Moisture Related Skin Breakdown
An Effective Treatment Option by Louise Taylor, Stoma Care Nurse Specialist

CASE STUDIES

Introduction
Faecal and urinary output along with other exudate can contribute to moisture associated skin damage leading to mild erythema, chemical erosion and moisture lesions. This is especially challenging in acute care settings where patients are less mobile with multiple, compromising health problems (Brunner et al 2012).

Urinary and/or faecal incontinence challenges the integrity of the skin by breaking down its natural barriers (Brunner M 2012, Gray M et al 2012). Four risk factors play a part in skin breakdown related to incontinence: moisture (urine, perspiration, stool, wound exudate), skin pH, colonisation with microorganisms and friction. Prolonged contact with the moisture leads to maceration of the skin resulting in a change to an alkaline base (Beldon P 2013, Beeckman D et al 2010, Colwell J et al 2011, Bianchi J 2012). Friction causes destruction of the maturated epidermides from bed linen or incontinence pads and bacteria continue to grow in the moisture (Gray 2007, Beeckman et al 2009).

Reducing the risk factors associated with the occurrence of moisture lesions will limit their incidence (Colwell J 2011, Gray 2012). Daily inspection of the skin and cleaning with a cleansing foam or pH neutral soap will help. Protection of intact or broken/weeping skin with a skin protectant or skin barrier is recommended. (Gary M et al 2012, Beeckman et al 2010, Colwell J et al 2011) ILEX Skin Protectant has been evaluated in the following case studies with often dramatic results.

CASE STUDY 1

Patient: 1yr 4mths baby boy who had pull through surgery, resulting in very frequent bowel motions and very excoriated skin.

Before ILEX
Pain score was 10/10 to 2/10 immediately after applying ILEX.

Day 2
of using ILEX wound size decreased to 2cm x 3cm (2). Day 4 of using ILEX wound is healed (3). Parents found ILEX to be significantly better than the barrier creams as ILEX is not fully removed at each nappy change. With reduction of pain baby could mobilise and return to normal activities.

Results
Day 1 Pain score 2/10 immediately after applying ILEX.

Day 2 of using ILEX wound size decreased to 2cm x 3cm (2).

Day 4 of using ILEX wound is healed (3).

Case study by Karen Dick, Specialist Surgeon, Paediatric Surgical Unit.

CASE STUDY 2

Patient: 66 year old female with poor mobility, nutrition and respiratory disease and a devascularised poorly sited stoma due to a medical emergency.

Before ILEX
Dehisced laparotomy wound with fistula. Excoriated skin due to the output from the fistula surrounding the deader wound. A different dressing, changed daily, had been used for 4 weeks with poor results.

Results
Day 1 (21.11.12) Deep wound 20cm x 10cm with paper thin excoriated skin surrounding it. Pain score 4-5/10 before application of ILEX was applied. Reduced to 1/10 immediately after application.

Day 4 (24.11.12) Skin surrounding the wound is no longer excoriated or broken. Pain score is now 2/10 before application of ILEX and 0/10 afterwards.

Case study by Karen Dick, Specialist Surgeon, Paediatric Surgical Unit.

CASE STUDY 3

Patient: 3 month baby boy who had very poor nutrition, respiratory disease and a denascularised poorly sited stoma due to a medical emergency.

Before ILEX
Pain score of 10/10. Morphine and chloral hydrate to try and control pain.

Baby’s peristomal skin and umbilicus were severely excoriated due to faecal contents spilling on the skin.

Over 7 weeks many treatments were tried and failed. Up to 10 stoma bags a day plus up to an hour of stoma care each time to change a bag.

Results
Day 1 Once ILEX is applied the pain score was 0/10.

Day 3 The wound area was 95% improved.

Day 5 The wound was 98% healed and a seal and stoma bag could be used.

Case study by Sara McGarry, Surgical Outreach Specialist Nurse, St Mary’s Hospital.

REFERENCES


ILEX Health Products Ltd
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Method
To monitor whether ILEX Skin Protectant is both a clinically effective and cost effective treatment option a series of case studies have been collated with the help of health care professionals and parents. Consent was obtained for publication. In each case ILEX has been used after several other treatments on excoriated skin have failed. The wounds have been caused by prolonged contact with moisture. Often the patient has also found the wounds very painful before commencing treatment with ILEX.

ILEX contains a copolymer which is hydroactive, causing a barrier to be instantly created on contact with moisture. ILEX can also be used in conjunction with other treatments if required such as antibacterial or antifungal creams - it is just applied over the treatment layer.