Creative Reconstructive Solutions for Challenging Burn & Reconstructive Problems

Presented by:

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Medical Director

Burn and Reconstructive Center at Swedish Medical Center

Health ONE Burn and Reconstructive Center
At Swedish Medical Center

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Thank You

Health ONE
Burn and Reconstructive Center
At Swedish Medical Center

About our Burn Center

- **5** Double-Boarded Hand/Wrist, Plastic, Microvascular, Burn Surgeons
- **8** bed Burn Intensive Care/Stepdown Unit
- Expanded Outpatient Burn and Reconstructive Clinic
- **2** Dedicated Operating Rooms
- **ABA Verified 4/2022**
- **ABA Re-Verified 6/2025**

- **Dedicated**:
  - Specialty trained staff, Outpatient Hand Therapists, Occupational and Physical Therapists, Social Worker/Therapist, Neuropsychologist, Nutritionist, Research Coordinator, Quality Department

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Benson Pulikkottil, MD

- Regis High School, NYC
- B.A. / M.D. Combined
  - Siena College & Albany M.S.
    - Played tailback Division 1AA
- General Surgery
  - Rutgers Biomedical & H.S.
- Research
  - Face & Hand Transplant, UPMC
  - 1st Double Arm Transplant 2009 Team



Benson Pulikkottil, MD

- **Plastic Surgery**
  - **UT Southwestern, Dallas**
- **Hand & Microsurgery**
  - **University of Pittsburgh Med Ctr**
- **Advanced Microsurgical Visiting Fellow**
  - **Chang Gung Memorial Hospital, Taiwan**
- **Medical Director Burn & Reconstructive Center**
  - **Swedish Medical Center ~10 years**



Lily Daniali, MD

- **Grew up in S.E. Texas**
- **<u>B.A. Public Health Studies</u>**
  - **Johns Hopkins University**
- **<u>M.D.</u>**
  - **University of Washington SOM**
- **<u>Plastic Surgery</u>**
  - **Rutgers Biomedical & H.S.**
- **<u>Fellowship Training:</u>**
  - **Craniofacial fellowship, Dallas**
  - **Hand & Microsurgery fellowship, UTSW, Dallas.**



Ryan Endress, MD

- Grew up in Eureka, Kansas
- B.S. Biology
  - Pittsburgh State University
- M.D.
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  - Hand Surgery/Peripheral Nerve Mayo Clinic

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Wojciech H. Przylecki MD, FACS

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- **M.D.**
  - **Harvard-M.I.T. Health Sciences & Technology Program, Boston**
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- **Fellowship**
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Kunj Desai MD

- **M.D.**
  - **Kasturba Medical College Manipal**
- **Residency**
  - **Rutgers Health/New Jersey Medical School**
- **Fellowship**
  - **Hand & Upper ExtremityUniversity of Texas Health Science Center San Antonio**

National Burn Statistics

- 500,000 burns annually (**1 every 30 minutes**)
- Fire locations:
  - 66% home –10% work – 8% MVA – 16% other
- Gender:
  - 70% male, 30% female
- **Sepsis:** causes the greatest amount of inpatient deaths
- **CO Poisoning:** 75% of deaths at the scene

Mechanism of Burn Injury

Nationally:

- Fire/Flame: 40%
- Scald: 30%
- Contact: 8%
- Electrical: 4%
- Chemical: 3%
- Other: 15%

* Most common cause of burns
Adults – flame
Children - scald

Criteria for Injuries Requiring Transfer to the Burn Center



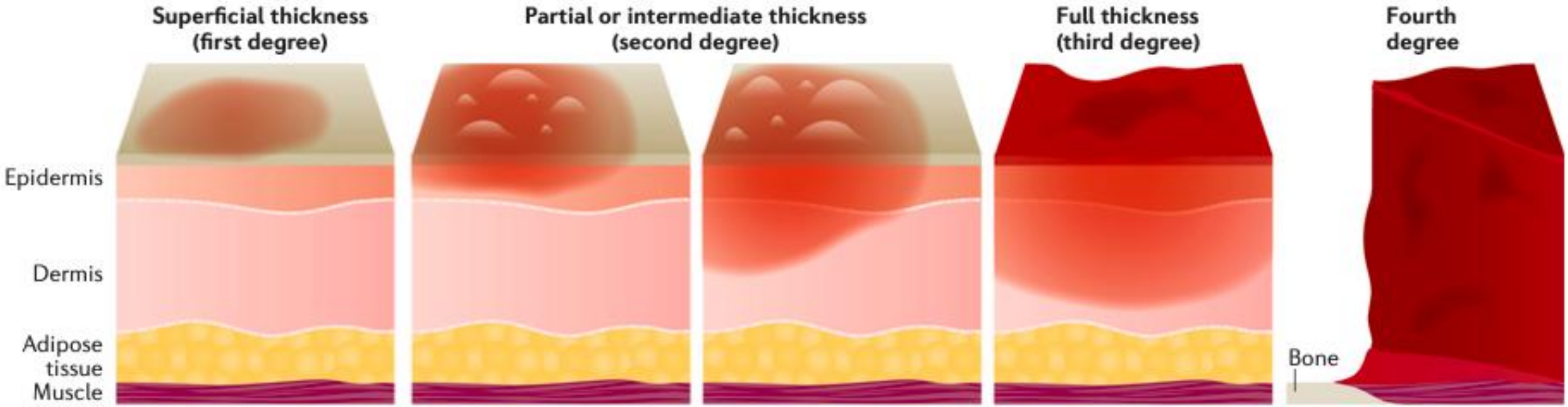
As established by the American Burn Association

Transfer Criteria

1. Partial thickness burn greater than or equal to 10% TBSA
2. Any burn involving the face, hands, feet, genitalia or major joint
3. Any third degree burn
4. Chemical burn injury
5. Electrical burn injury

Transfer Criteria

6. Inhalation injury
7. Burn injury in patients with pre-existing medical disorders
8. Burns involving concomitant trauma in which the burn injury poses the greater risk
9. Burned children in hospitals without qualified personnel or equipment for the care of children
10. Burn injury in patients who will require special social, emotional, or long-term rehab



- Painful
- Does not blister
- Does not scar

Superficial partial thickness burns do not require surgery, but may scar and be more painful

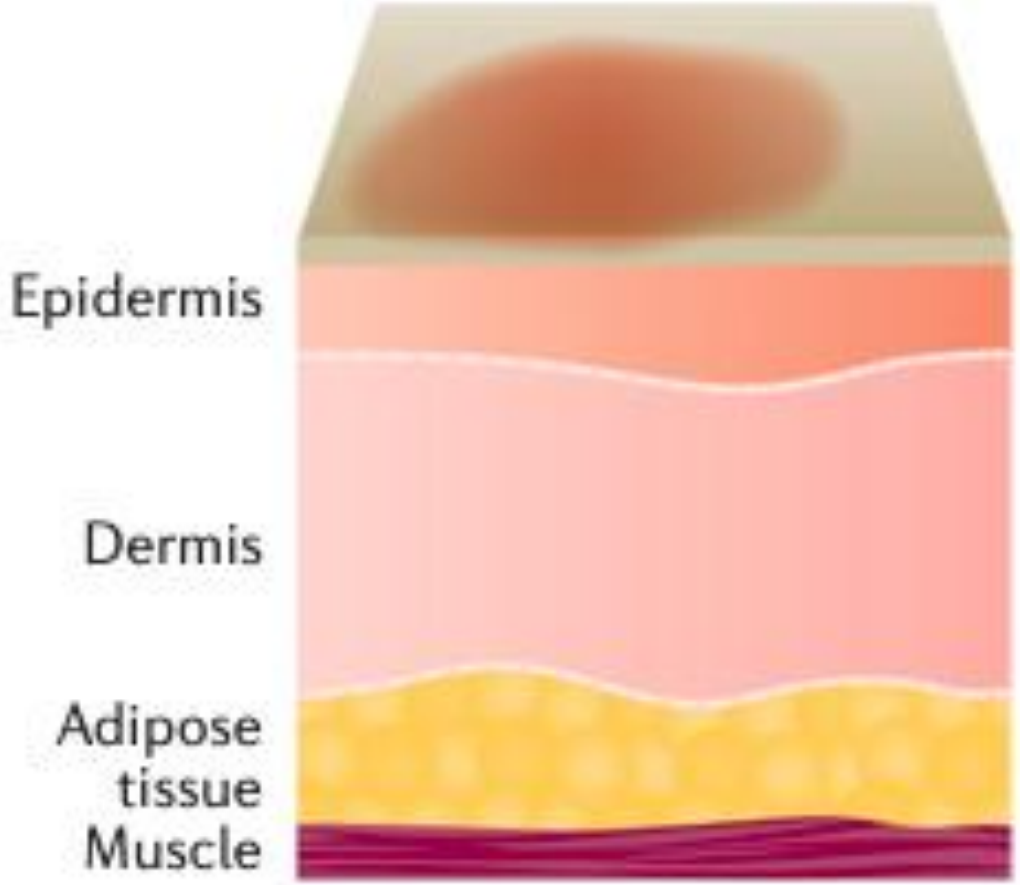
Deep partial thickness burns require surgery and form more scars and are less painful

- Blisters and weeps
- With increasing depth, increased risk of infection
- With increasing depth, increased risk of scarring

- Dry
- Insensate to light touch and pin prick
- Small areas will heal with substantial scar or contracture
- Large areas require skin grafting
- High risk of infection

- Involves muscle or bone
- Leads to loss of the burned part

First Degree (Superficial thickness)



