

Clinical and Medicolegal Profile of Burn Injury Cases Reported to a Tertiary Care Hospital: A Hospital-Based Observational Cross-Sectional Study.

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Abstract

Background:

Burn injuries remain a major clinical and medicolegal problem because they produce acute morbidity, disfigurement, disability, psychological distress, and preventable mortality. The pattern of burns varies with age, sex, occupation, domestic environment, source of flame, and intent of injury.

Objectives:

To assess the clinical and medicolegal profile of burn injury cases reported to a tertiary care hospital and to describe their severity, manner of injury, documentation pattern, and hospital outcome.

Methods:

This hospital-based observational cross-sectional study was conducted at Government Medical College, Mahbubnagar, Telangana, India, from January 2025 to December 2025. A total of 100 eligible burn injury cases were included. Sociodemographic variables, type and source of burn, place of occurrence, total body surface area involvement, depth of burn, inhalational injury, wound infection, surgical intervention, medicolegal details, dying declaration status, alleged dowry-related history, and final outcome were recorded. Data were analysed using descriptive statistics.

Results:

The mean age was 32.6 ± 14.8 years, and participants aged 21-30 years constituted 34.0% of the sample. Females represented 58.0% and homemakers 38.0% of cases. Flame burns accounted for 72.0%; 76.0% occurred at home, and the stove or gas flame was the source in 44.0%. Burns exceeding 40% of total body surface area were present in 44.0%, deep partial-thickness burns in 46.0%, inhalational injury in 20.0%, wound infection in 26.0%, and surgical intervention in 32.0%. Accidental, suicidal, and alleged homicidal burns comprised 76.0%, 18.0%, and 6.0%, respectively. The mortality rate was 24.0%.

Conclusion:

Burn injuries in this setting predominantly affected young adults and females, with domestic flame burns forming the major clinical pattern. Accidental burns were the leading medicolegal category, while extensive burns and complications contributed to poor outcomes.

Recommendations:

Strengthening domestic burn prevention, early referral, structured burn documentation, and medicolegal training can improve both patient care and legal clarity.

Keywords: burn injury; flame burns; total body surface area; medicolegal case; dying declaration.

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Introduction

Burn injury is a complex form of trauma that affects the skin, deeper tissues, respiratory system, metabolic balance, and social functioning of the patient. It is also one of the most preventable causes of injury-related morbidity and mortality. Global reviews show that burn epidemiology is influenced by socioeconomic conditions, domestic fuel practices, occupational exposure, age, sex, and regional safety standards [1-3]. In low- and middle-income settings, burns frequently occur in domestic environments, where cooking-related flame exposure, hot liquids, unsafe appliances, and delayed first aid continue to produce severe injuries.

The clinical burden of burn injury is determined by the extent of total body surface area involved, depth of tissue damage, anatomical site, inhalational injury, coexisting disease, infection, and timeliness of resuscitation [4-7]. Deep partial-thickness and full-thickness burns need careful wound care, fluid management, infection surveillance, analgesia, nutritional support, surgical intervention, and rehabilitation. Inhalational injury and burn wound infection are important determinants of adverse outcome because they add respiratory compromise, sepsis risk, prolonged hospitalization, and higher mortality [11,13].

In India, burns have a distinct public health and sociocultural profile. Hospital-based studies from South India have reported that flame burns, domestic occurrences, and young adult involvement form a large share of admitted burn cases [8]. Intentional burns require special attention because they overlap with mental health distress, domestic conflict, alleged assault, and gender-related vulnerability [2,9]. Therefore, burn evaluation in Indian hospitals extends beyond clinical stabilization and includes medicolegal registration, accurate history recording, police intimation, preservation of evidence, documentation of the manner of injury, and assessment of the need for a dying declaration. Medicolegal documentation is particularly important in burn cases because the history can change during treatment, patients with extensive burns can deteriorate rapidly, and the manner of injury has legal consequences. Accidental, suicidal, and homicidal burns need a structured evaluation of scene history, source of burn, body region involved, delay in presentation, statements by patient or relatives, and associated allegations. Fatal burn cases also require careful interpretation because septicemia, inhalational injury, and multiorgan dysfunction have been described as major contributors to mortality in autopsy-based and clinical burn literature [12,14].

