POSIE's Clinical Pathway
for Malignant/Fungating Wounds

In association with: NHS Sheffield Teaching Hospitals NHS Foundation Trust

Definition

A fungating wound develops as a result of direct infiltration of the skin, mucosa, blood and lymph vessels caused by a local tumour in which metatastic deposits from a distant primary site or from a primary skin tumour example being squamous cell carcinoma, basal cell carcinoma and a melanoma. (McMurray, 2003).

Pain (wound specific)	Odour	Skin	Infection	Exudate and Bleeding	Self
Pain can depend upon: • Wound location • Wound depth and tissue invasion • Nerve damage • Macerated skin • Inflamed skin • Dressing changes.	Odour occurs when the tissue on the wound has been deprived of oxygen and nutrients and becomes necrotic with bacterial growth on the tissue. The psychological effects may impact the patients quality of life.	The skin surrounding the wound can become sore and macerated due to exudate and frequent dressing changes. It can also become very itchy related to the tumour growth.	These wounds are at high risk of developing infection as the blood supply to the tumour is out grown which results in a necrotic area which can act as a medium for anaerobic bacterial infection.	Exudate is due to tissue damage and increased leakage from blood vessels and can vary in amount. Bleeding can be due to abnormal microcirculation, erosion or compression of blood vessels by the tumour or decreased platelet function. It can also be caused by dressings adhering to wounds.	These wounds can develop an array of emotions and psycho-social needs. Depression, anxiety, low self- esteem and loss of sexual intimacy are among some of the needs expressed by patients. It is important for the patient to feel supported.
Management					
• Ask the patient to describe their current level of pain • Give analgesia continually/ prior to dressing changes • Consider swabbing and treating infection if applicable • Apply a silicone based or enzyme based dressing if possible to minimise trauma and pain during application and removal such as: Atrauman (or your local contact layer dressing), UrgoTul Absorb Border, Biatain Silicone 3DFIT, Flaminal Hydro/Forte. • Refer to pain specialist nurse, palliative care team or GP for further advice.	• Undertake wound cleansing in accordance with the Wound Bed Preparation - NOT following the mechanical debridement element. • Apply Flaminal Hydro/Forte to aid autolytic debridement for devitalised tissue. • Apply an odour absorbing dressing as per your local formualry to assist with the management of malodour. • Increase dressing changes if necessary. • Consider using essential oils. • Consider onward referral to the Complementary Therapy Service at St John's Hospice/ St Lukes Hospice	• Protect the surrounding skin with a Medi derma S barrier protectant film applicator. • Consider the use of topical steroids, oral antihistamines and/ or onward Dermatology referral. • Consider the cause e.g. exudate, skin stripping or allergy to dressings. • Select a silicone dressings such as Atrauman - check as per under pain section re products, UrgoTul Absorb Border, Biatain Silicone 3DFIT • Use of an adhesive remover at dressing changes	• Undertake wound cleansing in accordance with the Wound Bed Preparation Pathway - NOT following the mechanical debridement element. • If there are clinical signs of infection refer to the Pathway for Wound Infection.	**Bleeding Light** • Apply pressure for 10 – 15 minutes with a moist Kaltostat. **Bleeding Heavy** • **Secondary Care:** Apply pressure to the wound and seek urgent medical advice (this is an emergency situation). • **Primary Care:** Apply pressure to the wound and consider admission to the emergency department depending on the stage of illness and the patient's wishes (this is an emergency situation). • Assess volume and appearance as this may indicate infection. • Protect the surrounding skin with a Medi derma S barrier protectant film applicator • Apply a Atrauman to reduce the risk of trauma/risk of bleeding. • Consider the absorbency of the secondary dressing. E.g Biatain Silicone 3DFIT or Kliniderm Super-absorbent pad (or local absorbent pad). • Refer to the Dietitian.	• Continually assess the psychological and social needs of the patient during each visit/appointment. • Discuss patient options for onward referral to support services i.e. the Complementary Therapy Service at St John's Hospice Doncaster / St Lukes Hospice.

Reference - Adapted and reproduced with kind permission from original work by Sharon Gardener and Kathryn Taylor Mersey Care NHS Foundation Trust.
Developed by the Skin Integrity Team Sept 2020. Updated April 2025 v4 in association with Sheffield. For review July 2027.