Fungating Malignant Wound Treatment Pathway

Version 3

Fungating malignant wounds are masses or ulcerative lesions which result from cancer cells infiltrating epithelial tissue.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Has your patient been referred to the relevant MDT?
What is your main objective with the wound?

Manage Exudate

- Commence use of barrier product following MASD pathway
- Use dressings appropriate to the level of exudate. For low to moderate exudate, use Allevyn. For Moderate to High exudate, use a wound contact layer (Atrauman or Urgotul) and Zetuvit Plus
- If itchiness is an issue, check patient for allergy to dressing. Also consider topical steroid and/or antihistamines

Malodour

- Establish cause: Is the wound infected?
  - Yes → Infection
  - No
- Is the cause slough/necrosis? If safe to do so, consider debridement using debridement products:
  - Flaminal forte or Urgoclean for high exudate.
  - Flaminal hydro for slight to moderate.
- Increase dressing changes if needed and consider odour control dressing: Charcoal dressing - Clinisorb
  - Reducing odour in rooms: -Febreze -Cat litter (in a tray or in pouches hung around the room)
  - Alternative odour control dressing – Cinesteam (Cinnamon based), can be requested via WCS/ TVN if no response to Charcoal dressing

Infection

- Is there signs of local wound infection
  - Yes
    - Treat wound with Antimicrobial dressing and consider antimicrobial irrigation solution e.g. Octenilin
    - Assess exudate
      - Slight to moderate levels of exudate use Flaminal Hydro or Urgotul AG
      - Moderate to high levels of exudate use Flaminal Forte or Aquacel AG Extra +
    - Second line treatment if there are ongoing concerns with wound infection or odour, consider topical or oral Metronidazole for 7 days use (see NICE guidance)
  - No
    - Follow exudate guidance

Bleeding

- Ensure appropriate prescription and medication is available for patients identified at risk of severe/catastrophic bleeding. Discuss with GP or palliative care for advice
- Dress with Urgoclean or Aquacel Extra (or Urgoclean Ag/ Aquacel Ag Extra + if infection present)
- For heavy bleeding, apply pressure and seek urgent advice from oncology/palliative care team. If in community setting, admission may be appropriate.
- If accessible- use dark towels to absorb blood to minimize distress to the person and their family.

Pain

- Administer analgesic 30 minutes before each dressing change. Review analgesic effect & involve GP/palliative care team if pain is uncontrolled.
- Consider adhesive removal spray/ wipes. Irrigate wound rather than using a gauze swab.
- Consider silicone wound contact layer (Silflex or Ulgotul), this can be left in place for up to 7 days if required. Cleansing can be carried out over the top. This can help reduce trauma. The outer dressings are then changed.
- Consider discussion with palliative care or hospice team regarding topical analgesics e.g. Topical opiates

Self

- Assess psychological and social impact by completing a holistic assessment at each visit.

  Also consider the psychological needs of the patient's carers/ relatives.
- Consider onwards referral for counselling or social support for patient/ carer/ relative e.g. Macmillan, Marie Curie, St. Peters Hospice, or other local services.

  Encourage supported self-care where able and appropriate.

  Refer to NICE guidance for further information: www.nice.org.uk

If there are any concerns, refer to the Tissue Viability/Wound Care Service

REMEMBER SIGNS OF INFECTION

- REDNESS/ALTERED PIGMENTATION (DARK SKIN TONES)
- HEAT (SURROUNDING SKIN)
- INCREASE IN EXUDATE
- ODOUR
- CHANGE IN EXUDATE: COLOUR/THICKNESS
- CHANGE IN GRANULATION TISSUE: BLEEDING / FRIABLE
- INCREASE IN SLOUGH OR NECROSIS
- SWELLING
- PAIN