Review of patients' experiences with fungating wounds and associated quality of life

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Review of patients’ experiences with fungating wounds and associated quality of life

Objective: To investigate the evidence exploring the experiences of patients with fungating wounds and associated quality of life, and to subsequently provide recommendations to how these implications may be addressed in practice.

Method: Using a systematic approach, a comprehensive literature search was conducted to investigate the most appropriate and relevant evidence regarding the experiences of patients with fungating wounds.

Results: Studies unveiled the enormity of the unrelenting, unique and devastating consequences that these wounds have on an individual’s life and that every domain of their life is negatively affected.

Conclusion: These findings must galvanise nurses to become aware of the extent of the devastation experienced and aspects of life affected by these wounds. The issues raised have multifaceted and challenging implications for practice; however, all aspects need to be addressed and satisfied in an attempt to improve the quality of life of individuals with fungating wounds.

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Fungating wounds can develop anywhere on the body and, although they may arise from malignant cell transformation from chronic wounds, they are commonly associated with breast cancer (62%), head and neck cancer (24%), genital and back cancer (6%), and others (8%). Tumour permeation disrupts surrounding blood and lymphatic vessels causing haemorrhage, tissue hypoxia, necrosis and infection, while proliferating cells cause the wounds to possess ‘cauliflower-like’ nodules.

Literature suggests that fungating wounds develop in the last 6 months of life and, for the cancer patient, have a devastating impact on quality of life (QoL). Although therapies such as chemotherapy, radiotherapy or hormone therapy may be used in an attempt to delay progression, fungating wounds are usually non-healing and prognosis is poor; care is therefore palliative, with an emphasis on patient comfort and QoL.

The exact prevalence of fungating wounds is unknown, as they are not recorded on any population-based cancer registers. The current estimation for the prevalence of fungating wounds in cancer patients is considered to be 5–10%, a figure supported by Alvarez et al. and Probst et al. However, DollBeault et al. suggest that some fungating wounds may never be brought to the attention of health professionals, due to embarrassment.

Early detection through patient education and screening (such as breast screening) may result in a reduction of such wounds, while some argue that with an ageing society and advances in health care, the number of people with these wounds is set to increase. Irrespective of the precise incidence of fungating wounds, they have a devastating impact on a patient’s life.

While there is a raft of literature and guidance around various aspects of wound care, fungating wounds appear to be overlooked. Information regarding fungating wounds appears to be based on anecdotal evidence, case studies or expert opinion. Therefore, perhaps unsurprisingly, studies relating to patient experience and QoL are even more limited. Goode infers that this gap in knowledge may be based around the ethical dilemma and challenge of gaining approval to research this client group; however, limited knowledge of patient experience in relation to fungating wounds restricts the delivery of care for the person as a whole. As Alexander points out, psychological aspects of an illness frequently create more suffering than physical ones.

Method

A literature search was conducted, using a systematic approach, to investigate the evidence regarding the experiences of patients with fungating wounds. This ensured that all pertinent literature was included.

Multiple databases were explored. CINAHL Plus, MEDLINE, EMBASE and PsycINFO were investigated using the key words ‘fungating’ OR ‘malignant’ AND ‘wound*’, ‘quality of life’ OR ‘experience*’ AND ‘psychosocial’. Internurse, Web of Knowledge, Google SCHOLAR, Scirus and Cochrane...
Library were also searched, using the key words ['fungating'], ['wounds'], ['quality of life'], ['experience'] and ['psychosocial'].

The period covered was 2000–2012. The inclusion criteria were adult patients, primary studies published in English after 1999 and QoL focused. Excluded articles consisted of those associated with paediatric patients, studies published before 2000 and literature evaluating wound management (Table 1).

**Results**

The search was considered complete when repetition of literature emerged and, following these search criteria, 158 articles were identified. A hand search discovered a further paper and the search was then refined. The final number of articles was reduced to 10 (Fig 1).

A thorough, critical analysis of the literature to ensure robustness, credibility and relevance of article was performed via implementation of the Critical Appraisal Skills Programme method, and each article was given a quality assessment score. From the 10 articles included in the review, a number of themes emerged, which have been combined into four primary themes: physical, social, psychological and spiritual.

