Fibrin Sealing of Facial Skin Plasties in Older Patients

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Abstract

The number of cases of facial skin tumors in older patients calls more and more for reconstructive operations in this age group. The delayed healing and more frequent hematoma formation may jeopardize the result. With fibrin sealing it is possible to avoid the age-associated risks. Used as an adjuvant to sutures, fibrin sealing guarantees prophylaxis of hematomas and edemas, which can be dangerous for grafts and plasties. In skin plasties, fibrin sealing is applied by a simultaneous technique. Furthermore, fibrin sealing (Tisseel or Tissucol Duo S) has demonstrated its value as an adjuvant in wound surface sealing. In addition to its hemostyptic effect, we observed accelerated healing.

Introduction

For 15 years we have operated using different tissue adhesives, at first in the Maxillofacial Surgery Department and later in the Dermatosurgical Department of the University of Leipzig. First, there were various cyanoacrylates, then gelatin-resorcinol-formalin (GRF) adhesive and finally, starting in 1981, fibrin sealing (Immuno AG, Vienna). In the application of fibrin sealing two effects were generally noticed: (1) the prominent hemostyptic effect, which, especially in patients with hemorrhagic diatheses, minimized the treatment risk, and (2) the acceleration of undisturbed wound healing [2].

Of the increasing number of facial skin tumors, basal cell carcinomas have a dominating place in older patients (Figs. 1, 2). This particular risk group places high demands on the dermatosurgeon with regard to plastic-reconstructive methods, especially in the facial region [1, 3, 4, 6]. Age-induced caused physiological alterations, above all in the vessels, allow formation of hematomas and/or edemas more frequently than in younger patients. This is dangerous for the skin plasties [7].

Beside general conditions caused by old age, accompanying diseases, e.g. diabetes, delay or endanger wound healing or healing of the skin plasties [5, 8].
Fig. 1. Age distribution in basal cell carcinoma patients 1967–1971

Fig. 2. Age distribution in basal cell carcinoma patients 1982–1986