



Use of Hyaluronic Acid–Based Biological Bilaminar Matrix in Wound Bed Preparation: A Case Series

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Keywords: wound, healing, Hyalomatrix, hyaluronic acid, extracellular matrix

Published February 22, 2018

Objectives: To analyze the efficacy of a hyaluronic acid–based matrix in the treatment of lesions where the extracellular matrix was lost. **Methods:** Prospective, noncomparative clinical case series. **Results:** Twelve patients with 12 serious surgical wounds of different etiologies participated in this project. Many defects showed exposed muscle, tendons, and/or bone. After thorough debridement, a hyaluronic acid–based matrix, with a removable, semipermeable silicone top layer, was applied for the purpose of generating a neodermis. In a number of cases, the matrix was combined with negative pressure wound therapy. All wounds developed granulation tissue. Nine wounds were subsequently closed with a split-skin autograft. There was no graft failure. Three wounds healed by secondary intention. All wounds showed complete reepithelialization. **Discussion:** Lesions with exposed tendon and bone are difficult to heal. Providing a granulation tissue through the use of an extracellular matrix in which cellular repopulation leads to the development of granulation tissue has been shown to be beneficial with regard to the speed and quality of healing. In this case series, the use of a hyaluronic acid–based matrix was shown to provide a granulation tissue and all lesions healed completely. **Conclusion:** This case series shows a strong trend for Hyalomatrix to play an important role in supporting wound healing in complex, surgical wounds.

As a surgical rule and represented in the well-documented recommendations of staged wound healing,^{1,2} removal of devitalized tissue is an essential part of wound treatment and the initiation of wound repair,³⁻⁵ whether the necrosis is caused by thermal or mechanical injury, infection, or any other reason. Unless the lesion is small enough to allow for relatively rapid reepithelialization by secondary intention, the lesion then should be covered by an autograft such as a split-skin graft or a flap.

Deep wounds pose a problem with regard to graft take: although grafting directly on clean, healthy muscle is possible,⁵ direct coverage of tendon and bone is difficult without

the development of granulation tissue over these structures.⁶ In addition, such practice may lead, upon healing, to a depression in the skin surface, which may be cosmetically undesirable.

Replacement of lost extracellular matrix (ECM) in deep wounds has been proven to be beneficial with regard to the development of granulation tissue and the quality and speed of healing.^{7,8} Many matrices are now available, and all aim at replacing the lost ECM with a matrix that will allow and encourage the production of a “neodermis.”⁹⁻¹²

Some of these products are based on esterified hyaluronan (also known as hyaluronic acid [HA]), which is a regular and abundant compound of the ECM and plays several roles in homeostasis and healing.¹³⁻¹⁶ Hyalomatrix* (eHAM; Medline, Mundelein, Ill) is a biodegradable dermal matrix contact layer, made of Hyaff (Medline), an esterified form of HA. The dressing has a protective outer silicone layer. The matrix acts as a scaffold for the creation of a neodermis, which can be grafted upon after removal of the top layer. eHAM has been used successfully as an ECM in different types of wounds.

This retrospective case series describes the use of eHAM in subjects with full-thickness lesions of different etiology, but primarily because of serious soft-tissue infections, and presents 2 typical, complex cases.

METHODS

eHAM was used on a trial basis in our clinic from August 2015 through September 2016, and all patients treated with eHAM were enrolled in the case series. Patients with different kinds of indications were referred to our clinic. One patient suffered from a complicated free latissimus dorsi flap with skin graft after reconstruction of an excised and radiated liposarcoma of the left leg. For all other patients, wound infection with necrosis and dehiscence, either primary or after surgical intervention, was the main indication for referral (Table 1). All wounds underwent rigorous surgical debridement: this included the removal of osteomyelitic bone and necrotic soft tissue including tendons, if and when present and indicated. In 4 cases, multiple debridement sessions were necessary to remove all necrosis. When the wound was properly debrided, eHAM was applied. Once tissue growth (granulation tissue) into the matrix was obtained, the silicone top layer was removed (although in 2 patients, the top layer came off by itself) and healing progress was assessed. If there was an indication for a split-skin autograft, as judged by the clinical appearance of the wound, a graft was taken and applied to the recipient site. Depending on the location and type of lesion, negative pressure wound therapy (NPWT, VAC; KCI/Acelity, San Antonio, Tex) or suturing with 3/0 chromic catgut was used for graft fixation.

