



Hypergranulation Tissue - Prevention & Basic Treatment Interventions Quick Reference Guide

Characteristics: Moist, shiny, red to dark red/purple, small, soft or hard, raised nodules, elongated, irregular, or cauliflower-like appearance. Usually 0.1 to 2.5 cm. Bleeds easily (friable) with any friction or pressure. Can be painful. Note: malignant tissue and enterocutaneous fistula have very similar appearances.

Causes: Excess moisture, friction/pressure, prolonged inflammation, infection.

Location	Prevention Interventions	Basic Treatment Interventions
<p>Wound/Incision/Skin Graft In wound bed or edge, incision or graft.</p> 	<p>Excess Moisture:</p> <ul style="list-style-type: none"> Use non-occlusive breathable dressings. Use appropriate size and type of absorbent dressing/packing. Apply skin barrier/protectant, (e.g., No-Sting Skin Prep) to surrounding skin. Endure an appropriate dressing change frequency. For wounds with copious drainage, consult NSWOC/Wound Clinician for possible pouching. <p>Friction/Pressure:</p> <ul style="list-style-type: none"> Properly secure non-bordered dressing, consider tape, mesh pants, binders, Montgomery ties, or Kling to hold dressing in place. <p>Prolonged Inflammation:</p> <ul style="list-style-type: none"> Thoroughly cleanse site and surrounding skin to remove dressing fibers, wound debris, and/or adhesive material. If suture or foreign material noted, inform MRP re removal. <p>Colonization/Infection:</p> <ul style="list-style-type: none"> Assess for bacterial colonization/local infection or fungal infection. 	<ul style="list-style-type: none"> Ensure all prevention interventions are in place. For excess moisture: <ul style="list-style-type: none"> Apply a non-silicone, non-border foam dressing, (e.g., Biatain Non-Adhesive) using firm, gentle pressure over the hypergranulation tissue area; secure with tape; pressure will help to reduce the size of the hypergranulation tissue. Consider sodium chloride (salt) impregnated dressing, (e.g., Mesalt) to dry out the hypergranulation tissue. Change daily and discontinue when moisture no longer an issue. For bacterial infection, use absorbent antimicrobial dressing; see HA/unit-specific Dressing Selection QRG. For fungal infection, consult MRP. <p>If not effective within 7 days consider advanced treatment, see Guideline.</p>
<p>Feeding Tubes G-Tube J-Tube, G-J Tube (At/around insertion site)</p> 	<p>Excess Moisture:</p> <ul style="list-style-type: none"> Assess routinely for tube migration; inform MRP if tube has migrated out of position. Ensure feeding tube fits abdominal opening correctly; consult CNE/NSWOC/Wound Clinician as needed. Check balloon inflation as per HA/site guideline/policy. Rotate tube as per H/site guideline/policy. Cleanse & dry area; leave open to air, do not use dressings. If leakage or bypassing, consult physician/NP. <p>Friction/Pressure:</p> <ul style="list-style-type: none"> If stabilization device (e.g., surgical zip-ties) present, determine if/when device can be removed. Apply skin barrier/protectant, (e.g., No-Sting Skin Prep) around tube site. Ensure tube is properly secured, not too loose or too tight. Adjust bumper, pm. <p>Prolonged Inflammation:</p> <ul style="list-style-type: none"> Routine cleansing to remove any irritants, (e.g. feeding solution, secretions). If tube suture or foreign material is the irritant, inform MRP re removal. <p>Colonization/Infection:</p> <ul style="list-style-type: none"> Assess for bacterial colonization/local infection or fungal infection. 	<ul style="list-style-type: none"> Ensure all prevention interventions are in place. For excess moisture: <ul style="list-style-type: none"> If appropriate for bumper, consider one of the following: <ul style="list-style-type: none"> One layer of tube/drain gauze dressing, change dressing when wet and discontinue when moisture no longer an issue. One layer of sodium chloride (salt) impregnated dressing, (e.g., Mesalt) to dry out the hypergranulation tissue. Change daily and discontinue when moisture no longer an issue. Consider white table salt (sodium chloride), dry or compress, to dry out the hypergranulation tissue; consult NSWOC (see procedure below). For bacterial infection, use absorbent antimicrobial dressing; see HA/unit-specific Dressing Selection QRG For fungal infection, consult MRP. <p>If not effective within 7 days consider advanced treatment, see Guideline</p>





Procedure: Use of Table Salt for Removal of Hypergranulation Tissue

Use procedure as per health authority/agency policy. May need NSWOC/Wound Clinician consult. Advise client they may feel slight discomfort with treatment.

Method 1 Dry Salt: Sprinkle 1-2 tsp of white table salt on the area, leave for 8-10 minutes then rinse area with tap water. Repeat daily as needed.

Method 2 Salt Compress: Add 2 teaspoons of white table salt in 1 cup (250 mL) body temperature water. Choose a smallest gauze size which will fit the area; for tubes; make a Y-cut if needed. Soak the gauze in the solution and place over the hypergranulation tissue and surrounding area. Leave in place 5-10 minutes then remove; do not rinse the area. Dry the area as needed. Repeat compress at least daily; may be done up to four times a day.

For the salt: open a new small box of white table salt, label it with client's name and store it for the purpose of treating hypergranulation tissue or use small packet of white table salt, if available.