-Painful

-Does not blister

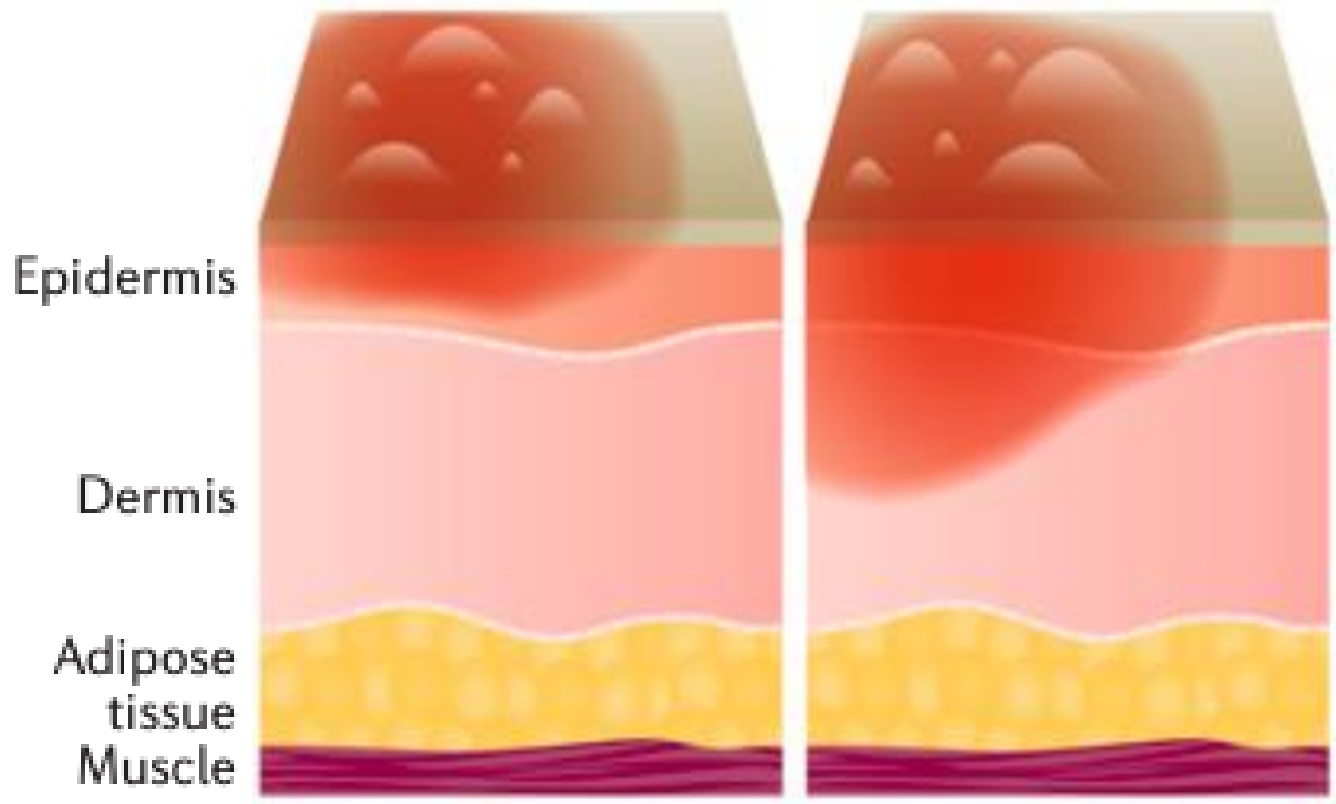
-Does not scar

-Heals in a few days

-Not included in TBSA



Second Degree (Partial or Intermediate thickness)



-<u>Superficial partial thickness</u> don't require surgery; can scar; more painful

-<u>Deep partial thickness</u> require surgery; form more scars; less painful

-Blister/weep; increased depth→increased infection and scarring

Second Degree (Partial Thickness) Burn

Superficial



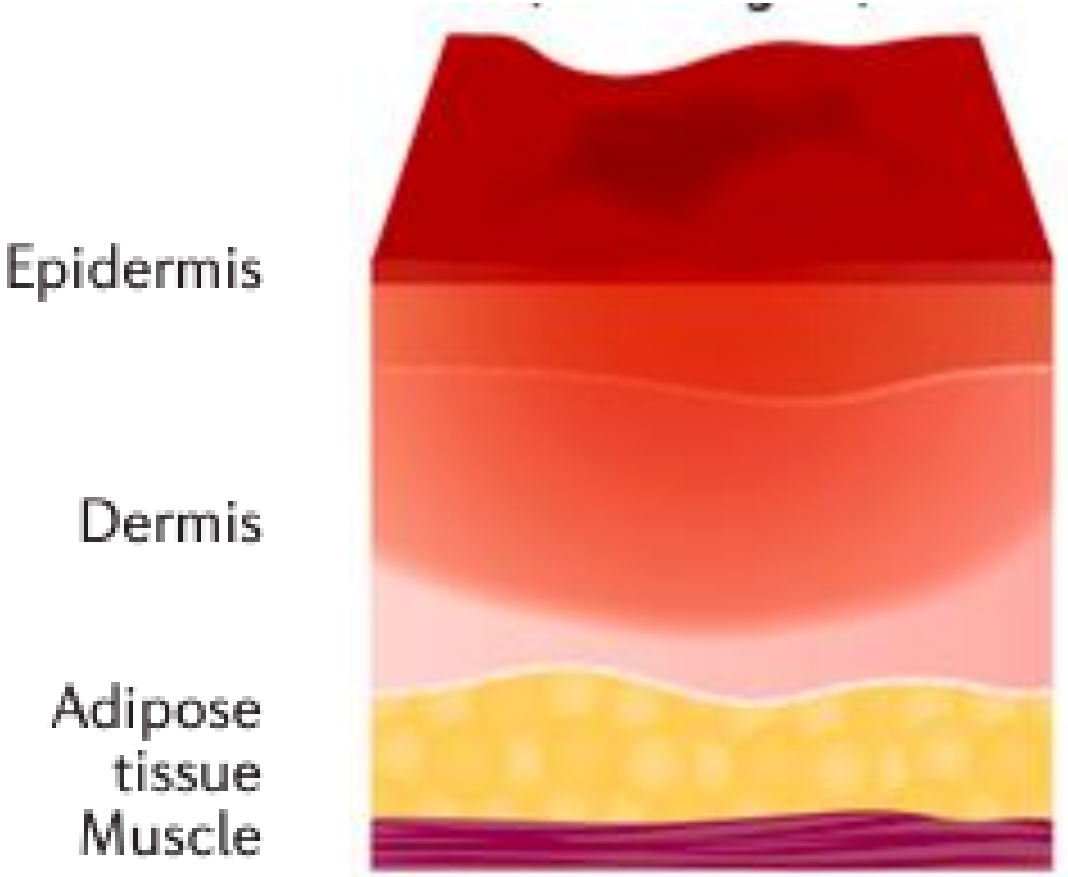
Superficial



Deep



Third Degree (Full thickness)



-Dry

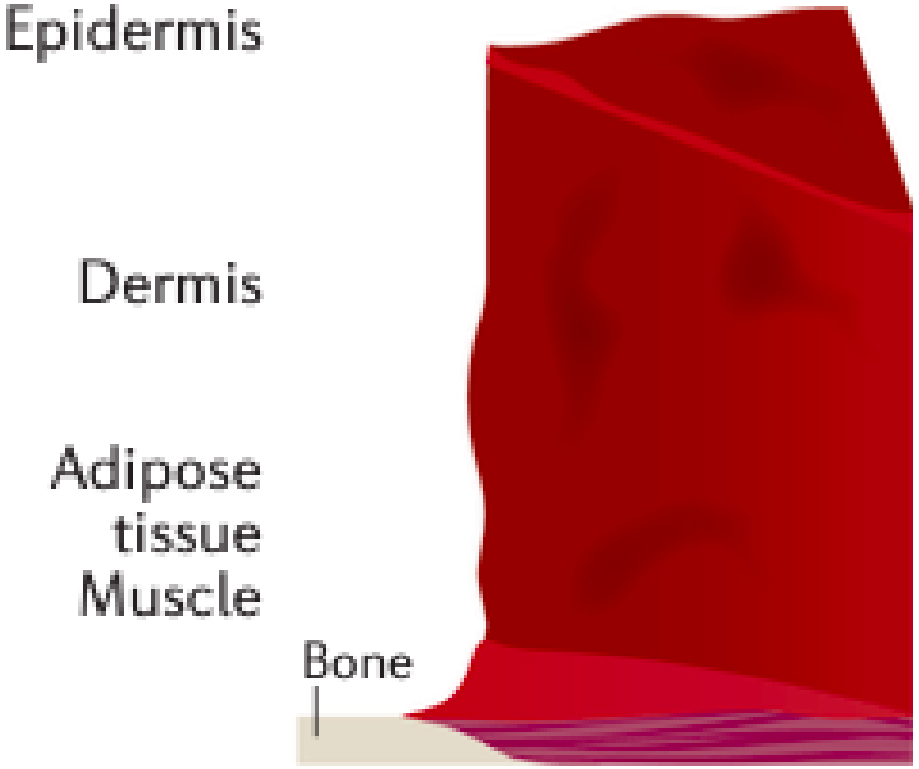
-Insensate to pinprick/light touch

-Small areas will heal with contracture/scar

-Large areas need skin grafting

-High infection rate

Fourth Degree



-Involves muscle or bone

-Leads to possible loss of burned part

Initial Assessment and Management

1. **STOP the burning process**
2. **ASSESS the patient – Rule out Trauma First**
3. **COVER the patient with dry linen/gauze**



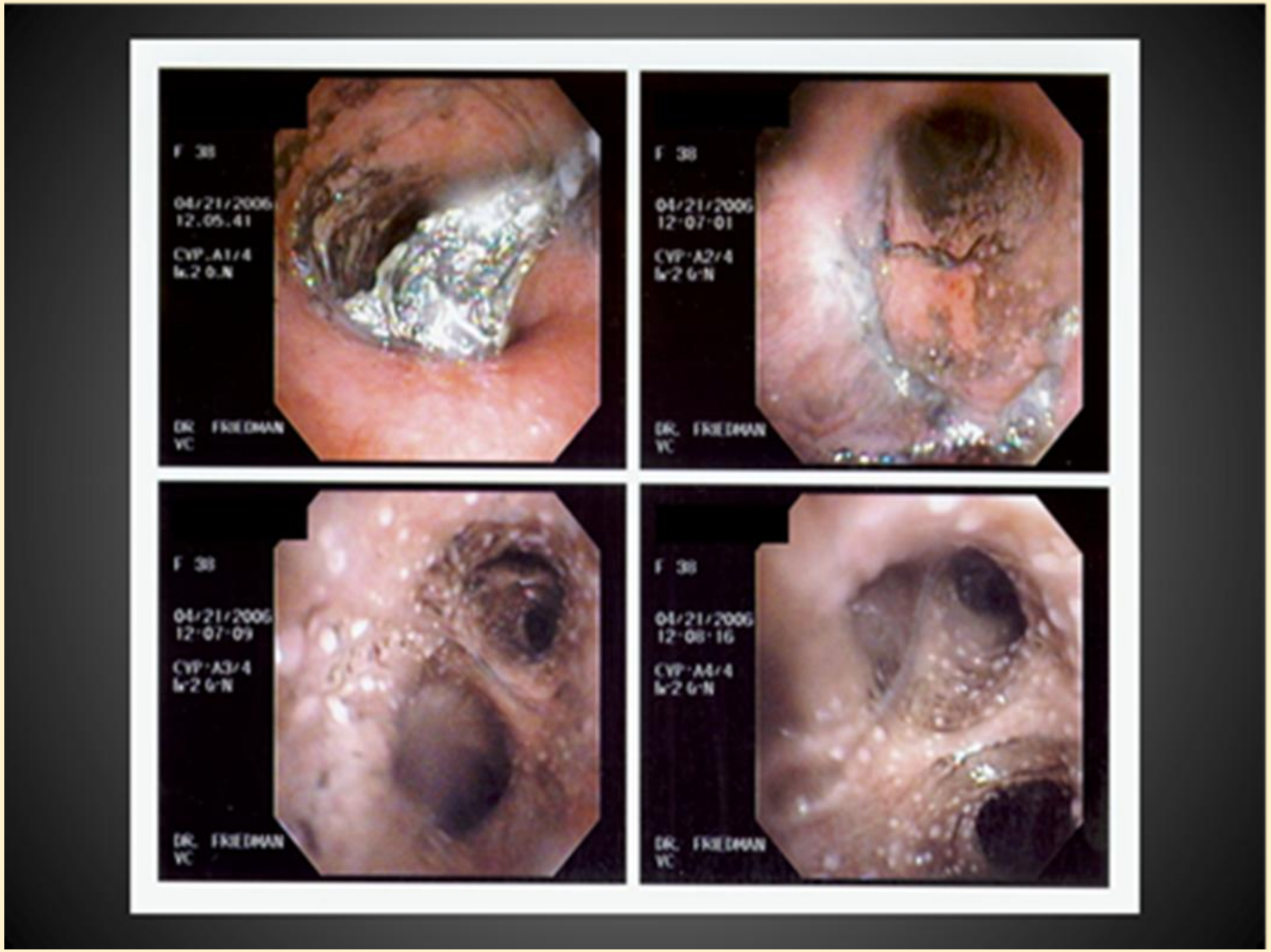
Look beyond the BURN!

