Ulcer Staging

Diabetic Foot Ulcers

Wagner Diabetic Foot Ulcer Staging
Wagner Grade 0 – Pre-ulcerative/high-risk foot (*has no break in the skin*)
Wagner Grade 1 – Superficial ulcer (*involves epidermis, dermis, or subcutaneous tissue*)
Wagner Grade 2 – Deep to tendon, bone, or joint (*penetrates through the subcutaneous tissue*)
Wagner Grade 3 – Deep with abscess/osteomyelitis (*goes as deep as Grade 2 but with infection*)
Wagner Grade 4 – Forefoot gangrene
Wagner Grade 5 – Whole foot gangrene

UT Diabetic Wound Classification System
The grades of the UT system include:

- **Grade 0:** Pre- or post-ulcerative site (epithelialized wound)
- **Grade 1:** Superficial wound, not involving tendon, capsule, or bone
- **Grade 2:** Wound is penetrating to tendon or capsule
- **Grade 3:** Wound is penetrating bone or joint

There are four stages within each wound grade:

- **Stage A:** Clean wounds (no infection, no ischemia)
- **Stage B:** Nonischemic, infected wounds
- **Stage C:** Ischemic, noninfected wounds
- **Stage D:** Ischemic and infected wounds (both present)

Venous Leg Ulcers
CEAP Classification

C0		No visible or palpable varicose veins
C1		Telangectasia (Thread veins / Spider veins / Broken veins)
C2	C2A	Varicose veins without any symptoms (Asymptomatic)
	C2S	Varicose veins with symptoms
C3		Swollen ankle (oedema) due to varicose veins or hidden varicose veins (venous reflux)
C4		Skin damage due to varicose veins or hidden varicose veins (venous reflux)
C5		Healed venous leg ulcer
C6		Venous leg ulcer

Pressure Ulcers
NPIAP Staging

NPIAP Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
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; these may indicate deep tissue pressure injury.

NPIAP Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin 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. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

NPIAP Stage 3 Pressure Injury: Full-thickness skin loss
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. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

NPIAP Stage 4 Pressure Injury: Full-thickness skin and tissue loss
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/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss