# Management of Malignant Fungating Wounds [MFW]

**Guidelines**

This document can only be considered current when viewed via the Trust intranet. If this document is printed or saved to another location, you are advised to check that the version you use remains current and valid, with reference to the review due date

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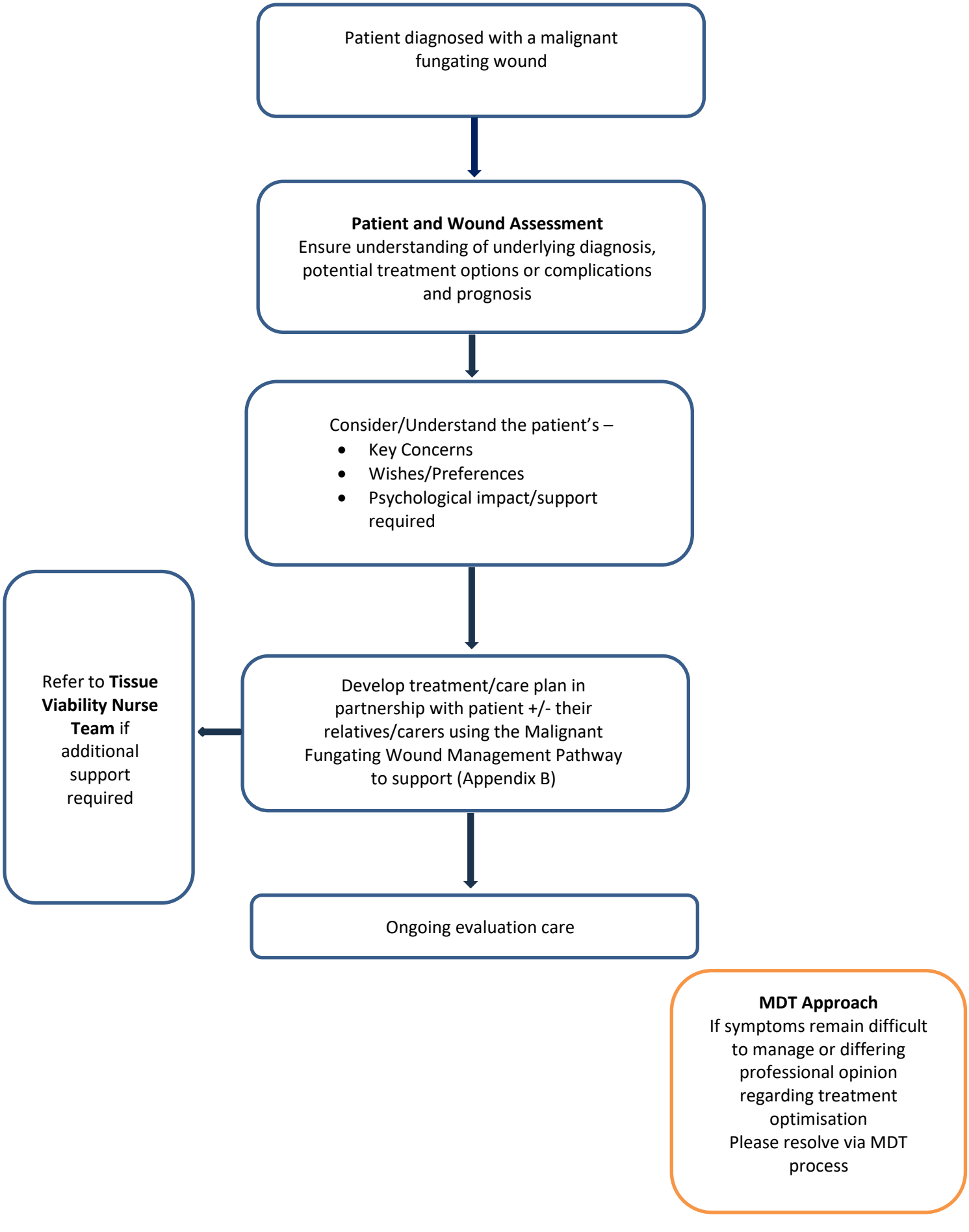
| **Applies to** | All clinicians managing/supporting patients with MFW's<br>(Adult patients only) | **Exclusions** | Children |

**Lynn Cornish (Tissue Viability Lead) at St Margaret's Hospice has supported the development of this protocol.**

## CONTENTS

## 1.0 FLOW DIAGRAM / ALGORITHM OR KEY STEPS



## 2.0 INTRODUCTION

2.1 The purpose of this protocol document is to support the safe management of patients with Malignant Fungating Wounds (MFW) within Somerset NHS Foundation Trust.

