GLOSSARY

Abrasion- Wound caused by scraping or friction to the skin's surface.

Abcess- Localized collection of purulent material in a cavity formed by necrosis or disintegration of tissue.

Active Support Surface- A powered support surface, with the capacity to change its load distribution properties, with or without applied load.

Adipose tissue- Vascular, loose connective tissue that stores fat and provides energy, cushioning, and insulation.

Aerobe- A microorganism that requires free oxygen in order to be able to live and grow.

Albumin- A serum protein that measures visceral protein stores (those available to respond to metabolic stress, such as wound healing). Half life of 18-21days.

Altered tissue perfusion- When oxygenated blood does not flow freely through the vessels to the tissue.

Anasarca- An accumulation of large amounts of fluid throughout all areas of the body. The diagnostic term used to document severe, generalized edema.

Anaerobe- A microorganism which thrives best or lives only without oxygen.

Angiogenesis- Formation of new blood vessel walls.

Antibacterial- An agent that inhibits the growth of bacteria.

Antimicrobial- Substance that destroys or inhibits the growth of microorganisms.

Antiseptic- Antimicrobial designed to reduce bacterial contamination on intact skin.

Arterial insufficiency- Decreased arterial blood supply, most commonly due to arteriosclerosis.

Arteriosclerosis- General term for thickening and hardening of arterial walls.

Atherosclerosis- Systemic, degenerative process in which the arterial lumen is gradually encroached upon by plaque formation.

Autolytic debridement- Form of debridement that uses endogenously produced enzymes to digest necrotic tissue.

Avascular- Lacking in blood supply; synonyms are dead, devitalized, necrotic, and nonviable. Specific types include slough and eschar.

Basement membrane- Thin membrane separating the epidermis from the dermis.

Bacteremia: Presence of bacteria in the blood.

Blanchable- Reddened area that temporarily turns white or pale when pressure is applied with a fingertip over a pressure site. It is usually due to a normal reactive hyperemic response.

Blister- Collection of fluid at the junction between the dermis and epidermis due to friction.

Bottoming out- Occurs when there is less than 1 inch of support material between the patient and support surface.

Callus- Localized buildup of stratum corneum cells due to pressure or friction.

Capillary closing pressure- Minimal amount of external pressure that must be applied to prohibit capillary blood flow, generally 13 to 32mm Hg.

Cellulitis- Inflammation of connective tissue; infection in or close to the skin; A diffuse, acute inflammation and infection of the skin and subcutaneous tissue that signifies a spreading infectious process.

Charcot foot- Neuropathic fracture/dislocation found in patient with diabetes.

Chronic wound- A wound, induced by various causes, whose progression through the phases of wound healing is prolonged due to underlying conditions.

Closed wound- A wound in which the epithelial integrity has been restored.

Colonization- The presence and growth of bacteria on the surface of the skin without any evident tissue damage.

Contamination- The entry of bacteria, other microorganisms, or foreign material into a previously clean or sterile wound or skin.

Contraction- Process by which myofibroblasts pull wound margins closer together thereby decreasing the size of the defect.

Cyanosis/Cyanotic- Bluish discoloration of the skin and mucous membrane resulting from an excessive amount of reduced Hemoglobin in the blood.

Cytotoxic- A substance that kills or damages tissue cells.

Debridement- The removal of necrotic tissue, foreign material, and/or debris from a wound bed.

Denuded skin- Loss of epidermis layer.

Deep Tissue Injury – See Suspected Deep Tissue Injury

Dehiscence- Separation of previously joined edges or wound margins, such as a surgical wound.

Dermatitis- Inflammation of the skin associated with itching, redness, and open lesions.

Dermis- Layer of skin which lies under the epidermis, containing blood vessels, lymph vessels, hair follicles, glands and nerves.

Diaphoretic- A condition marked by profuse perspiration.

Ecchymosis- Blotchy, superficial discoloration of the skin caused by the escape of blood into the tissues.

Edema- Abnormal accumulation of fluid in the body, particularly in the intercellular spaces, may be caused by poor lymphatic drainage, hypoproteinemia or CHF.

Enzymatic debridement- Form of debridement using topically applied exogenous enzymes to remove devitalized tissue.

Epidermis- Outer, avascular layer of the skin.

Epithelialization- Process by which keratinocytes resurface the wound defect. The new epithelial cells advance across the wound until they eventually meet epithelial cells moving in from the opposite direction.

Erythema- Redness of the skin due to dilation of the superficial capillaries.

Eschar- Black or brown hard necrotic, devitalized tissue that may be loose or firmly adherent. May become soft or soggy.

Evisceration- Protrusion of organs such as abdominal contents resulting from wound dehiscence.

Excoriation- Linear abrasion produced by mechanical trauma.

Exudate- Fluid from a tissue or its capillaries because of injury or inflammation. Made up of mixture of fluid, protein, and cells, can be bloody, sero-sanguineous, serous, or purulent

Fascia- Fibrous connective tissue that separates and surrounds structures. Facilitates movement between adjacent structures.

Fistula- An abnormal passage from an internal organ to the body surface or between two internal organs.

Friable granulation tissue- granulation tissue that bleeds easily (such as when gently manipulated with a cotton-tipped applicator) even though resident may not be on anticoagulation therapy.

Friction- The force of two surfaces moving across one another, such as the mechanical force exerted when the skin is dragged across a coarse surface such as bed linens.

Full thickness wound- Wound that extends through the epidermis and dermis and into or through subcutaneous tissue and possible muscle/bone.

Gangrene- Dead tissue that is dry, dark, cold, and contracted.

