International Journal of Research in Medical Sciences
Islam SF et al. Int J Res Med Sci. 2026 Dec;14(12):5632-5637
www.msjonline.org
pISSN 2320-6071 | eISSN 2320-6012
DOI: https://dx.doi.org/10.18203/2320-6012.ijrms20264462

Original Research Article

Epidemiological attributes of burn injuries among patients admitted to a tertiary burn hospital in Dhaka, Bangladesh

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Received: 04 October 2026
Accepted: 06 November 2026

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ABSTRACT

Background: Burn injuries remain an important cause of morbidity in Bangladesh, but contemporary hospital-based epidemiological data are limited. This study described the epidemiological characteristics of burn injuries among patients admitted to a tertiary burn hospital in Dhaka.
Methods: A descriptive cross-sectional study was conducted at the National Institute of Burn and Plastic Surgery, Dhaka, from January to December 2025. A total of 250 admitted burn patients were selected by non-probability convenience sampling. Sociodemographic characteristics, injury circumstances, burn depth and type, hospital stay, and surgical requirements were recorded. Frequencies and percentages summarized categorical variables, and Pearson's chi-square test assessed associations between burn depth and sex and residence.
Results: The mean age was 23.53±17.22 years; 107 (42.8%) patients were aged 1–15 years. Males comprised 153 (61.2%), and 193 (77.2%) had monthly family income ≤BDT 20,000. Cylinder gas explosions accounted for 100 (40.0%) cases and wood fires for 93 (37.2%); the kitchen was the commonest injury site (95, 38.0%), and 218 (87.2%) injuries were accidental. Superficial partial-thickness, deep partial-thickness, and full-thickness burns occurred in 82 (32.8%), 66 (26.4%), and 70 (28.0%) patients, respectively. Electrical burns accounted for 67 (26.8%) and scalds for 66 (26.4%). Hospitalization for 1–3 months occurred in 127 (50.8%), and 175 (70.0%) required surgery. Burn depth was significantly associated with sex, χ^2 (3) =23.063, p<.001, and residence, χ^2 (3) =16.669, p=0.001.
Conclusions: Burn admissions predominantly involved young males and were frequently accidental, domestic, gas-related, electrical, or scald injuries. The substantial burden of deep burns, prolonged hospitalization, and surgical treatment highlights significant clinical morbidity.

Keywords: Burn injury, Burn epidemiology, Burn depth, Tertiary hospital

INTRODUCTION

Burn injuries remain an important cause of preventable morbidity, disability, and death worldwide, with the burden distributed unevenly across countries and health systems. In a Global Burden of Disease 2019 analysis by Yakupu et al, approximately 8.38 million new burn cases and 111,292 deaths were estimated globally in 2019, while nearly 7.46 million disability-adjusted life-years were attributed to burns.[1] Although age-standardized rates of burn incidence, disability, and mortality were found to be declining in many regions, the absolute number of incident cases showed an increasing tendency. These patterns remain particularly important in low- and middle-income countries, where burn prevention, surveillance, referral systems, and access to specialized care are often limited.

