FLEX CEUs

Burn Treatment Advancement

Burn wound healing and treatment: review and advancements

Abstract

Burns are a prevalent and burdensome critical care problem. The priorities of specialized facilities focus on stabilizing the patient, preventing infection, and optimizing functional recovery. Research on burns has generated sustained interest over the past few decades, and several important advancements have resulted in more effective patient stabilization and decreased mortality, especially among young patients and those with burns of intermediate extent. However, for the intensivist, challenges often exist that complicate patient support and stabilization. Furthermore, burn wounds are complex and can present unique difficulties that require late intervention or life-long rehabilitation. In addition to improvements in patient stabilization and care, research in burn wound care has yielded advancements that will continue to improve functional recovery. This article reviews recent advancements in the care of burn patients with a focus on the pathophysiology and treatment of burn wounds.

Introduction

Acute thermal injuries requiring medical treatment affect nearly half a million Americans each year, with approximately 40,000 hospitalizations and 3,400 deaths annually [1]. The survival rate for admitted burn patients has improved consistently over the past four decades [2] and is currently a favorable 97 % for patients admitted to burn centers [3]. This can be largely attributed to national decreases in burn size, improvements in burn critical care, and advancements in burn wound care and treatment that have been driven by research, as reflected in the dramatic increase in burn publications over the last several decades [4, 5]. Since the first International Congress on Research in Burns over 50 years ago, progress has been made in a host of areas, and vital improvements in early resuscitation, infection management, wound excision and coverage, and fluid management have helped in the fight against burn mortality [6, 7]. This review presents an update on the care of burn patients, with special emphasis on the mechanisms underlying burn wound healing and recent advancements in burn wound care.

Pathophysiology of burn wounds

Thermal burns from dry sources (fire or flame) and wet sources (scalds) account for approximately 80 % of all reported burns [8] and can be classified based on the depth of burn [9, 10]. In addition to local injury at the site of burn, severe thermal injury over a large area of the skin, roughly 20 % total body surface area (TBSA) or greater, results in acute systemic responses collectively known as burn shock [11]. Burn shock is characterized by increased capillary permeability, increased hydrostatic pressure across the microvasculature, protein and fluid movement from the intravascular space into the interstitial space, increased systemic vascular resistance, reduced cardiac output, and hypovolemia requiring fluid resuscitation [12]. The edema that forms in the interstitial space forms rapidly in the first 8 h following burn injury, and continues to form more slowly for at least 18 h [13]. Volume requirements for resuscitation can be estimated by the total burn size and the patient's weight (or body surface area). Additional factors influencing these needs include the presence or absence of inhalation injury, the extent of full-thickness burns, and the time since injury [12]. The actual fluid infusion rate is then titrated hourly, based on the adequacy of physiological responses, such as the urine output [14].

Following successful resuscitation, patients with larger burns then enter a more prolonged period of hypermetabolism, chronic inflammation, and lean body mass wasting, all of which may impair wound healing [15].

Additionally, an increased susceptibility to infection due to altered immune status may lead to sepsis, further exacerbating systemic inflammation [16]. Sustained hypermetabolism and inflammation impair wound healing through delayed re-epithelialization [17, 18]. The extent of inflammation and hypermetabolism is related to the extent [19] and depth of burn, as deeper burns show higher levels of circulating cytokines [20] and a greater hypermetabolic response [21]. Similarly, the extent of burn is an efficient predictor of hospital length of stay [19, 22] and mortality [19, 23].

According to one model, the burn wound can be divided into three zones based on the severity of tissue destruction and alterations in blood flow [10, 24–26]. The central part of the wound, known as the zone of coagulation, is exposed to the greatest amount of heat and suffers the most damage. Proteins denature above 41 °C (106 °F), so excessive heat at the site of injury results in extensive protein denaturation, degradation, and coagulation, leading to tissue necrosis. Around the central zone of coagulation is the zone of stasis, or zone of ischemia, which is characterized by decreased perfusion and potentially salvageable tissue [10]. In this zone, hypoxia and ischemia can lead to tissue necrosis within 48 h of injury in the absence of intervention [27]. The mechanisms underlying apoptosis and necrosis in the ischemic zone remain poorly understood, but appear to involve immediate autophagy within the first 24 h following injury and delayed-onset apoptosis around 24 to 48 h postburn [27]. Other studies have shown apoptosis to be active as early as 30 min postburn [28] depending on the intensity of the burn injury [29]. Oxidative stress may play a role in the development of necrosis, as preclinical studies have demonstrated promising reductions in necrosis with systemic antioxidant administration [30]. At the outermost regions of the burn wound is the zone of hyperemia that receives increased blood flow via inflammatory vasodilation and will likely recover, barring infection or other injury [25].

Although burns are different from other wounds in some respects, such as the degree of systemic inflammation [31], healing of all wounds is a dynamic process with overlapping phases [32] (Table 1). The initial inflammatory phase brings neutrophils and monocytes to the site of injury via localized vasodilation and fluid extravasation, thereby initiating an immune response that is later sustained by the recruitment of macrophages by chemokines [31]. The inflammatory phase serves not only to prevent infection during healing, but also to degrade necrotic tissue and activate signals required for wound repair [33]. Following, and overlapping with the inflammatory response, the proliferative phase is characterized by keratinocyte and fibroblast activation by cytokines and growth factors [34]. In this phase, keratinocytes migrate over the wound to assist in closure and restoration of a vascular network, which is a vital step in the wound healing process [35]. This network of communication between stromal, endothelial, and immune cells determines the course of healing, including closure and revascularization.

Table 1 Phases of wound healing

Phase	Characteristics	Key players
Inflammatory	Vasodilation	Neutrophils
	Fluid extravasation	Monocytes
	Edema	Macrophages
Proliferative	Wound closure	Keratinocytes
	Revascularization	Fibroblasts
Remodeling	Wound maturation	Collagen
	Scarring	Elastin
		Fibroblasts/myofibroblasts

Overlapping with the proliferative phase, the final phase of healing involves remodeling the wound [36]. During the remodeling phase, the wound scar matures [31] as collagen and elastin are deposited and continuously reformed as fibroblasts become myofibroblasts [37]. Myofibroblasts adopt a contractile phenotype, and thus are involved in wound contracture [38]. The conversion from fibroblasts to myofibroblasts controls a delicate balance between contraction and re-epithelialization that, in part, determines the pliability of the repaired wound [39]. In addition to fibroblast conversion, apoptosis of keratinocytes and inflammatory cells are key steps in the termination of wound healing and the overall final appearance of the wound [40].

Optimization of burn wound healing

Inflammation

Inflammation is vital to successful burn wound healing, and inflammatory mediators (cytokines, kinins, lipids, and so forth) provide immune signals to recruit leukocytes and macrophages that initiate the proliferative phase [37]. Wound re-epithelialization, or closure, in the proliferative phase via keratinocyte and fibroblast activation, or migration from dedifferentiated hair follicles and other epidermal analogs [41, 42], is mediated by cytokines recruited in the inflammatory phase. While this indicates that inflammation is essential for wound healing, aberrant inflammatory pathways have also been linked to hypertrophic scarring, and anti-inflammatory treatments could potentially aggravate symptoms and delay wound healing [40, 43, 44].

Significant edema that is initiated by several factors including vasodilation, extravascular osmotic activity, and increased microvascular permeability often accompanies inflammation [45]. Excessive or prolonged edema and

inflammation exacerbate pain and impair wound healing [17, 18]. Interestingly, studies suggest that in the absence of infection, inflammation might not be required for tissue repair [46]. Since inflammation can have both beneficial and detrimental effects on burn wound healing, the clinical challenge becomes management, applying therapeutic intervention only when inflammation and edema become excessive.

Treatment of inflammation in large burns is difficult, as recently discussed in detail elsewhere [16]. Traditional anti-inflammatory treatments that focus on the inhibition of prostaglandin synthesis, such as nonsteroidal anti-inflammatory drugs or glucocorticoids, impair wound healing [47]. However, steroid administration has been shown to reduce inflammation, pain, and length of hospital stay in burn patients in several small studies [48, 49]. Early excision and grafting has become the gold standard for treatment of full and deep partial thickness burns [50, 51], in part because early excision helps reduce the risk of infection and scarring [52–54]. The timing of debridement coincides with the inflammatory phase of healing, as the burn eschar removed during excision is an inflammatory nidus and a rich pabulum for bacterial proliferation.

Nontraditional anti-inflammatory treatments, such as opioids, have gained considerable attention but have yet to translate promising preclinical results into clinical practice for wound healing. While the majority of animal studies have demonstrated consistent anti-inflammatory effects of opioids on peripheral neurons [55], clinical studies have shown little to no effect on inflammation [56]. Furthermore, topical morphine delayed the early inflammatory phase and accelerated the later proliferative phase [57, 58], which is supported by in vitro studies showing opioid stimulation of keratinocyte migration [59]. Large-scale clinical trials evaluating opioid efficacy on wound healing have not yet been conducted [60].

Infection

The skin functions as a barrier to the external environment to maintain fluid homeostasis and body temperature, while providing sensory information along with metabolic and immunological support. Damage to this barrier following a burn disrupts the innate immune system and increases susceptibility to bacterial infection [61]. Burn wound infection was defined in a rat model with *Pseudomonas aeruginosa* [62, 63], in which the following progression was observed: burn wound colonization; invasion into subjacent tissue within 5 days; destruction of granulation tissue; visceral hematogenous lesions; and leukopenia, hypothermia, and death. Burn patients are at high risk for infection [64], especially drug-resistant infection [65], which often results in significantly longer hospital stays, delayed wound healing, higher costs, and higher mortality [66]. Infection can lead to the development of a pronounced immune response, accompanied by sepsis or septic shock, which results in hypotension and impaired perfusion of end organs, including the skin – all processes that delay wound healing. Furthermore, the leading causes of death following a severe burn are sepsis and multiorgan failure [67–69], so prevention and management of infection is a primary concern in the treatment of burn patients. Early and accurate diagnosis of infection is difficult: C-reactive protein and the white blood cell count are most often used, since the diagnostic power of procalcitonin is questionable in burns [70]. Consensus definitions of sepsis and infection have recently been proposed that are more relevant to the burn population and are often used clinically but still require validation [71].

