

TYPES AND MODES OF BURN INJURIES AND MORTALITY RATE AT A TERTIARY
CARE HOSPITALDr. Maryam Tariq^{*1}, Dr. Ramza Naeem Butt² and Dr. Sikandar Riaz Cheema³

Pakistan.

*Corresponding Author: Dr. Maryam Tariq
Pakistan.
DOI: <https://doi.org/10.17605/OSF.IO/YGZ35>

Article Received on 21/06/2020

Article Revised on 11/07/2020

Article Accepted on 31/07/2020

ABSTRACT

Objective: To assess the various types and modes of burn injuries and mortality rate at tertiary care hospital. **Material and methods:** This retrospective study was conducted at Department of Plastic Surgery, Jinnah Hospital Lahore from January 2018 to June 2018 over the period of 6 months. Total 100 with burn injuries were selected from hospital record and analyzed. Etiology of burns, nature of burn injury and severity of burn injury was assessed. **Results:** Total 100 with burn injury were selected. Mean age of the patients was 32 years. 30-40years age group was the most commonly affected. Etiologies of injuries are flame burns (60%), scalds (25%), electrical burns (10%) and chemical burns (5%). Most of the burn injuries are accidental (65%), followed by suicidal (15%), industrial (12%) and homicidal (8%). **Conclusion:** Results of present study showed the male patients were more victim as compared female patients. Age group 30-40 was the most commonly affected age group. Most of the patients were found with flam burn. Most of the patients were found with 31-40% TBSA and higher number of mortality was noted in 71-80% TBSA.

KEYWORDS: Burn, Epidemiology, Trauma, TBSA, PTSD.

INTRODUCTION

Burn injuries constitute a serious life hazard and a severe emotional, psychological and social crisis for the affected individuals and their families. It is a huge.^[1] Burn injury is often followed by a profound hyper metabolic response that results in the damage of local tissue and internal organs.^[2,3] The extent of damage and duration of the response is related to the extent of burn injury sustained.³ Burn patients have supra-physiological metabolic activities, multi-organ dysfunction and local and systemic oxidant changes manifested by increased free radical activity and lipid peroxidation, inflammatory cytokines and acute phase proteins.^[4] Burns account for 1% of the global burden of diseases and cause more than 7.1million injuries, a loss of almost 18million disability-adjusted life years (DALYs), and more than 265,000 deaths worldwide annually.^[5-7] The burn unit in Jinnah Hospital Lahore caters to the needs of the poor people from Lahore district. Being a tertiary care center, burn cases get referred to the surroundings. Burns data from 100 consecutive adult cases (age >13years) admitted in the burns ward were analyzed retrospectively to study the epidemiological patterns, psychosocial factors, bacteriological profile, and management outcomes. The aim of the study was to study the various epidemiological factors like age group, sex, socioeconomic status, causative factors, comorbid conditions, and the severity of burns, psychological

aspects and treatment modalities which impact the outcome.

MATERIAL AND METHODS

This retrospective study was conducted at Department of Plastic Surgery, Jinnah Hospital Lahore from January 2018 to June 2018 over the period of 6 months. Patients with burn injury more than 10% TBSA were included. Patients with minor burn injuries were treated on OPD (outpatient department) basis. Patients who had taken discharge against medical advice and those declared absconded, patients not willing to enroll in the study were excluded. On admission, the detailed history and physical examination along with consent are obtained. Calculating the %TBSA of the burn was necessary for guided fluid resuscitation. Rule of nines was used for estimating %TBSA. Patients were managed according to percentage of burn. Burn wound were cleaned with soap and water, blisters and debris were removed. Patients were treated with saline wash and placement of venous access and urinary catheter. Fluid resuscitation was done according to the Parkland formula. Antibiotics, analgesics and H2 receptor antagonists are routinely given.

Application of silver sulphadiazine cream, debridement, and collagen application, surgical debridement, escharotomy, fasciotomy, excision and skin grafting are

made as required. High calorie, high protein diet was provided.

Physiotherapy was instituted for all cases for early mobilization. Laboratory investigations like complete blood count, serum electrolytes, urea, creatinine, random blood sugar were done. Wound swab culture and sensitivity were done whenever required. Blood transfusions were given whenever necessary.

As per the burns ward protocol, the variables entered in the admission record books were age, sex, residence, religion, type of burn, mode of burn, TBSA percentage, duration of hospitalisation, number of patients discharged and those who took discharge against medical advice (DAMA), absconded or died during the hospital stay. The data of each patient were collected in keeping with a standard pro forma, which included these variables. The data collected were entered into MS-Excel sheets and analysis was carried out. On the basis of analysis and observation, results were drawn and discussed and compared with other relevant literatures.

RESULTS

The average age of the burns patient in this study was 32years, 30-40years age group was the most commonly affected (Figure 1).

Females are more commonly affected than men. The ratio for male to female was 1:1.35. Etiologies of injuries are flame burns (60%), scalds (25%), electrical burns (10%) and chemical burns (5%) (Figure 2).

