

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

Trauma – Burn Clinical Pathway

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This pathway is intended as a guide for physicians, physician assistants, nurse practitioners, and other healthcare providers. It should be adapted to the care of a specific patient based on the patient's individualized circumstances and the practitioner's professional judgment.

Johns Hopkins All Children's Hospital
Trauma – Burn Clinical Pathway

Rationale:

This clinical pathway was developed by a consensus group of physicians, advanced practice providers, and nurses from Johns Hopkins All Children's Hospital (JHACH) to standardize the management of children with burn injuries to achieve the best possible outcomes. It addresses the following clinical questions or problems:

1. When to activate the Trauma Team for a burn patient
2. How to diagnose and classify burns
3. How to treat burns
4. When to consider transfer to a Burn Center for definitive treatment

Background:

Burns are the 3rd leading cause of injury deaths for children aged 5 – 9 years and the 5th for ages 1 – 4 years in the United States. Roughly 25% of all burn injuries occur in children under the age of 15 years. This clinical pathway outlines the essential elements of evaluating and managing burns, including the criteria for transferring patients to a Burn Center.

Diagnosis:

Primary assessment should include determining the mechanism of injury and other trauma, and control of any life-threatening injuries. These may include, but are not limited to, inhalation injury, carbon monoxide (CO) and/or cyanide (CN) poisoning, hypovolemia, hypoglycemia, hypothermia, and cardiac arrhythmia (electrocution).

After primary assessment and control of any life-threatening injuries, it is imperative to distinguish the depth of burn injury. Cutaneous burns are classified according to depth of tissue injury: superficial (1st degree), which only involves the epidermis; superficial-partial thickness (2nd degree), which involves the epidermis and upper dermal layers; deep partial thickness (2nd degree), which also includes deeper dermal layers; full-thickness (3rd degree) includes all epidermal and dermal layers of skin; full-thickness extension to deep tissues (4th degree).

A thorough estimate of burn size is essential for determining initial management, fluid resuscitation, and the need for transfer to a Burn Center. The extent of burns is expressed as the total percentage of body surface area (TBSA). There are several methods to calculate TBSA. Superficial burns are not included in calculating TBSA.

Palmar Method (Rule of Palms): Small or patchy burns can be approximated by using the surface area of the patient's palm. The palm of the patient's hand, excluding the fingers, is approximately 0.5 percent of TBSA, and the entire palmar surface, including fingers, is 1 percent in children and adults.

Lund-Browder Chart: The most accurate method for estimating TBSA for both children and adults. Refer to [Appendix A](#).

Burn injuries are classified into four categories based on the source of tissue injury. The categories further dictate clinical management and are listed below from most to least common:

1. Thermal
2. Chemical
3. Electrical
4. Radiation

Clinical Management:

Cooling of thermal burns:

1. All thermal burns should be immediately cooled with clean running water for 5 to 20 minutes
2. Cooling within 3 hours of injury has been shown to minimize the extent of tissue damage
3. During and after cooling, monitor for and treat any signs of hypothermia, particularly in young children with larger surface area to body volume ratios (< 12 years old)

Radiographic studies:

1. Consider computed tomography (CT) imaging of the head if the patient has altered mental status or associated head trauma from a fall
 - i. Do not let this delay therapeutic intervention for CO or CN poisoning
2. Consider plain chest films for smoke inhalation
3. Consider plain films if there is concern for concomitant trauma or foreign body/debris in wounds

Lab recommendations: Complete blood count (CBC), blood urea nitrogen (BUN), electrolytes, lactate, and coagulation profile when TBSA > 20%

Fluid resuscitation: Formal fluid resuscitation using the American Burn Association (ABA) Consensus Formula should be initiated for patients with partial thickness or worse burns covering 20% or more TBSA

1. 2 – 4 milliliters per kilogram (mL/kg)/% TBSA burn (using lactated ringers (LR)) in the 1st 24 hours
 - i. Give ½ in the first 8 hours post burn
 - ii. Give ½ in the next 16 hours post burn
 - iii. Adults: 2 mL/kg/% TBSA
 - iv. Children: 3 mL/kg/% TBSA
 - v. Electrical: 4 mL/kg/% TBSA

