

Oxford Community Hypergranulation Pathway

Definition

Hypergranulation, also known as overgranulation, is excessive granulation that protrudes above the wound surface, imposing a barrier to the inward-migrating epidermis, slowing epithelialisation, the last stage of wound healing.

Causes

Hypergranulation Type 1

Infection / Bioburden

Hypergranulation Type 2

Excessive moisture / High levels of exudate / Occlusion

Hypergranulation Type 3

Friction / Mechanical / Excessive device movement / Ill-fitting device / Movement on the wound bed

Hypergranulation Type 4

Inflammation / Allergy / Hypersensitivity / Reaction to foreign material / Prolonged irritation / Trauma

Stress

When undertaking a holistic assessment, it is imperative to assess for major life stressors. Stress stimulates the hypothalamic-pituitary-adrenal axis to produce stress hormones (Cortisol and Catecholamines) which prolong inflammation.

Presentation

Pink to red in colour*

Granular surface

Moist

Not friable *
(does not break down easily)

Protrudes above wound surface

Often shiny, soft & spongy/oedematous

Bleeds easily (highly vascular)

No pain or discomfort**

*Hypergranulation caused by infection has a high bioburden so can present as red to dark brown in colour and IS friable so will breakdown easily.



RED FLAGS - MALIGNANCY

Malignancy in a wound may be mistaken for hypergranulation. Suspect a malignant transformation when hypergranulation is irregular, hard to touch, exceeds the edges of the wound, may have a cauliflower appearance, does not respond to treatment, and has months of evolution. If there is any doubt, a referral to Dermatology should be completed.



Treatment

Elimination of causative factor (see page 3).

Consider watchful waiting option if hypergranulation is not impeding wound healing/closure or patient rehabilitation.

Treatment Aims

Type 1 - Infection

Treat localised wound bed infection
Lower bacterial load
Disrupt biofilm
Treat systemic infection if present

Type 2 - Moisture

Remove excessive moisture
Prevent occlusive and hypoxic wound environment

Type 3 - Friction

Remove cause/minimise friction
Ensure correctly sized equipment in situ
Protect wound bed

