

# Holistic management of malignant wounds in palliative patients

## Abstract

Malignant wounds are a complication of cancer, and usually occur in those individuals with advanced disease. When healing ceases to be the goal, treatment is centred around symptom control and improving quality of life. Caring for individuals with malignant wounds presents challenges for patients, their families and nurses alike. This article discusses the holistic management of malignant wounds, with an emphasis on the control of both physical and psychosocial symptoms of wound management, as well as the impact

that this may have on all those involved. Common physical symptoms of malignant wounds include malodour, bleeding, pain, exudate and pruritis. Psychosocial symptoms may result in social isolation and depression. All these symptoms have a huge impact, not only on patients and their families, but also on healthcare professionals both during and after care. Managing these symptoms requires a multidisciplinary approach to facilitate the best possible outcomes for patients and their caregivers.

■ Malignant wounds ■ Symptom management ■ Palliative patients  
 ■ Holistic approach ■ Quality of life

**M**alignant wounds are a complication of cancer and occur when the cancer or metastasis infiltrates into the skin, blood and lymph vessels (Grocott and Cowley, 2001; Mortimer, 2003). Therefore, while these wounds are generalised alongside all other types of wounds, they are, in fact, extruding cancers, and not simply wounds. Accurately ascertaining the prevalence of malignant wounds is difficult, as there is no register that monitors their incidence (Adderley and Smith, 2007). Further, it is believed that the prevalence of malignant wounds is under-reported due to feelings of shame, fear and embarrassment (Lund-Nielsen et al, 2011). Alexander (2009a) suggested that the prevalence of malignant wounds is 5–10% among people with cancer and further stated that these wounds generally occur during the last 6 months of life and very rarely heal (Alexander, 2010). Naylor (2002) reported that 62% of malignant wounds are a consequence of breast cancer; 24%, head and neck cancers; 6%, genital and back cancers; and 8%, other cancers. It would be realistic to assume that with the many new and innovative treatments available, as well as population ageing, the incidence of malignant wounds will rise as more people live longer with cancer.

Malignant wounds are easily recognisable by their crater or cauliflower appearance (Seaman, 2006), and although the underlying aetiology may vary, these wounds have the potential to have a devastating impact on the individual and their carers, and are accompanied by challenging symptoms

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(Young, 2017). When treatment becomes palliative, goals are centred around the management of challenging and distressing symptoms and improving quality of life for patients and their families. The most distressing symptoms for those suffering with malignant wounds are pain, odour, bleeding, exudate and pruritis (itch). Unfortunately, the ideal dressing to manage all of these challenging physical symptoms does not yet exist. The shape of some tumours, particularly the undulating proliferative type, location and distressing symptoms can make them difficult to dress. Increased awareness of patients with these wounds and their needs should encourage industry to develop dressings that better manage these wounds. Further, forming close working relationships with patients and their families and developing achievable goals, plans and strategies is key to good symptom control.



## Managing pain

Malignant wound pain has many aetiologies and may be physical, psychosocial or spiritual. Therefore, holistic patient assessment should be conducted to ascertain the cause. Pain may be caused by any of the following: the tumour pressing on other body structures, damage to the nerves by the growing tumour, swelling resulting from impaired capillary and lymphatic drainage, infection, exposed nerve endings and poor dressing change technique (Woo and Sibbald, 2010). Pain may be nociceptive, neuropathic or mixed in nature (Naylor, 2001). To achieve effective pain control, correct diagnosis of pain aetiology is vital.

Nociceptive pain is the most common type of pain and occurs when nerve fibres are triggered by inflammation, chemicals or physical events. Symptoms would be what patients describe as throbbing, aching, pressure or overall discomfort. As a general rule, this type of pain responds well to paracetamol, non-steroidal anti-inflammatory drugs and opioids.

Neuropathic pain may occur as a result of disease, chemotherapy treatment, malfunction or changes in the peripheral nervous system (Fallon, 2013). When pain is neuropathic, patients experience sensations that may be one or a combination of the following: burning, tingling, shooting, numbness or pins and needles. They may also experience allodynia (pain at the lightest touch), hypoaesthesia (reduced sensation) or hyperalgesia (increased response to pain), along with an altered thermal response. When the pain is assessed to be neuropathic, patients may not respond to medications that generally manage nociceptive pain well. Instead, they might benefit from using medications such as pregabalin, gabapentin and amitriptyline (Fallon, 2013).

Any infection in the wound could also result in pain, and if diagnosed, should be treated accordingly. It is important to question whether the pain is in the background, constant, procedural or incidental. What makes it better and what makes it worse? Thus, a full pain medication review is vital to ascertain the type of pain to ensure the correct treatment plan is followed.