2.2 MFW are a complication of cancer and may develop in patients with advanced disease. They are caused by direct infiltration of the skin, tissues, mucosa, blood or lymph vessels by a tumour or metastatic deposit.

2.3 MFW impact on both the physical and psychosocial life of a patient, and patients need a holistic approach to wound management. Patients and care givers may struggle to cope with the challenges associated with malodour, heavy exudate, pain, bleeding, disfigurement and social isolation.

2.4 The scope of this protocol is to support any Somerset FT staff in managing patients with this condition, across any care settings.

2.5 All staff are expected to work within the limitations of their Job Description, the Roles and Responsibilities Section of this document and their professional regulator (i.e. NMC, 2018).

2.6 The use of morphine sulphate and tranexamic soaks is off label use of licensed medicinal products. This guideline has been reviewed and approved by the Drugs and Therapeutics Committee and is supported by Somerset Foundation Trust. See the Trust policy for Procurement, Prescribing, Supply and Administration of Unlicensed Medicines for further information.

2.7 To support prescription and dispensing of these off label treatments within the community setting, this guideline had been discussed and approved at the ICB's Medicines Program Board.

## 3.0 DEFINITIONS

3.1 **Malignant Fungating Wound** - A wound which will not heal, and continues to deteriorate and grow (proliferate) or become larger and deeper (ulcerative).

3.2 **Haemorrhage** - An abnormal escape of blood from the vascular system. May occur in a body cavity or organ, into tissues such as muscles, or externally by way of a wound, or any other natural opening. Internal haemorrhage often causes a haematoma. High pressure haemorrhage results in dangerous loss of circulating blood volume and there may be insufficient to supply the heart muscle and the brain. Low pressure bleeding may persist and shorten life over hours.

3.3 **Exudate** - Leakage of fluid from the wound.

3.4 **Malodour** - Offensive smell, associated with either dead/dying tissue, or infection.

3.5 **Pruritus** – Itching caused by stretching of the skin as the tumour grows, which irritates nerve endings.

3.6 **Infection** - Invasion and multiplication of micro-organisms in body tissues.

3.7 **Psychosocial** - Involving both psychological and social aspects; for example, age, education, spiritual, marital and related aspects of a person's history.

## 4.0 ROLES and RESPONSIBILITIES

4.1 **Document Authors** are responsible for –

- Development of this protocol;
- Ongoing review of national guidance to ensure document is current;
- Ensuring appropriate provision for training linked to this protocol;
- Monitoring implementation and document adherence;

4.2 **Tissue Viability Specialist Nurses** are responsible for –

- Providing clinical colleagues with the specialist support and advice to manage patients with MFW's. Clinical colleagues in community care (such as general practice or district nursing) will implement these specialist plans;
- Liaise with the multi-disciplinary team to support the holistic approach to managing symptoms associated with MFW's (including Specialist Consultants and Palliative Teams).

4.3 **Clinical colleagues** are responsible for –

- Ensuring that they utilise this protocol to inform their management of patients with MFW's;
- Ongoing assessment of the wound and patient to ensure any issues are identified and managed holistically;
- Ongoing evaluation of wound and patient to ensure the treatment remains appropriate;
- Clearly documenting all assessment, care/treatment plans, evaluation and professional discussions about care to demonstrate clear process and decision-making;
- Escalating concerns to the medical team or clinical specialist involved in the patients care in a timely manner;
- Report any incidents relating via Trust's incident reporting system.

4.4 Other clinical roles and responsibilities relating to this protocol should be aligned to the Trust Wound Management Policy; consider individual Job Descriptions and competencies.

