Modified Meek technique using pre-folded polyamide gauzes: a 10-patient case series with extensive burns

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ABSTRACT – REZUMAT

Modified Meek technique using pre-folded polyamide gauzes: a 10-patient case series with extensive burns

Extensive burns still represent a major challenge due to high mortality rates and limited donor skin area availability, particularly in patients with inhalation injuries, advanced age, and large total body surface area (TBSA) burns. This case series presents the clinical outcomes of 10 patients treated with the modified Meek micrografting technique using pre-folded polyamide gauzes at the Emergency Clinical Hospital for Plastic, Reconstructive, and Burn Surgery in Bucharest between 2020 and 2025.

Patients included in this article sustained burns involving more than 20% TBSA, with an average of 56% and a mean Abbreviated Burn Severity Index (ABSI) score of 11. The Meek micrografting technique utilised expansion rates of up to 1:6 and was primarily employed in the initial grafting surgeries. The most commonly affected areas were the thorax, the upper limbs, and the lower limbs. A single Meek procedure was used in seven patients, while the remaining three patients required multiple surgeries, with one of them undergoing four Meek interventions.

In our cohort, the Meek technique demonstrated consistent performance, with actual expansion rates of 89% for the intended 1:6 ratio and 90.02% for the intended 1:4 ratio. Reliable graft take and coverage were achieved using the modified Meek procedure in all ten patients, with minimal regrafting (≤ 3% TBSA) required in initially grafted areas. Despite favorable local outcomes, overall mortality in our group remained high (90%), largely attributable to the severity of initial burn injuries and associated systemic complications.

The modified Meek micrografting technique has proven effective in maximising graft coverage in full-thickness, extensive burns with limited donor areas. However, patient prognosis primarily depends on the severity of burns and the extent of systemic compromise.

Keywords: *Meek grafting, burns, textile wound coverage, full-thickness burns, pre-folded gauze*

Tehnica Meek modificată utilizând comprese pre-plisate de poliamidă: serie clinică de 10 cazuri cu arsuri extinse

Arsurile extinse continuă să reprezinte o provocare majoră în practica medicală, din cauza mortalității ridicate și a disponibilității limitate a zonelor donatoare, în special in cazul pacienților cu leziuni inhalatorii, vârsta înaintată și suprafața corporală arsă (TBSA) extinsă. Prezenta serie de cazuri descrie rezultatele clinice obținute la 10 pacienți tratați prin tehnica de microgrefare Meek modificată, utilizând comprese pre-plisate de poliamidă, în cadrul Spitalului Clinic de Urgență de Chirurgie Plastică, Reparatorie și Arsuri din București, în perioada 2020–2025.

Pacienții incluși în studiu au prezentat arsuri afectând peste 20% din suprafața corporală totală, cu o medie de 56% și un scor ABSI (Abbreviated Burn Severity Index) mediu de 11. Tehnica Meek a fost aplicată în principal în intervențiile chirurgicale inițiale, folosind rapoarte de expandare de până la 1:6. Cele mai frecvent implicate regiuni au fost toracele, membrele superioare și membrele inferioare. Pentru șapte pacienți s-a efectuat o singură procedură de grefare Meek, iar ceilalți trei au necesitat intervenții multiple, unul dintre aceștia beneficiind de patru proceduri succesive.

În această serie, tehnica Meek a oferit rezultate constante, cu un raport efectiv de expandare de 89% pentru raportul teoretic de 1:6 și de 90,02% pentru raportul teoretic de 1:4. S-a obținut o supraviețuire și o integrare satisfăcătoare a grefelor pentru toți cei zece pacienți, cu o rată de regrefare minimă (≤3% TBSA) în zonele inițial grefate. În ciuda rezultatelor locale favorabile, mortalitatea generală a rămas ridicată (90%), aspect atribuibil în principal severității leziunilor inițiale și complicațiilor sistemice asociate.

