# When Classic Wound Care Intersects with Palliative Care: Part 1

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Michael Robinowitz, M.D., earned his medical degree from Chicago Medical School in Chicago, Ill. He completed a residency and fellowship in obstetrics and gynecology at Emory University School of Medicine. Dr. Robinowitz joined Piedmont in 2009 as the medical director of the Wound Care Center in Fayetteville. Prior to joining Piedmont, he was in private practice at Nova OB/GYN in Atlanta and served as a Clinical Assistant Professor at Emory School of Medicine and Attending Faculty Physician at Grady Health System's GYN/OB Clinic. He previously was in practice at Meridian Medical Group-Prucare of Atlanta where he served for some time as the President and Chairman of the Board. A fellow of the American Professional Wound Care Association and a diplomat of the American Board of Obstetrics and Gynecology, Dr. Robinowitz is board certified in obstetrics and gynecology and certified in wound care.

Purpose:

1. To clearly define palliative care, and when and how to institute it.
2. Explaining to patients and family what palliative care is and is not.
3. To reinforce that palliative care is multicentric, patient and family centric care, and that goals of care transition during life's continuum.

Patients with advanced illnesses represent a group in healthcare that experiences the highest prevalence and incidence of all wound types with pressure ulcers being the most common.[1] Patients with advanced illnesses tend to die with their wounds rather than as a consequence of their wounds. These are people whose life expectancy may be as little as six months. While six months is a frequently used time frame, it must be stated that this type of care can be provided at any time and not just at the end of life. We also must be aware that many patients and/ or their families are unaware of this. To many, just the mention of palliative care and/or hospice care may cause great fear and anxiety due to the lack of knowledge of the positive benefits these services can offer. According to Maida, the term "palliative care" should be avoided when possible as it is vague, imprecise and euphemistic. The term "palliative" should only be used to describe the goals and philosophies of care that are being prepared and not to describe a patient or a wound.[2]

IIn a two-year audit of a palliative care unit, 26.1% of 542 individuals were admitted with pressure ulcers and 12% acquired new pressure wound during their stay.[3] Pressure ulcers are thought to be largely preventable, but not always unavoidable due to other issues/comorbidities. One important point is that while we need to refocus, we cannot underestimate the importance of wound prevention. The three major elements of a successful prevention program include pressure relief/redistribution for bed, chair and heels and lubricating the skin with aggressive emollient therapy in order to try to prevent skin failure.[4]

In 2002, the World Health Organization defined palliative care as: as an approach of care that improves the quality of life of patients and their families facing problems associated with life threatening illnesses through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems to include physical and psychosocial issues.[5] The goals of palliative care may be different from traditional healing oriented care. How long the patient will live, does he or she have a healable wound, and what can be done to provide comfort become primary considerations. The benefits may include maximizing functional status and quality of life. Successfully incorporating palliative care into current treatment practices that focus on healing the wound at all costs can be difficult and requires constant attention to the current status of our patient when we see them in order to see if there are any changes in status.

Here are three examples of where patient-centered/holistic approach to care would be important.[6]

1. A patient with debilitating foot and leg ulcers due to venous insufficiency may not be able to tolerate even the mildest compression of his legs (the gold standard of care) either because of severe pain with the compression wrapping or the pain of putting on and/ or replacing the bandages.
2. A patient with a large abdominal wound that would definitely benefit from the use of NPWT (negative pressure wound therapy) who may not be able to tolerate either the noise of the machine, the dressing changes associated with the V.A.C.® Therapy System, as well as interfacing with an electro-mechanical medical device.
3. A patient with severe peripheral arterial disease who has had several smaller amputations over the last five years that include a first and fifth toe amputation. He now has a large heel ulcer that, despite several attempts at revascularization, hyperbaric oxygen therapy and several long courses of intravenous antibiotics for chronic osteomyelitis, is ready for a below-the-knee amputation in order to move on with his life.

At this time, the goals of palliative care may be different from traditional healing-oriented care. How long the patient will live, does he or she have a healable wound, and what can be done to provide comfort become primary considerations. The benefits include maximizing functional status and quality of life.

Cases like these are not uncommon, but the treatment for each is different than for otherwise healthy or healthier individuals. Again, the scientific principles of evidence-based palliative care management are tempered by the reality of the patient's physical and emotional limitations. Wound care, and palliative care specifically, is a holistic approach that is based on patient-centered care, multi-centric care and the integration of both.[7]

## CONCLUSION

The acceptance of palliative wound care is now part of our clinical thinking for severely ill patients where complete healing may not be possible. Due to many factors, including quickly rising healthcare costs for the treatment of chronic wounds in our aging and longer-living patients, these financial burdens and resource allocation sources become a major issue and cannot be cast aside.

The author wishes to thank Stacie Waddell, MLIS, Librarian at the Piedmont Atlanta Hospital Saul's Memorial Virtual Library for her assistance with the literature searches.

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