



Nursing Practice Reference

Title: CARE OF MALIGNANT WOUNDS

Effective Date: May, 2011

Approved:

Sites: All
 AC CSI FVC VC VIC Other

Reason for Directive:

To provide comprehensive evidence based practice guidelines for Registered Nurses who care for patients with a malignant wound.

Definition:

Malignant wounds are the result of cancerous cells infiltrating the skin and its supporting blood and lymph vessels causing loss in vascularity leading to tissue death. The lesion may be a result of a primary cancer or a metastasis to the skin from a local tumour or from a tumour in a distant site. It may take the form of a cavity, an open area on the surface of the skin, skin nodules, or a nodular growth extending from the surface of the skin (Wilson, V., 2005; Lazelle-Ali, C., 2007; Grocott, P., 2007). A malignant wound may present with odour, exudate, bleeding, pruritis and pain and interfere with the patient's quality of life.

Malignant wounds occur in 5%-10% of patients with metastatic disease, most often in the last six months of life (MacDonald, A., & Lesage, P., 2006).

Directive:

The Registered Nurse is responsible for accurate assessment, individual care plan development, treatment and comprehensive documentation of the patient's condition.

Principles of Palliative Wound Management:

Palliative wound management may be structured around three core principles: treatment of the underlying tumour and management of co-morbid conditions; symptom management; and local wound management (Grocott, P., 2007).

Treatment of the Underlying Tumour and Co-morbid Conditions

Treating the underlying cause of a malignant wound may involve surgery, radiation therapy, chemotherapy or hormone therapy. Managing symptoms such as bleeding, exudate and pain, reducing tumor size and promoting wound healing whenever possible can be additional aims of treatment (Grocott, P., 2007). A reduction in the impact of symptoms may contribute to the overall comfort of the patient.

Patients presenting with co-morbid conditions such as COPD, diabetes, poor nutritional status, advanced age or heart disease may be at risk for impaired wound healing. Nursing assessment should include a review of the patient's overall health status, including existing conditions in order to inform an individualized patient care plan.

Symptom Management

The predominant symptoms associated with malignant wounds include pain, irritation and discomfort from excoriated skin, pruritis, odour emanating from the wound, and bleeding. A variety of both systemic and local treatments can be recommended. Nursing actions are outlined below in the "Assessment and Care of Malignant Wounds" section.

Local Wound Management

Wound bed preparation is a framework for managing the local wound environment. Grocott (2007) describes the components of wound bed preparation as follows:

- debride dead tissue unless natural scab is indicated
- reduce bacterial overload and odour
- manage exudate by evaporating excess fluid
- protect peri-wound skin from excoriation/maceration
- prevent soiling
- curb frequency of dressing changes.

Autolytic Debridement: Autolysis uses the body's own enzymes and moisture to re-hydrate, soften and finally liquefy hard eschar and slough. Autolytic debridement, which is recommended when managing malignant wounds, is selective and only necrotic tissue is liquefied. It is also virtually painless for the patient. Autolytic debridement can be achieved with the use of occlusive or semi-occlusive dressings which maintain wound fluid in contact with the necrotic tissue.

Grocott (2007) suggests that the clinical gains of debridement should be assessed critically as there may not be any benefit to a patient whose life expectancy is limited and the consequent exudate is profuse.

Psychosocial Considerations:

The location, appearance and/or odor of a malignant wound may be a source of distress for both the patient and family. Depression, social isolation and anxiety can occur within this population (MacDonald, A., & Lesage, P., 2006).

Body image is defined as a subjective picture of one's own physical appearance established both by self-observation and by noting the reactions of others (Merriam-Webster 2007). Patients with a malignant wound may fear how others will react to them resulting in a loss of confidence which may impact upon their quality of life.

The assessment of a malignant wound requires the nurse to gain insight into the patient's perception of the wound and its consequent impact on his/her life (Lavery, D., 2003). Nursing care requires counseling skills and knowing how to provide care that is based on an awareness of and insight into the dying patient's experience (Lazelle-Ali 2007).