Tehnica de microgrefare Meek modificată s-a dovedit eficientă în maximizarea acoperirii cutanate în cazul arsurilor extinse, de grosime totală, la pacienți cu zone donatoare limitate. Cu toate acestea, prognosticul vital rămâne strâns corelat cu severitatea arsurilor și cu gradul afectarii sistemice.

Cuvinte-cheie*: tehnica Meek modificată, arsuri, acoperirea plăgilor, arsuri de grosime completă, comprese preplisate*

INTRODUCTION

Extensive burn injuries remain one of the principal causes of morbidity and mortality among the general population. Advances in resuscitation protocols, surgical approaches by early excision and grafting, and improved metabolic support have significantly contributed to reducing mortality rates among burn victims in recent decades. Nonetheless, factors such as

advanced age, a high percentage of total body surface area burned, the presence of full-thickness burns, and concomitant inhalation injury continue to be strong predictors of poor prognosis and high mortality rates [1].
Early burn injury excision and coverage with split-thickness skin grafts (STSGs) harvested from healthy donor areas using an electrical dermatome (autografting) remains the gold standard for treating deep burn injuries [2].
As the percentage of burned total body surface area (%TBSA) increases, the scarcity of available healthy donor areas becomes a significant challenge. To address this limitation, several skin graft expansion techniques have been developed to maximise graft coverage most efficiently and effectively.
The method described by Tanner in 1964 allows skin grafts to be expanded from 1.5 up to 9 times their initial surface using a meshing device [3]. However, an expansion ratio greater than 1:3 comes with several disadvantages, including a more fragile autograft that is harder to handle, a characteristic “fishnet” appearance, delayed re-epithelialization, and an increased risk of infection. Additionally, there may be a significant discrepancy between the declared and actual expansion rates [4–6]. Therefore, for extensive burn areas, the micrografting technique described by Meek in 1958 and widely adopted in the late 1990s has proven to be an effective solution for covering the remaining defects after excision. Comparing these two techniques (the mesh graft and the Meek micro grafts), the latter has a more reliable expansion rate, since it depends on the pre-folded fabrics rather than on the skin graft, the method of fixation onto the wound bed reduces the risk of shifting, and it uses smaller skin fragments [7].

METHODS

Study design

We conducted a retrospective analysis of patients admitted to the Burn Unit of the Emergency Clinical Hospital for Plastic, Reconstructive, and Burn Surgery in Bucharest from 2020 to 2025 who underwent one or more skin grafting procedures using the modified Meek technique. Medical records were reviewed, and the following data were collected for each patient: demographics, burn characteristics, operative management, and clinical outcomes. Patients who presented with burns on less than 20% of their body area were excluded, as in our practice, the Meek technique is dedicated exclusively to patients where the availability of uninjured skin is limited.

Surgical management

Once the patients had been adequately resuscitated and were confirmed to be hemodynamically and respiratory stable, they were taken to the operating room for early burn wound excision under general anesthesia. Full-thickness burn wounds were excised tangentially. When necessary, fascial excisions were performed. Hemostasis was achieved using topical epinephrine and electrocautery.

Description of the Meek technique

The split-thickness skin graft (STSG) is harvested using an electrical dermatome and then applied to a square piece of cork (42 × 42 mm), allowing for the assembly of even smaller graft remnants, much like a puzzle. The cork and the graft are then placed in a cutting machine, which cuts only the graft into 14 stripes of 3 mm width. The cork is rotated 90° and passed again, thus resulting in 196 squares of 3 × 3 mm each. After spraying the epidermal surface with an adhesive dressing spray, the covered cork is transferred to a pre-folded polyamide gauze arranged in 14 × 14 mm square pleats on an aluminium foil backing; the pleat size matches the cuts made in the graft. The cork is then gently lifted, leaving the graft islands adherent to the gauze. The polyamide gauze, along with the aluminium foil, is stretched until the pleats are fully extended. The aluminium backing is removed, and the trimmed polyamide gauze is applied to the wound bed with the graft facing down, secured in place with surgical staples. Staples are left in place for 7 days [3].