Location	Prevention Interventions	Basic Treatment Interventions
<p>Surgically Placed Tubes/Drains (Post-op drains, suprapubic catheters, nephrostomy tubes, trachs, medication tubes e.g. Duopa for Parkinson's)</p> 	<p>Excess Moisture:</p> <ul style="list-style-type: none"> • Use a breathable tube/drain gauze dressing to protect skin, where possible. • Ensure an appropriate dressing change frequency. • Use a cover dressing appropriate for the exudate as per specific tube/drain management protocol. • If tube/drain is leaking or bypassing, inform physician/surgeon. <p>Friction/pressure:</p> <ul style="list-style-type: none"> • Apply skin barrier/protectant, (e.g., No-Sting Skin Prep) around tube/drain site. • Properly secure tube/drain, not too loose or too tight. <p>Prolonged Inflammation:</p> <ul style="list-style-type: none"> • Cleanse to remove any irritants. • If tube/drain suture or foreign material is the irritant, inform MRP re removal. <p>Colonization/Infection:</p> <ul style="list-style-type: none"> • Assess for bacterial colonization/local infection or fungal infection. 	<ul style="list-style-type: none"> • Ensure all prevention interventions are in place. • For excess moisture: <ul style="list-style-type: none"> ◦ Consider sodium chloride (salt) impregnated dressing, (e.g., Mesalt) to dry out the hypergranulation tissue. Change daily and discontinue when moisture no longer an issue. • For bacterial infection, use absorbent antimicrobial dressing; see HA/unit-specific Dressing Selection QRG • For fungal infection, consult MRP. <p>If not effective within 7 days consider advanced treatment, see Guideline</p>
<p>Ostomy Stoma/Peristomal Junction</p> 	<p>Excess Moisture:</p> <ul style="list-style-type: none"> • Ensure flange fit and style appropriate for the stoma size and profile. • Apply pouching system correctly. • Use ostomy paste, powder, rings, liquid skin barrier to protect the skin. <p>Friction/Pressure:</p> <ul style="list-style-type: none"> • Ensure clothing, vehicle/workbelts, etc., are not too loose or too tight. • Ensure flange opening is not too small for the size of the stoma. • Ensure good adherence of the flange to the skin. <p>Prolonged Inflammation:</p> <ul style="list-style-type: none"> • Cleanse, as ordered, to remove any drainage, adhesive materials. • Assess for suture material as an irritant; inform NSWOC/surgeon re removal. <p>Colonization/Infection:</p> <ul style="list-style-type: none"> • Assess for bacterial colonization/local infection or fungal infection. 	<ul style="list-style-type: none"> • Ensure all prevention interventions are in place. • For excess moisture: <ul style="list-style-type: none"> ◦ Re-measure stoma and ensure appropriate fit of the pouching system. ◦ Consider use of white table salt (sodium chloride) to dry out the hypergranulation tissue (see procedure pg. 1); consult with NSWOC. • For bacterial infection, use absorbent antimicrobial dressing; see HA/unit-specific Dressing Selection QRG • For fungal infection, consult MRP. <p>If not effective within 7 days consider advanced treatment, see Guideline</p>
<p>Enterocutaneous Fistula (ECF) or Mucous Fistula At the fistula opening. May be challenging to see if fistula in the wound bed or on stoma margin.</p> 	<p>Excess Moisture:</p> <ul style="list-style-type: none"> • Where possible, protect peri-fistula skin; use a skin barrier/protectant, (e.g., No-Sting Skin Prep). • For moderate/high output, consult NSWOC re pouching system. • If in a wound or on an incision line, use a cover dressing appropriate for the amount of exudate. <p>Friction/Pressure:</p> <ul style="list-style-type: none"> • If fistula pouching system in place, consider ostomy belt for securement. • If tube/drain present, anchor with securement device. <p>Prolonged Inflammation:</p> <ul style="list-style-type: none"> • Routinely cleanse and protect peri-fistula area to prevent irritation from drainage. <p>Colonization/Infection:</p> <ul style="list-style-type: none"> • Assess for bacterial colonization/local infection or fungal infection. 	<ul style="list-style-type: none"> • Ensure all prevention interventions are in place. • Consult NSWOC for treatment interventions.
<p>Nails Around/at the nail plate.</p> 	<p>Moisture:</p> <ul style="list-style-type: none"> • If contractures present, weave gauze/wicking fabric between digits, (e.g., Interdry). <p>Friction/Pressure:</p> <ul style="list-style-type: none"> • Correctly file and/or trim nails. • Refer to OT for proper fitting of footwear. <p>Prolonged Inflammation:</p> <ul style="list-style-type: none"> • Cleanse nails to remove any dirt or debris. • If foreign body, (e.g., wood splinter) is present, consult MRP for removal. <p>Colonization/Infection:</p> <ul style="list-style-type: none"> • Assess for S&S of bacterial colonization/local infection or fungal infection. 	<ul style="list-style-type: none"> • Ensure all prevention interventions are in place. • For excess moisture: <ul style="list-style-type: none"> ◦ Consider use of white table salt (sodium chloride) dry or compress to dry out the hypergranulation tissue (see procedure pg. 1); consult with NSWOC. • Refer to Foot Care Nurse/Podiatrist for toe protectors (e.g., sili cone devices). • For bacterial infection, use absorbent antimicrobial dressing; see HA/unit-specific Dressing Selection QRG. • For fungal infection, consult MRP. <p>If not effective within 7 days consider advanced treatment, see Guideline</p>