MANAGEMENT OF A FUNGATING TUMOUR
HOW WOULD YOU BAG THIS?

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PATIENT HISTORY

- Grace (not the patient's real name) is a 39 year old mother of 3
- May 2012: Diagnosed with Advanced clear cell carcinoma of right posterior perineum, involving anal sphincter and posterior vaginal wall
- Diagnosed during her third pregnancy and went on to have a C/Section (June 2012) with APER, debulking of fungating tumour, vulvo-vaginal reconstruction & bilateral salpingectomies
- September 2012: Started chemotherapy
- Further surgery 2013 for ileostomy formation due to strictures, resulting in functioning ileostomy and a de-functioned colostomy

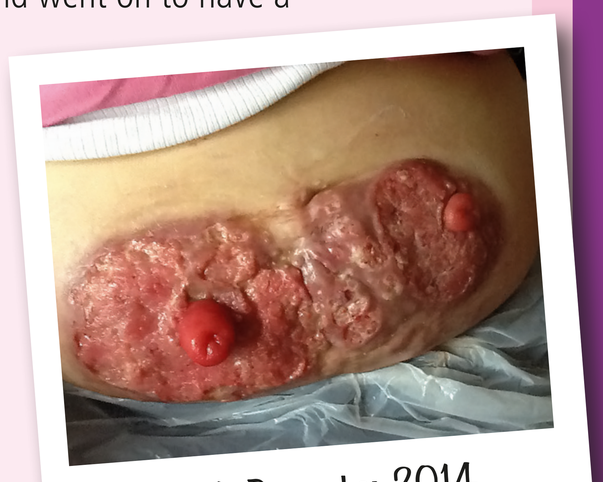

Fig 1: December 2014

OBSERVATIONS ON REFERRAL

My first meeting with this patient was in December 2014 at the hospice in which she was being cared for. I observed (Fig 1)

- Fungating tumours now surrounding both stomas and around vulval area/ flap, which was extending further
- Not for further active treatment
- Managing abdominal area with Aquacel, large Hollister Adapt Seal, Duoderm,
- Coloplast Seal drainable bag: but patient was experiencing leakage 4/5 times daily
- Area was very wet and boggy, also very tender
- Patient was reluctant to change/try alternatives as had used these products since initial surgery but agreed to try Orahesive powder to try and dry the area. A large SecuPlast Mouldable Seal and Confidence Natural Soft Convex with a belt loosely attached to secure
- Discussed wound manager, but Grace was not keen due to transparency and size

TREATMENT

In February 2015, leaks continued to occur and were affecting Grace's daily routine with her young family and general quality of life. I showed Grace a variety of wound managers and discussed incorporating both stomas in the one appliance together with the use of absorbent dressings for the wound beneath. Grace agreed to trial a large Oakmed wound manager as it appeared the most flexible and discreet, but unfortunately Grace didn't like the concept of including both stomas together and also the enormity of the appliance and bung closure.

I then discussed adaptations to equipment with Grace and hospice staff in order to maintain Grace's dignity and enable her to have days out with her family without the risk of leakage.

Figures 2, 3 and 4 show the following treatment method:

- Suprasorb was placed directly on the fungating wound
- An Oakmed Wound Manager base was cut out and two Dermacol Stoma Collars secured with Duoderm placed to incorporate both stomas
- Coloplast Assura flat drainable pouches were placed over the Dermacol collars
- Surrounding area secured with Mesorb/Opsite dressings at Grace's request in order to absorb any exudate

In the groin/ vulval area, a medicated plaster was used, containing 5% lidocaine.

In March 2015 the wound had continued to change and breakdown further, as shown in Figs 5 and 6. The wound manager base became uncomfortable for Grace, so an alternative primary dressing was used. We commenced the following method of treatment, as can be seen in Figs 7 and 8.

- Mepitel dressing, due to its ease of removal as low adherence
- Duoderm
- Stomahesive Paste: to seal area around stoma
- Coloplast flat bags: one drainable and one closed
- Mesorb Breathable: highly absorbent dressing
- Opsite
- Charcoal dressings were also used for only a short time as Grace found they made it very bulky and didn't help with disguising the odour

