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Research Article

SOCIO-DEMOGRAPHIC, CLINICAL AND CARE ASPECTS RELATED TO CHANGES IN THE QUALITY OF LIFE OF PEOPLE WITH VENOUS ULCERS

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ABSTRACT

Objective: To analyze the relationship of socio-demographic, clinical and care aspects changing the quality of life of people with venous ulcers (VU). **Method:** a Cross-sectional study conducted in a primary health care with 101 people with VU. Data was collected by a structured interview form and the Medical Outcomes Short-Form Health Survey (SF-36). The Friedman test, Mann-Whitney test, and Logistic Regression Binary test were applied. The study was approved by the Research Ethics Committee (CAAE N° 07556312.0.0000.5537). **Results:** Socio-demographic, clinical and care variables of greater influence were: age, sleep, intensity and presence of pain, injury time, guidance to regular exercise, guidelines for compression therapy, treatment time and reference and counter-reference. The variables sleep, presence and intensity of pain and guidance to exercise influence on the quality of life. **Conclusion:** Socio-demographic, clinical and care aspects, alone and together, influenced the quality of life of people with VU, especially sleep, pain, exercise guidance, reference, and counter-reference that should be considered in the comprehensive and multidisciplinary nursing care.

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INTRODUCTION

Ulcers in the lower limbs may be from different etiologies (Lazarus *et al.*, 2014; Prakash *et al.*, 2013; O'Donnel *et al.*, 2014). In England, more than half of the nursing work time is often spent with assistance directed to leg ulcers (Lilley, 2012), including the injury of venous origin, called venous ulcers (VU), being the most common type corresponding to 75.0% of cases (Prakash *et al.*, 2013; O'Donnel *et al.*, 2014; Lilley 2012; Scotton, 2014), whose prevalence ranges from 0.06% to 2.0% of the world's population and approximately 70.0% reappear in 10 years (O'Donnel *et al.*, 2014).

The VU diagnosis is usually clinical, but it is necessary a differentiation, because the treatment can be medical, surgical or compressive and includes a series of measures whose objectives are reduction of edema, wound healing, prevention of relapses and continuing care (Prakash *et al.*, 2013; O'Donnel *et al.*, 2014) directed to the individual as a whole, in a holistic perspective. This extended service is important because this chronic condition significantly impacts the quality of life (QOL) in the physical, social and psychological aspects (Prakash *et al.*, 2013; Gould *et al.*, 2015; Malaquias *et al.*, 2012; Green *et al.*, 2014; González-Consuegra and Verdú, 2011).

It is known that such injuries are more prevalent in women (Gould *et al.*, 2015; Malaquias *et al.*, 2012; Green *et al.*, 2014;

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González-Consuegra and Verdú,2011) and the elderly (Gould et al., 2015; Green et al., 2014; González-Consuegra and Verdú, 2011) and the clinical situation and the care provided can interfere with its healing. Understanding how the characteristics of the affected population may be related to losses or benefits in QOL becomes an important factor to be considered in the care planning.

There are studies evaluating this construct in people with VU from different generic or specific instruments, descriptively or after interventions, mostly finding decreased, especially in the physical domain (Wong et al., 2012; Ashby et al., 2014).

However, it is still necessary to investigate how interference of the variables inherent in the care process can occur and recognize the specific characteristics of individuals for the planning and execution of a resolute care (Malaquias et al., 2012). Given this context, this study aimed to analyze the relationship of socio-demographic, clinical and care aspects changing the quality of life of people with venous ulcers.

MATERIALS AND METHODS

Design and local

This is a descriptive and cross-sectional study with a quantitative approach, involving people with VU treated at primary health Care of Natal/Rio Grande do Norte, Brazil. The research was conducted in 37 family health units and five mixed health units totaling 42 services. The study addressed the entire population that has adapted to the eligibility criteria as people with active VU, with over 18 years old, able to communicate and ascribed in these units. There were 101 people with VU selected to form the sample in the data collection process.

Data Collection

Two instruments were applied: a structured interview form and collection of bio-physiological measures, based on clinical guidelines (Costa et al., 2015); and the Medical Outcomes Short-Form Health Survey (SF-36), which evaluates the quality of life-related to health. The SF-36 consists of 36 items presented in eight domains and total score range from zero to 100. The higher the score, the better the QOL. The Domains are: functional aspect, physical aspect, pain, general health, vitality, social function, emotional aspects and mental health; and the dimensions are: physical health and mental health (Ciconelli et al., 1999).

