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GLOBIAD

Ghent Global IAD Categorisation Tool

THE GHENT GLOBAL IAD CATEGORISATION TOOL

Version 1.0 June 2017

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PREFACE

Incontinence-associated dermatitis (IAD) is a specific type of irritant contact dermatitis characterized by erythema and oedema of the peri-anal or genital skin. In some cases, IAD is accompanied by bullae, erosion or secondary cutaneous infection (Gray et al., 2012). The aetiology of IAD is complex and multifactorial (Beeckman et al., 2009). Excessive skin surface moisture resulting in skin maceration, chemical, and physical irritation enhances the permeability of the skin compromising the skin barrier function (Mugita et al., 2015).

IAD prevalence and incidence figures vary by type of setting and populations. The prevalence of IAD is estimated between 5.7 and 22.8%, and the incidence of IAD between 3.4 and 50% (Gray et al., 2012). These differences may be explained by the lack of internationally agreed diagnostic criteria and the potential confusion with superficial pressure ulcers or other skin conditions (Beeckman et al., 2007). A recent Cochrane review revealed a substantial heterogeneity of reported outcomes and instruments in IAD research (Beeckman et al., 2016).

We are pleased to introduce the Ghent Global IAD Categorisation tool (GLOBIAD). The tool is the result of a two-year project involving 22 international experts and 823 clinicians from 30 countries. The GLOBIAD categorises IAD severity based on visual inspection of the affected skin areas. It aims to create an internationally agreed description of IAD severity, and to standardize the documentation of this condition in clinical practice and research.

The GLOBIAD is now available for introduction in clinical practice. We welcome any feedback and translations of the GLOBIAD in languages other than English. Please contact us via SKINT@UGent.be.

Kind regards

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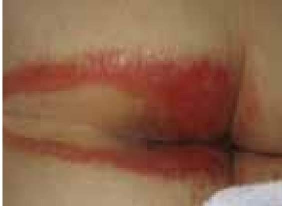
GLOBIAD

Ghent Global IAD Categorisation Tool

Category 1: Persistent redness

1A - Persistent redness without clinical signs of infection



Critical criterion

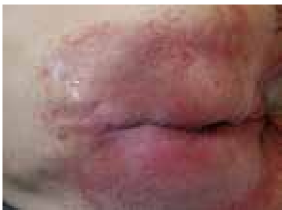
- Persistent redness
  A variety of tones of redness may be present.
  Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Additional criteria

- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

1A

1B - Persistent redness with clinical signs of infection



Critical criteria

- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.
- Signs of infection
  Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection).

Additional criteria

- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- The skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

1B

Category 2: Skin loss

2A - Skin loss without clinical signs of infection

Critical criterion

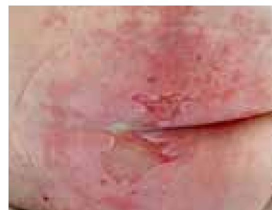
- Skin loss
  Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation.
  The skin damage pattern may be diffuse.

Additional criteria

- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

2A

2B - Skin loss with clinical signs of infection



Critical criteria

- Skin loss
  Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation.
  The skin damage pattern may be diffuse.
- Signs of infection
  Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection), slough visible in the wound bed (yellow/brown/greyish), green appearance within the wound bed (suggesting a bacterial infection with Pseudomonas aeruginosa), excessive exudate levels, purulent exudate (pus) or a shiny appearance of the wound bed.

Additional criteria

- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

2B

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The categories do not necessarily relate to the natural history of IAD and are not intended to suggest how IAD may develop or progress. This categorisation tool may prove useful in the monitoring of IAD prevalence and incidence, and for research purposes.