In a multicountry survey by Quinn et al., substantial differences in burn mechanisms, settings, and outcomes were observed across eight burn centers in Africa, Asia, and Latin America, indicating that locally generated epidemiological data are necessary for planning prevention and treatment services.[2] Within Bangladesh, a considerable burden has been reported across both community and hospital settings. In a population-based study from rural Bangladesh by He et al., burn morbidity and mortality rates were found 528 and approximately 2 per 100,000 population, respectively.[3] More than half of the injuries occurred among adults aged 25–64 years, females had a higher burn rate, most injuries occurred in kitchens, and flame was responsible for 88% of burns. Among children, a more recent national survey by Abedin et al reported an annual incidence of 866.7 non-fatal burns per 100,000 children, with the highest incidence, 2,028.3 per 100,000, observed among children aged 1–4 years.[4] Hot liquids, flames, and hot objects accounted for 44.7%, 32.5%, and 20.7% of childhood burns respectively, while 60.9% occurred in kitchens. Moreover, electrical injury has long been an important component of the Bangladesh burn profile. In a nationally representative survey by Mashreky et al (2011), approximately 31% of 1,999 recorded burn injuries were electrical.[5] Hospital-based evidence has further shown that the epidemiological pattern of severe burns in Bangladesh is changing. In the Dhaka component of the repeated cross-sectional survey by Quinn et al, 4,139 burn admissions were recorded in 2014 and 5,084 in 2019.[2] Males comprised 61% and 65% of admissions respectively, while flame, hot-liquid, and electrical burns remained prominent. Among flame burns, a marked shift was observed from solid fuel, which accounted for 77% in 2014, to liquefied petroleum gas, which accounted for 74% in 2019. Besides, the development of the South Asia Burn Registry was reported by Zia et al to address deficiencies in standardized burn surveillance across Bangladesh and Pakistan.[6] Gaps in community and referral care have also been documented. In rural Bangladesh, inappropriate first-aid practices and poor knowledge of referral pathways were reported by Biswas et al., while shortages of trained personnel, dedicated burn facilities, medicines, and referral capacity were identified at district and sub-district facilities by Biswas et al.[7,8] Across South Asia, variation has also been observed in burn mechanism, severity, hospitalization, and injury intent. In a review from Nepal by Tripathee and Basnet, flame burns were generally the most common mechanism among adults, whereas scalds predominated among children, and reported hospital stays ranged from 13 to 60 days.[9] In a tertiary hospital study from eastern India by Roy et al, most burns were accidental, thermal, and household-related.[10] Furthermore, in a South Asian scoping review by Bebbington et al, considerable heterogeneity was identified in the terminology and methods used to classify burn intent, and explicit methods for determining intent were described in only 17% of included studies.[11] These findings indicate that contemporary hospital-based descriptions should report burn mechanisms, depth, location, intent, and sociodemographic characteristics using clearly defined categories. Accordingly, the present study was conducted to describe the epidemiological attributes of burn injuries among patients admitted to a tertiary burn hospital in Dhaka, Bangladesh, including sociodemographic characteristics, circumstances and mechanisms of injury, burn depth, injury intent, hospital stay, surgical requirement, and the distribution of burn depth according to sex and place of residence.

METHODS

This descriptive cross-sectional study was conducted in the Inpatient Department of the National Institute of Burn and Plastic Surgery, Dhaka, Bangladesh, from January to December 2025. The study included 250 patients admitted with burn injuries who were selected using a non-probability convenience sampling technique. Patients of all age groups except infants were eligible for inclusion, provided that they or their legal guardians consented to participate; pregnant women were excluded. Data were collected through face-to-face interviews with patients and/or their close relatives using a pretested semi-structured questionnaire, supplemented by review of relevant medical records using a structured checklist. Information was obtained on sociodemographic characteristics, source and site of the burn incident, burn depth, motive of injury, type of burn, duration of hospitalization, and requirement for surgery. Total body surface area was assessed using the Lund–Browder chart, while burn depth was categorized as superficial or first-degree, superficial partial-thickness or second-degree, deep partial-thickness or second-degree, and full-thickness or third-degree burn. Data were coded, cleaned, and analyzed using the Statistical Package for the Social Sciences (SPSS). Continuous variables were summarized using means and standard deviations where available, while categorical variables were presented as frequencies and percentages. Pearson's chi-square test was used to examine the associations of burn depth category with sex and place of residence, with a p value < 0.05 considered statistically significant. Ethical approval was obtained from the Ethical Review Committee of the Bangladesh University of Health Sciences, and permission was obtained from the study hospital. Written informed consent was obtained from participants or their legal guardians, and confidentiality and voluntary participation were maintained throughout the study.

RESULTS

Among the participants, 107 (42.8%) were aged 1–15 years, followed by 60 (24.0%) aged 16–30 years, with a mean age of 23.53±17.22 years. Overall, males accounted for 61.2% of the sample. Regarding socioeconomic characteristics, 72.0% had either no schooling or education below the secondary level, while 77.2% belonged to households with monthly family incomes of BDT 20,000 or less. Slightly more than half, 53.2%, resided in urban areas, and 77.2% lived in households comprising four to six members (Table 1).

Table 1: Socio-demographic characteristics of the study participants, n=250.

