10.9: X Glossary

**Angiogenesis:** The process of wound healing when new capillaries begin to develop within the wound 24 hours after injury to bring in more oxygen and nutrients for healing.

**Approximated edges:** The well-closed edges of a wound healing by primary intention.

**Arterial insufficiency:** A condition caused by lack of adequately oxygenated blood supply to specific tissues.

**Braden Scale:** A standardized assessment tool used to assess and document a patient’s risk factors for developing pressure injuries.

**Deep tissue pressure injuries:** Persistent; non-blanchable; deep red, maroon, or purple discoloration of intact or nonintact skin revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin.

**Dehiscence:** The separation of a surgical incision.

**Dermis:** The layer of skin underneath under the epidermis, containing hair follicles, sebaceous glands, blood vessels, endocrine sweat glands, and nerve endings.

**Epidermis:** The very thin, top layer of the skin that contains openings of the sweat gland ducts and the visible part of hair known as the hair shaft.

**Epithelialization:** The development of new epidermis and granulation tissue in a healing wound.

**Eschar:** Dark brown/black, dry, thick, and leathery dead tissue in wounds.
**Excoriation:** Redness and removal of the surface of the topmost layer of skin, often due to maceration or itching.

**Friction:** The rubbing of skin against a hard object, such as the bed or the arm of a wheelchair. This rubbing causes heat that can remove the top layer of skin and often results in skin damage.

**Granulation tissue:** New connective tissue in a healing wound with new, fragile, thin-walled capillaries.

**Hemostasis phase of wound healing:** The first stage of wound healing when clotting factors are released to form clots to stop the bleeding.

**Hypodermis:** The bottom layer of skin, also referred to as the subcutaneous layer, consisting mainly of adipose tissue or fat, along with some blood vessels and nerve endings. Beneath this layer lies muscles, tendons, ligaments, and bones.

**Impaired skin integrity:** Altered epidermis and/or dermis.

**Impaired tissue integrity:** Damage to deeper layers of the skin or other integumentary structures. The NANDA-I definition of impaired tissue integrity is, “Damage to the mucous membrane, cornea, integumentary system, muscular fascia, muscle, tendon, bone, cartilage, joint capsule, and/or ligament.”

**Inflammatory phase of wound healing:** The second stage of healing when vasodilation occurs to move white blood cells into the wound to start cleaning the wound bed.

**Maceration:** A condition that occurs when skin has been exposed to moisture for too long causing it to appear soggy, wrinkled, or whiter than usual.

**Maturation phase:** The final stage of wound healing when collagen continues to be created to strengthen the wound and prevent it from reopening.

**Necrosis:** Tissue death.

**Necrotic:** Dead tissue that is black.

**Nonblanchable erythema:** Skin redness that does not turn white when pressed.

**Osteomyelitis:** Bone infection.

**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.

**Primary intention:** A type of wound that is sutured, stapled, glued, or otherwise closed so the wound heals beneath the closure.

**Proliferative phase of wound healing:** The third stage of wound healing that begins a few days after injury and includes four processes: epithelialization, angiogenesis, collagen formation, and contraction.

**Purulent:** Drainage that is thick; opaque; tan, yellow, green, or brown in color. New purulent drainage should always be
reported to the health care provider.

**Sanguineous:** Drainage from a wound that is fresh bleeding.

**Secondary intention:** A type of healing that occurs when the edges of a wound cannot be brought together, so the wound fills in from the bottom up by the production of granulation tissue. An example of a wound healing by secondary intention is a pressure ulcer.

**Serosanguinous:** Serous drainage with small amounts of blood present.

**Serous:** Drainage from a wound that is clear, thin, watery plasma. It’s normal during the inflammatory stage of wound healing, and small amounts are considered normal wound drainage.

**Shear:** Damage 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.

**Slough:** Inflammatory exudate in wounds that is usually light yellow, soft, and moist.

**Stage 1 pressure injuries:** Intact skin with a localized area of nonblanchable erythema where prolonged pressure has occurred.

**Stage 2 pressure injuries:** Partial-thickness loss of skin with exposed dermis. The wound bed is viable and may appear like an intact or ruptured blister.

**Stage 3 pressure injuries:** Full-thickness tissue loss in which fat is visible, but cartilage, tendon, ligament, muscle, and bone are not exposed. The depth of tissue damage varies by anatomical location. Undermining and tunneling may be present. If slough or eschar obscures the wound so that tissue loss cannot be assessed, the pressure injury is referred to as unstageable.

**Stage 4 pressure injuries:** Full-thickness tissue loss like Stage 3 pressure injuries but also have exposed cartilage, tendon, ligament, muscle, or bone.

**Tertiary intention:** The healing of a wound that has had to 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 pressure injuries:** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

**Venous insufficiency:** A condition that occurs when the cardiovascular system cannot adequately return blood and fluid from the extremities to the heart.