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Original Article

Quality of life of elderly patients with venous ulcers in primary health care: associated characteristics*

Qualidade de vida de idosos com úlcera venosa na atenção primária à saúde: características associadas

Calidad de vida de ancianos con úlceras venosas en atención primaria: características asociadas

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Abstract

Abstract: Objective: to assess the quality of life (QoL) and its association with the sociodemographic, health, clinical and care characteristics of elderly patients with venous ulcers. **Method:** cross-sectional study, conducted with 40 elderly people attended in Primary Health Care. Data were collected using the characterization form and Charing Cross Venous Ulcer Questionnaire. Descriptive and inferential statistics were applied ($p < 0.05$). **Results:** the QoL of the elderly with venous ulcer was compromised, especially in the Emotional State. Significant associations were found between pain and the domains Domestic Activities, Emotional State and Total Score; who performs the dressing and Emotional State; use of compressive therapy and domestic activities; and between the number of consultations and the domains Social Interaction, Domestic Activities, Emotional State and Total Score. **Conclusion:** absence of pain, dressing, treatment with compressive therapy and three or more visits per year were the characteristics that favored the QoL of elderly patients with venous ulcers.

Descriptors: Varicose Ulcer; Quality of Life; Aged; Nursing Care; Primary Health Care

Resumo

Objetivo: analisar a qualidade de vida (QV) e sua associação com as características sociodemográficas, de saúde, clínicas e assistenciais de idosos com úlcera venosa. **Método:** pesquisa transversal, realizada com 40 idosos atendidos na Atenção Primária à Saúde. Os dados foram coletados com formulário de caracterização e *Charing Cross Venous Ulcer Questionnaire*. Aplicou-se a estatística descritiva e inferencial (p <0,05). **Resultados:** a QV do idoso com úlcera venosa esteve comprometida, principalmente no Estado Emocional. Constataram-se associações significativas entre a dor e os domínios Atividades Domésticas, Estado Emocional e Escore Total; quem realiza o curativo e Estado Emocional; uso de terapia compressiva e Atividades Domésticas; e entre número de consultas e os domínios Interação Social, Atividades Domésticas, Estado Emocional e Escore Total. **Conclusão:** ausência de dor, realizar seu curativo, tratamento com terapia compressiva e três ou mais consultas ao ano foram as características que favoreceram a QV de idosos com úlcera venosa.
Descritores: Úlcera Varicosa; Qualidade de Vida; Idoso; Cuidados de Enfermagem; Atenção Primária à Saúde

Resumen

Objetivo: Analizar la calidad de vida (CV) y su asociación con las características sociodemográficas, de salud, clínicas y asistenciales de los ancianos con úlceras venosas. Método: estudio transversal, realizado con 40 ancianos atendidos en Atención Primaria de Salud. Los datos fueron recolectados utilizando el formulario de caracterización y el Cuestionario de Úlcera Venosa de Charing Cross. Se aplicó estadística descriptiva e inferencial (p <0,05). **Resultados:** La CV de los ancianos con úlcera venosa estaba comprometida, especialmente en el Estado Emocional. Se encontraron asociaciones significativas entre el dolor y los dominios Actividades Domésticas, Estado Emocional y Puntaje Total; quién realiza el vestuario y el estado emocional; uso de terapia compresiva y actividades domésticas; y entre el número de consultas y los dominios Interacción Social, Actividades Domésticas, Estado Emocional y Puntaje Total. **Conclusión:** ausencia de dolor, vendaje, tratamiento con terapia compresiva y tres o más visitas por año fueron las características que favorecieron la CV de ancianos con úlceras venosas.
Descriptores: Úlcera Varicosa; Calidad de Vida; Anciano; Atención de Enfermería; Atención Primaria de Salud

Introduction

Venous ulcer (UV) is an interruption of the continuity of skin tissue due to the complication of chronic venous insufficiency (CVI) by primary varicose veins, deep thrombosis, venous valve abnormalities, or other causes that interfere with the return of venous blood. It affects both sexes, with a predominance in females, corresponding to 70% to 90% of cases of ulcers in the lower limbs and represents a relevant global public

health problem.[1] UV is considered one of the most frequent causes of chronic wounds in people over 60 years of age, considering that its incidence increases with age[2] and reflects negatively on quality of life (QoL).[3]

