Wound Care in Hospice: To Heal Or Palliate?

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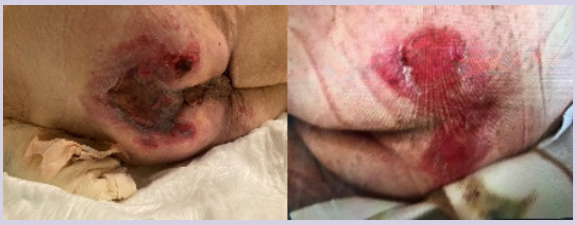
Patients often present to hospice and palliative care programs with wounds of varying etiologies which may include pressure injuries, skin tears, vascular wounds, malignant wounds, Kennedy terminal ulcers (KTU) and/or Trombley-Brennan terminal tissue injuries (TB-TTI) , among others. (For more information on the final two, see sidebar on following page.)

The wound is often a symptom of the underlying disease process. The skin, being the largest organ in the body, may fail along with other organs during multisystem organ failure.[1-4] The visual nature of skin failure may overwhelm patients, caregivers and clinicians.

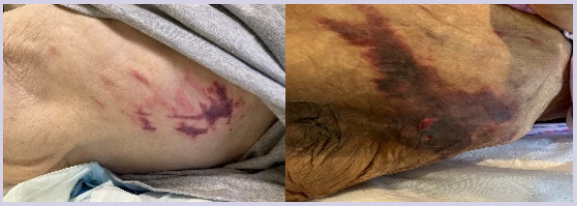
A multidisciplinary team approach is needed to address the complex physical, psychosocial and spiritual needs often accompanying the patient with advanced disease.

Although it may come as a surprise to some, many patients receiving hospice and palliative care do achieve wound healing, as demonstrated in the first two case studies below. There are, however, times when wound healing is not a realistic expectation, and the goals of care need to shift to symptom management. It is important for the team to have a united front and to discuss

A **Kennedy terminal ulcers (KTU)** is thought to be an ulcer/lesion that occurs/progresses rather rapidly because of the dying process and hyoperfusion. While they can occur on any part of the body, they typically occur at the sacral area. They may be pear, butterfly, horseshoe or heart-shaped and occur days to weeks before death. See examples below at the sacral regions.



A **Trombley-Brennan terminal tissue injuries (TB-TTI)** appears like a deep tissue pressure injury but may develop on areas not exposed to pressure. They may occur hours to days before death. See examples below at the left lower back and sacral/left hip regions.



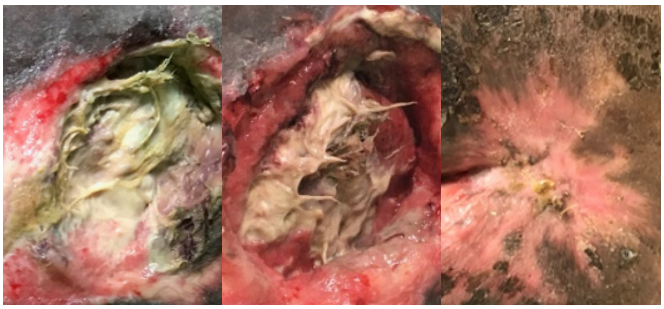
this with the patient and caregivers to avoid disappointment if healing is expected.

Distressing symptoms to be managed may include wound pain, odour, bleeding and/or excessive exudate. Non-healing wounds may include malignant wounds and extensive vascular wounds, as demonstrated in the last two case studies.

Pressure injuries may develop in the frail patient due to multiple factors, including poor mobility, incontinence, poor nutrition/hydration, multiple comorbidities and advanced disease.

Case 1

Case 1 involves an 86-year-old female with end-stage vascular dementia and multiple comorbidities including diabetes mellitus and respiratory failure. She had a tracheostomy and was tube fed. She presented to hospice with a sacral stage 4 pressure injury (PI) with bone exposed. Pressure injury prevention measures were instituted, including obtaining an appropriate support surface for her bed. The wound and periwound were cleansed with a wound cleanser spray and the periwound was protected with a skin barrier agent. The wound was debrided at the bedside using sharp debridement, in addition to using 0.125% sodium hypochlorite solution moistened gauze three times weekly short-term until it was cleaner with less necrotic tissue. Once it was cleaner, the treatment was changed to include calcium-alginate and a silicone foam dressing to manage the exudate two times weekly and as needed (PRN) if the dressing became soiled. The treatment was ultimately changed to hydrogel moistened gauze two times weekly and PRN as the exudate amount decreased. The wound treatment was changed as the wound characteristics changed to achieve a clean wound bed with moisture balance.



