Intravenous lidocaine for the treatment of background or procedural burn pain (Review)

Wasiak J, Mahar P, McGuinness SK, Spinks A, Danilla S, Cleland H

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Intravenous lidocaine for the treatment of background or procedural burn pain (Review)
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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEADER</td>
<td>1</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>1</td>
</tr>
<tr>
<td>Plain Language Summary</td>
<td>2</td>
</tr>
<tr>
<td>Background</td>
<td>2</td>
</tr>
<tr>
<td>Objectives</td>
<td>3</td>
</tr>
<tr>
<td>Methods</td>
<td>3</td>
</tr>
<tr>
<td>Results</td>
<td>4</td>
</tr>
<tr>
<td>Discussion</td>
<td>5</td>
</tr>
<tr>
<td>Authors’ Conclusions</td>
<td>5</td>
</tr>
<tr>
<td>References</td>
<td>6</td>
</tr>
<tr>
<td>Characteristics of Studies</td>
<td>7</td>
</tr>
<tr>
<td>Data and Analyses</td>
<td>10</td>
</tr>
<tr>
<td>Additional Tables</td>
<td>10</td>
</tr>
<tr>
<td>Appendices</td>
<td>10</td>
</tr>
<tr>
<td>What’s New</td>
<td>12</td>
</tr>
<tr>
<td>History</td>
<td>12</td>
</tr>
<tr>
<td>Contributions of Authors</td>
<td>12</td>
</tr>
<tr>
<td>Declarations of Interest</td>
<td>13</td>
</tr>
<tr>
<td>Index Terms</td>
<td>13</td>
</tr>
</tbody>
</table>

Intravenous lidocaine for the treatment of background or procedural burn pain (Review)
ABSTRACT

Background
This is an update of the review on 'Lidocaine for pain relief in burn injured patients' first published in Issue 3, 2007. Pain is a major issue for patients suffering from many different types of wounds, in particular those with burn injuries. Prompt, aggressive use of opioid analgesics such as morphine has been suggested as critical to avert the cycle of pain and anxiety, but side effects are encountered. It is proposed that newer agents such as lidocaine could be effective in reducing pain and alleviating the escalating opioid dosage requirements in patients with burn injury.

Objectives
To assess the safety and effectiveness of intravenous lidocaine as a means of pain relief versus no therapy, placebo, other drugs or two or more of the above therapies in combination in patients exposed to burn injury.

Search methods
We searched the Cochrane Central Register of Controlled Trials (The Cochrane Library 2011, Issue 2), MEDLINE (1966 to April 2011 week 4) and EMBASE (1980 to 2011 week 17).

Selection criteria
We included randomised controlled trials (RCTs) and controlled clinical trials (CCTs), published and unpublished, which assessed the efficacy of intravenous lidocaine in varying doses as a single-agent therapy with no therapy, placebo, other analgesics such as opioids, lidocaine plus another drug, or two or more of the above therapies as a means of pain relief in patients exposed to burn injury.

Data collection and analysis
Two review authors independently abstracted data and assessed the risk of bias of the studies identified.
Main results

This update identified one new randomised, double-blind, placebo-controlled, cross-over trial which included 45 participants and compared intravenous lidocaine against placebo as a means of pain relief in those with burns. Subjective pain ratings as measured by the verbal rating scale increased during procedures for both treatment arms, however, the increase was less for the lidocaine treatment arm. There were no significant clinical or statistical differences regarding the effects of lidocaine and placebo on opioid requests and consumption, anxiety or level of satisfaction during a wound care procedure.

Authors’ conclusions

As current clinical evidence is based on only one single RCT as well as case series and reports, intravenous lidocaine must be considered a pharmacological agent under investigation in burns care, the effectiveness of which is yet to be determined with further well-designed and conducted clinical trials.

