Incontinence-Associated Dermatitis

or

Pressure Ulcer?

When wiping and cleaning become a reportable event

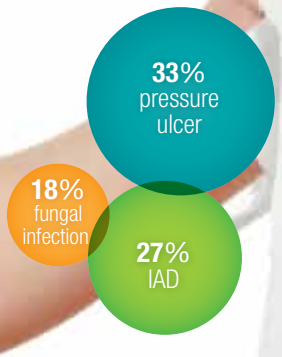
Although incontinence-associated dermatitis (IAD) and pressure ulcers are clinically and pathologically different conditions, differentiating them from each other remains a major challenge for clinicians.[1] And yet accurate identification is even more critical now that development of pressure ulcers affects Medicare reimbursement.

Incontinence prevalence

among nursing home residents[1]

sample size:
279,191 nursing home residents

In a sample of 279,191 nursing home residents, the prevalence of urinary incontinence was 46.4 percent, fecal incontinence was 29.5 percent and a combination of urinary and fecal incontinence was 25.6 percent.[2] In other words, a significant number of nursing home residents have the potential for developing IAD.



IAD & perineal skin injury

among incontinent patients at acute care facilties[3]

sample size:
3 acute care facilities

One study measured the prevalence of IAD and perineal skin injury in three acute care facilities in the United States and reported that among patients with incontinence, 33 percent had a pressure ulcer, 27 percent had IAD and 18 percent had fungal infections. Recent literature suggests that many wounds classified as stage I and II pressure ulcers may be attributable to IAD and not pressure. Also, the presence of moisture-associated skin damage may increase pressure ulcer risk.[3]

References

1. Doughty D, Junkin J, Kurz P, et al. Incontinence-associated dermatitis: consensus statements, evidence-based guidelines for prevention and treatment, and current challenges. *Journal of Wound, Ostomy, and Continence Nursing.* 2012; 39(3):303-315.
2. Nix D, Ermer-Seltun J. A review of perineal skin care protocols and skin barrier product use. *Ostomy Wound Management.* 2004; 50(12):59-67.
3. Long MA, Reed LA, Dunning K, Ying J. Incontinence-associated dermatitis in a long-term acute care facility. *Journal of Wound, Ostomy, and Continence Nursing.* 2012; 39(3):318-327.
4. Junkin J, Selekof JL. Beyond "diaper rash": incontinence-associated dermatitis: does it have you seeing red? *Nursing.* 2008; 38(11): 56hn1-56hn10.
5. Kehoe K. Strategies and interventions for prevention and management of incontinence-associated dermatitis. Medline University website. Available at: http://www.medlineuniversity.com. Accessed September 25, 2012.

Unlike pressure ulcers, areas of the skin affected by IAD have more irregular, diffuse margins in the locations exposed to urine and feces.

IAD has been defined as a "form of moisture-associated skin damage ... associated with changes in the skin's moisture barrier function, erythema (redness), rash or vesiculation (blistering), and adverse symptoms such as pain or itching."[3] It involves inflammation of the skin in the genitals, buttocks or upper thighs associated with either ongoing or recent urinary and/or fecal incontinence.[3]

Unlike pressure ulcers, areas of the skin affected by IAD have more irregular, diffuse margins in the locations exposed to urine and feces. Another difference between IAD and pressure ulcers is that IAD will not cause a full-thickness skin injury (unless complicated by infection).[4] In addition, whereas incontinence-associated dermatitis consists of lesions that develop from the top down, first presenting as reddened intact skin, and then progressing to blistering and loss of epidermal tissue; pressure ulcers develop from the bottom up, developing inside deep tissue and progressing toward the surface of the skin.[1]

Methods for preventing incontinence-associated dermatitis (IAD)

1. Identify and treat the cause of incontinence. Until incontinence is resolved, the skin must be consistently cared for and protected from excess moisture and bacteria.[4]
2. After determining that IAD is present or that the patient is at risk for IAD, regularly check the skin. Watch for skin color or integrity changes each time care is provided (i.e, when turning the patient or cleansing the skin).[4]
3. For someone who's incontinent, gently cleanse the skin with a product that is pH-balanced (4.5 - 5.5 pH of normal skin).

Accurate Classification of IAD Lesions and Pressure Ulcers

Many patients who are at risk for IAD are also at risk for pressure ulcers, and many of these patients have both conditions. Here are some ways to tell the difference between the two.[5]

	Pressure ulcer	IAD
Presentation	Non-blanchable erythema of intact skin (stage I)	Blanchable erythema of intact skin response
Underlying factors	Inflammatory response to ischemic damage of subdermal tissues over a bony prominence	Inflammatory response to urine or feces exposure confined to the epidermis or dermis
Location	Over bony prominences: coccyx, sacrum, ischium. Also under tubes and other devices	Perineum, buttocks, inner thighs, groin, lower abdominal folds and any areas exposed to urine and feces
Pain	Absent to severe	Mild to severe
Color	Pink, red, yellow, tan, gray, green, brown, black	Pink or red
Blistering	Sometimes (stage II)	Yes
Additional characteristics	Intact discoloration, partial thickness, full thickness	Rash, denudement, erosion, maceration

4. Regular cleansing is crucial to avoid the growth of high levels of *Staphylococcus aureus* or *Candida albicans*, which contribute to the development and severity of IAD.

5. To avoid friction, don't scrub while cleansing. Use pH-balanced cleansers; not harsh soaps. Pre-moistened wipes are also available.

6. Use emollients and skin agents that soften and soothe but that don't add excess water to the skin. Incontinent patients already have overhydrated skin that is possibly damaged from exposure to urine or feces (liquid stool is especially damaging to the skin) and possibly sweat. Avoid products with strong concentrations of humectants such as urea, glycerin, alpha hydroxyl acids, and lactic acid, which retain water in the skin.[1, 4]

7. Apply a protectant to the skin (for example, dimethicone, liquid clear film barrier, or zinc oxide) to prevent injury from future episodes of incontinence. Applying protectants may also assist in preventing other skin injuries such as pressure ulcers and skin tears.[1, 4]

8. Provide proper positioning by developing an individualized turning program for high-risk patients with limited mobility.

Although many efforts are being made to reduce pressure ulcer rates, bedside practice in the area of incontinence care has been slow to change despite the growing body of knowledge that IAD prevention is an effective way to reduce pressure ulcer incidence.[4]