Variables	N (%) or value
Age (years)	
1–15	107 (42.8)
16–30	60 (24.0)
31–45	51 (20.4)
46–55	32 (12.8)
Mean±SD	23.53±17.22
Range	1–55
Sex	
Male	153 (61.2)
Female	97 (38.8)
Religion	
Islam	213 (85.2)
Hinduism	33 (13.2)
Christianity	4 (1.6)
Place of residence	
Urban	133 (53.2)
Rural	117 (46.8)
Family size, persons	
1–3	41 (16.4)
4–6	193 (77.2)
7–10	16 (6.4)
Mean ± SD	4.60 ± 1.34
Educational status	
No schooling	80 (32.0)
Below secondary	100 (40.0)
Higher secondary	29 (11.6)
Graduate and above	41 (16.4)
Monthly family income, BDT	
≤20,000	193 (77.2)
20,001–40,000	35 (14.0)
40,001–60,000	22 (8.8)
Mean	13,272

BDT=Bangladeshi Taka; SD=standard deviation.

Table 2: Circumstances and reported sources of burn injuries among the study participants, n=250.

Variables	N (%)
Source of fire	
Cylinder gas explosion	100 (40.0)
Wood fire	93 (37.2)
Pump stove explosion	26 (10.4)
Kerosene	19 (7.6)
Petrol or diesel explosion	12 (4.8)
Site of incident	
Kitchen	95 (38.0)
Courtyard	64 (25.6)
Workplace	35 (14.0)
Motive of burn	
Accidental	218 (87.2)
Self-inflicted	18 (7.2)

Regarding the reported source of fire, cylinder gas explosions accounted for the largest proportion of injuries, 40.0%, followed closely by wood fires, 37.2%. Concerning the location of the incident, kitchens accounted for 38.0% of cases and courtyards for 25.6%, whereas workplaces accounted for 14.0%. By motive, 218 (87.2%) injuries were reported as accidental, while 7.2% were self-inflicted and 5.6% were politically motivated (Table 2).

Table 3: Burn characteristics, hospital stay, and surgical requirement among the study participants, n=250.

Variables	N (%)
Burn depth category	
Superficial or first-degree	32 (12.8)
Superficial partial-thickness or second-degree	82 (32.8)
Deep partial-thickness or second-degree	66 (26.4)
Full-thickness or third-degree	70 (28.0)
Type of burn injury	
Electrical burn	67 (26.8)*
Scald burn	66 (26.4)
Inhalation burn	53 (21.2)
Flame burn	36 (14.4)
Mechanical burn	14 (5.6)
Kitchen cylinder burn	10 (4.0)
Water burn/homicide, as reported	4 (1.6)
Length of hospital stay	
Short stay, measured in days†	109 (43.6)
1–3 months	127 (50.8)
>3 months	14 (5.6)
Short stay, measured in days†	109 (43.6)
Surgery required	
Yes	175 (70.0)
No	75 (30.0)

*Statistically significant.

Within the burn-depth categories, superficial partial-thickness second-degree burns constituted 32.8% of cases, followed by full-thickness third-degree burns at 28.0% and deep partial-thickness second-degree burns at 26.4%. Regarding the reported type of injury, electrical burns comprised 26.8%, scald burns 26.4%, and inhalation burns 21.2%. Concerning hospital utilization, 127 (50.8%) patients remained admitted for one to three months and 14 (5.6%) for more than three months; additionally, 175 (70.0%) patients required surgical intervention (Table 3).

Across male patients, full-thickness third-degree burns represented 37.3% of cases, compared with 13.4% among female patients. Conversely, superficial first-degree burns accounted for 21.6% of female cases and 7.2% of male cases. Overall, a statistically significant association was observed between sex and burn depth category, $\chi^2(3)=23.063$, $p<0.001$ (Table 4).

Table 4: Distribution of burn depth categories according to sex, n=250.

Burn depth category	Male, N (%)	Female, N (%)	Total, N (%)
Superficial or first-degree	11 (7.2)	21 (21.6)	32 (12.8)
Superficial partial-thickness or second-degree	49 (32.0)	33 (34.0)	82 (32.8)
Deep partial-thickness or second-degree	36 (23.5)	30 (30.9)	66 (26.4)
Full-thickness or third-degree	57 (37.3)	13 (13.4)	70 (28.0)
Total	153 (100.0)	97 (100.0)	250 (100.0)

Table 5: Distribution of burn depth categories according to place of residence, n=250.

