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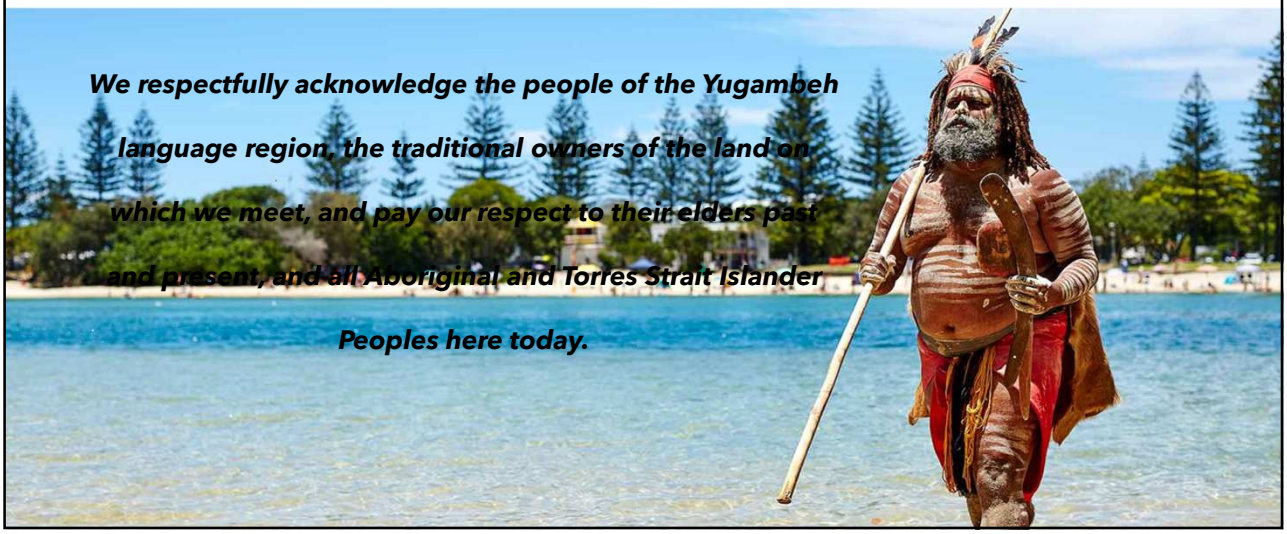
Acknowledgement of Country



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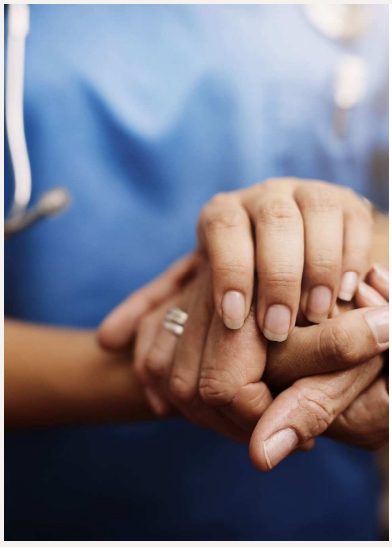

Learning Objectives

- The differences between palliative wounds and wounds associated with life's end
- Treatment strategies used to care for persons with palliative or end-of-life wounds
- The role of palliative care in supporting the person, caregivers, and health professionals
- How to identify escalation criteria and referral pathways
- Practical wound care strategies that can be used to control wound symptoms

4

Agenda

9:00 – 9:05am	**Introduction & Acknowledgement of Country**
9:05 – 9:35am	Skin Changes at Life's End / Terminal ulceration
9:35- 10:00am	Interactive case study
10:00 – 10:30am	*Morning Tea & Trade Display*
10:30 – 11.00am	Ischaemic ulceration of the lower limb
11:00 – 11:30pm	Pain management & wound care in palliative care
11:30 – 12:00pm	Panel discussion palliative care versus end-of-life care
12:00 – 12:50pm	Practical workshop
12:50 – 1:00pm	Summary & Evaluation

5

Recognising skin failure: Terminal ulcers, Skin Changes At Life's End & Trombley-Brennan Terminal Tissue Injuries

Dr Michelle Gibb

PhD M Nsg Sci(NP) M Wound Care BN

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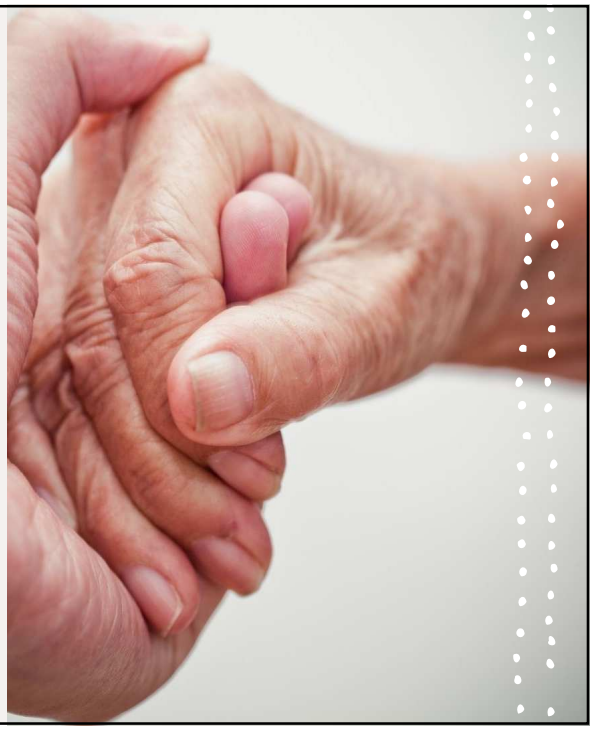

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'The skin is the largest organ of the body. If the heart, lungs, and kidneys are showing signs or failing, isn't it logical that the skin would also show signs of failing? Why is a pressure ulcer considered a sign of inadequate healthcare, when symptoms of heart disease or lung disease or kidney disease are not? In the terminally ill patient, a pressure ulcer may only be a sign of physical decline and mortality'

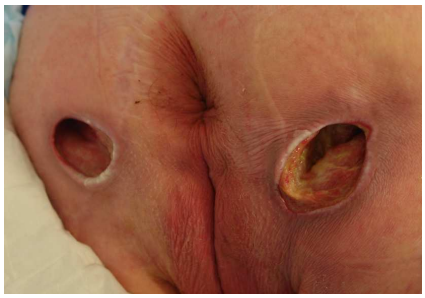
(Ayello et al., 2019)

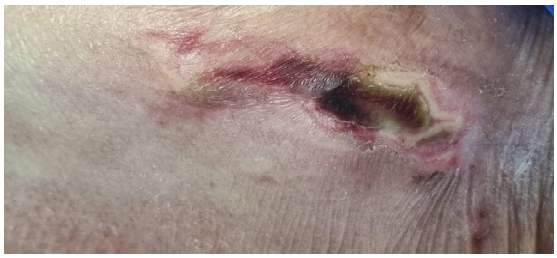
7

'If the heart, lungs, and kidneys are failing, is it not logical that the body's cover would also show signs of failure?'

