require close follow-up to ensure adherence with treatment.

The burn is cleansed with a mild soap and tepid water. Debridement of the burn includes removal of any embedded debris, chemicals, and devitalized tissue. Removal of intact blisters remains controversial. Some authorities argue that blisters provide a barrier against infection; others maintain that blister fluid is an effective medium for the growth of microorganisms. However, blisters should be broken if the burn is due to a chemical agent to control absorption. Most practitioners favor covering the burn with an antimicrobial ointment to reduce the risk of infection and to provide some form of pain relief. The dressing consists of non-adherent fine-mesh gauze placed over the ointment and a light wrap of gauze dressing that avoids interference with movement. This helps keep the burn clean and protect it from trauma. The caregiver is instructed to wash the burn, reapply the dressing, and return the child to the office or clinic as directed for burn wound observation. The frequency of dressing changes may vary from every other day to once a day.

Some practitioners prefer an occlusive dressing, such as a hydrocolloid, which is placed over the burn after cleansing. Hydrogel dressings, which are soothing and non-adherent, may also be used. The dressing is changed when leakage occurs—at regular intervals or at least weekly. This method eliminates the discomfort associated with frequent dressing changes but limits visualization of the burn surface.

If there is a high probability of infection or other complications or if there is doubt about the ability to carry out instructions, the caregiver may be directed to bring the patient in more often for dressing changes and inspection. Another option is to have a nurse make a home visit to inspect the burn and perform the dressing change. Frequent removal of the dressing is an effective mode of debridement. Soaking the dressing in tepid water or normal saline before removal helps loosen the dressing and debris as well as reducing discomfort. Burns of the face are usually treated by an open method. The burn is washed and debrided in the same manner and a thin film of antimicrobial ointment is applied to the skin without a dressing.

A tetanus history is obtained on admission. If there is no history of immunization or if more than 5 years have passed since the last