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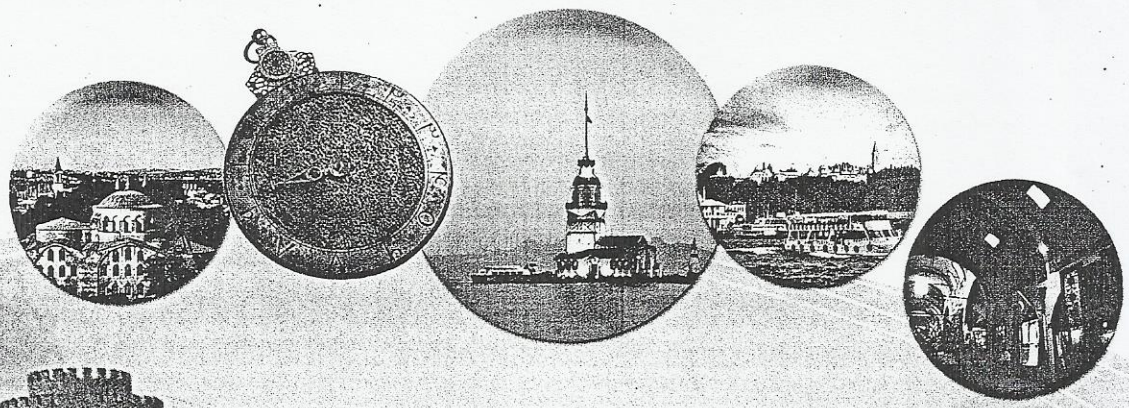

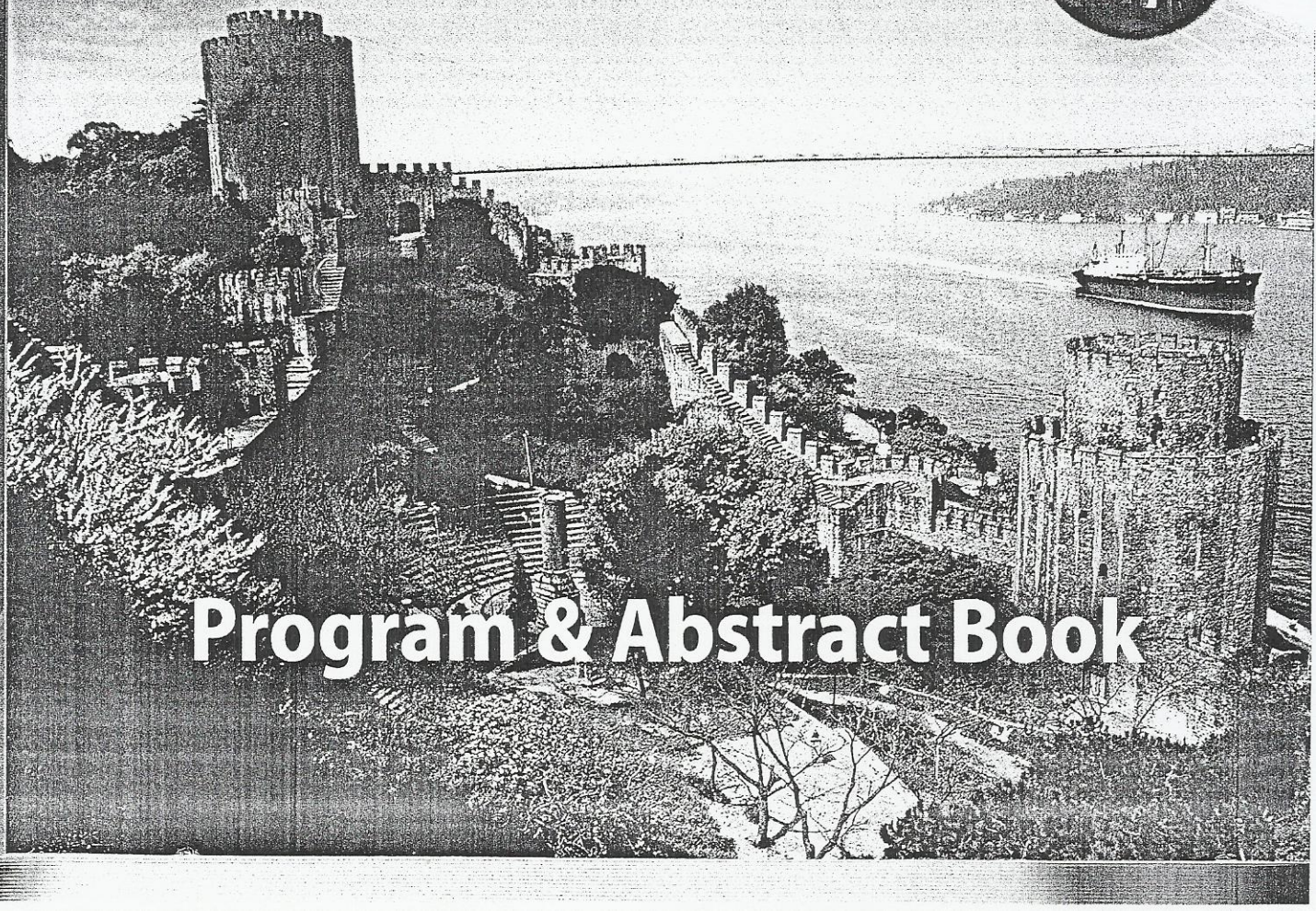

Program & Abstract Book

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TUMESCENT INFILTRATION OF LIDOCAINE AND ADRENALINE FOR THE ROUTINE PROCEDURES OF BURN SURGERY

