Assessment of the histological state of the healing wound

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ABSTRACT

The dynamic process of wound healing has various phases, and the knowledge of which is essential for identification of the pathology involved in a chronic intractable wound. Various instruments for the assessment of wound healing have been described, primarily for clinical assessment of the wound. However, very few instruments are currently available for histological grading of the wound. The aim of this article is to review all available literature from 1993 to 2014 on the objective histological scoring of the state of wound healing. This review article emphasizes the importance of histological grading of wounds based on the different parameters from each phase of wound healing and the need for an ideal grading system in order to help assessment of wound status. The parameter chosen in an experimental model should be defined by the scientific question, the underlying hypothesis and the pathogenesis of the disease.

Key words: Experimental wound assessment, grading of wound, histopathologic grading, wound assessment, wound grading, wound healing, wound histology

INTRODUCTION

The dynamics of wound healing are complex. A thorough understanding of the normal healing process is a prerequisite for unveiling the pathology. Wound healing begins with homeostasis at the site of injury, progresses to an inflammatory phase followed by proliferation of the epithelial and matrix components, and ends with the formation of scar tissue marked by laying down of a highly organized collagen matrix. Various factors, extrinsic and intrinsic to the injured tissue, affect the healing process. These are broadly categorized into local and systemic factors. Factors directly influencing the immediate wound environment are considered to be local factors, while the overall health of the individual affecting his ability to heal constitutes the systemic factors. Impaired wound healing is not an uncommon occurrence in clinical practice. Both local and systemic factors are responsible for impaired healing and weak scar tissue formation. Acute wounds heal following the normal sequence of the healing process. Acute wounds that fail to progress in a timely and orderly fashion through the normal stages of healing are described as chronic wounds. Because of associated early and late complications, chronic wounds remain an intractable clinical problem and a frequent cause of morbidity and mortality.

Various interventions are available for amelioration of impaired healing. Hence, it is important to evaluate wound healing in order to compare the efficacy of...
Disease: diabetes, keloids, fibrosis, jaundice, uremia

The proliferation phase overlaps with the preceding early migratory effect, leading to an arrest of the healing cytokine secretion. Inflammation phase.

The clot and wound tissue. The initial step assists in the protection of the vascular system to maintain the functionality of the organ. The clot formed as a result of coagulation provides a matrix for the cells involved in subsequent phases of hemostasis and inflammation. Various pro-inflammatory cytokines and growth factors are released by the clot and wound tissue. Inflammatory cells then migrate to the wound site by the process of chemotaxis and promote the inflammatory phase. Coagulation and hemostasis

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Factors influencing the wound healing

<table>
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<th>Systemic factors</th>
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<td>Oxygenation</td>
<td>Age, gender</td>
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<td>Foreign body</td>
<td>Disease: diabetes, keloids, fibrosis, jaundice, uremia</td>
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<td>Blood supply</td>
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<td>Immunocompromised status, AIDS, cancer, radiation</td>
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NSAIDs: Nonsteroidal anti-inflammatory medications, AIDS: Acquired immune deficiency syndrome

Table 1: Factors influencing the wound healing

Wound remodeling leading to scar formation

This phase marks the final step in tissue remodeling and differentiation leading to recovery of the skin and its aesthetic restoration. Reconstruction of the dermis occurs by reorganization of the matrix collagen, Fibroblasts differentiation into myofibroblasts, leading to wound contraction and closure.

ASSESSMENT OF THE WOUND

Impaired wound healing occurs secondary to disordered collagen formation and underlying predisposing conditions. In order to effectively manage chronic wounds, periodic assessment of the healing process is necessary. The insights gained from this type of assessment are expected to facilitate the development of novel therapies by stratifying their specific contributions to the wound healing process in time and stage-specific manner. Hence, a standardized and reproducible model is required to obtain information about the wound healing process as well as to better understand the pathology and improve medical technologies. Instruments to assess wound healing can help to enhance communication among clinicians by defining a common language and standardizing assessment of wound characteristics.

Because healing is a dynamic process, it is difficult to evaluate and requires consistent measurements. A complete assessment of the wound must include the size, associated attributes, host factors and environmental factors, all of which impact optimal wound management. In addition, demographics and quality of care also provided aid in assessing the repair process.

Various tools for assessing wound healing clinically have been described, including the Pressure Ulcer Score for Healing (PUSH), the Sussman Wound Healing Tool (SWHT), the Wound Healing Scale, the Leg Ulcer Measurement Tool (LUMT) and the granulometer. However, these instruments can only measure changes in wound healing and do not predict healing or measure wound characteristics. Additional tools to assess the status of the healing wound include Laser-Doppler Flowmetry (LDF) to evaluate cutaneous blood flow and planimetry. The assessment of the histological state of the healing wound is important in clinical practice for postoperative patient management. Histological evaluation should include the basic components of the healing process including angiogenesis, inflammation, fibroplasia and restoration of the connective tissue matrix, wound contraction and remodeling, epithelialization and differentiation.

