Impact of wound malodour on patients: how to assess and manage

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Impact of wound malodour on patients: how to assess and manage

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Wound malodour is a distressing symptom that significantly impacts the quality of life of patients and their caregivers, often leading to anxiety, stress, and social isolation. This review explores the multifaceted aspects of malodour management, highlighting its causes, assessment challenges, and potential interventions. A holistic, patient-centred approach is critical, ensuring regular reassessment of the wound and addressing concerns such as pain, poor sleep, anxiety, and depression. By incorporating evidence-based strategies and open communication, healthcare professionals can improve the overall wellbeing of patients and their caregivers.

KEYWORDS:
- Carbon superabsorbent dressing
- Patient quality of life
- Wound malodour
- Wound infection
- Management of malodour
- Malignant fungating wounds

Chronic wounds pose a significant burden on the NHS, clinicians, and patients, with their prevalence expected to rise in coming years due to an ageing population and the increasing complexity of comorbid conditions (Guest et al, 2020; Gethin, 2023a). These wounds are often in a cycle of unresolved inflammation and poor healing driven by factors such as ageing, comorbidities, medication, poor blood supply, unresolved infection and malignancy (Zhao et al, 2016; Edwards-Jones, 2018). The most reported symptoms that often accompany chronic wounds include pain, high exudate volume and malodour, which can profoundly impact on patient quality of life (Gethin, 2023a; Probst and Saini, 2024). Nurses who regularly manage wounds may have encountered situations in either a clinic room or a patient's home when the malodour coming from the wound is almost so overpowering that it lingers in the clinic room, or the smell lingers throughout the day. For those who have experienced this, it may be difficult not to show some reaction due to the odour, or to broach the subject with the patient for fear of causing embarrassment or distress. For patients, however, wound malodour can cause significant emotional distress and lead to embarrassment and diminished quality of life (Gethin et al, 2023a). This may result in reduced participation in activities and, in some cases, social isolation (Akhmetova et al, 2016; Gethin et al, 2023a). Furthermore, malodour from a wound may permeate clothing, bedsheets or even soft furnishings, compounding the patient's discomfort and anxiety (Black and Berke, 2020).

'The most reported symptoms that often accompany chronic wounds include pain, high exudate volume and malodour, which can profoundly impact on patient quality of life.'

Despite its significant impact, there is limited guidance in the literature on managing wound malodour — assessment frequently remains subjective and management is often suboptimal (Gethin et al, 2014; Gethin et al, 2023a). This article aims to enhance understanding of wound malodour, focusing on its causes, assessment methods, and available treatment options to better address this challenge in clinical practice.

WOUNDS COMMONLY ASSOCIATED WITH MALODOUR

Any wound has the potential to be malodorous, especially if infection is present (Gethin et al, 2014). However, the most common wounds associated with malodour are those linked to chronicity and high exudate volume, such as leg ulcers, diabetic foot ulcers, burns and malignant/fungating wounds (MFWs) (Gethin et al, 2023b).

CAUSES OF MALODOUR

Odour is most commonly associated with infection (International Wound Infection Institute [IWII], 2022). The chronic wound environment creates an ideal medium for bacterial growth, which contributes to sustained inflammation and perpetuates the chronicity of the wound (Zielinska et al, 2023). Most chronic and malignant wounds are polymicrobial and may contain a mixture of aerobic and anaerobic bacteria, which further increases the risk of hard-to-treat biofilm formation and contributes to the cycle of unresolved infection (Gethin

Susy Pramod, tissue viability matron, The Christie NHS Foundation Trust

et al, 2023b). It has been suggested that up to 80% of chronic wounds and 25% of malignant wounds have the presence of a biofilm (Malone et al, 2017; Edwards-Jones, 2018). Biofilm and wound infection increase the risk of unpleasant symptoms such as excessive exudate, pain, and malodour (Edwards-Jones, 2018). In the presence of infection or biofilm, odour arises during metabolic processes in which bacteria break down substrates like lipids, proteins, and carbohydrates through the action of various enzymes, producing volatile chemical compounds such as cadaverine, putrescine and sulfur containing compounds as a byproduct which are responsible for the odour (Fleck, 2006; Edwards-Jones, 2018). *Table 1* gives examples of common types of bacteria associated with wound odour.

