

# Distinguishing between Pressure Injury and IAD

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# The Problem

- Research demonstrates nurses have difficulty distinguishing pressure injury from incontinence Associated Dermatitis (IAD)
  - Beeckman et al (2010)
  - Mahoney et, al (2011)
- 17% agreement on the cause of the lesions in photographs
- Stages 1 and 2 pressure injury from IAD

# Definition

## Pressure injury (PI)

A pressure injury is localized damage to the skin and/or underlying tissue usually over a bony prominence or related to medical device. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue from pressure and shear may also be affected microclimate, nutrition, perfusion, co-morbidities and the condition of soft tissue.

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# Definition

- IAD- common skin disorder which causes contact dermatitis seen in patients with incontinence especially those with fecal incontinence. Included in Moisture Associated Skin Damage (MASD) along with intertriginous dermatitis (ITD).
- Type of irritant contact dermatitis
- Risk factor for PI but can occur in absence of pressure

# Other terms used

- Diaper/napkin/nappy dermatitis
- Diaper/napkin/nappy rash
- Irritant dermatitis
- Moisture lesions
- Perineal dermatitis
- Perineal rash

# Incidence of IAD

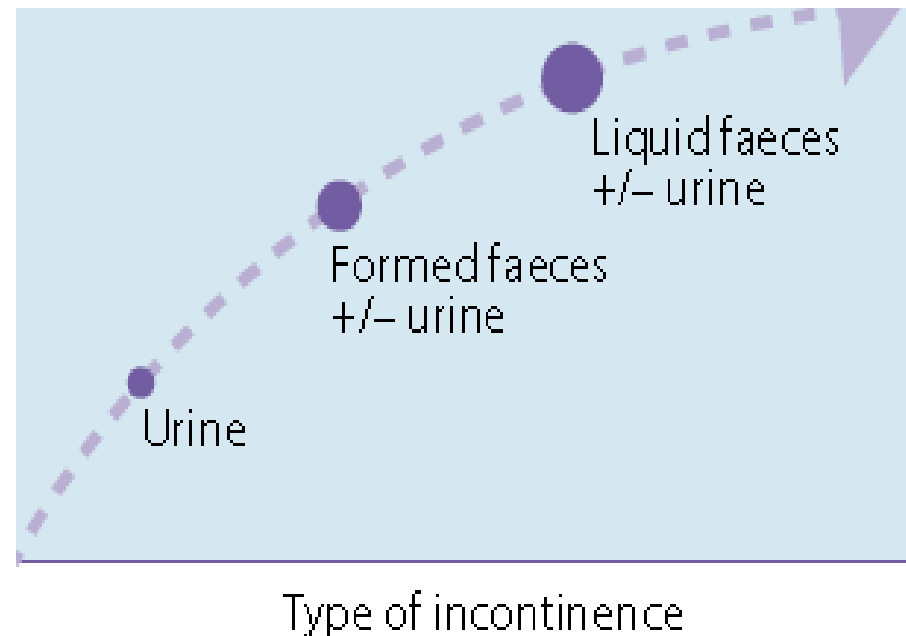
- 50% of nursing home residents have urinary incontinence
- 10 to 35% of community adults affected by urinary incontinence
- Fecal incontinence in nursing homes - 23-66%
- Unknown true incidence IAD

# Presentation of IAD

- Inflammation of skin surface characterized by redness which can lead to swelling and blister formation
- Urinary incontinence
  - in women seen in labia
  - In men the scrotum
  - In both inner thigh and buttocks
- Untreated lead to excoriation and skin breakdown

# Increasing Risk

Feces act as a direct chemical irritant to the skin and loose stools increase the risk and severity of IAD





# Risk Factors for IAD

- Incontinence: fecal, urinary, double incontinence
- Frequent episodes of incontinence
- Use of occlusive containment products
- Poor existing skin condition due to aging or \diabetes
- Decreased cognitive awareness
- Pain
- Inability to maintain personal hygiene

# Risk factors continued

- Medications such as steroids and antibiotics
- Poor nutritional status
- Critical illness
- Poor management of incontinence
- Poor mobility
- Increased body temperature

# Distinguishing IAD from PU injury

**TABLE 2 | Distinguishing IAD from pressure ulcers (adapted from<sup>10</sup>)**

Parameter	IAD	Pressure ulcer
History	Urinary and/or faecal incontinence	Exposure to pressure/shear
Symptoms	Pain, burning, itching, tingling	Pain
Location	Affects perineum, perigenital area; buttocks; gluteal fold; medial and posterior aspects of upper thighs; lower back; may extend over bony prominence	Usually over a bony prominence or associated with location of a medical device
Shape/edges	Affected area is diffuse with poorly-defined edges/may be blotchy	Distinct edges or margins
Presentation/depth	Intact skin with erythema (blanchable or non-blanchable), with/without superficial, partial-thickness skin loss	Presentation varies from intact skin with non-blanchable erythema to full-thickness skin loss  Base of wound may contain non-viable tissue
Other	Secondary superficial skin infection (e.g. candidiasis) may be present	Secondary soft tissue infection may be present

# Manage Incontinence

- Assess and treat reversible causes of incontinence
- Optimize nutrition, fluid management and toileting techniques
- Implement pressure injury prevention plan
- Implement Structured skin Care regiment
- Beeckman, D. (2015)

# Skin Care Regimen

Perform at least daily and after each fecal incontinence

- Cleanse-remove irritants from skin
- Protect-place a barrier on the skin to prevent direct contact with urine and/or feces
- Restore (when appropriate)-replenish the lipid barrier using suitable topical skin care product
- Beeckman, D. (2015)

# References

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