Foreword

Management of Burns

Not everybody will be diagnosed with cancer nor will everybody fracture a bone or develop a bowel obstruction, but almost everybody will suffer a burn one day. I was once taught that for every patient who is burned there is an element of adult behavioral failure (it was actually phrased differently). Certainly, some factors are well beyond our control: gas main explosions, deliberate violent acts, and other force majeure. However, a great deal of burns that people encounter are a direct result of loss of situational awareness. In the case of children who suffer burns, it is still usually an adult failure that leads to the injury. And burns are one of those consequences that is so devastating yet caused so quickly that it just takes a momentary lapse to yield sometimes horrific results. There is a reason the proverbial admonition states that we are playing with fire when we seek to do something dangerous.

Our visceral apprehension regarding burns is well founded early in life as even small burns leave a distinct impression on most people who get them. Later in life, we develop a better abstract sense of how disabling and disfiguring burns can be. Of course, these beliefs are formed culturally over decades or even centuries of collective and individual experience. Books, movies, and other lore are based on the consequences of surviving major burns.

This issue of the Surgical Clinics of North America, which is expertly crafted by Dr Sheridan and his colleagues, will provide the reader not only an opportunity to review what we have learned about the care of burn patients but also thoughts on goals and directions for future research. The ultimate goal, as suggested in the article by Drs Wolf, Tompkins, and Herndon, of no deaths, no scar, and no pain is an ambitious and laudable goal. In some respects, it is difficult to imagine how these goals can be met, but as the authors discuss, these are goals based on dealing with the consequences of mastering other problems that seemed impossibly challenging. Improvements in short-term survival and improvements in hospital care that allow these longer-term issues to exist have largely come along in our lifetime. So perhaps, their call to action is more akin to the Kennedy “moonshot.”
As with most things, it takes a confluence of circumstances to bring about change in either action or understanding. Improvements in medical care and understanding combined with advances in real-time information sharing and analysis have made it possible to accelerate the rate of learning. A well-coordinated and concentrated effort of medical personnel who truly specialize in the care of burned patients is now well established. The care of significantly burned patients is located in centers with resources and capacity to get the best results possible.

One sad commentary on surgical history is how much episodes of progress are intertwined with wars. Burn care is no different. The conflicts that have lasted since nearly the beginning of this century have provided more than ample burned patients to treat and to learn from. Many of the contributors to this issue of the *Surgical Clinics of North America* have direct and significant experience with patients who have been burned as a result of engagement in armed conflict.

Study of what is known about the physiology of burns and the care of the patients who suffer burns is useful to any discipline of surgery and perhaps to any discipline of medicine. We are in great debt to Dr Sheridan and his fellow contributors for the material they have given to us. Never getting burned in the first place is always best, but once a burn has occurred, we are always better for knowing how to keep from making matters worse and hopefully making them better. This volume should help greatly in that goal.

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