RESULTS

Patient demographics and burn characteristics

We identified 10 patients with extensive burns who were treated by the modified Meek skin autografting technique, comprising nine males and one female. Ages ranged from 39 to 89 years, with a mean age of 62.3 years. The mean body surface area affected was 56%, with a range of 30% to 85%. Out of ten patients, one sustained burns by contact with a hot liquid, while the remaining nine were injured by flame exposure. In one case, the injury was self-inflicted. All patients sustained grade III (full-thickness) burn injuries. In addition, seven patients also presented with inhalation injury. ABSI score was calculated upon admission for all patients, varying from 8 to 15. The mean ABSI score in our cohort was 11, reflecting severe injury patterns.
The upper limbs were affected in all patients, followed by the lower limbs and thorax (9/10 cases). Cervico-facial burns were observed in six patients, and five patients had injuries involving the perineum or external genitalia (table 1).

Surgical management and grafting procedures

Initial burn excision and grafting were performed between post-injury days 2 and 14, once patients were hemodynamically and respiratory stable. Seven patients required only a single Meek grafting procedure, while three underwent multiple procedures (two, three, or four grafting sessions). Three patients received additional mesh grafts to cover limited residual defects. In one case, severe lower-limb and forearm burns necessitated amputations.
The modified Meek technique was used predominantly in initial grafting procedures, employing expansion

Table 1

	Patient	Gender	Age	%TBSA	Inhalation Injury	ABSI score	Mechanism of injury
Case 1	I.V.	M	75	55%	Yes	12	Flame
Case 2	I.M.	M	45	55%	No	10	Flame
Case 3	S.E.	F	77	35%	No	10	Hot liquid
Case 4	T.M.	M	48	65%	Yes	12	Flame
Case 5	M.V.	M	39	75%	Yes	12	Flame
Case 6	R.V.	M	55	45%	Yes	10	Flame
Case 7	P.M.	M	89	45%	No	11	Flame
Case 8	P.C.	M	85	70%	Yes	14	Flame
Case 9	S.P.	M	60	30%	Yes	8	Flame
Case 10	P.I	M	50	85%	Yes	14	Flame

ratios from 1:4 to 1:6. The Mean donor area was 3.11% TBSA for first procedures and 2.63% TBSA for subsequent interventions. Detailed operative data, including grafted areas and expansion ratios, are summarised in table 2.

For the five patients who required a second debridement and grafting procedure, the surgery was conducted between days 3 and 9 after the initial intervention. In four of these cases, the modified Meek was again the technique of choice for skin expansion. Among patients treated using the Meek technique, an average of 12.5% of total body surface area (%TBSA) was covered during the first intervention. The %TBSA addressed during the second procedure ranged from 7% to 15%, with an average of 10.75%. None of the grafted areas during the initial intervention required regrafting during the second. Among the nine patients who underwent Meek grafting as the initial procedure, the mean donor area was 3.11% of TBSA. For the four patients undergoing a second Meek procedure, the average donor area was 2.63% TBSA. Operative details of the first skin grafting procedure for each case are presented in table 2.

Surgical outcomes

In our series, only two patients, Case 7 (P.M.) and Case 9 (S.P.), underwent more than two Meek-grafting procedures. In seven cases, the reason for discontinuation was a rapid decline in the patients' general status that ultimately resulted in death. One of the patients was transferred abroad for continuation of treatment at the family's request.

