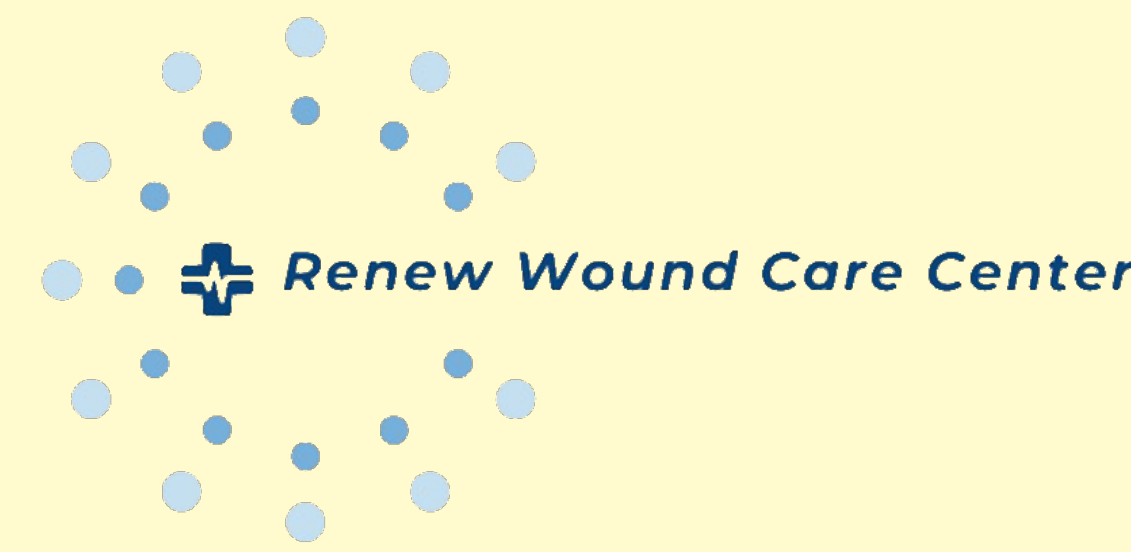


Best Practice to Manage Skin Tears



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INTRODUCTION

The author practices in a private wound care clinic. Skin tears can become complex wounds that can negatively affect patient outcomes. Best practices are crucial to manage skin tears to prevent complications while promoting healing. 10 patients are presented with Type 3 skin tears with total skin flap loss on the upper or lower extremities. Patients (male and female) ranged in age from 75 to 87 years old with various comorbidities. Four of the patients were treated using a variety of approaches without progress and clinical dissatisfaction with performance before being managed with polymeric membrane dressings (PMDs)*. Six patients were managed from injury presentation to closure with PMDs. All patients were on blood thinners: acetylsalicylic acid and/or apixaban. Skin tears were the result of: trauma, a fall or the patient hitting an object. One patient's skin tear was the result of medical adhesive related skin injury (MARS) from removal of a dressing.

RATIONALE

Polymeric Membrane Dressings are versatile dressings which encourage wound healing. The dressings help to prevent the formation of chronic wounds. PMDs control inflammation in the injured tissue, reducing persistent pain, pain associated with wound care procedures and activity which enhances the patient's wound care experience. PMDs contain a safe tissue-friendly cleanser system which is continuously cleansing the wound, reducing need for wound bed or periwound cleansing procedures during dressing changes. PMDs debride, balance moisture, and protect the wound bed. The built-in moisturizer (glycerin) helps maintain a moist healing environment. Glycerin, together with the mild cleanser, ensures the dressing does not adhere to the wound, reducing procedural pain and trauma, ideal for skin tears. PMDs provide an optimal moist environment and enhance autolysis.

METHODS

PMDs, without adhesive border, changed once/wk or twice/wk, depending on exudate per the Instructions for Use (IFU). Dressings were secured with a gauze wrap and or tubular bandage. PMD Silver extra-thick was applied for 1 patient, as patient's family could only do dressing changes once/wk. All wounds, prior to initial dressing application, were flushed with normal saline and hypochlorous acid (HA). HA is applied to gauze and wiped over the wound bed. There is no excess left, and the wound bed is not saturated but moist before PMD application. Compression was applied as needed for swelling.

Number of Dressing Days Before PMDs and After PMDs Initiated

Before PMDs were implemented dressings stuck to wounds, causing trauma and discomfort during dressing changes; wounds were slow to heal; frequent sharp debridements were required to remove fibrin/slough which increased care costs; and multiple products were required.

