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FACTORS FOR IMPROVING THE QUALITY OF TREATMENT OF SEVERE BURN INJURIES IN THE FIELD OF MEDICAL AVIATION

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E.A. Khakimov ., F.R. Abdurakhmonov .,T.Q. Jonuzoqov .
Samarkand branch of Republic,
Emergency Center

Relevance: The most severe stage of burn disease is burn shock. The further fate of the patient largely depends on timely and adequate anti-shock therapy. Therefore, the decisive factor in the rapid recovery from a severe clinical situation is timely delivery of the patient to the hospital and the correct assessment of the severity of the patient's general condition and the selection of quality treatment measures**.**

The purpose of the study: to improve the quality of treatment against burn shock in patients with severe burn injuries and combined inhalation injury in the pre-hospital and early inpatient stages.

Materials and Methods: Our study included 376 patients treated during 2021-2023, aged 4 months to 72 years, with total burn area ranging from 10% to 90% of body surface area, of which deep burn area ranged from 5% to 50%. First of all, the most important treatment indicators were considered to be the elimination of the thermal factor, cooling the burned skin, eliminating pain with non-narcotic analgesics, narcotic analgesics, neuroleptics, and antihistamines, delaying wound dressing as much as possible, covering the wound with sterile dressings, creating psychoemotional calm, and initiating invasive anti-shock therapy as soon as possible.

It should be noted that the initiation of anti-shock infusion therapy during transportation was the first important step to a positive outcome, and crystalloid and salt-free solutions (sodium chloride 0.9% solution, magnesium sulfate 25%, glucose 5%), administration of glucocorticoid drugs, warming the patient, giving humidified oxygen served as initial treatment measures.

Results: Emergency care for the treatment of burn shock consists of several steps. If the rule of three catheters is followed initially, 1) installation of a nasol catheter for oxygen therapy and cleaning of the obstructing entities, 2) catheterization of the main vein to provide sufficient fluid, 3) catheterization of the urinary bag to monitor diuresis, 4) installation of a nasogastric tube into the stomach if nausea and vomiting are observed. Also, the main treatment for burn

shock was regular anesthesia, which was initiated, and the hypovolemic state was eliminated as soon as possible through intensive infusion therapy under central venous pressure (CVP) control. The volume of fluid administered was adjusted to the patient's age, body weight, and comorbidities, as well as the time of initiation of anti-shock therapy. If delayed infusion therapy is detected or inhalation injury is present, the volume of fluid is increased to 40%, and if pathological conditions in cardiac or renal function are observed, the volume and frequency of fluid are reduced. 5) use of hormonal therapy (dexamethasone 4-8 mg or prednisolone daily dose 0.5-1 mg/kg in children, 1-2 mg/kg in adults). 6) antibiotic therapy - often does not provide anti-shock therapy, but if the wound is contaminated, it can be carried out on the second day of shock therapy.7) It is important to use isotonic sodium chloride solution together with magnesium sulfate. 8) Maintaining the temperature of the room where the patient is being treated at +27,+28 degrees is a key factor in the patient's early recovery from shock.All victims are admitted to the "red zone" of the emergency department of the district medical association, and traumatologists and resuscitators are connected live via the Telegram or WhatsApp network of the telephone system, who examine the patient with a burn injury and recommend urgent treatment until the arrival of a burn specialist. This manual has been implemented with the emergency departments of the medical associations of all districts of our Samarkand region.Treatment of acute burn shock in this way was carried out in the emergency department of the district medical association or in the interdistrict polytrauma department for 48 to 72 hours, and in some severe burn injuries for 4-7 days, until the patient's general condition stabilized. The treatment tactics carried out in this way were characterized by high treatment effectiveness in emergency situations observed in remote districts.The analysis conducted during the study revealed the following shortcomings: 1) lack of adequate analgesia; 2) insufficient volume of infusion therapy; 3) failure to comply with the three-catheter rule; 4) premature primary treatment of trauma in shock, which further aggravates the shock.

Conclusion. Adequate and high-quality prehospital assessment of the severity of patients and coordination with specialists in a specialized center, combined with adequate and high-quality anti-shock measures, are important factors in early hemodynamic stabilization of severely burned patients and improving the prognosis for survival and recovery. Before the introduction of this direction, the mortality rate was 23.2%, while the principles of accelerated treatment have reduced the mortality rate in patients with extensive deep burns by 5.5%.

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