

Poly Ulceration Patient Terminal: Kennedy Terminal Ulcer (KTU)

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Opinion

The principles of palliative wound and pressure ulcer care should be integrated along the continuum of wound care to address the whole person care needs of older people who often present with chronic debilitating diseases, advanced diseases associated with major organ failure (renal, hepatic, pulmonary or cardiac), profound dementia, complex psychosocial issues, diminished self-care abilities, and challenging wound-related symptoms [1].

Poly ulcerations injured patients may be reversible; on the contrary, the sudden appearance of multiple PUs in elderly patients may be indicative of the closeness of death [1]. The skin, like other organs and systems, suffers a physiological deterioration in the last stage of life, therefore increases the risk of PUs with torpid [2]. In the literature are studies that suggest that this circumstance is more common in terminally ill patients with non-neoplastic pathologies in the oncological origin [1].

The Kennedy Terminal Ulcer (KTU) is an unavoidable skin breakdown or skin failure that occurs as part of the dying process [3]. Research is limited but the literature suggests that KTUs are typically pear-shaped, red/yellow/black, similar in appearance to an abrasion, and tend to occur suddenly in the sacral/coccygeal region not long before death [4].

The term "Kennedy Terminal Ulcer" (KTU) was coined in 1983 by Karen Lou Kennedy [3], the author worked in a team of skin care, and noted that some people suffering from a certain type of UPP they died within two weeks after her appearance. The first description of the KTU appears in the National Pressure Ulcer Advisory Panel (NPUAP) in 1989.

The KTU has five essential characteristics: a) it is located on the sacrococcygeal area; b) it appears as a discoloration of the skin in the shape of a butterfly or pear; c) it is purple, red, blue, or black; d) it has a sudden onset; sometimes referred to as the 3:30 syndrome; and e) it has irregular borders.

The possibility of development of KTU means facing the treatment of PUs in terminally ill patients, with a different view, because if we set aimed at the prevention and cure of these fixed targets, they will be doomed to failure [5].

The vast majority of PUs Occur because pressure, or shear often accompanied by friction, overwhelms the skin's ability to tolerate these forces. In contrast, a KTU occurs when the body's vascular system is no longer reliable to adequately perfuse the skin. While life can be

transiently by increasingly sophisticated prolonged medical technology, vascular insufficiency is an unavoidable consequence of the dying process resulting in multiple-system organ failure and unavoidable skin damage. The presence of a KTU must be differentiated from PUs in order to provide optimal care to the dying patient both the family and [6].

The objectives in the approach are slightly different from the treatment of PUs. A patient in a terminal state does not mean that we should abandon the objective of avoiding the emergence of PUs, or at least not aggravate existing; we will consider that comfort is the highest priority in patients agonal phase, getting it to replace importance to prevention and wound care, so the treatment of ulcers always be set prioritizing comfort [7,8], so in agony it will have to assess the desirability of postural changes in the patient.

Care is palliative and are as follows [9,10]. Try to comfort terminally ill patients through a Plan of Care from a holistic perspective. Achieving the involvement of caregivers, both primary and secondary, in the implementation of care. Relieve pain and the smell of wounds.

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