For the elderly, the occurrence of UV can cause biopsychosocial repercussions, including changes in life habits due to the need for self-care and health care.[4-6] This type of wound negatively impacts QoL in several aspects, especially with regard to pain - due to compromising functional capacity - causing discomfort and adversity for social life; as well as high costs for the tissue repair process, which can be aggravated in the care process of the elderly.[3,5]

Thus, QoL stands out, which is defined as "the individual's perception of their position in life, in the context of the culture and value systems in which they live, as well as in relation to their goals, expectations, standards and concerns".[7:1405] QoL can be assessed through qualitative and quantitative strategies. Regarding quantitative methods, there is the use of instruments, which can be generic or specific. To assess the QoL of people with UV, we have the Charing Cross Venous Ulcer Questionnaire (CCVUQ). This instrument was created in England and applied worldwide in research with different populations, for example, in China[8] and Uruguay.[9]

In Brazil, the CCVUQ was validated, with excellent internal consistency, in a study[10] conducted with 50 individuals attended in public and private centers in the northeast region of the country.[10-11] However, national publications with and about this instrument are still recent and scarce.10-13 These addressed the validation of the questionnaire in Portuguese10 and the verification of internal consistency and stability in two regions of Brazil (Goiânia and Niterói);[11] the impact of UV on people's QoL attended in Primary Health Care (PHC) in Natal[12] and the evaluation of the responsiveness of the CCVUQ in the Brazilian population.[13]

Thus, the relevance of disseminating research on QoL in different contexts of the Brazilian reality is pointed out, as well as of evaluating the QoL of the elderly with UV assisted in the context of PHC, since the country presents continental characteristics and sociocultural inequalities in each region.[11] It is worth noting that aging can cause a series of physiological changes and PHC is the main gateway to health services. PHC can be a strategic space for the care management of these users by contemplating the needs of

each individual.[14] It is believed that identifying the association of sociodemographic, health, clinical and care characteristics, which greatly influence QoL, can enable the development of nursing interventions in favor of comprehensive care for the elderly with UV.

The theme is relevant because it subsidizes the care of the elderly and the evaluation/treatment of chronic wounds and quality of life, in line with the reference of person-centered care,[15] because, for nursing care to reach some level of problem-solving capacity, it depends on a methodologically instrumentalized clinical evaluation that meets the integrality of the elderly being and their health needs.

Based on the foregoing, this study aimed to assess the quality of life and its association with the sociodemographic, health, clinical and care characteristics of elderly people with venous ulcers.

Method

This is a cross-sectional study developed in PHC in a city in the central region of Rio Grande do Sul (RS), Brazil. At the time of collection, according to the Technical Note, the city had a population of 263,662, with coverage of 57.7% in Primary Care and 18% in the Family Health Strategy (FHS). In addition, it had 31 Basic Health Units (BHU) and 14 Family Health Units (FHU) in which 16 FHS teams worked.

After contact with the Municipal Health Department (SMS), PHC services that treated elderly people affected by venous ulcers in treatment and follow-up were identified and selected. It is noteworthy that a UBS, which centralized care for users with wounds that came from PHC, had a stomatherapist nurse and an angiologist.

During the period of data collection, the flow of care in PHC services was under restructuring and review. Patients with venous ulcers were linked to PHC and attended, at times, in the outpatient service of the University Hospital (HU).

To select the participants, the technique of non-probabilistic convenience sampling was used. Initially, we surveyed the records of people with wounds registered in the services and, by active search, those who attended for routine consultations or change of dressings. The elderly were indicated by the service teams for accessibility.

No sample size calculation was performed, including all patients aged 60 years or older, with at least one venous ulcer and attending the health service. After the selection, a date and time for the interview of the participants was scheduled.

Data collection took place from August to December 2016, in a private environment, in the referred service or at the participant's home, according to the preference and availability of the same. This was performed by the researcher herself through a form applied in a previous study,12 which contains sociodemographic, health, clinical and care data, as well as an instrument for measuring QoL, the CCVUQ.[10]

The independent variables evaluated were: sociodemographic (gender, age/age group, marital status, education, occupation/profession and income); health (Associated chronic diseases – Systemic Arterial Hypertension (SAH), Diabetes mellitus, heart disease, sleep, alcoholism/smoking); clinical (relapse, time of current venous ulcer, pain and signs of infection); and care (place of treatment in the last 30 days, who performs the dressing outside the health service, UV treatment time, makes use of compressive therapy - elastic stock/band, Unna's boot - in the last 30 days, guidelines for the use of compressive therapies/elevation of lower limbs/regular exercises, number of consultations with the angiologist in the last year).

