## Skin, Hair, and Nail Assessment

### PART ONE

#### STRUCTURE AND FUNCTION

**SKIN**
- Epidermis
- Dermis
- Subcutaneous Tissue

**HAIR**

**NAILS**

### PART TWO

#### NURSING ASSESSMENT

**COLLECTING SUBJECTIVE DATA**
- Interview Approach

**NURSING HISTORY**
- Current Symptoms
- Past History
- Family History
- Lifestyle and Health Practices

**COLLECTING OBJECTIVE DATA**
- Client Preparation

**Equipment and Supplies**
- Key Assessment Points

#### PHYSICAL ASSESSMENT

**VALIDATION AND DOCUMENTATION OF FINDINGS**
- Example of Subjective Data
- Example of Objective Data

### PART THREE

#### ANALYSIS OF DATA

**DIAGNOSTIC REASONING: POSSIBLE CONCLUSIONS**
- Selected Nursing Diagnoses
- Selected Collaborative Problems
- Medical Problems

#### DIAGNOSTIC REASONING: CASE STUDY

**SUBJECTIVE DATA**

**OBJECTIVE DATA**
The skin, hair, and nails are external structures that serve a variety of specialized functions. The sebaceous and sweat glands originating within the skin also have many vital functions. Each of these structures and their function is described separately.

**Skin**

The skin is composed of three layers, the epidermis, dermis, and subcutaneous tissue (Fig. 9-1). The skin is thicker on the palms of the hands and soles of the feet and is continuous with the mucous membranes at the orifices of the body. Subcutaneous tissue, which contains varying amounts of fat, connects the skin to underlying structures.

The skin is a physical barrier that protects the underlying tissues and structures from microorganisms, physical trauma, ultraviolet radiation, and dehydration. It plays a vital role in temperature maintenance, fluid and electrolyte balance, absorption, excretion, sensation, immunity, and vitamin D synthesis. The skin also provides an individual identity to a person’s appearance.

**EPIDERMIS**

The epidermis, the outer layer of skin, is composed of four distinct layers (see Fig. 9-1): the stratum corneum, stratum lucidum, stratum granulosum, and stratum germinativum. The outermost layer consists of dead, keratinized cells that render the skin waterproof. (Keratin is a scleroprotein that is insoluble in water. The epidermis, hair, nails, dental enamel, and horny tissues are composed of keratin.) The epidermal layer is almost completely replaced every 3 to 4 weeks. The innermost layer of the epidermis (stratum germinativum) is the only layer that undergoes cell division and contains melanin (brown pigment) and keratin-forming cells. Skin color depends on the amount of melanin and carotene (yellow pigment) contained in the skin and the volume of blood containing hemoglobin, the oxygen-binding pigment that circulates in the dermis.

**DERMIS**

The inner layer of skin is the dermis (see Fig. 9-1). It is connected to the epidermis by means of papillae. These papillae form the base for the visible swirls or friction ridges that provide the unique pattern of fingerprints with which we are familiar. Ridges also appear on the palms of the hands, the toes, and the soles of the feet. The dermis is a well-vascularized connective tissue layer containing collagen and elastic fibers, nerve endings, and lymph vessels. It is also the origin of hair follicles, sebaceous glands, and sweat glands.

**Sebaceous Glands**

The sebaceous glands (see Fig. 9-1) develop from hair follicles and, therefore, are present over most of the body, excluding the soles and palms. They secrete an oily substance called sebum that lubricates hair and skin and reduces water loss through the skin. Sebum also has some fungicidal and bactericidal effects.

**Sweat Glands**

Sweat glands (see Fig. 9-1) are of two types, eccrine and apocrine. The eccrine glands are located over the entire skin surface and secrete an odorless, colorless fluid, the evaporation of which is vital to the regulation of body temperature. The apocrine glands are concentrated in the axillae, perineum, and areolae of the breast and usually open through a hair follicle. They secrete a milky sweat. The interaction of sweat with skin bacteria produces a characteristic body odor. Apocrine glands are dormant until puberty, at which time they become active. In women, apocrine secretions are linked with the menstrual cycle.

**SUBCUTANEOUS TISSUE**

Merging with the dermis is the subcutaneous tissue, which is a loose connective tissue containing fat cells, blood vessels, nerves, and the remaining portions of sweat glands and hair follicles (see Fig. 9-1). The subcutaneous tissue assists with heat regulation and contains the vascular pathways for the supply of nutrients and removal of waste products from the skin.

**Hair**

Hair consists of layers of keratinized cells found over much of the body except for the lips, nipples, soles of the feet, palms of the hands, labia minora, and penis. Hair develops within a sheath of epidermal cells called the hair follicle. Hair growth occurs at the base of the follicle, where cells in
Hair serves useful functions. Scalp hair is a protective covering. Nasal hair and ear hair, as well as eyelashes and eyebrows, filter dust and other airborne debris.

There are two general types of hair: vellus and terminal. Vellus hair is short, pale, and fine and is present over much of the body. The terminal hair (particularly scalp and eyebrows) is longer, generally darker, and coarser than the vellus hair. Puberty initiates the growth of additional terminal hair in both sexes on the axillae, perineum, and legs. Hair color varies and is determined by the type and amount of pigment production. The absence of pigment or the inclusion of air spaces within the layers of the hair shaft results in gray or white hair.

Hair serves useful functions. Scalp hair is a protective covering. Nasal hair and ear hair, as well as eyelashes and eyebrows, filter dust and other airborne debris.

**Nails**

The nails, located on the distal phalanges of fingers and toes, are hard, transparent plates of keratinized epidermal cells that grow from a root underneath the skin fold called the cuticle (Fig. 9-2). The nail body extends over the entire nailbed and has a pink tinge as a result of the rich blood supply underneath. At the base of the nail is the lunula, a paler, crescent-shaped area. The nails protect the distal ends of the fingers and toes.
Collecting Subjective Data

Diseases and disorders of the skin, hair, and nails can be local, or they may be caused by an underlying systemic problem. To perform a complete and accurate assessment, the nurse needs to collect data about current symptoms, the client’s past and family history, and lifestyle and health practices. The information obtained provides clues to the client’s overall level of functioning in relation to the skin, hair, and nails. (See Risk Factors—Skin Cancer for more information.)

INTERVIEW APPROACH

When interviewing a client for information regarding skin, hair, and nails, ask questions in a straightforward manner. Keep in mind that a nonjudgmental and sensitive approach is needed if the client has abnormalities that may be associated with poor hygiene or unhealthful behaviors. Also, some skin disorders might be highly visible and potentially damaging to the person’s body image and self-concept.

