Hemosiderous staining is a brownish-purple discoloration most frequently seen in patients with chronic venous insufficiency. Red blood cells are trapped in the interstitial congestion, and when they die by apoptosis, the body lyses the dead cells and the hemoglobin attached to them. The by-products of this autolytic process migrate to the superficial cutaneous layers and cause the discoloration.
Ecchymosis or bruising is a result of deep tissue trauma that causes hemorrhaging of the blood vessels, resulting in dark-red-to-blue discoloration that goes through a sequence of colors (bluish-red to green to yellow) as it heals.
**Blanched or white skin**

Blanched or white skin relative to the person’s natural color is a result of decreased blood supply to the skin and may be a sign of underlying infection or a result of chronic venous insufficiency. In the latter case, it is termed **atrophie blanche**.
Jaundice (or yellow skin), sclerae, mucous membranes, and excretions including wound drainage) is a result of hyperbilirubinemia and may be associated with a variety of disorders such as cirrhosis, hepatitis, obstruction of the bile duct, or hemolytic blood transfusion reaction.
Changes in skin texture include a thin, shiny appearance with no hair (a result of peripheral arterial disease); thick, rough with thick scales (a result of chronic venous insufficiency); or orange peel texture, also called *peau d'orange* (a result of chronic edema). The skin may also become indurated, meaning the subcutaneous tissue is hard and firm (also a result of chronic edema, eg, with lymphedema) with fibrosis of the underlying connective tissue.
Edema results from abnormal amounts of water in the subcutaneous or interstitial tissue. When observed during an evaluation, further exploration of patient history, systems review, medications, and other symptoms is used to determine the cause of the edema. Again, the question, why?, has to be answered. Causes, measurement, and diagnosis of edema are discussed at length in Lymphedema. Examples of edema associated with wounds are shown in Note that sudden onset of edema in one extremity, edema associated with pain, or edema associated with any other cardiovascular symptoms require that the patient be seen by a medical specialist on an emergent basis.
Edema due to trauma
result in even edges include poor cardiac output and anemia due to other underlying disorders (eg, a gastrointestinal bleed or sickle cell anemia). In any of these cases, treatment of the underlying pathology is a must in order for wound healing to occur.
Uneven edges, also referred to as serpentine, are typically seen in wounds caused by chronic venous insufficiency.
Rolled edges occur when the epithelial cells at the edge are unable to migrate across the wound bed. This may be a result of an unhealthy wound bed, inability to produce the basement membrane that the epithelial cells adhere to, or a condition termed epibole in which the upper epidermal cells roll down over the lower epidermal cells and prevent epithelial migration across the wound bed.
Detached edges are a sign of undermining, wound regression possibly due to bacteria load, or premature epithelial migration.
Hyperkeratosis, or callus, is a result of overproduction of the stratum corneum or outer layer of the epidermis, usually as a result of repeated friction from shoes or some other device. It is most frequently observed on the foot from poorly fitting shoes or on the hands from mechanical labor, especially on an insensate foot or hand.
Epithelialization, the goal of every wound care intervention, is a sign that the wound is entering the final stages of the proliferative healing phase. Sometimes the preceding basement membrane can be observed on the edge of the granulation tissue, appearing as a thin clear film.
Wound odor can be a detective signal and something the evaluator learns to recognize. Almost all wounds will have some odor with dressing removal as a result of the interaction between the drainage, the wound, and the dressing; however, the odor to be concerned about is that which persists after the wound has been thoroughly cleaned. Following are some verbal descriptions of what one might smell. *Pseudomonas* has a distinctive sweet odor and usually accompanies drainage that has a greenish tint. *Infection* has a putrid smell, and *necrotic* tissue has a unique “dead” odor. *Malignant* tissue can have a musky odor similar to wet cardboard. Sometimes an odor will indicate what type of dressing or topical agent the patient has been putting on the wound edges indicates that the epithelium is detached from the underlying subcutaneous tissue. (eg, Dakins solution will smell like bleach, acetic acid will smell like vinegar, and dressings with iodine will smell like just that—iodine). If odor is present, lack of odor can be an appropriate initial goal.
ارزیابی زخم کلی
<table>
<thead>
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<th>ارزیابی بیمار</th>
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<tbody>
<tr>
<td>ارزیابی بیمار مبتلا به زخم یا مستعد زخم</td>
<td>✓</td>
</tr>
</tbody>
</table>

