Elastic suture: An alternative for extensive skin loss

Sutura elástica – uma alternativa para grandes perdas cutâneas.

INTRODUCTION

The treatment of complex wounds in soft tissues remains a major challenge for plastic surgeons. In this context, skin detachments, slow expansion, and presuture and elastic suture methods use the basic principles of skin biomechanics to correct various skin defects that are the result of various causes such as car accidents, tissue necrosis, resection of skin lesions, and scar formation, which would otherwise require grafts, flaps, or spreaders.

The elastic suture technique, as an alternative treatment of acute skin loss is a low-cost and easy procedure that provides satisfactory results in the most complicated cases of tissue loss.

Selecting the best technique is essential for the success of the reconstruction, and the fundamentals of reconstructive surgery were created under the assumption that the simplest repair is always the best. Therefore, primary wound closure is the first choice of treatment whenever possible. Elastic suture was introduced as an alternative therapeutic tool...
to grafts, flaps, and spreaders.

The anatomical and histological structures of the skin have viscoelastic properties that allow for gradual extension when subjected to continuous traction. This phenomenon is called the “creep phenomenon.”

In the technique proposed by Raskin in 1993 that aimed to perform fasciotomy without tissue loss, an interwoven elastic band is directly fixed to the skin of the wound edges to produce tension, which applies the concept of skin elasticity.

In 1996, Leite observed the incidence of skin necrosis in wound edges when the Raskin technique was used and proposed the fixation of the elastic band subcutaneously and to the superficial fascia to avoid tensile force-induced skin ischemia.

Therefore, the technique established in this study uses the total coverage of wound edges with a polypropylene mesh fixed to the skin and to the superficial fascia with several mononylon 2.0 anchoring stitches. This new technique maintains the basic principles of elastic suture associated with the distribution of the traction forces of the skin on the polypropylene mesh to avoid tissue ischemia in wound edges and to further improve the final result.

**METHODS**

Over 16 years of practice (from September 1996 to November 2012), 78 procedures of complex wound closure were performed by using the described technique of elastic suture. The 78 patients had skin wounds that exhibited tissue loss and did not allow primary closure. The following body areas were treated: scalp, upper limbs, lower limbs, and trunk. The patients’ ages ranged from 6 to 52 years, and most (87%) of the patients were male.

Prior to conduction of this study, the patients were informed about the proposed treatment and the need for photographic documentation, and informed consent was obtained.

The technique was performed in two basic surgical stages, interspaced by ambulatory procedures. The first surgical stage was performed under local anesthesia and antibiotic prophylaxis (2g of cefazolin IV) after antiseptic preparation. The wound edges were undermined, and a piece of polypropylene mesh (Marlex), adapted to the thickness of the edges, was fixed to the skin with mononylon 2.0 thread by using the continuous suture technique, and then subcutaneously and to the superficial fascia by using simple interrupted mononylon 3.0 stitches. The procedure was then repeated on the other edge of the wound (Figure 1).

The next step was to fix a sterile elastic band to the mesh at the apex of the wound by using the sterile elastic of the surgical gloves and interweaving it along the wound with lateral fixation to the mesh. The elastic thread was not tied to the mononylon 2.0 thread, as it should slide through the stitch. The elastic band was pulled and attached to the other edge after each lateral fixation, and the procedure was repeated with the other side of the elastic band, which resulted in the interweaving (Figure 2).

**RESULTS**

Over 16 years of experience with using the described technique, all the 78 cases with indication for elastic suture resulted in the expected approximation of the wound edges, thus allowing primary closure.

The duration of the treatment varies according to the distance between the edges and the technical rigor of both the main suture procedure and the tensile strength of the elastic band, every 3 days. On average, 14 days are required for wound closure.

The most common complication was scar widening; however, it did not cause pain to the patients. No wound infections were observed during the treatments, and an antibiotic prophylaxis was performed by using first-generation cephalosporins only in the primary surgical procedure. Moreover, the various body areas exhibited distinct speeds of wound edge approximation.
CLINICAL CASES

Case 1

Obs: First case of elastic suture in which the Raskin technique was used; the main complication of this technique (ischemic necrosis of the wound edges) can be observed.