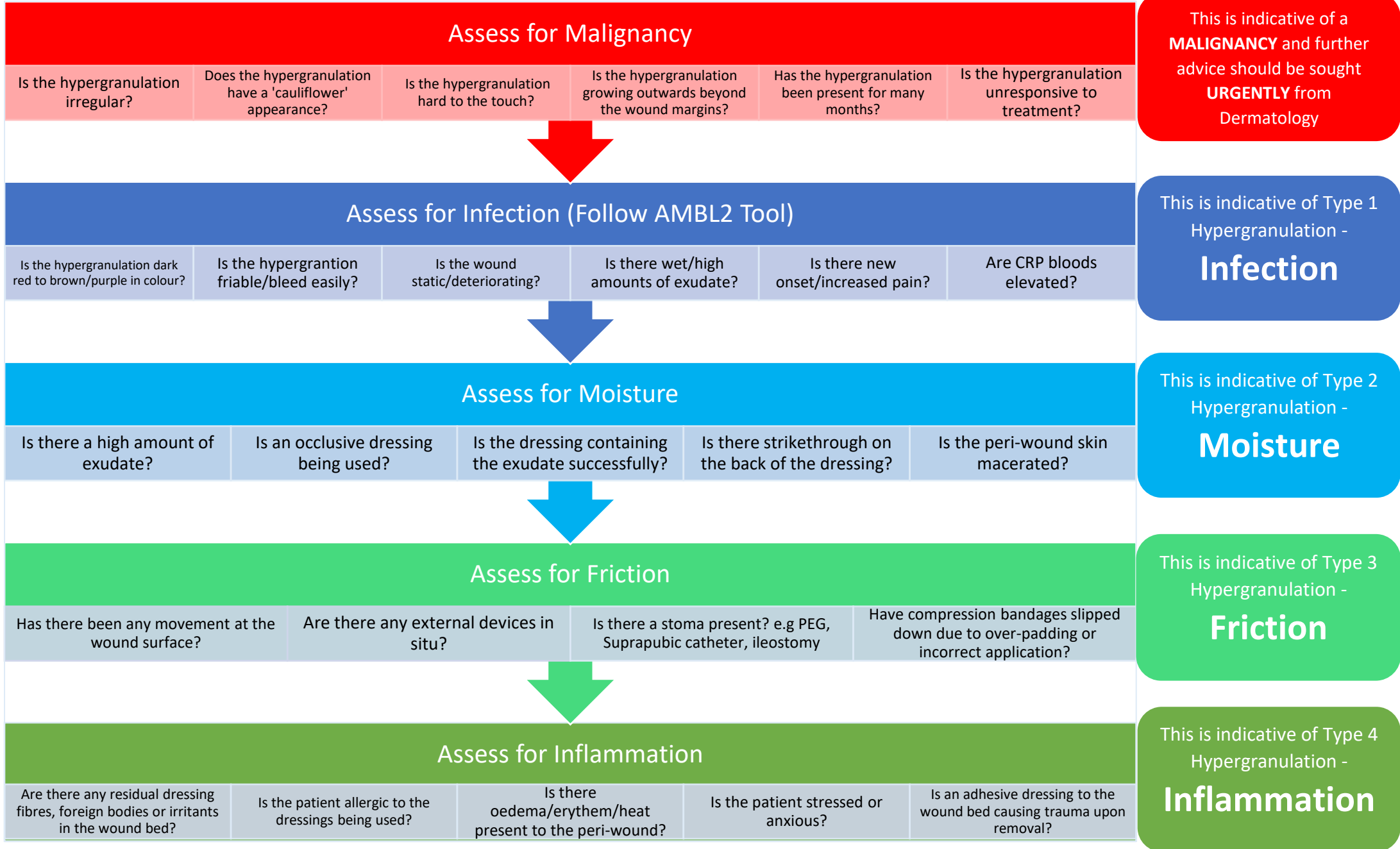
Type 4 - Inflammation

Treat inflammation
Remove cause of irritation, foreign body, allergen, remnant dressing fibres, wound debris and trauma
Reduce stress and anxiety

**Over time, innervation (the supply of nerve fibres to an organ or other body part) can occur, increasing sensation so pain can occur.

Assessment Pathway

The assessment pathway below can be used in combination with a full holistic assessment to determine causation of hypergranulation



Treatment Pathways

Please follow one pathway below depending on the hypergranulation causative factor determined during your full holistic assessment

Type 1 Hypergranulation Infection

Follow Biofilm Pathway for cleansing, debridement and dressing selection.

Use Alprep Pad to breakdown friable hypergranulation in addition to disruption of Biofilm. This is likely to cause bleeding but will stop upon application of gentle pressure.

Discontinue after 6 weeks and re-assess.

Type 2 Hypergranulation Moisture

Consider reasons for excessive moisture and treat.

If oedema is a contributing factor, please refer to Chronic Oedema Pathway.

Refer to Exudate Management Pathway to step up absorbency of dressings.

Refer to Skin Barrier Management Pathway if a barrier product is required to prevent maceration and skin deterioration.

Avoid use of occlusive dressings.

Secure dressings in such a way to allow management of exudate and vapour loss. Do not occlude dressing by applying multiple layers of adhesive film, use as a border only to secure in place.

Avoid use of creams or ointments to the wound bed as these are occlusive and also contribute to excessive moisture.

Type 3 Hypergranulation Friction

Secure external medical devices in such a way to minimise friction/movement around the site. Ensure any fixation plates are correctly positioned and avoid continuous traction on external devices.

Sub-bandage wadding and compression bandaging to be applied correctly and effectively to prevent slipping and friction.

Ensure stoma bags correctly sized and if required, appropriate seals are being used.

Ensure that the hole in the flange/baseplate of the stoma pouch is the correct size so that the edge does not rub against the stoma (1-2mm gap).

Ensure correct catheter size is in situ. Use catheter retention straps or adhesive catheter securement/stabilisation dressing to avoid continuous traction.

Use positioning aids such as Slide Sheets and Wendyletss under the body when repositioning and the in-built knee break to prevent friction and shear

Consider need for pressure relieving equipment.

Ensure finger and toe nails are cut short and are not rubbing against the skin.

Type 4 Hypergranulation Inflammation

Undertake thorough cleansing to ensure any cause of irritation, foreign bodies, allergens, remnant dressing fibres/adhesive or wound debris is removed.

Consider need for adhesive remover aerosol to prevent trauma.

Shave/trim any hairs present.

Avoid use of occlusive dressings.

Contact Tissue Viability for advice on the use of topical steroid ointment, prescripion request form and a specialist careplan.

UNRESOLVING

Where above treatment proves ineffective, seek support from and/or refer to the Community Tissue Viability Service.

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