Disclosure Information

• The presenters have no actual or potential conflicts of interest or financial relationships in relation to this presentation.
Objectives

• Understand the role of palliative care in managing chronic wounds
• Become familiar with the different types of chronic wounds
• Learn the materials and strategies used in the comprehensive management of chronic wounds

Chronic Wounds

• Fail to progress through an orderly and timely sequence of repair
• Pass through the repair process without restoring anatomic and functional results

Lazarus GS, Arch Dermatol, 1994
Chronic Wounds

• Persist for over 6 months
• Healing becomes unrealistic.
• Focus on wound management, palliative care

Chronic Wounds

- 14 to 28%: prevalence of pressure ulcers in the hospice care setting
- 35%: prevalence of skin issues in a study of 383 hospice patients
- 50% pressure ulcers, 20% ischemic ulcers, and 30% other skin issues (e.g., stasis ulcers, burns, skin tears, tumors)

Cuddigan J, Adv Skin Wound Care, 2001
Tippett A, Wounds, 2005

Chronic Wounds

- 26% and 10%: prevalence and 6-month incidence of pressure ulcers in a study of 980 hospice patients
- 5 to 10%: prevalence of malignant wounds in metastatic disease
- $1600 per patient per month: average cost of standard wound care

Reifsnyder J, Wounds, 2005
Haisfield-Wolfe ME, Ostomy Wound Manage, 1997
Tippett A, Wounds, 2005
Impact

• Patient
  - Altered body image
  - Rejection, shame and embarrassment
  - Fear and anxiety
  - Social isolation, withdrawal and reluctance to engage in social interaction
Impact

• Patient
  - Depression
  - Decreased appetite
  - Nausea
  - Weight loss
  - Lethargy

Bale S, Br J Nurs, 2004
Hack A, J Wound Care, 2003

Impact

• Caregiver/family
  - Revulsion and distress
  - Frustration
  - Limit contact
  - Inhibit intimacy
  - Permeate clothing, furniture and living quarters

Bale S, Br J Nurs, 2004
Paul JC, Ostomy Wound Manage, 2008
Impact

- Healthcare providers
  - Revulsion and distress
  - Frustration
  - Emotionally and physically challenged
  - Must try hard to manage the wound without reacting to avoid offending or alarming the patient

Lee G, J Wound Care, 2006

Palliative Care

- Provide Comfort
- Relieve Suffering
- Pain
- Odor
- Infection
- Psychosocial

Tippett A, Wounds, 2005
Burt T, Ann Longterm Care, 2013
Palliative Care of Chronic Wounds

September 18 and 19, 2014
Vanessa March, BSN, RN, CMSRN
Renato V. Samala, MD, FACP

Malignant Wound

- Cancerous cells invade epithelium, infiltrate supporting blood and lymph.
- Penetrate epidermis
- Tissue death and necrosis occur.
- Primary cancer or metastasis to skin
Malignant Wound

- Most common sites:
  - Breast
  - Head/neck
  - Trunk/Back
  - Abdomen
  - Axilla
  - Groin/Genital

Malignant Wound

- Goals of care may shift from healing to palliative
  - Most important being symptom management
  - Treatment of underlying tumor (if possible)
  - Manage exudate and odor
Malignant Wound

Kalinski C, *Wounds*, 2005

Venous Ulcer

- Venous insufficiency
- Affects 2-5% Americans
  - ½ million develop stasis ulcers
  - Women more than men
- At Risk if:
  - Obese, DVT, varicose veins
  - Pregnant, leg injury, cardiac history
Venous Ulcer

- Crater like irregular shape
- Medial gaiter region of ankle
- Pain varies
- Increase exudate
- Larger in size

Arterial Ulcer

• Occurs over toes, heels and bony prominences
• Borders and surrounding skin usually appear punched out.
• Yellow, brown, grey or black in color and usually does not bleed

Arterial Ulcer

• Skin usually is cool, brittle, hairless and shiny in appearance
• Usually very painful, especially at night- may be relieved by dangling
• Poor circulation, often caused by arteriosclerosis
Arterial Ulcer

Retrieved June 23, 2013 from Medscape:
http://emedicine.medscape.com/article/1298345

Arterial versus Venous

<table>
<thead>
<tr>
<th></th>
<th>Arterial</th>
<th>Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site (common)</td>
<td>Toes, foot, and ankle</td>
<td>Medial gaiter region</td>
</tr>
<tr>
<td>Edges</td>
<td>Punched out and well defined</td>
<td>Sloping and gradual</td>
</tr>
<tr>
<td>Wound bed appearance</td>
<td>Covered with slough and necrotic tissue</td>
<td>Covered with slough</td>
</tr>
<tr>
<td>Size</td>
<td>Small</td>
<td>Large</td>
</tr>
<tr>
<td>Exudate amount</td>
<td>Minimal</td>
<td>High</td>
</tr>
<tr>
<td>Pain</td>
<td>Yes</td>
<td>Minimal</td>
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</tbody>
</table>
Pressure Ulcer

- A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.
Pressure Ulcer Staging

- Stage I
- Stage II
- Stage III
- Stage IV
- Unstageable
- Suspected Deep Tissue Injury

Stage I

- Non-blanchable erythema over a bony prominence
- Intact skin, painful and tenderness
- May be difficult to detect in darker skin tones

Stage I

- Skin may be warmer, painful, cooler, soft or firm
- May indicate “at risk” persons

Stage II

- Partial thickness loss of dermis
- Wound bed is usually pink and red
- No present slough
- Can present as an intact or open blister

Stage III

- Full thickness tissue loss
- Subcutaneous fat may be present
- Bone, tendon, and muscle are not exposed at this stage.


