POSIE'S Pathway

Clinical Support Pathway for Malignant Wounds

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POSIES PATHWAY Written by Sharon Gardner and Kathryn Taylor 2018, updated February 2023

POSIE'S CLINICAL SUPPORT PATHWAY FOR MALIGNANT WOUNDS

This pathway has been produced to aid clinicians caring for patients with malignant wounds. Its aim is to give guidance and support to a comprehensive holistic assessment.

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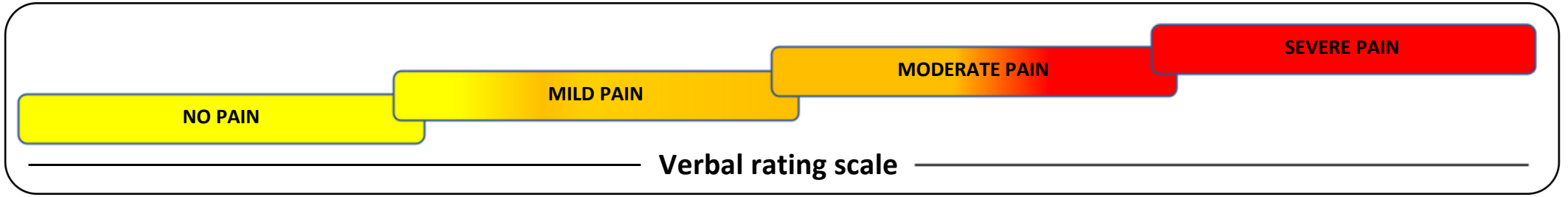
NB. Always follow local guidelines and seek specialist advice if needed when making wound management decisions.

PAIN (WOUND SPECIFIC)

Physical pain is a significant and complex phenomenon in malignant wounds. Pain can depend upon the area that the wound is located, the depth of the wound and its tissue invasion and damage and whether the nerves have been affected. Pain can also be due to macerated skin and inflammation as well as at dressing changes. It is important to consider the type and duration of pain.

Severity: Ask the patient which word best describes their current level of pain (use a recognised pain assessment scale)



Treatment plan:

- Choose dressings that minimise trauma and pain during application and removal (non-adherent atraumatic e.g. silicone). Evaluate patients need for pharmacological (topical/systemic agents) and non- pharmacological strategies to minimise
- wound related pain. See WHO/local analgesia guidelines.
- Swab wound and treat infection that may be causing pain if clinically indicated. Give analgesia continually, or prior to dressing changes, dependant on need. Always seek medical advice regarding analgesia.
- Refer to Pain Specialist Team, GP or Palliative Care Team if necessary for topical treatment advice. Use Polymeric membrane therapy dressing if clinically indicated.

ODOUR

This occurs when the tissue on the wound has been deprived of oxygen and nutrients and becomes necrotic with bacterial growth on the tissue. Malodourous wounds can have a negative impact on patients quality of life.

Establish cause of odour and reverse if possible: **Infection?** If suspected cause of odour is infection, then please refer to section on Infection **Slough/necrotic tissue in wound?** If suspected cause of odour is slough/necrotic tissue in the wound then follow the below steps:

Treatment plan:

Aid autolytic debridement with one of the following products: (if appropriate and safe)
(Surgical, sharp and mechanical debridement is not recommended for fungating malignant wounds).

- Hydrogel or Hydrogel sheet dressing. Some also contain antimicrobial properties.
- Alginate paste.

Odour controlling dressings should be considered as an adjunct to the above products if necessary (An activated charcoal dressings should be used for the containment of malodour and can be used as a secondary dressing over a non-adherent primary later).

- Gentle irrigation where necessary with normal saline or appropriate antibacterial cleansing agents.
- Commence Metronidazole antibiotic wound gel if exudate levels are low.
- Consider essential oils as per your local complementary therapy team.

European Oncology Nursing Society (2015) Recommendations for the Care of patients with Malignant Fungating Wounds.

For further help or advice, please refer to Tissue Viability or specialist team.

SKIN (AND TISSUE)

The skin surrounding the wound is very vulnerable to becoming sore and macerated due to exudate and frequent dressing changes, especially if there is an adhesive dressing being used.

The skin can also be very itchy (pruritis) which may be related to tumour growth.

If there is devitalised tissue in the wound, then please refer to the Odour section for debridement options.

Assessment of peri-wound skin:

Maceration:

- Protect the surrounding skin with a barrier film.
- Select an appropriate secondary dressing (see exudate section).

Excoriation

- Consider cause – exudate, skin stripping, allergy to dressings.
- Protect surrounding skin with a barrier film.
- Select alternative dressing if allergy is suspected.
- Consider silicone primary dressing if skin stripping evident.
- Consider topical steroid treatment.
- Consider adhesive remover required for dressing changes.

Itch:

- Consider cause of itch – exudate, allergy to dressing, endogenous.
- Reverse cause of itch if possible i.e. exudate management, alternative dressing etc.
- Consider topical steroid treatment.
- Consider bed linen and garments that reduce itching.
- Seek further medical advice if necessary.

INFECTION

These wounds are at high risk of developing infection due to the compromised blood supply to the tumour which results in necrotic tissue. This can act as a medium for anaerobic and aerobic bacterial infection.

