

Wound Terminology

- ▶ **Pressure Injury:** Localized damage to skin and underlying soft tissue usually over a bony prominence or related to a medical or other device; occurs as results of intense and/or prolonged pressure or pressure in combination with shear.
 - **Stage 1 Pressure Injury:** Non-blanchable erythema/redness, intact skin.
 - **Stage 2 Pressure Injury:** Partial thickness loss of dermis presenting as shallow open ulcer with red, pink wound bed, without slough; may also present as intact or open serum filled blister.
 - **Stage 3 Pressure Injury:** 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 depth; may include undermining and tunneling.
 - **Stage 4 Pressure Injury:** Full thickness loss with exposed bone, tendon, or muscle; slough or eschar may be present on some parts; often has undermining and tunneling.
 - **Unstageable Pressure Injury:** Full thickness tissue loss in which base of ulcer is covered (>50%) by slough and/or eschar.
 - **Deep Tissue Injury (DTI):** Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage or underlying soft tissue from pressure and/or shear.
 - **Medical Device Related Pressure Injury:** Results from the use of medical devices. The resultant injury generally conforms to the pattern or shape of the device.
 - **Mucosal Pressure Injury:** Mucosal pressure injury found on mucous membranes with a history of medical device in use at the location of the injury. Cannot be staged due to the anatomy of tissues.
- ▶ **Moisture Associated Skin Damage:** Inflammation and erosion of the skin caused by prolonged exposure to vapors sources of moisture, including urine or stool, perspiration, wound exudate, mucus, or saliva.
 - **Intertriginous (ITD):** Perspiration or moisture trapped in skin folds.
 - **Peristomal:** Urine, stool, chemical irritants and this with pH extremes, mechanical injury.
 - **Periwound:** Wound exudate, varies types of chemical irritants, pH extremes, mechanical injury (point of entry - organisms).
 - **Incontinence Associated Dermatitis (IAD):** Urine and stool.
 - **Irritant contact dermatitis (ICD):** Triggered by exposure to irritant such as rubbing alcohol, bleach, solvents, deodorants, soaps, cosmetics, fragrances, plants; erythema, edema, vesicles; TEWL normalizes in 6-12 days.
 - **Allergic contact dermatitis (ACD):** Immune related inflammatory response.
- ▶ **Skin Tear:** Traumatic wound caused by mechanical forces.
 - **Type 1 Skin Tear:** Skin tear: full thickness; can be fully approximated.
 - **Type 2 Skin Tear:** Skin tear: scant, moderate, or large tissue loss.
 - **Type 3 Skin Tear:** Skin tear partial thickness wound without epidermal flap present.
- ▶ **Abrasion:** Wearing away of the skin through some mechanical process (friction or trauma).

- ▶ **Cellulitis:** Painful especially with palpation, progressing erythema, inflammation/warmth, no crusting, port of entry present, unilateral, fever, leukocytosis.
- ▶ **Debridement:** Removal of foreign material and dead tissue from a wound.
- ▶ **Denuded/Eroded:** Skin gone via chemical means (urine, feces, sweat, exudate, etc.).
- ▶ **Dermatitis:** Itching, erythema/hyperpigmentation, inflammation, vesicles/crusting/scaling, no port of entry, unilateral/bilateral, no fever, weeping.
- ▶ **Epibole:** Rolled or curled under edges, premature closure, often in longstanding wound.
- ▶ **Epithelialization:** Process of epithelial cells migrating from wound margin or from hair follicles to complete wound healing causing a pink to lavender color.
- ▶ **Eschar:** Necrotic or non-vital tissue; appearance of leathery black or brown; can be soft, firm, adherent, or loose.
- ▶ **Excoriation:** Linear epidermal abrasion caused by scratching.
- ▶ **Friction:** The force of rubbing two surfaces against one another.
- ▶ **Fungal/yeast infection:** Erythematous, macular/papular, non-follicular pustules and satellite lesions outside advancing edge, maceration, burning and itching.
- ▶ **Granulation Tissue:** Formation of connective tissue and many new capillaries, red, moist, and looks bumpy/rough in appearance.
- ▶ **Hypergranulation:** Overgrowth of granulation tissue that often appears pale or deep red, boggy and friable.
- ▶ **Laceration:** A deep cut or tear.
- ▶ **Lesion:** A region in an organ or tissue which has suffered damage through injury or disease, such as ulcer, abscess, or tumor.
- ▶ **Maceration:** Softening and breaking down of the skin due to prolonged exposure to moisture. Often appears white or lighter in color than the skin next to it.
- ▶ **Medical Adhesive Related Skin Injury (MARS):** Top down skin injury. Erythema and or other manifestation of cutaneous abnormality persists 30 minutes or more after removal of adhesive dressings and tapes.
- ▶ **Neuropathic/diabetic Ulcer:** Ulcer caused by damage to nerves interfering with communication between brain/spinal cord and lower legs/feet. Plantar aspect of feet. Punched out appearance.
- ▶ **Satellite Lesions:** Extensions of red macular-papular rash that appears as red pinpoint papules or pustules nearby or outside the primary rash.
- ▶ **Shear:** A gravity force pushing down on the patient's body with resistance between the patient and the chair or bed.
- ▶ **Slough:** Consists of avascular (necrotic or non-vital) tissue, serous exudate, bacteria, fibrin, cell debris, intact leukocytes; soft, moist; it may be white, yellow, tan; firm or loosely adherent.
- ▶ **Tunneling:** A narrow opening or passage-way that can extend in any direction through soft tissue and result in dead space with potential abscess formation.
- ▶ **Ulcer:** Loss of skin with definite edges.
- ▶ **Undermining:** The destruction of the underlying tissue surrounds some or all of the wound margins. May extend in one or many directions underneath the wound edges.
- ▶ **Vascular ulcers:** Ulcer with acute pain, palpable purpura (raised non-blanchable erythema), typically on lower legs.

