OVERSEAS BURNS REFERRALS: A SINGLE CENTRE EXPERIENCE OVER 10 YEARS (P143)

*Chowdhry M.\(^1,2\), *Tan A.\(^1,2\), Dziewulski P.\(^1,2\)

\(^1\)St Andrew’s Centre for Plastic Surgery and Burns, Chelmsford, Great Britain  
\(^2\)StAAR Burns and Plastic Surgery Research Unit, Chelmsford, Great Britain

**Introduction:** The United Kingdom (UK) has a robust mechanism for assessing and treating burn patients through a network of regional burns centres and units. Patients are often referred from overseas to the UK for specialist burns treatment. There is no data to help understand the nature of these referrals. We aim to retrospectively evaluate overseas referrals to a regional burns centre to aid better understanding in these challenging cases.

**Methods:** Epidemiological and other key data were compiled and analysed from electronic and paper records.

**Results:** Thirty-eight cases of overseas burns referrals were identified. Of these, twenty were identified as being resuscitation size burns (greater than 10% total body surface area (TBSA) in children and greater than 15% TBSA in adults. Thirteen Males and 7 females were referred over a 10 year period. The average (mean) age was 22.6 years (range 2 years to 61 years). Nine were British resident suffering burns overseas (Switzerland, France, Spain, Ivory Coast, Sierra Leone, Tajikistan, Egypt and China). Eleven overseas nationals suffered burns in their resident countries: 4 were Emirati, 3 were Nigerian, 2 were Pakistani and 2 were Iraqi. Thirteen patients suffered flame burns, 5 suffered scald burns, 1 suffered chemical burns and 1 suffered electrical burns. The average (mean) TBSA involving burns was 27.25% (range 10% to 80%). Eighteen referring hospitals were able to clean and dress the burns and offer fluid resuscitation. One centre did not clean the burn but dressed it and used antibiotics for initial treatment while another centre offered basic first aid in an unsanitary environment. Four referring centres were able to provide initial debridement. Patients were transferred to the UK for burns care through insurance companies (45%), government facilitation (30%), employer facilitation (15%), charity aid (5%) or private finance (5%). The average (mean) time from suffering the burn to admission to UK regional burns centre was 10 days (range from 0 days to 37 days) regardless of the patient’s country of residence. Eighty percent of patients had a clinically infected wound that, guided by microbiology swabs, required systemic antibiotic treatment. Patients were managed by split thickness skin graft (80%), flap reconstruction (10%) or conservatively (10%). Out of twenty patients, 4 required multiple organ support and a further 4 required single organ support. The mean (average length of stay at a UK burns centre was 31.35 days (range from 11 days to 92 days). All patients survived to discharge.

**Conclusion:** Low and middle income countries have the capability for initial burn management and basic resuscitation but lack the resources and infrastructure for specialist burn care. This could explain why individuals and organisations seek further help. Safe movement of patients with complex medical needs across international borders is not only clinically challenging but requires significant financial and logistical expertise. Our data suggests most patients require help from larger organisations (such as governments, employers and insurance companies) to successfully access specialist burn care. The organizational challenges in these transfers have inherent time delays. This delay in burn treatment increases the risk of infection and larger burns demonstrate a higher risk of contamination and infection and can result in greater treatment needs and inpatient stay duration in addition to the effort needed to treat already significant burns.