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## Why do burn patients die

According to the American Burn Association (ABA), there are roughly 3,400 U.S. burn injury death cases each year. Burn injury death is often caused by burn complications, such as shock, organ failure, respiratory problems, or infection. In order to prevent burn injury death, severe burn patients should receive emergency medical attention to ensure a stable condition before burn wound treatment begins. Burn Injury Death Causes The majority of burn injury death cases result from arising complications, not the burn injury itself. Shock is a common cause of burn injury death. Burn injury death from shock typically occurs within a week of the incident. Burn Shock Burn shock occurs when the patient's body does not receive adequate oxygen supply. Treating burn shock is often critical in the prevention of burn injury death. Burn shock may be caused by hypovolemia, or low blood volume due to damaged blood vessels. Burn shock may also occur as a result of sepsis, which is a bodily response to burn infection. Burn Infection Infection is one of the leading causes of burn injury death and complication. This is because the skin plays a vital role in protecting the body from airborne bacteria, fungi, and other pathogens. In patients with severe burns, open wounds create vulnerability for pathogens to enter the patient's body and cause infection. Infection may also occur during treatment, such as pneumonia from breathing tubes or urinary tract infections from bladder catheters. Other burn complications leading to death include: Sepsis from infection Respiratory failure Anoxic brain injury due to lack of oxygen Hypothermia, or dangerously low body temperature Residential Burn Injury Death The Centers for Disease Control and Prevention (CDC) state that in 2009, roughly 85 percent of burn injury death cases occurred in the home. In these cases, the majority of deaths occur as a result of inhaling smoke and toxic gases as opposed to burn injuries. Burn injury death cases from residential fires have significantly reduced over the decades. However, experts believe that a large number of these deaths are preventable with the implementation of household fire safety techniques. Residential Fire Risk Factors The CDC estimates that 47 percent of residential burn injury deaths occur in homes that do not have smoke alarms. The majority of residential fires occur in the winter months. These fires are often caused by cooking and open heat sources such as candles and fireplaces. Additionally, it is estimated that roughly 40 percent of residential burn injury deaths are related to the consumption of alcohol. Sources: "Burns and Traumatic Injury." National Institutes of Health. U.S. Department of Health and Human Services, 29 Mar 2013. Web. 21 Dec 2014. < . Chinkes, David L., et al. "The leading causes of death after burn injury in a single pediatric burn center." Critical Care 13 (2009): R183. Academic OneFile. Web. 21 Dec. 2014. "Fire Deaths and Injuries: Fact Sheet." Centers for Disease Control and Prevention. U.S. Department of Health and Human Services, 11 Oct 2011. Web. 21 Dec 2014. < . Muller, M. J., S. P. Pegg, and M. R. Rule. "Determinants of Death Following Burn Injury." British Journal of Surgery 88.4 (2001): 583-587. Health Source: Nursing/Academic Edition. Web. 21 Dec. 2014. Background: With unprecedented survival rates in modern burn care, there is increasing focus on optimizing long-term functional outcomes. However, 3% to 8% of patients admitted to burn centers still die of injury. Patterns in which these patients progress to death remain poorly characterized. We hypothesized that burn nonsurvivors will follow distinct temporal distributions and patterns of decline, parallel to the trimodality of deaths previously described for trauma. Methods: We retrospectively identified all adult deaths from 1995 to 2007 in the National Burn Repository database (n = 5,975) and at our regional burn center (n = 237). We stratified patients by age and analyzed injury and death characteristics. We used objective criteria to allocate nonsurvivors to one of four trajectories: early rapid decline, early organ failure, late sudden death, or late-onset decline. Results: The greatest concentration of deaths in both samples and age groups occurred within 72 hours of injury and decreased subsequently with no later mortality peak. Death was most often caused by burn shock within the first week of injury, cardiogenic shock or lung injury in Weeks 1 to 2, and sepsis/multiorgan failure after Week 2. In decreasing frequency, trajectories to death fit the pattern of early rapid decline (58%), early organ failure (20%), late-onset decline (16%), and late sudden death (6%). Conclusion: Most burn deaths follow a pattern of early rapid decline or early organ failure manifested by death or critical illness within several days of the burn. These findings indicate that more than three quarters of burn deaths are attributable to failure or significant decompensation beginning in the resuscitation phase. Sporadic deaths later in hospitalization are uncommon. Despite significant advances in burn resuscitation, our data indicate that ongoing efforts to mitigate deaths in modern burn care should still focus on care improvements in the resuscitation phase. Level of evidence: Epidemiologic study, level III. Article contents Figures & tables Video Audio Supplementary Data R-231 Quality/Outpatient You do not currently have access to this article. burn, damage caused to the body by contact with flames, hot substances, certain chemicals, radiation (sunlight, X rays, or ionizing radiation from radioactive materials), or electricity. The chief effects of contact with flame, hot water, steam, caustic chemicals, or electricity are apparent promptly. There is a delay of several hours before the full effects of sun or ultraviolet burns are apparent and a delay of 10 to 30 days before the full effects of ionizing radiation burns are apparent.The severity of a burn depends largely on the depth of tissue destruction and the amount of body surface affected. Other factors—including the patient's age and prior state of health, the location of the burn wound, and the seriousness of any associated injuries—can also influence recovery from a burn. 44 Questions from Britannica's Most Popular Health and Medicine Quizzes