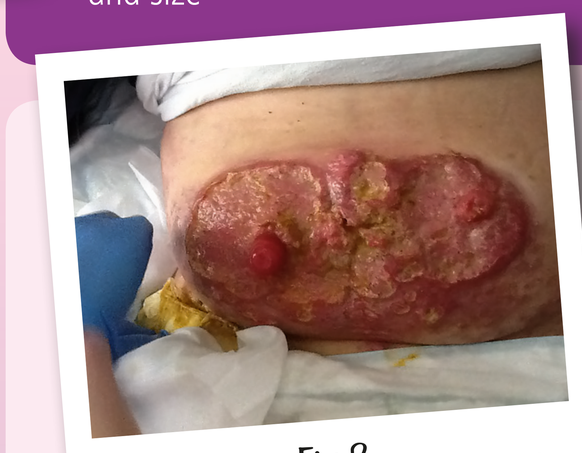

Fig 2

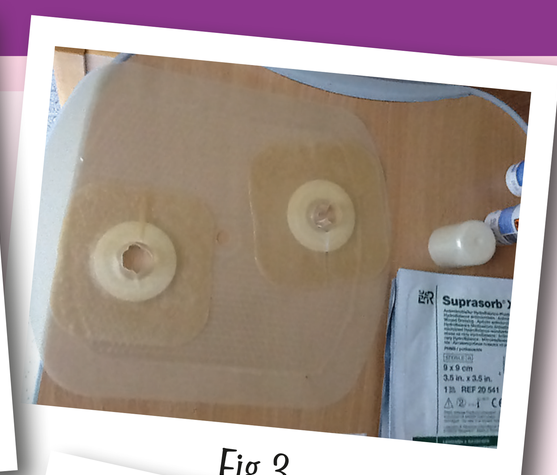

Fig 3

Fig 4

Fig 5

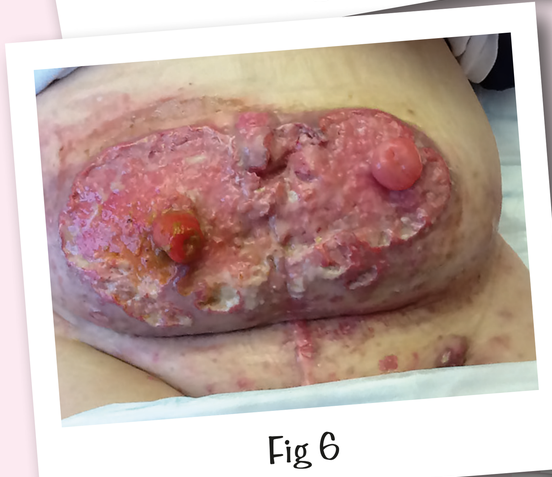

Fig 6

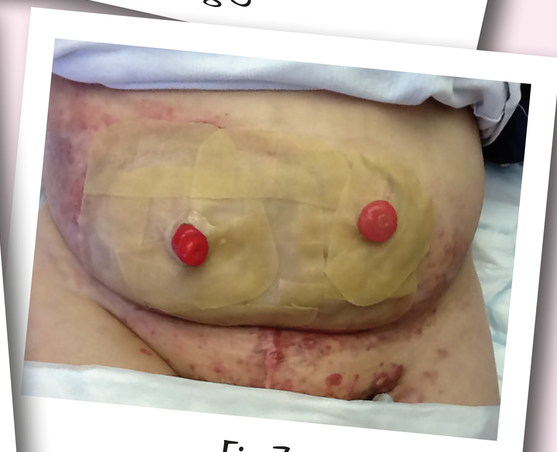

Fig 7

HOW WOULD YOU BAG THIS?

Fig 8

MEDICAL MANAGEMENT

Wound management included

- Daily changes, patient feels this is better for pain control and to control odour
- Loperomide 4mg qds
- Octreotide 300mcg s/c bd-(only tolerated for 1 week)
- Instillagel/Lidocaine patch 5% Mepitel/Mesorb
- Syringe driver-2200mg diamorphine
- Prn Oxynorm 160mg (1 hourly)
- Prn Oxynorm 200mg pre dressing
- Diamorphine 100-150mg(1 hourly)
- **In the event of excess bleeding**
- Adrenaline 1 in 1000-on bleeding areas
- Tranexamic acid soaked gauze if no success with Adrenaline

OUTCOME/CONCLUSION

Collaborative working with the hospice staff and Grace assisted with establishing a plan of care for the management of such a challenging and complex wound. Strategies had to be modified and revised regularly in order to keep abreast of changes occurring within the tumour bed. Adaptation of ostomy appliances and accessories helped with symptom control for Grace, reducing pain and discomfort. Equally this helped to reduce the psychological impact the wound was having on her daily quality of life with her young family. Grace directed and remained heavily involved in her treatment plan throughout.

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