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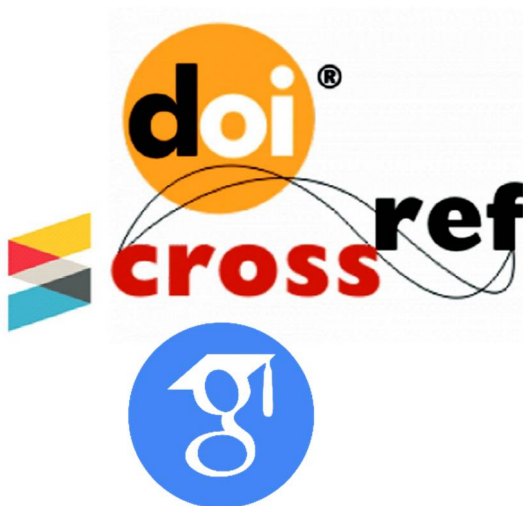
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БИМЕДИЦИНА ВА АМАЛИЁТ ЖУРНАЛИ

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EARLY SURGICAL TREATMENT OF DEEP BURNS IN ELDERLY PATIENTS

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ANNOTATION

The article is dedicated to the results of surgical treatment of elderly and senile patients with deep burns. The available data indicates that the best results can be achieved with a single-stage autologous skin grafting to close all wounds in one step for limited deep burns. For extensive burns, the best results are achieved using delayed autologous skin grafting performed in 1-2 stages. It has been reported that the use of early surgical intervention methods for deep burns in elderly and senile patients significantly reduces the recovery time of skin integrity, the frequency of burn disease complications, and mortality.

Keywords: deep burns, autologous skin grafting, surgical necrectomy, autologous skin transplant

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КЕКСА ВА ҚАРИ ЁШИДАГИ БЕМОРЛАРДА ЧУҚУР КУЙИШЛАРНИ ЭРТА ХИРУРГИК ДАВОЛАШ

АННОТАЦИЯ

Ушбу мақола чуқур куйиш жарохати олган кекса ва қари беморларни хирургик даволаш натижаларига бағишланган. Кекса ва қари беморларни хирургик даволашда чегараланган чуқур куйиш жараохатларида бир босқичда барча яраларни ёпиш учун бир босқичли аутодермопластикадан ҳамда кенг кўламли куйишлар учун эса, кечиктирилган аутодермопластика фойдаланиш энг яхши натижаларга эришиш мумкинлиги тўғрисида

маълумотлар келтирилган. Кекса ва қари беморларда эрта жарроҳлик усуллари қўллаш терининг тикланиш вақтини, қуйиш касаллиги асоратлари ва ўлимнинг частотасини сезиларли даражада камайтириши мумкинлиги баён қилинган.

Калит сўзлар: чуқур қуйиш, аутодермопластика, хирургик некрэктомия, аутодермотрансплантат

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РАННЕЕ ХИРУРГИЧЕСКОЕ ЛЕЧЕНИЕ ГЛУБОКИХ ОЖОГОВ У ПОЖИЛЫХ И ПРЕСТАРЕЛЫХ ПАЦИЕНТОВ

АННОТАЦИЯ

Статья посвящена результатам хирургического лечения с глубокими ожогами у пациентов пожилого и старческого возраста. При хирургическом лечении у пациентов пожилого и старческого возраста имеются данные о том, что наилучшие результаты одномоментной аутодермопластики с закрытием всех ран за один этап при ограниченных глубоких ожогах, а при обширных ожогах лучшие результаты - использование отсроченной аутодермопластики, выполненной за 1-2 этапа. Сообщалось, что применение раннее методов хирургического вмешательства с глубокими ожогами, у пациентов пожилого и старческого возраста, позволяет существенно уменьшить сроки восстановления кожных покровов, частоту осложнений ожоговой болезни и летальность.

Ключевые слова: глубоких ожогов, аутодермопластика, хирургические некрэктомии, аутодермотрансплантат

One of the main demographic trends in the world is population aging, with a continuous increase in the number of people aged 60 and older, including within the age group over 80. It is known that elderly and senile individuals, like children, are a high-risk group for thermal injury [1,7,11].

