Wound Characteristics by Type

	Arterial Ulcer	Venous Ulcer	Neuropathic Ulcer	Pressure Ulcer	Burns
Example					
Predisposing Factors/Cause	Peripheral vascular disease (PVD), diabetes mellitus, advanced age, chronic renal disease, vasculitis, HTN, arteriosclerosis, chronic venous insufficiency	Valve incompetence in perforating veins, history of deep vein thrombophlebitis and thrombosis, failed calf pump, history of venous ulcers or family history of ulcers, obesity, age, pregnancy (in women with a family history of venous ulcers), RA, lupus	Patients with diabetes, peripheral neuropathy and/or peripheral vascular disease	Multiple medical diagnoses, age, impaired mobility, decreased mental status, poor nutritional status, incontinence, impaired circulation	Can be caused by heat, chemicals, electricity, radiation or the sun White phosphorus chemical and heat burn
Location and Depth	Usually distal to impaired arterial supply, between toes or tips of toes, over phalangeal heads, around lateral malleolus, at sites subjected to trauma or rubbing of footwear; usually relatively shallow, but may be deep	May occur anywhere between the knee and ankle, with medial and lateral malleolus most common sites; usually shallow	Any sites on the foot and lower limb subjected to repetitive pressure, friction, shear or trauma; plantar aspect, metatarsal heads (especially first and fifth), great toe, heel; shallow to deep, may have tracking and/or undermining	On heels, sacrum, coccyx, occiput, any bony prominences subjected to pressure, friction or shear; depth ranges from persistent red, blue or purple area of intact skin (depending on skin color) to deep destruction and loss of tissue	Can occur anywhere on the body; depth varies depending on location and tissue damage Superficial Partial Thickness Full Thickness
Wound Bed & Wound Appearance	Punched out, pale, gray or dark red, with no evidence of new tissue growth; necrosis or cellulitis may be present; almost always accompanied by desiccated eschar in the wound bed; often accompanied by exposed tendons	Variable appearance, frequently ruddy, “beefy” red, granular tissue; calcification in wound base is common; a superficial fibrinous “gelatinous” necrosis may occur suddenly with healthy appearing granulation tissue underneath	Granular tissue unless PVD is present; often has deep necrotic area; may be dry; cellulitis or osteomyelitis may be present; neuropathic ulcers almost always have calloused edges; may be accompanied by eschar and exposed tendons;	Extensive necrotic tissue may be present; extensive undermining, sinus tracts or tunneling may be present (tissue necrosis is usually greater than suggested by the external appearance of the epidermal defect)	Varies depending on type and depth of tissue damage
Exudate/Drainage	Minimal exudate to dry	Frequently moderate to heavy exudate	Low to moderate exudate; an infected ulcer may have increased bleeding	Exudate amount varies	Varies with location and depth of tissue damage