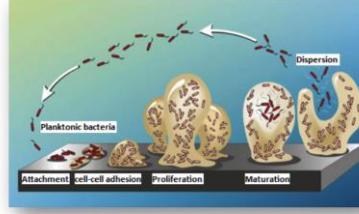


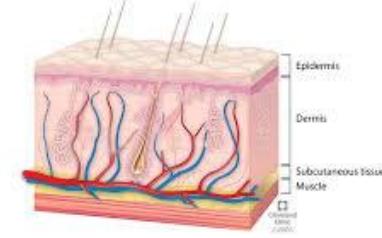
| Terminology and relevance | Explanation | Images / Links / Videos |
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| Acute wounds | Wounds that heal without complication. | |
| Ankle Brachial Pressure Index ABPI | ABPI is a test used to measure the arterial blood flow into the lower leg. It is taken using a hand-held ultrasound machine known as a Doppler. |  |
| Ankle flare | Distended veins in foot arch or ankle region and a sign of venous stasis |  |
| Antimicrobial | A term used to encompass antibiotics and antiseptics. They are used to reduce/control infection. | |
| Arterial leg ulcer | Also known as ischaemic ulcers. Wounds on the lower leg, usually on the feet. Caused by lack of blood flow to tissue in the leg |  |

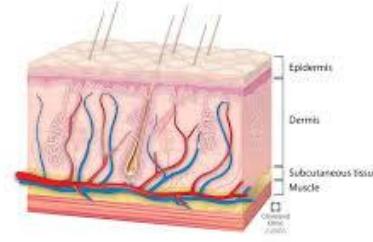
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| Aseptic | Free from contamination caused by harmful bacteria, viruses, or other microorganisms. Precautions are taken to prevent cross-contamination of microorganisms from health professionals, other patients, equipment or the environment. |  |
| Atrophy blanche | A type of scarring occurring in lower limb venous insufficiency which presents as ivory/white depressed areas on the skin with small red blotches within the white area. |  |
| Biofilm | A protective coating over bacteria or other microbes. Biofilms can grow anywhere with the right conditions. In wound care they can be a problem in open wounds and/or on medical devices such as catheters or artificial joints. Bacteria growing as a biofilm are hard to treat with antibiotics. They cannot be seen with the naked eyes |  |
| Burn depth classification | A grading system to calculate depth of the burn to determine the level of tissue damage. | |

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| Cavity wound | A cavity wound is defined as a wound that extends beneath the dermis, potentially exposing underlying structures such as fascia, tendons, muscle and bone |  |
| Cellulitis | An acute infection of the skin which needs urgent medical treatment. It presents as redness, heat, swelling, pain on the effected areas of skin. |  |
| Charcot foot | A neuropathic condition of the foot where there is joint destruction and inflammation. More likely to be seen in people with diabetes but can affect others. This increases the riks of pressure in the foot over bony prominences. Wounds can form over these areas. Often treated with pressure off-loading. |  |

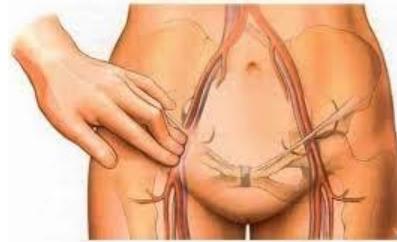
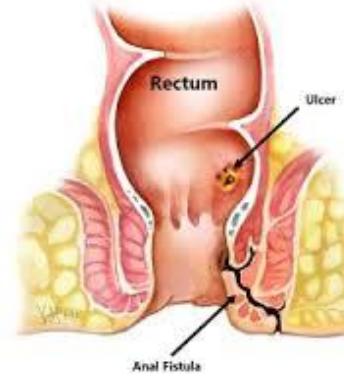
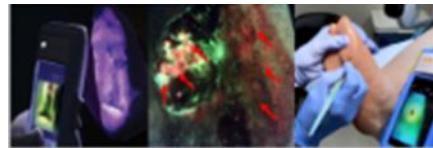
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| Chronic disease | Conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Examples: diabetes, heart failure, chronic obstructive pulmonary disease. | |
| Chronic wound | A wound that fails to progress through a normal, orderly, and timely sequence of repair, or in which the repair process fails to restore anatomic and functional integrity after three months. |  |
| Co-morbidities | Other diseases or medical conditions that the person has as well as the presenting disease. For example the person has a leg ulcer but also has Diabetes, heart failure and anaemia. These co-morbid conditions will likely be detrimental to healing. | |