(Ayello et al., 2019)

8



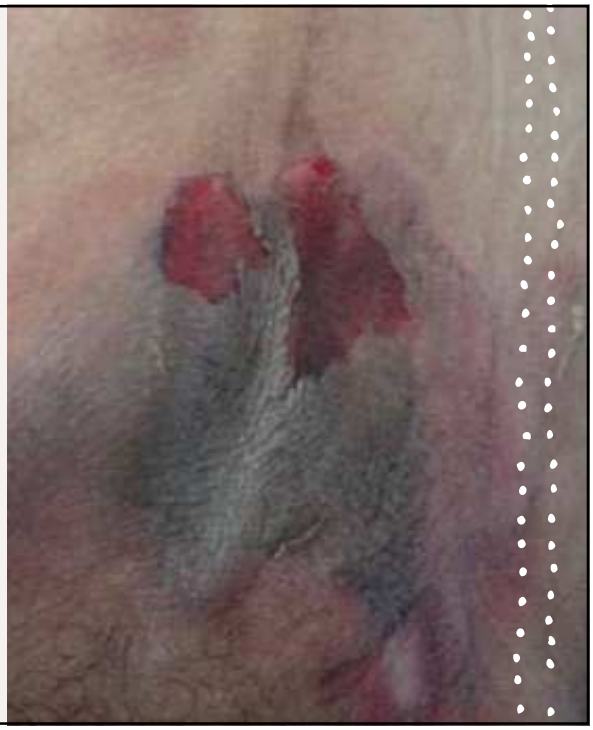


Skin failure: avoidable or unavoidable?

9

Pathophysiology

- Hypoperfusion
- Hypoxia
- Inflammation
- Vascular permeability
- Oedema



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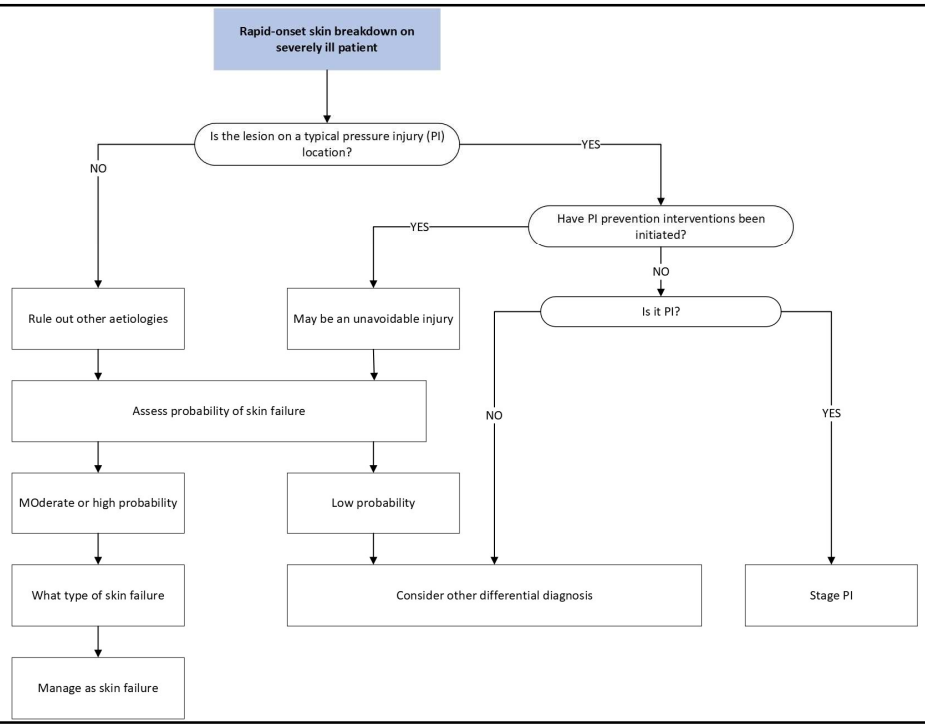
Risk Factors

- Hypotension / shock
- Mean arterial pressure <60
- Sepsis or multiorgan dysfunction syndrome
- Vasopressor/inotrope use
- Hypoalbuminemia
- Primary diagnosis related to altered blood flow (cardiovascular, vascular, DIC, clotting abnormalities)
- Respiratory insufficiency / mechanical ventilation
- Renal insufficiency
- Obesity
- Malnutrition
- Cachexia
- Reduced mobility

11

Assessment algorithm



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12

End-of-life wound assessment

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END-OF-LIFE WOUND ASSESSMENT TOOL

Patient Identification:

END-OF-LIFE WOUND DEFINITION: a sudden unavoidable skin injury that rapidly develops in some individuals at end of life. These include Skin Changes At Life's End (SCALE), Kennedy terminal ulcer, and Trombley-Brennan terminal tissue injury.

Instructions: Use this assessment tool if you suspect the skin injury is an end-of-life wound and ***NOT*** a pressure injury.

Section 1: SCREENING	Yes	No
1. Patient has been assessed by healthcare professional/s as ***dying?*** "Dying" is the terminal phase of life, where death is imminent and likely to occur in the following days, weeks, or months.		
2. Patient has been receiving ***regular pressure injury prevention strategies (eg, regular repositioning, support surfaces, nutrition, wheelchair cushions)?*** "Regular repositioning" is defined as patient body position changes (eg, 1-4 hourly) as determined by healthcare professional/s in collaboration with the patient/family.		
3. Patient has ***suddenly developed*** skin discoloration/injury/blister in the previous 24 hours of this assessment?		

Proceed to Section 2 if you answer **'Yes' to ALL THREE** screening questions.

Section 2: ASSESSMENT			
Wound characteristics	**Wound descriptors**	**Yes**	**No**
Location(s)	Coccyx, sacrum, or buttock (unilateral or bilateral), leg, heel, arm, shoulder, thoracic and lumbar spine, or other body locations		
Appearance (any combination)	• Bruise-like appearance (skin intact) • Similar to Stage 2-4 pressure injury (skin not intact)		
Shape(s)	Pear, horseshoe, butterfly shape, linear striations, or other shapes		
Color (any combination)	Red, yellow, or black. Deep darkening of the tissue (for individuals with dark skin tone). Nonblanchable pink, purple, or maroon. May have a white center.		
Speed of change	Sudden and rapid development with increase in size of skin discoloration/injury/blister in the previous 24 hours of this assessment.		

Complete Section 3 if you answer **'Yes' to TWO OR MORE** assessment questions

Section 3: CONFIRMATION and MANAGEMENT

In your assessment, is this an end-of-life wound? (circle one): **Yes** **No[a]**

End-of-life wound management plan developed? (circle one): **Yes[a]** **No[a]**

Consider:
1. Wound: manage wound infection, pain, odor, exudate
2. Patient and family involvement in care and education (wound management and end-of-life care)
3. Quality of life and psychosocial support
4. Clinical specialist referral
5. Documentation as per facility requirements

Completed by: Name: _____ Signature: _____
Date: _____ Time: _____

[a]Refer to European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers/injuries: Clinical practice guideline. Haesler E, ed. EPUAP/NPIAP/PPPIA; 2019:1-408.

