COMPLEMENTARY THERAPIES

- homeopathy: many remedies available, initially try equisetum tincture qid, consult practitioner for more symptom specific remedy if needed

GYNECOLOGICAL PROBLEMS

Dyspareunia = pain on vaginal penetration

PRESENTATION

May include:

- bleeding
- dyspareunia
- ulcers
- discharge
- pruritis

CAUSES

Refer to: *Practice Guidelines for Obstetrical and Gynecological Care of Women Living with HIV*.

APPROACHES AND INTERVENTIONS

Examination, investigation and treatment of underlying causes should be appropriate to the presentation, stage and context of the person and illness.

- maintain good genito-urinary hygiene
- provide stepwise analgesia (see Pain)

COMPLEMENTARY THERAPIES

- homeopathy: many highly effective remedies, consult practitioner

SKIN PROBLEMS

SKIN PAIN

PRESENTATION

May become worse with movement or on contact with clothing, sheets.

Infectious:

- abscesses
- cellulitis
- herpes simplex or zoster

Malignant:

- Kaposi's sarcoma (malignant ulcers)

Other:

- decubitus ulcers
- medication:
  - chemotherapy
- neuropathy:
  - HIV related
  - post-herpetic

APPROACHES AND INTERVENTIONS

Examination, investigation and treatment of underlying causes should be appropriate to the presentation, stage and context of the person and illness.

See below

PROBLEMS	INTERVENTIONS
pain	• provide stepwise analgesia (see Pain and Neuropathic Pain) • to reduce contact, irritation: – light, non-irritating clothing or bed coverings – over-bed cradle to keep sheets off hyper-sensitive skin – ensure even weight distribution on bed (see Skin Care/problems particularly support)

COMPLEMENTARY THERAPIES

- massage therapy

SKIN CARE[19,20]

GENERAL PRINCIPLES OF SKIN CARE

Skin care requires considerable attention, particularly as a person spends more time in one position on the bed, including:

APPROACHES	INTERVENTIONS
bathing	• bathe with non-abrasive soap and tepid water • air or towel dry • bathing stimulates circulation, reduces odours and the risk of infection • maintain body fluid precautions while bathing
bleeding	• manage small bleeding sites with silver nitrate sticks • more extensive bleeding may require the application of: – topical thrombin 1,000-5,000 units sprayed on the area of bleeding (Thrombostat®) – Kaltostat™ dressing (layer of Jelonet™ on top of Kaltostat™ will reduce sticking, and risk of bleeding) – absorbent pressure dressings • if there are risks of large bleeds, warn family and caregivers of potential risks and develop a clear management plan which may include: – the removal of family from the room – the use of red or dark coloured towels – analgesic and/or sedative medication – (see Bleeding)
dry skin	• maintain adequate hydration (see Dehydration) • use hydrating creams, ointments, oils, i.e. Uremol™ HC • humidify room