آرژیابی بیمار:

- تاریخچه بیمار
- وضعیت سیستم ایمنی
- سطح گلوكز خون هیدراتاسیون
- اكسبوزن رساني
- خونرسانی
- وضعیت نگهداري بیمار
- وضعیت تغذیه بیمار
ارزیابی بیمار

1- تاریخچه بالینی

✓ علت آسیب بافتی
✓ سایر بیماری‌های (دیابت، بیماری عروقی، سیستم ایمنی و....)
✓ داروها
✓ تغذیه
✓ سیگار
✓ مصرف الکل
✓ تحرک

2- اختلال سیستم ایمنی (اختلال سیستم ایمنی)
✓ داروهای سرکوب کننده سیستم ایمنی
✓ ایدز
✓ رادیوکیمی
ارزیابی بیمار

3- سطح قند خون بیمار

- کمتر از ۲۰۰
- بیشتر از ۲۰۰

4- هیدراتاسیون

5- اکسیژن و خورساني

- اختلال تبادلات گازی
- پایین بودن هموگلوبین خون
- پایین بودن فشار خون

- سیگار (نیکوتین منبع کننده عروقی، گاز ظرفیت حمل اکسیژن، آسیب به بافت ریه)
ارزیابی زخم

 محل زخم ✓
 سایز و عمق ✓
 بستر زخم ✓
 اگزودا ✓
 بو ✓
 لبه های زخم ✓
 پوست اطراف زخم ✓
 علایم عفونت ✓
 درد ✓
 زمان ✓
ارزیابی زخم

1- محل زخم

امکان بررسی محل زخم

سرعت ترمیم

علت شناسی زخم

2- علت شناسی زخم

زخم‌های وریدی پا (اغلب در سطح داخلی ساق پا بالای قوزک داخلی)

زخم‌های نوروپاتیک دیابتیک:  اغلب در کف پا

زخم‌های فشاری:  اغلب مناطق برجهنگ استخوانی
اندازه‌گیری ابعاد زخم

- نوار اندازه‌گیری
- صفحه‌های اندازه‌گیری
- برنامه‌های دیجیتال اندازه‌گیری
- سواپ‌های مدرج

طول زخم: بزرگ‌ترین قطر زخم صرف نظر از جهت آن
عرض زخم: قطر عمود بر طول زخم
عمق زخم: عمیق ترین قسمت زخم
3- بستر زخم

- رنگ بستر زخم
  - ۱. سیاه
  - ۲. قرمز
  - ۳. زرد
- نوع بافت
  - ۱. نکروز
  - ۲. اسلاف
  - ۳. گرانوله
  - ۴. اپیتیال

تاندون و استخوان، رگ، عصب، عضله!!
ارزیابی زخم - اگزودا و انواع آن

ترشح در زخم (اگزودا)

- مقدار
- رنگ
- نوع (سروزی، خونی، خونابه، چرکی)
- قوم
- بو

نوع ترشح:

1. سروزی: به رنگ شفاف یا زرد کم رنگ، رقيق و آبیکی
2. خونی: قرمز، رقيق
3. خونابه: صورتی تا قرمز کمرنگ، رقيق
4. چرکی: زرد مایل به کرم، سبز، یا قهوه‌ای بر رنگ، غلیظ
ارزیابی زخم - لبه زخم