Primary Survey

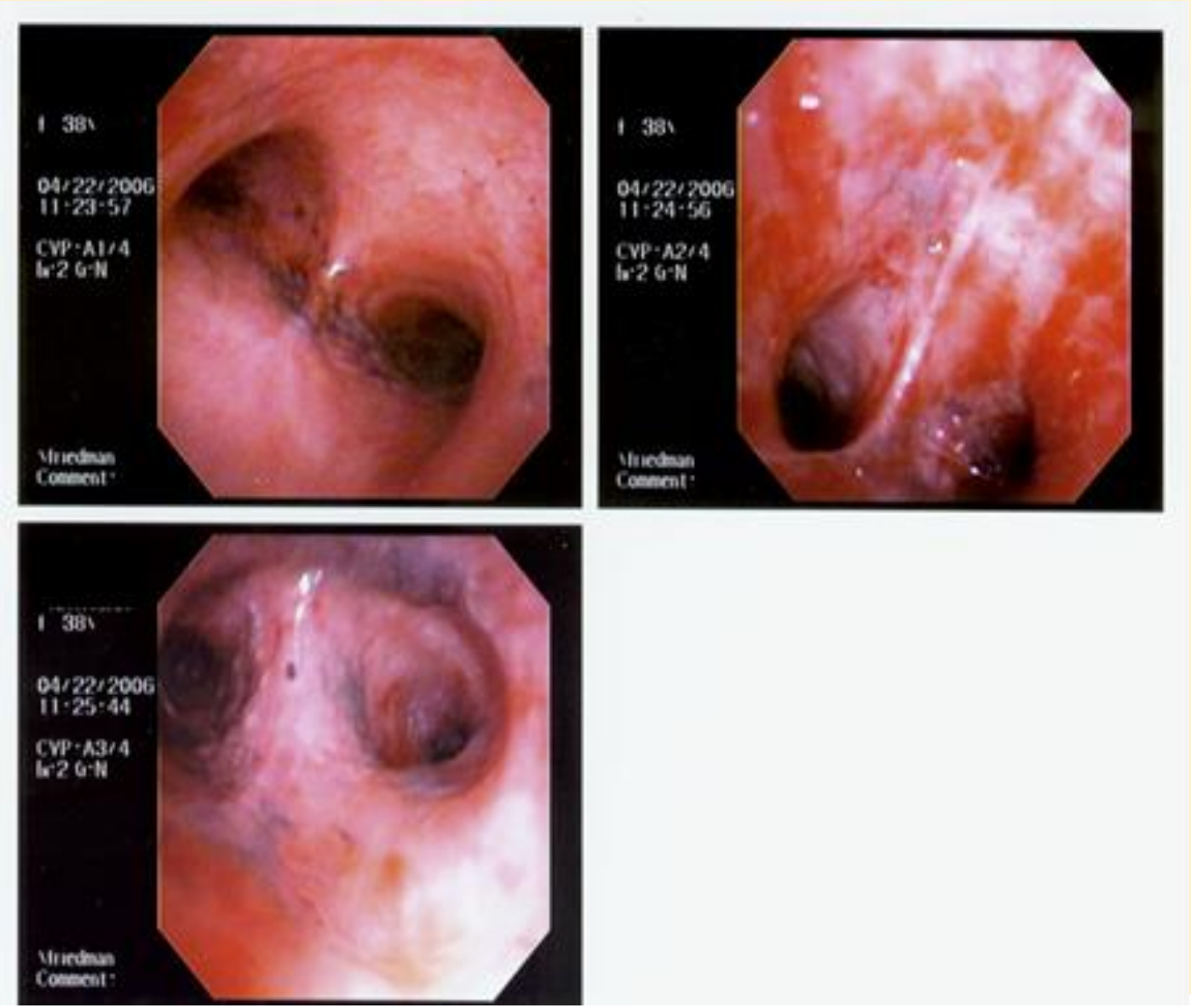
A. Airway with c-spine protection
B. Breathing and Ventilation
C. Circulation, cardiac status
D. Disability, Neurologic deficit, gross deformity
E. Exposure, Examine, Environment
F. Fluids, Foley

Airway

- **Assess immediately**
- **Establish Airway Control**
- **Intubate Early**
- **Secure ETT**
- **Early bronchoscopy**

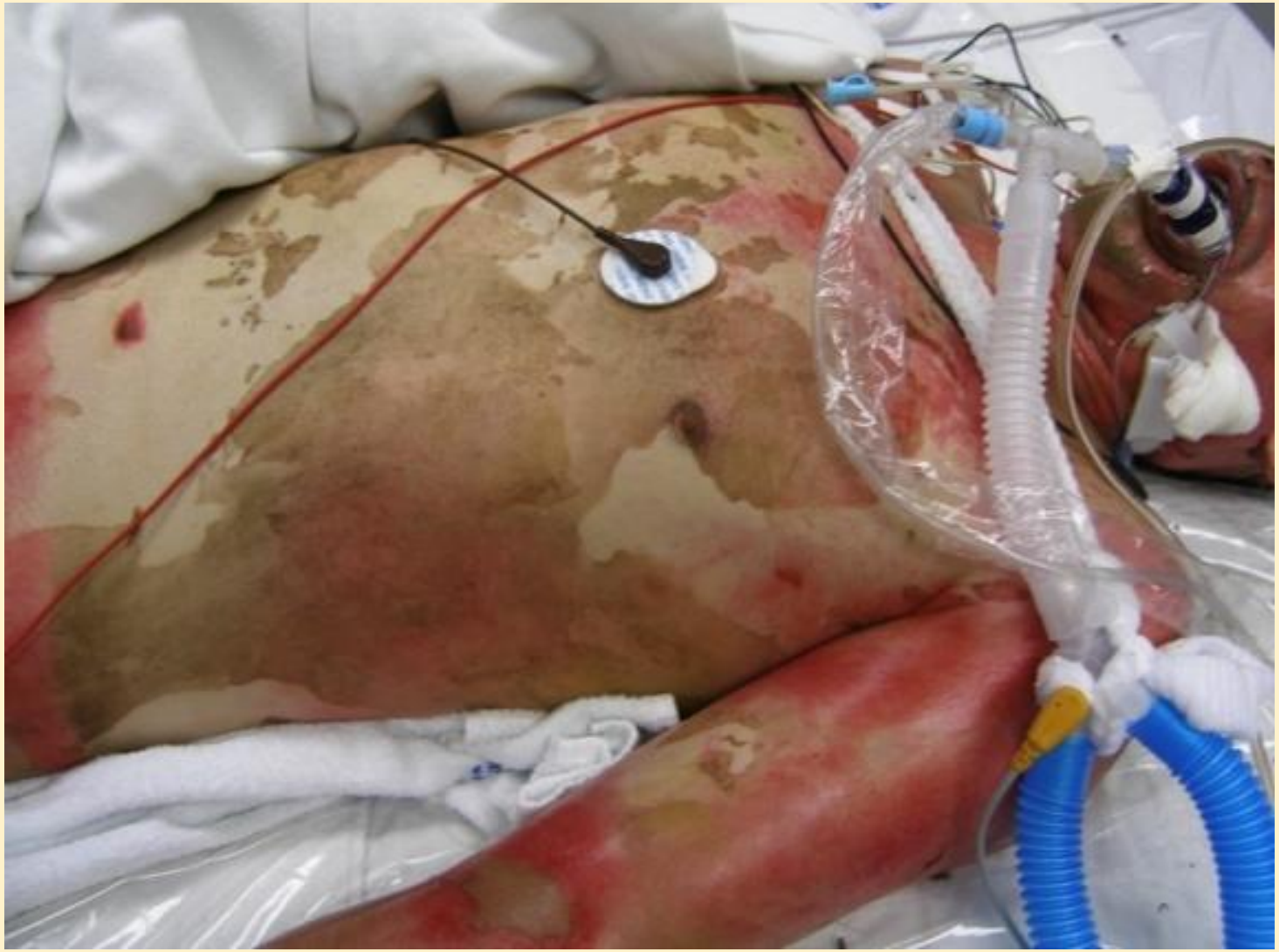


Airway


04/22/2006
11:23:57
CVP:A1/4
04/22/2006
11:24:56
CVP:A2/4
04/22/2006
11:25:44
CVP:A3/4

Breathing

- Assess Rate and Depth
- Administer High Flow Oxygen using non-rebreather
- Monitor ventilation closely with circumferential burns



Circulation

- Obtain VS *expect tachycardia (>120bpm r/t pain, anxiety, hypovolemia, inadequate oxygenation)
- Assess and Reassess Pulses *circumferential 3rd degree can impair circulation
- Establish IV access
- Start **Initial** Pre-hospital Fluid Rate



Initial Pre-hospital Fluid Rate

- **Warmed** Lactated Ringers:
  - **125** ml/hr: 5 years and younger
  - **250** ml/hr: 6-13 years old
  - **500** ml/hr: 14 years and older

Why Lactated Ringers?
Mimics intravascular fluid, treats hypovolemia, replaces intracellular sodium deficits

***Remember to start actively warming patient via Warmed fluids, Blanket warmer, etc.**

Disability, Neurologic Deficit and Gross Deformity

- **Alert, Verbal Response, Painful Stimuli response, Unresponsive**
- If not alert consider:
  - Associated Injuries
  - CO Poisoning
  - Substance abuse
  - Hypoxia
  - Pre-existing medical conditions

Exposure

- Trauma Naked → Remove all clothing, jewelry, diaper
- Remove Contact Lenses
- Stop the Burning Process, then pat dry
  - Maintain core temperature
  - Warm environment, warm fluids, dry linen/sheets, thermal blanket
- Apply Clean, Dry linen or gauze



Hypothermia Prevention

A study completed in 2017 showed that out of 142 severely burned patients 62.9% had hypothermia on arrival to the Emergency Department.

