mucoderm®

3D REGENERATIVE TISSUE GRAFT

Surgical guide

native
stable
three-dimensional

soft tissue
This surgical guide was created with the support of internationally renowned clinical experts to assist you in achieving the best possible and predictable results with mucoderm®, in the indications hereafter described.

On the following pages, you will find detailed information on the application of mucoderm®, with general handling tips and technical descriptions in order to handle specific clinical situations.

Each indication is described by a clinical case from an expert, demonstrating a recommended surgical procedure.

Why do we need soft tissue replacement grafts?

Today, modern techniques of plastic-aesthetic periodontal surgery ensure a predictable regeneration of soft tissue deficiencies in the majority of cases. The use of free mucosal transplants and subepithelial connective tissue grafts, both commonly harvested from the palate, is still considered the gold standard. However, the availability of connective tissue at the donor site is limited, particularly in patients with a thin gingival biotype or if multiple recessions should be treated1,2. Furthermore, connective tissue harvesting can be associated with significant disadvantages such as an increase in surgery time and patient morbidity as well as a higher risk for post-operative complications3,4.

To overcome the disadvantages associated with tissue harvesting, allogenic and xenogenic collagen-based materials have been developed in recent years. These may serve as an alternative to autologous grafts. One of these materials is mucoderm®, an acellular collagen matrix, derived from porcine dermis that undergoes a multi-step purification process, which removes all antigenic components. This processing results in a three-dimensional stable matrix, which consists of collagen and elastin with a natural collagen structure that resembles the human connective tissue5. After implantation, this collagen network serves as a scaffold for the ingrowth of blood vessels and cells, thus supporting a fast revascularization and tissue integration6. The simultaneous degradation of the matrix and the collagen production of adhering fibroblasts lead to a complete substitution of mucoderm® by the newly formed host tissue7.

mucoderm® has a collagenous architecture beneficial for cell ingrowth

Surface and cross sectional SEM as well as synchrotron analysis of mucoderm® demonstrated a highly interconnected porosity of the collagen matrix, making it an excellent scaffold for ingrowing cells and vessels6,8. Attracted by the signals of activated migrating and proliferating fibroblasts, blood vessels from the surrounding tissue will grow into the matrix. At the same time, fibroblasts adhere and spread onto the matrix. While collagen is produced by the adhering cells, the matrix is gradually degraded and finally replaced by host tissue.9

Histological examination after subcutaneous implantation in mice showed extensive ingrowth of vessels (immuno staining, endothelial marker) after 21 days6.

SEM image of mucoderm® (100 fold magnification).

Two weeks after subcutaneous implantation in rats (Mason Goldner staining). Good integration with invasion of cells and vessels7.

Fibre structure of mucoderm® shown by synchrotron analysis.
For a successful clinical outcome with mucoderm® in the treatment of recessions, patients must be selected based on their Miller-class type (I-III) and their compliance with the post-surgical instructions.

- mucoderm® must not be used in patients with acute or chronic inflammation at the implantation site.
- The size of the graft should be adapted to the specific situation. Cutting can be performed with scissors or a blade, preferably in a rehydrated state, while maintaining sterility.
- mucoderm® should always be applied after hydration (in sterile saline, defect blood, or platelet concentrates). For further details, please see page 5.
- If the matrix is only very shortly rehydrated, rounding of the edges can help to prevent a perforation of the gingiva following flap closure.
- Since mucoderm® is a multilayer matrix, its sides are comparable, i.e. no attention needs to be paid to the orientation of the graft.
- For augmentation of attached gingiva (in course of a vestibuloplasty), it is recommended to adapt mucoderm® to the wound bed using moderate pressure. The time required depends on the extent of the bleeding.
- Following application, mucoderm® should always be stabilized to avoid micromovements and ensure undisturbed revitalization, e.g. ingrowth of vessels and cells. When preparing a split flap, mucoderm® should be sutured to the intact periosteum to ensure close contact between the matrix and the periosteal wound bed. Single button or cross sutures may be used; the use of resorbable sutures is recommended.
- During open healing, the supply and revascularization of the matrix must be guaranteed, e.g. through close contact with the underlying periosteum. Always avoid exposure of mucoderm® when used in recession coverage or in combination with a bone grafting procedure.
- After surgery, it is necessary to avoid any mechanical trauma of the treated site. Patients should be instructed not to brush in the treated area for four weeks following the surgery. Plaque prevention can be achieved by rinsing with 0.12% chlorhexidine solution twice a day.
- Post-operatively, the patient should be recalled weekly for plaque control and healing evaluation.

Hydration of mucoderm®

The hydration protocol and its influence on the biomechanical properties of mucoderm® were analyzed in a study by Prof. Dr. Dr. Adrian Kasaj.

