NURSING DIAGNOSES IN PATIENTS WITH CUTANEOUS AFFECTIONS
DIAGNÓSTICOS DE ENFERMAGEM EM CLIENTES COM AFECCÕES CUTÂNEAS
DIAGNÓSTICOS DE ENFERMERÍA EN PACIENTES CON AFECCIONES CUTÁNEAS

Mariana Ferreira Soares¹, Euzeli da Silva Brandão², Gisella de Carvalho Queluci³, André Luiz de Souza Braga⁴, Júlia Santana de Aguiar⁵

ABSTRACT

Objective: to describe the nursing diagnoses, risk/related factors and defining characteristics presented by customers with cutaneous affections. **Method:** this is a bibliographical study, integrative-review-type of studies indexed from 1998 to 2018, in Portuguese, English and Spanish, on LILACS, MEDLINE and SciELO Virtual Library databases. The data were interpreted based on a comparison of theories, conclusions and implications of the study, presenting them in figures. **Results:** there was precariousness of published articles: only three, with level of evidence 4. The first one addressed nursing diagnoses in clients with various cutaneous affections; the second identified only nursing diagnoses in customers with leprosy and the third, in clients with autoimmune bullous dermatoses. **Conclusion:** there is a paucity of studies. All studies identified risk for infection, defined as the “vulnerability to invasion and multiplication of pathogenic organisms”, which can harm the “health”, as nursing diagnosis in all patients. **Descriptors:** Skin Diseases; Nursing Diagnosis; Dermatology; Skin; Nursing; Nursing Care.

RESUMO

Objetivo: descrever os diagnósticos de enfermagem, fatores de risco/relacionados e características definidoras apresentados pelos clientes com afecções cutâneas. **Método:** trata-se de estudo bibliográfico, tipo revisão integrativa de estudos indexados de 1998 a 2018, em português, inglês e espanhol, nas bases LILACS, MEDLINE e Biblioteca Virtual SciELO. Interpretaram-se os dados com base na comparação das teorias, conclusões e implicações dos estudos, apresentando-os em figuras. **Resultados:** observa-se precariedade de artigos publicados: apenas três, com nível de evidência 4. Abordaram-se, no primeiro, os diagnósticos de Enfermagem em clientes com diversas afecções cutâneas; o segundo identificou apenas os diagnósticos de Enfermagem em clientes com hanseníase e o terceiro, nos clientes com dermatoses imunobolhosas. **Conclusão:** verifica-se a escassez de estudos. Encontrou-se o risco de infecção, definido pela “vulnerabilidade à invasão e multiplicação de organismos patogênicos, que pode comprometer a “saúde”, como diagnóstico de enfermagem, em todos os pacientes, em todos os estudos. **Descritores:** Dermatopatias; Diagnóstico de Enfermagem; Dermatologia; Pele; Enfermagem; Cuidados de Enfermagem.

RESUMEN

Objetivo: describir los diagnósticos de enfermería, los factores de riesgo/relacionados y definir las características presentadas por clientes con afecciones cutáneas. **Método:** este es un estudio bibliográfico, tipo revisión integradora de estudios indexados desde 1998 a 2018, en portugués, inglés y español, en las bases de datos MEDLINE, LILACS y Biblioteca Virtual SciELO. Los datos fueron interpretados con base en una comparación de teorías, conclusiones e implicaciones del estudio, presentándolos en cifras. **Resultados:** se observó la precariedad de los artículos publicados: sólo tres, con nivel de evidencia 4. El primero artículo discute los diagnósticos de enfermería en clientes con diversas afecciones cutáneas; el segundo identifica sólo diagnósticos de enfermería en clientes con la lepra y el tercero, en clientes con dermatosis imunobolhosas. **Conclusión:** existe una escasez de estudios. Se encontró el riesgo de infección, definido por la “vulnerabilidad a la invasión y multiplicación de microorganismos patógenos”, que pueden perjudicar la “salud”, como diagnóstico de enfermería en todos los pacientes, en todos los estudios.

Descriptores: Enfermedades de la Piel; Diagnóstico de Enfermería; Dermatología; Piel; Enfermería; Atención de Enfermería.

