Understanding the differences between moisture lesions and pressure ulcers

Moisture lesions, frequently caused by incontinence, are often wrongly classified as pressure ulcers

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This one-part unit discusses the difference between pressure ulcers and moisture lesions. It explores the causes of these skin problems and highlights the need for patient care plans to reflect the underlying cause of the problem.

INTRODUCTION
Wounds on the sacrum are often classified as pressure ulcers and little thought is given to whether pressure is the true cause.

There are other reasons why wounds occur in this area. They are often related to incontinence, which can lead to incontinence dermatitis (ID) or incontinence-associated dermatitis (IAD).

ID is widespread superficial damage that is the result of episodes of incontinence. The whole sacral area can be red and angry, with multiple diffuse lesions.

Many practitioners still fail to differentiate between this and pressure damage.

Some lesions that are attributed to moisture (incontinence or perspiration) present with a much more focused area of damage than pressure ulcers. There may be a linear wound in the natal cleft between the buttocks or on the cheeks of the buttocks, with a wound often being present on both buttocks (a copy or kissing lesion).

It is important to identify the cause of lesions as the treatment and management of pressure ulcers and moisture lesions differ. A moisture lesion will not heal if treated purely by pressure reduction/relief. However, the presence of moisture may increase the risk of pressure ulceration so some pressure ulcer risk management is required.

Most healthcare environments now have good access to specialist beds, mattresses and seating, and most patients are routinely assessed for their pressure ulcer risk.

LEARNING OBJECTIVES
1. Identify the differences between pressure ulcers and moisture lesions.
2. Identify how management of moisture lesions may differ from that of pressure ulcers.

Unfortunately, the symptoms of incontinence are often managed with pads rather than the cause of the incontinence being investigated. This means that patients do not receive interventions to resolve or reduce the problems caused by moisture.

DEFINITION OF MOISTURE LESIONS
The European Pressure Ulcer Advisory Panel (EPUAP) first proposed that moisture lesions should be differentiated from pressure ulcers in 2005 (Defloor et al, 2005). This followed the work of a small working party which was reviewing the EPUAP pressure ulcer grading system (EPUAP, 1999).

It was apparent from many of the photographs of pressure ulcers reviewed during this process that a large proportion of the wounds identified as examples of grade 2 pressure damage were not ‘real’ pressure ulcers but lesions related to moisture and, possibly, friction. It was felt that this lack of differentiation inflated the number of pressure ulcers and led to inappropriate management.

This view is supported by Doughty (2005) who highlighted that accurate identification of causative factors is critical to effective skin care as good management begins with the correction of causative factors.

To prevent pressure damage, the most important factor is to reduce or relieve pressure. To prevent moisture damage, the most important factor is keeping the skin clean, dry and well hydrated. Clearly these are very different management options.

Clinically, separate identification of moisture lesions makes sense. They do not follow the same pattern as pressure ulcers. For example, they are not found over a bony prominence and can occur in areas of low pressure.

There has been some debate about whether there can be a true definition of a moisture lesion. Houwing et al (2007) studied 14 histopathological samples from patients with both pressure ulcers and incontinence lesions. Although he clearly identified two distinct histopathologies – an ischaemic pattern and a pattern of irritation – he concluded that this was insufficient evidence to justify the use of the term moisture lesion and he suggested the use of the term could be dangerous as it may lead to inadequate pressure ulcer prevention.

This conclusion seems inappropriate as incorrect identification of cause is likely to lead to inappropriate management and

TABLE 1. SHAPE OF SKIN DAMAGE (DEFOOR ET AL, 2005)

<table>
<thead>
<tr>
<th>Pressure ulcer</th>
<th>Moisture lesion</th>
<th>Remarks</th>
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<tbody>
<tr>
<td>● If the lesion is limited to one spot, it is likely to be a pressure ulcer.</td>
<td>● Diffuse different superficial spots are more likely to be moisture lesions.</td>
<td>● Irregular wound shapes are often present in combined lesions (pressure ulcer and moisture lesion).</td>
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<tr>
<td>● Circular wounds or wounds with a regular shape are more likely to be pressure ulcers; however, the possibility of friction injury has to be excluded.</td>
<td>● In a kissing ulcer (copy lesion), at least one of the wounds is most likely caused by moisture (urine, faeces, sweat or wound exudate).</td>
<td>● Friction on the heel may also cause a circular lesion, with full thickness skin loss. The distinction between a friction lesion and a pressure ulcer should be made based on history and observation.</td>
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pressure ulcer prevention should be based on the level of the patient’s measured risk rather than the existence of a wound on the sacrum. If there are distinct histopathological differences, there is a different cause and therefore a different diagnosis that would initiate different management.

**Clinical identification of moisture lesions**

To test the ability of nurses to grade pressure ulcers (using the EPUAP grading system) and also to differentiate between pressure ulcers and moisture lesions, EPUAP carried out a two-phase study using a standard set of 56 photographs of wounds (Defloor et al, 2006).

In the first phase of the study, a random selection of nine photographs from the set of 56 photographs were shown to 473 nurses. In the second phase, all 56 were presented to a different set of nurses (n=86) at baseline and again after a one-month interval (the photographs were presented in a different order on the second occasion).

The study found that nurses find it difficult to classify the grade of pressure damage and the difference between pressure ulcers and moisture lesions. The e-learning materials were tested with 212 qualified nurses and 214 student nurses (Beeckman et al, 2008).

The differential factors are: causes; location; shape; depth; necrosis; and edges and colour of the wound.

Descriptors are provided for each category to allow the clinician to identify the type of wound. Examples are given in Table 1.

**Combined presentation**

Although the descriptions seem clear – and differentiation therefore straightforward – this is frequently not the case in clinical practice.

A very common presentation is a combined lesion, where the patient has one or more wounds with elements of both pressure and moisture damage, for example in a patient who is immobile and has continence problems or who has pressure damage and a heavily exuding wound. It is important to be aware of all the causes of skin damage, assess the patient’s risk and plan management accordingly.

**REFERENCES**


**IMPORTANT OF CONTINENCE CARE**

Prevention and management of pressure ulcers has attracted a great deal of attention and resources but the same cannot be said for the management of incontinence.

Incontinence is frequently accepted as part of ill health, ageing and hospitalisation. In many instances, incontinence is simply managed with pads rather than the cause of the incontinence being investigated and interventions initiated. Incontinence remains a taboo subject. The prevalence of urinary or faecal incontinence is largely unknown and, where surveys have been undertaken, it is accepted that the figures are very much underestimates. Outbreaks of specific types of diarrhoea – for example those related to *Clostridium difficile* – raise the profile of faecal incontinence but this can lead to an assumption that all incontinence is manageable with antibiotics. This is not the case for most patients with incontinence.

**CONCLUSION**

Clinicians should develop assessment skills and management strategies to manage pressure ulcers, moisture lesions and also the combined lesion. In this way, best use can be made of resources and patient pain, suffering and loss of dignity can be avoided.