**Theme one: physical impact**

Physical implications emerged from a number of articles. The most frequently reported physical impact was malodour, with nine articles finding this to have a prevailing negative impact on patient quality of life; some of these studies revealed malodour as the symptom causing most anguish. Lo et al. constructed five comprehensive themes from their study, all of which revealed malodour as a key characteristic of physical duress experienced by patients. Patient attempts to disguise the odour from the wound by using perfume or towels to mask or dampen the smell, without success, and descriptions ranging from 'a smell that never goes away' to being compared with 'rotten meat' were common in several articles. Grocott highlighted irrepressible exudate as the principle problem for patients with fungating wounds, subsequently leading to skin irritation and maceration. Inadequate dressing fit also featured strongly, the consequences of which were further leakage, soiled clothing and recurrent dressing changes. These problems with wound management created lifestyle constraints in terms of frequent dressing changes and additional laundry. These findings are corroborated by other studies.

Evidence further suggests that haemorrhage is a factor in the physical wellbeing of these patients. Lo et al. constructed five comprehensive themes from their study, all of which revealed malodour as a key characteristic of physical duress experienced by patients. Patient attempts to disguise the odour from the wound by using perfume or towels to mask or dampen the smell, without success, and descriptions ranging from 'a smell that never goes away' to being compared with 'rotten meat' were common in several articles.

Uncontrollable exudate was also experienced and found to have a profound impact on QoL. Crockett highlighted irreversible exudate as the principle problem for patients with fungating wounds, subsequently leading to skin irritation and maceration. Inadequate dressing fit also featured strongly, the consequences of which were further leakage, soiled clothing and recurrent dressing changes. These problems with wound management created lifestyle constraints in terms of frequent dressing changes and additional laundry. These findings are corroborated by other studies.

Some patients resorted to taking spare clothes when they went out, or limiting their activities. The literature identified pain as a consequence of living with a fungating wound, which was described by patients as ‘stabbing’, ‘breakthrough’ and ‘constant’, and in some cases restricted nutritional intake to a soft diet. Other
functional restrictions in various activities of daily living were unearthed, such as reduced mobility as a result of the location of the wound, inability to sleep, fatigue, breathlessness, drooling, swallowing and speech problems, incontinence, depleted nutrition and hydration, and vision and hearing impairments. Functional compromise and physical deformity proved problematic with the fitting of clothing and individuals reported that cumbersome wound dressings emphasised their bodily disproportion due to the awkward anatomical locations of the wounds. The study conducted by Maida et al. was of a more substantial sample size and investigated various anatomical sites of fungating wounds, thus enabling a deeper, and more comprehensive and diverse analysis of patient experience and QoL; this study stated that many of those with visible fungating wounds, such as head or neck wounds, reported increased aesthetic anguish. In addition, Schultz et al. also discovered physical restraints affected the ability to self care, which consequently reduced independence.

These findings suggest that numerous physical problems are associated with living with a fungating wound. The studies further imply that these physical problems and functional limitations are also directly associated with social problems.

**Theme two: social impact**

Social relationships were found to have suffered as a direct result of malodour, exudate, altered body image, embarrassment, low self esteem, dressing regimes, the unpredictable nature of the wound and social stigma. Although Schultz et al. did not address financial implications of living with a fungating wound, this was the only study to acknowledge the need to investigate this aspect, as financial problems and inability to work are also associated with loss of social pastimes and networks.

Self withdrawal from family and society was expressed because, as a result of the wound, patients could not wear their preferred choice of clothing. Bulky dressings and inability to wear underwear caused women to reject others and left them feeling socially isolated. Patient fears regarding acceptance in society were evident as feelings and fears of social stigma, negative public response and subsequent self alienation from society were reported in a number of articles. An in-depth study by Pigin and Jones revealed that a lady described how her loss of self left her feeling poles apart from everyone else yet she endeavoured to ‘be normal’.

Others spoke of their decision not to inform their social circle of the wound and how they declined social invitations due to anxiety caused by the unpredictable nature of the wound, in turn diminishing social support. The literature search also identified two previous studies investigating fungating wounds from the viewpoint of the patient, albeit in varying depths.

One study similarly discovered that some people decided to conceal their wound from family members, believing that, if they saw the wound, they would be appalled at it. Individuals felt that exposure of the wound would damage how their family perceived them. Moreover, findings describe how stigma resulted in social withdrawal, as one individual gave an account of how people are unable to accept the wound. Altered relationships were evident; inability to fulfil the role of mother was expressed—not only due to the aforementioned physical restrictions caused by the wound, but also as a result of how people with fungating wounds perceive themselves and act.

