

# Skin tears: A literature review

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## Introduction

Skin tears are reported to be a common occurrence in the elderly<sup>1</sup> because of age related skin changes and associated disease processes. The depth of literature with regard to skin tears is indeed limited, yet skin tears may cause pain and suffering to the individual as well as monetary cost to the individual, hospital and community<sup>2-6</sup>. In some cases, skin tears may become infected and require surgical intervention, or become chronic wounds<sup>5,7-10</sup> and the occurrence of skin tears may present as an indicator of the quality of care in healthcare facilities<sup>9,11,12</sup>. However, there is no consensus for the prevention and management of skin tears, and evidence based protocols are limited<sup>12,13</sup>, with many of the existing protocols generated by dressing product manufacturers.

This literature review was conducted to identify the scope and management of these wounds in relation to a hospital based investigation into skin tear occurrence. Electronic sources searched included Pubmed, Proquest, CINAHL, Ovid, and Cochrane Collaboration. A hand search of Australian non-listed, or recently listed peer reviewed journals, such as the *Journal of Stomal Therapy Australia, Primary Intention, World Council of Enterostomal Therapy Journal*, and Australian Wound Management Association conference proceedings since the inaugural meeting was conducted.

Over the last twenty years, skin tears have been identified as a specific wound entity and classified by type<sup>11,14</sup>. There is limited literature as to the prevalence and incidence of skin tears, but common themes in the demographics of persons sustaining skin tears are reported. The common anatomical

locations where skin tears occur, specific predisposing risk factors, and causes of skin tears have also been described.

The effects of ageing cause significant skin changes, which predispose the elderly to skin tears. Australian reports show the general population is ageing. It is predicted the percentage of the Australian population aged 65 years and over will increase from 13.3% in 2006 to 21.2% in 2021<sup>15</sup>. This ratio will increase further to 27.1% by the year 2051. Of perhaps greater significance will be the number of 'older elderly', with the percentage of the population aged over 80 years expected to increase from 3.6% in 2006 to 10.4% in 2051.

## The Effects of ageing on the skin

There are a number of age related skin changes observed histologically. These include decreased collagen and elastin, flattening of the dermal-epidermal ridge through flattening of the dermal papillae and rete ridges, loss of dermal thickness, and loss of subcutaneous fat<sup>16-18</sup>. Vascular changes are evident with arteriosclerotic changes in the small and large vessels, thinning of vessel walls, and a reduction in the vascular network<sup>19,20</sup>. Cellular deficiencies include a reduction in mast cells, a decreased number of Langerhan's cells, loss of melanocytes, fewer T-lymphocytes with reduced responsiveness to specific antigens and mitogens, and a reduction in Merkel cells, Meissner cells and Pacinian corpuscles<sup>20,21</sup>. Glandular changes include a decrease in the number and function of sweat glands, and sebaceous gland hyperplasia with decreased sebum production<sup>21,22</sup>. An increased skin surface pH, increased transepidermal water loss and a reduction in skin moisture with ageing is also reported<sup>23</sup>.

As a consequence of these changes, the skin becomes thinner, wrinkled, fragile and dry. There is decreased vascular responsiveness and capillary fragility, decreased tactile sensitivity and pain perception, compromised thermoregulation, impaired immune responsiveness, reduced inflammatory response, delayed hypersensitivity and altered moisture retention. This leads to a diminished resistance to shearing forces and increased susceptibility to

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blistering or abrasion following mild mechanical trauma. Other physiologic changes include a reduction in skin repair rate, barrier function and sweat production<sup>19,21</sup>.

There are a number of other factors that affect the epidermal skin barrier. These include skin disorders due to the presence of oedema including that due to lymphoedema and venous insufficiency, eczematous conditions, xerosis, skin type and pigmentation<sup>24</sup>. Underlying disease processes such as diabetes mellitus and some medications may also influence the skin barrier<sup>24</sup>. Corticosteroids have a particularly detrimental effect on the skin with loss of dermal collagen, skin atrophy, increased capillary fragility and purpura, and delayed wound healing<sup>25,26</sup>. Other factors that impact on the skin barrier include moisture, sun exposure, radiation, environmental factors and topical agents<sup>22</sup>. Adequate nutrition and hydration are also important to maintain the structure and function of the skin. Inadequate intake of proteins, carbohydrates, fats, vitamin and minerals have a detrimental effect on skin regeneration and repair<sup>8,27</sup>.

The elderly may also experience concomitant disease processes that affect vision, mobility, mental state and general independence<sup>11</sup>. The effects of ageing and associated factors not only predispose the elderly to skin tears but also impair the wound healing process<sup>16</sup>.

