

November 2022 Education

Clinical Practice Disease-Specific Guidelines
Wound Classification



Agenda

SerenaGroup Clinical Guidelines
Wound Classification

- Definition
- Identification
- Quiz





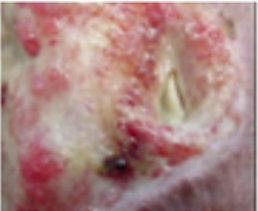
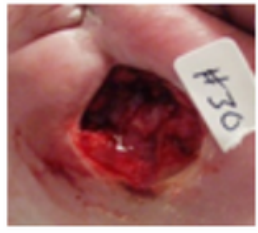


Wagner Grading System

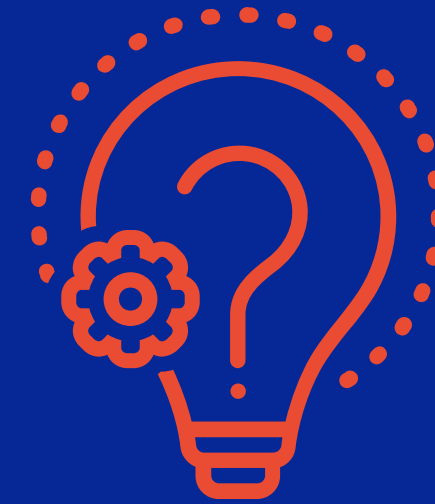


- DFU's are graded by severity. The Wagner grading system is the most commonly used acuity scale.
- - Wagner I: partial or full thickness not down to any underlying structure.
- - Wagner II: The ulcer extends down to deeper structure.
- - Wagner III: The ulcer extends into deep tissues such as the joint with abscess, infection and or osteomyelitis.
- - Wagner IV: localized gangrene in the foot
- - Wagner V: extensive gangrene in the foot



Wagner Grading System – Pics

WAGNER GRADE	DESCRIPTION	EXAMPLE
0	Intact skin.	
I	Superficial ulcer of skin or subcutaneous tissue.	
II	Ulcer penetrates through subcutaneous tissue and may extend into tendon, bone or joint capsule.	
III	Ulcer extends into tendon, bone or capsule and is complicated by infection of the bone or tissue. Including, but not limited to, abscess, osteomyelitis, pyarthrosis, osteitis or infection of the tendon and tendon sheaths.	
IV	Wet or dry gangrene of toe(s), forefoot, or any area with localized gangrene.	
V	Extensive gangrene involving the whole foot.	



Pressure Ulcers



- Staged according to severity:
- **Stage I**- Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration.
- **Stage II**- Partial thickness loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.



Pressure Ulcers – Cont.



- **Stage III**- Full thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds.
- **Stage IV**- Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and tunneling typically occur.



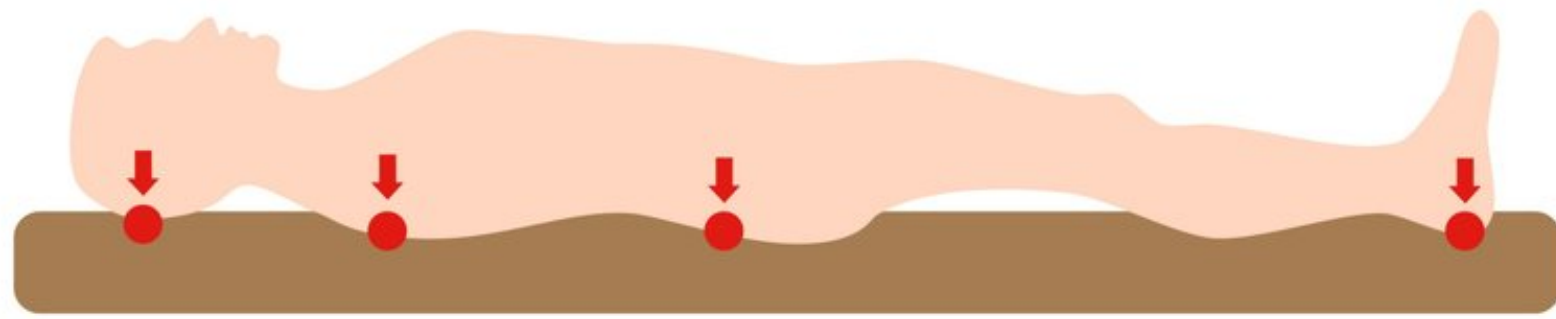
Pressure Ulcers – Cont.