The severity of injuries in elderly and senile patients is determined not only by the area and depth of burn wounds but also by comorbidities and age-related degeneration of all organs and systems [5,8,10]. Burn injuries typically exacerbate existing chronic diseases, significantly worsening the patients' condition and leading to complications, thereby deteriorating treatment outcomes [3,4,9].

In geriatric patients, the application of active surgical treatment methods is limited [2,6,12]. The main limiting factors are the high risk of surgical intervention and the presence of severe comorbid conditions.

Objective of the study. To determine the most rational surgical tactics based on the area of deep burns in elderly and senile patients.

Materials and Methods. The clinical research results from the comprehensive treatment of 69 patients in the combustiology department of the Samarkand City Medical Association from 2019 to 2023. Inclusion criteria for the study groups were: age 60 years and older; presence of deep burns of III-B to IV degree. All 69 patients had a Baux index exceeding 60 units.

Based on the clinical course and severity of thermal injury, severely burned elderly and senile patients were divided into three groups. The first group comprised 29 (42.1%) patients with a prognostic index from 61 to 80 units, indicating a relatively favorable prognosis. The second group included 27 (39.1%) patients with a Baux index (BI) from 81 to 100 units, indicating a doubtful prognosis. The third group consisted of 13 (18.8%) patients with an unfavorable prognosis (BI over 100 units). The average BI was 85.14 ± 15.97 units.

The study group included 39 (56.9%) men and 30 (43.1%) women. Among the observed cases, 48.6% of the patients sustained thermal injuries from flames. Thermal injuries from hot liquids also constituted a significant etiological share in this age group, accounting for 39.4%. Patients with contact burns (5.5%), burns from hot oil (3.7%), and electrothermal injuries (2.8%) were extremely rare.

The total burn area in patients ranged from 0.5% to 70% of the body surface, with an average of $16.7 \pm 13.1\%$ of the body surface area. All burn degrees were considered in the total area assessment - I, II, III-A, B, and IV degrees. Only 21 (30.4%) patients had limited burns of less than 10% of the body surface. In contrast, 13 (18.8%) patients had extensive burns covering more than one-third of the body surface.

The prevalence of deep burns due to different causative factors showed that in more than half of the patients with smaller areas of deep burns (up to 3% and 7% of body surface area), scalds from hot water were most common (55% and 50%, respectively). In contrast, among those with more extensive burns, flames were the primary etiological factor. In our observations, deep contact burns did not exceed 6% of body surface area, and deep electrical burns reached up to 9% of body surface area.

It is well known that one of the characteristic features of geriatric patients is the high frequency of one or more comorbidities. In this study, we considered it appropriate to account only for clinically significant diseases that could affect the outcome and treatment strategy. Overall, serious comorbidities were noted in 51 (73.9%) patients. As expected, cardiovascular diseases were the most frequent: 56% of the patients examined suffered from ischemic heart disease, and 20.2% of elderly and senile burn patients had arterial hypertension, corresponding to average figures for this age group. Circulatory disorders included cases of acute cerebrovascular accidents in the medical history (21.1%) and the consequences of chronic cerebrovascular insufficiency (1.8%). Additionally, about one in five to six burn patients had respiratory diseases (14.7%), diabetes mellitus (22.9%), and digestive diseases (20.2%). Isolated cases included chronic alcoholism (2.8%), kidney diseases (0.9%), and malignant neoplasms (0.9%).

In elderly and senile patients, we utilized surgical debridement (SD). Based on the timing, SDs were classified as early or delayed. In older age groups, early surgical debridement (ESD) was performed in the first week after the thermal injury, provided there were no inflammatory processes in the wound area. Delayed surgical debridement (DSD) was performed between 8 to 42 days after the injury.

Results and discussion. The approximately equal susceptibility of men and women in the older age group to thermal injuries may seem somewhat surprising at first glance. It is well known that almost all types of injuries, including burns, occur significantly more frequently in men. However, in our observations, there was no correlation between gender and the frequency of thermal injuries among elderly and senile patients.