Malodour is not always indicative of a problem within the wound and may naturally occur during the wound healing process (Fletcher, 2008). For instance, pungent odours such as cadaverine and putrescine are produced during the breakdown of amino acids in dead tissue, such as necrotic tissue, and are often described as rotting meat (Gethin et al 2014) and typically subside once the devitalised tissue is removed. Certain dressings, such as hydrocolloids, may also produce an unusual odour, which is not necessarily a cause for concern (Fletcher, 2008). Additionally, inadequate wound hygiene or poor personal hygiene may result in strong odours emanating from the wound or the surrounding skin. Even a generalised wound odour, which is not necessarily linked to a more serious issue, can be as distressing to patients as more pungent smelling wounds.

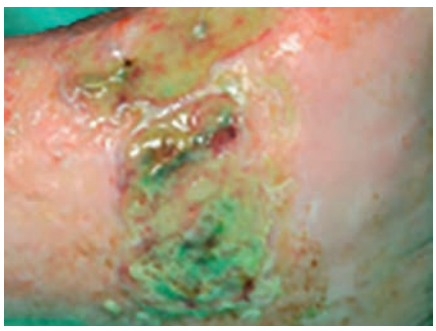

Figure 1.
Wound infected with Pseudomonas aeruginosa.

IMPACT OF MALODOUR ON A PATIENT

The impact that an individual and their carers experience when they have a malodorous wound should not be underestimated. Moreover, patients often resign themselves to living with wound odour, accepting it as an inevitable consequence of having a wound (Gethin et al, 2023a). Odorous compounds, such as putrescine and cadaverine, are known to facilitate gagging and vomiting in some individuals and persistent odour from other bacteria may cause nausea and lack of appetite — often experienced in patients with MFWs (Fleck, 2006). *Table 2* highlights some of the key challenges faced by patients experiencing malodour. This list is not exhaustive, as each individual may perceive and be affected by malodour in unique ways in their daily life.

Many patients and carers often become resilient and develop their own strategies to manage or mask the odour, such as frequent dressing changes, regular change of clothes and bed sheets, using fragrance sprays, candles and incense sticks (Fleck, 2006; Gethin et al, 2023a).

Table 1: Examples of odour producing bacteria (adapted from Edwards Jones, 2018; Akhmetova et al, 2016)

Aerobic bacteria
Proteus sp
Klebsiella sp
Pseudomonas aeruginosa (*Figure 1*)
Staphylococcus aureus
Methicillin resistant staphylococcus (MRSA)
Anaerobic bacteria
Bacteroides
Clostridium sp

ASSESSMENT OF MALODOUR

Comprehensive patient assessment is crucial for any wound to:

- Determine its aetiology
- Identify potential barriers to healing
- Understand the factors contributing to malodour
- Guide decision-making for appropriate treatment

(Marshall, 2022).

Assessment of malodour is an integral part of holistic assessment; however, it can be challenging and often subjective (Fletcher, 2008). These challenges can arise because

Table 2: Effect of malodour on an individual (adapted from Fleck, 2006; Salmala and Davis, 2015; Gethin et al, 2023a)

Psychological
Embarrassment/shame/depression
Negative body image/low self-esteem
Anxiety
Negative impact on sexual relationships
Physical
Taste and smell are closely associated and can result in reduced appetite or nausea
Sleep disturbances
Social
Isolation — social withdrawal and reduced interactions with loved ones
Financial implications — may affect ability to work
Impact on care
Patient resistance to treatment due to feelings of embarrassment; can impact long-term wound healing
Lack of confidence in clinicians — perception of poor care due to persistent odour
Impact on family/carers
Reduced interaction
Stressful to manage
Disengagement/lack of involvement in patient care because of odour
Perceived lack of hygiene
Distressing for caregivers

the perception of malodour varies between clinicians and patients (Gethin et al, 2023b). Additionally, some individuals, including healthcare professionals (HCPs) and patients, may experience a loss of taste and smell — anosmia — that never fully returned after Covid-19.

