Consensus on Burn Blister Management

(Based on London and South East of England Burn Network (LSEBN) Network Team document November 2011)[1]

Concern:
There is inconsistent recommendation given to non-Burn Unit clinicians for management of burn blisters throughout NSW, Australia.

Consultation:
Specialist clinicians from each of the three NSW Burn Units at the Children’s Hospital at Westmead, Concord Repatriation Hospital and Royal North Shore Hospital were consulted. Consensus was agreed on the following recommendation.

Rationale:
‘De-roofing’ (removal of skin and fluid) burn blisters [1-3]
- Allows assessment of burn wound bed
- Removes non-viable tissue
- Prevents uncontrolled rupture of blister
- Avoids risk of blister infection
- Relieves pain in tense blisters
- Reduces restriction of movement of joints

Recommendation:
The ACI Statewide Burn Injury Service (SBIS) recommends that:
- Appropriate analgesia must be administered prior to procedure
- Burn blisters ≤5mm can be left intact
- Burn blisters >5mm should be
  - ‘de-roofed’
  - dressed appropriately with a non or low-adherent dressing
  - referred to local ED/ burns service if your facility does not have the resources to ‘de-roof’ blisters
- Contact the SBIS to identify training/education needs

Consideration should be given to:
- The risk/ benefit of ‘de-roofing’ small, non-tense blisters
- The risk/ benefit of removing blister skin when infection may occur (i.e. in remote area)
- The risk/benefit of ‘de-roofing’ blisters on the palmar surface of the hand and the plantar aspect of the foot
- Patient compliance with the procedure and on-going care when considering the management of small, non-tense blisters i.e. patients with dementia, learning difficulties, and toddlers

References: