

Best Evidence Summary for the Management of Pediatric Burn Wounds

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Objective: To select and summarize the best evidence for the management of pediatric burn wounds, providing evidence-based guidance for clinical wound care practices for pediatric burn patients. **Methods:** Following the “6S” pyramid model for evidence-based resources, a systematic search was conducted across domestic and international guidelines, professional society websites, and databases to identify clinical decisions, guidelines, evidence summaries, best practices, expert consensus, and systematic reviews related to the assessment and care of pediatric burn patients. The search period was from the establishment of the database until March 24, 2024. Two evidence-based researchers independently evaluated the quality of the literature, extracted, categorized, and integrated the evidence from the included studies, ultimately forming the best evidence. **Results:** A total of 16 articles were included, comprising 10 guidelines and 6 expert consensus documents. Four key themes were summarized: nursing assessment, wound care, fluid resuscitation, and infection prevention. A total of 37 best evidence points were extracted. **Conclusion:** The summarized best evidence for the management of pediatric burn wounds is both scientifically rigorous and clinically applicable, providing an evidence-based foundation to enhance the quality of wound care for pediatric burn patients.

Keywords: Pediatric burns; Wound care; Evidence-based nursing; Evidence synthesis

Burn injuries are the second most common cause of accidental injury among children worldwide^[1]. According to the World Health Organization, approximately 238,000 people die from burns each year, with pediatric burns accounting for about 40% of these deaths^[2-3]. The highest incidence occurs in the age group of 0–14 years, with a burn incidence rate as high as 7.77%^[4], indicating that children are a high-risk group for burn-related accidents. Burn injuries can lead to hypertrophic scarring, limb contractures, and functional impairments, affecting both the physical and psychological development of children^[5]. In addition, burn injuries place a significant financial, time, and human resource burden on families. Although numerous guidelines and expert consensus documents on burn wound management exist internationally, few focus specifically on pediatric patients, hindering timely access to relevant information for caregivers and healthcare providers^[6]. Therefore, this study systematically reviews domestic and international guidelines, consensus doc-

uments, and systematic reviews to integrate evidence on pediatric burn wound management, aiming to provide clinical practitioners and caregivers with reference for evidence-based treatment strategies.

Materials and Methods

Problem Definition

The evidence-based question was constructed using the PICO framework [7]. Population (P): Pediatric burn patients; Intervention (I): A series of wound care measures; Professional (P): Healthcare providers and caregivers of children; Outcome (O): Wound exudation, skin integrity, patient comfort, and quality of life; Setting (S): Hospitals and burn incident sites; Type of Evidence (T): Clinical decisions, guidelines, evidence summaries, systematic reviews, expert consensus, best practices. This study has been registered at the Evidence-Based Nursing Center of Fudan University (Registration No. ES20244370).

Search Strategy

A systematic search was conducted on the following websites and databases: International Society for Burn Injuries, American Burn Association, Japanese

Society for Burn Injuries, UpToDate, Cochrane Library, BMJ Best Practice, PubMed, Web of Science, CINAHL, WHO, Guidelines International Network (GIN), National Guideline Clearinghouse (NGC), National Institute for Health and Care Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), Canadian Medical Association Practice Guidelines, Guideline Central, China National Knowledge Infrastructure (CNKI), Chinese Medical Journals Database, Wanfang Database, VIP Database, and others. The search period extended from the establishment of the database until March 24, 2024.

The search strategy for PubMed is shown in **Figure 1**.

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#1 "Burns"[Mesh] OR "Burn Units"[Mesh] OR "Burnout, Psychological"[Mesh]
OR "Open Waste Burning"[Mesh] OR "Eye Burns"[Mesh] OR "Burns, Inhalation"[Mesh] OR "Burns, Electric"[Mesh] OR "Burns, Chemical"[Mesh]
#2 "Skin Care"[Mesh] OR "Wound Care"[Mesh] OR "Wound Healing"[Mesh]
OR "Wound Treatment"[Mesh] OR "Burn Care"[Mesh]
#3 "Child"[Mesh] OR "Adult Children"[Mesh] OR "Disabled Children"[Mesh]
OR "Aid to Families with Dependent Children"[Mesh] OR "Homeless Youth"[Mesh] OR "Child, Adopted"[Mesh] OR "Child, Orphaned"[Mesh] OR "Child, Preschool"[Mesh] OR "Child, Hospitalized"[Mesh] OR "Child, Exceptional"[Mesh]
#4 "Guideline" [Publication Type] OR "Guidelines as Topic"[Mesh] OR "Expert Consensus"[Mesh] OR "Systematic Review" [Publication Type] OR "Systematic Reviews as Topic"[Mesh]
#5 #1 AND #2 AND #3 AND #4
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Figure 1. Search strategies in PubMed database

1.2 Inclusion and Exclusion Criteria

Inclusion criteria: ① Study subjects are burn patients aged under 18 years.

