



มหาวิทยาลัยราชภัฏนครปฐม  
Nakhon Pathom Rajabhat University

# Skin



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# outline

- ❖ Psoriasis
- ❖ cellulitis
- ❖ Steven-Johnson syndrome,
- ❖ herpes zoster
- ❖ herpes simplex
- ❖ Fungal infection
- ❖ burn



# Psoriasis

It is one of the most common skin disease.

It is thought that this chronic disease stems from a hereditary effect that causes overproduction of keratin.

**Incidence** - It affect approximately 2% of the population. It occurs in any age, most commonly occurs in people between 15-35 years of age.



## Definition

It is a chronic, non-infectious skin inflammation involving keratin synthesis that results in psoriatic

It is an inflammatory skin disease in which the skin cell replicate at an extremely rapid rate.

New cells are produced 8 times faster than normal but the rate at which old cells sloughed off is unchanged, this causes the cell build up on skin surface, forming thick patches or plaque of red sores, covered with flaky, silvery white dead skin cells (scale)

# Etiology

- ❖ Unknown
- ❖ Genetic
- ❖ Some factor may aggravate the condition such as: -
- ❖ Stress
- ❖ Smoking, alcohol
- ❖ Trauma
- ❖ Obesity
- ❖ Hormonal changes
- ❖ Climate
- ❖ Autoimmune disease

## Types of Psoriasis



Plaque



Guttate



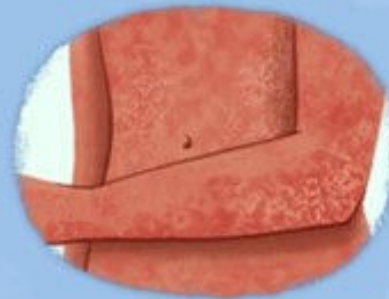
Pustular



Scalp



Nail



Psoriatic  
Erythroderma

# Diagnostic evaluation

History

Physical examination

Skin biopsy

Blood and radiography to rule out psoriatic arthritis.

# Nursing management

1. Nursing diagnosis - Impaired skin integrity related to lesion & inflammatory response as evidence by itching all over the body.

**Nursing goal** ❖ To maintain skin integrity Intervention

- ❖ To advice the patient not to scratch the affected areas.
- ❖ Too frequent washing produce more soreness & scaling water should be warm, not hot and the skin should be dry by patting a towel rather then rubbing.
- ❖ Apply a thin film of emollients after washing the area.
- ❖ Provide a calorie and high protein diet.



# Nursing management

**2. Nursing diagnosis - risk of infection related to hyponatremia as evidence by loss of protein and fluid from lesion.**

**Nursing goal - To prevent from infection**

## **Intervention**

**Monitor vital sign.**

**Examine for sign of infection.**

**Keep the lesion clean.**

**Motivate the patient to improve the nutrition.**

**To provide the antibiotics.**

# Nursing management

**3. Nursing diagnosis - acute pain related to inflammation as evidence by patient verbalization.**

**Nursing goal - to reduce the pain**

## **Intervention**

**Provide the emollients after washing the area it will relieve the soreness.**

**To provide the comfort measures.**

**To provide the pain medication which relieves pain.**



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# cellulitis

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# cellulitis

Cellulitis is a bacterial subcutaneous skin infection. It appears as a reddened, swollen area of the skin and is usually easily diagnosable through inspection. Cellulitis can occur from a simple break in the skin allowing bacteria to enter.



## Common causes include:

- ★ Injury to the skin (cuts, burns, puncture wounds)
- ★ Insect/animal bites
- ★ Skin conditions (eczema, chickenpox, shingles)
- ★ IV drug use
- ★ Infected surgical incisions
- ★ Poor hygiene practices when getting a tattoo or piercing

# Symptoms of cellulitis

- Cellulitis causes an area of skin to suddenly become:
- red
- hot
- swollen
- painful
- tender



★ It most often affects the lower legs, but can occur anywhere.

# The Nursing Process

**Cellulitis is a common diagnosis nurses will become familiar with in the inpatient setting. Patients often require education about this condition if they lack an understanding of potential causes, how their comorbidities influence skin infections, and why treatment is so important. Cellulitis can quickly become life-threatening so the nurse must monitor vital signs, lab work, and the skin for complications.**

# Risk For Infection Assessment

- 1. Assess for worsening infection.

Life-threatening infections can result from cellulitis such as osteomyelitis, sepsis, and gangrene. The nurse should monitor closely for systemic signs of infection.

- 2. Monitor lab work.

It will be expected for the WBC and CRP to be elevated. Monitor for these values trending up as infection worsens. Blood cultures or needle aspiration may be ordered to pinpoint a specific pathogen.



# Risk For Infection Assessment

- **3. Assess for contributing conditions.**

**Chronic conditions such as diabetes or a suppressed immune system can complicate an infectious process as well as predispose the patient to worsening infection.**

# Risk For Infection Interventions

- 1. Instruct on oral antibiotic use.

Oral antibiotics are the usual course for uncomplicated cellulitis. Instruct the patient to take all of their medication, even if the cellulitis has significantly improved or resolved. If the condition does not improve after a few days, have the patient contact their provider for a change in treatment.