Assessment of Clinical Presentation	Objective	Action
<p>4. Exudate</p> <p>a. Assess for clinical signs of infection:</p> <p>Local Infection - 2 or more of the following:</p> <ul style="list-style-type: none"> • change in nature of drainage from serous to purulent • erythema and/or edema of surrounding tissue • increased drainage • increased tenderness in and around wound <p>Systemic Infection:</p> <ul style="list-style-type: none"> • fever and WBCs > 10,000 <p>b. Assess for Odour</p> <p>c. Assess amount of exudate</p>	<p>Control wound bioburden</p> <p>Treat infection</p> <p>Manage odor</p> <p>Manage drainage</p>	<p>Cleanse well. If needed, use a 35 cc syringe with a 19 gauge cannula to clean with pressure. Avoid applying pressure to wounds prone to bleeding</p> <p>Culture wound (refer to Perry and Potter, 2010 pp.1143-1145)</p> <p>Consult with physician re: management of infection</p> <p>Increase dressing changes</p> <p>Confer with Physician regarding the use of a topical antimicrobial ointment and/or systemic antibiotics. Consider use of charcoal and/or barrier dressings</p> <p>Use absorbent hydrofiber or hydrocolloid dressings to prevent pooling of exudate:</p> <p><i>*** If drainage cannot be contained with dressings, consider layering, pouching, consult with ET nurse if available</i></p>
<p>5. Pruritus</p> <p>Irritation caused maceration. A creeping, intense itching sensation.</p>	<p>Improve comfort</p>	<p>Not generally responsive to treatment with antihistamines. Tricyclic antidepressant and paroxetine may be used. TENS (transcutaneous electrical nerve stimulation)</p>

Assessment of Clinical Presentation	Objective	Action
<p>6. Surrounding Skin</p> <p><i>a. Intact</i></p> <p><i>b. Irritated/macerated</i></p> <p><i>c. Pain with Dressing Change and/or Wound Pain</i></p> <p><i>d. Sensitivity / Allergies to Dressing Products and / or Tapes</i></p>	<p>Protect skin Prevent trauma Promote skin integrity</p> <p>Prevent or manage skin infection</p> <p>Prevent / control pain</p>	<p>Consider use of barrier ointment Use non-adherent, moisture retentive dressing for fragile skin Keep skin clean and dry</p> <p>Consider yeast infection if area moist and shows erythema, papular rash, burning, itching, and scaling. Consult physician</p> <p>Assess routinely using pain assessment tool Symptom Management Guidelines : BC Cancer Agency Administer analgesic prior to dressing change Use topical anaesthetic creams, gels, spray or cold packs Consider use of relaxation, therapeutic touch (TT), etc.</p> <p>Assess at each dressing change Minimize use of tape</p>
<p>7. Functional Compromise</p>	<p>Develop individualized care plan which addresses obstacles to managing ADL's</p>	<p>Patient assessment to include identifying any deficits related to the characteristics or location of the wound i.e. sensory losses affecting sight and hearing or change in ability to mobilize and/or manage self care</p>

Recommended Applications

Application	Actions and Indications	Considerations
1. Hydration (hydrocolloids, hydrogels, hydrofiber, foam dressings, polysaccharide beads or paste and alginate dressings)	<ul style="list-style-type: none"> ▪ Maintains a moist wound environment which prevents trauma resulting from wound drying and fissuring ▪ Stimulates epithelial cell migration over any normal tissue to facilitate resurfacing ▪ Can be placed directly into a cavity ▪ Prevents dressing adherence, bleeding or pain ▪ Wounds with slough or necrotic tissue requiring debridement ▪ Minimally exudating wounds 	<ul style="list-style-type: none"> ▪ Not advised for heavily draining wounds
2. Absorbent (hydrofiber)	<ul style="list-style-type: none"> ▪ Managing heavy exudate ▪ Increase absorption and protect skin from exudate ▪ Supporting debridement in exudating wounds ▪ Preventing trauma to fragile wound tissue ▪ Can be packed into cavities ▪ Preventing leakage, contamination and peri-skin breakdown ▪ Decreasing dressing bulk ▪ Promoting comfort ▪ Aesthetic covering 	<ul style="list-style-type: none"> ▪ Product may increase slightly in size with absorbing action ▪ Layer wicking prevents maceration of peri-wound skin ▪ Layering dressing increases absorption capability ▪ Adhesive styles of dressings may facilitate odour containment
3. Non-Adherent	<ul style="list-style-type: none"> ▪ Fragile tissue protection ▪ Useful as wound contact layer ▪ Prevention of adherence and pain 	<ul style="list-style-type: none"> ▪ Minimal absorption capability