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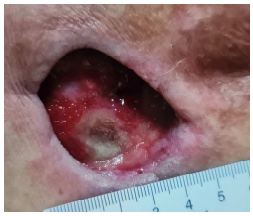
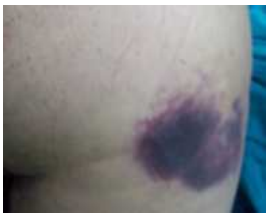
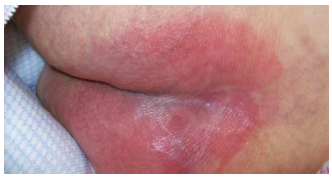
ADVANCES IN SKIN & WOUND CARE

13







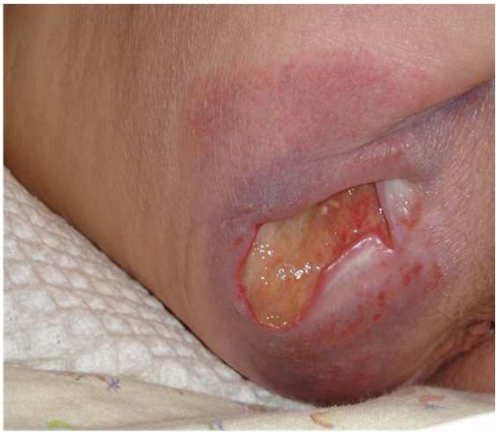
Differential diagnosis

- Pressure injury
- Incontinence associated dermatitis
- Gluteal compartment syndrome
- Traumatic wounds

14

What is a PI?

- Localised injury to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device.
- Result of intense and/or prolonged pressure or pressure in combination with shear



15

Pressure Injury Staging

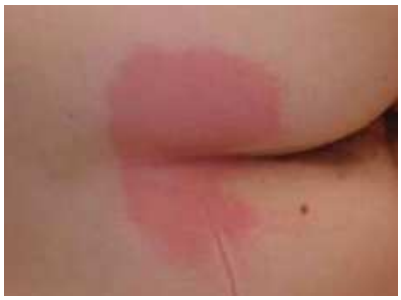
PI's are staged as:

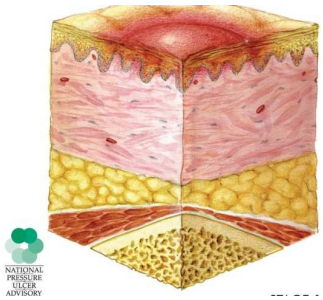
- Stage I
- Stage II
- Stage III
- Stage IV

- Unstageable
- Suspected Deep Tissue Injury

The higher the stage number the deeper the tissue involvement

16





Stage 1 Pressure Injury

(NPUAP/EPUAP/PPPIA 2014)

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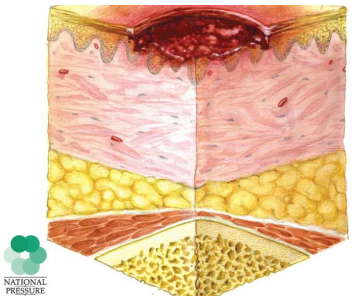
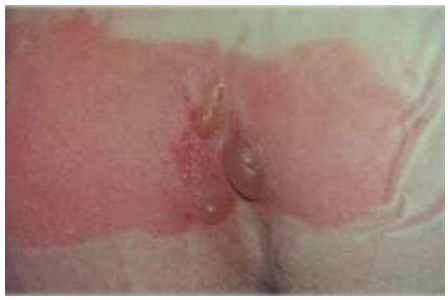


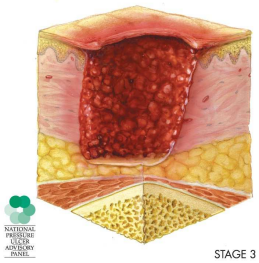


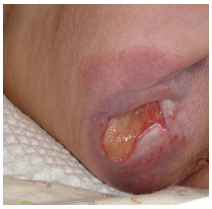
Stage 2 Pressure Injury

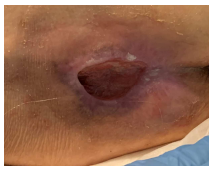
(NPUAP/EPUAP/PPPIA 2014)

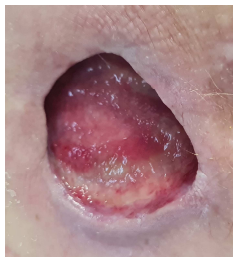
18

Stage 3 Pressure Injury









(NPUAP/EPUAP/PPPIA 2014)

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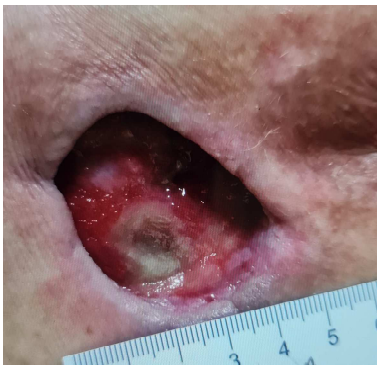

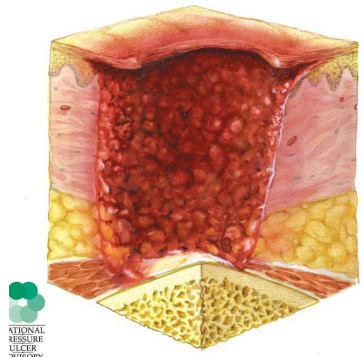

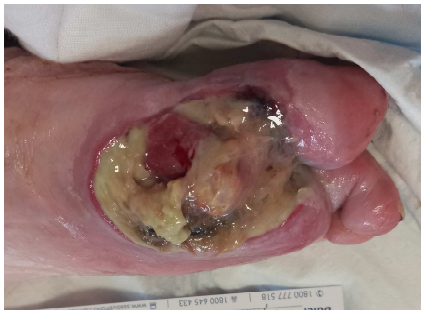

Stage 4 Pressure Injury

(NPUAP/EPUAP/PPPIA 2014)

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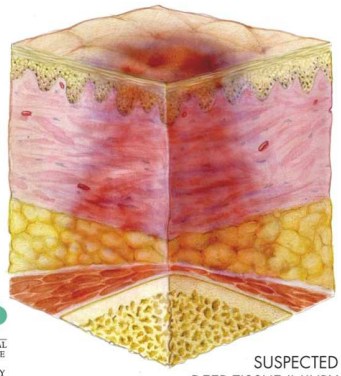
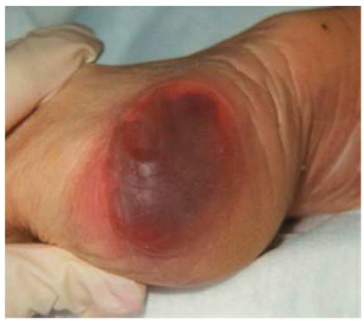
Suspected Deep Tissue Injury



NATIONAL PRESSURE ULCER ADVISORY PANEL

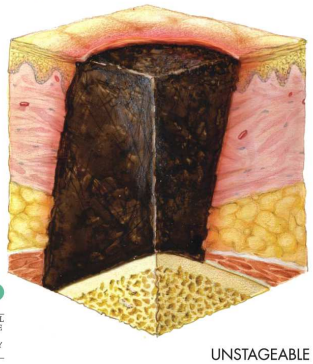
SUSPECTED DEEP TISSUE INJURY



(NPUAP/EPUAP/PPPIA 2014)

21

Unstageable



NATIONAL PRESSURE ULCER ADVISORY PANEL

UNSTAGEABLE

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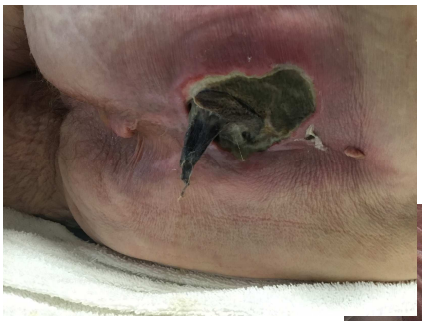

