Palliative Wound Care for Malignant Fungating Wounds

Holistic Considerations at End-of-Life

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KEYWORDS

• Malignant fungating wound • Fungating wounds • Malignant wounds • Odor • Symptoms • Qualitative • Psychological • Quality of life

KEY POINTS

- A holistic approach is essential to caring for people with malignant fungating wounds (MFWs) because they suffer from a devastating and often crippling physical symptom burden that may subsequently lead to spiritual and psychosocial distress with diminished quality of life.
- A comprehensive patient- and family-centered care planning approach at end-of-life includes PALCARE: *P*rognosis, *A*dvance care planning, *L*iving situation, *C*omprehensive history, *A*ssessment, evidence-based *R*ecommendations and *E*ducation of patient, family and staff.
- Interventions aimed at easing the suffering of terminally ill people with MFWs should be realistic and based on the best available evidence, balancing respect for goals of care with available resources.
- The complexity of caring for patients with MFWs necessitates specialist-level guidance by a wound, ostomy, and continence nurse (WOCN) preferably with a palliative care background and certification in the hospice and palliative care specialty (CHPN, ACHPN).

INTRODUCTION: THE MAGNITUDE OF SUFFERING

Malignant fungating wounds (MFWs) afflict 5% of patients with advanced cancers[1] and 10% of patients with metastasis[2] with life expectancy averaging 6 to 12 months.[2–4]

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Unfortunately, no population-based cancer register records the incidence of MFWs,[5] and prevalence is underreported because of shame, embarrassment, and fear,[6] thus a more precise estimate is currently impossible. Incidence is anticipated to increase rapidly as the number of new cancer cases in the aging population rises with people living longer because of significant innovations in treatment. Because MFWs are managed primarily through palliative wound care approaches and most of these patients do not survive, it is realistic to project that more and more people with MFWs will enter hospice programs. Developing a pragmatic, patient- and family-centered palliative wound care plan is a key to alleviating suffering.

MFWs have been referred to in the literature by multiple names using interchangeable terms.[7,8] MFWs are defined by Grocott[9] as the infiltration and proliferation of malignant cells in to the skin and its supporting blood and lymph vessels. "Fungating" is described by Mortimer[10] as infiltration and erosion through the skin by a proliferation of malignant tumor cells ultimately causing ulceration. MFWs may result from primary tumors or secondary lesions (metastasis) (**Fig. 1**).[11] MFWs of the breast and head and neck are by far the most prevalent (**Box 1**).

The root of suffering in this population is based largely in physical symptom distress; excruciating and debilitating pain, unbearable pruritus, malodor, excessive exudates, and unpredictable bleeding resulting in psychological anguish, shame, humiliation, loss of confidence, fear, guilt, depression, anxiety, and social isolation.[3,4,12,13] The devastating effects of MFWs on quality of life have also been described.[14,15]

Most early publications and research emphasize physical description and management of symptoms. Interventional research in the area of MFWs has remained sparse, with a recent Cochrane Review of topical agents and dressings for MFWs finding the evidence base negligible.[5] This dearth of research presents a multitude of challenges to practitioners.

The cases of Ms. C and Ms. A are used to introduce the PALCARE mnemonic (*P*rognosis, *A*dvance care planning, Living situation, *C*omprehensive history, *A*ssessment, evidence-based *R*ecommendations and *E*ducation of patient, family and staff) (**Box 2**) as a framework for developing a holistic, systematic, patient-centered

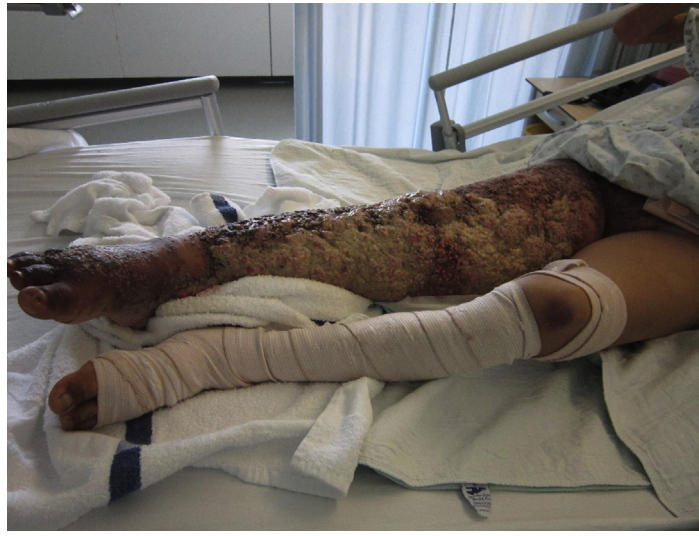

Fig. 1. MFW of entire right leg with lymphedema from metastatic colon cancer.