

Ensure adequate volume; maintain MAP > 65 mmHg

- Maintain ionized Ca >1.1 mmol/L.
- Start with vasopressin 0.04 units/min. **DO NOT TITRATE.**
- Second line pressor: norepinephrine 2-20 mcg/min.
- Refractory shock: consider epinephrine or phenylephrine infusion.
- Refractory shock: consider adrenal insufficiency, give hydrocortisone 100mg IV Q8 hours.
- Manage acidemia (pH < 7.2): Use ventilator interventions first, then bicarbonate.
- Renal replacement therapy if available (Contact USAISR Burn Center DSN 312-429-2876).

Assessment/Interventions:

- Complete full secondary trauma exam
- Ensure thermoregulation; administer warmed fluids; cover with space blanket; elevate burned extremities.
- Superficial burn (1st degree): Sunburn, no blister, blanch readily; NOT included in TBSA
- Partial thickness (2nd degree): Blanch, moist, blisters, sensate
- Full thickness (3rd degree): Leathery, white, non-blanching, dry, insensate, thrombosed vessels
- Protect eyes with moisture shields if corneas exposed or blink reflex slow; apply ophthalmic erythromycin ointment at least Q2hrs.
- Prompt intubation for facial burns, suspected inhalation injury, TBSA >40%
 - Anticipate induction-associated hypotension.
 - Use size 8 ETT.
 - Secure ETT with cloth tie, not adhesive tape.
 - Reassess ETT position at teeth Q1 hour as edema develops and resolves.
 - Intubated patients require oro/naso-gastric tube for decompression.
 - Administer IV proton-pump inhibitor.
- Monitor bladder pressure at least Q4hrs for large burns or high-volume resuscitations.
 - Abdominal compartment syndrome: decreased UOP, increased pulmonary pressures, difficulty ventilating, bladder pressure remains > 20 mmHg.
 - Avoid decompressive laparotomy; consider percutaneous peritoneal drainage.
 - Reduce crystalloid volume using colloid or vasopressors.
- Monitor pulses hourly: palmar arch, dorsalis pedis, posterior tibial with Doppler.
 - Consider escharotomy if signal diminished; refer to Burn CPG for technique (Call USAISR Burn Center DSN 312-429-2876).
- Monitor extremity compartment pressures as clinically indicated.
 - Elevate burned extremities at all times.
 - Extremity compartment syndrome: pain, paresthesia, pallor, paralysis, pulselessness (late sign)
 - Fasciotomy may be required.
- Wound care
 - Thoroughly cleanse burn wounds, preferably in Operating Room.
 - Select topical antimicrobial in consultation with Burn Surgeon (Call USAISR Burn Center DSN 312-429-2876) based on product availability, expected transport time, etc.
 - Acceptable to cover burns with dry sheets or clean dressings for first 48 hours.
- All definitive burn surgery done at USAISR Burn Center for US Service Members (DSN 312-429-2876).