The authors analyzed more extended sites, such as: scalp, face/neck, trunk and limb. In 1936, Michel Salmon's "Les artères de la peau" showed in anatomical study the great variability of skin vascularization regarding the location. Thus, we were learned that cutaneous envelope is better supplied but have less elasticity in head and neck zone than in trunk and limbs. Therefore, the justification of our study to focus on lower limb is the difficulty to lead an expansion procedure on this very area. It has low vascularity and some adherent spots (tibial crest and foot plant). Moreover, Pandya have shown that limbs are more correlated to complications than other sites [4].

In their study, Smolle et al. had very innovative data readouts such as the shape of the prosthesis. It would be interesting to assess if a particular shape was correlated to more (or less) complication, and more specifically rectangular ones. In our experience, unfolding rectangular prosthesis, at the beginning of inflating phase, can induce sharpness feeling under the skin. This sometimes led to ischemic spots postponing injection to avoid necrosis and prosthesis exposure.

The complications reported in Smolle's article were comparable to our study. We described some nervous compressions of sensitive superficial fibers that induced resolutive pain, at the end of inflating procedure.

Smolle et al. proposed to use Clavien-Dindo classification to manage complications of skin expansion. It retrospectively considers the consequences of these complications [5] and offer the asset of a global care of the patient. In our study we used the Manders classification [6]. It shows a prospective vision in order to give guidelines for the practitioner to cope with a minor or a major complication.

To conclude, Smolle et al. have done a great analysis of skin expansion complications in a large nosological framework. Our work aimed to highlight some technical points on a very specific facet of this type of procedure.

Once more we would like to congratulate Smolle et al. on their work and hope to hear more from the authors in the future.

Conflict of interest

None.

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http://dx.doi.org/10.1016/j.burns.2018.10.005

Letter to the Editor

Call for more translational research in burn injury prevention

Dear Editor,

We read with great interest the recent article by Makhubalo et al. entitled "Acceptability and functionality of the "Kettle Strap": an attempt to decrease kettle related burns in children" [1]. They were motivated to develop the Kettle Strap, a simple tool to prevent the kettle and its cord from being pulled, based on their previous finding that kettle scalds were a major cause of child burn injury, which were mainly caused by "pulling the dangling kettle cord" [1,2]. To date, many studies have been conducted to identify risk factors for child burn injury, but little has been reported about the attempt to prevent it especially in low- and middle-income countries where the vast majority of global burn-related deaths and disabilities occur. Makhubalo's contribution is a good example of translational research in burn injury prevention which is called for.

We are now trying to carry out such a research in Mongolia with one of the highest child burn mortality rate globally [3]. To tackle child burn injury, we reviewed previous studies to understand how burn injury happened to children but its etiology was unclear in Mongolian settings [4]. Since risk factors for burn injuries should vary between countries and settings, based on which interventions should be tailored, we conducted a hospital-based survey at the National Trauma and Orthopedic Research Center, only the hospital providing tertiary care for burn injury in Mongolia [5]. From August 2015 to July 2016, 906 burn patients aged <16 years were admitted to the Center, of

whom 83% were aged 3 years or below, 65% were injured inside a *ger*, a traditional tent-like dwelling, 41% were scalded with electric pots (mainly by falling into the pots) and another 15% with electric kettles (mainly by pulling the kettles). Moreover, 62% of major burn injuries were inflicted by electric pots or kettles. In Mongolia, a majority of people live in a *ger* or simple detached house with no separate kitchen, where electric pots and kettles are commonly used on the floor or low table, allowing children an easy access to these heat sources [5].

These findings informed us that over half of burn injuries, especially severe ones, could be prevented if electric pots and kettles are made inaccessible to children. Given a limited space inside the traditional dwelling, we came to develop a box-like kitchen rack in which electric pots and kettles can be kept out of the reach of children. An idea is consistent to Makhubalo's, i.e., "childhood burns are mainly environmentally determined and therefore preventable" [1]. Note that the development of the kitchen rack is still underway and will require a rigorous evaluation of its effectiveness in burn prevention. We hope that more translational research such as Makhubalo's will be reported in the journal.

Conflict of interest

None.

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http://dx.doi.org/10.1016/j.burns.2018.09.035

Letter to the Editor

Chronic burn wound treatment by Erbium: YAG fractional ablation: First described report and literature review

In the past, the largest concern of a severe, acute thermal injury was survival. With a current estimated survival rate of 96.8% of patients admitted to burn centers [1], burn survivors are now plagued with the lifelong consequences of burn scar morbidity. Treatments for hypertrophic scarring, specifically burn scar contracture, have been heavily explored in the literature; however, there is a paucity of studies exploring chronic wounds post thermal injury [2]. While treatments for these wounds range from debridement and wound care [3] to hyperbaric oxygen therapy [2], patients are often troubled with these wounds for indefinite amounts of time.

Fractional laser resurfacing (FLR) is a new technology that has proved efficacious in relieving hypertrophic burn scar tension. A safe [4] and relatively quick procedure, fractionated laser treatments are well-tolerated with minimal morbidity in addition to having minimal postoperative downtime. While there is evidence that FLR improves symptoms associated with hypertrophic burn scarring [5,6], there are no examples in the surgical literature of its effectiveness in promoting the closure of chronic wounds associated with hypertrophic burn scars. Herein, we describe the first known example of such a phenomenon.

A 53-year-old male with no past medical history presented in September 2017 to the burn clinic of our American Burn Association-verified burn center for evaluation of a chronic wound. He originally suffered a full-thickness flame burn to his left leg after gasoline ignited at the age of 6 years old. The patient had subsequently undergone multiple skin grafts to his left leg, which left him with significant hypertrophic scarring that formed a tight scar band in his left leg. This band, in turn, led to a chronic open wound in his popliteal fossa for over 18 years. In August 2016 he presented for evaluation in our burn clinic for a 2 cm nonhealing ulcer in his left popliteal fossa and underwent hypertrophic scar release and ulcer excision with 5 cm × 3 cm rotational flap coverage to his left popliteal fossa. The patient was sent home with daily xeroform dressings and a knee immobilizer for 2 weeks. The patient returned postoperatively with partial skin dehiscence and flap necrosis. He was left with a large, 5 cm chronic open wound in his popliteal fossa with plans for trial of nonoperative wound care management (Fig. 1A). The patient subsequently underwent several months of wound care including multiple rounds of sharp debridement as well as 20+ visits to a hyperbaric oxygen chamber between November and December of 2016.

The patient was next seen in September 2017 for evaluation for laser contracture release of the hypertrophic scar band in