Long-Term Care Survey Alert

Wound Assessment: Don't Let Pressure Ulcer Impostors Rob You of Solid Clinical and Survey Outcomes

If these wound types aren't on your 'rule out' list, you can't rule out F314 and F309 tags.

You've no doubt heard the saying, "if it walks and quacks like a duck, then it's probably a duck." Some skin wounds, however, may initially look and act like a pressure ulcer when they are really wounds of a very different feather. And incorporating the right assessment strategies can help identify the true nature of these wounds as soon as possible.

Cautionary example: A clinician assessed a wound located on a patient's right hip as a pressure ulcer and created a treatment plan for it, said **Beth Hawkins Bradley, RN, MN, CWOCN,** with Care On Call LLC in Blythewood, S.C., during an Eli-sponsored audioconference on wound care. During treatment, the wound developed a necrotic center after having been 100 percent granular.

Rather than carrying on the pressure-wound treatment, Bradley asked the patient if he had an idea of what caused the wound. The patient then shared that he didn't know because he never lies on his side. That piece of information led Bradley to investigate the patient's history because "you can't have a pressure ulcer without pressure," she relayed.

"It turned out that the patient had a five-year history of lymphoma" and the wound was actually caused by the lymphoma rather than by pressure, said Bradley. And that diagnosis paved the way for a new treatment plan.

Terry Treadwell, MD, has seen two patients with lymphoma of the foot. "One person had four or five areas of skin breakdown that were draining a little bit." Clinicians thought one of the areas was a diabetic foot ulcer, reports Treadwell, medical director for the Institute of Advanced Wound Care in Montgomery, Ala.

Cancer lesions, in fact, "can appear anywhere," Treadwell counsels. "They may be primary [cancers] or part of metastatic disease."

Follow These 4 Detection Steps

Cancer-related lesions aren't the only ones that can confound wound assessors. But you can avoid being duped -- here's how.

1. Take a close look at a wound's location. "The key to diagnosing a pressure ulcer is that the ulcer should be in a pressure-prone area, which is most commonly over a bony prominence," says **Michael Miller, DO,** medical director of Wound Healing Centers in Bedford and Greenwood, Ind.

Make sure a so-called pressure ulcer isn't really a callus, which would be in a place where the body builds a callus to protect a bone from repeated friction. **Steven Warren, MD, DPA**, has seen providers mistake calluses for pressure ulcers. In one recent case, a physician ordered debridement of what was really a small amount of skin breakdown on top of a large callus. The debridement "created a deep, ugly wound," says Warren, a nursing home medical director in Bountiful, Utah.

Another example: Wounds caused by deep intramuscular (IM) injections will appear in the hip area, but IM injections aren't typically administered over a bony prominence, says Treadwell (for details, see MDS Alert, Vol. 8, No. 9, or for a free copy of the article, e-mail the editor at KarenL@Eliresearch.com).

2. Examine the wound for certain telltale characteristics. "Pressure ulcers typically have a rounded appearance, if they were caused purely by pressure and not friction-sheering forces," says Miller. Wounds caused by friction and shear are

usually "elongated in the direction of the friction or shear."

3. Home in on non-healing wounds. In addition to asking what caused a wound, ask why a wound isn't healing, advised Bradley in the Eli audioconference. Answering that question may help you correctly diagnose a non-pressure ulcer, as it did for Bradley, so the team can move to Plan B quickly.

Key clue: "If you're providing pressure relief -- and a skin ulcer is expanding -- then it's time to do a tissue biopsy," says Miller. He advocates "doing a small tissue biopsy of the wound base and also the skin-wound interface where you get a piece of skin and wound." A biopsy can identify whether you're dealing with "cancer, an autoimmune process, or some unusual condition masquerading as a wound," he adds.

Example: A pyoderma gangrenosum, which is an "autoimmune bacterial wound," can be misdiagnosed as a pressure ulcer, says Warren. He's seen facilities and wound-care providers start out treating such wounds as pressure ulcers -- "and the wounds just keep getting worse. Then the nurses report the wound [on the MDS] as a pressure ulcer, and the facility gets cited for a non-healing pressure ulcer," Warren cautions. "You may have to use drugs to treat the autoimmune condition and several different antibiotics to heal the wounds."

Of course, infection can cause both non-pressure and pressure-related skin ulcers to stop healing or deteriorate. And you might see a non-pressure related abscess caused by methicillin-resistant Staphylococcus aureus or another organism in an area of the body with excessive moisture, such as the buttocks or perineal area, says Treadwell. "You have to do a biopsy culture to best determine if a wound is clinically infected."

4. Use a team approach to evaluate tricky wounds. "Sometimes you have to do a little detective work to get the etiology of a wound correct," says **Elizabeth A. Ayello, PhD, RN, ACNS-BC, CWON, MAPWCA, FAAN,** president of Ayello, Harris & Associates Inc., in Albany, N.Y. "You need the team to look at a wound with different eyes, get a comprehensive assessment of the resident, and ask: 'What are we seeing?'"