eHAM that was bolstered with NPWT was covered with Xeroform (DeRoyal, Powell, Tenn). Wounds for which NPWT was not used were covered with Aquacel Ag (Conva-Tec, Bridgewater, NJ) or Xeroform, depending on the amount of exudate. Dressings were changed twice a week after the first postoperative dressing. All patients received 1 dose of antibiotics per our operative protocol unless antibiotics were already initiated by infectious disease colleagues.

*Hyalomatrix. In the European Union, the matrix is called Hyalomatrix PA.

Twelve patients, 8 men and 4 women, participated in this study. The average age was 52.4 years (min: 26; max: 76). The diagnoses and locations of the lesions are listed in Table 1. One patient (9%) was an active smoker, 3 patients (25%) were obese, and 7 patients (58%) suffered from diabetes mellitus type I or II.** Three of these (25% of total) also suffered from peripheral neuropathy (Figure 1).

Cases 1 and 2 of Table 1 are presented in details.

Table 1. *Diagnoses**

Patient number	Etiology/primary surgical intervention	Diagnosis/indication for eHAM	
1	Abscess	Postexcisional debridement due to necrotizing infection	Neck
2	TMA	Gangrenous forefoot after TMA. Osteomyelitis, failed HBO	Right foot
3	CABG	Sternal wound dehiscence, soft-tissue necrosis left breast	Sternum; left breast
4	Nec Fasc leading to disarticulation in the hip	Extensive debridement acetabular region, anterior superior iliac crest, os pubis, ligaments	Left hip
5	Amputation toe	Extensive soft-tissue necrosis dorsum	Left foot
6	Extended period of unconsciousness while kneeling	Full-thickness necrosis	Right knee
7	Fournier gangrene	Debridement + colostomy	Perineum; scrotum
8	Repair ventral hernia	Dehiscence, postoperative infection, debridement nonhealing for 1 y	Midline abdomen
9	CABG	IV site infiltrate, soft-tissue necrosis. Debridement	Right hand
10	Nec Fasc after dog bite	Amputation of all digits at the metacarpal joint	Left hand
11	Excision liposarcoma	Reconstruction with a flap and radiation. Subsequent flap dehiscence and 30 × HBO (failed)	Left ankle
12	TMA	Stalled wound with osteomyelitis and failed HBO treatment	Left foot

*TMA indicates transmetatarsal amputation; HBO, hyperbaric oxygen therapy; CABG, coronary artery bypass grafting; and Nec Fasc, necrotizing fasciitis.

Case 1

A 68-year-old woman with a history of diabetes and status post disarticulation of the left hip due to necrotizing fasciitis was referred to long-term acute care (LTAC) hospital for wound care, nutritional support, and intravenous antimicrobial therapy. The large wound was treated with multiple bedside debridements and NPWT. The wound stalled and several

**Note that percentages may not add up to 100% due to rounding.

bony areas became exposed, most notably the acetabular region, anterior superior iliac crest, and the os pubis. No granulation occurred over these areas.

The patient was taken to the operating room (OR) and underwent debridement (Figure 2a) of her wound, including bone and ligaments. eHAM was applied (Figure 2b) in combination with NPWT. After a period of 3 weeks, the top silicone layer of the matrix and the eHAM remnants were removed (Figure 2c). A meshed split-skin autograft was applied (Figure 2d) and was secured with NPWT for 2 weeks. The skin graft showed 100% take, and after 2 weeks, the wound was completely healed (Figure 2e).

