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Burn Therapy

BURN THERAPY IN CHILDREN Children represent a large proportion of the 2,000,000 people hospitalized each year for burns. The first-aid treatment consists of reassurance and wrapping the involved area in clean cotton or linen until the extent and severity of the burn can be evaluated. No child should be transported until respiratory difficulties are relieved and control of the airway is obtained. Upon arrival at the hospital, the order of procedure is as follows. 1) Adequacy of the airway is checked, and oxygen, tracheal intubation, tracheostomy and ventilatory assistance are provided as indicated. 2) Sedation is given only if necessary, using the intravenous route. 3) All clothing is removed and the patient weighed. 4) An intravenous catheter that is adequate to deliver fluids at a high rate of flow is inserted. A central venous pressure catheter is desirable in patients with extensive burns. 5) The extent and depth of the burn are evaluated. 6) The burned area is covered with gauze dressings wet with 5 per cent silver nitrate, using sulfamylon for facial burns, and 7) areas of potential contractures are splinted. 8) Blood samples for baseline laboratory studies are obtained; 9) fluid requirements and fluid routines are established. 10) A Foley catheter is inserted and urine specimens are obtained for analysis. 11) A tabular chart of intake and output, vital signs and chemical values of blood and urine is prepared. 12) Prophylactic antibiotic therapy with penicillin is started, and 13) appropriate protection against tetanus is given. 14) A detailed history, including circumstances and time of injury, is obtained. 15) Consideration should then be given to means of achieving temporary and permanent skin cover and 16) nutritional support, treatment of anemia and hypoproteinemia, and rehabilitation, including physiotherapy and emotional support. A balanced salt solution rather than plasma is now used in the early treatment of burns. Two ml/per cent burn/kg plus 1,500 ml/m² of Ringer's lactate solution are administered every 24 hours. An increase in the rate of infusion is necessary if the urinary output decreases to below 30 ml/m²/hour or if the hematocrit rises above 50 per cent. Serum albumin or plasma is not administered unless blood pressure, central venous pressure and urinary output cannot be maintained by an infusion of Ringer's lactate solution of 300 ml/m²/hour. No more than the volume required for a 50 per cent burn should be infused even if the burn covers more than 50 per cent of the body surface. Half of the estimated first day's fluid requirement should be given in the initial eight hours after the burn. The rate of fluid administration must be decreased if anesthesia or surgery is necessary because these procedures commonly lead to antidiuresis. The aim of fluid therapy is to keep the urine flow at 40 ml/m²/hour, urinary sodium at 20 to 80 mEq/l, serum sodium between 130 and 140 mEq/l, and serum potassium between 3.5 and 5.0 mEq/l. The requirements for sodium chloride are very much increased by the use of silver nitrate wet dressings. Chloride is lost at a rate of 3.5 mm/100 cm² of deep second- or third-degree burn/day. Alkalinization is an advantage if hemoglobinuria is present. (Herrins, J. T., and Crawford, J. D.: *Care of the Critically Ill Child—Major Burns, Pediatrics* 45: 449 (March) 1970.)