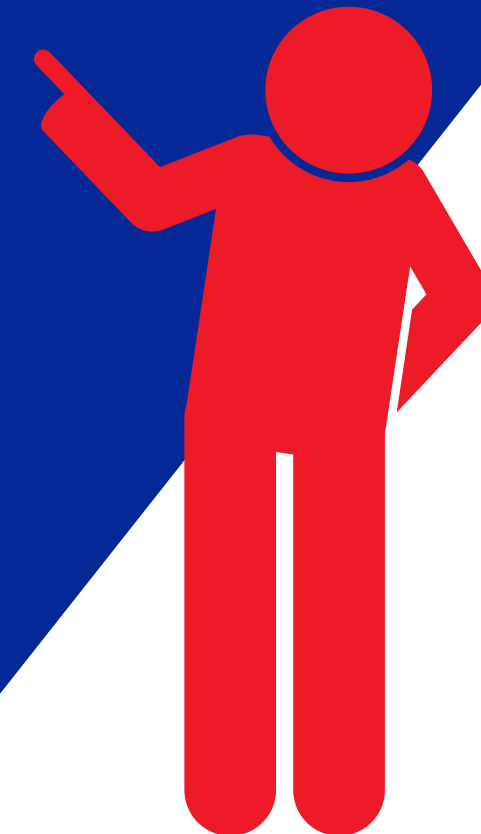
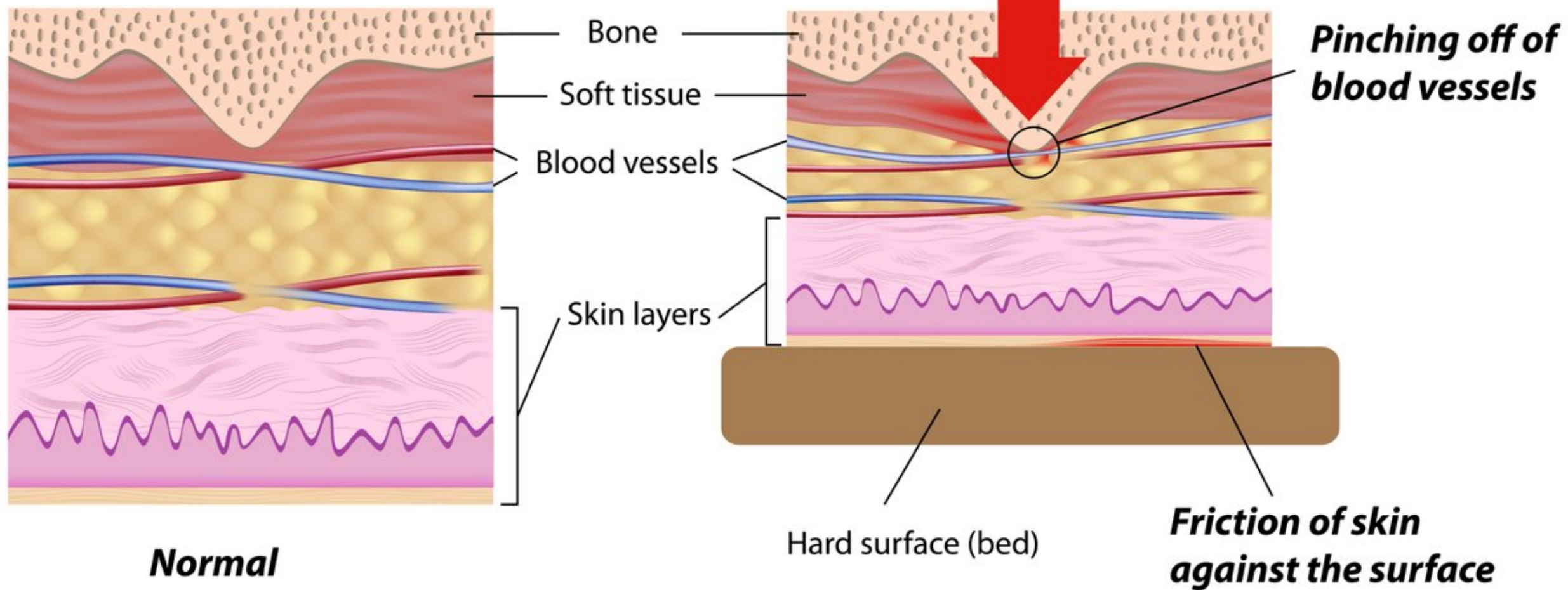
- **Unstageable**- Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.
- **Deep Tissue Injury (DTI)**- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin.