infections	• fungal infections: – topical or systemic anti-fungals as indicated • staphylococcal or streptococcal infections, i.e. cellulitis: – staphylococcal-cloxacillin 250-500 mg po, iv q6h for 10 days – streptococcal-clindamycin 450 mg po q6h or – amoxicillin 250-500 mg po q8h – topical antibiotics with or without occlusion • anaerobic infections, i.e. malignant ulcers: – metronidazole 10% cream bid-tid or – silver sulfadiazine (Flamazine®) cream bid-tid – if extensive: • systemic metronidazole 250-500 mg po, iv tid or • metronidazole vaginal ovules diluted with 50 mls N/S or iv solution mixed with N/S and sprayed onto lesions will prevent buildup associated with creams
massage	• can enhance capillary blood flow, reduce the risk of local ischemia of skin, and relax muscles and stiff joints • may shift peripheral edema • should be avoided on erythematous or open leaking areas
movement, turning	• intermittent moving and turning reduces the risk of skin breakdown and reduces position fatigue/discomfort • combine with massage prior to turning • a draw sheet may assist turning and will reduce shearing forces • pillows behind the back and between legs/ankles will provide support and prevent skin-to-skin contact pressure ulcers • if turning is painful, it may need to be stopped. An air mattress or air bed may be the only way to prevent skin breakdown
odour control	• air fresheners, filters • place charcoal dressing on top of non-stick dressings • apply yogurt and honey directly to the lesion • place Cepacol® soaked gauze on top of other dressings (do not get Cepacol® onto wound site) • place kitty litter or activated charcoal in the room (under the bed) • vinegar or vanilla also reduce odour in room
protection	• cover reddened pressure points clear plastic dressings to reduce shearing, tearing and pain • cover pressure ulcers with hydrocolloid dressing to provide cushioning as well as reduce shearing, tearing and pain (see Skin Breakdown/ Pressure ulcers)
pruritis	• consider medication, environmental or food allergies • bathe with/without oatmeal or oils • maintain adequate hydration (see Dehydration) • apply astringents such as calamine (if indicated) • apply protective creams, oils • consider topical steroids (except when herpetic lesions are present) • consider oral antihistamines, especially hydroxyzine, cyproheptadine • apply camphor, menthol, praxnoxine (Sarna-P®) prn • for severe, refractory pruritis, consider oral steroids: – prednisone 10-60 mg po od • if jaundice present, consider ammonium ion exchange resins, i.e. cholestyramine

support	• for intact skin, use a thick (>4 inch) egg-crate, air or bubble mattress • for extensive edema, skin breakdown or pain on turning, an air mattress or air bed may be more effective • under all circumstances, try to avoid contact with plastic or abrasive materials
sweating, night sweats	• reduce body and skin temperature (see fever) • bathe as above, dry thoroughly • remove plastic and use absorbant bed coverings, i.e. terry cloth, flannelette • re-evaluate medications: – alcohol, morphine, tricyclic anti-depressants • maintain hydration (see Dehydration) • indomethacin 25-75mg po, pr q8-12h for night sweats • if extreme, try hyoscyamine (Levsin®) 0.125-0.25 mg po, sl q4h routinely or prn • NSAID's may be useful if due to morphine • if limited to palms, soles and/or axillae, use 20% aluminum chloride hexahydrate (deodorant) • manage associated anxiety (see Anxiety)
temperature	• keep warm, but not too hot: – coverings (warm, but light weight) – appropriate room temperature • manage fever (see Fever)
wet, leaking skin, exudates	• clean regularly to remove exudates and debris • Burrow's compresses 1/20 bid-tid • cover with non-stick dressings, including non-stick meshes, i.e. Jelonet™ with dry gauze wrapping

LAST HOURS OF LIVING	INTERVENTIONS
skin care	As the dying person loses his/her ability to move, skin care may become increasingly problematic if the process becomes prolonged. In addition to general skin care: • turning may need to be reduced or discontinued, particularly if it is painful • bathing should be continued right up until death

COMPLEMENTARY THERAPIES

- homeopathy: for periodic sweats: sulphur 30 ch bid-tid, if ongoing, may need to drop to 6 ch, prn
- aromatherapy: geranium and lavender oils are soothing
- infrared-helium neon laser therapy may improve decubitus ulcers
- massage: sweet almond oil nourishes dry skin

SKIN BREAKDOWN/PRESSURE ULCERS[19,20]

Ulcer **=** a loss of substance on a cutaneous or mucous surface, causing gradual disintegration and necrosis of the tissues.

Pressure/decubitus ulcer **=** an ulceration caused by prolonged pressure on an area of skin in a person confined to bed for a prolonged period of time.

Skin breakdown/ulceration is the result of ischemia in the affected area and occurs in persons who are:

- poorly nourished/cachectic
- immobile and lie in the same position constantly
- dehydrated/have dry skin
- edematous/have wet skin
- dependant on others for personal hygiene

PRESENTATIONS

Stage 1	nonblanchable erythema of intact skin (the heralding lesion of skin ulceration, not to be confused with reactive hyperemia)
Stage 2	partial thickness skin loss involving epidermis and/or dermis
Stage 3	full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
Stage 4	full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

Note:

- identification of stage 1 pressure ulcers may be difficult in those whose skin is darkly pigmented
- when eschar is present, accurate staging is not possible until the eschar has sloughed or the wound has been debrided

CAUSES

Malignant:

- malignant ulcers

Other:

- reactive hyperemia

APPROACHES AND INTERVENTIONS

Examination, investigation and treatment of underlying causes should be appropriate to the presentation, stage and context of the person and illness.