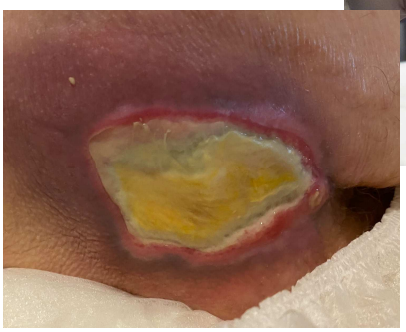

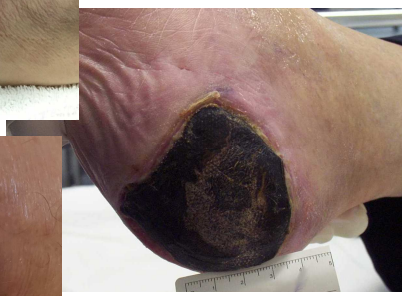

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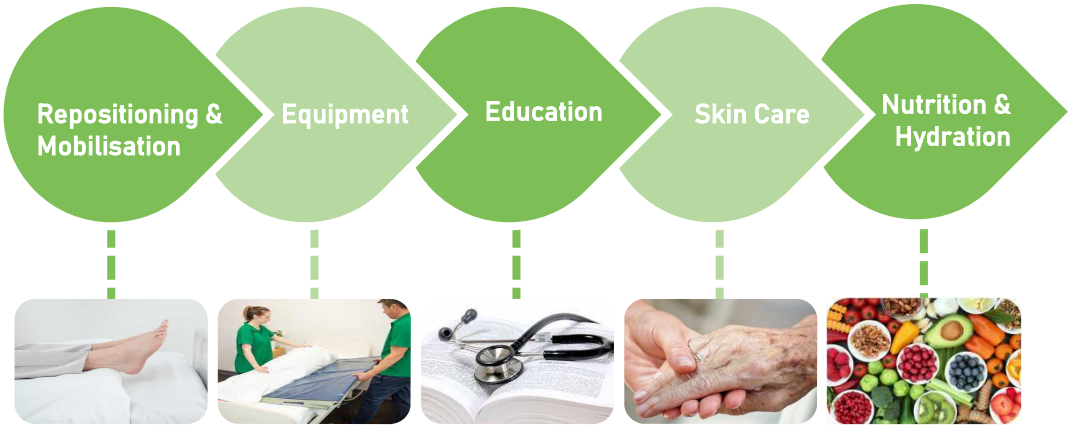
PI Management & Prevention Strategies



23

Assessment & Monitoring

SET TREATMENT GOALS

AIM FOR AN IMPROVEMENT WITHIN 2 WEEKS

REASSESS EVERY TWO WEEKS TO MONITOR PROGRESS INCLUDING SIZE

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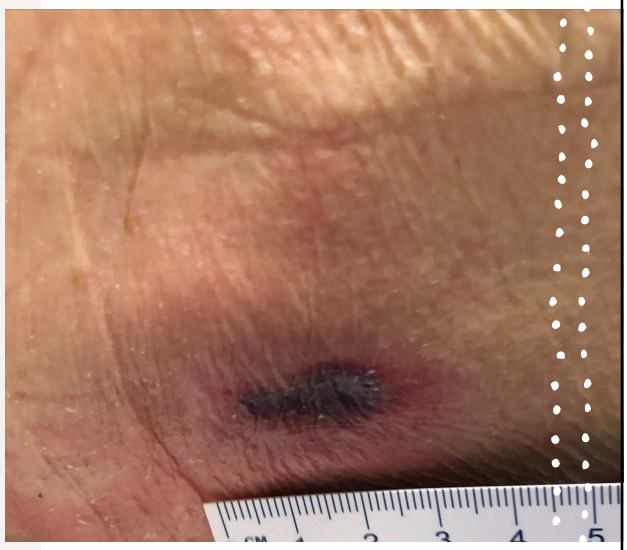
24

Skin failure

- Skin & underlying tissue ischaemia
- Secondary to hypoperfusion
- Occurs concurrent with severe dysfunction or failure of other organ systems
- Acute, chronic or end stage
- Life expectancy variable
- Generally over bony prominence but can be anywhere
- Unavoidable in most instances



25

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Acute skin failure

- Hypoperfusion state leading to tissue death
- Occurs with critical illness
  - Septic shock
  - Multiorgan failure
  - Poor tissue perfusion
  - Prolonged mechanical ventilation

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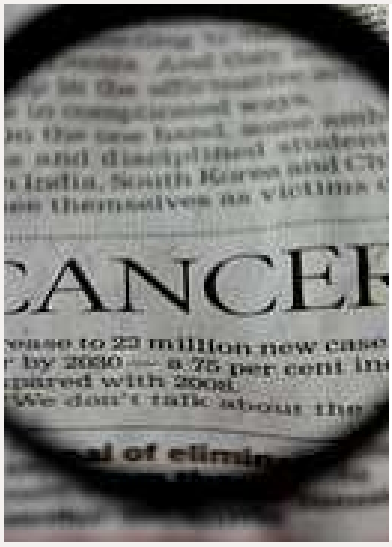

Chronic skin failure

- Occurs concurrently with chronic conditions
  - Multiple sclerosis
  - Malignancy

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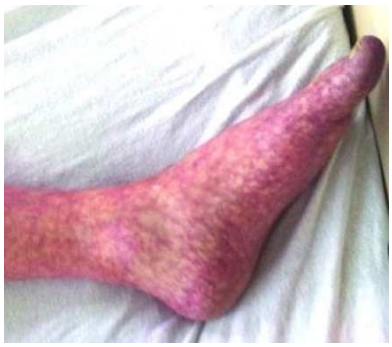
End-stage skin failure

28

Skin Changes at Life's End (SCALE)

- Describes a group of clinical phenomena
- Physiological changes that occur as a result of dying process
- Observable skin changes (colour, turgor, integrity)
- Localised pain
- Unavoidable



Levido reticularis

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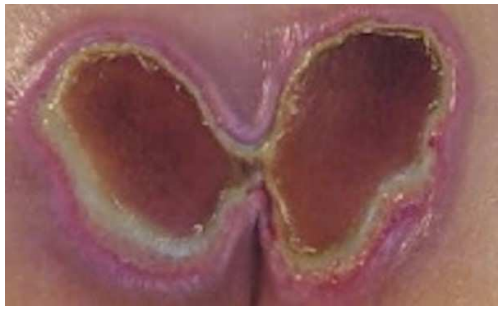
29

Kennedy Terminal Ulcers (KTU)

- Pear shape or butterfly or horseshoe shape
- Irregular borders
- First appears as erythematous and/or purpuric evolving to yellow and/or black colour with or without erosion of the skin
- Predominantly on sacrum or coccyx but can include hip, heel, ischium
- Red, yellow and black tissue
- Sudden onset
- Life expectancy 2 weeks to several months



