Managing complex wounds in palliative care: A practical approach

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Overview

- Palliative wounds
- Psychosocial aspects
- Malignant fungating wounds
- Skin failure at life's end
- Practical wound care

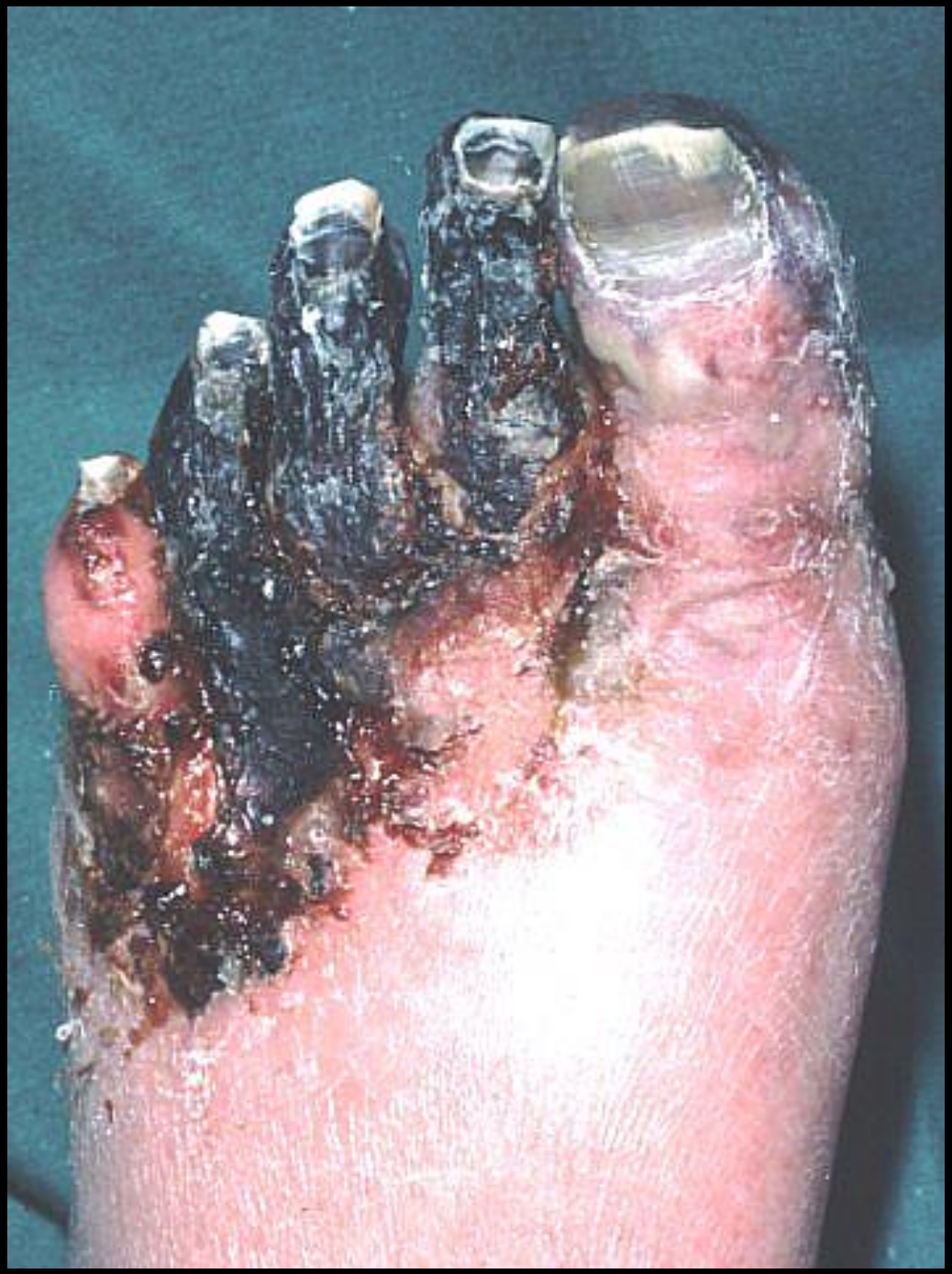
Wound Healing

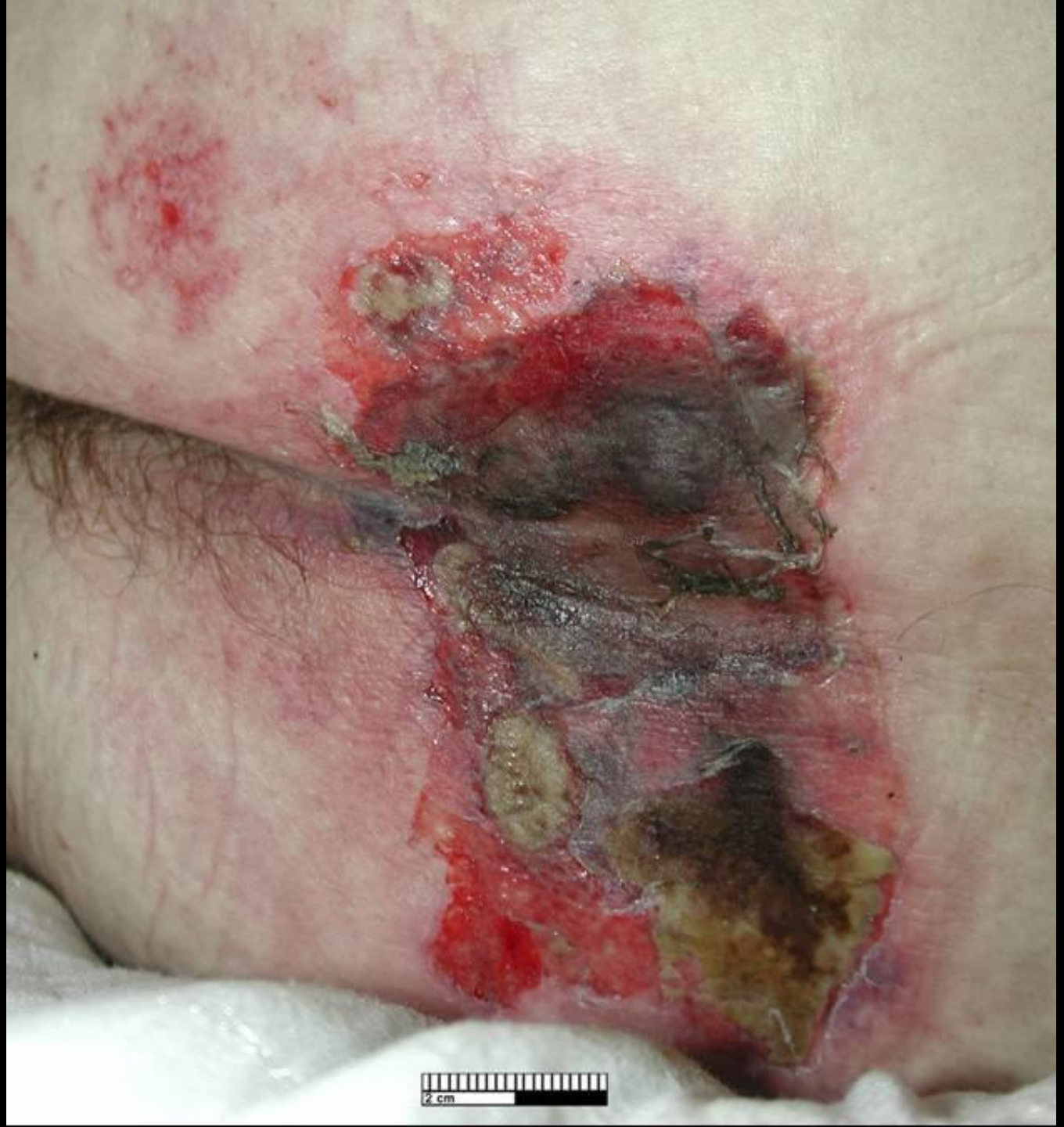
- Normal healing
  - Healing proceeds as would be expected for the wound type
- Hard-to-heal
  - Despite best efforts healing is prolonged (>6 months) or never achieved
- Not going to heal = “palliative wounds”
  - Patient and wound related factors mean there is no potential for healing

When do wounds become palliative?

- Underlying condition cannot be corrected
- End stage disease
- Healing is not a priority of care
- Treatment demands too great
- End-of-life

= No healing potential or no time to heal

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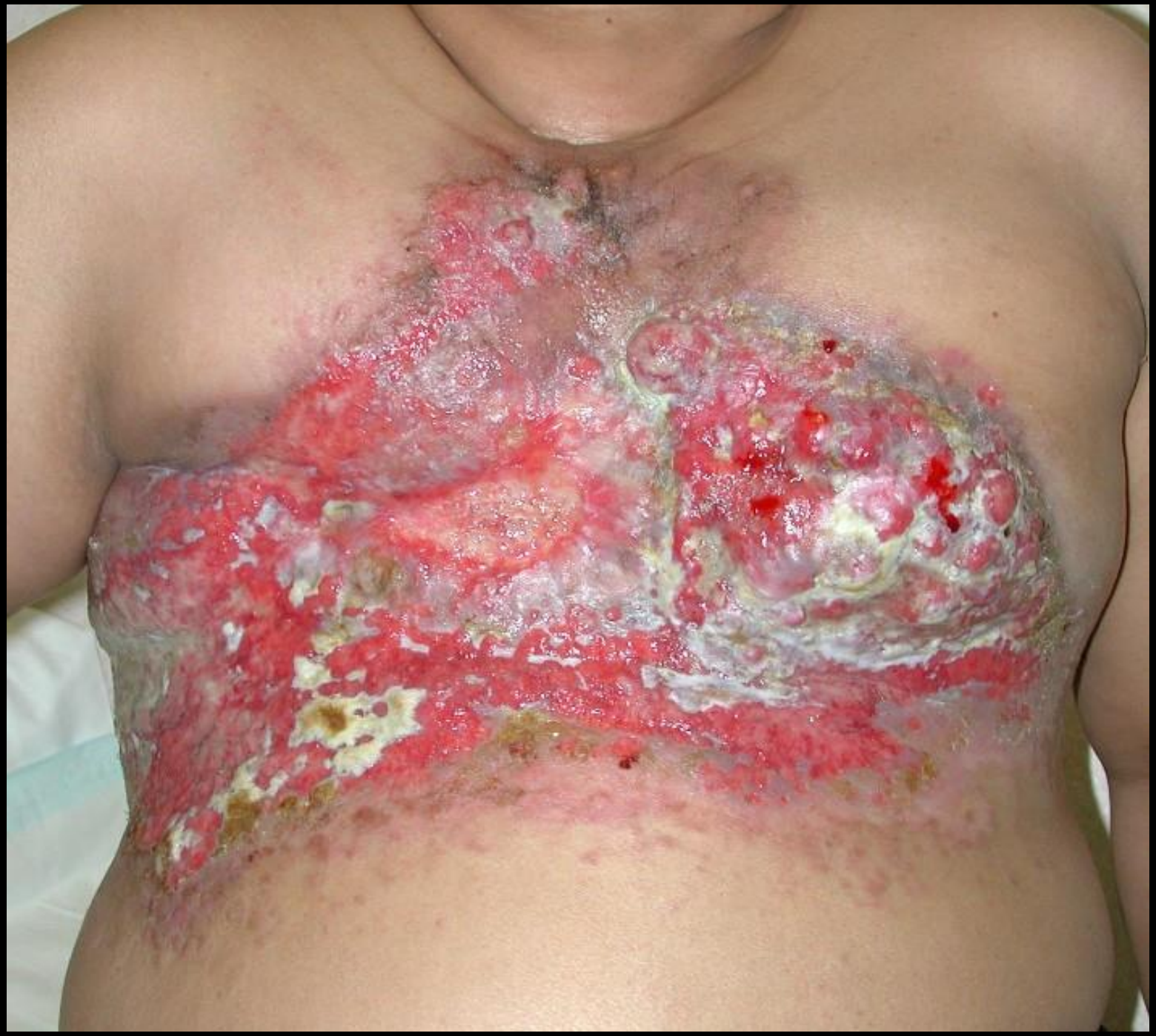


