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ISBI Practice Guidelines for Burn Care[☆]



ISBI Practice Guidelines Committee^{1,2}

ARTICLE INFO

Article history:

Accepted 17 May 2016

ABSTRACT

Practice guidelines (PGs) are recommendations for diagnosis and treatment of diseases and injuries, and are designed to define optimal evaluation and management. The first PGs for burn care addressed the issues encountered in developed countries, lacking consideration for circumstances in resource-limited settings (RLS). Thus, the mission of the 2014–2016 committee established by the International Society for Burn Injury (ISBI) was to create PGs for burn care to improve the care of burn patients in both RLS and resource-abundant settings. An important component of this effort is to communicate a consensus opinion on recommendations for burn care for different aspects of burn management. An additional goal is to reduce costs by outlining effective and efficient recommendations for management of medical problems specific to burn care. These recommendations are supported by the best research evidence, as well as by expert opinion. Although our vision was the creation of clinical guidelines that could be applicable in RLS, the ISBI PGs for Burn Care have been written to address the needs of burn specialists everywhere in the world.

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[☆] Conflict of interest statement: All of the 32 authors have declared no conflict of interest.

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<http://dx.doi.org/10.1016/j.burns.2016.05.013>

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ISBI Practice Guidelines for Burns Care

1. Introduction

1.1. Background

Practice guidelines (PGs) are recommendations for diagnosis and treatment of diseases and injuries. These recommendations, which are supported by systematic reviews of the literature as well as assessments of the benefits and harms of the presented options, are developed through an assiduous interactive process among a dedicated panel of experts [1]. The purpose of setting forth practice guidelines is to define the most effective and efficient methods of evaluation and management [2–5].

The multiple objectives for PGs include standardization of care, quality improvement, reduction of risk, and optimization of cost-benefit ratios. PG recommendations focus on important clinical options, often-critical decision points and subsequent courses of action which are most likely to influence outcomes. The degree to which these recommendations are crafted upon evidence-based medicine is dependent on the existence of high-class scientific studies, the concurrence of conclusions among published studies, and the consensus of experienced practitioners. In the end, the utility of PG recommendations may rest less on scientific certainty and more on decisions based on costs, benefits, potential harms, values and preferences. It has been said, “. . . While knowledge is more than research evidence, knowledge translation strategies can harness the power of scientific evidence and leadership to inform and transform policy and practice” [6].

Several attributes of PGs ensure guideline credibility and utility. These attributes include validity, reliability and reproducibility, clinical applicability, clinical flexibility, clarity, multidisciplinary process, scheduled review, and documentation [7]. Construction of high-quality PGs requires a standardized yet punctilious process; such a process has been elaborately described by the Guidelines Review Committee of the World Health Organization (WHO) in the *WHO Handbook for Guideline Development* [8].

Creation of PGs for burn care began in 1998–1999 and culminated in the publication of a supplement to the *Journal of Burn Care and Rehabilitation* in 2001 [9]. This effort was supported by the Evidence-based Guidelines Group, the American Burn Association (ABA), and Paradigm Health Corporation. Since the publication of those PGs in 2001, the ABA, acting through its Committee for the Organization and Delivery of Burn Care, has published PGs on burn shock resuscitation [10], electrical injuries [11], pain [12], prophylaxis of deep venous thrombosis [13], and ventilator-associated

The mission of the ISBI Practice Guidelines Committee is to create a set of clinical guidelines to improve the care of burn patients and reduce costs by outlining recommendations for management of specific medical problems encountered in burn care, recommendations which are supported by objective and comprehensive reviews of the literature as well as by expert opinion. Our vision is that these guidelines for burn care in resource-limited settings (RLS) will recognize the current best and most cost-effective methods of treatment.

pneumonia [14]. A summary of clinical guidelines in the management of burn was published in 2014 [15].

The International Society for Burn Injuries (ISBI) has long recognized a need to provide burn care practitioners with recommendations for patient care. The motto of ISBI, “One World, One Standard of Care,” espoused by Past President David Mackie of the Netherlands in 2012, speaks directly to the need to harmonize practice across the world of clinical efforts. This effort is likely to best achieve optimal clinical outcomes after burn. In 2012, the International Network for Training, Education and Research in Burns (Interburns[®]) developed a set of operational standards for burn care services in Resource-Limited Settings³ (RLS). These standards define the human and physical resources needed to provide good clinical outcomes [9]. The Interburns[®] report summarized the knowledge, skills, facilities and equipment required to achieve this end; the complement to that report is the precise elaboration of the clinical options which are the focus of education and training efforts.

With this in mind, the current ISBI president, Rajeev Ahuja of Delhi, undertook the challenge of guiding a panel of burn experts through the process of writing much-needed PGs that would be applicable in all settings regardless of resource availability. On March 24, 2014, the first face-to-face (F2F) meeting was held in Boston, Massachusetts, at which time a preliminary discussion involved the mission and vision statements, composition and function of the subcommittees, elaboration of the list of topics to be addressed, description of

³ Throughout these documents, the term resource-limited settings (RLS) will be used to define medical situations in which there are inadequate personnel, training, supplies and equipment. Although most RLS occur in low- and middle-income countries (LMIC), there are also zones of poverty in upper middle- and high-income countries as well. Additionally, mass casualty situations can turn any setting into one in which resources are limited.

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