^{1,2,3,4,5}Fluminense Federal University/UFF. Niterói (RJ), Brazil. <http://orcid.org/0000-0002-8487-157X> <http://orcid.org/0000-0001-7961-3552> <http://orcid.org/0000-0001-8988-8103> euzelibrandao@gmail.com <http://orcid.org/0000-0002-7961-9038> <http://orcid.org/0000-0003-0496-8513>

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INTRODUCTION

Working with skin care involves observing, listening and decoding signs and symptoms issued, making the Nursing care extremely complex. In this context, the nursing consultation stands out, which is a nursing activity regulated by the Professional Practice Law 7.498/86,¹ providing autonomy in the practical fields to fit nurses' specific knowledge, regardless of prescriptions of other health professionals. Therefore, its focus is the integrality of the customer in addition to the disease, favoring its different dimensions (physical, mental, spiritual).²

In this way, the Nursing Care Systematization constitutes a technology that directs the reasoning, aiming to qualify the care through clinical, diagnosis, interventions and Nursing outcomes assessment, allowing evaluating its efficiency and effectiveness, in addition to enabling its modification according to the results obtained. This tool enables the integration and organization of information, ensuring its quality and continuity by the team.³

In this sense, the nurse is responsible for the systematization of his/her service and, consequently, for the use of the Nursing process, methodological tool that enables the identification, understanding, description, explanation and/or prediction of how the client responds to health problems, thereby determining the aspects that require professional intervention. Therefore, to achieve the expected results, the Nursing interventions stand out, based on judgments about specific human phenomena, such as Nursing Diagnoses (ND).⁴

The identification of Nursing diagnoses is the clinical assessment by the nurse, from individual, family or community responses to actual or potential health problems health or vital processes. The identification of diagnoses allows identifying the proper procedures to achieve satisfactory results.⁵ Moreover, for the NANDA-International and the International Classification for Nursing Practice (ICNP®), the nursing diagnosis aims at standardizing the language and communication between nurse and team.⁶

Regarding the importance of Nursing care in the recovery of the client with cutaneous affections, a systemized assistance becomes necessary, because an accurate diagnosis will ensure an effective decision making on measures and resources to be implemented.⁷ Therefore, the development of this study may offer subsidies for the planning of nursing care to this specific clientele.

OBJECTIVE

- To describe the nursing diagnoses, risk/related factors and defining characteristics presented by customers with cutaneous affections.

METHOD

This is a bibliographical study, integrative-review type.⁸ In the first step, the following guiding question emerged: "What are the nursing diagnoses, risk/related factors and defining characteristics presented by customers with cutaneous affections?"

The second step consisted of the search on Latin American and Caribbean Literature in Health Sciences (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE), and Virtual Library Scientific Electronic Library Online (SciELO) databases. The Health Sciences Descriptors (DeCS) and Medical Subject Headings (MeSH) used were: "*Diagnóstico de Enfermagem/Nursing Diagnosis/Diagnóstico de Enfermería*", "*Dermatologia/Dermatology/Dermatología*" and "*Pele/Skin/Piel*", with the boolean operator "AND". The search was conducted on 18 April 2019, using the following inclusion criteria: articles published in the period from 1998 to 2018, in Portuguese, English and Spanish. There were excluded duplicate works and those that did not address the study theme.

The time period established aimed to encompass all academic work developed based on the NANDA taxonomy II.

The third step involved the extraction of important data of the selected works, including the definition of the subjects, methodology, sample size, measurement of variables, method of analysis and concepts employed.

The fourth step consisted of classifying the studies according to their levels of evidence:⁸ Level 1 - evidence from meta-analysis of multiple controlled and randomized clinical studies; Level 2 - evidence obtained in individual studies with experimental design; Level 3 - evidence of quasi-experimental studies; Level 4 - evidence from descriptive studies (non-experimental) or with a qualitative approach; Level 5 - evidence from case or experience reports; Level 6 - evidence based on expert opinions.

In the fifth step, the data collected were interpreted in relation to the selected studies based on comparison of their theories, conclusions and implications. In this step, there emerged suggestions for researches, finding new themes for future studies.

The sixth step consisted of assessing the conclusion and results of the selected studies.

Figure 1. Flowchart of study selection, according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyzes (PRISMA 2009). Rio de Janeiro, Brazil, 2019.

N	Bases	Title of the study	Dissertation-Journal/Year	Authors	Level of evidence
1	LILACS	Identification of Nursing Diagnoses at a Dermatologic Clinics ⁹	Dissertation Postgraduate Program in Sciences of the Disease Control Coordination of the São Paulo State Health Department. 2005	- Bassoli	4
2	LILACS	Identification of the most frequent nursing diagnosis for affected patients by leprosy ¹⁰	<i>Hansenologia Internacionalis</i> . 2007	Bassoli; Guimarães; Virmond.	4
3	MEDLINE	Nursing diagnoses in patients with immune-bullous dermatosis ¹¹	Rev Latino-Am Enfermagem. 2016	Brandão; Santos; Lanzillotti; Ferreira; Gamba; Abulafia.	4

Figure 2. Presentation of the studies selected for the IR. Rio de Janeiro, Brazil. 2019.