Application	Actions and Indications	Considerations
<p>4. Control bleeding (Hemostatic agents and dressings)</p>	<ul style="list-style-type: none"> ▪ Mineral or biologic materials used to improve the efficacy of dressings to control bleeding in noncompressible areas ▪ Maintain hemostasis ▪ Calcium alginates exchange sodium ions with calcium ions in the wound bed and encourage blood clotting cascade ▪ Thromboplastin, a natural blood-clotting agent obtained from bovine plasma, is available as a powder for topical application. However, systemic injection or absorption can lead to serious clotting. ▪ Absorbable gelatin is available as a sterile sponge-like dressing or sterile powder. It can be applied dry or saturated with sterile sodium solution and is absorbed within 4–6 weeks. When applied, fibrin is deposited in the interstices of the foam, resulting in swelling of the sponge, thereby forming a large synthetic clot. ▪ Fibrin sealants are derived from human plasma and reproduce the final steps in the coagulation pathway to form a clot. 	<ul style="list-style-type: none"> ▪ May be prohibitively expensive for regular usage
<p>5. Odour Reducing (activated charcoal and barrier dressings)</p>	<ul style="list-style-type: none"> ▪ Ability to absorb the small gas molecules that are responsible for the production of malodour ▪ These molecules are attracted to the surface of the carbon and are held there ▪ Absorbs bacterial spores ▪ Provides a barrier to support odour reduction 	<ul style="list-style-type: none"> ▪ May be used a secondary dressings ▪ Some products have activated ingredients that require use as the primary contact layer
<p>6. Multiple or Layered Dressings</p>	<ul style="list-style-type: none"> ▪ Apply individual dressings over each area of the wound if possible. This allows areas of heavy exudate to be treated more frequently without disturbing other areas of the wound ▪ If dressings overlap, apply the dressing with the longest wear time first. Label dressings with date ▪ Ensure that the underlying dressing is moisture resistant. Transparent films, hydrocolloids and waterproof tape enhance moisture resistance 	<ul style="list-style-type: none"> ▪ Areas of flexion and extension require dressings with effective adhesion ▪ Skin folds and creases require individual assessment and management in order to prevent migration of drainage

Care of the Skin During Radiation Therapy

Refer to the Care of Radiation Skin Reactions document for recommendations associated with the care of malignant wounds in patients being treated with external beam radiation.

[Radiation Skin Reactions : BC Cancer Agency](#)

References:

- Benbow, M., (2008). Exuding wounds. *Journal of Community Nursing*. 22, (11), pp. 20-26.
- Grocott, P., (2007). Care of patients with fungating malignant wounds. *Nursing Standard*. 21 (24), pp. 57- 66.
- Haisfield-Wolfe, M.E. & Baxendale-Cox, L.M. (1999). Staging of malignant cutaneous wounds: A Pilot Study. *Oncology Nursing Forum*. 26 (6), pp. 1055-1064.
- Haisfield-Wolfe, M.E. & Rind, C. (1997). Malignant cutaneous wounds: A Management Protocol. *Ostomy/Wound Management*. 43 (1), pp. 56-66.
- Hampton, S., (2008). Malodorous fungating wounds: how dressing alleviate symptoms. *Wound Care*. June 2008, pp. S31-S38.
- Harmer, V., (2008). Breast cancer. Part 3: advanced cancer and psychological implications. *British Journal of Nursing*. 17 (17), pp. 1088-1098.
- Laverty, D., (2003). Fungating wounds: informing practice through knowledge/theory. *British Journal of Nursing*. 12 (15), pp. S29-S40.
- Lazelle-Ali, C., (2007). Psychological and physical care of malodorous fungating wounds. *British Journal of Nursing*. 16 (15), pp. S16-S24.
- Lloyd, H., (2008). Management of bleeding and malodour in fungating wounds. *Journal of Community Nursing*. 22 (8/9), pp. 28-32.
- McDonald, A., & Lesage, P., (2006). Palliative Management of Pressure Ulcers and Malignant Wounds in Patients with Advanced Illness. *Journal of Palliative Medicine*. 9 (2), pp. 285-295.
- Merriam-Webster's Medical Dictionary, (2007). Merriam-Webster, Inc.
<http://www.merriam-webster.com/medical/body%20image>. Visited on January 5, 2011.
- Milne, C., Corbett, D., & Dubuc, D., (2003). Wound, ostomy and continence nursing secrets. http://books.google.ca/books?id=xSCuk2ySfwAC&dq=psi+to+cleanse+wounds&source=gbs_navlinks_s. Visited on February 24, 2011.
- Nazarko, L., (2006). Malignant fungating wounds. *Nursing & Residential Care*. 8 (9), pp. 404-406.

Perry, A., & Potter, P., (2010). *Clinical Nursing Skills & Techniques*. Seventh Addition. Mosby, Inc., St. Louis, Missouri, USA. pp. 1143-1145.

Schulz, V., Kozell, K., Biondo, PD., Stiles, C., Tonkin, K., & Hagan. N.A., (2009). The malignant wound assessment tool: a validation study using a Delphi approach. *Palliative Medicine*. 23, pp. 266-273.

Wilson, V., (2005). Assessment and management of fungating wounds: a review. *Wound Care*. March 2005, pp. S28-34.

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