

Wound terms and definitions



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Effective communication between disciplines and between geographic areas is critical for quality care. Yet, different definitions may be used for the same term. In 2015, JWCET will include common wound, ostomy and incontinence-related terms and definitions. These will also be available on the WCET website. If you use a different definition or have other terms, please send them to me at editor@wcetn.org so we can include them. Be sure to include the reference. This journal has wound terms and definitions. June and September will have ostomy terms and definitions. December will focus on incontinence.

WOUND TYPE	
Pressure ulcer	A pressure ulcer is localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated ¹ . And/or
	A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s) ¹ . Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers ² .
Stage I	Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour 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 ¹ . And/or
	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 parameters: <ul style="list-style-type: none"> • Skin temperature (warmth or coolness); • Tissue consistency (firm or boggy); • Sensation (pain, itching). And/or 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 ² .
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 or serosanguineous-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence-associated dermatitis, maceration or excoriation. * Bruising indicates deep tissue injury ¹ . And/or
	Partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater ² .

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. <i>May</i> include undermining and tunnelling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable ¹ . And/or
	Full-thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
Stage IV	Full-thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable ¹ . And/or
	Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.
Unstageable	Full-thickness skin or tissue loss — depth unknown Full-thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. 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 ¹ .
Suspected deep tissue injury (sDTI)	Purple or maroon localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or <i>shear</i> . 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 ¹ .
Avoidable pressure ulcers	Avoidable means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate
Unavoidable pressure ulcer	Unavoidable means that the resident developed a pressure ulcer even though the facility had evaluated the resident’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.
Arterial	Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus ² . Ulceration occurs as the result of arterial occlusive disease when non–pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis. And/or
	A wound which results from inadequate arterial blood supply or flow. Frequently, these wounds are located on the distal extremities ² .



Venous	Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg ² (previously known as “stasis ulcer”) is an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pretibial area of the lower leg or above the medial ankle. Venous ulcers are reported to be the most common vascular ulceration and may be difficult to heal, may occur off and on for several years, and may occur after relatively minor trauma. The ulcer may have a moist, granulating wound bed, may be superficial, and may have minimal to copious serous drainage unless the wound is infected. The resident may experience pain which may be increased when the foot is in a dependent position, such as when a resident is seated with her or his feet on the floor ² . And/or
	Ulcerations related to venous hypertension.
Diabetic	Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Requires a diagnosis of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load-bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful ² .
	Wound on the foot of a diabetic individual. About 60–70% is associated with loss of protective sensation, caused by pathology commonly associated with the disease, such as peripheral neuropathy ³ .
Skin tear	Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full-thickness ² . And/or
	Traumatic peeling away of the epidermis from the dermis ³ .
Moisture-associated damage	Moisture-associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. MASD is also referred to as incontinence dermatitis ² .
Burn	Skin and tissue injury caused by heat or chemicals and may be in any stage of healing ² .
Surgical	Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites ² .
Rash	Can range from redness of the skin or small red bumps to swelling, redness, and larger blisters. Can be from multiple causes ³ .
Trauma	(Abrasion) Caused by friction against rough surface; superficial; for example, road rash — lines of scraped skin with tiny spots of bleeding ³ .
Cut	(Laceration) A torn or jagged wound, tear. Caused by blunt trauma (such as a blow, fall, or collision; little or profuse bleeding; ragged edges do not readily line up ⁴ .
Mixed	A wound that has a combination of types such as diabetic foot ulcer on an area of pressure.
Other	Any wound not contained in the list.

WOUND LOCATION

Sacrum	Large triangular bone situated at the lower part of the vertebral column and at the upper rear portion of the pelvic cavity where it is inserted like a wedge between the two innominate bones (the two large flat bones that form the sides of the pelvic cavity) ³ .
Buttocks	Large fleshy mass of the posterior lower trunk. It is composed of the gluteus maximus, medius and minimus along with other smaller muscles. It defines the body surface from the lower lateral edge of the sacrum moving laterally to the crest of the ilium (boney ridge top of the os inominatum bone. When viewing a skeleton, this os inominatum bone and its counterpart form the large flat sides of the pelvic cavity. The bone is actually three parts fused during growth, the Ilium, Ischium and Os Pubis) and downward to the top/proximal posterior thigh forming a skin fold or “c” shape tissue structure ³ .

