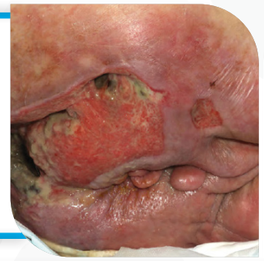
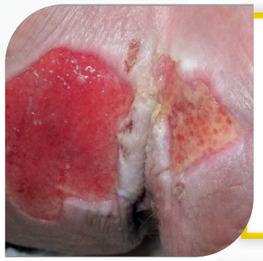
Pressure Ulcer or Moisture Associated Skin Damage (MASD)?[1]

A **pressure ulcer** is 'localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear





MASD is defined as inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus or saliva

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Wound Attributes	Pressure Ulcer	MASD	Additional Comments
Cause	Pressure or shear present	Moisture must be present	If both pressure/shear and moisture present it could be a combined lesion
Location	Over a bony prominence	May occur over a bony prominence but pressure and shear should be excluded as causes, and moisture should be present.	A combination of moisture, pressure and friction may cause moisture lesions in skin folds.
Shape	Circular wounds or wounds with a regular shape are most likely, but the possibility of friction injury has to be excluded.	Indistinct superficial spots are more likely. In a kissing ulcer at least one of the wounds is most likely caused by moisture.	Irregular or diverse wound shapes are often present in a combined lesion.
Depth	Partial-thickness skin loss is present when only the top layer of the skin is damaged (cat 2). In full thickness skin loss, all skin layers are damaged (cat 3 or 4)	Superficial depth (partial thickness skin loss). In cases where the moisture lesions get infected, the depth and extent of the lesion can be enlarged/deepened extensively	If friction is exerted on a moisture lesion, this will result in superficial skin loss in which skin fragments are torn and jagged
Necrosis	A black necrotic scab on a bony prominence is a pressure ulcer.	There is no necrosis in MASD	Necrosis softens up and changes colour but is never superficial. Distinction should be made between necrotic scab and a dried-up blood blister
Edges	If edges are distinct, most likely.	Often have indistinct, diverse or irregular edges	Jagged edges are seen in moisture lesions that have been exposed to friction.
Colour	**Red:** if non-blanchable, most likely cat 1 For people with darkly pigmented skin persistent redness may manifest as blue or purple **Red in the wound bed:** granulation tissue and likely cat 2, 3 or 4 **Yellow in wound bed:** slough or softened necrosis, likely cat 3 or 4 **Black in the wound bed:** Black necrotic tissue indicates cat 3 or 4	**Red:** If not uniformly distributed, likely to be a moisture lesion **Pink or white surrounding skin:** Maceration due to moisture	**Red skin:** If the skin (or lesion) is red and dry or red with a white sheen, it could be a fungal infection. **Green in wound bed:** Infection likely.

References:
1. Susan Yates (2012) Differentiating between pressure ulcers and moisture lesions. Wound Essentials 2012, Vol 2 p16-22

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