A 26-year-old patient had an infected hematoma in the left forearm that progressed to compartment syndrome. Drainage and local fasciotomy were performed; and at a later stage, a large open wound area was formed in the inside of the forearm that did not allow primary closure. The therapeutic option was to perform elastic suture followed by primary closure, and functional and aesthetic recovery of the limb (Figures 3–5).

Case 2

A 46-year-old patient had undergone a left mastectomy (Halsted technique) and breast reconstruction with a rectus abdominis myocutaneous flap. The patient developed necrosis in the anterior wall of the abdomen (Figure 6), which resulted in a large open wound area of 10–20 cm after local undermining (Figure 7). The wound was subjected to elastic suture by using the proposed technique (Figure 1). Because of the thickness of the abdominal wall, two elastics were fixed to the mesh, one posteriorly (Figure 2) and the other anteriorly (Figure 8). Figure 6 shows the results obtained 12 days after the elastic suture, when the elastic bands and mesh are removed, and the primary and definitive suture is performed. Figure 7 shows the final result after primary closure.

Case 3

A 32-year-old patient who was in a car accident and lost part of the scalp in the frontoparietal region was treated with elastic suture by using the described technique (Figures 9–11).

Figure 3. Tissue loss in the forearm

Figure 4. Elastic suture in the forearm

Figure 5. Final result of the primary closure of elastic suture

Figure 6. Appearance of the abdominal necrotic wound.

Figure 7. Undermined necrotic tissue with lateral fixation of the polypropylene mesh.

Figure 8. A new layer of intertwined elastic bands over the first layer because of the thickness of the wound edges.

Figure 9. Scalp wound with tissue loss.
Case 4
A 58-year-old patient who had been run over 40 days previously presented a compound fracture in the distal third of the tibia, which resulted in an area of bone exposure of 9.3 cm (Figure 12). Elastic suture using the described technique (Figures 13 and 14) was indicated. The size of the wound was initially 3.0 cm in its most wide portion and was reduced to 0.3 cm 7 days after elastic suture (Figure 15). On this occasion, the elastic suture and the mesh were removed, and the wound was closed with mononylon 2.0 interrupted stitches (Figure 16).

Therefore, in this series of 78 patients and 16 years of experience, the results obtained by using the elastic suture technique were satisfactory and effective in the treatment of extensive skin wounds that would otherwise require reconstruction with grafts or flaps, which sometimes result in aesthetic and functional problems. The scars were usually wide; however, this aesthetic problem was expected. Furthermore, the functional and aesthetic results on the scalp were good, and the elongation did not cause permanent alopecia.

DISCUSSION

The use of the biomechanical principle of tissue tension, that is, the increase in metabolic activity that induces vessel growth and collagen fiber proliferation, allows the skin to extend beyond the normal limits of expansibility.

The good results obtained in this study show that extensive skin defects can be corrected without major detach-
ments. The comparison of the initial cases in which the Raskin technique was used and those in which the proposed technique was used showed that the inclusion of the polypropylene mesh allowed a better distribution of the forces on the wound edges, thus avoiding tissue necrosis and providing satisfactory aesthetic and functional results.

CONCLUSION

The elastic suture technique proved to be highly effective, better than grafts and flaps, in the treatment of extensive skin defects because it is easy to execute, does not result in new scars, and only requires local anesthesia in the first and last surgical stages. It can be used on ulcer sites that are difficult to treat, such as the distal third of the leg (as in case 4).

REFERENCES

1. Mathes SJ, Nahai F. Reconstructive Surgery. Principles, Anatomy Technique. Churchill Livingstone and Qualit Medical Publishing Inc., 1997.
2. Briggs SE, Banis JR, Kaebnick H. Distal Revascularization and Microvascular Free Tissue Tranfer. J. Vasc Surg. 1985; 2:806–11.
3. Raskin, KB. Acute vascular injuries of de upper extremity. In Shaw Wilgis, EF. (ed): Vascular disorders. Hand clin. 1993;9:115–130.
4. Reis, FB. Tratamento de ferimentos deixados abertos com o método da sutura elástica. Rev Bras Ortop. 1996;31(8)):687–9.
5. Vidal, MA, Sutura elástica. Atualização em cirurgia plástica SBCP. 2006;124:965–970.

Corresponding author: Manoel Alves Vidal
Avenida Orlando Zancaner, 497 – Vila Amendola – Catanduva/SP
E-mail: manoel.a.vidal@gmail.com