PALLIATIVE WOUND CARE

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Learning Objectives:
- Describe the aspects of palliative wound care.
- Demonstrate palliative practices used in the care of a variety of wounds.

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Palliative Wound Care

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Learning Objectives & Outline

• Differentiate palliative wound care from standard wound care
• Demonstrate examples of the palliative approach to wound care while reviewing different types of wounds

‘Standard’ Wound Care

• The focus of standard wound care is to correct the underlying pathophysiology
• Requires a high level of involvement of patient and family support
• Requires a coordinated group of professionals for most cases of complicated wounds
• Complete healing within an expected time frame
**Wound Care Experience**
**Extensive, Intrusive and Costly**

- Visits
- Care at Home
- Dressings and Supplies
- Home Health
- DME: wheelchairs, walkers, mattresses
- Orthotics
- Biologics
- Hyperbaric Oxygen

- Pharmacy
- Labs
- Radiographs
- Special equipment: Pneumatic Compression Stockings
- Transition of Care Issues
- Specialist Care

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**Palliative Care of Wounds**

- There is no such thing as a ‘Palliative Wound’
- There are wounds that we decide to treat palliatively for several reasons
- We = Patient, Caregiver and Wound Care Team
- Requires a high level of family and caregiver support
- Requires a coordinated group of professionals in most cases of wounds treated palliatively

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Palliative Patients with Wounds

• There are patients that are receiving care for chronic or terminal diseases that also develop wounds
  – Related directly to the underlying illness
  – Consequence of debility from the disease
  – Consequence of treatment for the illness
• There are patients that are frail who have wounds where the focus on comfort is more sensible than a focus on cure or in those cases where a cure is not expected

Palliative Approach to Wound Care

• Patient goals are identified and prioritized
  – Support Issues
• Simplify wound management
  – Comfort Management
  – Limit Visits
• Pain Management
• Odor Issues
• Infection Control

Perspectives in Palliative Wound Care

• Patient Perspective
  – End-of-life
  – End-stage process
  – Patient-directed after options are explained or from prior experiences
• Clinician Perspective
  – Incorporating palliative concepts throughout the continuum of wound care
Wound Types

- Venous Ulcerations
- Arterial Wounds
- Pressure Ulcers
- Fungating Wounds
- Diabetic Neuropathic Ulcers
- Skin Tears
- Pyoderma Gangrenosum
- Other wound types

Venous Stasis Ulcerations
Pathophysiology

Venous Stasis Ulcerations
Treatment

- Compression
- Response from the patient is:
  - Painful, it doesn’t work, can’t get them on, can’t get them off, no one there to help me, too expensive, can’t take a shower
- What was the Root Cause of Failed Compression
Compression Therapy

• Most of the time, failure to compress successfully was due to inappropriate compression recommendations
  – Patients labeled as ‘non-compliant’
• Education at every visit is vital
• Product choice is also important
• Safety of compression with testing

VSU Palliative Paradox

• You are often left in a situation where compression, as uncomfortable as it is for many patients, is the key to changing the ability of the patient to function
Bilateral Lower Extremity Edema

Start of Treatment

Three Weeks After Compression

Venous Stasis Disease

Initial Visit with Concurrent Thyroid Cancer

Week One: Mild Compression, Lost 13 lbs, Wound 80% Smaller

Clinical Pearls

• Textbook answer to proper compression forces are 30-40 mm Hg pressure
• Clinically, 20-30 mm Hg pressure works extremely well for most patients
• I would rather have some form of compression on the patient 100% of the time, than the ‘correct’ compression never
Tubular Stockings in Various Sizes
Disposable, Temporary Solution, Easy to Reach a Goal

Measuring Chart Based Upon Circumference at 30cm from Sole of the Foot
You measure to the largest limb

Tubular Compression
First Layer of Stocking Placement on the Lower Extremity
Second Layer of Stocking Placed on the Lower Extremity

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Venous and Arterial Disease Mixed Etiology

- Arterial disease in patients with venous insufficiency ranges from 15% to 30%
  - Severe Arterial Insufficiency
    - Ankle pressure < 70 mm Hg
    - Toe Pressure < 50 mm Hg
  - Moderate Arterial Insufficiency
    - ABI 0.5 - 0.9
    - Toe Pressure 50 – 70 mm Hg

Arterial Ulcerations

- The treatment for arterial ulcerations is to repair the arteries
- Wounds from minor trauma on the extremities, that in patients with normal arteries is reparable, are unable to heal in patients with inadequate blood flow (oxygenation)

Arterial Ulcer Paradox

- If the patient with severe arterial insufficiency develops ulcerations and they choose not to have any corrective procedures, the chances of recovery with standard wound care is unlikely
- Statistics
  - 5 Year Survival in patients with PAD is 50%
Critical Limb Ischemia

- Proven occlusive arterial disease
  - Rest pain due to ischemia
  - Gangrene
  - Ulcerations
- Mortality in these patients is high
  - One year mortality ~ 20%
  - Two year mortality ~ 32%

Arterial Ulcerations Treatment

- Screening test confirmation
  - Bedside ABI, SPP and PVR, Arterial Dopplers
- The next step is a consultation with either a vascular surgeon or an interventionalist
- Bypass surgery vs. interventional therapy
- Communication with the specialist is required so that the goals of the patient are made clear

Arterial Ulceration in Area of Pressure With Probable Osteomyelitis of Great Toe
Fungating Cancer Wounds

- When a patient presents with this type of wound many questions arise
- This is visible, measureable disease for the patient
- Disabling for the entire professional staff
Palliative Care of Fungating Wounds

- Local Control
  - Pain
  - Bleeding
- Systemic Holistic Issues
  - Oncologist for Palliative Care Treatments
  - Hospice Discussions
  - Advocate
- Do you touch the wound?

Fungating Cancer of the Breast
Seven Years After Lump Detection

Patient Two: Metastatic Breast Cancer
Initial Visit with no prior care. Odor, itching, draining and bleeding from friability.
Patient Two: Metastatic Breast Cancer
After one week with less necrotic tissue, odor, continued bleeding noted controlled with clotting cloth at home.

Metastatic Bladder Cancer to Neck
Already had radiation to the neck with brachial plexus injury.

Mechanical Forces Causing Wounds
- Friction
- Shearing
  - Superficial (Skin Tear)
  - Deep Tissue Injury (DTI)
- Pressure
  - >12-32 mm Hg pressure = capillary closing pressure
  - Plus ‘prolonged’ time relative to the disease burden of the patient
Pressure Ulcer Care

- Prevention is the key
  - Pressure redistribution
- Treatment
  - Pressure redistribution
- Are there negative consequences of pressure redistribution?
  - Comfort issues related to mattress choice, turning schedules, floating or protecting heels
  - Otherwise, no negative outcomes for prevention

Stage III or IV Ulcer Palliative Patient

- Do you debride?
- What are the goals of the debridement?
  - Removal of necrotic tissue
- Where do you debride?
  - Can it be done at the bedside safely with pain and control of bleeding?
- Terminal Patient
  - Foul odor, pockets of infected material, necrotic material, easier to dress

Palliative Care of a Pressure Ulcer

Pressure Injury in Paraplegic First Visit
Pressure Ulcer in Same Patient 15 Months Later
Diabetic Ulcers

- Diabetic Neuropathic Foot Ulcers
  - Treatment requires redistribution of pressure away from the ulcer to the entire foot surface
  - The goal is to get the patient into a Total Contact Cast (TCC)
    - Stable gait
    - Reliable (not to get it wet, for example)
    - No infection, especially in the bone
    - Moisture (drainage) is under control
- Pain is often not an issue in these ulcerations
TCC for Diabetic Neuropathic Ulcer

First Visit Prior to TCC

26 Days after TCC

Diabetic Neuropathic Ulcer
Elderly, Frail Woman

Initial Visit

• 91 year old with unstable gait pattern that requires offloading

Amputation in a Diabetic Patient

• 50% Five Year Survival after an amputation in a patient with diabetes
Skin Tears

• Frequent in our elderly population
• Keep the treatment simple
• Steri-strips can be messy and painful
• Wound glue can occlude drainage
• Recommend a porous, semi-transparent, flexible netting with silicone tackiness
• Draw an arrow in the direction that the dressing should be removed
Pyoderma Gangrenosum

- Etiology unknown
- Associated with immune dysfunction
- Atypical appearance and or reaction to usual types of wound care
- Very painful
- Treatment
  - Steroids or cyclosporine orally
  - Topical antibiotic ointment, steroids (Class 1)
Pyoderma Gangrenosum

Livedoid Vasculopathy

- Hyalinization and thrombosis of the microscopic vessels
- Very painful ulcerations
- Mostly woman
- Mimics Venous Stasis Ulcerations
- Look for history of thrombotic disorders

Livedoid Vasculopathy
Iatrogenic Wounds

- Pressure Ulcerations
  - Mechanical devices
- Dressing Injuries
  - Tears
- Extravasations
  - Medications

Extravasation in Patient with Lung Cancer

First Visit Post Hospitalization
Furosemide

Last Visit 2 Months Later

Hyperostosis of the Skull

History of Squamous Cell
Parietal Bone

Eighteen Months Later
### Palliative Issues in the Care of Wounds

- **Odor**
  - Crushed metronidazole, cadexomer iodine, charcoal, silver
  - Debridement
- **Exudate**
  - Decreasing the frequency of dressings should be the goal
- **Bleeding**
- **Infection**
- **Pain**
  - Local: Lidocaine both topical and injectable
  - Systemic

### The Pain Question in Wound Care

- Choose the form of the question very carefully as it will influence your palliative treatments
  - Debridement pain
  - Dressing change pain
  - Wound Pain
  - Pain from the underlying illness
  - Time frame: how was your pain experience this past hour vs. week

### Documentation of Palliative Care of Wounds

- **Communication with the patient, family and specialists**
- **Document what you discussed and the options that were offered**
- **Do this more than once**
  - Check and Balance
Summary

• Palliative wound care is an approach to the treatment of wounds that is specifically directed to the well-being of the patient rather than solely to the cure of the wound.
• Incorporating palliative concepts throughout the continuum of wound care
• Palliative wound care involves a committed involvement of caregiver and clinical team

Questions?