The dependent variable (Quality of Life) was collected through the CCVUQ, composed of 21 items organized into four domains: Social Interaction (items 2A, 2B, 2C, 2D, 3A, 8), Domestic Activities (items 3A, 5A, 5B, 5C, 5D), Aesthetics (items 3C, 3E, 4, 7A, 7B, 7C) and Emotional State (items 3F, 3B, 6, 3E, 3D). These items are presented in a four-point Likert scale for questions 1, 4, 6, and 8; and five points for the others. The questionnaire score ranges from zero to 100, and the lower the score, the better the QoL.[10]

The data were coded and double-typed in Excel spreadsheets and, after checking for errors and inconsistencies in typing, the results were treated and analyzed in the Statistical Package for the Social Science (SPSS), version 18.0, by means of descriptive and inferential statistics. For categorical variables, absolute and relative frequencies were calculated and, for quantitative variables, mean and standard deviation were calculated when they presented normal distribution, and median, interquartile range,

minimum and maximum when they did not present normal distribution. To verify the distribution of normality of the data, the Shapiro-Wilk test was performed.

To verify differences between the median scores of the quality of life dimensions of the CCVUQ and other variables, the Mann-Whitney U Test was adopted, with a significance level of 5% ($p<0.05$), and reliability was assessed by means of Cronbach's alpha coefficient, being considered satisfactory Alpha >0.70. The CCVUQ showed satisfactory internal consistency (Cronbach's alpha=0.84).

This study is in line with the ethical recommendations for conducting research involving human beings according to Resolution 466, of 2012, of the National Health Council. The project received a favorable opinion from the Research Ethics Committee with protocol number 1,670,636 and Certificate of Presentation for Ethical Appreciation 58255016.0.0000.5346, on August 10, 2016. All participants received verbal and written information about the study and signed the Free and Informed Consent Form. The guidelines of the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) were followed for the clarity and transparency of the writing of the present manuscript.

Results

Participants were 40 elderly with venous ulcers who belonged to 25 health units. The highest percentage were women (n=23; 57.5%), with a mean general age of 71.9 (±8.40) years, minimum of 60 years and maximum of 87 years. Among the female participants, the mean age was 73.3 (±8.01) and the mean age was 70.1 (±8.81). They were aged 70 years or older (n=21; 52.5%), single, without a partner, widowed or divorced (n=25; 62.5%), with schooling up to elementary school (n=35; 87.5%), retired (n=34; 85.0%) and with an income of up to one minimum wage (n=36; 90.0%), with an average family income of R$ 1,450.00 (±1320.63).

Regarding health variables, there was a prevalence of elderly people with associated chronic diseases (n=28; 70.0%), such as hypertension (n=27; 67.5%), diabetes (n=10; 25.0%) and heart disease (n=4; 10.0%), with daily sleep greater than or equal to six hours (n=30; 75.0%), non-smokers and who did not consume alcohol (n=39; 97.5%).

In the analysis of the CCVUQ domains, the median score of total quality of life was 43.9, with the highest value in the domain in the Emotional State domain (57.4), followed by Aesthetics (44.7), Domestic Activities (29.9) and Social Interaction (27.9). Table 1 presents the comparisons of the CCVUQ domains in relation to sociodemographic and health variables.

Table 1 – Evaluation of the comparison of the domains of the CCVUQ in relation to the sociodemographic and health variables of the elderly with venous ulcer. Santa Maria, RS, Brazil, 2023. (n=40)