The present study was conducted with the objective of assessing the clinical and medicolegal profile of burn injury cases reported to Government Medical College, Mahbubnagar, Telangana, India. The specific objectives were to describe the sociodemographic characteristics of

burn victims, identify the type, source, place, extent, and depth of burns, document the medicolegal manner of injury and related legal procedures, and assess the final hospital outcome among 100 burn injury cases.

Methodology

Study design and setting:

This hospital-based descriptive observational cross-sectional study was conducted at Government Medical College, Mahbubnagar, Telangana, India. The college is attached to an approximately 300-bed government tertiary-care teaching hospital that provides 24-hour emergency and trauma care, general medicine, general surgery, orthopaedics, obstetrics and gynaecology, paediatrics, anaesthesiology, intensive care, laboratory and radiological diagnostics, and forensic and medicolegal services. The hospital receives direct and referred patients from the Mahbubnagar district and the surrounding rural and semi-urban areas of southern Telangana. Burn cases are initially managed through the emergency department and relevant surgical services, with forensic medicine support for medicolegal registration, police intimation, injury documentation, and dying-declaration procedures when indicated.

Study period and study population

The study was carried out from January 2025 to December 2025. A total of 100 burn injury cases reported to the hospital during the study period and satisfying the eligibility criteria were included in the final analysis. Consecutive eligible cases were considered until the required sample size of 100 cases was obtained. Both male and female patients of all age groups with thermal, scald, electrical, or chemical burns were included.

Inclusion and exclusion criteria

All patients with clinically documented burn injury and available hospital records were included. Cases were included irrespective of whether the injury was accidental, suicidal, or alleged homicidal. Patients with incomplete key records, postmortem burns without hospital admission, old healed burn scars without acute injury, and cases brought dead without adequate clinical or medicolegal details were excluded from analysis.

Data collection procedure

Data were collected using a predesigned case record form. Sociodemographic variables included age, sex, marital status, and occupation. Clinical variables included type of burn, place of occurrence, source of burn, anatomical region involved, total body surface area, depth of burn, inhalational

injury, wound infection, and requirement of surgical intervention. Burn depth and clinical severity were classified from treating-unit documentation and standard burn assessment principles [4-7].

Medicolegal variables

Medicolegal case registration status, police intimation, source of history, manner of injury, dying declaration status, and alleged dowry-related history were recorded from medicolegal case sheets, casualty records, inpatient files, and police intimation documentation. The manner of burn injury was categorized as accidental, suicidal, or homicidal/alleged assault based on the recorded history and medicolegal documentation. A dying declaration was considered advised or recorded when it was documented by the treating physician or competent authority.

Outcome assessment

The final hospital outcome was classified as improved and discharged, referred to a higher centre, left against medical advice, or death. Wound infection was recorded when clinical documentation supported infection during hospital stay. Inhalational injury was recorded when there was clinical suspicion or documentation of facial burns, soot exposure, respiratory symptoms, airway involvement, or related treatment.

Statistical analysis

Data were entered into a spreadsheet and analysed using descriptive statistics. Continuous variables were summarized as mean and standard deviation. Categorical variables were presented as frequency and percentage. Since the objective was descriptive profiling, no inferential comparison was performed. The findings are presented in text and tables with appropriate denominators.

Ethical considerations

The study was conducted after approval from the Institutional Ethics Committee, Government Medical College, Mahbubnagar, Telangana, India. Patient identifiers were removed during analysis. Data confidentiality was maintained. The study involved record-based descriptive analysis and did not interfere with patient management or medicolegal procedures.

Results

Participant flow

One hundred consecutive eligible burn injury cases were enrolled. No enrolled case was excluded because of missing key clinical, medicolegal, or outcome information; all 100 cases were therefore included in the final analysis (Figure 1).