RESULTS

The search for the scientific works to compound this ILR revealed the scarcity of studies that met the research-guiding question and the inclusion criteria established.

In relation to the selected studies, all presented level of evidence 4, highlighting the need to conduct new research aimed at Nursing

diagnoses in clients with cutaneous affections with levels of evidence more relevant.

- **Nursing Diagnoses found in the selected studies**

Figure 3 shows all ND identified in customers with cutaneous affections in the selected studies. The study 3 found all ND present in all evaluated subjects.

N	Frequency of Nursing Diagnoses according to NANDA found in the clientes with cutaneous affections	Year NANDA	Distribution of clientes by cutaneous affections
1	Risk for infection ⁽¹⁵³⁾ subjects); Risk for loneliness ⁽¹⁵²⁾ ; Social isolation ⁽¹⁵¹⁾ ; Impaired skin integrity ⁽¹⁴⁹⁾ ; Risk for constipation ⁽¹⁴⁸⁾ ; Risk for impaired skin integrity ⁽¹⁴⁷⁾ ; Risk for trauma ⁽¹⁴²⁾ ; Changes Altered dentition ⁽¹³⁹⁾ ; Acute pain ⁽¹³⁰⁾ ; Altered nutrition: Less than bodily needs ⁽¹²⁸⁾ ; Impaired tissue integrity ⁽³⁷⁾ ; Impaired physical mobility ⁽²⁸⁾ ; Risk for imbalanced body temperature ⁽²⁷⁾ ; Impaired tissue perfusion ⁽²⁶⁾ ; Ineffective protection ⁽²³⁾ ; Risk for disuse syndrome ⁽²¹⁾ ; Impaired gait ⁽¹⁸⁾ ; Anosognosia ⁽¹⁶⁾ ; Risk for peripheral neurovascular dysfunction ⁽¹⁴⁾ ; Risk for altered glucose metabolism ⁽¹⁴⁾ ; Risk for fluid volume deficit ⁽¹³⁾ ; Risk for injure ⁽¹⁰⁾ ; Diarrhea ⁽⁹⁾ ; Anxiety ⁽⁸⁾ ; Ineffective upper airway clearance ⁽⁸⁾ ; Impaired gas exchange ⁽⁸⁾ ; Impaired oral mucous membrane ⁽⁸⁾ ; Imbalanced nutrition: more than bodily needs ⁽⁸⁾ ; Hyperthermia ⁽⁷⁾ ; Impaired verbal	1999-2000	153 research subjects: Leprosy ⁽⁵¹⁾ ; Psoriasis ⁽¹⁶⁾ ; Diabetes Mellitus ⁽¹⁴⁾ ; Erythroderma ⁽¹³⁾ ; Paracoccidioidomycosis ⁽¹⁰⁾ ; Chromoblastomycosis ⁽¹⁰⁾ ; Pemphigus ⁽⁷⁾ ; Cancer ⁽⁷⁾ ; Eczema ⁽⁴⁾ ; Leishmaniosis ⁽⁴⁾ ; Contact dermatitis ⁽²⁾ ; Bullous pemphigoid ⁽²⁾ ; Factitious disease ⁽²⁾ ; Mycetoma ⁽²⁾ ; Mycosis fungoides ⁽²⁾ ; Lichen planus ⁽¹⁾ ; Necrobiosis lipoidica ⁽¹⁾ ; Pyoderma gangrenosum ⁽¹⁾ ; Systemic lúpus eythematosus ⁽¹⁾ ; Hidradenitis ⁽¹⁾