The management of burn wound infections has been extensively reviewed elsewhere [61, 64–66, 72–77]. Since the adoption of topical antibiotics, such as mafenide in the 1960s and silver sulfadiazine in the 1970s, and of early excision and grafting in the 1970s and thereafter, systemic infections and mortality have consistently decreased [68, 72, 78]. However, Gram-positive and Gram-negative bacterial infections still remain one of the most common causes of mortality following burn injury [73]. Bacterial cultures can aid in the selection of an appropriate antibiotic, especially in cases of bacterial drug resistance, but altered pharmacokinetic parameters in burn patients must be considered and dosing should be adjusted accordingly to maximize antibiotic efficacy [79]. Importantly, effective topical antimicrobials do not exist for invasive fungal infections, and fungal wound infections are associated with greater mortality rates in large burns (>30 % TBSA) [80]. Owing to high lethality, suspicion of an invasive burn wound infection mandates rapid diagnosis, often by histopathology, and excision or re-excision of the wound.

Nutrition

Sustained hypermetabolism, hormone elevations, and muscle wasting following severe burn injury all contribute to the clinical outcome, with magnitude and duration that are unique to burns [81, 82]. Accordingly, reducing the impact of a hypermetabolic state and providing adequate nutrition are key factors that affect burn wound healing and recovery [83], as has been reviewed elsewhere [84]. There is a difficult balance between the additional caloric needs to meet the demand from hypermetabolism and the consequences of nutrient overconsumption. Nutritional support following a burn injury is a complex issue. For example, early excision and aggressive feeding in children does not diminish energy expenditure but is associated with decreased muscle protein catabolism, a decreased rate of burn sepsis, and significantly lower bacterial counts from excised tissue

[85]. In adults, early nutritional support is correlated with shorter stays, accelerated wound healing, and decreased risk of infection [86].

Several nutritional factors must be considered. For example, excess carbohydrate consumption may lead to hyperglycemia [87] that can exacerbate systemic inflammation and muscle degradation [88, 89]. Furthermore, excess fat consumption may exaggerate the immunosuppressed state [90]; and since major burn injuries may also result in immunosuppression [91], this exaggeration may increase the risk for infection and sepsis. Carbohydrate and fat intake must therefore be closely monitored in burn patients. Guidelines for nutritional support of burn patients vary, but consensus recommendations have been given by the American Burn Association and the American Society for Parenteral and Enteral Nutrition for carbohydrates, proteins, and fats [84].

In addition to support with amino acids and vitamins [84], administration of insulin has been shown to decrease healing time by reducing protein catabolism and increasing skeletal muscle protein synthesis [92–96]. More research is needed to optimize insulin delivery, as many recombinant growth factors, such as epidermal growth factor and transforming growth factor, are often cost prohibitive [93]. Other anabolic agents, such as oxandrolone, have been shown to increase lean body mass recovery, decrease length of stay, and improve overall outcomes, including wound healing [97–100]. Additionally, while conventional theory suggests that hemoglobin levels must be maintained above 10 g/dl to promote wound healing [101], preliminary evidence suggests that mild to moderate anemia has no effect on graft success if perfusion is maintained with proper circulatory volume [102]. The results of a multicenter, randomized, controlled trial (ClinicalTrials.gov NCT01079247) comparing blood transfusion with lower volumes (target hemoglobin of 7 to 8 g/dl) and conventional volumes (target hemoglobin >10 g/dl) for a large cohort of patients are expected soon and will allow for more definitive clinical guidelines on blood transfusion volumes.

Resuscitation

Severe thermal injuries over a large area of the skin (>20 % TBSA) require fluid resuscitation for stabilization. Although volume guidelines and fluid compositions vary widely between centers, the goal of fluid resuscitation is to maintain organ perfusion with the least amount of fluid necessary [12]. Common traditional resuscitation formulas, such as the modified Brooke, and Parkland formulas, employ crystalloids such as lactated Ringer's that contain sodium, chloride, calcium, potassium, and lactate. During large-volume resuscitations, the addition of colloids (for example, albumin, fresh frozen plasma) as adjuncts has been successful in reducing the total volume [12]. Despite extensive research into resuscitation fluid compositions and volumes, little is known about the effect of resuscitation on wound healing. A recent meta-analysis showed a positive association between the number of grafting procedures and hypernatremia, suggesting that high serum sodium levels may inhibit graft take [103]. Additionally, we have recently shown that the rate of wound closure (healing rate) is significantly faster in patients who received lower 24-h fluid resuscitation volumes [104]. More work is needed to evaluate the effect of resuscitation on wound healing trajectories before clinical recommendations for preferred fluid compositions and volumes can be made.

Wound coverage and grafting

Early excision and grafting has been the standard of care for decades. Most studies have shown that excision within 24 to 48 h after injury is associated with decreased blood loss, infection, length of hospital stay and mortality, and increased graft take [105–108], although mortality reductions may only occur in patients without inhalation injury [109]. Since one of the main challenges in treating acute thermal injuries is preventing infection, excising the eschar and covering the wound as early as possible are critical. The standard for rapid and permanent closure of full-thickness burns is a split-thickness skin graft from an uninjured donor site on the same patient (autograft). Such grafting provides sufficient coverage without risk of rejection, although meta-analyses have yet to determine the failure rate of split-thickness skin grafts in burn patients. Split-thickness skin grafts can be meshed with variable expansion ratios to increase the coverage area, but concerns remain over the effect that meshing has on range of motion [110] and the graft site healing rate. On the other hand, donor sites are painful and impose their own wound-healing burden on the patient [111]. Various dressings have been used to cover donor sites during healing, with variable results [112].

Patients with more extensive burns often require temporary coverage with an allograft, xenograft, skin substitute, or dermal analog due to insufficient or unavailable donor sites. Allografts, or tissue taken from a living or deceased human donor, and xenografts, taken from a different species, promote re-epithelialization and prepare the wound bed for autograft, increasing the healing rate when compared with traditional dressings [113]. A recent meta-analysis suggested that since allografts and xenografts appear to be equally effective, xenografts may be a superior choice for their increased safety and reduced price [114]. However, caution should be exercised in drawing broad conclusions from this meta-analysis because the cited studies lack standardization and critical details such as depth and size of burn, and many studies cited were merely anecdotal. A cadaver allograft

is thus widely considered the best material for temporary closure of excised wounds in patients with extensive, life-threatening burns and inadequate donor sites. The cadaver allograft is also the preferred material for protection of widely meshed autografts (3:1 or higher meshing ratios) during healing. In the latter setting, the allograft is applied over the meshed autograft in the manner of a sandwich.

A variety of different skin substitutes and dermal analogs exist [115–119] (Table 2) that can be broadly divided into those which replace the epidermis or replace the dermis [120, 121]. Epidermal substitutes are normally only a few cell layers thick and lack normal dermal components [122, 123]. Commercially available dermal substitutes include acellular matrices, commonly from human – for example, Alloderm (LifeCell, Bridgewater, NJ, USA) or GraftJacket (KCI, San Antonio, TX, USA) – or other sources (for example, Integra; Integra LifeSciences, Plainsboro, NJ, USA). Biobrane (Smith & Nephew, London, UK) is a semisynthetic, bilaminar material consisting of a nylon-mesh dermal analog (bonded with porcine collagen) and a silicone epidermal analog. Biobrane is used for temporary closure of superficial burns and donor sites [124, 125]. Products currently under development integrate the concept of dermal scaffolds that actively promote revascularization by incorporating stem cells and growth factors to recreate a favorable cellular microenvironment [126, 127].

Numerous options exist for dressings [128, 129]. The selection of an appropriate dressing depends on several factors, including depth of burn, condition of the wound bed, wound location, desired moisture retention and drainage, required frequency of dressing changes, and cost. While many factors must be considered in dressing selection, the goals in selecting the most appropriate dressing should include providing protection from contamination (bacterial or otherwise) and from physical damage, allowing gas exchange and moisture retention, and providing comfort to enhance functional recovery. The traditional approach to burn wound care developed at the US Army Burn Center includes alternation of mafenide acetate cream in the morning and silver sulfadiazine cream in the evening, with gauze dressings used over the creams. More recently, silver-impregnated and other dressings have been introduced. Major classes of dressings include: alginate, for example Aquacel (ConvaTec, Bridgewater, NJ, USA), Comfeel (Coloplast, Minneapolis, MN, USA), or Sorbsan (Mylan, Morgantown, WV, USA); antimicrobial, for example Acticoat (Smith & Nephew, London, UK) or Silverlon (Argentum, Geneva, IL, USA); collagen, for example Fibracol (Johnson & Johnson, New Brunswick, NJ) or Puracol (Medline, Mundelein, IL, USA); hydrocolloid, for example Duoderm (ConvaTec, Bridgewater, NJ, USA), Granuflex (ConvaTec, Bridgewater, NJ, USA), or Tegaderm (3M, Maplewood, MN, USA); hydrogel, for example Dermagel (Maximilian Zenho & Co, Brussels, Belgium), SilvaSorb (Medline, Mundelein, IL, USA), or Skintegrity (Medline, Mundelein, IL, USA); and polyurethane foam, for example Allevyn (Smith & Nephew, London, UK) or Lyofoa (Molnycke, Gothenburg, Sweden). Notably, many of these dressings exhibit antimicrobial properties through silver impregnation, but recent studies suggest silver may delay wound healing and should not be routinely used on uninfected donor skin [130, 131] even though silver dressings may reduce wound pain [132]. In patients with extensive or deep burns, antimicrobial efficacy should be the first priority in burn wound care.

