TOTAL BARRIER PROTECTION™
PREVENT. PROTECT. REPAIR. RESTORE.
WWW.TBPSKINCARE.INFO

Sirona care & health

Important Notification of Product Change within Sirona Care and Health

On 1st November 2017, Secura Barrier Cream D and Proshield were replaced with:

MEDI DERMA-S
Total Barrier Cream
and
Total Barrier Film

MEDI DERMA-*PRO*
Skin Protectant Ointment
and Foam & Spray
Incontinence Cleanser

Sirona Care and Health switched from Secura Barrier Cream D and Proshield to **MEDI DERMA-S** Skin Barrier products on 1st November 2017 in conjunction with North Bristol NHS Trust, UH Bristol, Weston Area Health Trust, Bristol Community Health and North Somerset Community Partnership.

Please visit: **www.tbpskincare.info** for clinical guidance and further information regarding the **MEDI DERMA-S** and **MEDI DERMA-*PRO*** Skin Protectants Range.

PART OF OUR SKIN PROTECTANTS & WOUND CARE RANGE

HEALTHCARE GRADE CERTIFIED FORMULATION

For any other enquiries, please contact:
Lisa Parry (Territory Manager), Medicareplus International on 07464 678948,
or email **lisa.parry@medicareplus.co.uk**

Medicareplus INTERNATIONAL

Medicareplus International Limited
Chemilines House | Alperton Lane | London | HA0 1DX | UK
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www.medicareplus.co.uk

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Pressure Ulcer vs Moisture Lesion

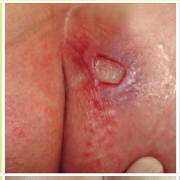
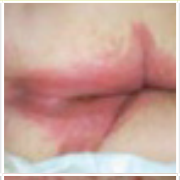
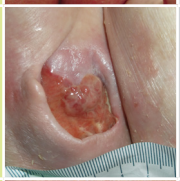
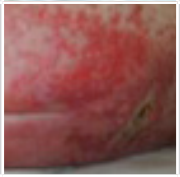
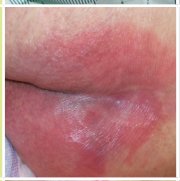
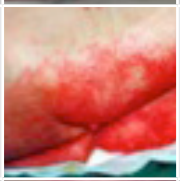
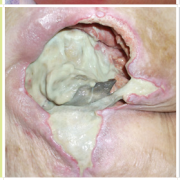
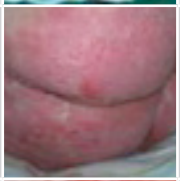
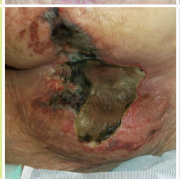
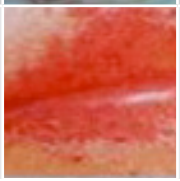
Skin damage, particularly on the sacral area, is often considered to be due to pressure damage, when frequently it is the result of prolonged exposure of the skin to moisture. Correct differentiation between pressure and moisture lesions is important for planning appropriate prevention and treatment strategies.

Definitions:

Pressure Ulcer
'Localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear'.[1]

Moisture Lesion
'Skin damage caused by excessive moisture'.[2]
Includes terms such as perineal and diaper dermatitis and incontinence-associated dermatitis (IAD).[2]
NB. Combined lesions can occur in the presence of both moisture and pressure/shear, both of which must be treated appropriately.

How to Diagnose[3]:

Cause	Pressure Ulcer Identifiable cause of pressure or shear		Moisture Lesion Identifiable cause of excess moisture eg. Incontinence, wound exudate, perspiration	
Location		Most likely over a bony prominence		Can occur over a bony prominence - exclude pressure and shear. A linear (straight) lesion limited to the anal cleft is likely a moisture lesion. Peri-anal redness/irritation is most likely a moisture lesion due to faeces
Shape/Edges		Regular shape with a more defined wound edge		Diffusely scattered, irregularly shaped. If a 'kissing' lesion is observed across two adjacent surfaces, at least one is likely due to moisture
Colour		Non-blanching redness or blue/ purple discolouration is likely due to pressure damage. Red granulation, soft/black necrotic or sloughy tissue in the wound bed indicates a pressure ulcer		If redness or discolouration is uneven, moisture damage is the likely cause. Pink or white surrounding skin indicates maceration
Depth		Can vary in depth from unbroken non-blanching erythema to full thickness tissue loss extending to tendon or bone		Superficial – Partial thickness skin loss, but may enlarge when infection is present
Necrosis		Presence of necrosis (black scab or softening blue, brown, grey or yellow tissue) indicates a pressure ulcer		Moisture lesions do not contain necrotic tissue

MPL722/MCP/MD-S/SIRONA/FORMULARY LAUNCH&PUVSML/A5/11.18

References: 1. National Pressure Ulcer Advisory Panel (2007) available at: www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/ accessed 16th August 2015. **2.** Wounds UK (2012) Moisture Lesions Supplement, Wounds UK, London. **3.** Defloor T, Schoonhoven L, Fletcher J et al. (2005) Pressure Ulcer Classification: Differentiation between Pressure Ulcers and Moisture Lesions available at www.epuap.org/archived_reviews/EPUAP_Rev6.3.pdf accessed on 16th August 2015.

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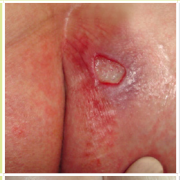
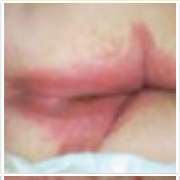
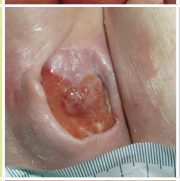
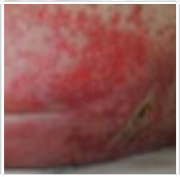
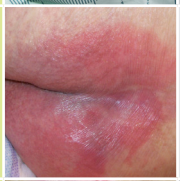
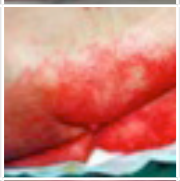
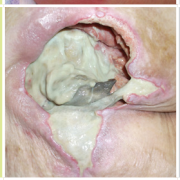
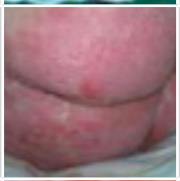
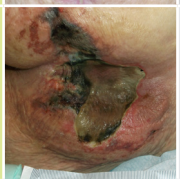
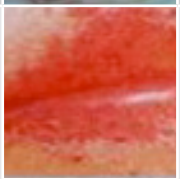
Location		Most likely over a bony prominence		Can occur over a bony prominence - exclude pressure and shear. A linear (straight) lesion limited to the anal cleft is likely a moisture lesion. Peri-anal redness/irritation is most likely a moisture lesion due to faeces
Shape/Edges		Regular shape with a more defined wound edge		Diffusely scattered, irregularly shaped. If a 'kissing' lesion is observed across two adjacent surfaces, at least one is likely due to moisture
Colour		Non-blanching redness or blue/ purple discolouration is likely due to pressure damage. Red granulation, soft/black necrotic or sloughy tissue in the wound bed indicates a pressure ulcer		If redness or discolouration is uneven, moisture damage is the likely cause. Pink or white surrounding skin indicates maceration
Depth		Can vary in depth from unbroken non-blanching erythema to full thickness tissue loss extending to tendon or bone		Superficial – Partial thickness skin loss, but may enlarge when infection is present
Necrosis		Presence of necrosis (black scab or softening blue, brown, grey or yellow tissue) indicates a pressure ulcer		Moisture lesions do not contain necrotic tissue

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