Poster Presentation

Topic : Management of a moist desquamation wound in a patient with low self-care efficiency

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Management of a moist desquamation wound in a patient with low self-care efficiency

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Introduction

Radiation dermatitis is a common adverse effect of radiotherapy, occurring in up to 95%[1]. Patients with supraglottic squamous cell carcinoma can develop severe acute radiation-induced skin reactions. The most common radiation-induced dermatitis symptoms include irritation, pain, itching, peeling, and pain[2,3]. Moist Desquamation (MD) occurs typically after a cumulative dose of 30 Gy, due to the destruction and sloughing of dermal layers. It is characterized by serous fluid drainage and pain, often beginning as small patches and can progress to involve larger, confluent areas of irradiated skin[4].

Case report

A patient diagnosed with supraglottic squamous cell carcinoma underwent pharyngo-jejunal resection and jejunal-esophageal anastomosis with open gastrostomy and tracheostomy tube. After RT 32/33F, he had pain in peeling skin with dermal exposure, ulceration, and exudate on the neck. Due to the location, he is unable to clean the wound and tracheostomy care by himself and inability to talk and communicate with others meanwhile doesn't have family or a caregiver to support him at home (Figure1). He visits ostomy clinic for wound and tracheostomy care. After cleansing the skin. He had MD at the right neck, wound size 5x2 Cms., 50% granulation tissue, 50% yellow slough with moderate purulent exudates and scabs below tracheostomy (Figure 2).

Figure1 Before cleansing

Figure 2 After cleansing

Objective

The goal of management are manage exudate, prevent infection, maintain skin integrity, and pain control.

Intervention

1. Clean peri-wound with a moisturizing skin cleanse.
2. Clean wound bed with 0.9% NaCl.
3. Protect wound edge and peri-wound from exudates with skin barrier film.
4. Prevent infection with Hydrofiber Ag.
5. Manage exudate and pain with Hydrofiber foam dressing, and change the dressing every 3 days (Figure 3).

Figure 3 Wound healing progression during treatment

Results

After 14 days, wound size was decreased. Wound bed are 70% clean wound non-granulation tissue, 30% yellow slough tissue and without signs of wound infection (Figure 4).

Figure 4 Improved wound (Day 14)

Conclusions

Moist desquamation wound at the neck, which is complex to self-care. The patient needs specialized care. It becomes a success when managed by ETN. Regularly scheduled dressing changes can reduce the frequency of hospital visits including the appropriate use of advanced wound dressings can promote wound healing, and keep the patient safe from complications.

References

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