Symptom Management Guidelines:
CARE OF MALIGNANT WOUNDS

SYMPTOM MANAGEMENT | RESOURCE | CONTRIBUTING FACTORS | APPENDIX

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. A malignant wound may present with odour, exudate, bleeding, pruritis and pain and interfere with quality of life. Malignant wounds occur in 5%-10% of patients with metastatic disease, most often in the last six months of life.

Focused Assessment

SYMPTOM ASSESSMENT

Normal
- Have you noticed any changes to your wound?
- What have you been doing to care for your wound?

Onset
- How long have you had this wound?

Provoking / Palliating
- What makes it feel better or worse?

Quality (in the last 24 hours)
- Do you feel that the plan for caring for your wound has been effective (type of dressing, cleansing of wound)

Region
- What areas are affected?

Severity / Other Symptoms
- Since your last visit, how would you rate the discomfort associated with your wound? between 0-10? What is it now? At worst? At best? On average?
- Have you been experiencing any other symptoms: fever, discharge, bleeding, odour.

Treatment
- How have you been managing the wound?
- Are you currently using any medications? How effective are they? Any side effects?

Understanding / Impact on You
- Is your wound and treatment impacting your activities of daily living (ADL)?
- Is your wound impacting your relationships with family and friends?
- Do you require any support to (family, home care nursing) care for your wound?
- Are you having any difficulty sleeping, eating, drinking?

Value
- What is your comfort goal or acceptable level for this symptom?

PHYSICAL ASSESSMENT

Vital Signs
- As clinically indicated

Assessing Wound
- Location
- Size of area
- Colour (black/necrotic, green/yellow sloughy)
- Depth (superficial/deep/layers involved)
- Signs of infection – local or systemic (see Appendix A)
- Exudate (colour, amount)
- Presence or absence of odour
- Description and intensity of pain
- Signs of fistula/sinus formation
- Presence or absence of bleeding
- Presence or absence of pruritis
- Condition of surrounding skin
- Ease and effectiveness of dressing protocol

Principles of Malignant Wound Management	
• Malignant wound care can be organized around three core principles: treatment of the underlying problem and co-morbid conditions; local wound management; and symptom control • Clinical assessment, documentation and evaluation are particularly important in palliative wound management where the evidence is not well established • The focus of care should also include: the individual's level of understanding about the wound and their preferences, impact on their quality of life, social and financial concerns, emotional, cognitive, behavioural and/or mental health concerns, impact of individual's environment on care	
Treatment of the Underlying Problem and Co-morbid Conditions	• Strict lines of demarcation between curative and palliative approaches may be inappropriate as disease modifying treatments can be used to make the day-to-day management of a wound easier and improve the quality of life • Treatments selections should include those that provide minimum side effects and maximum benefit to the patient • Treatments may include: surgery, chemotherapy, radiotherapy and hormone manipulation • Co-morbid conditions such as COPD, diabetes, or heart disease may put the patient at risk for impaired wound healing
Local Wound Management	• Establish goal of care healing vs palliation • Wound bed preparation will vary based on the goal. If healing is the goal, the wound bed should be free of bacteria and harmful enzymes that could delay healing. If palliation is the goal, careful debridement of dead tissue and management of bacterial overload is required to minimize odour and decrease risk of infection • Debridement can be **mechanical** (use of gentle wound irrigation with normal saline) or **Autolytic** (using the body's own enzymes and moisture to re-hydrate, soften and liquefy hard eschar and slough) • When associated with careful cleansing, dressings may contribute to wound cleanliness and can limit the symptoms associated with malignant wounds • For further wound management guidance, please refer to the *Decision Support Tool: Wound bed preparation for healable and non healable wounds* https://www.clwk.ca/buddydrive/file/guideline-wound-bed-preparation/
Symptom Control	• Symptoms can be systemic or local • Symptoms specific to the wound include: pain, irritation from excoriated and/or macerated periwound skin, pruritis, odour, exudates, spontaneous bleeding and hemorrhage • The need to manage more than one symptom at a time

Dressing Choices for Malignant Wounds

Type of Wound	Goals of Care	Dressing Choice
Low Exudate	• Maintain a moist environment • Prevent dressing adherence and bleeding	• Non-adherent contact layers • Amorphous hydrogels • Sheet hydrogels • Hydrocolloids – contraindicated with fragile surrounding skin, may increase odour • Semipermeable films – contraindicated with fragile surrounding skin
Moderate – High Exudate	• Absorb and contain exudates • Prevent dressing adherence and bleeding	• Alginates • Foams • Starch copolymers • Gauze • Absorbent cover dressings that contain exudates • Menstrual pads (excessive exudates)
Malodorous Wounds	• Wound Cleansing to prevent/control build-up of wound debris and microbes • Reduce or eliminate odour	• Activated Charcoal dressings • Topical antimicrobials • Dressings that support autolytic debridement

Adapted from: Bates-Jensen, B.M., Seaman, S., and Early, L. (2006). Skin Disorders: Tumor Necrosis, Fistulas and Stomas. In Betty R. Ferrell and Nessa Coyle (Eds.), *Textbook of Palliative Nursing 2nd edition* (pp.329-343) Oxford: Oxford University Press.