Remember, if the client reports any symptom, you need to explore it further with a symptom analysis. Use the COLDSPA mnemonic as a guide:

- **CHARACTER**: Describe the sign or symptom. How does it feel, look, sound, smell, and so forth?
- **ONSET**: When did it begin?
- **LOCATION**: Where is it? Does it radiate?
- **DURATION**: How long does it last? Does it recur?
- **SEVERITY**: How bad is it?
- **PATTERN**: What makes it better: What makes it worse?
- **ASSOCIATED FACTORS**: What other symptoms occur with it?

Rationale Any of these symptoms may be related to a pathologic skin condition and may affect the client’s response. Bruises, welts, or burns may indicate accidents or trauma or abuse. If these injuries cannot be explained or the client’s explanation seems unbelievable or vague, physical abuse should be suspected.

**Q** Describe any birthmarks, tattoos, or moles you now have. Have any of them changed color, size, or shape?

**R** You need to know what is normal for the client so that future variations can be detected. A change in the appearance or bleeding of any skin mark, especially a mole, may indicate cancer.

**Q** Have you noticed any change in your ability to feel pain, pressure, light touch, or temperature changes? Are you experiencing any pain, itching, tingling, or numbness?

**R** Changes in sensation may indicate vascular or neurologic problems, such as peripheral neuropathy related to diabetes mellitus or arterial occlusive disease. Sensation problems may put the client at risk for developing pressure ulcers.

**Q** Have you had any hair loss or change in the condition of your hair? Describe.

**R** Patchy hair loss may accompany infections, stress, hair-styles that put stress on hair roots, and some types of chemotherapy. Generalized hair loss may be seen in various systemic illnesses such as hypothyroidism and in clients receiving certain types of chemotherapy or radiation therapy.

A receding hair line or male pattern baldness may occur with aging.
Skin Cancer

OVERVIEW

Skin cancer is the most common of cancers. It occurs in three types: melanoma, basal cell carcinoma (BCC), and squamous cell carcinoma (SCC). BCC and SCC are nonmelanomas. It was estimated that 92,000 new melanoma cases and 2.75 million nonmelanocyte cases occur worldwide each year (Armstrong & Dricker, 1995). The American Cancer Society predicted that there would be 1,900 deaths from nonmelanoma skin cancers and 7,700 deaths from melanoma during the year 2000.

The incidence of melanoma (new cases per 100,000 population) increased from 5.7 to 13.8 between 1973 and 2000. Melanoma accounts for 4% of skin cancers but 79% of skin cancer deaths. Nonmelanocyte skin cancers are the most common and are also increasing in populations that are heavily exposed to sunlight, especially in areas of ozone depletion. Davidowitz, Belafsky, and Amedee (1999) state that melanoma will develop in 1 in 70 white Americans.

Intermittent exposure to the sun or ultraviolet radiation is associated with greatest risk for melanoma and for BCC, but overall amount of exposure is thought to be associated with SCC. SCC is most common on body sites with very heavy sun exposure, whereas BCC is most common on sites with moderate exposure (ie, upper trunk or women’s lower legs).

Precursor lesions occur for some melanomas (benign or dysplastic nevi) and for invasive SCC (actinic keratoses or SCC in situ), but there are no precursor lesions for BCC (Gloster & Brodland, 1995).

RISK FACTORS

- Sun exposure, especially intermittent pattern with sunburn; risk increases if excessive sun exposure began in childhood
- Nonsolar sources of ultraviolet radiation (tanning booth, sunlamps)
- Medical therapies, such as PUVA and ionizing radiation
- Family history and genetic susceptibility (especially for malignant melanoma)
- Moles, especially atypical lesions
- Pigmentation irregularities (albinism, burn scars)
- Fair skin that burns and freckles easily; light hair
- Immunosuppression
- Age; risk increases with increasing age
- Male gender (for nonmelanoma cancers)
- Chemical exposure (arsenic, tar, coal, paraffin, some oils for nonmelanoma cancers)
- Human papillomavirus (nonmelanoma cancers)
- Xeroderma pigmentosum (rare, inherited condition)
- Long-term skin inflammation or injury (nonmelanoma)

CULTURAL CONSIDERATIONS

The darkness of skin pigmentation affects the incidence of all skin cancers, with the lowest rates occurring in Asians and the highest rates in white Australians. The most susceptible are people with pale white, freckled skin and red hair. Australians have mounted an intense campaign that emphasizes wearing sunscreen, long sleeves, and hats any time they are in the sun. Although less susceptible to skin cancer, African Americans have two additional risk factors beside the ones listed previously. These are higher incidences of chronic inflammatory skin diseases and chronic discoid lupus erythematosus (Halder & Bridgeman-Shah, 1995). Teaching about skin cancer prevention and diagnosis should be provided to African Americans and Asians, even though they have a lower incidence than whites (Hall & Rogers, 1999).

RISK REDUCTION TEACHING TIPS

- Reduce sun exposure.
- Always use sunscreen (SPF 15 or higher) when sun exposure is anticipated.
- Wear long-sleeved shirts and wide-brimmed hats.
- Avoid sunburns.
- Avoid intermittent tanning.
- Understand the link between sun exposure and skin cancer and the accumulating effects of sun exposure on developing cancers.
- Examine the skin for suspect lesions. If there is anything unusual, seek professional advice as soon as possible.
HEALTH ASSESSMENT IN NURSING

Q Have you had any change in the condition or appearance of your nails? Describe.
R Nail changes may be seen in systemic disorders such as malnutrition or with local irritation (eg, nail biting).

Q Do you have trouble controlling body odor? How much do you perspire?
R Uncontrolled body odor or excessive or insufficient perspiration may indicate an abnormality with the sweat glands or an endocrine problem such as hypothyroidism or hyperthyroidism. Poor hygiene practices may account for body odor, and health education may be indicated.

Perspiration decreases with aging because sweat gland activity decreases.

Because of decreased sweat production, most Asians and Native Americans have mild to no body odor, whereas Caucasians and African Americans tend to have a strong body odor (Andrews & Boyle, 1999), unless they use antiperspirant or deodorant products. Any strong body odor may indicate an abnormality.

LIFESTYLE AND HEALTH PRACTICES

Q Do you sunbathe? How much sun or tanning-booth exposure do you get? What type of protection do you use?
R Sun exposure can cause premature aging of skin and increase the risk of cancer. Hair can also be damaged by too much sun.

