

NHS Forth Valley

**Guidelines for the
Management of Malignant Wounds**

M:EMPHIS PATHWAY

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M:EMPHIS PATHWAY

Patients living with malignant fungating wounds, require a full holistic assessment to address their psychological aspects, social and emotional needs. This pathway is a guide to help manage the challenging, local wound symptoms your patient may experience.

Malignant wounds – local symptom management guide

Exudate

Malodour

Pain

Haemorrhage

Infection

Skin Issues

MALIGNANT WOUNDS

Malignant fungating wounds are defined as an infiltration of a tumour or the metastasis into the skin and can involve the afferent blood and lymph vessels. They can develop anywhere in the body, but are most common on the breast, head and neck areas. (EONS 2015).

Management of these types of wounds is conservative management of patient symptoms and is not a curative approach.

Always use a Wound Assessment and Treatment Chart.

EXUDATE

Malignant, fungating wounds can often produce excessive amounts of exudate, which can be difficult to manage effectively. The exudate is due to the tumour cells causing tissue damage and increased leakage from blood vessels/lymph vessels.

– NB Negative pressure Wound Therapy cannot be used on malignant wounds

The presence of malignancy is considered a contraindication to the use of negative pressure wound therapy (NPWT) because of concerns that it may promote tumour genesis (stimulate proliferation of malignant cells/ tumour development) and expedite metastasis.

Refer to Forth Valley Exudate Pathway for further guidance on assessing the volume and consistency/colour of exudate.

<https://staffnet.fv.scot.nhs.uk/wp-content/uploads/2019/03/Exudate-pathway.pdf>

Always use a non adherent wound contact layer over the wound to reduce the possible risk of trauma and bleeding on removal.

Consider the absorbency of secondary dressings such as alginates, hydrofibres, foams and step up to superabsorbent dressing as necessary. Aim to achieve a close fitting dressing with a good seal to prevent leakage. Nutritional support may be required if exudate levels are excessive when related to loss of protein – consider a referral to dietician as appropriate.

MALODOUR

Malodour from malignant wounds is thought to be caused by a combination of bacteria, aerobic and anaerobic, necrotic tissue, poorly vascularised tissue and high levels of exudate.

If odour is thought to be due to infection – refer to section on Infection

If odour is thought to be due to high levels of exudate – refer to section on Exudate

If slough and/or necrotic tissue in the wound is thought to be contributing to malodour then consider treatment advice below:

- Surgical or sharp debridement is not recommended due to high risk of bleeding
- Autolytic debridement is the preferred option using appropriate primary dressing to provide a moist wound healing environment. Consideration should be given to levels of exudate.
- The use of mild antiseptic wound cleansers such as Prontosan to irrigate or as a soak, which contains PHMB* can help reduce odours by disrupting bacteria. (*polyhexamethylene biguanide).
- Use of hydrogels, alginate fibres, hydrofibres, medihoney ointment, Prontosan wound Gel X or alginogel such as Flaminal Hydro or Flaminal Forte if wound wet ad sloughy(refer to manufacturer's instructions)
- Consider odour controlling dressings with activated charcoal – for example actisorb silver 220 (wound formulary) carboflex (non wound formulary)

- Consider using essential oils with guidance from local complimentary therapy team – contact local Hospice for advice (01324 826222)

PAIN – related to a wound

It is important to consider the type and duration of a patient’s pain. Pain associated with malignant fungating wounds can have multiple aetiologies, detrimental effects on quality of life and is a common distressing complaint.

Pain can depend on where the wound is located on the body, the extent and depth of the wound and the invasion of the tissues. Damage to the nerves can also affect the pain being felt. Pain may also be related to periwound skin damage such as maceration or inflammation (see section on SKIN) as well as disturbance of the wound at dressing changes.