The average timing for performing early surgical debridement (ESD) was 6.1 ± 0.2 days. Delayed surgical debridement (DSD) was performed, on average, at 9.7 ± 0.7 days.

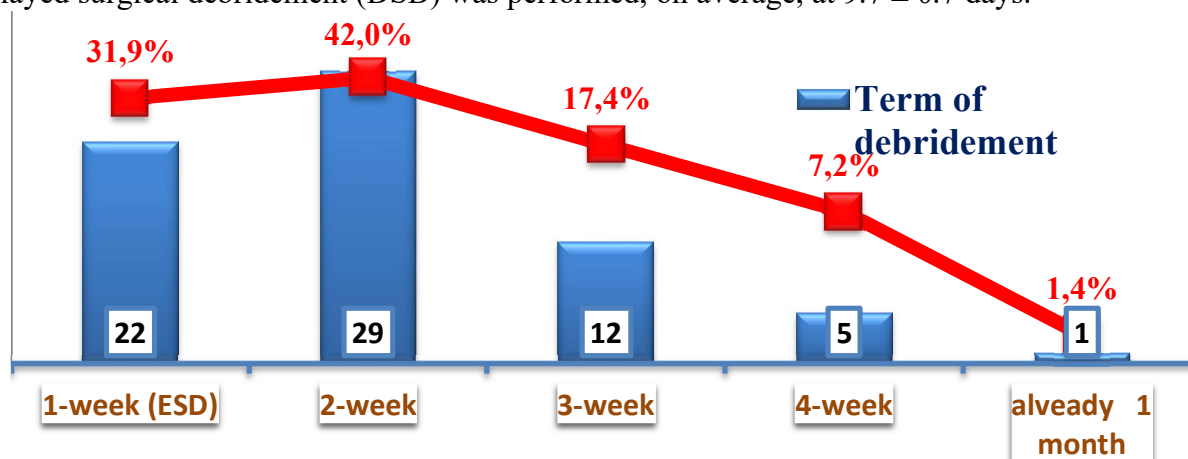


Fig. 1. Distribution of patients by timing of necrectomy, n=69

Delayed surgical debridement, n=47

A total of 22 (31.9%) elderly and senile patients who underwent SD had early debridement, while 47 (68.1%) had delayed debridement. In 18 (26.1%) cases, SD was performed later than 14 days post-injury due to the following reasons:

1. The need for prolonged preoperative preparation due to the severe general condition of the patients.
2. The deepening of III-A degree burns.
3. Late hospital admission (9-40 days post-injury).

In cases of extremely severe thermal injury, with a Baux Index (BI) exceeding 100 units, general and local conditions allowed for early surgical debridement (ESD) in only 2 cases (see Fig. 2). Among those with less severe thermal injuries, with a BI of 81-100 units, ESD was performed in less than a quarter of patients (22.2%). Conversely, for elderly patients with a BI ranging from 60-80 units, we were able to utilize the benefits of so-called active surgical tactics (early debridement) in approximately half of the cases (48.3%).

