Wound Care - Glossary of Terms

Abrasion
Wearing away of the skin through some mechanical process (friction or trauma).

Abscess
Accumulation of pus enclosed anywhere in the body.

Cellulitis
Inflammation of the tissues indicating a local infection; characterized by redness, oedema and tenderness.

Collagen
Main supportive protein of the skin.

Colonized
Bacteria which exist in an area (wound) in sufficient number to cause local or systemic signs and symptoms; not an infection.

Debridement
Removal of foreign material and devitalized or contaminated tissue from a wound until healthy tissue is exposed.

Dehiscence
Separation of wound edges.

Denude
Loss of epidermis.

Epidermis
Outermost layer of the skin.

Erode
Loss of epidermis.

Erythema
Diffuse redness of the skin.

Eschar
Thick, leathery black crust; it is nonviable tissue and is colonized with bacteria.

Excoriation
Linear scratches on the skin.

Exudate
Accumulation of fluids in a wound.

Friction
Rubbing that causes mechanical trauma to the skin.

Full-thickness
Tissue destruction extending through the dermis to involve subcutaneous level and possibly muscle, fascia or bone.

Granulation
Formation of connective tissue and many new capillaries in a full-thickness wound; typically appears as red and cobblestoned.

Hydrophillic
Attracting moisture.

Infection
Overgrowth of microorganisms in sufficient quantities to overwhelm the body's defenses.

Lesion
Broad term referring to wounds, sores.

Maceration
Softening of tissue by soaking in fluids; looks like "dishpan hands."

Necrotic
Dead.

Oedema
Swelling.

Partial-thickness
Wounds that extend through the epidermis and may involve the dermis; these wounds heal by re-epithelialisation.

Periwound
The area immediately around the wound.

Pus
Thick fluid composed of leukocytes, bacteria, and cellular debris.

Shear
Sliding of skin over subcutaneous tissues and bones causing a kink in cutaneous capillaries which may lead to ischaemia.

Stage I Pressure Ulcer
An observable pressure-related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

Stage II Pressure Ulcer
Involves the epidermis, dermis or both. It is a superficial wound and may present as an abrasion, blister or shallow crater.

Stage III Pressure Ulcer
Involves subcutaneous tissue that may extend down to, but not through, underlying fascia. It may present as a deep crater with or without undermining of tissue.

Stage IV Pressure Ulcer
Involves muscle, bone or supporting structures. Undermining or sinus tracts may also be present.

Sinus tract
A course or pathway which can extend in any direction from the wound base; results in dead space with potential for abscess formation.

Slough
Stringy, necrotic tissue; usually yellow.

Strip
Removal of epidermis by mechanical means, usually tape.

Ulcer
Loss of epidermis/dermis or mucous membrane with definite margins.

Undermine
Skin edges of a wound that have lost supporting tissue under intact skin.

Unstageable Pressure Ulcer
Covered with eschar or slough which prohibits complete assessment of the wound.

Wound

A break in the integrity of the skin; an injury to the body which causes a disruption of the normal continuity of the body structures.

Wound margin
Rim or border of a wound.