	communication ⁽⁴⁾ ; Acute confusion ⁽⁴⁾ ; Impaired bed mobility ⁽⁴⁾ ; Risk for aspiração ⁽⁴⁾ ; Risk for self-mutilation ⁽⁴⁾ ; Excessive fluid volume ⁽³⁾ ; Body image disorder ⁽²⁾ ; Decreased cardiac output ⁽²⁾ ; Poor fluid volume ⁽¹⁾ ; Impaired swallowing ⁽¹⁾ ; Perceived constipation ⁽¹⁾ ; Risk for urinary retention ⁽¹⁾ .		
2	Risk for infection ⁽⁵¹ subjects); Impaired skin integrity ⁽⁵¹⁾ ; Risk for impaired skin integrity ⁽⁵¹⁾ ; Risk for trauma ⁽⁵¹⁾ ; Risk for loneliness ⁽⁵⁰⁾ ; Social isolation ⁽⁴⁹⁾ ; Risk for constipation ⁽⁴⁹⁾ ; Pain ⁽⁴⁸⁾ ; Altered nutrition: less than bodily needs ⁽⁴⁶⁾ ; Altered dentition ⁽⁴⁵⁾ ; Impaired tissue integrity ⁽²¹⁾ ; Impaired tissue perfusion ⁽¹⁵⁾ ; Impaired physical mobility ⁽¹⁴⁾ ; Risk for imbalanced body temperature ⁽¹⁰⁾ ; Impaired gait ⁽⁹⁾ ; Risk for injure ⁽⁹⁾ ; Risk for disuse syndrome ⁽⁸⁾ ; Risk for peripheral neurovascular dysfunction ⁽⁷⁾ ; Risk for fluid volume deficit ⁽⁶⁾ ; Anxiety ⁽⁶⁾ ; Self-care deficit ⁽⁵⁾ ; Ineffective protection ⁽⁵⁾ ; Diarrhea ⁽⁵⁾ ; Impaired gas exchange ⁽⁵⁾ ; Risk for altered glucose metabolism ⁽³⁾ ; Risk for self-mutilation ⁽³⁾ ; Impaired bed mobility ⁽³⁾ ; Ineffective upper airway clearance ⁽²⁾ ; Impaired oral mucous membrane ⁽²⁾ ; Imbalanced nutrition: more than bodily needs ⁽²⁾ ; Hyperthermia ⁽²⁾ ; Impaired verbal communication ⁽²⁾ ; Acute confusion ⁽²⁾ ;	2005-2006	51 medical charts of leprosy patients

	Risk for aspirations ⁽²⁾ ; Excessive fluid volume ⁽²⁾ ; Decreased cardiac output ⁽²⁾ ; Perceived constipation ⁽²⁾ ; Risk for imbalanced nutrition: more than bodily needs ⁽²⁾ ; Altered sensory perception ⁽²⁾ ; Body image disorder ⁽¹⁾ ; Risk for retenção urinária ⁽¹⁾ ;	
3	Ineffective protection; Impaired skin integrity; Risk for infection; Impaired comfort; Risk for compromised human dignity; Poor knowledge; Risk for unstable blood glucose; Risk for electrolyte imbalance; Risk for fluid volume imbalance; Body image disorder; Low situational self-esteem; Anxiety; Risk for body temperature imbalance; Social isolation.	2012-2014 14 research subjects: Pemphigus vulgaris ⁽⁹⁾ ; Pemphigus foliaceus ⁽²⁾ ; Bullous pemphigoid ⁽³⁾ .

Figure 3. Nursing diagnoses found in clients with cutaneous affections according to NANDA, according to the selected articles. Rio de Janeiro, Brazil, 2018.

DISCUSSION

Considering the period and sources researched, there is precariousness of articles published about nursing diagnoses in clients with cutaneous affections. Of the three studies selected, all with level of evidence 4, the first one approached the nursing diagnoses in clients with various cutaneous affections; the second identified nursing diagnoses only in customers with leprosy and the third, and last, in clients with autoimmune bullous dermatoses. Due to the diversity of ND found, the suthors chose to discuss the diagnoses presented by 50% or more of the subjects of studies 1 and 2, and, in study 3, the analysis of the ND considered.

The most frequent ND found in the selected studies was “Risk for infection”, defined by the “vulnerability to invasion and multiplication of pathogenic organisms that may endanger the health”,¹² found in all patients, in all studies. In study 1, the risk/related factors of this diagnosis that stood out were: “increased exposure to the hospital environment”; “chronic disease”; “inadequate primary defenses (skin rupture)”; “immunosuppression”; ”invasive procedures”; “age”; “inadequate secondary defenses

(decreased hemoglobin and hematocrit levels)”; “inadequate acquired immunity”; “pharmaceutical agents”; “trauma” and “enteral probe”. In the article on customers with leprosy, the related risk factors considered were: “chronic disease”; “inadequate primary defenses”; “inadequate secondary defenses”; “immunosuppression”; “inadequate acquired immunity”; “invasive procedures” and “altered nutrition”. In the article relating to clients with autoimmune bullous dermatoses, the risk factors related to this diagnosis were: “increased environmental exposure”; “poor knowledge to avoid exposure to pathogens”; “inadequate primary and secondary defenses” and “chronic disease”.

The related risk factors directly relate to the lack of skin integrity and consequent loss of the protective barrier between the external and internal environment, besides of the immunosuppression caused by hospitalization and use of drugs, much used in the area of dermatology for the treatment of various diseases, such as leprosy reactions, autoimmune bullous dermatoses, pyoderma gangrenosum, psoriasis, among others¹³.