2. LR is the fluid of choice for formal fluid resuscitation
3. Avoid crystalloid boluses
4. Place a foley catheter in patients receiving formal fluid resuscitation and monitor urine output (UOP) for a goal of 1 mL/kg/hour in patients < 30 kg and 0.5 mL/kg/hour in patients \geq 30 kg
5. If the patient is less than 30 kg, add dextrose-containing maintenance fluids (dextrose 5% (D5) LR or D5 normal saline (NS))

Pain management: (based on age of patient, size, and depth of wound)

1. Small burn injuries: acetaminophen and nonsteroidal anti-inflammatory drugs
2. Deeper burn: non-opioid analgesics in combination with opioids
 - i. Intranasal (IN) fentanyl 1.5 micrograms (mcg)/kg/dose (max dose: 100 mcg/dose)
 - ii. Oxycodone:
 - i. Patients < 50 kg: 0.1 to 0.2 milligrams (mg)/kg/dose (max dose: 5 mg/dose) enterally every 4 to 6 hours as needed (PRN)
 - ii. Patients \geq 50 kg: 5 mg/dose enterally every 4 to 6 hours PRN
3. Referral to a Burn Center is needed when pain is too severe (or anticipated) to perform dressing changes and wound care without intravenous (IV) opioids or conscious sedation

Additional considerations:

1. Tetanus booster is warranted if not received within the last 12 months in patients with deep, superficial, or partial thickness burns
2. Antimicrobial prophylaxis is not routinely recommended
3. Remove any tight-fitting jewelry, belts, scarves, or items that could become stuck when the skin starts to swell

Concerns for non-accidental burn injuries: Does the injury match the reported history?

1. Is the age of the burn consistent with the provided history?
2. Most caregivers would seek health care assistance immediately; if there is a delay in care, is there a clear and adequate reason?
3. Does it appear as if a reasonable treatment plan has been implemented before a provider's involvement if there is a delay?
4. Is the pattern suggestive of an abusive injury?
 - i. Cigarette burns and lighter burns (especially when multiple burns are present)
 - ii. Submersion burns reveal sharp demarcations with stocking/glove appearance with or without sparing of skin folds/buttocks
 - iii. Clear patterns with iron, curling irons, radiators, heaters, stoves, etc., are nearly always concerning because contact with such surfaces should be transient in a neurologically normal child

ABA Burn Center Referral Criteria: (May be a telephone consultation to determine if patient transfer is warranted)

- Partial thickness burns > 10% TBSA
- Burns that involve the face, hands, feet, genitalia, perineum, or major joints
- 3rd degree burns
- Electric burns, including lightning injury
- Chemical burns
- Inhalation injury
- Severe pain despite enteral opioid therapy

Florida Trauma Burn Centers:

1. Tampa General Hospital:
(813) 844-7000
<https://www.tgh.org/institutes-and-services/burn-center>
2. Shands Health Care: (352) 265-8000
<https://ufhealth.org/uf-health-shands-burn-center>
3. Jackson Memorial Hospital and Ryder Trauma Center:
(305) 243-6256
<https://jacksonhealth.org/burn-center/#gref>

Table 1: Recommendations of Treatment Based on Burn Type

<p>General Considerations</p>	<ul style="list-style-type: none"> • Remove clothing that is hot, burned, or has been exposed to chemicals/smoke • Remove jewelry that may become constrictive after tissue swells • Observe for signs of smoke inhalation in patients who have suffered thermal burns (e.g., singed nasal hairs, soot around or in the mouth, coughing) • There is <u>NO</u> role for topical steroids or antimicrobials in the initial treatment of minor burns, as this may increase the risk of infection and impair healing • <u>NO silver sulfadiazine</u> cream as it is cytotoxic and slows wound healing • Wrap fingers and toes individually • Maintain neutral to extended anatomical position with access to fingertips and toes for circulation to avoid contractures
<p>Circumferential Burns</p>	<ul style="list-style-type: none"> • At risk for acute compartment syndrome (ACS) <ul style="list-style-type: none"> ○ ACS may necessitate fasciotomy • May require escharotomy if there is distal ischemia <ul style="list-style-type: none"> ○ Rarely required in the immediate aftermath of a burn • Consider Trauma Team activation • Frequent assessment of extremity perfusion • High risk finding for non-accidental trauma <ul style="list-style-type: none"> ○ Refer to the Physical Child Abuse Clinical Pathway
<p>Chemical Burn with Powder</p>	<ul style="list-style-type: none"> • Don personal protective equipment: gloves, non-permeable gowns (trauma gowns), and masks with a face shield • Remove all the patient's clothing and jewelry • Brush off all visible powder from skin using gloved hands • Await Emergency Center (EC) or Trauma Team recommendations • Consult Poison Control (1-800-222-1222) for assistance identifying chemicals and treatment recommendations

