**Wound Healing**By Josie Schantz , MSN, RN-BC, WCC

 Wounds are classified as acute or chronic.  Most wounds,  of  whatever etiology, go on to heal without difficulty.  Acute wounds    follow the well defined steps of hemostasis, inflammation,               proliferation, and remodeling.  In these wounds, there is an increase in the mitogenic activity, decrease in the inflammatory cytokines, decrease proteases, and mitotically competent cells.  Chronic wounds, such as venous leg ulcer, however, are stuck in the inflammatory stage and will not heal for a long time.

The overall prevalence of venous ulcers in the United States is approximately one percent. Venous ulcers are more common in women and older persons.  The primary risk factors are older age, obesity, previous leg injuries, deep venous thrombosis, and phlebitis. Venous ulcers are often recurrent, and open ulcers can persist from weeks to many years.  Severe complications include cellulitis, osteomyelitis, and malignant change

The clinical findings of venous insufficiency are:

* Edema which ranges from pitting to non pitting and you may even see skin weeping, even dripping  in some cases.
* Hemosiderin staining is a chronic brown discoloration  caused from red blood cells dying and breaking down into the patient’s leg tissue
* White atrophic or dying tissue and Sclerotic or hardened patches
* A woody appearance to the skin also known as Lipodermatosclerosis
* Varicose veins
* Venous stasis dermatitis which is generally dry, itchy skin
* Pain can be severe, characterized as dull or aching and tend to  improve with leg elevation

A thorough history and physical examination is essential to the diagnosis of VLU.  In obtaining the history, the clinician should focus on risk factors such as hx of DVT, leg trauma, CHF, previous total hip or total knee replacement, hx of previous VLU, HIV infection, obesity, advanced age, etc.  These risk factors are usually predictors of poor outcome.