For our Burn Center, hypothermia is described as < 36 degrees Celsius

Ehrl, et al 2018

Secondary Survey

After your Primary Survey is finished and Initial Fluid Rates are started:

- Complete history
- Head-to-toe exam
- Obtain labs and imaging
- Obtain Weight
- Manage Pain and anxiety
- Manage Wounds

Injury Circumstances

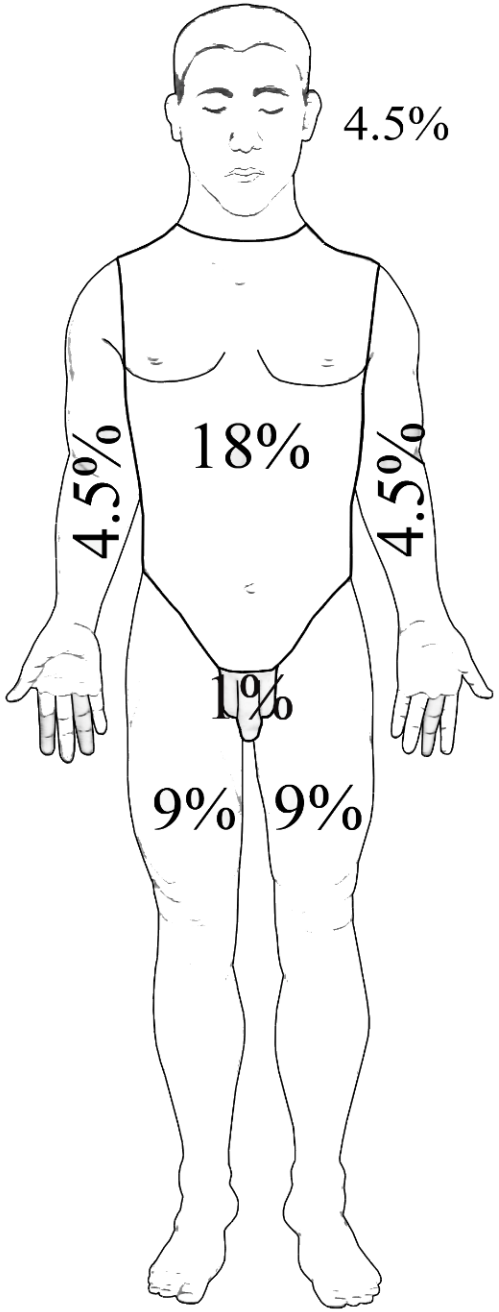
Mechanism	Important history questions
Flame	Indoors or outdoors? Loss of consciousness? Clothes caught on fire?
Scald	Type and temperature of liquid?
Chemical	What agent? Duration of contact? Any contamination done?
Electrical	What voltage? Was there an associated fall? Loss of consciousness? Any CPR?
Concern for abuse/neglect	History consistent with injury pattern? Delay seeking care?

Determine Extent of the Burn

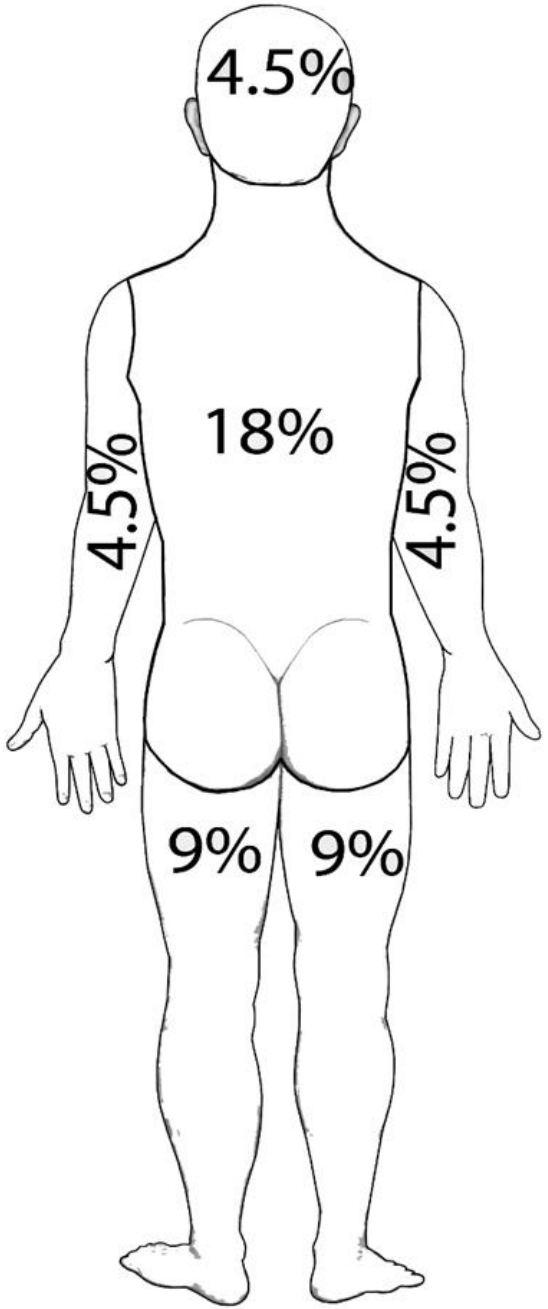
- Calculate the Total Body Surface Area (TBSA) burned using the Rule of Nines

Calculate TBSA for 2nd and 3rd degree burns ONLY, not 1st degree

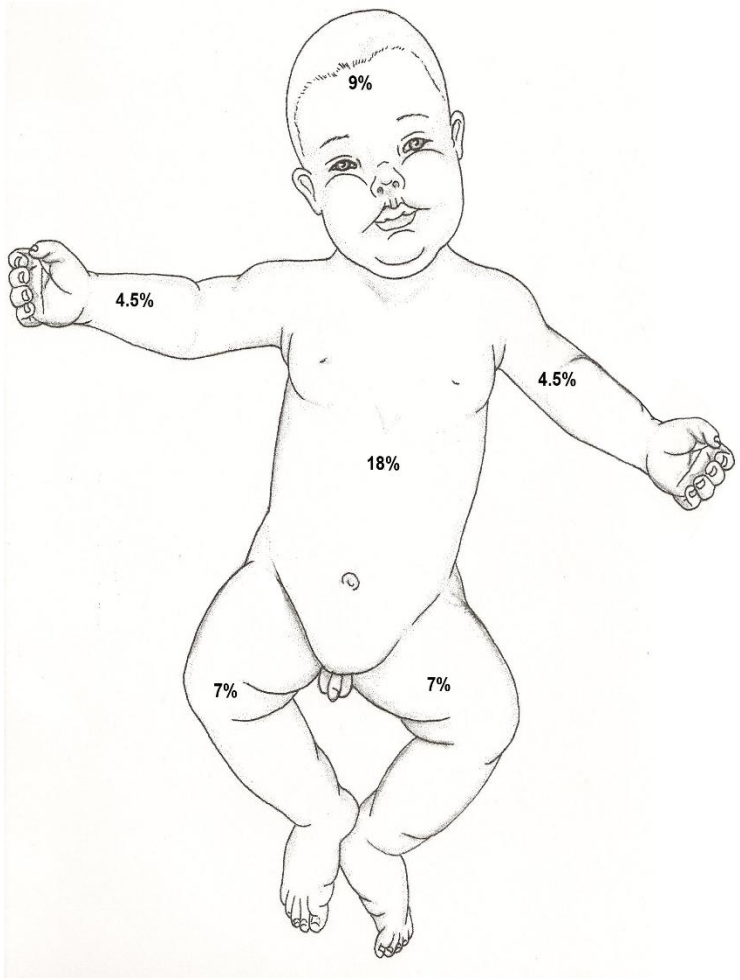
Rule of Nines



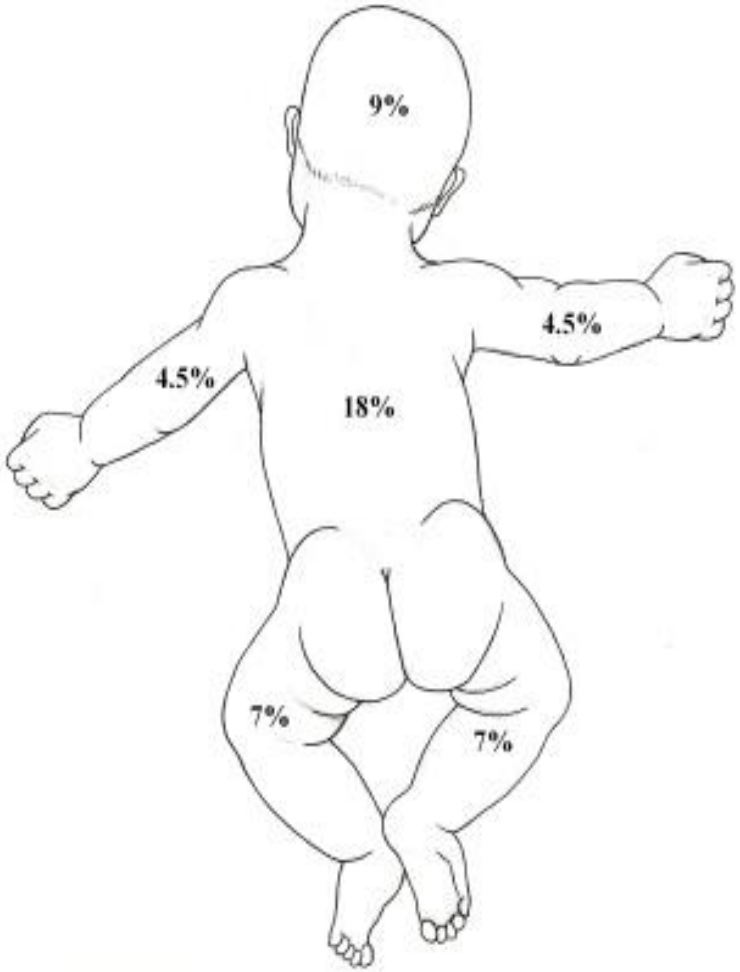
2nd Degree and higher Only



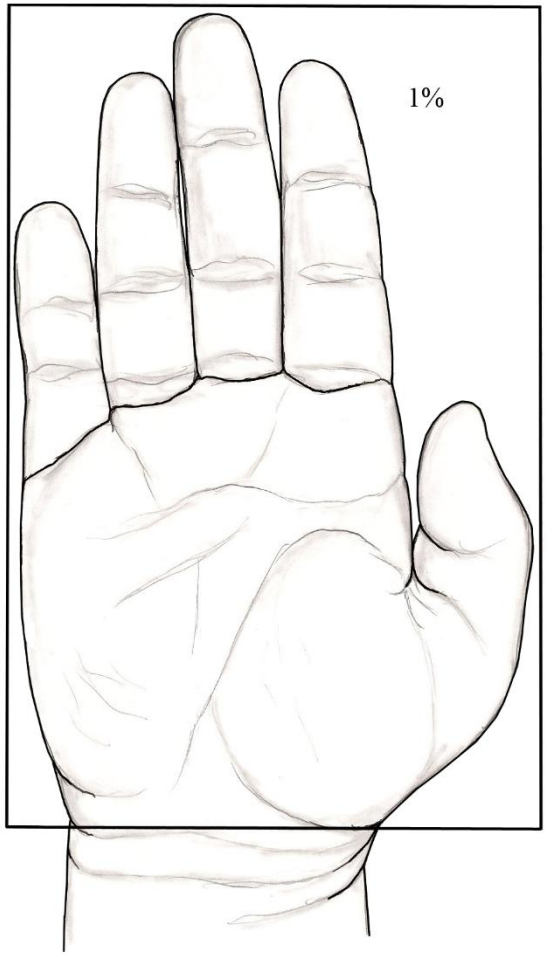
Rule of Nines



2nd Degree and higher Only



Rule of Nines



The Patients palmar surface (hands +fingers) is 1% TBSA

Adjusted Fluid Resuscitation

*Once the patient has reached the ED – or has delayed transport, we start the adjusted fluid rate