② The study focuses on wound care measures for burn patients. ③

The study type includes publicly available clinical decisions, best practices, guidelines, expert consensus, and systematic reviews.

Exclusion criteria: ① Duplicated publications. ② Translated versions or those

with updated editions. ③ Incomplete or inaccessible full-text articles. ④

Low-quality literature based on quality assessment.

Literature Quality Assessment Standards

The highest quality evidence is determined by clinical decision support systems, and the evidence entries are directly included in the grading and recommendation levels^[9]. Guidelines are evaluated using the Appraisal of Guidelines for Research and Evaluation (AGREE II) system^[10]. The quality assessment for expert consensus documents follows the corresponding quality criteria of the Australian JBI Center for Evidence-Based Health Care^[11].

Literature Quality Assessment Process

Two researchers, trained in standardized evidence-based methodology, independently reviewed each article. Disagreements were resolved through discussion with a third researcher to reach a consensus.

Evidence Synthesis and Grading

The included original studies were graded using the evidence pre-grading and recommendation level system (2014 edition) from the Australian JBI Center for Evidence-Based Health Care^[12]. The recommendation level of evidence was determined through group discussions, based on feasibility, clinical relevance, suitability, and effectiveness. For conflicting evidence, the principle of “evidence

-based evidence priority, high-quality evidence priority, most recently published evidence priority” was followed^[13].

Literature Screening Process and Results

A preliminary search yielded 971 articles. After removing duplicates and screening titles and abstracts, 33 articles were selected for full-text review. After further reading, 16 articles were included, comprising 6 expert consensus documents and 10 guidelines. The literature screening process and results are shown in **Figure 2**.

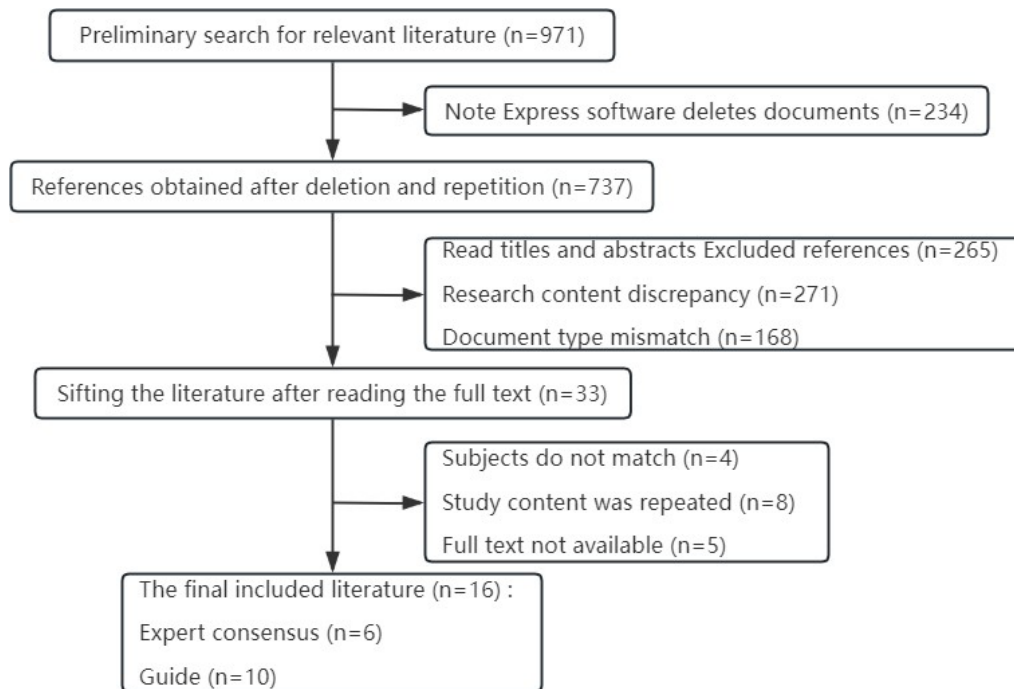


Figure 2. Flowchart of Literature Screening and Results

The general characteristics of the included literature are shown in **Table 1**.