## Skin tear definition and classification

The term 'skin tear' was possibly first described by Cuzzell in 1986<sup>14</sup> and has emerged in the literature as a definitive wound entity<sup>9,12-14,28-30</sup>. Skin tears are caused by trauma – commonly friction and shear forces. The skin injury presents as a laceration or skin flap, with separation of epidermis and/or dermis<sup>1</sup>.

Payne and Martin<sup>14</sup> provided an operational definition of a skin tear that acknowledged the cause, type and location of skin injury, as well as the population most affected, and this was later refined to:

A skin tear is a traumatic wound that occurs principally on the extremities of older adults, as a result of friction alone, or shearing and friction forces, which separate the epidermis from the dermis (partial thickness wound) or which separate both the epidermis and dermis from underlying structures (full thickness wound)<sup>31</sup>.

A classification system for skin tears is described by Payne and Martin<sup>31</sup> and outlines skin tear appearance and degree of tissue loss at the site of injury:

Ia. A linear skin tear is a full thickness wound which occurs in a wrinkle or furrow of the skin. Both the epidermis and the dermis are pulled apart as if an incision has been made, exposing the tissue below.

Ib. A flap type skin tear is a partial thickness wound in which the epidermal flap can be completely approximated or approximated so that no more than one (1) millimeter of the dermis is exposed.

IIa. A skin tear with scant tissue loss is a partial thickness wound in which 25 % or less of the epidermal flap is lost and in which at least 75% or more of the dermis is covered by the flap.

IIb. A skin tear with moderate to large tissue loss is a partial thickness wound in which >25% of the epidermal flap is lost and in which >25 % of the dermis is exposed.

III. A skin tear with complete tissue loss is a partial thickness wound in which the epidermal flap is absent.

An increasing use of this definition and classification system has been reported internationally<sup>2,3,5,11,32-37</sup>, but there is no published evidence as to the inter-rater reliability of the Payne Martin skin tear classification system.

## Skin tear incidence and prevalence

Skin tears have presented as a common problem in the older population and this is reflected in the settings where most skin tear prevalence and incidence is reported:

- Payne and Martin<sup>14</sup> report a 2.23% (n=20) incidence of skin tears across ten long-term care facilities (896 beds) in Louisiana during a five-month period. There was a total of 50 skin tears, or an average of 2.5 per resident. These residents were referred for inclusion into the study and this may have underestimated the actual number of residents acquiring skin tears.
- In a large urban long-term care facility in Wisconsin a retrospective review of skin tear incident reporting over a one-year period found 321 reports met the study criteria with a 0.92 per patient per year skin tear incidence<sup>9</sup>. However, it was recognised that there may have been substantial under-reporting, with skin tears possibly occurring at three times this rate.
- A 347 bed Western Australian aged care facility found an incidence of 133 skin tears over a six-month period<sup>13</sup>. Prior incidence of skin tears was reported to be 41.5% in 1991.

- In a retrospective study of a 120 bed Jewish nursing facility in Eastern Virginia over a six-month period, an average of 14% of the population per month had a skin tear<sup>12</sup>. Following this, a one-year concurrent study found 85 residents with 227 incidents of skin tears, the equivalent of 16% of the population sustained a skin tear per month with an average of 2.67 skin tears per resident.
- Mason<sup>38</sup> reports a 24.8% (n=43) incidence of skin tears amongst 173 residents of a long-term care facility in Louisiana over a four-month period. The rate per resident varied from 0.42 to 0.7 skin tears per month. Lower rates (0.43 vs 0.66) were recorded for those residents who received an emollient antibacterial soap instead of the non-emollient antibacterial soap.
- In Veterans Affairs nursing facilities in Washington DC, a prospective review of incidents over six months was undertaken<sup>11</sup>. There were 154 incidents of skin tears amongst 154 residents. It appears that each resident had one skin tear. In this group 79.2% experienced previous tears.
- Edwards et al<sup>39</sup> report that 54 residents acquired skin tears from four wards (approximately 120 beds) in two Australian nursing homes during a three-month trial of different dressing regimens.
- A Western Australian community domiciliary nursing care provider found skin tears (excluding the lower leg) comprised 5.5% (n=92) of all wounds in their wound prevalence survey<sup>40</sup>. In a similar wound care prevalence survey amongst a community Department of Veteran Affairs population, a 19.5% (n=43) prevalence of skin tears was demonstrated with 10% occurring on the lower leg and 9.5% elsewhere<sup>41</sup>.
- A retrospective study<sup>4</sup> found a prevalence of 23.5% amongst 29 bed-bound residents in a 72-bed long-term care facility prior to a change in skin care and bathing practices. Post-intervention rates reduced to 3.5%, a substantial reduction when compared with previous prevalence rates of 25 – 39% during the preceding eleven months.
- McErlean et al<sup>37</sup> report a skin tear point prevalence of 10.7% (n=20) amongst a sample of 187 patients in eleven wards at a Repatriation General Hospital in South Australia, with rates as high as 27% in the palliative care ward, 21.7% in the respiratory medicine ward and 18.5% in the aged care ward.
- A similar skin tear point prevalence conducted at a Western Australian adult tertiary teaching hospital identified a prevalence of 9.4% (n=39) with a total of 72 skin tears<sup>42</sup>.
- A skin tear incidence of 6.6% (n=2) during a ten-month period was recorded following implementation of a skin care program for the prevention of skin tears and pressure ulcers in a thirty bed residential Alzheimer's Unit in Arizona<sup>2</sup>.