Table 1 – Recommendations of Treatment Based on Burn Type (continued)

<p>Suspected or Reported Electrical Burns</p>	<ul style="list-style-type: none"> • Consider electrocardiogram (EKG), cardiac enzymes, creatine kinase (CK), and urinalysis to check for myoglobin due to rhabdomyolysis • Any patient in contact with a high voltage source should have continuous cardiac monitoring • Await recommendations for wound care
<p>Carbon Monoxide (CO) Poisoning</p>	<ul style="list-style-type: none"> • For victims of house fires with CO poisoning, oxygen saturation by pulse oximetry will often be normal or elevated and falsely reassuring relative to directly measured oxygen saturation <ul style="list-style-type: none"> ○ CO level is available on a blood gas measurement and appears as “COHb.” • Treat the patient with high flow oxygen until carboxyhemoglobin (CoHbg) levels drop to less than 10% (12 – 15% in smokers)
<p>Inhalation Injury</p>	<ul style="list-style-type: none"> • The leading injury in the upper airway is thermal injury, resulting in erythema, ulceration, and edema • Aggressive fluid administration to treat burn shock may promote early edema formation (monitor closely during and after resuscitation) • Increased production of thick secretions can cause distal airway obstruction, atelectasis, and impaired gas exchange • Tracheobronchial injury is usually caused by chemicals in smoke <ul style="list-style-type: none"> ○ Symptoms include coughing and wheezing, soot-containing airway secretions, increased work of breathing resulting in hypoventilation, erythema, and increased pulmonary shunting from lobar collapse or atelectasis • May have a normal chest radiograph • Consider Trauma Team activation • Remove all smoke-covered clothing • Frequent respiratory assessments • May require intubation or tracheostomy <ul style="list-style-type: none"> ○ These could be difficult, and the Critical Airway Team should be utilized (call extension 7-4300 to request)
<p>Patterned Burns</p>	<ul style="list-style-type: none"> • High risk finding for non-accidental trauma <ul style="list-style-type: none"> ○ Refer to the Physical Child Abuse Clinical Pathway
<p>Burn-like Diseases</p>	<p>Diseases that mimic the appearance of burn injuries and may vary in depth (e.g., superficial, partial thickness, full thickness)</p> <p><u>Superficial:</u></p> <ul style="list-style-type: none"> • Staphylococcal scalded skin syndrome • Toxic epidermal necrolysis • Epidermolysis bullosa <p><u>Partial to full thickness:</u></p> <ul style="list-style-type: none"> • Stevens-Johnson syndrome • Pemphigus vulgaris • Necrotizing fasciitis

