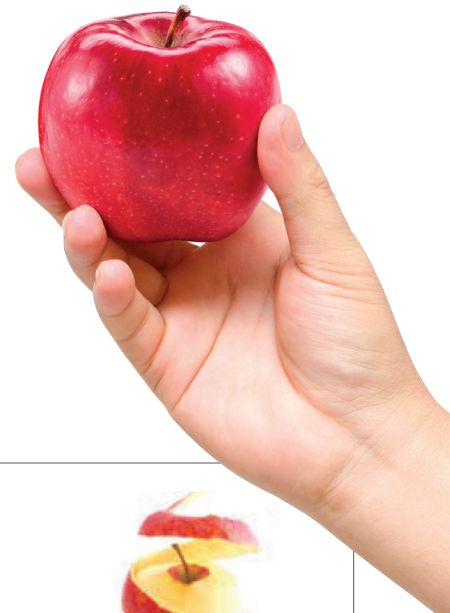








# Pressure Injury Staging is as Easy as Apple P.I.E.

Follow this **P**ressure **I**njury **E**xplanation guide to see how the state of an apple compares to the stage of a pressure injury.



<p><b>Stage 1</b></p> <p>Intact skin with a localized area non-blanchable erythema, which may appear differently in darkly pigmented skin.</p> 	<p><b>Stage 2</b></p> <p>Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.</p> 
<p><b>Stage 3</b></p> <p>Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are present.</p> 	<p><b>Stage 4</b></p> <p>Full-thickness skin and tissue loss with directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer.</p> 
<p><b>Unstageable</b></p> <p>Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.</p> 	<p><b>Deep Tissue Pressure Injury (DTPI)</b></p> <p>Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister.</p> 

Find more skin health insights and expertise at [MedlineSkinHealth.com](https://www.MedlineSkinHealth.com)

