

# Occurrence and management of neoplastic wounds in women with advanced breast cancer

*Ocorrência e manejo de feridas neoplásicas em mulheres com câncer de mama avançado*

*Ocurrencia y gestión de heridas neoplásicas en mujeres con cáncer de mama avanzado*

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## ABSTRACT

**Objective:** To characterize the socio-demographic profile of women with breast cancer who present neoplastic wounds, and to identify the dressings used most for treating these wounds. **Methods:** This study has a quantitative approach, is cross-sectional and retrospective. The data was collected through a review of hospital records of women with breast cancer in the period 2000-2011.

**Results:** The sample was constituted of 62 women with a mean age of 55.4 years old; 75.8% were white, 55% had invasive ductal carcinoma and 27.4% were in clinical stage IIIb. Of the deaths recorded, 27% occurred in less than 1 year after the appearance of the wound. The symptoms recorded were pain (32.2%), bleeding (35%) and necrosis (21%). The products used were silver sulfadiazine (23%) and Essential Fatty Acid (EFA) (16.1%). **Conclusion:** The results point to a lack of systematization of nursing care related to oncological wounds in this service.

**Keywords:** Breast neoplasms; Palliative Care; Nursing; Wounds and injuries.

## RESUMO

Objetivo deste estudo foi caracterizar o perfil sociodemográfico de mulheres com câncer de mama que apresentam feridas neoplásicas e identificar as coberturas mais utilizadas para o tratamento das feridas. **Métodos:** Trata-se de um estudo de abordagem quantitativa, de corte transversal e retrospectivo. Os dados foram coletados por meio de revisão de prontuários de mulheres com câncer de mama no período de 2000 a 2010. **Resultados:** A amostra constituiu-se de 62 mulheres com idade média de 55,4 anos; 75,8% eram de cor branca, 55% apresentaram carcinoma ductal invasor e 27,4%, estágio clínico IIIb. Dos óbitos registrados, 27% ocorreram em menos de um ano após o aparecimento da ferida. Os sintomas registrados foram dor (32,2%), sangramentos (35%) e necrose (21%). Os produtos utilizados foram a sulfadiazina de prata (23%) e o ácido graxo essencial (16,1%). **Conclusão:** Os resultados apontam para falta de sistematização da assistência de enfermagem relacionada às feridas oncológicas neste serviço.

**Palavras-chave:** Neoplasias da mama; Cuidados paliativos; Enfermagem; Ferimentos e lesões.

## RESUMEN

**Objetivo:** Caracterizar el perfil socio-demográfico de mujeres con cáncer de mama que han presentado heridas neoplásicas e identificar los productos más utilizados para el tratamiento de las heridas. **Métodos:** Enfoque cuantitativo, transversal y retrospectivo. Datos recogidos a través de revisión de las historias de las mujeres con cáncer de mama en el período de 2000 hasta 2010. **Resultados:** Muestra con 62 mujeres con media de edad de 55,4 años; el 75,8% eran blancas; el 55% tenían carcinoma ductal invasor y el 27,4% estadio clínico IIIb. De las muertes registradas, 27% ocurrieron en período inferior a un año después de la aparición de la herida. Los síntomas destacados fueron: dolor (32,2%), hemorragia (35%) y necrosis (21%). Los productos más populares fueron la Sulfadiazina de Plata (23%) y ácidos grasos esenciales (16,1%). **Conclusión:** Los resultados apuntan para la falta de sistematización de la asistencia de enfermería relacionada a las heridas oncológicas en este servicio.

**Palabras-clave:** Neoplasias de la mama; Cuidados paliativos; Enfermería; Heridas y traumatismos.

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## INTRODUCTION

Malignant fungating wounds (MFW), also termed tumoral wounds, malignant wounds, fungoid lesions or ulcerating wounds occur due to the breaking of the integrity of the skin, resulting from uncontrolled cellular proliferation with consequent infiltration of malignant cells into the structures of the skin<sup>1</sup>.