## 5.0 PROCESS DESCRIPTION

5.1 Wounds/lesions must be assessed in line with the Trust Wound Management Policy.

5.2 The flow chart in Section 1 highlights the key processes relating to the care of patients with MFW's.

5.3 Assessment should include an understanding of the underlying diagnosis, what current/potential treatment options are available/suitable (e.g. chemotherapy, radiotherapy, hormone therapy or surgery), prognosis and any potential complications (vessel compression or major haemorrhage). See Appendix A for additional information regarding the assessment process and key symptom considerations.

5.4 Assessment should explore the patient's main concerns and wishes regarding treatment aims/goals.

5.5 Treatment and care plans to be developed in partnership with the patient and other key professionals involved in (or leading) the patient's care; with a clear focus on addressing the patient's key concerns and any symptoms identified during the assessment.

5.6 Staff can use Appendix B (**Malignant Fungating Wound Symptom Management Pathway**) to support the assessment and treatment/care planning process.

5.7 Staff can use Appendix C to support use of topical morphine in palliative wound care.

5.8 Staff can use Appendix D (**Management of Bleeding Malignant Fungating Wound**) to manage patients with bleeding wounds or those at risk of significant bleeding. Medication leading to sedation may not be as important as a person being with those who are bleeding. Such support is inevitably troubling and may require support after the bleed, even if the bleeding has not led to death. These situations can be difficult for all involved.

5.9 Evaluation of the wound care is important to ascertain effectiveness, this should be done at regular intervals, and agreed as part of the patient's care plan.

5.10 All care associated with the care of patient's with MFW's must be documented in the patient's clinical records. This should include details of wound assessments, aims of treatment, patient's concerns and care preferences, treatment/care plan, wound evaluations and any communication with other health professionals. The care documents used in the different care settings across the Trust is highlighted in the Wound Care Guidelines.

5.11 Where there are concerns regarding care, the patient's personal choices are in conflict with healthcare professional's advice or staff feel unable to manage the patient's care needs/symptoms within the guidance in this protocol, an MDT meeting should be instigated with the key health professional (including the Specialist Palliative Care Team) involved in the patient's care. An MDT meeting should also be held if the patients has multiple wounds (requiring topical morphine or tranexamic acid treatment), to allow a discussion regarding safe dosage to be had.

5.12 Open, honest communication regarding the management of MFW, and the impact on quality of life is critical. Consider referral to appropriate professionals for psychological support as required.

5.13 Managing such cases may be distressing for staff, managers should consider use of debriefs, clinical supervision and the training/competency needs of their teams.

## 6.0 TRAINING/COMPETENCE REQUIREMENTS

6.1 Training and competencies should be managed in line with the Wound Management Policy.

6.2 Staff should feel confident and able to manage MFW's and the treatments associated with them highlighted in the guidance in the Appendices. Colleagues should be supported to develop their knowledge and experience for managing patients with MFW's.

6.3 Other key skills required to support the care in this document include aseptic technique, knowledge of the Somerset Wound Formulary and advanced communication skills.

## 7.0 MONITORING

7.1 Monitoring will be done via review of reported incidents associated with the management of MFW's and will be reported via annual governance processes for the Tissue Viability Service.

## 8.0 REFERENCES


8.1 Naylor, W. (2002) Symptom control in the management of fungating wounds. World Wide Wounds. Online. Available at: Part 1: Symptom control in the management of fungating wounds (worldwidewounds.com) (accessed 19.06.23).

8.2 Scottish Palliative Care Guidelines (2019) Available at: Scottish Palliative Care Guidelines - Bleeding (accessed 19.06.23)

8.3 Wilcock, A., Howard, P., Charlesworth, S. (2022) Palliative Care Formulary PCF8. 8th Edition. England: Pharmaceutical Press.

8.4 St Giles Hospice (2021) Clinical Guideline for the Management of a Major Catastrophic Bleed for People at the End of Life. Available at: Major-bleed-guidelines-SPAGG-2021-v3.pdf (westmidspallcare.co.uk) (accessed 19.06.23)

8.5 Lister, S., Dougherty, L., McNamara, L. (eds) (2019) The Royal Marsden Manual of Cancer Nursing Procedures. John Wiley & sons Ltd.

8.6 Zeppetella G, Ribeiro MD. (2005). Morphine in intrasite gel applied topically to painful ulcer. J Pain Symptom Manag, 29; 118-119.

8.7 Seaman, S. (2006). Management of Malignant Fungating Wounds in Advanced Cancer. Seminars in Oncology Nursing, 22(3); 185-193.