Table 1. General characteristics of the included literature

	Included literature	Year	Source of evidence	nation	type	Document subject
1	Mark D Joffe, MD ^[14]	2023	UpToDate	USA	guide	Moderate and severe thermal burns in children: Emergency management
2	ABA ^[15]	2023	UpToDate	USA	guide	American Burn Association Clinical Practice Guidelines on Burn Shock Resuscitation
3	AWMF (DE) ^[16]	2015	GIN	DEU	guide	Treatment of heat injuries in children
4	JSBI ^[17]	2022	UpToDate	JPN	guide	Japanese Society for Burn Injuries (JSBI) Clinical Practice Guidelines for Management of Burn Care (3rd Edition)
5	(ACI)Statewide Burn Injury Service ^[18]	2020	UpToDate	AUS	guide	Child life therapy Burn patient management Clinical guide
6	ISBI ^[19]	2016	UpToDate	international	guide	ISBI Practice Guidelines for Burn Care
7	ISBI ^[20]	2018	UpToDate	international	guide	ISBI Practice Guidelines for Burn Care, Part 2
8	ABA ^[21]	2023	UpToDate	USA	guide	Clinical Practice Guideline: Early Mobilization and Rehabilitation of Critically Ill Burn Patients
9	(ACI)Statewide Burn Injury Service ^[22]	2020	UpToDate	AUS	guide	Burn Patient Management, 4th Edition
10	SA Health ^[23]	2015	UpToDate	AUS	guide	South Australian Paediatric Clinical Practice Guidelines Burns in Children

11	RCSEd\BBA ^[24]	2019	UpToDate	GBR	Expert consensus	Management of Burns in Pre - Hospital Trauma Care
12	Chinese Burn Association ^[25]	2023	Chin J Burns Wounds	CHN	Expert consensus	Expert consensus on the management of deep partial-thickness burn wounds in pediatric patients (2023 version)
13	Pediatric Disaster Branch of Chinese Pediatric Society of Chinese Medical Association ^[26]	2021	CNKI	CNN	Expert consensus	Expert consensus on the prevention and first-aid management of burns in children
14	Pediatric Burn Study Group, Burn Surgery Branch of Chinese Medical Association ^[27]	2023	Chinese Journal of Injury Repair and Wound Healing	CNN	Expert consensus	Expert consensus on fluid resuscitation of early pediatric burn shock (version 2023)
15	The Burn and Trauma Branch of Chinese Geriatrics Society ^[28]	2020	Chin j Burns	CNN	Expert consensus	National expert consensus on psychological rehabilitation of burn children (2020 version)
16	Chinese Burn Association ^[29]	2024	Chin J Burns Wounds	CNN	Expert consensus	Expert consensus on the treatment of second-degree burn wounds

(2024 edition): pre-hospital first aid and non-surgical treatment

2.3 Quality evaluation results of the included literature

2.3.1 Literature quality evaluation results of expert consensus

A total of 6 expert consensus papers were included in this study, as shown in **Table 2**.

Table 2. Results of literature quality evaluation by expert consensus

Included literature	item					
	1	2	3	4	5	6
Management of Burns in Pre - Hospital Trauma Care ^[24]	yes	yes	yes	yes	yes	yes
Expert consensus on the management of deep partial-thickness burn wounds in pediatric patients(2023 version) ^[25]	yes	yes	yes	yes	yes	yes
Expert consensus on the prevention and first-aid management of burns in children ^[26]	yes	yes	yes	yes	yes	yes
Expert consensus on fluid resuscitation of early pediatric burn shock (version 2023) ^[27]	yes	yes	yes	yes	yes	yes
National expert consensus on psychological rehabilitation of burn children(2020 version) ^[28]	yes	yes	yes	yes	yes	yes
Expert consensus on the treatment of second-degree burn wounds(2024 edition): pre-hospital first aid and non-surgical treatment ^[29]	yes	yes	yes	yes	yes	yes

2.3.2 Results of literature quality evaluation of the guidelines

A total of 15 guidelines were included in this study, as shown in **Table 3**.