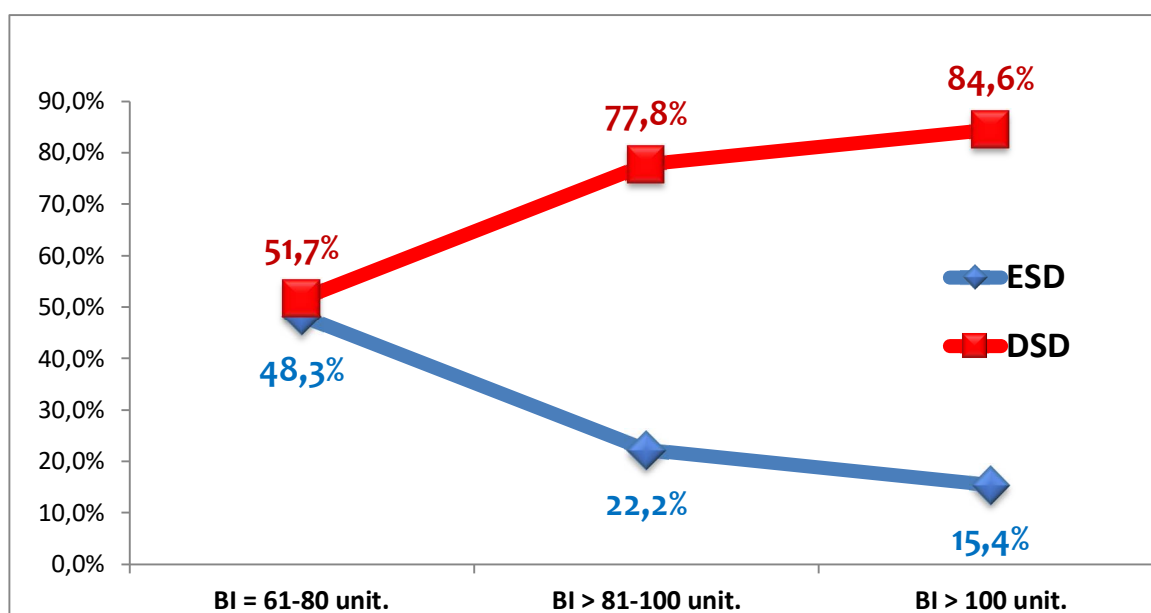


Fig. 2. Correlation between the severity of thermal injury and the timing of surgical debridement.

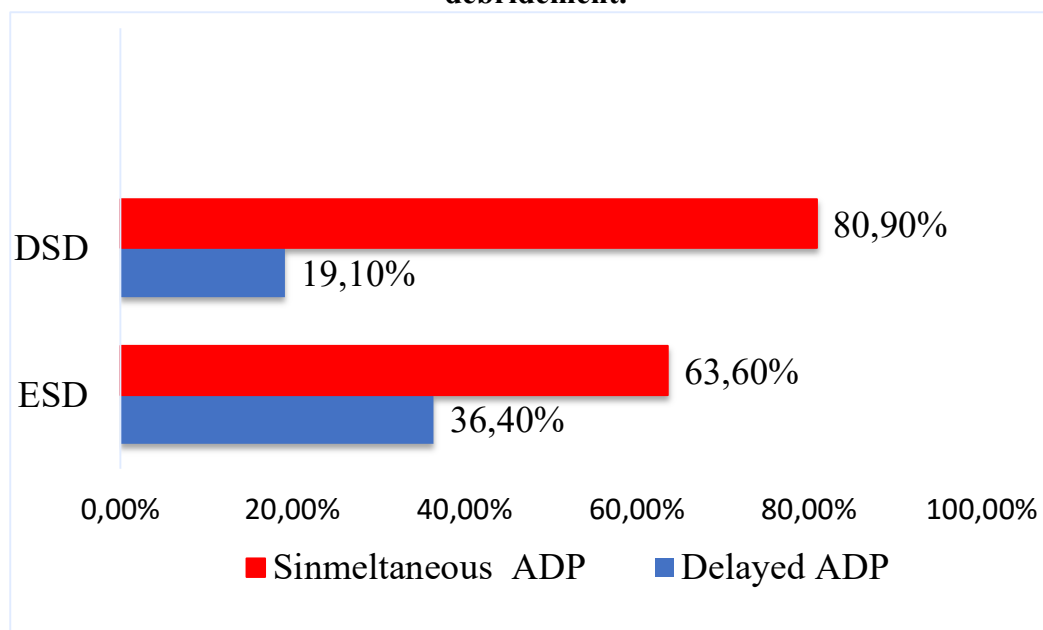


Fig. 3. Distribution of patients based on the nature of autodermplasty and debridement, n (%)

The average area of necrotic tissue removal during necrectomy was $11.7 \pm 0.7\%$ of body surface area (BSA). This indicator did not significantly differ between the groups of patients undergoing ESD and DSD ($12.1 \pm 0.5\%$ and $10.8 \pm 1.2\%$ BSA, respectively). However, among burn patients with a Baux Index (BI) exceeding 80 units, we had to remove necrotic tissues over a significantly larger area (see Table 1).

