

Burn Blister Management Guideline

South West Burn Care
Operational Delivery Network

These recommendations are formulated from the best available evidence for burn blister management in order to provide guidance for healthcare professionals working in pre-hospital, emergency, primary or secondary services, expected to manage patients with burn blisters.

Seek early advice from [local Burn Service](#), particularly for management of burn blisters in **major burns, children & palms and soles of feet**

Telephone support and advice on initial care of any patient with a burn injury is available at all times

All burn injuries that fall within the [Burn Referral Criteria](#) should be discussed with the **local Burn Service**

SWUK ODN guidelines are available via the website:
southwest-burncare-network.nhs.uk

SPECIALISED BURNS SERVICES

The Welsh Burns Centre & Paediatric Unit
Morriston Hospital, Swansea
Tel: 01792 703 802
Switch: 01792 702222

SWUK Paediatric Burns Centre
Bristol Royal Hospital for Children
Tel: 0117 342 7901
Switch: 0117 923 0000 (Bleep 6780)

Bristol Burns Unit
Southmead Hospital
Tel: 0117 414 3100/3102
Switch: 0117 950 5050 (Bleep 1311)

Salisbury Burns Unit
Salisbury District Hospital
Tel: 01722 345 507
Switch: 01722 336262

Plymouth Burns Facility
Derriford Hospital, Plymouth
Switch: 01752 202082 (Bleep 0024
Plastics Trauma Team)

Burn Blisters

Burn Blisters occur as a response to a burn injury whereby increased capillary permeability results in oedema formation that separates the epidermis from the underlying dermis. Burn blisters occur primarily in superficial partial thickness burns but also may overlay deeper burns.

Criteria for deroofing

LEAVE INTACT	Small non-tense blisters (<6mm)	Natural method of pain control. Unlikely to rupture spontaneously, damage underlying tissue, or impede healing.
	Deroofing is not the priority in care for severe and extensive burns.	
DEROOF	Thick-walled blisters on fingertips, palms and soles of feet	Blisters on these areas are associated with discomfort and limited mobility. Alternative management is to cut a sizeable "window" to remove fluid and enable assessment of the wound.
	Large (>6mm) and thin-walled blisters	Most likely to occur on hair-lined surfaces and rupture spontaneously, which increases the risk of infection.
	Ruptured blisters and loose skin	Remove any necrotic and possibly contaminated material from the wound.

Rationale for deroofing

- ☑ Allows proper observation of the wound bed and accurate assessment of the burn depth, including capillary refill time and sensation, to determine appropriate treatment.
- ☑ Removes non-viable tissue from the wound bed, allowing faster wound healing and decreasing likelihood of scarring.
- ☑ Evacuates blister fluid that may suppress local and systemic immune function, improving the patient's ability to defend against infection.
- ☑ Reduces the risk of wound infection associated with uncontrolled blister rupture and prolonged presence of non-viable tissue.
- ☑ Prevents pressure on underlying tissue, preserving the wound microcirculation and preventing the burn depth progression.
- ☑ Enables movement of joints, reducing the likelihood of burn contracture.
- ☑ Improves the efficacy of topical wound therapy.

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