Granulation Tissue- Tissue growth of small blood vessels and connective tissue to fill in full-thickness wounds. Tissue is healthy when bright, beefy red, shiny and granular with a velvety appearance. Poor vascular supply appears as pale pink or bleached to full, dusky red color.

Healed wound- A closed wound with tissue strength approaching normal. Will only be as much as 80% its original tensile strength.

Hemosiderin deposition- Occurs when the by-product of the breakdown of red blood cells is forced into the interstitium by venous hypertension.

Hypergranulation- Error of the proliferative phase in which too much granulation tissue is formed and grows above wound edge causing delay in epithelialization.

Induration- Process of hardening or the quality of being hard, an abnormally hard spot or hardened area of tissue. Firm edema.

Infection- Invasion and multiplication of microorganisms within body tissues in sufficient quantity to damage tissue or impair healing; wound culture reveals greater than 10^5 microbes per gram of tissue. Typical signs and symptoms of infection include purulent exudates, odor, erythema, warmth, tenderness, edema, pain, fever, and elevated white cell count. However, clinical signs of infection may not be present, especially in the immunocompromised or a resident with poor perfusion.

Inflammation- First phase of wound healing. Physiological changes occurring at the site of infection or injury.

Ischemic- Localized and temporary inadequacy of blood supply to a body part or area due to an obstruction in the circulation.

Ischemic ulcer- Arterial insufficiency ulcer.

Lipodermatosclerosis- Hyperpigmentation and accompanying erythema, induration, and plaque like structural changes due to long-standing venous insufficiency.

Lymphedema- Accumulation of protein-rich fluid due to congenital malformation of the lymphatics or impaired lymph transport.

Maceration- Process of softening of the tissue caused by prolonged contact with a fluid such as urine or drainage from a wound. Usually appears white, friable, over hydrated and sometimes wrinkled.

Maturation or remodeling phase- Final phase of wound healing during which collagen matures and reorients along the lines of stress.

Mechanical debridement- Form of debridement using force to remove devitalized tissue, foreign material, and debris from a wound bed.

Mottled- Condition of irregular discoloration of body surface areas, might be observed in upper/ lower extremities of residents with poor circulation or in residents who have recently died.

Necrotic tissue- Dead, devitalized tissue adhered to the wound bed.

Neuropathic ulcer- Ulcer due to insensitivity; previously referred to as a diabetic ulcer.

Non-blanchable- Redness that persists when fingertip pressure is applied over a pressure site and pressure to area has been relieved for 15-30 minutes.

Non-granulating- Absence of granulation tissue; wound surface appears smooth as opposed to granular. For example, in a wound that is clean but non-granulating, the wound surface appears smooth and red as opposed to berry-like.

Non-selective debridement- The removal of nonspecific areas of devitalized tissue.

Osteomyelitis- Inflammation of bone and marrow, usually caused by pathogens that enter the bone during an injury or surgery.

Partial-thickness ulcer- Wound involving damage to the epidermis, dermis or both.

Petechiae - Small flat, pinpoint, round purplish-red spots, caused by intradermal or submucous hemorrhage.

Periwound- Area of tissue around the wound.

Pre-albumin- Transport protein used as an indicator of nutritional status. Half life 1-2 days.

Pressure Redistribution – The ability of a support surface to distribute load over the contact areas of the human body. This term replaces prior terminology of pressure reduction and pressure relief surfaces.

Pressure Ulcer- Wound caused by unrelieved pressure, shear, or friction.

Proliferation- Second phase of wound healing; building and regenerating phase consisting of angiogenesis, granulation tissue formation, wound contraction, and epithelialization.

PSI - Pounds per square inch – a unit of pressure, in this case, the pressure exerted by a stream of fluid, against one square inch of skin or wound surface.

Purpura- Discoloration of the skin or mucosa due to extravasation of blood.

Reactive hyperemia- Localized area of blanchable erythema.

Reactive Support Surface – A powered or non-powered support surface with the capacity to change its load distribution properties only in response to applied load.

Scab- Collection of necrotic cells, fibrin, collagen, and platelets that covers a superficial wound.

Selective debridement- Removal of specific areas of devitalized tissue.

Sharp debridement - Selective debridement using forceps, scissors or scalpel.

Shear- The effect of a sliding condition in which the skin surface remains stuck to a support surface while the underlying bony structure moves in a direction tangential to the surface.

Sinus tract- Course or path of tissue destruction occurring in any direction from the surface or edge of the wound; results in dead space with potential for abcess formation. Also sometimes called 'tunneling'. (Can be distinguished from undermining by the fact that sinus tract involves a small portion of the wound edge, whereas undermining involves a significant portion of the wound edge.

Slough- Soft moist avascular necrotic (devitalized) tissue that is white, yellow, tan, or green in color; may be loose or firmly adherent; may be stringy or mucinous in consistency.

Stage I pressure ulcer- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

Stage II pressure ulcer- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury.

Stage III pressure ulcer- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage IV pressure ulcer- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. *Often* include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Surgical debridement- the use of scalpels, scissors, or lasers in a sterile environment by a physician or podiatrist to remove tissue, foreign material, and debris from the wound bed.

Suspected Deep Tissue Injury- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal
treatment.

Tissue anoxia- Reduction of oxygen levels below normal. Can be a direct result of ischemia.

Total lymphocyte count (TLC)- Indirect measure of nutritional status and immune function.

Tunneling- A narrow passageway within a wound bed.

Undermining- Area of tissue under the wound edge that becomes eroded resulting in a large wound with a smaller opening; commonly seen in shear injuries. Can be distinguished from sinus tract (tunneling) by the fact that undermining involves a significant portion of wound edge.

Unstageable pressure ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

Venous stasis ulcer- Ulcer caused by venous insufficiency.

Wound Edge - Rim or border of wound.