

Reconsidering the Clinical Value of Halo Split-Skin Grafts Compared with Standard STSG

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We read with great interest the article by Jimenez-Balcells, titled “Efficacy of Halo Split-Skin Grafts for Treating Non-Melanoma Skin Cancers in the Foot and Ankle: A Clinical Case Series” [1]. The author aimed to demonstrate the feasibility of the halo split-skin graft (HSSG) in the treatment of nonmelanoma skin cancer in difficult anatomical locations. However, we would like to share some concerns about this technique from a clinical practice perspective.

The case images in the article show, for example, that even at five weeks, there were noticeable scars and areas of incomplete epithelialization in the lesion area. However, with the split-thickness skin graft (STSG) method we use in our routine practice, the donor area heals completely with epithelialization within 7–10 days [2,3]. This demonstrates that STSG offers more predictable results in terms of healing time and patient comfort.

On the other hand, with full-thickness skin graft (FTSG), the donor area does not heal spontaneously; primary suturing or flap closure is required [4]. The HSSG technique recommends harvesting the graft with a razor blade. However, this method lacks the controllable thickness adjustment provided by the use of a dermatome. This can create additional risks, such as spontaneous epithelialization or trauma to the donor site [5].

In conclusion, while the HSSG technique is noteworthy, its superiority is clear in routine practice, given the rapid donor site healing, predictable thickness adjustment, and more reliable cosmetic/functional results provided by the standard STSG technique. In this context, we believe that the advantages of the halo split-skin graft should be evaluated in larger patient series and controlled studies, directly comparing it with established methods such as STSG.

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