Participant Flow

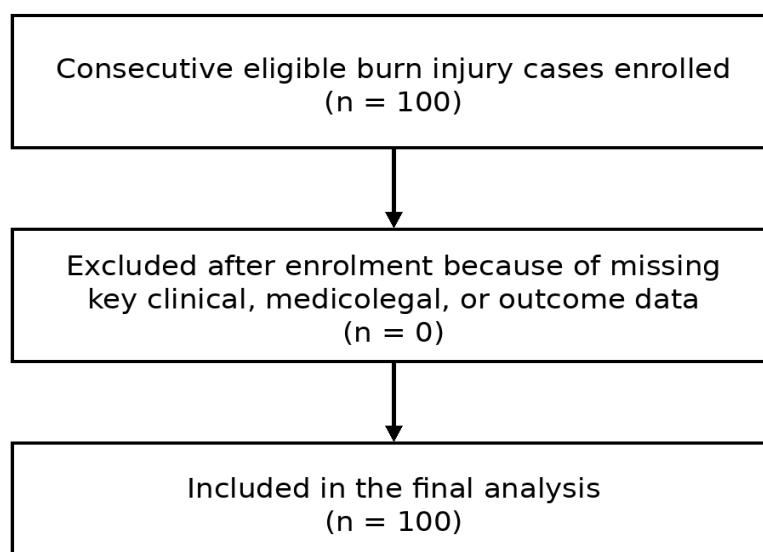


Figure 1. Participant flow through the study.

All 100 consecutive eligible burn injury cases enrolled during the study period had complete key clinical, medicolegal, and outcome information and were included in the final analysis. The mean age was 32.6 ± 14.8 years. The 21-30-year age group comprised 34 (34.0%) cases, followed

by the 31-40-year group with 24 (24.0%). Females accounted for 58 (58.0%) cases, 66 (66.0%) participants were married, and homemakers formed the largest occupational group with 38 (38.0%) cases (Table 1).

Table 1 *Sociodemographic Profile of Burn Injury Cases*

Variable	Category	n	%
Age group	≤10 years	6	6.0
	11-20 years	12	12.0
	21-30 years	34	34.0
	31-40 years	24	24.0
	41-50 years	14	14.0
	>50 years	10	10.0
Sex	Male	42	42.0
	Female	58	58.0
Marital status	Married	66	66.0
	Unmarried	34	34.0
Occupation	Homemaker	38	38.0
	Labourer	22	22.0
	Student	14	14.0
	Farmer	10	10.0
	Skilled worker	8	8.0
	Others	8	8.0

Flame burns were the predominant injury type, occurring in 72 (72.0%) cases. The home was the place of occurrence in 76 (76.0%) cases, and stove or gas flame was the leading source in 44 (44.0%), followed by kerosene flame in 18

(18.0%) and hot liquids in 16 (16.0%). Upper-limb and trunk involvement was documented in 64 (64.0%) and 58 (58.0%) cases, respectively; more than one body region could be affected in the same patient (Table 2).

Table 2 *Clinical Profile and Pattern of Burn Injuries*

Variable	Category	n	%
Type of burn	Flame burn	72	72.0
	Scald burn	16	16.0
	Electrical burn	8	8.0
	Chemical burn	4	4.0
Place of occurrence	Home	76	76.0
	Workplace	14	14.0
	Outdoor/public place	6	6.0
	Others	4	4.0
Source of burn	Stove/gas flame	44	44.0
	Kerosene flame	18	18.0
	Hot liquid	16	16.0
	Electrical contact	8	8.0
	Chemical exposure	4	4.0
	Other flame sources	10	10.0
Body region involved*	Upper limb	64	64.0
	Trunk	58	58.0
	Lower limb	46	46.0
	Head, face, and neck	34	34.0
	Perineum/genital region	8	8.0

Note. Multiple body regions were involved in some cases; therefore, percentages exceed 100%.

Burns involving less than 20% of total body surface area were recorded in 30 (30.0%) patients, whereas 44 (44.0%) had involvement exceeding 40%, including 18 (18.0%) with more than 60% involvement. Deep partial-thickness burns were present in 46 (46.0%) cases and full-thickness burns in

30 (30.0%). Inhalational injury was suspected in 20 (20.0%), wound infection was documented in 26 (26.0%), and surgical intervention was required in 32 (32.0%) cases (Table 3).