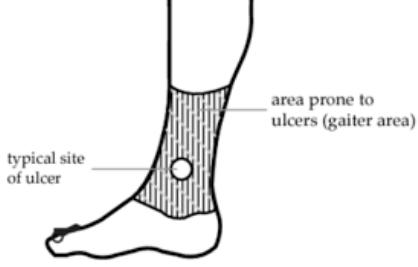
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| Compression bandaging | <p>The application of specialised bandages to provide graduated compression up the leg to improve venous return.</p> |  |
| Compression hosiery | <p>The application of specialised compression stockings to provide graduated compression up the leg to improve venous return.</p> |  |
| Debridement | <p>Removal of non-viable tissue in the wound base eg slough and necrosis. Types of debridement include: sharp using a scalpel, autolytic using dressings to create an environment for the body to self-debride, larval using fly larvae or mechanical where physically removed with pads.</p> |  |

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| Dermatitis | Describes skin inflammation and irritation usually leading to itchy, dry skin or a rash. Sometimes referred to as eczema. |  |
| Dermis | Layer of skin found underneath the epidermis. It contains nerves, capillaries, lymphatics, hair follicles and sebaceous glands. It is waterproof, highly flexible and strong. |  |
| Diabetic foot | A term commonly used to classify people with diabetes who have foot complications from diabetes. These may be related to neuropathy (loss of sensation), ischaemia (lack of arterial blood flow) and infection. |  |

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| Epidermis | The outer most layer of the skin above the dermis. To appreciate the depth – it can be seen as the covering of a fluid filled blister. |  |
| Epithelializing islands within wound | Appears as pearly pink tissue growing as islands within the wound bed. This only present in partial thickness wounds. This demonstrates healing. | |
| Epithelial margins | Appears as pearly pink tissue growing at wound margins (edge of wound). This demonstrates the wound is healing at the margins. |  |
| Erythema | Redness of the skin eg red area around an inflamed wound. It is caused by dilation of superficial blood vessels in skin. |  |

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| Eschar | The dry, hard tissue covering a wound. It often appears as a black crust. |  |
| Excoriation | An area of abraded skin where the skin has been torn or worn off | |
| Exudate | The discharge from a wound. It is produced by the body in response to tissue damage. | |
| Fascia | A thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fibre and muscle in place. Fascia is a stringy, white substance made mostly of collagen. |  |

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| Femoral pulse | A pulse in the groin used to assess blood flow into the leg. |  |
| Fistula | An abnormal connection between two body parts, such as an organ to organ, or organ to outside skin surface. Fistulas are usually the result of an injury or surgery. They often have very high discharge levels. |  |
| Fluorescence imaging in wound care | A non-invasive imaging technique that visualizes cells and molecules by attaching fluorescent dyes (fluorophores) to them, causing them to emit light when excited by a light source. In wound care it can be used to for bacterial detection to help direct treatment planning |  |

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| Foreign bodies | Organic or non-organic objects retained within a wound. It can be large object eg piece of wood or very small eg a hair. These promote infection and may lead to infection. |  |
| Fungating wound | Where a tumour growing under the skin breaks out through the skin to cause a wound. Initially these may present as blisters but as they grow can lead to open cavities or an extending tumour growth of granulation tissue. |  |
| Friable granulation | This is granulation which bleeds easily. This usually means the granulation tissue is not healthy. | |
| Gaiter area | The area between the ankle and base of calf including the whole circumference of that section of leg. |  |

