

## Increasing Rehabilitation Measures for Patients Who Have Maxillofacial Thermal Wounds

*Haydarova Nargiza Muxiddinovna*<sup>1</sup>

**Annotation:** Facial burns account for approximately 2% of the maxillofacial region's tissue damage. About 25% of burns happen in the head, face, and neck region. Burns can be caused by radiation, chemicals and heat. The area of the face on the body is 3.12% of its total surface area. Individuals who suffer burns to their face, neck, and scalp along with respiratory and eye injuries eventually develop severe illness and burn shock. Sixty patients, ages twenty to forty-three, had maxillofacial thermal burns. Of those who received first aid in the burn department of the Bukhara city RSMP between 2022 and 2023, 39 (61.9%) were men and 21 (38.1%) were women. Two groups comprising 28 patients (18 men and 10 women) were designated as the main group for the study, while 32 patients (21 men and 11 women) made up the control group.

**Keywords:** burns, face, thermal, therapy, combustiology.

**Introduction:** Of the tissue damage to the maxillofacial region, facial burns make up about 2%. In the head, face, and neck area, about 25% of burns occur. Heat, chemicals, and radiation can all result in burn injuries. The face makes up 3.12% of the body's total surface area. Patients who sustain burns to their face, neck, and scalp and also sustain damage to their eyes and respiratory system ultimately become critically ill and experience burn shock.

Even in cases where a victim has isolated II–IV degree facial burns, the extent of his condition is determined by factors such as good facial innervation and vascularization, disfigured facial features, and an adverse mental state. The skin is thin and varies in thickness in different parts of the face, resulting in uneven relief. This is because burns of different depths can happen on the face when exposed to the same thermal agent, even in regions that are near to one another. The eyebrows, ears, nose, lips, chin, and cheekbones are the prime locations for deep burns; the tissues of the forehead and eyelids are frequently impacted. When someone has deep burns, their eyebrows develop a thin scar that makes the upper eyelid more averted and stops hair growth.

An ear's cartilage can be damaged by deep burns that sometimes reach charring. Auricle abnormalities and deformities arise when the dead cartilage segments are rejected. The tip and wings of the nose, as well as occasionally the entire surface, are affected by burns. When the alar and triangular cartilages are injured, chondritis and necrosis develop as a result. The nose develops irreversible deformity and tissue flaws. When the zygomatic region and cheek tissues are burned, the tissue up to the parotid fascia may perish, revealing the parotid salivary gland. The lower eyelid inverts and the mouth corner shifts outward as a result of scarring of the surrounding tissues. The zygomatic bone may be necrotic. Lip burns frequently result in a necrotic red border that does not heal. It is advised to feed patients with lip burns via nasogastric tube. Still, edema causes the red border to enlarge and creates a "fish mouth." Lip burns can cause problems with eating through the mouth, the development of a microstomy, and a disruption of the perioral area's shape. Damage from deep forehead burns may result in necrosis of the frontal bone's external compact plate, frontal sinusitis, and other complications.

When someone gets lip burns, the red area frequently becomes necrotic and does not heal. It is advised to feed the patient with a nasogastric tube if they have lip burns. But in spite of this, edema causes the red border to enlarge and a "fish mouth" to form. In addition to changing the perioral area's shape, lip

<sup>1</sup> Assistant, Bukhara state medical institute



burns can cause microstomy formation and make it difficult to eat with the mouth. Deep forehead burns may cause harm to the frontal bone, which may then result in frontal sinusitis and necrosis of the bone's external compact plate. It is not impossible that the inflammatory process will spread to the dura mater. It is possible to completely damage the eyelids when exposed to a strong thermal agent, exposing and possibly scorching the cornea and sclera. Keratitis develops when the remaining eyelashes are positioned incorrectly, causing damage to the cornea. The cartilaginous plate undergoes deformation in conjunction with cicatricial eversion of the eyelids, even in the absence of thermal effects. It's important to assess the eyes' health when dealing with burns on the lids. An ophthalmologist should treat the patient if there is damage to the facial tissue.

**The study's goal is** unique method for managing thermal burns to the maxillofacial region.

**Material and research methods.** We looked at 60 patients, ages 20 to 43, who had stage III thermal burns to their maxillofacial region. Of those who received first aid in the burn department of the Bukhara city RSMP between 2022 and 2023, 39 (61.9%) were men and 21 (38.1%) were women.

Two groups comprising 28 patients (18 men and 10 women) were designated as the main group for the study, while 32 patients (21 men and 11 women) made up the control group. Patients in the main group had their burn wounds treated with special therapeutic dressings (sterile unrefined cottonseed oil + Unitro Derm Aqua hydrophobic KPE304), while patients in the control group underwent standard care for a week.

**The findings and their discussion.** Sixty patients, ages twenty to forty-three, had maxillofacial thermal burns. Of those who received first aid in the burn department of the Bukhara city RSMP between 2022 and 2023, 39 (61.9%) were men and 21 (38.1%) were women. Two groups comprising 28 patients (18 men and 10 women) were designated as the main group for the study, while 32 patients (21 men and 11 women) made up the control group. The likelihood of developing widespread infectious burn disease complications rises sharply with the extent of deep damage. Accordingly, as soon as the patient is taken out of burn shock, complex therapy for victims with extensive deep burns covering more than 20% of the body surface includes antibacterial therapy for the purpose of prevention and treatment of burn disease complications. These patients received all antibacterial medications intravenously, and at the same time, the surface of the wound was covered with special therapeutic dressings (Unitro Derm Aqua hydrophobic KPE304 + sterile unrefined cottonseed oil).

**Conclusion.** Therefore, depending on the patients who received traditional treatment for a week, regeneration of the wound surface following a thermal burn was epithitized earlier in the main group of patients. After applying a unique therapeutic dressing (sterile unrefined cotton oil + Unitro Derm Aqua hydrophobic KPE304), the wound's surface smoothed out and the amount of swelling and hyperemia reduced.

Even though the frequency and severity of infectious complications of burn disease can be reduced by the prudent use of antibacterial therapy and the use of a special therapeutic dressing (sterile unrefined cotton oil + Unitro Derm Aqua hydrophobic KPE304) in the complex treatment of burn patients, these complications still pose a serious risk to the lives of victims of thermal injury. For this reason, one of the top goals in combustiology is the ongoing development of infection prevention and treatment strategies.

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