Scenario I

A 50-year-old female was brought to the A&E after **sustaining burn injuries in a house fire 30 minutes ago**. She reports that her clothing caught fire while she was near an open flame in the kitchen, and she struggled to extinguish the flames before being rescued.

Upon arrival, she is conscious and complains of severe pain in her back, right arm, and right leg. She is breathing comfortably and speaking in full sentences, with no hoarseness or stridor.

She denies any significant past medical history or known drug allergies.

Physical Examination:

- **Body Weight**: 70 kg
- **Vital Signs**: BT 37.5°C, BP 100/60 mmHg, PR 120 bpm, RR 22 bpm.
- **Skin** (as Figure 1):
    - **Right arm, forearm, and hand**: erythematous and blanchable, showing significant blistering, extremely painful
    - **Right lower leg**: pale pink, non-blanchable, mottled appearance, less moist, slightly reduced sensation to touch.
    - **Upper back and part of the lower back**: pale gray to white, dry, and leathery, with markedly reduced sensation.
- **Other**: No evidence of facial or neck burns. No other traumatic injuries noted.

Initial assessment of airway, breathing, and circulation is initiated. The team evaluates the extent and severity of the burn injuries and discusses fluid resuscitation, infection prevention, and the need for transfer to a specialized Burn Unit.

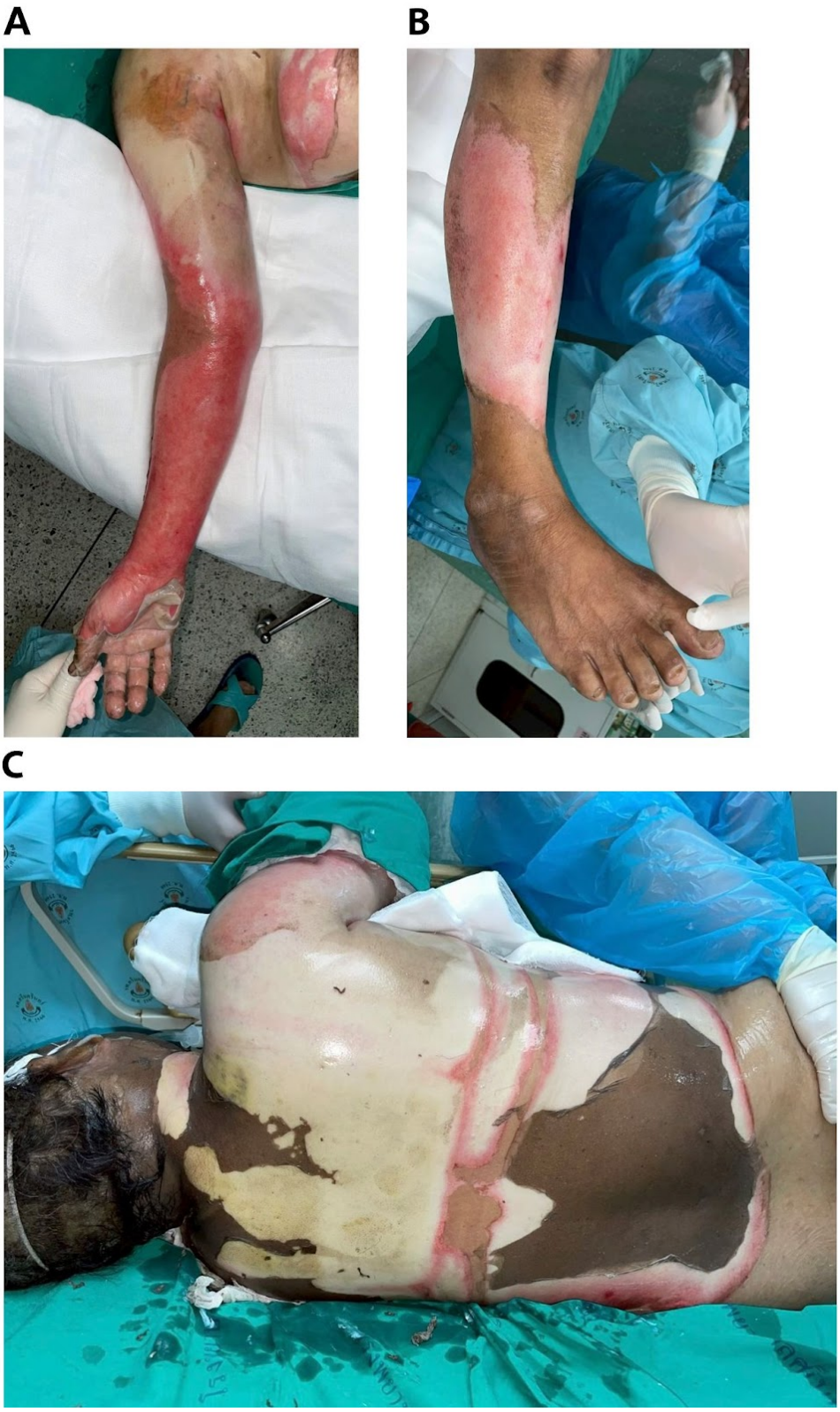

Figure 1: The burn wounds on the right arm (**A**), right leg (**B**), and the back (**C**).