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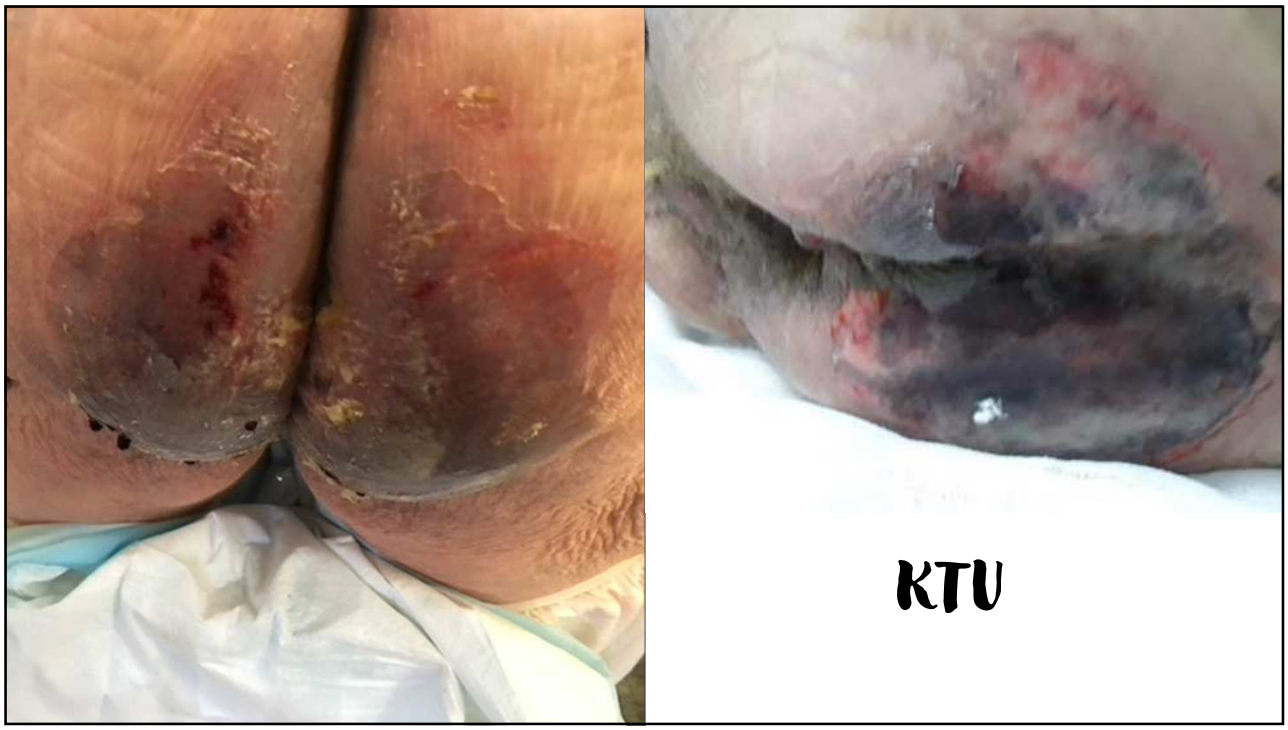
KTU

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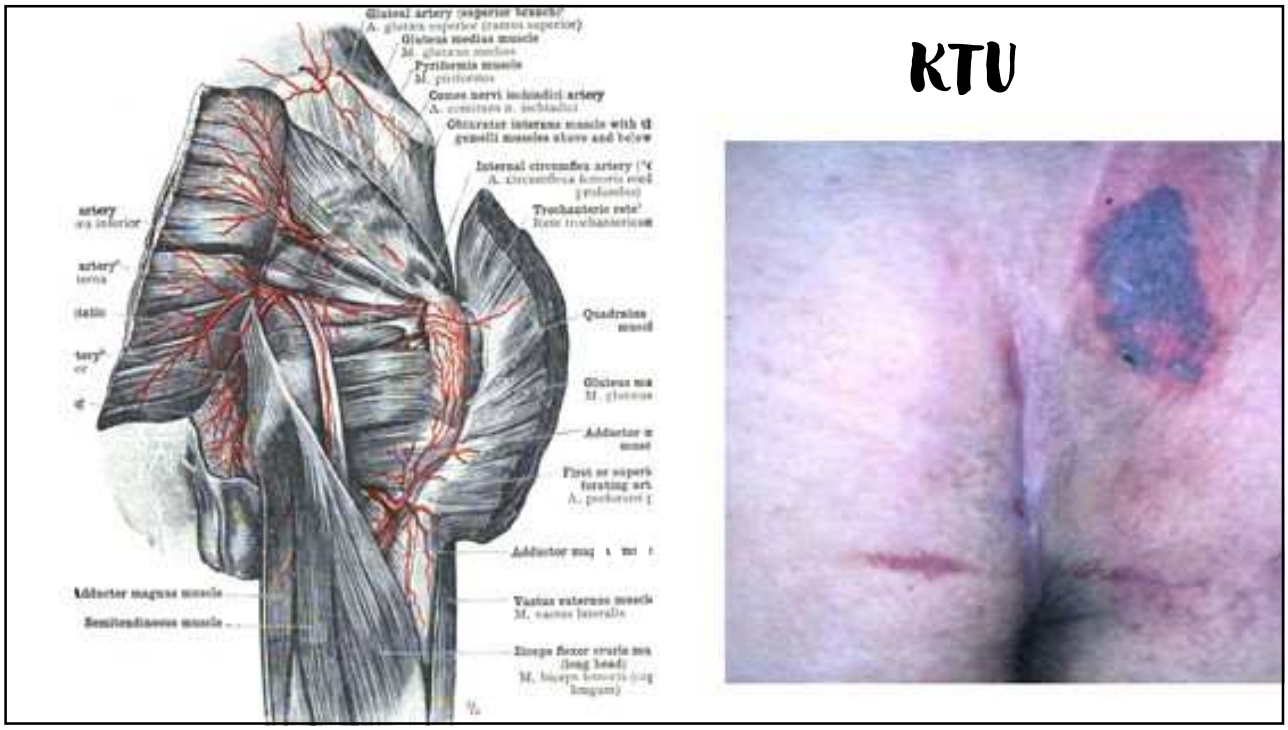
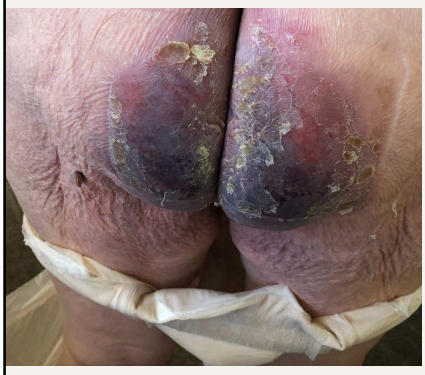
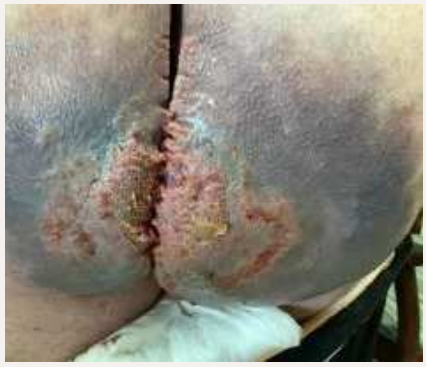