Variables Sociodemographic and Health		Domains of the *Charing Cross Venous Ulcer Questionnaire* (CCVUQ)				
		Social interaction	Domestic activities	Aesthetics	Emotional state	Total Score
Gender	Female	27.9	36.3	40.7	50.4	43.3
	Male	27.9	25.8	47.1	64.8	47.5
p-valor*		0,401	0.871	0.745	0.315	0.935
Age Range	60 to 69 years	30.6	31.4	46.6	55.9	43.3
	≥ 70 years	24.3	20.8	40.7	58.9	45.7
p-value		0,390	0.936	0.294	0.630	0.555
Marital Status	Single	27.9	33.7	45.8	64.3	45.7
	Married	27.9	24.1	43.6	54.2	35.6
p-value		0,233	0.455	0.825	0.659	0.455
Education	Up to Elementary School	27.9	31.4	45.8	58.9	44.5
	High School/Higher Education	33.1	25.8	43.6	55.9	35.6
p-value		0,473	0.968	0.691	0.751	0.843
Income	Until 1 SM†	27.9	32.0	46.2	61.8	46.0
	> 1 SM	32.4	24.1	37.9	43.8	39.5
p-value		0,528	0.744	0.324	0.324	0.37
Chronic diseases	Present	26.8	27.1	41.3	55.1	42.9
	Absent	33.5	33.2	50.0	66.8	46.2
p-value		0.260	0.493	0.247	0.850	0.313

Note: *Mann-Whitney U test, †SM: minimum wage R$ 880.00, value in force in 2016

Regarding the clinical variables, a higher percentage of elderly had UV recurrences (n=27, 67.5%), current UV time less than or equal to one year (n=21, 52.5%),

reported the presence of pain (n=23, 57.5%) and no signs of infection (n=31, 77.5%). Table 2 presents the comparisons of the QoL domains of the CCVUQ in relation to the clinical variables of the UV.

Table 2 – Comparison of the domains of the CCVUQ in relation to the clinical characteristics of the elderly with venous ulcer. Santa Maria, RS, Brazil, 2023. (n=40)

Clinical Variables		Domains of the *Charing Cross Venous Ulcer Questionnaire* (CCVUQ)				
		Social interaction	Domestic activities	Aesthetics	Emotional state	Total Score
Relapse	Yes	27.9	31.4	47.1	54.2	42.5
	No	33.1	28.4	39.1	64.3	45.7
p-value		0.407	0.407	0.512	0.475	0.458
Current venous ulcer time	≥ 1 year	27.9	28.4	39.1	55.9	42.5
	Until 1 year	27.9	33.7	52.4	58.9	48.0
p-value		0.708	0.708	0.810	0.169	0.957
Pain	Yes	31.1	42.9	52.4	71.3	47.9
	No	23.6	20.8	37.4	35.6	32.7
p-value		0.066	0.066	0.048	0.075	0.034
Signs of infection	Yes	27.9	42.9	54.1	71.1	47.9
	No	27.9	28.4	43.6	55.9	42.5
p-value		0.649	0.649	0.275	0.486	0.445

Note: *Mann-Whitney U test

Regarding the care characteristics (Table 3), the study participants referred to the health service (n=34; 85.0%) as the predominant place for dressing, and the concomitant use of more than one site during treatment was frequent, among which the UBS (n=22; 55.0%) and the outpatient clinic of the UH (n=21; 52.5%) were highlighted. Regarding the therapies used, they did not use compressive therapy (n=24; 60.0%) and, among those who did, Unna's boot was used (n=16; 40.0%). They were instructed about the elevation of the lower limbs (n=40; 100.0%), compressive therapies (n=28; 70.0%) and regular exercises (n=18; 45.0%). In addition, they had up to three consultations with the angiologist per year (n=34; 85.0%).

Table 3 – Comparison of the domains of quality of life in relation to the care variables of the elderly with venous ulcer. Santa Maria, RS, Brazil, 2023. (n=40)

Healthcare Variables		Domains of the *Charing Cross Venous Ulcer Questionnaire* (CCVUQ)				
		Social interaction	Domestic activities	Aesthetics	Emotional state	Total Score
Place of treatment	Home	35,6	29,9	42,1	57,4	44,5
	Health Service	25,0	30,5	46,2	59,5	43,5
p-value		0,127	0,127	0,644	0,839	0,726
Who performs the dressing	Professional	30,3	35,8	46,9	68,1	47,4
	Patient	23,6	20,3	39,9	36,1	34,6
p-value		0,439	0,439	0,130	0,57	0,045
Time of treatment	> 1 year	31,6	29,9	42,1	61,6	46,5
	≤ 1 year	24,6	30,5	46,4	45,4	37,6
p-value		0,312	0,312	0,757	0,443	0,312
Makes use of Compression Therapy	No	30,3	37,0	44,7	69,9	45,1
	Yes	25,1	20,3	41,2	36,6	33,6
p-value		0,244	0,244	0,031	0,838	0,134
Number of consultations	≤ 3 /year	30,3	32,0	46,9	64,5	47,4
	> 3/ year	21,6	16,8	29,1	25,6	28,9
p-value		0,033	0,033	0,033	0,137	0,025