Table 1.

Average area of necrectomy during ESD and DSD in burn patients with different severity of thermal injury, % body surface.

Groups	ESD, n=22	DSD, n=47	average, n=69
Baux index 60-80, n=29	7,3±0,6	7,1±0,7	7,2±0,5
Baux index > 81-100, n=27	13,0±0,7	12,6±2,4	12,9±1,5
Baux index > 100, n=13	15,1±0,8	14,2±2,2	14,7±1,4
Total, n=69	12,1±0,5	10,8±1,2	11,7±0,7

After performing fascial necrectomy, simultaneous autodermplasty was carried out. Simultaneous autodermplasty was performed only in a quarter - 17 (24.6%) - of elderly operated patients (see Fig. 3). Perforated skin grafts were used in all cases. Generally, favorable conditions for simultaneous autodermplasty were present in elderly patients with limited deep burns. Delayed autodermplasty was performed in 52 (75.4%) patients within 1-10 days after surgical necrectomy, on average 4.1 ± 1.9 days later.

The possibility of simultaneous radical excision of necrotic tissues and, consequently, performing simultaneous autodermplasty was not significantly dependent on the timing of debridement. Simultaneous autodermplasty was achieved in only 36.4% and 19.1% of patients undergoing ESD and DSD, respectively, within their respective groups ($\chi^2=0.122$). Typically, these were burn patients with predominantly limited deep burns (burn area of IIb-IV degree exceeding 7% of body surface in only 2 (2.9%) patients undergoing simultaneous autodermplasty).

Delayed autodermplasty following ESD was performed in 14 (63.6%) burn patients on average 2.9 days later. In one case, autodermplasty was delayed for 32 days due to general medical reasons (severe prolonged pneumonia, sequelae of a previous stroke). Additionally, in 2 patients from the DSD group, autodermplasty was delayed by 2 weeks (17 and 22 days) after necrotic tissue excision due to the development of secondary necrosis and sluggish wound healing in the context of diabetes mellitus.

On average, the timeframe for autodermplasty after trauma in the group of patients undergoing surgical necrectomy was 13.4 ± 0.9 days (see Table 2). Depending on the type of debridement - early or delayed - the closure times with skin grafts differed approximately twofold, with respective averages of 8.4 ± 0.5 and 16.1 ± 1.2 days ($p < 0.001$). Although these figures are somewhat conditional, considering both simultaneous and delayed autodermplasty, they unequivocally highlight the advantages of early necrectomy in reducing the recovery time of skin coverage.

Table 2.

Average timings of autodermplasty after injury with primary and delayed surgical debridement

Groups	ESD, n=22	DSD, n=47	Average
Baux index 60-80, n=29	7,7±1,4	15,7±0,9	12,9±1,1
Baux index > 81-100, n=27	9,8±1,6	15,5±1,5	13,7±1,8
Baux index > 100, n=13	10,2±2,3	17,9±1,3	15,5±1,7
Total, n=69	8,4±0,5	16,1±1,2	13,4±0,9

The timing of autodermplasty (ADP) did not significantly differ among patients with varying severity of thermal injury. For instance, the difference between patients with a Baux index within 60-80 units and those with Baux index over 80 units in terms of this indicator was 1-2 days ($p > 0.05$).

Overall, among burn patients with similar severity of thermal injury, the difference in timing for wound closure using autodermotransplants can reach up to 15 days. The choice of timing for surgical debridement (SD) and subsequent ADP was determined by the patient's admission time to the hospital, their condition, presence of comorbidities and complications, among other factors. For example, in patients with Bo index over 80 units undergoing primary SD with simultaneous ADP, wounds closed with transplants in 6.3 ± 0.2 days, whereas with delayed SD and subsequent ADP, closure occurred in 17.0 ± 0.8 days (Table 3). Similar operations were conducted within these timeframes for patients with Bo index over 100 units.