Stage III

- Slough may be present but does not obscure the depth.
- Undermining and tunneling can be included
- Depth vary by anatomical location

Stage III

- Full thickness tissue loss with exposed bone, tendon or muscle.
- Slough or eschar may be present
- Undermining and tunneling

Stage IV

Black J, Dermatol Nurs, 2007
Stage IV

- Can extend into muscle or supporting structures
- Osteomyelitis possible at this stage

Unstageable

- Full thickness tissue loss
- Base of ulcer is covered by slough and/or eschar in the wound bed
- The true depth and stage cannot be determined until enough slough and/or eschar is removed to expose the base of the wound.

Black J, Dermatol Nurs, 2007
Suspected Deep Tissue Injury

- Purple or maroon localized area of intact skin
- The tissue to the surrounding area may be painful, firm, mushy, boggy, warmer or cooler.
- SDTI will be staged as an ulcer once the amount of tissue loss is apparent or “declares itself”.

Black J, Dermatol Nurs, 2007
**Assessment**

- **Braden Scale**
  - (15-18) at risk
  - (13-14) moderate risk
  - (10-12) high risk
  - (>9) very high risk

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**Assessment Risk Assessment Scale**

<table>
<thead>
<tr>
<th>Braden Category</th>
<th>Braden Score 1</th>
<th>Braden Score 2</th>
<th>Braden Score 3</th>
<th>Braden Score 4</th>
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</thead>
<tbody>
<tr>
<td>Nutritional Status</td>
<td>Braden Equal 6</td>
<td>(15-18) at risk</td>
<td>(13-14) moderate risk</td>
<td>(10-12) high risk</td>
</tr>
<tr>
<td>Braden Equal 7</td>
<td>(10-12) high risk</td>
<td>(&gt;9) very high risk</td>
<td></td>
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</tbody>
</table>

**Braden Score Calculation**

1. Nutritional Status
2. Mobility
3. Medication
4. Level of Activity
5. Skin Tissue
6. Personal Hygiene
7. Social Interaction

**Braden Scale Scoring**

- 6 points: Normal; no factors present
- 5 points: Low risk
- 4 points: Moderate risk
- 3 points: High risk
- 2 points: Very high risk

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**References**


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**Table Source**

Assessment

- Mobility
- Nutrition
- Moisture
- Education

Assessment

- Friction/shear involvement
- Skin hygiene
- Support systems
- Sensory perception
- Infection
Dressings and Treatment

• Assess support surfaces
• Establish every 2 hour repositioning schedule
• Determine cause of wound
• Manage any incontinence (if any)
• Select appropriate dressing based on wound type and ulcer stage

Dressings and Treatment

• Wound depth and moistness for appropriate treatment
• Infection present – may need antimicrobials
• Foam dressings
• Non-adherent dressings
Dressings and Treatment

- Debridement may be needed if necrotic or slough tissue present
  - Autolytic
  - Mechanical
  - Enzymatic
  - Surgical
  - Conservative Sharp Debridement
  - Biological

Symptom Management

- Pain
- Anxiety
- Nausea
- Odor
- Exudate
Symptom Management

- Bleeding
- Anorexia
- Pruritus
- Fatigue

Prevention of Complications

- Nutrition consult
- Skin cleansing
- Skin lubrication
- Management of moisture
- Infection
Prevention of Complications

- Support surfaces
- Body positioning
- Proper wound dressing
- Education

Psychosocial Support

- Patient and family education and emotional support
- Feelings regarding the wound and their quality of life
- Fear
- Embarrassment/shame
Psychosocial Support

- Social isolation
- Depression
- Denial
- Image
- Address the goals of care (full, partial, or for comfort) of wound healing

Team Approach

- Patient and family are supported through an interdisciplinary approach.
- Keep an open communication
- Involve everyone in the plan of care
Adjunct Therapies

- Utilize holistic therapies (spiritual care, music, massage/touch, or healing services)
- Social work and case management
- Physical Therapy, Hyperbaric Therapy
- Surgery/Plastic Surgery consult

Case 1: John

- 66-year-old widower and loner with decline in appetite, weight and function
- Sister, the only support system, noted foul odor and damp shirt.
- Finally agreed to go to hospital and diagnosed with extensive squamous cell carcinoma on abdominal wall metastatic to lymph node and liver.
- John confided being distressed about the pain and odor coming from his large wound.
Case 1: John

Case Discussion

- Assessment/staging
- Type of dressing
- Symptoms
- Prevention of complications
- Psychosocial issues
- Adjunct therapies
Case 1: Maria

- 35-year-old mother of 3 with breast cancer, S/P mastectomy and chemoradiation
- Recently discovered metastasis to thoracolumbar spine with cord compression resulting in pain, appetite loss, and decreased movement and sensation in lower extremities
- Assessment revealed stage II sacral ulcer
- Admitted to Palliative Medicine Unit for symptom management and wound care

Case 2: Maria
Case Discussion

- Assessment/staging
- Type of dressing
- Symptoms
- Prevention of complications
- Psychosocial issues
- Adjunct therapies

Summary

- Chronic wounds bear considerable impact to patients and caregivers, and their management often shifts from a healing perspective to one of optimizing comfort and quality of life.
Summary

• Comprehensive palliative care of chronic wounds consist of accurate assessment, use of appropriate dressings and treatments, all-embracing symptom management, prevention of complications, tending to psychosocial concerns, maintaining collaborations, and utilizing adjunct therapies.