Bacterial infection can be expected and should be treated accordingly:

- Local infection should be treated with topical cleansing, autolytic debridement (if appropriate) and antimicrobial agents. Please refer to local formularies and guidance.
- Medical grade honey, alginate paste, silver and carbon dressings should be assessed for the suitability in topically managing FMW.
- Systemic infection should be assessed and treated accordingly and the use of oral or IV antibiotics may be required.

If you are concerned that the wound is clinically infected as evidenced by erythema, induration, increased pain, exudate, and fever, a wound swab and antibiotics should be considered. N.B. Only consider systemic antibiotics if the patient is unwell and pending a swab result.

Metronidazole Topical Gel is a commonly accepted treatment for both aerobic and anaerobic bacteria and is delivered topically, thus avoiding the side effects of oral Metronidazole. The British National Formulary advises that this should be prescribed for short term use usually daily for 5-7 days. The use of gel can cause increased exudate which may exacerbate problems if exudate is a challenge which should be considered and discussed with the patient prior to commencement.

EXUDATE

Malignant wounds depending on their characteristics could have a tendency to produce moderate to high levels of exudate. Exudate is due to tissue damage and increased leakage from blood vessels and can vary in amount.

- Assess the colour, consistency, odour levels and amount of exudate to establish if increased levels are due to infection.
- Consider absorbency of secondary dressing being used. If current dressings are not absorbent enough then switch to a superabsorbent dressing. Always apply a non-adherent primary contact layer below any absorbent dressing to reduce the risk of trauma/ bleeding on removal.
- In wounds with high levels of exudate it is important to protect the surrounding skin from maceration/excoriation/wound edge breakdown by applying a skin barrier film.
- Consider a referral to a dietician for nutritional support where exudate is excessive due to loss of protein, which may affect wound healing and the well-being of the patient.

EXUDATE AND BLEEDING

Bleeding can be due to abnormal microcirculation, erosion, or compression of blood vessels by the tumour, decreased platelet function. It can also be caused by dressings adhering to wounds. Bleeding can be traumatic for both patients and their families/care givers. Prevention where possible is best, dressing changes and cleansing should only be performed where necessary.

Dressings should be removed carefully, using normal saline where required to minimize trauma (NICE, 2015). A medical adhesive removal product can also be used to minimize bleeding caused by removing adhesive dressings.

Radiotherapy and electrochemotherapy may be useful to control repetitive bleeds. Although fatal haemorrhage is rare, head and neck wounds that are adjacent to carotid arteries or those near the femoral artery are most likely to haemorrhage. The patient and family should be aware of this possibility and have sedative medications to hand should this event occur.

EXUDATE AND BLEEDING CONTINUED

Light bleeding:

- Local pressure should be applied for 10 – 15 minutes (with a moist non-adherent dressing) to external bleeding, which can help restrict bleeding vessels – however this should be done with caution as it may cause pain.
- Apply an alginate/ haemostatic dressing to aid haemostasis in wounds with light bleeding or where blood is present in the exudate. These work by encouraging the blood clotting mechanism to work.
- Alternatively, a non-adherent silicone wound contact layer can be used to reduce the number of dressing changes and to minimise the risk of trauma and discomfort on dressing removal.

Heavy bleeding:

- Apply pressure to the wound and seek urgent medical advice (this is an emergency situation, and you should call 999, unless there is appropriate documentation to advice patient not for hospital admission).
- Admission to hospital may be necessary depending on the stage of illness and the patients' wishes. Patient wishes should be clearly documented in the plan of care.

Severe end of life bleeding:

- Ensure family/carers have emergency contact numbers (this may not be 999 if PPC is home – families need to know this).
- Ensure a supply of dark sheets or towels along with other equipment – gloves, aprons, plastic sheet and clinical waste bags.

Ensure the following medications are in the patients home:

- Benzodiazepine (midazolam 10mg can be given into a large muscle such as deltoid, gluteal).
- Adrenaline (epinephrine) 1 in 1,000 for gauze soaks applied with pressure for 10 minutes.

9. Anti-fibrinolytic - tranexamic acid may be useful but only prescribed after specialist advice. Tranexamic acid topically at dressing changes 500mg / 5mls, 5-10 mls – as a preventative measure – off licence drug. Oral antifibrinolytics three times a day are prescribed if there is a tendency to bleed or bled before.

These wounds can develop an array of emotions and psycho-social needs.

Depression, anxiety, low self-esteem, and loss of sexual intimacy are among some of the needs expressed by individuals. It is important for the patient to feel supported.

Continually assess the psychological and social needs of the patient during each visit/appointment by thorough holistic assessment.

Research has shown that families are often the ones to support the patients, and they themselves may experience extreme psychological distress. As part of assessment for 'self' families and care giver needs should be considered too.

Discuss with the patient options for referral to counselling support services, Macmillan nurses and other services for social support for themselves and family members.

NICE (2015) Palliative Cancer Care – Malignant Skin Cancer, Clinical Knowledge Summaries www.nice.org.uk/palliative-care-malignant-skin-ulcer Accessed September 2018

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