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A Proposal for Selective "Delayed Closure" of the Donor Area

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During the past year I have adopted a policy of delaying the donor closure for 30-60 minutes, until after the recipient sites have been made, and placing a temporary, moist dressing in the wound. The initial impetus for this change in my order of procedures was that I was unhappy with the fact that, in a large percentage of my cases, I was undermining the inferior donor edge (and sometimes the superior one also) in order to facilitate closure. It finally dawned on me that the most likely reason for the two edges not abutting each other easily after donor harvesting was simply the fact that I had just tumesced the tissues on both sides and underneath with 60-100cc of saline solution, much of which was still present. The simple physical presence of this solution in the tissues, I believe, makes donor closure more difficult at that time in the procedure and clouds one's initial judgment as to how difficult the closure will be. Thus, the temptation to undermine is increased. My suspicions were confirmed after only a few cases, when I discovered the passage of this short period of time did in fact allow the saline to dissipate and the tissues to go back to their normal soft, supple state, and in 90% of my cases, the closure was remarkably easy. Figures 1, 2, and 3 show a patient's open donor wound (donor strips removed totaled 1cm in width) initially (Figure 1), with gentle pressure at that time (Figure 2), and 40 minutes later (Figure 3).

For those surgeons who do not tumesce the donor area, this change in routine may not be of much value, except for two small advantages: one, the opportunity to check the donor bed on two separate occasions for bleeders; and two, the possibility of simply enlarging the existing, open donor bed, should a small, additional amount of hair be needed to completely fill the recipient sites. Regarding bleeders, on initial inspection of the freshly made donor wound space, I usually find two or three bleeding sites (rarely an arterial one) that require cautery with the Infrared Coagulator. I now invariably find

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Figure 1

Figure 2

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