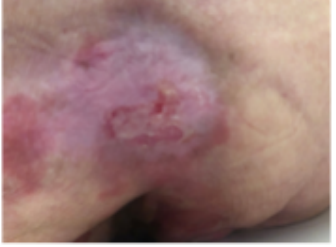




Pressure Ulcers



*Pressure of bone
against hard surface*



Pressure Ulcer Staging – Pics

STAGE	DESCRIPTION	EXAMPLE
I	Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Affecting the epidermis layer.	
II	A shallow open ulcer. Partial thickness loss to the epidermis and some of the dermis. Wound bed should be pink or red and free of slough.	
III	Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present. Wound may undermine and/or tunnel. Full thickness tissue loss.	
IV	Full thickness tissue loss with exposed bone, tendon, or muscle. Often includes undermining and tunneling. Slough or eschar may be present on part of the wound bed.	
Unstageable	Full thickness tissue loss in which the wound bed is covered by slough, eschar, and/or necrotic tissue in the wound bed, which must be debrided before a true depth can be obtained.	



QUIZ TIME

Wound Classification

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Question 1

Traumatic Wounds

A diabetic foot ulcer with abscess in the deep tissue is a Wagner 2.

FALSE

TRUE



Answer 1

Wound Classification

A **Wagner 3** is a diabetic foot ulcer that extends into deep tissue with abscess, osteomyelitis, osteitis, pyarthrosis or infection to the tendon.

FALSE



Question 2

Wound Classification

A gangrenous heel or midfoot qualifies as a Wagner 4.

FALSE

TRUE



Answer 2

Wound Classification

Wagner 4 is defined as localized gangrene in the foot. While this could mean just the toes, it could always mean another isolated part of the foot.



Question 3

Wound Classification

A stage II pressure ulcer is defined as partial thickness loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.

FALSE

TRUE



Answer 3

Wound Classification

Stage II Pressure Ulcers - Partial thickness loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.



Question 4

Wound Classification

If the wound base of a pressure ulcer cannot be visualized, assume it is a Stage IV.

FALSE

TRUE



Answer 4

Wound Classification

The are considered unstageable!

Unstageable - Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

FALSE



Bonus Question

Wound Classification

What Wagner grades qualify for hyperbaric oxygen therapy?



Bonus Answer

Wound Classification

Wagner Grade 3, 4, or 5.

Remember, once a Wagner grade always that Wagner grade until closure!



Reference

To view the SerenaGroup Clinical Practice Disease-Specific Guidelines -- go to www.serenagroupinc.com in the Member's Portal



Evidence-Based Wound Care Practice Guidelines

2nd Edition

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Thank you!

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