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Health Matters

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Skin Failure

Unlike other failing organs, skin changes are visible

As caregivers know, a serious skin issue could manifest something like this: *A relatively healthy person with Alzheimer's who is well cared for in a long-term care residence suddenly develops a pressure ulcer on the coccyx. Despite immediate intervention, the patient's condition deteriorates. Within days there is further skin breakdown including blisters and mottling. Compassionate palliative care ensues and the person dies within three weeks.*

This is "skin failure," the topic of a very thought provoking commentary by Dr. Jeffrey Levine and published in **Advances in Skin Care**, May 2017.

In the editorial, Levine describes the urgent need to develop a new classification system; one that would unify the language of pressure injuries, be consistent across all settings and easy to understand. He also says that what must follow is research for better patient outcomes.

Levine – a renowned geriatric expert specializing in wound care and pressure ulceration – walks readers through many issues including the array of names for terminal ulceration: Decubitus ominosus, Trombley-Brennan Terminal Tissue Injury, and Skin Changes at Life's End (**SCALE**), all which (he says) can leave caregivers "deservedly confused."

More to the point, Levine cites sources of diverse opinion, where some thought leaders view pressure injuries *as* skin failure while others view pressure injuries and skin failure as separate entities.

Additionally, he describes conundrums that must be solved:

"…to the hospice community, there are 2 phases prior to death: the preactive phase of dying and the active phase of dying. On average, the preactive phase may last approximately 2 weeks, whereas the active phase lasts approximately 3 days. If a pressure injury occurs during the preactive or active phase of dying, most wound care specialists would agree that this could be classified as a terminal ulcer. But what if a pressure injury occurs before the active or preactive phase -is this still a terminal ulcer? And what if a patient develops a pressure injury, and his/her life is prolonged by medical interventions, or he/she recovers from the brink of death?"

Ultimately, Levine proposes: **Skin failure should be recognized as the common denominator for unavoidable wounds that occur close to death**, and further argues it would be the catalyst for defining the common mechanisms of organ failure while also leading to its acceptance as a medical diagnosis that could one day go beyond its "terminal" designation.

Readers also learn that it was the great 19th century French neurophysiologist, Jean Martin Charcot (1825-1893), who recognized that skin ulcers precede death, and who described and named them decubitus ominosus.

A few other points from Levine's commentary:

- Skin (the largest organ of the body) can fail regionally as well as systemically
- Presently, the most distinctive diagnostic criterion for terminal ulcer is the acknowledgement that a patient is dying
- Recognition of skin failure across the continuum will create opportunities for developing a unifying concept defined by poor tissue tolerance and many other factors (hypoxia, decreased clearance of toxic metabolites etc.) that lead to a lowered threshold for injury from mechanical stress

Reference

Unavoidable Pressure Injuries, Terminal Ulceration, and Skin Failure: In Search of a Unifying Classification System
Levine, Jeffrey M. MD, AGSF, CMD, CWSP
Advances in Skin & Wound Care: May 2017 - Volume 30 - Issue 5 - p 200–202