Living with a Chronic Wound

- **Pain**, exudate and malodour
- Anxiety, depression, self-neglect
- Loss of self-esteem/ Loss of control
- **Social isolation**
- Poor sleep
- Role functioning (work, financial, mobility)
- Inconvenience (dressings, clinic etc)

(Beitz & Goldberg, 2005; Templeton, 2005; Neil & Munjas, 2000)

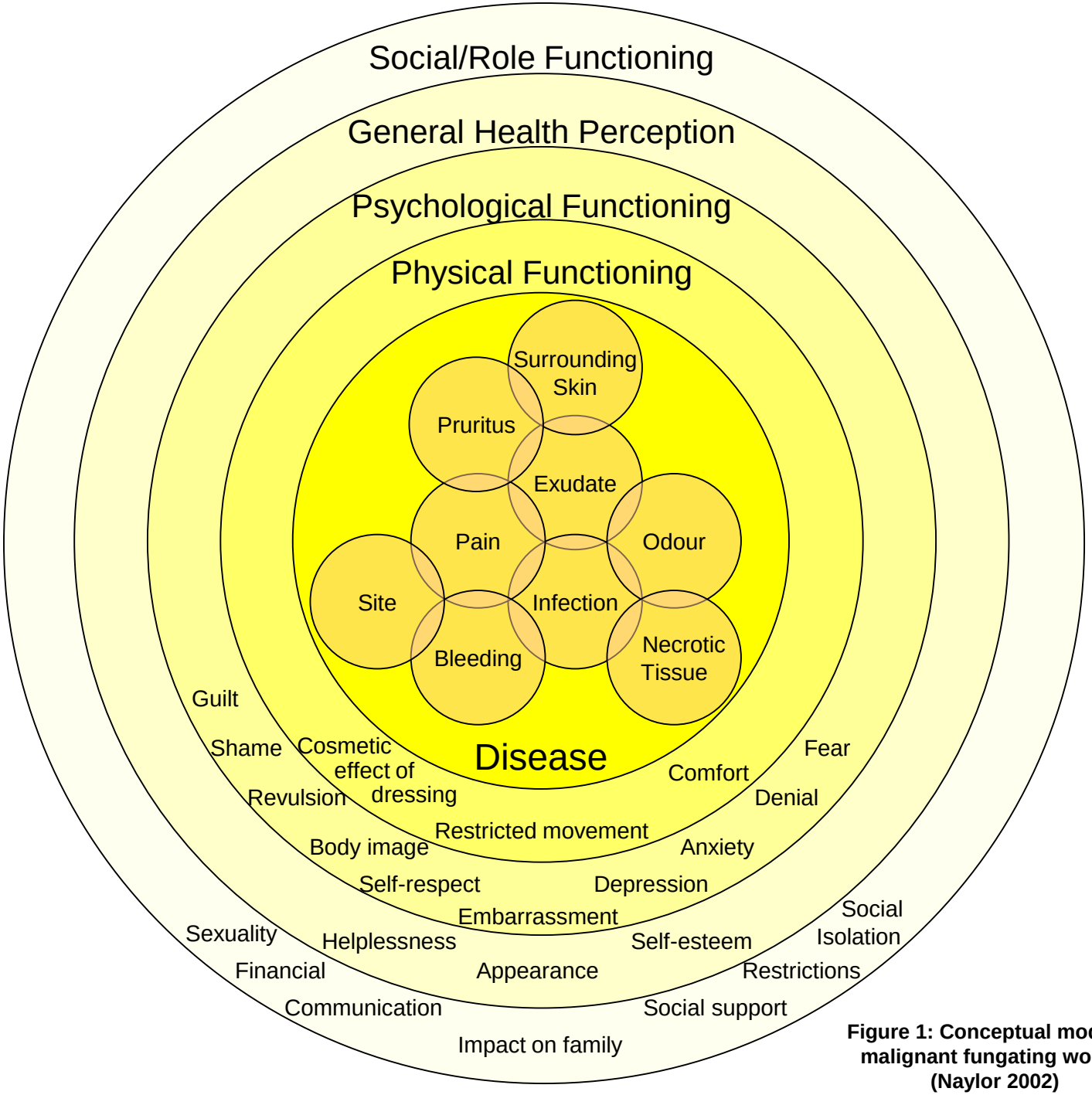
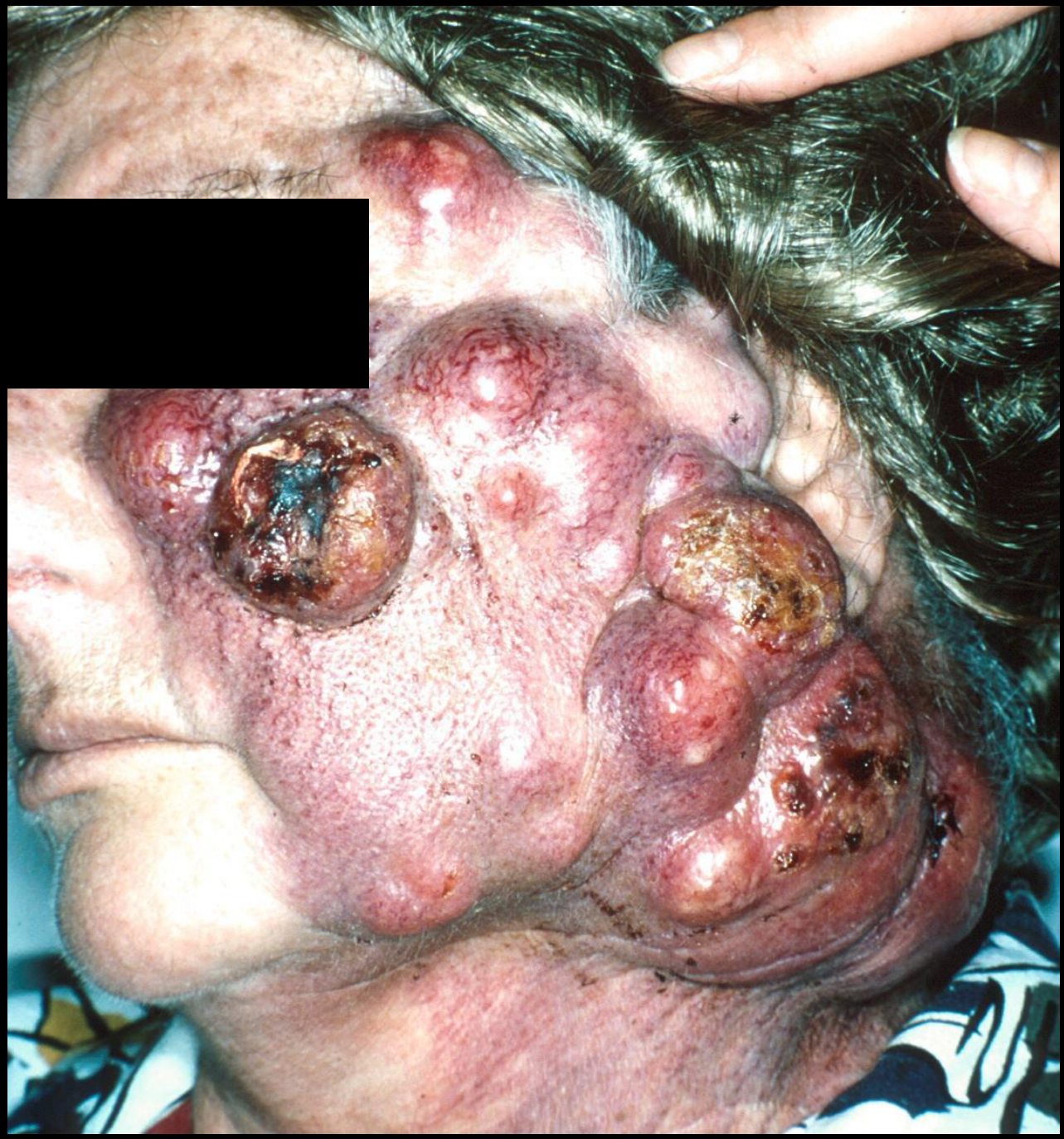
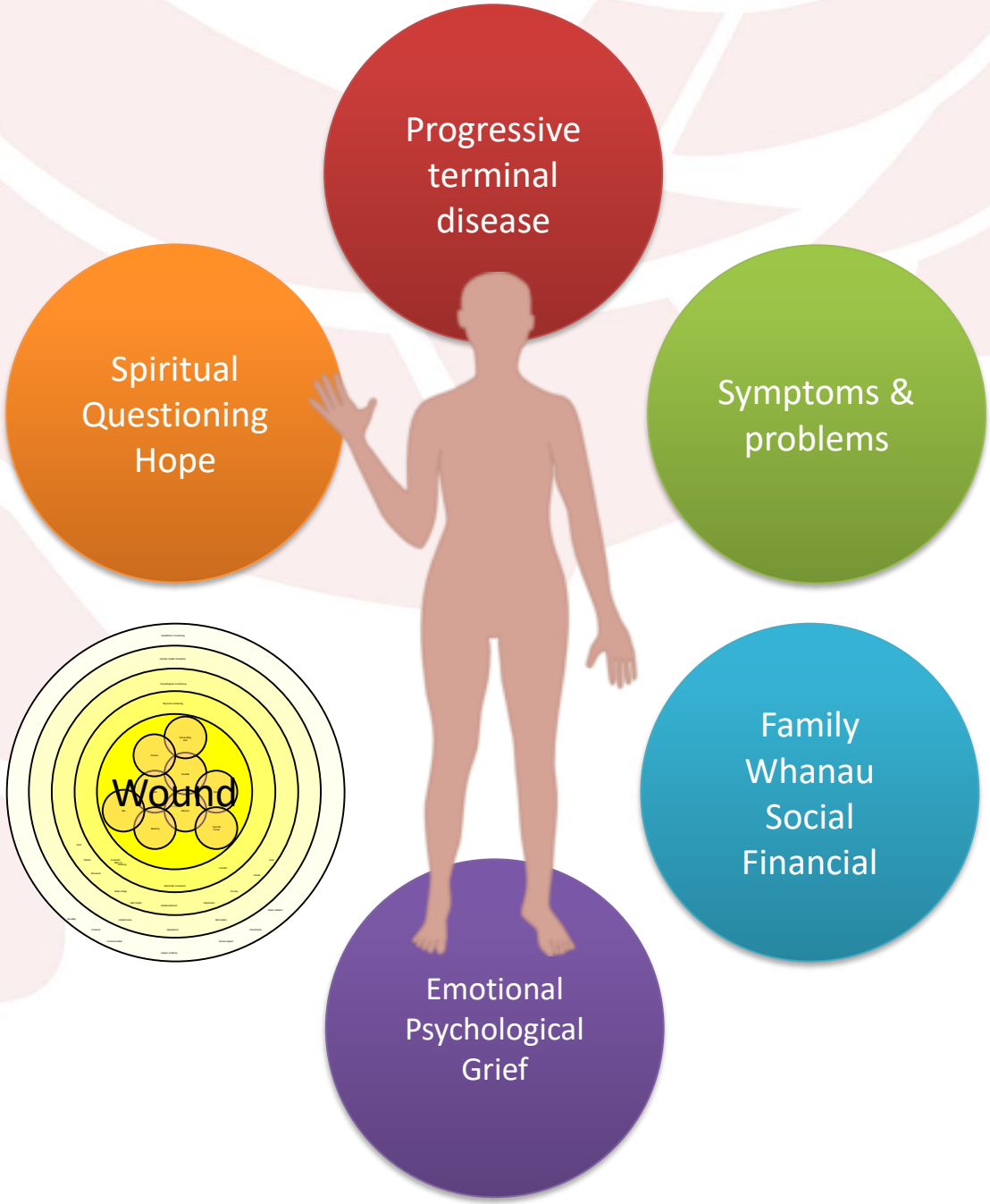


