Poster Presentation

Topic : Ulcerative lesion management in patient received immunostimulants

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Introduction

Immunostimulants can induce drugs hypersensitivity in autoimmune of patients and lead to skin irritation. The most common treatment-related adverse events (AEs) were such as fatigue (19.4%), pruritus (10.7%), decreased appetite (10.5%), itching/rash (9.7%)[1]. The frequencies of AEs found in clinical when immunostimulants was used at 10 mg/kg and more than 2 weeks[2]. However, in the moist skin area around peristomal skin where frequent contact with effluent, more severe conditions may progress under inappropriate management of peristomal skin.

Case Report

A Thai male, known case CA Bladder S/P open radical cystoprostatectomy with bilateral PLND with Ileal conduit who has a pulmonary nodule at lateral basal segment at RLL. after receiving immunostimulants 200 mg. about one month, the patient complained itching, especially around peristomal skin and informed that pouching was still easily peeling and had to change pouching 2-3 times/day; moreover, the peristomal skin developed into ulcerative lesion. Enterostomal Therapy nurse was consulted for pouching and managing of ulcerative lesion. The goal of management was to promote wound healing and peristomal skin protection from effluent leakage.

Clinical Assessment

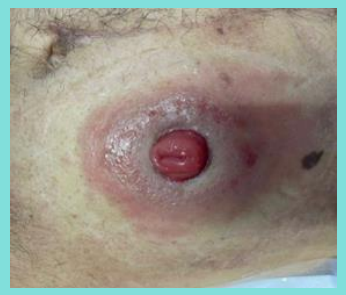

Figure 1 hyperemic lesion on 1 month.

1 month after receiving immunostimulants 200 mg. First assessment ileal conduit at right lower quadrant, round shape size 24 mms. Red moist and moderate protruding, opening of lumen at apex, mucocutaneous suture line intact, peristomal skin had hyperemic lesion around 50%, maceration 25-50% (Figure 1) yellow liquid effluent. Applied skin barrier film and skin barrier paste. Pouching with one-piece urostomy.

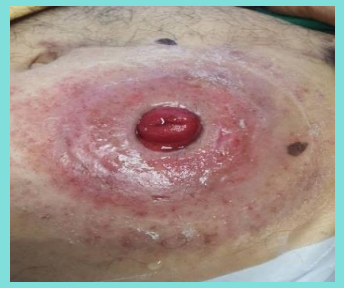

Figure 2 erosive lesion on 1 month and a half.

1 month and a half the peristomal skin had erosive lesion 50% (Figure 2). Manage erosive lesion by crusting technique and skin barrier paste. Pouching with one-piece urostomy bags with medical grade Manuka honey added.

2 month and a half later, the peristomal skin developed into ulcerative lesion around > 50% (Figure 3) and change pouching 2-3 times/day. As a consequence changing management. (details according to the intervention)

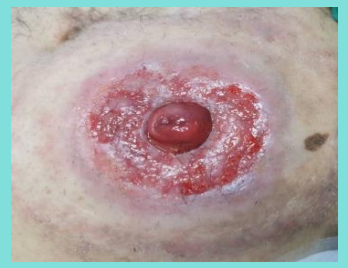

Figure 3 ulcerative lesion on 2 month and a half.

Intervention

1. Cleansing with water.
2. Manage ulcerative lesion by crusting technique as following
   - apply skin barrier power on the ulcerative lesion then apply skin barrier film cover on skin barrier power and around peristomal skin.
   - Repeat 2 or 3 times that depend on amount of exudation.
3. Contouring with skin barrier paste.
4. Pouching with 2-piece urostomy pouch with durahesive skin barrier to be introduced. As it is moldable; turtlenecking (Figure 4) helps create a secure seal without harming skin and uses an ostomy belt for firming.

Figure 4 show the turtlenecking model.

Result

After using by 2-piece urostomy pouch with durahesive skin barrier and turtlenecking. Twenty-one days later, the ulcerative lesion was healed, (Figure 5) during that time did not stop immunostimulants.

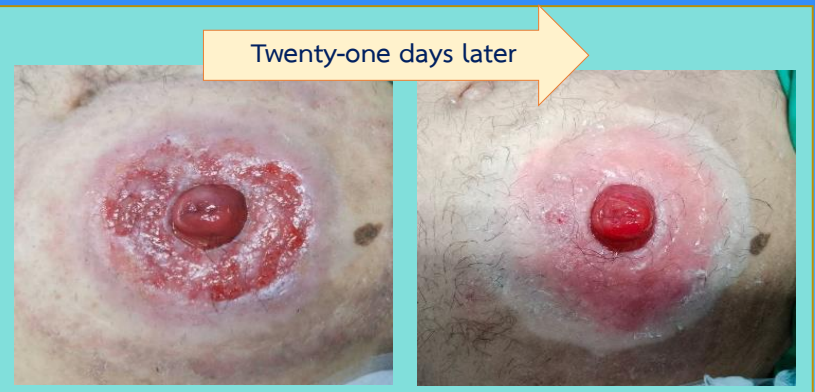

Figure 5 Twenty-one days later, the ulcerative lesion was healed.

Conclusion

Side-effects of immunostimulants can be cause of skin irritation, especially in ileal conduit with liquid effluent contact. The challenge is finding the most suitable and convenient way for patient to reduce complication in peristomal skin.

Reference

1. Chatterjee M, Turner DC, Felip E, et al. Systematic evaluation of pembrolizumab in patients with advanced non-small-cell lung cancer. Ann Oncol 2016; 27: 1291-1298.

2. Gerry Kwok, Thomas C. C. Yau, Joanne W. Chiu, Eric Tse, Yok-Lam Kwong. Pembrolizumab (Keytruda). Human Vaccines & Immunotherapeutics. 2016; 12: 2786.