

# Management of malignant/cancerous wounds



Margi Moncrieff

Nurse Practitioner

Flinders Medical Centre

November 2008

# Skin cancer definitions

- ◆ A break in the epidermal integrity by infiltration of malignant cells
- ◆ May originate in the skin i.e. melanoma, BCC, SCC (primary skin cancer)
- ◆ Local invasion of skin by a primary or recurrent cancer (i.e. breast)
  - ◆ Metastatic spread from a distant cancer
  - ◆ 5% - 10% of cancer patients have cutaneous metastases

# Primary malignant wounds

- ◆ BCC's (most common): when completely excised, are expected to heal
  - ◆ SCC's curable if treated early; can metastasise
- ◆ A chronic wound can convert to a malignant wound (i.e. SCC)
  - ◆ Melanomas most serious and fatal

# Malignant wounds

Local invasion of skin by a primary or recurrent cancer (i.e. breast) or metastatic spread

The most common sites for malignant wounds, in order of prevalence are;

- ◆ Chest and abdomen (breast cancer patients having the highest prevalence of 47.1%)
  - ◆ Head and neck
  - ◆ Groin and extremities

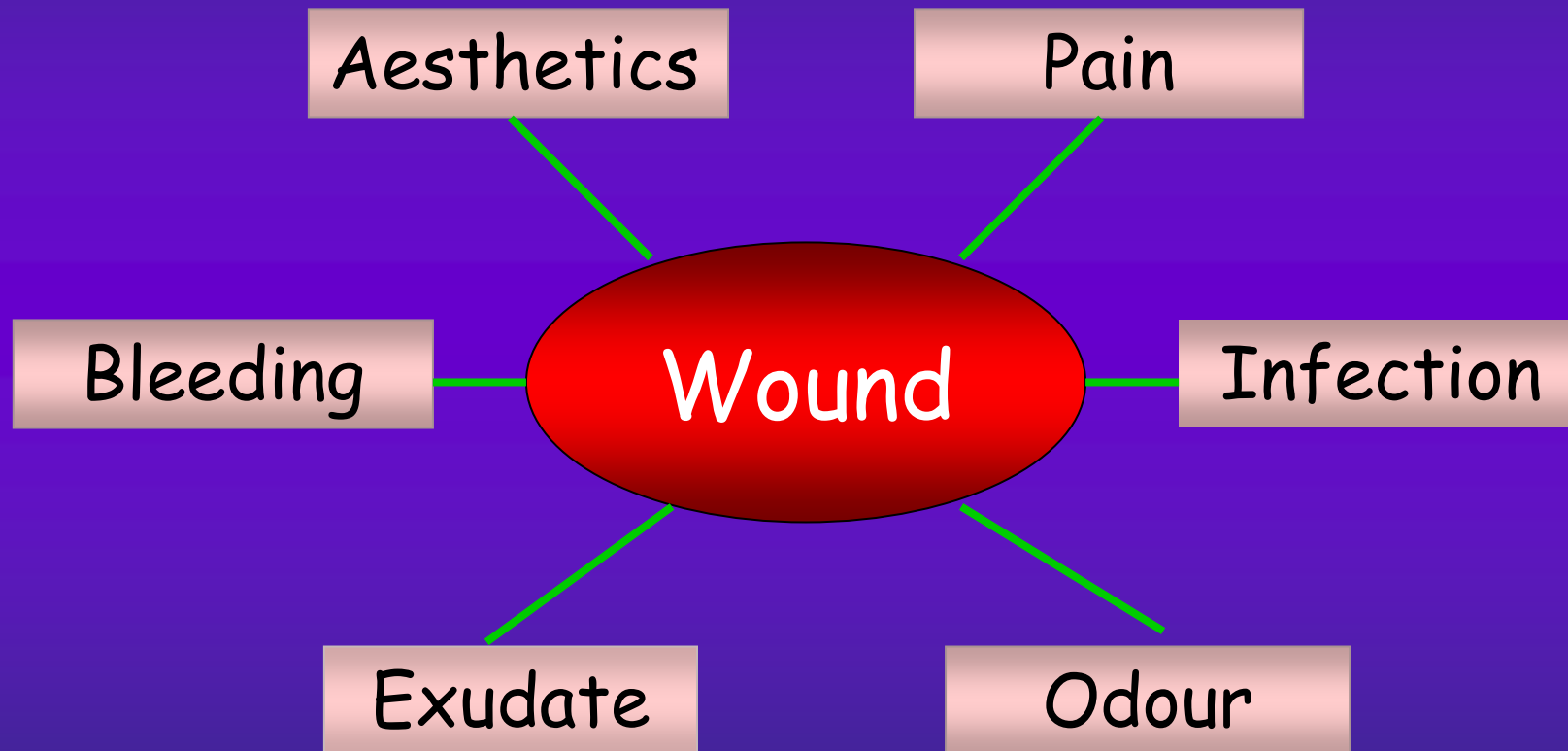
# Principles of wound management

- ◆ Define wound etiology
- ◆ Identify factors affecting healing
- ◆ Wound assessment & documentation
  - ◆ Product selection, regime of care
  - ◆ Evaluation of healing
- ◆ Discharge planning/continuity of care

# Local wound management

- ◆ Healing is not the goal
- ◆ Symptom management
- ◆ Dressing choice dependent on good wound assessment (& re-assessment)
- ◆ Determine moisture balance/imbalance
  - ◆ Understand product function
    - ◆ Creativity

# Considerations for symptom management of malignant wounds



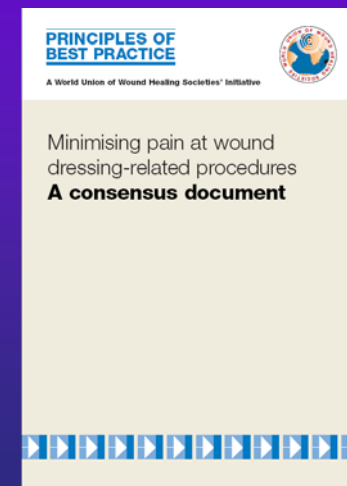
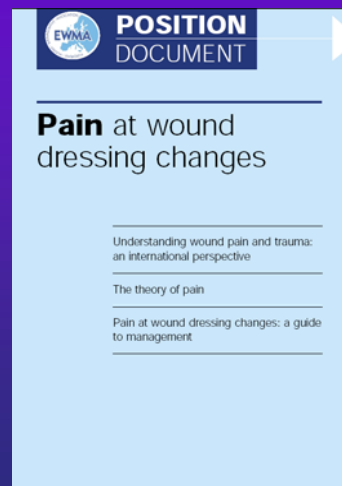
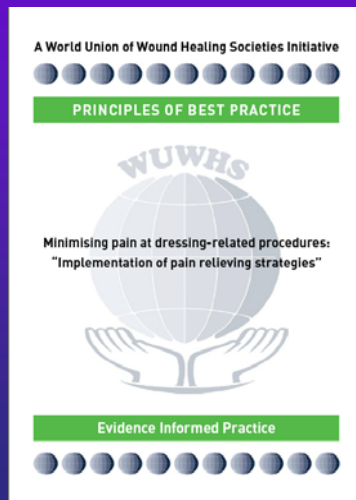
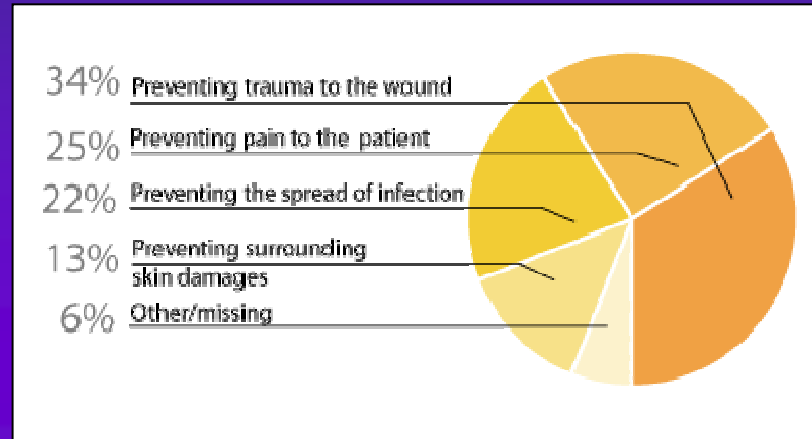
# Pain