Figure 1: Conceptual model of malignant fungating wound (Naylor 2002)




Progressive terminal disease
Spiritual Questioning Hope
Symptoms & problems
Wound
Family Whanau Social Financial
Emotional Psychological Grief

“Can we begin to imagine what it must feel like for a patient to see part of his body rotting and to have to live with the offensive smell from it, see the reaction of his visitors (including doctors and nurses) and to know that it signifies lingering death?”

(Doyle 1980 cited in Ivetić & Lyne 1990)

Malignant Fungating Wounds

- The extension of a malignant tumour into the structures of the skin producing a raised or ulcerating necrotic lesion.

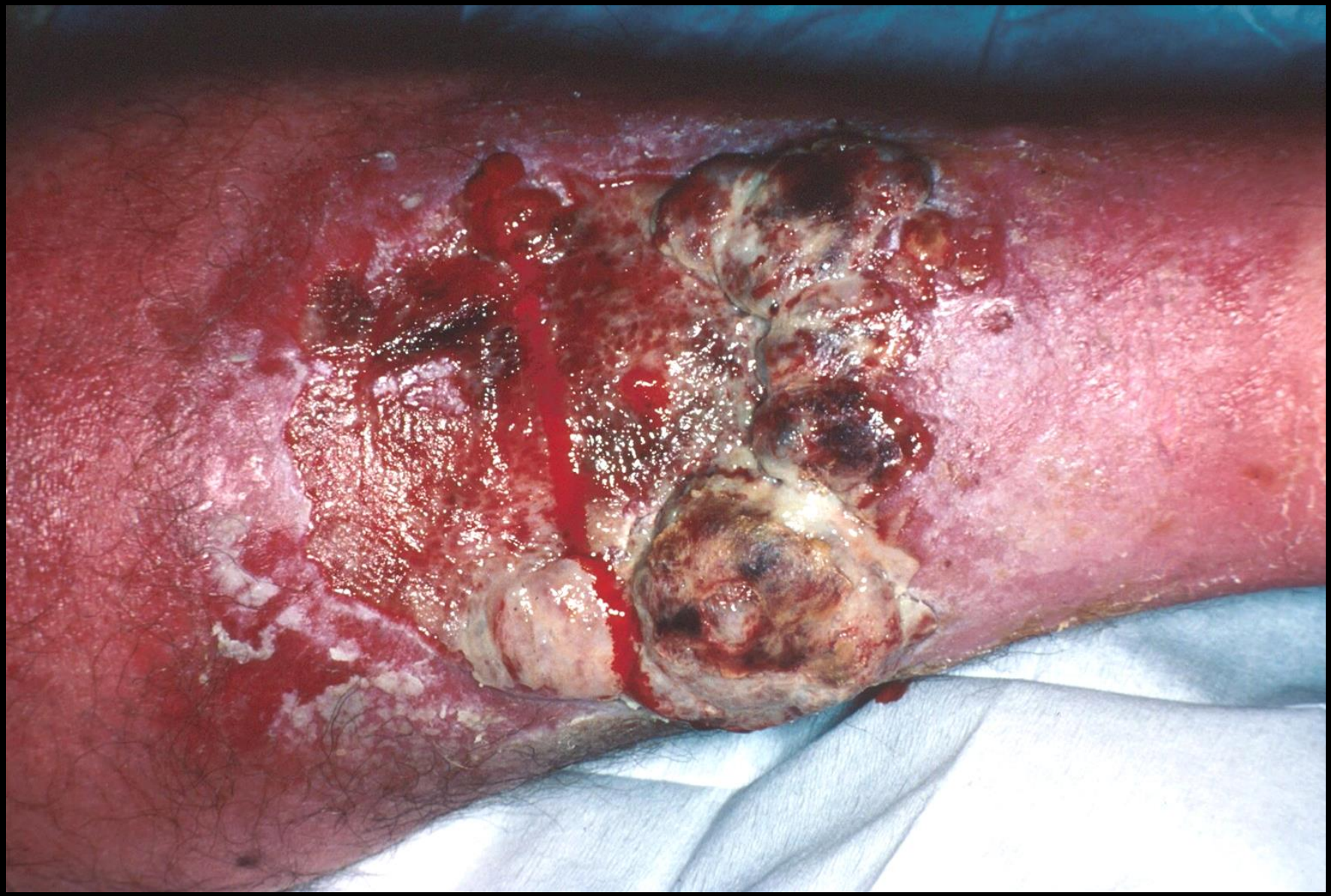
(Grocott 1999, Collier 1997b, Haisfield-wolf and Rund 1997)

