

WOUND EDUCATION

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TRAINING SESSION 11
RECOMMENDED READINGS

Recommended Readings

Clinical practice

Ten top tips: palliative wound care



Authors:
Patricia Hotaling and Joyce Black

Wounds are a common occurrence in patients with terminal illnesses. Of the more than 1.6 million patients who receive care from hospice programmes across the United States, nearly 1 in 3 patients suffer from some form of wound as they near the end of life. In home-based palliative care settings, pressure injury/ulcers are perhaps the most common wound, with reported prevalence and incidence rates at 13.1% and 13.0%, respectively (Artico et al, 2018a).

In the hospice and palliative care setting, the comfort and care preferences of patients are always the primary focus of care providers. Throughout the span of a patient's care, and as terminal illness progresses, bodily wounds may occur. Wounds, if left untreated or improperly cared for, impact patients not only physically, but psychosocially as well, and can erode the quality of life that remains for the patient who is dying. Proper wound care provides healing for not only the body, but for the whole person. These top ten tips will provide guidance on how and when to care for the wound in a dying patient.

1 Appreciate that this wound may not follow the usual trajectory of healing: Most healthcare providers are called in to care for patients in whom wound healing, while delayed, is still possible. Aggressive treatment plans are implemented to facilitate the healing process. Patients who are dying and have existing wounds differ from the usual patient seen by clinicians.

These wounds are at significant risk of not healing or deteriorating. The skin of dying patients can be fragile, flaking and sensitive, and is subsequently at risk of being compromised from wound exudate, body fluids, pressure, shear and friction (Hughes, 2005). The provider must also adjust their usual treatment plans in light of the goals for care. Once the goals of care are established, aggressive treatments may be indicated for symptom management. Ideally, to maintain comfort and reduce pain, dressing changes are done infrequently. Patients receiving hospice services can sometimes heal wounds, but this is not always an achievable outcome.

2 Establish wound-specific goals with the patient and family: Wounds, and the end-of-life process, affect the patient's whole

person, as well as the lives of family, friends and caregivers. Hospice and palliative care organisations employ a multidisciplinary team of healthcare professionals and various care practices to improve the physical, emotional, social and spiritual wellbeing of all who are on the end-of-life journey. Interdisciplinary is preferred as the team uses each other's expertise to create common and cohesive goals, rather than multidisciplinary, where each team member creates individual goals. This interdisciplinary team should be utilised to assist in creating appropriate wound-specific goals and reasonable outcomes. Patients should have an individualised, systematic approach to assessment, planning, treatment and evaluation of their wounds in the context of their life-threatening illness. Be clear about the probable deterioration on the wound, considering the comorbid conditions of the patient. Discuss the patient's nutritional status, perfusion, infections, and cancer as the deterrents to healing (Figure 1). Given the underlying life-threatening condition, wounds and the nature of pain associated with the wound should be fully assessed, described, and an appropriate plan of care established. Setting mutual goals for healing is best done with an interdisciplinary team that includes the patient and family. Some of the roles of team members are as follows: the physician should address outcomes of untreated wounds, such as sepsis or infection; the chaplain provides support for suffering, private religious sacraments; the social worker can assist with procuring any needed money for products; physical therapists are used to prevent contractures and promote mobility, and the pharmacist can assist with identifying compounded products for the wound bed. Nurses can aid in planning how and when wound care will be done, as well as assess the family's desired involvement with wound care and other cares. Not all wounds fail to heal or deteriorate. Dincer (2018) reported that 74% of 277 patients in hospice healed pressure injury. Artico et al (2018) also studied the outcomes of pressure ulcer injury in palliative care and reported that 13% of patients in home palliative/hospice care acquired an ulcer and found 24.6% of the ulcers that occurred prior to 7 days before death healed. In this particular study, no ulcer that occurred within 7 days of death healed.