Q In your daily activities, are you regularly exposed to chemicals that may harm the skin (eg, paint, bleach, cleaning products, weed killers, insect repellents, petroleum)?
R Any of these substances have the potential to irritate or damage the skin, hair, or nails.

Q Do you spend long periods of time sitting or lying in one position?
R Older, disabled, or immobile clients who spend long periods of time in one position are at risk for pressure ulcers.

Q Have you had any exposure to extreme temperatures?
R Temperature extremes affect the blood supply to the skin and can damage the skin layers. Examples include frostbite and burns.

Q What is your daily routine for skin, hair, and nail care? What products do you use (eg, soaps, lotions, oils, cosmetics, self-tanning products, razor type, hair spray, shampoo, coloring, nail enamel)? How do you cut your nails?
R Regular habits provide information on hygiene and lifestyle. The products used may also be a cause of an abnormality. Improper nail-cutting technique can lead to ingrown nails or infection.

Decreased flexibility and mobility may impair the ability of some elderly clients to maintain proper hygiene practices, such as nail cutting, bathing, and hair care.

Q What kinds of foods do you consume in a typical day? How much fluid do you drink each day?
R A balanced diet is necessary for healthy skin, hair, and nails. Adequate fluid intake is required to maintain skin elasticity.

Q For female clients: Are you pregnant? Are your menstrual periods regular?
R Some skin and hair conditions can result from hormonal imbalance.

Q Do skin problems limit any of your normal activities?
R Certain activities such as hiking, camping, and gardening may expose the client to allergens such as poison ivy. Moreover, exposure to the sun can aggravate conditions such as scleroderma. In addition, general home maintenance (eg, cleaning, car washing) may expose the client to certain cleaning products to which he or she is sensitive or allergic.

PAST HISTORY

Q Describe any previous problems with skin, hair, or nails, including any treatment or surgery and its effectiveness.
R Current problems may be a recurrence of previous ones. Visible scars may be explained by previous problems.

Q Have you ever had any allergic skin reactions to food, medications, plants, or other environmental substances?
R Various types of allergens can precipitate a variety of skin eruptions.

Q Have you had a fever, nausea, vomiting, gastrointestinal (GI), or respiratory problems?
R Some skin rashes or lesions may be related to viruses or bacteria.

FAMILY HISTORY

Q Has anyone in your family had a recent illness, rash, or other skin problem or allergy? Describe.
A Acne and atopic dermatitis tend to be familial. Viruses (eg, chickenpox, measles) can be highly contagious. Some allergies may be identified from family history.

Q Has anyone in your family had skin cancer?
A A genetic component is associated with skin cancer, especially malignant melanoma.
**Q** Describe any skin disorder that prevents you from enjoying your relationships.

**R** Skin, hair, or nail problems, especially if visible, may impair the client’s ability to interact comfortably with others because of embarrassment or rejection by others.

**Q** How much stress do you have in your life? Describe.

**R** Stress can cause or exacerbate skin abnormalities.

**Q** Do you perform a skin self-examination once a month?

**R** If clients do not know how to inspect the skin, teach them how to recognize suspicious lesions early (Display 9-1).

---

**DISPLAY 9-1. How to Examine Your Own Skin**

You can systematically and regularly assess your skin for abnormalities by using the following recommended procedure for skin assessment from the American Cancer Society.

**Step 1**
Make sure the room is well-lighted, and that you have nearby a full-length mirror, a hand-held mirror, a hand-held blow dryer, and two chairs or stools. Undress completely.

**Step 2**
Hold your hands with the palms face up, as shown in the drawing. Look at your palms, fingers, spaces between the fingers, and forearms. Then turn your hands over and examine the backs of your hands, fingers, spaces between the fingers, fingernails, and forearms.

**Step 3**
Now position yourself in front of the full-length mirror. Hold up your arms, bent at the elbows, with your palms facing you. In the mirror, look at the backs of your forearms and elbows.

**Step 4**
Again, using the full-length mirror, observe the entire front of your body. In turn, look at your face, neck, and arms. Turn your palms to face the mirror and look at your upper arms. Then look at your chest and abdomen; pubic area; thighs and lower legs.

**Step 5**
Still standing in front of the mirror, lift your arms over your head with the palms facing each other. Turn so that your right side is facing the mirror and look at the entire side of your body: your hands and arms, underarms, sides of your trunk, thighs, and lower legs. Then turn, and repeat the process with your left side.
Collecting Objective Data

Physical assessment of the skin, hair, and nails provides the nurse with data that may reveal local or systemic problems or alterations in a client’s self-care activities. Local irritation, trauma, or disease can alter the condition of the skin, hair, or nails. Systemic problems related to impaired circulation, endocrine imbalances, allergic reactions, or respiratory disorders may also be revealed with alterations in the skin, hair, or nails. The appearance of the skin, hair, and nails also provides the nurse with data related to health maintenance and self-care activities such as hygiene, exercise, and nutrition.

A separate, comprehensive skin, hair, and nail examination, preferably at the beginning of a comprehensive physical examination, ensures that you do not inadvertently omit part of the examination. As you inspect and palpate the skin, hair, and nails, pay special attention to lesions and growths.

CLIENT PREPARATION

To prepare for the skin, hair, and nail examination, ask the client to remove all clothing and jewelry and put on an examination gown. In addition, ask the client to remove nail enamel, artificial nails, wigs, toupees, or hairpieces as appropriate.
PHYSICAL ASSESSMENT

ASSESSMENT PROCEDURE NORMAL FINDINGS ABNORMAL FINDINGS

SKIN INSPECTION

Inspect general skin coloration. Keep in mind that the amount of pigment in the skin accounts for the intensity of color as well as hue. Small amounts of melanin are common in whiter skins, while large amounts of melanin are common in olive and darker skins. Carotene accounts for a yellow cast. A blue hue may be from cyanosis, a sign of illness.

Evenly colored skin tones without unusual or prominent discolorations.

The older client’s skin becomes pale due to decreased melanin production and decreased dermal vascularity.

Pallor (loss of color) is seen in arterial insufficiency, decreased blood supply, and anemia. Pallid tones vary from pale to ashen without underlying pink.

Cyanosis makes white skin appear blue-tinged, especially in the perioral, nailbed, and conjunctival areas. Dark skin appears blue, dull and lifeless in the same areas.

Central cyanosis results from a cardiopulmonary problem whereas peripheral cyanosis may be a local problem resulting from vasocostriction.

To differentiate between central and peripheral cyanosis, look for central cyanosis in the oral mucosa.