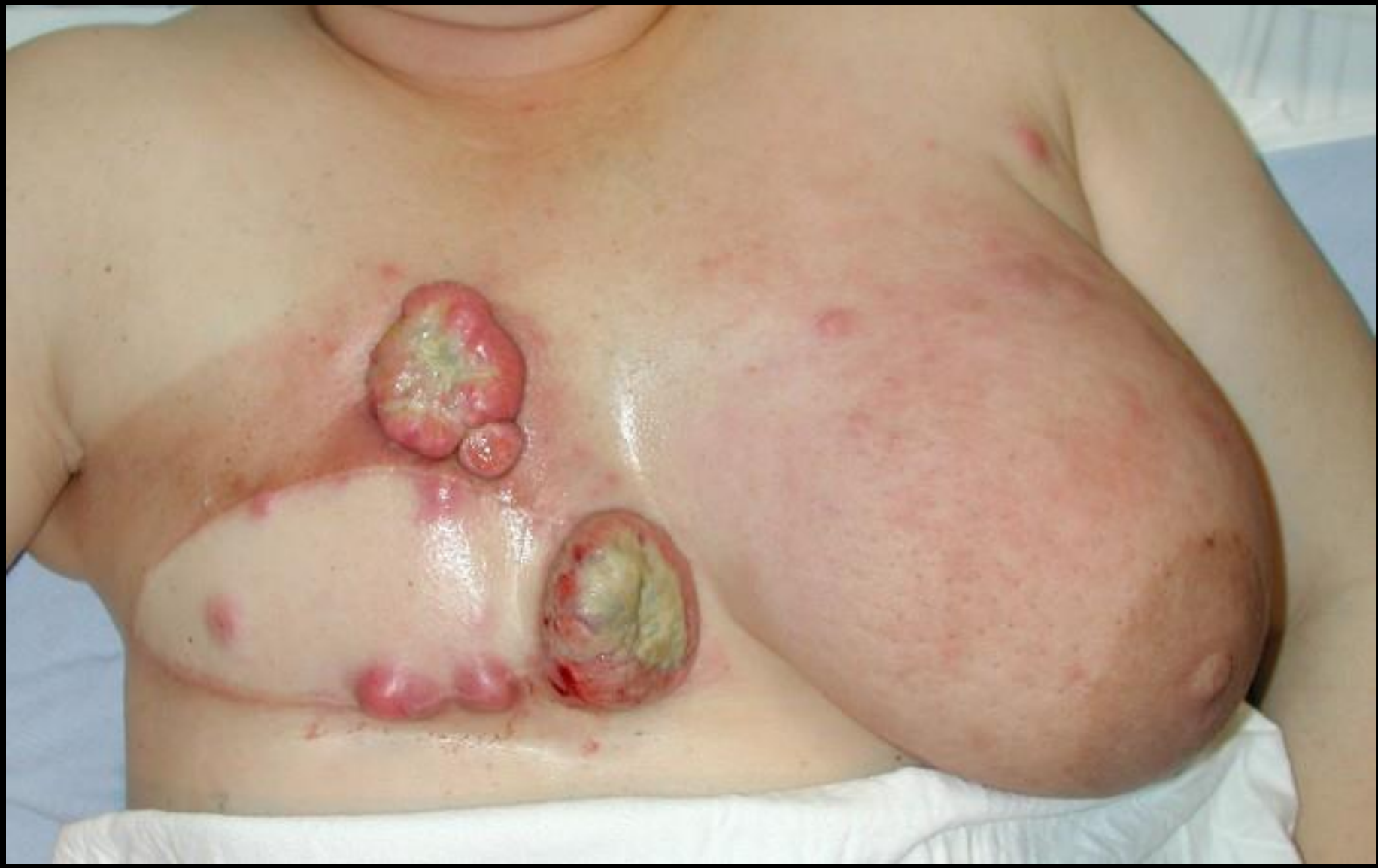
Incidence

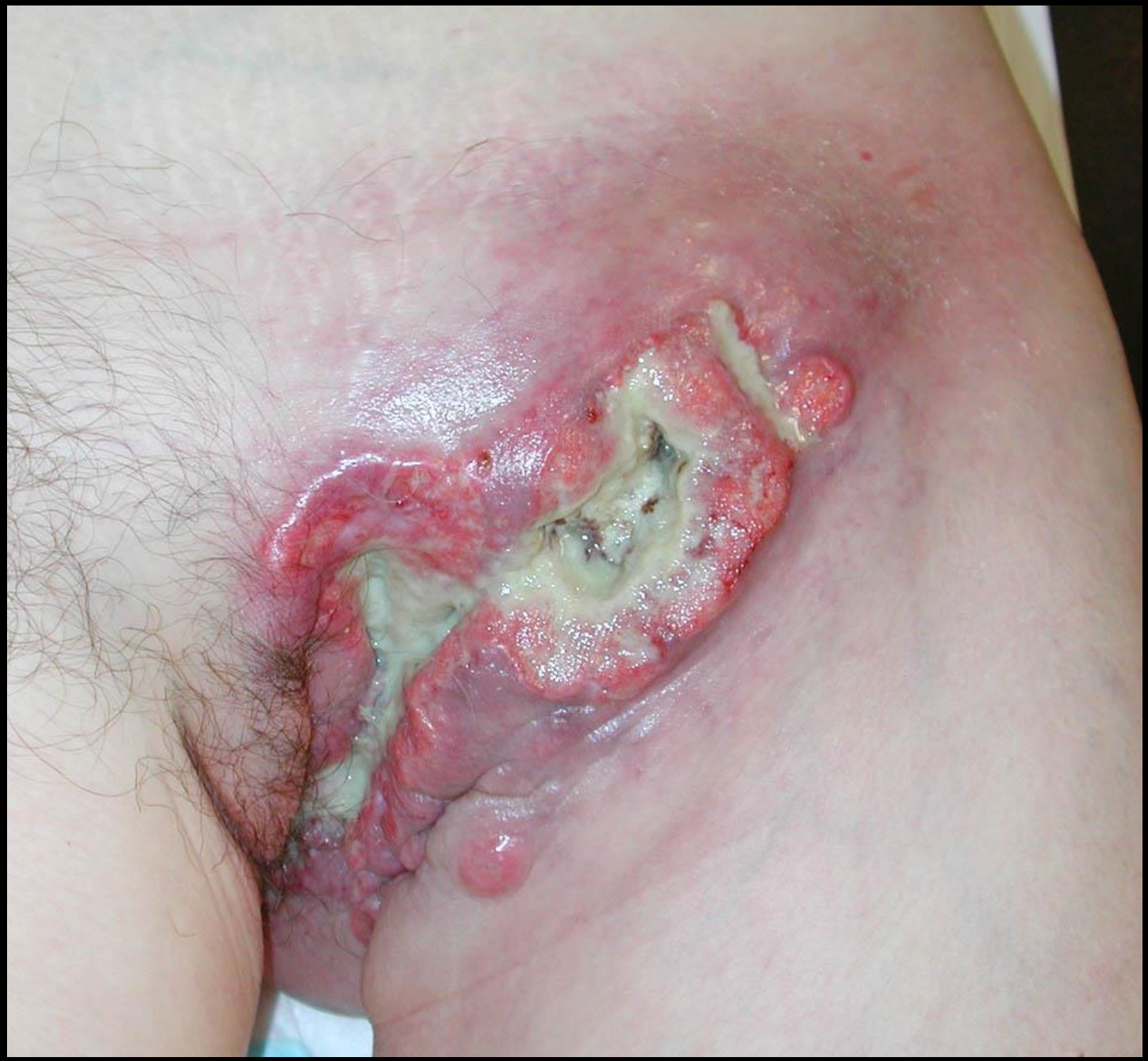
- Not well studied
- 5-10% of cancer patients with metastatic cancer will develop a fungating lesion
- Can arise from almost any cancer
- Breast most common site (39-62%), head and neck second (24-33%), may occur anywhere on body
- Age over 60 most affected
- Usually occur in last 6 months of life

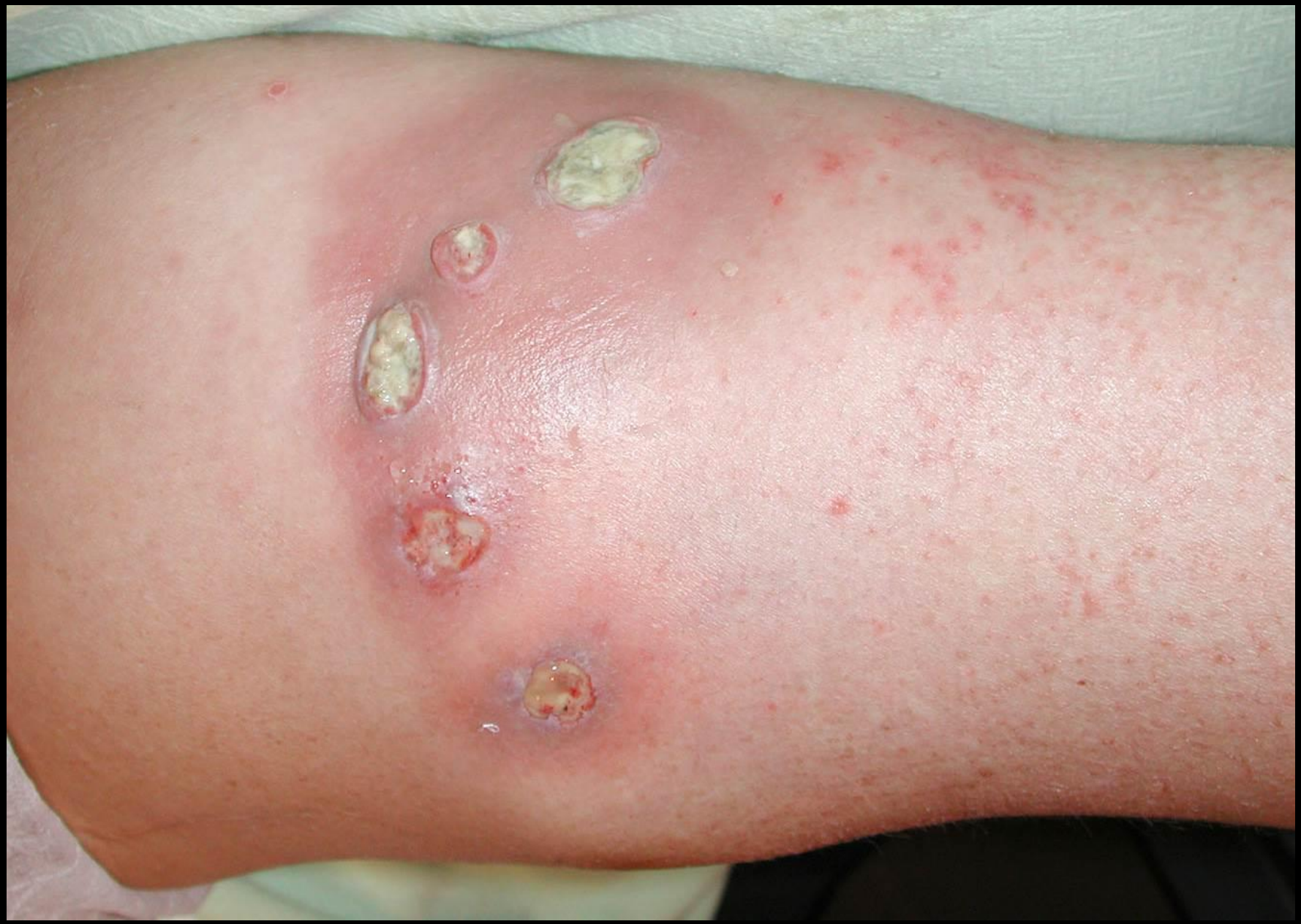
Pathophysiology

- Primary skin tumour
- Direct skin invasion by underlying tumour
- Metastatic spread
- ‘Seeding’ or implantation
- Marjolin’s Ulcer