It is calculated that approximately 5% to 10% of patients with metastatic cancer<sup>2</sup> or with a primary tumor located close to the surface of the skin present MFW, which generally appear during the disease's terminal phase<sup>3,4</sup>. Although any type of cancer can affect the skin, among women, those most commonly associated with the formation of MFW are those of the breast (70.7%) and melanoma (12%)<sup>2</sup>.

The MFWs may initially be manifested as an inflammation, characterized by hardening, hyperemia, heat and/or local sensitivity. When alterations in vascular and lymphatic flow occur, due to the expansion of the tumor, there is destruction of tissues and consequent formation of an ulcer<sup>2</sup>. The appearance of these lesions may be associated with the patient's delay in seeking medical assistance and/or late diagnosis, with consequent delay in the starting of treatment<sup>5</sup>.

The principal symptoms include: friable, painful lesions with a fetid odor, which liberate a large quantity of exudate and bleeding<sup>2</sup>, as well as progressive bodily disfigurement. The appropriate control of these symptoms is essential, given that in addition to physical and psychological suffering related to the diagnosis of cancer, the patient presents social isolation, impaired body image, a sense of self-disgust and embarrassment, caused by the presence of these lesions<sup>6</sup>.

The care directed at these lesions is specific and different from the guidance found in studies in the area of the care of wounds in general, as rather than a cure, it aims for the control of the symptoms - that is, palliative care<sup>3</sup>. In this context, studies<sup>2,6,7</sup> indicate the need to undertake research to validate protocols, with the objective of controlling the symptoms resulting from this type of lesion, in this way improving the care and reducing the stress experienced by the patients, the family members and the health professionals.

It is understood, therefore, that the patient with MFW constitutes a challenge for the health professionals, in particular the nursing team, in relation to the control of the physical and psychological signs and symptoms resulting from these lesions. In addition to this, the quality of this care can become the most significant factor in the determination of these patients' quality of life<sup>8</sup>, as it may be observed that the symptoms resulting from the lesion are the most important cause of reduction in the levels of their quality of life<sup>9</sup>.

The development of an MFW entails a major impact, both physically and emotionally, on these women, and one can observe the scarcity of data in the scientific literature on incidence and appropriate management. One can also observe that the assistance with this occurrence is little valued among women with breast cancer, in addition to which, the institution

where the present study was undertaken does not have a protocol for care and for management adapted for these patients. Therefore, the present study had two objectives: to characterize the socio-demographic profile of women with breast cancer with MFW who are monitored in the Mastology Outpatient Center of the Teaching Hospital of the Ribeirão Preto Faculty of Medicine of the University of São Paulo (HCFMRP-USP), and to identify the dressings most used in the treatment of these wounds.

## METHOD

This study has a quantitative approach, is cross-sectional and retrospective. It used secondary data extracted from the hospital records of women with breast cancer, attended in the Mastology Outpatient Center of the Teaching Hospital of the Ribeirão Preto Faculty of Medicine, of the University of São Paulo, in the period January 2000 - December 2011.

In 1999, a dressings room was installed in this outpatients center, under the responsibility of a nurse, although it was only from 2000 that activities took place. For that reason, it was decided to start data collection from that year. This professional undertakes the evaluation and monitoring of all the women assisted in the service who need dressings for skin lesions, due to dehiscence of surgical procedures or MFW.

There is no exact information on the quantity of women with MFW attended in the above-mentioned outpatients center. Following the obtaining of a list in the Medical Data sector of the above-mentioned hospital, a previous selection was made of 3000 hospital records of men and women assisted in the dressings room. A selection was made of 200 hospital records of patients with breast cancer who had visited the locale various times. These were later read and 62 hospital records were identified which met the inclusion criteria, thus constituting the study's final sample.