Jaundice in light- and dark-skinned people is characterized by yellow skin tones, from pale to pumpkin, particularly in the sclera, oral mucosa, palms, and soles.

Acanthosis nigricans, roughening and darkening of skin in localized areas, especially the posterior neck (Stuart, et al., 1999).

While inspecting skin coloration, note any odors emanating from the skin.

A strong odor of perspiration or foul odor may indicate disorder of sweat glands. Poor hygiene practices may indicate a need for client teaching or assistance with activities of daily living.

Inspecting the palms is an opportunity to assess overall coloration. (© B. Proud.)

Slight or no odor of perspiration, depending on activity.

Clients from conservative religious groups (eg, Orthodox Jews or Muslims), may require that the nurse be the same sex as the client. Also, to respect the client’s modesty or desire for privacy, provide a long examination gown or robe.

EQUIPMENT AND SUPPLIES

- Examination light
- Penlight
- Mirror for client’s self-examination of skin
- Magnifying glass
- Centimeter ruler
- Gloves
- Wood’s light
- Examination gown or drape

KEY ASSESSMENT POINTS

- Inspect skin color, temperature, moisture, texture
- Check skin integrity
- Be alert for skin lesions
- Evaluate hair condition; loss or unusual growth
- Note nailbed condition and capillary refill

(text continues on page 132)
Characteristic butterfly rash of lupus erythematosus.

Rashes, such as the reddish (in light-skinned people) or darkened (in dark-skinned people) butterfly rash across the bridge of the nose and cheeks, characteristic of discoid lupus erythematosus (DLE).

Albinism is a generalized loss of pigmentation.

Erythema (skin redness and warmth) is seen in inflammation, allergic reactions, or trauma.

Erythema in the dark-skinned client may be difficult to see. However, the affected skin feels swollen and warmer than the surrounding skin.

Inspect localized parts of the body, noting any color variation. Keep in mind that some clients have sun-tanned areas, freckles, or white patches known as vitiligo (Display 9-2). The variations are due to different amounts of melanin in certain areas. A generalized loss of pigmentation is seen in albinism. Dark-skinned clients have lighter-colored palms, soles, nailbeds, and lips. Frecklelike or dark streaks of pigmentation are also common in the sclera and nailbeds of dark-skinned clients.

White-skinned clients have darker pigment around nipples, lips, and genitalia. Mongolian spots on the lower back, buttocks, or even on the upper back, arms, thighs, or abdomen occur in most blacks, Asians, Native Americans, and some whites. These bluish, bruise-like markings usually fade by 2 years of age (Overfield, 1995).
### Inspect for Skin Integrity
Check skin integrity, especially carefully in pressure point areas (eg, sacrum, hips, elbows). If any skin breakdown is noted, use a scale to document the degree of skin breakdown.

### Inspect for Lesions
Observe the skin surface to detect abnormalities.

**Tip From the Experts** When examining female or obese clients, lift the breasts (or ask the client to lift them) and skin folds to inspect all areas for lesions. Note color, shape, and size of lesion. For very small lesions, use a magnifying glass to note these characteristics.

If you suspect a fungus, shine a Wood’s light (an ultraviolet light filtered through a special glass) on the lesion.

If you observe a lesion, note its location, distribution, and configuration.

### Palpate Skin to Assess Texture
Use the palmar surface of your three middle fingers to palpate skin texture.

### Palpate to Assess Thickness
If lesions are noted when assessing skin thickness, put gloves on and palpate the lesion between the thumb and finger. Observe for drainage or other characteristics. Measure the lesion with a centimeter ruler.

### ASSESSMENT PROCEDURE | NORMAL FINDINGS | ABNORMAL FINDINGS
--- | --- | ---
Inspect for Skin Integrity | Skin is intact, and there are no reddened areas. | Skin breakdown is initially noted as a reddened area on the skin that may progress to serious and painful pressure ulcers (Display 9-3). Depending on the color of the client’s skin, reddened areas may not be prominent, although the skin may feel warmer in the area of breakdown than elsewhere. |
Inspect for Lesions | Smooth, without lesions. Stretch marks (striae), healed scars, freckles, moles, or birthmarks are common findings (see Display 9-2). | Lesions may indicate local or systemic problems. Primary lesions (Display 9-4) arise from normal skin due to irritation or disease. Secondary lesions (Display 9-5) arise from changes in primary lesions. Vascular lesions (Display 9-6), reddish-blush lesions, are seen with bleeding, venous pressure, aging, liver disease, or pregnancy. Skin cancer lesions can be either primary or secondary lesions and are classified as squamous cell carcinoma, basal cell carcinoma, or malignant melanoma (Display 9-7). |
Tip From the Experts | Older clients may have skin lesions because of aging. Some examples are seborrheic or senile keratoses, senile lentigines, cherry angiomas, purpura, and cutaneous tags and horns. | Blue-green fluorescence indicates fungal infection. |
| Lesion does not fluoresce. | Normal lesions may be moles, freckles, birthmarks, and the like. They may be scattered over the skin in no particular pattern. | In abnormal findings, distribution may be diffuse (scattered all over), localized to one area, or in sun-exposed areas. Configuration may be discrete (separate and distinct), grouped (clustered), confluent (merged), linear (in a line), annular and arciform (circular or arcing), or zosteriform (linear along a nerve route; Display 9-8). |
| Rough, flaky, dry skin is seen in hypothyroidism. | Very thin skin may be seen in clients with arterial insufficiency or in those on steroid therapy. | |

(continued)
### Palpate to Assess Mobility and Turgor

As the client to lie down. Using two fingers, gently pinch the skin on the sternum or under the clavicle. Mobility refers to how easily the skin can be pinched. Turgor refers to the skin’s elasticity and how quickly the skin returns to its original shape after being pinched.

<table>
<thead>
<tr>
<th>ASSESSMENT PROCEDURE</th>
<th>NORMAL FINDINGS</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin pinches easily and immediately returns to its original position.</td>
<td>Decreased mobility is seen with edema. Decreased turgor (a slow return of the skin to its normal state taking longer than 30 seconds) is seen in dehydration.</td>
<td></td>
</tr>
<tr>
<td>The older client’s skin loses its turgor because of a decrease in elasticity and collagen fibers. Sagging or wrinkled skin appears in the facial, breast, and scrotal areas.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Palpate to Detect Edema

Use your thumbs to press down on the skin of the feet or ankles to check for edema (swelling related to accumulation of fluid in the tissue).

