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

A buttock ulcer 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.

REFERENCES


Example of wording for Early IAD:
“After assisted to a semi-prone position for exam, dry, intact erythematous skin is observed surrounding the anus and along both sides of the gluteal cleft from bilateral gluteal creases to the top of the gluteal cleft. The edges are diffuse and irregular. By palpation there is no bony prominence and it is blanchable erythema. When area is gently palpated, patient reports tenderness. In the gluteal cleft there is white skin, evidence of maceration, and in this area is a superficial fissure 2cm along the mid-line of the cleft.”

Example of wording for Moderate IAD:
“After assisted to a semi-prone position for exam, an area of erythematous skin with numerous punctuate areas of bleeding and diffuse, irregular border is noted 6cm around the anus and extending past bilateral gluteal creases 4 cm on posterior thighs. This area would include tissue over the ischial tuberosities, but is blanchable erythema therefore by definition not a pressure ulcer injury.”

Example of wording for Severe IAD:
“After assisted to a semi-prone position for exam, areas of epidermal denudement are noted on each buttock on the surfaces that would be touching the bed or bed pad in a recumbent position. EMTs report that person was found lying in bed in a pool of stool at home. Denuded areas are red, shiny and oozing minimal serosanguinous exudate. Borders are diffuse and irregular. There are no bony prominences in the denuded areas.”

Example of wording for Pressure Ulcer:
“After assisted to a semi-prone position for exam, an area of non-blanchable erythema is noted over the sacral prominence, just below the level of the iliac crests. There is an area of superficial denudement on the right buttock 3cm to the right of the gluteal cleft. On palpation this is noted to be over the right iliac posterior superior iliac spine. The cleft and peri-anal skin is intact. There is also very superficial excoriation between the 2 bony prominences injuries in an abrasion pattern so likely friction is a main risk factor in these pressure ulcer injuries.”
Discussion

The chances of developing a PU are 22 times more likely in someone with fecal incontinence. 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 bony 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-IT© to determine the interventions that will most likely result in a healing outcome.