

American Burn Association Practice Guidelines Burn Shock Resuscitation

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RECOMMENDATIONS

Standards

There are insufficient data to support a treatment standard treatment at this time.

Guidelines

- Adults and children with burns greater than 20% TBSA should undergo formal fluid resuscitation using estimates based on body size and surface area burned.
- Common formulas used to initiate or resuscitation estimate a crystalloid need for 2 to 4 ml/kg body weight/%TBSA during the first 24 hours.
- Fluid resuscitation, regardless of solution type or estimated need, should be titrated to maintain a urine output of approximately 0.5–1.0 ml/kg/hr in adults and 1.0–1.5 ml/kg/hr in children.
- Maintenance fluids should be administered to children in addition to their calculated fluid requirements caused by injury.
- Increased volume requirements can be anticipated in patients with full-thickness injuries, inhalation injury, and a delay in resuscitation.

Options

- The addition of colloid-containing fluid following burn injury, especially after the first 12 to 24 hours postburn, may decrease overall fluid requirements.

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The opinions or assertions contained herein are the private views of the authors, and are not to be construed as official or as reflecting the views of the Department of the Army or Department of Defense.

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- Oral resuscitation should be considered in awake alert patients with moderately sized burns and is worthy of further study.
- Hypertonic saline should be reserved to providers experienced in this approach. Plasma sodium concentrations should be closely monitored to avoid excessive hypernatremia.
- Administration of high-dose ascorbic acid may decrease overall fluid requirements, and is worthy of further study.

OVERVIEW

Purpose

The purpose of this guideline is to review the principles of resuscitation after burn injury, including type and rate of fluid administration, and the use of adjunct measures. It presents a rational approach for the initial treatment of burn patients.

Users

This guideline is designed to aid those physicians who are responsible for the triage and initial management of burn patients.

Clinical Problem

Burns greater than 20 to 25% TBSA are associated with increased capillary permeability and intravascular volume deficits that are most severe in the first 24 hours following injury. Optimal fluid resuscitation aims to support organ perfusion with the least amount of fluid necessary, at the least physiological cost. Under-resuscitation leads to decreased perfusion, acute renal failure, and death. Since the adoption of weight and injury-size based formulas for resuscitation, multiple organ dysfunction caused by inadequate resuscitation has become uncommon in modern American burn care. Instead, administration of fluid volumes well in excess of 4 ml/kg/%burn has been reported by multiple centers. This phenomenon has been termed "fluid creep."^{1–3} Just as under-resuscitation is associated with poor outcome, in-

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