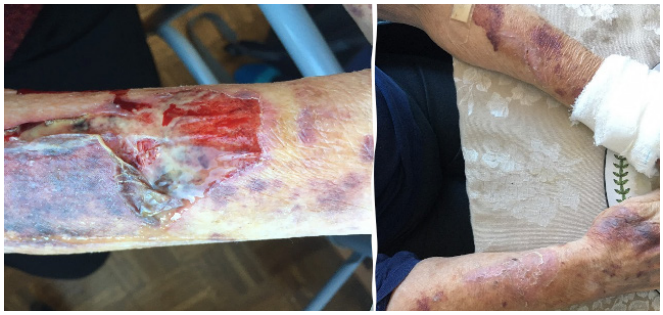
Case 1: Sacral stage 4 PI initially, 1.5 weeks later and 11 months later

The frail patient was also prone to skin tears due to factors such as advanced age, poor nutrition/hydration, comorbidities and medications, such as steroids, antiplatelets and anticoagulants.

Case 2

Case 2 involves an 85-year-old female with lung cancer, coronary artery disease and recurrent skin tears. The treatment plan included discontinuing the aspirin after a discussion with the patient and caregiver regarding the burden versus

benefit at this juncture of her life. Topically, a wound cleanser spray was used to gently cleanse the wound and periwound, a non-stick petrolatum/bismuth gauze was applied, covered by gauze and secured with a gauze wrap twice weekly.

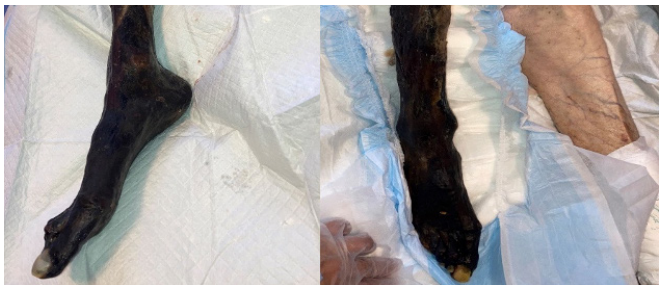


Case 2: Right arm, initially and two weeks later

The next two case studies take a palliative approach when wound healing was not possible.

Case 3

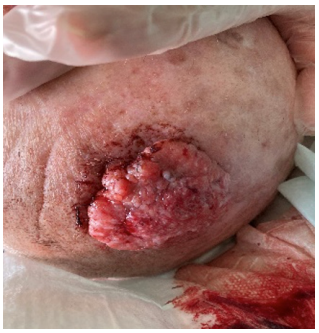
Case 3 involves a 100-year-old female with extensive peripheral vascular disease and gangrene to her right leg. The treatment focused on comfort measures. The topical treatment included metronidazole 5% powder to the open clean area below her knee and painting the necrotic tissue with povidone-iodine for palliation, as well as applying covering with abdominal pads and gauze wrap twice weekly. Caregivers were educated to avoid any moist dressing or creams to prevent converting this dry gangrene to wet gangrene. This regimen helped her remain in the comfort of her home until she passed away peacefully a few months later.



Case 3: Right leg, initially and two months later as the gangrene progressed

Case 4

Case 4 involves a 95-year-old male with multiple comorbidities, including a malignant wound on his scalp. No pain was reported, but caregivers were concerned about episodes of bleeding and odour, as well as the amount of exudate. The treatment regimen to address their concerns included wound cleanser or sodium hypochlorite solution to gently cleanse as needed for odour management, a silver gelling fibre, which contains chitosan, to manage the odour and for its hemostatic and absorptive capabilities. The periwound was protected with a moisture barrier agent and the secondary dressing was an abdominal pad secured with a tubular elastic net dressing retainer twice weekly and PRN. Over time, the bleeding episodes increased and oxymetazoline 0.05% spray was added, off-label, to use on the site as needed for bleeding episodes, with dressing changes. As the exudate amount decreased, the primary dressing was changed to a petrolatum gauze twice weekly. Also, the team reviewed environmental options to manage the odour such as a tray of kitty litter under the bed to absorb the odour. This regimen managed the symptoms that were concerning for the patient and his caregivers to allow quality time with loved ones.



Case 4: Scalp malignant

The following four tables present options to consider for managing wound pain, bleeding, odour and/or excessive exudate.