Certain medical conditions and medications can also contribute to anosmia (Li and Lui, 2023). Patients themselves may become desensitised to the smell over time, although this is not necessarily the case for their relatives or the HCPs providing care (Fleck, 2006).

Table 3: Odour measurement scales (adapted from Browne et al, 2004; Fletcher, 2008; World Union of Wound Healing Societies [WUWHS], 2019)

Type of odour measurement	Components of assessment
Visual analogue scale 1–10	▸ 1=no odour; 10=very strong odour
Teler® odour scale — focus on strength of odour	▸ Code 5: no odour ▸ Code 4: odour is detected on removal of dressing ▸ Code 3: odour evident on exposure of dressing ▸ Code 2: odour evident at arm's length from patient ▸ Code 1: odour evident on entering room ▸ Code 0: odour evident on entering ward/house/clinic
Teler® impact of odour — considers how odour impacts an individual, this score uses components relating to how many are experienced by the patient	Components: ▸ a: aware of odour ▸ b: concerned that other people will notice it ▸ c: reluctance to socialise ▸ d: affects appetite ▸ e: nauseated by odour Code for how many components are experienced: ▸ Code 5: no components experienced ▸ Code 4: one component experienced ▸ Code 3: two components experienced ▸ Code 2: three components experienced ▸ Code 1: four components experienced ▸ Code 0: five components experienced
Baker and Haig, 1981	▸ Strong: odour is evident when patient enters the room or 6–10 feet away with dressing intact ▸ Moderate: odour is present when patient enters the room with dressing removed ▸ Slight: odour is present at proximity when dressing is removed ▸ No odour: no odour is present

Table 4: Treatment of infection following the wound infection continuum (adapted from IWII, 2022)

Position on wound continuum	Signs and symptoms	Treatment options
Local infection	Overgranulation, bleeding friable tissue, increased exudate, delayed healing, wound breakdown, erythema, warmth, swelling, increased pain and malodour	Cleansing and debridement. Consider treatment with topical antimicrobial, e.g. silver, iodine, PHMB, honey
Spreading infection	All of the above plus: spreading erythema into surrounding tissues >2cm, crepitus, wound breakdown and swelling of the lymph glands	Cleansing and debridement. Commence systemic antibiotics and consider adjunctive treatment with topical antimicrobial agent. Swab wound using Levine technique to correctly identify organism present and antimicrobial sensitivities
Systemic infection	All of the above plus: malaise, lethargy, loss of appetite, fever/pyrexia, septic shock, organ failure, death	Urgent medical referral needed and start of systemic antibiotics. Topical antimicrobials may be used as adjunctive therapy

Currently, there is no standardised assessment tool for odour (Akhmetova et al, 2016), further complicating its evaluation and classification. A survey conducted by Gethin et al (2014) involving 1,444 HCPs found that only 12% assessed odour, primarily using descriptive terms, while just 4.5% of nurses utilised a scale to evaluate odour.

Marshall (2022) suggests that assessment of malodour should be multifactorial and consider:

- How the patient perceives odour and its impact on their psychological wellbeing and activities of daily living
- Odour type using descriptors such as putrid, acrid, pungent and offensive, foul, sweet, strong, smelly. Some bacteria omit particularly identifiable odours, e.g. aerobic bacteria such as *Pseudomonas* has been described as ripe/fruity (grape-like) or fishy, while anaerobic bacteria are often described as more pungent or rotten (Edwards-Jones, 2016; Fleck, 2006)
- Strength of odour.

Existing grading/classification scales for malodour have been developed and used in clinical practice and are summarised in *Table 3* (Fletcher, 2008; Akhmetova et al, 2016). Using an objective approach to odour measurement aids in defining the problem in a more concise manner. However, not all the measurement scales take into consideration the psychological or social impact of malodour. The Visual Analogue Scale and the Haig and Baker Scale are simpler to use compared to the Teler® Scale, which can be completed in two parts: one focusing solely on the strength of the odour and the other assessing its impact on the individual (Browne et al, 2004; Fletcher, 2008).