- mucoderm® demonstrated optimal mechanical properties after a rehydration time of 10 to max. 20 minutes
- Hydration in blood can improve the biomechanical properties of mucoderm®
- The optimal hydration time depends on the applied technique as well as individual preferences and is mentioned in each of the following cases

Importance of revitalization and tissue integration

Since mucoderm® is an acellular matrix, it requires proper revitalization through blood vessels and cells, which grow in from the underlying or overlying soft tissue.

A complete flap reposition over the matrix is of utmost importance when the revascularization from underneath is not likely, e.g., when the mucoderm® is placed on:

- Denuded tooth root surfaces (recession coverage)
- Grafting materials (soft tissue thickening in combination with GBR)
- In direct bone contact (e.g. thickening of periimplant tissue)

In which clinical situations is an open healing possible?

mucoderm® should only be left for open healing, if a revitalization from the surrounding or underlying wound bed is ensured. Open healing is feasible in the case of a vestibuloplasty, if mucoderm® is sutured to the periosteum.

In this case mucoderm® should be closely fixed to the periosteum. This facilitates an increase in the width of the attached gingiva but not in the thickening of the tissue. Open healing is also possible if only minor parts of the matrix are exposed and revascularization is ensured by the surrounding margins of the flap or by the underlying periosteum. Please note that the degradation time depends on the extent of the exposure and will be faster due to bacterial decontamination and resorption.

Hydration in blood

Hydration in NaCl

Ultimate Strength [MPa]
mucoderm® for the treatment of gingival recessions

Indications for mucoderm®

- mucoderm® may be used to treat Miller-class I and II recessions (single and multiple adjacent), as a successful alternative to autologous connective tissue transplants.\(^{10,11}\)

- Although the application of mucoderm® in the treatment of Miller-class III recessions has been reported with a positive outcome, results are typically less predictable compared to those obtained in Miller-class I and II recessions.\(^{10}\) In principle, the predictability and success rate for the treatment of defects in the maxilla is higher as compared to that of mandibular defects.

- mucoderm® can be used in combination with all mucogingival surgical techniques, including coronally advanced flap and tunnel techniques. Notably, the classical coronally advanced flap or the modified coronally advanced flap ensure a good view on the prepared donor bed and facilitate the coronal repositioning of the flap over the matrix.

- For recession coverage, mucoderm® must always be completely covered by the flap in order to ensure revitalization of the graft. Post-operative exposure of mucoderm® may cause premature resorption of the matrix and must therefore be avoided.

- Advanced flaps need to be sufficiently mobilized to avoid tension of the soft tissue. When applying mucoderm® for recession coverage, special attention must be paid to achieve sufficient flap mobilization and tension-free closure.

- A proper vascular supply from the prepared flap is critical to achieve an appropriate revascularization of the mucoderm® matrix. In particular, split flaps must be sufficiently thick to ensure revitalization of the matrix and the remodeling into the patient’s own connective tissue.

- If it is not possible to mobilize the flap appropriately and a submerged healing of mucoderm® cannot be ensured, the application of an autologous graft should be preferred.

- A creeping substitution, i.e. a later improvement of the outcome up to one year post-operatively can often be observed.
**CLINICAL CASE BY**
Prof. Dr. Dr. Adrian Kasaj, University of Mainz, Germany

**RECESSION COVERAGE WITH THE MODIFIED CORONALLY ADVANCED FLAP TECHNIQUE**

- Hydrate mucoderm® in blood or sterile saline for about ten minutes until its flexibility allows improved adaptation to the root surfaces.
-Immobilization of mucoderm® by suturing to the periosteum helps to avoid micromovements and ensures undisturbed revitalization, e.g. ingrowth of vessels and cells.
-Flap mobility should allow tension-free repositioning of the flap over mucoderm® and suturing (Check of the flap mobility: surgical papillae should rest passively on anatomical papillae).
- Pay attention to a complete coverage of the matrix.

**Tips for using mucoderm® to treat gingival recessions**

**CLINICAL CASE BY**
Prof. Dr. Dr. Adrian Kasaj, University of Mainz, Germany

**RECESSION COVERAGE WITH THE MODIFIED CORONALLY ADVANCED FLAP TECHNIQUE IN COMBINATION WITH STRAUMANN® EMDOGAIN®**

mucoderm® helps to maintain or increase gingival tissue thickness 19, which may be of advantage in thin gingival biotype.

