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Introduction to Supplement 8(2): The identification and management of moisture lesions

### Original Citation

Ousey, Karen (2012) Introduction to Supplement 8(2): The identification and management of moisture lesions. *Wounds UK*, 8 (2). S3. ISSN 1746-6814

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SUPPLEMENT

Wounds<sub>UK</sub>



# THE IDENTIFICATION AND MANAGEMENT OF MOISTURE LESIONS

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To reference this document, cite the following:

Wounds UK (2012) *Moisture Lesions Supplement*. Wounds UK, London

## INTRODUCTION

Moisture lesions, moisture ulcers, perineal dermatitis, diaper dermatitis and incontinence associated dermatitis (IAD) all refer to skin damage caused by excessive moisture. Yet there is often confusion between pressure ulcers and this kind of lesion. Distinguishing between the two is of clinical importance since prevention and treatment are quite different for each (Defloor et al, 2005a). Due to the location of moisture lesions, they are often mistaken for pressure ulcers (Defloor et al, 2005b), however, skin damage as a result of excessive moisture is defined as being associated with incontinence and not pressure or shear (Defloor et al, 2005a), although moisture can contribute to the formation of pressure ulcers (EPUAP and NPUAP, 2009).

Gray et al (2012) defined IAD as erythema and oedema of the surface of the skin, sometimes accompanied by bullae with serous exudate, erosion, or secondary cutaneous infection. The risks of developing pressure ulcers or other problems with the skin increase where there is faecal and/or urinary incontinence, often resulting in maceration of the skin and friction (Cutting and White, 2002). This leads to the protective barrier of the skin being breached, allowing enzymatic attack (Wishin et al, 2008). It is of paramount importance that clinicians are able to correctly identify this and implement strategies for the prevention and/or treatment of these lesions.

The significance of correct identification and classification has never been more central, with many trusts identifying that moisture lesions are often incorrectly categorised as category 2 pressure ulcers. There are a range of tools that can be used for evaluation of IAD, including the Perineal Assessment Tool (Nix, 2002); the Peri-rectal Skin Assessment Tool (Storer-Brown, 1993); IAD Skin Condition Assessment Tool (Kennedy et al, 1996); and the IAD and its severity instrument (Borchert et al, 2010).

Proactive protection of the skin from maceration should be a priority, with regular skin inspection and cleansing and accurate recordings of skin assessment and frequency of incontinence episodes (Ousey and Gillibrand, 2010). A structured skin cleansing regimen that does not deplete the skin of moisture should be implemented. Nix (2006) recommended the use of as humectants, such as glycerine, esters, lanolin, cetyl or stearyl alcohol, and mineral oils, as they prevent the loss of natural moisture from the skin. Treatment goals recommended by Gray et al (2012) include protection of the skin from further exposure to irritants, establishment of a healing environment, and eradication any cutaneous infection.

Karen Ousey, June 2012

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