Participants found that they were suddenly propelled into different relationships with themselves and others, as they described how their existence had been brutally altered as they became almost unrecognisable to their former self. Loss of identity and disfigurement were linked to self disgrace and blame, and were found to affect femininity and sexuality; one woman reported how she was no longer the person her husband once loved and how she felt that she had to cover her body because of the possible traumatic effects it would bestow on her husband.

Loss of femininity and sexuality were familiar themes in other studies. Research by Lund-Nielson et al. focused on and explored the feminine and sexual perspectives of 12 women with breast cancer and fungating wounds. Similar to Grocott, this study formed part of an evaluation of dressing interventions, which may have affected impartiality. Lund-Nielson et al. revealed that wound dressings affected their choice of underwear, which subsequently affected their self esteem and femininity. Moreover, altered body image and exudate also affected choice of clothing (such as bras) and consequently further impacted on femininity. Women described how intimacy and sexuality were also found to be affected by the appearance of the wound, often due to malodour and uncontrolled exudates, with one woman disclosing how she and her husband never discussed the wound. These findings were echoed by Probst et al. where the wound was found to be considered a ‘taboo’ for some couples. Difficulty in patients and their partners touching the wound were equally discussed, often due to wound progression.

Literature suggests that people living with a fungating wound experience a range of detrimental implications in relation to their social lives, which has a negative impact on their QoL. Common views comprise attempts to conceal the wound, self withdrawal from family, friends and society, lack of social
acceptance and stigma, inability to fulfil roles, altered relationships, reduced femininity and sexuality. Evidence demonstrates that fungating wounds have a profound impact and, of significant, consequence is that all of the literature reviewed also refer to psychological concerns.

**Theme three: psychological impact**

The psychological impacts of fungating wounds were found to be far-reaching and Alexander even went so far as to say that the emotional effects of fungating wounds were the most devastating. Extensive feelings of embarrassment and shame due to the physical issues were reported by patients, and it was these feelings that compelled some patients to self care. For some, these psychological consequences prevented them from seeking professional care and meant neglecting their wound and only reporting to health professionals when the wound became unmanageable, which resulted in logical consequences prevented them from seeking professional care and meant neglecting their wound and only reporting to health professionals when the wound became unmanageable, which resulted in difficulties conversing about the wound, when it had been previously concealed. It should be noted that a number of patients in this study displayed personality or anxiety disorders and, as such, it may prove difficult to establish the extent that these issues accounted for their responses. With the lack of a control group these findings cannot be transferable to patients without neglected fungating wounds or those without these disorders; therefore, more research is required into this aspect.

Grocott and Schultz disclosed how the uncontrollable nature of fungating wounds strained coping abilities. The challenges posed by an unreliable body and loss of control were described as a feeling of susceptibility, in addition to reports of altered personalities and attrition of one’s self with bouts of anger and aggression. A sense of loss ranged from a loss of everyday living, as participants described how their existence had been brutally altered as their lives were ruled by the wound, to not being able to nurture their children to maturity. Guilt also featured in relation to letting people down, the impact on children, failure to fulfil roles and of becoming a burden.

Feelings of being dirty and bodily decay were expressed as people described themselves as ‘fester-ing’ and ‘rotting meat’. Reports of the wound acting as an indication of either the response to treatment or advancement of cancer were evident, and the effects of fungating wounds were considered to be the worst aspect of cancer. This direct reminder of cancer was related to disease progression and death, which, in addition to the above implications and a fear of life threatening haemorrhage, often caused depression, distress, anxiety and anguish. Alexander is the only author to provide an insight into the lasting intensity of the memories fungating wounds leave carers. The distressing details and images engraved on their minds appeared to be unforgettable, even years after the death of the patient.

On analysis, the literature suggests that the psychological impacts of living with fungating wounds are the most devastating. A multitude of emotions were expressed with several common feelings featuring strongly. Among these were an unwillingness to seek help and difficulty talking about the wound, a sense of loss, embarrassment and shame, lack of self esteem, guilt, fear, distress, anger, anxiety and depression. Feelings of being dirty, bodily decay and living with an untrustworthy body were present, in conjunction with accounts of how the wound acts as a constant reminder of cancer, progression of the disease, an association with death and a lasting impact on carers.

**Theme four: spiritual impact**

In spite of spirituality having scarcely been explored with people with fungating wounds, studies touch on this aspect. Piggin and Jones imply that hope is difficult to achieve when faced with a visual representation of the internally progressing cancer; yet, according to Alexander, reports of hope of a peaceful death or preserving hope of discovery of a cure were revealed. Conversely, it was disclosed how hope for a cure also caused distress and conflict between family and health professionals, as they appreciated the importance of rendering hope but were also mindful of the need to foster realism. Revelations of patient existence were portrayed as a ‘new mode of being-in-the-world’ and, despite patient efforts to accept this, time is often in short supply for people with a fungating wound trying to adapt or to truly come to terms with this new way of life.