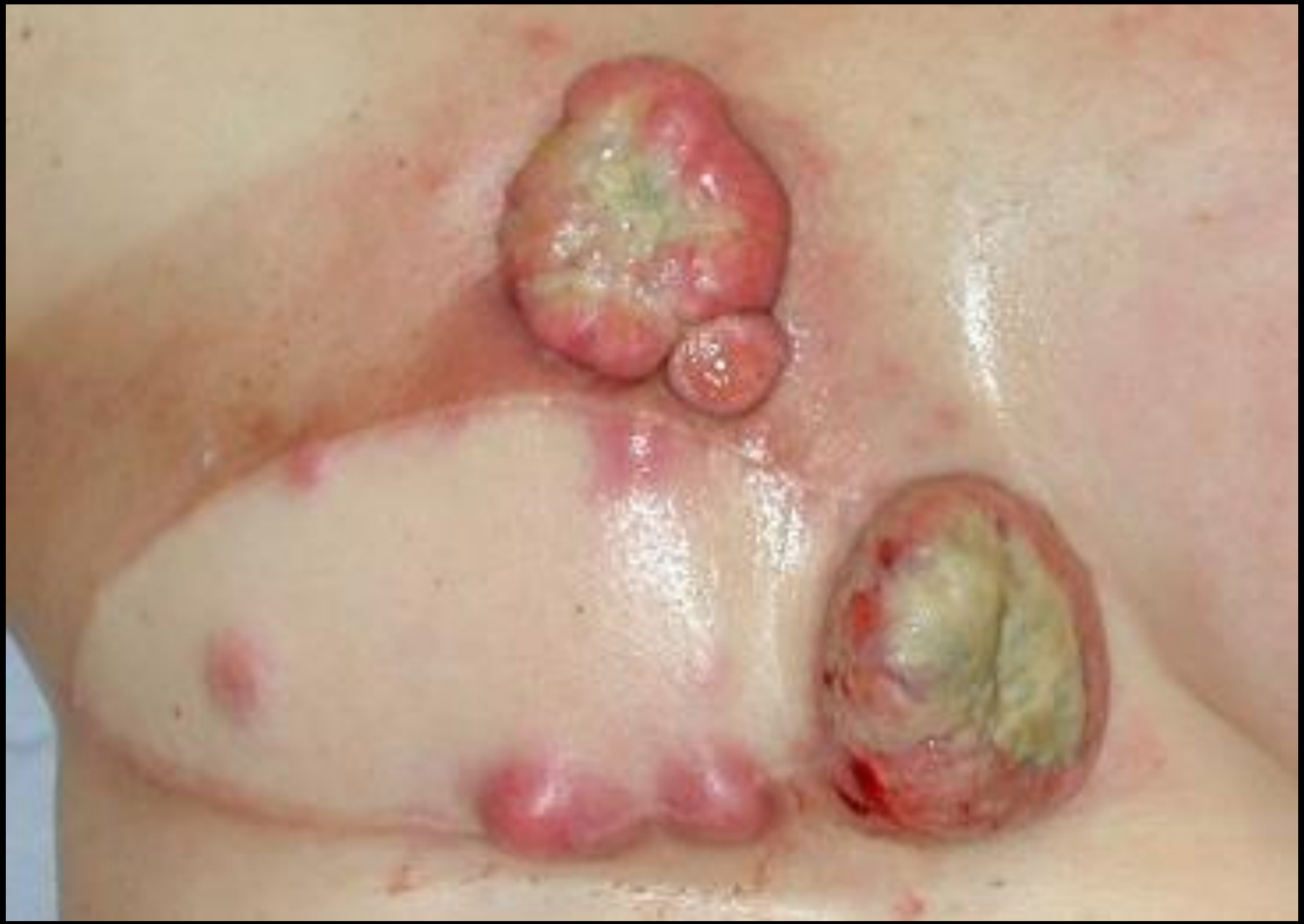


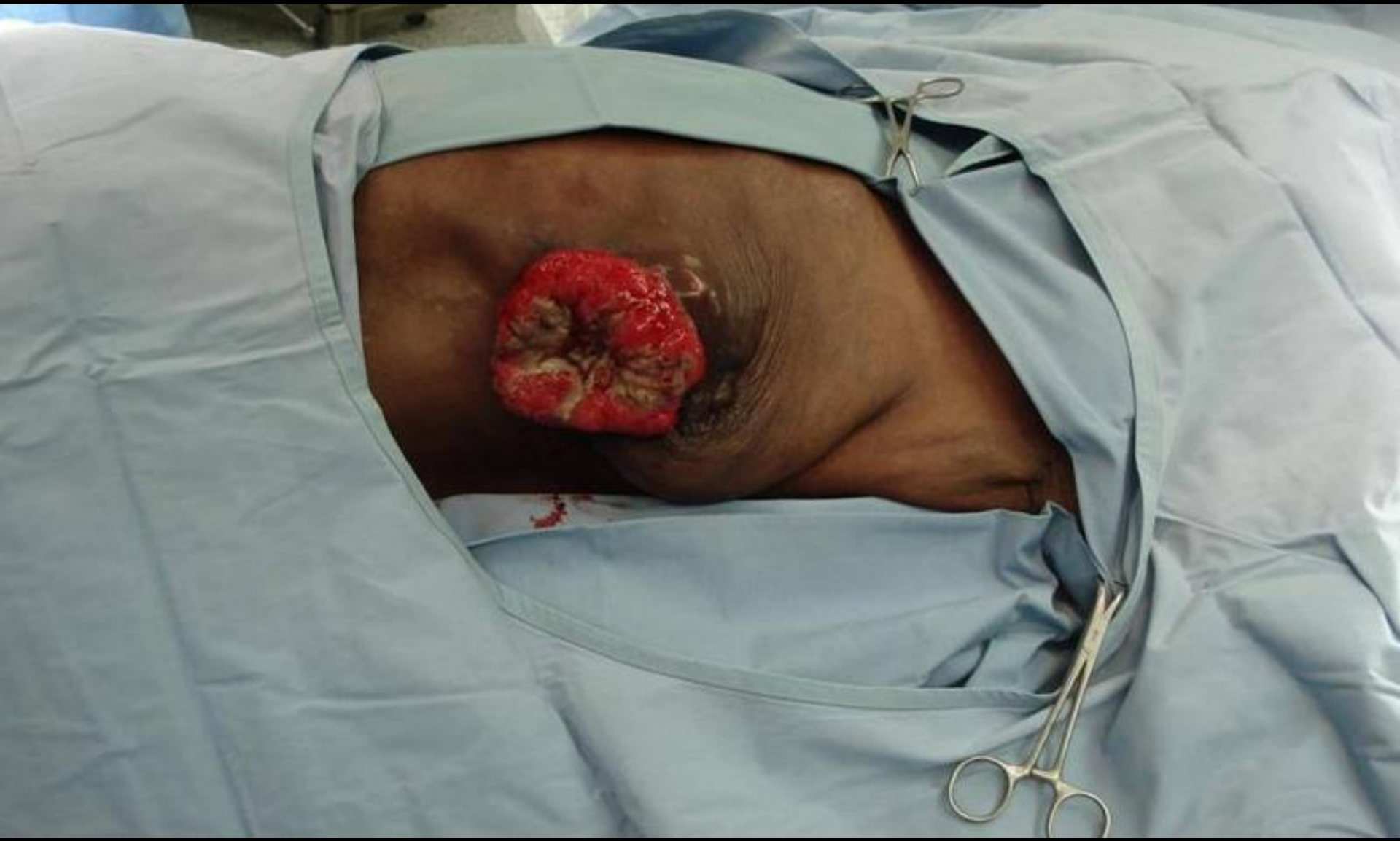


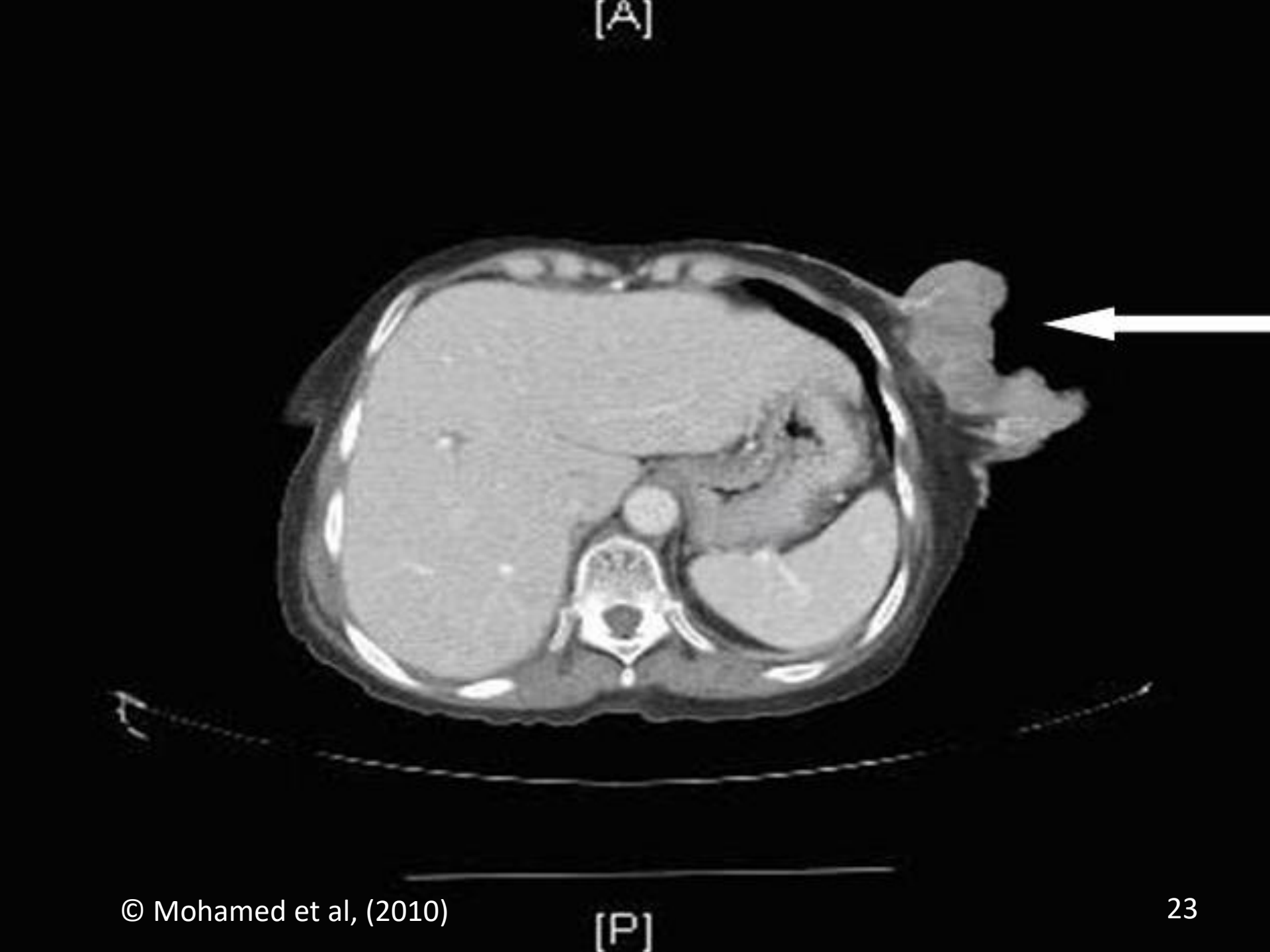
Pathophysiology

- Initially present as discrete, non-tender nodules
- Disruption of skin capillaries causes tissue hypoxia and necrosis
- May progress to raised, nodular lesion or ulcerating crater with distinct margin

(Manning 1998, Collier 1997a, Haisfield-Wolfe and Rund 1997, Fairbairn 1993, Moody and Grocott 1993)







