

FUNGATING WOUNDS: CAUSES, CHARACTERISTICS AND IMPACT ON PATIENTS

Fungating wounds 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. They can be painful, produce high levels of exudate, cause bleeding and be malodorous. Management rather than healing is the objective of wound care, and management is complex. This article discusses the characteristics, symptoms and impact of fungating wounds on the patient and their family/carers.

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Living with a cancer diagnosis can be one of the most difficult and challenging times in a patient's life. This diagnosis may be incurable and an impending sense of doom in recognising their own mortality can be hard to come to terms with (O'Regan, 2007; Naylor, 2002). For some patients with cancer this is made even more challenging when the diagnosis includes a fungating tumour, which serves as a visual reminder of their own mortality as the cancer infiltrates their skin in the most intrusive way. Fungating wounds are a devastating complication of a cancer diagnosis that may develop in patients with advanced disease (Grocott, 2007). It is estimated that fungating wounds occur in approximately 5–15% of patients with a metastatic cancer diagnosis (Stringer et al, 2014) and up to 9% of all cancer patients (da Costa Santos et al, 2010).

This article aims to highlight the reasons wounds fungate, their characteristics, the impact on the patient, their carer(s) and health professionals, the management of symptoms, and where specialist advice and support can be obtained.

Why wounds fungate

Fungating wounds are caused by direct infiltration of the skin, tissues, mucosa and blood and lymph vessels by a local tumour, from a metastatic deposit from a distant primary site or from a primary skin tumour, such as squamous cell carcinoma, basal cell carcinoma or malignant melanoma (McMurray, 2003). Without treatment, they have the potential to extend and cause massive damage to the wound site (McMurray, 2003).

Characteristics of fungating tumours

Fungating tumours are often easily recognised by their fungal, crater or cauliflower appearance (Seaman, 2006). They can grow rapidly and may ulcerate, proliferate or fistulate. They have varying physical symptoms, which include pain, high levels of exudate, excessive bleeding and malodour. They can also cause psychosocial problems, such as denial, embarrassment, fear, social isolation and disgust on their changing appearance (Naylor et al, 2001).

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The most common site is fungating breast wounds (O'Regan 2007; Probst et al 2013) but fungating wounds can occur virtually anywhere on the body and are very individual in presentation. They most commonly develop from cancer of the head and neck, breast melanoma and soft tissue sarcoma, often occurring in the terminal stages of the disease.

Managing symptoms

Essentially, healing is not the objective of wound care when looking after a patient with a fungating wound. Symptom control is the primary goal and holistic assessment of the patient and wound can support this. These wounds are invariably chronic in nature, complex to manage and demand a plan that is individualised (McMurray, 2003). The treatment plan will often include a significant amount of psychological and social support for both the patient and relatives.

Regular assessment

Regular review of a fungating wound should include the assessment of (O'Regan, 2007):

- ▶ Location and size of the wound
- ▶ Tissue type in the wound bed
- ▶ Exudate level and type
- ▶ Odour
- ▶ Pain level
- ▶ Condition of the surrounding skin
- ▶ Effects on daily activities of living
- ▶ Frequency of dressing change
- ▶ A patient's overall physical, psychological and emotional status
- ▶ How the patient's family is coping or adjusting
- ▶ Presence of infection.

Wound management objectives

There are a number of objectives when managing fungating wounds (O'Regan, 2007):

- ▶ Maintenance of optimum wound

- ▶ humidity to minimise pain
- ▶ Non-adherent dressing to prevent trauma and thus minimise pain during dressing changes
- ▶ Facilitation of debridement if appropriate
- ▶ Control of the main symptoms, such as excess exudate, bleeding, malodour, pain
- ▶ Maximisation of cosmetic acceptability.

Pain

Pain can be experienced in different ways and is unique to each individual. It can be influenced by age, gender, culture, emotion and social factors (Casey, 1998). The assessment and subsequent management of pain due to a fungating wound is a vital aspect of the patient's holistic assessment (World Union of Wound Healing Societies [WUWHS], 2004). Using a recognised numeric scale such as 0–3 or 1–10 is a good way of assessing severity of pain, but the healthcare professional also needs to assess what makes the pain better or worse, where it is, and whether it is continuous, intermittent, occasional (i.e. dressing changes) or varies with the time of day (WUWHS, 2004).

Pain should be managed by using regular effective systemic analgesia, such as opioids and NSAIDs. The effect of these should be monitored and changes to prescriptions made based on this regular assessment. In addition, the adjunctive use of Entonox and topical analgesics, such as diamorphine, for procedural pain relief have been shown to be effective in the management of pain relating to fungating wounds (Back and Finlay, 1995). The use of non medication-based solutions should not be forgotten. Such solutions include: (McMurray 2003; WUWHS 2004):

- ▶ Distraction techniques during dressing changes
- ▶ The use of truly non-adherent dressings, i.e. silicone wound contact layers

- ▶ Warming of any cleansing solutions before wound cleansing
- ▶ Maintenance of optimum wound humidity by using dressings that create a moist wound-healing environment
- ▶ Protecting the surrounding skin from any trauma from dressings and maceration from uncontrolled exudate.

