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.

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.

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.\(^3\)
Healthy Skin

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

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

For someone who’s incontinent, gently cleanse the skin with a product that is pH-balanced (4.5 - 5.5 pH of normal skin).

References
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

<table>
<thead>
<tr>
<th>Pressure ulcer</th>
<th>IAD</th>
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<tbody>
<tr>
<td><strong>Presentation</strong></td>
<td>Non-blanchable erythema of intact skin (stage I)</td>
</tr>
<tr>
<td><strong>Underlying factors</strong></td>
<td>Inflammatory response to ischemic damage of subdermal tissues over a bony prominence</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Over bony prominences: coccyx, sacrum, ischium. Also under tubes and other devices</td>
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<tr>
<td><strong>Pain</strong></td>
<td>Absent to severe</td>
</tr>
<tr>
<td><strong>Color</strong></td>
<td>Pink, red, yellow, tan, gray, green, brown, black</td>
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<tr>
<td><strong>Blistering</strong></td>
<td>Sometimes (stage II)</td>
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<tr>
<td><strong>Additional characteristics</strong></td>
<td>Intact discoloration, partial thickness, full thickness</td>
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</tbody>
</table>

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