- Skin rebounds and does not remain indented when pressure is released.
- Indentations on the skin may vary from slight to great and may be in one area or all over the body. See Chapter 17, Peripheral Vascular Assessment, for a full discussion of edema.

### Palpate to Assess Temperature

Use the dorsal surfaces of your hands to palpate the skin. You may also want to palpate with the palmar surfaces of your hands because current research indicates that these surfaces of the hands and fingers may be more sensitive to temperature (Cantwell-Gaw, 1996).

- Skin is normally a warm temperature.
- Cold skin may accompany shock or hypotension. Cool skin may accompany arterial disease. Very warm skin may indicate a febrile state or hyperthyroidism.
At 1-inch intervals, separate the hair from the scalp and inspect and palpate the hair and scalp for cleanliness, dryness or oiliness, parasites, and lesions.

Scalp is clean and dry. Sparse dandruff may be visible. Hair is smooth and firm, somewhat elastic. However, as people age, hair feels coarser and drier.

Individuals of black African descent often have very dry scalps and dry, fragile hair, which the client may condition with oil or a petroleum jelly like product. (This kind of hair is of genetic origin and not related to thyroid disorders or nutrition. Such hair needs to be handled very gently.)

Excessive scalpiness may indicate dermatitis. Raised lesions may indicate infections or tumor growth. Dull, dry hair may be seen with hypothyroidism and malnutrition. Poor hygiene may indicate a need for client teaching or assistance with activities of daily living.

### SCALP AND HAIR: CONDITION AND TEXTURE

<table>
<thead>
<tr>
<th>ASSESSMENT PROCEDURE</th>
<th>NORMAL FINDINGS</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have the client remove any hair clips, hair pins, or wigs. Wear gloves if lesions are suspected or if hygiene is poor. Then inspect the scalp and hair.</td>
<td>Natural hair color, as opposed to chemically colored hair, varies among clients from pale blond to black to gray or white. The color is determined by the amount of melanin present.</td>
<td>Excessive generalized hair loss may occur with infection, nutritional deficiencies, hormonal disorders, thyroid or liver disease, drug toxicity, hepatic or renal failure (Sabbagh, 1999). It may also result from chemotherapy or radiation therapy.</td>
</tr>
<tr>
<td>Inspect amount and distribution of scalp, body, axillae, and pubic hair. Look for unusual growth elsewhere on the body.</td>
<td>Varying amounts of terminal hair cover the scalp, axillary, body, and pubic areas according to normal gender distribution. Fine vellus hair covers the entire body except for the soles, palms, lips, and nipples. Normal male pattern balding is symmetric.</td>
<td>Hirsutism (facial hair on females) is a characteristic of Cushing’s disease and results from an imbalance of adrenal hormones, or it may be a side effect of steroids.</td>
</tr>
<tr>
<td>At 1-inch intervals, separate the hair from the scalp and inspect and palpate the hair and scalp for cleanliness, dryness or oiliness, parasites, and lesions.</td>
<td></td>
<td>Patchy hair loss may result from infections of the scalp, discoid or systemic lupus erythematosus, and some types of chemotherapy. (Courtesy Neutrogena Skin Care Institute.)</td>
</tr>
</tbody>
</table>

---

(continued)
<table>
<thead>
<tr>
<th>ASSESSMENT PROCEDURE</th>
<th>NORMAL FINDINGS</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAILS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect nail grooming and cleanliness.</td>
<td>Clean and manicured.</td>
<td>Dirty, broken, or jagged fingernails may be seen with poor hygiene. They may also result from the client’s hobby or occupation.</td>
</tr>
<tr>
<td>Inspect nail color and markings.</td>
<td>Pink tones should be seen. Some longitudinal ridging is normal.</td>
<td>Pale or cyanotic nails may indicate hypoxia or anemia. Splinter hemorrhages may be caused by trauma. Beau’s lines occur after acute illness and eventually grow out. Yellow dis-coloration may be seen in fungal infections or psoriasis. Nail pitting is common in psoriasis (Display 9-9).</td>
</tr>
<tr>
<td>Inspect shape of nails.</td>
<td>There is normally a 160-degree angle between the nail base and the skin (see Display 9-9).</td>
<td>Early clubbing (180-degree angle with spongy sensation) and late clubbing (greater than 180-degree angle) can occur from hypoxia. Spoon nails (concave) may be present with iron deficiency anemia (see Display 9-9).</td>
</tr>
<tr>
<td>Palpate nail to assess texture.</td>
<td>Nails are hard and basically immobile.</td>
<td>Thickened nails (especially toenails) may be caused by decreased circulation.</td>
</tr>
<tr>
<td>Palpate to assess texture and consistency, noting whether nailplate is attached to nailbed.</td>
<td>Smooth and firm; nailplate should be firmly attached to nailbed.</td>
<td>Paronychia (inflammation) indicates local infection. Detachment of nailplate from nailbed (onycholysis) is seen in infections or trauma.</td>
</tr>
<tr>
<td>Test capillary refill in nailbeds by pressing the nail tip briefly and watching for color change.</td>
<td>Pink tone returns immediately to blanched nailbeds when pressure is released.</td>
<td>There is slow (greater than 2 seconds) capillary nailbed refill (return of pink tone) with respiratory or cardiovascular diseases that cause hypoxia.</td>
</tr>
</tbody>
</table>
DISPLAY 9-2. Common Skin Variations

Many skin assessment findings are considered normal variations in that they are not health- or life-threatening. For example, freckles are common variations in fair-skinned clients, whereas unspotted skin is considered the ideal. Scars and vitiligo, on the other hand, are not exactly normal findings because scars suggest a healed injury or surgical intervention and vitiligo may be related to a dysfunction of the immune system. However, they are common and usually insignificant. Other common findings appear below.

- **Freckles**: flat, small macules of pigment that appear following sun exposure. (© B. Proud.)
- **Striae** (sometimes called stretch marks). (Courtesy E. R. Squibb.)
- **Seborrheic keratosis**, a warty or crusty pigmented lesion. (With permission from Goodheart, H. P. [1999]. *A photo guide of common skin disorders: Diagnosis and management.* Baltimore: Williams & Wilkins.)
- **Mole** (also called nevus), a flat or raised tan/brownish marking up to 6 mm wide.
- **Cutaneous tags**, raised yellow papules with a depressed center. (Courtesy of Steifel Laboratories, Inc.)
- **Vitiligo of forearm** in an African American client. (Courtesy Neutrogena Care Institute.)
- **Scar.**
Valuation and Documentation of Findings

Validate your normal and abnormal findings with the client, other health care workers, or your instructors. Next, document the skin, hair, and nail assessment data that you have collected on the appropriate form your school or agency uses. The following is a summary of areas of coverage and findings that are considered normal in a skin, hair, and nail assessment. Of course, abnormal findings would be carefully documented too. Normal findings can act as a baseline for findings that may change later.

