Monitoring and control of infection

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Patients with major burns steadily become immunocom - promised, having large portals of entry to pathogenic and opportunistic bacteria and fungi via the burn wound. They have compromised local defences in the lungs and gut owing to oedema, and usually have monitoring lines and catheters, which themselves r epresent portals for infection. Control of infection begins with policies on handwashing and other cross-contamination prevention measures. Bacteriological surveillance of the wound, catheter tips and sputum helps to build a picture of the patient’s flora. If there are signs of infection, then further cultures need to be taken and antibiotics started. This is often initially on a best guess basis, hence the usefulness of prior surveillance; close liaison with a micro - biologist is essential. In patients with large burns who remain catabolic, the core temperature is usually reset by the hypo thalamus above 37°C. Significant temperatures are those above 38.5°C, but often other signs of infection are more useful to the clinician. These include significant rise or fall in the white cell count, thrombocytosis, incr easing signs of catabolism and decreasing clinical status of the patient.

Figure 46.11 (a) Scar band contracture marked with multiple Z-plasties. when the Z-plasties are sutured.

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