The inclusion criteria were: hospital records of women with breast cancer, irrespective of the phase of the disease, with the presence of MFW, who were assisted in the dressings room of the Mastology Outpatients Center of a University Hospital, in the period 2000-2011.

An instrument was elaborated for extracting the data with the following variables: socio-demographic, staging of the disease at the time of diagnosis, hormone receptors, treatments used for the cancer; time since the appearance of the lesion, place of the lesion, characteristics (bleeding, pain, necrosis, exudate, itching, signs of infection, odor, desquamation), products used in dressing the wound, in the service and at home, and the time between the lesion's appearance and the patient's death.

The data was organized in a Microsoft Excel spreadsheet, after which the descriptive analysis of the study's variables was undertaken.

The study was approved by the Research Ethics Committee of the Ribeirão Preto School of Nursing, under number 8602/2011. It was requested to dispense with the Terms of Free and Informed Consent.

## RESULTS

The age of the 62 patients who made up the sample varied from 33 to 96 years old, and the mean age was 55.4 years old, with a standard deviation of 15.7 years. The majority (80.6%) were white, 93.5% had invasive ductal carcinoma, and the predominant clinical staging was IIIb (30.6%). Of the total of the women, 77.4% died, with 27% of these deaths occurring in periods of less than one year after the appearance of the MFW. In 11.3% of the cases, there was loss to follow-up in the service (Table 1).

Regarding the hormone receptors, 45.2%, 30.6% and 40.3% of the women had the Estrogen receptor, the Progesterone receptor, and HER-2-neu positive, respectively (Table 1).

Regarding the point when the wound developed, 45% of the women already had the MFW during the consultation when the diagnosis of breast cancer was confirmed. For 50% of the women, the wounds were located in the right breast, and in 91.9%, the wound was restricted to the area of the breast (Table 2).

In relation to the treatments, 90.3% of the women received chemotherapy, this being the most frequent treatment when compared with the others. Considering the treatment prior to the appearance of the lesion, chemotherapy and surgery are the most-used treatments (Table 3).

Considering the symptoms related to MFW, the most frequent was pain, followed by bleeding, necrosis and exudate. Reports were observed of women with two or more symptoms, as well as hospital records with reports of the same (Table 4).

Regarding the treatment of the wounds, that is, the dressings used in applying dressings, the most frequent was silver sulfadiazine (22.5%) followed by essential fatty acid (16.1%), (Table 5). It stands out that only 9.7% of the records indicate that patients and/or family members/caregivers received guidance on how to apply dressings at home.

Also noticed was an information gap in relation to the treatment of the lesions, as a significant number of hospital records (62.9%) did not give a description of the application of the dressing, the evaluation and progression of the wound, and the product used.

## DISCUSSION

Considering the age of the patients who had MFW, the authors found conflicting studies in the literature, with mean ages varying from 79.3 years old<sup>4</sup> to 52.1 years old<sup>9</sup>. In general, however, these wounds affect patients of advanced age, that is, over 70 years old<sup>3</sup>. It is emphasized that this difference in the age range may result from the type of tumor which gave rise to the wound, as well as the differences between countries regarding tracking, the diagnostic methods adopted, and the population's level of education.

Regarding life expectancy, this varied from six months to one year<sup>5</sup>. In a study undertaken with patients with MFW in the case of cancer of the head and neck or breast, the patients lived with the

**Table 1.** Distribution of the women with MFW by age, color, hormone receptor, type of tumor and staging. Ribeirão Preto, 2012. (n = 62)