8.8 NHS Tayside (2010) wound formulary - Section 10: Wound Complications - Fungating Wounds. Available at: **Back to Section 14 Selection Page (scot.nhs.uk)** (accessed 23.06.23)

8.9 Ciałkowska-Rysz, A., Dzierżanowski, T. (2019) Topical morphine for treatment of cancer-related painful mucosal and cutaneous lesions: a double-blind, placebo-controlled cross-over clinical trial. Arch Med Sci. Jan;15(1):146-151. doi: 10.5114/aoms.2018.72566. Epub 2018 Jan 2. PMID: 30697265; PMCID: PMC6348368. **Topical morphine for treatment of cancer-related painful mucosal and cutaneous lesions: a double-blind, placebo-controlled cross-over clinical trial - PMC (nih.gov)** (accessed 23.06.23)

8.10 Somerset Foundation Trust (2023) Procurement, Prescribing, Supply and Administration of Unlicensed Medicines Policy - June 2023.

## 9. APPENDIX A - Guidance for assessment of MFW's

### Focus on patient's main concerns/issue.

Patients' wishes and concerns must be considered, and conversations held to ascertain patient goals, and to achieve a partnership between healthcare professionals and patients. The patient should at all times feel that they are equally involved in the management of their MFW.

All people should be asked **'What bothers you most about having the wound?'**

### Managing pain

Ascertain cause – Is there background, incident, procedural pain?

Review medication. Is the prescribed regular and/or breakthrough analgesia sufficient to manage the wound symptoms?

Consider the use of neuropathic analgesia for nerve pain if regular analgesia is not managing wound pain.

Procedural pain - Consider analgesia 30 minutes prior to dressing changes to minimise dressing/procedural associated pain. i.e. Entonox (not usually available outside of hospital), immediate release oral opioid, Fentanyl (sub lingual), topical local anaesthetic preparations.

Transcutaneous electric nerve stimulation (T.E.N.S.) can be used in consultation with Pain Control Teams.

Consider the use of complimentary therapy treatments. Massage, relaxation and distraction techniques can help relieve pain.

Do not use topical analgesic treatment around the eyes, or on patients with severe impairment of the central nervous system e.g. increased intracranial pressure, or head injury.

### Managing malodour

Research shows malodour is on the top of patients' lists of the most distressing symptom. It is important to manage the psychosocial aspects.

Investigate and define cause. Malodour is usually associated with the presence of devitalised tissue (sloughy/necrosis) or infection/increased bioburden.

See MFW Pathway (Appendix B) for treatment option to manage these symptoms.

### Managing pruritus (itch)

Pruritus is thought to be caused by the infiltrating tumour stretching the skin which irritates the nerve endings, or excoriation to surrounding tissue. Pruritis does not usually respond to antihistamines.

Assess and consider cause – treatment/care planning should aim to remove or reduce factors that may exacerbate symptoms.

## Infection

Assess and monitor wound/patient for signs of infection and sepsis. If wound appears infected then take a swab and treat accordingly.

## Managing exudate

Assess and determine the cause of increased or problematic exudate.

Select primary dressings that address key underlying causes (i.e. infection/increased bioburden) and minimise trauma.

See MFW Pathway (Appendix B) for treatment option to manage these symptoms.

## Bleeding

Bleeding is caused by the erosion of the blood vessels either by the tumour, secondary necrosis, sloughing of tissues or trauma and friction from either an adherent dressing being applied or clothing rubbing. There may also be anatomical or radiographic evidence of tumour being in close proximity to a major blood vessel where direct infiltration can lead to a high pressure bleed.

Minor bleed - more controllable with specific measures.

Major bleeding - severe acute bleeding which is life threatening. Risk factors include: smaller warning bleeds, local infection at the tumour site (may present as odour), prescribed medication (review/discontinue any medication that may impair clotting), clotting abnormalities, type/Site of cancer – i.e. head and neck, haematological, co-existing disease – i.e. liver failure, oesophageal varices, gastrointestinal bleeding.

Discuss balance of using oral systemic tranexamic acid with GP or medic, as a prophylactic measure.

See Management of Bleeding Malignant Fungating Wounds Appendix D for guidance on managing this symptom.