The only research to directly address spirituality was supported by an independent grant-giving charity. The researcher claims to be the first to examine palliative care concerns in Kenya and focused on QoL in patients with fungating wounds. With this in mind, the findings may not be transferable due to different health systems and lifestyles; however, this study provides an insight into patient experience. Employing the Functional Assessment of Chronic Illness Therapy (FACIT) measurement system (a series of questionnaires which assessed QoL for patients with chronic illness), Marete suggested that individuals found comfort and strength from faith or spiritual beliefs. These findings were reiterated in one of the two case studies included in the paper, where a lady revealed a lack of contentment and gratification in life, but although she occasionally felt that her faith had deserted her, she also found reassurance from it.

Reflecting on these results, future research is required in this area. It would appear that the spiritual
Impact of fungating wounds is extremely individual; for some, spirituality may be difficult given the anguish the wound may cause, while others cling to hope for varying reasons. Equally, where one person may find peace this may cause another distress.

Implications for practice
The literature provides a compelling argument that patients with fungating wounds experience multifaceted challenges, which have an immense, unique and devastating impact on QoL, creating enormous exiguous implications for practice. Although these wounds may appear to affect a relatively small number of individuals, the consequences are huge. Despite a lack of clinical guidance for fungating wounds, nurses are the predominant professionals involved in holistic care of patients and their families; therefore, these aspects need to be addressed to improve patient QoL.

Recommendations
The patient
Lack of patient information was identified, which influenced the ability to self care and increased anxiety and pain. Provision of information regarding aetiology, symptoms, care, management, emotions, coping mechanisms and how to access support (practical and psychosocial) should be promoted. This facilitates patient understanding of their condition, simultaneously encouraging self care, empowerment and partnership, and enabling patients to make informed decisions about their care, further allowing a sense of control over their life.

Information is linked with reducing anxiety and stress. This should be endorsed through information leaflets/booklets written in an appropriate way for the patient, or by recording consultations, as literature suggests that patients’ ability to understand and remember information—particularly during times of high levels of stress—is often diminished. This is supported by research that explored patients’ capabilities to recall information following a standardised theoretical clinical situation. With a generous sample size (n=755), less than half of the participants were able to correctly recall some aspects of the scenario. It could be argued that this recorded hypothetical setting may not reflect true experience, yet another study reinforces this notion.

Demir et al. interviewed women undergoing breast biopsies, which were recorded to ensure authenticity, and findings revealed that many participants lacked comprehension or failed to remember verbal information.

A simple, specific self assessment tool, which incorporates all aspects of QoL from the patient experience and perspective, could be completed in private by the patient prior to consultations. Although this structured approach may not represent all individual experiences, it may provide the opening for the professional to discuss sensitive information, inviting the patient to discuss areas of concern. This may prove beneficial if the patient feels unable to verbally initiate such issues. The Wound and Symptoms Self-Assessment Chart was designed with the intent that patients could portray how fungating wounds affected their lives, and an adaptation of such a tool may also be utilised to identify the effects and needs of family/caregivers. Advantages of such practice have been demonstrated via the ‘distress thermometer’ for patients in oncology and palliative care. Despite the potential benefits to this approach, anecdotal evidence suggests that practitioners often overlook such tools.

Literature suggests that a designated section in multidisciplinary care plans for patients with complex wounds to document information they wish professionals to be aware of promotes empowerment. This may be particularly problematic for patients with fungating wounds, as psychological implications dominate QoL, and as these people experience shame and embarrassment, often attempting to conceal the wound, the ability to share sensitive or distressing information with a range of professionals may be compromised. In these circumstances, a patient diary may not only evaluate effectiveness of treatment but also encourage opportunities to convey unlimited and extensive feelings, which the patient and nurse can address together.

The impact of fungating wounds on QoL can be immense, diverse, personal and unique. Information may enable the patient to take greater control over their life and relieve anxiety, while patient participation in their own care allows this to be shaped around any aspect of life that is affected or considered important to the individual.