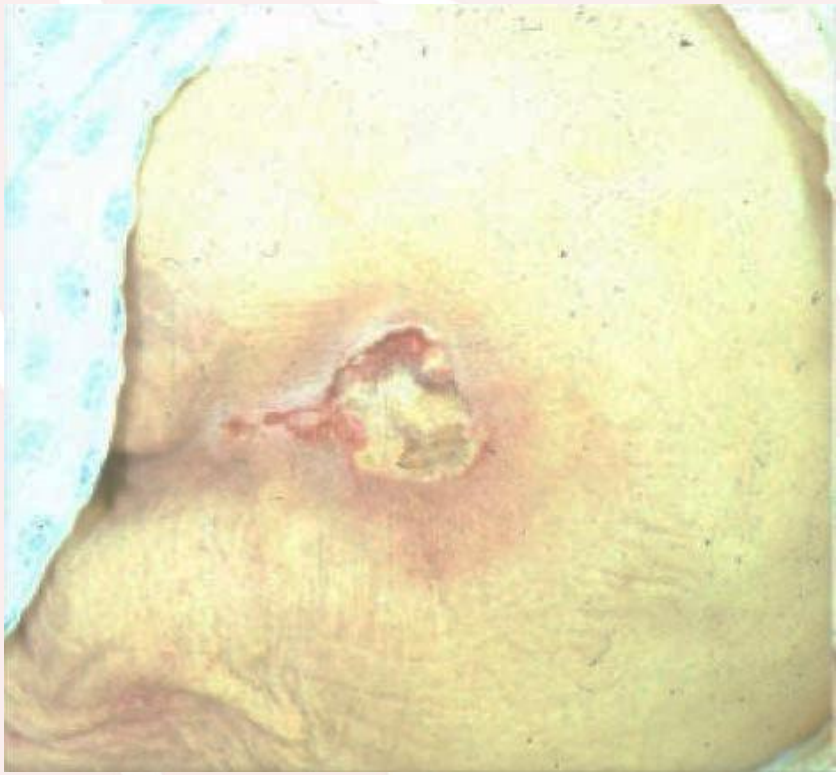
Skin Changes At Life's End

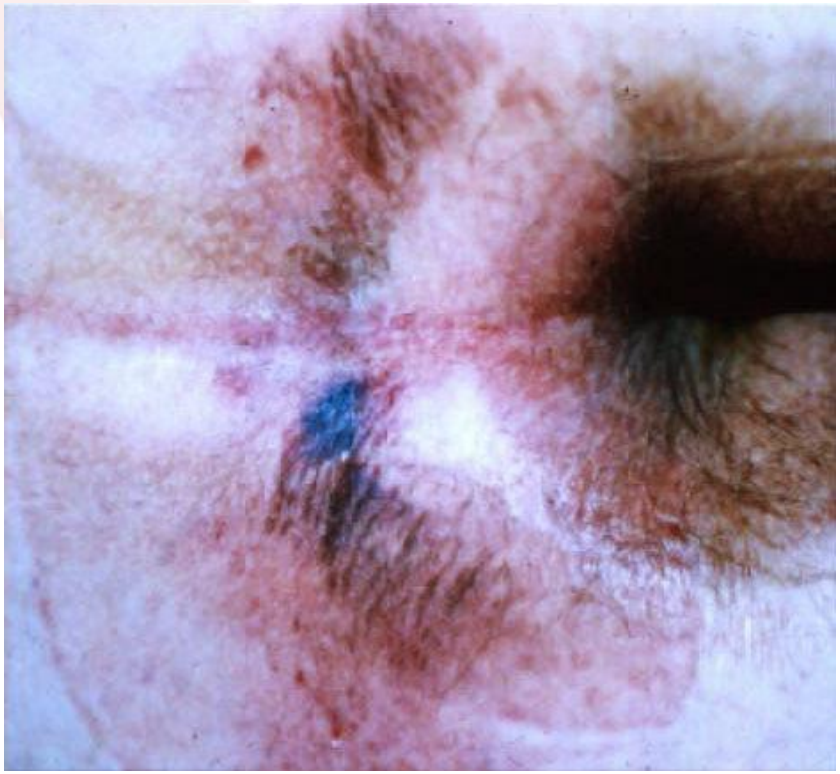
- Skin is the largest organ system
- Like other organs at end of life, the skin can fail
- Manifestation of disease burden rather than poor care
  - Hypo-perfusion concurrent with severe organ dysfunction or failure
  - A reflection of compromised skin - reduced soft-tissue perfusion, decreased tolerance to external insults, and impaired removal of metabolic wastes
  - Increased risk of injury
  - Sudden onset and rapid deterioration
- SCALE: Skin Changes at Life's End: Final Consensus Statement (2009). http://www.epuap.org/scale-skin-changes-at-lifes-end

Kennedy Terminal Ulcer

- Charcot 1877 - decubitus ominosus
- Kennedy Terminal Ulcer (1989)
- A pressure injury some people develop in the last days or hours of life
  - Usually presents on the sacrum
  - Can be shaped like a pear, butterfly or horse shoe
  - Can have the colours of red, yellow, black or purple
  - Borders of the ulcer are usually irregular
  - Has a sudden onset – “3:30 ulcer”

Kennedy Terminal Ulcer





PRACTICAL PALLIATIVE WOUND MANAGEMENT

Assessment

- General health and well-being
  - Physical, psychological, social, spiritual
- Main concerns and expectations of…
  1. Patient
  2. Family/carer
  3. Health professionals
- Wound and surrounding skin

Establish Goals

- Patient focussed
- Achievable
- Meaningful
- Use “alternative endpoints”
  - Wound is unlikely to heal
  - Healing is not the priority of care
  - Limited treatment options
  - Substitute or “clinically meaningful” endpoint

Saunders & Regnard, 1989

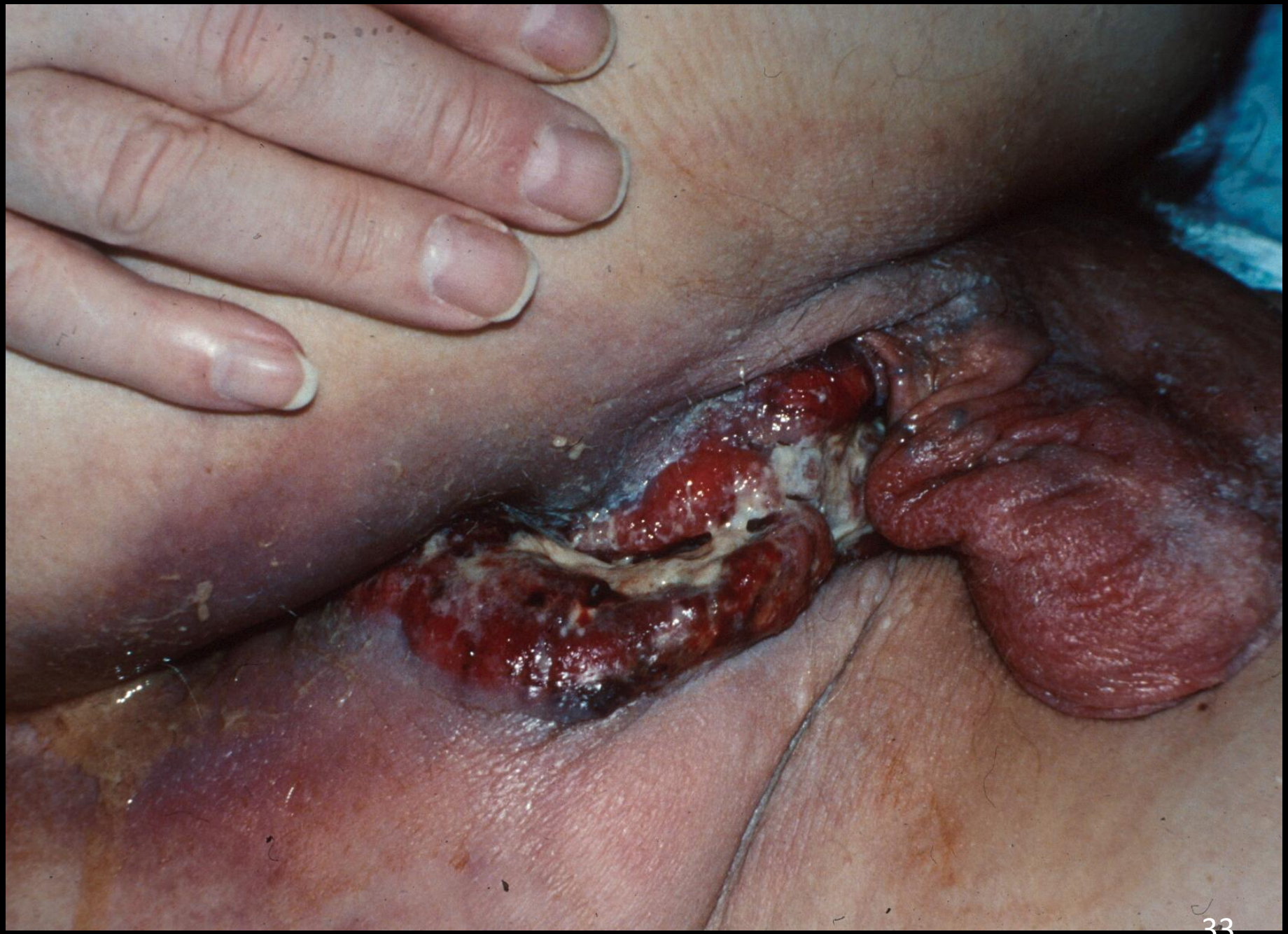
- Treatment should be realistic and accepted by the patient and carers.
- If the treatment does not promote quality of life and sense of well-being, it should be changed.
- Few treatments are absolute.
- When the prognosis is short, the primary aim should be to promote comfort.”

Palliative Wound Care Principles

- Key Principles
  - Prevent wound development / deterioration
  - Correct / treat underlying cause
  - Control wound related symptoms
  - Utilise patient self-assessment
  - Provide psychosocial support
  - Promote independence
  - Improve quality of life
  - It is NOT an excuse for poor wound care

Malodour

- May be the one of the most distressing wound symptoms
- Caused by:
  - bacterial colonisation/infection of devitalised tissue within the wound
  - Stale exudate in dressing
- Desensitisation does not occur with fungating wound odour



Malodour Management

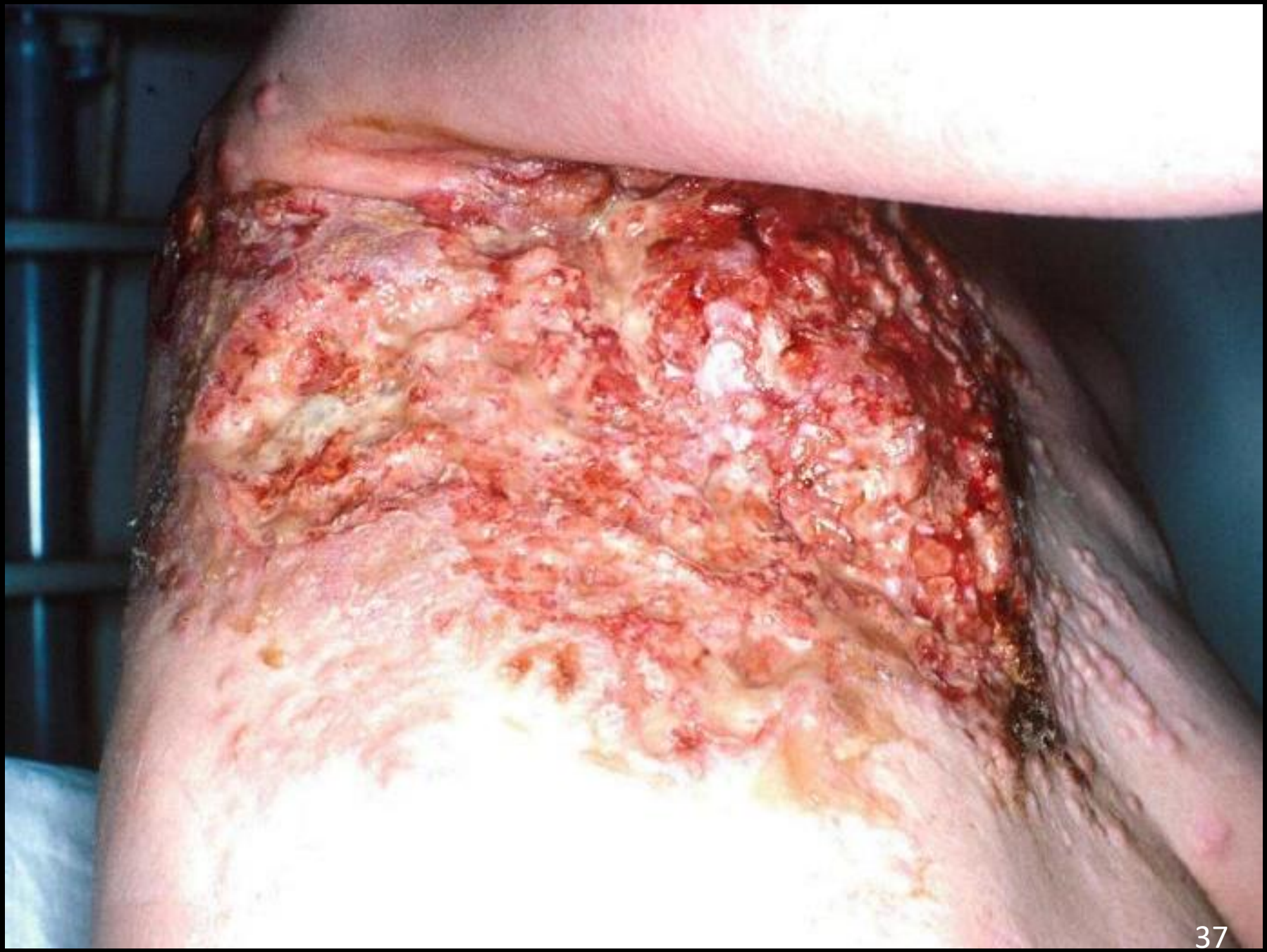
- Remove Cause
  - Debridement of necrotic tissue
- Treat cause – antimicrobials
  - Metronidazole (topical/ systemic)
  - Microdacyn gel
  - Prontosan soak/gel
  - Silver dressings
  - Honey dressings
- Control/contain – wound dressings
  - Activated charcoal
  - Occlusive dressings