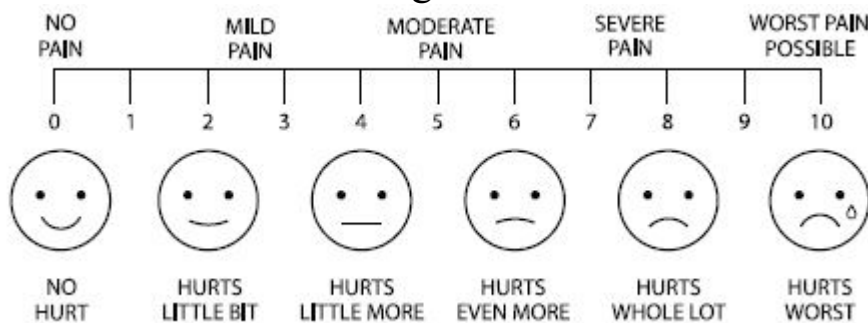
Managing Pain

Wound cleansing – limit to when necessary to remove excess exudate and debris. Irrigate wound with an appropriate cleansing solution rather than gauze swabs to cleanse area.

Dressings – choose low adherent dressings that minimise trauma and pain during application and removal eg silicone based products/low adherent dressings. Use dressings that provide a moist environment rather than dry dressings. Use dressings that will address other issues such as exudate and odour to minimise the frequency of dressing changes.

Infection – if any clinical signs of infection, then swab wound for bacteriology culture and treat as necessary to reduce possible pain caused by infection.

Analgesia – Ensure analgesia administered as prescribed and according to patients need. Use a recognised Pain Assessment Tool:



Refer to pain specialist team as necessary. Application of topical opioids to the wound may be useful in reducing pain – refer to palliative care team/Hospice Team/TV Team for advice as necessary.

HAEMORRHAGE

Bleeding from a malignant fungating wound can be common due to malignant cells eroding blood vessels; this is compounded by decreased platelet function within the tumour itself. Bleeding can also be caused by inappropriate dressings or rubbing from clothing. A medical adhesive removal product can also be used to aid removal of dressings to minimise trauma and bleeding.

Bleeding can be an emergency situation and would require a 999 response/possible surgical intervention for cauterisation unless other strategies have been pre documented in patients advanced care plan.

Light Bleeding

Apply gentle local pressure to bleeding point for 10 –15 minutes with a moist, non-adherent dressing, which can help restrict bleeding vessels. Apply an alginate/ haemostatic dressing to aid haemostasis for lightly bleeding wounds. These encourage the body's blood clotting mechanism to work. Often advisable to use a non adherent silicone dressing beneath an alginate dressing to ensure it does not adhere to wound bed when bleeding stops.

Heavy Bleeding

If applying pressure and simple haemostatic dressing are failing to work then depending on stage of patient's illness and documentation in advanced care plan, there are other haemostatic agents that could be utilised under specialist/medical guidance if admission to hospital is not the course of action to be followed:

- Oral tranexamic acid or tranexamic acid (antifibrinolytic agent) made into a paste applied under dressings. Tranexamic acid 500mg in 5ml soaked into gauze and applied with pressure for 10 minutes.
- Topical sucralfate paste; can be made by crushing two 1-gram tablets in 5mL of water soluble gel and applied topically 1-2 times daily.
- Topical adrenaline (epinephrine) 1 in 1000 (1mg in 1ml) can be applied on gauze along with pressure to areas that are bleeding heavily to induce local vasoconstriction. Be aware may also cause 'rebound' bleeding once these effects wear off. Excessive use can cause ischaemic necrosis.
- Silver nitrate sticks can be used to cauterise small bleeding points
- Haemostatic surgical dressings/sponges can be used for heavier bleeding. They are often used in the operating theatre, but are not readily available in the community but may be obtainable through liaison with the local surgical services. For example: Spongostan; Ferrosan, Celox dressings. Contact Hospice/TVS Team for advice.