## Debridement

Active debridement (mechanical, sharp, and biological) is not appropriate.

If appropriate to the situation, wound treatment products should be selected that support autolytic debridement. See Somerset Wound Formulary for details or seek support from the Tissue Viability Team.

## Dressing Management and Techniques

Assess the benefits of cleansing, to remove exudate or devitalised tissue, the disadvantages of causing pain, trauma and bleeding. Do not use cotton wool as these shed fibres and increase the risk of infection.

Clinician to assess if aseptic or ‘clean’ technique is acceptable. Use 0.9% sterile normal saline on immunocompromised patient.

Showering can cleanse the wound but avoid soaps and direct water pressure on wound.

Refer to Somerset Wound Formulary for appropriate choice of dressing. It should be explained to the patient that dressing choice is aimed at managing symptoms, and improving quality of life as opposed to healing.

The packing and probing of MFW's is not recommended. This could cause pain, distress and bleeding. Any packing undertaken should only be done to wick away exudate, with a small volume of dressing.

Use high absorbency dressings to manage the exudate. Use appropriate comfortable, non- adherent and conformable dressings (which is acceptable to the patient) from the Somerset Wound Formulary.

Consideration of dressing wear time when making selection to minimise dressing changes as much as possible.

Dressings can be secured by other means for comfort i.e. netting, adapted garments or tubular bandage. Some patients may need prosthetics or bra/underwear advice.

Refer to members of the multidisciplinary team as required and seek assistance from Specialist Nurses or Tissue Viability Team if necessary.

Compression and Negative Pressure Wound Therapy are not recommended without Consultant, VSN, or TVN risk assessment.

Consider and promote self-management when appropriate.

## Nutritional management

Assess the patient's nutrition and hydration status and refer as appropriate. Aim to improve quality of life for the patient.

## Management of psychosocial symptoms

A MFW affects all dimensions of a patient's existence: physical, psychosocial and spiritual. Table A below highlights key psychosocial factors to consider.

Holistic wound assessment should ensure physical and psychosocial factors are all given consideration and care planned, including the level of information that patient wishes to be shared with them and their loved ones regarding their treatment and care.

Patients must feel they are able (and given time) to voice concerns, fears, and discuss with healthcare professionals exactly what impact the wound has had on their quality of life. A patient's view may not replicate that of the healthcare professional. Ensure the patient's dignity and privacy is always maintained. Consider referrals to support psychosocial issues when appropriate.

| **Table A - Aspects to take into consideration when assessing the psychosocial factors (Naylor, 2002)** | | | | |
|---|---|---|---|---|
| Determine expectations and needs | Determine short/long term goals | Depression<br>Anxiety | Embarrassment | Lack of respect or self-esteem |
| Denial | Anger | Shock | Guilt | Fear |
| Coping strategies/style | Beliefs and values/ meaning of the event | Cultural issues/marginalisation | Alterations in life related to wound and dressings- family, career, social activities | Financial issues |
| Impact on role within the family. | Functional ability | Impact on family and partner e.g. relationship problems, sexual intimacy | Spiritual issues | Support and support networks |
| Informational needs | Body Image | Communication difficulties | Identification of the person who will do wound care | Social isolation |

## 9.1 Appendix B - Malignant Fungating Wounds Management Pathway

Holistic assessment

### PAIN

Choose non-adherent dressings that minimises trauma/pain during application and removal

Evaluate need for pharmacological and non-pharmacological strategies for pain management

Give prescribed regular and breakthrough analgesic, as per analgesic ladder and local guidelines

Refer to GP, Palliative Care Team, TVN or Pain Team if additional support required

If all other avenues exhausted or patient experiencing side-effects of medication
Consider use of topical morphine
See **Appendix C**

Consider is pain caused by infection?