Age	Number	%
30-40	14	22.6
41-50	12	19.4
51-60	13	21.0
61-70	13	21.0
Over 71	10	16.1
Color	Number	%
White	50	80.6
Black	6	9.7
Mixed race	5	8.1
Asian	1	1.6
Estrogen Receptor	Number	%
Positive	28	45.2
Negative	23	37.1
Not reported	11	17.7
Progesterone Receptor	Number	%
Positive	19	30.6
Negative	32	51.6
Not reported	11	17.7
HER-2/neu*	Number	%
Positive	25	40.3
Negative	24	38.7
Not reported	13	21.0
Medical Diagnosis	Number	%
Invasive Ductal Carcinoma	58	93.5
Others	4	6.4
Staging at diagnosis	Number	%
III a	9	14.5
IIIb	19	30.6
IV	18	29.0
Others	14	22.6
Not reported	2	3.2
Death**	Number	%
Yes	48	77.4
No	7	11.3
Lost to follow-up	7	11.3

\* HER-2/neu: Oncogene which determines the production of the HER-2 protein (Receptor 2 of the growth factor of the Human Epidermis); \*\* Data collection finalized in September 2012.

**Table 2.** Distribution of the women by place of the wound, treatment used and when the MFW appeared. Ribeirão Preto, 2012. (n = 62)

Place of the wound	Number	%
Right breast	31	50
Left breast	26	42
Multiple lesions	5	8
Treatment used	Number	%
Chemotherapy	56	90.3
Radiotherapy	42	67.7
Surgery	42	67.7
Hormone therapy	23	37.1
Time of the appearance of the wound	Number	%
Diagnosis	28	45
Recurrence/Metastasis	14	22.5

**Table 3.** Distribution of the women by treatment used when diagnosed and in the recurrence. Ribeirão Preto, 2012. (n = 62)

Treatment used*	Total N%	When diagnosed N%	In the recurrence N%
Chemotherapy	55 88%	50%	38.7%
Radiotherapy	42 67.7%	46.8%	19.3%
Surgery	42 35.5%	25.8%	38.7%
Hormone therapy	24 38.7%	19.4%	12.9%

\* Each woman analyzed may have received more than one mode of treatment.

**Table 4.** Distribution of the women with MFW by the characteristics of the wound. Ribeirão Preto, 2012. (n = 62)

Characteristics*	Number	%
Bleeding	22	35.4
Pain	20	32.2
Necrosis	13	20.9
Exudate	10	16.1
Itching	7	11.3
Signs of infection	7	11.3
Odor	5	8.1
Desquamation	1	1.6

\* Each wound may present more than one characteristic.

presence of the lesion for a mean of 8.49 months<sup>9</sup>, data which corroborates with that observed in this study.

The location of the wound is an important aspect in relation to body image<sup>10</sup> and application of the dressing used in the treatment of the lesion<sup>2</sup>. Patients who have a visible lesion tend to isolate themselves and present psychological and social

**Table 5.** Distribution of the women with MFW by dressing used for treating the wound. Ribeirão Preto, 2012. (n = 62)

Products*	Number	%
Silver sulfadiazine	14	22.5
Essential fatty acid	10	16.1
Normal saline 0.9%	4	6.4
Vaseline	4	6.4
Hydrogel	2	3.2
Hydrocolloid dressing	2	3.2
Activated charcoal	2	3.2
Boric water	1	1.6
Cold cream	1	1.6
Hydrocolloid paste	1	1.6
Nebacetin®	1	1.6
Cetoconazol	1	1.6
Metronidazole	1	1.6
Not reported	39	62.9

\* The same woman may have used more than one product in the treatment of the wound.

problems<sup>9</sup>. In addition to this, those with lesions in intimate regions, such as the breast or genitals, may experience problems related to sexuality<sup>4</sup>. Thus, the professionals must take such aspects into account in order to propose an appropriate care plan which satisfies the patients' needs.

Some treatments, such as radiotherapy, chemotherapy and hormone therapy are used for reduction of the symptoms<sup>7</sup>, the first two of these being the first choice<sup>5,11</sup>. The first destroys tumor cells through radiation, leading to a reduction in the size of the lesion and the quantity of exudate and bleeding, as well as providing greater comfort to the patient. Chemotherapy, on the other hand, reduces the size of the tumor and the pain, but increases the risk of hemorrhage. Hormone therapy also helps to reduce the symptoms of the patient with tumors with positive hormone receptor, such as that of the breast<sup>5,11</sup>.