When pain is related to dressing changes and all other preventative measures have been undertaken without success, a fast, short-acting analgesic, such as entinox or fentanyl, may be considered. When wound pain is constant, a hydrogel or ibuprofen foam dressing may prove beneficial. The topical application of lidocaine patches (5%) may also help (Woo et al, 2015).

For more persistent wound pain, the topical application of diamorphine injectable 6.25–15 mg (usually 10 mg) mixed with 8 g of an amorphous gel might prove effective. However, topical diamorphine is most effective when the nerve receptors have not been damaged by the tumour, as the agent works by binding to nerve receptors (Twillman et al, 1999). Therefore, if nerve endings have been damaged, this treatment may prove ineffective. Transcutaneous electric nerve stimulation (TENS) has been used to alleviate wound pain with some success (Grocott, 2000), along with complementary therapy, distraction and relaxation techniques.

Dressings used for malignant wounds should be non-adhesive, soft, comfortable and sufficiently large to cover the entire area

without causing trauma. Correct application and removal techniques are vital, and cleansing should be kept to the minimum to prevent additional pain and trauma. Debriding by way of autolysis is preferred, and depending on the patient's prognosis, it may be pertinent to leave hard, necrotic tissue intact and simply protect the area.

Psychosocial and spiritual pain may be more difficult to diagnose and may not become apparent until a relationship between the nurses and patient has been formed. Supportive, in-depth and meaningful conversations should take place to enable the clinician to retrieve information regarding the cause of emotional pain. It may take time for the patient to discuss matters that they may have been suppressing for some time. It may be that the patient requires referral to members of the multidisciplinary team for them to access the correct professional who would be most effective in resolving any problems.

## Odour

Malodour is a common symptom of malignant wounds and is often described as one of the most distressing symptoms (Stringer et al, 2014). The characteristic odour is attributed to proliferation of bacteria (Tilley et al, 2016), appears able to remain on the clothes of patients and nursing staff and is very difficult to retain within one room when excessive. Odour can cause nausea, loss of appetite, social isolation and depression, and its impact on family, friends, carers and healthcare professionals may result in avoidance to spend time with the patient (Naylor, 2002; Morris, 2008). Like all other symptoms, accurately diagnosing the cause of odour is vital to ensure that the correct choice of treatment is made.

Dressings containing charcoal can trap and absorb odour particles, and those containing silver or honey work by reducing the bacterial and fungal load. Any of these dressings may prove effective in managing odour. All dressings should be completely sealed to prevent the odour escaping into the environment. For many years, metronidazole has been used to manage exudate and odour. However, some patients experience an increase in exudate with the use of this drug, and this possible side effect should be fully explained to them prior to commencing treatment.

Cleansing, if necessary, should be performed using a warmed solution of choice, which should be determined on the basis of wound status and the patient's wishes. An irrigation method should be used, as any rubbing of the tumour could cause bleeding, pain and trauma. If the patient is able to shower, this would not only cleanse the wound but could also have a positive impact on the patient's wellbeing. However, the quality, temperature and flow of the water would require assessment to ensure safety (Wilson, 2005).

Managing the environment is also key to maintaining the quality of life of patients with malignant wounds. When associated feelings such as embarrassment, shame and disgust are managed, patients and their families will be able to spend quality time together. The use of aromatherapy, atomizers, cat litter, charcoal, shaving foam and complementary treatments have been utilised (Gethin et al, 2014). Products such as cat litter and shaving foam should be placed in a suitable container in



an unobtrusive position within the room, and they should be refreshed frequently. These measures would need to be discussed with the patient and their family to ensure that no offence is caused with their use. It is important to remember that each malignant wound is unique, and that what is effective for one may not be for another. Only the individual patient and clinician can assess their effectiveness in any particular instance.

## Bleeding

Friable tissue within malignant wounds results in the ever-present threat of haemorrhage (Adderley, 2003). An advance care plan (ACP) should be in place to ensure that every potential event is covered, and that the person/persons caring for the patient have everything at hand to provide the correct treatment. Sympathetic conversations should be had in advance with the patient and their family regarding what may happen, and assurances should be given that those caring for the patient are in a position to administer the appropriate treatment to manage the situation (Hulme and Wilcox, 2008).

