

## Clinical Practice Guidelines<sup>2</sup>

### 4. Consider Functional and Aesthetic Outcome

- a. Debride blisters that impede functional ability especially ROM (burns to the hands)
- b. Debride blisters to speed healing time

### 5. Use Wound Healing Strategies

- a. Remove non-viable tissue from the wound bed to promote healing
- b. Maintain a moist wound healing environment by using synthetic dressings
- c. Use dressings that don't cause mechanical trauma to the woundbed
- d. Silver sulfadiazine should be used as a last resort (debris accumulation and daily dressing changes)

### 6. Optimize Patient Comfort

- a. Small blisters can be left intact as a natural method of pain control
- b. Stage debridement (aspirate first)
- c. Choose dressings with longer wear times to minimize discomfort

### 7. Improve Cost-Effectiveness

- a. Synthetic dressings can speed healing, reduce dressing frequency, decrease narcotic use, potentially reduce hypertrophic scarring and decrease need for additional treatments / procedures

## Dressing Options - ACH

### 1. Hydrofiber with Silver

- a. With absorbent soft silicone dressing (moist healing); 2-3 days wear time for mid to deep partial thickness burns
- b. With bulky gauze dressing (allowed to dry out and adhere to superficial partial thickness burn); up to 14 days wear time

### 2. Nanocrystalline Silver

- a. Moisten with sterile H<sub>2</sub>O *not* saline
- b. Needs to be kept continually moist (should use hydro gel with absorbent silicone dressing); up to 3 days wear time
- c. Can be painful without hydro gel

### 3. Absorbent Soft Silicone Dressing with Silver

- a. Direct application; up to 7 days wear time

### 4. Polymyxin B Sulfate and Gramicidin Ointment

- a. Can use with absorbent silicone dressing (1-2 days wear time) or with soft silicone dressing and gauze (daily change)

### 5. Silver Sulfadiazine

- a. Can use with absorbent soft silicone dressing or soft silicone dressing and gauze *but* requires a daily dressing change

## References

1. Sibbald RG, Orsted HL, Coutts PM and Keast DH. Best practice recommendations for preparing the wound bed: Update 2006. *Wound Care Canada – Reprint*. 2006;4(1):R6-R18.
2. Sargent R. Management of blisters in the partial-thickness burn: An integrative research review. *Journal of Burn Care and Research*. 2006;1(1):66-81.
3. Alsbjorn, et.al.. Guidelines for the management of partial-thickness burns in a general hospital or community setting – Recommendations of a European working party. *Burns*. 2007;33:155-160.

# Clinical Practice Guidelines

## Quick Reference Guide

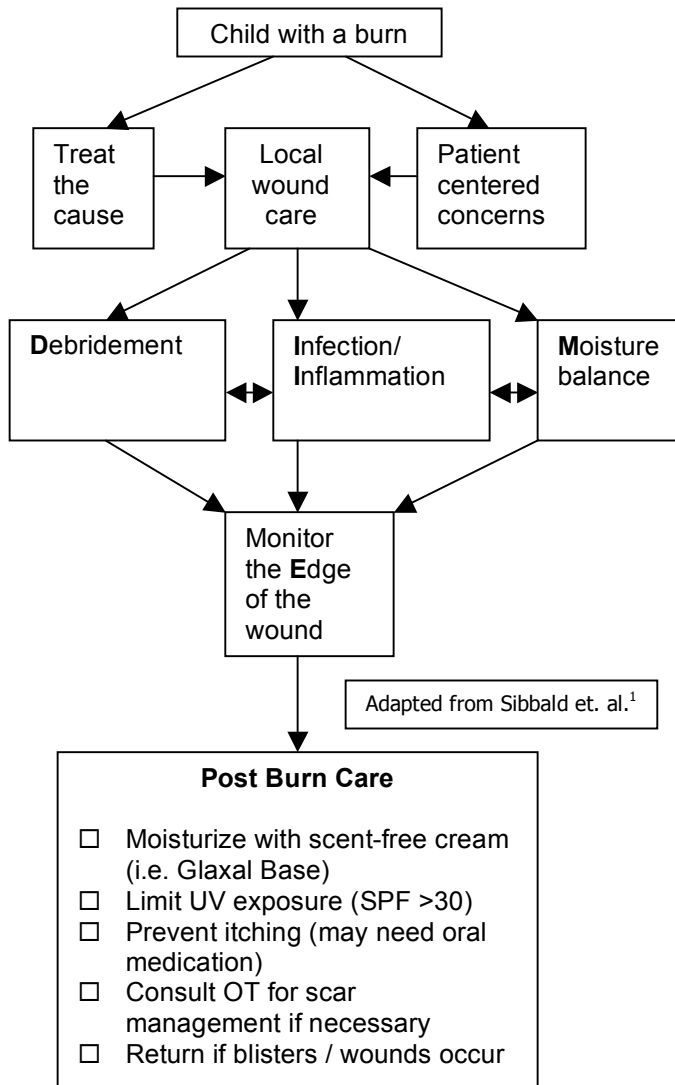
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## Partial Thickness Burns and Blister Management

Alberta Children's  
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# Wound Bed Preparation Paradigm



Adapted from Alsbjorn et. al.<sup>3</sup>

## The Paradigm Explained

### Treat the Cause

- ❑ Teach prevention
- ❑ Consider co-factors to healing (nutrition, co-morbid diagnoses, smoking)

### Address Patient-centred Concerns

- ❑ Foster adherence to plan of care
- ❑ Consider quality of life (pain)
  - Medicate prior to treatment
- ❑ Educate the pt / family / caregiver

### Local Wound Care

- ❑ Prevent burn wound desiccation
- ❑ Cleanse the burn wound with low-toxicity solutions
  - Sterile Water / Saline
  - Potable Tap Water

### Debridement

- ❑ Remove non-viable tissue to reduce bacterial burden
  - Gauze, forceps, scissors

### Infection / Inflammation

- ❑ Assess and treat with topical antimicrobials

### Moisture Balance

- ❑ Select a dressing that fits the needs of the wound

### Monitor the Edge of the Wound

- ❑ Consider referral to Plastic Surgery to assess for possible skin grafting if projected wound closure to be > 2-3 weeks

## Clinical Practice Guidelines<sup>2</sup>

### 1. Use Infection-Prevention Strategies

- a. Blisters should be debrided to:
  - i. Remove non-viable tissue from the wound bed
  - ii. Allow proper visualization of burn depth
  - iii. Remove fluid that may suppress local and systemic immune function

### 2. Consider Blister Size

- a. Blisters under 6 mm in diameter may be left intact (less likely to rupture spontaneously, impede healing or function)
- b. Large blisters should be debrided to:
  - i. prevent spontaneous rupture
  - ii. prevent mechanical pressure on wound bed

### 3. Consider Blister Type

- a. Debride thin-walled blisters to prevent spontaneous rupture
- b. Thick-walled blisters **may** be left intact as they are less likely to rupture (often occur on soles of feet or palms of hand – may not apply to younger pediatric population) **unless** they restrict range of motion (ROM)