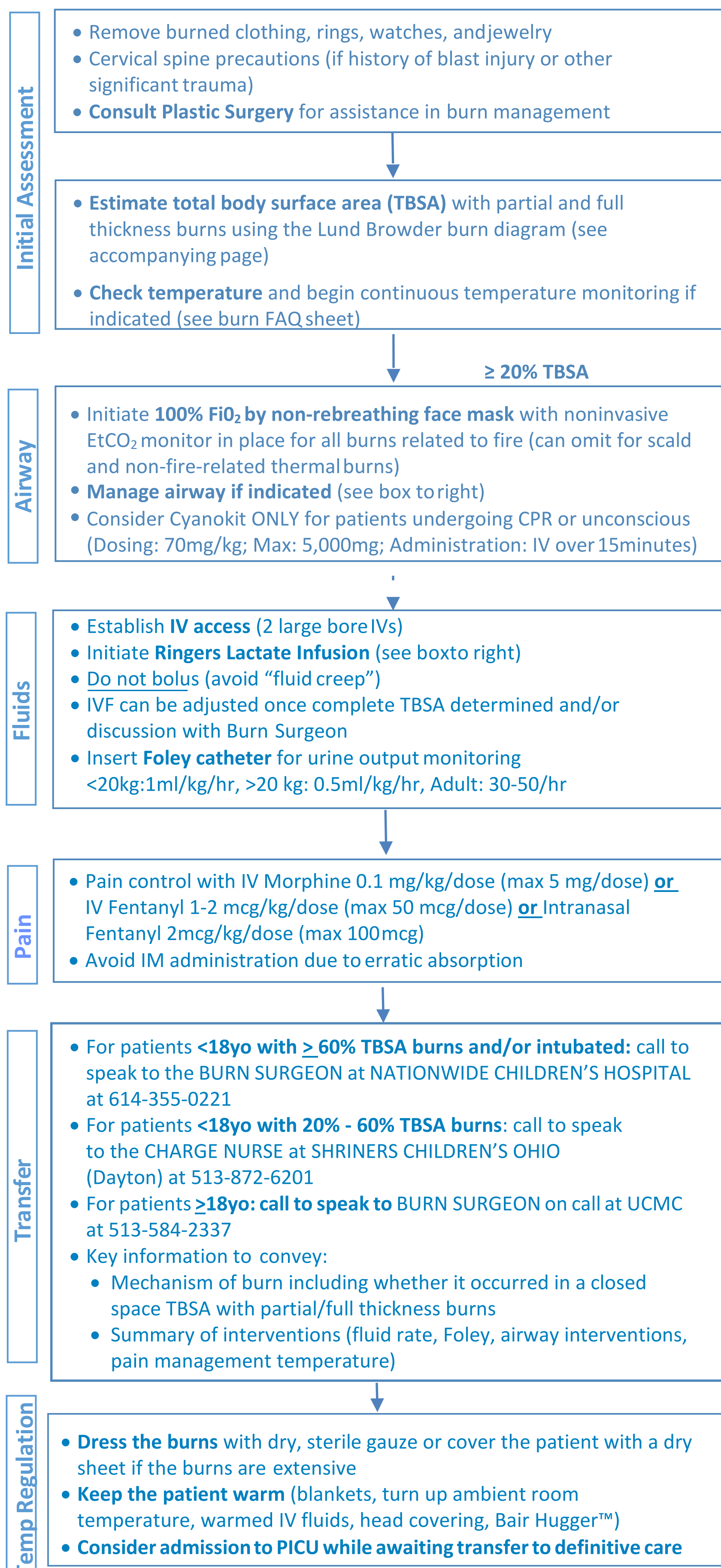
Large Burns ≥ 20% TBSA in STS



Pitfalls to Avoid

- Overestimation of TBSA
- Over/under resuscitation with IV fluids
- Endotracheal intubation when not indicated
- Inadequate temp monitoring and hypothermia

Indications for emergent airway management in a burn patient

- Obtundation with absent airway reflexes (no cough/no gag)
- Hoarse voice or cry, stridor, drooling, difficulty speaking, respiratory distress, obvious swelling of the oropharynx
- Extensive (> 40%) TBSA burns

In the absence of the above findings, emergent intubation may not be indicated. Flash facial burns, singed nasal/facial hair, and carbonaceous material (soot) in the naso/oropharynx are not absolute indications for emergent intubation as long as the patient is breathing comfortably.

Fluid administration recommendations

- Begin 2X maintenance of warm (LR) Lactated Ringers solution
- Add D5LR MIVF if pt <20kg

Labs/Studies to Consider

- I Stat
- Renal profile and CBC
- Noninvasive carbon monoxide measurement
- Venous co-oximetry (ie carboxyhemoglobin level)
- Lactic Acid (Stat)
- Cyanide level
- Urine or blood hCG (if post-menarchal)
- CXR, Type and Screen (if history of blast injury or other significant trauma)

Vital Sign Monitoring:

Age	Acceptable HR	Minimum Systolic B/P	Minimum Mean B/P
0-1 yr.	120-168	65	45
1-2 yr.	120-168	68	45
3-5 yr.	95-145	72	50
6-7 yr.	95-145	75	50
8-9 yr.	95-145	80	50
10 & older	72-120	80	55

Revised 07/2022