Management of Malignant Fungating Wounds

Document Details	
Title	**Management of Malignant Fungating Wounds**
Trust Ref Number	**NEW** 2526
Main points the document covers	This policy provides a clear framework for the management of malignant fungating wounds in both inpatient and community settings.
Who is the document aimed at?	All clinicians managing fungating wounds in adult patients only
Author	Medicines Management Team
Approval process	
Approved by (Committee/Director)	Patient Safety Committee
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Document Links	
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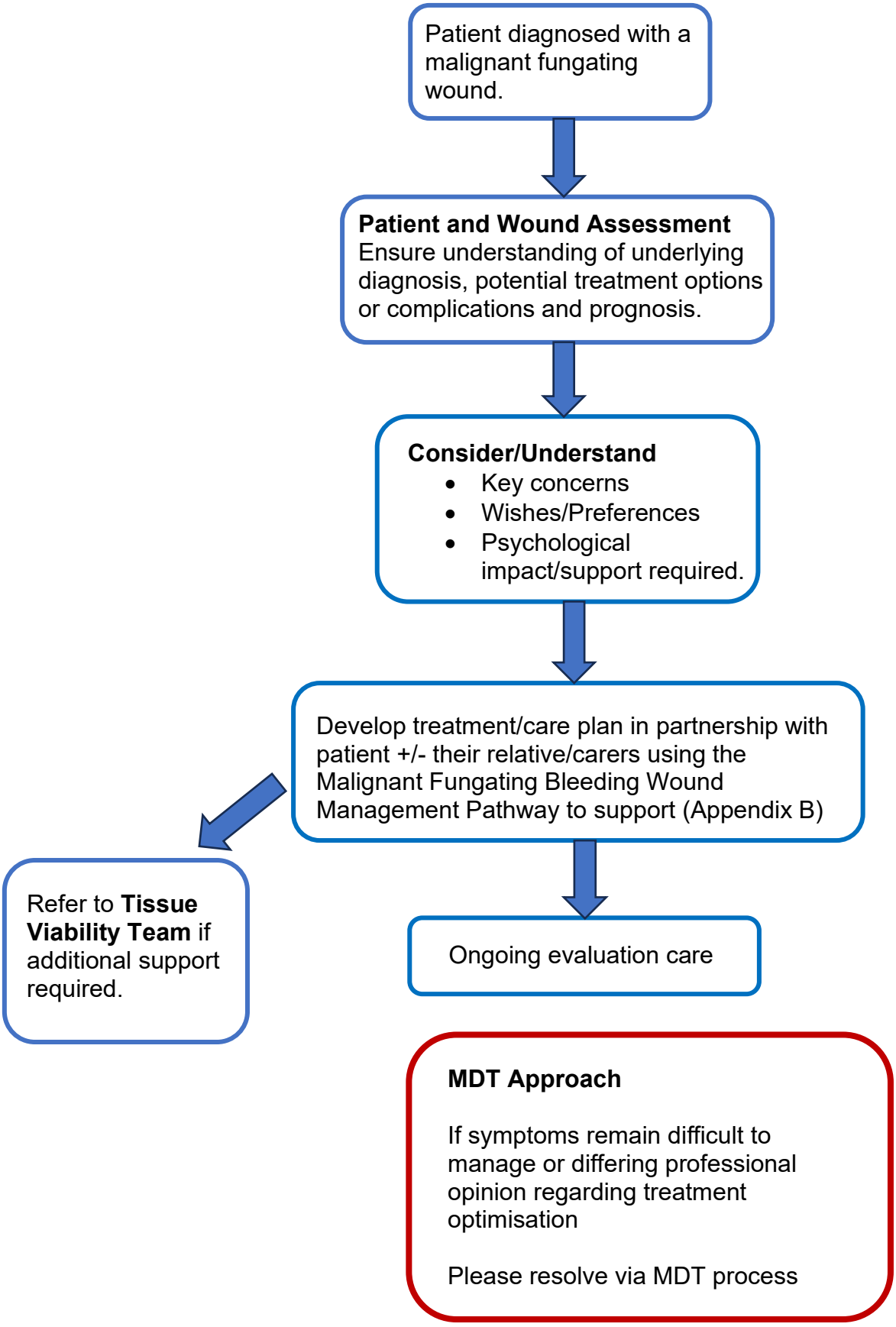
Required by NHLSA	N/A

Amendments History		
No	Date	Amendment
1	April 2025	New publication

1.0 Flow Diagram



2.0 Introduction

2.1 The purpose of this policy is to support the safe management of patients with Malignant Fungating Wounds (MFW) within Shropshire Community NHS Trust.