MANAGEMENT OF MALODOUR

There is little guidance on validated treatment options available to manage wound malodour (Gethin et al, 2023b). This can lead to a trial-and-error approach to management resulting in poorer outcomes

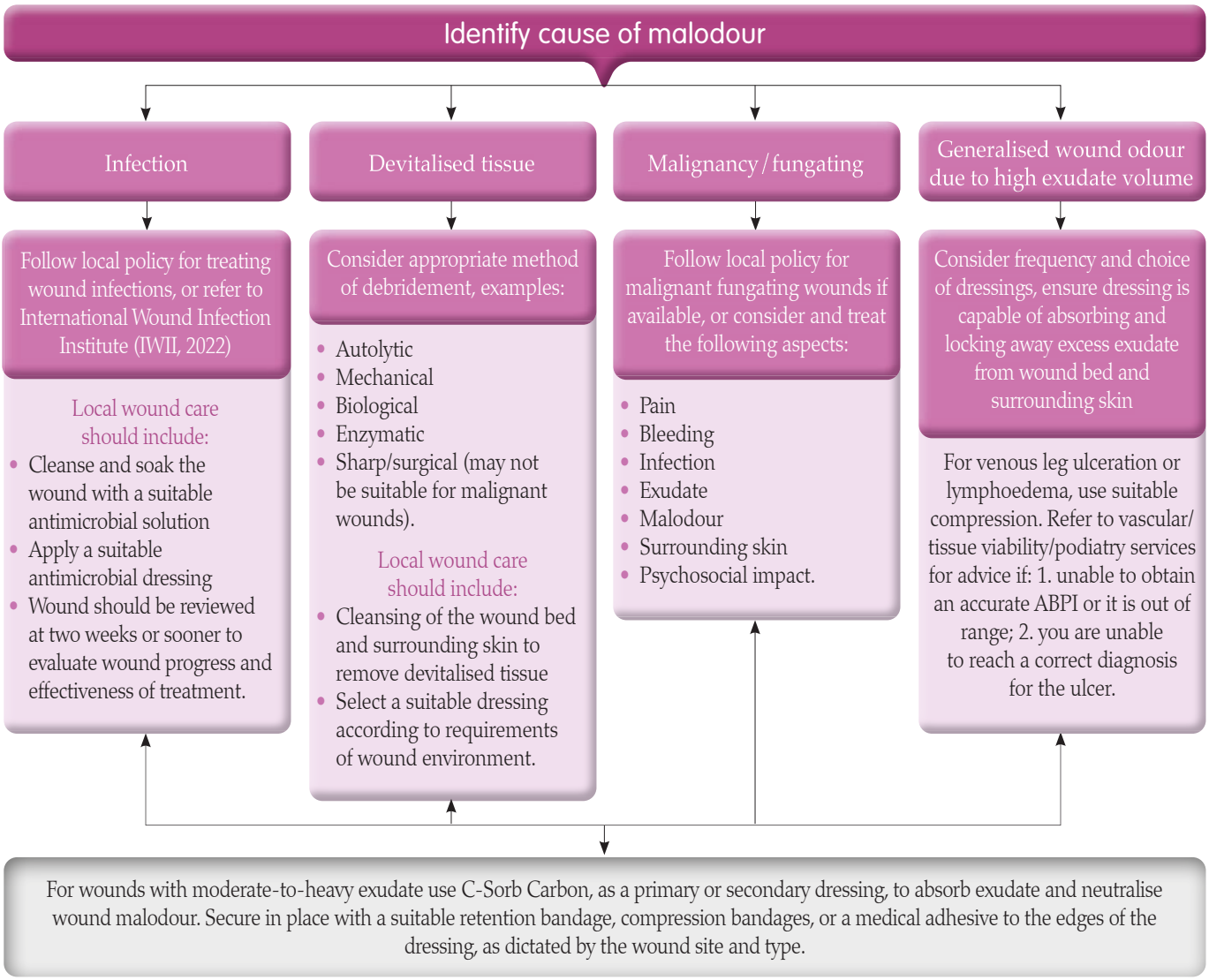

Figure 2.
Wound malodour pathway to treat and neutralise wound malodour (reproduced courtesy of Richardson Healthcare).