Table 3. Results of literature quality evaluation for the guidelines

Included literature	Percentage of field standardisation(%)						>6 0%field	>3 0%field	Rec om men dati on l evel
	Scope s and object s	Partici pant	Rigou r of guidel ines	Clarit y of guidel ines	Appli cation of g uideli nes	Indep enden ce of guidel ines			
Moderat e and se vere ther mal bur ns in ch ildren: E mergenc y manag ement ^[14]	95.83	80.21	86.90	90.62	83.33	87.50	6	6	A
America n Burn Associati on Clini cal Pract ice Guid elines o n Burn Shock R esuscitati on ^[15]	98.61	79.17	88.10	87.50	80.56	91.67	6	6	A
Treatmen t of heat injuries in chldr en ^[16]	97.22	85.42	79.76	90.62	83.33	89.58	6	6	A
Japanese Society for Burn Injuries (JSBI)Clinical Practice Guidelin e s f o r Manage ment of	100	92.71	87.50	90.62	79.17	93.75	6	6	A
Burn Care (3rd Edition) ^[17]									
Child lif e therap y Burn patient m a n a g e ment Clinical gui de ^[18]	98.61	83.33	80.95	93.75	84.72	95.83	6	6	A
ISBI Practice Gu idelines for Burn Care ^[19]	97.22	80.21	84.52	91.67	87.5	97.92	6	6	A
ISBI Pra ctice Gu idelines for Burn Care, P art 2 ^[20]	98.61	84.38	87.50	91.67	83.33	95.83	6	6	A
Clinical Practice Guidelin e: Early Mobiliza tion and Reha bilit ation of Critically Ill Bur n Patient s ^[21]	98.61	86.46	89.88	89.58	79.17	89.58	6	6	A
Burn Pat ient Ma nagemen t, 4th Edition ^[22]	98.61	80.21	87.50	89.58	81.94	91.67	6	6	A
South A ustralian Paediatric Clinical Practi ce Guid elines B urns in Children ^[23]	95.83	81.25	79.76	91.67	76.39	93.75	6	6	A

2.4 Evidence Summary

Through the extraction, classification and integration of the evidence on the treatment of children's burn wounds, a total of 37 pieces of best evidence were extracted from 4 topics, including nursing assessment, wound care, fluid resuscitation and infection prevention, as shown in **Table 4**.

Table 4. Summary of best evidence on burn wound management in children

Evidence items	Evidence content	Level of evi dence	Reco mme ndedlevel
Nursing e valuation	1.Ventilation evaluation: Fiberbronchoscopy is the “gold standard” for the diagnosis of inhalation injury; Bilateral respiratory sounds are ausculted to determine respiratory rate and depth, assess the patient's ability to adequately ventilate and oxygenate, rule out airway burns or inhalation injuries, and assess the status of the lungs, chest wall, and diaphragm [18,20,27].	1a	A
	2.Area assessment: Lund-Browder chart method and(new) nine-point method were used[16-17,20,26-28].	1a	A