CATEGORY 1: PERSISTENT REDNESS

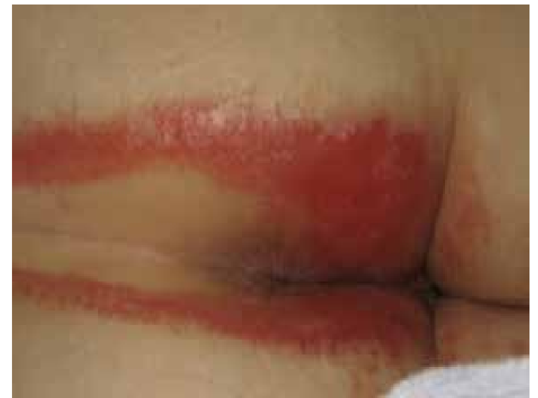
Category 1A: Persistent redness without clinical signs of infection

Critical criterion

Persistent redness

A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Additional criteria



- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

Category 1B: Persistent redness with clinical signs of infection

Critical criteria

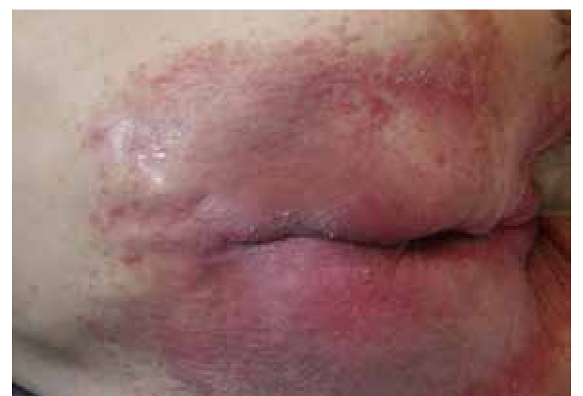
Persistent redness

A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour.

Signs of infection

Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection).

Additional criteria



- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

CATEGORY 2: SKIN LOSS

Category 2A: Skin loss without clinical signs of infection

Critical criterion

Skin loss
Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.

Additional criteria

- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

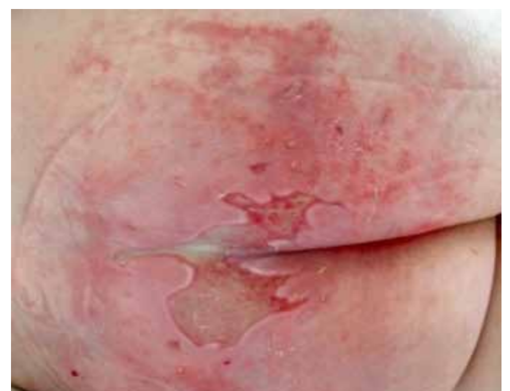
Category 2B: Skin loss with clinical signs of infection

Critical criteria

Skin loss
Skin loss may present as skin erosion (may result from damaged/eroded vesicles or bullae), denudation or excoriation. The skin damage pattern may be diffuse.

Signs of infection
Such as white scaling of the skin (suggesting a fungal infection) or satellite lesions (pustules surrounding the lesion, suggesting a Candida albicans fungal infection), slough visible in the wound bed (yellow/brown/greyish), green appearance within the wound bed (suggesting a bacterial infection with Pseudomonas aeruginosa), excessive exudate levels, purulent exudate (pus) or a shiny appearance of the wound bed.

Additional criteria



- Persistent redness
  A variety of tones of redness may be present. Patients with darker skin tones, the skin may be paler or darker than normal, or purple in colour
- Marked areas or discolouration from a previous (healed) skin defect
- Shiny appearance of the skin
- Macerated skin
- Intact vesicles and/or bullae
- Skin may feel tense or swollen at palpation
- Burning, tingling, itching or pain

GLOSSARY

Bulla	A circumscribed lesion > 1 cm in diameter that contains liquid (clear, serous or haemorrhagic), a large blister
Erosion	Loss of either a portion of or the entire epidermis
Excoriation	A loss of the epidermis and a portion of the dermis due to scratching or an exogenous injury
Maceration	An appearance or surface softening due to constant wetting - frequently white
Papule	An elevated, solid, palpable lesion that is ≤ 1 cm in diameter
Pustule	A circumscribed lesion that contains pus
Scale	A visible accumulation of keratin, forming a flat plate or flake
Swelling	Enlargement due to accumulation of oedema or fluid, including blood
Vesicle	A cicumscribed lesion ≤ 1 cm in diameter that contains liquid (clear, serous or haemorrhagic), a small blister

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