Patient P.M. (Case 7), who suffered burns involving 45 % of total body surface area, underwent initially two excision procedures followed by Meek grafting to the anterior thorax and abdomen, as previously described. On post-injury day 13 (six days after the second procedure), a third grafting procedure was performed, targeting the posterior trunk and left arm, totalling approximately 15% TBSA. A 1:4 expansion

Table 2

	Number of SGP*	Day of First Surgery	Technique	%TBSA grafted	%TBSA donor	Expansion rate	Grafted areas
Case 1	1	3	Meek	10%	3%	1:4	Upper limbs Thorax
Case 2	2	3	Mesh**	8%	-	1:3	Left calf
Case 3	2	14	Meek	8%	2%	1:4	Left forearm Right thigh Right hemithorax
Case 4	2	2	Meek	14%	4%	1:4	Bilateral upper limbs
Case 5	1	5	Meek	17%	5%	1:4	Right lower limb Left Upper limb
Case 6	1	4	Meek	10%	2%	1:6	Bilateral lower limbs-anterior face
Case 7	4	2	Meek	10%	3%	1:4	Anterior Thorax
Case 8	1	12	Meek	18%	3%	1:6	Posterior Thorax Gluteal region
Case 9	4	4	Meek	11%	3%	1:4	Anterior Thorax Bilateral upper limbs
Case 10	1	6	Meek	15%	3%	1:6	Left lower limb

Note: * SGP = skin grafting procedures; ** Case 2 – The initial grafting employed the mesh technique, followed by subsequent grafting using the Meek technique.

ratio was used. On postoperative day 5, after removal of carrier gauzes, local evolution was assessed as favourable, with the grafts adherent to the wound bed, despite stagnation in epithelialization. An isolated area of unsatisfactory evolution, characterised by a non-viable wound bed, was noted at the level of the anterior trunk, involving approximately 1.5 %TBSA.

A last procedure was conducted 6 days later and addressed the right lumbar area, right flank, right arm, and cervical region, with a total grafted surface of 7% TBSA. The same expansion ratio of 1:4 was used. Unfortunately, the patient's general condition deteriorated, leading to death three days following the last grafting session.

Patient S.P. (Case 9) sustained self-inflicted burns involving 30% of total body surface area (%TBSA), affecting primarily the trunk and cervical area. Lower and upper limbs were affected to a lesser extent. The initial two surgeries addressed the thorax, abdomen, arms, and flanks. The grafting technique of choice was Meek, with expansion ratios of 1:4 and 1:6, both of which yielded satisfactory results. On post-injury day 15 (day 6 after the second procedure), a third Meek grafting procedure was performed on 10% TBSA. The procedure involved the thighs, right cervical area, and the right flank, the latter being the only site where regrafting was necessary.

After the removal of polyamide gauzes and staples on post-operative day 7, daily dressings were performed using a non-adherent, sterile gauze. The post-operative course was assessed as satisfactory by the surgical team, with approximately 90% of the skin grafts adherent to the wound bed. A final grafting procedure was conducted 15 days later. Given the limited area addressed (left cervical area) and the low rate of expansion needed, the mesh technique was employed. Despite an initial favourable course, marked by good epithelialization of the wound injuries, the patient's general condition declined, with death occurring on day 37 post-admission. Figures 1–3 demonstrate different stages in the course of treatment.

DISCUSSIONS

In our clinic, the mesh technique remains the most frequently employed method for skin graft expansion in small and moderate burns, due to its simplicity, speed, effective fluid drainage, and adaptability to body contours [8]. Despite these benefits, the mesh technique has notable limitations when treating extensive burns, as the expansion achieved is significantly lower than the theoretical ratios. For example, at a theoretical expansion ratio of 1:3, only 53.1% of the expected expansion rate was obtained in practice [9]. This discrepancy is critical in major procedures, where maximising skin coverage while minimising donor site harvesting is essential.

Consequently, to address this limitation, the Meek technique is preferred for patients presenting with extensive burns and limited donor areas. First described in 1958 by an American surgeon, the method was developed on the principle that skin grafts epithelialize from the periphery, and reducing graft size increases the cumulative perimeter-to-area ratio, thereby accelerating wound closure. In the original method, micrografts were applied onto parachute silk carriers and placed on the wound bed. Although conceptually innovative, the technique was technically demanding: the silk needed soaking, graft separation required two operators, and additional steps were needed for perforation and trimming. Due to its

Fig. 2. Polyamide gauze is applied with the graft facing down onto the wound bed and secured in place with surgical staples

Fig. 1. Initial presentation of patient S.P. (case 9) with full-thickness burns on the anterior trunk

Fig. 3. Skin graft islands in different stages of epithelialization, 5 days after the third grafting procedure

complexity and time-consuming nature, the Meek technique did not gain popularity and was eclipsed by the more expedient technique of mesh grafting [10, 11].