Considering the symptoms related to the MFW, the most frequent were pain, bleeding, necrosis and exudate - symptoms also observed as the most frequent in other studies, in addition to fetid odor and sleep disturbance<sup>4,9</sup>. Pain is a complex symptom resulting from tumoral growth, the pressure of the tumor on other structures of the body, the edema resulting from impaired lymphatic and capillary drainage, the presence of infection and the exposure of the nerve endings due to the changing of the dressings<sup>4</sup>, this last possibly being attributed to the professional's lack of skill or the unavailability of dressings which are appropriate for the treatment<sup>6</sup>. In relation to pain management, there is the use of systemic analgesia, indicated prior to starting the dressings change. Other local measures include: the use of topical lidocaine or the use of ice before or after treatment of the lesion<sup>2</sup>.

Pain must be evaluated, in relation to the place of the lesion and the changing of dressings, and must include aspects such as: place, nature, duration, frequency, intensity, impact on daily activities, factors which alleviate or worsen the pain, current analgesia and the effects of the treatment. One must consider the use of validated tools such as the visual analog scale during the changing of dressings, which is when the patients generally feel pain, it being possible to use this information to evaluate the type of dressing adopted<sup>8</sup>. It was noted that in spite of the pain having been the symptom identified most frequently in the hospital records of women with cancer who had MFW, there was no description regarding the use of evaluative tools or when the pain occurred and the treatment adopted with a view to controlling it. It is perceived that the recording of this data is fundamental, to the degree that it allows one to identify whether the cause is related to the changing of dressings or to the type of product used, and to evaluate the improvement in the pain as the treatment is used.

Bleeding, a characteristic which was also frequent in this study, is caused by the interruption of the hemostasis of the blood, lymph, and cellular and interstitial environment due to the infiltration of tumor cells. Another aspect refers to the fact that the viable tissue in an MFW may be very friable and bleed easily with the slightest handling. In addition to this, the patients may have coagulation disorders related to the disease or to the treatment<sup>2</sup>. For the control of spontaneous bleeding, one can use oral antifibrinolytics as well as measures such as: care in the application and removal of the dressing by using gentle cleaning techniques<sup>8</sup> and the use of normal saline, aiming for a reduction in the probability of trauma, principally when the dressings are adhering to the wound bed<sup>2</sup>. Other measures include the application of direct pressure for 10 to 15 minutes, the local use of ice, and gauze saturated with topical vasoconstrictors such as adrenaline. If these actions are not efficacious, local hemostatic agents such as collagen gelatin and other alginate dressings may be applied beneath a compression dressing<sup>5</sup>. One must be attent to the fact that these products can adhere to the wound bed, causing further bleeding<sup>10</sup>. It is emphasized that these dressings were not identified in this study.

Excess exudate is another fundamental problem of these MFW, particularly in lesions which are large or advanced. This results from abnormal capillary permeability caused by the disorganization of the tumoral vasculature, and from the secretion of vascular permeability factor by the tumor cells, as well as from the autolysis of the necrotic tissue by bacterial proteases<sup>7</sup>. This sign causes the patient discomfort, skin irritation around the lesion, and increases the risk of infection. The use of modern dressings, such as alginate and hydrofiber foams, is recommended for lesions which present a large quantity of exudate, due to these products' function of absorption<sup>7,10</sup>. For wounds with low exudate, the use of hydrogels and hydrocolloids is indicated, as these contain it, maintain a humid environment, and are responsible for autolytic debridement<sup>7</sup>. This sign can also be reduced through the use of topical steroids which reduce the inflammation<sup>2,7</sup>. The prolonged contact of the exudate with the

skin around the lesion can macerate the edges and provoke loss of skin integrity, leading to the enlargement of the wound. The use of a protective barrier, such as Cavilon<sup>®</sup> for example, must be made for the protection of the skin in the perilesional region<sup>7</sup>.