لبه های زخم و پوست اطراف آن

لبه زخم در زخم های وریدی اغلب ؟

لبه زخم در زخم های شریانی اغلب ؟

لبه زخم در زخم های نروپاتیک اغلب ؟

لبه زخم در زخم های فشاری اغلب ؟

نوش اتصال به بستر زخم

.ι

ضخامت

.ιi

ادم

.ιii

رطوبت

.ιv

نوع پوست اطراف

.ιv

رنگ

.a

سفید ؟

.b

قرمز ؟

.c

کبود ؟
ارزیابی زخم - عفونت

علایم کلاسیک عفونت موضعی زخم

- درد
- قرمزی
- ادم
- گرمایی
- چرک

معیارهای علایم عفونت در زخم های مزمن

آبسه
- سلولیت
- ترشح غیر معمول
- ترمیم به تأخیر افتاده
- تغییر رنگ
- درد غیر منتظره
- بوی غیر طبیعی
- بافت گرانوله غیر استاندارد
درد در بیماران دارای زخم

i. معیار visual analogue scale VAS

ii. معیار verbal rating scale VRS

iii. معیار numeric pain intensity scale NPIS

ثبت

1- عکس

2- فرم ارزیابی

3- افزایش گیری
**Frash arzibabi**

**Assessment Chart for Wound Management**

For multiple wounds complete formal wound assessment for each wound. Add inserts as needed.

**Factors which could delay healing:**
*(Please tick relevant box)*
- Immobility
- Poor Nutrition
- Diabetes
- Incontinence
- Respiratory/Circulatory Disease
- Anaemia
- Medication
- Wound Infection
- Inotropes
- Anti-Coagulants
- Oedema
- Steroids
- Chemotherapy
- Other...
- Allergies & Sensitivities...

**Body Diagram**

![Body Diagram](image)

Mark location with ‘X’ and number each wound

**Type of Wound**
- Leg Ulcer
- Surgical Wound
- Diabetic Ulcer
- Pressure Ulcer
- Other, specify

**Total number & duration of each type of wound**

**Date referred to:**
- TVN
- Physiotherapist
- Podiatrist
- Dietician
- Other (i.e. D/Nurse)

**Assessors signature:**

**Date:**

---

**Foot Diagram**

![Foot Diagram](image)

Mark location with ‘X’ and number each wound
Instructions for use

General Guidelines:
Fill out the attached rating sheet to assess a wound’s status after reading the definitions and methods of assessment described below. Evaluate once a week and whenever a change occurs in the wound. Rate according to each item by picking the response that best describes the wound and entering that score in the item score column for the appropriate date. When you have rated the wound on all items, determine the total score by adding together the 13-item scores. The higher the total score, the more severe the wound status. Plot total score on the Wound Status Continuum to determine progress. If the wound has healed/resolved, score items 1, 2, 3 and 4 as 0.

Specific Instructions:
1. **Size:** Use ruler to measure the longest and widest aspect of the wound surface in centimeters; multiply length x width. Score as 0 if wound healed/resolved.

2. **Depth:** Pick the depth, thickness, most appropriate to the wound using these additional descriptions, score as 0 if wound healed/resolved:
   - 1 = tissues damaged but no break in skin surface.
   - 2 = superficial, abrasion, blister or shallow crater. Even with, &/or elevated above skin surface (e.g., hyperplasia).
   - 3 = deep crater with or without undermining of adjacent tissue.
   - 4 = visualization of tissue layers not possible due to necrosis.
   - 5 = supporting structures include tendon, joint capsule.

3. **Edges:** Score as 0 if wound healed/resolved. Use this guide:
   - Indistinct, diffuse = unable to clearly distinguish wound outline.
   - Attached = even or flush with wound base, no sides or walls present; flat.
   - Not attached = sides or walls are present; floor or base of wound is deeper than edge.
   - Rolled under, thickened = soft to firm and flexible to touch.
   - Hyperkeratosis = callous-like tissue formation around wound & at edges.
   - Fibrotic, scarred = hard, rigid to touch.