Before PMDs/Dressings/Products	Number of Days Prior to PMDs, Managed Without Progress	Number of Days to Closure After PMDs initiated
Pt 2: Topical wound gel, Bismuth Tribromophenate, cellular, acellular, and matrix-like products (CAMPS), collagen dressing, gauze 4 x 4, gauze roll and tubular bandage	127 days	43
Pt 5: Topical wound gel, Bismuth Tribromophenate, collagenase, gauze roll	7 days	17
Pt 6: Topical wound gel, Bismuth Tribromophenate, collagen dressing, gauze roll, tubular bandage	45 days	21
Pt 10: Bismuth Tribromophenate, gauze roll, tubular bandage	7 days	50

PMDs did not stick to wounds, eliminating wound trauma and pain. PMDs encouraged autolysis, so less need for sharp debridement; reduced supply cost because fewer supplies required at each dressing change; no need to switch to different dressing types during wound healing progress- only one wound dressing needed (PMDs) and less time required to perform wound assessment and care during patient visits.

RESULTS

PMDs did not stick to wounds, eliminating wound trauma and discomfort during dressing changes. Pain that was previously intermittent throughout the day and night was eliminated. Periwound complications of erythema, swelling, discoloration resolved.

PMDs encouraged autolysis so wounds required little or no debridement, reducing the supply cost of debridement which also reduced treatment time by up to 10 minutes during approximately 30-minute visits. Time savings is significant because it allows for improved efficiency with patients and between patients; the clinic used the extra time for other necessary things like documentation, maintaining stock, following up with other providers, returning calls to patients/providers, following up with family and the general duties of running a wound care clinic.

Pt. 2, 5, 6, and 10 were initially managed by another provider in the clinic using other wound care approaches. Examples of other wound care approaches: Bismuth Tribromophenate, topical wound gel, collagen dressing and collagenase. When these wounds were not progressing, the author switched to PMDs; as a result, all 10 patients' skin tears closed.

PMDs improved time to wound closure. As an example, prior to the case study, **Pt 5** had a history of skin tears. A 12 sq cm wound managed with Bismuth Tribromophenate and combination wound care products closed in 17 days (**0.7 sq cm/day closure**). In contrast, on the same patient, using PMDs on an 89 sq cm wound closed in 24 days (**3.7 sq cm/day closure**).

The clinic works with home health companies, so PMDs streamline care for the health providers by saving time. PMDs save time as they do not have to use multiple wound care products. Many home health care providers are not able to sharp debride and PMDs encourage autolytic debridement which encourages wound healing and also help to streamline the care. PMDs dressing changes are easy to teach to staff, patients and non-professional caregivers which makes it easy for the clinic to provide education about the function and changing of the dressings.

DISCUSSION

PMDs addressed the problems experienced with prior approaches such as dressings stuck to wounds, causing trauma and discomfort during dressing changes; slow healing; costs associated with frequent sharp debridement to remove fibrin/slough; and multiple products required. PMDs reduced the need for frequent debridement, reduced wound trauma during dressing changes, reduced supply costs and dramatically improved time to wound closure. PMDs improved the experience of care for patients, promoted healing and comfort, while reducing the cost of care. No complications occurred. PMDs are the preferred dressing to manage skin tears.

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Patient 3 | Skin Tear on Left Leg, After Striking Leg on an Object

- Patient: 85-year-old female
- Medical History: Hypertension, congestive heart failure, hypothyroidism, hyperlipidemia



Wound measurement: 4 cm x 3 cm x 0.2 cm
10% fibrin/slough



- Wound closure achieved in 7 days with PMDs
- Pain resolved with PMDs

- Moderate sanguineous drainage
- Periwound: erythema, swelling, discoloration
- Pain at 2 (0-10 scale) intermittently and procedural pain with dressing changes prior to PMDs

Patient 6 | Skin Tear on Right Forearm, From Trauma

- Patient: 84-year-old male
- Medical History: Hypertension, hyperlipidemia, congestive heart failure, hypothyroidism



Wound measurement: 1.5 cm x 2.0 cm x 0.1 cm



- Hypergranulation tissue resolved with PMDs in 7 days
- 21 days after PMDs were applied, the skin tear closed with PMDs

- Wound care products were applied during course of management before PMDs for 45 days: topical wound gel, Bismuth Tribromophenate, collagen dressing, gauze roll, tubular bandage; resulted in hypergranulation tissue
- Photo with hypergranulation tissue before PMDs applied