Plain language summary

Lidocaine for pain relief in burn-injured patients

Burns are very common and sometimes fatal, and the pain associated with such injury is one of the most difficult types of suffering to relieve. The use of high-dose opioid medications like morphine is common, but side effects are encountered. Alternative agents such as lidocaine, an anaesthetic, have been proposed. This is an update of the review of the same name first published in Issue 3, 2007. There is currently one relevant randomised controlled trial, involving only 45 participants, but showing a benefit from intravenous lidocaine for pain relief in burns patients. The trial did not show a difference in opioid consumption, patient anxiety or level of patient satisfaction with the use of intravenous lidocaine.

Background

Description of the condition

This is an update of the review on ‘Lidocaine for pain relief in burn injured patients’ first published in Issue 3, 2007 (Wasik 2007). Burn injuries are a particularly emotive injury with which pain is frequently associated. Burn pain continues to be an ongoing issue of investigation and concern (Dauber 2002; Richardson 2009). Inflammatory reactions pursuant to injured tissue or nerves may result in the overproduction of inflammatory mediators which may result in allodynia and primary hyperalgesia in injured areas and secondary hyperalgesia in surrounding tissue (Meyer 1981; Richardson 2009). Repetitive painful stimuli can cause neuroplastic adaptations throughout the central nervous system (CNS) whereby pain afferent sensory impulses undergo facilitation and amplification to a given stimulus, contributing to the generation and maintenance of chronic pain (Richardson 2009). Pain from burn injuries has been associated with a number of mental health conditions such as depression, anxiety, post-traumatic stress disorder and suicide (Edwards 2007; Summer 2007).

Opioid analgesics, and in particular intravenous opiates, have long been the mainstay of analgesia for procedure-related burn pain. Use of high-dose opiates, however, can be associated with both short-term adverse effects, including respiratory depression and constipation, as well as long-term consequences, such as the development of tolerance and reward-based behaviour to opiate medication.

Description of the intervention

Lidocaine (also named lignocaine) is a local anaesthetic agent of the amide type that has been used for local anaesthesia and systematically as an anti-arrhythmic drug. Intravenous lignocaine has been proposed as a means to alleviate the debilitating effects of various types of pain and is currently used in the management of many acute, chronic and neuropathic pain conditions (Edwards 1999; Ferrante 1996; Koppert 2004; Hand 2000; McLeane 2001). The most common timing of use of analgesia tends to be during debridement. Systemic lidocaine has also been reported to be effective in treating burn injury in numerous case series, case studies and experimental studies (Cassuto 2003; Holthsuen 2000;
How the intervention might work

Lidocaine reversibly binds to subunits of voltage-gated sodium channels in the nerve membrane, consequently inhibiting nerve conduction. The depression of conduction in afferent nerves secondary to lidocaine administration may act to modify pain in burn patients, and avoid the adverse effects of high-dose opiates during procedures associated with burn management likely to elicit repetitive painful stimuli.

Why it is important to do this review

A number of clinical trials over recent years have attempted to use non-opioid therapies to treat procedural pain with mixed degrees of success (Finn 2004; Harandi 2004; Konstantatos 2009; Zor 2010). Although many burns units employ a number of different therapies, there is still no widely accepted alternative or uniform adjunctive treatment to intravenous opioids for the management of procedural burn pain supported by meta-analysis of randomised controlled trials (RCTs). Given the importance of pain control in acute burn injuries, further evidence should be sought with respect to non-opioid analgesic agents, particularly in the context of procedural pain control. As systemic lidocaine has been shown to be safe and effective for the management of some neuropathic conditions that have been refractory to standard interventions, it is expected that we could establish that systemic lidocaine may help reduce the pain of burns.

OBJECTIVES

The objective of this review was to assess the safety and effectiveness of intravenous lidocaine as a means of pain relief versus no therapy, placebo, other drugs or two or more of the above therapies in combination in patients exposed to burn injury.

