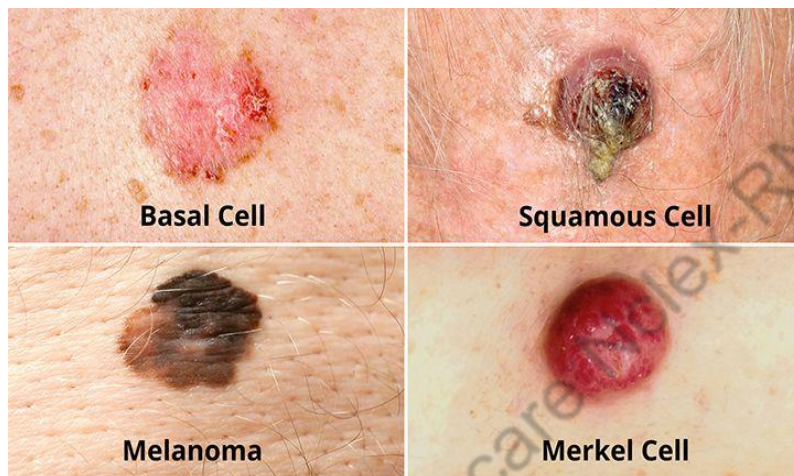


Skin

Skin cancer is most commonly diagnosed cancer.

Clinical manifestations: Asymmetry, border irregularity, color change and variation, diameter of 6mm or more and evolving in appearance.

Risk factors: Fair skin type, blond or red hair, blue or green eyes, history of chronic sun exposure, family history of skin cancer and exposure to tar and systemic arsenicals, outdoor occupations, living near equator, tanning beds.



Nonmelanoma skin cancer either basal cell or squamous cell carcinoma. It develops in the epidermis.

Pressure ulcers

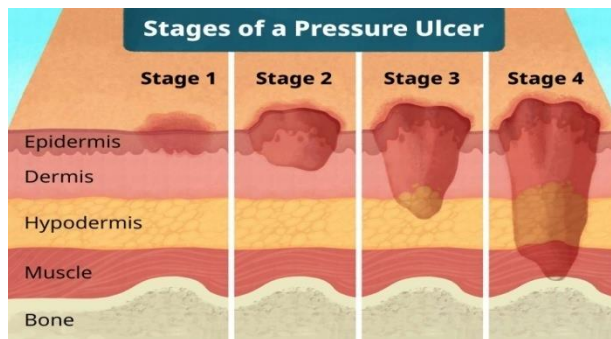
Pressure ulcer starts on the skin and often progresses to deeper tissue. It is caused by impaired circulation to the tissue from pressure over a period of time. Without adequate blood flow and the nutrition it brings, the tissue will die.

Stage 1: Firm warm areas of skin from poor circulation. Spongy reddened tissue from increased pressure (no layer breakdown).

Stage 2: Opening in the skin with surrounding erythema from pressure (blister, skin breakdown).

Stage 3: the ulcer is deep, down to the dermis with red base and some drainage.

Stage 4: A deep ulcer involving muscle and bone, with visible signs of tissue death.



Clean wound with soap and water or saline. Dressing to protect the wound from moist and promote healing. Hydrocolloids which keep moisture in. Non-adherent dressing such as aquaphor. Bulk dressings to absorb copious drainage. Semi permeable dressings which allow for transfer of gases but are impermeable to liquids. Antibiotic ointment for infected wound, specialized mattresses.

Egg tray mattresses to remove pressure ulcers.

Impetigo: Beta hemolytic streptococci, staphylococci or combination of both. Associated with poor hygiene. Primary or secondary infection. Vesiculopustular lesions that develop thick honey colored crust surrounded by erythema. Most common on face as primary infection.

Treatment: systemic antibiotics such as oral penicillin, bezathine pencillin, erythromycin. If not treated well, glomerulonephritis possible.

Cellulitis: Inflammation of subcutaneous tissues possibly secondary complication or primary infection. Often following break in skin. Staphylococcus aureus and streptococci usual causative agents. Hot tender, erythematous and edematous area with diffuse borders, chills, malaise and fever.

Prevention: moist heat, mobilization and elevation, systemic antibiotic therapy, hospitalization if sever. Gangrene is possible if untreated.

Bees and wasps: Hymenoptera species. Intense burning, local pain, swelling and itching. Severe hypersensitivity leading to anaphylaxis.

Treatment: cool compresses, local application of antipruritic lotions. Antihistamine if indicated (diphenhydramine, Benadryl and steroid).

Pediculosis (head lice, body lice and pubic lice): γ-benzene hexachloride

Scabies: Severe itching especially at night, usually not on face, presences of burrows, flexor surface of wrists, genitalia and anterior axillary folds. Treatment: 5% permethrin, topical lotion, one overnight.

Seborrheic dermatitis: Instruct the patient to remove the scale daily by shampooing with the mild baby shampoo or an over the counter antiseborrheic shampoo containing sulfur and salicylic acid. Massage the scalp with warm mineral oil before shampooing helps loosen scales.

Eyelid dermatitis: (Blepharitis) is treated with warm tap water compresses and cleansing with no tear baby shampoo.

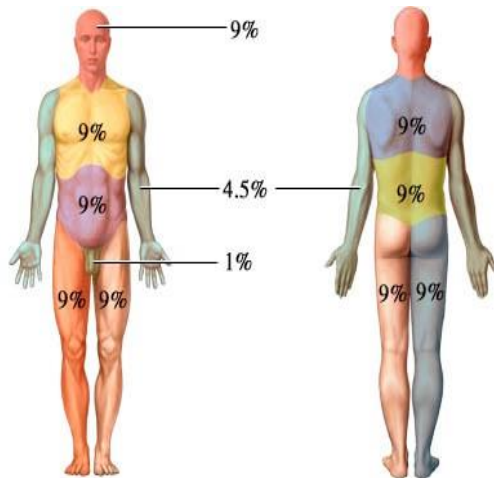
Seborrheic dermatitis: diaper area is often secondary infected with candida albicans and require appropriate treatment. Lotion and creams tend to aggravate the condition and should not be used.

Thrush (oral candidiasis): is a superficial fungal Infection of the oral mucous membrane that is common in infants. **Fluconazole** administered once a day may be used for treatment of thrush in infants.

Acne: is a disorder of the sebaceous hair follicles.

Oral antibiotics: tetracycline (teeth staining, avoid sunlight), minocycline, erythromycin, clindamycin. Oral isotretinoin (Accutane) has dramatically improved the condition of adolescent with severe cystic acne.

Burn



What is the Parkland Formula?

Used to calculate initial fluid requirements in burn patients

$$4\text{mL} \times \text{Body Weight (kg)} \times \text{TBSA (\%)} = \text{Total crystalloid fluids in first 24 hours}$$

- Half of the total volume is given in the *first 8 hours*
- Half of the total volume is given over the *next 16 hours*
- **IMPORTANT:** First 8 hours is from the time of the burn injury
 - It is not from the time of evaluation or calculation
- Only *partial thickness & full thickness* burns are included in the calculation

For example: For a 70kg patient with a 50% of TBSA burn. Calculate the first 8 hour fluid requirement.

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