### INFECTION

Swab wound
Consider systemic antibiotics/treatment

Use **Somerset Wound Formulary** to select antimicrobial dressings appropriate to presentation and symptoms

Consider topical metronidazole wound gel – if infected or bacterial overload

### ODOUR

**CAUSE** –
Infection/increased bio-burden

**CAUSE** –
Presence of devitalised tissue

Use the **Somerset Wound Formulary** to support autolytic debridement as appropriate

Consider irrigation solution (i.e. Prontosan) to reduce bioburden

Increase dressing frequency as required

Consider odour controlling dressing (activated charcoal)
Place this over the absorbent dressing/pad in wet wounds as less effective when charcoal becomes wet

Consider extrinsic products to alleviate odour in the environment (not applied to the wound)

- Cat litter in tray under the bed
- Shaving foam
- Baking soda
- Deodorisers
- Aromatherapy scents

### EXUDATE/BLEEDING

Exudate:
Assess volume and appearance, as change may indicate infection
Consider absorbency of secondary dressing
Protect surrounding skin

Consider wound management bag/pouches

Consider dietician if excessive exudate

Bleeding:
Follow **Management of Bleeding Malignant Fungating Wounds (Appendix D)**

For consideration of psychological factors – see **Appendix A**

### SKIN

**Maceration**:
Select appropriate absorbent secondary dressings

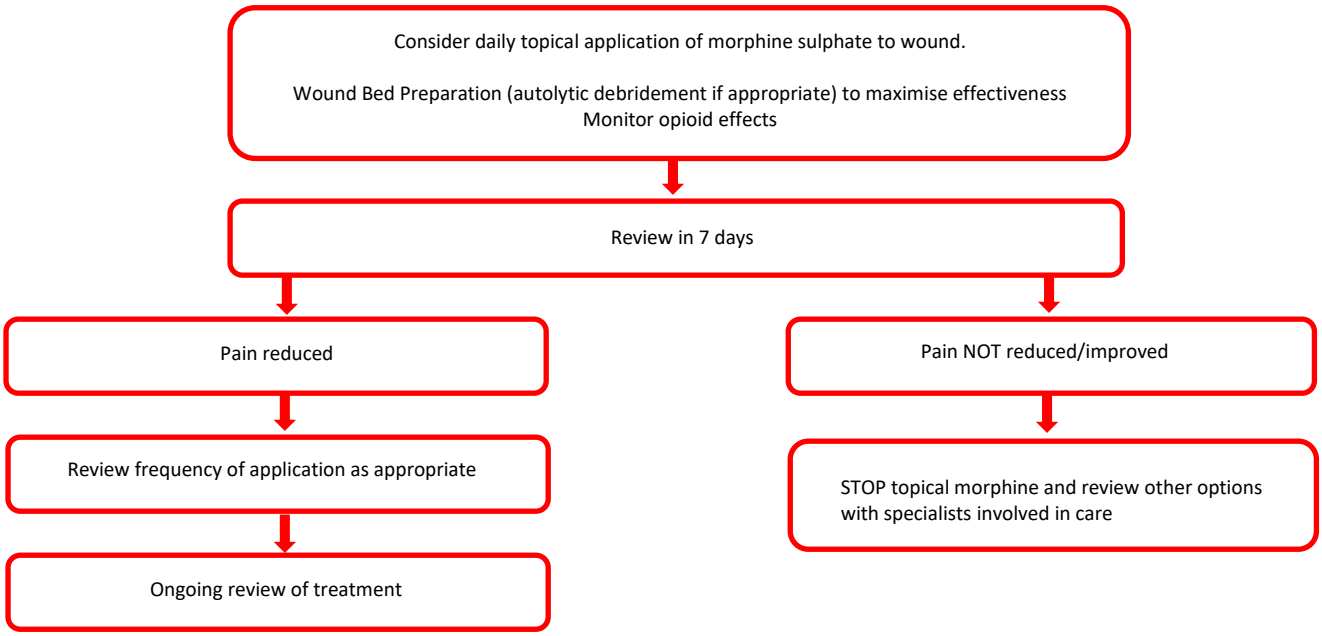
**Excoriation**:
Consider cause – exudate, skin stripping, allergy
Select alternative dressings if allergy suspected
Use adhesive remover if skin stripping issue

Protect skin with barrier film
Use **Trust Skin Protection Pathway**

Itching:
Consider cause and address
Oral antihistamine may not be effective

Consider soft clothing/bedding
Cool, soft, comfortable dressings, avoid tapes/adhesives
Hydrate/moisturise skin
Cool compress
Seek further advice as needed