Malodour Management

- Adjuvant approaches
  - Daily dressing changes / disposal of soiled dressings
  - Deodorisers
    - Essential oils
    - Charcoal blocks / cat litter
    - Air filtration system

Exudate

- Difficult problem for both the patient and nurse
- Major source of embarrassment for patients
- Caused by:
  - Infection
  - Necrotic tissue breakdown (autolysis)
  - Fungating wounds - increased permeability of blood vessels, secretion of vascular permeability factor



Exudate Management

- Absorb
  - Low exudate
    - Low adherent, absorbent dressings
    - Hydrocolloid sheets
    - Semi-permeable films
  - High exudate
    - Low adherent wound contact layer plus secondary absorbent pad
    - Foam dressings
    - Alginates / Hydrofibre
- Contain
  - Stoma appliance / wound manager bag

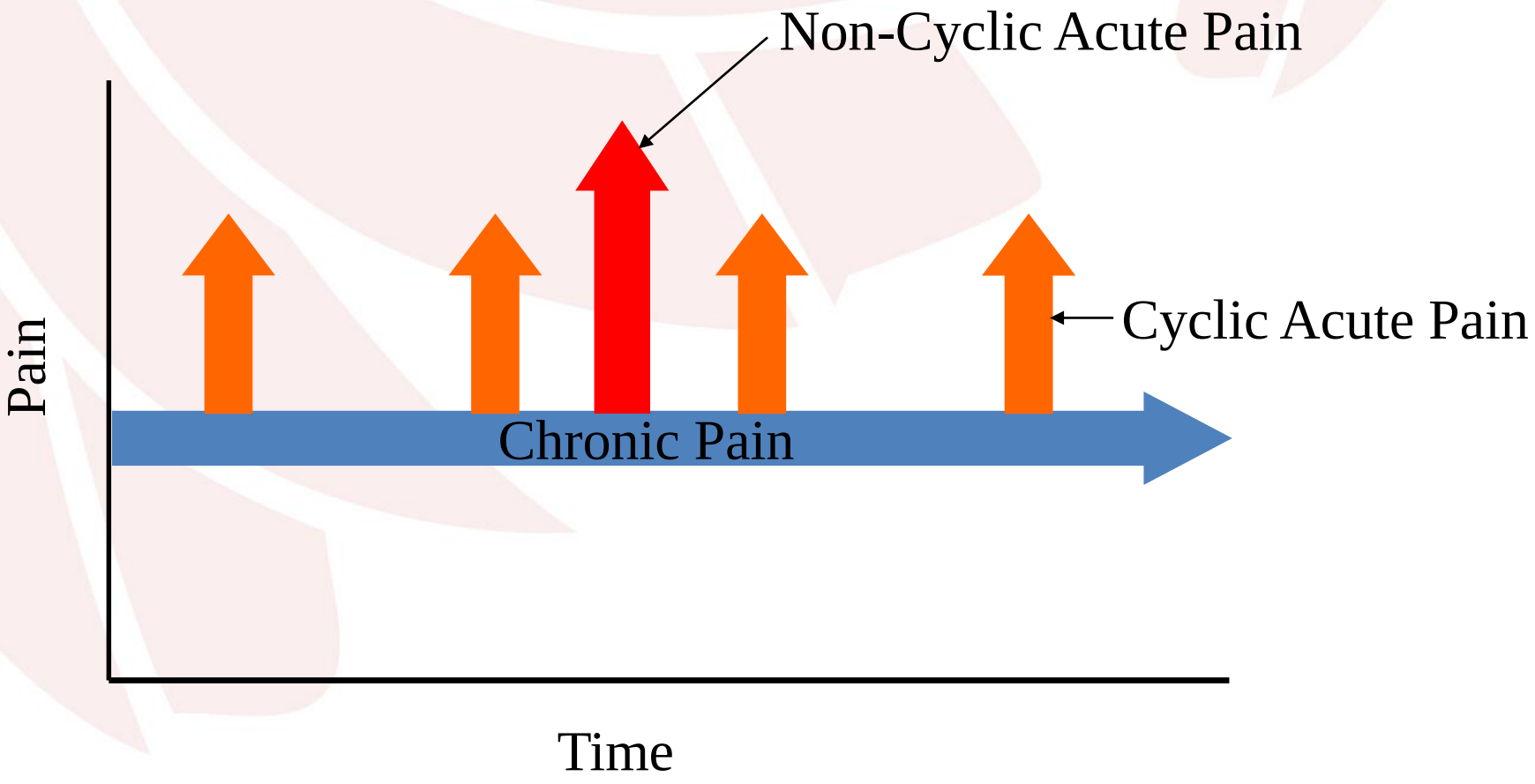
Exudate Management

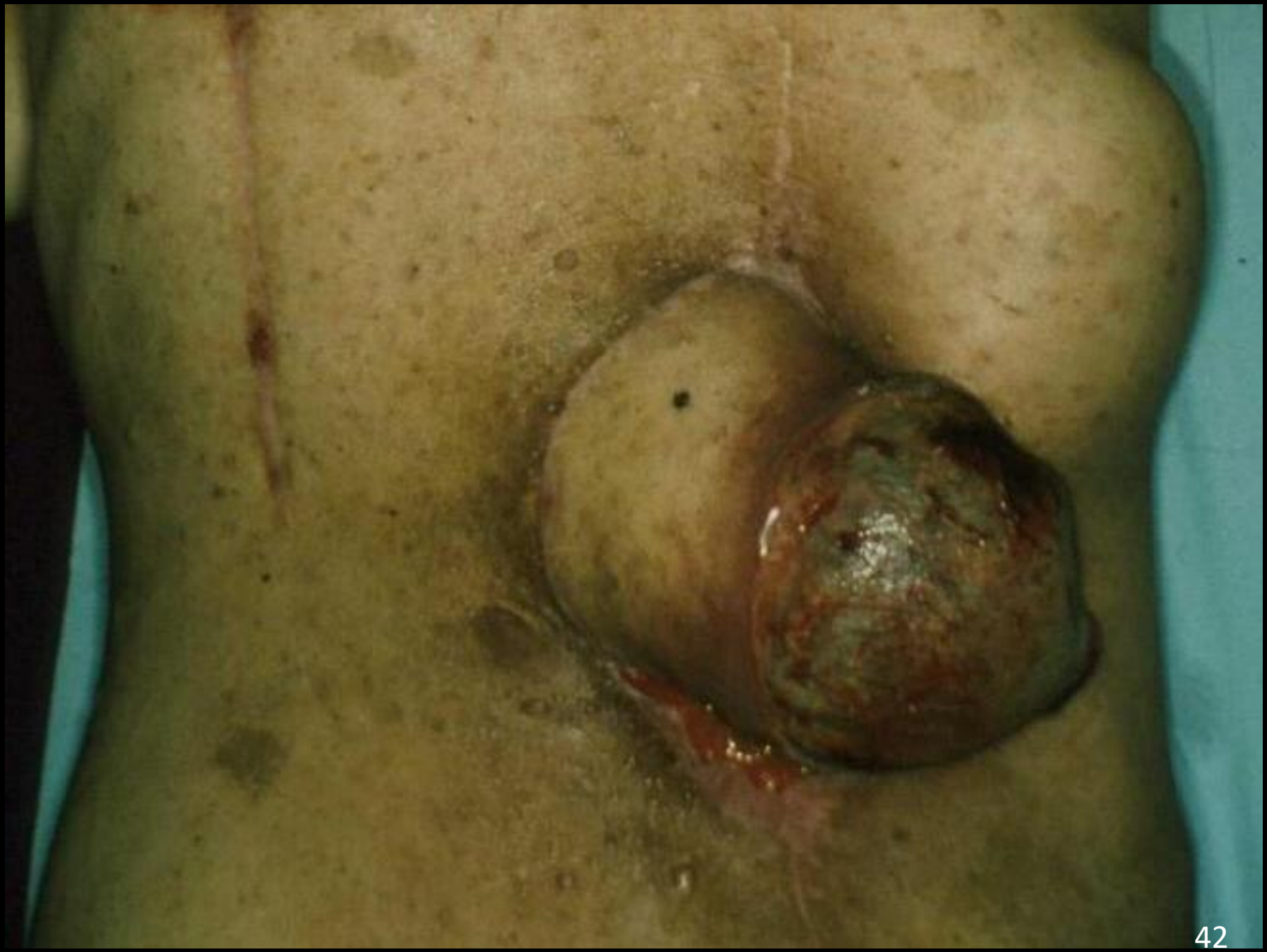
- Reduce
  - Manage oedema, lymphoedema
  - Treat infection
  - Reduce inflammation
- Protect skin
  - Skin barrier film
  - Frame wound
  - Moisturiser

Wound Pain

- Inappropriate beliefs and attitudes
- Lack of knowledge about pain
- Poor or non-existent pain assessment
- Inefficient prescribing of analgesia
- Poor wound care

Wound Pain


Non-Cyclic Acute Pain
Cyclic Acute Pain
Chronic Pain
Pain
Time



Prevent Acute Wound Pain

- Irrigate gently with warm 0.9% sodium chloride or water
- Use a sterile gloved hand
- Use modern dressing products
- Maintain moist wound environment