 Adding Straumann® Emdogain® to a root coverage procedure with mucoderm®

- Improves the quality type of the attachment 14,15
- Stimulates angiogenesis 16,17, which may improve revascularization and integration of the mucoderm® collagen matrix
- Improves the quantity of keratinized tissue 18, which may be beneficial in case of less or no residual keratinized gingiva

mucoderm® and Straumann® Emdogain® present a possible alternative to connective tissue graft for the treatment of multiple adjacent gingival recessions, when the modified coronally advanced tunnel technique is applied. These treatment modalities are associated with decreased patient chair time and decreased post-operative patient morbidity 20.
Clinical situation before surgery: multiple adjacent recessions

Using a microsurgical blade and tunneling knives, mucoperiosteal flaps were raised beyond the mucogingival junction at each involved tooth.

Hydration of mucoderm® for about five min in sterile saline or blood and adapting its shape according to the width of the recession defects.

mucoderm® was fixed at the CEJ of each treated tooth by means of sling sutures. The tunnel flap was moved coronally and fixed by sling sutures, to cover the mucoderm® matrix completely.

Preoperative measurement of the recession depths.

Flaps were then extended laterally from each recession forming a mucoperiosteal tunnel. Interdental papillae were left intact, having only been slightly undermined.

All muscle insertions and collagen fibres were cut, achieving a tension free coronal movement of the flap. mucoderm® is pulled into the tunnel by mattress sutures and fixed to the inner aspect of the flap.

Stable clinical situation at 24 months post-surgery.

Tips for using mucoderm to treat multiple recessions with tunneling techniques:

- For the tunnel technique, a hydration of about ten minutes is recommended. This ensures a sufficient flexibility of the graft.
- Cutting all muscle insertions and inserting collagen fibres helps to achieve a tension-free coronal movement of the flap.
- In case of multiple adjacent recessions, mucoderm® can be pulled through the tunnel as described by Allen.
- The matrix is pulled in the tunnel by means of mattress sutures and fixed at the inner aspect of the tunnel flap.
- To avoid movements of the matrix, mucoderm® can be fixed at the CEJ level of each treated tooth by means of sling sutures.
Tips for using mucoderm® to augment the attached gingiva

- A band of at least 1 mm of keratinized gingiva should be present to provide the biological information needed for regeneration of the grafted site.
- Prior to application, mucoderm® should be hydrated in sterile saline or blood for about five minutes.
- A close contact between mucoderm® and the wound bed is required for the revitalization of the graft. Close adaptation may be achieved by pressing the matrix to the wound bed for several seconds.
- Deep periosteal sling sutures and superficial mattress or single interrupted sutures may be applied to immobilize the graft and achieve tight contact to the underlying periosteum.
- If possible, mucoderm® should be sutured tension-free to the surrounding soft tissue. A sufficient depth of the vestibule is necessary for a tension-free suturing of the apical aspect of mucoderm®.
- mucoderm® can be left exposed for open healing without any wound dressing23,24,25 as described on page 5.
- A shrinkage of the augmented tissue might be observed even after several months. Long-term follow-up studies are currently being performed to quantify the degree of shrinkage and tissue stability for this particular indication.
- mucoderm® may also be applied to correct scars and create fixed gingiva in case of lip or cheek frenulum section. Complete immobilization of mucoderm® is of utmost importance in these indications.

Tips for using mucoderm® to thicken the periimplant soft tissue

- Thickening of the mucosa can be performed prior to implantation or with simultaneous implant placement. In both cases a mucoperiosteal flap can be prepared and mucoderm® can be placed with direct contact to the bone.
- Prior to application, mucoderm® must be hydrated in sterile saline or blood for ~ten minutes to ensure a sufficient flexibility of the graft.
- After hydration, mucoderm® can easily be perforated.
- mucoderm® should extend mesiodistally to the neighbouring teeth, buccally ~10 mm and lingually ~5 mm beyond the implant margin.
- mucoderm® should be covered by the flap to ensure revitalization of the matrix. If only minor parts of the matrix are exposed, revascularization can occur from the surrounding margins of the flap.
mucoderm® is a three-dimensional collagen matrix that supports fast vascularization and soft tissue integration.

- mucoderm® remolds completely into newly formed tissue within approx. six to nine months, providing a valuable alternative to the patient’s own tissue in certain indications.
- Its high tensile strength allows mucoderm® to be shaped and used for any surgical soft tissue techniques (including the tunnel technique).

mucoderm® provides a suitable alternative in specific indications to the patient’s own connective tissue. Further advantages of mucoderm® are:

- Reduced patient chair time
- Reduced surgical and post-surgical bleeding
- No need for donor tissue harvesting (i.e., no donor site morbidity/pain, faster recovery from surgical intervention)
- Good integration into surrounding tissue with respect to color and texture

### Product Specifications

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### References

Innovation.
Regeneration.
Aesthetics.

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hard tissue

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