Red/dark towels should be stored close to the patient, along with a 'crisis' dose of midazolam (10 mg) (European Oncology Nursing Society, 2015). This dose can be repeated as prescribed, which would be discussed and agreed with a doctor in advance. Tranexamic acid (0.5–1 g) 5–10 ml (first line) or adrenaline 1:1000 (5–10 ml) can be applied topically to each point of bleed, in order to stem the bleeding. Injectables should be the first-line treatment, but crushed tranexamic acid tablets 500 mg in 10 ml of water to make a paste to apply to the wound would be acceptable, although they can leave a 'crust' on the wound. This should be left in place for 10–15 minutes, applying pressure if possible, and then removed. If the dressing dries out, it will adhere to the wound and cause more trauma at the next dressing change. Caution should be exercised with the use of adrenaline, as it may cause ischaemia, and has the associated risk of rebound bleeding (Naylor, 2002). For bleeding in the oral cavity, tranexamic acid mouthwash 5 mg in 50 ml of warm water can be used.

Non-adherent dressings and those with haemostatic properties should be used to manage superficial bleeding (Naylor, 2002), and once again, the correct application and removal techniques should be used. The use of tranexamic acid during each dressing change as a preventative measure on those wounds that have been known to bleed is becoming more commonplace. These agents are prescribed outside their licence, and careful documentation is required to meet professional and legal requirements (Twycross et al, 2014). A heavy bleed, even if it is not fatal, is distressing to the patient, family and clinician alike, and support should be available for all these individuals before, during and after the episode.

## Exudate

Increase in exudate may be caused by increased permeability within the tumour, infection or devitalised tissue (Alexander, 2009b). Management of exudate is essential for patient

confidence and comfort and can also contribute to decreased odour (Graves and Sun, 2013). Malignant wounds can produce up to 1 litre of exudate per day (European Oncology Nursing Society, 2015). This can be life changing and prevent individuals from socialising for fear of embarrassing strikethrough (Probst et al, 2013).

If infection is present, it should be treated appropriately. Dressings containing silver or honey, which have demonstrated antibacterial properties (Parsons, 2005; Cooper, 2007), should be used combined with those that are superabsorbent (Wounds UK, 2013). Wound pouches may be beneficial if the wound is situated in an area where one can be attached. The surrounding tissue would require barrier preparations to prevent maceration (Romanelli et al, 2010). More frequent dressing changes during the day and extra absorbent layers overnight may be required.

## Pruritis (itch)

Pruritis or itching is attributed to stretching of the skin, which irritates the nerve endings, and it does not usually respond to drugs such as antihistamines. However, if the patient is willing and able to take oral medications, their use may be worth discussing with a doctor. One intervention that could help relieve pruritis is TENS, as it stimulates nerves that carry non-painful messages to the brain (overriding and stopping the pain messages) and can also initiate the release of endorphins (Grocott, 2000).

Dressings that keep the skin well hydrated, such as hydrogel sheets, also help to keep the skin cool, which prevents pruritis. Garments and bed linen that relieve pruritis from climatological conditions such as eczema (cottons and silks) can help patients with malignant wounds. Menthol creams and bath additives with oils can be used on intact skin. Tepid baths and cool compresses may also ease itch (European Oncology Nursing Society, 2015).

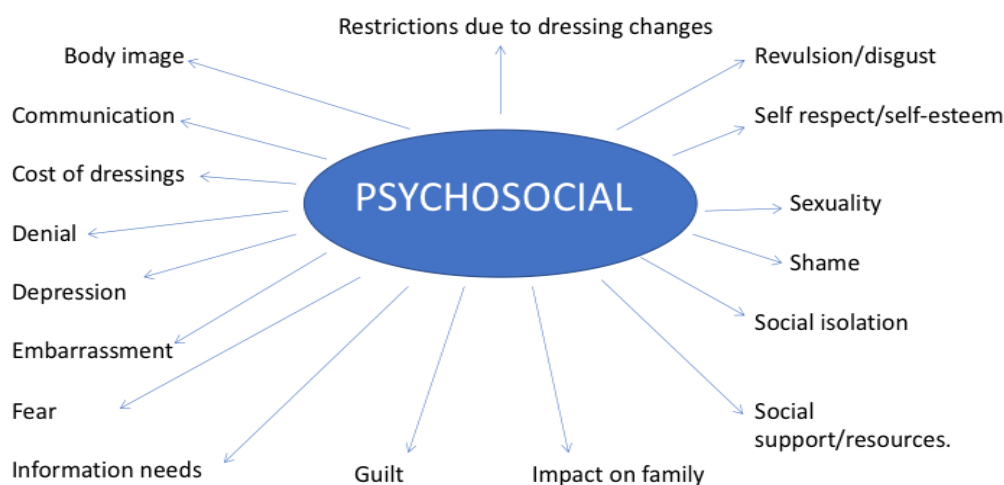
Maintaining a good quality of life is vital, and achieving effective management of the physical symptoms may be the most effective way of alleviating the psychosocial symptoms and improving quality of life and wellbeing. This is true even in the case of malignant wounds.

