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Fire is one of the earliest friends of mankind. It is a necessity of life. It has also caused great suffering to mankind too. The thermal injuries are very old. With the advancement of science, modes and quantum of thermal injuries have increased tremendously. In India itself one lac and ten thousands deaths are reported each year due to thermal injuries (Sinha 1988). Out of which 1200 deaths occur in Bombay alone. Approximately 3000 persons are severely burnt every year in Bombay city and of these 74% are domestic burns and 79% of all domestic burns involve women and children.

Various modes of treatment were suggested and used from time to time yet it has to gain perfection. In ancient days the emphasis in treatment of burn wounds was local application of various medicinal products like resins and Bitumen, vinegar, extracts of plants, honey and bran, gum, Goat’s hair and other funny things as milk from a mother who gave the birth to a male baby. Subsequently these local applicants changed to chemicals as tannic acid, silver nitrate, gentian violet and petroleum gauze. With the advent of antimicrobials the emphasis turned to antimicrobials as local applicants as nitricide or sodiumlca, silver sulphadiazine, cerium
nitrate and other antibiotics as gentamicin and soframycin.

In spite of the local treatment mortality and morbidity remained almost unchanged which led to the appreciation of basic concept of burn injuries in the form of metabolic changes in the body secondary to discharge and infection of raw burn area. There is excessive loss of body constituents e.g. water, minerals, proteins and secondary infection due to invasion by microorganism. This infection interferes with and delays the normal healing process resulting in deformities, contractures cicatrices and scars. Other problems include denution of nerve endings causing pain leading to restriction of movement ultimately resulting in contractures.

Hence present day emphasis in the management of burn, is on covering the raw area. A superficial burn e.g. with many of the deep epithelial cells preserved has the potential for good healing within two weeks.

The coverage of the uninfected raw area with autograft is ideal however, the availability of autograft particularly when the burn area is large is rather limited or at times not possible for various reasons. The next best solution is the coverage of
burn area with homograft. Here again the availability is limited. Various other biodressings and synthetic materials have been used by different workers. The biodressings include cadaver skin, porcine skin, foetal membranes (amnion and/or chorion), synthetic skin and collagen sheets. The synthetic materials include various fibres, foams, fabrics, sprays, gels and laminates.

In the present work the burn surface has been covered with two different biodressings, i.e. human amniotic membrane and collagen sheet. At the same time a comparative study is made to assess the superiority of either of them.