KTU
Pyriformis muscle
Quadratus
Adductor magnus muscle
Semitendinosus muscle

32

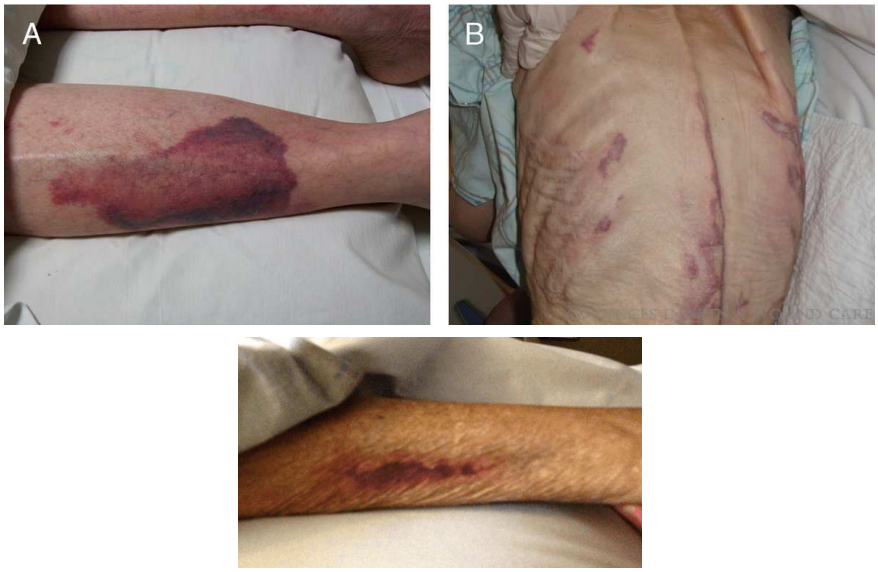

KTU

33

Trombley-Brennan Terminal Tissue Injury (TB-TTI)

- Spontaneous skin changes
- Rapid evolution, speed of enlargement and progression
- Appears in areas of little to no pressure on thighs and lower legs
- Unavoidable
- Related to organ failure
- Bruise-like appearance (pink, purple or maroon coloured)
- May be butterfly pattern
- Can be linear striations on lower legs that extend downwards or on thoracic or lumbar spine that present horizontally
- Skin remains intact and does not break down

34



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35

Relevance

CLINICAL

LEGAL

PSYCHOLOGICAL

FINANCIAL

36

Goals of care

- Identification of risk factors
- Clinical care should be patient centred, address pain & activities of daily living
- Reduce risk of infection & skin breakdown where possible
- Communication regarding expectations around patient's end of life goals & concerns
- Discussion around skin changes, skin breakdown & pressure injuries
- Skin breakdown may be an unavoidable despite interventions that meet or exceed standard of care

37

Intervention strategies – 5 P's

- Prevention
- Prescription (may heal with appropriate treatment)
- Preservation (maintenance without deterioration)
- Palliation (provide comfort and care)
- Preference (patient desires)

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38

Assessment

- Key to effective management
- Significantly improves healing rates & reduces incidence of complications
- Many patients not referred for specialist assessment

39

Wound management

- Manage wound infection
- Pain management
- Wound & skin hygiene
- Odour
- Exudate
- Protection of the periwound skin
- Patient & family education
- Specialist referral
- Interdisciplinary collaboration
- Documentation
- Optimise health related quality of life

40

Why apply a dressing?

- To provide rapid & cosmetically acceptable healing
- To remove or contain odour
- To reduce pain
- To prevent or treat infection
- To contain exudate
- To cause minimum distress or disturbance to the patient

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41

Dressings by function

Cleansers
what you use to clean the wound & periwound skin

Barrier Preparation
what you use to protect the skin around the wound

Skin Care
what you use to improve skin integrity

Primary Dressing
what goes on the wound

Secondary Dressings
what you use to absorb exudate

Retention / Fixation
what you use to hold dressings on

42

Wound dressings by function

- Wound / skin protection products
- Moisture retention products
- Moisture donation products
- Exudate management products
- Products to manage bacteria or wound infection
- Products to absorb odour
- Products to aid autolytic debridement

43

Summary

- KTU, TB-TTI are terminal ulcers at end of life
- Skin failure does not include pressure injuries
- Skin failure may not be preventable
- Need for more research

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44

Questions

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45

References

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46

Interactive Case Study

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47

Case Study

Jack is a 75-year-old male

Health History

- Infiltrative squamous cell carcinoma
- Multiple excisions of lesions & grafting
- Hypertension

Medications

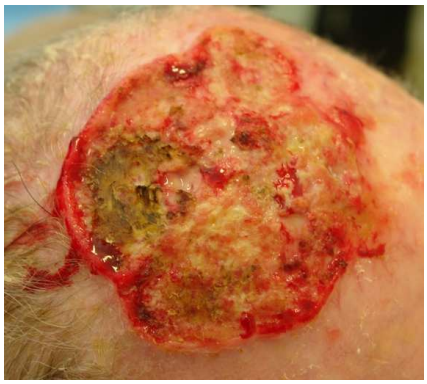
- Telmisartan
- Paracetamol

History of presenting condition

Jack's general health condition is progressively deteriorating secondary to infiltration of SCC into deeper tissue structures. Completed radio and chemotherapy. Not suitable for any further surgical intervention. He has a poor appetite and is losing weight. Jack is usually independent with activities of daily living but is now requiring more assistance because of pain, loss of vision, headaches and short-term memory loss.

Social History

Jack is a retired schoolteacher and lifeguard. He likes nothing more than to be in the great outdoors. He has a strong social support network. Lives at home with his wife of 50 years and has two adult children and four grandchildren who live nearby. Non-smoker, occasional alcohol intake.



Top of head

- Moderate level of odouress serous exudate
- Occasionally bleeds when dressings are removed
- Painful when dressings are applied & removed and when in bed at night

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48

49

Nicola Morley

VASCULAR NURSE PRACTITIONER

GOLD COAST HOSPITAL & HEALTH SERVICE

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50

- Insert Nicola Morley's slides

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51

Tracey Norling

NURSE PRACTITIONER

GOLD COAST SPECIALIST PALLIATIVE CARE

GOLD COAST HOSPITAL AND HEALTH SERVICE

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52

Pain management and wound care in Palliative Care

September 2024

Tracey Norling
Nurse Practitioner
Gold Coast Specialist Palliative Care
Gold Coast Hospital and Health Service

53

Jingeri.
We acknowledge the Traditional Custodians of the land in which we work, live and grow, the Kombumerri, Wangerriburra, Bullongin, Minjungbal and Birinburra peoples, of the Yugambeh Language speaking nation. We also pay our respects to Elders past, present and emerging. We also acknowledge other Aboriginal and Torres Strait Islander people present today.

54

Learning Objectives

1. **Understand what palliative care is and who provides the care?**
2. **Understand the five steps to advance care planning**
3. **Pain management and wound care in palliative care.**
   - Understand the concept of total pain and assessment
   - Understand the different types of pain
   - Understand the pharmacological management of pain associated with wounds
   - Understand non-pharmacological treatments associated with pain
   - Understand interventional treatments
4. **Explore a case study**

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Slide 55

Queensland Government

55

The World Health Organisation defines palliative care as an approach that improves the quality of life for patients with a life-limiting illness[1]

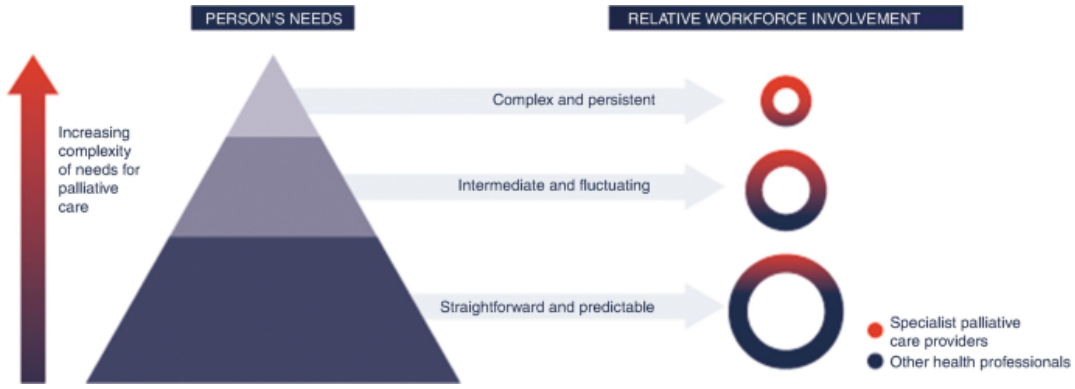
Gold Coast Health always care

Slide 56

Queensland Government

56

Who provides palliative care[2]



Wound care in palliative care [3]

Wounds can cause significant suffering, are often untreated and can reduce Quality of Life.