“Impaired skin integrity” appears in all studies, defined as “altered epidermis and/or dermis”.¹² The first study cite the following risk/related factors: “changes in turgor”; “immune deficit”; “altered metabolic condition”; “physical immobilization”; “medications”; “altered sensitivity”; “altered nutritional condition”; “extreme ages”; “altered pigmentation”; “mechanical factors”; “bone prominences”; “altered fluid condition”; “hyperthermia or hypothermia”; “altered movement”; “wet skin”; “driving force” and “moisture”. The following defining characteristics stood out: “skin surface (epidermis) bursting”; “destruction of skin layers (dermis)” and “invasion of body structures”. The second study defined as related risk factors: “physical immobilization”; “extreme ages”; “medications”; “altered metabolic condition”; “bone prominences”; “immune deficit”; “altered sensitivity”; “altered nutritional condition”; “altered pigmentation”; “altered movement” and “changes in turgor”. The defining characteristics of these factors were: “invasion of body structures”; “destruction of skin layers (dermis)” and “skin surface (epidermis) bursting”. The third study presented only defining characteristics, namely: “Destruction of layers and skin surface bursting”. However, the authors suggest the inclusion of the related risk factor “autoimmune bullous dermatoses”, justifying that such inclusion would improve the definition of the diagnostic category, helping in its identification.¹¹

The ND “risk for impaired skin integrity” is the “vulnerability to changes in the epidermis and/or dermis that may harm the health”,¹² mentioned in two studies (1 and 2). The risk factors identified in the first one were: “Changes in turgor”; “immunological”; “altered physical mobility”; “nutritional condition”; “bone prominences”; “altered sensitivity”; “altered pigmentation”; “mechanical factors”; “hypothermia or hyperthermia”; “altered movement” and “wet skin”. The related risk factors presented by the second study were: “age”; “bone prominences”; “immunological”; “altered sensitivity”; “changes in turgor”; “nutritional condition”; “physical immobilization”; “altered pigmentation” and “altered movement”.

Although the ND “Impaired skin integrity” and “Risk for impaired skin integrity” have very similar nomenclature, they have distinct definitions because: while the first one already classifies the skin as injured, the other indicates a risk for injury occurrence.¹² Analyzing the number of customers who showed such diagnostic categories, in the studies, “impaired skin integrity” has: study 1, 149 of 151 assessed clients; study 2, 51 of 51 assessed clients and study 3, 14 of 14 evaluated clients; “risk for impaired skin integrity”: study 1, 147 of 151 assessed clients and study 2, 51 of 51 evaluated clients.

In the dermatological client, the cutaneous affection occurs when there is an attack by an agent to the intact tissue and, consequently, there is a break in the skin continuity, affecting its integrity. Moreover, clients with cutaneous affections already have a sensitized skin and become vulnerable to new lesions resulting from technical procedures implemented during the treatment, from any type of pressure on the skin, during transport/walking, from the implementation of hygiene habits (shower, brushing the teeth), while performing the life basic needs (food, vesicointestinal eliminations, sexual act). Thus, it is extremely necessary that the nursing professional use his/her clinical judgment to develop strategies that minimize the risk for damage to the intact tissue.

The client’s assessment and determination of a ND directly relate to the personal judgment of the nurse, who must have knowledge, skills and attitudes that allow applying his/her scientific knowledge in his/her care practice. This fact leads to the questioning whether Nursing professionals would be really prepared to identify Nursing diagnoses predetermined by NANDA¹² and even develop new diagnostic categories or just use ND established by evaluation instruments, which focus on the most frequent diagnoses in the clients.

The diagnosis “social isolation”, defined as “loneliness experienced by the individual and perceived as imposed by others and as a negative or threatening state”¹², appears in three studies. Nevertheless, study 3 does not determine its defining characteristics and related risk factors. The first study identified as risk/related factors: the “altered state of well-being” and “changes in physical appearance” and, in relation to the defining characteristics, it mentions “altered state of well-being”, “absence of significant people”, “evidence of physical disability” and “retracted”. The related risk factors identified in the second study were “changes in physical appearance” and “altered state of well-being”, characterized by “physical evidence” and “altered state of well-being”. The diagnostic category has the same definition as the defining characteristic and related/risk factor “altered state of well-being”, however, this is a definition found in Nanda 2005, which has already passed through constant updates.

In relation to the diagnosis “Risk for loneliness”, defined as “vulnerability to experiencing discomfort associated with the desire or need for more contact with others, which may jeopardize the health”¹², this was identified in studies 1 and 2. In the first study, the related risk factors exposed were “affective deprivation”, “social isolation”, “change in physical appearance” and “lack of energy”. In the second

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study, the related risk factors were “affective deprivation” and “social isolation”.