Burn depth category	Urban, n (%)	Rural, n (%)	Total, n (%)
Superficial or first-degree	23 (17.3)	9 (7.7)	32 (12.8)
Superficial partial-thickness or second-degree	35 (26.3)	47 (40.2)	82 (32.8)
Deep partial-thickness or second-degree	28 (21.1)	38 (32.5)	66 (26.4)
Full-thickness or third-degree	47 (35.3)	23 (19.7)	70 (28.0)
Total	133 (100.0)	117 (100.0)	250 (100.0)

Among urban patients, full-thickness third-degree burns accounted for 35.3%, compared with 19.7% among rural patients. In contrast, superficial partial-thickness burns accounted for 40.2% of rural cases compared with 26.3% of urban cases, while deep partial-thickness burns accounted for 32.5% and 21.1%, respectively. Overall, burn depth category differed significantly according to place of residence, χ^2 (3) =16.669, p=0.001 (Table 5).

DISCUSSION

The present study showed that burn admissions at the tertiary burn hospital were characterized by a young patient population, male predominance, substantial socioeconomic disadvantage, frequent domestic exposure, and a high requirement for prolonged hospital care. Among 250 patients, 107 (42.8%) were aged 1–15 years, and the mean age was 23.53±17.22 years. A substantial pediatric contribution has also been reported elsewhere. In the Central China series by Han et al, pediatric patients constituted 43.9% of all burn admissions, while 54.9% of admissions were children in the tertiary referral study by Salendo et al.[12,13] In Bangladesh, the particular vulnerability of young children was demonstrated by Abedin et al, where the highest annual non-fatal burn incidence, 2,028.3 per 100,000, was found among children aged 1–4 years.[4] However, direct comparison of age proportions should remain cautious because pediatric age definitions differed across the studies. Male patients constituted 153 (61.2%) of the present cohort. A closely comparable male predominance was previously reported in Dhaka by Quinn et al, where males accounted for 61% of admissions in 2014 and 65% in 2019.[2] Male predominance was also reported by Akter et al, with 63.8% males among adult burn survivors attending the specialized burn institute in Dhaka, and by Li et al, where 66.8% of 6,325 burn patients were male.[14,15] However, population-based findings from Bangladesh have not consistently shown male predominance. In rural Bangladesh, 71% of non-fatal burn cases were found among females by He et al, while female children had a higher overall incidence than male children in the national survey reported by Abedin et al.[3,4] Thus, the current finding appears consistent with tertiary hospital admission patterns rather than necessarily indicating a higher population incidence among males. Socioeconomic disadvantage was also prominent. In total, 72.0% of patients had either no schooling or education below the secondary level, and 193 (77.2%) had a monthly family income of BDT 20,000 or less. A similar economic profile was observed by Akter et al, where 62.4% of participants reported a monthly family income of BDT 6,000–18,000.[14] Nevertheless, the present study did not include a non-burn comparison group, and low education or income cannot therefore be interpreted as independent risk factors. Residence was almost equally distributed, with 133 (53.2%) urban and 117 (46.8%) rural patients. This differed from the Dhaka data reported by Quinn et al, where 79% of admissions were classified as rural in 2019, and from the recent Dhaka survivor cohort of Akter et al, where 56.5% were rural.[2,14] Differences in sampling, referral patterns, age composition, and definitions of residence may have contributed to this variation. Cylinder gas explosion was the most frequently reported source of fire, accounting for 100 (40.0%) cases, followed by wood fire in 93 (37.2%). The importance of gas-related burns in Dhaka has been documented previously. Among flame burns, LPG accounted for 74% in 2019 compared with 10% in 2014 in the survey reported by Quinn et al.[2] However, that percentage was calculated only among flame burns and should not be directly compared with the present 40.0% proportion calculated across the entire study population. Gas explosions represented 12.1% of hospitalized burns in the Serbian series reported by