Follow this link to the Canadian Association of Wound Care website to find detailed information about dressing choices.

http://cawc.net/images/uploads/store/UPDATED_Product_Picker.pdf

Symptom Management	
Pain	For detailed information about pain management refer to the Symptom Management Guideline: Pain H:\EVERYONE\nursing\REFERENCES AND GUIDELINES\Symptom Management Guidelines\11. Pain.pdf • Can result from many causes and include emotional factors • Generally pain is of mixed etiology • Requires careful assessment, administration of appropriate analgesia (systemic, topical or both), monitoring of pain levels and emotional support • Pain may be present constantly or only at dressing changes – premedication may be required prior to dressing change • Topical analgesia include: topical anaesthetic creams, gels, sprays or cold packs • Considering use of relaxation, Therapeutic Touch (TT) prior to or during dressing change
Discomfort and/or Irritation from Macerated and Excoriated Skin	Goal is to protect and prevent damage of surrounding skin by: • Controlling exudates. • Protecting surrounding skin – barrier ointments or ostomy skin barriers • Limiting use of adhesive dressings – consider flexible netting, tube dressings, sports bras, mesh panties. If use of tape is unavoidable, apply hydrocolloid to skin first, then tape onto it.
Odour	Odour can have a profound emotional impact on both the patient and caregivers and can result in social isolation. There are limited strategies to use to control odour. They include: • Local cleansing – showering, gentle saline irrigation • Removal of necrotic tissue – with gentle irrigation, autolytic debridement or local debridement of dead tissue • Managing exudate • Use of topical or systemic antimicrobials • Use of activated charcoal dressings and/or barrier dressings • Use of essential oils or other aromatherapy products • Use of mentholatum to nostrils to assist with masking odour at dressing changes • Use of cat litter in the environment around the patient
Exudate	• Experiencing unexpected drainage on clothing or bedding may lead to feelings of distress and loss of control • Consider using absorbent hydrofiber and absorbent cover dressings with high absorbent capacity or hydrocolloid dressings to prevent pooling of exudate. • If drainage cannot be contained with dressings, consider layering, pouching, or consultation with Enterostomal Therapy Nurse if available. • Regularly scheduled clinical assessment for local or systemic infection
Pruritis	• Often described as a creeping, intense itching sensations • Can be disabling and difficult to treat • Generally does not response to treatment with antihistamines • Tricyclic antidepressant and paroxetine may be used • Antipruritic creams/lotions • TENS (transcutaneous electrical nerve stimulation) may be beneficial

Bleeding/Hemorrhage	• Viable tissue in a malignant lesion may be very friable, causing bleeding • Prevention is the best approach – using non adherent contact layer dressings and dressings that will maintain moisture balance • If dressings adhere, carefully soak off with saline soaks • If bleeding does occur the first intervention should be direct pressure for 10-15 minutes. Other interventions include use of hemostatic agents/dressings • On rare occasions, the tumour/wound will erode a major vessel resulting in a fatal bleed. These can be very distressing situations and being prepared ahead of time can be helpful (i.e. using dark coloured sheets, having dark towels available, preparing family and friends ahead of possibility

RESOURCES & REFERRALS	
Referrals	• BCCA Pain and Symptom Palliative Care • Home Health Nursing • Patient Support Centre, Patient Review • Telephone Care for follow up
Nursing Practice Reference	• Symptom Management Guideline: Pain H:\EVERYONE\nursing\REFERENCES AND GUIDELINES\Symptom Management Guidelines\11. Pain.pdf • Symptom Management Guideline: Radiation Dermatitis H:\EVERYONE\nursing\REFERENCES AND GUIDELINES\Symptom Management Guidelines\14. Radiation Dermatitis.pdf
Related Online Resources	• E.g. Fair Pharmacare; BC Palliative Benefits http://www.bccancer.bc.ca/NR/rdonlyres/AA6B9B8C-C771-4F26-8CC8-47C48F6421BB/66566/SymptomManagementGuidelinesRelatedResources.pdf
Bibliography List	• H:\EVERYONE\nursing\REFERENCES AND GUIDELINES\Symptom Management Guidelines\Bibliograpy - Master List.pdf

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Appendix A: Clinical Signs and Symptoms of wound infections

https://www.clwk.ca/buddydrive/file/guideline-summary-wound-infection-2017-january/

Appendix B: Factors to Consider When Managing Malignant Wounds

Factors to Consider When Managing Malignant Wounds	
Evidence and Guidelines	• Treatment of ulcerating and fungating wounds secondary to malignancy represents a clinical challenge given the paucity of evidence-based guidelines or established protocols • Managing malignant wounds is frequently based on expert opinion and the personal experiences of clinicians • Irrespective of the nature and requirements for managing the wound, the individual's wishes and expectations should form the basis of the decision-making process
Medical History Cancer Diagnosis and Co-morbidities	• Breast cancer (deep necrotic ulcerations or extensive cutaneous chest wall infiltration and necrotic cauliflower like structures) • Ovary, cecum, rectum cancers (abdominal wall invasion with necrotic cauliflower like structures) • Rectum and genitourinary tract cancers can cause protruding perineal growth, gross deformity and loss of normal function – potential for fistulas involving bladder bowel and vagina • Head and neck cancers (distortion of the face, fistulas, potential bleeding) • Chronic Obstructive Pulmonary Disease • Heart Disease • Anemia • Diabetes Mellitus • Compromised Immune System • Advanced age • Tobacco use
Nutritional Status	• Malignancy alone can compromise nutritional status. Patients who are poorly nourished may be at risk for poor wound healing and management
Psychosocial Impact	• The location, appearance and/or odour 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 • 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 • Nursing care requires counseling skills and knowing how to provide care that is based on an awareness of and insight into the patients' experience
Previous treatments and medications	• Previous surgery, chemotherapy and radiation may all have an impact on the care and management of the wound • Medications such as non-steroidal anti-inflammatory drugs and systemic corticosteroids
Availability of Resources and Social Network	• Dressing supplies can be expensive and may not be readily available • Family and friends may be relied upon to help care for malignant wounds

Appendix C: Flow Diagram, Principles of Wound Management