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When treating severe burns donor skin is of great importance. This was the motivating force to start a centralised Skin Bank by the Dutch Burns Foundation in 1976. Due to the international nature of this discipline, the name was changed in 1991 to the Euro Skin Bank. Since 2009, the Euro Skin Bank has been a division of the Euro Tissue Bank.

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-effects of an acellular dermal matrix on the wound healing process in patients with chronic wounds.

References

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A prospective, randomized, controlled, intra-individual comparative study of Glyaderm with split thickness skin graft versus split thickness skin graft alone has been conducted at the Ghent Burn Centre in 25 patients. Objective measurement with the Dermalab (objective skin elasticity measurement device) showed significant improved elasticity of the scars treated with Glyaderm and split skin at one year after healing (ref 6).

A European multicentre prospective, randomized, controlled clinical trial has started in 2010. Early results show good take of the Glyaderm (> 90%) and the autologous skin (>90%).

Glyaderm® is an acellular dermal collagen-elastin matrix obtained from human donorskin. The unique natural structure of the collagen-elastin fibres remains present in the matrix while antigenic structures are removed using a method with low concentration of NaOH (ref 1, 2). The collagen-elastin fibres provide a scaffold to host fibroblasts. Glyaderm can be used for dermal restoration in burn surgery and plastic and reconstructive surgery (ref 3). Application of Glyaderm as a dermal replacement layer underneath a split thickness skin graft will lead to enhanced functional and aesthetic outcome with improved scar quality.

Easy handling and storage as Glyaderm is preserved in 85% glycerol which inactivates micro-organisms and viruses (scientifically proven). Glyaderm is produced and distributed by Euro Skin Bank, a non-profit tissue bank; therefore cost effectiveness is greatly improved.

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Clinical results

An initial pilot study of 20 patients treated in the Burn Centre in Ghent showed promising clinical results with take rates above 90% and improved scarring (ref 4, 5, 6) as shown for the patient below:

1. Full thickness burn in the neck
2. Wound after removal of burned tissue and wound bed preparation with donor skin
3. Glyaderm applied to the wound
4. Progressive ingrowth of blood vessels as measured by Laser Doppler Imaging
5. Transplantation of a thin autologous, perforated split thickness skin graft
6. Full Take of the split skin after 1 week
7. Good cosmetic results after six years
8. Pliable, soft scar after six years.

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Indications

Glyaderm is intended for use in the reconstruction of the dermis in full thickness skin defects in combination with autologous split-skin grafts to achieve a bi-layered skin restoration. Glyaderm is especially suitable for treatment of deep dermal and full thickness burns and scar reconstructions.

Other indications in plastic and reconstructive surgery include: reconstruction after oncological resection, giant melanocytic nevi, reconstruction after necrotising fasciitis and reconstruction after free flap harvest and trauma.

Key surgical points

Adequate wound bed preparation is necessary with surgical debridement of all non-viable tissue followed by the use of donor allograft or topical negative pressure wound therapy. A healthy granulating wound bed ensures integration of the glyaderm dermal matrix.

Glyaderm should be rinsed and immersed in sterile water for at least 10 minutes to wash out residual glycerol immediately prior to application.

Glyaderm can be meshed 1:1 (without enlargement) for wound drainage.

Fixation of Glyaderm to the wound bed can be done using sutures, surgical staples or fibrin glue.

Iodine antiseptic gel can be used in conjunction with a non-adherent dressing (algin or nitro) and daily gauze to ensure moist wound healing and protect the glyaderm against micro-organisms.

The dense and durable collagen-elastin matrix of Glyaderm is well integrated after 5 to 7 days.

The Glyaderm should be prepared by careful removal of eventual non-viable parts and gentle scrubbing, before coverage with a thin split thickness skin graft to ensure a stable bi-layered skin restoration.

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