- assess risk of skin breakdown using Norton[21] or Braden[22] assessment scales
- consider consulting a wound care specialist, i.e., enterostomal therapist, dermatologist or plastic surgeon
- remove necrotic tissue by cross-hatching with a scalpel, then apply a debriding agent, i.e. elase, elase with chloromycetin, hypertonic gel, (i.e. Hypergel®, Intrasite Gel®)
- treat clinical infection
- obliterate dead spaces with packing or gel
- remove exudates
- keep wound clean, moist (enhances growth of new tissue):
  - clean with normal saline or diluted hygeol in head and neck area
  - avoid iodine containing solutions when there is any skin breakdown/ulceration as this inhibits re-epithelialization
- insulate, protect wound surface
- maintain adequate circulation
- laser therapy may be useful

PROBLEMS	INTERVENTIONS
stage 1 pressure ulcer	• clean with normal saline • apply a transparent adhesive dressing, i.e. Tegaderm®, OpSite®, to protect against shearing forces • **do not massage**
stage 2 pressure ulcer	• apply a protective hydrocolloid dressing, i.e. Comfeel Ulcus®, Duoderm®
stage 3 and 4 pressure ulcer	• use saline gel, i.e. Normagel® and absorptive dressing, i.e. gauze, or Mesalt® to absorb thick exudates • non-stick dressings may be applied first, e.g. Telfa®, Jelonet® with petroleum jelly, Mepital® to reduce tearing with dressing changes

COMPLEMENTARY THERAPIES

- laser therapy: infrared-helium neon laser therapy may improve pressure ulcers

AIDS SPECIFIC SKIN PROBLEMS

Standard therapies for these problems follow. For hard to manage situations, consider consulting a dermatologist.

PROBLEMS	INTERVENTIONS
bacillary angiomatosis	• Refer to *Module 1* • also itraconazole 100-200 mg po od
folliculitis	• topical skin cleansers, i.e. povidone-iodine, erythromycin in alcohol, triclosan (Tersaseptic®), hexachlorophene (Phisohex®) • topical anti-fungals i.e., itraconazole 100-200 mg po od • systemic antibiotics and anti-fungals
herpes simplex, herpes zoster	• for primary management refer to *Module 1* • continue prophylactic treatment as long as possible in order to avoid symptomatic recurrences • for associated pain, see Neuropathic Pain
impetigo	• warm soaks • topical and systemic antibiotics
malignant ulcers (KS, skin carcinomas and melanomas)	• for the primary management of Kaposi's sarcoma, refer to *Module 1* • malignant ulcers may require more extensive cleansing with: – Burrow's compresses – 10% Proviodine® – N/S – 3% boric acid solution • manage exudates, superimposed infections and odours as in general principles of skin care (see Skin breakdown/Pressure uclers)
psoriasis	• apply topical corticosteroids in combination with anti-fungal, i.e. ketoconazole, terbinafine • if very scaly, add salicylic acid • calcipotriol (Dovonex®) ointment, apply bid • consider oral vitamin A therapy
scabies	• clean laundry • topical lindane 1% lotions
seborrheic dermatitis	• terbinarfine 125 mg po bid or 250 mq po od • apply hydrocortisone 1% and anti-fungal cream combinations, i.e. ketoconazole, terbinafine, clotrimazole • use ointment forms if very dry
warts, molluscum contagiosum	• cryofreeze with liquid nitrogen • apply topical cantharidin (Cantharone®) once q1-2 weeks • for diffuse areas, apply 5% fluouracil cream q3-7 days (use with caution, very irritating)