Coccyx	Boney, beak-like shaped structure at the distal end of the sacrum. It is usually four small segments of bone. It serves as ligamentous attachment for the gluteal region muscles and the Levator Ani muscle. It is the boney surface that can be palpated in the gluteal cleft ³ .
Ischial tuberosity	Is the distal end of the Ischium (the large lower back part of the os inominatum). It is the large rounded eminence/boney protrusion on which the trunk rests when in the sitting position ³ .
Lower leg	The portion of the lower extremity from the distal half of the knee joint to the proximal portion of the ankle joint encompassing the tibia and fibula ³ .
Ankle	The portion of the lower extremity from the superior aspect of the medial and lateral malleolus (“ankle bone”) to the inferior aspect of the same, circumferentially ³ .
Heel	The posterior portion of the foot from the mid-point of the malleolus posterior to the end of the calcaneus bone ³ .
Foot	The boney structure from the inferior aspect of the malleolus distally to the end of the phalanges. Two surfaces: Dorsum (top), Plantar (bottom) ³ .
Plantar foot	The portion of the foot that is used as the weight-bearing surface when standing or walking ³ .
Toes	Five digits composed of three segments of bones each, extending from the main portion of the foot. Dorsum is the upper/top surface and plantar is the weight-bearing surface ³ .
Abdomen	The anterior surface of the trunk from the xyphoid process (distal end) of the sternum distally to the superior aspect of the suprapubic region ³ .
Back	The posterior aspect of the trunk from the upper aspect of the posterior shoulder and base of the neck distally to the level of the sacrum ³ .
Head	Head/skull is supported on the summit of the vertebral column and is oval-shaped, wider in the back than in the front. It is divided into two parts: cranium that encases the brain and the face. The head begins at the point of movement on the spine and progresses superiorly/upward to the apex/top and then distally over the face over the lower jaw bone/mandible ³ .
Neck	Circumferentially that portion of the spine from the base of the skull to the level of the superior aspect of the trunk. This section has anterior, lateral and posterior aspects ³ .
Ear	The cartilaginous protrusion (pinna or auricle) on the lateral aspect of the head. This section has anterior, posterior, superior and inferior aspects. Note: Pressure ulcers on this surface rapidly progress from Stage I to Stage III/IV due to the absence of subcutaneous tissue ³ .
Face	The anterior portion of the skull superiorly from the hairline distally to the level of the lower jaw and laterally to the small triangular protrusion at the most anterior aspect of the ear (eminentia triangularis) ³ .
Nose	A triangular form that is directed downward and projects from the center of the face, immediately above the upper lip. Its summit or root is connected directly with the forehead. The lateral lower surfaces (nares/nostrils) are of varied shape in each individual and terminate in a rounded eminence, ala nasi. Note: Pressure ulcers on this surface rapidly progress from Stage I to Stage III/IV due to the absence of subcutaneous tissue, especially on the bridge of the nose ³ .
Mouth	The oral or buccal cavity is two parts: an outer smaller portion, the vestibule and an inner, larger part, the cavity proper of the mouth. It is a slit-like aperture, bounded in front and laterally by the lips and cheeks; behind and internally by the gums and mouth. Above and below it is limited by the reflection of the mucous membrane from the lips and cheeks to the gum covering the upper and lower alveolar arch (the part of the upper or lower jawbones in which the teeth are set) respectively ³ .
Forearm	That portion of the upper extremity, which is situated between the elbow and the wrist. Its skeleton is composed of two bones, the radius and the ulna. The surface when the palm is facing upward is the called volar and when the palm is facing down is called the dorsum. The wrist is the joint juncture of the distal radius and ulna with the bones of the hand ³ .



Hand	The hand is three sections of bones; eight Carpus (Carpal) bones at the wrist, five Metacarpus (Metacarpal) bones forming the palm and the fourteen Phalanges which form the five digits (fingers). The palmer surface is called volar and opposite surface like the forearm is called dorsum ³ .
Fingers	The digit/finger visually begins at the web-space of the palm and continues to the end including the nail on the dorsum ³ .
WOUND ASSESSMENT	
Dimensions	
Length	Measurement of longest length from head to toe (12–6). ²
Width	Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length ² .
Depth	Measurement of the deepest aspect of the wound to the skin level ² .
TISSUE PRESENT IN WOUND	
Epithelial	New skin that is light-pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the centre and edges of the ulcer. In full-thickness, Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound ² .
Granulation (red)	Pink or red tissue with “cobblestone” or bumpy appearance, moist granular appearance, bleeds easily when injured ² .
Slough (yellow)	Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed ² .
Fibrinous (white)	May appear prior to wound opening; skin surface is white or grey ² .
Eschar (black)	Dead or devitalised tissue that is hard or soft in texture; usually black, brown, or tan in colour, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound ² .
Bone	Shiny, smooth, milky white appearance when healthy ⁴ .
Muscle	Pink to dark red, firm, highly vascular, striated ⁴ .
Tendon	Gleaming yellow or white, shiny when healthy, strong fibrous tissue, attaches muscle to bone ⁴ .
Other	Any wound tissue that is present and not previously described.
WOUND EXUDATE	
Exudate	Accumulated fluid in a wound ⁵ .
EXUDATE DESCRIPTORS	
Sanguineous	Bloody ⁵ .
Serous	Clear or pale yellow fluid ⁵ .
Sero/Sanguineous	Serous and blood tinged ⁵ .
Purulent	Pus made up of inflammatory cell and tissue debris often is green/brown or yellow ⁵ .
EXUDATE AMOUNT DESCRIPTORS	
Scant	Tiny amount noted when dressing is removed ⁵ .
Minimal	Small amount detectable when dressing removed less than 33% of the dressing surface ⁵ .
Moderate	Exudate is covering less than 67% of the dressing surface May soak through secondary dressing ⁵ .
Large	Exudate is covering more than 67% of the dressing surface. Dressing is often saturated and may be soaked through secondary dressing ⁵ .
Wound odour	Strong, foul, pungent, faecal, musty, sweet smell, noticeable AFTER wound has been cleaned ⁵ .

WOUND'S MARGINS/EDGES

Regular	Well-defined, attached tissue ⁵ .
Irregular	Undefined, macerated or varying in consistency ⁵ .
Not attached	Sides or walls are present; floor or base of wound is deeper than edge ⁵ .
Rolled under (Epibole)	Epithelial tissue migrates down sides of the wound instead of across. Edges that roll over will ultimately cease in migration secondary to contact inhibition once epithelial cells of the leading edge come in contact with other epithelial cells ⁴ .
Callous	(Hyperkeratosis) callous-like tissue formation around wound and at edges ⁴ .
Undermining	The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface ² .
Tunnelling	A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound ² .

REFERENCES

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