EXAMPLE OF SUBJECTIVE DATA

Thirty-five-year-old woman with no history of skin lesions, excessive hair loss, or nail disorders. Reports one episode of fine, raised, reddened rash on trunk after taking ampicillin for ear infection. Rash cleared within 3 days after discontinuation of ampicillin and administration of antihistamine. Showers in AM and bathes in PM with deodorant soap. Shampoos with baby shampoo each AM. Applies moisturizer to skin after each cleansing; conditions hair after shampoo. Uses antiperspirant twice daily. Shaves legs and axillae with electric razor twice weekly. Weekly, trims toenails and fingernails and applies nail enamel to fingernails. Denies exposure to chemicals, abrasives, or excessive sunlight.

EXAMPLE OF OBJECTIVE DATA

Skin pink, warm, dry, and elastic. No lesions or excoriations noted. Old appendectomy scar right lower abdomen, 4 inches long, thin, and white. Sprinkling of freckles noted across nose and cheeks. Hair brown, shoulder-length, clean, shiny. Normal distribution of hair on scalp and perineum. Hair has been removed from legs, axillae. Nails form 160-degree angle at base; are hard, smooth, and immobile. Nailbeds pink without clubbing. Cuticles smooth; no detachment of nail plate. Fingernails well manicured with clear enamel. Toenails clean and well trimmed.

After you have collected your assessment data, analyze the data, using diagnostic reasoning skills. You can review the key steps in diagnostic reasoning in Chapter 7. Then, read on to “Diagnostic Reasoning: Possible Conclusions.” This discussion features an overview of common conclusions that you may reach from raw data after a skin, hair, and nail assessment. Then, “Diagnostic Reasoning: Case Study” shows you how to analyze skin, hair, and nail assessment data for a specific client. Finally, you will have an opportunity to analyze data in your laboratory manual/study guide in the “Critical Thinking Exercise.”
During any skin assessment, the nurse remains watchful for signs of skin breakdown, especially in cases of limited mobility or fragile skin (e.g., elderly or bedridden clients). Pressure ulcers, which lead to complications such as infection, are easier to prevent than to treat. Some risk factors for skin breakdown leading to pressure ulcers include poor circulation, poor hygiene, infrequent position changes, dermatitis, infection, or traumatic wounds. The stages of pressure ulcers appear below.

**Stage I.** Skin is unbroken but appears red; no blanching when pressed.

**Stage II.** Skin is broken, and there is superficial skin loss involving the epidermis alone or also the dermis. The lesion resembles a vesicle, erosion, or blister.

**Stage III.** Pressure area involves epidermis, dermis, and subcutaneous tissue. The ulcer resembles a crater. Hidden areas of damage may extend through the subcutaneous tissue beyond the borders of the external lesion but not through underlying fascia.

**Stage IV.** Pressure area involves epidermis, dermis, subcutaneous tissue, bone, and other support tissue. The ulcer resembles a massive crater with hidden areas of damage in adjacent tissue.

Primary skin lesions are original lesions arising from previously normal skin. Secondary lesions can originate from primary lesions.

**MACULE, PATCH**
- *Macule:* <1 cm, circumscribed border
- *Patch:* >1 cm, may have irregular border
- Flat, nonpalpable skin color change (color may be brown, white, tan, purple, red)

**Examples:**
Freckles, flat moles, petechiae, rubella, vitiligo, port wine stains, ecchymosis

**PAPULE, PLAQUE**
- *Papule:* <0.5 cm
- *Plaque:* >0.5 cm
- Elevated, palpable, solid mass
- Circumscribed border
- Plaque may be coalesced papules with flat top

**Examples:**
- *Papules:* Elevated nevi, warts, lichen planus
- *Plaques:* Psoriasis, actinic keratosis

Warts, circumscribed elevations caused by a virus.
(Courtesy of Reed and Carnick Pharmaceuticals.)
DISPLAY 9-4. Primary Skin Lesions (Continued)

NODULE, TUMOR
- Nodule: 0.5–2 cm
- Tumor: >1–2 cm
- Elevated, palpable, solid mass
- Extends deeper into the dermis than a papule
- Nodules circumscribed
- Tumors do not always have sharp borders

Examples:
Nodules: Lipoma, squamous cell carcinoma, poorly absorbed injection, dermatofibroma
Tumors: Larger lipoma, carcinoma

VESICLE, BULLA
- Vesicle: <0.5 cm
- Bulla: >0.5 cm
- Circumscribed, elevated, palpable mass containing serous fluid

Examples:
Vesicles: Herpes simplex/zoster, chickenpox, poison ivy, second-degree burn (blisters)
Bulla: Pemphigus, contact dermatitis, large burn blisters, poison ivy, bullous impetigo

Herpes zoster (shingles), an acute, inflammatory, infectious skin disease caused by a herpes virus.
WHEAL
- Elevated mass with transient borders
- Often irregular
- Size, color varies
- Caused by movement of serous fluid into the dermis
- Does not contain free fluid in a cavity (e.g., a vesicle)

Examples:
Urticaria (hives), insect bites

PUSTULE
- Pus-filled vesicle or bulla

Examples:
Acne, impetigo, furuncles, carbuncles

CYST
- Encapsulated fluid-filled or semisolid mass
- In the subcutaneous tissue or dermis

Examples:
Sebaceous cyst, epidermoid cyst

Wheal.
Insect bites.
Pustule.
Acne. (Hoechst-Roussel Pharmaceuticals, Inc.)
Cyst.
Epidermoid cysts are nodular.
DISPLAY 9-5. Secondary Skin Lesions

Secondary skin lesions result from changes in primary lesions.

**EROSION**
- Loss of superficial epidermis
- Does not extend to dermis
- Depressed, moist area

*Examples:*
Ruptured vesicles, scratch marks, aphthous ulcer

**ULCER**
- Skin loss extending past epidermis
- Necrotic tissue loss
- Bleeding and scarring possible

*Examples:*
Stasis ulcer of venous insufficiency, pressure ulcer

**SCAR [CICATRIX]**
- Skin mark left after healing of a wound or lesion
- Represents replacement by connective tissue of the injured tissue
- Young scars: red or purple
- Mature scars: white or glistening

*Examples:*
Healed wound or surgical incision

Aphthous ulcer. (With permission from Goodheart, H. P. [1999]. *A photo guide of common skin disorders: Diagnosis and management.* Baltimore: Williams & Wilkins.)

