



CHALLENGING WOUNDS

Pressure
Ulcers

Malignant
Wounds

Skin Disorders are important in
palliative/hospice
nursing care



PRESSURE ULCER

- 40-50% of wounds are from pressure
- Failure of the skin as an organ
- Some are unavoidable
- Healing is possible



PRESSURE ULCER

- Result of mechanical injury to the skin/underlying tissue
- Pressure causes ischemia/hypoxia of the tissues
- Occurs over bony prominences
- Diminished soft tissue creates less tissue for compression
- Results: more susceptible to skin breakdown

PRESSURE ULCER EXTERNAL FACTORS

-Pressure

-Shear

-Friction



OTHER RISK FACTORS

- Sensory Loss
- Age
- Moisture/Incontinence
- Nutrition



UNRELIEVED PRESSURE

Alteration in the vascular network allows an increase in the interstitial fluid pressure which exceeds the venous flow. This results in an additional increase in the pressure and impedes circulation.

UNRELIEVED PRESSURE

- Capillary vessels collapse
- Thrombosis occurs
- Fluid loss through capillaries
- Tissue edema
- Autolysis
- Lymphatic flow is decreased
- Tissue necrosis

UNRELIEVED PRESSURE

- Build up of waste products: Ischemia
- Tissue deprivation of oxygen and nutrients
- Absence of Oxygen: cells utilize anaerobic pathways for metabolism and produce toxic byproducts
- Toxic byproducts lead to tissue acidosis, increased cell membrane permeability and cell death

END OF LIFE

- Skin as an organ fails
- Decrease cutaneous perfusion: hypoxia
- Decrease ability to use nutrients to maintain normal skin function
- Damage to deeper structure
- Damage to muscle and fat tissues
- Malnutrition: less tissue increases risk

PRESSURE ULCERS

- Skin breakdown occurs 6-12 hours in normal tissue
- <2 hours in patients at risk



PREVENTION

Is a key element for palliative/hospice care
Spare patients tiresome/painful/overwhelming
treatment!

COMPREHENSIVE ASSESSMENT

Includes:

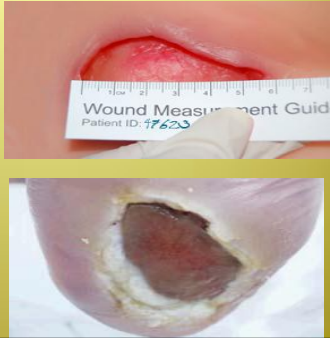
- Severity
- Status
- Total patient

SEVERITY

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable
- Deep Tissue Injury

STATUS

- Location
- Measurements
- Exudate
- Periwound skin
- Edges
- Tissue type



WOUND TISSUE

- Epithelial
- Granulation
- Slough
- Necrotic
- Eschar



TOTAL PATIENT

- | | |
|----------------------|--------------------------|
| History and Physical | Cultural |
| Cause | Economic |
| Reason for Admission | Comorbidities |
| Expectation | Previous Management |
| Perceptions | Labs and Diagnostic test |
| Psychological | Pain |
| Social | Caregiver |

PRESSURE ULCER MANAGEMENT

- Reposition in accordance with their wishes
- Maintain adequate nutrition/hydration
- Set treatment goals
- Value the patient's goal
- Assess the impact on quality of life and enhance quality of life
- Manage with appropriate dressings

PRESSURE ULCER MANAGEMENT

- Management of exudate and odor
- Assess wound pain-care appropriately
- Prevention of complications
- Obtaining and maintaining a clean wound
- Preserve remaining intact skin

MALIGNANT WOUNDS

Physical and emotional challenge for the patient, caregiver, and clinician



MALIGNANT WOUNDS

- Pain
- Odor
- Bleeding
- Unsightly appearance
- Decrease in self esteem
- Social isolation



Malignant Wounds

Infiltration of the skin by local invasion of a primary tumor or by metastasis from another site.

Therapies to slow tumor growth: chemo, radiation, hormone therapy....temporary.

MAGLIGNANT WOUNDS

Initially may manifest as

Inflammation with induration

Redness

Heat

Rash

Tenderness

Skin fixed to underlying tissue

Enough tissue destruction: skin ulcerates

MALIGNANT WOUNDS

Changes in vascular and lymphatic flow lead to edema, exudate and tissue necrosis

Fungating: the tumor mass extends above the surface with a fungus or cauliflower-like appearance

MALIGNANT WOUNDS

- Tissue is friable or necrotic or both
- Periwound skin is red, fragile, tender, macerated from excess drainage
- If necrotic tissue occurs: leads to ideal culture medium for bacterial colonization that leads to odor

WOUND ODOR

- Anaerobic and aerobic bacterial proliferate
- Necrotic tissue
- Excess drainage
- Poor hygiene of the wound
- Tumor
- Inappropriate wound care/dressings

WHAT DOES ODOR CREATE?