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| Granulation tissue | This is the new tissue laid down in the wound base to fill the cavity. It should have a bright red, granular appearance. It is made up of new microscopic blood vessels, collagen fibrils, elastin and many other molecules. |  |
| Haemosiderin pigmentation | Reddish brown pigmentation due to deposits of haemosiderin in the lower legs as a result of venous insufficiency. |  |
| Healability | The capacity of a wound to heal | |
| Healing process | The four stages of healing – haemostasis, inflammation, proliferation and maturation | |
| Hyper-granulation | Sometimes known as over-granulation. It appears as protruding granulation that is proud of the wound surface. |  |

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| IAD - Incontinence Associated Dermatitis | Skin redness due to contact with urine, faeces or mixture of both. In more severe cases there may be superficial skin breakdown and oozing. |  |
| Ischaemia | Lack of blood flow to an area. |  |
| Ischaemic ulcer | Lack of blood to a wound. Characterised by pain, necrosis, cool to touch, lack of pulses. | |

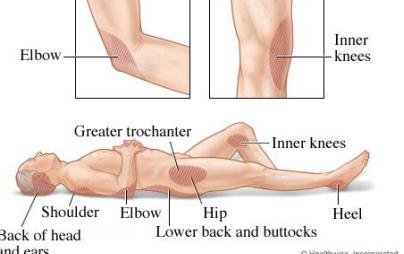
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| Lipodermatosclerosis | Related to venous insufficiency. The leg has the appearance of an inverted champagne bottle. The skin is firm and indurated. Around the ankle area. |  |
| Lymphoedema | A protein rich swelling caused by blockage or inability of the lymphatic system to drain adequately. |  |
| Macerated | Saturated skin caused by high moisture level retained on the skin. The skin has a white appearance, sometimes wrinkled. |  |

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| Maintenance of wounds | Relates to wounds having treatment that are not healable for some reason. Aim of treatment is to manage symptoms and maintain and where possible improve quality of life. | |
| Malignant wound | The underlying cause of the wound is cancer. |  |
| Malodour | Unpleasant smell from wound. Often associated with bacteria and or necrosis. | |
| MASD Moisture Associated Skin Damage | Skin damage or breakdown caused through excessive moisture against the skin eg through exudate or perspiration. |  |

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| Moisture balance | Maintaining a moist environment for wound healing. Ensuring it is not too dry or wet. |  |
| Mummified toes | |  |
| Necrotic tissue | Non-viable (dead tissue) in a wound caused by death of cells in localized area of body. May be due to inadequate blood supply, infection or trauma. |  |

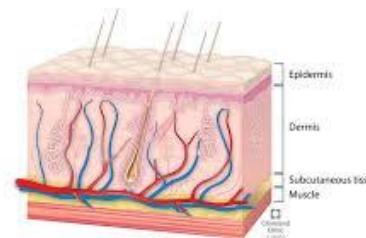
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| Necrotising fasciitis | This is a very serious infection where bacteria invade the fascia. It has a high mortality rate if not treated early. |  Te Whatu Ora Health New Zealand |
| Neuropathic ulcer | A wound on the foot related to sensory loss. May initially present as callous over a weight bearing area of the foot that then ulcerates. A common complication of diabetes. |  |
| Non-concordant | When the person is not following the advised clinical recommendations for whatever reason. | |
| NPWT Negative Pressure Wound Therapy | NPWT refers to wound dressing systems that continuously or intermittently apply sub atmospheric pressure to the surface of a wound to assist healing. |  |

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| Oedema | Abnormal swelling secondary to fluid accumulation in the tissues. |  |
| Palliative care | The focus of treatment is symptom management and maintaining or improving quality of life. | |
| Palliative wound | Relates to wounds having treatment that are not healable for some reason. Aim of treatment is to manage symptoms and maintain and where possible improve quality of life. | |
| Pathogen | A microorganism eg bacterial, fungal or viral causing infection or disease. | |
| Pedal pulses | Pulses in the foot which are felt when assessing blood flow in foot. |  |
| Peri-wound | This is the local skin surrounding the wound. It is approximately 4cm margin around the wound. | |