In the present study, hydrocolloid and hydrogel dressings and paste were little used. However, considering the data, it was not possible to identify whether the use of these dressings was in accordance with the characteristics of the MFW.

The presence of necrotic tissue and a large quantity of exudate, characteristics of this type of lesion also identified in this study, provide an ideal environment for the growth of anaerobic microorganisms, contributing to the presence of fetid odor<sup>2</sup>. The fetid odor is caused by the rupture of proteins of the necrotic tissue by anaerobic bacteria of the species *bacteroides spp* and *clostridium spp*. This results in the production of chemical products such as putrescine, cadaverine and short-chain volatile fatty acids. Aerobic bacteria are also present in these lesions. Strong, disagreeable odors can lead to involuntary gagging, provoking the vomit reflex and reduction in appetite and taste, which interferes with nutritional status. Furthermore, it directly affects the patients' quality of life, leading to psychological stress and social isolation<sup>3,7</sup>.

Exudate and fetid odor are the symptoms which most frequently cause suffering to the patient<sup>7</sup>. In a study whose objective was to explore the meaning of living with a malignant wound in the breast, the authors corroborated this assertion in that they identified that these two signs, associated with pain, had a significant impact on the participants' quality of life. It was also observed that the management of this type of lesion was a difficult and complex task for the patients, the control of the exudate, odor and bleeding being indicated as the greatest difficulty<sup>4</sup>. For these reasons, the control of the odor is fundamental<sup>10</sup>, in spite of its having been described in only 8.1% of the hospital records of the women attended in the dressings room. The management of this sign includes actions such as the use of systemic (metronidazole, topical metronidazole and/or antimicrobial agents, as well as the use of activated charcoal dressings<sup>4</sup>.

Oral metronidazole can be administered, but it must be used cautiously as it can cause antibiotic resistance. Another argument for its non-use refers to the lack of provision of blood for the necrotic tissue as, as a consequence, the therapeutic levels of the drug do not arrive at the place of the lesion. Topical metronidazole 0.8%, on the other hand, applied directly to the wound once or twice a day, is an effective practice in the substantial elimination or reduction of the fetid odor, being efficient within two or three days<sup>7</sup>, as well as being a dressing which is easy to use, low-cost and easily available. The activated charcoal dressing filters the fetid chemicals, impeding their liberation into the air. This dressing has been scientifically proven to be efficacious, is easy to use and is available in many countries, as well as being well-accepted by the patients - although it has the disadvantage of being expensive<sup>3</sup>. Another factor which is important in the management of the odor is the removal of exudate

and detritus, loose on the surface of the lesion, through the use of warmed normal saline 0.9%<sup>2,7</sup>. This practice was identified in few of the hospital records, however, it was not possible to define whether the normal saline was used as a dressing or in the process of cleaning the wound, and whether it was warmed.

The authors observe that among the products recommended in the literature<sup>2,3,7</sup>, little use was made of metronidazole and activated charcoal. However, the use of silver sulfadiazine stood out as the dressing of preference in the present study, although in the literature there is no data proving its efficacy with these lesions<sup>7</sup>. It is noted that the appropriate use of a product for undertaking wound dressing with a view to reducing the signs and symptoms related to MFW has been suggested as a key factor in the control of the same<sup>9</sup>.

It stands out that the management of MFW in the home, and the woman's attempts to keep the symptoms controlled, requires work and time. This means that the wound comes to take a central place in the life of these patients, who have to adjust their daily activities due to the time spent for undertaking the dressings<sup>4</sup>. Another important factor refers to the guidance directed at the patients and family members/caregivers regarding undertaking the wound dressing at home - which, according to the records in the hospital records, was very scarce. This data is corroborated by the results of another study which demonstrated a lack of information and appropriate support from the health professionals for women with this condition<sup>4</sup>.