Stojanović et al, indicating considerable variation between settings.[16] The kitchen was the most frequent site of injury in the present study, accounting for 95 (38.0%) cases. Kitchen predominance was also observed in Bangladesh, with 60.9% of childhood burns occurring in kitchens in the study by Abedin et al, while approximately 78% of non-fatal rural burns occurred in kitchens in the study by He et al[3,4] A closely comparable proportion was found by Gupta et al, where kitchen burns represented approximately 37.1% of the total hospital cohort.[17] Most injuries were accidental, accounting for 218 (87.2%) patients. Accidental burns were also predominant in the South Indian study by Mahalingam et al, where 74.0% were accidental, while all 191 pediatric burns were reported as accidental in the North Indian study by Ali et al.[18,19] The present self-inflicted proportion of 7.2% was lower than the 24.0% reported by Mahalingam et al.[18] Comparisons of intentional injury should nevertheless be made carefully because the terminology and ascertainment of burn intent differ substantially between South Asian studies, as previously demonstrated by Bebbington et al.[11] Regarding burn depth, superficial partial-thickness burns were found in 82 (32.8%) patients, deep partial-thickness burns in 66 (26.4%), and full-thickness burns in 70 (28.0%). The proportion of full-thickness burns was higher than the 15.0% third-degree proportion reported by Mahalingam et al, but lower than the 40.1% reported by Li et al and the 40.6% reported by Salendo et al.[13,15,18] Thus, substantial variation in burn depth appears to exist across tertiary-care populations. Within the reported burn-type categories of the present study, electrical burns accounted for 26.8% and scalds for 26.4%. This pattern was broadly consistent with previous Dhaka data, where direct electrical and hot-liquid burns accounted for 33% and 32% respectively in 2019.[2] Electrical burns were also prominent in the recent Dhaka cohort reported by Akter et al, accounting for 37.6%.[14] A considerable requirement for prolonged treatment was observed. In total, 127 (50.8%) patients remained hospitalized for 1–3 months, 14 (5.6%) for more than 3 months, and 175 (70.0%) required surgery. Prolonged treatment was also reported by Akter et al, where 71.6% had a hospital stay of at least 1 month and 82.0% had undergone at least one surgical procedure.[14] However, that study included adult survivors at least four weeks after injury and should not be considered directly equivalent to an acute admission cohort. Internationally, shorter median hospital stays of 17 days were reported by Salendo et al and Li et al, while a median stay of 15 days and surgery in 39.4% were reported by Stojanović et al.[13,15,16] These differences indicate a substantial treatment burden in the current setting. Significant associations were found between burn depth and both sex and residence. Full-thickness burns occurred in 57 (37.3%) male patients compared with 13 (13.4%) female patients, and the association between sex and burn depth was significant, $\chi^2(3) = 23.063$, $p<.001$. A compatible pattern was reported by Li et al, where full-thickness burns were significantly more frequent among males and overall burn-severity indices were higher among men.[15] However, this association should not be interpreted as a direct effect of sex because differences in occupational, electrical, flame, or explosion exposures may contribute. Full-thickness burns were also more frequent among urban patients, 47 (35.3%), than rural patients, 23 (19.7%), with a significant association between residence and burn depth, $\chi^2(3)=16.669$, $p=0.001$. Comparable evidence for this direction is limited. In the study by Oprita et al, more severe burns were descriptively observed among rural patients, but no statistical testing of the residence difference was performed.[20] Therefore, the urban association with greater burn depth in the present study should be regarded as a distinctive finding requiring confirmation rather than as an established epidemiological pattern.

Limitations

This study was conducted at a single tertiary burn hospital using non-probability convenience sampling; therefore, the findings may not represent the overall epidemiology of burn injuries in Bangladesh. In addition, the cross-sectional design and available variables did not permit assessment of causal relationships, while factors such as total body surface area, occupational exposure, and detailed clinical outcomes were not included in the final analysis.

CONCLUSION

Burn injuries among patients admitted to this tertiary hospital in Dhaka were characterized by a substantial proportion of children and adolescents, male predominance, low educational and household-income profiles, and frequent domestic exposure. Cylinder gas explosions and wood fires were the leading reported sources of fire, the kitchen was the most common site of injury, and most burns were accidental. Electrical and scald burns were prominent, while more than one-quarter of patients had full-thickness burns. Prolonged hospitalization and surgical treatment were common, indicating a considerable treatment burden. Burn depth was significantly associated with both sex and place of residence, with full-thickness burns occurring more frequently among male and urban patients. These findings provide contemporary hospital-based information on the epidemiological characteristics of admitted burn patients and may support prevention strategies directed toward household fire safety, gas-cylinder safety, electrical hazards, and protection of high-risk groups.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee.

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Cite this article as: Islam SF, Nahar S, Rahman T, Nabi FN. Epidemiological attributes of burn injuries among patients admitted to a tertiary burn hospital in Dhaka, Bangladesh. Int J Res Med Sci 2026;14:5632-7.