Ulcer from venous stasis.

Mature healed wound.

(continued)
**DISPLAY 9-5. Secondary Skin Lesions (Continued)**

**FISSURE**
- Linear crack in the skin
- May extend to dermis

**Examples:**
- Chapped lips or hands, athlete's foot

![Fissure](image1)

Athlete's foot.

**SCALES**
- Flakes secondary to desquamated, dead epithelium
- Flakes may adhere to skin surface
- Color varies (silvery, white)
- Texture varies (thick, fine)

**Examples:**
- Dandruff, psoriasis, dry skin, pityriasis rosea

![Scales](image2)

Psoriasis. (Roche Laboratories.)

**CRUST**
- Dried residue of serum, blood, or pus on skin surface
- Large adherent crust is a scab

**Examples:**
- Residue left after vesicle rupture: impetigo, herpes, eczema

![Crust](image3)

Ruptured vesicles of herpes simplex. (Dermik Laboratories, Inc.)
**DISPLAY 9-5. Secondary Skin Lesions (Continued)**

**KELOID**
- Hypertrophied scar tissue
- Secondary to excessive collagen formation during healing
- Elevated, irregular, red
- Greater incidence in African Americans

**Example:**
Keloid of ear piercing or surgical incision

[Image: Keloid]

**ATROPHY**
- Thin, dry, transparent appearance of epidermis
- Loss of surface markings
- Secondary to loss of collagen and elastin
- Underlying vessels may be visible

**Examples:**
Aged skin, arterial insufficiency

[Image: Atrophy]

**LICHENIFICATION**
- Thickening and roughening of the skin
- Accentuated skin markings
- May be secondary to repeated rubbing, irritation, scratching

**Examples:**
Contact dermatitis, often resulting from exposure to aero allergens, chemicals, foods, and emotional stress

[Image: Lichenification]

---

Ear keloid. (© 1992 J. Barabe.)

Dry, translucent, aged skin. (With permission from Goodheart, H. P. [1999]. *A photo guide of common skin disorders: Diagnosis and management*. Baltimore: Williams & Wilkins.)

Contact dermatitis, chronic inflammation of the skin. (Courtesy of Geigy Pharmaceuticals.)
Vascular skin lesions are associated with bleeding, aging, circulatory conditions, diabetes, pregnancy and hepatic disease, among other problems.

**PETECHIA (PL. PETECHIAE)**
- Round red or purple macule
- Small: 1–2 mm
- Secondary to blood extravasation
- Associated with bleeding tendencies or emboli to skin

**ECCHYMOSIS (PL. ECCHYMOSES)**
- Round or irregular macular lesion
- Larger than petechia
- Color varies and changes: black, yellow, and green hues
- Secondary to blood extravasation
- Associated with trauma, bleeding tendencies

**HEMATOMA**
- A localized collection of blood creating an elevated ecchymosis
- Associated with trauma
DISPLAY 9-6. Vascular Skin Lesions (Continued)

CHERRY ANGIOMA
- Papular and round
- Red or purple
- Noted on trunk, extremities
- May blanch with pressure
- Normal age-related skin alteration
- Usually not clinically significant

SPIDER ANGIOMA
- Red, arteriole lesion
- Central body with radiating branches
- Noted on face, neck, arms, trunk
- Rare below the waist
- May blanch with pressure
- Associated with liver disease, pregnancy, vitamin B deficiency

TELANGIECTASIS (VENOUS STAR)
- Shape varies: spiderlike or linear
- Color bluish or red
- Does not blanch when pressure is applied
- Noted on legs, anterior chest
- Secondary to superficial dilation of venous vessels and capillaries
- Associated with increased venous pressure states (varicosities)
With the exception of malignant melanoma, most skin cancers are easily seen and easily cured, or at least controlled. Malignant melanoma can be deadly if not discovered and treated early, which is one reason why professional health assessment and skin self-assessment can be life-saving procedures. The most commonly detected skin cancers are illustrated below.

**Basal cell carcinoma on patient’s face. (CMSP Paul Parker/Science Photo Library.)**

**Squamous cell carcinoma.**

**Kaposi’s sarcoma of foot. (Owen/Calderma.)**

**Malignant melanoma is usually evaluated according to the mnemonic ABCDE: A for asymmetrical; B for borders that are irregular; C for color variations; D for diameter exceeding 6 mm; and E for elevated, not flat. Danger signs of malignant melanoma include asymmetry of pigmented lesions, irregular borders (margins), varying colors (black, blue, red brown, tan, white) and diameter greater than 6 mm. However, smaller areas may indicate early stage melanomas. Other warning signs include itching, burning, and a change in size or bleeding of a mole. New pigmentations are also warning signs. (American Cancer Society; American Academy of Dermatology.)**
Describing lesions by shape, distribution, or configuration is one way to communicate specific characteristics that can help to identify causes and treatments. Some common configurations include the following:

- **Linear configuration:** straight line as in a scratch or streak.
- **Annular configuration:** circular lesions.
- **Zosteriform configuration:** linear lesions clustered along a nerve route.
- **Discrete configuration:** individual and distinct lesions.
- **Polycyclic configuration:** circular lesions that tend to run together.
- **Confluent configuration:** lesions run together.
Many clients have nails with lines, ridges, spots, and uncommon shapes that suggest an underlying disorder. Some examples follow:

A Beau’s lines (acute illness)

B Spoon nails (iron deficiency anemia)

C Early clubbing (oxygen deficiency)

D Late clubbing (oxygen deficiency)

E Pitting (psoriasis)

F Paronychia (local infection)
Diagnostic Reasoning: Possible Conclusions

Listed below are some possible conclusions that the nurse may make after assessing a client’s skin, hair, and nails.

SELECTED NURSING DIAGNOSES

After compiling subjective and objective data related to the client’s skin, hair, and nails, you will need to identify abnormalities and cluster the data to reveal any significant patterns or abnormalities. These data may then be used to make clinical judgments (nursing diagnoses: wellness, risk, or actual) about the status of the client’s skin, hair, and nails. The following is a list of selected nursing diagnoses that may be identified when analyzing data from a skin, hair, and nail assessment.