The nurse
The literature repeatedly comments that nurses are poorly prepared to care for patients with fungating wounds and recognises the need for professional education and support. There does appear to be some progress in this area, as the European Oncology Nursing Society hopes to devise an ‘educational toolkit’, which aims to support best practice by providing nurses with clinical guidelines and information regarding the pathophysiology and assessment of fungating wounds. These toolkits should be available to all nurses who are likely to care for those with a fungating wound, or at the very least specialist nurses, such as tissue viability, oncology or palliative care nurses.

Support should be offered by community nurses by allocating sufficient time for home visits. Community nurses frequently provide the only source of social contact for some patients with chronic wounds, yet the level of social support provided by
community nurses is deemed insufficient for these patients.43 Wound-care clinics have been found to increase social contact for patients with complex wounds;44 however, with the various anatomical locations of fungating wounds people may be reluctant to attend these appointments. In addition, adequately timed visits may encourage therapeutic relationships and allow patients to express their concerns; the nurse must be attentive to patient feelings of anguish, as opposed to primarily focusing on caring for the wound.45,46

Therapeutic relationships are considered vital to people with fungating wounds;47 involving a consistent and minimal number of staff in care may allow this relationship to flourish, providing efficient symptom management and enabling patients to express their innermost or personal problems.48 Evidence further demonstrates how rapport positively influences how patients with non-healing wounds approach everyday activities and encouraged empowerment and self care, providing patient autonomy, dignity and psychological wellbeing in palliative care.49–54 When encouraging patients to express their concerns, the nurse must be equipped to address and act on issues raised; offering counselling to patients may be one way to achieve this, simultaneously improving psychological support. Professional opinions must not hinder this valuable aspect of care and an awareness of the potential benefits must be recognised, as nurse education regarding counselling proficiencies results in improvements in psychological care for patients with wounds.45

Therapeutic relationships may enhance spiritual care and, as growing evidence demonstrates the effects of spirituality on health, wellbeing and QoL,55–59 this should be considered in an attempt to deliver holistic care, yet this aspect is often neglected by nurses.53 Nurses highlight a gap in knowledge in this area,50 which may account for this omission of care; therefore, education must be rolled out to nurses in order for them to deliver this effectively.61

Self assessments/patient diaries could be used in conjunction with specific wound assessments to establish individual care and effective dressing selection.7 Literature recognises the role of wound assessment in this process and the benefits to QoL6,39,62 and two tools have been designed with this in mind: • TELER (Treatment Evaluation by A Le Roux)63 focuses on the evaluation of dressings • The malignant wound assessment tool64 claims to consider clinical aspects of the wound and patient issues surrounding practical, social and psychological aspects.

However although tools such as these may assist practice, studies reveal that they are rarely utilised.65 Studies demonstrate how effective dressings can improve patient QoL.16,21 Thomas48 states neither the ‘ideal wound’ nor the ‘ideal dressing’ exist, but provides several considerations in an attempt to select a suitable dressing. Fungating wounds are far from an ‘ideal wound’ and rarely heal; therefore, the selection of dressing must conform to patient choice and improve QoL. Types of dressings and topical applications are too substantial for the scope of this article; however, various practical measures can be undertaken by nurses to improve patient QoL. The awkward positions of fungating wounds pose frequent problems for nurses67 and Fletcher68 offers a useful guide on dressing adaptation by re-designing and re-shaping dressings to suit the wound. Some patients may also be suitable for chemotherapy, radiotherapy or hormone therapy, which may reduce the wound and associated symptoms.5

Pain should be continually assessed, addressed and evaluated.69 The World Health Organization pain ladder69 focuses on these aspects using chemical analgesia, while the involvement of pain specialists may be of further benefit. Dressing changes should be done in a suitable time frame to maximise therapeutic analgesic effects, and nitrous oxide and oxygen (such as Entonox) may also prove useful to tackle pain during procedures. The nurse needs to be imaginative in practice and the benefits of complementary therapies must not be forgotten or underestimated during dressing changes.70 Relaxation may be advantageous to some patients, while distraction techniques, such as music therapy or conversation, may reduce anxiety and pain.

Various other complementary therapies can also be employed, if the practitioner has completed relevant training and is competent.71 Fenton72 describes the potential for these therapies, revealing how massage provided comfort for a lady with a fungating wound, simultaneously improving her overall health and wellbeing, while aromatherapy could be used to mask odours. There is diminutive evidence to support the outcomes of these approaches; however, a recent pilot study by Lim et al.73 examining the effects of acupuncture suggested symptom improvement with palliative cancer patients.

