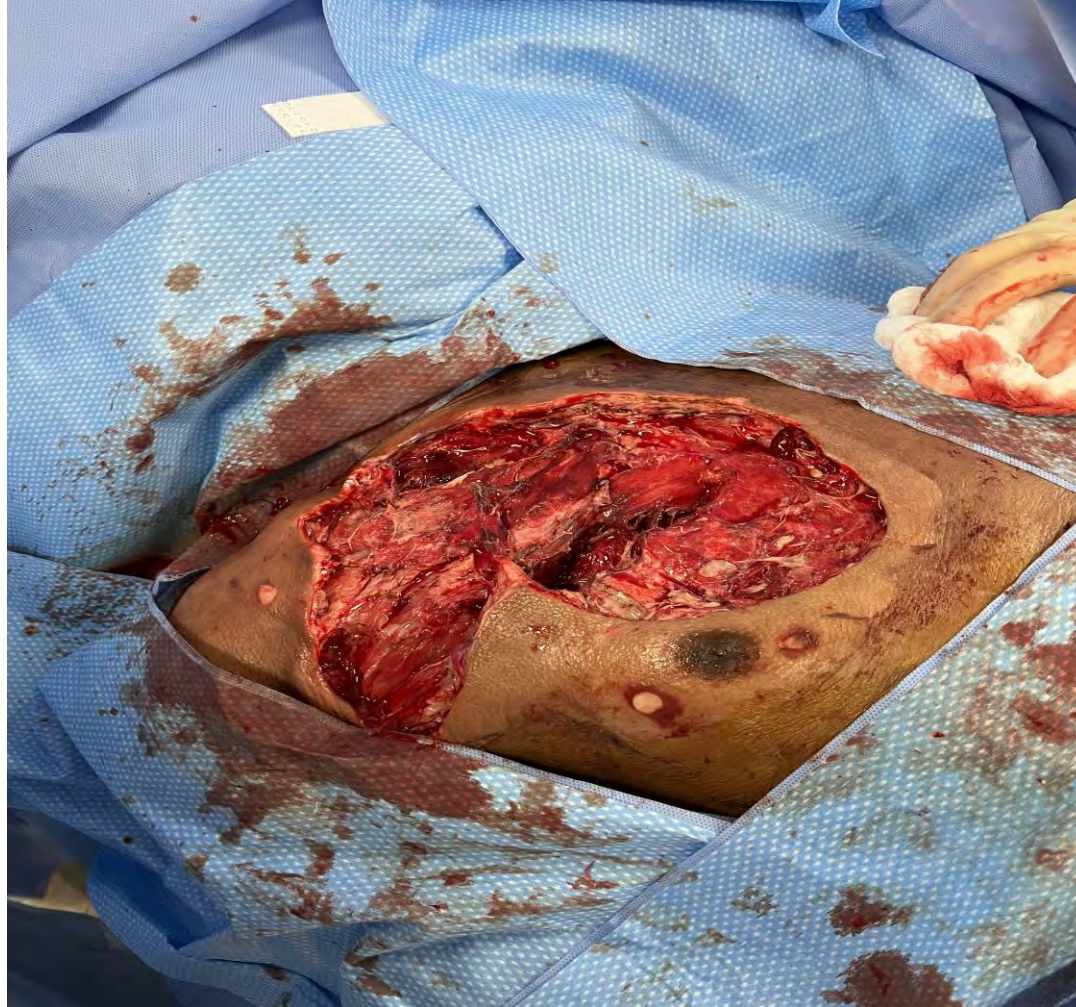
12 Weeks Post-STSG



Case #1 Summary

- Two surgical visits to OR
- One vac change in OR at week 1
- LOS: 3 weeks (uninsured)
- FSG to skin graft: 14 days

Case #2: 50-Year-Old with Uncontrolled DM/Psych – Necrotizing Soft Tissue Infection



