Abscess: A circumscribed collection of pus that forms in tissue as a result of acute or chronic localized infection. It is associated with tissue destruction and frequently swelling.

Abrasion: Circumscribed removal of the superficial layers of skin.

Bacteremia: The presence of viable bacteria in the circulating blood.

Cellulitis: Inflammation of cellular or connective tissue. Inflammation may be diminished or absent in immunosuppressed individuals.

Clean Dressing: Dressing that is not sterile but is free of environmental contaminants such as water damage, dust, pest and rodent contaminants, and gross soiling.

Clean Wound: Wound free of purulent drainage, devitalized tissue or dirt.

Contaminated: Containing bacteria, other microorganisms or foreign material. The term usually refers to bacterial contamination and, in this context, is synonymous with colonized. Wounds with bacterial counts of 105 organisms per gram of tissue or less are generally considered contaminated; those with higher counts are generally considered infected.

Culture (Bacterial): Removal of bacteria from a wound for the purpose of placing them in a growth medium in the laboratory to propagate to the point where they can be identified and tested for sensitivity to various antibiotics. Swab cultures are generally inadequate for this purpose.

Dead Space: A cavity remaining in a wound.

Debridement: Removal of devitalized tissue and foreign matter from a wound. Various methods may be used for this purpose:

- **Autolytic Debridement**: The use of synthetic dressings to cover a wound and allow eschar to self-digest by the action of enzymes present in wound fluids.

- **Biologic**: The topical application of sterile maggots to break down devitalized tissue

- **Enzymatic (Chemical Debridement)**: The topical application of proteolytic substances (enzymes) to break down devitalized tissue.

- **Mechanical Debridement**: Removal of foreign material and devitalized or contaminated tissue from a wound by physical forces rather than by
chemical (enzymatic) or natural (autolytic) forces. Examples are wet-to-dry dressings, wound irrigation, whirlpool and dextranomers.

**Sharp Debridement**: Removal of foreign material or devitalized tissue by a sharp instrument such as a scalpel. Laser debridement is also considered a type of sharp debridement.

**Dehiscence**: Separation of the layers of a surgical wound.

**Denude**: Loss of epidermis.

**Dressing**: The material applied to a wound for the protection of the wound and absorption of drainage.

**Edema**: Presence of abnormally large amounts of fluid in the interstitial space.

**Epibole**: Edges or top layers of epidermis have rolled down to cover lower edges of epidermis, including basement membrane, so that the epithelial cells cannot migrate from wound edges; also described as closed wound edges.

**Epithelialization**: The stage of tissue healing in which the epithelial cells migrate (move) across the surface of a wound.

**Erythema**: Redness of the skin.

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

**Nonblanchable Erythema**: Redness that persists when fingertip pressure is applied. Nonblanchable erythema over a pressure site is a system of a Stage I pressure ulcer.

**Eschar**: Thick, leathery, necrotic, devitalized tissue.

**Excoriation**: Linear scratches on the skin.

**Exudate**: Any fluid that has been extruded from a tissue or its capillaries, more specifically because of injury or inflammation. It is characteristically high in protein and white blood cells.

**Fascia**: A sheet or band of fibrous tissue that lies deep below the skin or encloses muscles and various organs of the body.

**Friction**: Mechanical force exerted when skin is dragged across a coarse surface such as bed linens.
Full-Thickness Tissue Loss: Loss of tissue below the dermis level, involving subcutaneous and possibly other tissue layers, to include loss of fascia, tendons, muscles, bone or other underlying structures. Full thickness wounds heal by formation of granulation tissue, contraction, and epithelialization.

Granulation Tissue: The pink/red, moist tissue that contains new blood vessels, collagen, fibroblast and inflammatory cells which fills an open, previously deep wound when it starts to heal.

Healing: A dynamic process in which anatomical and functional integrity is restored. This process may be monitored and measured. For wounds of the skin, it involves repair of the dermis (granulation tissue formation) and epidermis (epithelialization). Healed wounds represent a spectrum of repair, they can be ideally healed (tissue regeneration), minimally healed (temporary return of anatomical continuity,) or acceptably healed (sustained functional and anatomical result). The acceptably healed wound is the ultimate outcome of wound healing but not necessarily the appropriate outcome for all patients.

Primary Intention Healing: Closure and healing of a sutured wound.

Secondary Intention Healing: Closure and healing of a wound by the formation of granulation tissue and epithelialization.

Tertiary Healing: Wound left open above the fascia layer which is surgically closed at a later time.

Induration: Abnormal firmness of tissue with a definite margin.

Irrigation: Cleansing by a stream of fluid, preferably saline.

Ischemia: Deficiency of blood supply to a tissue, often leading to tissue necrosis.