Pre-emptive measures, such as the creation of an ‘emergency box’ with suitable dressings, medication and dark coloured towels (to disguise haemorrhage), could be left in the home of the patient. The box could be separated into two sections—one for the patient/carer (with relevant advice and instructions) and one for the professional—and would be constantly available and may be useful for emergency situations to relieve patient/family distress. The potential benefits of such boxes are supported by the successful implementation in areas such as end-of-life care and end-stage motor neurone disease.74–77

Delivering holistic care for a patient with a fungating wound can be complex, and nurses must acknowledge their limitations and seek advice from experts, when appropriate. The central role and

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special relationship with the patient enables the nurse to act as the connection between patient and other professionals. Multidisciplinary involvement for these patients is important, but as highlighted previously, this approach should be assessed on an individual basis, as patients often experience embarrassment and may not feel comfortable sharing personal problems or innermost feelings with a multitude of people. Despite these considerations, patients confirm how they value the contribution of expert help, and how this enables them to live more optimistically.

Nurses report how they often struggle to restrain their own emotions when caring for patients with offensive wounds, and studies expose how nurses caring for people with fungating wounds experience profound anguish in relation to numerous aspects of patient care. Examination into how nurses should address their emotions reveals conflicting advice. Hawthorn affirms that nurses should conceal their reactions and emotions when delivering care to patients with a fungating wound, whereas Aranda argues that suppression of feelings by professionals not only confines the patient to silence, as they feel unable to discuss obvious symptoms, but may also have detrimental effects on the nurse. To combat these challenges faced by nurses, Hawthorn suggests that practice reflection alleviated some distress, while recognition of these stresors by senior professionals and subsequent support should be offered to promote staff well-being and high-quality patient care.

To optimise and maximise patient QoL, nurses need to be educated regarding effective holistic care for those with fungating wounds. Sufficient time must be allocated to care for patients to address their needs fully and allow therapeutic relationships to develop, acknowledging patient/family needs and acting on their concerns by being adaptable and creative in their approach to care, seeking support if appropriate. To enable high quality care, support should also be available for nurses, if they so desire.

Organisations
Increased public awareness and education are called for regarding the detection of early signs and symptoms of cancer, in an attempt to minimise the development or progression of the disease and consequently the development of a fungating wound. Increased frequency of screening programmes may further reduce the development of fungating wounds; however, for those who conceal these wounds from health professionals, the uptake to participate in these programmes may be limited. Disparities of education and health-care systems in developing countries should be addressed, as these may be contributing factors in the significant number of people presenting with fungating wounds in such countries. Allocating funding and resources into a greater understanding of fungating wounds may initiate interventions to inhibit their development.

A formal reporting process is required to establish the true extent and prevalence of fungating wounds, and simultaneously provide official statistics and highlight trends regarding where/why these wounds proliferate (anatomically and geographically), and enabling efficient focusing of resources. Moreover, in today’s modern health-care system, where evidence-based nursing is paramount, it appears astonishing that nurses are delivering care without any formal guidance. Therefore, information collation from the reporting process and financial investment would provide a rationale for research towards comprehensible recommendations and local, national and international evidence-based guidelines on which to base nursing practice. Randomised controlled trials or systematic reviews are deemed the pinnacle of the evidence hierarchy, however, given the sensitive nature and ethical considerations surrounding fungating wounds, perhaps guidelines based on less favourable methods, such as case studies or qualitative or anecdotal evidence may be employed.

National guidance, research and training around fungating wounds may also reduce financial expenditure on wound care. Increased awareness of the devastating effects may stimulate funding into the tissue viability industry to enhance the lives of people living with a fungating wound through development of innovative wound-care strategies. Examples of such innovation may include exploration into ‘dry wound management’, advancements into dressing systems and the creation of more effective dressings and applications, where the emphasis of wound care moves towards QoL rather than healing.

Organisations must raise awareness of the signs and symptoms of cancer and increase the regularity of screening programmes to reduce the development of fungating wounds. A formal reporting process and guidance is required on which to anchor best practice, while funding and research into the prevention and management of fungating wounds may reduce the incidence of these wounds, alleviate the disturbing experiences of patients and improve patient QoL.

Conclusion
Fungating wounds are a seldom-researched topic, while the sensitive nature of fungating wounds adds further complexities. This literature review provided an insight into the experiences of patients living with a fungating wound, which evidence suggests are overwhelming, unrelenting and affect every domain of life. These findings must galvanise nurses to become aware of the extent and devastation of these wounds. With a paucity of evidence in all areas relating to fungating wounds, the need for further research is paramount.