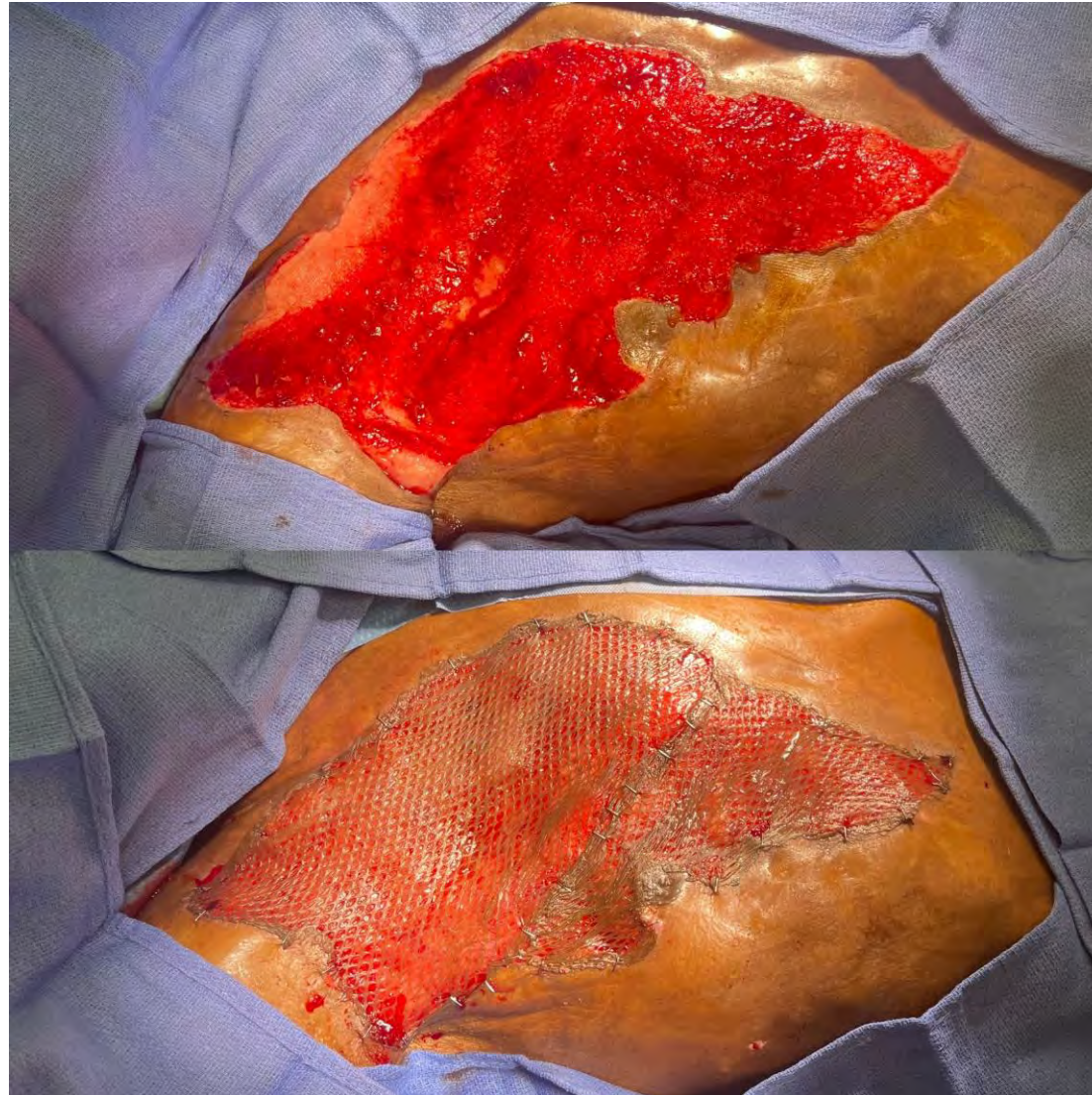
DM = diabetes mellitus.