METHODS

Criteria for considering studies for this review

Types of studies

We included studies in this review if they were RCTs and controlled clinical trials (CCTs), published and unpublished, that assessed the analgesic efficacy of intravenous lidocaine in patients exposed to burn injury.

Types of participants

We included all adults (> 18 years) with any burn injury who required lidocaine as a means of pain relief. It was expected that studies would be included regardless of the method of burn injury. However, we excluded burn patients requiring pain relief measures for multiple treatment regimes such as skin-grafting procedures.

Types of interventions

We considered administration of intravenous lidocaine of varying doses as a single-agent therapy with no therapy, placebo, other analgesics such as opioids, lidocaine plus another drug, or two or more of the above therapies in combination regardless of the duration of the treatment.

Types of outcome measures

Primary outcomes

Studies were eligible for inclusion if they reported on one or more of the following primary outcome measures: pain measured by a visual or verbal analogue scales (VAS), a numerical rating scale, or other validated assessment tool, categorical rating of pain intensity in circumstances in which numerical ratings may be problematic, time to re-medication and requirements for rescue analgesia.

Secondary outcomes

Studies that reported on secondary outcomes alone such as adverse effects, measures of satisfaction, physical functioning without reference to pain, emotional functioning without reference to pain, patient preference and assessment of quality of life would not be included.

Search methods for identification of studies

The original search for this review was run in March 2007. For this update we searched the Cochrane Central Register of Controlled Trials (The Cochrane Library 2011, Issue 2), MEDLINE (1966 to April 2011 week 4) and EMBASE (1980 to 2011 week 17). In MEDLINE, we combined the search strategy with the optimum trial search strategy described in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins 2011). We applied no language restrictions. The search strategies for all databases can be found in Appendix 1. We adapted the search strategy for other databases. Please see Appendix 1 for the MEDLINE search strategy.
Data collection and analysis

Selection of studies
In the original review, both review authors (JW and HC) reviewed titles and abstracts to identify potentially relevant studies using the selection criteria. We did not review studies that clearly failed to meet the inclusion criteria. Both review authors independently retrieved and reviewed those that could not be excluded in full text. In all instances, we resolved differences of opinion by discussion among the authors. In this update, three independent review authors (JW, PM and SMcG) retrieved, scanned and reviewed records in a similar manner.

Data extraction and management
Three review authors (JW, PM and SMcG) independently extracted data from the eligible studies using standardised forms developed for this review. Data extracted included: study characteristics, participant demographics, intervention and comparison details plus outcome measures and results. We contacted primary authors to provide missing information. In all instances, we resolved differences of opinion by discussion among the review authors.

Assessment of risk of bias in included studies
In this update, we assessed the risk of bias for each study according to the recommendations described in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011). The risk of bias tool incorporates assessment of randomisation (sequence generation and allocation concealment), blinding (of participants, treatment providers and outcome assessors), completeness of outcome data, selection of outcomes reported and other sources of bias. We resolved discrepancies in ratings by discussion.

Measures of treatment effect
If possible, we expressed dichotomous data as risk ratios (RR) and 95% confidence intervals (CIs). We expressed continuous data as mean difference (MD) and 95% CIs. We planned all analyses to be made on data reported for intention-to-treat (ITT) results. However, none of the studies used such analyses.

Assessment of heterogeneity
If possible, we tested statistical heterogeneity using the Chi² test with significance at *P* < 0.10 and a quantification of the degree of heterogeneity using the I² statistic, and planned to carry out further exploration using subgroup analyses.

Subgroup analysis and investigation of heterogeneity
No specific subgroup analyses were pre-specified.

RESULTS

Description of studies
See: Characteristics of included studies; Characteristics of excluded studies.

Results of the search
In the original review (Wasiak 2007), we identified a total of 25 studies from searching the literature. Independent scrutiny of the titles and abstracts identified five potentially relevant studies. Of the five potentially relevant studies, we excluded all because they did not report on primary clinical outcome measures (Holthiessen 2000; Koppert 2004; Mattsson 2000) or used an alternative study design such as a case report (Cassuto 2003) or a case series (Jonsson 1991).