4. **Undermining:** Score as 0 if wound healed/resolved. Assess by inserting a cotton tipped applicator under the wound edge; advance it as far as it will go without using undue force; raise the tip of the applicator so it may be seen or felt on the surface of the skin; mark the surface with a pen; measure the distance from the mark on the skin to the edge of the wound. Continue process around the wound. Then use a transparent metric measuring guide with concentric circles divided into 4 (25%) pie-shaped quadrants to help determine percent of wound involved.
   - 0 = 0%; 1 = 25%; 2 = 50%; 3 = 75%; 4 = 100%
5. **Necrotic Tissue Type:** Pick the type of necrotic tissue that is predominant in the wound according to color, consistency and adherence using this guide:
- White/gray non-viable tissue
- Non-adherent, yellow slough
- Loosely adherent, yellow slough
- Adherent, soft, black eschar
- Firmly adherent, hard/black eschar

6. **Necrotic Tissue Amount:** Use a transparent metric measuring guide with concentric circles divided into 4 (25%) pie-shaped quadrants to help determine percent of wound involved.

7. **Exudate Type:** Some dressings interact with wound drainage to produce a gel or trap liquid. Before assessing exudate type, gently cleanse wound with normal saline or water. Pick the exudate type that is predominant in the wound according to color and consistency, using this guide:
- Bloody = thin, bright red
- Serosanguineous = thin, watery pale red to pink
- Serous = thin, watery, clear
- Purulent = thin or thick, opaque tan to yellow or green may have offensive odor

8. **Exudate Amount:** Use a transparent metric measuring guide with concentric circles divided into 4 (25%) pie-shaped quadrants to determine percent of dressing involved with exudate. Use this guide:
- None = wound tissues dry.
- Scant = wound tissues moist; no measurable exudate.
- Small = wound tissues wet; moisture evenly distributed in wound; drainage involves ≤25% dressing.
- Moderate = wound tissues saturated; drainage may or may not be evenly distributed in wound; drainage involves >25% to ≤75% dressing.
- Large = wound tissues bathed in fluid; drainage freely expressed; may or may not be evenly distributed in wound; drainage involves >75% of dressing.

9. **Skin Color Surrounding Wound:** Assess tissues within 4cm of wound edge. Dark-skinned persons show the colors "bright red" and "dark red" as a deepening of normal ethnic skin color or a purple hue. As healing occurs in dark-skinned persons, the new skin is pink and may never darken.

10. **Peripheral Tissue Edema & Induration:** Assess tissues within 4cm of wound edge. Non-pitting edema appears as skin that is shiny and taut. Identify pitting edema by firmly pressing a finger down into the tissues and waiting for 5 seconds, on release of pressure, tissues fail to resume previous position and an indentation appears. Induration is abnormal firmness of tissues with margins. Assess by gently pinching the tissues. Induration results in an inability to pinch the tissues. Use a transparent metric measuring guide to determine how far edema or induration extends beyond wound.

11. **Granulation Tissue:** Granulation tissue is the growth of small blood vessels and connective tissue to fill in full thickness wounds. Tissue is healthy when bright, beefy red, shiny and granular with a velvety appearance. Poor vascular supply appears as pale pink or blanched to dull, dusky red color.

12. **Epithelialization:** Epithelialization is the process of epidermal resurfacing and appears as pink or red skin. In partial thickness wounds it can occur throughout the wound bed as well as from the wound edges. In full thickness wounds it occurs from the edges only. Use a transparent metric measuring guide with concentric circles divided into 4 (25%) pie-shaped quadrants to help determine percent of wound involved and to measure the distance the epithelial tissue extends into the wound.
BATES-JENSEN WOUND ASSESSMENT TOOL

Complete the rating sheet to assess wound status. Evaluate each item by picking the response that best describes the wound and entering the score in the item score column for the appropriate date. If the wound has healed/resolved, score items 1, 2, 3, & 4 as 0.

