

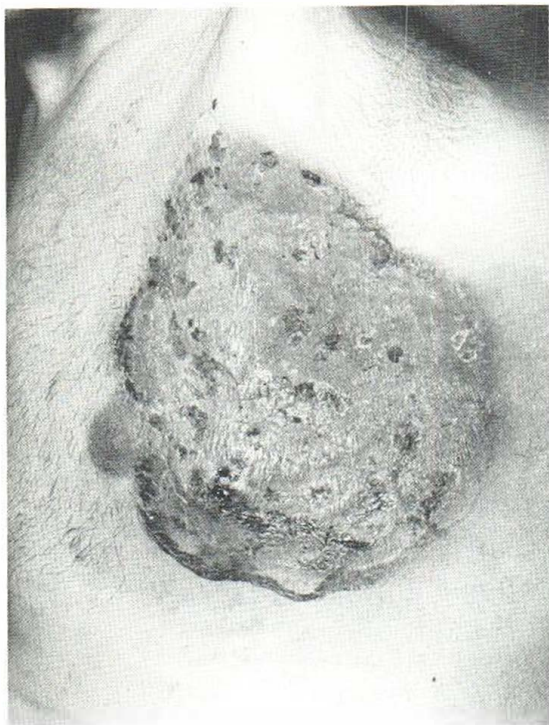


Fig. 1. Lesion on left side of the trunk. Note the bullous edge.

cytotoxic vasculitis, pyoderma gangrenosum, chronic pyelonephritis and a paraproteinaemia. Immunosuppressive drugs often clear the lesions of pyoderma gangrenosum. This was also the case in our patient. We have no indication of any relationship between his early death and this treatment. Although not all cases of bullous pyoderma gangrenosum (3) appear related to leukaemia, patients with this disease should be investigated with this relationship in mind. The report of Perry & Winkelmann (8), together with the present report, indicate that pyoderma gangrenosum may well signify a poor prognosis when associated with leukaemia.

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Wound Dressing with Collagen Film in Skin Planing

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A variety of dressings have been used following skin planing. None has proved ideal, however. Ointment compresses containing antibiotics have been popular, but are not advisable because of the risk of sensitization. They may also lead to the development of local resistant strains of bacteria. Compresses are difficult to apply and simple bandages are adherent and hard to remove. In most cases heavy crusts form.

The present report describes the use of a newly developed collagen film in skin planing.

MATERIAL AND METHODS

Seven patients suffering from four different skin diseases were subjected to skin planing. The diagnoses were post-acne scars, rhinophyma, scarring following neurotic excoriations, and Darier's disease. With the exception of the last patient who had skin planing done to lesions on her arms, all dermabrasion was performed on facial skin. Der-



Fig. 1. Wound covered with collagen film, photographed on the day of dermabrasion.

mabrasion was done with a motor-driven rotating steel brush after local freezing anaesthesia. Immediately following skin planing a moistened sterile collagen film (kindly supplied by Pharmacia AS) was cut to the size of the wound surface and applied direct to the skin. The film is about 0.06 mm thick and supplied in sizes of 5×8 cm and 20×8 cm. The collagen film is manufactured from native skin collagen of bovine origin (3). The wounds received no further covering. The film was allowed to dry and was easily removed after wetting on the 4th day following surgery.

RESULTS

The collagen film adhered satisfactorily to the wet bleeding surface (Fig. 1) and achieved prompt haemostasis. Crust formation was negligible. The film was well tolerated. On drying, it shrank a little and in spite of its good adherence it was easily removed. Three of the patients, who had previously had skin planing performed using a conventional ointment dressing with carbonet gauze, expressed preference for the collagen film.

DISCUSSION

Although bovine collagen was tested as a dressing material as early as 1966 (4) and 1967 (2) this type of dressing seems not to have come into common usage until very recently. No reports have been found in the literature on the use of collagen film dressing after skin planing.

For third degree burns, Abbenhaus & Donald (1) found that collagen appeared to afford excellent protective coverage, reduced fluid loss and helped to maintain sterility. These properties, together with an excellent haemostatic effect, are equally important in dressings to be used after dermabrasion.

No antigenic reactions have been reported following the use of collagen dressings. The present material has also been tested with predictive patch tests, the guinea pig maximization test as well as in an immunization test on rabbits with homogenized collagen film in Freund's complete adjuvant and no immunogenic effect was demonstrated (3).

Our results, though on a limited number of patients, indicate that collagen film seems to be a particularly well suited dressing for use after skin planing.

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