Wound Care Certification Review #1
Assess Wound Etiology and Status

1. A wound on the plantar surface of the foot with a punched-out appearance, surrounded by callus, and minimal drainage is most consistent with:
A. Arterial ulcer
B. Diabetic neuropathic ulcer
C. Venous stasis ulcer
D. Pressure injury

2. A stage 3 pressure injury differs from a stage 2 injury primarily by the involvement of:
A. Epidermis only
B. Dermis and subcutaneous tissue
C. Muscle and bone
D. Adipose and epidermal layers

3. Which of the following is most characteristic of an arterial ulcer?
A. Irregular wound edges and moderate drainage
B. Pitting edema and hemosiderin staining
C. Pale wound bed with necrotic eschar and minimal exudate
D. Beefy red granulation tissue with heavy drainage

4. A wound on the medial lower leg with irregular borders, shallow depth, and moderate serous drainage is most consistent with:
A. Arterial ulcer
B. Venous ulcer
C. Neuropathic ulcer
D. Pressure ulcer

5. A wound described as “taunt” with shiny, edematous periwound skin most likely indicates:
A. Venous hypertension
B. Arterial insufficiency
C. Lymphedema
D. Increased tissue tension from edema

6. A surgical wound that has dehisced and shows delayed healing with rolled wound edges is classified as:
A. Acute wound
B. Chronic wound
C. Partial-thickness wound
D. Superficial wound

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7. A partial-thickness wound involves which of the following skin layers?
A. Epidermis only
B. Epidermis and part of the dermis
C. Dermis, subcutaneous tissue, and fascia
D. Subcutaneous tissue only

8. A diabetic foot ulcer is most often located:
A. On the medial malleolus
B. On the plantar metatarsal heads
C. On the posterior heel
D. On the anterior shin

9. Which of the following findings suggests an infected chronic wound rather than colonization?
A. Mild odor
B. Increase in exudate and pain
C. Stable wound size over 2 weeks
D. Minimal drainage and red granulation

10. A burn injury involving blister formation, pink moist wound bed, and painful sensation is best classified as:
A. First-degree burn
B. Superficial partial-thickness burn
C. Deep partial-thickness burn
D. Full-thickness burn

11. A chronic wound that fails to progress through the normal stages of healing beyond 30 days is most accurately described as:
A. Delayed primary wound
B. Nonhealing acute wound
C. Chronic nonhealing wound
D. Secondary intention wound

12. A full-thickness wound differs from a partial-thickness wound in that it:
A. Extends through the dermis into subcutaneous tissue
B. Heals primarily by epithelial resurfacing
C. Involves only the epidermis and papillary dermis
D. Has no necrotic tissue

13. A wound on the lateral malleolus with “punched out” edges, shiny pale surrounding skin, and pain on elevation is most likely:
A. Arterial ulcer
B. Venous ulcer
C. Pressure ulcer
D. Neuropathic ulcer

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14. Atypical wounds such as pyoderma gangrenosum are often misdiagnosed because they:
A. Respond quickly to debridement
B. Have clear bacterial etiology
C. Worsen with trauma or debridement
D. Are painless and self-limiting

15. In assessing a pressure injury on the sacrum covered completely with black eschar, the appropriate stage classification is:
A. Stage 3
B. Stage 4
C. Unstageable pressure injury
D. Deep tissue pressure injury

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Answer Key with Explanations

1. B — Diabetic neuropathic ulcer:
Typically found on weight-bearing areas of the foot with callus formation and a punched-out appearance. Caused by neuropathy and pressure.
2. B — Dermis and subcutaneous tissue:
Stage 3 pressure injuries involve full-thickness skin loss extending into subcutaneous tissue, unlike stage 2 which involves only partial-thickness skin loss.
3. C — Pale wound bed with necrotic eschar and minimal exudate:
Arterial ulcers have poor perfusion, causing pale or necrotic tissue and minimal drainage.
4. B — Venous ulcer:
Venous ulcers appear on the medial lower leg, are shallow, and produce moderate to heavy drainage with irregular borders.
5. D — Increased tissue tension from edema:
“Taunt” refers to shiny, stretched skin from underlying edema or swelling increasing interstitial pressure.
6. B — Chronic wound:
A wound that fails to heal as expected and exhibits rolled edges (epibole) is considered chronic.
7. B — Epidermis and part of the dermis:
Partial-thickness wounds extend into, but not through, the dermis.
8. B — On the plantar metatarsal heads:
Neuropathic ulcers develop over pressure points in insensate areas, most commonly under the metatarsal heads.
9. B — Increase in exudate and pain:
A sudden increase in drainage, pain, or odor indicates infection, distinguishing it from colonization.
10. B — Superficial partial-thickness burn:
Characterized by moist pink tissue, blistering, and pain due to intact nerve endings.
11. C — Chronic nonhealing wound:
A wound that does not progress after 30 days of appropriate care is termed chronic.
12. A — Extends through the dermis into subcutaneous tissue:
Full-thickness wounds penetrate deeper structures, requiring granulation and contraction for closure.
13. A — Arterial ulcer:
Typically found on bony prominences such as the lateral malleolus, with well-defined edges and pain worsened by leg elevation.
14. C — Worsen with trauma or debridement:
Pyoderma gangrenosum is an inflammatory condition; debridement can trigger pathergy and worsening.
15. C — Unstageable pressure injury:
When full-thickness tissue loss is obscured by eschar or slough, the wound cannot be staged until debrided.

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