for patients (Gethin et al, 2014). Therefore, successful treatment of malodour should focus on identifying and treating the underlying cause (Black and Berke, 2020). Salmala and Davis (2015) proposed a novel approach using the acronym RACE, which gives a structured approach to malodour management.

R = removal of necrotic tissue and cleansing

Removal of devitalised tissue such as slough and necrosis will not only assist in reducing malodour but also facilitate healing and reduce risk of infection (IWII, 2022). The method of debridement will depend on the clinical environment, characteristics of the wound and clinical skills of the HCP. Debridement options commonly used in practice are autolytic, mechanical, biological (larval therapy), sharp debridement and surgical debridement. For MFWs, sharp and surgical debridement may not be suitable due to the risk of excessive bleeding of the friable tissue and a more conservative approach may be more appropriate (Black and Berke, 2020).

'Salmala and Davis (2015) proposed a novel approach using the acronym RACE, which gives a structured approach to malodour management.'

The wound and periwound skin should be cleansed with an appropriate cleansing agent at each dressing change, in accordance with local policy, to remove loose debris from the wound and surrounding skin. This process also helps to disrupt any biofilm that may be present (Black and Berke, 2020; Murphy et al, 2020). Cleansing agents containing both a surfactant and antimicrobial agent can also be considered to reduce bioburden such as polyhexamethylene biguanide (PHMB) and octenidine dihydrochloride (OCT) (Black and Berke, 2020).

A = antibacterial agent and absorbent dressing

Antibacterial agent

Infection is the most common cause of wound odour (Akhmetova et al, 2016). Thorough patient assessment and clinical examination should guide the clinician in selecting appropriate treatment, which may include a topical antimicrobial or systemic antibiotics. Treatment decisions should align with local policy and

consider the wound's position on the wound infection continuum (IWII, 2022; *Table 4*).

Use of topical antibiotics should not be encouraged due to antimicrobial resistance, apart from cases of MFWs where anaerobic bacteria are believed to cause distressing odour. The use of 0.75% topical metronidazole gel has been shown to reduce odour and enhance quality of life for palliative patients (Watanabe, 2016).

Absorbent dressings

When selecting an appropriate dressing to manage malodour, one that can absorb exudate and control odour may offer the advantage of being both cost-effective and efficient (Probst and Saini, 2024).

Carbon and activated charcoal (derived from carbon) have a large active surface which can trap and absorb the volatile organic compounds that produce malodour.

Superabsorbent polymer (SAP)-containing dressings are capable of absorbing and containing a large volume of exudate and have the potential to lock away bacteria into the core of the dressing and, when combined with a carbon layer, are an effective combination for malodour and exudate management (Probst and Saini, 2024).

C = concealers

Various agents have been used in attempts to mask wound malodour, including scented candles, incense, vanilla beans, and air fresheners (Samala and Davis, 2015; Black and Berke, 2020). Additionally, odour absorbing products such as cat litter and baking powder have been suggested (Samala and Davis, 2015; Black and Berke, 2020). However, the effectiveness of these methods has not been thoroughly investigated, and they remain supportive measures as they do not address the underlying cause of the odour.

E = education and support

As said, wound malodour can cause significant stress and anxiety for both patients and caregivers (Fleck, 2006). Regular re-evaluation of the patient is essential (Black and Berke, 2020). Healthcare professionals should not only assess the wound for signs of improvement or deterioration, but also take the time to understand the concerns of the patient and their family. Particular attention should be given to factors impacting the individual's quality of life, such as pain, poor sleep, anxiety and depression (Samala and Davis, 2015). Developing a patient-centred management strategy helps ensure that patients feel heard as well as addressing concerns that are negatively affecting their quality of life (Samala and Davis, 2015).