Bleeding

A common complication of a fungating wound is superficial bleeding. This is due to fragile tumour capillaries in the wound bed, and platelets being absent or their function suppressed (Naylor, 2002). The management of superficial bleeding could include non-adherent dressings, pressure dressings, alginates and haemostatic dressings (Naylor, 2002). Erosion of the local blood vessels in the wound bed can cause significant blood loss and in some instances, such as erosion into the carotid artery, can cause major haemorrhage and ultimately death. For patients where erosion into a major artery is a potential complication, they and their families should be prepared for this potentially catastrophic event and provided with an emergency pack to use at home to make such an event as manageable and minimally distressing as possible (Hulme and Wilcox, 2008). The emergency pack should contain an appropriate medication for emergency administration (rectal diazepam, 10 mg, intramuscular/subcutaneous midazolam, 10 mg or intravenous/subcutaneous diamorphine), information for the patient and his/her relatives as determined on an individual basis, and red or dark coloured blankets/sheets. Carotid artery rupture will result in a massive haemorrhage and a multidisciplinary team meeting should take place to discuss what preparation is needed and when. Issues such as informing relatives and patients should be handled sensitively and

at an appropriate time, following local guidance.

Exudate

The level of exudate in a fungating wound can cause significant quality of life issues for patients and can be very challenging for healthcare professionals to manage. It is essential to treat or remove the underlying cause of the high exudate production where possible, such as treating infection with antibiotics and using antimicrobial dressings such as those containing honey, silver or iodine (Wounds UK, 2013).

To manage the exudate level, topical and often highly absorbent dressings are required. Such dressings include foams, alginates, hydro-fibres, super-absorbents and even wound management bags for very high and unmanageable exudate levels (Wounds UK 2013). When deciding on an appropriate dressing, the healthcare practitioner should consider the size of the fungating wound, its depth, shape and location, as this assessment will dictate the dressing choices available and how these will be secured effectively.

In addition to considering the wound itself, it is essential to consider care of the surrounding skin. Barrier film products are useful, as this skin is often very fragile, damaged and at risk of deterioration (Romanelli et al, 2010). In some instances patients may be offered palliative radiotherapy. This may be beneficial in reducing the exudate level associated with a fungating wound. Radiotherapy has potential side effects, however, which would need to be considered alongside the benefits for the wound.

Malodour

Malodour is a common symptom of fungating wounds and can be one of the most distressing (Stringer et al, 2014). It can be caused by anaerobic or aerobic organisms (McMurray,

2003). The malodour from a fungating wound can make a patient feel like he or she is rotting away. It can permeate into the surrounding environment, making tasks such as mealtimes and receiving visitors unachievable for some patients. Alongside the malodour, there might be a large amount of exudate that can leak onto clothing, further exacerbating the situation.

The healthcare professional could use an odour indicator tool, such as the TELER (Treatment Evaluation by a LE Roux's method) tool, to assess malodour (Grocott, 2001). It measures odour using a scale and the impact of odour on a patient, therefore giving more impactful data about the effectiveness of strategies such as dressings to control odour, it may, however, not be practical to use in everyday practice.

As well as the patient's feelings and response to a malodourous wound, malodour may have a negative impact on family, carers and healthcare professionals, who may avoid spending time with the patient (Naylor, 2002; Morris 2008).

The aim of treatment is to eliminate the odour, often by killing the microorganisms responsible. This can be achieved in various ways, such as the use of systemic and or topical antimicrobials (Butcher, 2006), topical antibiotics (Bale et al, 2004), effective wound cleansing, wound debridement, and dressings that assist in odour control such as those containing charcoal (Bale et al, 2004; Seaman, 2006)

Product choice

Dressing selection is important and challenging, as dressings are square when wounds are not and there are a limited number of dressing sizes that make it difficult to find one that will cope with the challenges of certain wounds, particularly in instances where there are high levels

of exudate. Wound care companies need to design products that can mould around awkward shapes and difficult-to-dress areas to ensure that patients are comfortable. Fungating wounds can be in the most challenging of areas and patients may have a remarkable sense of what works and what does not – after all they are living with the wound. Do not reinvent the wheel if you have a patient admitted or transferred into your care. Ask him or her what has proven useful, listen and adapt your usual methods. If the patient is comfortable and the symptoms are well managed, then you have succeeded in your role in caring for the patient with a fungating wound.

The impact of fungating tumours

The psychosocial impact of a fungating wound will vary depending on each individual patient and his or her family. The location and visibility of the fungating wound may also have an impact on the emotional distress it may cause.

Maintaining a good quality of life for a patient living with a fungating wound is vital. Patients can often feel isolated and alienated, lonely and depressed (Stringer et al, 2014). Having a fungating wound means that they are living with a constant reminder of their cancer and the fact that their skin is deteriorating, an issue exacerbated by the fact that they may be aware that the wound is highly unlikely to heal (Naylor, 2001). This can have huge impact on their personal body image and can cause distress to them, their family and friends. It can also distress healthcare professionals caring for them if this is a wound that they have yet to encounter (O'Regan 2007).

Good communication with the patient and his or her significant others is vitally important. Counselling skills and coping mechanisms should be fully utilised

when helping a patient cope with the challenges of living with a fungating wound (Naylor et al, 2001; O'Regan 2007).

Specialist help available

If you are looking after a patient with a fungating wound and despite all of the above information you still feel that you cannot manage this wound yourself, then you should have specialist advice on hand to guide you in care planning for these patients. You could access a tissue viability nurse, Macmillan cancer nurse or the patient's oncologist for advice on the wound, as they will have seen and cared for many patients in this situation before and will be happy to advise you and your patient on the best course of action to manage their symptoms, which may include radiotherapy in certain circumstances. **WE**

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