Severe / Catastrophic End of Life Bleeding

If possible significant bleeding can be anticipated, then the patient/family/carers should be forewarned and the following suggested guidance implemented:

Ensure a supply of dark sheets and towels are available along with other equipment eg haemostatic dressings, gloves, aprons, clinical waste bags. Just in case medications available as per local protocols including Benzodiazepines to lessen patient's distress.

This should all be recorded clearly in the patients ACP.

(Scottish Palliative Care Guidelines (2013) Updated 2019 Health Care Improvement Scotland. Available at: <https://www.palliativecareguidelines.scot.nhs.uk>)

INFECTION

Malignant fungating wounds are at a high risk of developing infection as the blood supply to the tumour is outgrown which results in necrosis. Conditions in a necrotic wound are ideal for bacterial invasion and multiplication (commonly aerobic and anaerobic bacteria).

If the wound presents as clinically infected as evidenced by the presence of erythema, induration, increased pain, exudate and fever, take a wound swab for bacteriology and culture and antibiotics may need to be considered. The wound should be cleansed prior to taking bacteriology swab to ensure results are not contaminated by surface debris. NB Antibiotics should only be considered if wound swab positive and patient systemically unwell.

An antimicrobial dressing can be applied to help reduce the number of bacteria present in the wound and help reduce odour.

For dry /low levels of exudate – Flaminal Hydro or Honey based dressings tulle or ointment.

For moderate to high levels of exudate – Flaminal Forte, Hydrofibre dressings with silver.

Wound cleansers containing Polyhexamethylene Biguanide (PHMB) such as Prontosan can also be useful in helping reducing the bacteria burden

The appropriate use of antimicrobial dressings should be used in conjunction with the use of Ropper Infection Ladder – consult FV Wound Management Formulary.

<https://staffnet.fv.scot.nhs.uk/a-z/nursing/assuring-better-care/campaigns/tissue-viability/>

Metronidazole Topical Gel

Limited evidence from small clinical trials has shown topical Metronidazole to be effective in the elimination or substantial reduction of malodour. It's particularly effective against anaerobic bacteria and protozoa. Thus, helping to reduce malodour.

However topical Metronidazole may be ineffective when diluted with large amount of exudate or in the presence of thick necrotic tissue.

The British National Formulary advises that this gel should be prescribed for short term use only, usually daily for 7 days.

SKIN ISSUES

The skin surrounding a malignant fungating tumour – periwound skin – is susceptible to erythema, irritation, overhydration and maceration caused by excess exudates and/or occlusive dressings. There can also be associated pruritus with this skin damage or due to the tumour growth itself when the skin is stretched and nerve endings are irritated.

Maceration

Protect the periwound skin with a suitable barrier film depending on the type of skin damage. Do not use adhesive dressings on the vulnerable skin.

Ensure appropriate absorbent dressings are used to address exudate levels – consult FV Exudate Pathway

Excoriation

Consider what the cause is – is it excess exudate, skin stripping, allergy to dressing products

- Protect surrounding skin with barrier film
- Consider use of silicone secondary dressing if skin stripping evident
- Select alternative dressing if allergy suspected
- Consider topical steroid treatment if no response to above or skin excoriation is severe
- Consider if adhesive remover is required at dressing changes

Pruritus (Itch)

Consider the cause of the itch – exudate, allergy to dressings, endogenous.

- Reverse the cause of the itch where possible i.e. exudate management, alternative dressings, good skin hygiene technique at dressing changes
- Skin Barrier Film if appropriate
- Simple emollient may be required if skin dry but not able to be used in conjunction with adhesive dressings.
- Consider oral antihistamine under medical advice
- Consider topical steroid treatment
- Seek further medical advice as necessary.