Location: Anatomic site. Circle, identify right (R) or left (L) and use *X* to mark site on body diagrams:
- Sacrum & coccyx
- Trochanter
- Ischial tuberosity
- Heel
- Buttock
- Other site: __________

Shape: Overall wound pattern; assess by observing perimeter and depth.
- Irregular
- Linear or elongated
- Round/oval
- Square/rectangle
- Butterfly
- Other Shape

<table>
<thead>
<tr>
<th>Item</th>
<th>Assessment</th>
<th>Date Score</th>
<th>Date Score</th>
<th>Date Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Size*</td>
<td>*0 = Healed, resolved wound 1 = Length x width &lt; 4 sq cm 2 = Length x width 4 to 16 sq cm 3 = Length x width 16.1 to &lt;36 sq cm 4 = Length x width 36.1 to &lt;80 sq cm 5 = Length x width = 80 sq cm</td>
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<tr>
<td>2. Depth*</td>
<td>*0 = Healed, resolved wound 1 = Non-blanchable erythema on intact skin 2 = Partial thickness skin loss involving epidermis &amp;/or dermis 3 = Full thickness skin loss involving damage or necrosis of subcutaneous tissue; may extend down to but not through underlying fascia; &amp;/or mixed partial &amp; full thickness &amp;/or tissue layers; obscured by granulation tissue 4 = Obscured by necrosis 5 = Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures</td>
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<tr>
<td>3. Edges*</td>
<td>*0 = Healed, resolved wound 1 = Indistinct, diffusus, none clearly visible 2 = Distinct, outline clearly visible, attached, even with wound base 3 = Well-defined, not attached to wound base 4 = Well-defined, not attached to base, rolled under, thickened 5 = Well-defined, fibrotic, scarred or hyperkeratotic</td>
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<tr>
<td>4. Undermining*</td>
<td>*0 = Healed, resolved wound 1 = None present 2 = Undermining &lt;2 cm in any area 3 = Undermining 2–4 cm involving &lt;50% wound margins 4 = Undermining 2–4 cm involving &gt;50% wound margins 5 = Undermining &gt;4 cm or Tunneling in any area</td>
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<tr>
<td>5. Necrotic Tissue Type</td>
<td>1 = None visible 2 = White/gray non-viable tissue &amp;/or non-adherent yellow slough 3 = Loosely adherent yellow slough 4 = Adherent, soft, black eschar 5 = Firmly adherent, hard, black eschar</td>
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<tr>
<td>6. Necrotic Tissue Amount</td>
<td>1 = None visible 2 = &lt;25% of wound bed covered 3 = 25% to 50% of wound covered 4 = &gt;50% and &lt;75% of wound covered 5 = &gt;75% to 100% of wound covered</td>
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<tr>
<td>Item</td>
<td>Assessment</td>
<td>Date Score</td>
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<tr>
<td>7. Exudate Type</td>
<td>1 = None</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>2 = Bloody</td>
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<td></td>
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<tr>
<td></td>
<td>3 = Serosanguineous: thin, watery, pale red/pink</td>
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<td></td>
<td>4 = Serous: thin, watery, clear</td>
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<td></td>
<td>5 = Purulent: thin or thick, opaque, tan/yellow, with or without odor</td>
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<tr>
<td>8. Exudate Amount</td>
<td>1 = None, dry wound</td>
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<tr>
<td></td>
<td>2 = Scant, wound moist but no observable exudate</td>
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<tr>
<td></td>
<td>3 = Small</td>
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<td></td>
<td>4 = Moderate</td>
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<td></td>
<td>5 = Large</td>
<td></td>
<td></td>
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<tr>
<td>9. Skin Color</td>
<td>1 = Pink or normal for ethnic group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 = Bright red &amp;/or blanches to touch</td>
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<tr>
<td></td>
<td>3 = White or gray pallor or hypopigmented</td>
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<tr>
<td></td>
<td>4 = Dark red or purple &amp;/or non-blanchable</td>
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<tr>
<td></td>
<td>5 = Black or hyperpigmented</td>
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<tr>
<td>10. Peripheral Tissue Edema</td>
<td>1 = No swelling or edema</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>2 = Non-pitting edema extends &lt;4 cm around wound</td>
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<tr>
<td></td>
<td>3 = Non-pitting edema extends &gt;4 cm around wound</td>
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<td></td>
<td>4 = Pitting edema extends &lt;4 cm around wound</td>
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<td></td>
<td>5 = Crepitus and/or pitting edema extends &gt;4 cm around wound</td>
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<tr>
<td>11. Peripheral Tissue Induration</td>
<td>1 = None present</td>
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<tr>
<td></td>
<td>2 = Induration &lt;2 cm around wound</td>
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<td></td>
<td>3 = Induration 2-4 cm extending &lt;50% around wound</td>
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<td></td>
<td>4 = Induration 2-4 cm extending &gt;50% around wound</td>
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<td></td>
<td>5 = Induration &gt;4 cm in any area around wound</td>
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<tr>
<td>12. Granulation Tissue</td>
<td>1 = Skin intact or partial thickness wound</td>
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</tr>
<tr>
<td></td>
<td>2 = Bright, beefy red; 75% to 100% of wound filled &amp;/or tissue overgrowth</td>
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<tr>
<td></td>
<td>3 = Bright, beefy red; &lt;75% &amp; &gt;25% of wound filled</td>
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<tr>
<td></td>
<td>4 = Pink, &amp;/or dull, dusky red &amp;/or fills ≤25% of wound</td>
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<tr>
<td></td>
<td>5 = No granulation tissue present</td>
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<tr>
<td>13. Epithelialization</td>
<td>1 = 100% wound covered, surface intact</td>
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</tr>
<tr>
<td></td>
<td>2 = 75% to &lt;100% wound covered &amp;/or epithelial tissue extends &gt;0.5 cm into wound bed</td>
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<tr>
<td></td>
<td>3 = 50% to &lt;75% wound covered &amp;/or epithelial tissue extends to &gt;0.5 cm into wound bed</td>
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<tr>
<td></td>
<td>4 = 25% to &lt;50% wound covered</td>
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<td></td>
<td>5 = &lt;25% wound covered</td>
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</tbody>
</table>