Decades later, with the improved early survival, the lack of suitable donor sites in severely burned patients emerged as a significant limiting factor in wound closure. The renewed interest in the micrografting technique among plastic surgeons led to the development of the Modified Meek technique, which used pre-folded polyamide gauzes with an aluminium foil backing. This new design allowed for faster expansion by a single operator, eliminating the need for bandage perforations. As a result, this innovation reduced operative time [12, 13]. Beyond practicality, the polyamide carrier introduced important functional advantages:

- pleated structure ensuring predictable expansion ratios up to 1:9 [14, 15];
- mechanical stability providing secure fixation, preventing graft shifting, and acting as a first protective layer [13];
- controlled geometry of pleats ensures consistent spacing and layout of skin elements, critical for optimal re-epithelialization [12, 13, 16];
- semi-transparent fabric that enables wound monitoring before removal;
- semi-permeable structure facilitates drainage and gas exchange, preventing desiccation and creating a favourable wound environment [6, 17–22].

In our clinical experience, those properties translated into reliable outcomes. At a 1:6 expansion ratio, an average of 14.33% TBSA was successfully grafted, utilising approximately 2.66% TBSA of donor skin, equivalent to 89% of the expected coverage. Among the patients where an expansion ratio of 1:4 was used, an average of 12% TBSA was grafted from a mean donor area of 3.33% TBSA, corresponding to 90.02% of the predicted surface. Although the expansion rates achieved in our series are slightly lower than those reported by Kamolz et al. [9], they remain remarkably high, reinforcing the Meek technique as the preferred option when treating extensive burns.

In our cohort, the Meek technique demonstrated a high rate of graft take, even in patients with poor general health. Only limited areas were submitted to regrafting, specifically a region of approximately 1.5% on the trunk for patient P.M. (Case 7) and an area of approximately 3% TBSA on the right flank for patient S.P. (Case 9).

Despite favourable local outcomes of burn injuries treated by the Meek technique, the overall prognosis remained poor, with nine of ten patients succumbing to their injuries. This high mortality rate is primarily attributable to the severity of the initial injuries and associated systemic complications. Additionally, old age is a well-established factor of negative prognosis in burn survival. In our cohort, the mean age was 62.3, with two patients aged 85 and 89, respectively, which is higher than in all patient populations included in the systematic review by Quintero et al. [6].

This apparent paradox illustrates a crucial point: while material and textile innovations can ensure reliable local outcomes, they cannot overcome systemic determinants of mortality. From a clinical practice perspective, this highlights the role of textile-based carriers, such as polyamide gauzes, in enabling optimal wound closure, while underscoring the need to integrate aggressive resuscitation, critical care optimisation, infection control, and multidisciplinary support alongside surgical strategies.

Limitations of our study include a small number of cases, the unicentric and retrospective design, and the reliance on subjective assessments documented by the treating clinical team in patients' records.

CONCLUSION

The Meek micrografting technique represents a superior method for achieving wound coverage in extensive full-thickness burn injuries and is commonly used in our centre. This 10-patient case series demonstrated high graft take, with a reduced need for further regrafting in the initially treated areas, even at high expansion rates. Although the overall survival rate remained low, primarily due to inhalation injury, systemic complications, and advanced age, this method is a valuable tool in the surgical management of extensive burns, particularly when donor sites are limited.

ETHICAL APPROVAL

This case series was approved by the Ethics Committee of the Emergency Clinical Hospital for Plastic, Reconstructive, and Burn Surgery (Resolution No. 16/24.07.2025). All procedures were conducted in accordance with the principles outlined in the Declaration of Helsinki.

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