Categor	Age and weight	Adjusted fluid rate
Flame or scald	Adults and older children (≥14 years old)	**2** ml LR x kg x % TBSA
	Children (<14 years old)	**3** ml LR x kg x % TBSA
	Infants and young children (≤30kg)	**3** ml LR x kg x % TBSA Plus D5LR at maintenance rate
Electrical injury	All ages	**4** ml LR x kg x % TBSA

Adult Fluid Resuscitation

14 years old and above

- Only for 2nd degree and higher with ≥ 20% TBSA
- Lactated Ringers: Warmed
- Parkland Formula:
  - **2** ml x kg x %TBSA = Total 24 hr. Fluid Volume
  - ½ of total in first 8 hrs.
  - ½ of total in remaining 16 hrs.
  - Titrate to UOP goal of 0.5 ml/kg/hr (30-50 ml/hr)
    - Increase or decrease rate by 1/3

4 ml x kg x %TBSA for Electrical

Pediatric Fluid Resuscitation

***Less than 14 years old ***

- Only for 2nd degree and higher with ≥ 20% TBSA
- Lactated Ringers: Warmed
- Parkland Formula:
  - **3** ml x kg x %TBSA = Total 24 hr. Fluid Volume
  - ½ of total in first 8 hrs.
  - ½ of total in remaining 16 hrs.
  - Titrate to UOP goal of 1 ml/kg/hr
    - Increase or decrease rate by 1/3

4 ml x kg x %TBSA for Electrical

***If Child is Less than or Equal to 30kg they receive an additional* maintenance fluid of D5LR**

Maintenance Fluid in Child ≤ 30 kg

D5 Lactated Ringers:

- **4** ml/hr for each kg up to 10kg
- **2** ml/hr for each kg from 11-20kg
- **1** ml/hr for each kg > 20kg



This Maintenance fluid rate remains unchanged during fluid resuscitation

Adult Example: 38yr (70kg) male with 67% TBSA

Prehospital, pre-TBSA estimate (LR): 500 ml/hour

Resuscitation (LR):

2ml x 70kg x 67% TBSA = 9,380 ml

½ in the 1st 8 hours = 4,690 ml

Adjusted fluid rate 4,690/8 = 586 ml/hour

Hourly UOP goal: 35 – 70 ml

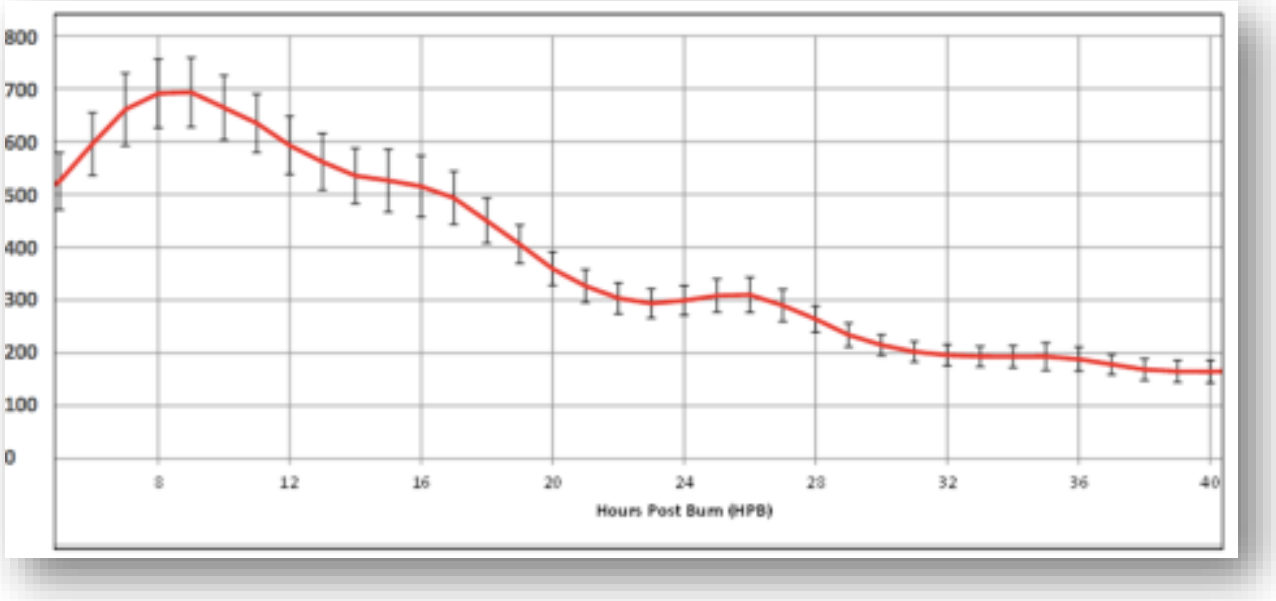
Goals of Fluid Resuscitation

- **Excessive** Fluid Resuscitation:
  - More common
  - Exaggerates edema formation
  - Leads to morbidity of extremity/abdominal compartments
  - Contributes to lung, cerebral edema

- **Inadequate** Fluid Resuscitation:
  - Shock and AKI related to hypovolemia
  - Increase in capillary leak
  - Leads to increased fluid requirement
  - Organ failure
  - Infection

Goals of Fluid Resuscitation

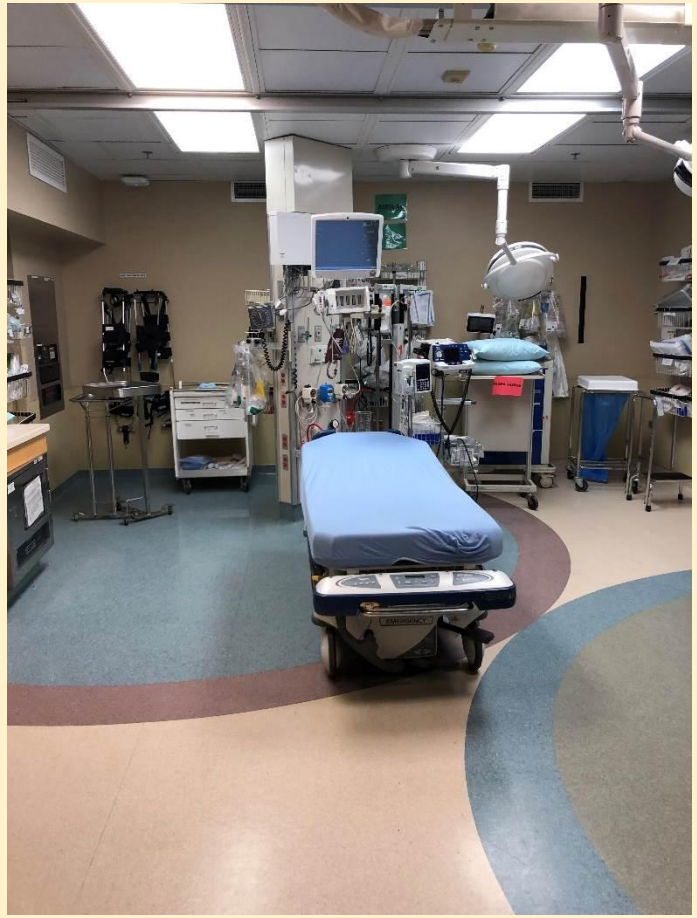
- Progressive fluid intake, sustained overtime
- Restore cardiac output and tissue blood flow
- Prevent organ failure
- Avoid administering too little or too much fluid
- Avoid bolusing unless hemodynamically unstable



Upon Arrival to the Burn Center

What will the Burn Team be listening for….

- **Current Weight**
- **Time of Injury**
- **Total IVF intake**
- **Total Urine Output**
- **Temperature**



Key Points for ≥ 10% TBSA Transfers:

- Keep head covered
- Blankets past shoulders
- Cocoon in for warmth
- May use clean Garbage bag in between sheet and blankets for insulation or thermal blanket if no warmer available
- If patient has wet linen, remove + apply dry warm linen
- Warm IVF



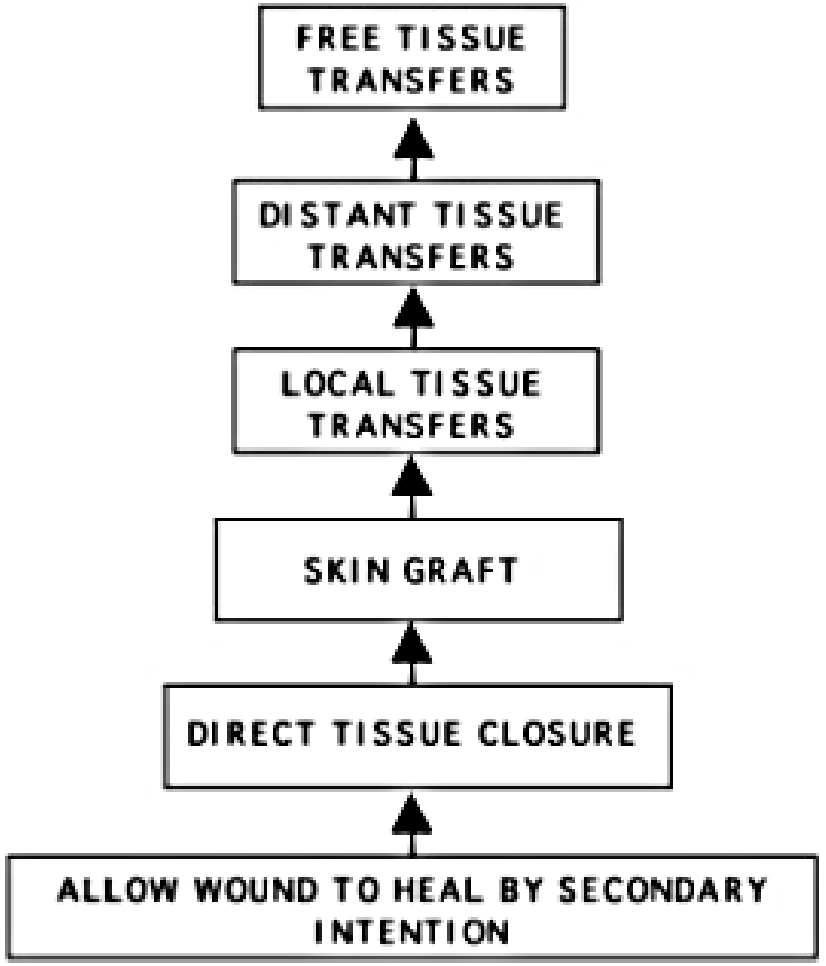
	First 8 Hours									Next 16 Hours															
Time of Injury 0900																									
Hour from injury	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Time	0900	1000	1100	1200	1300	1400	1600	1600	1700	1800	1900	2000	2100	2200	2300	0000	0100	0200	0800	0400	0500	0600	700	0800	
LR Rate						1580	790	988	888	888	444	—		—			1	185	18[illegible]		2	372		279	
Albumin rate							790	988	988	988	988	988		1	1	4		741	741	1		—		279	
FFP rate																				1				—	
PRBCs						LR bolus 1000			1 cc/kg 100	100	100	100	1			10								279	
Total Resuscitation Rate/Cumulative Total						1580 / 2580	1580 / 4160	1976 / 6136	1976 / 8112	1976 / 10,088	1532 / 11620	1088 / 12708	60 / 68	1	1	1	1 / 5	924 / 1871	924 / [illegible]	9 / 20	89 / 21.	744 / 22,164			
Urine Output						25	10	0	50	80	155	255	1				6	130	145	15		105		175	
Vital Signs								add albumin	add bicarb		↓80 cc UA	stop UA	↓250 Mannitol			Rule				RED cyano/dusky		625 / 279			
Core Temp								98.2	98.2	97.7	36.3	36.4		3		8		100.9	101.9		5	101.5		101.5	101.3
HR							130	114	108	102	90	97						116	138			134		128	
BP								101/90	100/84	102/94	105/93	109/93	47			81	13	124/58	119/55	1		91/50		100/59	
RR								20	20	20	20	20						14	14			[illegible]		14	
Sp02							88	91	97	98	100	100						95	98			95		95	
Fi02																	40	30%	30%			30%		30%	
Bladder Pressure							16	9	6	16	16	12	3	4	3		7	9		3	8	10		9	
Hemodynamic Parameters									Dr. Gusen notified																
CO									6.6	7.3	7.5	7.1	7		9			10.9	16.3			8.6			
CI									3.7	4.1	4.2	4.0	4					6.	6.8		0	4.9			
SV									58	71	74	72		65	65				75			64			
SVV									19	11	9	11				9		21	24			35	28		
SVR/SVRI									1188	1227	1211	1285	1			5	7	533	907			[illegible] 865	1146		1219
CVP																									
Labs																									
pH									7.19																
Bicarb									17.6																
Base Deficit									-11																
Lactate									3.3																
Hgb									18.2																
Hct									52.9																
PT									11.7																
PTT									23																
INR									1.1																
Sv02																									