M:EMPHIS pathway for malignant wounds
 This pathway is designed to aid clinicians caring for patients with malignant fungating wounds
 FOR FURTHER INFORMATION ON ANY ELEMENT BELOW PLEASE REFER TO THE M:EMPHIS GUIDELINE BOOKLET



Consider all aspects of wound management below

EXUDATE	MALODOUR	PAIN (related to a wound)	HAEMORRHAGE	INFECTION	SKIN ISSUES
<ul style="list-style-type: none"> Assess volume and appearance as change may indicate infection 	<p>If cause of odour is devitalised tissue then aid Autolytic debridement using Flaminal Hydro/Forte, hydrogel, hydrofibres dressing</p>	<p>Limit wound cleansing to only when necessary to remove excess exudate and debris</p>	<p>BLEEDING:</p> <ul style="list-style-type: none"> LIGHT—apply pressure for 10-15 mins with moist non-adherent dressing and apply alginate/haemostatic dressing HEAVY—apply pressure to wound. Utilise other haemostatic agents—see M:EMPHIS Guideline—seek urgent advice if no management plan already in place. 	<p>If wound is locally or clinically infected, an antimicrobial dressing should be applied:</p> <ul style="list-style-type: none"> For dry/low exudate—Flaminal Hydro or honey based dressings or ointment. <p>Metronidazole Gel can be considered for short term use.</p> <ul style="list-style-type: none"> For moderate/high exudate—Flaminal Forte or silver based hydrofibres dressings. <ul style="list-style-type: none"> Use of wound cleansers/soaks at dressing changes with PHMB* can be useful such as Prontosan. <p>*Polyhexamethylene Biguanide</p>	<p>MACERATION:</p> <ul style="list-style-type: none"> Protect surrounding skin with a barrier film Select an appropriate absorbent secondary dressing
<p>Consider absorbency of secondary dressing</p>	<p>Consider activated charcoal dressings as adjunct to above products. Place odour control dressing over absorbent dressing in wet wounds as it will not be effective when it becomes wet</p>	<p>Choose dressings that minimise trauma and pain during application and removal</p>	<p>SEVERE END OF LIFE BLEEDING ANTICIPATED/SUSPECTED—Give emergency contact Numbers to family/carers.</p> <p>Supply dark sheets/towels/gloves/aprons/plastic sheet/clinical waste bags</p> <p>Ensure Benzodiazepine, Adrenaline and calcium alginate dressings are in patient's home (see M:EMPHIS Guideline or further details)</p>	<p>If clinical signs of infection (increased pain, exudate, fever etc):</p> <ul style="list-style-type: none"> Take wound swab Consider antibiotics (only if patient is unwell and pending swab result) 	<p>EXCORIATION:</p> <ul style="list-style-type: none"> Consider cause i.e. exudate, skin stripping, allergy Protect surrounding skin with a barrier film Select alternative dressing if allergy suspected Consider topical steroid Use adhesive remover if skin stripping is the cause
<ul style="list-style-type: none"> Always apply non-adherent contact layer below to reduce trauma/bleeding risk 	<p>Irrigate or use soaked gauze on wound with PHMB* cleanser eg Prontosan at dressing changes</p>	<p>Give analgesia continually or prior to dressing changes dependent on need</p>			
<ul style="list-style-type: none"> Protect surrounding skin with barrier in highly exuding wounds 	<p>Commence Metrotop antibiotic wound gel if exudate levels are low. (7 days treatment) If high exudate then commence Flaminal Forte</p>	<p>Evaluate need for pharmacological and non-pharmacological strategies to minimise wound related pain</p>			
<ul style="list-style-type: none"> Consider referral to dietician if exudate is excessive 	<p>Increase dressing changes if necessary</p>	<p>Swab wound and treat infection that may be causing pain</p>			
<p>REFER TO EXUDATE PATHWAY FOR FULL GUIDANCE</p>	<p>Consider essential oils as per your local complementary therapy team guidance</p>	<p>Refer to pain specialist nurse, GP or palliative care team as necessary for further advice</p>			<p>ITCHING:</p> <ul style="list-style-type: none"> Consider cause—exudate, allergy, endogenous Reverse cause where possible Consider topical steroid Consider oral antihistamines Seek further advice if needed

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