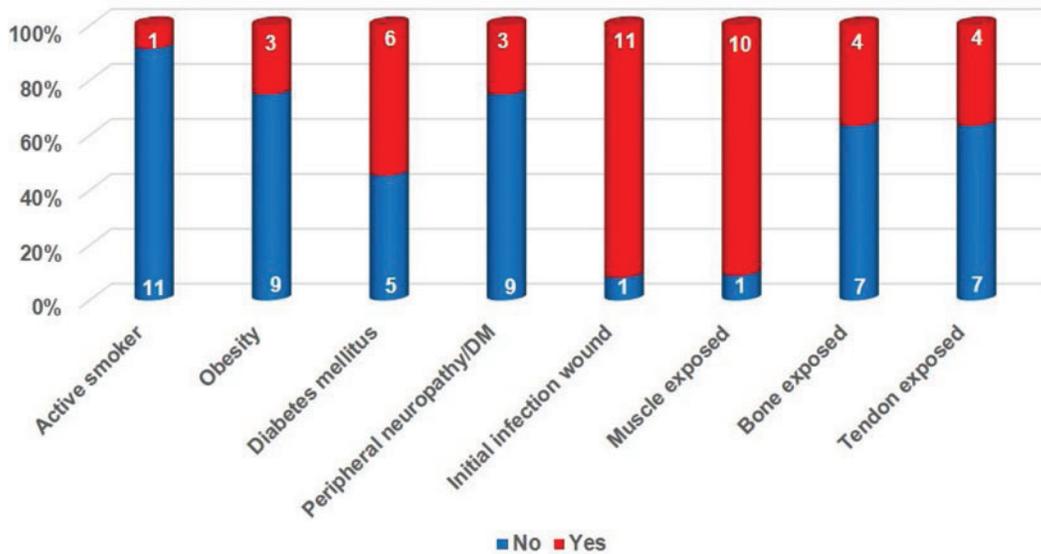


Figure 1. Compromising factors, wound characteristics. DM indicates diabetes mellitus.



Figure 2a
 Abscess due to ingrowth hair.
 Post incision/excision in a healthy, 26-year old male



Figure 2b
 Post ventral hernia repair with post-operative infection and dehiscence in a 67-year old male



Figure 2c
 Fournier's gangrene in a 63-year old male with diabetes mellitus and obesity. Post-operative view

Figure 2. Clinical examples of lesions for which the matrix was used.

Case 2

A 58-year-old woman with diabetes and peripheral neuropathy was admitted through the emergency department to the hospital with a necrotizing soft-tissue infection of her left foot and advanced osteomyelitis of her left middle toe. After receiving surgical debridement, including a toe amputation, and intravenous antibiotic therapy in combination with proper wound care, she was admitted to the LTAC with residual soft-tissue necrosis including the extensor tendons (Figure 3a).

The patient was taken to the OR for surgical debridement of her foot including tendons (Figure 3b). eHAM was applied (Figure 3c) over the defect to cover her tendons and combined with NPWT. After 1 week, the silicone layer came off and the wound was dressed twice daily with wet and moist dressing using quarter strength Dakin's solution. The affected extremity was kept elevated until it was ready for skin grafting 2 weeks later. A meshed split-skin autograft was applied to the wound with NPWT for a week to secure the graft. During the following week, dressing changes were done daily until the wound was completely healed (Figure 3d).

