

MODULE IV: PRESSURE ULCERS: UNDERSTANDING AND STAGING PRESSURE ULCERS

Avascular – lacking blood supply; synonym are dead, devitalized, necrotic, and non-viable.

Blanching – becoming white, maximum pallor.

Blister – a collection of fluid below or within the epidermis.

Bony prominence – a bony elevation or projection on an anatomical structure.

Braden Scale – scale use to determine the risk for pressure ulcer development.

Crater – tissue defect extending through the layers of skin.

Dermis – inner layer of the skin that lies under the epidermis; contains blood vessels, lymph vessels, hair follicles, glands and nerves.

Dermatitis – inflammation of the skin.

Documentation – required part of the medical record.

Dermal-Epidermal Junction – the area that separates the epidermis from the dermis; also referred to as the basement membrane zone.

Edema – presence of abnormally large amounts of fluid in the interstitial space.

Epidermis – outermost layer of the skin.

Epithelialization - regeneration of the epidermis across a wound surface.

Epithelial migration – the movement of epithelial cells in the resurfacing or repair process.

Erosion – wearing away or gradual destruction of a surface caused by inflammation, injury or other causes.

Erythema – a redness of the skin due to dilation of the superficial capillaries.

Eschar – black or brown necrotic, devitalized tissue; tissue can be loose or firmly adherent, hard, soft or soggy.

Excoriation – linear scratches on the skin.

Exudate – any fluid that has been extruded from a tissue or its capillaries, such as fluid, cells, or cellular debris, which has escaped from blood vessels and has been deposited in tissue surfaces.

Friction – the force of two surfaces moving across one another, such as the mechanical force exerted when skin is dragged across a coarse surface.

Full-thickness - tissue destruction extending through the dermis to involve the subcutaneous tissue and possibly muscle and bone.

Granulation tissue – pink to red, moist tissue that contains new blood vessels, collagen, fibroblasts, and inflammatory cells that fills an open, previously deep wound when it begins to heal; typically appears deep pink or red with an irregular, granular surface.

Maceration – over-hydration or softening of the stratum corneum.

NPUAP – National Pressure Ulcer Advisory Board, www.npuap.org.

Necrotic tissue – dead avascular tissue.

Non-blanchable – does not becoming white, or reaches maximum pallor after light pressure is applied and removed.

Norton Risk Assessment Scale – scale use to determine the risk for pressure ulcer development.

Partial-thickness – tissue destruction into or through the epidermis, and possibly the extending into but not through the dermis.

Pressure ulcer – is a localized injury to the skin and or underlying tissue, usually over a bony prominence that is a result of pressure, or pressure in combination with shear and friction.

Rete ridges or pegs – fingerlike projections in the epidermis that interlock with upward projections of papillary dermis; helps anchor the epidermis to the dermis.

Risk Assessment – assessment to determine which, if any, risk factors are present that might contribute to the development of skin ulceration.

Sinus tract – course or path of tissue destruction occurring in any direction from the surface or edge of the wound; results in dead space with potential for abscess formation. Also referred to as tunneling.

Shear – the mechanical force that is parallel rather than perpendicular to the surface area of the body; trauma caused by tissue layers sliding against each other, results in disruption or angulation of blood vessels.

Slough – soft moist avascular (devitalized) tissue; may be white, yellow, tan or green; may be loose or firmly attached.

Stage I Pressure Ulcer – Intact skin with non-blanchable redness on a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from surrounding area; Area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue; May be difficult to detect in individuals with dark skin tones; May indicate “at risk” persons (a heralding sign of risk).

Stage II Pressure Ulcer – Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister; presents as a shiny or dry shallow ulcer without slough or bruising; should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Stage III Pressure Ulcer – Full Thickness Tissue Loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling; depth varies by anatomical location; the bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow; areas of significant adiposity can develop extremely deep Stage III pressure ulcers; bone and tendon is not visible or directly palpable.

Stage IV Pressure Ulcer – Full-thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes tunneling or undermining; Depth varies by anatomical location; The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue; Stage IV ulcers can be shallow; Can extend into the muscle and/or supporting structures (fascia, tendon, or joint capsule) making osteomyelitis possible; Exposed bone/tendon is visible or directly palpable.

Suspected Deep Tissue injury (sDTI) – is purple or maroon-colored skin that is intact, or a blood-filled blister created due to damage to underlying soft tissue, from pressure or shear; tissue is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin; may be difficult to detect in individuals with dark skin tones; its evolution may include a thin blister over a dark wound bed; it may further evolve and become covered by a thin eschar; may progress rapidly, exposing additional layers of tissue even with optimal nursing care.

Subcutaneous tissue – same as hypodermis; superficial fascia, forms a subcutaneous layer beneath the dermis.

Tissue tolerance – the condition or integrity of the skin and supporting structures that influence the skin’s ability to redistribute applied pressure.

Undermining – area of destruction extending under intact skin along the periphery of a wound, a shelf-like space; commonly seen in shear injuries; involves a significant portion of the wound edge.

Unstageable – is described as full thickness tissue loss in which the base of the ulcer is covered by slough, which may be yellow, tan, gray, green or brown, as well as by eschar in some cases. That eschar may be tan, black, or brown, and it prevents the wound bed from being viewed.

Wound bed – uppermost viable tissue layer of the wound; may be covered with slough or eschar.

Source:

Taber's Cyclopedic Medical Dictionary

Acute & Chronic Wounds: Bryant and Nix, 3rd edition

WOCN Clinical Practice Guidelines: Volume 2

Wound Care Essentials: Practice Principles, Baranoski, Ayello, 2nd edition