

The Use of a Fenestrated Dehydrated Complete Human Placental Membrane Allograft in a Lower Eyelid Mohs Defect

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Initial Wound with dCHPM applied



Wound Resolution

PATIENT BACKGROUND & INITIAL APPLICATION

A 79-year-old male with a history of nonmelanoma skin cancer (NMSC) and hypertension presented with a nodular basal cell carcinoma on the left central malar cheek. The lesion measured 1.2 cm x 1.5 cm. Mohs micrographic surgery was determined to be the appropriate method to remove the tumor due to the anatomical location. The patient underwent three stages of the Mohs procedure, which resulted in a final defect of 2.2 cm x 3.3 cm.

The physician documented the need for a complex repair due to the extensive undermining required, lack of skin elasticity in surrounding tissue, the size of the defect, and to preserve functional and aesthetic anatomy. On the inferior portion of the defect, the physician performed undermining into the superficial subcutaneous fat to allow for primary intent reconstruction of the deep subcutaneous tissue, superficial fascia, and dermis. Retention sutures were utilized to prevent dehiscence from high tissue tension. The superior portion of the defect, near the lower eyelid border, remained open. The physician applied a fenestrated dehydrated complete human placental membrane (dCHPM) allograft to the remaining open defect. Both the sutured portion and the portion applied with the fenestrated dCHPM allograft were dressed with petrolatum and an absorbent pressure dressing (Figure 1a). The patient returned three days later, at which point the graft was integrating into the defect (Figure 1b). The defect was redressed with petrolatum and an absorbent pressure dressing.



Figure 1. (a) Day 0. Post-complex repair. Fenestrated dCHPM allograft applied to the lower eyelid defect. (b) Day 3. Incorporation of the fenestrated dCHPM allograft.

SECOND APPLICATION

The patient returned 10 days after the first application for a wound assessment and second application. The defect measured 1 cm x 1.8 cm, and the physician noted some drainage from the defect (Figure 2). The defect was cleaned, and a second fenestrated dCHPM allograft was applied, followed by petrolatum and an absorbent pressure dressing.



Figure 2. Day 10.

WOUND RESOLUTION

The patient returned 7 days later for a wound check. The dressing was noted to be clean, dry, and in place, and the defect was appropriately granulated (Figure 3a). The defect was cleaned and dressed with an antibiotic ointment and absorbent dressing. The patient was instructed to continue standard wound care until the defect fully resolved. The patient returned two months later for a standard skin check, at which time the wound had resolved. Over the next three months, the new dermis remodeled (Figure 3b).

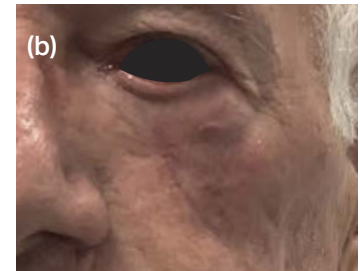


Figure 3. (a) Day 17. Defect was appropriately granulated. (b) Day 158 post-Mohs procedure.



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