In this update, we identified a total of 406 further references. Independent scrutiny of the titles and abstracts identified no potentially relevant studies. One additional study, undertaken by the review authors (JW, AS and HC) and not yet indexed at time of the search date met the inclusion criteria (Wasiak 2011).

Included studies
We included one cross-over RCT in this review (Wasiak 2011). In Wasiak 2011, 47 patients were initially recruited although only 45 participants with burn injuries (mean % total body surface area (TBSA): 12.96%, range: 3% to 55%) undergoing wound care procedures (i.e. dressing changes and/or debridement) over two consecutive days following split skin graft surgery were randomised to receive lidocaine of 1.5 mg/kg/body weight followed by two boluses of 0.5 mg/kg at five-minute intervals followed by a continuous infusion, whilst during the control condition, 0.9% sodium chloride was administered at an equivalent volume, dose and rate to that of lidocaine. The primary outcomes measured were change in verbal rating scale (VRS) scores measured before, during and after the procedure; time to rescue analgesia; opioid requests and consumption using patient-controlled analgesia (PCA); and overall patient anxiety and level of satisfaction. Subjective pain ratings as measured by the verbal rating scale increased during procedures for both treatment arms, however, the increase was less for the lidocaine treatment arm. Results for the individual study are in a separate table (see ’Table 1’).

Excluded studies
In this update, we added no excluded studies. For previous excluded studies, see the ‘Characteristics of excluded studies’ table.
Risk of bias in included studies

In this update we have used the new ‘Risk of bias’ tool. The commentary on the individual study is reported in the ‘Risk of bias’ section of the Characteristics of included studies table by the authors not involved in the RCT (SMcG, SD). Using the definitions provided by Higgins (Higgins 2011), the study by Wasiak 2011 described adequate allocation concealment and blinding of both patients, staff and study researchers. Although Wasiak 2011 indicated an intention-to-treat analysis, the study had two patients lost to follow-up as one dressing was done in the outpatient setting and the other stopped due to uncontrolled pain.

Effects of interventions

Wasiak 2011 reported that verbal rating scale (VRS) scores were significantly lower for lidocaine (0.34) compared with placebo (0.70) when measured before, during and after the procedure (difference (95% CI) = 0.36 (0.17 to 0.55), P value < 0.001). Rescue analgesia was required during six wound care procedures, all involving the removal of staples. During the six procedures, all participants had required intravenous ketamine during dressing procedures prior to rescue analgesia; four participants during the lignocaine arm, one during the placebo arm and one during both. Comparison of opioid demand and consumption showed no significant clinical or statistical differences between lidocaine and placebo arms. Measures of overall anxiety and satisfaction levels showed no appreciable difference between the groups. There were no significant clinical or statistical differences between the lidocaine and placebo arms with regard to anxiety scores prior to or after the wound care procedures.

DISCUSSION

This review aimed to assess the safety and effectiveness of intravenous lidocaine as a means of pain relief versus no therapy, placebo, other drugs or two or more of the above therapies in combination in patients exposed to burn injury.

Intravenous lidocaine has been a well-documented treatment for other clinical conditions such as cardiac arrhythmias and neuropathic pain. In recent times and in the setting of burns pain, there has been growing evidence in the form of case reports or series to suggest that lidocaine can improve the analgesic efficacy, alleviate the deleterious effect of opioid administration, and minimise the necessity of escalating opioid dosages in patients with thermal injury (Cassuto 2003; Edwards 1999; Jönsson 1991) although these were excluded from our original search.

