



Figure 6-18 A pediatric spine board is an excellent stabilization device.

Tip

While spinal injuries are not common in children, the high frequency of head injury means that spinal stabilization should be part of the care of most pediatric patients with a significant mechanism of blunt trauma.

The appropriate use of a child restraint seat in an ambulance is controversial. When “car seats” are utilized for EMS transport, both the device and the method of securing the seat to the gurney must conform to industry standards and meet local requirements. If EMS local policy allows, have the child’s caregiver remain within view or speaking distance of the child, if the caregiver’s presence does not compromise the child’s treatment or crew safety. This is comforting for the conscious and **hemodynamically stable** child.

Pediatric Burn Patients

The assessment and management priorities for the burn patient are the same as for any other trauma patient. Make sure the scene is safe before approaching the child. Always anticipate exposure to hazardous materials and carbon monoxide, and use protective

Tip

The use of specially designed pediatric spinal stabilization devices is more efficient than on scene modification of adult devices.

Controversy

The use of car seats to transport injured children in ambulances remains controversial. Each EMS Agency should have consistent policy on this issue that conforms to local or state guidelines.

measures. Get technical help, if needed, from authorities on hazardous materials.

Assessment

Assess the scene for risk factors for airway and breathing. Important considerations in patients with fire and smoke exposures include the following:

- Enclosed space
- Heavy smoke
- Fumes
- Steam
- Hot vapors
- Chemical hazards
- Explosions with blunt or penetrating injury

Assess the patient for signs of smoke or particle inhalation and thermal burns of the airway. Give 100% oxygen for suspected carbon monoxide poisoning in children with abnormal appearance or ALOC, or in children exposed to fire or smoke in an enclosed space. Anticipate hidden injuries (especially abdominal) from a fall or a blast injury.

Make a quick estimation of burned body surface area. A modified anatomic diagram of children of different ages gives an approximation of burned body surface area, as shown in

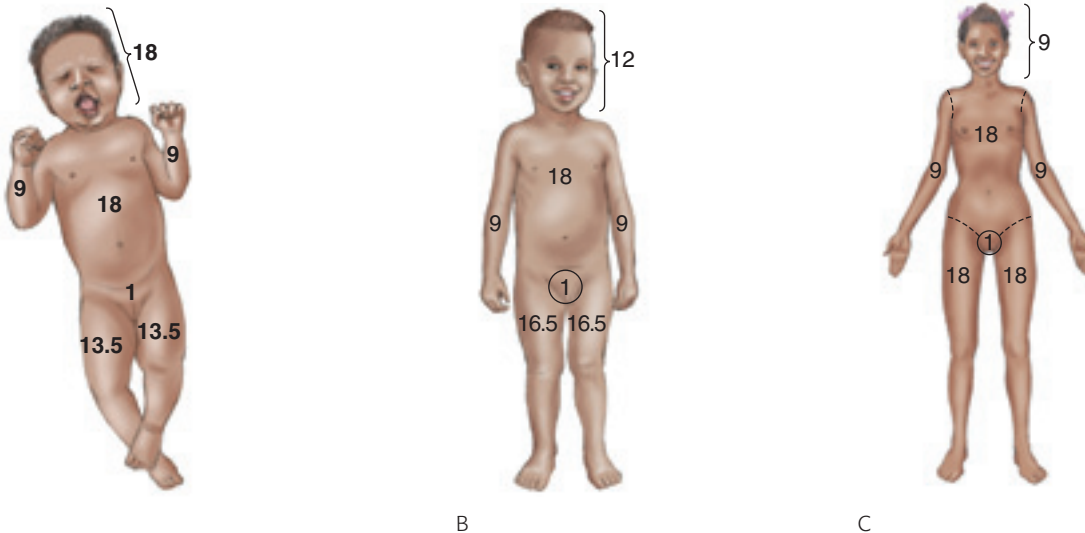


Figure 6-19 Modified anatomic diagrams of children of different ages give an approximation of involved body surface area for calculation of extent of burn in (A) infant, (B) child, and (C) adolescent.

Figure 6-19 A–C. If such a diagram is not available, use the “rule of palms,” which states that the patient’s palm plus fingers equals 1% of body surface area (**Figure 6-20**). The percent of burned body surface area is therefore roughly equal to the number of patient palm plus fingers-sized areas burned.

Although most burns are unintentional, assess all burn patients for risk factors for intentional injury. **Scald** and **contact burns** are common in children and are frequent findings in child maltreatment victims, as explained in Chapter 12. A “pattern” burn (where there is a clear demarcation of an object in the burned skin), “glove” or “stocking” distribution of a scald burn (**Figure 6-21**), or a history that is inconsistent with the injury are suspicious circumstances for intentional injury.

Management

Remove any burning clothes. Give 100% oxygen to all patients with flame or blast burns. High-flow oxygen therapy is the only field treatment for suspected carbon monoxide poisoning. Because of the risk of hypothermia, do not flush or wet burned areas unless necessary to decontaminate or stop the burning process. Cover burned areas with clean dry sheets or nonstick

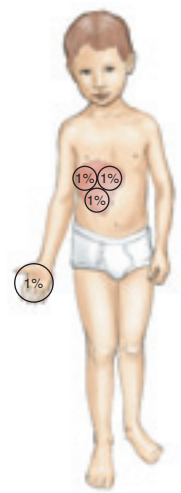


Figure 6-20 The palm plus fingers is approximately 1% of the body surface area.



Figure 6-21 Consider intentional injury with a suspicious pattern of the burn, especially a “stocking” or “glove” distribution.