Wound care Routine care	3. Depth assessment: The depth of burn was assessed by the three-degree method ^[26] .	5b	A
	4. Pain assessment: Burn specific pain anxiety scale was used (BSPAS) ^[18] .	2a	A
	5. Mental status assessment: Glasgow Coma Scale was used (GCS)[20,21,23].	1a	B
	6. Cool the wound: Cool the burn with running water for 20 minutes or until the pain is fully relieved. The ideal water temperature is 15°C[14,16,20-24,26-27,29].	1a	A
	7. Wash with sterile gauze in saline[20,23].	2c	B
	8. Burn and over-hairy areas of the scalp should be shaved, extending the burn boundary by 2-5cm[9,16,20,[23].	1a	A
	9. For the deep II degree burn wound with area $\leq 15\%$ TBSA in children with stable circulation, the wound can be debrided within 24h after injury, and then covered with moisturizing wound covering[15,25].	5b	A
	10. For children with deep second-degree burns whose burn area is less than 15%TBSA with unstable circulation, debridement should be performed after adequate fluid resuscitation and stable circulation[17,25].	1c	A
Special part	11. For deep second-degree burn wounds with an area of $> 15\%$ TBSA in children, the necrotic tissue of the wound should be removed after the shock period, and then the wound should be covered with various moisturizing wound coverings[25-26].	5b	B
	12. Monitor the child's body temperature and keep the room temperature between 28°C and 31°C. If the child's body temperature drops below 35°C, stop cooling[16,20-21,23-24,27].	2c	A
	13. Upper respiratory tract burns: Care should be taken in a semi-upright position with moderate elevation of the head and torso, and if airway patency is threatened, tracheal intubation or tracheotomy is required[20-21].	1a	A
	14. Facial burns: The eye needs to be stained with 2% fluorescein drops to detect corneal damage, in most cases the face does not need a dressing, a soft white paraffin ointment should be used to moisten the wound and heal. Use about 3 times a day [19,23-24].	1a	A
	15. Neck burn: Remove the pillow to maintain a neutral neck position ^[23] .	1a	A
	16. Burns around the nose: Tracheostomy tape can be used when the tape is unsuitable for securing the nasogastric tube[19,23].	1a	A
	17. Back ear burns: Padding should be used to prevent the burned surfaces from touching each other, impregnated gauze is usually the first choice for ear dressings, and rings made of soft foam can be placed around the ear to prevent pressure on the ear ^[23] .	1a	A
	18. Finger burns: Within 24-48h, it is recommended to wrap each finger separately by using an appropriate primary dressing. For deep II degree burn wounds of hands, collagenase ointment and bromelain are recommended for enzymatic debridement[23,28].	1a	A
Blister care	19. Perineal burns: catheterization to reduce pain; After defecation, the area should be cleaned with soapy water to keep it as clean as possible, and intestinal management is needed to prevent dressing contamination[16,23-24].	1a	A
	20. Preserve the blister skin as completely as possible in early out-of-hospital first aid, and do not remove the blister prematurely[4,17-18,24].	1c	A
	21. The damaged or undamaged wound blisters with large, thin walls, easy damage or serious surface contamination will be removed[4,23-24].	2c	A
	22. For fresh clean children with deep second-degree burn wounds, the blister skin can be retained after the initial drainage of blister fluid, and the blister skin is generally appropriate to be retained until 3-5 days after the injury. If there is no subcutaneous infection of the blister, the retention time of blister skin can be extended ^[25] .	5b	A

	23. For children with dirty surface and higher possibility of infection, the deep II degree burn wounds should be debrided, the blister skin should be removed, and external antibacterial drugs should be used for treatment, daily or every other day, and functional wound dressings with antibacterial effects can also be used for treatment[23,25].	2c	A
Dressing application	24. After cold treatment, the wound was covered with a clean, low-adhesion dressing as a temporary dressing[20,22].	1a	A
	25. For early (24-48h after injury) deep second-degree burn wounds, it is recommended to use blister dressing, hydrocolloid dressing and other dressings with good absorption and moisturizing function, followed by the use of oil gauze containing oil cream such as sulfadiazine silver to cover the wound[23-24].	1a	A
	26. For infants (<3 years old) with deep II degree burn wounds, it is recommended to give priority to collagenase ointment and bromelain for enzymatic debridement[22,24].	2a	A
	27. Modern dressings such as hydrocolloids, silver ions, silicone blisters, silicone (only applied to intact skin), impregnated gauze and biofilms are the preferred dressing options[16,20,23,29].	1b	A
	28. Silver-containing dressings are effective topical antimicrobials, supplemented by a 0.5%AgNO ₃ solution that keeps the gauze on the wound constantly moist[17,21].	1a	A
	29. Some deep burns have wound exudates, and foam and alginate can be selected ^[20] .	2c	B
Fluid resuscitation	30. Children with an area of more than 10%TBSA or early signs of shock should be regularly rehydrated as soon as possible according to body weight and burn percentage[6,15,17,26].	1b	A
	31. For patients aged 1-12 years with an area of 15-45%TBSA, early use of albumin preparations can reduce fluid volume, prevent fluid creep, and shorten hospital stay[14-17,20,23,27-28].	1c	A
	32. Evans formula or modified Parkland formula can be used to estimate resuscitation fluid volume in early fluid resuscitation[6,15,17,26].	1a	A
	33. The infusion speed was adjusted according to the child's reaction and urine volume, and the target urine volume ^[26] .	5b	B
Prevention of infection	34. If the child has not received tetanus vaccine booster shots within 5 years, and the depth of the burn is II or III degrees, tetanus vaccine should be given[14,20].	1a	A
	35. Burn patients should not be treated with prophylactic systemic antibiotics for acute burns within 5-10 days after injury to reduce burn wound infection[7,20-21].	1b	A
	36. The ideal antibacterial drug for external use should have the characteristics of broad spectrum activity, good skin penetration ability, long action time and low toxicity[21,29].	5b	B
	37. Keep the hospital environment clean, strictly adhere to aseptic procedures and infection control measures, and use laminar flow isolation rooms[7,20-21].	2a	A