Several mechanisms have been proposed for this action, namely that systemic lidocaine can depress conduction in afferent nerves, inhibit dorsal horn neural transmission and modify the cerebral perception of pain (Abelson 2002; Attal 2000). More so, it has been postulated that burn injury is likely to trigger the release of inflammatory agents such as histamine, serotonin and prostaglandins which in turn could trigger nociceptive impulses, making lidocaine’s potent anti-inflammatory properties integral to the suppression of pain (Edwards 1999).

We included only one study (Wasiak 2011) involving the addition of lidocaine infusions to patient-controlled analgesia (PCA) morphine as compared to placebo involving 45 randomised burn-injured patients. Outcomes included pain intensity as measured by verbal rating scale (VRS), time to rescue analgesia, opioid requests and consumption, and overall anxiety and level of satisfaction. There were statistically significant differences in VRS score which was lower in lidocaine patients as compared to placebo; however, there were no statistically significant differences with respect to other primary outcomes. Significantly, lidocaine administration did not result in a significantly lower demand by patients for opioids. The study was conducted in a burns centre in Melbourne, Australia where the authors of the trial acknowledge that the standard opioid-based pain management regimes of the unit usually lead to a high degree of satisfactory pain control. In this context, it may have been difficult to improve upon an already established baseline of pain control and this limits generalisability of this trial to clinical practice in burn centres where opioid-based pain management has not been optimised or is contra-indicated in certain patients.

Whilst the included study failed to show a reduction in opioid consumption or demand, or a difference in degree of patient satisfaction whilst the adjuvant use of intravenous lidocaine for pain relief during burn wound dressing changes was administered, the use of intravenous lidocaine as a form of pain relief at other stages during burn wound management remains unexplored in the form of randomised controlled trials (RCTs). Given that a number of RCTs in a non-burn context and case series involving burn patients highlight that intravenous lidocaine may lead to a reduction in participants’ procedural and background pain levels, lead to less opiate requirements and consequently fewer associated complications, there is a need for ongoing RCTs to assess the utility of intravenous lidocaine in burn patients.

AUTHORS’ CONCLUSIONS

Implications for practice

As this review update now includes one study, the conclusions have changed since the original publication. The findings of this review update indicate that the use of intravenous lidocaine as an adjuvant analgesic agent in combination with morphine (patient-controlled analgesia), although appearing to be well-tolerated, confers little benefit on opioid consumption and demand, patient anx-
iety and satisfaction or time to rescue analgesia. These findings, however, are based on one single institution study where the intervention was implemented during procedural dressing changes. For this reason, it is impossible to draw any meaningful conclusions about the effect of intravenous lidocaine on burn-associated pain at other stages in burn management, such as for pain control during the acute stages of presentation, or in the management of chronic pain.

**Implications for research**

In order to evaluate better the effect of intravenous lidocaine as an analgesic agent in burn-related injuries in a procedural context, more research in the form of clinical randomised controlled trials (RCTs) should be undertaken with greater sample sizes and across multiple institutions. Future RCTs assessing the clinical effectiveness and safety should be undertaken at different stages of presentation in burn-injured patients. Examples might include early in the patient’s admission to a burns center and, where possible, before initiation of high-dose opiate medications or for the treatment of chronic pain refractory to opiates or anti-neuropathic medications.

**REFERENCES**

**References to studies included in this review**

Wasiak 2011 (*published data only*)


Holthuusen 2000 (*published data only*)


Jönsson 1991 (*published data only*)


Koppert 2004 (*published data only*)


Mattsson 2000 (*published data only*)


**Additional references**

Abelson 2002


Finn 2004


Hand 2000


Harandi 2004


Higgins 2011

Lefebvre C, Manheimer E, Glanville J on behalf of the Cochrane Information Retrieval Methods Group. Chapter

Konstantatos 2009

McLeane 2001

Meyer 1981

Richardson 2009

Summer 2007

Zor 2010

References to other published versions of this review

Wasiak 2007

* Indicates the major publication for the study
# Characteristics of included studies  
*ordered by study ID*

