

Skin Assessment

A skin assessment begins with inspecting the surface of the skin, ideally from head to toe. Skin inspection begins by observing abnormal skin pigmentation changes. Remember skin pigmentation is generally consistent throughout the body and linked to the patient's genetic heritage. Observe the skin for pallor by inspecting areas where superficial blood capillaries, like oral mucous membranes or sclera may appear pale as this is an absence or decreased amount of oxygen-rich blood. Erythema occurs where vasodilation or areas of excess intravascular blood can be visualized, and may be linked to a fever or other systemic inflammatory condition. Cyanosis is found in places where superficial capillaries are present, such as the tips of fingers or the nose. Cyanosis presents as a bluish mottling and can vary based on race or ethnicity. Jaundice is presented as a yellowish hue, occurring when there is an excessive amount of bilirubin in superficially vascular areas such as the hard and soft palate of the mouth. Palpate the skin to determine temperature. Temperature can range from cool to warm, and provides valuable information about systemic circulation, areas of inflammation, or concerning areas of decreased perfusion. Tactile and visual observation for excess or an absence of moisture on the skin can reveal valuable insight about a patient's current condition. Diaphoresis, or sweating, occurs when the body tries to cool itself when under high metabolic stress, such as during a heart attack or during strenuous cardiovascular activity. A patient exhibiting signs of dehydration may have dry, flaky skin. Checking the skin for edema, or fluid accumulation interstitially, occurs by imprinting your thumb for 3 to 4 seconds on a dependent location such as the patient's anterior tibia and looking for "pitting edema." Finally, look for lesions on the skin and note six characteristics: color, elevation, pattern or shape, size, location and distribution and presence of exudate. Conclude the assessment by palpating any lesions present to support observation of the six characteristics.



PLAY PICMONIC

Inspect the skin

Observe for Abnormal Skin Pigmentation

Abnormal Pig

Assess the patient's skin from head to toe, asking the patient if there are concerning areas or lesions. Skin color derived from the pigments melanin, carotene and underlying vascular tone can result in differing hues of light (or hypopigmented) and dark (hyperpigmented) color. Abnormal presentation on inspection can be an area of skin with differing pigmentation than the surrounding tissue or reciprocal (e.g. right arm compared to left arm) area of the body.

Inspect for Cyanosis

Cyan-crayon

A bluish mottling of skin resulting from decreased perfusion, cyanosis presents in tissues with high levels of deoxygenated blood. Inspect lips, the nose, cheeks, ears and oral mucous membranes for signs of cyanosis. An expected finding in dark-skinned people of Mediterranean origin is a bluish tone of the lips, and this is not associated with cyanosis.

Observe Skin for Pallor

Pail with Pallor

Pallor is the color of collagen (connective tissue) in the skin and results from the absence of red-pink tones characteristic of oxygenated hemoglobin in the blood. Inspect areas like the mucous membranes, lips, conjunctiva and nail beds for signs of pallor. Stressful events, such as a panic attack, can result in vasoconstriction of superficial, peripheral capillaries (e.g. fingers, toes, face), leading to pallor in these areas.

Observe for Jaundice

Jaundice-janitor

Bilirubin present in the blood can produce a yellowish hue of color to the skin. Physiologic jaundice can be present with newborns without concern. Pathologic jaundice is associated with an underlying condition leading to rising bilirubin levels, and can be first noted by inspecting the hard and soft palate of the mouth and in the sclera of the eyes.

Inspect for Erythema

Earth-red

Erythema is a result of excess blood present to dilated superficial capillaries on the surface of the skin. When a person blushes on their face and cheeks, this is an example of erythema resulting from an emotional reaction. Other examples include erythema from a fever, with associated increased skin temperature.

Palpate the Skin

Check the Temperature

Thermometer

Palpate the skin for temperature, checking each side for localized temperature changes, which can range from cool to warm. Warm skin reflects normal circulation, cool skin could represent a possible underlying condition, such as shock or hypothyroidism, or impaired arterial circulation to a limb. Localized warm areas could be a result of inflammation, infection, or burns, in addition to conditions such as a fever or hyperthyroidism.

Observe the Skin for Moisture

Inspect for Diaphoresis or Dehydration

Sweaty-sweatband and Empty-canteen

Observe for moisture content in the skin. It should be dry with a minimal amount of perspiration. Skin-fold areas should also be fairly dry. Overly dry skin appears red and flaky. Overly moist skin may be caused by anxiety, obesity, or a warm environment. Heavy sweating (diaphoresis) usually accompanies fever, strenuous activity, cardiac diseases, or any condition that elevates metabolic rate

Check skin for edema

Imprint Thumb Firmly for 3 to 4 Seconds

Imprinting Thumb with (3) Tree and (4) Fork Seconds-timer

Edema results from fluid accumulation in interstitial spaces under the skin. Firmly imprinting your thumb to the patient's ankle malleolus or anterior tibia for 3-4 seconds facilitates inspection of "pitting edema," or the presence of fluid movement trapped within the interstitial space. Notably, edema can mask the presence of jaundice or cyanosis as it lies between the outer pigmented surface (epidermis) and inner vascular layer.

Look for lesions

Note the Characteristics

Notes of Characters

When inspecting lesions like moles, freckles, or other concerning areas, six characteristics are helpful. They are noting the 1) color, 2) elevation (flat, raised), 3) pattern or shape of the lesion (e.g. annular or a circle; grouped in an area), 4) size (in centimeters), 5) location and distribution (e.g. around the right wrist) and 6) presence of exudate (including color and consistency).

Palpate Lesion

Paw Leeches

First, wear gloves if there is anticipated contact with blood, mucosa or other bodily fluids. Second, palpate the lesion and appreciate if it is firm, soft, moveable, irritated (e.g. bleeds easily), or produces any exudate with palpation. Also, note any temperature changes or if the lesion is removed easily with palpation.