- ◆ Directly related to tumour activity
  - ◆ Stimulation of nerve endings (nociceptive pain)
- ◆ Nerve dysfunction (neuropathic pain)
  - ◆ Dressing related (wound allowed to dry out, adherent dressings, irritant solutions)

# Pain

- Minimize pain associated with dressing change
- Appropriate analgesia including inhalation & topical
  - Topical opiates for nociceptive pain (morphine mixed with gel; 1mg/ml)
- Select dressings that are non-adherent
- Choice dependent on wound assessment and moisture balance

A wound care survey conducted in eleven countries identified that preventing pain and trauma at wound dressing change was a concern. Since the survey, several consensus documents have been released by WUHS and EWMA



# Wound Hydration

- ◆ Hydrogels; donate moisture
- ◆ For the dry cancerous wound where dressing adhesion has been a problem
  - ◆ Gels, gel sheet, gel packing
  - ◆ Most need a secondary dressing

# Moisture retentive

- ◆ Hydrocolloids
  - ◆ Adhesive, interactive dressings
- ◆ Exudate combines with inner layer and forms a gel
- ◆ Indicated for moist wounds that do not require re-dressing for up to 5 days

# Primary contact dressings

- ◆ Low adherent
- ◆ Paraffin gauze
- ◆ Cellulose acetate fabric with petrolatum
  - ◆ Can be used with gels beneath

# Infection

- ◆ Cancerous wounds are prone to bacterial burden and infection due to the presence of devitalized tissue
- ◆ Risk increases with immuno-suppression
  - ◆ Regular and gentle wound cleansing
    - ◆ Systemic antibiotics
    - ◆ Topical treatments

# Inadine

- ◆ Impregnated with an ointment containing 10% povidone iodine
  - ◆ Sustained release (antiseptic)
  - ◆ Gentle application, easy to remove
- ◆ Colour change indicates when dressing needs changing

# Silver Sulphadiazine

- ◆ Bacteriostatic: activity against gram -ve & +ve bacteria: especially effective against *Pseudomonas*
  - ◆ 12 hour spectrum of activity
  - ◆ Impregnate into a medium

# Honey

- ◆ Manuka or Leptospermum have antiseptic/antibacterial activity
- ◆ On interaction with wound exudate, honey releases hydrogen peroxide that kills bacteria
- ◆ Available as gel (for dry wounds), or impregnated into calcium alginate (exuding wounds)

# Silver dressings

- ◆ Silver provides antimicrobial protection
- ◆ Bactericidal, effective against MRSA and VRE
  - ◆ First choice in the immunosuppressed
- ◆ Need to understand type of silver, how much and how it interacts with the wound/exudate

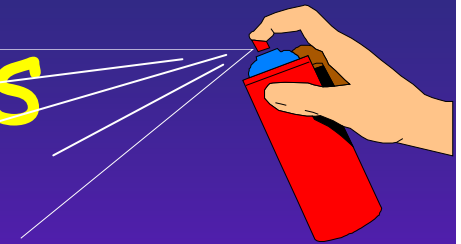
# Odour

- May be due to bacteria, infection or necrotic tissue
  - Anaerobic bacteria most common
- Necrotic tissue is a medium for bacterial proliferation
  - Cautious sharp debridement
- Impacts on QOL for the individual and the family
  - Impacts on nursing staff/carers

# Managing odour

- Regular dressing changes
- Systemic control: oral Metronidazole
- Topical control: Metronidazole Gel, dressings that are occlusive, bacteriocidal or charcoal impregnated
- Environmental control: Room deodorants, aromatherapy, kitty litter, ventilation