**Wasiak 2011**

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<th>Details</th>
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<td><strong>Methods</strong></td>
<td>Randomised, double-blind, placebo-controlled cross-over study. Allocation concealment stated; method of randomisation stated; patients, staff and outcome assessors blind to treatment assignment and medication administration</td>
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<tr>
<td><strong>Participants</strong></td>
<td>45 participants with burns (mean %TBSA: 12.96%, range: 3% to 55%) undergoing wound care procedures (i.e. dressing changes and/or debridement) on 2 consecutive days following split skin graft surgery. Participants were aged between 16 to 68 years</td>
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<td><strong>Interventions</strong></td>
<td>Lidocaine dose of 1.5 mg/kg/body weight followed by 2 boluses of 0.5 mg/kg at 5-minute intervals followed by a continuous infusion. For the control condition, 0.9% sodium chloride was administered at an equivalent volume, dose and rate to that of lidocaine</td>
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<td><strong>Outcomes</strong></td>
<td>Verbal rating scale (VRS) scores measured before, during and after the procedure; time to rescue analgesia; opioid requests and consumption using patient-controlled analgesia (PCA); and overall patient anxiety and level of satisfaction</td>
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<td><strong>Notes</strong></td>
<td>%TBSA: percentage of total surface area</td>
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**Risk of bias**

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<th>Support for judgement</th>
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<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Authors state “subjects were randomized to one of two treatment sequence groups i.e. treatment A or treatment B, using block randomization”</td>
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<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>Authors state “Allocation of treatment regime was done using the opaque sealed envelope technique, in which envelopes with cards detailing which treatment regime were allocated to patients on the morning of each dressing”</td>
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<tr>
<td>Blinding (performance bias and detection bias)</td>
<td>Low risk</td>
<td>Authors state “Subjects, staff and researchers were blinded to treatment assignments with all study medications identical in appearance. During the infusion, research staff administering the study medication was blind to the outcome assessments and the patient and research assistant were blinded to the study medication administration”</td>
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### Characteristics of included studies

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<td>Jönsson 1991</td>
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<td>Koppert 2004</td>
<td>Did not report on relevant primary outcome measures</td>
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<td>Mattsson 2000</td>
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### Characteristics of excluded studies

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<td>Mattsson 2000</td>
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DATA AND ANALYSES

This review has no analyses.

ADDITIONAL TABLES

Table 1. Results of individual study

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<tr>
<th>Study ID</th>
<th>Dose of lidocaine</th>
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<th>Numbers in trial</th>
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<th>Efficacy</th>
<th>Adverse events (intervention)</th>
<th>Adverse events (placebo)</th>
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<tr>
<td>Wasiak 2011</td>
<td>Initial bolus dose of 1.5 mg/kg/body weight followed by 2 boluses of 0.5 mg/kg/body weight at 5-minute intervals and an infusion run at 2 mg/minute throughout duration of dressing</td>
<td>0.9% NaCl (normal saline) at equivalent dose, rate and volume as intervention</td>
<td>45</td>
<td></td>
<td>Verbal rating scale (VRS) scores lower for lidocaine compared with placebo. No difference between groups in time to rescue analgesia; opioid requests and consumption using patient-controlled analgesia (PCA); and overall patient anxiety and level of satisfaction</td>
<td>Pre-dressing: twitchiness 1/45 and nausea/vomiting 8/45, Dressing: nausea/vomiting 4/45 and severe pain 1/45 Post-dressing: nausea/vomiting 4/45</td>
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APPENDICES

