Editorial

What's in a name?

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The recent NPUAP consensus meeting in Chicago has provided the community with an array of changes to specific terms related to the clinical conditions that forms the focus of many papers in the Journal of Tissue Viability. In particular, they will adopt the term “pressure injury” to replace “pressure ulcer” in the NPUAP Pressure Injury Staging System. Their justification for this change in terminology is that it more accurately describes damage to both intact and ulcerated skin. In the previous staging system Stage 1 and Deep Tissue Injury (DTI) described injured intact skin, while the other stages described open ulcers. This has led to a perceived confusion because the definitions for each of the stages referred to the injuries as “pressure ulcers”. This change will align NPUAP with the Pan Pacific Pressure Injury Alliance, who had adopted “pressure injury” a number of years ago, although both organisations were happy to actively endorse the combined 2014 guidelines on “Prevention and Treatment of Pressure Ulcers”[1].

Does the name really matter? Indeed change is not uncommon and depending on your age and native tongue, many will have used different terms to describe the clinical condition over their professional careers. One of my opening slides on aetiology reminds the audience that Pressure Ulcers (yes we will still use this term) have also been known as (aka) “bed sores”, “pressure sores” and “decubitus”.

According to the Cambridge dictionary Injury is defined as “physical harm or damage to someone's body caused by an accident or an attack”. This definition implies acuity and, as such, we suggest that replacing “ulcer” by “injury” can prove problematic for several reasons.

From a bioengineering point of view pressure injury can be misleading as it could be interpreted as instantaneous trauma, often associated with impact damage. Indeed impact damage involves a completely different damage mechanism than the sustained or quasi-static mechanical loading considered to be critical in pressure ulcer aetiology. We refer to the 2014 clinical practice guidelines published by the NPUAP, EPUAP and PPPIA which clearly states that: “Sustained loading refers to a load that is applied for a long duration (minutes to hours or even days). In technical terms this is called a quasi-static mechanical loading. At high tissue deformations resulting from pressure and shear, damage to the cells is visible on a microscopic level within a few minutes, although it may take hours of sustained loading to become a deep tissue injury or pressure ulcer. Impact damage, which usually occurs as a result of an accident or trauma, does not fall under the definition of pressure ulcers. Within a fraction of a second a very high mechanical load is applied to the tissue. The mass of the objects plays an important role and inertia effects leading to shock/pressure waves in the tissue may cause very high external and internal damage, all within a fraction of a second. This impact injury is not considered a pressure ulcer (page 19, [1])”

The research examining pressure ulcer aetiology also highlights the significance of the element of prolonged time, even though a specific time or specific pressure is not identified as it is highly dependent on an individual tolerance to pressure, which needs to be factored into the equation. Moreover, from a clinical perspective, the time element is critical. It is at the very basis of repositioning, which represents one of the major preventative measures in clinical practice. Using terminology which in lay language is associated with instantaneous trauma, may therefore be sending the wrong message to patients and their caregivers.

Also by replacing the word “ulcer” the condition will be distinguished from other chronic conditions which we aim to prevent and manage, namely “Diabetic Foot Ulcers” and “Leg Ulcers”. Indeed in

discussions at the 2015 UK Annual Podiatric Conference it became clear how considerable the overlap between the aetiology of diabetic foot ulcers and the causative factors associated with pressure ulcers.

Nurses and health care professionals treat all these chronic wounds and define them as ulcers. Changing the terminology from ulcer to injury may suggest pressure ulcers are distinctly different. Besides, the community involved in preventing and managing these conditions would surely present more powerful evidence to bodies associated with Patient Safety, Quality of Care and Implementation if they were combined than as separate entities – clearly there are parallels with the

political stand taken in the recent UK referendum.

Other less contentious recommendations agreed in Chicago included the addition of Medical Device Related Pressure Injury (MDRPI) and Mucosal Membrane Pressure Injury. MDRPIs result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure ulcer generally conforms to the pattern or shape of the device. The recognition of medical devices

as a source of pressure is important. As has been highlighted by Professor Joyce Black and other US colleagues about 30% of all pressure ulcers are device related. Identifying devices as a potential source of harm will increase awareness and hopefully lead to a change in manufacturing and clinical use of the devices. This forms the basis of our activities in the UK Network in Medical Devices and Vulnerable Skin, which is funded by the UK EPRSC until 2019 ([www.southampton.ac.uk/mdvsn)](http://www.southampton.ac.uk/mdvsn%29).

**Reference**

[1] National Pressure Ulcer Advisory Panel, European pressure ulcer advisory panel

and Pan Pacific pressure injury alliance, in: Emily Haesler (Ed.), Prevention and

treatment of pressure ulcers: clinical practice guideline, Cambridge Media, Osborne

Park, Western Australia, 2014.