Table 3.
Average timing of immediate and delayed autodermoplasty (ADP) after trauma.

Groups	ADP timing (in days)			
	ESD, n=22		DSD, n=47	
	Simultaneous ADP, n=8	Delayed ADP, n=14	Simultaneous ADP, n=9	Delayed ADP, n=38
Baux index 60-80, n=29	$5,5 \pm 1,6$	$10,1 \pm 2,0$	$10,9 \pm 1,7$	$20,2 \pm 0,6$
Baux index > 81-100, n=27	$6,3 \pm 1,2$	$11,0 \pm 1,4$	$15,6 \pm 1,5$	$17,0 \pm 0,8$
Baux index > 100, n=13	$6,9 \pm 1,7$	$12,2 \pm 1,5$	$15,0 \pm 1,9$	$17,3 \pm 2,1$

ADP was performed on average over an area of $9.8 \pm 0.2\%$ of total body surface area (Table 4). The average area of ADP did not significantly differ between the early and delayed surgical debridement groups. In all cases, efforts were made to maximize coverage of deep skin defects with autografts, resulting in significant differences in ADP area among subgroups with different severity of thermal injury. According to the extent of debridement, autodermoplasty was performed on different areas in patients with Baux index within 60-80 units and in those with Baux index over 100 units, covering areas of $7.6 \pm 0.5\%$ and $12.6 \pm 1.3\%$ of total body surface area, respectively.

Table 4.
Average area of ADP during debridement

Groups	ADP area* (body surface %)		
	ESD, n=22	DSD, n=47	Total
Baux index 60-80, n=29	$6,7 \pm 0,9$	$7,9 \pm 0,7$	$7,6 \pm 0,5$
Baux index > 81-100, n=27	$13,2 \pm 1,6$	$11,7 \pm 0,9$	$12,8 \pm 0,8$
Baux index > 100, n=13	$14,3 \pm 2,6$	$12,4 \pm 1,1$	$12,6 \pm 1,3$
Total, n=69	$9,8 \pm 0,4$	$9,9 \pm 0,3$	$9,8 \pm 0,2$

* - If staged ADP was performed, the area of the first stage was taken into account.

Staged ADP was used to close all deep defects in one stage for 53 (76.8%) elderly and aged patients, and in two stages for 16 (23.2%). In the group of patients who underwent ESD (n=22), a total of 31 ADP procedures were performed: one successful procedure for 16 patients, two-stage procedures for 3 patients, repeated procedures due to graft lysis for 4 patients, and 3 procedures in one case (two-stage ADP followed by repeat autograft due to graft lysis).

Among burn patients with DSD (n=47), a total of 51 ADP procedures were performed: one successful procedure for 34 patients, two-stage autograft for 4 patients, and repeat operations due to graft lysis after one-stage (n=3) and two-stage procedures (n=1).

The average time for skin recovery after trauma with surgical necrectomy was 30.6 ± 2.0 days on average, with 28.4 ± 1.7 days for ESD group and 32.2 ± 1.6 days for DSD group (a difference of 4 days on average, $p < 0.05$). These indicators also significantly differed between groups of patients with Baux index less than 80 and more than 100.

Longer skin recovery times in individuals with extensive and deep burns were due to both staged ADP and local complications, as well as epithelialization rates of IIIA-degree burns, which

healed within 21-28 days. Against the background of ESD with simultaneous autodermplasty, the average skin recovery time was 19.6 ± 1.9 days, allowing for a reduction in treatment duration by 3-8 days compared to average values in the DSD group.

Complications were noted in 9 (13.0%) out of 69 elderly patients, with pneumonia observed in all cases of complications. Other complications of burn disease occurred at a frequency of 1.4-4.3%. A nearly twofold increase in complication rates was observed in burned patients with more severe thermal trauma ($Baux > 100$), which was expected. However, no significant difference in complication rates was found between the ESD and DSD groups. It is noteworthy that none of the 8 patients with limited (less than 10% body surface) deep burns who underwent ESD with simultaneous autodermplasty experienced burn disease complications.