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| Popliteal pulse | A pulse located in the popliteal fossa (in the back of the knee) felt when assessing for lower limb blood flow. |  POPLITEAL PULSE Located in the inferior region of the popliteal fossa |
| Postnatal wound | A surgical wound at the time of the birth of a baby eg caesarean section, episiotomy. | |
| Pressure injury | Localised injury to skin and underlying tissues over a bony prominence due to sustained pressure, shear, friction or combination of these forces. |  © Healthwise, Incorporated |
| Pressure off-loading | The use of orthotic felt, splints or casts to off load pressure over bony prominences eg on the diabetic foot |  |

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| Primary intention | Wounds where the margins have been approximated and secured with sutures, staples, clips or glue. |  |
| Revascularization | Surgical operation to restore the blood flow to an area of the body. | |
| Secondary intention | When a wound is left open to heal from the base. No sutures or other materials are used to close the wound. Dressings are applied instead in order to protect the wound from contamination. |  |
| Scar - hypertrophic | A scar where the scar keeps growing but it is contained within the original size of the wound. |  |

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| Scar – keloid scar | A scar that keeps growing and becomes bigger than the original wound |  |
| Scar tissue | Early scar appears purple and raised. As it ages it flattens and pales over several months |  |
| Sinus also known as tunnelling | A wound sinus is a blind-ended tract leading down to a cavity or abscess. It may be present in an open wound. |  |

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| Skin tear | A traumatic injury where the layers of skin separate or peel back. More likely occurring in the elderly as a result of bumping something, dressing changes, or washing or drying the skin harshly. They most often happen on the arms or legs. |  |
| Slough | The appearance of slough is typically a pale yellow, viscous fibrinous substance that can range from yellow to tan. It consists of fibrin, leucocytes, dead and living cells, microorganisms and proteinaceous material. It can be loosely adhered to firmly attached. |  |
| Subcutaneous tissue | Subcutaneous tissue is the deepest layer of skin. Made up mostly of fat cells and connective tissue, it is where the majority of body fat is stored. It acts as a layer of insulation to protect internal organs and muscles from shock and changes in temperature. |  |

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| SSI Surgical site infection | Development of a localized infection in the area where the surgery took place. |  |
| TIME framework A tool to assist in a systematic way to assess the wound: | T – appearance of tissue I – signs of inflammation or infection M – level of moisture E – wound edge or margin | |
| Traumatic wound | A wound resulting from trauma |  |
| Tunneling also known as sinus | A wound that has developed a tunnel tracking out from one or more points in the wound. |  |

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| Venous leg ulcer | A chronic wound on the lower leg caused by inadequate venous return. |  |
| Venous stasis | Also known as venous insufficiency. A condition where venous return from the feet to the heart is impaired so there is pooling of the blood in the veins. Can present with swelling, with the skin appearing brown and hard. |  |
| Wound assessment | A structured, systematic approach that includes assessing the events leading up to wound development, general factors, wound assessment and factors affecting healing. This information is collated and interpreted in preparation for goals of care. | |
| Wound bed preparation | A wound needs to be prepared to an optimal state to encourage healing. This will include removing debris and non-viable tissue, controlling inflammation and infection, ensuring moisture balance to promote healing. | |

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| Wound bridging or pocketing | <p>Wound Bridging - presents as stringy tissue bridging between either side of the wound.</p> <p>Wound Pocketing - presents a small pockets as if a small section has been scooped out.</p> <p>Both are signs of infection in surgical wounds.</p> | |
| Wound dehiscence | The total or partial breakdown of a suture line post-surgery. |  |
| Wound edge | The wound edge separating the skin and the wound. Often referred to as wound margin. |  |

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| Wound infection | A proliferation of microbes in a wound leading to local or systemic host reaction such as spreading inflammation, increase in exudate, increase in pain, pus, wound deterioration, wound dehiscence, pyrexia etc. |  |
| Wound margin | The wound edge separating the skin and the wound. |  |