Post-Application: Day 10 with STSG



4 Weeks Post-Op



Case #2 Summary

- 4 surgical visits to OR
- 3 vac change in OR
- LOS: 3.5 weeks
- FSG to skin graft: 10 days

Case #3: Palmar Friction Burn



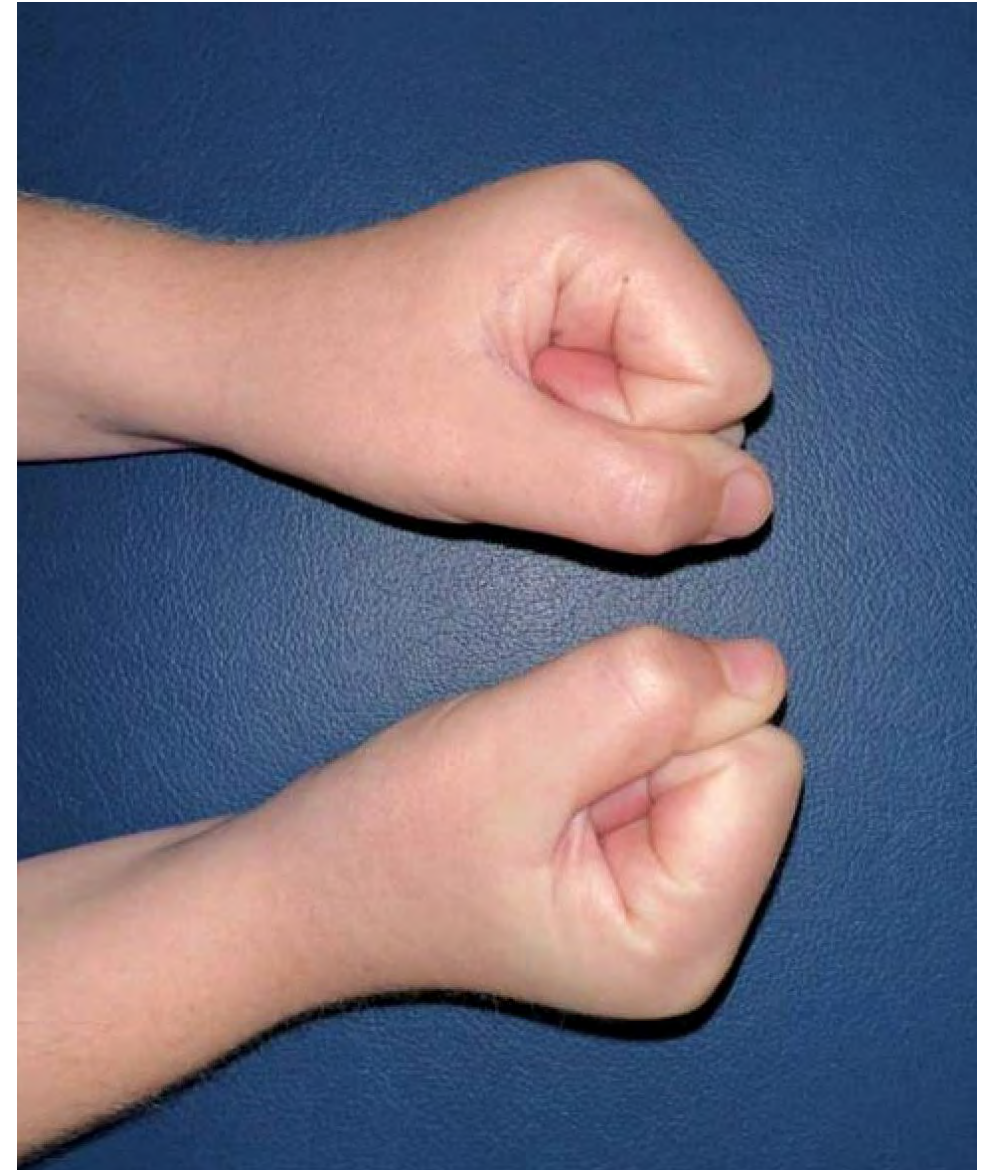
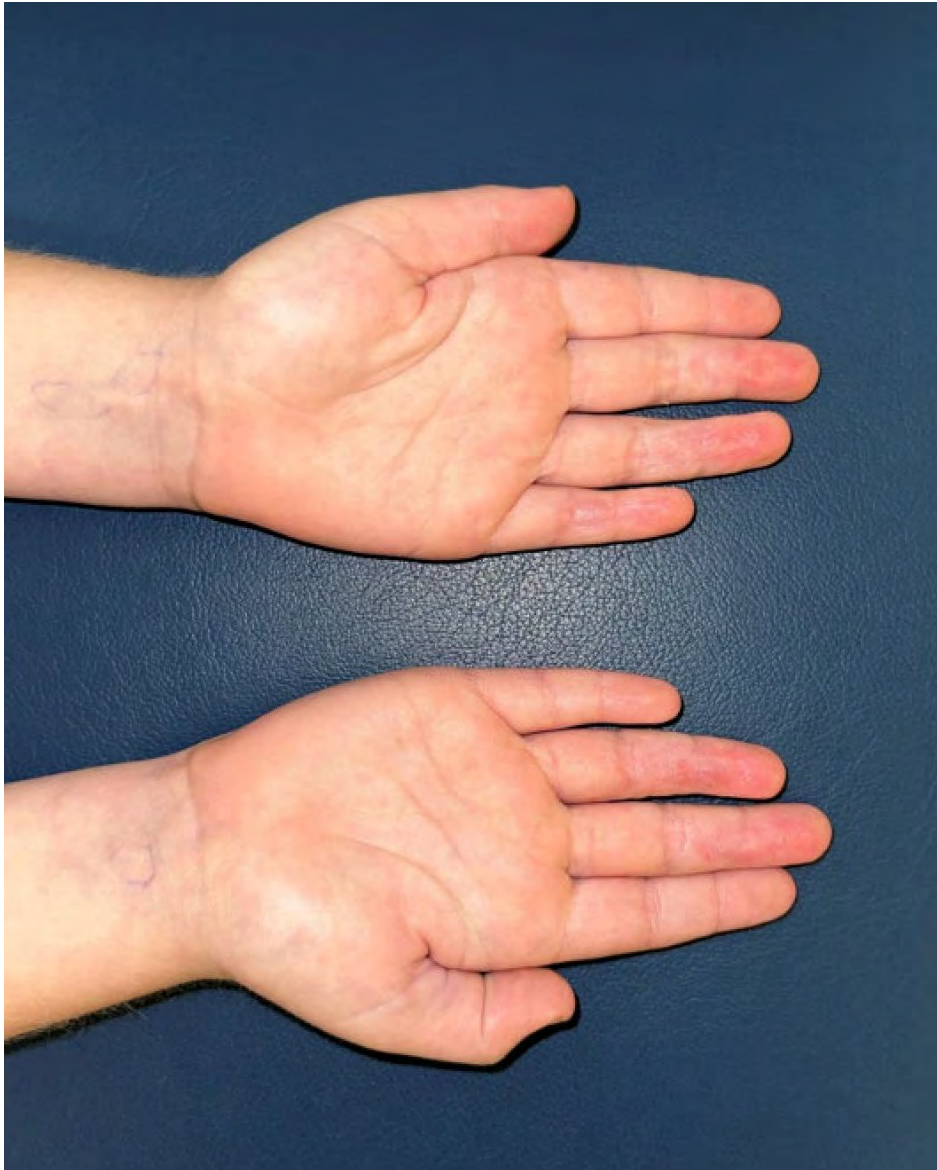
1 Week Post-Initial Application



