**Integumentary – Pressure Ulcer: Treatment of Unstageable**

SECTION: 4.19

**Strength of Evidence Level:** 3

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**PURPOSE:**
To identify dressing and treatment modality options for Unstageable pressure ulcers.

**CONSIDERATIONS:**

1. **Unstageable:** Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.  
   *Further description:* Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and stage cannot be determined.  
   - Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s’ natural (biological) cover” and should not be removed.

2. When a pressure ulcer is covered with eschar, it may not be possible to stage the ulcer accurately until the wound bed is visible. *(See Scoring of Eschar.)*

3. Obtain physician’s order for all treatment and cleansing agents.

4. Normal saline is an acceptable agent for cleansing pressure ulcers.

5. Use clean technique.

6. **Topical treatment options for unstageable pressure ulcer includes:**
   a. **Palliative:** Offloading, keep wound dry and free of infection; paint with betadine or cover with skin prep.
   b. **Restorative:** Sharp, mechanical, enzymatic and/or autolytic debridement of necrotic tissue.

7. Continue to follow procedures for prevention and assessment of pressure ulcers. *(See Integumentary - Pressure Ulcer: Prevention and Pressure Ulcer: Assessment.)*

8. Certified wound consult may be indicated.

**Option I:**
Dry, stable eschar with no induration, erythema, or exudates (goal is to keep dry and free from infection). Initiate offloading, keep wound dry and free of infection; paint with betadine or cover with skin prep; apply dry gauze dressing, if needed.

**Option II:**
Debridement of necrotic tissue.

**CONSIDERATIONS:**

1. Debridement is the removal of dead or devitalized tissue. Sharp, mechanical, enzymatic and/or autolytic debridement techniques may be used for removal of devitalized tissue per physician’s orders.
   a. Sharp debridement involves the use of a scalpel, scissors or other sharp instrument to remove the devitalized tissue.
   b. **Mechanical debridement** includes wet-to-dry dressings, hydrotherapy, wound irrigation (pulsed lavage).
   - Wet-to-dry dressings remove necrotic tissue and absorb a small amount of exudates. Since it is not selective, this method can injure exposed healthy tissue in the wound bed. Caution should be used to ensure the dressing procedure is followed consistently among caregivers. *(See Application of wound dressing.)*
   - Wound irrigation removes necrotic tissue with fluid delivered at 8-12 pounds per square inch (psi). Follow manufacturers’ instructions when using commercially prepared irrigation systems *(See Integumentary - Wound Irrigation.)*
   c. **Enzymatic debridement** is accomplished by applying topical proteolytic enzymes to devitalized tissue on the wound surface.
   - Enzymes break down necrotic tissue without affecting viable tissue.
   - A physician’s order and prescription are required for use of these products.
   - Follow manufacturers’ guidelines carefully for use of all enzymes.
   d. **Autolytic debridement** involves the use of synthetic dressings to cover a wound and allow devitalized tissue to self-digest from enzymes normally present in wound fluids.
   - Use transparent film or hydrocolloid wafer dressings to promote autolysis in superficial wounds.
   - Use calcium alginites and exudate-absorptive dressings, which absorb many times their weight, to debride extensive ulcers and to promote autolysis.
   - **DO NOT** use autolytic debridement if the wound is infected.

2. Heel ulcers with dry eschar should not be debrided if they do not have edema, erythema, fluctuance or drainage.

3. Pain is often associated with debridement. Use appropriate methods to prevent or manage pain.

**EQUIPMENT:**

*See Integumentary - Wound Cleansing, Wound Irrigation, Application of Transparent Film and Dressing Changes.*
PROCEDURE:
1. Follow manufacturers’ guidelines on all products used for debriding.
2. See Integumentary - Wound Cleansing, Wound Irrigation Transparent Film Application and Dressing Changes.

AFTER CARE:
1. Document in patient's record:
   a. Procedure.
   b. Patient’s response to procedure.
   c. The condition of the patient according to the assessment procedure for pressure ulcers.
2. Instruct the patient/caregiver in:
   a. Care of the pressure ulcer.
   b. Pressure reduction techniques. (See Integumentary - Pressure Ulcer: Prevention.)
   c. Reporting signs and symptoms of infection and other areas of breakdown.
   d. Diet to promote healing.
   e. Medications/disease processes that may be impeding healing.
   f. Activities permitted.