**TOTAL SCORE**

**SIGNATURE**

**WOUND STATUS CONTINUUM**

Plot the total score on the Wound Status Continuum by putting an "X" on the line and the date beneath the line. Plot multiple scores with their dates to see at a glance regeneration or degeneration of the wound.
دبریدمان
تعریف: برداشتن بافت نکروتیک، باکتری‌ها، اگزودا و مواد زائد متابولیک از روبی زخم برای تسهیل یا تسریع روند ترمیم زخم.

خارج کردن هر آنچه منع مانع از رشد سلول‌های سالم می‌شود.

بافت مرده عامل محرک التهاب و تغذیه باکتری‌دردیمن باعث مشخص شدن ابعاد دقیق زخم می‌شود.
اصول دبیریمان زخم

1- محیط مناسب

• مکان مناسب به همراه وسایل وسایل لازم
• در حین کار پنجره ها بسته بباشد
• درب اتاق بسته بباشد
• رفت و آمد کمتر باشه
• دستگاه های بهویه خانگی قبل شروع کار خاموش باشند تا هوا جریان نداشته باشد

2- مشاهده دقیق زخم

• کمترین آسیب به بافت سالم زخم
• تشخیص نقصه زخم
• بررسی دقیق تر برای اقدامات لازم

3- صلاحیت

• علمی
• عملی
دلایل دریمان:

- کنترل عفونت (بافت مرده محیطی مناسب برای رشد باکتری است)
- کنترل بوی بد زخم
- عدم اختلال عملکرد سلولی بافت نکروز (آسیب در مهاجرت سلولی و مهار فاکتور های رشد)
- جمع شدن زخم (تشکیل اسکار یا بافت نکروز می تواند برای تکثیر و مهاجرت سلول های جدید لازم باشد)
- کاهش تراکم و غلظت میکروب ها
- کنترل عفونت و انتشار آن به بافت اطراف
انتخاب نوع دبریدمان به عوامل زیر بستگی دارد:

- سرعت مورد نیاز برای برداشتن بافت مرده
- میزان درد
- وجود یا عدم وجود عفونت
- هزینه
- وضعیت کلی بیمار
- محل و وسعت آسیب
- قابلیت دسترسی در محیطی که دبریدمان انجام می‌شود
- توانایی کادر درمانی