Table 2 – Recommendations of Treatment and Wound Care Based on Burn Depth

<p>Superficial (1st degree)</p>	<ul style="list-style-type: none"> • <u>Appearance</u>: Minor damage, erythematous (pink to reddened skin), painful, dry, without blisters • <u>Course</u>: Heals without scarring in 3 – 5 days • <u>Treatment</u>: Moisturize for comfort, topical antimicrobial not needed for intact epidermis
<p>Partial Thickness Burns (2nd degree)</p>	<ul style="list-style-type: none"> • <u>Appearance</u>: Partial destruction of dermis, bright pink to cherry red skin <u>with</u> blisters, skin moist to wet, very painful and edematous • <u>Course</u>: Heals in 7 – 10 days with minimal scarring • <u>Treatment</u>: <ol style="list-style-type: none"> 1. Do not aspirate or rupture intact blisters, as this increases the risk of infection and causes pain 2. Cleanse with NS (baby shampoo PRN) 3. Apply Mepilex[®] Ag to the wound <ol style="list-style-type: none"> a. AMepilex[®] Ag should overlap the wound by at least 2 centimeters (cm) onto the surrounding skin b. Apply the adherent side to the wound c. Remove the film and mold the dressing in place – do not stretch d. Hold the Mepilex[®] Ag in place with dry gauze or wrap, secure with tubular gauze – no tape to skin e. Mepilex[®] Ag is left in place for up to 7 days 4. Change gauze only as needed
<p>Deep Partial Thickness (2nd degree)</p>	<ul style="list-style-type: none"> • <u>Appearance</u>: Greater than 50% of dermis affected, moderate eschar/slough or ruptured blisters, less painful because nerves are damaged (not complete anesthesia) • <u>Course</u>: Heals in 2 – 3 weeks; severe scarring can occur, risk of skin scar contracture <ul style="list-style-type: none"> ○ May require skin grafting • <u>Treatment</u>: <ol style="list-style-type: none"> 1. Debride/remove eschar and necrotic skin, including ruptured blisters <ol style="list-style-type: none"> a. Extensive debriding is rarely necessary and may be deferred until the follow-up visit 2. Cleanse wound with NS plus baby shampoo 3. Apply Mepilex[®] Ag to the wound <ol style="list-style-type: none"> a. Mepilex[®] Ag should overlap the wound by at least 2 cm onto the surrounding skin b. Apply the adherent side to the wound c. Remove the film and mold the dressing in place – do not stretch d. Hold the Mepilex[®] Ag in place with dry gauze or wrap, secure with tubular gauze – no tape to skin e. Mepilex[®] Ag is left in place for up to 7 days 4. Change gauze only as needed
<p>Full Thickness Burns (3rd and 4th degree)</p>	<ul style="list-style-type: none"> • <u>Appearance</u>: Damage to all skin layers (3rd degree) and may involve fat, muscle, and bone (4th degree) <ul style="list-style-type: none"> ○ Skin is severely charred, waxy white, pale, leathery, no bleeding, painless (complete anesthesia) • <u>Course</u>: Higher risk for infection and fluid loss, systemic antimicrobial prophylaxis not recommended • <u>Treatment</u>: <u>Immediate referral to a Burn Center and/or Plastic Surgery consult</u>

Documentation Reminders:

The following items should be documented within the medical record:

1. History of burn injury
 - i. When? The initial time of burn is important if fluid resuscitation is warranted
 - ii. How? Fire, steam, chemicals, electrical, and/or hot material
 - iii. Where? Enclosed space (inhalation injury)
2. Burn TBSA, type, and depth in Epic Burn Narrator utilizing the [Lund-Browder Chart](#)
3. Medical history: comorbidities (e.g., insulin-dependent diabetes mellitus, immunosuppression)
4. Medication history: steroid use, anticoagulants, diabetic medications, etc.
5. Allergies
6. Last tetanus booster is warranted if not received within the last 12 months in patients with deep, superficial, or partial thickness burns
7. Wound assessment
8. Treatment performed
9. Follow-up
10. Referrals

Follow-Up Care:

Patients with superficial or partial thickness burns, < 10% TBSA, can be referred to the [JHACH Outpatient Wound Care Clinic \(PAWS\)](#).

The Wound Team can be consulted while the patient is in the EC for assistance with burn care. If the Wound Team is unavailable, then the Trauma Team can be consulted if needed. Other follow-up options:

1. Blake Medical Center Outpatient Burn and Wound Reconstruction Clinic (must be older than 1 year of age)
(941) 567-2876
<https://blakemedicalcenter.com/specialties/burn-care>
2. Tampa General Hospital Outpatient Hand and Burn Therapy Program
(813) 844-7706
<https://www.tgh.org/institutes-and-services/burn-center>