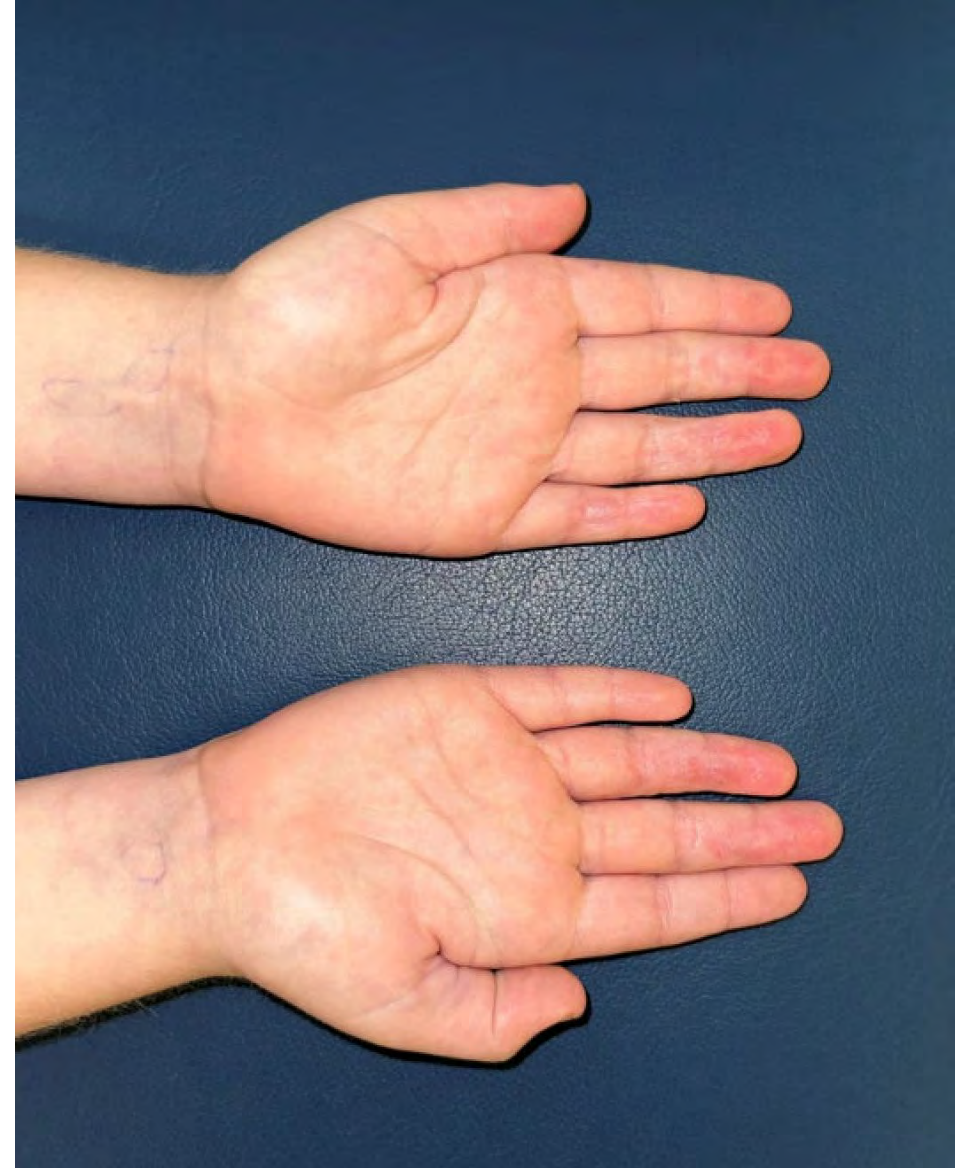
2 Weeks Post-Application



3 Weeks Post-Application



Before and After



Case #3 Summary

- 1 surgical visit to OR
- FSG to healed: 21 days
- LOS: 1 day
- No donor site

Case #4: 40-Year-Old with Right Elbow Contracture











10 Days Post-FSG



6 Week Follow-Up



6 Week Follow-Up



Before and After



Synthetic Polyurethane Foam

Case #1: 50-Year-Old, Deep Third-Degree Buttock Burns, Multiple Myeloma, DVT, PE, Chemo



DVT = deep vein thrombosis; PE = pulmonary embolism.

