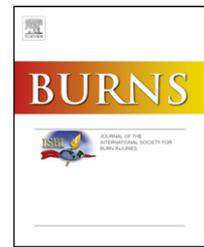


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## Letter to the Editor

### The ultra postage stamp skin graft



After devising the mesh skin graft in 1964 (Zimmer Manufacturing Co, Warsaw Indiana), we realized that the traditional meshing of autografts frequently was still insufficient for extensive burn skin defects.

Soon after, we experimented with a derivative of the mesh skin graft by remeshing a meshed skin graft as published in PRS Sept 1966 [1]. So we obtained innumerable small skin islands attached to a 3M micropore paper tape (Minnesota Mining and Manufacturing Company, St. Paul, Minnesota), all correctly oriented, regularly distributed and ready to be applied over an appropriate burn wound. The method lets you save time and labor. The expansion reaches easily 1–9. The technique has been reliable in our hands. The “learning curve” should be minimal.

We called it the “Ultra Postage Stamp Skin graft”, but regretted that the burn community has never shown any interest in this technique.

On the other hand we are happy to notice that recently several articles report on the beneficial results of another expansion technique, the “modified Meek micrograft” method as introduced by Kreis et al. in 1993 [2] in the treatment of extensive burns.

Nevertheless we have to mention that the “Ultra Postage Stamp Skin graft” technique does not require new equipment, allograft or a specific expandable gauze.

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## Letter to the Editor

### Successful tissue expansion: A question of complication management.



Dear Sir,

We would like to compliment Abellan Lopez and colleagues on their recent article “Tissue expansion of the lower limb: Retrospective study of 141 procedures in burn sequelae”. The authors lined out the difficulties associated with lower limb tissue expansion and provided profound insights in their approach to the problem while supporting their experiences with valuable data from 141 cases.

Tissue expansion in general remains to be a somewhat underestimated treatment for skin lesions, concerning the difficulty of the surgical procedure itself on the one hand, and its potentials in skin resurfacing if performed correctly on the other hand. Abellan Lopez and colleagues reported a complication rate of only 29.1% and a success rate of 81.6% in their cohort [1]. The authors attributed their results mainly to technical key points such as choice of the correct prosthesis size, location of the internal valve, positioning of the drain and delayed inflation start. We agree with the authors that a well-planned surgical approach with all due patience during the expansion process is crucial for therapy success.

In our own retrospective analysis, the complication rate was comparably higher (36.6%) while the failure rate was as low as 14.1%. However, in a logistic regression analysis we also found that factors which cannot be influenced by the physician contributed to the risk for developing complications. For instance, tissue expansion in women had a 4-fold increased risk for complications as compared to men and older patients were more likely to suffer complications. The likelihood of severe complications was furthermore increased in patients with low BMI whilst low blood pressures were associated with better outcome [2]. In contrast to the recent literature [3], in our cohort burn patients actually had a lower risk for complications [2]. Rather than dividing complications into “major” and “minor” according to Manders et al. [4], we made use of the Clavien-Dindo classification [5] to categorise complications in accordance with their therapeutic consequences. By doing that we intended to illustrate our own complications as objectively as possible. In order to compare our results to those of Lopez, we took the liberty to sort their complications also according to the classification we used (Table 1).