Once ulceration has occurred, it is necessary to assess and document the ulcer location, area (length and width), depth, drainage, tissue type present in wound bed (necrotic, sloughed tissue, granulation tissue), and presence of cellulitis. Serial photographs may be useful.

- The goal of wound bed preparation is to provide the ulcer with an optimal environment for healing. The optimal wound bed is one that is highly vascularized with minimal exudate.

- The treatment consists of: (i) débridement, (ii) bacterial balance, and (iii) control of exudates.

- Application of wet-to-dry gauzes is common. The gauze adheres to the necrotic tissue. The area is then dressed with a transparent film, thereby delaying wound healing.

- The use of biologically degradable dressings (hydrocolloids or wound films) helps to create an environment that promotes the breakdown of the necrotic tissue by the body’s own enzymes, thus aiding in the healing process.

- Sharp débridement always should be considered when the patient is suspected of having cellulitis or sepsis.

- Managing the bacterial burden is an important consideration.

- Clinical signs of infection include: (i) presence of a malodorous, purulent exudate, (ii) excessive drainage, (iii) bleeding in the ulcer, and (iv) pain.

- Treatment using silver-imregnated dressings or topical silver sulfadiazine decreases bacterial burden.

- Exudates are best managed by selecting the appropriate dressing. Currently, more than 300 different dressings are available for treating pressure ulcers. The dressings can be classified as: (i) gauze, (ii) petroleum-based non-adherent gauze, (iii) transparent films, (iv) hydrocolloids, (v) foam islands, (vi) alginate, (vii) hydrogels, (viii) composites, and (ix) combinations.

- Regardless of the type of dressing selected, the goal should be to keep the pressure ulcer moist.

- Negative pressure therapy should be considered for highly exudative pressure ulcers. Negative pressure therapy reduces excessive exudate from the ulcer, increases local blood flow, and promotes formation of granulation tissue. Negative pressure therapy should not be used if osteomyelitis is present or suspected or in the presence of eschar, exposed blood vessels, or organs.

- The Pressure ulcer Scale for Healing (PUSH) and the Pressure Sore Status Tool (PSST) are both valid and reliable tools for assessing healing of pressure ulcers.

- Less than 5% of pressure ulcers require surgical intervention other than simple débridement. However, if surgery is indicated, the most common procedures are: (i) direct closure, (ii) skin grafting, (iii) skin flaps, (iv) musculocutaneous flaps, and (v) free flaps.

- Most adjunctive therapies have not been rigorously studied. The most promising adjunctive therapies include: (i) electrical stimulation, (ii) topical application of growth factors, (iii) use of skin equivalents, and (iv) hyperbaric oxygen.

- Pressure ulcers can develop within 2 to 6 hours. The anatomic areas most vulnerable for ulceration are the heels of the feet and the skin over the coccyx, sacrum, and femoral trochanters.

- Numerous risk factors have been identified for pressure ulcer development, including: (i) age 70 years or older, (ii) male gender, (iii) white race, (iv) diabetes, smoking history, (v) low body mass index, (vi) impaired mobility, (vii) altered mental status (i.e., confusion), (viii) urinary and fecal incontinence, (ix) malnutrition, (x) physical restraints, (xi) malnutrition, diabetes mellitus, (xii) cerebrovascular accidents, (xiii) pneumonia, (xiv) heart failure, (xv) fever, (xvi) sepsis, (xvii) hypotension, (xviii) renal failure, (xix) dry, scaly skin, (xx) history of pressure ulcers, (xxi) anemia, (xxii) lymphopenia, and (xxiii) hypalbuminemia.

- The majority of critically ill patients are placed on dynamic surfaces. Although these surfaces are more effective in redistributing pressure, some of their adverse effects include dehiscence, sensory deprivation, and loss of muscle strength. Data are lacking to support the view that different support surfaces are better (or worse) for preventing or healing pressure ulcers.