Skin Exam

Welcome to this video on skin assessment.

The skin is the largest organ of the body and has many areas involved in its assessment. In this video, I'll be focusing on a general assessment of the skin as well as how to implement measures to maintain skin integrity and prevent skin breakdown. Diseases of the skin may be local, or they may be caused by an underlying systemic problem. In order to perform a complete and accurate assessment, the nurse needs to collect data about current symptoms, the patient's past and family history, and health and lifestyle practices.

When looking at current symptoms, ask the patient:

- About skin problems such as rashes, dryness, oiliness, bruising, open sores, itchiness, etc.
- Any birthmarks or moles?
- Any change in the ability to feel pain, pressure, touch, or temperature?
- Any numbness or tingling?
- Trouble controlling body odor?
- Any body piercings or tattoos?

Guideline for collecting the needed information about symptoms...

Character - Describe the sign or symptom

Onset - When did it begin?

Location - Where is it?

Duration - How long does it last Does it recur?

Severity - How bad is it? Does it bother you?

Pattern - What makes it better or worse?

Associated factors / How it affects the patient - What other symptoms occur with it? How does it affect you?

When assessing **past health history**, ask the patient...

- To describe any previous skin problems and any treatment or surgery that was done
- Any allergic skin reactions?
- Any recent fever, N/V, or respiratory problems?
- (For female patients) Are you pregnant? Are menstrual cycles regular?
- Any history of smoking or drinking alcohol?
- Any history of anxiety, depression, or other psychiatric problems?

When looking at the **family history**, ask the patient...

- Has anyone in your family had a recent illness, allergy, rash, or other skin problem?
- Anyone in your family had skin cancer?
- Any family history of keloid scars?

Some skin conditions tend to be hereditary or contagious, so it is beneficial to know what the patient has been exposed to and what runs in their family.

Lifestyle and health practices play a big role in the assessment of skin. Ask the patient...

- Do you sunbathe or tan?
- Are you regularly exposed to chemicals that may harm the skin, such as paint, bleach, cleaning products, petroleum, insect repellant, etc.?
- Do you spend a long time sitting or lying in one position?
- Any exposure to extreme temperatures?
- What do you use daily on your skin, such as soaps, lotions, oils, cosmetics, type of razor?
- What do you eat and drink in a typical day?
- Do skin problems limit any of your normal activities or prevent you from enjoying relationships?
- Describe the stress in your life.
- Do you perform a monthly skin self-examination?

The **physical assessment of the skin** involves inspection and palpation, and may reveal local or systemic problems in the patient.

INSPECTION involves looking at the following:

General skin color - abnormal findings would include pallor, cyanosis, or jaundice
Color variations - look for rashes or erythema
Skin integrity - carefully check pressure point areas
Lesions - note the color, shape, and size.

When PALPATING the skin, it is important to note:

- **Texture** - it should be smooth and even
- **Thickness** - very thin skin may indicate steroid therapy or arterial insufficiency
- **Moisture** - increased moisture is felt with fever and hyperthyroidism, decreased moisture occurs with dehydration or hypothyroidism

- **Temperature** - cool skin may accompany arterial disease, cold skin is felt in shock or hypotension, and very warm skin is felt with fever or hyperthyroidism
- **Turgor** - refers to the skin's elasticity and should pinch easily, then immediately return to its original position
- **Edema** - the skin should rebound and not remain indented when pressure is released.