2.2 MFW are a complication of cancer and may develop in patients with advanced disease. MFW's develop when cancer that is growing under the skin breaks through the skin to create a wound. As the cancer grows, it blocks and damages tiny blood vessels, which can starve the area of oxygen. This causes the skin and underlying tissue to die (necrosis). There may also be infection, and areas of the wound may become ulcerated.

2.3 MFW's impact on both the physical and psychosocial life of a patient, 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 Shropshire Community Health 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 System Wound Management Steering Group.

2.7 Topical use of Tranexamic acid, Adrenaline, Morphine and Sucralfate are classified in the STW Formulary as Amber Specialist Recommendation therefore initiation and maintenance of prescribing is approved in Primary Care following recommendation from a specialist.

2.8 To support prescription and dispensing of these off-label treatments within the community setting, this guideline had been discussed and approved at the Integrated Medicines Optimisation Committee.

3.0 Definitions

3.1 **Malignant Fungating Wound (MFW)-** 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 (bleed) 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 blood 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.

3.8 **SCHT** - Shropshire Community Health NHS Trust

3.9 **STW** – Shropshire, Telford and Wrekin

4.0 Roles and Responsibilities

4.1 **Tissue Viability Specialist Nurses** are responsible for:

- Providing nursing 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 Staff** 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 (Datix).

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 management 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 patients 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 Severn Hospice Specialist Palliative Care Team) involved in the patient's care. An MDT meeting should also be held if the patients have 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 SCHT 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 Shropshire Community Health NHS Trust Wound Formulary and advanced communication skills.

7.0 Monitoring

7.1 Community MFW are routinely referred to the Tissue Viability Team at SCHT. If there are any incidents or issues with the management of these wounds the tissue viability service lead/wound healing service manager will escalate to the patient safety team.

8.0 Guidance for assessment of MFW's

8.1 **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 always 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?'

8.2 **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.

8.3 **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.

8.4 **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.

8.5 **Infection**

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

8.6 **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.

8.7 **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 haemorrhage (bleed) - more controllable with specific measures.

Major haemorrhage (Major bleeding) - severe acute bleeding, which is life threatening, sometimes referred to as 'Catastrophic'. 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.
In addition, refer to the Management of Bleeding Malignant Fungating Wounds Appendix D for guidance on managing this symptom.

8.8 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 the Shropshire, Telford and Wrekin Debridement Pathway for details of formulary choice or seek support from the Tissue Viability Team.

8.9 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 STW 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 STW 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 Wound Healing 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.

