Home Care

Teaching the client and family experiencing the diagnosis and treatment of malignant melanoma involves self-care and ongoing self-monitoring. Education for the client and family is specific to the type of treatment. In addition to wound care, clients who have had a lymph node dissection need instructions in how to protect the extremity from bleeding, trauma, and infection. In addition, address the following topics.

Nursing Care Plan

A Client with Malignant Melanoma

Geoff Sanders, age 69, is retired from the postal service. He has always been an avid participant in outdoor sports. When he was younger he played baseball and tennis, and for the last 10 years he has played golf at least twice a week. He now lives in Connecticut, but as a younger man he lived in Florida for almost 15 years. Mr. Sanders has a variety of warts and moles and rarely pays attention to them. However, after taking a shower one day he noticed that a mole on his left lower leg looked bigger and darker. Mr. Sanders had just seen a public announcement on television about the dangers of changes in moles, and he immediately called his primary HMO physician for an appointment at the dermatology clinic.

ASSESSMENT

On arriving at the clinic, Mr. Sanders is interviewed and examined by Tom Hall, a clinical nurse specialist. Following the assessment, Tom documents the following information.

Mr. Sanders has a family history of skin cancer; his father had several squamous cell cancers removed from his face. He has numerous nevi on his body; the one causing concern is located on the medial anterior left leg, 2 inches below the patella. Mr. Sanders states that the mole has been present for years but that he noticed just yesterday that it has become larger and darker. On further questioning, he states that the mole itches sometimes but has never hurt or bled. Mr. Sanders lived in Florida for 15 years and now experiences a sunburn early each summer before he tans. The sunburn involves the lower legs because Mr. Sanders wears shorts during his twice-weekly golf game.

A complete skin assessment reveals various freckles, warts, and nevi. With the exception of the nevus that prompted Mr. Sanders to come to the clinic, all lesions appear normal. The nevus in question is raised, 3 cm in diameter, with irregular borders and a nodular surface. It is variegated in color, with various shades of brown. The skin surrounding the nevus is slightly erythematous. Inguinal lymph nodes are not enlarged or painful. Tom Hall takes a photograph of the lesion with Mr. Sanders’s permission.

Following the assessment, Mr. Sanders discusses the lesion with a surgeon, who recommends excision. They discuss the possibility of skin cancer and the importance of early detection and treatment. Mr. Sanders is scheduled for a biopsy of the nevus under a local anesthetic the following morning. Following the biopsy, histologic examination reveals lentigo maligna melanoma. Staging of the tumor reveals that it is a melanoma in situ, with no metastasis to regional lymph nodes. Mr. Sanders undergoes a wide excision of the lesion the following afternoon.

DIAGNOSIS

- Impaired skin integrity related to excision of melanoma from the left lower leg
- Risk for infection related to surgical wound on left lower leg
- Acute pain related to wide excision of melanoma on left lower leg
- Anxiety related to diagnosis of skin cancer

EXPECTED OUTCOMES

- Demonstrate complete healing of the incision without manifestations of infection.
- Verbalize relief of pain by the time the incision is healed.
- Verbalize fears and concerns about his diagnosis.

PLANNING AND IMPLEMENTATION

- Make the first dressing change, but ensure that Mr. Sanders can safely change the dressing himself prior to discharge the day after surgery.
- On discharge, provide adequate dressings and tape for the first home dressing change; include in discharge instructions necessary information about where to buy supplies and how many dressing supplies will be needed.
- Review and provide written instructions for prescribed systemic antibiotic and pain medication.
- Provide written instructions for dressing change, manifestations of infection, and phone number of clinic; stress importance of calling if any abnormal symptoms occur.
- Teach how to protect the incision from bumps and to protect the site from irritants.
- Discuss diagnosis, positive outlook for treatment of melanoma in situ, and the client’s concerns.
- Stress importance of lifelong regular health care evaluations to identify any recurrence or metastasis.