Over-resuscitation trigger rate
5mk/kg/hr (1st 8 hours): 1695

Over-resuscitation trigger rate
5mk/kg/hr (Next 16 hours): 404

Reconstruction

Reconstructive Ladder



“Replace Like with Like”

-Sir Harold Gillies

Definition

- **Flap: unit of skin and/or other tissues that maintains its own intravascular circulation while being transferred from a donor to a recipient site.**

Definition

- **Graft free transfer of tissue without its own blood supply. Graft survival depends entirely on the blood supply at the recipient site**

Burn Reconstruction

Case Presentation

- 24yo M h/o electrical burn to hand/forearm after high voltage wire contact
- Median, Ulnar and Radial nerve sensation intact to moderate pressure
- Flexor tendons primarily repaired → failed and nonviable
- Needed a creative solution…

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PROBLEM: Exposed thumb distal phalanx with pulp loss

SOLUTION: Sensate First dorsal Metacarpal Artery Flap

Replantation

Migraine Surgery

Cancer Reconstruction

PROBLEM: Nasal melanoma

SOLUTION: Forehead flap with conchal bowl cartilage





The Grizzly Bear Attack

PHONE CALL

- Middle aged man attacked by bear
- Multiple trauma, avulsed midface, multiple open facial fractures, L open forearm fracture, L thigh laceration
- Patient ambulatory & awake
- Intubated for transport
- Midface on ice
- Large amount of blood loss

PRIOR TO ARRIVAL

- Notified ER
- Notified burn/plastics reconstruction team
- Notified orthopedics

- Room set up and all attempts made to preserve patient confidentiality

PATIENT ARRIVAL

- Followed ATLS principles

- Specific concerns:
  - Intact airway
  - Ruling out vascular injury to head and neck
  - Ruling out thoracoabdominal trauma
  - Evaluation of wounds
  - Antibiotic choice
  - Operative plan

Emergency Care Principle #1

- Follow ATLS principles.
- Will keep the patient safe
- Provides well thought out order of priorities one should not deviate from.

Injuries

- Face/head: Multiple complex fractures to face (BL orbits, maxillary sinuses, maxilla)
- **Not Injured**
  - **Globes & Neuro intact**
- Extremities: Crush injury left forearm
  - Left open radius fracture
  - Left humerus fracture
  - Left leg lacerations

Case

- 59 yo M elk hunting in Wyoming attacked by grizzly bear w cubs
  - Sunday 11:00 am: Midface subunit avulsed in attack → walks out of forest for 1.5 hrs carrying midface → regional hospital intubates & subunit put on ice ~ 4pm → transfer to Denver Swedish MC
  - Monday 12:30 am: trauma bay → OR @ 1:30 am
    - Extreme contamination

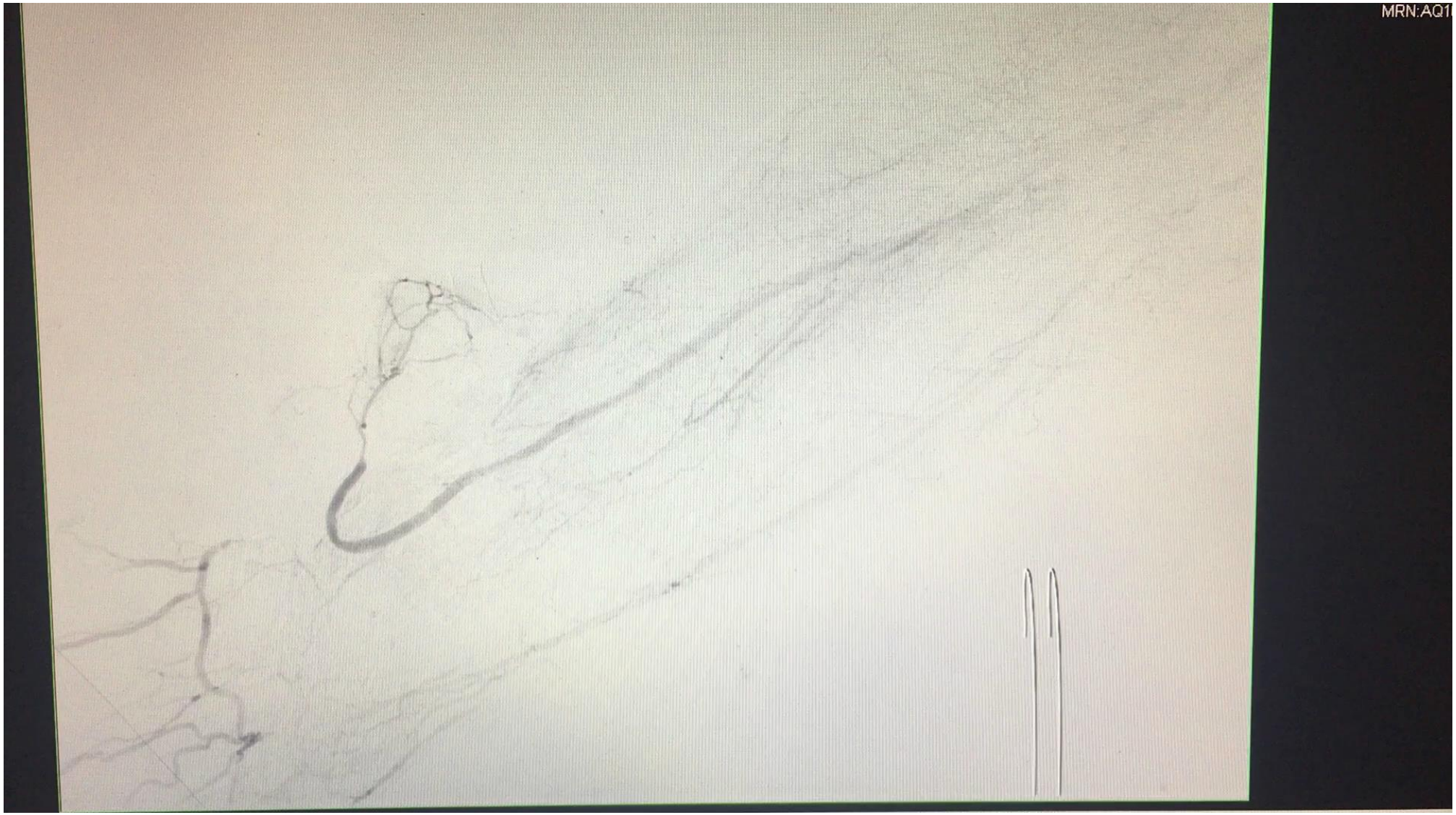
Emergency Care Principle #2

- Treat any amputated part the same way as an amputated digit.
  - Wrap in saline moistened saline sterile gauze
  - Put part in a biohazard bag
  - Set bag on top of an ice water slurry. Do not submerge.

Case

- Monday 12:30 am: trauma bay → OR @ 1:30 am
  - Extreme contamination
- Monday 3:00 am: Ectopic replant to R arm
  - Arterial In flow:
    - R Angular artery → end to end R radial artery at snuffbox
  - Venous Outflow:
    - L labial vein → end to end Cephalic b.
    - R labial vein → end to end R radial v.c
    - Supratrochlear vein → end to side Cephalic

Right Arm Angiography



Hospital Course

- HD1: intubated & paralyzed
  - Angio face/neck, R arm, B/l LEs
- HD2: OR for washout & debridement, PEG & trach
  - L side of lip (Hx of L unilateral cleft lip) congested → leeches initiated to L lip only
  - Bleeding → heparin gtt held
- HD4
  - OR for Washout & Debridement & 1 U pRBC

Reconstructive Principle #1

- Critical to eliminate contamination first
  - Thorough debridement
  - Appropriate antibiotic therapy
    - Infectious disease service expertise

Injured Facial Structures

	LEFT	RIGHT
SKIN /Tendon	Lacerations Total midface soft tissue loss L medial canthal tendon	Lacerations Total midface soft tissue loss
NERVE	Facial nerve: Marginal mandibular	Facial nerve: Frontal b to orbicularis, Zygomatic & buccal
ARTERY/VEIN	Supraorbital & supratrochlear	
BONY	ZMC + orbital floor NOE Anterior maxilla	NOE Anterior Orbital floor

Craniofacial Reconstruction

Skeletal

Reconstructive Principle #2

- Soft tissue follows the bone structure underneath
  - If facial bones are not returned and fixated into the correct anatomic position, soft tissue contracture occurs rapidly and cannot be corrected later.

Craniofacial Reconstruction

Soft Tissue

Reconstructive Principle #3

- Hardware needs to be covered with healthy, vascular tissue so it doesn’t become infected.

Next Steps…
Upper Lip Reconstruction

Upper Lip Reconstruction

- Need upper lip for dental protection & oral competence
- Opportunity to bring hair bearing tissue to help mask scars
  - Pre-injury moustache & part of patient pre-injury identity
- Scalp excellent donor site
- Creative solution:
  - Prelaminated temporoparietal fascial flap

Reconstructive Principle #5

- Creativity and staged reconstructive procedures is necessary to solve complicated problems.