Data were collected in health units or at their home, according to the preference of the participants. Data were collected between February and September 2014, carried out by previously trained nurses and nursing students about the instruments and other aspects related to the research. The interviews lasted on average 30 minutes per participant.

The independent variables were grouped into socio-demographic, clinical and care characteristics. Then, they were categorized for bivariate analysis. Consequently, the dependent variable was the quality of life.

In the socio-demographic characteristics, there are gender, age, marital status, education, occupation and income per capita. The value of the minimum wage during the period of data

collection was R\$ 724.00 (US\$ 296.72, trading on September 30, US\$ 2.44). Clinical variables were self-reported by the subject: Diabetes Mellitus (DM), hypertension (SAH), other diseases, presence and intensity of pain, recurrence, sleep, alcohol consumption, smoking, and time of the injury. The variables of group care characterization were training the responsible for the curative, reference and counter-reference, Doppler examination, and guidance on compression therapy, lifting legs, regular exercise and use of compression therapy.

Data Analysis

Data were organized in tables in Microsoft Excel and exported to the SPSS software, version 20.0 for descriptive and inferential analysis with $\alpha = 5.0\%$. The average scores of the domains and dimensions of the SF-36 evaluating the QOL were descriptively presented in minimum, maximum, average and standard deviation. The Friedman test was used to identify differences between domains and dimensions averages. The mean difference between each domain and dimension with all variables (socio-demographic, clinical and care) were analyzed using the Mann-Whitney test. After identifying the aspects differing significantly with the average of the domains and dimensions of QOL (SF-36) analysis of binary logistic regression was performed.

Ethical Aspects

This research followed the ethical principles of Resolution N° 466/12 and the Declaration of Helsinki, and it was approved by the Ethics Committee on Research of the Federal University of Rio Grande do Norte (UFRN) under CAAE N° 07556312.0.0000.5537.

RESULTS

Most of the population was female (66.3%), aged greater or equal to 60 years old (61.4%), married or in a stable relationship (63.4%), elementary school (52.5%) and not literate (14.9%), unemployed (75.2%) and received up to one minimum wage (90.1%).

Table 1 Distribution of the average of the domains and dimensions of quality of life (SF-36) according to a minimum, maximum, average and standard deviation. Natal, Rio Grande do Norte, Brazil, 2016

Quality of life (SF-36)	Minimum-Maximum	Average (Standard deviation)	Friedman Test
Dimensions			
Mental Health	0 – 100	64.8 (26.8)	Better QOL*
Vitality	0 – 100	62.4 (27.1)	
Emotional Aspects	0 – 100	50.5 (46.1)	↕
General Health	0 – 97	48.9 (21.9)	
Social function	0 – 100	47.6 (36.4)	< 0.001
Pain	0 – 100	44.1 (30.4)	
Functional aspect	0 – 100	34.6 (28.4)	Worst QOL*
Physical aspect	0 – 100	13.6 (30.5)	
Dimensions			
Mental Health	8 – 95	54.8 (23.4)	< 0.001
Physical Health	5 – 91	40.6 (19.6)	

*Quality of life (QOL)

According to the results obtained with SF-36, mental health and vitality domain showed higher scores (64.8 and 62.4, respectively) rather than physical and functional appearance

(34.6 and 13.6, respectively), with significant difference ($p < 0.001$, Friedman test), as shown in Table 1. Participants had a mean score of mental health dimension (54.8) rather than the physical dimension (40.6).

In the clinical conditions, sleep, presence, and intensity of pain and injury time showed significant differences in QOL. People who slept six hours or more per day had the best results for functional aspect, physical aspect, emotional aspect, physical aspect and mental health dimension.

Table 2 Average differences between the domains and dimensions of quality of life and socio-demographic variables and clinical conditions. Natal, Rio Grande do Norte, Brazil, 2016