Alternatively, cell-based techniques for more permanent coverage have made progress. Research on cultured

Table 2 Skin substitutes and coverage options

Product name	Classification	Characteristics	Availability (company)
EpiDex	Autologous	Keratinocyte-based	No (Modex, Lausanne, Switzerland)
Alloderm	Acellular	Human origin	Yes (LifeCell, Bridgewater, NJ, USA)
		Dermal matrix	
GraftJacket	Acellular	Human origin	Yes (KCI, San Antonio, TX, USA)
		Tissue scaffold	
Integra	Acellular	Bovine/shark origin	Yes (Integra, Plainsboro, NJ, USA)
		Bilayer matrix	
Biobrane	Acellular	Biocomposite dressing, nylon fibers in silicone with collagen	Yes (Smith & Nephew, London, UK)
Dermagraft	Cellular	Bioabsorbable polyglactin mesh scaffold with human fibroblasts (neonatal origin)	Yes (Organogenesis, Canton, MA, USA)
Epicel	Cellular	Keratinocyte-based cultured epidermal autograft	Yes (Genzyme, Cambridge, MA, USA)
Recell	Cellular	Autologous cell suspension of keratinocytes, fibroblasts, Langerhans cells and melanocytes	Yes (Avita, Northridge, CA, USA)
		Sprayable after culture	

epithelial cells has made advancements, especially with respect to culture time. Culture-based options, such as Epicel (Genzyme, Cambridge, MA, USA), use a small biopsy of the patient's skin to provide keratinocytes, which are expanded over 2 to 3 weeks (for Epicel, in the presence of proliferation-arrested murine fibroblasts) into a confluent epidermal autograft. Other options, such as ReCell (Avita, Northridge, CA, USA), take a small biopsy of the patient's skin and prepare a mixture of keratinocytes, melanocytes, and stem cells in a liquid formulation for spraying onto the excised burn wound during the same operation [133–135]. These techniques may reduce the amount of donor skin needed for treatment of large burns, significantly reducing the healing time of both the donor and the burn sites, and increasing overall graft success and scar quality [136]. More work is needed on cell-based coverage options before widespread implementation can be recommended.

Keratinocytes and stem cells

As mentioned previously, keratinocytes play a vital role in wound closure. Cytokine activation causes keratinocyte migration in the proliferative phase, leading to closure and restoration of a vascular network [35]. Keratinocytes can also be activated by mu opioid receptor agonists [59] but the role of these agonists on inflammation and wound closure remains unclear [57, 58]. Despite positive studies with EpiDex (Modex, Lausanne, Switzerland) – an engineered, fully differentiated autologous skin substitute derived from keratinocytes showing efficacy comparable with split-thickness skin grafts in wound closure and healing [137] – results have yet to translate into clinically viable options. Studies evaluating expansion of keratinocytes on human fibroblasts following trypsin extraction [138], and using engineered skin with keratinocytes on a fibrin matrix [139], have demonstrated improvements in wound healing. Retrospective analyses on autologous keratinocytes showed that cultured allogeneic or autologous keratinocytes may accelerate wound healing [140, 141]. Taken together, the future impact of keratinocyte-mediated cell coverage options is promising, but more research is needed [134]. Additionally, keratinocyte-based treatments should be pursued carefully, as overactivation of keratinocytes can contribute to the development of hypertrophic scarring [43, 142].

The use of adult stem cells, including bone marrow stem cells, hair follicle stem cells, and adipose stem cells, in acute burn care is an exciting topic [143]. Addition of bone marrow stem cells to nonhealing chronic wounds leads to engraftment of cells and enhanced wound healing [144, 145]. Moreover, studies have reported that bone marrow stem cells can transdifferentiate towards multiple skin cell types [146]. Mechanisms of action of bone marrow stem cells in burns are not fully elucidated, but modulation of inflammation has occurred after radiation burns in humans [147]. Similarly, adipose stem cells accelerate re-epithelialization by paracrine activation of host cells via growth factor secretion [148, 149]. Also, hair follicle stem cells are capable of generating a stratified epidermis on human burn wounds [150]. Additionally, the possibility of generating a cellular skin equivalent is being explored. Hair follicle stem cells have been incorporated into products, such as Integra, to investigate wound healing [151]. A cultured skin substitute using adipose stem cells and keratinocytes has been developed that produces epidermal, dermal, and hypodermal stratification [152]. Moreover, human adipose stem cells that would normally be discarded have recently been isolated from debrided burn eschar tissue [153] and used to generate a tri-layered, vascularized construct [154]. Promising data with nonembryonic stems cells such as these have stimulated interest into future applications and development, and undoubtedly further investigations will produce exciting results.

Other considerations and future directions

Monitoring and predicting wound healing

No new skin-based technology can substitute for careful attention by the burn team to the progress (or lack thereof) of wound healing. The WoundFlow computer software program was developed as an enhancement over the traditional paper Lund–Browder diagram to more accurately quantify and track burn injuries over time [104, 155]. WoundFlow is an electronic mapping program that calculates burn size and tracks wound healing [104, 155]. The ability to accurately track burn wound healing over time will support both clinical care and future studies that compare healing rates and outcomes following different treatments. Notably, this study demonstrated that delayed wound healing was associated with a significantly higher risk of mortality [104, 155].

The ability to predict whether a burn wound will spontaneously heal or not would greatly improve patient care. Furthermore, the ability to uniquely tailor treatment to each individual patient would improve patient outcomes and decrease the time to functional recovery, reducing the overall cost of care. Biomarkers may provide a means to allow for tailored treatments and to give insight into wound healing mechanisms [156–161]. Significant efforts in the search for predictive biomarkers for wound failure have determined that serum cytokines, such as interleukin-3 and 12p70, and serum procalcitonin are independently associated with wound failure [161]. Additional candidates have been identified [158–160] but further work is needed to model complex, temporal serum cytokine profiles into an effective predictor for wound healing. In addition to evaluating serum cytokine profiles, candidate biomarkers have been identified in

wound effluent [161], which may be a better medium for predicting local wound healing than cytokines in the circulation [162]. Wound exudate has been shown to contain elevated levels of immunosuppressive and proinflammatory cytokines, such as interleukin-1β, interleukin-2, interleukin-6, and tumor necrosis factor alpha [163]. In fact, dipeptidyl peptidase IV and aminopeptidase have been identified in burn wound exudate with a significantly different ratio from that found in plasma [164]. Other work on local wound biomarkers using biopsies has shown that a host of proteins are upregulated during wound healing [165]. More work is needed to establish a biomarker profile that can accurately predict wound healing and to identify potential novel areas for therapeutic intervention.

In addition to examining burn wounds directly, and the wound exudate, another potential method for examining the ability of burn wounds to heal is non-invasive imaging [166]. To this end, a number of non-invasive imaging techniques have been investigated for their use in determining burn depth. Such techniques include terahertz imaging, spatial-frequency-domain imaging, near-infrared spectroscopic imaging, and reflectance-mode confocal microscopy, among others [167–172]. While many of these techniques have not yet been refined sufficiently for clinical application, the most successful research efforts into imaging techniques for burn wounds examine blood flow, such as laser Doppler imaging and indocyanine green angiography [173]. Laser Doppler imaging provides the most evidence for accurately assessing burn severity [174], but it has been shown that laser Doppler imaging is only superior to visual assessment 48 h after thermal injury [175]. Additional studies are needed to fully explore the potential for incorporation of non-invasive imaging modalities into the routine treatment of burn wounds.

Obese patients

As the obese population continues to grow [176], new treatment approaches will be required. Obese burn patients present with a variety of unique characteristics that include: increased rates of diabetes, hypertension, cardiac disease, and pulmonary disease; altered pharmacokinetics and pharmacodynamics; and altered immune responses [177]. Even the commonly used Lund–Browder chart for estimation of TBSA is problematic for obese patients because it fails to account for altered body-mass distribution in these patients [178]. Hence, analysis of group differences and controlled clinical studies in unique patient populations are needed [179].

Older patients

Census predictions suggest that the older population will double in the next 20 years. Since older people are at increased risk for burn injury, an increasing number of burn injuries among the older population should be expected. A recent review delineated the unique burn pathophysiology, comorbidities, and treatment strategies for the older population [180]. Detailing all of the unique considerations for the older burn population is outside the scope of this review, but several key points are noteworthy. Most burns among older people occur at home, especially in the kitchen and bathroom, due to diminished alertness, slower reaction time, and reduced mobility [181]. Reductions in metabolic rate and skin thickness with age result in more severe burns, and more extensive full-thickness burns are associated with increased mortality [182]. Comorbidities such as diabetes and cardiovascular disease complicate treatment, and may exacerbate the postburn hypermetabolic response [183]. Several formulas for predicting the survival of older patients, such as the Baux score [184], have received wide acceptance and can help guide clinicians in patient treatment. Unique treatment considerations for older patients should include attentive resuscitation to reduce the risk of volume overload, judicious ventilator support, careful analgesic administration, prudently timed excision and grafting, and extended rehabilitation for functional recovery [180]. The older population presents a unique challenge to the burn clinician, and the treatment of patients must be carefully considered on a case-by-case basis.

