Top tips for identifying a moisture lesion

This article looks at methods for avoiding the development of incontinence-associated dermatitis (IAD) and provides some useful tips for practice.

A systematic approach to assessment of IAD helps with early recognition of whether a patient is at increased risk of complications. It also helps healthcare practitioners to identify when prevention strategies should be put into place. This section describes the important elements of both assessment and prevention strategies which should be employed to avoid IAD.

1 RISK ASSESSMENT

It is essential that, when presented with a patient who is incontinent, clinicians take a full history and carry out a full assessment to ensure that an effective treatment plan can be implemented (Bardsley, 2008). Clinicians should also consider whether any of the procedures that will be carried out, or prescribed drugs, have the potential to cause loose bowel movements.

2 ROUTINE SKIN ASSESSMENT

If the risk assessment has indicated that the patient is at high risk of developing IAD, the skin should be inspected routinely. IAD is characterised by inflammation of the surface of the skin with erythema, oedema and, in some cases, bullae (vesicles) containing clear exudates. In severe cases, erosion of the epidermis can also be seen. Kennedy and Lutz (1996) noted that the erythema may be patchy or consolidated (*Figure 1*).

Observation of the distribution of these symptoms will help clinicians to differentiate between other types of tissue damage, including intertrigo (inflamed skin folds caused by exposure to perspiration, friction and bacterial or fungal bioburden), periwound maceration (skin breakdown as a result of exposure to wound exudate) and pressure ulcers.

Gray (2007) observed that IAD associated with urinary incontinence tends to occur in the skin folds and the labia majora in women or the scrotum in men, whereas IAD associated with faecal incontinence tends to originate in the perianal area. In severe cases, the erythema may extend to the lower abdomen and sacrum (Beldon, 2008). Candidiasis is a common complication of IAD and will manifest itself as a macropapular rash with satellite lesions.

3 GRADE THE LEVEL OF DAMAGE

When reviewing the language clinicians use to describe the degree of IAD, Bianchi and Johnstone (2011) found there was no consistency. In order to help clinicians to accurately grade the degree of skin damage and suggest management strategies, the National

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Figure 1.

Erythema may be patchy or consolidated.

Association of Tissue Viability Nurses Scotland (NATVNS) developed an excoriation grading tool, which includes clinical images, grades the level of excoriation and offers management advice This tool may also help to encourage a consistent approach in care of patients with IAD.

4 CLEANSING ROUTINE

In some cases, timely and appropriate skin cleansing and protection can prevent and heal IAD. Soap and water should be avoided, however, as soap is made up of a mixture of alkalis and fatty acid and the alkalis are thought have the potential to raise the pH of the skin damaging the acid mantel (Beldon, 2008). Perineal skin cleansers are the best choice for individuals with IAD. They come in different forms, including emulsions, foams and sprays. They combine detergents and surfactant ingredients to loosen and remove dirt and irritants. Many are also pH balanced and/or contain moisturising agents, which restore or preserve optimal barrier function.

5 SKIN PROTECTION

The aim of skin protection products is to isolate exposed skin from harmful or irritant substances. In the case of IAD, skin protectors isolate the skin from excessive moisture, urine or faeces. Liquid barrier films and moisture barrier creams or ointments are frequently used products.

Bliss (2005) compared four skin care regimens in the prevention of IAD, including:

- Acrylate polymer-based liquid film
- Petroleum ointment (43%)
- Zinc oxide in 1% dimethicone (12%)
- Petroleum ointment (98%).

With all of the regimens, Bliss et al (2005) found that the incidence of IAD was low and there was no significant difference in the development of IAD between them. These results suggest the use of a defined skin care regimen using quality skin care products will prevent the occurrence of IAD.

If the IAD does not improve using these measures, the recommendations for napkin dermatitis in babies and children may be an appropriate route to follow. Relevant literature suggests that when napkin dermatitis does not improve when using barrier products, a weak topical steroid such as 1% hydrocortisone cream or ointment can be applied twice a day for 3–5 days. If candidiasis is present, 1% clotrimazole cream is recommended, or else a combined hydrocortisone/clotrimazole cream when both dermatitis and candidiasis are present (Hunter et al, 2002; Bianchi et al, 2011).