One Week s/p Excision and Allograft

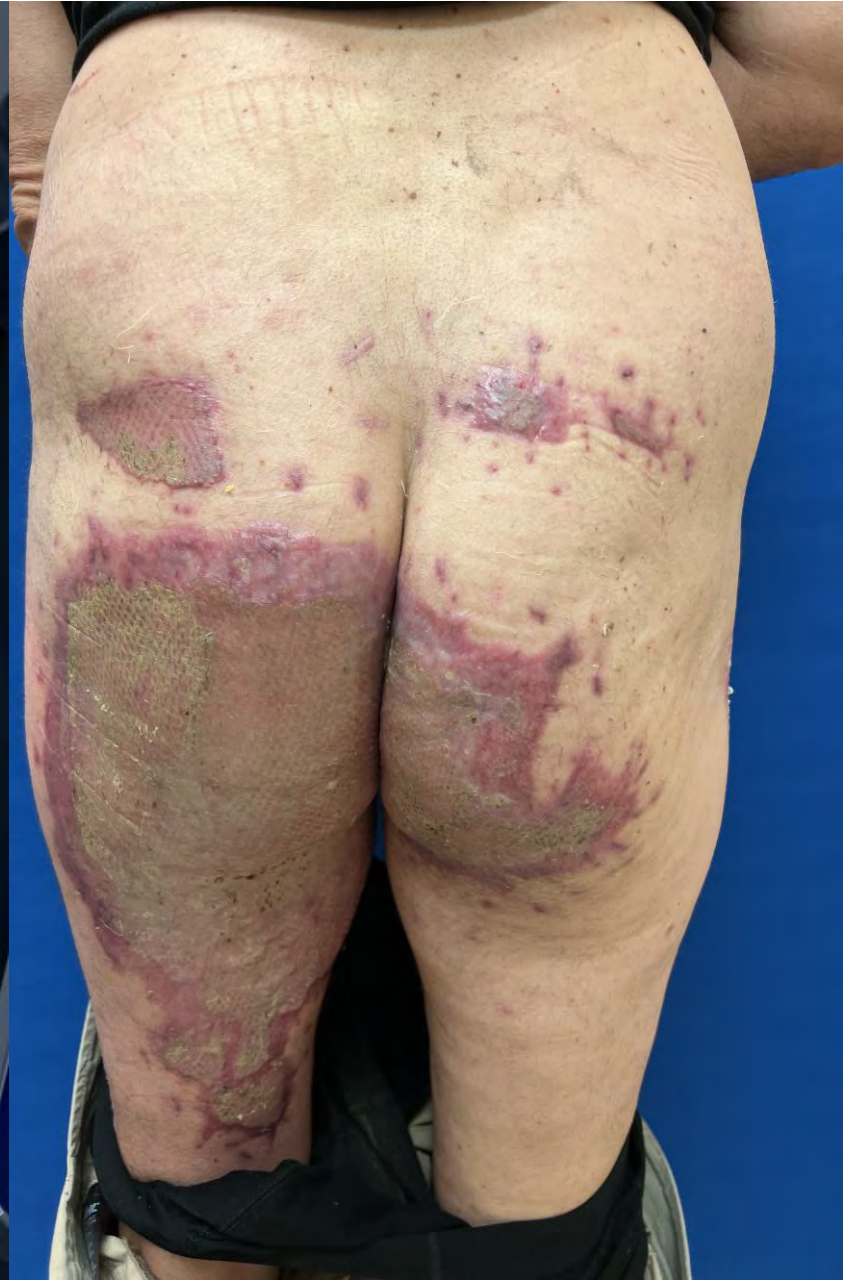


Intra-Op



4 Weeks Post-Application: Bleeding? Game Over?





Synthetic Polylactide Membrane

Case #1: Day of Injury, Pre-Application



Day of Injury, Pre-Application



Application



Follow-Up



Follow-Up



Follow-Up



Summary

- Use the treatment that is best suited to the wound, not a specific product
- Always identify and optimize comorbid factors that may impair healing
- Focus on preparing and maintaining a healthy wound bed; the wound bed is more important than the product or dressing itself
- Avoid creating donor site wounds unless necessary
- Prioritize the quality and viability of tissue over simply achieving wound closure
- Select interventions that promote durable, functional tissue healing