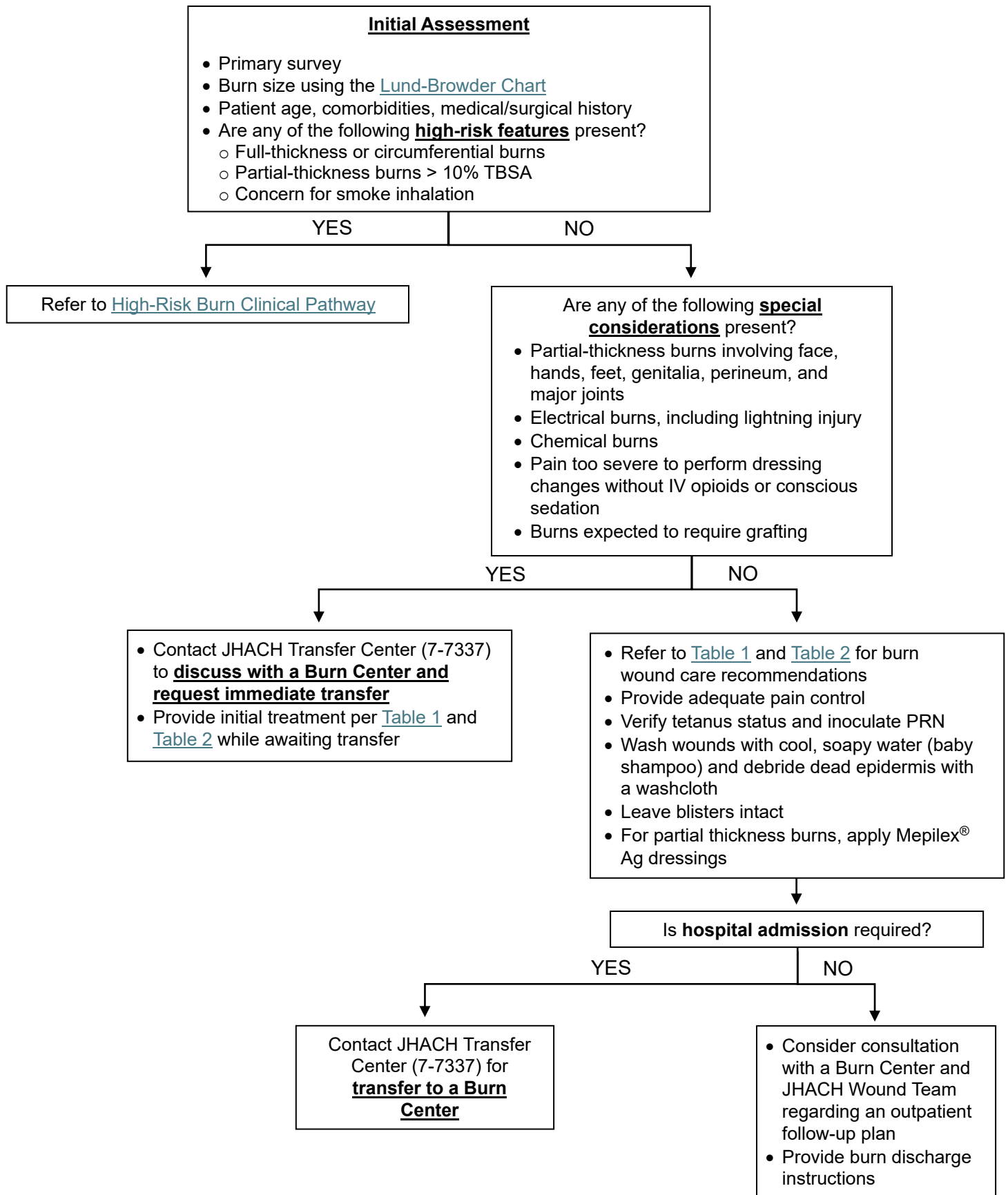
If blisters persist for several weeks without resorption, this suggests a possible underlying deep partial- or full-thickness burn, warranting referral to a Burn Center.

Follow-up care includes assessing for signs of infection, scarring, and contractures. Referral to Physical/Occupational Therapy if the patient presents with signs of skin scar contractures. Scarring and contracture can result in long-term disfigurement and disability.

