

Pressure Ulcer vs Moisture Lesion

Skin damage, particularly on the sacral area, is often considered to be due to pressure damage, when frequently it is the result of prolonged exposure of the skin to moisture. Correct differentiation between pressure and moisture lesions is important for planning appropriate prevention and treatment strategies.

Definitions:

Pressure Ulcer

'Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.'¹

Moisture Lesion

'Skin damage caused by excessive moisture.'²
Includes terms such as perineal and diaper dermatitis and incontinence associated dermatitis (IAD).²

NB. Combined lesions can occur in the presence of both moisture and pressure/shear, both of which must be treated appropriately.

How to Diagnose³:

Cause	Pressure Ulcer Identifiable cause of pressure or shear	Moisture Lesion Identifiable cause of excess moisture eg. Incontinence, wound exudate, perspiration
Location	 Most likely over a bony prominence	 Can occur over a bony prominence - exclude pressure and shear. A linear (straight) lesion limited to the anal cleft is likely a moisture lesion. Peri-anal redness/irritation is most likely a moisture lesion due to faeces
Shape/Edges	 Regular shape with a more defined wound edge	 Diffusely scattered, irregularly shaped. If a 'kissing' lesion is observed across two adjacent surfaces, at least one is likely due to moisture
Colour	 Non-blanching redness or blue/purple discoloration is likely due to pressure damage. Red granulation, soft/black necrotic or sloughy tissue in the wound bed indicates a pressure ulcer	 If redness or discoloration is uneven, moisture damage is the likely cause. Pink or white surrounding skin indicates maceration
Depth	 Can vary in depth from unbroken non-blanching erythema to full thickness tissue loss extending to tendon or bone	 Superficial - Partial thickness skin loss, but may enlarge when infection is present
Necrosis	 Presence of necrosis (black scab or softening blue, brown, grey or yellow tissue) indicates a pressure ulcer	 Moisture lesions do not contain necrotic tissue

Incontinence Continuum for Skin Barrier Protection

How to Choose the Right Skin Barrier Product:

	Low	Moderate	High
Level of Incontinence Related Skin Damage			
Type and Severity of Incontinence	Urinary Incontinence +/- occasional Faecal Incontinence usually requiring infrequent to regular cleansing pad changes*	Urinary and/or Faecal Incontinence, usually formed or soft stool, usually requiring regular cleansing and pad changes**	Urinary and/or Faecal Incontinence, often liquid stool, usually requiring frequent cleansing and pad changes***
Skin Integrity	Intact +/- Erythema	Erythema/Dermatitis with <50% broken skin	Erythema/Dermatitis with >50% broken skin
Cleansing	Skin Friendly, pH Balanced Skin Cleansing Solution or Wipe		
Skin Barrier Protection	MEDI DERMA-S BARRIER CREAM 2g Sachet applied as required after each episode of incontinence		MEDI DERMA-S BARRIER FILM 1ml Film Applicator applied every 48-72 hours



*1-3 changes in 24 hours. **4-7 changes in 24 hours. ***≥8 changes in 24 hours (Guidance only). Adapted from the Nix DH (2002) Validity and Reliability of the Perineal Assessment Tool OWM 48(2): 43-49 and the (2009) Excoriation Tool available at www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/excoriation_tool.aspx accessed November 2015. **References:** 1. National Pressure Ulcer Advisory Panel (2007) available at: www.npuap.org/resources/educational-and-clinical-resources/npup-pressure-ulcer-stagescategories/ accessed 16th August 2015. 2. Wounds UK (2012) Moisture Lesions Supplement, Wounds UK, London. 3. Defloor T, Schoonhoven L, Fletcher J et al. (2005) Pressure Ulcer Classification: Differentiation between Pressure Ulcers and Moisture Lesions available at www.epuap.org/archived_reviews/EPUAP_Rev6.3.pdf accessed on 16th August 2015.