FV Tissue viability Service

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

NHS Forth Valley

Consider all aspects of wound management below

EXUDATE

- Assess volume and appearance as change may indicate infection
- Use superabsorbent secondary dressing (refer to local formulary)
- Always apply non-adherent contact layer below to reduce trauma/bleeding risk
- Protect surrounding skin with barrier in highly exuding
- Consider referral to dietician if exudate is excessive
- REFER TO EXUDATE PATHWAY FOR FULL GUIDANCE

MALODOUR

- If cause of odour is devitalised tissue then aid Autolytic debridement using Flaminal® Hydro/Forte, hydrogel , Honey or hydrofibre dressings
- Consider activated charcoal or Cinesteam 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
- Irrigate or use soaked gauze on wound with PHMB * cleanser eg Prontosan at dressing changes
- Commence Metrotop antibiotic wound gel if exudate levels are low. (7 days treatment) If high exudate then commence Flaminal® Forte
- Increase dressing changes if necessary
- Consider essential oils as per your local complementary therapy team guidance

PAIN

- Limit wound cleansing to only when necessary to remove excess exudate and debris
- Choose dressings that minimise trauma and pain during application and removal
- Give analgesia continually or prior to dressing changes dependent on need
- Evaluate need for pharmacological and non-pharmacological strategies to minimise wound related pain
- Swab wound if suspected infection is the cause of the pain
- Refer to pain specialist nurse, GP or palliative care team as necessary for further advice

HAEMORRHAGE

BLEEDING:

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.

SEVERE END OF LIFE BLEEDING ANTICIPATED/ SUSPECTED–

Give emergency contact Numbers to family/carers.

Supply dark sheets/towels/ gloves/aprons/plastic sheet/ clinical waste bags

Ensure Benzodiazepine, Adrenaline and calcium alginate dressings are in patient's home

(see M:EMPHIS Guideline or further details)

INFECTION

If wound is locally or clinically infected, an antimicrobial dressing should be applied:

- For dry/low exudate—Flaminal® Hydro or honey based dressings or ointment. Metronidazole Gel can be considered for short term use. (maximum 7 days)
- For moderate/high exudate—Flaminal® Forte or silver based hydrofibre dressings.
- Use of wound cleansers/ soaks at dressing changes with PHMB* can be useful such as Prontosan.

If clinical signs of infection (increased pain, exudate, fever etc):

- Obtain wound swab
- Consider antibiotics (only if patient is unwell and pending swab result)

SKIN ISSUES

Refer to MASD guidance booklet

MACERATION:

- Protect surrounding skin with a barrier film
- Select an appropriate absorbent secondary dressing

EXCORIATION:

- Consider cause i.e. exudate, skin stripping, allergy
- Protect surrounding skin with Flamigel® or a barrier film
- Select alternative dressing if allergy suspected
- Consider topical steroid (diminishing regime)
- Use adhesive remover if skin stripping is the cause

ITCHING:

- Consider cause—exudate, allergy, endogenous
- Reverse cause where possible
- Consider topical steroid
- Consider oral antihistamines
- Seek further advice if needed

With permission—ADAPTED FROM POSIES PATHWAY by SHARON GARDNER AND KATHRYN TAYLOR, STOCKPORT NHS TRUST. SUPPORTED AND PRODUCED BY FLEN HEALTH UK Ltd.