Integumentary Assessment

Introduction
The integumentary system includes the skin, hair and nails. Make sure there is adequate lighting and have the patient change into a gown. Have a small tape measure or magnifying glass available to measure or examine lesions more closely. A thorough skin examination is particularly important in older adults. Ageing causes atrophy and xerosis (drying) of the skin, leading to increased susceptibility to skin breakdown and pressure injury. Skin cancer risk increases with age. Other at-risk groups include patients with chronic diseases such as diabetes and peripheral vascular disease, and patients on chronic corticosteroids (topical or systemic).

Patient History
Obtain a history of the patients skin conditions, skin changes and risk factors. Risk factors for poor skin health include ageing, chronic steroid use, diabetes, peripheral vascular disease, peripheral neuropathy, smoking, alcohol abuse, familial or personal history of skin cancer, history of severe sunburns, tanning bed use, dehydration, incontinence, radiation therapy, and poor nutrition.

Optimal Patient Positioning
- If possible, examine the patient first seated, then standing; or examine the patient while supine, then prone.
- Ask permission to expose any areas covered by the gown before adjusting the gown to see each area.
- Consider patient comfort, modesty, and having a chaperone present during these examinations.
- Use good lighting and magnifying lens, when needed.

Exam Methods
- Inspection
    - To ensure that all areas are examined, consider this order for inspection.
        - *While patient is seated*
            - Assess the hair, noting the distribution, texture, and quantity.
            - Use your fingers or cotton-tipped applicator to separate the hair and examine the scalp from one side to the other.
            - Inspect the head and neck, including forehead, eyebrows, eyelids, eyelashes, conjunctivae, sclerae, nose, ears, cheeks, lips, oral cavity, chin, and beard.
            - Have the patient lean forward to assess the upper back.
            - Inspect the shoulders, arms, and hands, including the fingernails.
            - Inspect the anterior chest and abdomen, followed by the anterior thighs and legs.
            - Assess the feet and toes including the soles, interdigital areas, and toenails.
        - *While patient is standing*
            - Inspect the lower back, followed by the buttocks, posterior thighs and legs.
            - Lastly, inspect the breasts, axillae, and genitalia including hair in the axillae and pubic area.

- Palpation
    - While inspecting the integumentary system, palpate the fingernails and toenails, and also any lesions to determine texture, firmness, and scaliness.

PEARLS

- Skin color findings:
    - Pallor indicates anemia.
    - Cyanosis can indicate decreased oxygen in the blood or decreased blood flow in response to a cold environment.
    - Jaundice, or yellowing of the skin, results from increased bilirubin.
- Longitudinal bands of pigment on the nails are normal in people with darker skin.
- Special considerations for darkly pigmented skin:
    - Erythema may appear dark brown, instead of pink or red
    - Eczema may appear as scaly lesions with grayish or dark brown hue
    - Wheals may appear lighter in color
    - Dry skin may appear whitish or ashy and/or a reduction in shininess of skin
- If performing a routine physical assessment, integrate aspects of the integumentary assessment into that examination. For example, when auscultating the lungs posteriorly, fully assess the back at that time.
- Skin breakdown can result from ill-fitting casts or other medical devices.
- Special considerations for hospitalized patients or patients who are largely confined to a bed or wheelchair:
    - Acutely or chronically ill patients with poor mobility, malnutrition, incontinence and altered sensation are often identified as having a high risk of developing a pressure injury.
    - Assess for skin integrity over bony prominences, such as the sacrum and heels.
    - In some cases, deep tissue injury can occur before any changes on the surface of the skin are discernible. Note changes in skin color compared with the surrounding skin or in comparison to the skin on the contralateral side of the body.
    - Blanchable erythema is a sign of redness on the skin that turns white when pressed with a fingertip and returns to red when the pressure is removed. Blanchable erythema is an indicator of potential capillary injury that can develop into a pressure injury.
- Note any variations in heat or firmness.
- Teach the patient about regular skin self-examination and the ABCDE-EFG method for assessing moles.
- Document your findings using the correct terminology to describe skin lesions. Photographs of wounds and rashes are helpful for documenting a baseline and response to treatment.

References

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