“Skin Failure” as a Cause of Pressure Ulcers: Accurate Terminology, Misnomer, or Cop Out?

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Many in the wound care community use the term skin failure to suggest a cause for the development of a pressure ulcer. I respectfully challenge the term in that context.

In the May 2012 issue of Ostomy Wound Management, the authors of “A Prospective, Descriptive Study of Characteristics Associated With Skin Failure in Critically Ill Adults” stated, “Critically ill patients with multi-organ failure are especially susceptible to problems with skin integrity, including skin failure. These patients frequently have alterations in tissue perfusion and, because of their failed organs, are unable to maintain homeostasis. This may lead to the death of the skin and underlying structures.” The key terms here are susceptible and tissue perfusion. I agree skin is susceptible to pressure ulcers, but in this context, skin rarely dies without pressure. This article defines skin failure as “an event in which skin and underlying tissues die due to hypoperfusion concurrent with critical illness.” I challenge this definition by asking, Where does the skin die? A similar question may be asked regarding the Kennedy Terminal Ulcer. In true skin failure, it would be reasonable to expect to see dying skin over any part of the body. However, in most of the literature, when the term skin failure is used in relation to pressure ulcers, almost all of the “skin failures” are over pressure points.

That begs the question: What is failing — we clinicians or the skin? In the dermatological literature, skin failure is defined in different ways. In my opinion, Isaac’s definition is most accurate: “There is interference with skin function as a result of damage or loss of a large area of skin resulting in loss of barrier function, haemodynamic problems, impaired thermal regulation, alterations in immunological functions, metabolic, endocrine and haemodynamic changes.” The author gives several examples of where the skin actually fails or dies: exfoliative dermatitis, toxic epidermal necrolysis, staphylococcal scalded skin syndrome, Steven-Johnson Syndrome, acute graft versus-host disease, necrotizing fasciitis, and Toxic Shock Syndrome.

Why is it important how we use the term skin failure when dealing with pressure ulcers? If a patient in the ICU develops a pressure ulcer, how do we determine whether this was due to multi-organ failure and skin failure or to our lack of implementing adequate pressure relief? Although I am not implying all pressure ulcers are preventable, it is often too easy to attribute a pressure ulcer to “skin failure.” In my opinion, skin failure-based pressure ulcers are few and far between. More concerning is that pressure ulcers are far too common in our ICUs; almost all of them could have been prevented.

The bottom (and heel and occipital) line: Clinicians need to consider whether skin failure actually caused the pressure ulcer, is a misnomer in the context of pressure ulcers, or is a cop out to explain our lapse in care. We can all judge for ourselves.

References
2. Olshansky K., Kennedy Terminal Ulcer and “skin failure”: where are the data? J WOCN. 2010;37(5):466.

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Correction
In the article Schlüer AB, Halfens RJ, Schols JG. Pediatric pressure ulcer prevalence: a multicenter, cross-sectional, point prevalence study in Switzerland. Ostomy Wound Manage. 2012;58(7):18-31, one of the authors’ names was incorrectly presented. It should read Prof. Jos. MGA Schols, MD, PhD. The Editors apologize for the error.