Macerate: To soften by wetting or soaking. In (a healing) context, it refers to degenerative changes and disintegration of skin when it has been kept too moist.

Moisture: In the context of this document, moisture refers to skin moisture that may increase the risk of pressure ulcer development and impair healing of existing ulcers. Primary sources of skin moisture include perspiration, urine, feces, drainage from wounds or fistulas.

Necrotic Tissue: Tissue that has died and has, therefore, lost its usual physical properties and biological activity. Also called “devitalized tissue.”

Osteomyelitis: Inflammation of the bone marrow and adjacent bone, often due to infection.
Pressure (Interface): Force per unit area that acts perpendicularly between the body and the support surface. This parameter is affected by the stiffness of the support surface, the composition of the body tissue and the geometry of the body being supported.

Pressure Reduction: Reduction of interface pressure, not necessarily below the level required to close capillaries (i.e., capillary-closing pressure).

Pressure Relief: Reduction of interface pressure below capillary-closing pressure.

Pressure Ulcer: A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

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.

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.

Stage I: 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.

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: 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.

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:** 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.

The depth of 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:** 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.

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.

**Unstageable:** 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.

The staging system was defined by Shea in 1975 and provides a name to the amount of anatomical tissue loss. The original definitions were confusing to many clinicians and lead to inaccurate staging of ulcers associated or due to perineal dermatitis and those due to deep tissue injury.

**Prevalence:** The number of cases present in a population at one point in time.

**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.
Purulent Discharge/Drainage: A product of inflammation that contains pus – i.e., cells (leukocytes, bacteria) and liquefied necrotic debris.

Qualitative Data: Information that describes the nature or qualities of a subject.

Quantitative Data: Information obtained of a subject that is measurable.

Reactive Hyperemia: Reddening of the skin caused by blood rushing back into ischemic tissue.

Sepsis: The presence of various pus-forming and other pathogenic organisms, or their toxins, in the blood of tissues. Clinical signs of blood-borne sepsis include fever, tachycardia, hypotension, leukocytosis, and deterioration in mental status. The same organism is often isolated in both the blood and the pressure ulcer.

Shear: Mechanical force that acts on a unit area of skin in a direction parallel to the body’s surface. Shear is affected by the amount of pressure exerted, the coefficient of friction between the materials contacting each other, and the extent to which the body makes contact with the support surface.

Sinus Tract: A cavity or channel underlying a wound that involves an area larger than the visible surface of the wound.

Skin Flap: A procedure that moves a section of skin and associated subcutaneous tissue from one part of the body to another, with the vascular supply maintained for nourishment. The vascular attachment can be the original vessel, rotated along with the flap, changed from one part of the flap to another; or reestablished by microvascular anastomoses once it has been placed in the new location. One disadvantage of local flap closure is that the flap essentially redistributes an already inadequately perfused tissue and is randomly dependent on an unpredictable local blood supply.

Skin Graft: A procedure that moves a segment of dermis and a portion of epidermis. The graft is completely separated from its blood supply and donor site and moved to a recipient site. Skin grafts contain varying portions of epidermis and dermis and can be full thickness or partial thickness, depending upon how much dermis is included in the graft. One disadvantage of skin grafts applied to granulating bone is that there is no padding and they quickly erode.

Slough: Necrotic (dead) tissue in the process of separating from viable portions of the body. This tissue can present as dried out, tenacious and without odor, or soft, stringy, very moist, and odiferous.

Stasis Ulcer: Ulceration associated with ambulatory venous hypertension.

Stratum Corneum: Outermost layer of the epidermis.
<table>
<thead>
<tr>
<th><strong>Surfactants:</strong></th>
<th>A surface-active agent that reduces the surface tension of fluids to allow greater penetration.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tissue Biopsy:</strong></td>
<td>Use of a sharp instrument to obtain a sample of skin, muscle or bone.</td>
</tr>
<tr>
<td><strong>Topical Antibiotic:</strong></td>
<td>A drug known to inhibit or kill microorganisms that may be applied locally to a tissue surface.</td>
</tr>
<tr>
<td><strong>Tunneling:</strong></td>
<td>A passageway under the surface of the skin that is generally open at the skin level; however, most of the tunneling is not visible.</td>
</tr>
<tr>
<td><strong>Underlying Tissue:</strong></td>
<td>Tissue that lies beneath the surface of the skin such as fatty tissue, supporting structures, muscle and bone.</td>
</tr>
<tr>
<td><strong>Undermining:</strong></td>
<td>A closed passageway under the surface of the skin that is open only at the skin surface. Generally, it appears as an area of skin ulceration at the margins of the ulcer with skin overlying the area. Undermining often develops from shearing forces.</td>
</tr>
</tbody>
</table>