Most of the burn injuries are accidental (65%), followed by suicidal (15%), industrial (12%) and homicidal (8%) (Figure 3).

Less than 10% TBSA cases were usually treated as outpatients. 40-70% of TBSA formed the major bulk of admissions (63%) (Figure 4). Wound swab, Culture studies are done after 5th post-burn day for specific antibiotic therapy. *Klebsiella pneumonia* was is the most commonly isolated organism followed by *Pseudomonas* and methicillin resistant *staphylococcus aureus*. The incidences of diabetes, COPD, ischemic heart disease, seizure disorders were studied. The mean length of stay of all the patients was 10.6days. The length of stay for each 10 %TBSA group was also studied (Table 1).

Patients with psychiatric manifestations requiring psychiatric management were studied. Patients with pre-existing psychiatric illness already under medication were 5%. Patients who developed psychiatric manifestations during the burns treatment was 25%. 12% of patients suffered from PTSD (Post Traumatic Stress Disorder), anxiety disorder 8%, depression 5% (Figure 5). Overall mortality was high (49%). Mortality up to 30% TBSA was low 0%. Mortality of TBSA from 30-60% was 41.1%. Mortality for TBSA above 60% was high (87.5%). The commonest cause of death was septicemia (80%) followed by burns shock 15% (Table 2).

Figure 1: Distribution of Age group.

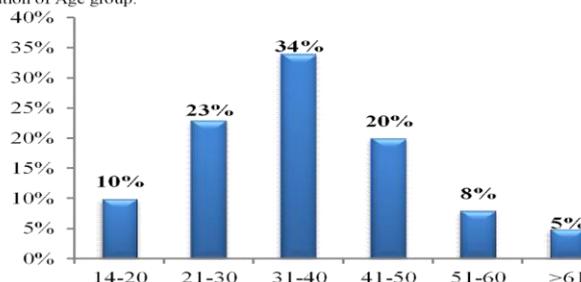


Figure 2: Distribution of etiology of burns.

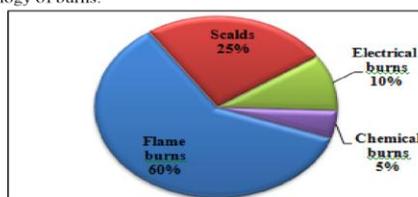


Figure 3: Distribution of nature of injury.

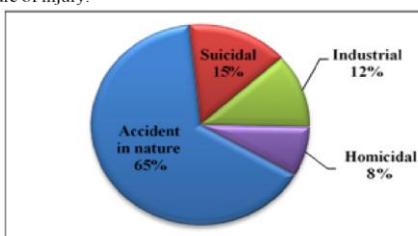
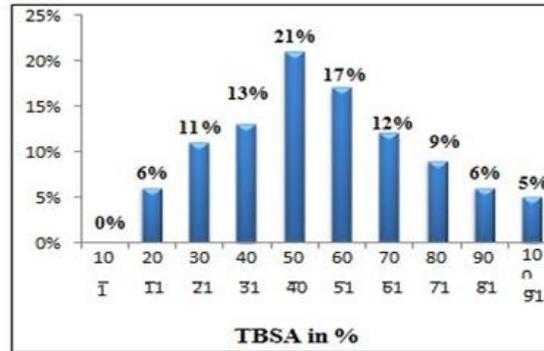
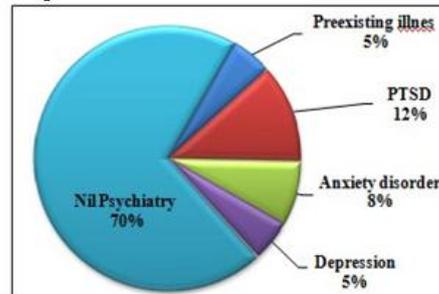


Figure 4: Severity of burn injury.**Figure 5:** Distribution of psychological factors.**Table 1:** Distribution of duration Of stay at hospital.

TBSA in %	Length of stay (in days)
1-10%	0
11-20%	10
21-30%	22
31-40%	24
40-50%	18
51-60%	13
61-70%	8
71-80%	6
81-90%	3
91-100%	2

Table 2: Distribution of mortality.

TBSA in %	Percentage of death
1-10%	0%
11-20%	0%
21-30%	0%
31-40%	23%
41-50%	38%
51-60%	59%
61-70%	75%
71-80%	89%
81-90%	100%
91-100%	100%

DISCUSSION

This study was undertaken as a trial study on the burn injury cases admitted in Burns ward, TVMCH. The

commonly affected age group was 20-40years and females are involved more in burn injuries. This correlates well with other studies conducted in this country (Goswamy P et al) but differs from the studies

from the west (Othman N et al) where male case more commonly involved.^[8,9] This is mainly due to the socioeconomic situation in this country where women cook using kerosene stoves and chulhas and wearing long flowing dresses like sarees and long skirts. Flame burns were the common cause 60% followed by scalds 25% and electrical burns 10% and chemical burns 5%.^[10,11]

Nature of burns 65% has accidental burns, 15% suicidal burns, 12% industrial burns, 8% homicidal burns. The high incidence of accidental burns correlates well with other studies.^[12,13]

TBSA is an important risk factor, and various treatment modalities are adjusted accordingly. 40%-60 % TBSA of burns formed the major bulk of cases admitted. Overall mortalities up to 30% TBSA was low. Mortality for TBSA above 60% was high at 87.5%.^[8] Klebsiella was the most common organism isolated from the culture studies followed by *Pseudomonas* and methicillin resistant *staphylococcus aureus*.^[12]

The average hospital stay in this series is 10.6days as compared to other studies. 30-50% TBSA had the longest stay averaging 21days. For TBSA less than 30% the average stay was 8.5days. For TBSA more than 60% average stay was 4.75days.^[8,14] Diabetes, IHD, and COPD constitute significant comorbid conditions leading to higher morbidity and mortality rates. 3 cases of uncontrolled seizure disorders leading to accidental burn injuries were treated. These comorbid conditions result in increased morbidity and mortality and prolonged hospital stay.^[15]

Psychological factors: 5% of these cases suffered from pre-existing psychiatric illness taking treatment. During the admission, 25% of cases developed clinical depression, anxiety disorders, and PTSD and were treated by psychiatrists.^[16] the leading cause of death was septicemia and MOF and cardiorespiratory arrest. Other causes were burn shock in cases having more than 90% TBSA.

CONCLUSION

Results of present study showed the male patients were more victim as compared female patients. Age group 30-40 was the most commonly affected age group. Most of the patients were found with flam burn. Most of the patients were found with 31-40% TBSA and higher number of mortality was noted in 71-80% TBSA.

REFERENCES

1. Setline RE, Arnsberg J, Sopyy EJ, Sun dell B. Long-term functional sequelae after paediatric burns. *Burns*, 1998; 24(1): 3-6.
2. Williams FN, Herndon DN, Justice MG. The hyper metabolic response to burn injury and interventions

- to modify this response. *Clin Plastic Surg*, 2009; 36(4): 583-96.
3. WHO. WHO Health Estimates Summary Tables: Deaths and Global Burden of Disease, 2014. http://www.who.int/healthinfo/global_burden_disease/en/. (Accessed on 21 December 2018), 2014.
4. Honnegowda TM, Udupa EG, Rao P, Kumar P, Singh R. Superficial burn wound healing with intermittent negative pressure wound therapy under limited access and conventional dressings. *World J Plastic Surg*, 2016; 5(3): 265.
5. Celsius A, Ouida M, Mohsen S, Al-Shaikh M, Okayed S, Abo-Shaba N, et al. Epidemiology and outcomes of hospitalized burn patients in Gaza Strip: a descriptive study. *Ethiopian J Health Sci.*, 2016; 26(1): 9-16.
6. Setline R. Late outcome of paediatric burns scarred for life? *Ann ChirurgiaeGynaecol*, 1998; 87: 80-80.
7. Gupta JL, Machida LK, Bajaj SP. National programmer for prevention of burn injuries. In *J Plastic Surg: Off Pub Assoc Plastic Surg India*, 2010; 43: S6.
8. Goswamy P, Segovia P, Sinha AK, Tutu T. Five-year epidemiological study of burn patients admitted in burns care unit, Tata Main Hospital, Jamshedpur, Jharkhand, India. In *J Burns*, 2016; 24(1): 41.
9. Othman N, Kendrick D. Epidemiology of burn injuries in the East Mediterranean Region: a systematic review. *BMC Public Health*, 2010; 10(1): 83.
10. Shawnee CP, Ahuja RB, Goal A. Burns in India: epidemiology and problems in management. In *J Burns*, 1993; 1(1): 1-4.
11. Chauhan N, Kumar S, Sharma U. Profile of acute thermal burn admissions to the intensive care unit of a tertiary burn care center in India. In *J Burns*, 2012; 20(1): 68.
12. Deshpande JD, Navistar PK, Pale DB. Epidemiological study of hospitalized burn patients in rural area. *Inter J Biomed Advanced Res*, 2012; 3(4): 263-7.
13. Sharma BR, Harish D, Sharma V, VI K. Kitchen accidents vies-a-vies dowry deaths. *Burns*, 2002; 28(3): 250-3.
14. Ahuja RB, Goswamy P. Cost of providing inpatient burn care in a tertiary, teaching, hospital of North India. *Burns*, 2013; 39(4): 558-64.
15. Akhtar MS, Ahmad I, Khan AH, Khurram FM, Haq A, Bazar R. Burn injury associated with comorbidities: Impact on the outcome. In *J Burns*, 2014; 22(1): 51.
16. Palma R, Soutine K, Viola J, Isomers E. Mental disorders after burn injury: a prospective study. *Burns*, 2011; 37(4): 601-9.