3.1 Nursing Assessment

Nursing assessment is a critical component in the management of pediatric burn wounds. Effective assessment guides clinical decisions, optimizes nursing plans, and enhances treatment outcomes. Ventilation assessment is an important part of nursing evaluation, particularly for children with facial and neck burns. Timely evaluation of airway obstruction is essential to maintain normal respiratory function in pediatric patients. Fiberoptic bronchoscopy is the "gold standard" for diagnosing inhalation injury^[18,20,27]. The Lund-Browder chart method and the new Rule of Nines are the most commonly used and practical

methods for burn area assessment in clinical practice^[16-17,20,26-28]. Superficial burns are usually treated conservatively, while deep burns may require surgical intervention, typically

evaluated using the three-degree, four-part classification system^[26]. Accurate and objective pain assessment is the prerequisite for effective pain management. The Burn Specific Pain Anxiety Scale (BSPAS) is used as a tool to assess acute pain in burn patients^[18].

3.2 Wound Care

Wound care is crucial in burn management, encompassing routine wound care, special site care, blister management, and the selection and application of dressings. Refined nursing measures effectively promote wound healing and significantly improve the overall recovery of patients, ensuring the best possible prognosis. Evidence summaries from items 6 to 12 focus on the routine care of burn wounds. In theory, any method that can reduce the local temperature of the burn wound can be considered a form of cryotherapy^[29]. For children with stable circulation and burn areas $\leq 15\%$ TBSA, debridement can be performed within 24 hours post-injury. For children with burn areas $> 15\%$ TBSA and at risk of shock, debridement should generally be delayed until after shock resolution, with adequate fluid resuscitation and circulatory stabilization^[25-26]. Multiple relevant guidelines, including the International Society for Burn Injuries (ISBI) clinical practice guidelines, recommend the use of clean, low-adherence dressings, such as clean cloths, to cover the wound after cryotherapy^[23,29]. Evidence from items 13 to 19 summarizes wound care for special sites. Statistical data indicate that children under 10 years old account for nearly 30% of all hand burn cases^[30]. According to the “early intervention principle,” prioritizing prompt management of hand wounds is one of the strategies in clinical burn treatment^[31]. The facial region, with its protruding organs such as the ear and nose, has minimal subcutaneous tissue and lacks buffering during burns^[23,32]. Early skin grafting remains the primary treatment for deep facial burns. The perineum is a relatively uncommon area for burns, so it is especially important to control wound contamination and infection^[16,32]. Items 20 to 23 summarize blister management, and due to the risk of infection, it is recommended not to remove blisters too early, as blister skin forms a natural physical barrier^[17-18,24], thereby reducing pain by covering exposed skin nerves. Items 24 to 29 summarize the use of dressings. Silver-containing dressings play a significant role as a local treatment option^[17], while silver polyurethane foam and soft silicone dressings, although not improving wound healing time, can reduce pain and costs, and thus are also recommended for use^[17,21].

3.3 Fluid Resuscitation

Fluid resuscitation is an indispensable component of burn care, especially in the case of large burns. By accurately calculating and administering

fluids, it can effectively prevent shock and organ failure. Timely and appropriate fluid resuscitation stabilizes the circulatory system, improves prognosis, and increases survival rates. The Parkland formula has long been used to determine the amount of fluid required for resuscitation^[15,17,26]. The ISBI burn care practice guide lines state that when a child's burn area exceeds 10% TBSA^[17], intravenous fluid therapy should be administered. The principles of fluid resuscitation for pediatric burns follow those used for adults: adequate volume replacement and correction of electrolyte imbalance, while preventing renal failure (under-resuscitation) and pulmonary edema (over-resuscitation)^[34].

3.4 Infection Prevention

Prevention of infection is a key component in burn care. Children with burns exceeding grade I should receive tetanus prophylaxis as needed^[14]. For patients who have not been vaccinated, human tetanus immunoglobulin should be administered within 21 days post-injury^[14,20]. Preventive antibiotics should not be used within 5-10 days post-injury to reduce the risk of burn wound infection^[20]. A clean hospital environment and high standards of hygiene are crucial for preventing the transmission of healthcare-associated pathogens^[20-21].

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