INTRODUCTION
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Thermal injury has been troubling mankind since he started using fire, and has caused great suffering to mankind physically, socially as well as economically.

Almost every minute of the day somewhere in the world at least one human being becomes a victim of burn. The magnitude of this problem is indicated by the fact that there are one lac cases of burns resulting in ten thousand deaths per year in India (Sinha, 1968). More so because burns are one of the necessary accompaniments of rapid progress including mechanization of life, where the susceptibility to burns has increased tremendously.

About 74% of all burn cases are domestic burns and 79% of all domestic burn involves women and children. Thermal burns are caused by application of heat to the body, the depth of the resulting burn injury is dependent on the intensity and duration of this heat application and conductivity of tissue involved. The most common source of heat are open flame and hot liquids. In addition, thermal injury is also frequently observed in patients who have been exposed to direct contact with hot metal,
toxic chemicals or high voltage electricity. Industrial mishaps, civilian assaults, laboratory accidents and inexpert application of agents used for medical purposes accounts for most of chemical burns in civilian population.

A principal difference between chemical and thermal injury is the length of time during which tissue changes continue, the chemical agents causes progressive damage until inactivated by the tissue, while thermal injury changes case shortly after removal of heat.

Various modes of local treatment have been suggested and used from time to time but the dilemma continues and the search for an ideal agent continues. In ancient times the emphasis in treatment of burn wound was local application of various medicinal products like resins and bitumen vinegar, extract of plants, honey and bran, gum, goat hairs and other funny things as milk from mother who gave birth to a male child. Subsequently these local applicants changed to specific chemicals as tannic acid, silver nitrate, gentian violet and petroleum gauze. With the advent of anti-microbials the emphasis turned to their local application as sulfanylon, sulphadizine cream etc.

Inspite of the local treatment, mortality and morbidity remains almost unchanged, which focussed the attention on three basic concepts regarding the local
problems of burn injury. (1) Burn injury provides a large raw area which causes a loss of large amount of water, electrolytes and plasma proteins, studies show that denuded skin increases the insensible loss up to 75 times and this also increases the heat loss.

(2) Large raw area with serum exudate provide huge culture plate for micro-organisms and lead to wound sepsis which is the basic problem in the management of burn wound. (3) The problem of pain caused by irritation of exposed nerve endings. To combat these problems, the coverage of burn wound is the only answer. The coverage of these raw area expeditiously still remains an integral but unsurmountable part of treatment.

To minimize the effect of raw surface produced by burn injury, various biological and synthetic covering materials have been used by various workers at different times. Different biological and synthetic coverings are homografts, skin hetrografts, skin collagen sheets and amniotic membrane, solid silicon, polymer membrane, cotton gauze fabrics, sprays, gels and laminets etc. But a perfect wound dressing is still a dream because covering materials although being good dressing materials have their limitations and disadvantages like subgraft suppuration, limited availability, high cost and cany potential risk of transmission of disease like hepatitis.
The management of burn wound sepsis is still a very challenging problem in terms of morbidity and mortality, inspite of the vast advancements in medical science and availability of various broad spectrum antibiotics. The avascular nature of burn tissue as a result of thrombosis of vessels limits the delivery of endogenous phagocytic cells and also decreases the efficacy of systemically administered antibiotics leading to propagation of infection. In addition to infection, wound maceration and pressure necrosis also favour microbial proliferation and impairs circulation. This local source of virulent organisms in the presence of lowered body resistance can alter the fragile balance between resistance and infection leading to frank septicaemia and death at any time (Liedberg, N.C.F., Reiss, E. and Artz, C.P., 1954).

Thus, it is necessary that treatment of local infection be given top priority and since systemic delivery of antibiotics is sub-optimal, more reliance is to be put on local methods of control of infection.

With this view, recently a combination of P.V.P. iodine and neosporin powder (Neomycin, Polymyxin B and Bactricin) are being tried in superficial and deep burns. Because of the inadequacy of presently used local application, we needed to re-examine a new combination of
locally applied chemotherapeutics/antibiotics and at the same time comparative study is made to assess the superiority of the dressing material.