8.10 **Nutritional management**

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

8.11 **Management of psychosocial symptoms**

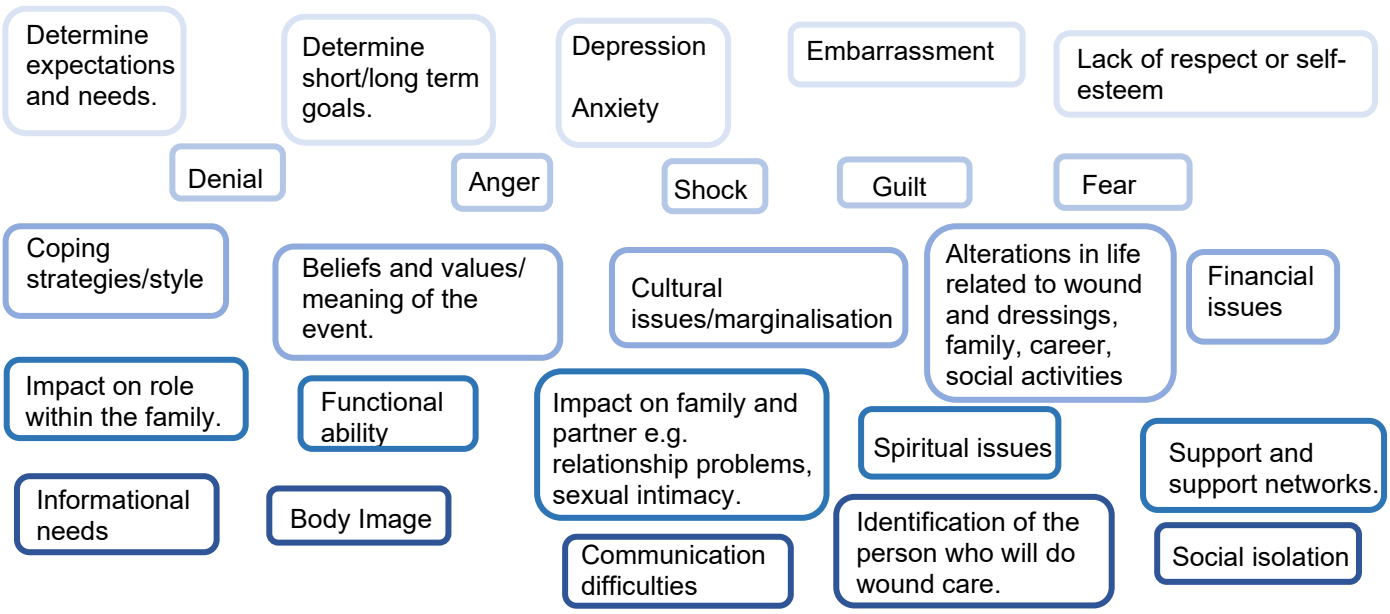
A MFW affects all dimensions of a patient's existence: physical, psychosocial and spiritual. Table A below highlights key psychosocial factors to consider.

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.

Appendix A

Aspects to take into consideration when assessing the psychosocial factors (Naylor, 2002)



Appendix B

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 Shropshire Wound Management Formulary. to select antimicrobial dressings appropriate to presentation and symptoms

Consider irrigation solution (i.e.Octenilin®) 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 topical metronidazole gel (Anabact® metronidazole 0.75% topical gel)[5] – if infected or bacterial overload. Initially for 7 days, if there is a partial response, consider continuing treatment for a further 7 days. Treatment may be ongoing.

Consider Oral metronidazole 400mg[5] THREE times a day (unlicenced) dose based on clinical decision and discussion with patient. Prescribe for 5-7 days, if there is a partial response consider continuing treatment for a further 7 days.

Odour

Cause- Infection/Increased bioburden.

Cause- Presence of devitalised tissue.

Use the **Shropshire Wound Management Formulary** to support autolytic debridement as appropriate. Available on this link: Shropshire Wound Management Formulary.

Consider extrinsic products to alleviate odour in the environment (**not applied to the wound) in tray under bed:**

- 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. Check wound formulary for current list of available absorbent 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, soft clothing/bedding, comfortable dressings, avoid tapes/adhesives Hydrate/moisturise skin Cool compresses. Seek further advice as needed

Appendix C- Topical Morphine Sulphate Management and Application Guide for painful Fungating Malignant Wounds

Inclusion criteria:

- Palliative patients only with the aim of symptom management rather than wound healing
- Painful superficial chronic wounds
- Non-neuropathic, localised pain
- Opioid naïve patients – only where the introduction of systemic opioids would be inappropriate or is refused by the patient.
- Opioid tolerant patients – only where side effects prevent adequate dose escalation of the systemic opioid dose.

Exclusion criteria:

- Hypersensitivity (e.g. rash) to morphine or other opioid derivatives.
- Hypersensitivity to Intrasite gel®
- More than 2 wounds of <10cm diameter.
- Any wound greater than 10cm diameter
- Age <18 years old
- Deep wounds where opioid receptors are absent (morphine gel will not provide pain relief on deep wounds)
- Wounds around the eye area
- Severe impairment of central nervous system
- Acute respiratory depression
- Infected wound- systemic management needed

Consider topical application of morphine sulphate to wound once or twice a day depending on frequency of dressing change. Wound Bed Preparation (autolytic debridement if appropriate) to maximise effectiveness Monitor opioid effects.

Review in 3 to 7 days.

Pain reduced.

Review frequency of application as appropriate

Ongoing review of treatment

Pain **NOT** reduced/improved.

STOP topical morphine and review other options with specialists involved in care.

Components required:

- MAR Chart
- Morphine sulphate (injectable)- 10mg/1ml
- Intrasite gel®- (or another amorphous hydrogel)[9,14]
- 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:

1. Ensure Morphine and Intrasite gel® is correctly prescribed on the MAR chart.
2. Check Morphine as per Controlled Drugs Policy.
3. Transfer the 8 grams of Intrasite gel® and syringe into sterile pot.
4. Draw up 10milligrams of morphine, using a filter needle to prevent shards of glass contaminating the morphine.
5. Add the morphine to the Intrasite gel® in the sterile pot and mix with sterile spatula or equivalent.
6. Dispose of used sharps as per policy.
7. The mixture should be used immediately and not stored.
8. The mixture can be applied directly to the wound bed[2,5,7], or a soaked gauze can be used[2,8]. If applying directly to the wound move to step 13.
9. Place the gauze swabs into the sterile pot and agitate until completely covered in the mixture.
10. If preferred use spatula to 'spread' mixture onto gauze.
11. Ensure that the gauze is evenly coated in the mixture, and that no mixture remains in the pot.
12. Apply the soaked gauze to the wound.[2,8] Leave in situ.
13. Dress as per wound care plan.
14. Dispose of any equipment that has been in contact with the CD Drug in a sharps bin.

Appendix D - Management Haemorrhaging Malignant Fungating Wounds

Risk assess - 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 possibly fatal major haemorrhage

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

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

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

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

Consider need for just in case (JIC) Midazolam prescription for a major (potentially terminal) haemorrhage (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.

Minor Haemorrhage

1st Line Topical Alginate Dressings (**Kaltostat®**) ensure pressure is applied to the wound/area to stem bleed. (Dressings should be removed carefully (soak adherent dressings with sodium chloride 0.9% before removal to minimise trauma)

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 minutes applying pressure if possible.

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 Tranexamic Acid 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

2nd Line -Topical tranexamic acid (TA) application guidance

Draw up the dose (500mg in 5mls ampoule) of Tranexamic Acid using a filter needle to avoid shards of glass getting into the wound bed.
Remove the needle and soak sterile gauze with Tranexamic Acid.

Apply soaked gauze to the wound bed and leave for 10 minutes, applying pressure to areas that are actively bleeding, if possible, before covering with a dressing.
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.

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.

3rd Line, Topical Adrenaline soaks-should **only be considered under the direction of Severn Hospice Consultant.** Apply 5–10 mL of adrenaline 1 in 1000 (1mg in 1 mL) to a gauze swab which can be applied with pressure for 10–20 minutes. This causes local vasoconstriction but may also cause 'rebound' bleeding once these effects wear off. Care should be taken to avoid ischaemic necrosis.[9]

DO NOT LEAVE THE ADRENALINE-SOAKED GAUZE ON THE WOUND AFTER APPLICATION.[9]

9.0 References

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2. Prescribing & Preparation of Topical Morphine Mixture in Palliative Care | Right Decisions NHS Borders Last reviewed:30/12/2023 Next review date:31/12/2026
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6. British National Formulary (BNF) Last updated April 2025.
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8. Management-of-malignant-fungating-wounds.pdf- Somerset NHS FT. Dec 2023.
9. Tranexamic acid medication – West Midlands Palliative Care. SPAGG Guidelines June 2024

10. Consultation

The following people were consulted during development of this policy:

Susan Watkins – Chief Pharmacist
Jodie Jordan – Lead Tissue Viability Nurse
Di Kitching – Lead Pharmacist for CYP&F and Governance
Victoria Jefferson – Hospice Pharmacist
Peter Prokopa – LPN Lead and Community Pharmacist

The policy was approved at the following meetings ahead of final ratification at Patient Safety Committee:

- System Wound Management Steering Group November 2024
- Integrated Medicines Optimisation Committee June 2025