Options in Practice presents different management approaches to the same clinical situation. You are invited to submit a brief case description, including the specialty nursing care provided, and several glossy, black-and-white photographs of the clinical situation. The case material will then be sent to another wound, skin, ostomy or continence care clinician, who will also address management concerns. Alternative solutions to difficult wound, skin, ostomy, or incontinence clinical situations will be published.

CASE
Pressure Ulcer Care for a Terminally Ill Patient Being Cared for at Home

A 66-year-old man was cared for by a visiting nurse service after a recent onset of paralysis caused by spinal metastasis from prostate cancer. His medical history included a right nephrectomy, double by-pass surgery, and radiation therapy treatments for prostate cancer. The patient was unable to leave his bed for approximately 1 month. He lived with his wife, who worked part-time. An elderly aunt stayed with the patient during the day. His appetite was poor and movement with difficult and painful. His pain was managed with oxycodone plus acetaminophen (Percocet) and fentanyl transdermal patches. A 16F Foley catheter was in place, and the patient was frequently incontinent of stool. Explosive diarrhea often occurred, despite a bowel program of Theravac (docusate sodium and glycerine) enema every other day and senna plus docusate sodium (Senokot S), four tablets daily.

Initial nursing problems included pain management, medication teaching, bowel management, dietary teaching, pressure relief, personnel care, and terminal care. Certified home health aides were available for 1 hour daily to assist with bathing, hydration, turning and positioning. In 1993, when this patient was cared for, Medicare did not reimburse for devices designed to relieve pressure; the plan to prevent pressure ulcers therefore comprised turning and positioning only. In addition, the patient had a 2-inch foam overlay on his hospital bed.

Two weeks after home visits were begun, blisters were observed on the patient’s heels, and a stage I nonblanching pressure ulcer was noted over the coccyx. Because Medicare did reimburse for pressure ulcer treatment measures in 1993, a hospital bed with an alternating pressure pad (Huntleigh BetaBed; Huntleigh Healthcare, Manalapan, N.J.) was ordered with physician approval. The primary nurse treated the wounds with Duoderm (Convatec, Princeton, N.J.) applied over the coccyx. The dressing was changed every 4 to 5 days, and a transparent dressing was applied to the heels. The patient subsequently lost all sensation in his legs. A blister was observed on his right pelvic bone, caused by friction from the adult briefs he was wearing and Duoderm was applied to this site. The pressure ulcer on the coccyx area progressed to a deep purple color, 9 x 9 cm, with a 2 cm skin tear, and Duoderm treatment was continued.

Family teaching was attempted but the patient’s wife was repeatedly unable to observe the wound and care for the dressing. Family instruction regarding turning and positioning was continued, and a trapeze was ordered to help the patient change his position. A pillow was used to elevate his heels off the bed and relieve pressure. The patient’s appetite remained poor, and a protein supplement drink was given two to three times daily.

Four weeks after the initial visit, the Duoderm on the coccyx was reinforced with a transparent dressing because stool was undermining the dressing and reducing adhesion. Two weeks later (6 weeks after initial visit), the primary home health nurse consulted an ET nurse. The wound on the patient’s coccyx was now a full-thickness stage III or IV ulcer, and dressings were being changed twice daily because of copious amounts of tan, foul-smelling drainage. The wound measured 9 x 8 x 2.5 cm, with tunneling and necrotic slough in the wound bed. Goals now included containment of the wound exudate, odor control, and adequate pain control in the home setting.

Jerra-Marie Sullivan, RN, BSN, CETN: Because Medicare allowed only

Jerra-Marie Sullivan, RN, BSN, CTEN, is Community Health ET Nurse Specialist, VNS of Southern Maine, Saco, Maine.

Dianne M. Mackey, BSN, PHN, CTEN, is Wound/Skin Care Coordinator, Home Health Department Kaiser Permanente, San Diego.


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Poor nutrition and tumor erosion in the area probably contributed to poor healing.

After 1 month, a transparent film cover was added to protect the underlying dressing from infrequent episodes of explosive diarrhea. The wound now measures 9 x 6 x 5 cm. The slough in the wound had been debrided autolytically by the dressings, and the wound bed was red with granulation tissue (Figure 1). Subsequent attempts to decrease dressing changes to every other day by using Mitraflex (Calgon Vestal Laboratories, St. Louis, MO.) in place of the Kerlix sponges, ABD and a transparent film dressing failed to contain the drainage and the previous regimen was reinstituted. Several weeks later, Metrogel (Curatek, Elk Grove, IL.) was added to the wound care protocol to help decrease odor. The client’s nutritional intake had improved, and the protein supplement drinks continued to be given three times a day.

As his condition gradually deteriorated, the patient accepted a referral to our hospice. At that time he was only taking fluids and his wound measured 8 x 5 x 3 cm, with exposure of underlying bone. Poor nutrition and tumor erosion in the area probably contributed to poor healing. The patient died at home, 8 months after the initial referral. Our goals to keep him home, to provide adequate pain control, to keep him comfortable, to contain the wound exudate, and to control odor had been met.

Dianne Mackey, BSN, PHN, CETN:
In my practice, I often use the Bard Absorpive Dressing (C.R. Bard, Inc., Laguna Niguel, Calif.), Kaltostat Fortex Dressing (Calgon Vestal), or the Super Fluff Kerlix Sponge (Kendall) as a primary dressing for moderate to large amounts of exudate. These can be covered with an ABD (Kendall) for additional absorption and coverage.

In deep wounds, with small to moderate exudate and tissue necrosis or slough, I frequently use wet-to-dry normal saline packing as the primary dressing, with Super Fluff Kerlix Sponges or ABD as the secondary dressing. For odor control, I might use one-quarter strength Dakin’s solution, wet to dry with daily changes. Additional odor control may be attained with Puri-Clens (Sween Corp., Mankato, Minn.) for cleaning and packing wounds and a charcoal-impregnated dressing applied as a secondary cover. To minimize pain associated with the wound, I recommend a moist wound care product, such as a calcium alginate, hydrogel, or hydrocolloid, rather than a wet-to-dry gauze packing.

The diarrhea this patient had may be managed by a combination of medications. Diphenoxylate with atropine (Lomotil) or loperamide (Imodium) in combination with a topical fecal collector (Bard Fecal Containment Device; C.R. Bard) may provide effective relief from recurring episodes of explosive diarrhea. I prefer this fecal collection device because of its pliability, ease of application, and duration (approximately 3 to 5 days). Careful monitoring for loss of adhesion is completed during each home visit, and the family is also taught to monitor the device for undermining or leakage.