6 TREATMENT AND MANAGEMENT OF INCONTINENCE

The ultimate goal for any clinician caring for an individual with urinary or faecal incontinence is to alleviate and control bowel/bladder function (Cooper, 2011). Causes of incontinence are numerous and multifactorial (*Table 1*). A multidisciplinary approach may be required, with the continence advisor included in the team of clinicians involved in planning care.

7 CONTAINMENT OF URINE OR FAECES

In individuals where bladder and or bowel control is not possible, there are a range of containment products available.

Body worn pads: these disposable pads come in various sizes depending on the volume of fluid expected. They are made of super-absorbent material, which turns to a gel when it comes into contact with fluid, helping to lock the fluid away from the skin. It is essential to change soiled products on a regular basis.

Urinary catheters: Urinary catheterisation is not without risk and should not be carried out unless there is a sound rationale. In the case of uncontrolled urinary incontinence with skin damage, the clinician should carry out a risk assessment to determine

Table 1
Causes of incontinence

Possible causes of faecal incontinence

- Anal sphincter damage or weakness: obstectric trauma to anal sphincter muscles; surgery e.g. latertal sphincterotomy, haemorroidectomy, anal stretch
- Neurological conditions: spinal chord injury; multiple sclerosis; Parkinson's disease; spina bifida; stroke
- Impaction with overflow: frail or immobile patient; cognitive impairment e.g. dementia; immobility/physical disability
- Ano-rectal pathology: rectal prolapse; congenital abnormalities; anal/recto-vaginal fistula
- Diarrhoea/intestinal hurry: Chrone's disease; ulcerative colitis; drugs e.g. antibiotics.

Possible causes of urinary incontinence

Stress incontinence
- Pelvic floor muscles damaged or weakened
- Urethral sphincter damage.

Intertriginous dermatitis
- Urinary tract infection
- Neurological conditions as above
- Bladder cancer
- Increasing age
- Bladder outlet obstruction/stones
- Benign prostatic hypertrophy (men)
- Unknown cause.

Overflow incontinence
- Enlarged prostate gland (men)
- Bladder stones
- Constipation
- Surgery to the bowel or spinal cord
- Weak bladder muscles
- Nerve damage
- Some medications

Medications associated with urinary incontinence include:alpha-adrenergic agonists; alpha-adrenergic blockers; angiotensin-converting enzymes; diuretics; cholinesterase inhibitors; some medications with anticholinergic effect; hormone replacement therapy; opioids; sedatives and hypnotics.

whether short-term catheterisation with an indwelling catheter is the best course of treatment for the individual.

Anal bags: These disposable containment bags are applied to the peri-anal area. The skin-friendly adhesive holds the product in situ. While they are useful, they may not be appropriate for high output of faecal fluid or where the skin is already damaged by IAD.

Faecal management systems: In cases of severe or high-volume diarrhoea, IAD and widespread skin breakdown can occur very rapidly. In this instance it may be appropriate to consider the use of a faecal management system (*Figure 2*).

Figure 1.

A faecal management system in situ.

These temporary faecal containment devices consist of a soft flexible silicone catheter, which is inserted digitally into the rectum and held in place by a low pressure balloon cuff that is inflated with saline or water. The catheter is then attached to a closed-ended collection bag, which enables accurate fluid balance to be maintained. These appliances are vital if the patient is at risk of dehydration.

The device can be left in situ for 29 days and is a cost effective way of managing acute diarrhoea (Johnstone, 2005). While there is a paucity of evidence for their use at the present time, if there is a risk of cross-infection with Clostridium difficile or norovirus, faecal management systems may reduce risk to other patients due to their ability to contain faecal matter.

8 DOCUMENT FREQUENCY OF EPISODES OF INCONTINENCE AND STOOL CONSISTENCY

It is important to observe changes in frequency of faecal or urinary incontinence as this may indicate an increase in risk status. Equally, if incontinence is becoming infrequent, the patient may be at less risk of skin breakdown. The Bristol stool chart should also be used to classify the form of the faeces.

9 EDUCATION OF PATIENTS AND/OR CARERS

Education should be based around the use of a structured skin care programme, including skin cleansers, skin protectors and continence management. It is important for the clinician to be aware of the possible causes of faecal and urinary incontinence. This knowledge will aid early identification of risk and timely intervention.

CONCLUSION

If clinicians adopt the tips described here they may be able to reduce the number of patients developing IAD and the associated pain, discomfort and embarrassment. WE

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