Patricia Hotaling is Instructor, College of Nursing, University of Nebraska Medical Center, Omaha, Nebraska, United States; Joyce Black is Professor, College of Nursing, University of Nebraska Medical Center, Omaha, Nebraska, US

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extra

Palliative Wound Care Management Strategies for Palliative Patients and Their Circles of Care



1 AMA PRA Category 1 Credit™



2.5 Contact Hours

Kevin Y. Woo, PhD, RN, ACNP, GNC(C), FAPWCA • Assistant Professor • School of Nursing, Faculty of Health Sciences, Queen's University • Kingston, Ontario, Canada • Adjunct Research Professor • MCEC Program, School of Physical Therapy, and Faculty of Health Sciences, Western University • London, Ontario • Wound Care Consultant • West Park Healthcare Centre • Toronto, Ontario • Clinical Web Editor • *Advances in Skin & Wound Care*
Diane L. Krasner, PhD, RN, CWCN, CWS, MAPWCA, FAAN • Wound and Skin Care Consultant • Harrisburg Area Community College-York Campus • York, Pennsylvania
Bruce Kennedy, BSc (Pharm), MBA • Clinical Pharmacy Specialist • Palliative Care, Community, and End-of-Life Program • Fraser Health/Surrey Memorial Hospital • Surrey, British Columbia, Canada
David Wardle, BSc • Research Assistant • Queen's University • Kingston, Ontario
Olivia Moir • Nursing Student • Queen's University • Kingston, Ontario

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PURPOSE: To provide information about palliative wound care management strategies for palliative patients and their circles of care.
TARGET AUDIENCE: This continuing education activity is intended for physicians and nurses with an interest in skin and wound care.
OBJECTIVES: After participating in this educational activity, the participant should be better able to:
1. Recognize study findings, assessment tools, and non-pharmacologic strategies used for patients with palliative wounds.
2. Summarize pharmacologic and dressing treatment strategies used for wound care management of palliative patients.

A large fungating skin lesion in an elderly nursing home resident

Yolanka Lobo, Tristan Blake, Tony Blake, Jim Muir

CASE

A nursing home resident aged 80 years presented for an influenza vaccination when he was noted to have a large fungating lesion with rolled edges on his right chest (Figure 1). The lesion was believed to have been present for many months. There was no history of preceding trauma or insect bite, recent travel or immunosuppression. His past medical history was significant for moderate dementia, hypertension, hypercholesterolaemia, benign prostatic hypertrophy, osteoarthritis and alcoholic liver cirrhosis. His medications included dutasteride/tamsulosin, escitalopram, frusemide, perindopril, propranolol and thiamine. He was a retired bricklayer of Scottish heritage with an eight pack-year smoking history.

QUESTION 1

What is the differential diagnosis?

QUESTION 2

What initial investigations are required?

ANSWER 1

A skin cancer would be the primary differential diagnosis, namely a basal cell carcinoma, squamous cell carcinoma (SCC) or amelanotic melanoma. A secondary metastasis from an internal malignancy is possible. An infective aetiology

cannot be excluded, such as atypical mycobacterium (eg *Mycobacterium abscessus* or *M. marinum*), cutaneous melioidosis, ecthyma gangrenosum or deep fungal infection. This lesion may also represent an inflammatory dermatosis such as pyoderma gangrenosum or, less likely, a traumatic or pressure ulcer, calciphylaxis, cholesterol embolism, small- or medium-vessel vasculitis, vasculopathy or medication reaction. A venous, arterial or neuropathic ulcer is unlikely given the location of the lesion and absence of diabetes mellitus in the patient's medical history.

ANSWER 2

An adequate biopsy specimen needs to be sent in formalin for histopathology. Options include an incisional or large 6-8 mm punch biopsy from the ulcer edge. If considering deep fungal infection or

mycobacteria, a 'fresh' tissue specimen must be collected and placed on a saline-soaked gauze swab in a sterile container. This tissue can be obtained from a small punch biopsy from the ulcer edge. Fresh tissue must not be placed in formalin and requires prompt collection as the specimen is unpreserved. Swabs should be sent for bacterial and fungal microscopy and culture, which may identify resistant organisms and direct systemic therapy for infected wounds.¹ For optimal clinicopathological correlation, it is important that the pathology request form contains relevant medical history; the lesion's clinical appearance, size and location; and a differential diagnosis list.²

CASE CONTINUED

Histopathological examination from an incisional biopsy showed an



Figure 1. A 10 cm fungating lesion with rolled edges on the right side of the chest

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