There stands out amount of individuals with the diagnoses: “Risk for loneliness” and “social isolation” in the first and second studies. Therefore, one can say that these issues are significant in the lives of clients with skin involvement, because the individual is often stigmatized for presenting signs evident on his/her skin. In the face of the impact brought by the cutaneous involvement to these people, the loss of their skin integrity makes them feel helpless, unprotected, which means that the protection layer is physical and psychological at the same time, granting individuality and separating the inside from outside, and classified as matters little researched in the literature.¹³

In this sense, the skin is a facilitator of interpersonal relations, because the society had established aesthetic standards that appreciates the beautiful. In turn, the client with cutaneous affection has, in his/her appearance, the physical consequences of his/her pathology, resulting in a negative self-image perception.¹⁴ It affects the individual, because he/she does not feel good about him/herself, in his/her relationships and interaction with the world. From another perspective, the society itself, due to its lack of knowledge, tends to associate cutaneous affections to contagion, excluding the individual from social life.¹⁵

The ND “Risk for constipation” appeared in studies 1 and 2, being defined as “vulnerability to decrease in normal defecation frequency accompanied by difficult or incomplete elimination of feces that may endanger the health”¹². The related risk factors selected from the first study were: “change of environment”; “decreased intake of fibers and liquids”; “insufficient physical activity”; “medicines”; “difficulty to walk”; “poor food habits” and “dehydration”. In the second study, the related risk factors were “medicines”, “change of environment”, “decreased intake of fibers and liquids” and “insufficient physical activity”.

The frequency of intestinal elimination is directly related to the type of food, use of medication, pattern of physical activity, privacy, stress level and the environment.⁹ In turn, the aging represents a major risk factor for constipation.¹⁶ The aging process causes changes in the organic functions of the individual which, in turn, may be related to intrinsic factors related to advancing age and to extrinsic factors, such as diet, smoking habit, physical activity and body composition. Such changes in organic functions of the elderly person can lead to constipation.¹⁷ Therefore, “aging” should be included as a physiological risk factor of the ND “Risk for constipation.”

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The ND “Risk for trauma”, defined as “vulnerability to accidental tissue lesion (e.g., wound, burn, fracture) that may endanger the health”¹², was pointed out in studies 1 and 2. The related risk for first study were “slippery floor”, “altered mobility”, “wheelchair”, “beds without grating”, “extreme age”, “altered sensitivity”, “temperature of bath water”, “weakness”, “poorly made bed” and “poor vision” and, in the second study: “slippery floor”; “beds without grating”; “wheelchair”; “poor vision”; “reduced temperature and/or tactile sensation”, “weakness” and “balance difficulties”.

This ND was identified in all clients of study 2 and in a large part of the subjects of study 1. In study 1, the related risk factor “slippery floor” was the only one that appeared in all subjects.

Although the ND “Risk for trauma” was identified in clients diagnosed with leprosy, there draws attention the fact that “risk for peripheral neurovascular dysfunction”, defined as “vulnerability to disturbance in the movement, sensitivity and mobility from one end that may endanger the health,”¹² appeared in a lower amount of individuals in study 2, carried out exclusively with people with the medical diagnosis of leprosy. In the case of leprosy, neurological changes occur due to the inflammation of peripheral nerves (neuritis) caused either by the action of the bacillus in the nerves or by the reaction of the organism to the bacillus, or by both. Some clinical manifestations are: pain and thickening of peripheral nerves, loss of sensitivity (mainly in the eyes, hands and feet) and loss of muscle strength (in the eyelid and upper and lower limbs).¹⁸

In relation to this, NANDA underscores the importance of prioritizing the ND so that these priorities are based on the needs of the individual, family, groups and community.¹² It is important to prioritize the diagnosis for the Nursing team to understand the real needs of the individual, answering them promptly, evaluating, in this way, whether such needs were remedied with the correct application of Nursing interventions. Nevertheless, one should bear in mind that the client should always be seen integrally, valuing his/her biopsychosocial spheres.²

The ND “Risk for injury” is defined as “vulnerability to injury as a result of environmental conditions interacting with the individual’s adaptive and defensive resources, which may compromise health.”.¹² Regarding this diagnosis in clients with leprosy, injuries are related to changes in sensitivity and, regarding the location, these lesions may appear in any region of the body, including the nasal mucosa and oral cavity; however, in areas such as face, ears, buttocks, upper and lower limbs and back, they appear with greater frequency.¹⁸

The ND “Impaired dentition” is defined as the “break in patterns of dental development/eruption or the structural integrity of each tooth”, identified in studies 1 and 2, with the first study presenting the following related risk factors “ineffective hygiene”, “economic obstacle to professional care” and “self-care barriers” and as defining characteristics, “absence of teeth”, “use of prosthesis”, “decayed teeth” and “halitosis”. The related risk factors identified in the second study were “ineffective hygiene” and “economic obstacle to professional care” and, as defining characteristics, “absence of teeth”, “decayed teeth” and “use of prosthesis”.