## 9.2 Appendix C- Topical Morphine Sulphate Management and Application Guide For Painful Malignant Wounds




**Components required:**

- MAR chart
- Morphine Sulphate (injectable) – 10mg/1ml
- Intrasite gel - 8 grams tube
- Sterile pot / tray (to mix components)
- Sterile spatula or equivalent (to mix components)
- Sterile gauze swabs
- PPE
- Filter needle and syringe
- Sharps bin

**Preparation process:**

- Ensure Morphine and IntraSite gel is correctly prescribed on MAR chart
- Check Morphine as per Controlled Drugs Policy
- Transfer the 8 grams of IntraSite gel and syringe into sterile pot
- Draw up the 10mgs of morphine, using a filter needle to prevent shards of glass contaminating the morphine
- Add the morphine to the IntraSite gel in the sterile pot and mix with sterile spatula or equivalent
- Dispose of used sharps as per policy
- The mixture should be used immediately and not stored
- Place the gauze swabs into the sterile pot and agitate until completely covered in the mixture
- If preferred use spatula to 'spread' mixture onto gauze
- Ensure that the gauze is evenly coated in the mixture, and that no mixture remains in the pot
- Apply the soaked gauze to the wound. Leave for 15 – 20 minutes and then **remove**
- Dress as per wound care plan
- Dispose of any equipment that has been in contact with the CD Drug in a sharps bin

REFERENCES: Naylor (2002), Wilcock et al (2022), Zeppetella & Ribeiro (2005), NHS Tayside (2010), Ciałkowska-Rysz & Dzierżanowski (2019)
See p7 for full detailsage

## 9.3 Appendix D – Management of Bleeding Malignant Fungating Wounds

Risk assess to calculate risk of a minor or major haemorrhage

Correct any risk factors possible, to reduce risk safely (this may require balancing risk of clotting with bleeding and may need wider discussion)

Use non-adherent dressings to reduce risk of sticking/trauma on removal, if alginate used for bleeding episode must be soaked off at next dressing change

### Risk of a large or possibly fatal bleed

Preparation and emotional support is essential where there is risk of a major haemorrhage.

Ensure patient and family are aware of the possibility of a large or possibly fatal bleed, that treatments have been discussed, and reassurance given.

A personalised care plan should be in situ in case of a major bleed.

The most effective intervention is being with a person as they bleed to comfort and care for them.

Consider need for just in case (JIC) Midazolam prescription for catastrophic bleed (see Trust Guideline "Management of Terminal haemorrhage in advanced malignancy including carotid artery rupture (adult)")

JIC medication to be stored close to patient.

Dark towels should be kept close at hand.

### Bleeding Wound

**1st line** Topical Alginate Dressings
Ensure pressure is applied to the wound/area to stem bleed

**Discuss need for escalating care with TVN's**

**2nd line option**

**Tranexamic acid** soaked gauze applied directly to the bleeding points at dressing changes or soaked gauze directly onto the wound and leave for 10-15 minutes applying pressure if possible.
**DO NOT LEAVE THE SOAKED GAUZE UNDERNEATH THE DRESSING**.

**<u>Topical tranexamic acid (TA) application guidance</u>**

Draw up the dose (500mg in 5mls ampoule) of TA using a filter needle to avoid shards of glass getting into the wound bed.

Remove the needle and soak sterile gauze with TA.

Apply soaked gauze to the wound bed and leave for 10-15 minutes, applying pressure to areas that are actively bleeding if possible.

Remove gauze and apply routine dressings as per treatment plan.

TA can be used daily as a prophylactic measure to reduce the risk of worsening bleeding. Recommend 2 weeks therapy and review.

Consider MDT review if struggling to manage symptoms, other treatments (such as topical Adrenaline soaks) should only be considered under the direction of Palliative Care Team/medics.

**NB – Use of TA for this purpose (off label) has been reviewed and discussed at MPB (ICB) who support the prescribing and dispensing in community setting**

### Mouth

For bleeding of the oral cavity a Tranexamic Acid mouthwash 5% prescribed (if not available - A 5% solution can be made by crushing and dispersing a 500mg tablet in 10ml water or diluting the contents of one 500mg/5ml ampoule to a final volume of 10ml) discuss frequency with Palliative Care Team

REFERENCES: Scottish Palliative Care Guidelines (2019), Naylor (2002), St Giles Hospice (2021)
See p7 for full details