Figure 2 shows an example of a pathway to guide malodour management.

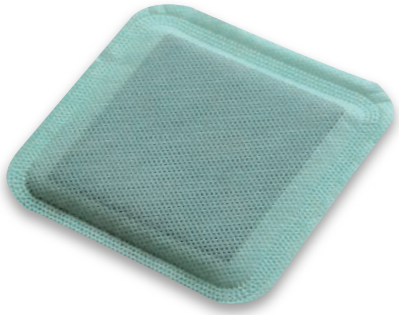

Figure 3.
C-Sorb Carbon superabsorbent dressing.

C-SORB CARBON

C-Sorb Carbon is a 2-in-1 product that combines a superabsorbent pad made from SAPs with an integrated carbon layer (*Figure 3*).

C-Sorb Carbon has been developed with the following properties in mind for odour control and exudate management:

- To neutralise odour — the dressing contains a carbon layer. As said, carbon absorbs and traps odour molecules (Probst and Saini, 2024). Wound malodour can significantly impact patient quality of life, leading to distress (Gibson and Green, 2013), embarrassment and social isolation (WUWHS, 2019). However, odour-minimising dressings can positively impact quality of life for both patients and their families (Black and Berke, 2020)
- Absorbency — C-Sorb Carbon is formulated with SAPs. SAPs can absorb a medium-to-high volume of exudate (Browning et al, 2016). Such a dressing property can extend wear time, reduce frequency of dressing changes, which in turn saves valuable nursing time (Gardner, 2016)
- Lock away technology — when fluid is absorbed, the superabsorbent core transforms into a gel to lock in exudate. If bacteria is kept away from the wound bed in such a way, this also prevents periwound maceration (Le Blanc et al, 2021)
- Even fluid dispersion — the gel is designed to evenly distribute exudate across the dressing, so as to prevent uncomfortable bulking in one area
- Soft contact layer — this is designed to minimise adherence to the wound. Non-adherence

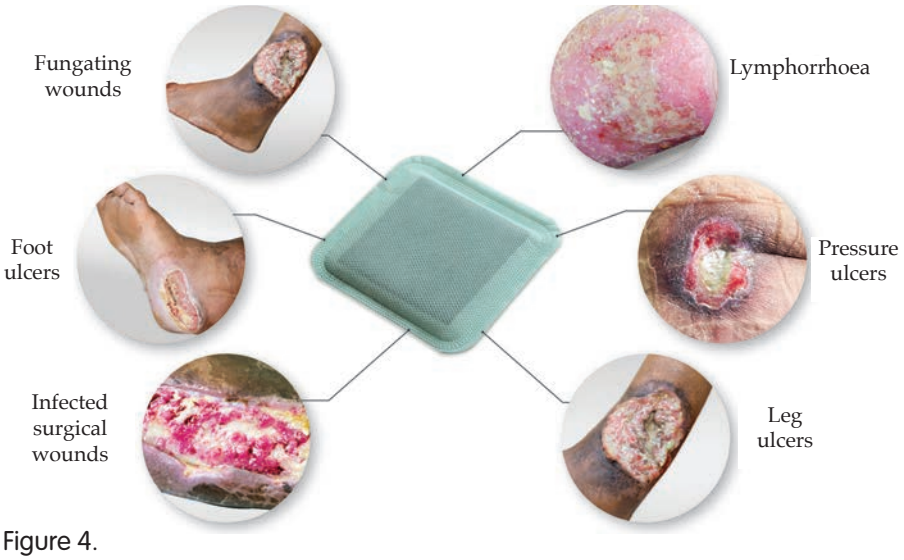

Figure 4.
Indications for C-Sorb Carbon superabsorbent dressing.