Quality of life (SF-36)	Socio-demographic condition		Clinical conditions		
	Age group Up to 59/≥ 60a†	Sleep Up to 6h/> 6h‡	Presence of pain Yes/No	Intensity of pain Absent-Low/ Moderate-Severe	Time of injury Up to 6m/> 6 m§
		Dimensions			
Mental health	57.7/ 69.2 0.037*	61.3/ 65.5 0.251	64.6/ 65.8 .798	66.8 /64.1 0.798	68.3 /63.5 0.218
Vitality	54.6/ 67.3 0.014	60.8/ 62.7 0.239	61.6/ 68.1 0.740	65.6 /61.4 0.549	68.9 /60.1 0.109
Emotional aspect	39.3/ 57.5 0.060	24.1/ 56.2 0.039	50.0/ 53.9 0.431	45.9/ 51.9 0.431	59.2 /47.3 0.618
General health	43.7/ 52.2 0.062	53.6 /47.9 0.618	47.8/ 56.7 0.032	57.4 /46.3 0.032	54.4 /46.9 0.565
Social function	48.2 /47.2 0.885	34.2/ 50.5 0.087	45.4/ 63.0 0.104	53.5 /45.8 0.382	45.9/ 48.3 0.751
Pain	42.4/ 45.1 0.798	48.7 /43.1 0.091	39.1/ 78.0 <0.001	72.5 /35.2 <0.001	44.7 /43.8 0.772
Functional aspects	36.4 /33.4 0.610	26.1/ 36.4 0.009	32.6/ 48.1 0.199	42.1 /32.2 0.199	40.4 /32.4 0.010
Physical aspect	8.3/ 17.0 0.505	1.39/ 16.3 0.001	13.1/ 17.3 0.201	19.8 /11.7 0.201	16.7 /12.5 0.671
		Dimensions			
Physical health	36.9/ 42.9 0.163	38.0/ 41.2 0.007	38.7/ 53.5 0.003	51.2 /37.2 0.003	44.9 /39.0 0.198
Mental health	48.7/ 58.7 0.040	46.8/ 56.5 0.032	53.8/ 61.5 0.534	57.8 /53.9 0.534	59.3 /53.2 0.336

*Mann-Whitney/ †a: years/ ‡h: hours/ §m: months

Table 3 Average of difference between the quality of life (SF-36) and the variables of care conditions. Natal, Rio Grande do Norte, Brazil, 2016

Quality of life (SF-36)	Care conditions			
	Guidance/ exercises Yes/No	Guidance/ compression Yes/No	Time of treatment Up to 6m/> 6m†	Reference/ Counter-reference Yes/No
		Dimensions		
Mental Health	66.8 /63.4 0.756	56.7/ 71.8 <0.001*	72.0 /63.3 0.743	55.9/ 68.2 0.052
Vitality	71.2 /56.2 0.006*	62.4/62.4 0.908	72.0 /60.5 0.991	55.7/ 65.0 0.246
Emotional aspects	48.4/ 51.9 0.580	46.8/ 53.7 0.384	56.8 /49.2 0.063	53.5 /49.3 0.632
General health	57.6 /42.8 <0.001*	52.3 /46.0 0.114	58.2 /47.0 0.109	43.7/ 50.9 0.128
Social function	47.0/ 48.1 0.791	42.5/ 52.1 0.162	55.1 /46.1 0.364	41.6/ 49.9 0.330
Pain	48.8 /40.7 0.150	44.5 /43.6 0.932	46.3 /43.6 0.832	29.4/ 49.7 0.002*
Functional aspects	37.8 /32.4 0.308	33.0/ 35.9 0.848	45.9 /32.3 0.015*	29.8/ 36.4 0.429
Physical aspect	15.5 /12.3 0.250	15.4 /12.0 0.433	19.1 /12.5 0.582	16.1 /12.7 0.739
		Dimensions		
Physical Health	46.0 /36.7 0.008*	41.5 /39.8 0.502	48.1 /39.1 0.308	34.8/ 42.8 0.052
Mental Health	58.1 /52.4 0.284	52.1/ 57.1 0.254	62.8 /53.2 0.956	50.0/ 56.6 0.260

In the average differences test between the independent variables with QOL, some of them showed statistically significant results (Table 2). In the socio-demographic variables, individuals aged 60 or more had better results for the physical health domain, vitality, and the mental health dimension.

The smallest injury time than six months showed a significant difference in functional aspect, indicating better QOL. Individuals who felt pain had worse averages for general health, body pain, and physical dimension. People who reported moderate to severe pain had significantly worse averages in the body pain domain, general health, and physical health dimension.

As for the care conditions, the results are shown in Table 3.

People who have not received guidance for exercise had worse scores in general health, vitality, and physical health dimensions. People who have not received guidance for compression therapy showed a better QOL.

The variable time of treatment showed a significant difference with the average functional aspect domain, so people with up to six months of treatment showed better results. Regarding the reference and counter-reference, the individuals who used them showed worse QOL for pain.

Based on the statistically significant results, binary logistic regression was performed to evaluate how the set of variables interfere in the QOL (Table 4).

When checking data of age, the significantly highlighted age group were the individuals 60 years old or more with better QOL for vitality, mental health, and mental health dimension. This result was not expected since the cognitive and mental changes are related to aging, affecting all aspects of the life of older people (Jokinen, 2014). However, young adults may face more difficulties with injuries due to limitations caused by influencing vitality as it was seen.