Future directions

Adult burn patients with increased markers of inflammatory stress exhibit reduced serum levels of vitamin A despite normal markers of oxidative stress [185–187]. Additionally, limited preclinical studies show that polyprenoic acid and retinol can facilitate wound healing [188], and that retinoids are efficacious on a variety of other skin conditions [189]. Moreover, early clinical studies have shown that retinoid treatment effectively increases scar elasticity [190, 191]. Taken together, these

Table 3 Recommendations for the intensivist

Accurate measurement of burn size using a Lund–Browder chart
Carefully titrated fluid resuscitation, to balance risks of edema formation with those of ongoing hypoperfusion
Early initiation of effective topical antimicrobial therapy (mafenide acetate or silver-based creams/dressings)
Daily inspection of the wounds by a qualified surgeon or wound care expert
Early excision and grafting of all full thickness and deep partial thickness burns
Aggressive treatment of infected wounds (resuscitate, broad-spectrum topical and systemic antimicrobials, excision, or re-excision)
Rehabilitation in the ICU to minimize the functional consequences of prolonged immobilization and contracture formation

data highlight the need for studies evaluating retinoids on burn wound healing outcomes.

Pirfenidone was originally developed as an antihelminthic and antipyretic agent, but recent work has demonstrated that it also has anti-inflammatory, antioxidative, and antiproliferative effects [192]. In particular, the antifibrotic properties of pirfenidone attenuate fibroblast proliferation and collagen deposition in vitro and in preclinical models [192]. Pirfenidone is approved for the treatment of idiopathic pulmonary fibrosis in Europe, Japan, and the USA. The antifibrotic actions of pirfenidone and other data suggest that pirfenidone could modulate the tissue response to injury at multiple stages of wound repair to improve scarring and function as an adjuvant for abnormal wound healing processes. Preclinical investigations are currently underway in rabbits [193, 194] and rats [195], but controlled clinical studies are needed to evaluate the safety and efficacy of pirfenidone on abnormal wound healing.

The treatment of burn wounds with hyperbaric oxygen was first investigated in the mid-1960s and garnered some attention in the decades following, but controversy remains over potential risks and costs [196, 197]. Recent work in rat models has shown that hyperbaric oxygen reduces healing time and improves scar appearance of burn injuries [198]. Advancements in hyperbaric chambers have reduced the overall cost associated with treatment, and controlled clinical trials in humans are beginning to produce data supporting the conclusion that hyperbaric oxygen is safe and effective for improving burn wound healing [199–201]. However, more data are needed before broad conclusions can be made about the overall utility of hyperbaric oxygen for treating burns.

Future research on burn patient care will focus on a variety of areas [202]. Considering a current survival rate of over 97 % for burn patients [3], major advancements from the past several decades have improved patient care such that significant future improvements in patient survival rate will be more difficult. However, improvements are still needed in individualized care, namely prediction of patient outcomes and the ability to tailor treatment to optimize functional recovery. Improvements are also needed to accelerate wound closure and healing and to improve psychological care to promote successful reintegration. Research in inflammation, infection, stem cells, grafting, biomarkers, inflammation control, and rehabilitation will continue to improve individualized care and create new treatment options.

Conclusion

The various clinical challenges in treating acute thermal injuries include balancing the many factors that affect wound healing to reduce the length of stay (and associated cost of treatment), the risk of infection, the time to wound closure, and the overall time to functional recovery. The treatment of burn wounds has evolved over several decades through clinical and preclinical research. Significant advancements have been made in patient care, including tracking wound healing, developing novel graft and coverage options, controlling inflammation, optimizing dietary needs, and testing unique pharmacological interventions. As a result of these efforts, patient survival has improved along with a concomitant decrease in the length of stay, which in turn results in a decreased cost to the patient and the medical providers. A summary of selected clinical recommendations is provided (Table 3) to aid the intensivist, but it is important to remember that burn patients present unique challenges based on multiple variables (for example, age, TBSA, comorbidities) and treatment decisions must be tailored to each patient's needs. Current and future research will continue to identify novel targets and treatment paradigms to further improve burn wound care.

Abbreviation

TBSA: Total body surface area.

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Skin tissue engineering advances in severe burns: review and therapeutic applications

Abstract

Current advances in basic stem cell research and tissue engineering augur well for the development of improved cultured skin tissue substitutes: a class of products that is still fraught with limitations for clinical use. Although the ability to grow autologous keratinocytes in-vitro from a small skin biopsy into sheets of stratified epithelium (within 3 to 4 weeks) helped alleviate the problem of insufficient donor site for extensive burn, many burn units still have to grapple with insufficient skin allografts which are used as intermediate wound coverage after burn excision. Alternatives offered by tissue-engineered skin dermal replacements to meet emergency demand have been used fairly successfully. Despite the availability of these commercial products, they all suffer from the same problems of extremely high cost, sub-normal skin microstructure and inconsistent engraftment, especially in full thickness burns. Clinical practice for severe burn treatment has since evolved to incorporate these tissue-engineered skin substitutes, usually as an adjunct to speed up epithelization for wound closure and/or to improve quality of life by improving the functional and cosmetic results long-term. This review seeks to bring the reader through the beginnings of skin tissue engineering, the utilization of some of the key products developed for the treatment of severe burns and the hope of harnessing stem cells to improve on current practice.

Keywords: Burns, Skin tissue engineering, Stem cells, Cultured epithelial autografts, Dermal substitutes, Microskin grafting

Background

Despite the recent question on whether skin is the largest organ in the human body [1], no one can dispute its protective, perceptive, regulatory and cosmetic functions. The top layer of the skin, the epidermis which comprised mainly of keratinocytes, is critical for survival as it provides the barrier against exogenous substances, chemicals, pathogens and prevents dehydration through the regulation of fluid loss. Other cells within the epidermis include melanocytes which give pigmentation and Langerhans' cells which provide immune surveillance. Beneath the epidermis, the dermis is a thicker layer of connective tissues that consists mainly of extracellular matrix (ECM) or structural components (predominantly collagen and elastin) which give mechanical strength, elasticity and a vascular plexus for skin nourishment. Cells interspersed within the ECM include fibroblasts, endothelial cells, smooth muscle cells and mast cells [2]. These two morphologically distinct layers — the epidermis and the dermis — are in constant communication across various levels (example at the molecular or cellular level, growth factor exchange, paracrine effects, etc.) to establish, maintain, or restore tissue homeostasis. Between the epidermis and dermis is the basement membrane (BM), a highly specialized ECM structure (composed of a set of distinct glycoproteins and proteoglycans) that physically separates the two layers rendering primarily a stabilizing though still dynamic interface and a diffusion barrier [3]. In general, the BM contains at least one member of the four protein families or subtypes of laminin, type IV collagen, nidogen, and perlecan, a heparan sulfate proteoglycan [4].

Populating the epidermal and dermal layers are the various skin appendages such as the hair follicles, sweat glands, sebaceous glands, blood vessels and nerves.

Extreme loss of skin function and structure due to injury and illness will result in substantial physiological imbalance and may ultimately lead to major disability or even death. As much as it is claimed that tissue-engineered skin is now a reality to treat severe and extensive burns, the fact remains that current skin substitutes available are still fraught with limitations for clinical use. This is clearly evident amongst burns or wound-care physicians that there is currently no single tissue-engineered substitute which can fully replicate the spilt-thickness skin autografts for permanent coverage of deep dermal or full thickness wounds in a one-step procedure. Indeed, clinical practice for severe burn treatments have since evolved (Fig. 1) to incorporate some of these tissue-engineered skin substitutes (Table 1), usually as an adjunct to speed up epithelisation for wound closure and/or to improve quality of life by improving functional and cosmetic results long-term. However, we must not lose hope, relook at our current practices, press on with innovation and develop new strategies in biology, material science and technological know-how as we seek to achieve the holy grail of creating a fully functional tissue-engineered composite skin with appendages for the clinics.

Review

Birth of skin tissue engineering

A coincidence?

The year 1975 seems to be a special year for skin tissue engineering, even before the term "tissue engineering" was officially adopted more than a decade later by the Washington National Science Foundation bioengineering panel meeting in 1987 [5] and later its definition elucidated further by Langer and Vacanti [6] in 1993. The beginnings of skin tissue engineering can be attributed to the pioneering work of two groups in the United States forty years ago. First, Rheinwald and Green reported the successful serial cultivation of human epidermal keratinocytes in vitro [7] in 1975 and later made possible the expansion of these cells into multiple epithelia suitable for grafting [8] from a small skin biopsy. In today's term, the work is termed "tissue engineering of the skin epidermis". Concurrently, Yannas, Burke and colleagues reported their maiden work on the in vitro and in vivo characterization of collagen degradation rate [9] in 1975 which we believe pave the way for the design of artificial biological dermal substitute [10], resulting in the "tissue engineering of the skin dermis".

Another coincidence?

Interestingly, six years later in 1981, both groups independently reported the clinical use of their respective tissue-engineered substitutes for the treatment of severe

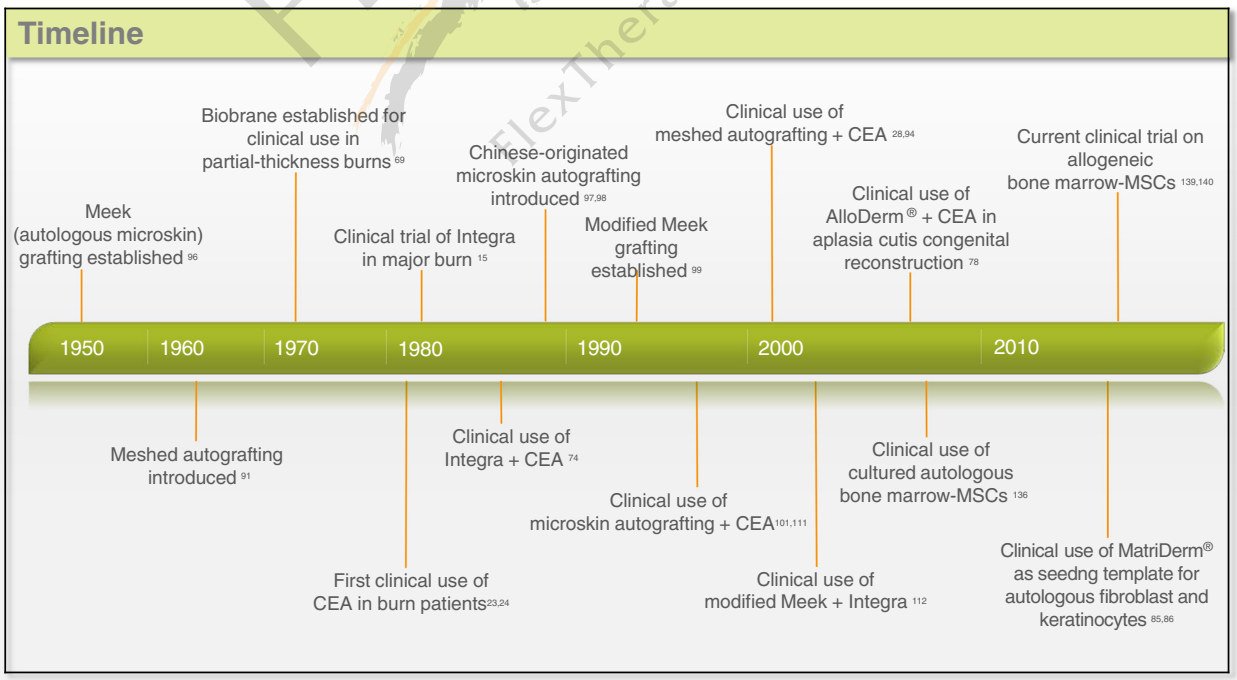

Fig. 1 Timeline of skin tissue engineering in burn surgery

Table 1 Tissue-engineered skin substitutes and current surgical techniques

	Skin substitute/surgical technique	Structure	Advantage	Disadvantage	References
EPIDERMAL	**Cultured epithelial autograft (CEA)**	Confluent autologous keratinocytes	In-vitro expansion for large burn area, permanent	Fragility, infection, high cost, variable take rate	7,11-13, 19-22,37
	CUONO's method *(CEA with split thickness allograft)*		Extensive burns	Two-stage procedure, precise grafting time coordination	25,27,28,33
	CEA with meshed split thickness skin autograft		Expansion 1:4, no rejection	Beyond 1:4 expansion: poor cosmetic and functional results, delayed re-epithelisation	83-86
	CEA with microskin autograft		Expansion 1:9-15,no rejection, high take-rate, shorter epithelisation time	Time-consuming, labor-intensive, hypertrophic scarring	84,85, 92,93,100
DERMAL	**Integra™**	cross-linked bovine tendon collagen-based dermal matrix linked with glycosaminoglycan (GAG)		Two-stage procedure, Infection, Hematomas, seromas	48-51
	Integra™ with CEA		Good long term aesthetic and functional outcome	High cost, poor adhesion	13,43,66
Artificial biological materials	Integra™ with Meek				104,105
	MatriDerm®	Bovine non-cross-linked lyophilized dermis, coated with alpha-elastin hydrolysate	One-stage procedure, promote vascularization, improves stability and elasticity of regenerating tissue	Need more scientific evidence to verify efficacy of one-step procedure	44,56,57
	Composite skin substitute	Matriderm as a template, seeded with expanded autologous skin fibroblast and keratinocytes	Full wound closure		76-78
	Biobrane®	silicone membrane and nylon mesh impregnated with porcine dermal collagen	One-stage procedure, coverage of partial thickness burns	Intolerant to contaminated wound bed	68-70
	AlloDerm®	Human acellular lyophilized dermis	Acellular, immunologically inert, provide natural dermal porosities for regeneration and vascularization on the wound bed	High cost, risk of transmitting disease, two-stage procedure	43,44,60,61,63
Natural biological materials	AlloDerm® with CEA			Multiple applications	69, 70
	Permacol™	Porcine acellular lyophilized dermis	Good aesthetic and functional outcome	Infection, Hematomas, seromas	
	Transcyte®	porcine collagen-coated nylon mesh seeded with allogeneic neonatal human foreskin fibroblasts	Immediate availability, ease of storage	Temporary	43,44
Synthetic materials	**Dermagraft®**	bioabsorbable polyglactin mesh scaffold seeded with cryopreserved allogeneic neonatal human foreskin fibroblasts	Ease of handling, no rejection, chronic wounds – diabetic ulcers	Poor ECM structure, infections, cellulitis,	
DERMO-EPIDERMAL	**PermaDerm™**	collagen-glycosamino-glycan substrates containing autologous fibroblasts and keratinocytes	permanent replacement of both dermal and epidermal layers, one-step procedure	No clinical trial reported yet	2,71-75
	DenovoSkin	plastically compressed collagen type I hydrogels engineered with human keratinocytes and fibroblasts	Near-normal skin architecture	Long culture time, no clinical series reported yet	79-82

and extensive burns, albeit in different approaches. O'Connor et al. reported the world's first grafting of extensive burns with sheets of cultured epithelium (expanded from autologous epidermal cells) on two adult patients with success at the Peter Bent Brigham Hospital [11, 12]. These autologous cultured sheets (Fig. 2) termed cultured epidermal autografts (CEA) were also subsequently demonstrated to provide permanent coverage of extensive full thickness burns in another two paediatric patients [13].

Meanwhile, Burke et al. (a few months after O'Connor et al.'s report) reported the successful use of a physiologically acceptable artificial dermis in the treatment of extensive burn injuries with full thickness component on ten patients [14]. This was followed by a randomized clinical trial for major burns led by Heimbach et al. [15] on the use of this artificial dermis, now known as Integra™ Dermal Regeneration Template. This successful multi-centre study involving eleven centres and many other studies [16, 17] might have inevitably given this dermal substitute a "gold standard" status for full thickness burns treatment [18].

While ground breaking, the work of the above two groups are still far from reaching the ultimate goal of replacing skin autografts for permanent coverage of deep dermal or full thickness wounds in extensive burns.

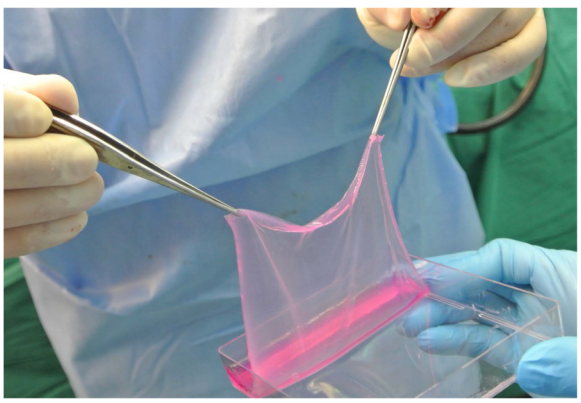

Fig. 2 Cultured epithelial autograft supported on a fibrin mat [38] used at the Singapore General Hospital Burns Centre to treat major burns

CEA: a bumpy ride for prevalence in the clinics

Importance of Cuono's method

One of the main disadvantages of the CEA technology was apparently the lack of consistency in engraftment, with poor "take" reported mainly on wounds devoid of dermal elements, even with properly cultured keratinocytes [19–22]. It was later demonstrated in the mid-1980s by Cuono and his colleagues on the importance of having the dermal component present when they reported good graft take of the CEA laid on healthy vascularized allogeneic dermis in a full thickness wound bed [23, 24]. For the Cuono's method to be effective, a two-stage procedure is required. First, there must be available human skin allografts ready to be grafted on excised full thickness wound. This is followed by a wait of about two to three weeks which would provide the patient with necessary protection and coverage as the underlying cadaver dermis vascularizes while the autologous epithelial sheets from the harvested small skin biopsy can be prepared simultaneously by culture. When the cultures are ready, the highly immunogenic cadaver epidermis placed on the patient earlier will have to be removed by dermabrasion to make way for the CEA to be grafted (Fig. 3). This two-stage composite allodermis/cultured autograft technique has been adopted by several centres with fairly reproducible success since the 1990s [25–27]. One relatively recent success story came from the Indiana University experience that reported a final graft take of 72.7 % with a 91 % overall survival rate on eighty-eight severe burn patients. These results as the authors mentioned "gives much optimism for continuing to use CEA in critically burned patient" [28].

The detractors

However, there are still detractors to this Cuono's method for a number of reasons. Firstly, there might not be readily available skin allografts, especially in the East Asian region where organ and tissue donation is still not prevalent [29, 30]. In addition, skin allografts carry some risks of infection and antigen exposure [31]. Secondly, the timing of the CEA placement could be a tricky balancing act. It was mentioned that if cadaver skin or epithelium is rejected or sloughed off prior to the availability of cultured epidermal grafts for the burn patients, the opportunity to use the cadaver dermis as vascularized dermal support (based on Cuono's method) might be lost [32]. The coordination of CEA use with the timing of surgery is therefore a concern. In another scenario, the wound bed might be ready for CEA grafting but yet the cultured keratinocytes were not ready or sufficient for grafting. On the other hand, there were situations where the CEA cultures were ready for grafting but the wound bed was not or the patient was too sick to undergo surgery. It is known that once the keratinocytes form a sheet in culture, the sheets need to be used within the shortest time as possible to maintain efficacy especially for treatment of full thickness burns [28, 33]. Otherwise, the keratinocyte stem cell population in the cultures would be compromised and these critical cells for regeneration would move towards an irreversible unidirectional process from holoclones (stem cells) to paraclones (highly differentiated cells) [34–36]. In such a case, the efficacy of the CEA would drop drastically, rendering poor engraftment and sub-optimal wound healing [37]. Even though there was a recommendation to use colony forming efficiency assay of keratinocytes (Fig. 4) as an indirect and simple quality check for the "regenerative property" of CEA cultures [36, 38], there were not too many adopters.

