Terminology

Amorphous: Without a clear shape as in a wound dressing in gel form

Antimicrobial: An agent that inhibits the growth of bacteria

Arterial Ulcer: Related to the presence of arterial occlusive disease. Presenting symptoms mainly involve pain and tissue loss.

Autolytic Debridement: Removal of devitalized tissue through normal wound exudate or through the use of any topical dressing or preparation that encourages moisture retention or by the body's own mechanisms

Bedsore: The traditional name for a pressure ulcer. Also called a decubitus ulcer.

Beefy Red: A term used to describe a healthy looking wound with good blood supply

Blanching: To become white with pressure

Biocompatible: refers to the ability of a product to perform its desired function without eliciting any undesirable effects

Cellulitis: Inflammation of tissue characterized by redness. Signifies a spreading infection.

Chemical Debridement: The removal of dead or devitalized tissue by using enzymatic debriding agents.

Chronic Wound: A wound that takes longer than normal to heal due to underlying conditions such as pressure, diabetes, poor circulation, immune deficiencies or infection.

Contraction: The pulling together of wound edges/margins in the healing process.

CWOCN: Same as "ET Nurse" (Certified wound, ostomy, continence nurse).

CWS: Certified Wound Specialist

Debride: to remove dead or devitalized tissue

Debridement: Removal of dead or devitalized tissue.

Decubitus Ulcer: The Latin term for a pressure ulcer. (Sometimes referred to as a "decub.")

Dehisced: Describes a surgical wound which has broken open or is not healing properly

Denuded: Loss of epidermis.

Depth: Distance from the wound's surface downward. The last measurement in wound description in centimeters.

Dermis: The second layer of skin that contains hair follicles, sweat glands, sebaceous glands, blood vessels and lymph vessels: involved in stage 2, 3, and 4 pressure ulcers as well as partial and full thickness wounds.

Edema: Observable swelling from fluid accumulation in body tissues

Enterostomal Therapy Nurse or Certified Wound, Ostomy, Continence Nurse : Often referred to as "ET nurse." Nurse who provides Care expertise to patients with abdominal stomas, draining wounds and fistulas, incontinence and general wound care.

Terminology (cont)

Epidermis: The outer cellular layer of the skin

Epiboly: edges of the top layer of the epidermis roll down to cover lower edge of epidermis, causing the inability of epithelial cells to migrate from wound edges. Wound healing cannot take place in this circumstance.

Epithelialization : Regeneration of the epidermis across a wound surface

Erythema: Redness of the skin surface produced by widening of the blood vessels.

Eschar: Thick, leathery dead or devitalized tissue.

Etiology: The science and study of the causes of diseases and their mode of operation.

ET nurse: Commonly used term for an Enterostomal Therapy Nurse.

Excoriation: Linear scratches on the skin.

Exudate: Accumulation of fluids in a wound.

Continued

Fenestrated: sliced or cut open

FibrousTissue: Tightly bound yellow film found on the granulation tissue surface composed of or containing fibroblasts

Friable: refers to a delicate wound that may bleed easily

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

Full Thickness Wound: Tissue destruction extending through the dermis to involve subcutaneous tissue and possibly muscle/bone.

Granulation Tissue: The formation or growth of small blood vessels and connective tissue in a full thickness wound and a stage 3 and 4 pressure ulcer: beefy red, shiny, granular tissue which generally indicates healing.

Growth Factors: refers to naturally occurring substances capable of stimulating cellular growth and proliferation

Hydrophilic: Attracting moisture

Hydroactive: Activated by moisture

Hypertonic: movement of water from a high H2O concentration inside the cell, to a low H2O concentration outside the cell. Hypertonic wound dressings pull water or exudate out of an area and create a moist environment that is more conducive to wound healing.

Hypergranulation: Increased thickness in the granular layer of the epidermis.

Ionic exchange: Denotes the processes of purification, separation, and decontamination.

Infection: Overgrowth of microorganisms capable of tissue destruction and invasion, accompanied by local or systemic symptoms

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Continued (cont)

Inflammation: Defensive reaction to tissue injury: involves increased blood flow and capillary permeability Signs and symptoms include heat, redness, swelling and pain of the affected area.
Inflammatory Phase: The first phase in the normal wound healing process that lasts approximately from time of the initial injury to four days post injury.
Ischemia: A deficiency of blood supply due to functional constriction or obstruction of a blood vessel.
Maceration: A “waterlogged” appearance of the area surrounding a wound which is an indication of excessive moisture or an inappr-opriate dressing or dressing application.
Macrophage: “Giant Eater:” eats up unwanted dead tissue, cleans the wound and releases chemicals.
Mechanical Debridement: The removal of dead or devitalized tissue, for example by the use of wet:**to:**dry dressings, whirlpool or surgical debridement.
Moisture Retentive Dressings: Dressings that allow wounds to remain moist.
MMP’s: Enzymes in chronic wounds which when imbalanced with their natural inhibitors can become destructive and delay the healing process.
Necrotic: Dead
Negative pressure: a vacuum:**action that is used to reduce pressure around a wound, drawing out excess fluids and cellular wastes.
Nonocclusive: Allowing the passage of moisture and air
Occlusive: A dressing that prevent the passage of air that can dry out a wound bed or to prevent unwanted or unneeded moisture from going into or out of an area.
Osmotic: relating to osmosis: a physical process in which a solvent moves, without input of energy, across a semi:**permeable membrane. This term relates to movement of wound fluid from one place to another.
Osteomyelitis: Inflammation of the bone marrow and adjacent bone.
Partial Thickness Wound : Tissue destruction through the epidermis extending into but not through the dermis.
Periwound: Around the wound
Permeability: Ability to pass through
Pressure Ulcer: An area of localized damage caused by ischemia due to pressure.
Serous: Producting a serous secretion or containing serum
Sinus tract: A pathway which can extend in any direction from the wound surface resulting in dead space
Sodium Hypochlorite: a chemical compound frequently used as a disinfecting agent

Continued (cont)

Slough: Necrotic tissue that is usually loose, stringy, yellow, tan, white or gray in color.
Shear: Trauma caused by tissue layers sliding against each other.
Stasis: Stagnation of blood caused by venous congestion.
Staging: An anatomical description of depth used to describe pressure ulcers.
Surgical Debridement: The removal of dead or devitalized tissue by a physician or trained healthcare professional at the bedside or in the operating room.
Tunneling: Tissue destruction underlying intact skin along wound margins.
Ulcer: An open lesion or sore
Undermining: Another term used to describe **tunneling:** tissue destruction underlying intact skin along wound margins
Vasoconstriction: Dilation of blood vessels
Vasodilation Dilation of blood vessels
Venous : pertaining to the veins.
Venous Ulcer: Local losses of epidermis and variable levels of dermis and subcutaneous tissue occuring over or near the ankle and/or lateral lower leg.
WOCN: An acronym for Wound, Ostomy, Continence Nurse

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