# Deodorising dressings



- ◆ Often multi-layered dressings
- ◆ Contact layer of alginate
  - ◆ Activated carbon or charcoal cloth
- ◆ Indicated for exudating, malodorous, wounds

# Exudate

- Most malignant wounds are highly exudating
- Tumor cells secrete vascular permeability factor
- Inflammatory response and the breakdown of bacterial proteases
  - Infection (observe quality )
    - Fistula
    - Reduces quality of life

# Managing exudate

- Use highly absorbent dressing products
  - Wound drainage/ostomy bags
    - TNP may be an option
    - Protection of bedding
  - May compromise surrounding skin
    - Skin protection
  - Frequent change of dressing

# Exudate management: moderate

- ◆ Foams
- ◆ Ability to absorb and hold a moderate amount of exudate
- ◆ Non-adherent wound contact layer
- ◆ Adhesive and non-adhesive

# Exudate management; heavy

- ◆ Calcium alginate dressings
  - ◆ Haemostatic properties
  - ◆ Hydrofibre dressing
- ◆ Both have the ability to absorb a considerable amount of exudate

# Other absorbent products

- ◆ May need to be creative!
  - ◆ Ostomy/wound bags
    - ◆ Absorbent pads
    - ◆ Sanitary napkins
- ◆ Incontinent sheets/protectors

# Skin protection

- ◆ Excessive exudate and strongly adhesive dressings can cause damage to the delicate surrounding skin
  - ◆ Avoid tapes/adhesives
- ◆ Incorporate skin protection in local management
- ◆ Creams containing zinc oxide & other ingredients to protect, repel fluid, soften, maintain skin pH
  - ◆ Protective barrier wipes to apply film over skin
    - ◆ Ostomy bags, hydrocolloids

# Holding dressings in place

When tape or adhesives may cause trauma....

- ◆ Tubular stockinette
  - ◆ Net panties
  - ◆ Crepe bandage
  - ◆ "boob tubes"

# Bleeding

- ◆ Due to erosion of capillaries or major vessels
- ◆ Decreased platelets and increased pressure from tumor infiltration
  - ◆ Infection
  - ◆ Trauma at dressing change

# Bleeding

- ◆ Non-adherent dressings
  - ◆ Cautious debridement
- ◆ Alginates, adrenaline, silver nitrate sticks, haemostatic agents, sucralfate.

# Aesthetics

- ◆ Wounds can be extensive and visible
  - ◆ Impact on body image
- ◆ Feelings of isolation, shame, depression
  - ◆ Sensitive approach/respect
- ◆ Dressings need to be comfortable and aesthetic

# Conclusion

- These wounds are challenging, complex and time consuming
- Require accurate assessment and re-assessment
- Multidisciplinary approach to achieve outcomes
  - Creativity
  - Persistence

## References

- ◆ Collier M, 2002, " Management of patients with fungating wounds" Nursing Standard Nov 29, vol 15, No 11
- ◆ EWMA - European Wound Management Association [www.ewma.org/](http://www.ewma.org/)
- ◆ [www.emedicinehealth.com](http://www.emedicinehealth.com)
- ◆ Grocott P, 2003, "The palliative management of fungating malignant wounds"  
[www.sawma.org.au/documents/fungating\\_wounds](http://www.sawma.org.au/documents/fungating_wounds)
- ◆ Naylor W, 2002, "Part 1: Symptom Control in the management of fungating wounds" [www.worldwidewounds.com](http://www.worldwidewounds.com)
- ◆ Vancouver Island Health Authority, 2007 "Wound and Skin Care Clinical Guidelines"; Chapter 9  
[www.viha.ca/ppo/learning/wound\\_skin\\_care.htm](http://www.viha.ca/ppo/learning/wound_skin_care.htm)
- ◆ World Union of Wound Healing Societies [www.wuwhs.org/](http://www.wuwhs.org/)