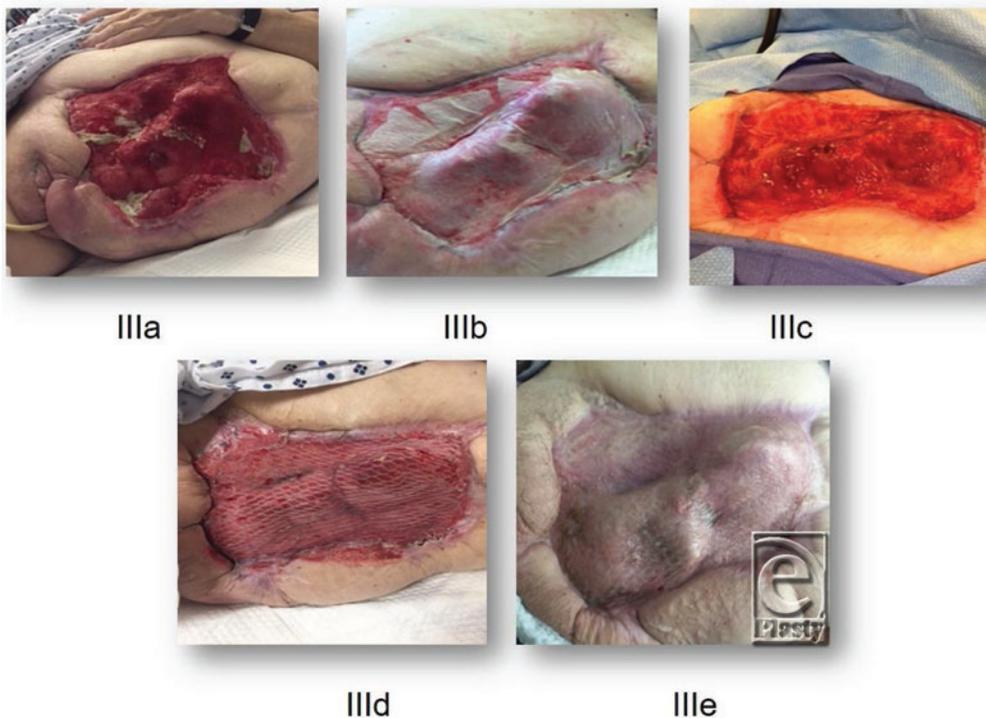


Figure 3. Status post disarticulation of the left hip in a 68-year-old female with a history of diabetes. Disarticulation was necessary because of extensive necrotizing fasciitis. The wound shows exposed bone.

RESULTS

Lesions ranged from relatively small in healthy patients (Figure 4a) to relatively large but “simple” (Figure 4b) to large and complex (Figure 2b). Muscle was exposed in 11 patients (92%) and tendon and/or bone in 5 patients (42%). In 11 patients (92%), wound infection was the primary reason for debridement and application of eHAM (Figure 1).



Figure 4. (a-c) Clinical examples of different types of lesions.

In all patients, extensive sharp debridement and excision were performed in the OR. For most wounds, debridement could be limited to 1 session but multiple sessions were necessary for some patients (N = 4; 25%) where a good wound bed could not be reached within 1 session. In 10 patients (83%), 1 application of eHAM suffices. One patient (8%) required 2 applications, and 1 patient (8%) needed 4 applications.

NPWT was used in 9 patients (75%) for securing eHAM, and sutures were used in the remaining 33 cases (25%). On average, the period a wound was (pre) treated with eHAM was 22.6 days (min: 14, max: 56).

In 9 cases (75%), the wound was grafted with a split-skin graft. In 8 of these cases (89%), the graft was fixated with NPWT and in 1 case (11%) with a splint. In 3 cases (25%), healing per secondary intention occurred.

All lesions reached complete healing. For all lesions that healed by secondary intention, time to reepithelialization was 42 days (N = 3). For those that were grafted, the average total healing time, measured from the initial application of eHAM, was 37.9 days (min: 21, max: 70).

DISCUSSION

Tissue loss, whether through trauma, infection, or surgical causes, can be a major impediment to rapid wound closure. Infection per se as a complication in patients with impaired immunocompetence through local or systemic causes such as diabetes mellitus may lead to major tissue loss after debridement: infection in diabetic patients is one of the major reasons for nontraumatic amputations.¹⁷ Primary infections such as necrotizing fasciitis and Fournier gangrene require radical excision of all infected and dead tissues, which, per definition, also lead to major tissue loss.^{18,19}

With proper wound management, even large tissue defects may heal by secondary intention, but the process requires a large amount of time and, in fact, may stall. The use of split-skin autograft is an easy way to obtain more rapid coverage, but such a graft requires a clean and granulating wound bed.

Several matrices are designed to both fill in gaps caused by tissue loss and provide such a wound bed. Replacement of lost ECM has been proven to be beneficial with regard to the quality and speed of healing as proven in many indications.^{7,8} Burk and colleagues²⁰ were the first to develop and use an artificial ECM made out of collagen and glycosaminoglycan. Several other products now are available. Some contain cells, whereas others are acellular but provide an “dermal environment” that encourages repopulation with cells. All these products are designed to replace lost ECM and to produce a neodermis⁹⁻¹² and a proper wound bed.

