F. PRINCIPLES OF TREATMENT BASED ON ETIOLOGY (TREAT THE CAUSE)

F.7 MALIGNANT WOUND

7.1 Background to Etiology and Instructions for use

Primary cutaneous cancers include:

- Basal Cell (in areas of chronic sun exposure)
- Squamous cell (from sun-induced pre-cancerous lesions)
- Marjolin’s (Squamous cell proliferating or transforming from a chronic wound)
- Melanoma (in areas of chronic sun exposure)
- Kaposi’s Sarcoma

Secondary malignant wounds that occur from metastatic disease (local or distant primary tumors) or from direct invasion of a primary tumour into the skin and will be either:

- crater-like or cavity ulcerations with fragile tissue prone to bleeding, infection, pain and malodorous exudate or
- proliferating/fungating nodular & grotesque lesions prone to bleeding, infection, pain and malodorous exudates.

When malignant wounds occur near blood vessels, there is the risk of a catastrophic bleed with imminent death.

- Pruritis can occur to such a degree that it deserves the same attention as uncontrolled pain.

Fatigue, anorexia, nausea, dyspnea, lymphedema, impaired mobility and activity levels

7.2 Algorithm

7.3 Self-Care Teaching Tool – to be developed later in 2011

7.4 Client/Patient Teaching and Learning Resources to be developed later in 2011

7.5 Clinical Interventions (From SWCCAC Wound Management Program March 2011).

Determine client’s goals

☐ Healing Service Plan

- If surgical removal and radiation treatment are not an option, then wound is considered palliative.

☐ Maintenance Service Plan

- Maintain wound environment
- Teach client/caregiver wound management
- Goals may now be pain, exudate and odour control

Wound Assessment:

The Malignant Wound Assessment Tool (MWAT) (see resources 7.6) differs from other wound assessment tools in that it asks for the client’s perception of a number of clinical domain items, and includes other symptoms, physical functional and social interactions as part of the assessment. The MWAT-C is in the public domain and therefore available for public use. To duplicate the tool, please cite the following reference: Schulz V, Kozell

**Key Interventions:**
- Pain-free dressing changes
- Pain management between dressing (may need topical analgesia as part of dressing routine)
- Management of pruritis changes
- Psychological and psychosocial support.
- Management of exudates
- Plan for catastrophic bleeding (if appropriate)
- Assess and control malodour (remember that odour is always what the patient says that it is, just like pain)

☐ **Healing Service Plan**

**Wound Bed Prep:**
- Debridement is not always appropriate for patients who have extensive exuding wounds or multiple dry necrotic lesions, but bacterial balance, exudate control, and protection of periwound skin remain important.
- Flushing these wounds to cleanse may not be tolerated due to pain.
- If pain is increased when the dressing is removed or the wound cleansed, warm the cleansing solution and prepare the entire dressing to allow for a quick, painless dressing change.
- Choose a non-adherent dressing or absorptive product with non-stick surface as primary dressing, with exudate-absorptive secondary dressing that is semi-occlusive or occlusive. Clean the wound as directed by the dressing manufacturer- some dressings can be left in-situ for several days with only the secondary dressing being changed.
- Choose Antimicrobial dressings with non-stick surface for superficial infection

**Malodor associated with anerobic bacteria proliferation:**

**Metronidazole** may be administered:
- **Orally** (capsules or tablets). ***Do not open the capsules to apply the powdered contents to wounds*** (Hazardous Inhalation Precautions).
- **Topically** -clear gel Metrogel is available, but vaginal cream (which is licensed for the treatment of malodorous fungating tumours in the UK but not in Canada, is commonly used with effect- has a stronger concentration of the drug. *(Hampson 1996).*

**Friable Tissue:**
- Plan for small bleeds- have calcium alginate in the home to apply to small areas of bleeding but note that some alginate dressings appear to cause increased bleeding in malignant wounds; d/c if this is seen.
- If alginates cannot be used for small amounts of bleeding, it may be necessary to obtain a prescription for Gel-foam or similar dressings from the physician to have on hand in home.
Client Education re:
- self care (if appropriate)
- progress of tumour
- prevention of infection and deterioration of wound, improvement of nutrition and general health status
- Risk of catastrophic bleeding (if appropriate) & actions

☐ Maintenance/ Palliative Service Plan
If surgical removal and treatment are not an option, then wound is considered palliative.

Malodor categories:
- **Strong**: odour is evident on entering the room when the dressing is intact.
- **Moderate**: Odour is evident on entering the room when the dressing is removed.
- **Slight**: Odour is evident at close proximity to the patient when the dressing is removed.
- **No odour**: No odour is evident at the patients’ bedside even when the dressing is removed (Haughton and Young in Alexander 2009).

7.6 Resources
MWAT Tool Available at: [http://www.cancerpainnet.ca/research_tools](http://www.cancerpainnet.ca/research_tools)

Please note that the Winnipeg Regional Health Authority (Manitoba) has an excellent 67 page resource available on-line that contains extensive detail regarding malignant wounds and cancer treatment associated wounds. Malignant Wounds Assessment and Management. Winnipeg Regional Health Authority, 2008. Available at: [http://www.wrha.mb.ca/professionals/woundcare/files/08MalignantWounds.pdf](http://www.wrha.mb.ca/professionals/woundcare/files/08MalignantWounds.pdf)

7.7 References


Hampson JP. The use of metronidazole in the treatment of malodorous wounds. *J Wound Care* 1996; 5:421-6