

## Treatment of burn: Personal approach.

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### Editorial

Wound care is an important part of the daily outpatient practice of a plastic surgeon. Most wounds have an acute, chronic or burn related aspect. Wound care consists of approximately 40% of my outpatient consultations, especially pediatric burns. Burns are considered as basic wounds in the day by day restorative practice and may have major physical and mental effects. Burns influence all ages. Around 250.000 individuals face major injuries due to burns every year in the United Kingdom. 13000 individuals of these are admitted to the hospitals with and it causes a death rate of 300 every year. Burns are a significant issue in the developing countries with higher death rate than in the developed countries. Requirement for hospitalization and liquid revival are enforced when the burn covers over 15% of the aggregate body surface in grown-ups and over 10% of the body surface in kids. Other different signs are uncontrolled pain and social signs (no accomplice, high age etc.) [1]. Skin grafting is approved for the hospitalized patients sooner after the primary damage (around 1.7-2.5 days). Around 9 days later, the outpatients treated with local injury care, experience skin grafting (10.7-12.3 days). Likewise, outpatients have an essentially minimum skin grafted territory in contrast to inpatients with similar skin grafting surgery [2]. This means the underlying burn profundity assessment might be troublesome and thus second degree burnt zones are dealt as serious high thickness wound with broader debridement and skin grafting surgery as fundamental. As a consequence of major skin grafting surgery, the visual appearance will be low with shading contrasts, surface contrasts and the hazard for extra scar tissue at the edges of the treated zones. The expenses for outpatients treated by debridement and skin joining are considerably lower contrasted with an inpatient treatment up with a factor 7 difference [2]. Availability wound dressings is broad and significant, and the product value difference among various organizations exist.

### Treatment Methods

#### Corticosteroid creams

In the circumstance of hyper granulation wounds, which may happen amid the treatment of profound dermal/full thickness consumes, I want to apply joined fusidic corrosive corticosteroid creams secured by fluidic corrosive intertulle to smooth the hypergranulation tissue, to encourage the reepithelialization procedure, to diminish the bacterial load and to decrease scar tissue. I substitute with silver froth dressings which can likewise be utilized as a part of wounds with hypergranulation tissue [3].

#### Treatment by Hydrogel

In this method the initial step is sanitization of the injury region

with povidone iodine/saline and then a hydrogel twisted dressings on the uncovered injury areas is followed, once per 2-3 days to elevate autolytic debridement and to make a wet injury bed for incitement of reepithelialization of the injury. The gel is secured by a paraffin bandage or with fusidic corrosive impregnated intertulle secured by sterile dressings. Joined hydrogel intertulle dressings are available. Hydrogel treatment alone might be adequate to auxiliary close shallow dermal injuries [4]. I leave rankle skin in place which fills in as a characteristic dressing, only the avital rankle skin is removed. Broad difficult rankles or rankles with practical block is cut without expulsion of the skin which fills in as a characteristic boundary.

### Conclusion

By the help of above mentioned treatment protocols, 98% cases have been successfully treated. These include mid dermal burns, 2nd degree buns etc. As per most literature reports, the recovery time is 10-14 days for severe burns, 2 months for mid dermal damage [5].

I saw a diminishment in the specified mending times with a normal of 7-12 days when utilizing the dressings composes portrayed previously. Current trends in wound healing should accept a cost effective protocol and these protocols should be made effective to reduce the chances of surgical treatments.

### References

1. Hettiaratchy S, Dziewulski P. ABC of Burns. *BMJ* 2004; 329: 504-506.
2. Gore DC. Outcome and cost analysis for outpatient skin grafting. *J Trauma* 1997; 43: 597-600.
3. Hon KL, Wang SS, Lee KK, et al. Combined antibiotic/corticosteroid cream in the empirical treatment of moderate to severe eczema: Friend or foe? *J Drugs Dermatol* 2012; 11: 861-864.
4. Vernon T. Intrasite gel and intrasite conformable: The hydrogel range. *Br J Community Nurs* 2000; 10: 511-516.
5. Bullocks JM, Patrick WH, Shayan AI, et al. Plastic surgery emergencies, principles and techniques. Thieme 2017; 2.

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