Wound Pain[5,6]

- Pain assessment with validated tool (may be multidimensional pain)
- Pre-medicate with an appropriate pain med prior to painful wound care (30-60 minutes for oral, IV/SQ about 15 minutes prior)
- May include opioids (assess for any risk for substance use disorder—includes patient and others in the home), non-opioids, non-pharm approaches. Opioid regimen may include short-acting, long-acting agents (e.g., morphine, oxycodone, hydromorphone, methadone, fentanyl)
- Topical agents may also be helpful, e.g., lidocaine, lidocaine-prilocaine about 20 min before debridement or dressing changes
- Less frequent dressing changes
- Non-adherent dressing such as a petrolatum gauze if minimal exudate or consider a multifunctional polymeric membrane dressing
- May need an antimicrobial dressing short-term such as twice weekly & PRN x 2 weeks to manage pain/bleeding from bacteria causing inflammation/irritation, e.g., silver, cadexomer iodine, methylene blue/gentian violet or honey-based dressings
- Systemic or topical antibiotic may be indicated (case by case basis, considering goals of care, disease progression)

Wound Bleeding[7,8]

- Less frequent dressing changes
- Non-adherent dressing
- Consider a multifunctional polymeric membrane dressing
- Check meds that may contribute to bleeding (antiplatelets, anticoagulants)
- May need an anti-microbial dressing short-term to manage pain/bleeding from bacteria causing inflammation/irritation (and/or systemic agent where appropriate), e.g., silver, cadexomer iodine, methylene blue/gentian violet or honey-based dressings
- Hemostatic dressings such as calcium-alginate, chitosan-based gelling fibre dressings for moderate exudate/bleeding
- Off-label use of oxymetazoline nasal spray to the wound; topical aluminum chloride solution, ferric subsulfate hemostatic solution, silver nitrate sticks, aminocaproic acid, epinephrine or topical 5% tranexamic solution or systemic tranexamic acid, e.g., 650mg bid po prn
- Many over the counter hemostatic agents available
- Herbal agents such as the Chinese herb Yunnan Baiyao for wound bleeding, pain, inflammation
- Palliative radiation therapy, e.g., single fraction of 8-10 Gy or 20 Gy in 4-5 fractions for bleeding, pain, odour depending on patient performance status and goals of care

Wound Odour[9,10]

- Thorough wound and periwound cleansing (evaluate for odour after cleansing and removing soiled dressing from the immediate environment). May consider cleansing with sodium hypochlorite or sodium hypochlorous solution PRN odour
- Debridement as appropriate to manage the odour caused by necrotic tissue (exceptions may be malignant wounds due to bleeding risk). Intact eschar at the heel without signs and symptoms of infection should not be debrided without a vascular consult, where appropriate, to confirm adequate perfusion to the area.
- Evaluate for signs and symptoms of infection
- May need an anti-microbial dressing short-term to manage odour (and/or systemic agent where appropriate), e.g., silver, cadexomer iodine, methylene blue/gentian violet or honey-based dressings BIW and PRN
- Metronidazole as a spray, powder, gel or crushed tablets to the site with dressing changes
- Odour specific dressing such as charcoal dressing where appropriate (may use as the outer dressing to increase the wear-time as it is inactivated once wet and can be costly)
- Environmental options to consider include kitty litter, charcoal, coffee grounds in the room to absorb the odour, essential oils, commercially prepared odor eliminators

Excessive Wound Exudate[11,12]

- Thorough wound and periwound cleansing
- Debridement where appropriate as necrotic tissue may lead to increased exudate as the body attempts to autolytically debride the moist necrotic tissue
- Absorptive dressings such as calcium-alginates, hydrofibres, gelling fibres, foam dressings and super absorbent polymer core dressings. May need anti-microbial versions of these absorbent dressings short-term to decrease the microbial count such as BIW and PRN x 2 weeks and re-evaluate ongoing need as they can be costly
- May need an ostomy pouching system to manage large amount of exudate e.g., with the presence of a fistula
- Negative pressure wound therapy where appropriate

Conclusion

In conclusion, patients receiving hospice or palliative care services may present with wounds of varying etiologies and complexities, and while wound healing may not always be possible, there is much we can do to improve the quality of life for our patients and their caregivers. It takes the whole team to support our patients and caregivers during a difficult time in their lives. Wounds can make the caregiving more complicated and lead to complicated grieving if loved ones feel guilty about the wounds occurring or not healing, and need to be educated about the underlying disease process at play despite optimal care.

Editor's note: Specific products/medications mentioned in this article are described as used in the US. Individual products/medications may have different names, indications or alternatives in Canada.

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