

APPENDIX A: GLOSSARY – PRESSURE ULCER TERMS

Abscess: A cavity containing pus and surrounded by inflamed tissue in any part of the body—a result of a localized infection.

Aerobe: A microorganism that lives in the presence of free oxygen.

Altered tissue perfusion: A condition in which cells have a decrease in nutrition and oxygenation caused by a deficient capillary blood supply

Anaerobe: A microorganism that grows without any or with little free oxygen.

Antibacterial: An agent that kills or stops the growth of bacteria.

Antimicrobial: An agent that kills or stops the growth of microbes.

Approximated incision: Wound edges are brought together, often by surgical closure.

Autolysis: Disintegration or liquefaction of tissue or of cells by the body’s own mechanisms (leukocytes/enzymes).

Bacterial burden: The number, diversity and virulence of bacteria in the wound.

Bactericidal: An agent that destroys bacteria.

Bacteriostatic: Inhibits the growth or multiplication of bacteria.

Blanching Test: A test to check circulation of fingers and toes. Pressure is applied over nail until all color is gone. When pressure is removed, the rate at which color returns determines circulation.

Cell migration: Movement of cells in the repair process.

Cellulitis: Inflammation of tissue around a lesion. Characterized by heat, redness, swelling, and tenderness. Signifies a spreading infectious process.

Collagen: The main supportive protein which combines to form of the skin, tendon, bone, cartilage, and connective tissue.

Colonized: Presence of bacteria which cause no local or systematic signs or symptoms.

Contamination: To infect by contact or introduction of organisms into a wound.

Contraction: Tissue pulling together the wound edges in the healing process.

Crater: A circular depression with a raised area around the periphery.

Cytokine: Any of several regulatory proteins, such as the interleukins and lymphokines, that are released by cells of the immune system and act as inter cellular mediators in the generation of an immune response

Debridement: Removal of damaged tissue.

Debris: Remains of broken down or damaged cells or tissue.

Decubitus ulcer: Ulcer of the skin caused by prolonged pressure over the affected area.

Degranulate: Release of granules from cells, for example the rupture of platelet granules leading to the release of cytokines/growth factors.

Denude: Loss of epidermis.

Dermal: Related to skin or derma.

Dermal wound: Loss of skin integrity; may be surface level or deeper.

Dermis: The inner layer of skin in which hair follicles and sweat glands reside; involved in Stage II to IV pressure ulcers.

Edema: The presence of larger than normal amounts of fluid in the interstitial space.

Enzymes: Biochemical substances that can break down necrotic tissue.

Enzymatic debridement: Breakdown to liquid form of necrotic wound debris by chemical agents.

Epidermis: The outer most layer of skin.

Epibole: Rolled over wound edges so the epithelial cell migration stops and the wound is unable to resurface.

Epithelial cell migration: The progression or traveling of epithelial cells from the wound edges to resurface the wound

Epithelialization: Regrowth of the epidermis across wound surface.

Erythema: Redness of skin surface produced by vasodilation.

Eschar: Thick, leathery necrotic tissue; damaged tissue.

Excoriation: damage to the surface of the skin from trauma, e.g., scratching, abrasion.

Exuberant granulation: Formulation of large amounts of granulation tissue that may protrude above the margins of a wound.

Exudate: Fluid that leaks from damaged tissue.

Fibroblast: Any cell of the body from which connective tissue is developed.

Fibroplasia: The formation of connective tissue.

Friction: Surface damage caused by skin rubbing against another surface.

Full-thickness: Wounds that extend through the epidermis, and entire dermis, and possibly muscle or bone.

Granulation: The formation of growth of small blood vessels and connective tissue in a full thickness wound.

Granulation tissue: Healing tissue composed of new capillaries and fibroblasts.

Hemostasis Phase: Stage of wound healing that occurs in acute full thickness wounds.

Horney layer: The thin top most layer of the epidermis.

Hydrophilic: Attracts moisture.

Hyperalimentation: Nutritional supplement given either enterally or parentally.

Hyperemia: Presence of excess blood in the vessels: engorgement.

Induration: Abnormal firmness of tissue with a defined edge.

Infection: Overgrowth of microorganisms capable of tissue destruction and invasion followed by local or systemic symptoms.

Inflammation: Reaction to tissue injury; involves increased blood flow and capillary permeability and requires physiologic cleanup of wound. Accompanied by increased

heat, redness, swelling, and pain in the affected areas.

