Introduction

Description and identification of skin ulcers are key components of a sound assessment. The etiology of injury drives several aspects of care:

- Interventions based on main causes of injury are more effective
- Coding for reimbursement must be accurate
- Pressure ulcer prevalence and incidence data is published and is considered a marker of the quality of care

Buttock ulcers or non-blanchable erythema is designated as a pressure ulcer if it is over a bony prominence; therefore it is essential to document the location of bony prominences if present. We propose an educational tool for all clinical settings that is intended to teach skills necessary in this very important endeavor. Use of the process of elimination improves the ability of staff to determine whether a buttock ulcer is a pressure ulcer (PU), and to identify incontinence-associated dermatitis (IAD), moisture-associated skin damage or another etiology.

Step 1: Position the person for optimal exam

- Turn the person to a side-lying position
- Place pillow(s) in front of the person and move them forward
- Place their upper arm and leg on the pillow(s)

Step 2: Look, listen and feel!

- Feel
  - Gently palpate the area under and near the wound. Displace the skin toward the head while palpating since this often occurs when a person is sitting up.
  - Is there a bony prominence or not near the buttock?
  - Is it firm, does it blanch?

- Look
  - Is there intact red skin, be sure to palpate and document also whether it is blanchable erythema or not.

- Listen
  - Does the person moan or speak of pain or tenderness when areas are palpated?

Step 3: Document your findings

- Use current wound flow sheet or assessment form but add details for the initial assessment in clinician notes. See examples of wording above.

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Other buttock ulcers, such as IAD, abrasions or maceration, are described as partial-thickness or superficial. NOT as a Stage 1 or 2 PU.1

If a PU is identified, refer to the NPUAP November 2009 staging system and guidelines for treatment.1

If the injury is not over a bony prominence, or due to a device, the main etiology is likely not pressure; the injury should not be staged using the NPUAP system.1

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Discussion

The chances of developing a PU are 22 times more likely in someone with fecal incontinence.1 The consequences of PUs are quite serious, both from a personal perspective and from a facility and professional perspective. We must learn to differentiate the types of skin injury in order to treat them early and avoid devastating Stage 3 or 4 PUs. Palpation is a necessary part of the assessment for any ulcer in the buttock area. Using anatomic landmarks, a professional can accurately determine whether an ulcer is likely over a bone prominence, even when the prominence is not palpable due to overlying adipose tissue. Once the location and etiology are accurately determined, the clinician can proceed using either a PU care plan (NPUAP November 2009 staging system and guidelines) or the IAD-I” to determine the interventions that will most likely result in a healing outcome.


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Review of posterior pelvic anatomy

The sacral prominence occurs where the last lumbar vertebra joins the sacrum. It rests between the iliac crests at the top of the gluteal fold (often called the “buttock crease”). In larger individuals the sacral prominence may not be palpable. Use anatomic landmarks described when documenting findings. For example: “The sacral bone is in the mid-line at the level of the iliac crests; therefore, it is determined to be a sacral prominence pressure ulcer”. The sacral bone is triangular and located just below the prominence. The coccyx is closer to the area, near the level of the trochanters. It only protrudes in a sitting position, which makes it difficult to palpate. Coccyx PUs are only in the mid-line and occur in a sitting position. They are much less common than sacral or ischial ulcers.