► **Wound:** Break in the skin.

Ulcer Characteristics			
	Venous	Arterial	Neuropathic
Location	Lower extremities anywhere between ankles and knees or typical gaiter area or medial malleolus	Tips of toes; pressure points of foot/ankle, areas of trauma	Plantar aspect of feet over pressure points and deformities; common location is interphalangeal joint of great toes and 1 st and 5 th metatarsal heads
Wound Base and Edge and Peri-wound	Irregular shape, shallow ruddy red color, yellowish, slough, granulation	Usually small shape with varying depth and possible tunnels; wound base is pale or minimal, with varying degrees of necrotic tissue, well defined and smooth wound edge	Punched out appearance, wound base varies, callus usually around wound bed
Exudate	Moderate to large exudate	Often dry with minimal exudate	Small to moderate exudate
Other Considerations	Systemic infection uncommon; pitting edema; pain is dull/aching and improves with elevation of lower extremities; dry scaly skin	Infection common; pain worsens with elevation; no edema; thick nails; sparse or no hair; shiny skin	Infection common; neuropathic pain; charcot foot; thickened nails
Treatment	Compression is ideal therapy	Revascularization via bypass surgery with vein graft is ideal; avoid leg elevation	Offloading is first priority; total contact casting ideal treatment
Diagnostic	ABI or TBI; Venous Duplex Ultrasound	ABI and TBI; Arterial Duplex Ultrasound	TBI

Differentiating Between MASD and Pressure Injuries		
	MASD	Pressure Injuries
Location	Diffusely distributed	Usually over bony prominence
Color	Pink or red	Red to bluish/purple
Depth	Partial thickness, blistering	Partial or full thickness
Necrosis	No slough or eschar	Without or without slough or eschar
Pain	Yes	May or may not be present

Pressure Injury	Bottom up skin injury: Localized damage to skin and underlying soft tissue usually over a bony prominence or related to a medical or other device; can present as intact skin or open ulcer and may be painful; occurs as results of intense and/or prolonged pressure or pressure in combination with shear; the tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and conditions of soft tissue.
Stage 1: Non-blanchable erythema	Intact skin, non-blanchable redness; may be painful, soft, warmer or cooler
Stage 2: Partial thickness skin loss	Partial thickness loss of dermis presenting as shallow open ulcer with red pink wound bed, without slough; may also present as intact or open serum filled blister Presents as shiny or dry shallow ulcer without slough or bruising
Stage 3: Full thickness skin loss	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 depth; may include undermining and tunneling Depth varies by anatomical location; nose bridge, ear, occiput, and malleolus do not have subq tissue; can also be very deep without bone, tendon, and muscle exposure
Stage 4: Full thickness tissue loss	Full thickness loss with exposed bone, tendon, or muscle; slough or eschar may be present on some parts; often has undermining and tunneling Depth varies on location; can extend into supporting structures making osteomyelitis possible
Unstageable: Depth unknown	Full thickness tissue loss in which base of ulcer is covered by slough and/or eschar Until enough slough/eschar is removed wound cannot be staged
Deep Tissue Pressure Injury (DTPI)	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage or underlying soft tissue from pressure and/or shear

Moisture Associated Skin Damage (MASD)	Top down skin injury (outer layers of skin are damaged first): Inflammation and erosion of the skin caused by prolonged exposure to vapors sources of moisture, including urine or stool perspiration, wound exudate, mucus, or saliva
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Peristomal	Urine, stool, chemical irritants and this with pH extremes, mechanical injury
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