Figure 5.
C-Sorb Carbon applied to a fungating breast wound.

of wound dressings reduces the risk of friction and shearing (Punjataewakupt and Aramwit, 2022)

- To be comfortable and conformable — if dressings are flexible and can adapt easily to the contours of the body, this helps with patient comfort during use. Also, MFWs can occur anywhere on the body, which may make application and retention difficult (Naylor, 2002), such as the scalp and breast (*Figure 5*). Thus, absorbent flexible dressings which prevent leakage and periwound maceration are suitable for such wound types (Verdon, 2015; LeBlanc et al, 2021)
- Strikethrough free — the dressing has a fluid repellent backing to help prevent strikethrough. Preventing strikethrough can allow for longer wear time (Browning et al, 2016). Furthermore, strikethrough of exudate can be upsetting for patients, leading to social isolation and reduced quality of life (WUWHS, 2019)
- Suitable under compression — C-Sorb is suitable for use under compression therapy (Surgical Material Testing Laboratory [SMTL], 2019)
- Cost-effective — if dressings can be used for longer due to their absorption capacity, this reduces the frequency of dressing changes (Velickopvic et al, 2024). The carbon layer in C-Sorb Carbon aims to eliminate the need for an extra dressing, making it a versatile primary or secondary dressing that can potentially save both nursing time and resources.

Indications

C-Sorb Carbon is indicated for wet malodorous wounds, e.g. MFWs, pressure ulcers, leg ulcers, foot ulcers and infected surgical wounds (*Figures 4* and *5*). Frequency of dressing changes will depend on the condition of the wound and periwound skin, as well as volume of exudate. C-Sorb Carbon should not be cut, but is available in a range of sizes to suit a variety of wound shapes and sizes (*Table 5*). As the product is non-adherent, it requires securing with bandages, hosiery or surgical tape.

Contraindications

C-Sorb Carbon is not suitable for use on dry or low exuding wounds.

'By adopting a holistic and individualised approach, clinicians can help alleviate the distress caused by wound malodour and enhance the overall care experience.'

CONCLUSION

Wound malodour presents a significant challenge, profoundly affecting patients' physical and emotional wellbeing. Effective management requires a thorough understanding of its underlying causes, regular reassessment, and an emphasis on patient-centred care. Addressing the root cause, such as infection, with appropriate treatments is crucial, alongside the use of odour-controlling dressings and supportive interventions. While masking agents and odour absorbing products may provide temporary relief, they are not substitutes for addressing the primary source of malodour. Healthcare professionals should also prioritise the psychosocial aspects of care, acknowledging patient and caregiver concerns and tailoring management strategies to improve quality of life. By adopting a holistic and individualised approach, clinicians can help alleviate the distress caused by wound malodour and enhance the overall care experience. JCN

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Table 5: C-Sorb Carbon ordering details and dressing sizes

RHC code	Dressing size (cm)	PIP code	NHS code	Pack quantity
206510	10x10	422-1800	ELV85012	10
206512	12.5x12.5	422-1768	ELV85010	10
206520	10x20	422-1792	ELV85011	10
206522	20x20	422-1784	ELV85013	10
206530	20x30	422-1776	ELV85014	10

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KEY POINTS

- Wound malodour is a distressing symptom that significantly impacts the quality of life of patients and their caregivers, often leading to anxiety, stress, and social isolation.
- Despite its significant impact, there is limited guidance in the literature on managing wound malodour.
- The most common wounds associated with malodour are those linked to chronicity and high exudate volume, such as leg ulcers, diabetic foot ulcers, burns and malignant/fungating wounds (MFWs).
- Assessment of malodour is an integral part of holistic assessment; however, it can be challenging and often subjective.
- Successful treatment of malodour should focus on identifying and treating the underlying cause.
- Healthcare professionals should also prioritise the psychosocial aspects of care, acknowledging patient and caregiver concerns and tailoring management strategies to improve quality of life.

Revalidation Alert

Having read this article, reflect on:

- Your knowledge of and how to identify the causes of malodour in wounds
- How to assess such wounds
- Treatment options available
- The emotional distress that malodorous wounds can cause
- Why it is important to be sensitive to the challenges that come with malodorous wounds and mindful of personal reactions.

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