## Demographics

Skin tears are most often reported in the elderly female population with ratios ranging from 4:1 to 10:1 females to males<sup>9,11,14,35,38,39</sup>. This difference is not found to have significance, but is postulated to be a reflection of females living longer and female numbers being greater in residential facilities<sup>11</sup>. Recent Australian data (2001 – 2003) support this with only 35% of males having a life expectancy of 85 years compared with 53% of females<sup>15</sup>.

The age of individuals who sustain skin tears is usually >80 years with many studies reporting the mean age at 85 years<sup>4,7,9,11,12,14,35,38,39</sup>. Carville and Lewin<sup>40</sup> found that the greatest cause of wounds in those aged 80 years and over is trauma. The incidence of skin tears also increases significantly with increasing age<sup>9</sup>.

## Anatomical location of skin tears

Skin tears usually occur on the extremities and this is reflected in the Payne Martin skin tear definition and the literature generally<sup>7,9,11,14,35,37</sup>. Most skin tears occur on the upper extremity or body with up to 80% reported on those anatomical positions<sup>7,9,11,14,35,37</sup> as evident in Table 1. Exceptions to this were found by Everett and Powell<sup>13</sup> who report 58% occurred on the lower limb, and Edwards et al<sup>39</sup> who report 60% occurrence on the lateral or anterior aspect of the lower leg.

## Skin tear classification

There are few descriptive studies where the categories of skin tears are reported<sup>11,14,37</sup>. The majority of these skin tears, with the exception of the small sample reported by Payne and Martin<sup>14</sup>, were found to have either no tissue/flap loss, or <25% tissue loss, that is category Ia, Ib, or IIa (see Table 2).

## Risk factors

Many risk factors for skin tears have been identified and are listed below:

Author and Year	Anatomical Location						
	Upper arm	Forearm	Elbow	Hand	Wrist	Leg	Other
Payne and Martin 1990 <sup>14</sup>	7%	16%	42%	13%	-	22%	-
						Anterior 10%, Posterior 13%	
Malone et al 1991 <sup>9</sup>	17.8%,	24%	18.4%,	19.6%	-	10.9%,	Head 4%, Foot 3.1%, Trunk 1.2%
Everett and Powell 1994 <sup>13</sup>	13% (not reported separately)		11%	13%	-	50%	Head 4%, Foot 8%, Other 2%
White et al 1994 <sup>12</sup>	59% (Upper extremity – not reported separately)					29%	Other 12%
McGough-Csarny & Kopac 1998 <sup>11</sup>	11%	39.1%,	8.2%,	15.1%,	-	18.5%	Head 3.4%, Back 1.4%, Feet 1.36%
Thomas et al 1999 <sup>35</sup>	3% (Shoulder)	34%	12%	12%	9%	29%	-
Meuleniére* 2002 <sup>7</sup>	3%	32%	9%	18%	6%	32%	-
McErlean et al 2004 <sup>37</sup>	-	-	-	-	-	-	Upper body 63%, lower body 36%
Morey et al 2004 <sup>42</sup>	10%	23%	19%	10%	-	30%	Foot 2%, Buttock 2%, Abdomen 2%, Back 2%

– Not all studies recorded individual skin tear locations.

\*This study included only category I and II skin tears

Table 1. Studies Reporting Anatomical Locations of Skin Tears.

