20.15: XX Glossary

**Angiogenesis:** The development of new capillaries in a wound base.

**Arterial ulcers:** Ulcers caused by lack of blood flow and oxygenation to tissues and typically occur in the distal areas of the body such as the feet, heels, and toes.

**Debridement:** The removal of nonviable tissue in a wound.

**Dehiscence:** The separation of the edges of a surgical wound.

**Diabetic ulcers:** Ulcers that typically develop on the plantar aspect of the feet and toes of patients with diabetes due to lack of sensation of pressure or injury.

**Ecchymosis:** Bruising that occurs when small veins and capillaries under the skin break.

**Edema:** Swelling.

**Epithelialization:** The development of new epidermis and granulation tissue.

**Erythema:** Redness.

**Eschar:** Dark brown/black, dry, thick, and leathery dead tissue in a wound base that must be removed for healing to occur.

**Exudate:** Fluid that oozes out of a wound; also commonly called pus.

**Granulation tissue:** New connective tissue in a wound base with fragile, thin-walled capillaries that must be protected.
**Hematoma:** An area of blood that collects outside of larger blood vessels.

**Hemosiderin staining:** Dark-colored discoloration of the lower legs due to blood pooling.

**Hemostasis phase:** The first phase of wound healing that occurs immediately after skin injury. Blood vessels constrict and clotting factors are activated.

**Induration:** Area of hardened tissue.

**Inflammatory phase:** The second phase of wound healing when vasodilation occurs so that white blood cells in the bloodstream can move into the wound to start cleaning the wound bed.

**Maceration:** The softening and wasting away of skin due to excess fluid.

**Maturation phase:** The final phase of wound healing as collagen continues to be created to strengthen the wound, causing scar tissue.

**Necrotic:** Black tissue color due to tissue death from lack of oxygenation to the area.

**Nonblanchable erythema:** Skin redness that does not turn white when pressure is applied.

**Osteomyelitis:** Bone infection.

**Peripheral neuropathy:** A condition that causes decreased sensation of pain and pressure, typically in the lower extremities.

**Periwound:** The skin around the outer edges of a wound.

**Pressure injuries:** Localized damage to the skin or underlying soft tissue, usually over a bony prominence, as a result of intense and prolonged pressure in combination with shear.^[1]\(^{[1]}\)

**Primary intention:** Wound healing that occurs with surgical incisions or clean-edged lacerations that are closed with sutures, staples, or surgical glue.

**Proliferative phase:** The third phase of wound healing that includes epithelialization, angiogenesis, collagen formation, and contraction.

**Purulent drainage:** Wound exudate that is thick and opaque and can be tan, yellow, green, or brown in color. It is never considered normal in a wound, and new purulent drainage should always be reported to the health care provider.

**Sanguineous drainage:** Wound drainage that is fresh bleeding.

**Secondary intention:** Wound healing that occurs when the edges of a wound cannot be approximated (brought together), so the wound fills in from the bottom up by the production of granulation tissue. Examples of wounds that heal by secondary intention are pressure injuries and chainsaw injuries.

**Serosanguinous drainage:** Wound exudate contains serous drainage with small amounts of blood present.
Serous drainage: Wound drainage that is clear, thin, watery plasma. It is considered normal in minimal amounts during the inflammatory stage of wound healing.

Shear: A mechanical force that occurs when tissue layers move over the top of each other, causing blood vessels to stretch and break as they pass through the subcutaneous tissue.

Skin tears: Wounds caused by mechanical forces, typically in the nonelastic skin of older adults.

Slough: Inflammatory exudate that is light yellow, soft, and moist and must be removed for wound healing to occur.

Tertiary intention: Wound healing that occurs when a wound must remain open or has been reopened, often due to severe infection.

Tunneling: Passageways underneath the surface of the skin that extend from a wound and can take twists and turns.

Undermining: A condition that occurs in wounds when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound’s edge.

Unstageable: Occurs when slough or eschar obscures the wound so that tissue loss cannot be assessed.

Venous insufficiency: A medical condition where the veins in the legs do not adequately send blood back to the heart, resulting in a pooling of fluids in the legs that can cause venous ulcers.

Venous ulcers: Ulcers caused by the pooling of fluid in the veins of the lower legs when the valves are not working properly, causing fluid to seep out, macerate the skin, and cause an ulcer.

Wound vac: A device used with special foam dressings and suctioning to remove fluid and decrease air pressure around a wound to assist in healing.