Intravenous Access Guideline:
Arnold Luterman Regional Burn Center
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Background: burn patients often require significant resuscitation, medications, and prolonged access. In addition, lines must be durable and withstand the physical manipulation of frequent wound care.

The choice of IVs must take into consideration multiple factors, including:

- BURN: burn proximity, >5cm away is ideal to mitigate infection
- TISSUE: local edema may worsen and compromise PIV sites in extremities or burned skin
- PATIENT: examine venous anatomy and circumstances such as infection (?IV vanc) and organ failure (?pressors, or HD access)

Peripheral Access

Obtain early and try to get two 20 20ga or larger lines distal to anticubital fossa

Anticipate edema – will the PIV survive edema in this location?

Midline or PICC Access

Obtain early when prolonged access predicted so that PIV sites are preserved. These lines are not placed through burn

PICCs > Midline in those who will need Vancomycin

Anticipate PIV problems – will the PIVs burn out or IV access become an issue with treatments?

Central Access

Obtain using sterile techniques if other sites not viable such as when the burn distribution obscures viable sites, or when the patient has renal failure.

Sonogram Guided IJ optimal

Femoral line > other central line Through burn

Right IJ is the optimal location if hemodialysis is anticipated

Subclavian lines have higher incidence of central venous stenosis