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MOISTURE LESIONS SIMPLIFIED



This simplified leaflet is intended to give you guidance on the prevention and management of MASD to aid clinical practice

MOISTURE ASSOCIATED SKIN DAMAGE

There are many terms used to describe moisture induced skin damage (Beekman et al, 2004). A moisture lesion is defined as being caused by urine and/or faeces and perspiration that is in continuous contact with intact skin of the perineum, buttocks, groins, inner thighs, natal cleft, skin folds and where skin is in contact with skin (AWTVF, 2014).

Moisture lesions can occur in any age group, but within the older age group the skin is more fragile and it can become damaged more easily.

Prolonged exposure causes the skin to become increasingly permeable, making it weaker and less elastic and more susceptible to physical damage from friction and shearing forces (Beekman et al, 2009).

Moisture lesions and Moisture Associated Skin Damage (MASD) occurs when moisture remains in constant contact with the body for prolonged periods of time, when the effluent contains irritating substances or when the effluent contains potential bacterial or fungal pathogens, or when moisture exposure increases friction at the skin surface.

FOUR TYPES OF MOISTURE ASSOCIATED SKIN DAMAGE

Incontinence associated dermatitis (IAD)

- The skin maintains a naturally acidic pH, usually between 4.0 and 5.5 (Bianchi, 2012)
- Ammonia from urine and enzymes from stool can disrupt the acid mantle of the skin and eventually cause the skin to break down stools (Rees and Pagnamenta, 2009)
- A systematic approach to the assessment of IAD, helps with early recognition of whether a patient is at increased risk of complications (Bianchi, 2012)



Periwound moisture associated dermatitis

- Excessive amounts of exudate can cause maceration and breakdown of periwound skin
- Exudate from chronic wounds has been found to contain a higher concentration of proteolytic enzymes as compared to exudate from acute wounds (Romanelli et al, 2010)
- Accurate and in depth wound and patient assessment must take place so that the most appropriate treatment can be planned for each individual (Forder, 2014)

Peristomal moisture associated dermatitis

- Inflammation and erosion of skin related to moisture that begins at the stoma/skin junction and can extend outwards in a 10cm radius (Colwell et al, 2011)



Intertriginous dermatitis

- An inflammatory skin condition that affects opposing skin surfaces
- Commonly found in the axillary and inguinal skin folds as well as under breasts in females
- Sweat is trapped in skin folds with minimal air circulation
- Leads to inflammation and dehydration of the skin making the area more prone to infection

PRESSURE ULCER V'S MOISTURE LESIONS

There is often confusion between a pressure ulcer and a moisture lesion due to the presence of moisture, which may be as a result of incontinence of urine and/or faeces (EPAUP, 2010)

- Moisture lesions are often reported as Stage II pressure damage
- Important to identify the cause of any skin damage, as the treatment and management of pressure damage and moisture lesions may differ (Fletcher, 2008)

PRESSURE ULCERS		MOISTURE LESIONS
Causes	Pressure and/or shear must be present	Desiccation and loose skin may indicate additional shearing injury
Location	A wound NOT over a bony prominence is unlikely to be a pressure ulcer	Moisture lesion may occur over a bony prominence. Pressure and shear should be excluded as causes, should moisture be present
Shape	Circular wounds with a regular shape that are limited to a single spot are likely to be a pressure ulcer	Diffuse, different superficial spots are more likely to indicate moisture lesions
Depth	Partial thickness up to full thickness skin loss	Superficial to partial thickness skin loss Depth may increase if they become infected
Necrosis	Necrosis can be present	No necrosis
Edges	Distinct edges	Diffused or irregular edges
Colour	Non blanchable, red skin is likely to be a pressure ulcer. However, within a wound red tissue indicates granulation whereas black necrotic tissue is likely to be a pressure ulcer	Redness that is not uniformly distributed is likely to be a moisture lesion whereas pink or white skin surrounding a wound is likely to be maceration due to moisture

PATIENT AND SKIN ASSESSMENT

Skin assessment and hygiene is a fundamental part of nursing care that is often neglected (Wounds UK, 2012)

A full and detailed patient review should include an assessment of the patient's continence status, mobility, nutrition, allergies and previous skin problems/wounds (Dowsett & Allen, 2013)

A risk assessment for skin breakdown that includes pressure ulcer risk assessment should be performed using a recognised tool (NPUAP/EPUAP 2009)

If skin is excoriated consider use of an excoriation Tool (HIS/NATVS, 2009)

PREVENTION AND TREATMENT OF MOISTURE LESIONS AND MOISTURE ASSOCIATED SKIN DAMAGE

- Wash skin after every episode of incontinence using water and emollients
Do not use soap (Beeckman et al, 2009)
- Ensure skin is thoroughly dried after washing
- Use moisturisers after washing and drying; antimicrobial content may be considered
- Consider a barrier protectant film or cream
- Consider the use of antifungal or antimicrobial creams
- Consider the use of body worn pads to protect the skin
- Consider the use of incontinence management aids
- Refer to a continence nurse where available (Guy, 2012)

References

- Beeckman D, Schoonhoven L, Verhage S, Heyneman A, Defloor T (2009) Prevention and treatment of incontinence associated dermatitis: literature review *J Adv Nurs* 65(6): 1141-54. Bianchi, J. (2012) Top tips on avoidance of IAD. *Wounds UK Supplement. The Identification and Management of Moisture Lesions.* 8 (2). Colwell JC, Ratliff CR, Goldberg M, et al (2011) MASD part 3: perisotimal moisture-associated dermatitis and periwound moisture-associated dermatitis: a consensus. *J Wound Ostomy Continence Nurse* 38(5): 233-241. EPAUP (2010) Pressure Ulcer classification – Differentiation between pressure ulcers and moisture lesions. EPAUP panel. Washington DC USA: NPAUP. Fletcher, J. (2008) Understanding the differences between moisture lesions and pressure ulcers. *Nursing Times.* 104,50/51 38-39 Forder,B.(2014) *ActivHeal PocketGuide. Exudate.* 4th Ed. Guy, H.(2012) The differences between moisture lesions and pressure ulcers. *Wound Essentials Vol 1.*36-44. Health Improvement Scotland/National Association of Tissue Viability Scotland (2009) *Wound Excoriation Tool.* All Wales Tissue Viability Nurses Forum (2014) Prevention and management of moisture lesions, available at: http://www.welshwoundnetwork.org/files/5514/0326/4395/All_Wales-Moisture_Lesions_final_final.pdf. Dowsett, C and Allen, L (2013) Moisture Associated Skin Damage. *Wounds UK* (9) 4.