Comparison of histologic patterns with the known physiologic variation in tissue morphology assists in

qualitative derivation of the diagnosis. The degree of changes observed when scored on an ordinal scale, namely, low, medium or high grade, provides a semi-quantitative score. On the other hand, the exact quantitative measurement in terms of the absolute number of cells and areas of tissue gives a quantitative score. A quantitative scoring system, while being highly specific and standardized, is difficult to score because in most cases it is difficult to objectify the exact interval between two values. Hence, semi-quantitative scoring systems remain in wide use in the world of the biomedical research.

Various studies have been conducted, and wound healing models have been proposed to understand the normal healing process and to standardize the semi-quantitative and quantitative evaluation of selected parameters of wound healing. In a study assessing wound healing in the maxillofacial region, Sultana et al. utilized scoring of 6 histological parameters to give a healing score [Table 2]. The total healing score in each case was calculated by adding the scores of individual criteria, with lower scores indicating poorer wound healing. Healing status was graded as good (16-19), fair (12-15) and poor (8-11). Using this healing score, Sultana et al. concluded that risk factors in the study group were correlated with delayed wound healing in comparison to the control group.

While studying the overall process of wound healing, Braiman-Wiksman et al. evaluated the role of multiple processes involving the skin components including the epidermis, dermis, hypodermic, blood vessel and connective tissue [Table 3]. They stressed an objective assessment and quantification of wound healing. Using a quantitative assessment method, the authors provide insight into the specific defects found at various stages, which involve a variety of cells and pathways in the process of wound healing.

In their experimental model of open-skin wound healing in corticosteroid-treated and diabetic rats, Gal et al. used both semi-quantitative and quantitative methods in a time- and stage-bound assessment of wound healing [Table 4]. Consistent with previous studies, they concluded that there is only a quantitative difference between primary and secondary wound healing. In contrast to the quantitative method, the semi-quantitative scoring system can evaluate keratinization, suggesting that keratinocyte differentiation is important in wound healing. Hence, a quantitative assessment alone is not sufficient to demonstrate significant differences in skin wound healing.

Lemo et al. provided a mathematical model for healing and a remodeling index in experimental skin wounds. The mathematical model involves measurement of five specific parameters [Table 5], based on which three indices can be determined: the superficial contraction index (SCI), the deep contraction index (DCI) and the wound contraction index (WCI). These indices, however, measure only the contraction of the wound, which represents the initial stage of healing. To assess the mid- and long-term healing process, Lemo et al. provide the global healing index (GHI), given by the formula $GHI = SCI + DCI - WCI$. This index allows scoring of the healing process and follow-up of its progress.

Tascilar et al. used Abramov's histologic scoring system to demonstrate the effectiveness of N-acetyl cysteine administration in alleviation of the negative effects of radiotherapy on incisional wound healing. Abramov's histologic scoring system encompasses a semi-quantitative...
scoring of acute and chronic inflammation, the amount of granulation tissue, the level of fibroblast maturation, the amount of collagen deposition and the level of reepithelialization and neovascularization. Ancillary techniques such as special stains and immunohistochemistry in addition to light microscopic examination can help in the accurate assessment of the components of a healing wound. For instance, Masson’s trichrome staining is used to demonstrate the presence of collagen in the healing wound. In addition, various immunohistochemical markers have been used to demonstrate the components of the healing wound, such as antiloricrin for epithelial differentiation, CD31 for angiogenesis and antibodies against cytokine ligands and receptors. Some authors have studied apoptosis using Annexin V-FITC binding assay and TUNEL Assay. Histopathology has always been the gold standard in diagnosing certain infectious, degenerative or neoplastic diseases in humans and animals. The number of studies performed to provide a standardized system for histological evaluation of the wound demonstrates the importance of histopathology. Careful assessment of chronic wounds can shed light on the exact pathology and assist in developing a strategy for further management. It can also be a powerful tool in the evaluation of the effect of novel drugs on wound healing. Histopathology also provides information on the usefulness of combination therapy and determining effective drug dosage in order to minimize adverse effects.

There are numerous scoring systems provided by various pioneers in the field. However, the need for uniformity persists. Although the selection of parameters in most scoring systems is generally based on a basic knowledge of the wound healing, the parameters chosen in an experimental model should be defined by the scientific question, the underlying hypothesis and the pathogenesis of the disease.

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REFERENCES