- PSYCHOLOGICAL PROBLEMS
 - Body image
 - Depression
 - Embarrassment
 - Fear
 - Guilt
 - Decreased self esteem
 - Isolation
 - Anxiety



MALIGNANT WOUND ASSESSMENT

Wound appearance

Size

Friability

Odor

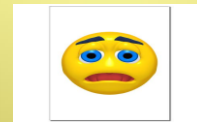
Exudate

Radiation related skin damage

Fistula

Infection

MALIGNANT WOUND ASSESSMENT



Pain

Deep/superficial

During dressing changes only?

Pain: depends on tissue invasion, damage, and nerve involvement

MALIGNANT WOUND MANAGEMENT GOALS

- Control infection and odor
- Management of exudate
- Prevention and control bleeding
- Management of pain
- Airway precautions

MALIGNANT WOUND GOALS

- Formulate appropriate treatment plan
- Allow for adjustment to plan
- Recognize complications
- Wounds change depending on aggressiveness of the cancer
- Strive to help patients maintain their goals

CHALLENGING WOUNDS

- Strive to provide the BEST care
- Involvement with:
 - Patient
 - Family
 - Caregiver
 - Healthcare Team



Care with Wounds

- Appropriate Dressings
 - Dressing changes less frequent
 - Dressings to absorb drainage
 - Dressing to provide (slight) moisture
 - Dressings/wound care products that cause less pain
 - Dressings to prevent bleeding/infection
 - Dressings to absorb odor

LEAKING OSTOMY: NOT ON MY BUCKET LIST!



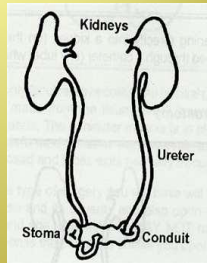
OSTOMITES

Types of Diversions

- Ileoconduit: created using the ileum
- Ileostomy: created using the ileum
- Colostomy: created using the large colon
- Mucous Fistula: distal in GI tract

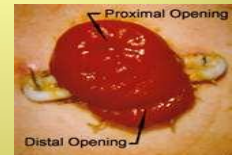
CONSIDERATIONS IN ILEOCONDUIT

- Ileoconduit
 - s/s UTI
 - Leg or night drainage bag
 - Stent



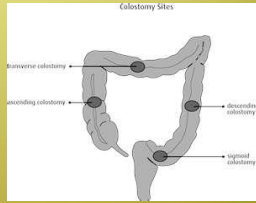
CONSIDERATIONS IN ILEOSTOMY

- Ileostomy
 - High output
 - Frequent emptying
 - Risk of dehydration
 - Peristomal skin irritation
 - Undigested meds/food
 - Liquid output: urostomy pouch



CONSIDERATIONS IN COLOSTOMY

- Colostomy
 - Risk for constipation
 - Can use closed end pouch
 - Irrigation
 - Less skin breakdown
 - Increase in odor



Mucous Fistula



Colostomy with Hernia and Peristomal Pressure Wounds



Ileostomy and Peristomal Tumor



Prolapsed Stoma



OBSTACLES FOR POUCHING

- Rods
- Stents
- Prolapse
- Skin fold
- Peristomal wounds
- Peristomal tumors



CHOOSING THE CORRECT OSTOMY PRODUCT

- Assess abdominal contour
- Assess stoma characteristics
- Assess peristomal skin
- Assess patient preference
- Assess ability to perform application

OSTOMY APPLIANCES

- | | |
|---------------|-----------------|
| • One piece | • Two piece |
| • Flat flange | • Convex flange |
| • Transparent | • Opaque |

OSTOMY PRODUCTS

- Stomahesive paste
- Rings/wafers
- Stomahesive powder
- Skin prep
- Urostomy adaptors
- Adhesive remover
- Ostomy belt
- Ostomy binder



FISTULAS

- An abnormal passage or opening between two or more body organs or spaces
- Develops
 - Obstruction from the malignancy
 - Radiation side effect
 - Postsurgical adhesions
 - Inflammatory bowel disease
 - Small-bowel obstructions
 - Hematoma/abscess formation

FISTULA MANAGEMENT

- Assessment of fluid and electrolyte balance
- Managed with an ostomy pouch
- Pouches range from pediatric to wound drainage pouches
- Pouching allows for odor control
- Pouching protects the surrounding skin
- Wound care and negative pressure

PALLATIVE/HOSPICE CARE

- Assist the patient in completing THEIR bucket list
- Stay positive
- Guide them in making safe decisions
- Arrange care: best time of day for patient
- Educate to prevent anxiety/fears
- Respect their decisions

Comfort