Often non-healing, and the symptoms are associated with declining physical function, social isolation and a sense of loss of control.

Holistic multidisciplinary support is required, including understanding the person's goals of care and completing Advanced Care Planning.

Five Steps to Advance Care Planning [4]

1. Talk about values, goals and future health care choices
2. Start the ACP conversation
3. Documentation of choices
4. Storing ACP documents
5. Revising and updating ACP documents

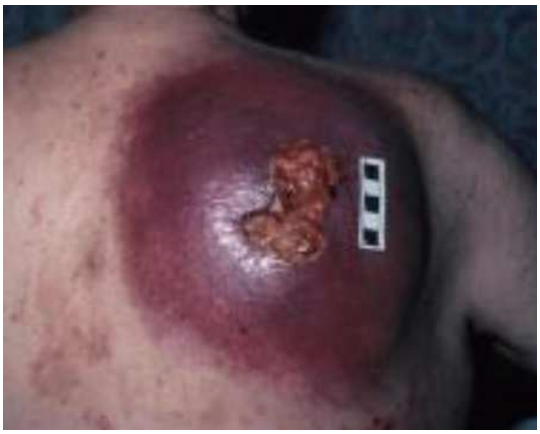
59

Malignant wounds in palliative care [3]

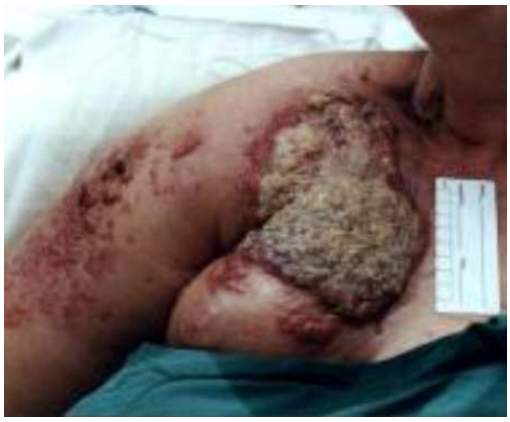
- About 15% of cancer patients develop malignant wounds
- Skin, breast, head and neck, gastrointestinal, and lung cancers are the most likely to result in malignant wounds
- Symptoms include pain, swelling, exudate, malodour, pruritus, and bleeding
- Pain is the most common symptom

60

Malignant wounds in palliative care



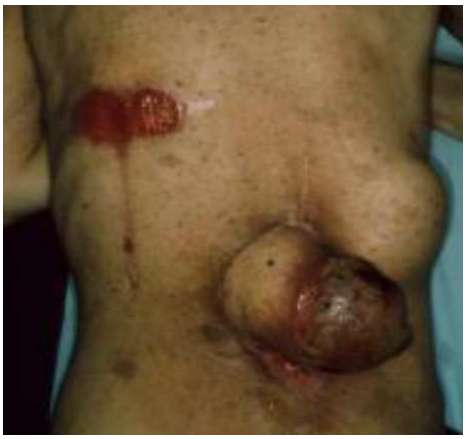
Malignant fungating melanoma



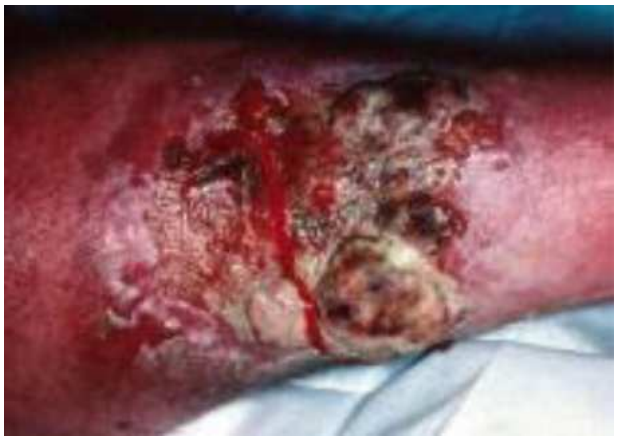
Malignant fungating breast cancer

61

Malignant wounds in palliative care



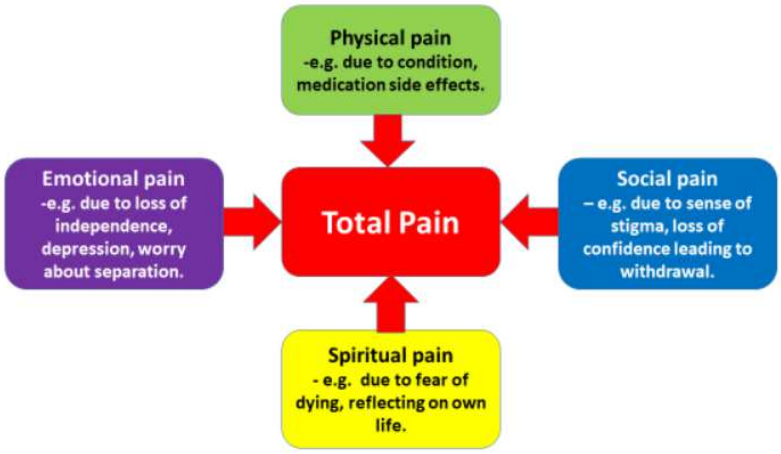
Fungating wound wound on back from lung cancer



Bleeding fungating wound SCC

62

Total Pain [2,3]



63

Assessing Pain[3]

Wound assessment

- Location: head & neck, chest, abdomen, perineal, limbs
- Wound appearance: nodular, ulcerative, necrotic, fungating, sloughy, exposed/underlying structures
- Size and depth: superficial, deep, layers involved
- Wound edge and peri-wound skin appearance
- Complications: infection, fistula formation, pockets,
- Lymphoedema

Symptoms

- Pain: intensity (numerical rating scale 1–10), onset, quality (aching/stabbing, burning/shooting), time course, exacerbating and relieving factors, effectiveness of analgesia
- Bleeding: amount, type (contact, spontaneous, oozing)
- Exudate: amount, colour, quality (serous, purulent)
- Malodour: intensity, impact on patient/caregivers
- Other symptoms: nausea, fatigue, dyspnoea, pain, anorexia

64

Assessing Pain[3]

Impact on function

- Head & neck wounds: impact on swallowing, speech, hearing, vision
- Anal/perineal wounds: faecal and urinary continence
- Function: ability to mobilise, perform activities of daily living, impact on sleep
- Nutritional assessment: monitor intake, if recent weight loss consider need for high-protein high-energy nutritional supplement and referral to a dietician

Psychological impact:

- Impact on mood, depression, anxiety, body-image, self-esteem, feelings of hopelessness/despair, anger, frustration, fear

65

Assessing Pain[3]

Social impact

- Social isolation, withdrawing from family/friends, feelings of loneliness and isolation, impact on sexuality, ability to fulfil social roles
- Provision of care: specialists, general practitioner, caregivers
- Financial concerns: cost of wound dressing supplies, other financial stressors

Spiritual impact

- Fear of dying
- Examination of their life and expressions of regrets

Patient's goals of care

- Discussion with the patient about their ideas, concerns and expectations about treatment goals and their understanding of prognosis

66

Types of pain in malignant wounds [3,6]

Nociceptive pain

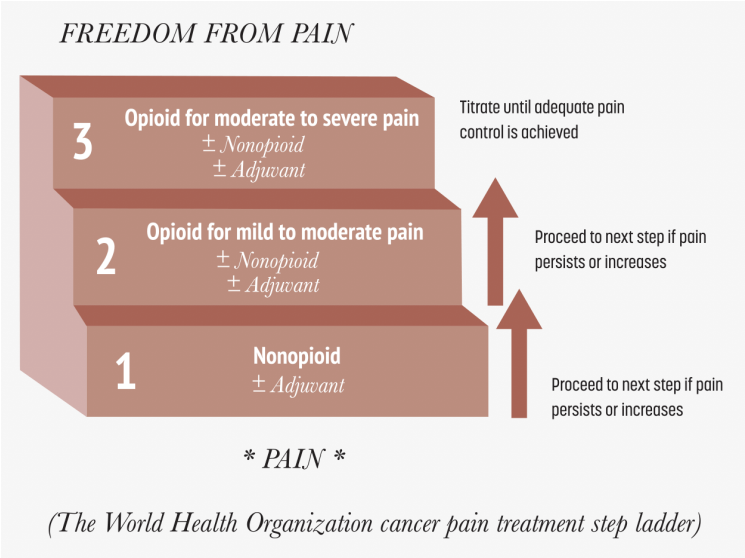
- Caused by tissue injury
- Usually associated with some inflammation
- Most common type of pain
- Often acute

Neuropathic pain

- Caused by nerve damage
- Often chronic pain

67

Opioid ladder - wait there is more! [7]



(The World Health Organization cancer pain treatment step ladder)

68

Systemic Pain Medications [3,6]

Systemic analgesics are often required to relieve pain associated with malignant wounds but can be only partially effective.

Adjuvant therapies target neuropathic pain are often required.

Includes: antidepressants (amitriptyline and duloxetine) & calcium channel ligands (gabapentin and pregabalin).

69

Anticipatory pre-wound care medications [3]

Pain is common during dressing changes

Consider providing analgesia prior to dressing changes

The time to onset of action of systemic opioids should be considered.

Oral immediate release morphine should be taken 30 minutes prior, whereas rapid-onset opioids have faster onset of action including transmucosal fentanyl

70

Topical pain medications [3]

Topical opioids have a role through its local analgesic effect

Mix 10mg morphine with 10g of a water-soluble carrier gel (e.g. Solugel, Intrasite gel). Apply the gel to the wound either directly or to a non-absorbent dressing placed over the wound.

Cover with an appropriate dressing, based on the wound assessment.

The topical analgesic effect may last up to 24 hours, but the gel can be applied up to 3 times daily if required.

Topical opioids may reduce side-effects, particularly constipation; however, the bioavailability of morphine when applied over broken skin is highly variable.

Weak evidence to date.

71

Other treatments [3,8,9]

Non-pharmacological

- Psychology
- Music therapy
- Education
- Odour control

Radiotherapy

- Shrink the cancer cells
- Decrease excaudate, promote healing, control pain and bleeding.
- Won't cure cancer but can control progression
- Ulceration could seem worse in the beginning of treatment due to skin reaction to the radiotherapy

Interventional radiology

- Nerve block for neuropathic pain. With nerve ablation can last for months

72

Case Study

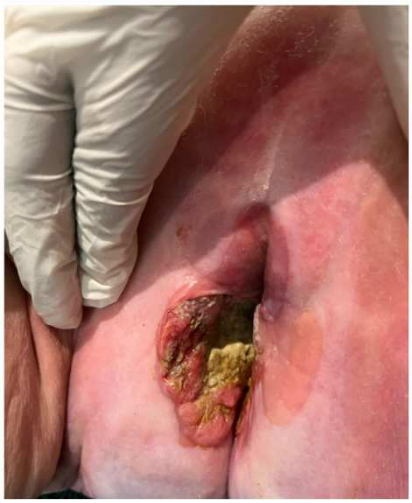
- 96yo lady with SCC of the vulva – Fistulating fungating wound progressing over 12 months
- Dual incontinence or urine and faeces
- Needs assistance with all ADLs
- Cognitively intact – very sharp
- Goals of care- not for active treatments for SCC
- Erythematous appearance of surrounding skin – no signs of infection
- Stoic lady – under reports her pain
- Obvious symptoms of severe pain on movement and during wound cleaning
- Sensitive to pain medications - has tried buprenorphine, Tapenatadol, morphine, oxycodone – all made her feel drowsy and nauseated

Social:

- Moved to aged care home 6 months ago
- Supportive family support – 6 children

Subject line: Vulva SCC

Photo 1 of 3



What can we do?

- Pain management
- Radiotherapy
- Interventional radiology
- Non-pharmacological treatments

75

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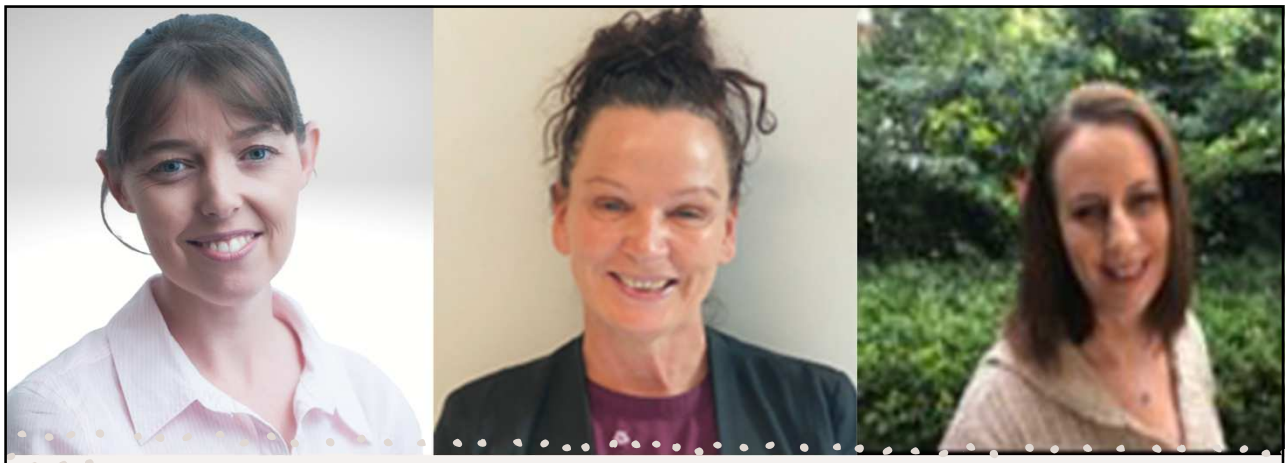
76



Panel Discussion

77

Practical Activities

78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79