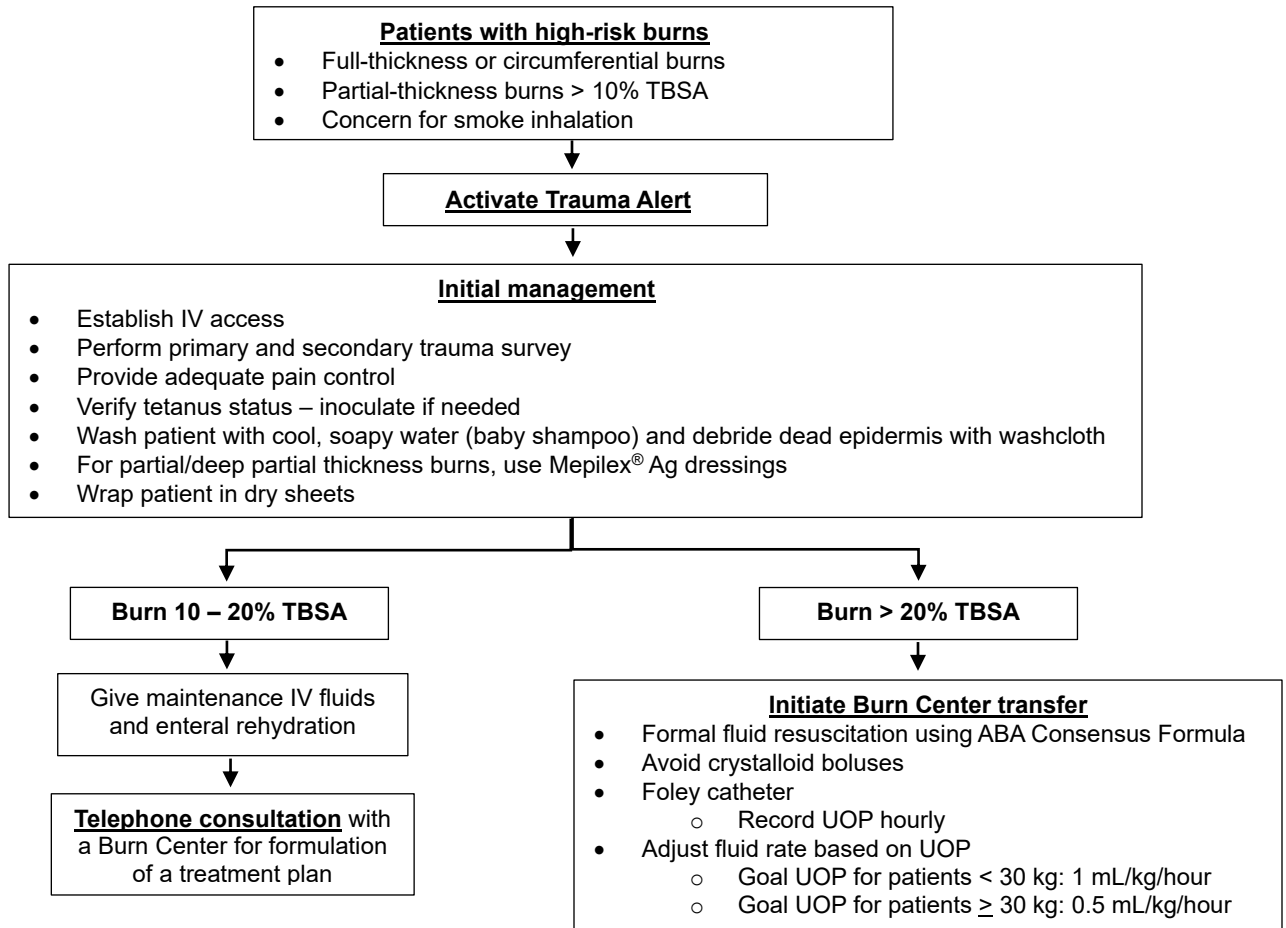
Patient/Caregiver Education:

Discharge instructions are noted in [Appendix B](#).

