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Moisture-associated Skin Damage: a Timely Report of an Oft Forgotten Clinical Problem

Letter to the Editor - Intensive & Critical Care Nursing

Dear Editor

I thank Johansen and colleagues for raising the visibility and awareness of the problem of moisture-associated skin damage (MASD) in the intensive care unit (ICU) patient population through their thoughtful and timely point prevalence study (Johansen et al., 2020). MASD is seldom prioritised by critical care researchers and consequently remains an under-reported phenomenon in clinical practice. However, MASD is an umbrella term that encompasses several dermatitis conditions: intertriginous dermatitis, peristomal dermatitis, periwound dermatitis and incontinence-associated dermatitis (IAD) (Beeckman et al., 2015).

In the ICU, IAD is an iatrogenic condition. IAD is seen in the patient in ICU because of the pathophysiological sequelae of the critical illness itself (e.g. gut hypoperfusion) and treatments such as multiple antibiotics, inotropes, sedation, pain relief and enteral feeding. Further, critically ill patients are invariably bed bound and unable to self-toilet thus enhancing their risk for the development of IAD (Beeckman et al., 2015, Coyer and Campbell, 2018).

Epidemiological studies, such as Johansen and colleagues work, are being increasingly used as gauges of quality of care and effectiveness of skin integrity protocols. Johansen et al. (2020) in their point prevalence investigation, identified rates of MASD where MASD was classified as IAD, or MASD other than IAD. Although in recent years, our understanding of MASD and IAD has improved (Beeckman, 2017), the use of clear clinical definitions for conditions accompanied by when conducting prevalence and incidence studies is paramount (Baharestani et al, 2009). While I acknowledge undertaking work in a fledgling area is difficult, I question the reported IAD prevalence rate of 5.4% (6/112) displayed in Table 2. Defining the study 'at risk' population will have a fundamental impact on the study findings. If patients are not incontinent, they cannot develop IAD. Johansen and colleagues clarify this where they report IAD prevalence because of faecal or urinary incontinence (10.5%, 5/48) in their results section. This is the true IAD prevalence rate of this study. Valid application of the results of prevalence studies relies on clear presentation of study definitions, including denominators and numerators.

Interestingly, Johansen et al. (2020) found a low prevalence of skin breakdown and that skin care was a priority for Norwegian nurses working in the ICU. Johansen's study used the gold standard of a prospective visual skin assessment, a commendable undertaking. Notably, their study found low rates of care plans for the prevention and management of MASD in this patient population. This is consistent with other international work and highlights the lack of focus on this important area of essential clinical practice (Coyer and Campbell, 2018).

Well conducted international studies are essential to raise awareness of MASD and IAD in the critically ill patient population. Johansen and colleagues' study (2020) provide important information on this topic and makes a valuable contribution to optimising patient skin safety.

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