FUNGATING/MALIGNANT WOUND FLOW CHART

Derbyshire Community Health Services
NHS Foundation Trust

WHAT IS YOUR MAIN OBJECTIVE WITH THIS WOUND?

Manage Exudate

Light irrigation of wound if needed with n/saline or tap water.

Commence a barrier product to wound margins and surrounding skin - refer to DCHS wound formulary for product selection.

Use Low adherent absorbent dressing;

- 1st line - Suprasorb P Sensitive Border
- 2nd line - Mepilex Border Comfort
- 3rd line - Sorbion sachet.

Please refer to TV team if exudate is not controlled.

If itchiness is an issue, check patient for allergy to dressing. Also consider topical steroid and/or antihistamines.

Malodour

Could the wound be infected?

Yes → Infection

No

If the cause is slough and necrosis.
If safe to do so consider debridement:

- 1st line - Revamil
- 3rd line - Flaminal - Forte (for high exudate) or Hydro (for low to moderate exudate)

Increase dressing changes if needed and consider odour control dressings:

- Clinisorb charcoal dressing.

Infection

Wound is infected or showing signs of infection.

Exudate level?

- High → Flaminal® Forte
- Low to moderate → Flaminal® Hydro

As infections are often Anaerobic, **Metronidazole / METRAtop** can be considered to aid with infection control and also for symptom management as a topical antibiotic and can be used for up to 7 days.
It can cause increased levels of exudate and therefore should be discussed with the patient first.

Pain

Consider cause of pain Could the wound be infected?

Yes → Infection

No

To reduce pain at dressing change use a low adherent contact layer.

Consider silicone wound contact layer:

- Mepitel One

Can be left in place for up to 7 days if required. Cleansing can be carried out over the top. Can help reduce trauma. Then the outer dressings are changed.

Consider an analgesic prior to each dressing change.
Pain review- GP/Palliative care colleagues

Bleeding

Is the bleeding light or severe?

- Light
- Severe

Apply pressure for 10-15 mins with moist non-adherent dressing.

Alginate dressing should be considered for haemostatic properties.

- 1st line - Kaltostat

Fatal haemorrhage is rare, patients family and carers should be forewarned and sedation meds should be on hand

Please see separate flow chart

- 1st line - Tranexamic acid (Adrenaline if out of stock)

TRANEXAMIC ACID USE IN THE TREATMENT OF MALIGNANT/FUNGATING WOUNDS

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ONLY FOR USE IN CASE OF A MAJOR BLEED

Please ensure discussion with GP, Palliative care team and Tissue viability have taken place

Fatal haemorrhage is rare, however patients, family and carers should be forewarned and sedation medication should be on hand.

IF SEVERE END OF LIFE BLEEDING SUSPECTED

- Malignant growth may erode a major blood vessel and a serious haemorrhage may occur, if the wound is heavily bleeding and is not responding then an Emergency admission to hospital for cauterisation or ligation may be required.
- **THIS IS AN EMERGENCY SITUATION SO WILL REQUIRE A 999 RESPONSE** unless it is the patient's choice to remain at home and this is documented in their advanced care plan.

1. Stay calm - If possible summon assistance.
2. Ensure someone is with the patient at all times.
3. If possible - nurse in the recovery position to keep airway clear.
4. Stem/disguise bleed with dark coloured sheets/towels.
5. **Tranexamic acid 500mg/5ml Ampule for injection (10%) Should be soaked into gauze and applied with pressure for 10 mins.**

999 to be contacted in the meantime (unless against patient wishes).
EOL medication to be given as per patient EOL plan.

If Tranexamic acid is out of stock Adrenaline 1:1000 soaked on gauze to be used in the same way

Please note if Adrenaline is used then this can cause tissue ischaemia.

GUIDANCE CREATED BY DCHS TV TEAM, DCHST.DCHSTissueViability@nhs.net. SUPPORTED BY FLEN HEALTH UK Ltd.