Johns Hopkins All Children's Hospital
Emergency Center Burn Clinical Pathway



High-Risk Burn Clinical Pathway



Special Considerations and Additional Information:

Consider intubation before transfer IF:

- Extensive head, neck, and/or facial burns
- > 40% TBSA burn
- Stridor, wheezing, hoarse voice, dyspnea
- CoHgb > 30% and obtunded
- If persistent lactic acidosis, consider CN poisoning
- Contact Critical Airway Team (7-4300)

ABA Criteria for injuries requiring referral to a Burn Center

- Partial thickness burns > 10% TBSA
- Burns that involve the face, hands, feet, genitalia, perineum, or major joints
- 3rd degree burns
- Electric burns, including lightning injury
- Chemical burns
- Inhalation injury
- Severe pain despite enteral opioid therapy

Consider escharotomy or fasciotomy after consultation with the Burn Surgeon:

- Full-thickness circumferential burns
 - Clinical signs of [compartment syndrome](#)
 - Full-thickness chest burns with restricted respiratory excursion
- AND**
- OR**

ABA Consensus Formula

- 2 – 4 mL/kg/% TBSA burn (using LR) in the 1st 24 hours
 - Give ½ in the first 8 hours post burn
 - Give ½ in the next 16 hours post burn
- Adults: 2 mL/kg/% TBSA
- Children: 3 mL/kg/% TBSA
- Electrical: 4 mL/kg/% TBSA

Patients ≥ 30 kg:

- Adjust fluid rate for goal UOP 0.5 mL/kg/hour

Patients < 30 kg:

- Adjust fluid rate for goal UOP 1 mL/kg/hour
- If < 30 kg, add maintenance fluids that include dextrose (D5LR or D5NS) in addition to the consensus formula

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Western Trauma Association. (2019). Preferred triage and initial management of the burned patient. *Journal of Trauma and Acute Care Surgery*, 87(5), 1239–1243

Outcome Measures:

- EC length of stay
- Number of patients with burns transferred to Burn Centers
- Return to EC for burn issues

Clinical Pathway Team
Trauma – Burn Clinical Pathway
Johns Hopkins All Children’s Hospital

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Disclaimer:

Clinical Pathways are intended to assist physicians, physician assistants, nurse practitioners, and other health care providers in clinical decision-making by describing a range of generally acceptable approaches for diagnosing, managing, or preventing specific diseases or conditions. The physician must make the ultimate judgment regarding the care of a particular patient in light of the patient's individual circumstances.

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Appendix A: Lund-Browder Chart



JOHNS HOPKINS
MEDICINE

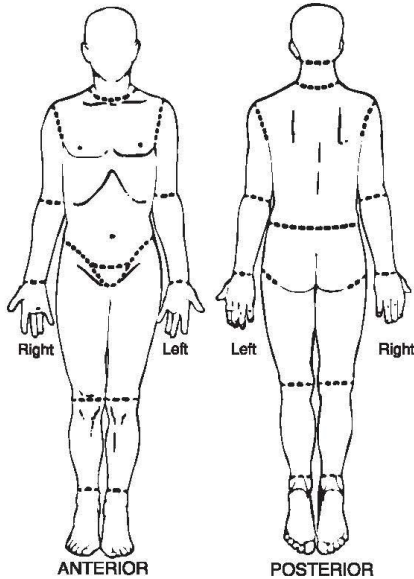
- Johns Hopkins Bayview Burn Center
- Johns Hopkins Hospital Children's Center

Lund & Browder Chart (TBSA) Total Body Surface Area

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4



4007157000-121



Addressograph _____

DATE _____

COMPLETED BY _____

X

SHALLOW INDETERMINATE OR DEEP

SHALLOW (PINK, PAINFUL, MOIST)

INDETERMINATE OR DEEP (DRY, LESS SENSATION, WHITE, MOTTLED, DARK RED, BROWN OR BLACK, LEATHERY)

Percent Surface Area Burned
(Berkow Formula)

