As the COVID-19 pandemic escalates across the globe, several measures are being employed to minimise exposure to the virus, prevent spread and rapidly detect persons with deteriorating status. Aside the pathogenesis of the disease, the phenomenon of lockdowns of cities across the globe where individuals are required to be confined to their homes only to exit under clearly defined circumstances is still ongoing. Though the latter is beneficial to prevent further community spread, the approach may have significant ramifications for the burn care community. In this blog, we highlight some pertinent issues warranting attention.

**Burn care studies** in developed and developing countries have identified the “home” as the commonest site for burn injury occurrence. Children and the elderly without adequate supervision during this period are particularly at risk of being injured in the home setting with reference to the bathrooms, dining halls and kitchens. Usage of faulty cylinders and electrical wirings in homes during this period could place community members at risk of being injured should an explosion occur. This could be a particular risk in slums given the proximity of the shelters. Power cuts or intermittent power supply could increase the use of candles and other items which increases the risk of burn injury and loss of property to open flames. Persons who engage in indoor smoking without exercising caution could also increase burn injury risk. Anecdotal evidence also suggests the occurrence of chemical burns caused by some sanitizing agents. Besides, usage of sanitizers close to open flames could pose a significant risk to the occurrence of burns. Thus, even though we are currently fighting COVID-19, the period is still an opportunity for the burn care community to augment burns prevention campaigns.

For hospitalised burn injured persons, this period could be particularly challenging as the first line of defense (skin) has been destroyed. In case of a spread, the diminished immune function that accompanies extensive burn injuries implies susceptibility to worse outcomes. Thus, strict infection prevention and control (IPC) measures from the site of injury to a healthcare facility becomes paramount. Though IPC measures may be enforced in the burn unit, pre-hospital care remains an issue of concern. More worrying is the fact that emerging evidence suggests the COVID-19 infection could rapidly progress to acute respiratory distress syndrome (ARDS) requiring ventilatory support; a clinical syndrome which could also occur in burn patients with inhalational injury. Staying indoors during the lockdown can increase the risk of inhalational injury in case of an episode of fire outbreak. If the new infection is to spread with affected persons presenting severe symptoms, then we need to brace ourselves to ration the use of ventilators.

Further to the above is the issue of interrupting the recovery process of burn survivors. Recovery following burns is a complex, protracted phenomenon which requires continuous support after discharge. In recent times, the process of recovering from burns has been likened to living with a chronic condition given the course of long-term adjustment. Closure of outpatient departments in various healthcare facilities imply that the contact of burn patients with available follow-up care is reduced. The lack of structured outreach services further
diminishes the support received by burn survivors which can push them further into the “trauma-bubble”. This may be an opportunity for the burn care community to consider telehealth services and provide outreach services at a distance to facilitate recovery.

The occurrence of burns usually leads to varied emotional responses among family members. Thus, a burn can be described as a family injury. The implication of this assertion is that the family recovers as the patient also recovers. The current situation requires adherence to strict visiting hours to healthcare facilities, if at all possible, which can create a seemingly difficult distance between burn patients and their families. Staying physically away from one’s social circle for a period could present with some mental health issues which adds on existing emotional reactions following the occurrence of the injury. This could be a very difficult situation for burn care teams, patients and families which requires negotiations to ensure a win-win situation and facilitate availability of adequate support.

The current pandemic presents unique challenges and opportunities for the burn care community across the spectrum of care. Thus, we should not presume that it has no impact on the burn care community. Cities are under lockdown but burns prevention campaigns and support need to remain an ongoing activity. Burn care practitioners remain critical “front-liners” and need to reconsider these issues and opportunities to better support the burn patients and their families.