- 2. Administer IV antibiotics.

Some patients will require hospitalization and IV antibiotics. The usual pathogen is either streptococci or staphylococcus and the antibiotic prescribed should address this.

# Risk For Infection Interventions

- 3. Prepare for I&D.

Once abscess formation occurs, it must be drained as antibiotic therapy alone will not treat it. The nurse can assist the provider with bedside incision & drainage by preparing a sterile field with all medication and equipment. The nurse should premedicate the patient as this can be a painful procedure.

- 4. Teach the patient about signs of infection.

If the patient is treating cellulitis at home or has recently undergone surgical intervention, the nurse should educate on worsening signs of infection. Encourage the patient to monitor the skin for worsening redness or swelling along with any discoloration or drainage. If they experience fever or changes in breathing or LOC, they should seek immediate treatment.



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# Stevens-Johnson syndrome (SJS)

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# What is Stevens Johnson syndrome / toxic epidermal necrolysis?

Stevens Johnson syndrome /toxic epidermal necrolysis (SJS/TEN) is a very severe and acute skin disease, almost always caused by a drug. SJS/TEN is characterised by an extensive necrosis and detachment of the epidermis, which involves skin and mucosal surfaces (genitals, eyes, and mouth).



**Mucosal involvement**



**Epidermal necrolysis**



**Cream applied to red skin**

# signs and symptoms

You may have a fever and chills up to 2 weeks before you have skin symptoms. You may also have a cough and sore throat, headache and body aches, and feel more tired than usual. Skin symptoms include the following:

Sores that look like targets

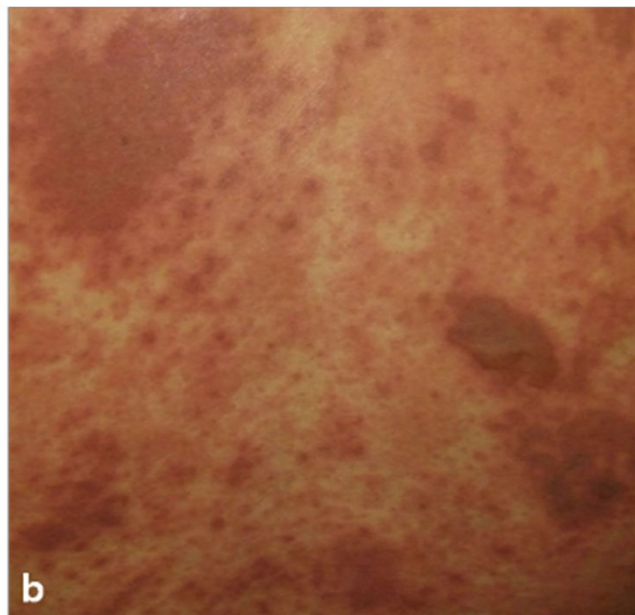
Painful mouth sores that make it hard to swallow or breathe

Painful blisters on your skin, eyes, or genitals

Sunburned appearing skin once the top layer falls off

## How is SJS diagnosed?

Your healthcare provider may diagnose SJS when he sees your skin. Tell your healthcare provider if you have been taking any medicines recently. A sample of your skin may be taken and sent for tests to check for SJS.





# What medicines may be used to treat SJS?

The goal of treating SJS is to stop symptoms from getting worse. You are put in the hospital to treat SJS. Your healthcare provider will stop the medicine you were taking that caused SJS. You may need any of the following:

**Antacids** may be needed if sores grow in your stomach and cause bleeding.

**Antibiotics** may be given to help treat an infection in your blood. Antibiotics may also be put on your skin to lower your risk for infection.

# What medicines may be used to treat SJS?

**Eye drops** may be used to help eye sores heal and to prevent infection.

**Pain medicines** help take away or decrease your pain.

**Immune globulins** may be given to make your immune system stronger. You may need immune globulins to treat or prevent an infection.

**Pressors** may be given to increase your blood pressure. A normal blood pressure helps protect your heart, lungs, brain, kidneys, and other organs.

## treatments

**Wound care is done to protect skin sores and help them heal. Hydrotherapy is done in a whirlpool to help clean your wounds, and to remove dead tissue from your skin.**

**Physical therapy may be needed to help your arm and leg movement if you have to stay in bed.**

# treatments

**Surgery may be needed if your skin does not heal properly. You may need debridement to clean the wounds and to remove dirt or dead tissues. A skin graft may be done to cover and help heal the areas where you lost skin.**

**TPN is liquid nutrition that provides your body with protein, sugar, vitamins, minerals, and sometimes fat (lipids). TPN is used when you have problems with eating or digesting food.**

# Supportive care

**Fluid replacement and nutrition.** Because skin loss can result in significant loss of fluid from your body, replacing fluids is an important part of treatment. You may receive fluids and nutrients through a tube inserted in the nose and guided to the stomach (nasogastric tube).

**Wound care.** Cool, wet compresses might help soothe blisters while they heal. Your health care team may gently remove dead skin and put petroleum jelly (Vaseline) or a medicated dressing over affected areas.

**Eye care.** You may also need care from an eye specialist (ophthalmologist).