How much do you know about human anatomy? How about medical conditions? The brain? You'll need to know a lot to answer 44 of the hardest questions from Britannica's most popular quizzes about health and medicine. For an appreciation of how depth and size of a burn affect the severity of the injury, some understanding of the anatomy and physiology of the skin is necessary. Human skin is composed of two layers: an upper layer called the epidermis, and a lower layer known as the dermis (or corium). The largest of the body's organs, skin performs a number of vital functions. Its foremost job is to separate the external environment from the body's interior. The epidermis, the outer surface of which consists of dead, cornified cells, prevents infectious microorganisms and other harmful environmental agents from gaining entrance to the body. The dermis, by contrast, is made up of fibrous connective tissues that prevent the evaporation of body fluids. Embedded within the dermis and opening to the skin surface are the sweat glands. These secrete perspiration, the evaporation of which helps regulate body temperature. Perspiration also contains small amounts of sodium chloride, cholesterol, aluminum, and urea; it thus plays a role in regulating the composition of body fluids. The dermis also contains all of the skin's blood vessels and nerves, including sensory nerve endings that respond to touch, pressure, heat, cold, and pain. The skin therefore also serves as a sense organ that enables a person to adjust to changing environmental conditions. One final function of the skin is the synthesis of vitamin D, a compound essential to growth and maintenance, particularly of bone. Vitamin D is formed by the action of sunlight on certain cholesterol compounds in the dermis. Destruction of the skin by deep or extensive burns can disrupt all of these functions, subjecting the victim to serious complications.Physicians have traditionally categorized burns as first-, second-, or third-degree injuries, according to the depth of skin damage (see illustration). In a first-degree burn, only the epidermis is affected. These injuries are characterized by redness and pain; there are no blisters, and edema (swelling due to the accumulation of fluids) in the wounded tissue is minimal. A classic example of a first-degree burn is moderate sunburn.The damage in a second-degree burn extends through the entire epidermis and part of the dermis. These injuries are characterized by redness and blisters. The deeper the burn the more prevalent the blisters, which increase in size during the hours immediately following the injury. Like first-degree burns, second-degree injuries may be extremely painful. The development of complications and the course of healing in a second-degree burn depend on the extent of damage to the dermis. Unless they become infected, most superficial second-degree burns heal without complications and with little scarring in 10 to 14 days.Third-degree, or full-thickness, burns destroy the entire thickness of the skin. The surface of the wound is leathery and may be brown, tan, black, white, or red. There is no pain, because the pain receptors have been obliterated along with the rest of the dermis. Blood vessels, sweat glands, sebaceous glands, and hair follicles are all destroyed in skin that suffers a full-thickness burn. Fluid losses and metabolic disturbances associated with these injuries are grave.Occasionally burns deeper than a full thickness of the skin are incurred, as when part of the body is entrapped in a flame and not immediately extricated. Electrical burns are usually deep burns. These deep burns frequently go into the subcutaneous tissue and, at times, beyond and into the muscle, fascia, and bone. Such burns are of the fourth degree, also called black (because of the typical colour of the burn), or char, burns. Fourth-degree burns are of grave prognosis, particularly if they involve more than a small portion of the body. In these deep burns toxic materials may be released into the bloodstream. If the char burn involves only a small part of the body, it should be excised down to healthy tissue. If an extremity is involved, amputation may be necessary.Surgeons measure the area of a burn as a percentage of the body's total skin area. The skin area on each arm is roughly 9 percent of the body total, as is the skin covering the head and neck. The percentage on each leg is 13, and the percentage on the trunk is 18 on the front and 13 on the back. The percentage of damaged skin affects the chances of survival. Most people can survive a second-degree burn affecting 70 percent of their body area, but few can survive a third-degree burn affecting 50 percent. If the area is down to 20 percent, most people can be saved, though elderly people and infants may fail to survive a 15 percent skin loss.Severe burns cause immediate nervous shock. The victim grows pale and is confused, anxious, and frightened by the pain and may faint. Much more dangerous is the secondary shock that comes a few hours later. Its chief features are a dramatic fall in blood pressure that leads to pallor, cold extremities, and eventual collapse. This secondary shock is precipitated by loss of fluid from the circulation, not just the fluid lost in the destroyed tissue but fluid that leaks from the damaged area that has lost its protective covering of skin.Burns kill not just by damaging tissue but by allowing this leakage of fluid and salts. If more than a fifth of the blood volume is lost to the circulation, insufficient blood returns to the heart for it to maintain blood pressure. And the loss of salts, particularly sodium and potassium salts, not only disturbs their balance in the body but changes the osmotic balance of the blood and body fluids. The significance of these physiological changes was understood in 1905, but not until the 1930s were doctors able to correct them with transfusions of blood or plasma.The treatment of a burn is, of course, dependent upon the severity of the injury. In general, first-degree burns can be adequately treated with proper first-aid measures. Second-degree burns that cover more than 15 percent of an adult's body or 10 percent of a child's, or that affect the face, hands, or feet, should receive prompt medical attention, as should all third-degree burns, regardless of size.



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