Putting the Nose back on…

Staged Nasal Reconstruction

Ectopic Midface Replant Hospital Course

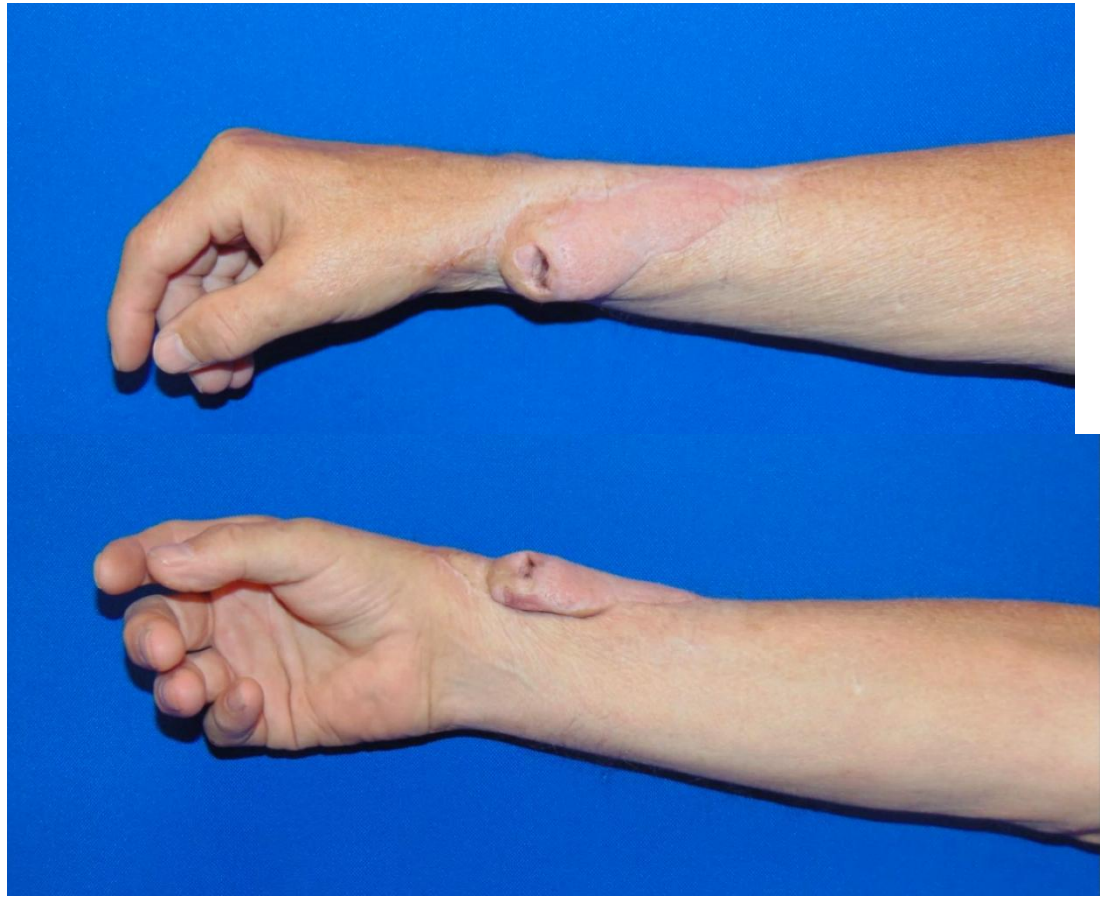
- HD 9:
  - Acute onset congestion
  - Again to IR for angio → poor flow → Nitroglycerin + tPA → Return of perfusion to central and R nose; L heminasal & lip congested
  - Leeching → HD 16 when leeching no longer needed.
- HD 16:
  - L heminasal & lips clearly not viable → debrided
  - Nasal septum not viable → debrided
  - Epidermolysis of R nasal subunits & columella → Integra
- HD 38:
  - Integra silicone removed → STSG

What we are missing:

- **L heminose: skin & lining**
- **Nasal projection from debrided septum**
- **Deep R nasal lining**

What we have:

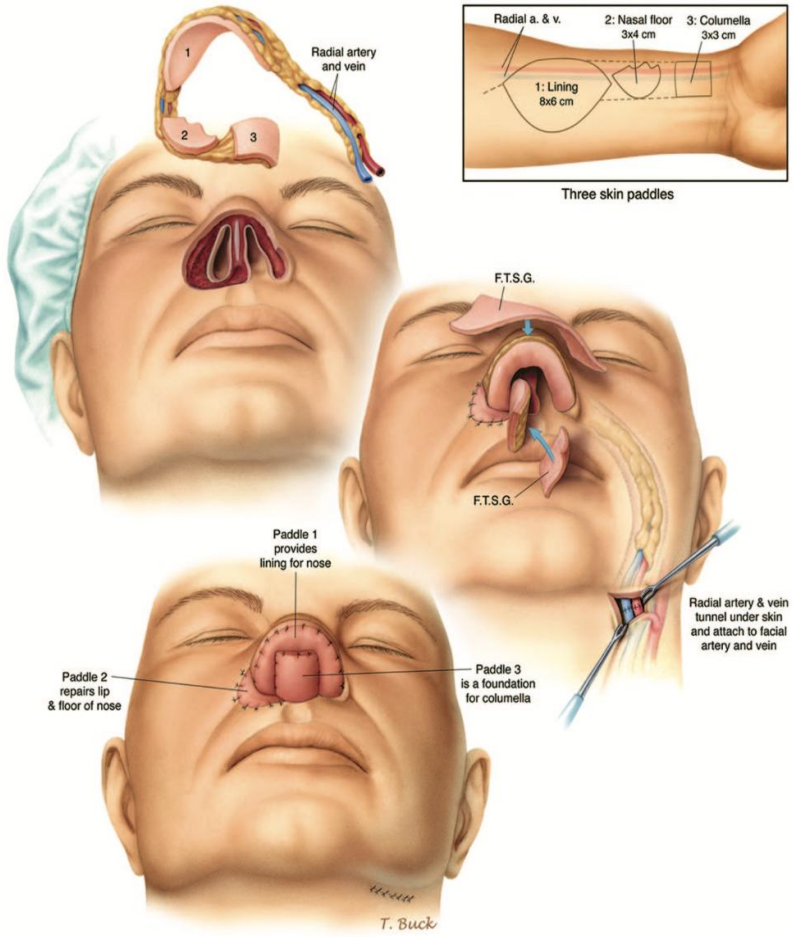
- **R heminose with R cartilage framework intact**
- **Columella**
- **Glabella**



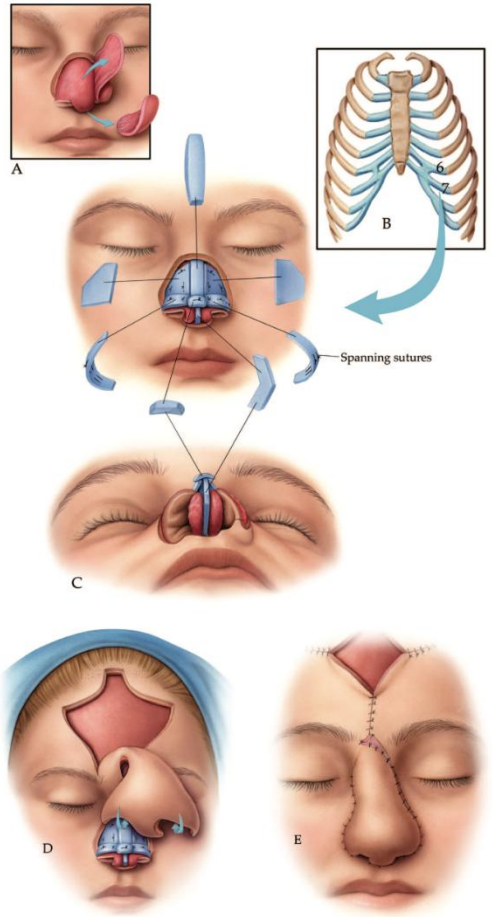
Reconstructive Principle #6

- Do not “throw away” tissue you may be able to use later.