The oral health in Brazil is in a serious epidemiological situation due to social and economic conditions of the population, small investment that the area receives in relation to the sum intended to the UHS and the lack of information on the basic health care provided to the population. Despite the high technological development of the dentistry area, it is not able to meet the entire demand of problems related to oral health, even because public policies related to dental care are geared to the target group, such as children, elderly people or low-income family.¹⁹

The ND “Acute pain” appears in studies 1 and 2, and is defined as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such injury [...] sudden or slow onset, mild to intense, with early or foreseeable termination”¹². The related risk factors identified in the first study were “health-disease process” and “harmful agents”, and as defining characteristics, “verbal reports of pain”, “observed evidence”, “facial expression”, “changes in appetite,” “analgesic position” and “autonomous responses”; the second study presents, as related risk factors, “health-disease process”, and, as defining characteristics, “verbal reports of pain” and “observed evidence”. The pain is a sensory and emotional experience that may be related to a real or potential injury, i.e., the pain involves both the perception of the painful stimulus as the response of the organism to that stimulus. Physical, mental, biochemical, physiological, psychological, social, cultural and emotional factors influence the experience of pain. Thus, the reaction to painful stimuli is individual and depends directly on the physical and emotional condition of the individual.²⁰

It is important to analyze the complaint of pain during hospitalization, with the Nursing as the main responsible for conducting this care. In this analysis, there must be included the characterization of the site, intensity, frequency, duration and quality of the symptom. When not investigated, pain can interfere in everyday life

habits and modify behavioral patterns of individuals.²¹

The ND “Imbalanced nutrition: less than bodily needs”, defined as “insufficient ingestion of nutrients to satisfy the metabolic needs”¹², appeared in studies 1 and 2, with the first study presenting as related risk factors “economic factors”, “lack of knowledge about the nutritional needs” and “inability to ingest food”. The defining characteristics highlighted were “inadequate food intake”, “weight loss”, “pale conjunctival and mucous membranes”, “delay in healing of lesions”, “increased air-fluid noises”, “difficulty to swallow”, “nasogastric probe” and “nasogastric probe”. The related risk factors pointed out in the second study were “economic factors”, “lack of knowledge about the daily nutritional needs”, highlighting, as defining characteristics, “inadequate food intake”, “weight loss” and “pale conjunctival and mucous membranes”.

Most of the clients diagnosed with leprosy, who participated in study 2, presented pale conjunctival and mucous membranes and body weight below the ideal.¹⁰ This fact reveals the need for joint action between the nursing staff and the nutritional service, reaffirming the idea that multiprofessional team is responsible for the care to the client with cutaneous affection. In this sense, many nutrients are involved in the formation of new tissue and an adequate supply of nutrients becomes essential for the prevention, maintenance and recovery of the skin and/or mucous membranes.²²

In study 3, the ND “Ineffective protection”, constituting the “reduction in the capacity to protect oneself from internal or external threats, such as illnesses or injuries”¹², and not significantly identified in studies 1 and 2, is among the most relevant, presenting, as related risk factors, “immunological disorders”, “extreme age”, “inadequate nutrition” and “therapies with drugs”. Its defining characteristics were “deficiency in the immunity”, “inaction”, “insomnia”, “poor healing” and “itchy”. Regarding external protection, the epidermis acts as a barrier and, when broken, the organism loses this first line of defense. Regarding internal protection, second defense line of the organism, by some factor inherent to the individual’s characteristics, such as immunosuppression or decreased immune response, the body is unable to defend itself against the action of microorganisms²³ and, resulting from the loss of these factors, the client with cutaneous affections becomes even more prone to invasion by organisms.

The ND “Impaired comfort”, defined as “the perception of lack of comfort, relief and transcendence in psychospiritual, physical, environmental, cultural and/or social

dimensions”¹² occurred in all clients of study 3. The related risk factors were “lack of privacy and control of the situation”, “insufficient resources” and “symptoms of disease”, and the defining characteristics include “anxiety”, “inability to relax”, “fear”, “disturbed sleep pattern”, “report of pruritus” and “report of uncomfortable feeling”. Study 3 states that the lack of skin integrity in clients with autoimmune bullous dermatoses directly affects the issues related to the pattern of sleep and rest.¹¹ The nurse should be attentive to observe such needs so that they can be remedied, promoting physical and mental well-being of the individual, helping in his/her recovery process.