Table 3: Severity and Hospital Course of Burn Injury Cases

Variable	Category	n	%
Total body surface area involved	<20%	30	30.0
	21-40%	26	26.0
	41-60%	26	26.0
	>60%	18	18.0
Depth of burn	Superficial partial thickness	24	24.0
	Deep partial thickness	46	46.0
	Full thickness	30	30.0
Inhalational injury	Present	20	20.0
	Absent	80	80.0
Wound infection	Present	26	26.0
	Absent	74	74.0
Surgical intervention	Required	32	32.0
	Not required	68	68.0

Accidental burns constituted 76 (76.0%) cases, suicidal burns 18 (18.0%), and homicidal or alleged assault-related burns 6 (6.0%). All 100 cases were registered as medicolegal cases and communicated to the police. A dying declaration was advised or recorded in 28 (28.0%) cases,

and an alleged dowry-related history was documented in 8 (8.0%). Sixty-eight (68.0%) patients improved and were discharged, 4 (4.0%) were referred, 4 (4.0%) left against medical advice, and 24 (24.0%) died (Table 4).

Table 4: Medicolegal Profile and Outcomes of Burn Injury Cases

Variable	Category	n	%
Manner of burn injury	Accidental	76	76.0
	Suicidal	18	18.0
	Homicidal/alleged assault	6	6.0
Medicolegal case registration	Registered	100	100.0
Police intimation	Given	100	100.0
History given by	Patient	72	72.0
	Relatives	24	24.0
	Police/others	4	4.0
Dying declaration advised/recorded	Yes	28	28.0
	No	72	72.0
Alleged dowry-related history	Present	8	8.0
	Absent/not reported	92	92.0
Final outcome	Improved and discharged	68	68.0
	Referred to the higher centre	4	4.0
	Left against medical advice	4	4.0
	Death	24	24.0

In summary, young adults and females formed the largest affected groups. Domestic flame burns were the dominant clinical pattern, accidental injury was the principal

medicolegal classification, and mortality occurred in nearly one-quarter of the study population.

Discussion

The principal findings were a concentration of burns among young adults and women, with the 21-30-year age group contributing 34.0%, females 58.0%, and homemakers 38.0% of cases. Flame burns accounted for 72.0%, 76.0% occurred at home, and stove or gas flames caused 44.0%. Clinically important severity indicators included total body surface area involvement above 40% in 44.0%, deep partial-thickness burns in 46.0%, full-thickness burns in 30.0%, inhalational injury in 20.0%, wound infection in 26.0%, and a requirement for surgery in 32.0%. Accidental burns comprised 76.0%, while suicidal and alleged homicidal burns together represented 24.0%. The in-hospital mortality rate was 24.0%.

The predominance of the 21-30-year age group indicates that burn injuries disproportionately affected people in an economically and socially active period of life. Female predominance and the large proportion of homemakers suggest sustained exposure to cooking appliances, open flames, hot liquids, loose clothing, and poorly ventilated domestic environments. Kumar et al. reported a closely comparable mean age of 32.11 years and a female-predominant male-to-female ratio of 0.83:1 among patients admitted to a tertiary burn centre in coastal South India [8]. The agreement supports a recurrent regional pattern, although differences in referral systems, household fuels, and admission thresholds may influence the magnitude of female predominance.

The dominance of flame burns (72.0%) and domestic occurrence (76.0%) reinforces the home as the principal setting for prevention. Kumar et al. observed flame burns in 82.2%, home occurrence in 80.2%, and accidental manner in 79.2% of their cases [8]. Farooq et al. likewise reported that 79.2% of burn injuries occurred at home in Rawalpindi [10]. The slightly lower flame-burn proportion in the present study may reflect the inclusion of scald, electrical, and chemical injuries, while the similar household proportions indicate shared risks related to cooking, fuel handling, appliance maintenance, and delayed first aid.

The severity findings require cautious interpretation. Forty-four percent of patients had burns involving more than 40% of total body surface area, and 76.0% had either deep partial-thickness or full-thickness burns. These patterns imply substantial fluid requirements, delayed epithelialisation, greater grafting need, and higher susceptibility to infection and systemic complications [4-7]. Inhalational injury was suspected in 20.0% and wound infection was documented in 26.0%; both complications are recognised contributors to respiratory failure, sepsis, prolonged hospitalisation, and death [11-14]. The observed mortality of 24.0% is therefore clinically plausible in a tertiary referral population

containing extensive and deep burns. However, because the analysis was descriptive and did not perform stratified or multivariable testing, the study cannot quantify the independent effect of each severity factor on mortality.