It is perceived, therefore, that the management of these lesions is complex and requires multidisciplinary care. A good evaluation of the patient is essential so as to understand the wound's psychological impact in relation to the patient and her family<sup>10</sup>, measure the results of the interventions, and take decisions<sup>7</sup>. The care must be flexible and focus on the patient's priorities as well as on the management and control of the signs and symptoms<sup>2</sup>. The evidence points to the need for evaluation and progression of the treatment's results<sup>3</sup>. The evaluation of the wounds must be undertaken regarding location, size, presence of signs and/or symptoms and the extent of the caregiver's/family member's understanding, as this evaluation can guide the elaboration of the best nursing practice regarding dressing of the wound<sup>10</sup>.

The nurse must always take the objectives of the treatment of wounds into account for her care plan for the patient: comfort; quality of life; the controllability of symptoms, and the promotion of trust and a feeling of well-being<sup>12</sup>. Furthermore, the nurse must always consider that the treatment of the person with the wound is dynamic, and must keep abreast of scientific and technological advances<sup>13</sup>. As evidenced in other studies, both Brazilian and international<sup>3,5,11</sup>, it was possible to observe in this study that the care for MFW remains little known by health professionals. In addition to this, the treatment of these lesions is complex and the recommendations are generic and include different conducts, which hinders the elaboration of protocols.

The nurses are responsible for the provision of the care and support for patients diagnosed with MFW. They must, therefore,

be conscious of the physical and psychological impact which these wounds have on patients with cancer, and offer appropriate treatment through the use of dressings which are appropriate for the management of their symptoms<sup>9</sup>. The care given by nurses to patients with MFW is not a cure, as often this is not possible. However, the nursing interventions can favor comfort and pain relief, as well as reduce the disease's impact and improve this clientele's quality of life<sup>14</sup>.

## CONCLUSIONS

The products which are most frequently used for treatment, according to the records in the hospital records of the women with breast cancer who present MFW, were silver sulfadiazine and EFA products which are not recommended by the scientific literature. Another relevant aspect refers to the most commonly observed signs and symptoms related to MFW, such as bleeding, pain, necrosis and exudate. Although the odor is a characteristic directly related to exudate and has a high occurrence with this type of lesion, it is observed with low frequency, when compared with the other characteristics of the wounds.

Also noted was a gap in the recording of data in the hospital records regarding the evaluation of the lesion and of the pain with the use of scales and treatments adopted for its relief, the quantity of exudate, a scale for evaluation of the odor, the care and products adopted during the dressing of the wound and the area of necrosis, making it impossible to undertake an evaluation in relation to the progression of the lesion and the efficacy of the treatment adopted, as well as to report whether the products were in accordance with the lesion's characteristics.

It is noted therefore that - in spite of there being a nurse responsible for undertaking the dressings - there is a need for standardization of the products used and for the elaboration of protocols, as well as for the use of those whose efficacy has been scientifically proven. The re-evaluation of the treatment adopted, and the recording of the progression of the lesion, are also essential aspects for an appropriate care plan.

One cannot fail to mention that the objective in the management of a cutaneous wound is to promote the patient's quality of life with the relief of signs and symptoms and improvement in appearance, as well as the psycho-social reactions such as fear, anxiety, depression and low self-esteem, among others. It is essential to control the exudate, reduce the odor, and to increase the patient's comfort and confidence. For this, the appropriate evaluation of the wound, the correct indication of the product and the continuous follow-up and evaluation of the characteristics of the wound and of the response to the products used are fundamental for the appropriate management of these wounds.

It is emphasized that the data presented here must be analyzed with caution, the generalization of the results not being possible as the sample was made up of only 62 women. The importance is emphasized of undertaking further studies on this issue so as to contribute new knowledge to the nursing care of neoplastic wounds in women with advanced breast cancer.

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