Appendix 1. MEDLINE search strategy

via OVID for this update in 2011:
1. exp Burns/
2. burn*.mp.
3. thermal injur*.mp.
4. 1 or 2 or 3
5. Lidocaine/
6. (lidocaine or lignocaine).mp.
7. 5 or 6
8. 4 and 7
9. mp = protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier

via Ovid for the original review in 2007:
1. exp BURNS/
2. (burn or burns or burned).mp
3. (burn$ or burns$ or burned$).au
4. burn.ti. or burn.ab. or burns.ti. or burns.ab. or burned.ti. or burned.ab.) and (burn$ or burns$ or burned$).au
5. 2 not 3
6. 4 or 5
7. burn.ti. or burn.ab. or burns.ti. or burns.ab. or burned.ti. or burned.ab.
8. 2 not (1 or 3 or 7)
9. 6 or 8
10. 1 or 9
11. thermal injur$.mp
12. 10 or 11
13. Lidocaine/
14. (lidocaine or lignocaine).mp
15. 13 or 14
16. 12 and 15

In addition we checked the reference lists of the relevant trials and reviews. We did not contact current researchers in the field for unpublished data and ongoing trials.

Appendix 2. CENTRAL search strategy

#1 MeSH descriptor Burns explode all trees
#2 burn*
#3 thermal injur*
#4 (#1 OR #2 OR #3)
#5 MeSH descriptor Lidocaine; this term only
#6 lidocaine or lignocaine
#7 (#5 OR #6)
#8 (#4 AND #7
**Appendix 3. EMBASE search strategy**

1. exp burn/
2. burn*.mp.
3. thermal injur*.mp.
4. 1 or 2 or 3
5. lidocaine/
6. (lidocaine or lignocaine).mp.
7. 5 or 6
8. 4 and 7

**key**

mp = title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer

**WHAT’S NEW**

Last assessed as up-to-date: 2 April 2012.

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**HISTORY**

Protocol first published: Issue 1, 2006

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<td>The contact details of Patrick Mahar were amended for this update review conducted in April 2011</td>
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<td>4 August 2011</td>
<td>New citation required and conclusions have changed</td>
<td>This update includes one new study by Wasiak 2011 involving 45 participants. Previous readers of this review would benefit from re-reading this review as there is now one small study included</td>
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<td>4 August 2011</td>
<td>New search has been performed</td>
<td>This review was brought up to date to April 2011; the original review was published in Issue 3, 2007</td>
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<td>24 September 2010</td>
<td>Amended</td>
<td>Contact details updated.</td>
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<tr>
<td>30 October 2008</td>
<td>Amended</td>
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CONTRIBUTIONS OF AUTHORS

Jason Wasiak: designed and co-ordinated the review. Extracted data and checked quality of data extraction. Undertook and checked quality assessment. Performed statistical analysis, interpreted data and checked the analysis. Completed first draft of the review update and advised on subsequent drafts. Made an intellectual contribution to the review and approved the final review prior to submission. Will be responsible for future updates of this review.

Heather Cleland: designed the review. Completed the first draft of the review and advised on subsequent drafts. Made an intellectual contribution to the review and approved the final review prior to submission. Performed previous work that was the foundation of the current review.

Patrick Mahar: extracted data and checked quality of data extraction. Made an intellectual contribution to the review and approved the final review prior to submission.

Siobhan McGuiness: extracted data and checked quality of data extraction. Made an intellectual contribution to the review and approved the final review prior to submission.

Stefan Danilla: provided burns expertise and content to the review. Checked quality of data extraction and approved the final review prior to submission.

For the first version of this review in 2007:

JW: principal author, conception, guarantor of the review, responsible for updating future version of this review.

HC: co-author, burn surgeon, content expert.

DECLARATIONS OF INTEREST

Mr Jason Wasiak and Miss Heather Cleland were co-authors of the included study evaluated in this review article (Wasiak 2011).

INDEX TERMS

Medical Subject Headings (MeSH)

Analgesia [methods]; Anesthetics, Intravenous [*administration & dosage]; Anesthetics, Local [*administration & dosage]; Burns [*complications; therapy]; Lidocaine [*administration & dosage]; Pain [*drug therapy; etiology]; Pain Management [methods]; Randomized Controlled Trials as Topic

MeSH check words

Humans