CEA sheets are fragile in nature and extreme care must be taken to avoid tangential and shearing forces while moving the patient's limb or repositioning the patient to prevent any loss of the cell layers. Therefore not surprising, it was reported that CEAs placed on anterior sites were amendable to improved take rates [28]. However with the need to keep the grafted site completely immobile [39] and given the limited sites for grafting of CEAs (recommended to be placed on "non-pressure sites" to prevent shearing off of these friable grafts), these led to some form of resistance to CEA use by

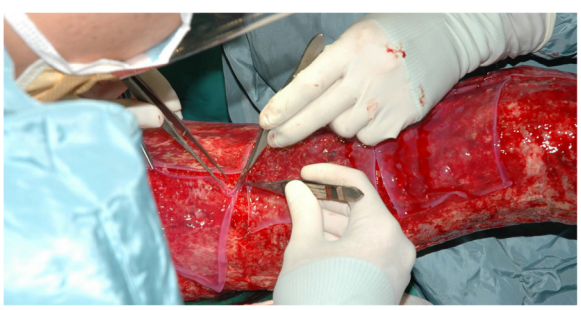

Fig. 3 Grafting of cultured epithelial autografts on allodermis at Singapore General Hospital Burns Centre based on Cuono's two-stage method

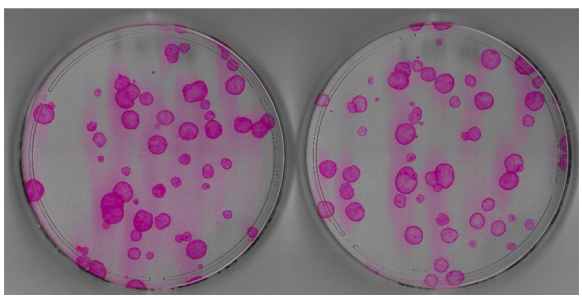

Fig. 4 Colony forming efficiency assay: a simple way of measuring the clonogenic ability of keratinocytes and estimating the growth capacity of these cells

certain burn surgeons. In addition, the higher vulnerability of CEA to bacterial contamination on the wound site which could result in almost complete loss of the grafts compared to meshed autograft [22, 40] also exacerbate the reluctance of CEA use in the clinical setting.

Issue of cost

Finally, the high cost of production of CEA has often been quoted as one of the major hindrance for its widespread use in many review papers [37, 39, 41]. This cost is going to escalate further as there is a trend of directing cellular therapeutic products with "substantial manipulation" (this would include keratinocyte expansion) to be produced in a Good Manufacturing Practice (GMP) setting for administrative demands like quality, safety controls and regulations [42]. GMP is a pharmaceutical quality system which ensures that products are consistently produced in a tightly-controlled cleanroom environment according to stringent quality standards. Typically, adoption of this practice especially for autologous human cellular therapeutic products would entail much higher cost in terms of overheads such as manpower and facility resources as there is no economy of scale for such tailored cellular products unlike the manufacturing of allogeneic cells [43].

Dermal substitutes: a not so bumpy ride for prevalence in the clinics

Two-stage procedure

Based on the knowledge that there are now many dermal substitute products available commercially and with many of such products widely reviewed and tested in both pre-clinical and clinical settings [2, 18, 32, 41, 43–46], it is self-evident that the challenges for their therapeutic use (especially for acellular ones) is less than CEA (cellular-autologous products) insofar as their respective functional requirements (dermal versus epidermal) are totally different. If epidermis is "life": providing the protection crucial for our survival, then dermis is the "quality of life". Most current biocompatible dermal substitutes are to a certain extent able to mimic the basic properties of the ECM in the human skin by providing some form of structural integrity, elasticity and a vascular bed. However, the fact remains that these products lack an epithelial layer and in most cases, the use of such products will need to be followed up with grafting of split thickness skin autograft for permanent coverage, usually in a two-stage procedure. While there are advantages of harvesting thinner split-thickness skin autografts and that donor sites heal faster [15], there is still harvest site morbidity with a possibility of insufficient donor sites in extensive burns.

Integra™

Being the most widely accepted artificial biological dermal substitute [47], the use of Integra™ which is made up of bovine collagen and chondroitin 6-sulfate, has been reported to give good aesthetic and functional outcomes when compared to using split thickness skin autograft alone [48]. However, it is known that infection still remains the most commonly reported complication of Integra™ [49–51] . Meticulous wound bed preparation before the use of this template (or similar type of artificial biological materials) has been reported to be critical to ensure good take. Otherwise with the collection of hematomas and seromas beneath the material, the product is susceptible to infection resulting in a costly loss of an expensive tissue-engineered product and manpower time, while increasing the length of hospital stay for the patient.

But with much progress in the development of newer wound care products, the use of advanced antimicrobial silver dressing such as Acticoat dressing as an overlay to Integra™ [44] as well as the use of topical negative pressure or vacuum assisted closure (VAC) in combination with Integra™ [52–54] have been reported to mitigate the rates of infection with positive results. In one study, it was reported that the application of topical negative pressure dressings to dermal templates can reduce shearing forces, restrict seroma and haematoma formation, simplify wound care and improve patient tolerance; even as it was reported that the negative pressure did not accelerate vascularization of the Integra dermal template based on histological assessment [55].

MatriDerm®

Another newer generation of artificial biological dermal substitute that is gaining wider acceptance for use in the clinics recently is MatriDerm®. Made up of bovine collagen and an elastin hydrolysate, this product is touted for use in a single-stage procedure. MatriDerm® was shown to be able to accommodate split thickness skin autograft safely in one step with no compromise in take on burn injuries [56, 57]; and it seemed to be feasible for use in critically ill patients [58]. It was suggested that unlike Integra™ which has antigenic properties due to the presence of chondroitin-6-sulfate, the combination of collagen and elastin in MatriDerm® can promote vascularization quicker through the support of ingrowth cells and vessels while improving stability and elasticity of regenerating tissue [44]. Furthermore, higher rate of degradation and difference in neodermal thickness of MatriDerm® compared to Integra™ [59] might give the former an extra edge; even though there is still relatively weak scientific evidence on their comparison in the current literature [58].

Other dermal substitutes

There are also other categories of dermal substitutes available commercially. On top of substitutes made from "*Artificial Biological Materials*" described above for Integra™ and MatriDerm®, the other two commonly recognised classifications are : "*Natural Biological Materials*" and "*Synthetic Materials*" [43, 44]. Decellularized human skin allografts (such as AlloDerm®) and decellularized porcine xenografts (such as Permacol™) are dermal products derived from "*Natural Biological Materials*" as typically these products are "de-epidermalized" and processed to remove the antigenic cellular components while retaining the structure of the native dermis. Known as acellular dermal matrix (ADM), the advantage of using this class of product is that the templates derived from decellularized tissues provide natural dermal porosities for regeneration and vascularisation on the wound bed in-vivo. In vitro studies have shown that such products support adhesion, growth, and function of several cell types [60, 61]. In addition, there is partial conservation of BM which might aid epidermal cell attachment [62]. Nevertheless these products are known for their high cost with the risk of transmitting infectious diseases and they are usually used in two surgical procedures [63]. But with advancement in processing of human skin allografts and also with the use of negative pressure therapy, studies using a one-stage procedure of co-grafting with human ADM (CG derm) and autologous split thickness skin grafts have been reported with some success [64, 65].

Finally, dermal substitutes using synthetic materials seem to be less widely used since their inception in the 1990s for burn treatment. Such products include Transcyte®, a porcine collagen-coated nylon mesh seeded with allogeneic neonatal human foreskin fibroblasts bonded to a silicon membrane; and Dermagraft®, a bioabsorbable polyglactin mesh scaffold seeded with cryopreserved allogeneic neonatal human foreskin fibroblasts. It was reported that both of these products are currently off the market but their technologies have been licensed to Advanced BioHealing for further production and marketing to improve the product [44].

This brings to the issue about cost of dermal substitutes. In general, dermal substitutes are deemed to be costly for clinical usage as mentioned in a report comparing the clinical outcome of MatriDerm® and Integra™ [66]. Based on a tabulated comparison of cost per cm^2 between different dermal substitutes in 2007, it was noted that Dermagraft™ was about twice the cost of Integra™ [67], and that might explain why Dermagraft™ is presently off-market.

Biobrane®

As opposed to Transcyte®, Biobrane® is still widely used as a synthetic skin substitute as it is known for its success in the definitive management of partial thickness burns (Fig. 5) in many centres [68–70]. Biobrane® is the exact product of Transcyte® less the neonatal human fibroblasts and is also used as a dressing to hold meshed autografts and cultured keratinocyte suspension [69, 71]. On top of the versatility in usage, the popularity of Biobrane® is likely due to its lower cost and yet, it is as efficacious in treating partial thickness burns compared to Transcyte® [72]. In a recent comparison of Biobrane® and cadaveric allograft for temporizing the acute burn wound, Austin et al. concluded that Biobrane® is superior in terms of lower procedural time and associated cost largely due to the relative ease of application of this product [73]. Indeed, Greenwood et al. in a sharing of their experience using Biobrane® on 703 patients concluded that Biobrane® is relatively inexpensive, easy to store, apply and fix, and reliable when used according to guidelines [69].

