Wound Care Essentials:
Quick Reference Nursing Guides

What is a Stage II Pressure Ulcer?

When unrelieved pressure causes damage to the skin and underlying structures, an ulceration can develop, known as a pressure ulcer. There are many factors that can contribute to the development of a pressure injury such as friction, shear, moisture, pressure, limited mobility, obesity, or other comorbidities. **Stage II** is a partial-thickness skin loss with exposed dermis.

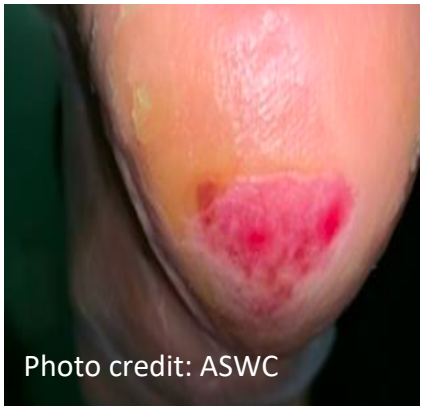
Photo credit: ASWC

How do you identify it?

Pressure injuries tend to occur over bony prominences on the body such as the shoulders, elbows, hips, sacrum, buttocks, ankles, heels and toes. In **Stage II pressure injuries**, the outermost layer of skin is disrupted, exposing a pink or red wound bed. Note that it can also present as a ruptured or intact fluid-filled blister. Granulation tissue, slough, and eschar are *not* present. Careful not to confuse Stage II pressure ulcers with similar wound types such as moisture-associated skin damage (MASD), skin tears, burns, or abrasions, which look similar but have a different etiology altogether. A good history of the how the wound began will help you to determine the correct wound type.

How do you treat it?

The main goal in treating a **Stage II** injury is to relieve pressure and prevent deterioration. All of the pressure relieving techniques (such as positioning and managing moisture) utilized in treating a Stage I applies, but now we must also manage the open wound itself. Collagen or honey are often good options to promote healing in the wound bed, then cover with a dressing to prevent infection.

Advantage
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