

Title	Guideline: The Management of People with Malignant Wounds
Background	See “Guideline: The Assessment of People with Malignant Wounds”
Indications	This guideline is intended to be used by health care providers, to guide their management of individuals presenting with a malignant wound.
Guideline	<p>Healable Wounds: healable malignant wounds are those that the cause can be corrected with treatment. For example, excision with clear resection of margins. Furthermore, co-morbidities and medications do not prevent wound healing from occurring following resection or surgical intervention. If this is the case, treat the wound as either a surgical wound or follow the guideline for the appropriate wound etiology. For example, leg ulcer if it is located on the lower leg. The following guideline will focus on Not-healing and Non-healable malignant wounds.</p> <p>Not-healing/Non-Healable Wounds</p> <ol style="list-style-type: none"> 1. If the cause of the wound cannot be treated (ex. wide spread metastasis, chronic osteomyelitis, advanced cutaneous malignant condition) or there are factors mitigating adherence to the treatment plan (lack of resources, patient declines surgical intervention, etc) then treat the wound as either non-healable or not-healing. However, continuously reassess healing goals with the patient and/or SDM if appropriate. In some cases, healing goals can change over time. 2. DO NOT SHARP DEBRIDE. Careful debridement of dead tissue using mechanical or autolytic debridement is appropriate. This will help to reduce odour, decrease risk of infection, and can improve pain experience. 3. Management using HOPES can be helpful <ol style="list-style-type: none"> a. Hemorrhage or Bleeding Control: granulation tissue in a malignant wound is often friable. Calcium alginate dressings, silver nitrate, and other topical hemostatic agents may be required to control bleeding. If the patient requires a topical hemostatic agent due to frequent bleeding and you do not have access to a topical hemostatic agent consult with your agencies wound care specialist, SWRWCP representative, and/or the patient’s primary care provider for further direction. Note: on rare occasions, the tumor may erode a major vessel resulting in a fatal bleed. These can be very distressing situations. Ensure that the care plan includes interventions to manage a major hemorrhage if the patient is at risk. If you are uncertain regarding risk contact the primary care provider. b. Odour: Unpleasant smell and putrid drainage are often associated with increased bacterial burden, specifically anaerobic and specific Gram-negative bacteria (such as <i>Pseudomonas</i>). Odour can be very distressing to the patient. Topical metronidazole may be prescribed to help control odor – follow the pharmacist or primary care provider’s directions regarding application. Activated charcoal can also be used to control odor. Do NOT cut these dressings and ensure that they come into direct contact with the wound exudate. c. Pain: Pain is reported as one of the most disruptive symptoms of a wound. Wound related pain is often associated with dressing changes or the dressing material itself. Granulation tissue and capillary loops can grow into the product (this is especially true for gauze) making dressing removal traumatic and painful for the patient. Choose dressings that reduce the frequency of