Nursing Diagnoses (Wellness)
- Opportunity to enhance skin, hair, and nail integrity related to healthy hygiene and skin care practices, avoidance of overexposure to sun
- Health-Seeking Behavior: Requests information on skin reactions and effects of using a sun-tanning booth

Nursing Diagnoses (Risk)
- Risk for Impaired Skin Integrity related to excessive exposure to cleaning solutions and chemicals
- Risk for Impaired Skin Integrity related to prolonged sun exposure
- Risk for Impaired Skin Integrity related to immobility, decreased production of natural oils, and thinning skin
- Risk for Impaired Skin Integrity of toes related to thickened, dried toenails
- Risk for Altered Body Temperature related to severe diaphoresis
- Risk for Infection related to scratching of rash
- Risk for Impaired Nail Integrity related to prolonged use of nail polish
- Risk for Altered Nutrition: Less Than Body Requirements related to increased vitamin and protein requirements necessary for healing of a wound

Nursing Diagnoses (Actual)
- Altered Health Maintenance related to lack of hygienic care of the skin, hair, and nails
- Impaired Skin Integrity related to immobility and decreased circulation
- Impaired Skin Integrity related to poor nutritional intake and bowel/bladder incontinence
- Body Image Disturbance related to scarring, rash, or other skin condition that alters skin appearance
- Sleep Pattern Disturbance related to persistent itching of the skin
- Fluid Volume Deficit related to excessive diaphoresis secondary to excessive exercise and high environmental temperatures

SELECTED COLLABORATIVE PROBLEMS

After grouping the data, certain collaborative problems may become apparent. Remember that collaborative problems differ from nursing diagnoses in that they cannot be prevented or managed with independent nursing interventions. However, these physiologic complications of medical conditions can be detected and monitored by the nurse. In addition, the nurse can use physician- and nurse-prescribed interventions to minimize the complications of these problems. The nurse may also have to refer the client in such situations for further treatment of the problem. The following is a list of collaborative problems that may be identified when assessing the skin, hair, and nails. These problems are worded as Potential Complications (or PC), followed by the problem.

- PC: Allergic reaction
- PC: Skin rash
- PC: Insect/animal bite
- PC: Septicemia
- PC: Hypovolemic shock
- PC: Skin infection
Diagnostic Reasoning: Case Study

The case study presents assessment data for a specific client. It is followed by an analysis of the data, by following the seven key steps found in Chapter 7, to arrive at specific conclusions.

Mary Michaelson, a 29-year-old divorced woman, works as an office manager for a large, prestigious law firm. She reports she recently went to see a doctor because “my hair was falling out in chunks, and I have a red rash on my face and chest. It looks like a bad case of acne.” After doing some blood work, her physician diagnosed her condition as discoid lupus erythematosus (DLE). She says she has come to see you, the occupational health nurse, because she feels “so ugly,” and she is concerned that she may lose her job because of how she looks.

During the interview, she tells you that she is a surfer and is out in the sun all day nearly every weekend. She shares that she uses sunscreen but forgets to put it on at regular intervals during the day.

Your physical examination reveals an attractive, tanned, thin, anxious-appearing young woman. You note confluent and nonconfluent maculopapular lesions on her neck, chest above the nipple line, and over the shoulders and upper back to about the level of the T5 vertebra. Many of the lesions appear as red, scaling plaques with depressed, pale centers. A few of the lesions on her forehead and cheeks appear blistered. Patchy alopecia is also present. Her vital signs are within normal limits, and no other abnormalities are apparent at this time.

1. Identify abnormal data and strengths (in both subjective and objective data).

SUBJECTIVE DATA
- “Hair falling out in chunks”
- Red rash on face and chest—“looks like a bad case of acne”
- “So ugly”
- Concerned that she may lose her job because of how she looks
- Surfer—out in the sun all day on weekends—minimal use of sunscreen
- Sought out occupational health nurse

OBJECTIVE DATA
- Anxious appearing
- Diagnosed with discoid lupus erythematosus
- Red, raised plaques on face, neck, shoulders, back, and chest
- Patchy alopecia

MEDICAL PROBLEMS

After grouping the data, it may become apparent that the client has signs and symptoms that require medical diagnosis and treatment. Referral to a primary care provider is necessary.
### CHAPTER 9 | SKIN, HAIR, AND NAIL ASSESSMENT

#### Table 9.1: Possible Nursing Defining Cue Clusters Inferences Diagnoses Characteristics Confirm or Rule Out

<table>
<thead>
<tr>
<th>Cue Clusters</th>
<th>Inferences</th>
<th>Possible Nursing Diagnoses</th>
<th>Defining Characteristics</th>
<th>Confirm or Rule Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surfer, out in sunlight weekly</td>
<td>Excessive sun exposure can worsen lesions causing blistering, weeping, and scarring</td>
<td>Risk for Altered Health Maintenance related to knowledge deficit of effects of sunlight on skin lesions</td>
<td><strong>Major:</strong> Reports unhealthy practice (not using sunscreen effectively) <strong>Minor:</strong> None</td>
<td>Confirm diagnosis because it meets major defining characteristics and is validated by client.</td>
</tr>
<tr>
<td>• Inadequate applications of sunscreen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Possibly seeking information about managing her illness</td>
<td>Health-Seeking Behavior</td>
<td><strong>Major:</strong> Sought out occupational health nurse <strong>Minor:</strong> None</td>
<td></td>
</tr>
<tr>
<td>• Sought out occupational health nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Anxious appearing</td>
<td>Perceives current position depends on attractive appearance</td>
<td>Anxiety related to possible loss of work position secondary to perceived unattractiveness</td>
<td><strong>Major:</strong> Physical appearance (unspecified anxiety) and self-deprecation (about physical appearance) <strong>Minor:</strong> None</td>
</tr>
<tr>
<td>• Concerned that she may lose her job because of how she looks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office manager in large, prestigious law firm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Document Conclusions

The following nursing diagnoses are appropriate for Ms. Michaelson at this time:

- Body Image Disturbance related to changes in physical appearance
- Risk for Altered Health Maintenance related to knowledge deficit of effects of sunlight on skin lesions
- Anxiety related to possible loss of work position secondary to perceived unattractiveness

Collaborative problems related to the medical diagnosis could include:

- PC: Skin Infection/Scarring
- PC: Ischemic Ulcers
- PC: Systemic Lupus Erythematosus (SLE) and all related complications (1 in 20 people diagnosed with discoid lupus erythematosus [DLE] progress to systemic lupus erythematosus [SLE])

#### References and Selected Readings


**Risk Factors–Skin Cancer**


**For additional information on this book, be sure to visit** [http://connection.lww.com](http://connection.lww.com).