Currently, there is also an increasing trend to use Biobrane® as an alternative to cadaver allografts as temporizing dressings after excision of major burn injuries [68, 69, 73]. However, the caveat of using this technique is that the wound bed must be meticulously prepared to prevent any infection and there is still the lack of existing literature and published clinical protocols [68] to

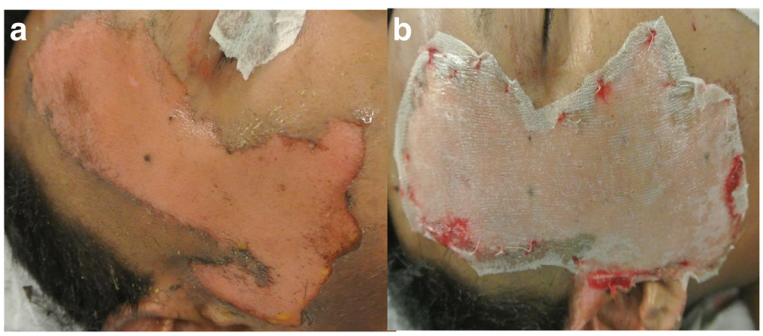

Fig. 5 Application of Biobrane. **a.** Before application **b.** After application

prove that it can be a worthy replacement of the human skin allografts, especially in the treatment of full thickness burn wounds.

Towards a composite skin substitute for permanent replacement

Combining CEA and Integra™

The first thing that comes to mind for an autologous composite skin to be used for permanent coverage is to just individually combine the artificial dermal substitute (Integra™) and the CEA on the wound bed. After all, both have their roots in 1975 and their first respective independent clinical use to treat severe burns was reported in 1981. The first hint of their combined use was in 1984 when Gallico et al. reported the permanent coverage of large burn wounds with autologous cultured epithelium in *The New England Journal of Medicine* [13]. In the study, it was mentioned that *Patient 1* with flame burns of 97 % total body surface area had received excision to the level of muscle fascia on certain part of the body and were covered temporarily by human cadaver skin allograft or a collagen-glycoaminoglycans-silastic sheet (later known as Integra). This was followed by grafting with CEA even though it was not mentioned whether the Integra™ was replaced with the cultured epithelium. It was only in 1998 that the use of cultured autologous keratinocytes with Integra in resurfacing of acute burns was presented in a case report by Pandya et al. [74]. Used as a two-step procedure, the authors resurfaced the neodermis (vascularized Integra™) by the third week with ultra-thin meshed autografts and CEA on the anterior torso of the patient in two mirror-image halves. It was found that the CEA performed as well as the side covered with split thickness autograft in terms of appearance, durability and speed of healing. This positive result was not surprising as a month earlier in the same journal, another group [31] reported that vascularized collagen-glycoaminoglycan matrices produced a favourable substrate for cultured epithelial autografts in a porcine model.

Interestingly, there were practically no subsequent bigger clinical series which describe the two-stage use of Integra™ followed by the grafting of CEA. One of the reasons as alluded by Pandya et al. [74] was that of cost when they mentioned the combination of Integra™ and autologous cultured keratinocytes was very expensive. The other reason quoted was that direct application of cultured keratinocytes to an Integra™ wound bed was found to be problematic due to the poor adhesion of the cells to the template [43]. This might be attributed to the lack of fibroblasts migrated into the Integra™ which delayed the maturation of the BM between the epithelial grafts and the neodermis. In a bilayered skin equivalent tested in-vitro, the presence of fibroblasts with keratinocytes was reported to be important for the formation of high levels of collagen type IV and laminin, some of the key elements of the BM [32, 75]. In fact it was further validated later in another skin equivalent model that only in the presence of fibroblasts or of various growth factors, laminin 5 and laminin 10/11, nidogen, uncein, type IV and type VII collagen (all of which are components of the BM) were decorating the dermal/epidermal junction [76].

Combining CEA and other skin substitutes

Similarly it was also observed that there were scanty clinical reports on the two-stage use of AlloDerm®, (a decellularized human ADM product that was first approved by the FDA to treat burns in 1992 [77]) and CEA. One notable case report in 2009 was the successful treatment of aplasia cutis congenita using the combination of first applying on the defect with AlloDerm® followed by CEA grafting two weeks later. It was reported that during a two-year follow-up period, there were no complications such as motion limits resulting from hypertrophic scarring or scar contracture. Coincidentally, there was also an earlier attempt in 2000 to use allogeneic dermis and CEA as a one-stage procedure to reconstruct aplasia cutis congenita of the trunk in a newborn infant [78]. While the results were reported to be promising, it was noted that three additional applications of CEAs were required for 90 % of the wound to be healed.

Autologous dermo-epidermal composite skin substitutes

By far, the most promising autologous dermo-epidermal (composite) skin substitute reported is the cultured skin substitutes (CSS) developed in Cincinnati in the United States. This substitute is composed of collagen-glycosaminoglycan substrates which contains autologous fibroblasts and keratinocytes. Reported to be able to provide permanent replacement of both dermal and epidermal layers in a single grafting procedure [2, 79–83], this product was later commercialised as PermaDerm™ [43]. PermaDerm™ can currently be engineered within 30 days. It is indicated for the treatment of large full-thickness skin defects, however it has not yet obtained Food and Drug Administration (FDA) approval and clinical trials on its efficacy remain to be seen. More recently, a German group reported the development of an engraftable tissue-cultured composite skin autograft using MatriDerm® as a template for the seeding of expanded autologous skin fibroblasts and keratinocytes [84]. They reported that this developed skin composite has strong homology to healthy human skin based on the characterization of the epidermal strata, comparison of the differentiation and proliferation markers and the presence of a functional basal lamina. This skin

substitute was subsequently used clinically on two patients with full thickness wounds. While the wounds are relatively small in size (the largest being 9 x 6 cm), there was positive outcome with full wound closure for all the defects treated [85, 86].

There are many promising autologous cellular bilayered skin substitutes proposed out there such as DenovoSkin developed at Tissue Biology Research Unit, University Children's Hospital, Zurich, Switzerland. This product is based on plastically compressed collagen type I hydrogels engineered with human keratinocytes and fibroblasts from a small skin biopsy [87, 88]. The same group has further reported for the first time, a more advanced bioengineered human dermo-epidermal skin graft containing functional dermal blood and lymphatic vessels using human keratinocytes,fibroblasts, and microvascular endothelial cells [89, 90]. However the challenge for the utilization of such products remains; that is: how soon can we culture sufficient autologous cells, impregnate them into the scaffold and get the substitute ready for grafting. Time is of essence especially for a massive burn case with little donor site and options.

Adapting the use of skin tissue engineering products to current practice in the clinics

Combining CEA and widely-meshed autografting

One of the solutions adopted in the clinical setting autografting to quickly treat extensive full-thickness burn wounds is to use widely-meshed split thickness skin grafts to cover the large injured surfaces after the technique of meshing was introduced by Tanner et al. in 1964 [91]. However at expansion rate greater than 1:4, such meshed grafts have been reported to be difficult to handle. Worse still, re-epithelialization might be delayed or even absent when a meshed piece of skin was expanded beyond a ratio of 1:6 [92]; and with substantial areas left uncovered in the interstices, there would be cosmetically unsatisfactory "string vest" appearance [93]. To address these disadvantages, use of CEA in combination with widely meshed autografts (Fig. 6) has been reported with success in a clinical series of 12 children with major burns. As the authors in the study mentioned, this synergistic combination of autografts and autologous cultured epidermis sheets appeared more effective than one of these techniques applied alone [94]. Based on the Indiana University experience of eighty-eight patients who received CEA (an earlier-mentioned study deemed to be one of the success stories in CEA usage), the authors also reported that if an insufficient amount of cadaver dermis remains after allografting (Cuono's method), 1:6 meshed split thickness autografts (if available) would be placed onto recipient wound bed under the CEA sheets. This was to minimize shear forces and hasten graft take in areas with inadequate allodermis [28]. Other variant technique involving the use of sprayed cultured autologous keratinocytes in combination with meshed autografts to accelerate wound closure in difficult-to-heal burn patients was also reported [95].

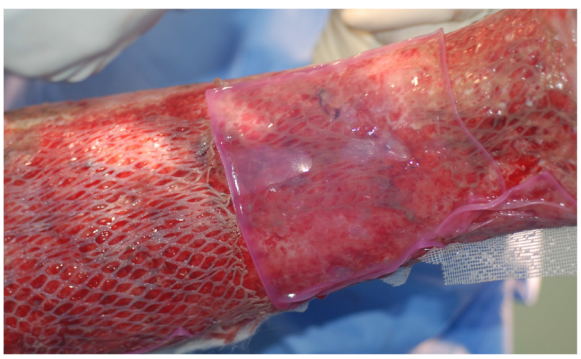

Fig. 6 Combining cultured epithelial autografts and widely-meshed autografts

Resurgence of microskin autografting

Based on the current literature, there seems to be a resurgent towards the use of autologous microskin grafting (Fig. 7) even though the concept of using small skin bits for autografting was described by Meek in 1958 [96], before the use of meshed grafts. Chinese-originated microskin autografting was described in the 1980s for the treatment of extensive burns [97, 98]. Later in 1993, Kreis et al. improved on Meek's original technique [99] and popularised the so-called modified Meek method which was found to be superior to widely-meshed autografts when higher expansion rates (up to 1:9) were used in adult patients with major burns [100]. While the modified Meek method or the Chinese-originated microskin grafting method (expansion rate of up to 1:15) is still time-consuming and laborious with the need for more staff in the operating theatre [101], these problems do not seem to serve as a deterrent because this procedure which can be performed almost immediately is seen as life-saving [102]. Outcome is generally positive with reliable take rate even on difficult wound bed [103], shorter epithelization time [101, 104, 105], less prone to loss due to infection [92, 100] as well as satisfactory functional and aesthetic results [106–108]. Moreover if the Meek graft fail, it was restricted to a partial area without affecting the neighbouring skin islands [103] formed from the epithelial migration from the borders of each of the skin bits. More recently, the use of micrograft transplantation with immediate 100-fold expansion for epidermal regeneration on both healthy and diabetic wounds in porcine models was reported [109]. In the same report, it was mentioned early clinical results confirmed the utility of this technique in a case report of a

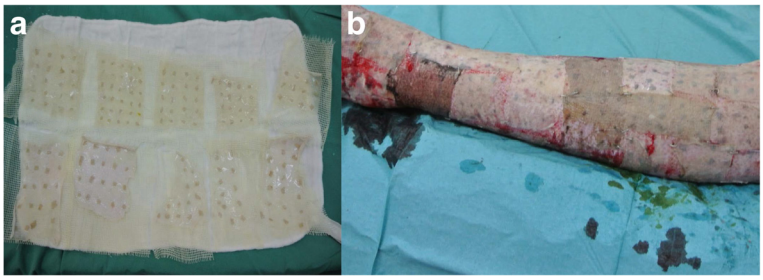

Fig. 7 Microskin autografting on an extensive-burn patient at the Singapore General Hospital Burns Centre. **a.** Split thickness skin autografts were cut into small pieces and laid in close proximity with one another on cadaveric allografts. **b.** Sheets of autologous microskin-allografts were grafted onto recipient wound bed

civilian patient with fifty-four percent total body surface area burn admitted to a U.S. Army military hospital in Iraq and successfully treated with the described micrografting technique [110].