	<p>dressing changes. If the patient has skin sensitivities, patch testing the dressing is recommended to determine if a reaction will occur. Barrier wipes, sprays, and liquids are useful to protect the peri-wound from irritating exudate. If the patient has prescribed analgesics, it is advised that they take their medication prior to the dressing change if necessary. If pain is assessed to be poorly controlled, contact the primary care provider to provide an update.</p> <ul style="list-style-type: none"> d. Exudate: Moisture is contraindicated in non-healable wounds. Hydrating gels and moisture retentive dressings should be avoided. Choose a dressing that will absorb any exudate to keep the wound dry. e. Superficial Infection: use topical antimicrobial agents for superficial wound infection and URGENTLY refer to the patient's primary care provider if a spreading or systemic infection is suspected. <ol style="list-style-type: none"> 4. Paint and/or cleanse the wound with sterile water or normal saline unless otherwise directed by the wound care specialist or primary care provider 5. Choose an appropriate dry gauze based non-adherent dressing or combination of dressings. Choose a dressing that will: <ul style="list-style-type: none"> i. Promote a dry wound environment ii. Minimize bacterial contamination iii. Prevent strike through of exudates while wicking moisture away from the wound surface iv. Be cost effective v. Comfortable to wear, not causing increased pain during wear time or on removal 6. Choose an appropriate dressing change frequency based on: <ul style="list-style-type: none"> i. Your wound assessment, including the patient's risk for infection ii. Dressing products used and their ability to manage the drainage anticipated iii. Patient's comfort and acceptability <p>Management Guidelines for ALL Malignant Wounds</p> <p>Consider referrals to (see "Criteria for Interdisciplinary Referrals"):</p> <ul style="list-style-type: none"> iv. Wound Care Specialist for treatment plan guidance and advanced therapies v. Dietician: diet, nutrition, glycemic control, supplementation, weight control vi. Speech Language Pathologist: swallowing problems vii. Physiotherapy: mobility/exercise plan, mobility/gait/range of motion assessment, adjunctive therapies viii. Occupational therapist: assistive devices, modifications to activities of daily living ix. Social Work: psychosocial and economic supports x. Palliative Care Outreach Team (PCOT) <ol style="list-style-type: none"> 7. Patient centered concerns: <ul style="list-style-type: none"> i. Coordinated pre-dressing change analgesia as prescribed ii. Regular dosing of pain medications as prescribed iii. Use of appropriate medications to manage neuropathic pain as prescribed iv. Use of topical analgesics (i.e. morphine) or anesthetic (i.e. EMLA or lidocaine) if pain during dressing changes as prescribed v. Consider non-pharmacological methods of pain management, i.e. appropriate
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	<p>dressing choice, distraction, guided imagery, pressure redistribution, music, time-outs during dressing changes, less frequent dressing changes, etc.</p> <p>8. Infection control:</p> <ul style="list-style-type: none"> a. Teach that new onset or worsening pain is a sign of infection and requires immediate medical attention <p><i>NOTE: Topical antimicrobials can be used to reduce bacterial burden in the presence of superficial wound infection, but <u>never</u> take the place of systemic antibiotics when those are needed for deeper infections</i></p> <ul style="list-style-type: none"> b. If you suspect a superficial or spreading infectious process update the primary care provider urgently <p>9. Notify the primary care provider immediately if the following occur:</p> <ul style="list-style-type: none"> a. Acute onset of pain or increasing pain b. Wound probes to bone if this is a new finding c. Signs of localized and/or systemic infection develop <p>10. Educate the patient and/or their caregiver, the importance of the following:</p> <ul style="list-style-type: none"> a. Quitting/Reducing smoking b. Exercising regularly and eating a well-balanced diabetic diet as tolerated c. Signs and symptoms of infection/complications and when to seek IMMEDIATE help <p>11. Provide resources/links to reinforce health teaching: SWRWCP's "My Malignant Wound" Available at: https://swrwoundcareprogram.ca/Uploads/ContentDocuments/SWRWCP_MalignantWOUND.pdf</p> <p>12. Re-evaluate:</p> <ul style="list-style-type: none"> a. Regularly and consistently measure the ulcer, weekly at a minimum, using the same method b. Reassess pain at EVERY dressing change and more frequently as needed, using the same pain tool/scale each time. Report pain management issues to the patient's primary care physician or primary care nurse practitioner c. Reassess the patient's quality of life if the patient reports alterations in their QOL or if their caregiver verbalizes that they suspect as much <p>13. Documentation:</p> <ul style="list-style-type: none"> a. Document initial and ongoing assessments as per your organizations guidelines b. Document care plans, implementation strategies, and outcome measurements as per your organizations guidelines
Outcomes	<p>1. Intended:</p> <ul style="list-style-type: none"> a. The wound is maintained and infection free b. The patient indicates that pain is manageable (less than 3/10) c. The patient understands their role and incorporates recommended activities and interventions to manage intrinsic/extrinsic/iatrogenic factors

	<ul style="list-style-type: none"> d. The patient can identify signs and symptoms of infection, and can describe how, when and whom to contact when problems occur e. The patient becomes independent in the self-management of their wound if this is the goal <p>2. Unintended:</p> <ul style="list-style-type: none"> a. The wound becomes infected b. The patient expresses concerns about poorly managed pain c. The patient does not understand their role and does not adopt suggested interventions to manage intrinsic/extrinsic/iatrogenic factors d. The patient shows no evidence of understanding and acting on educational information received e. The patient does not understand the signs and symptoms of infection/complications, and when, how and whom to seek help from f. The patient does not become independent in self-management of their wound
References	<ul style="list-style-type: none"> 1. Woo, K.Y. and Sibbald, R.G. 2010. Local wound care for malignant and palliative wounds. <i>Advances in Skin & Wound Care</i>, 23, pp. 417-428. 2. Young, T. 2017. Caring for patients with malignant and end-of-life wounds. <i>Wounds UK</i>. 3. Langemo, D., et al. 2007. Managing fungating wounds. <i>Advances in Skin & Wound Care</i>, 20(6), pp. 312-314. 4. BC Cancer. Symptom management guidelines: Care of malignant wounds. Available at: http://www.bccancer.bc.ca/nursing-site/Documents/10.%20Malignant%20Wounds.pdf