the suffering of patients in treatment, analgesics could be appropriately applied.

1.5. *Sunscreen protection and anti-scarring agents*

The patients were advised to moisturize the area and to use sunscreen protection. To prevent severe scar formation, anti-scarring agents could be applied when necessary.

2. Conclusion

For the first time, by combining chitosan-based biogel with sterile polyethylene film, a paradigm was created for MMOBT in clinical trials. Our experiences indicated that MMOBT may be a superior therapy for severe thermal burns. The application of sterile polyethylene film is essential to the modification of MOBT. To further confirm the superiority of MMOBT, much more related studies are still urgently needed.

Conflicts of interest

None.

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Letter to the Editor

Toxic epidermal necrolysis therapeutic standardization: A holistic approach

Dear Sir,

We have carefully reviewed the publication "Care in patients with epidermal necrolysis in burn units. A nursing perspective" [1]. First, thank the authors for the research work carried out.

We would like to add that, from our perspective as facultatives of the Polytechnic University Hospital La Fe, we completely agree on the need to establish international guidelines that globally standardize the care for patients with TEN, focusing on certain aspects, such as the indications of fluid therapy and systemic treatment, aspects which need a higher level of evidence for clinical indication.

In our Burn Care Unit, the approach to this disease has undergone a noticeable change in a short period of time, mainly due to the greater influx of patients with this disease compared to previous years. This fact has led to progressive changes in initial management, such as direct interconsultation to Clinical Ophthalmology section of all patients –with or without ocular symptomatology-, initial application of silver foam dressings or antiseptic mouth washes. All of them are aspects that were not carried out in our unit during the period in which our staff was interviewed, and which have been progressively introduced.

We firmly believe that the approach of toxic epidermal necrolyisis should be done from specialized Burn Care Units, and reach an agreement for a standardized treatment of these. Finally, we want to encourage the authors to conduct a second interview with these units, with the aim of analyzing the improvements in the management of this pathology.

Best regards.

Declarations of interest

The authors declare not to have any conflicts of interest.

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Letter to the Editor

"An improvement on burn care" — A full audit cycle on accuracy & appropriateness of burn injury referrals from an Emergency Department through a Burns Network

Dear Sir,

We have recently carried out a full audit cycle assessing the accuracy of assessment and appropriateness of referrals from the Emergency Department (ED) affiliated with our Burns Facility, to the regional Burns Unit and Burns Centre. We had received reports of some potentially inappropriate referrals, which led us to carry out this project.

Our method for data collection was to generate a list of patients from the International Burn Injury Database, seen at the Burns Unit and Burns Centre, who lived in postcodes served by our trust. We then cross-referenced this list with hospital or ED notes to find the relevant information regarding the assessment of the injury, both in our Trust, and the receiving Trusts. The information we gathered included: assessment of Percentage Total Body Surface Area (%TBSA) and depth of injury; aetiology; any high-risk features such as special areas (hand, face, etc.), circumferential, chemical, or inhalational injury. We compared both assessments against our regional guidance, as well as making comparisons between the initial assessment in the ED, and by the receiving Plastic Surgery team. At the time of assessment, there was no official guidance on how to determine if an assessment of %TBSA was accurate, as such we decided that, if the final assessment was 10% or less, the initial assessment should be within a standard deviation of 1 (%TBSA), and if the final assessment was over 10%, then the initial assessment should be within a standard deviation of 2 (%TBSA). For example, if the final assessment for a patient was 9% TBSA, the appropriate range for the initial assessment would be 8–10% TBSA; for a final assessment of 13% TBSA, the appropriate range for the initial assessment would be 11–15% TBSA.

The guidance of the Midlands Burn Operational Delivery Network regarding referral of burn injuries from a burn facility is seen in Table 1 [1,2].

Our first study demonstrated that a third of patients did not have an assessment of %TBSA documented in their initial assessment (Fig. 1). Despite this however, 90% of the onward referrals were still appropriately made, based on their initial ED clinical assessment due to other qualifying criteria such as special area involvement (Fig. 2). When considering the final

Table 1 – MBODN guidance on which injuries a burn facility can manage, and which should be referred.

	Children (6months–16years)	Adults (>16years)
Can manage these injuries	• %TBSA ≤5 (Full thickness %TBSA ≤1)	• %TBSA ≤10 (Full thickness %TBSA ≤5)
Should refer these injuries	• Full thickness (%TBSA >1)	• Full thickness %TBSA >5
	• Circumferential	• Circumferential
	• Chemical	• Chemical
	• Electrical	• Electrical
	• Inhalational	• Inhalational
	• Special area involvement (face/hands/feet/genitals)	• Special area involvement (face/hands/feet/genitals)
		• Immunocompromised patients
		• Pregnant patients

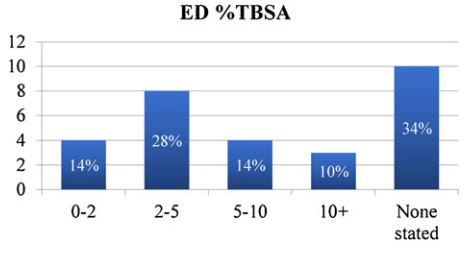

Fig. 1 – ED %TBSA assessment — 1st audit.