AREA	1 YEAR	1-4 YEARS	5-9 YEARS	10-14 YEARS	Y 15 YEARS	ADULT	SHALLOW	INDETERMINATE OR DEEP
Head	19	17	13	11	9	7		
Neck	2	2	2	2	2	2		
Anterior Trunk	13	13	13	13	13	13		
Posterior Trunk	13	13	13	13	13	13		
Right Buttock	2½	2½	2½	2½	2½	2½		
Left Buttock	2½	2½	2½	2½	2½	2½		
Genitalia	1	1	1	1	1	1		
Right Upper Arm	4	4	4	4	4	4		
Left Upper Arm	4	4	4	4	4	4		
Right Lower Arm	3	3	3	3	3	3		
Left Lower Arm	3	3	3	3	3	3		
Right Hand	2½	2½	2½	2½	2½	2½		
Left Hand	2½	2½	2½	2½	2½	2½		
Right Thigh	5½	6½	8	8½	9	9½		
Left Thigh	5½	6½	8	8½	9	9½		
Right Leg	5	5	5½	6	6½	7		
Left Leg	5	5	5½	6	6½	7		
Right Foot	3½	3½	3½	3½	3½	3½		
Left Foot	3½	3½	3½	3½	3½	3½		
TOTAL								

Completed by Resident/Attending _____

Print Name _____ Date _____ Time: _____

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Appendix B: Burn Care Instructions

Why does my child need follow-up care for their burns?

It is important to follow up with your child's Burn Care Specialist or Primary Care Physician to ensure the burn is healing properly, prevent scarring, and help the skin return to its normal color as much as possible. This appointment may be needed within the first week of discharge. Review the After Visit Summary (AVS) for information on setting up an appointment.

When should I call a healthcare provider?

If you have questions or concerns about your child or if you notice any of the following symptoms, call your child's Burn Care Specialist or Primary Care Physician.

- Redness or swelling of the burned area
- Increased pain **or** pain not relieved by pain medicines
- Fever, rash, or bad-smelling drainage from the burns (clear yellow drainage is normal)

When should I give pain medicine?

Superficial and partial-thickness burns can be very painful!

- It is better to prevent pain than to wait until your child is in pain to give medicine.
- The pain medication instructions will be included in your After Visit Summary (AVS) discharge instructions.
- If your child is freely moving their burned body part, it is likely that their pain is controlled.
- **Provide your child with pain medication 30 minutes before dressing changes and follow-up appointments.**
- Encouraging your child to move the burned body part regularly is an important part of burn healing.

For all dressing types...

- Wash hands before and after any contact with burns or burn dressings.
- Keep supplies as clean as possible.
- Give pain medication 30 minutes before dressing change and/ or clinical visit.

Appendix B:
Burn Care Instructions (continued)

Silver-impregnated foam dressing (Mepilex® Ag):

- Silver-impregnated foam dressing sticks to the burn like a “Band-Aid” as it is healing.
- There is no need to change the silver-impregnated foam layer – it can stay in place for up to seven days.
- Keep the dressing dry and provide sponge baths.
- You only need to change the white outer gauze and stretch net dressing if it is completely wet with drainage; clear or yellowish drainage is normal.
- Additional supplies can be purchased at most pharmacies.
- One extra piece of silver-impregnated foam dressing will be provided, just in case the current dressing falls off. If the silver-impregnated foam dressing falls off:
 1. Wash the burn gently with mild soap and water – pat dry
 2. Reapply a new piece of silver-impregnated foam dressing
 3. Wrap with gauze
 4. Cover with a stretching net dressing

Bacitracin and non-adherent mesh dressing:

- Change the dressing daily during bath time.
- If the dressing is stuck on the burn, put your child in the bath with the dressing on, allowing the water to moisten the dressing and allow for easier removal.
- Apply bacitracin ointment to the non-adherent dressing and apply it to the burn/wound.
- Wrap with a gauze roll starting from the furthest part of the body (toes to hips, fingers to shoulders, etc.) and cover with a stretch net dressing.

Hand burns:

- After applying bacitracin ointment and a non-adherent dressing, each finger should be wrapped separately in a straight position.
- First, wrap the gauze around the wrist to prevent it from sliding off the fingers.
- From the wrist, move the gauze up the back of the hand towards the tip of the finger.
- Wrap around the finger – from the tip down to the palm – overlapping half of each wrap.
- Wrap gauze around the wrist again before starting on the next finger. Continue wrapping each burned finger following the above steps.
- Do not stretch or pull hard on gauze. Wrapping should be fitted but not constricting. Your child should be able to move their fingers easily with a full range of motion.

Please refer to your child's After Visit Summary (AVS) for additional instructions.