Combining CEA and microskin autografting

However, scar contracture and hypertrophic scar formation (as would be seen in cases using widely-meshed autografts) are problems frequently associated with microskin autografting, especially where high expansion ratios are used for the treatment of extensive burns with high percentage of deep dermal or full thickness component [92, 93]. Therefore as what was described earlier for widely-meshed skin autografts, CEA was also reported to be used in combination with microskin autografting to accelerate wound closure [93, 101, 111]. Results reported have been positive with one of the earliest studies by Raff et al. describing that the combination of widely expanded postage stamp split thickness grafts and CEA provided an excellent take rate and durable wound closure within a short time while avoiding the problems associated with engraftment of CEA on fascia [101]. Menon et al. also reported that with the use of sprayed CEA and modified Meek technique, they observed no cases of blistering or scar contracture in those treated sites but unfortunately, the problem of hypertrophic scar remained [93].

Modified Meek technique and Integra™

The modified Meek technique in combination with Integra™ dermal template in a two-stage procedure has been reported in extensive burns with some success in a case report involving three patients [112]. As well, radical resection and reconstruction of a giant congenital melanocytic nevus with meek-graft covered Integra was also reported [113]. However, there are very few reports that utilised the above described technique subsequently. On top of cost and issue of infection, it can be speculated that the lack of popularity of this two-stage procedure is that it would incur a delay in utilising the microskin for epithelization which is the main strength of the micrografting technique.

Where is the next trajectory?

Stem cells

Advances in research of adult stem cells and embryonic stem cells offer hope for the therapeutic deficiencies in severe burn treatment using existing skin tissue-engineered products. The therapeutic power of stem cells resides in their clonogenicity and potency [114] and these can be delivered in conjunction with skin composites or by various other methods, including direct application [115]. More recently, there is a burgeoning interest in human induced pluripotent stem cells (hiPSCs) as this Nobel-winning technology pioneered by Shinya Yamanaka and his team [116, 117] enables the reprogramming of adult somatic cells to embryonic-stage cells. hiPSCs technology therefore allows for patient- and disease-specific stem cells to be used for the development of therapeutics, including more advanced products for skin grafting and treatment of cutaneous wounds [115]. However, the recent suspension of the world's first clinical trial involving hiPSCs to treat age-related macular degeneration continues to raise questions about the safety of this new technology. hiPSCs often acquire mutations with epigenetic and chromosomal changes in culture [118]. Hence, human epidermal and mesenchymal stem cells remain the more promising options for clinical use to treat severe burns, at least in the near term.

Enriching for epidermal stem cells

Poor engraftment of CEA even on a properly-prepared vascularised wound bed with dermal element is thought to be due to epidermal stem cell depletion during graft preparation. A solution for this would be to start with a pure population or higher percentage of these stem cells as suggested by Charruyer and Ghadially [119]. Epidermal stem cells can be enriched from the patient's own skin and a recent study demonstrated that ABCG2, a

member of the ATP binding cassette (ABC) transporter family, was a robust stem cell indicator in the human interfollicular keratinocytes that could potentially be used to quickly enrich for keratinocyte stem cells [120]. Mavilio et al. showed that sheets of epithelium grown from autologous holoclones or keratinocyte stem cells (modified genetically) could be used to treat a patient with junctional epidermolysis bullosa [121], demonstrating the power of this graft refinement. The use of enriched population epidermal stem cells for the preparation of cultured grafts for patients offers hope of overcoming several limitations of current skin substitutes as in a suitable microenvironment, keratinocyte stem cells can also form appendages such as hair, epidermis and sebaceous glands [122, 123]. However finding or creating that elusive microenvironment (in vivo or in vitro) - to provide the necessary molecular or cellular signals for the stem cells to regenerate a fully functional skin with all its appendages - remains a challenge.

Harnessing allogeneic mesenchymal stem cells

During the past decade, adult tissue-derived MSCs have rapidly moved from in-vitro and animal studies into human trials as a therapeutic modality for a diverse range of clinical applications. MSCs raise great expectations in regenerative medicine, not only because of their multipotent differentiation characteristics, trophic and immunomodulatory effects but also for their extensive sources and biostability when cultured and expanded in vitro [124]. Apart from bone marrow and adipose tissues, human MSCs can also be isolated from a variety of other tissues such as the amniotic membrane [125], umbilical cord [126, 127], cord blood [128] as well as the hair follicle dermal papilla [129] and sheath [130, 131].

MSCs have demonstrated a number of properties in-vitro that can promote tissue repair, including the production of multiple growth factors, cytokines, collagens, and matrix metalloproteinases [132, 133] in addition to the ability to promote migration of other skin cells such as keratinocytes [134]. MSCs have also been reported to enhance wound healing through differentiation and angiogenesis [135]. In the current literature, several clinical cases on the use of cultured autologous bone marrow MSCs for localized and topical treatment of chronic wounds have been reported. Yoshikawa et al. treated twenty patients with various non-healing wounds (i.e., burns, lower extremity ulcers, and decubitus ulcers) using autologous bone marrow–derived mesenchymal stem cells expanded in culture and a dermal replacement with or without autologous skin graft [136]. The authors reported that 18 of the 20 wounds appeared healed completely with the cell-composite graft transfer, and the addition of mesenchymal stem cells facilitated regeneration of the native tissue by histologic examination. For allogeneic MSCs usage, Hanson et al. [137] reported the use allogeneic bone marrow- or adipose-derived, MSCs to treat partial-thickness wounds of Göttingen Minipigs and demonstrated the safety, feasibility and potential efficacy of these MSCs for treatment of wounds.

In our opinion, the immunomodulatory effect of MSCs is key to the immediate utilization of these cells for rapid treatment of severe burns. It is now clear that MSCs modulate both innate and adaptive responses and evidence is now emerging that the local microenvironment is important for the activation or licensing of MSCs to become immunosuppressive [138]. Without this property, there is no way we can harness the regenerative and pro-angiogenic effects of the MSCs in the first place. Thankfully, we can have this off-the-shelf option to use MSCs as an allogeneic source of cells which can be pretested for safety and potency before use. And as vascularization of dermal template is crucial for permanent skin graft take - whether in a one-stage or two-stage procedure, the presence of allogeneic MSCs would definitely give that extra edge towards angiogenesis.

It is therefore not surprising to learn that the first worldwide clinical trial which uses allogeneic bone marrow MSCs to treat 10 patients with large severe deep burns is in progress in Argentina. This is done by treating the wound with the application of MSCs through a fibrin-based polymer spray over an acellular dermal biological matrix [139]. The same group, Mansilla et al. has just reported their preliminary experience treating a patient with 60 % total body surface burned with positive results [140]. A search using "allogeneic mesenchymal stem cells for burns" in ClinicalTrials.gov (as at Nov 2015) also revealed that two of such trials have been filed [141] which further reinforce the hypothesis that allogeneic MSCs might have a role in major burn treatment.

Conclusions

Similar to the what was mentioned that no single treatment can be recommended in the management of diabetic foot ulcers based on the current and emerging therapies [142], there is no particular approach that is definitely superior for the treatment of severe burns. But based on existing technologies and products available for rapid coverage of extensive burns wounds - the use of Biobrane or similar products to cover the partial thickness component whilst the coverage of the deep dermal or full thickness component with skin allografts after excision, followed by a definite closure with autografts (meshed, microskin, CEA or in combination) - seem to be one of the efficacious and cost-effective management approaches. If the quality of life of the patients is to be considered such as to reduce scarring and

contractures, tissue-engineered dermal templates can be used but they typically come at a cost. Therefore, before technology can catch up in terms of producing a truly functional substitute that comes at a reasonable cost, the need for skin allograft tissue banks, whether local or regional, to serve healthcare centres that treat severe burns cannot be overstated. This is especially true in the event of mass casualty [143]. Having a facility that can double up as both a skin allograft bank and an autologous epithelial cell sheet culture laboratory would be a bonus as we seek to train and build up a critical mass of skin tissue engineers, scientists as well as administrators specializing in finance, quality assurance and regulatory affairs. Only by working closely with clinicians to fully appreciate the requirements for the patients, can this specialized pool of personnel innovate, harness emerging technologies, manage cost and navigate through the regulatory minefields for a realistic advancement of this exciting field of skin-based regenerative medicine.

Abbreviations

ADM: acellular dermal matrix; ATP: ATP binding cassette; BM: basement membrane; CEA: cultured epithelial autografts; CSS: cultured skin substitutes; ECM: extracellular matrix; FDA: Food and Drug Administration; GMP: Good Manufacturing Practice; hiPSCs: human induced pluripotent stem cells; MSCs: mesenchymal stem cells; VAC: vacuum assisted closure.

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