From a medicolegal perspective, accidental burns were most frequent (76.0%), but intentional injuries were not uncommon: suicidal burns constituted 18.0% and alleged homicidal or assault-related burns 6.0%. Natarajan highlighted that intentional burns in India have distinct gender, domestic-conflict, and prevention implications [9]. The finding that dying declarations were advised or recorded in 28.0% demonstrates the need for early assessment of consciousness and fitness to give a statement, because clinical deterioration may occur rapidly. Alleged dowry-related history in 8.0% should not be interpreted as a confirmed legal cause; rather, it indicates cases requiring neutral documentation, police investigation, and preservation of the patient's own account.

Taken together, the findings favour a combined clinical and public-health response. Household prevention should focus on safe gas connections, stove maintenance, flame-resistant clothing practices, secure kerosene storage, supervision of children, and immediate cooling with running water. Within hospitals, standardised burn charts, early airway assessment, infection surveillance, timely surgical referral, and structured medicolegal documentation may improve both clinical continuity and legal clarity.

Generalizability

The findings are most applicable to government tertiary-care hospitals in Telangana and neighbouring regions that receive a mixture of rural and semi-urban burn referrals and follow similar medicolegal procedures. Generalisation to dedicated burn institutes, private hospitals, primary-care facilities, and community populations should be cautious because case severity, referral pathways, access to surgical care, and documentation practices may differ. The study nevertheless provides locally relevant evidence for domestic prevention, emergency burn management, and medicolegal preparedness.

Conclusion

This hospital-based observational cross-sectional study of 100 burn injury cases showed that young adults, females, and homemakers formed prominent affected groups. Flame burns (72.0%) and home-based injuries (76.0%) predominated, with stove or gas flames accounting for 44.0%. Clinically severe features included burns involving more than 40% total body surface area in 44.0%, deep partial-thickness or full-thickness injury in 76.0%, inhalational injury in 20.0%, and wound infection in 26.0%. Accidental burns accounted for 76.0%, while intentional or

alleged assault-related burns comprised 24.0%. The mortality rate of 24.0% underscores the need for household prevention, early referral, structured burn care, and complete medicolegal documentation.

TBSA: Total body surface area

Conflict of Interest

The authors declare no conflict of interest.

Source of funding

The study had no funding.

Author contributions

MG—Conceptualisation, study design, data interpretation, literature review, and preparation of the first draft. SS—Study design, supervision, medicolegal interpretation, statistical interpretation, and critical revision of the manuscript. MA—Literature review, data interpretation, draft preparation, and critical revision. All authors approved the final manuscript and accept accountability for the work.

Data availability

Data available on request

Author Biographies

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Limitations

This study was limited by its single-centre design and sample size of 100 cases. The analysis depended on hospital and medicolegal records, so undocumented social, scene-related, and prehospital factors could not be evaluated. The total number of burn cases screened before the target of 100 eligible cases was reached was not separately documented in the source register. Long-term scarring, functional disability, psychological morbidity, rehabilitation, and microbiological correlates of wound infection were not assessed. Referral bias is also possible because patients with extensive or complicated burns may be overrepresented in a tertiary-care hospital.

Recommendations

Domestic burn prevention should be strengthened through community education on safe cooking, safe gas handling, kerosene storage, child supervision, and first aid. Hospital burn protocols should include early triage, rapid fluid resuscitation, pain control, inhalational injury screening, infection surveillance, and timely surgical referral. Medicolegal documentation should be standardized using structured forms for history, manner of injury, police intimation, dying declaration, and alleged dowry-related information. Regular training of casualty medical officers, surgeons, forensic medicine specialists, nursing staff, and interns can improve clinical care and legal accuracy. Public health programmes should focus on household safety, early referral, and timely care.

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Abbreviations

ABA: American Burn Association

GMC: Government Medical College

LAMA: Left against medical advice

MLC: Medicolegal case

SD: Standard deviation

SJHRA: South Journal of Health Research and Applications

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