## Psychosocial symptoms

The psychosocial impact of a malignant wound can be varied and depends on many factors, including the personality of the individual, the site and visibility of the wound, and the impact that the wound has on quality of life and everyday living (Figure 1).

A malignant wound serves as a constant visible reminder of a patient's cancerous process, advanced and incurable disease and impending death (Alexander, 2010; Watret, 2011). Patients often refer to themselves as 'rotting away' (Alexander, 2010). Those with malignant wounds feel able to share their cancer diagnosis but will hide their malignant wound due to its repugnant nature (Lo et al, 2008). This can have a huge impact on their self-esteem, and can result in emotional





**Figure 1.** Problems associated with malignant fungating wounds

distress, isolation and depression. Clinical depression has been identified in individuals with malignant wounds, and appropriate pharmacological and non-pharmacological treatments can help (Maida et al, 2016).

The management of malignant wounds is time consuming for everyone involved. Patients' lives can revolve around dressing changes and waiting for community nurses to attend. It is vital, therefore, that the dressings chosen manage symptoms for as long as possible, as the need for frequent dressing changes can reduce the patient's independence and increase the emotions of guilt and shame (Adderley, 2003).

### Effect on carers

Family members caring for a loved one with a malignant wound face daily challenges (Probst et al, 2012). The presence of a malignant wound and advanced cancer contributes to a change in relationships between the patient and carer, and carers require support to assist them in caring for their loved ones. The need for appropriate, honest and timely information for both patient and carer is vital (Probst et al, 2012).

Carers may become socially isolated as a result of not wanting to leave their loved one, or possibly, they stop inviting friends to their home because of the patient's distressing and embarrassing wound symptoms. This may result in the carer losing their support network of friends. Some family members may wish to help manage these wounds, while others may not be able to, and it is therefore vital that good, honest relationships are formed between all parties, to ascertain the needs of both the patient and family members.

### Effect on nurses

Palliative nurses practising in all settings should have the basic knowledge necessary to manage malignant fungating wounds (Graves and Sun, 2013). Nurses working within hospices have the enhanced knowledge and experience in managing these wounds, along with the support of an equally knowledgeable

and experienced multidisciplinary team readily at hand. In the community, this availability of experience and knowledge may be limited, and community nurses often care for these patients without much support. Dressing changes can be lengthy, and nurses need sufficient time to re-dress the wound as well as to talk to the patient to help alleviate any psychosocial concerns and to ascertain if referrals are required to specialist practitioners. This can prove difficult in a community setting where nurses have many patients who require their expertise and a limited number of hours in a day.

Managing malignant wounds can be both physically and emotionally difficult for nurses (Wilkes et al, 2001). The fact that these wounds will not heal can be distressing for clinicians, and when combined with lack of experience, training and resources, this may evoke feelings of inadequacy, frustration and distress, particularly if it is the first time they are encountering such a wound (O'Regan, 2007). Physical wound symptoms may be as distressing for nurses as they are for patients and their families. It is vital therefore that appropriate resources are available to enable nurses to care for these patients to the best of their ability. Nurses will require appropriate and effective dressings at their disposal. They also require support, by way of education and access to experienced clinicians from whom they may seek help. Local hospices should be available to offer advice and support when required. Debriefing sessions should be conducted often, and peer support should be ongoing.

### Conclusion

Due to the rise in cancer survival rates, palliative care is becoming increasingly important, not just for healthcare professionals, but for society as a whole (Probst et al, 2012). There will inevitably be an increase in the prevalence of malignant wounds in the future.

Managing malignant wounds presents challenges for patients, carers and healthcare professionals alike. Physical wound symptoms are distressing and life changing, and living with a malignant wound, or caring for one can be emotionally



distressing for all involved (Young, 2017). Nurses caring for these wounds require appropriate access to resources and support from all members of the multidisciplinary team. The likelihood is that these wounds will deteriorate regardless of all the nursing care that is invested in them. Nonetheless, when symptom control is achieved, quality of life for patients and their families can be improved beyond expectations, which is all that can be hoped for, and success rates should be measured against this. **CWC**

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## KEY POINTS

- Caring for malignant wounds is complex and requires specialist guidance and a multidisciplinary approach
- A holistic approach is essential, as patients and their families often experience distressing, debilitating and life-changing symptoms and a reduced quality of life
- Nurses often find malignant wounds difficult to manage, both from a physical and an emotional perspective
- Even when healing is not the goal, successful symptom management can improve the quality of life for both patients and their families.

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## CPD REFLECTIVE QUESTIONS

- What distressing symptoms do patients with a malignant wound experience?
- How would you assess and treat the different types of pain?
- How do malignant wounds impact on nurses caring for them, and how may any problems be overcome/avoided?

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