Among these, matrices based on hyaluronan have been shown to be particularly effective. HA, an anionic, nonsulfated glycosaminoglycan, is a major component of the normal ECM.

HA plays an essential role in all stages of normal wound healing. It provides wounds with a moist environment, stimulates angiogenesis,¹⁴ facilitates and directs cell proliferation,¹³ including fibroblast migration,¹⁵ regulates tissue hydrodynamics,¹⁶ stabilizes the newly built ECM,²¹ and regulates many other different processes involved in healing.¹³

In its native form, HA is difficult to handle and it has a short half-life, particularly in the presence of large amounts of hyaluronidases, as may be the case in stalled wounds.²² Esterification changes the physical properties of HA, for example, rendering it longer lasting in a tissue environment without scission of the polymer chain and dissolution. The level of esterification can be adjusted using a proprietary technology²³ where the end product is called Hyaff and is presented as fibers produced through the process of electrospinning. In a series of preclinical tests, Hyaff was shown to be appropriate as a scaffold for tissue engineering. The material's properties (vs native hyaluronan), in combination with improved residence time, were found to provide an expansion of the possible applications of HA in the biomedical field.^{15,23-25}

eHAM is a biodegradable dermal matrix contact layer, made of Hyaff, which, post-electrospinning, is made into a soft, nonwoven mat of fine fibers. The dressing has an outer silicone layer that is semipermeable. This silicone layer provides physical, protective coverage of the underlying wound tissues and controls water vapor loss. The matrix acts as a scaffold for cellular colonization (eg, fibroblasts) and capillary ingrowth, creating granulation tissue. Once tissue has grown into the dressing and granulation tissue has formed, the silicone top layer can be removed by peeling off and the resulting wound bed can be grafted. The dressing has been used successfully as an ECM in several indications,²⁶⁻²⁹ thus contributing to the healing of very different types of lesions, including lesions with exposed bone and/or tendons³⁰⁻³³ and infected diabetic foot ulcers.³⁰ eHAM also has been used for the reconstruction of syndactyly³⁴ and the revision of scars.³⁵

All the patients in this case series had major tissue loss, and many of them had exposed bone and/or tendons and/or muscle and some of them were suffering from osteomyelitis. In addition, a number of patients suffered from diabetes mellitus or obesity or were active smokers, all conditions known to impede wound healing.³⁶⁻³⁹ In all cases, extensive debridement was followed by the application of eHAM to fill in tissue gaps and to provide granulation tissue as part of wound bed preparation. In 3 cases, the wounds continued to heal and reepithelialize on their own whereas the remainder of the wounds were autografted. All lesions achieved complete reepithelialization, on average within 42 days for those that healed by secondary intention and on average in 37.9 days for those that were grafted.

A case series, as opposed to a comparative clinical trial, can only show trends and cannot be used to demonstrate superiority of a given product, other than via comparison with literature results on similar indications. Moreover, most case series are generated using a limited series of inclusion and exclusion criteria, making for a nonhomogeneous study cohort.

However, when results are very consistent, even when the indications and etiologies within the patient cohort are diverse, as is the case in the 12 patients demonstrated here, strong trends may be observed.

CONCLUSION

In a series of 12 patients with a variety of surgical and, mostly, very serious and complex wounds, the combination of thorough debridement and the creation of granulating wound bed through the application of eHAM allowed for rapid and complete reepithelialization spontaneously or with the application of split-thickness skin graft. Of the 12 patients, 3 were treated exclusively with eHAM matrix until reepithelialization was complete. For the remaining 8 patients, eHAM proved efficacious in preparing the wound bed by enhancing granulation tissue formation and readiness for a split-skin graft. There was no incident of graft failure observed in any of the cases, and all presented wounds, whether grafted or not, healed in 5 to 8 weeks from presentation.

The study clearly demonstrated a strong trend showing that eHAM provides a good wound bed for both healing by secondary intention and split-skin autografting without graft failure and contributed to rapid and complete healing of all wounds.

Acknowledgments

The authors thank Michel H. E. Hermans, MD, president of Hermans Consulting LLC (Doral, Fla), for editing the manuscript.

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