Six (8.7%) out of 69 operated burn patients of elderly age experienced fatal outcomes after surgical necrectomy. Pneumonia was the immediate cause of death in 3 patients. In 1 patient, acute heart failure due to acute myocardial infarction was the immediate cause of death, and pulmonary embolism was the cause in 2 patients.

Thus, in elderly and aged burn patients, early surgical necrectomy, contrary to concerns of some specialists, did not significantly worsen mortality rates.

Graft lysis in elderly and aged burn patients occurred in approximately every fifth case – in 14 (20.3%) patients who underwent surgical necrectomy with subsequent ADP. In groups with different severity of thermal trauma, the frequency of graft lysis varied from 13.8% ($Baux = 60-80$) to 30.8% ($Baux > 100$). However, with an observation count of 69, the difference in indicators was not statistically significant ($p > 0.05$) (Table 5). The fact that this complication occurs in every third patient with more severe thermal trauma ($Baux > 100$) is likely due to the severe condition of the patients and the use of a higher perforation ratio of flaps (1:4, 1:6).

Table 5.

Frequency of autodermotransplant graft lysis, n (%).

Groups	Lysis < 10%	Lysis 10-50%	Lysis > 50%	Total
Baux index 60-80, n=29	2 (6,9)	2 (6,9)	-	4 (13,8)
Baux index > 81-100, n=27	3 (11,1)	2 (7,4)	1 (3,7)	6 (22,2)
Baux index > 100, n=13	2 (15,4)	1 (7,7)	1 (7,7)	4 (30,8)
Total, n=69	7 (10,1)	5 (7,2)	2 (2,9)	14 (20,3)

The total and subtotal graft lysis occurred in only 2 cases (2.9% of all lysis cases). Partial (up to 50%) rejection of the transplanted autologous skin was much more frequent, observed in 12 patients (17.3% of all lysis cases).

During simultaneous autodermplasty, where skin grafts were placed on the excised burn wound, the frequency of graft lysis was 11.8% (2 cases out of 17 ADP procedures). However, with delayed grafting onto granulating wounds, this rate doubled to 23.1% (12 out of 52 cases).

In elderly patients after performing ESD, out of 22 ADP cases, only 3 episodes of graft lysis were recorded (13.6%). Interestingly, this complication was slightly more frequent in patients with delayed ADP compared to those with simultaneous grafting (21.4% versus 12.5%). Following DSD, 10 cases of graft lysis were observed among 47 patients (21.3%). Notably, patients undergoing simultaneous ADP had significantly better outcomes, experiencing graft lysis more than twice as rarely as those with delayed skin grafting (11.1% versus 23.7%).

Comparison of graft lysis rates between ESD and DSD (18.2% and 21.3%, respectively) did not reveal a statistically significant difference.

Thus, when employing surgical debridement followed by autodermplasty for treating deep burns in elderly patients, the average skin recovery period after injury was 30.6 ± 2.0 days. The average frequency of autodermotransplant graft lysis was 20.3%. Notably, better outcomes were achieved with simultaneous autodermplasty compared to delayed ADP (11.8% versus 23.1%). Complications were noted in 9 out of 69 patients (13.0%), all of whom developed pneumonia. The average postoperative mortality rate among burned patients with thermal injuries was 8.7%, with mortality

not exceeding 6.9% in patients with a Baux index of 60-80, but reaching 11.1% in patients with more severe trauma.

Conclusions.

1. The application of surgical debridement methods in elderly patient groups significantly reduces the recovery time of skin surface, frequency of burn disease complications, and mortality rates.
2. The rational application of early surgical treatment methods in elderly patients should be carried out following appropriate preoperative preparation and stabilization of their condition.
3. Simultaneous autodermoplasty with closure of all wounds in one stage is effective for limited deep burns.
4. Delayed autodermoplasty performed in 1-2 stages yields better outcomes for extensive burns in elderly patients.

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