Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

a career subspecialty, this doesn't necessarily translate into a successful succession planning. Over 25% of UK burns consultants will reach retirement age within the next 10 years [2] furthermore as Burns injuries are increasing every year and more victims are surviving and require long term follow ups, therefore workload of each consultant is increasing annually [3]. This means greater numbers will be needed to replace the retiring cohort and take on the workload [3].

In conclusion we echo our colleagues suggestions for succession planning in Burns with the addition of the beneficial value of mentorship [4] by current Burns consultants who trainees find aspirational.

Declaration

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S. Sepehripour*, E. Chipp
Queen Elizabeth Hospital Birmingham, Mindelsohn Way, Birmingham B15 2TH, United Kingdom
E-mail address: sarvnazsepehri@googlemail.com (S. Sepehripour).

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* *Corresponding author.*

Burns from hair dye in recovered COVID-19 patients, a new presentation for further investigation

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Dear Editor,

I would like to raise awareness among the Burns professionals about a current finding in a number of media outlets in the UK. Hairdressers are noticing the occurrence of chemical burn from hair dye in their clients who recently recovered from COVID-19 infection [1,2]. Although chemical burns from hair dye products have been reported in the literature [3]. To my knowledge, I have not come across any of these incidents in recovered COVID-19 patients. I appeal for a wider audience within the burns community to find out whether these reports in the media are actually substantiated with actual presentations and admissions to the burns service.

Misinformation about COVID-19 related illnesses have caused a great amount of confusion among the public since its onset. Thus, it is of paramount importance that we keep aware of reporting for burns relating to COVID and also to ensure that we get correct information across when misinformation can easily occur.

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Mohamed Abdelaty*
Bradford Teaching Hospitals NHS Foundation Trust, Department of Plastic Surgery, Bradford Royal Infirmary, United Kingdom
E-mail address: mohamed.abdelaty@bthft.nhs.uk

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* *Correspondence to: Bradford Teaching Hospitals NHS Foundation Trust, Department of Plastic Surgery, Bradford Royal Infirmary, Duckworth Ln, Bradford BD9 6RJ, United Kingdom.*

"Reply: Letter to the Editor on recommendations for burns care in mass casualty incidents: WHO Emergency Medical Teams Technical Working Group on Burns (WHO TWGB) 2017–2020."

Dear Sir,

We thank Prof. Struzyna and colleagues for their interest in our recent publication [1]. In our reply, we would like to address their concerns sequentially.

Firstly, Struzyna and colleagues stress the need for triage to help the maximum number of victims with the available resources and recommend following the American Burns Association's instruction for segregating casualties [2]. We agree that the purpose of triage is to ensure optimal use of available resources. Thus, the WHO TWGB recommended using conventional triage processes on scene, augmented by burn specific criteria to guide correct care for burns, rather than implementing a separate system for burns in mass casualties [1]. The main reason for adding burn-specific criteria would be to avoid overwhelming hospitals with unnecessary burden and help prioritize resources. However, we do see triage as an ongoing, repeated measure during the onward surge. On-scene triage is merely the first step and should not be overly ambitious in a civilian mass casualty event, where victims in need of hospital care should be expeditiously transported to a hospital. The real risk of misdiagnosing severity and extent of burns, especially when undertaken by non-experts, represents a significant risk for improper use of resources in an overwhelming setting with very limited access to high-level care. Interestingly, the 2001 Volendam accident analysis could not identify any benefits from a more thorough on-scene triage than direct transport to the hospital. The authors highlighted that detailed assessment of burn victims is only practical in a hospital setting [3]. The WHO TWGB has structured the triage recommendations in sections of "on-scene," "on-arrival," and "definitive," where the latter two are steps of "in-hospital" or "secondary" triage [1,2,4]. A proper and accurate assessment is the priority of the WHO TWGB recommendations, and we believe these are in line with the previous publications on the matter [5–9]. In first-receiving hospitals during the initial days of the surge, the ABA triage decision table may well be used for secondary triage [9]. However, the WHO TWGB has purposefully chosen not to offer specific recommendations for such decision tables as these are likely to differ widely between different regions of the world.

Secondly, Struzyna and colleagues are concerned by potentially delayed and insufficient fluid resuscitation and question the use of the oral route. These topics have been thoroughly addressed in the analysis they cite [10]. Briefly, we fully agree with the vital importance of adequate fluid resuscitation for burned patients. However, the WHO TWGB recommendations are not about optimal fluid resuscitation of the individual burn patient. They are simple guidelines for disaster medicine, i.e., adjusting organization and standards of care to achieve the best possible outcome for the greatest number of casualties under severe resource scarcity. To that aim, the WHO TWGB recommends (recommendation #8a) a simplified initial fluid management strategy using oral or IV fluids depending on % TBSA, followed by a recommendation (#8b) to regularly assess the fluid status and to adjust the fluid regime accordingly. In the simplified fluid formula analysis, the WHO TWGB recommended resuscitation volumes fell within current non-disaster guidelines for major burns below 60% TBSA and seemed to under-resuscitate burns beyond 60% TBSA [10]. The WHO TWGB found that early optimal individually tailored fluid resuscitation for all burn victims often meets serious issues in real burn disasters. Severe resource scarcity makes monitored fluid resuscitation unrealistic, let alone accurately calculating TBSA as a starting point for resuscitation needs. We agree that delayed or insufficient fluid resuscitation may cause severe damage. However, excessive resuscitation and undue delays in casualty management and evacuation due to complex and resource-intensive interventions may also be harmful, hence the trade-off proposed for burns in mass casualty situations. In this setting, for burns up to 40% TBSA and provided patients can drink, evidence is admittedly scarce. Still, reported findingssupport the feasibility and safety of initial oral resuscitation with oral rehydration solution [10–13].

Thirdly, Struzyna and colleagues are concerned by the lack of specific timing recommendations for cooling and recommend hydrogel dressing for first aid cooling due to uncertain access to running water in low- and middle-income countries. Actually, the TWGB discussed whether or not to recommend