Insulation: Keeping wound temperature close to body temperature.

Ischemia: A deficiency of blood because of functional constriction or obstruction of a blood vessel to a body part.

Keloid: A large, bulging scar caused by excessive amounts of collagen in connective tissue.

Lesion: A broad term referring to wounds or sores.

Leukocyte: White blood cell.

Leukocytosis: An increase in the number of leukocytes (above 10,000 per cu. Mm) in the blood.

Maceration: Softening of tissue by soaking in fluids.

Macrophage: Cells which have the ability to destroy bacteria and devitalized tissue.

Mechanical debridement: The loosening and removal of necrotic wound debris by means of water, brush, gauze, and etc.

Moist wound healing: Healing of a wound that is kept moist as opposed to allowing the wound to dry. Moist wound healing eliminates desiccation of viable tissue, allows faster reepithelialization and granulation tissue to form at wound surface. It minimizes scab and eschar formation. It also allows autolysis by inflammatory cells and enzymes in exudates. Moist wound healing helps comfort level of the patient.

Necrotic: Dead; avascular.

Neoangiogenesis: The new growth of new capillaries from preexisting blood vessels.

Neovascularization: (See neoangiogenesis.)

Osteomyelitis: an infection of bone or bone marrow

Norton scale: As assessment of physical condition, mental status, activity, mobility, and incontinence to determine the risk of pressure ulcer development.

Pallor: Lack of natural color; paleness.

Partial-thickness: Wounds that extend through the epidermis and part of the dermis.

Pathogen: Any disease producing agent or microorganism.



Phagocytosis: Autodebridement of bacteria and necrotic debris from the wound.

Platelet: Found in the blood plasma, functions to promote blood clotting

Pressure: A force applied to skin compromising circulation.

Pressure sore: An area of localized tissue damage caused by ischemia because of pressure.

Proud flesh: (See exuberant granulation.)

Pus: Thick fluid indicative of infection that contains leukocytes, bacteria, and cellular dermis.

Pyogenic: Producing pus.

Reactive hyperemia: The body produces extra blood in vessels in response to a period of blocked blood flow.

Remodeling: Reorganization of collagen fibers in a healing wound.

Sanguineous drainage: Bloody drainage.

Scab: Dried fluid, cells, or other substances that have been discharged covering a superficial wound.

Serum: A clear fluid from the body, having a watery consistency.

Serous: Producing a secretion or containing serum that moistens mucus membranes.

Serous drainage: Serum like drainage having a watery consistency.

Serosanguineous drainage: Exudate containing serum and blood.

Secondary intention: Healing of a wound by granulation resulting in significant scar tissue.

Sharp debridement: Surgical removal by scalpel or scissors of the eschar and/or any devitalized tissue within the pressure ulcer.

Shear: Trauma to the skin caused by tissue layers sliding against each other results in disruption or angulation of blood vessels.

Sinus Tract: A course or pathway that can extend in any direction from the wound surface; results in space with potential for abscess formation.

Slough: Loose, stringy necrotic tissue.

Stratum corneum: The thin top layer of the epidermis.

Strip: Remove epidermis by mechanical means: denude.

Subcutaneous layer: Masses of loose connective and fat tissues located beneath the dermis.

Surgical debridement: a type of sharp debridement using a scalpel, scissors, or other instrument to cut dead tissue from beyond the wound edges and is usually performed by the Physician.

Tissue tensile strength: The degree of strength scar tissue is able to endure before it tears. Add

Tunneling: A narrow channel/passageway extending into healthy tissue.

Ulcer: An open sore.

Undermine: Tissue destruction underlying intact skin along wound edges.

Varicosities: Dilated tortuous superficial veins.

Vasoconstriction: Constriction of the blood vessels.

Vasodilatation: Dilation of blood vessels—especially small arteries and arterioles.

Wound base: Top viable tissue layer of wound; may be covered with slough or eschar.

Wound margin: Edge or border of a wound.

Wound repair: The healing process. Partial-thickness involves epithelialization; full thickness involves contraction, granulation, and epithelialization.

Glossary adapted from Mosby's Medical Dictionary, eighth edition, Taber's Cyclopedic Medical Dictionary 19th edition, Clinical Practice Guidelines by the Health Care Research and Quality (AHRQ), NPUAP and Bryant and Nix: Acute & Chronic Wounds -Third Edition .



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