How to differentiate Granulation Tissue from Epithelial Tissue

**Granulation Tissue** – ****Only visible in full thickness wounds****

The pink/red, moist tissue comprised of new blood vessels, connective tissue, fibroblasts, and inflammatory cells, which fills an open wound when it starts to heal; typically appears deep pink or red with an irregular, “berry-like” surface.

**Epithelial Tissue**

Epithelialization is the regeneration of epidermis (outermost layer of skin) across a wound surface.

In the bottom image, epithelial tissue is outlined (it is usually smooth and pink) and is beginning to close the wound by extending in from the edges over the granulation tissue, granulation tissue has filled the depth, and the yellowish discoloration is simply dried serous fluid.

- Partial thickness wounds do not extend deep enough into the tissue to require granulation to close. If you see granulation tissue, slough, or any other type of necrotic tissue – you are NOT dealing with a partial thickness wound.
- Stage II pressure ulcers are partial thickness wounds – they do NOT granulate or develop necrotic tissue
- Incisions healing by primary intention CANNOT be considered partial/early/full granulation because you cannot visualize granulation tissue.

**100% Epithelialized:** The final image in the progression below depicts complete Epithelialization.