- Advanced age: The most common risk factor with the majority being aged 80 years or over <sup>7,9,11-14,41</sup>.
- Dependence for activities of daily living, including the need for bathing, dressing and transferring <sup>7,11,12</sup>.
- Impairment in mobility with poor locomotion or unsteady gait, and confinement to bed, chair or wheelchair <sup>11-14</sup>.
- A history of previous skin tears <sup>7,11,12,14</sup>.
- Compromised nutritional status due to poor nutritional intake, hypoalbuminaemia, eating disorders, inability to feed oneself, or being tube fed <sup>7,11,14</sup>.
- Sensory and cognitive deficits inclusive of communication difficulties, impaired decision making, dementia, Alzheimer's disease, decreased tactile sensation, hearing impairment and visual deficits <sup>7,11-14</sup>.
- Visible changes in the skin condition including senile purpura, loss of subcutaneous tissue, skin fragility, bruises, pitting oedema and dry skin <sup>11-14</sup>.
- Polypharmacy regimens (four or more regularly prescribed medications) and drugs such as corticosteroids, anticoagulants, analgesics, antidepressants, sedatives and drugs with dehydrating effects <sup>7,11,13,14</sup>.
- Agitation and resistive or combative behaviour in the elderly <sup>9,11,13</sup>.
- Cardiac, pulmonary and vascular disorders <sup>7,11</sup>.

## Causes

Whilst the primary cause of skin tears is mechanical trauma in the form of friction and shear, the precipitating activities

Author and sample	Payne Martin Skin Tear Classification % by category				
	Ia	Ib	IIa	IIb	III
Payne and Martin <sup>14</sup> 10 patients, 31 skin tears	12.9	6.4	25.8	9.7	45
McGough et al <sup>11</sup> 154 patients with skin tears	50.6	26	16.9	3.9	2.6
McErlean et al <sup>37</sup> 20 patients, 33 skin tears	9	21	36.3	15	18
Morey et al <sup>42</sup> 39 patients, 72 skin tears	21	15	23	8	33

Table 2. Skin Tear Occurrence by Classification.

include movement by the patient or carer in combination with equipment or environmental factors<sup>7,11-13</sup>.

Common precipitating causes include:

- A knock, eg the simple act of getting out of bed or bumping into bed rails, other furniture or equipment<sup>7,9,13,39</sup>.
- Transferring out of beds or chairs<sup>7,9,11,12,14</sup>.
- Falls<sup>9,11,13,37</sup>.
- Bathing, dressing and putting on or taking off stockings<sup>7,39</sup>.
- The use of restraints<sup>7,9</sup>.
- Removal of tapes or adhesive dressings, and taking blood<sup>3,7</sup>.
- Staff jewellery, watches, fingernails and silverware<sup>11</sup>.

However, in many cases the cause of the skin tear remains unknown<sup>9,14</sup>.

## Dressings for skin tears

There is no consensus as to a preferred wound dressing for skin tears. Often the skin flaps are stabilised or secured with skin closure strips<sup>2,5,8,13,14,18,30,37,39,43,44</sup>. Almost all dressing categories have been reported for use on skin tears, often in combination with skin closure strips, and include:

- Paraffin gauze<sup>13,18,37,43</sup>.
- Low or non-adherent dry dressings<sup>5,18,37,39</sup>.
- Polyurethane transparent films<sup>5,8,9,35,37,39,44</sup>.
- Hydrogels<sup>5,7,18,43</sup>.

- Hydrocolloids<sup>5,13,14,37,39</sup>.
- Calcium alginates<sup>5,13,43,44</sup>.
- Foams<sup>5,7,13,35,39</sup>.
- Composite dressing (eg Combiderm ACD™)<sup>44</sup>.
- Hydrofibres<sup>37</sup>.
- Soft silicone net<sup>7</sup>.
- Soft silicone foam<sup>45</sup>.

Antiseptic agents are also used for the treatment of skin tears, where contamination occurred at the time of injury or there is subsequent infection of the skin tear<sup>5,13,37,43</sup>. The type of dressing selected often varies according to the classification of the skin tear, exudate amount, skin fragility and individual patient factors<sup>7,13,37,44</sup>. General principles of management endorsed by most authors include cleaning the skin tear, removing any residual clot or debris, replacing and securing the skin flap where present and covering with a dressing<sup>1,5,7,13,18,30,37,39,43,44</sup>. These authors promote moist wound healing principles and protection of the wound and surrounding skin from further trauma.

## Conclusion

Skin tears may not be recognised as a major wound entity because of their limited depth of injury and yet there is emerging recognition of their impact in health care settings. It is important to recognise the needs of our ageing population and to educate and prepare at-risk individuals for their occurrence. Therefore, to optimise outcomes, it becomes the responsibility of healthcare providers to educate, prevent, protect and treat individuals at risk of skin tears. This review reflects the need for further research into skin tear occurrence and management across a range of settings.

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