The presence of VU has periods of remission and exacerbation (Jokinen, 2014) and may lead to family and social isolation of the person (Malaquias et al, 2012; Green et al., 2014;Costa et al., 2015) predisposing to depression and other psychological symptoms (Malaquias et al, 2012; Costa et al., 2015).

Table 4 Presentation of isolated and multiple logistic regression between the quality of life (SF-36) and socio-demographic, clinical and care variables that showed statistically significant differences in the average of SF-36. Natal, Rio Grande do Norte, Brazil, in 2016.

Quality of life (SF-36) Domains	Socio-demographic, clinical and care variables	Regression r ² (p-value)	
		Isolated	Multiple
Mental health	Age group	0.093 (0.009)	0.054 (0.122)
	Guidance for compression	0.060 (0.507)	
Vitality	Age group	0.077 (0.016)	0.079 (0.049)
	Guidance for physical exercises	0.097 (0.006)	
Emotional aspects	Sleep	0.082 (0.012)	0.082 (0.012)
	Presence of pain	0.023 (0.189)	
General health	Intensity of pain	0.034 (0.108)	0.152 (0.007)
	Guidance for physical exercise	0.133 (0.001)	
	Presence of pain	0.078 (0.014)	
Pain	Intensity of pain	0.283 (>0.001)	0.396 (<0.001)
	Reference and counter-reference	0.160 (<0.001)	
	Sleep	0.003 (0.628)	
	Time of treatment	0.056 (0.047)	
Functional aspect	Time of VU*	0.027 (0.166)	0.059 (0.240)
	Sleep	0.089 (0.032)	
Physical aspect	Dimensions		0.089 (0.032)
	Sleep	0.011 (0.379)	
Physical health	Presence of pain	0.083 (0.013)	0.121 (0.029)
	Intensity of pain	0.104 (0.005)	
Mental health	Age group	0.114 (0.003)	0.09 (0.034)
	Sleep	0.079 (0.014)	

*Quality of life (QOL)

The sets that showed the highest regression values were the presence and intensity of pain and use of reference and counter-reference in the pain domain (r=0.396), presence and intensity pain and guidance of physical exercises with the general state of health domain (r=0.152) and pain intensity, presence of pain and sleep in the physical dimension (r=0.121) indicating that together, they better explain the influence in the domains and dimensions of QOL.

DISCUSSION

The socio-demographic profile found in the study population did not differ from other studies (Gould et al., 2015; Malaquias et al., 2012; Green et al., 2014; González-Consuegra and Verdú, 2011), identifying the most vulnerable to this disease.

Regarding the QOL results obtained using the SF-36 the domains and dimensions related to physical health were more affected than mental health because usually, the aspects of functionality are the most affected (Wong et al., 2012; Ashby et al., 2014). Previously active individuals feel uncomfortable with the situation that is perceived as a limitation and disability attributed by VU. (Silva et al., 2015; Maddox, 2012)

which prolongs the pain and discomfort (Green et al., 2014). The wound usually has exudate and fetid odor (Green et al., 2014; Salomé, 2010) needing constant dressings and other care that interfere with lifestyle (Salomé, 2010).

Another study corroborated that depressive symptoms appear in these patients to isolate them for fear of suffering prejudice, which causes a negative impact on quality of life. Moreover, also, they often wear clothes to cover the lower limbs due to the shame of self-image, which can cause relationship problems (Silva et al., 2015).

This situation can also interfere with sleep, and daily rest and, in this study, sleep was more often influencing QOL in physical, functional and mental aspects, being a variable that must have full attention from health professionals who want an expanded care and influence for welfare. An Australian research (Edwards et al., 2014) that aimed to identify the set of most common symptoms in people with VU found the presence of sleep disorders as the most common, which is a factor also associated with worsening of QOL, whose occurrence was

linked to fatigue, depression, and pain, affecting the physical and emotional health.

It is noteworthy that the sleep pattern changed (Green *et al.*, 2014; Green *et al.*, 2010; Hopman *et al.*, 2013) and pain (Green *et al.*, 2014) are characteristics mentioned and correlated by this population (Maddox, 2012) and physical issues, as seen in this study in which the intensity of pain alone and together with pain and sleep influenced the physical dimension.