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Background: Tumescent infiltration is a widely used type of regional anesthesia in cutaneous surgery. In this technique, high-dosage of lidocaine can be administrated within the safety limit, leading to diminution in pain and bleeding during the operation. In this study, tumescent infiltration of lidocaine and adrenaline was used for the routine procedures of burn surgery involving escharectomy, debridement, tangential excision and skin grafting.

Methods: In seventeen patients who had burned with scald and flame, tumescent infiltration was made prior to surgical procedures under either general anesthesia or intravenous sedation. After waiting 15 minutes, escharectomy, debridement of necrotic tissues, tangential excision of the burned skin, removing of the granulation tissue and harvesting of the skin graft were performed.

Results: No complication occurred. All of vital signs remained within safety limits during the operations. Hemorrhage was minimal so that operations could be performed easily and fast. While removing the granulation tissue, very few bloodless occurred so that both excision of the granulation tissue and skin grafting could be finished rapidly because of no need of hemostasis. Moreover, duration of the surgery considerably shortened. Neither hematomas nor bruising developed after surgery. As hematocrite levels decreased less than 3%, no blood transfusion required. Postoperative analgesia especially in first 8 hours was so satisfactory.

Conclusions: Tumescent infiltration of adrenaline and lidocaine is a simple, effective and safe technique which makes not only anesthesia on the large areas of the burned body surface, but also less bleeding, easy surgical dissection, hydrodissection, reduced postoperative swelling and bruising, which lead to fast, easy and painless burn surgery.

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INFECTIONS IN PEDIATRIC BURN UNIT

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Objectives: The aim of this study is to determine the infections and causative agents seen in pediatric burn unit.

Materials and Methods: Patients younger than 17 years admitted to Pediatric Burn Unit during the period January and December 2009 with the diagnosis of infection were included in this study. Demographic characteristics, type of infection, causative agent, clinical and laboratory findings were obtained from the patient records. A structured form was filled with these parameters for all patients.

Results: Twelve patients were enrolled to the study. Seven of them were male. Mean age of the patients were 5.41 years (2-11 years). Total burn surface was in the range of 5%-60%. Most of the burn injuries (9 of 12) were due to hot water. Five of the patients had central venous catheter and two were intubated. Eighteen (2 were polymicrobial) infection episodes were diagnosed; 13 were burn wound infections, 3 were urinary tract infections, 2 were bloodstream infections. The causative agents were mostly gram positive (Staphylococcus spp., Enterococcus spp., Group A beta hemolytic streptococcus) in the early period namely first 7 days. Infections due to gram negative bacteria predominated in the late period i.e. later than 14 days. Causative agents isolated in the late period were mostly multi-drug resistant Acinetobacter spp and Pseudomonas spp. strains. In addition most of these strains were sensitive only to colistin. No prophylactic antibiotics were prescribed. All patients recovered after receiving appropriate antimicrobial therapy.

Conclusion: Infections seen in pediatric patients during the early period were mostly due to gram positive bacteria as in the literature. A wide spectrum antimicrobial therapy directed at multi-drug resistant strains should be instituted in the late period.

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SUCCESSFUL USE OF A NEWLY AVAILABLE LIQUID BANDAGE ON NON-HEALING BURN WOUNDS

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Introduction: A liquid bandage that consists of a non-toxic, poly(urea-urethane) liquid emulsion polymer is newly available. The FDA cleared product adheres to the contours of the skin and forms a hydrophobic, elastomeric coating that provides a barrier against moisture, infection and further injury. The product is a single component solution that forms a uniform film that is permeable to oxygen and therefore allows healing. No information is currently available in the literature on the use of this product on non-healing hypertrophic burn wounds.

Methods: A 56 year-old patient with 50% TBSA burns involving the neck, chest, back and both upper extremities underwent serial excision and grafting procedures during her initial burn treatment. The course was complicated by extensive patchy skin breakdown in the regions of her chest and back which was unresponsive to multimodal therapy over a two-month period. Two similarly appearing wounds were identified on the patient's shoulder and chest. Liquid bandage solution was applied topically to these wounds using an atomizer or sterile cotton applicator (at regular intervals).

Results: Wound closure occurred in both lesions and was not complicated by infection, pain, itching, or other discomfort. The liquid bandaged allowed for an alternative treatment for this

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