EVALUATION

Mr. Sanders returned to the dermatology clinic 1 week after his surgical incision. His incision is well approximated and shows no signs of infection. He is taking his antibiotic 4 times a day as prescribed and reports that his need for pain medications is decreasing. During his clinic visit the following week, Tom Hall removes the sutures and assesses the wound as healed. Mr. Sanders completed his antibiotics and no longer requires pain medications. He says he is still “scared to death” about having cancer, but he has decided to join a local cancer support group. He also says he had gotten a list of skin safety rules from the American Cancer
SKIN TRAUMA

Trauma to the skin can be unintentional or intentional (as in the case of surgery). Chemicals, radiation, pressure, or thermal changes cause skin trauma. This section discusses pressure ulcers and frostbite, as well as intentional trauma from cutaneous and plastic surgery or treatment. Thermal injury, or burns, is discussed in Chapter 15.

THE CLIENT WITH A PRESSURE ULCER

Pressure ulcers are ischemic lesions of the skin and underlying tissue caused by external pressure that impairs the flow of blood and lymph (Porth, 2002). The ischemia causes tissue necrosis and eventual ulceration. These ulcers, also called bed sores or decubitus ulcers, tend to develop over a bony prominence (such as the heels, greater trochanter, sacrum, and ischiae), but they may appear on the skin of any part of the body subjected to external pressure, friction, or shearing forces.

INCIDENCE

The incidence of pressure ulcers in hospitals, long-term care facilities, and home settings is high enough to warrant concern for health care providers. The incidence in hospitals has been reported as ranging from 3.5% to 29%, whereas the incidence in long-term care facilities is reported to be around 23%. Little research has been done to determine the extent of the problem in the home setting. However, with increasing numbers of clients (and especially older adult clients) being cared for in the home, it is probable that the incidence is great enough to warrant plans of care to prevent their occurrence.

PATHOPHYSIOLOGY

Pressure ulcers develop from external pressure that compresses blood vessels or from friction and shearing forces that tear and injure vessels. Both types of pressure cause traumatic injury and initiate the process of pressure ulcer development.

External pressure that is greater than capillary pressure and arteriolar pressure interrupts blood flow in capillary beds. When pressure is applied to skin over a bony prominence for 2 hours, tissue ischemia and hypoxia from external pressure cause irreversible tissue damage. For example, when the body is in the supine position, the body’s weight applies pressure to the sacrum. The same amount of pressure causes more damage when it is applied to a small area than when it is distributed over a large surface.

Shearing forces result when one tissue layer slides over another. The stretching and bending of blood vessels cause injury and thrombosis. Clients in hospital beds are subject to shearing forces when the head of the bed is elevated and the torso slides down toward the foot of the bed. Pulling the client up in bed also subjects the client to shearing forces. (For this reason, always lift clients up in bed). In both cases, friction and moisture cause the skin and superficial fascia to remain fixed to the bed sheet, while the deep fascia and bony skeleton slides in the direction of body movement.

When a person lies or sits in one position for an extended length of time without moving, pressure on the tissue between a bony prominence and the external surface of the body distorts capillaries and interferes with normal blood flow. If the pressure is relieved, blood flow to the area increases, and a brief period of reactive hyperemia occurs without permanent damage. However, if the pressure continues, platelets aggregate in the endothelial cells surrounding the capillaries and form microthrombi. These microthrombi impede blood flow, resulting in ischemia and hypoxia of tissues. Eventually, the cells and tissues of the immediate area of pressure and of the surrounding area die and become necrotic.

Alterations in the involved tissue depend on the depth of the injury. Injury to superficial layers of skin results in blister formation, whereas injury to deeper structures causes the pressure ulcer area to appear dark reddish-blue. As the tissues die, the ulcer becomes an open wound that may be deep enough to expose the bone. The necrotic tissue elicits an inflammatory response and is subject to infection.

Critical Thinking in the Nursing Process

1. Consider reasons why people who notice a change in a skin lesion put off seeking health care. What can nurses do to effect change?
2. Design a teaching plan for young adults for preventing skin cancers.
3. What would you say to Mr. Sanders if he called the clinic and said that the antibiotics were making him sick and he didn’t think he needed them anyway?
4. Design a nursing care plan for Mr. Sanders for the diagnosis of Powerlessness.

See Evaluating Your Response in Appendix C.

Nursing Care Plan

A Client with Malignant Melanoma (continued)

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