Pain is a symptom that causes discomfort and often referred by people with VU (Green *et al.*, 2014; Roaldsen *et al.*, 2011), impacting negatively on the QOL of individuals with this injury (Green *et al.*, 2014; González-Consuegra *et al.*, 2011). It interferes with physical and mental health, among others and persists with the functional limitations despite the wound healing (Nogueira *et al.*, 2012). It affects leisure and can cause limited mobility with a consequent need of someone help to perform household chores. (Silva *et al.*, 2015)

Regarding the functional aspects and time of injury, people with a wound for more than six months had worse QOL. This situation may result from complications of ulcers, increasing the healing time, as found in a study that identified long injury in people in advanced stages of the clinical situation (Tew *et al.*, 2015).

Another factor that may have influenced to increase the time of injury is the quality of care, increasing the treatment time and achieving a significant difference with the functional aspect. The increase in treatment time promotes greater familiarity with the limitations. A large randomized trial comparing stockings and compression bandages for people with VU found similar results when identifying that the treatment time was a variable associated with the physical dimension of QOL (Ashby *et al.*, 2014).

Another care variable in the results was the use of the reference and counter-reference system, and the assisted individuals had worse averages for the pain domain. The presence and intensity of pain and the use of reference and counter-reference worked together interfering with the pain domain of the SF-36. Pain intensity and reference and counter-reference, alone also significantly affected the pain. Thus, it is important to develop actions involving several dimensions of care, objectively and subjectively, with a commitment to comprehensive care, using intersectional with emphasis on health promotion, disease prevention, treatment and rehabilitation of these patients (Silva *et al.*, 2011).

It is important to note that most respondents performed the treatment only in primary care by difficulties to consult an angiologist by the public health system and only go to another health level in more complicated situations. Thus, those who were referenced and often counter-referenced were in worse clinical condition compatible with pain worse.

It is essential an adequate functioning of this system since to prevent the recurrence of the injury is as important as preventing the occurrence (O'Donnell *et al.*, 2014). To this end, strategies are relevant for better functioning of the referral to continue its care.

Finally, the guidelines for performing compression therapy use and exercises showed significant results. Individuals oriented to

perform exercises had better QOL, while individuals oriented to the compression had achieved worse QOL. A case-control study (Nogueira *et al.*, 2012) found that people with VU are less active than people without injury and, in many cases, they do not exercise because of the pain, the bulky bandages, leg edema, wound exudate, old age and the need to use large and broad shoes, besides the fear of movement also associated with the experience (Nogueira *et al.*, 2012).

Guidance for exercise together with age influences vitality and, alone and together with pain, it affected the general state of health domain. The exercises can be useful to improve the injury. However, there are few studies that show results specifically based on these interventions (Tew *et al.*, 2015). It was possible to find randomized protocols in the literature that intervened with exercises to improve the calf pump and self-management of the health situation. However, they are meant only for adults (O'Brien *et al.*, 2014), disregarding the age as an important factor in QOL, as seen in this study.

People who have not received guidance for the use of compression therapy showed a better average in the mental health domain. This result differs from the expected as the targeted people should have better adherence to treatment and wellness. The compression therapy is recognized as the gold standard in the treatment of lesions originated from venous insufficiency (Ashby *et al.*, 2014), and it is extremely important the professionals encourage its use.

It is known that physical activity in combination with compression therapy is a treatment option because it improves the effects of venous hypertension, decreases healing time, prevents relapses and post-ulcer limitations. Exercises with the legs and walking are considered effective at stimulating muscle pump that ensures venous return (Hopman *et al.*, 2013).

Previous research has found that the person with VU is likely to develop problems that jeopardize their physical and emotional health being essential to identify the multiple dimensions that are influenced to live with the wound to pursue strategies that enhance adaptation to the chronic situation and promote quality of life (Silva *et al.*, 2015).

As explained before, knowing the aspects that affect the QOL of this population allows health professionals, especially nurses, incorporating them into the planning of assistance through interventions that break through wound healing.

This study was limited to the very cross-sectional design and the restriction on the location, which does not allow generalizations. On the other hand, it is an advance in understanding the multiple factors that can influence the QOL of people with VU, pointing to those in which the health team can intervene in the search for a humanized and comprehensive care.

CONCLUSION

Age groups, pain, sleep, time of injury and treatment, use of reference and counter-reference system and guidelines for exercise and compression therapy were the variables highlighted as influencing QOL in the population studied. Together, the variables also showed to influence the construct, especially sleep, presence and intensity of pain and guidance for exercise.

From the perspective of the search for a more humanized care and to know these aspects for comprehensive health care, multicenter and longitudinal surveys are suggested to obtain better evidence to identify the needs of people with venous injury, making a multidisciplinary, and integral care and favoring the improvement of the quality of life.

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