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## Letter to the Editor

# “European Resuscitation Council 2015 burn 1st Aid recommendations–concerns and issues for first responders”

## Keywords:

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## A B S T R A C T

As the lead author of a recently published systematic review on hydrogel burn dressings in pre-hospital, I was alarmed to read the claim by the authors to the effect no one method of burn wound cooling was superior to any other; “There is no evidence to recommend a specific temperature or method of cooling”.

The reputation and prominence of the ERC within the circle of resuscitation councils now delving into 1st Aid recommendations leads to the conclusion that misguided recommendations may cause confusion amongst first responders, may falsely misdirect 1st Aid providers to unsupported practices or alternatively create a window of opportunity for marketers or sellers of alternative burn 1st Aid technologies to make unsupported claims in respect of comparable efficacy of their own product versus “traditional” methods.

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Dear Editor,

I wish to highlight concerns in regard to statements and conclusions appearing in the 2015 European Resuscitation Council recommendations on burn 1st Aid.

As the lead author of a recently published systematic review on hydrogel burn dressings in pre-hospital [1], I was alarmed to read the claim by the authors to the effect no one method of burn wound cooling was superior to any other; “There is no evidence to recommend a specific temperature or method of cooling”.

The ERC authors ventured a slightly different take on the same line of reasoning with the unsupportable claim; “There are no scientifically supported recommendations for the specific cooling temperature, the method of cooling (e.g. gel pads, cold packs or water) or the duration of cooling”.

The reputation and prominence of the ERC within the circle of resuscitation councils now delving into 1st Aid recommendations leads to the conclusion that misguided recommendations may cause confusion amongst first responders, may falsely misdirect 1st Aid providers to unsupported practices or alternatively create a window of opportunity for marketers or sellers of alternative burn 1st Aid technologies to make

unsupported claims in respect of comparable efficacy of their own product versus “traditional” methods. [2,3]

That the authors included just five largely unrepresentative studies after “GRADE” analysis in part explains the ERC’s burn 1st Aid recommendations. The studies themselves when examined, demonstrate; some did not employ standard 1st Aid interventions [4], another may not be generalizable to all ages [5], one has been misquoted [6], the setting and design of another is irrelevant to pre-hospital 1st Aid [7], are exceptions to existing evidence [8] or contradict earlier European 1st Aid guidelines. [9]

The exclusion of a large body of useful evidence, much of it forming the basis for the current consensus position of the major burns associations, belies statements made by the authors themselves that such evidence may be “potentially...used where human data is lacking”.

Data gleaned from this very large pool of historical and contemporary studies provides a compelling picture of the most effective elements of burn 1st Aid. [10–15]

Further examination of the ethical “big picture” in burn research and contributions by a burns expert reviewer on their panel may have also aided in more informed judgements than those drawn from the included studies. [16,17]

Whilst I concur with the authors on a number of other recommendations made in the guidelines for example, on difficulties in the best choice for burns dressing [18], they have also made an additional statement of grave concern by prioritising one aspect of burn 1st Aid over another (amelioration of burn depth via cooling methods versus hypothermia or infection risk).

Concerns about Hypothermia have shaped pre-hospital burn 1st Aid practice across the continents and the issue remains highly controversial. Hypothermia also directly impacts surgical interventions whilst paramedic cooling remains problematic to a reduction in hypothermic burn patients seen in ED's. [19]

Ignoring chemical and electrical burns (except ocular burn trauma) ignores an entire subset of the burn population.

### Conflict of Interest

The author describes no conflicts of interest. The submission by the author was self-funded and independently contributed. There are no co-authors.

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