The ND “Risk for compromised human dignity”, reported as “vulnerability to perceived loss of respect and honor that can jeopardize the health”,¹² occurred in all clients of study 3, having, as related risk factors, “stigma” and “exposure of the body.” Since the consequence of most dermatological diseases is the cutaneous involvement, with the exposure of the lesions, there becomes inevitable to hide the pathology from judging eyes of society.¹⁴

The ND “Poor knowledge” is “the absence or deficiency of cognitive information related to a specific topic”¹², registered in all customers of study 3, presenting, as related risk factors, “lack of familiarity with the resources of information”, “lack of interest in learning and ability to remember”, “misinterpretation of information” and “cognitive limitation” and, as defining characteristics, “inappropriate behavior”, “verbalization of the problem” and “inadequate follow-up of instructions”. In this sense, health education is one of the main strategies of Nursing to promote guidelines aiming at prevention, treatment or recovery of the population's health, so that individuals are the main responsible for their care. In relation to clients diagnosed with autoimmune bullous diseases, the aforementioned ND becomes perfectly predictable, because they are rare diseases in society and little publicized by the media. Furthermore, during the process of orientation, the Nursing must ascertain whether the individual understands the message, because, depending on the stage of the disease, in view of the degree of discomfort for the individual, he/she will not absorb the information that will be passed.²⁴

Study 3 cites the diagnoses “Risk for unstable glycemia”, defined as the “vulnerability to varying levels of glucose/sugar in the blood, in relation to the normal variation, which may jeopardize the health”¹², “Risk for electrolyte imbalance” and “Risk for imbalance in the volume of liquids”, having in view that the subjects, clients autoimmune bullous dermatoses, were under treatment with high doses of corticosteroids or

immunosuppressive drugs¹¹. The use of high doses of corticosteroids, for long periods or repeatedly, leads to complications with greater frequency, including insulin resistance and glucose intolerance²⁵. The identification of the ND “Risk for unstable glycemia” draws attention to the need for controlling glycemia and identifying signs of hypoglycemia and hyperglycemia, considering that one of the effects of corticosteroids in the body is the increase in liver gluconeogenesis, favoring the formation of glucose. However, once corticosteroids are antagonists of insulin, they bind to insulin receptor of cells, causing the available glucose in blood be not absorbed.²⁵ Immunosuppressants are drugs that act on cell division and have anti-inflammatory properties, as well as are prescribed in the treatment of chronic autoimmune and inflammatory diseases, in Dermatology, mainly in the treatment of psoriasis.²⁶ Moreover, a systematic review presented 15 articles containing 27 cases of HIV-positive patients with psoriasis treated with immunobiological products like etanercept, infliximab, adalimumab or ustekinumabe, and the majority of the cases reported excellent clinical responses, limited adverse events and well-tolerated treatment.²⁷

The ND “Risk for electrolyte imbalance” is the “vulnerability to changes in the levels of serum electrolytes capable of compromising the health”¹², and the risk for change in volume of body fluids can be identified as “Risk for imbalanced fluid volume”, defined as the “vulnerability to decrease, increase or rapid change from one location to another of the intravascular, interstitial and/or intracellular fluid, which may compromise the health”. It refers to the loss, gain, or both, of bodily fluids”¹², and both can occur in clients with cutaneous affections, mainly in those with extensive areas of impaired skin and/or mucosa, causing loss of fluids and electrolytes. The imbalance of electrolyte levels in the body may lead to changes in the volume of body fluids, and in the client that makes use of corticosteroids, there may occur the retention of liquids as a side effect of the medication.

CONCLUSION

This ILR revealed the scarcity of studies focused on the Nursing diagnoses in clients with cutaneous affections, requiring the development of further studies with more significant levels of evidence.

The ND “Risk for infection” was identified in all participants in all three studies. It leads to reflecting on the importance of the Nursing work to identify possible risk factors related and then develop the Nursing interventions, seeking strategies to reduce the incidence of this

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complication in individuals with cutaneous affections.

All Nursing diagnoses identified in this clientele reflect not only the vulnerability to risks caused by the lack of skin integrity, but also the social consequences of cutaneous involvement, in addition to the complications resulting from the use of medications.

Regarding the physical, social and emotional consequences of cutaneous involvement, the professional must evaluate the individual holistically, valuing his/her different dimensions, highlighting the need for a multidisciplinary work.

Therefore, the Nursing professional must possess knowledge, skills and attitudes to develop its his/her assistance to reduce or mitigate risks and possible complications indicated by the ND, being able to apply his/her clinical judgment and scientific knowledge for decision-making.

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Corresponding authors

Euzeli da Silva Brandão

Email: euzelibrandao@gmail.com

André Luiz de Souza Braga

Email: andre.braga@globo.com

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