Stage 1



Stage 2

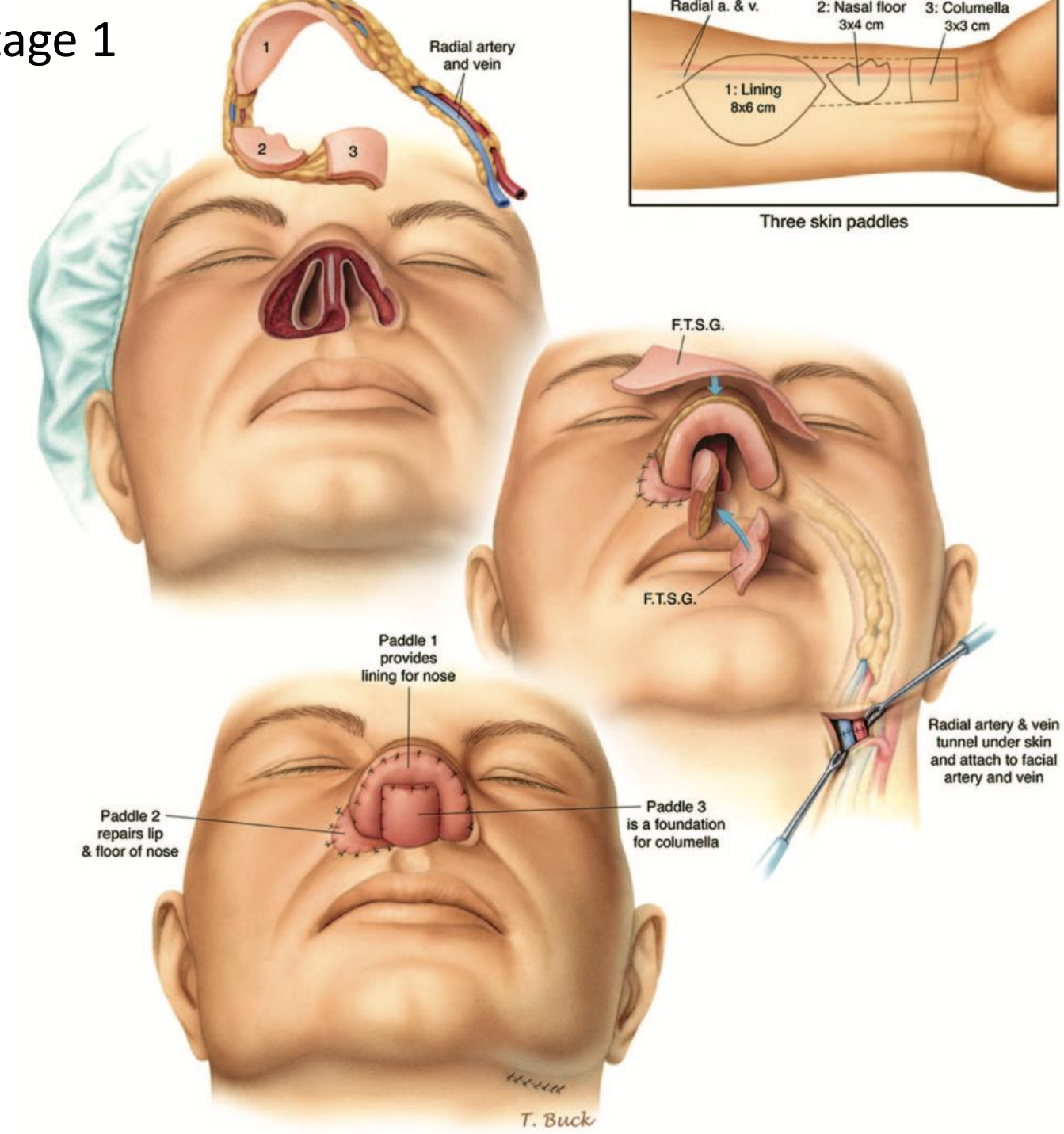


Refining the Nose…
Staged Nasal Reconstruction

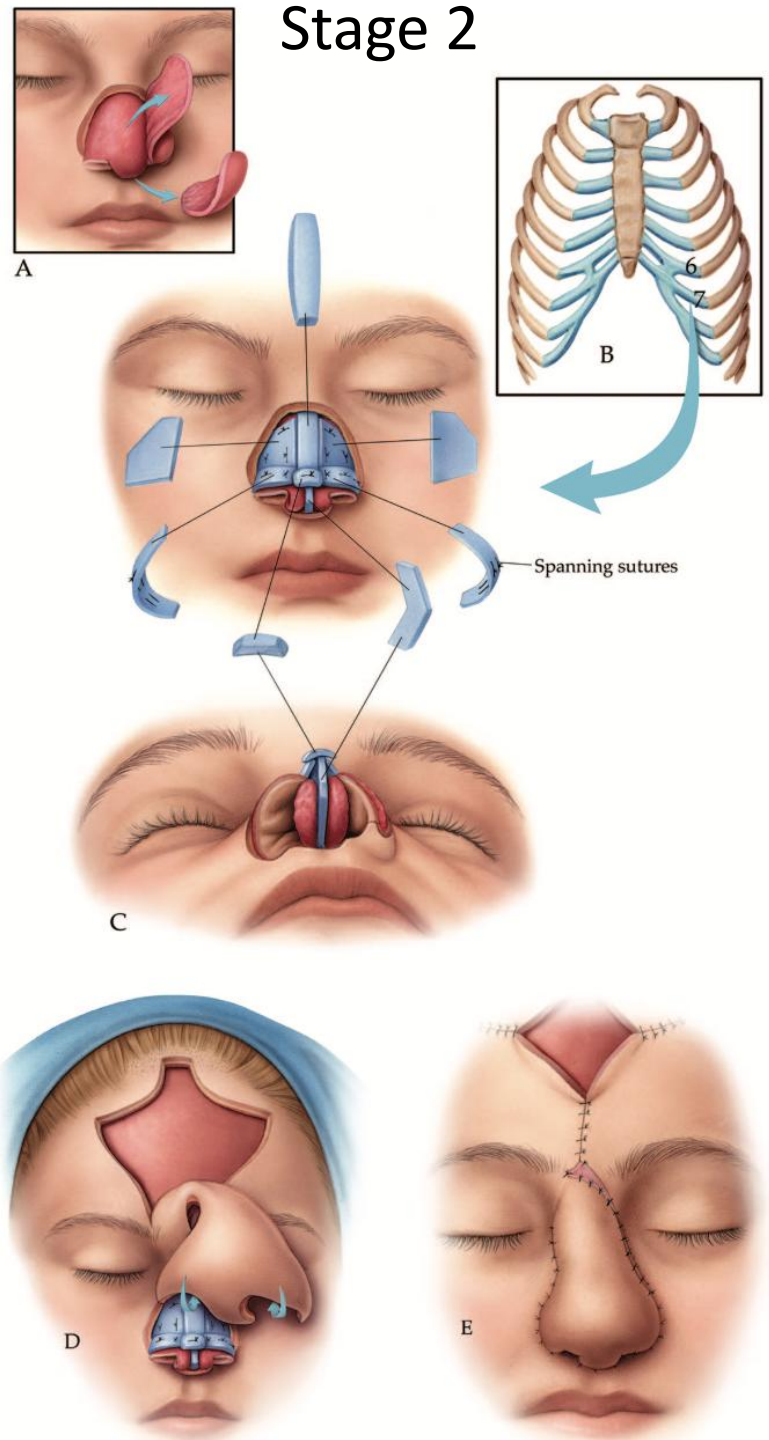
Refining the Nose

- Pre-expanded forehead flap
  - Tissue expander placed to R forehead under course of supratrochlear artery
  - Serial expansion over 6 wks
  - Expander removed and forehead flap transferred for external skin coverage of nose
- Rib Cartilage Grafting
  - For structure to prevent soft tissue collapse
- Debulking

Stage 1



Stage 2



Rehabilitation
Caring for the Body & Soul

Reconstructive Principle #7

- The care & rehabilitation of traumatized patients requires a multi-disciplinary approach.

- Goal is integration back into society with a restored sense of self-identity.

Health ONE Swedish Medical Center



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OPERATING ROOM
OCCUPATIONAL THERAPY
CERTIFIED HAND THERAPY
PHYSICAL THERAPY
PSYCHOLOGY SERVICES

Summary

- Initial stabilization & ATLS protocols
- Reconstructive Principles
- Staged reconstructive procedures can obtain aesthetic results over time.
- Multi-disciplinary collaboration
- Focus on rehabilitation & reintegration into society.

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By Wayne Drash, CNN
Updated 2:06 PM ET, Tue November 21, 2017



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‘Grey’s Anatomy’ Season 16 Episode 14: Too Much to Bear (RECAP)

Dan Clarendon

1 year ago

▷ ✕





Disney+ Episode 9 “If She Smells Me”





Services - Adult and Pediatric

Burns

Thermal
Chemical
Electrical
Friction Burn/Road Rash
Frostbite
Inhalation
Radiation
Hyperbaric Oxygen Therapy

Skin & Soft Tissue Disorders

Skin Sloughing Disorders
Necrotizing Fasciitis
Necrotizing Soft Tissue Diseases
Fournier's Gangrene
Staphylococcal Scalded Skin Syndrome
Stevens-Johnson Syndrome (SJS)
Toxic Epidermal Necrolysis (TENS)
Diabetic wounds

Hand & Extremity Injuries

Complex/Traumatic Injuries
Crush Injuries
Degloving
Upper and Lower Extremity Limb Salvage
Peripheral Nerve Surgery
Brachial Plexus Surgery
Targeted Muscle Reinnervation
Amputee Care

Plastic & Reconstructive Surgery

Skin Cancer Reconstruction
Head & Neck Reconstruction
Breast Reconstruction
Mohs Reconstruction
Migraine Surgery
Lymphedema Surgery
Facial Reconstruction
Laser Scar Therapy

Access our burn referral app

VitalEngine is a secure, HIPAA-compliant application that allows providers to easily send patient information, photos, and other documents directly to the burn care team. The burn experts can provide a quick evaluation and treatment recommendations. This platform is used in conjunction with the HCA HealthOne Swedish Access Center to improve the efficiency and accuracy of a burn consultation, referral, and or transfer.

HCA HealthONE Swedish

How to access the VitalEngine Burn Referral App*

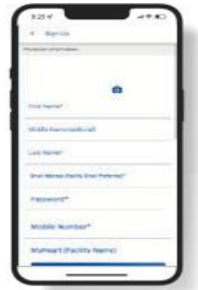
*Only needs to be done one time



1. Download the VitalEngine App



2. Click sign up for VitalEngine



3. Complete all fields



4. Check for confirmation email



5. Activate from link in email



6. Success! You're ready to begin

For patient transfers and referrals: 888.796.6378

Thank You!!

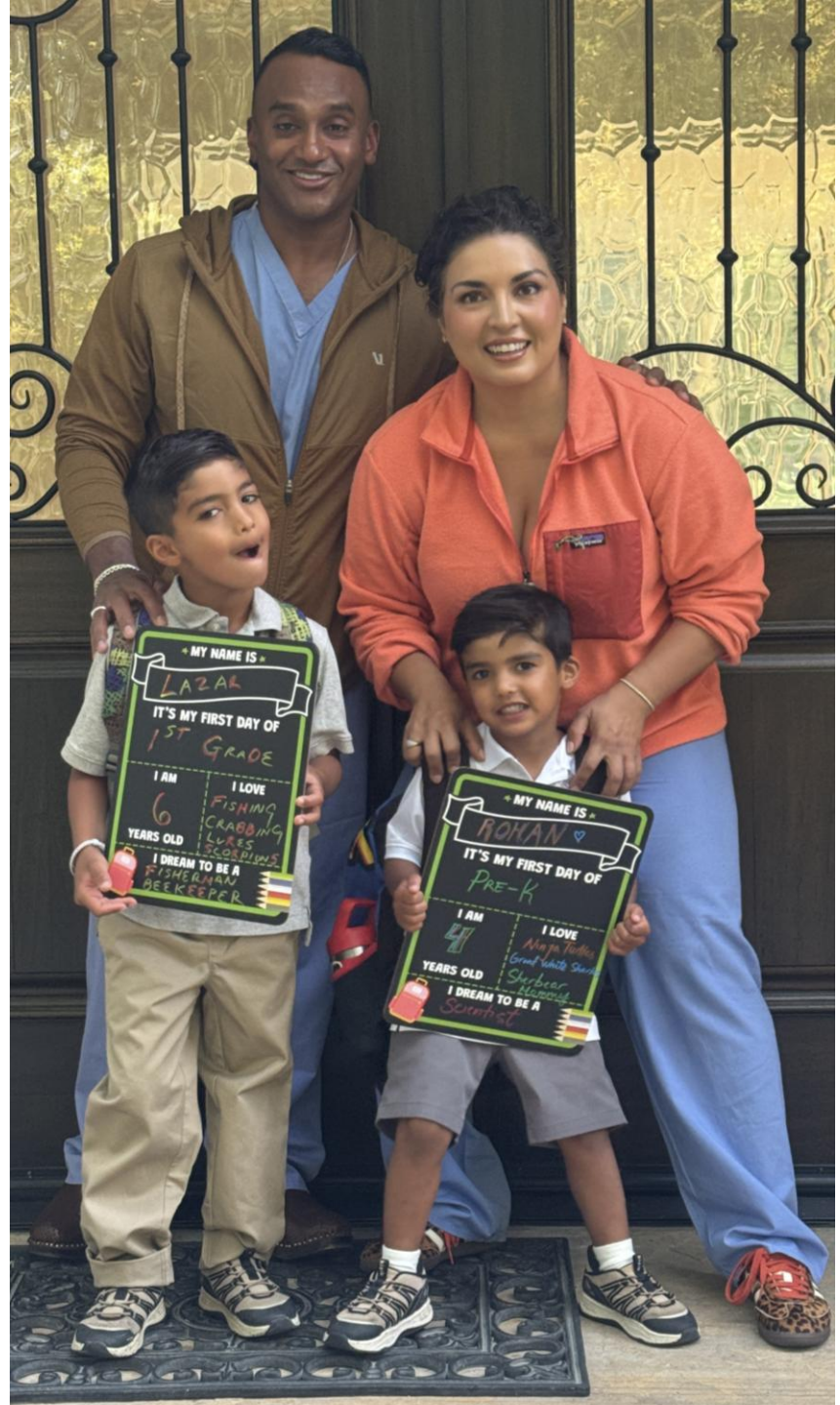
Benson Pulikkottil MD (720) 788-3203

If you every have questions, or would like guidance on treatment…

Call our Burn Access Line

844 802 6264

Health ONE
Burn and Reconstructive Center
At Swedish Medical Center


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IT'S MY FIRST DAY OF
1ST GRADE
I AM
6
YEARS OLD
I LOVE
FISHING
CRABBING
LURES
SCORPIONS
I DREAM TO BE A
FISHERMAN
BEEKEEPER
MY NAME IS
ROHAN
IT'S MY FIRST DAY OF
PRE-K
I AM
4
YEARS OLD
I LOVE
I DREAM TO BE A