INTRODUCTION
Nigerian reports on burn injury abound, and infer outcomes for burn care are poor, with high costs.1-4 Whilst reports from part of Nigeria and other regions are available,3-5 reports from the south east including costs are largely unavailable. Burn costs have been largely under reported.6

MATERIALS AND METHODS
A retrospective study of nine patients brought in simultaneously for major flame burn injuries and managed from the resuscitation phase to discharge or death at the National Orthopaedic Hospital, Enugu in 2001 was done. The disaster involved students who sustained injury following a gas explosion in the female hostel. The building was not purpose built, and had a narrow passage way, without fire extinguishers. Students there also cooked on kerosene stoves.

That day a gas cylinder ignited and the whole building became engulfed. Those with minor injuries were managed at the university hospital. Those with major injuries were transferred during resuscitation. Information about impending transfer was made by the sending institution to the recipient Medical Director and Head of trauma. In preparation for them the emergency room as well as the temporary burn facility was evacuated. The burn injury ranged from 30% to 95% body-surface-area. The patients were distributed among the four consultant units, the day's unit-on-take took three. One senior resident oversaw all patients.

Twice daily ward rounds were conducted with a consultant. Daily haematological and twice weekly electrolyte investigations were ordered. Other investigations were done ad hoc. The average length of stay was 19 days. There was (and still is) no functional Intensive Therapy Unit or ventilator. Ceftriaxone was commenced from the time of admission for 72 hours, thereafter based on the clinical status of patients antibiotic cover was offered.

1% silver sulpadiazine was the choice for dressings. Gentamicin cream was used for facial burns occasionally. A few patients had a combination of dressing materials at various periods.

Tangential excision or early skin grafting was excluded. Skin banking was (and is) unavailable. The frequency of dressing was influenced by manpower considerations. The burn unit had and has no dedicated theatre.

All patients presenting to the unit and requiring surgery had to be operated on a single weekly list. Survivors had split skin grafting and were discharged with skin dyschromia for which one sought treatment overseas. Funds promised by the State government to cater for the injuries are still being awaited.

RESULTS
There was one male and eight females. The first mortality was a female with 30% burns following acute renal shutdown and persistent pigmented urine. All those with extensive injuries (above 40%) died within two weeks from Disseminated Intravascular Coagulation, respiratory failure and Multiple Organ Dysfunction Syndrome.

Laboratory investigations cost $941.67; haematology tests accounted for 157 requests and cost $535.73 (table 1). Medicament cost $4467.97; antibiotics (the costliest single heading) accounting for more than half [$2416.03]. The total cost was $8162.90; with an average of 19 days stay for 9 persons the cost was $47.74 per day. Antibiotics accounted for 30% of the total cost.

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Table 1: summary of costs for 9 medical students

- Haematologic tests and blood transfusion 157 tests: N80,360 [$535.73]
- Microbiology 24 tests 6,490 [$43.27]
- Clinical chemistry 54,400 [$362.67]
- Antibiotics 362,405 [$2416.03]
- Other medicament including oxygen 307,791 [$2051.94]
- Other Hospital bills 412,989.60 [$2753.26]
Programmes to reduce burns using various media reaching the communities, and enforcement of existing legislation are urgent. Government should increase funding to improve Burn care. Ten years on no functional intensive therapy room or ventilator exists in the centre and the aid from the government is still awaited.

CONCLUSION
Burn care in eastern Nigeria appears costly and inadequate.

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REFERENCE