THE BEST SKIN GRAFTING METHOD
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Background
Skin grafting is a surgical procedure when a patient has a skin patch transplanted to an area of skin that may be damaged or missing due to trauma of the tissue layers. Skin loss or trauma may be caused by burns, infections, skin cancer, pressure injuries and slow healing wounds. However, skin grafting is most commonly used for patients who sustain burn injuries. There are three primary types of skin grafting: split-thickness (STSG), full-thickness (FTSG), and composite grafts.

Purpose
Each method has risks and benefits and they must be carefully weighed before deciding on a particular type of skin transplantation for each patient. An analysis of peer-reviewed articles with an emphasis on evidence-based practice will be conducted to identify which method leads to the best patient outcomes, particularly for patients with burn injuries requiring surgical grafting interventions.

Review of Literature
Autologous split-thickness skin grafts are considered the gold-standard for surgical burn treatment of full and deep partial-thickness wounds (Kohlhauser et al., 2021). Since a third-degree burn is considered a full-thickness wound, this method of grafting is appropriate for these patients. Meshing is a technique that uses split-thickness skin grafts which allows for a larger surface area to be grafted while preventing fluid buildup (Braza & Fahrenkopf, 2021). FTSGs allow the patients to have better functional and aesthetic results, however, they have various limitations and criteria that must be met in order to use them such as eligible donor site, skin quality and color, texture, UV ray damage, size, contractility and scar formation. Because of these various limitations, the usage of FTSGs should be reserved for reconstruction of smaller areas that are delicate, particularly where potential scarring may be of concern because FTSGs reduce the risk of scar development and achieves maximum cosmetic results (Bogdanov et al., 2021). Lastly, composite grafts are indicated in situations where a patient has lost muscle or bone in addition to skin (Prohaska, 2021).

Recommendations/Implementation
Because composite grafts are indicated in situations where a patient has lost muscle or bone in addition to skin, this would not be recommended for patients with third-degree burns. Additionally, unless the burn is in a delicate area such as the face or hands, a FTSG is not favorable. Contraindications to skin grafting include incomplete cancer removal, uncontrolled bleeding, active infection, smoking, bleeding disorder, malnutrition, anticoagulant or chronic corticosteroid use (Prohaska, 2021). A careful assessment by the surgeon should be conducted, taking into account the depth and size of the burn in addition to contraindications to determine the best course of treatment. For autologous skin grafts, the client will have two wounds, one from the original site and one from the donor site where the skin has been taken off. After the local anesthetic wears off in a few hours, the skin may become tender. Until the stitches are removed, the client must take great care of the incisions, such as avoiding exertion and stretching the area; until stitches are removed, it is advised not to rub the site because it may dislodge the graft. Some signs of infection of the graft could be pain, redness, or discharge; then the client needs to consult the doctor (Havill, n.d).

Conclusion
Autologous, split-thickness skin grafts are the gold-standard for most patients with third-degree burns who require a graft. However, it’s important to note that each burn is unique, therefore each clinical picture is different and some patients may require other types of grafts that promote healing best for that particular patient. For sensitive areas where aesthetics is concerned, FTSGs are optimal in order to achieve minimal scarring. Composite grafts are not appropriate for third-degree burns.