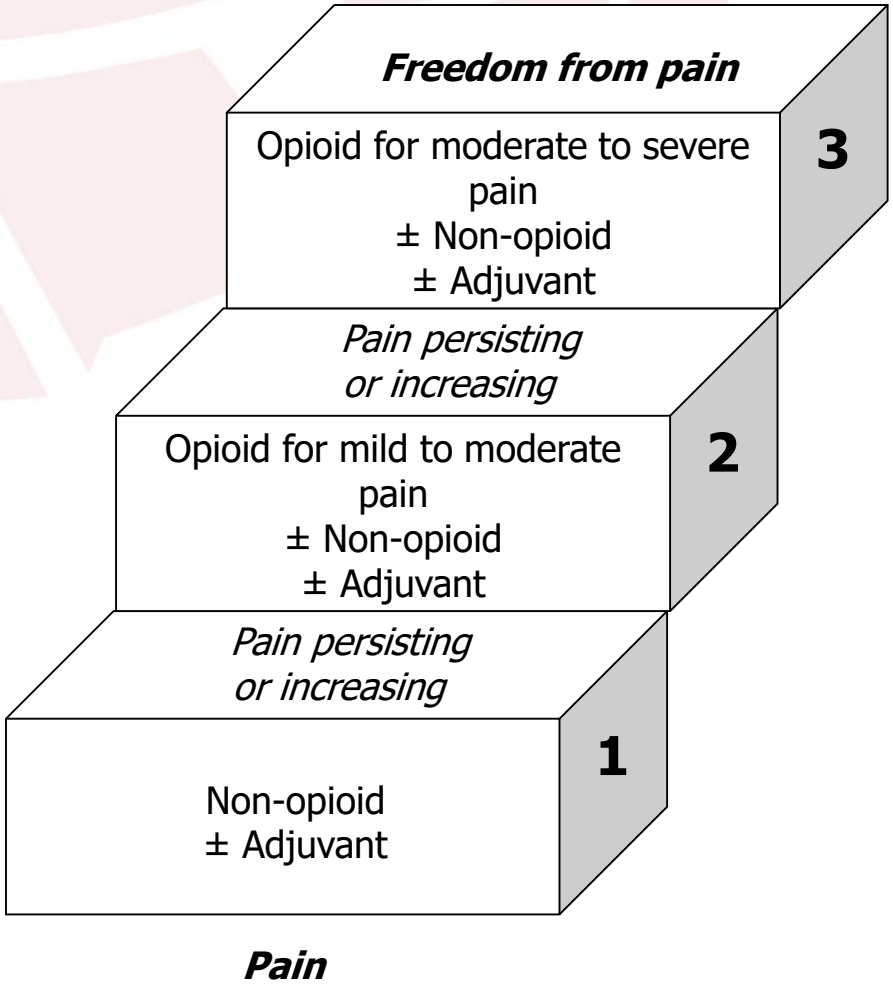
Non-Cyclic or Cyclic Acute Pain

- Premedication
  - Short acting opioid
  - ‘Booster’ dose of regular analgesia
  - Entonox gas
- Local anaesthetic
  - Topical
  - Nerve block
- Wound management practices / dressings
  - All over adhesive dressings - use with caution
  - Protect surrounding skin

Chronic Pain

WHO analgesic ladder

1. By the ladder
2. Plus adjuvants
3. By the clock

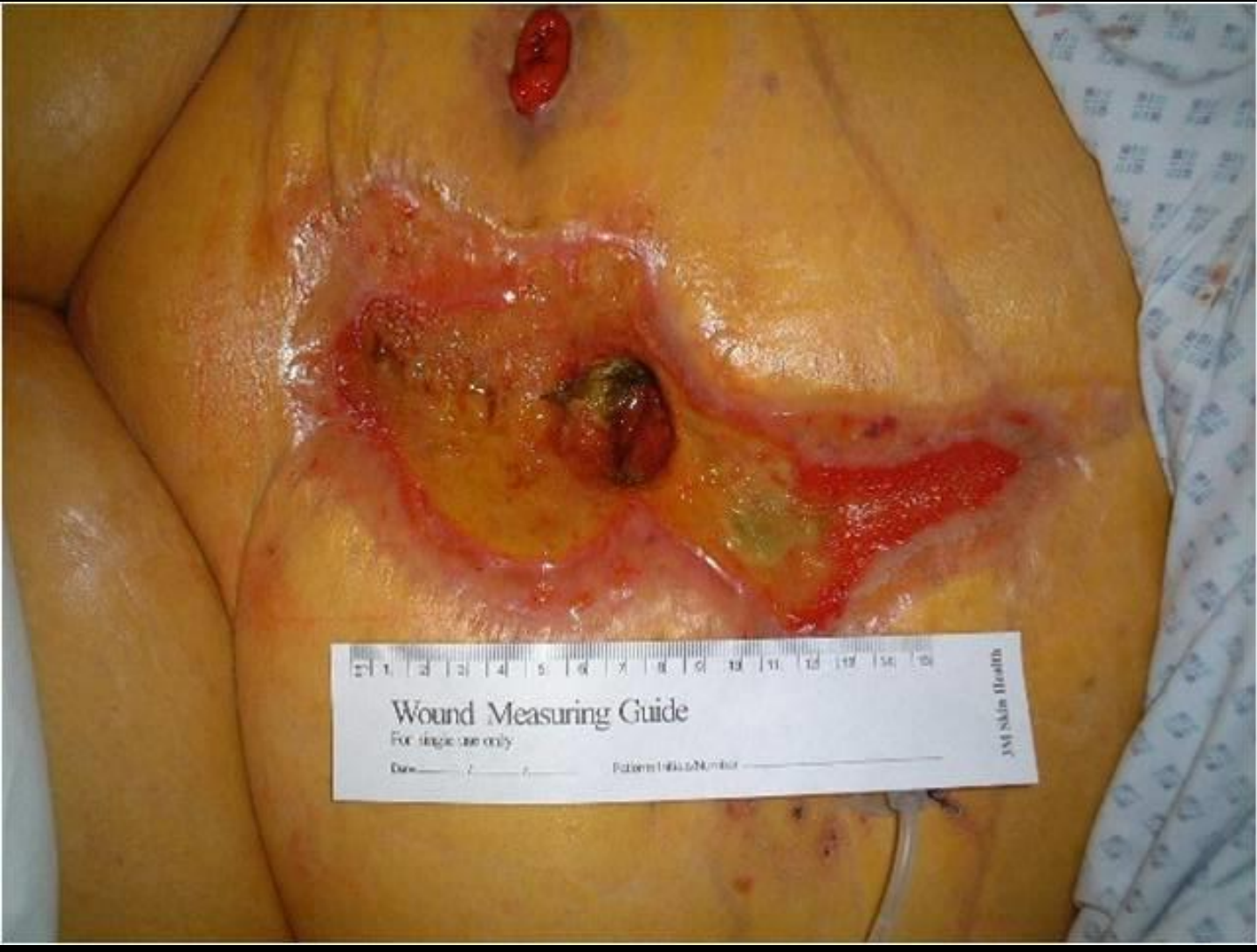


Topical Opioids

- Opioid receptors present on peripheral nerves
- Enhanced during inflammation
- Activated by exogenous opioids
- Inhibit nerve excitability, action potential conduction and neuropeptide release
- Example – Morphine 1mg to 1g of hydrogel, applied topically to wound surface once a day

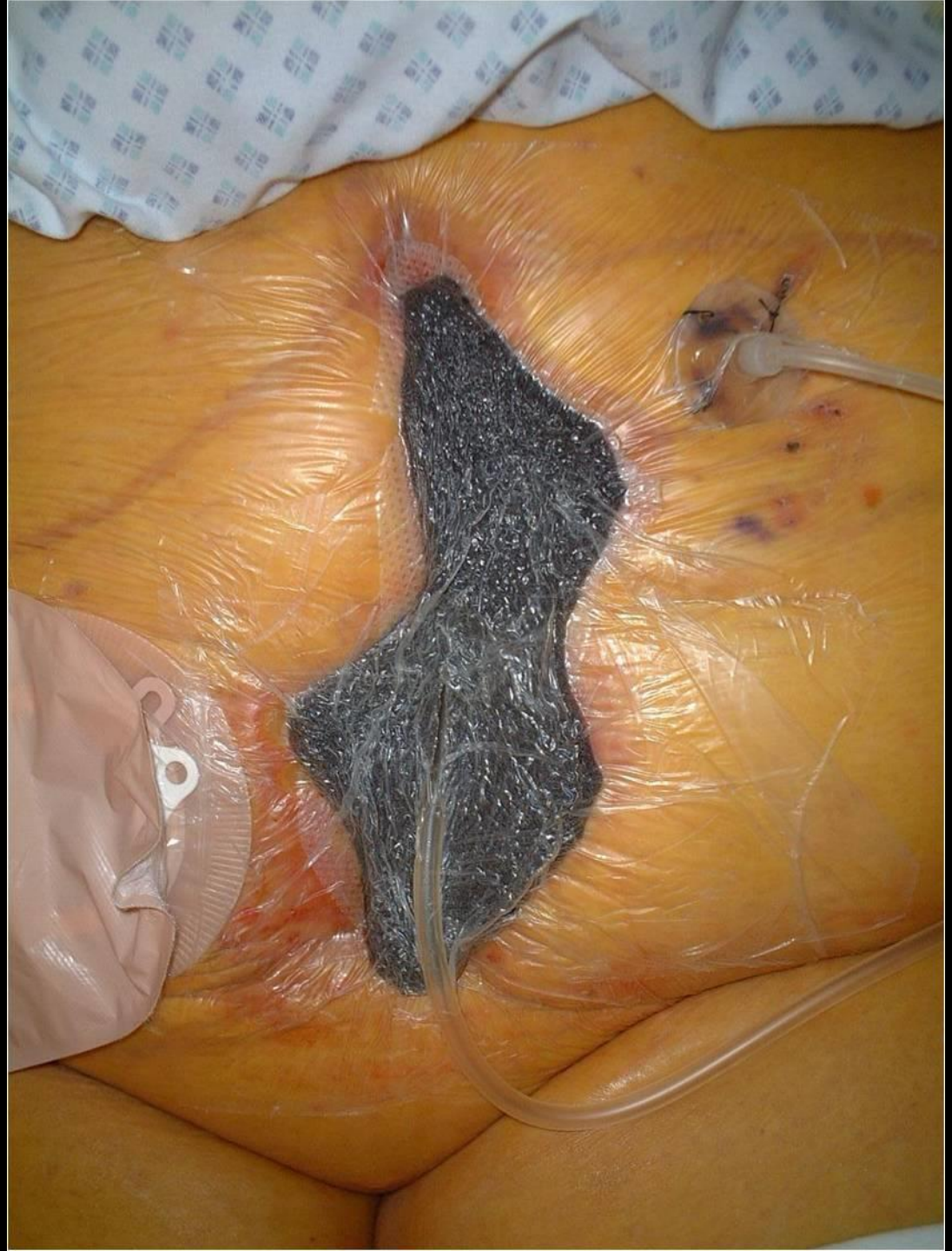
Case Study: Mary

- Bowel cancer
- Bowel resection
- Failed anastomosis and dehisced abdominal wound
- Liver failure
- Small bowel fistula
- Copious corrosive exudate
- Not going to recover, palliative approach


Wound Measuring Guide

Management Plan

- Improve comfort and QoL
- Contain exudate
- Protect skin
- Reduce dressing changes
- Transfer from ICU to ward for palliative care




QUESTIONS