

Pressure Ulcers vs Incontinence-Associated Dermatitis (IAD): A Differentiation Guide

Moisture-Associated Skin Damage (MASD)

MASD is an umbrella term used to describe inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture¹ i.e. urine, faeces, wound exudate, perspiration and stoma effluent.

Incontinence-Associated Dermatitis (IAD)

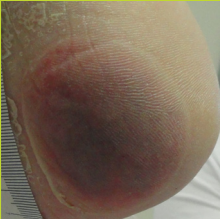









Skin damage as a result of continuous exposure to urine and/or faeces is known as incontinence-associated dermatitis (IAD), one of the commonly recognised causes of MASD. It typically presents as localised redness, with areas of partial thickness skin loss. Whereas pressure ulcers are localised

damage to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.²

Pressure Ulcers & Incontinence-Associated Dermatitis (IAD)

Skin damage, particularly around the sacral area, is often considered to be due to pressure damage, when frequently it is a result of IAD. These two conditions can present simultaneously in an individual, so must be correctly identified to plan appropriate prevention and treatment strategies.

Differentiation Guide

| Cause | Pressure Ulcer Established cause - Pressure and/or shear | Incontinence-Associated Dermatitis (IAD) Established cause - Continuous exposure to urine and/or faeces |
|-------------|--|---|
| Location |  Most likely over a bony prominence |  Can occur over a bony prominence if moisture present - 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. Where there is necrotic tissue within the IAD, this will be due to a combination of both pressure and moisture damage and should be reported as a pressure ulcer. ⁴ |

References: 1. Grey M, Black JM, Baharestani MM, et al (2011) Moisture associated skin damage: an overview and pathophysiology. *J Wound Ostomy Continence Nurse* 38(3): 233-41. 2. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Australia; 2014. 3. Beekman D, Woodward, S & Gray, M. (2011). Incontinence-associated dermatitis: Step-by-step prevention and treatment. *British journal of community nursing*. 16(8): 382-9. 4. NHS Improvement (2018) Pressure ulcers: revised definition and measurement Summary and recommendations. All images are reproduced with the kind permission of their respective owners.