Note: *Mann-Whitney U test

Discussion

In the analysis of the sociodemographic characterization, the results evidenced here corroborate those of other studies.[8-9,12] In a study that also used the CCVUQ with users attended in PHC services in the Northeast region, greater impairment was found in the Emotional State and Aesthetic domains.[12] Thus, there are biopsychosocial repercussions that need interventions in health care. Still, a review study points to better evidence when focusing care on the person with wounds, with positive results in QoL.[15]

The high number of elderly women with UV may reflect the feminization in the elderly group and also the demand for health services by this public in PHC. In addition, it reinforces their greater longevity in relation to men.[16]

The largest number of UV cases in the age group of 70 or more years of age is close to the results of a study conducted in China,[8] where the CCVUQ was applied to 100

patients with an average age of 70 years. However, when applying the same instrument in Uruguay[9] and in a Brazilian bicentric study,[11] the mean ages were respectively 63.4 and 61.4 years, being divergent from the findings found in the present study.

In the case of elderly patients with leg ulcers, married individuals present a possibility of support for care in relation to the change of dressing and for other daily care.[17] Thus, the results indicate the need for interventions by the nursing team to support those who live alone. One can look for links in the family structure or groups in the community that can support these people, contributing to a better management of self-care. Thus, they consider the user as a whole within the cultural context in which they are inserted and in which care is provided, which contributes to health care and adds benefits in QoL.[15]

The elderly, even though they were mostly retired, were living with reduced per capita income and low schooling, which was also evidenced in other studies.[9,12] These questions can be justified by the little incentive to education that occurred in other times and that hinder the self-care of the elderly due to the lack of knowledge of their clinical situation and financial difficulties for the continuity of care.[5] Thus, the importance of carrying out emancipatory educational actions in search of the QoL of the elderly is evidenced, as well as of adding, to these processes, strategies of universalization and equalization of information and forms of income expansion.

Education stands out as an important tool in health promotion, in the guarantee of autonomy and in the QoL of the elderly. Care practices need to go hand in hand with health education in order to promote self-care and improve QoL. In this context, the role of the nurse in PHC as a mediator of the teaching-learning process is relevant to develop the autonomy of users and make them independent in relation to their daily care. It is reiterated the need for nurses to evaluate their knowledge about educational measures, whether they are being understood for the control of the disease and prevention of complications. In addition, it is up to him to stimulate and encourage users and family members to perform continuous care with venous ulcer and CVI control.[18]

In the context of aging, the association of comorbidities causes damage to the maintenance of independence and preservation of QoL. In a Brazilian study, it was found that, when the elderly have comorbidities concomitantly (SAH and diabetes), they

are 1.7 times more likely (95%CI=1.12-2.78) to develop some degree of dependence than when they have only SAH.[19] Thus, identifying the associated comorbidities enables the planning of nursing care according to the health conditions of each user, with a view to favoring the healthy aging process, independent and autonomous, considering the needs of each individual as a unique being.[15]

Considering this, it is relevant to develop studies that may present new contributions to improve QoL and, consequently, active aging. Even more than the prevalence of chronic non-communicable diseases constitutes an epidemiological panorama common to the aging population. The increase in longevity brings to the elderly the coexistence with these diseases for a long period, which can compromise their QoL, especially in the case of the elderly with leg ulcer, and it is necessary to consider the biopsychosocial aspects related to the injury for the elaboration of effective nursing interventions.[16,20] Thus, the elderly should be evaluated holistically, taking into account their lifestyle and general health factors, such as associated health conditions and family history.[21] The patient-centered model can contribute to improve the treatment and QoL of the elderly with venous ulcer.

In this sense, the need for multiprofessional care for the elderly is reinforced, since the greater impairment of the emotional domain indicates that psychological issues are impaired by the existence of the ulcer.[3-5] The recognition of this emotional vulnerability of the elderly by nursing needs to be considered in the therapeutic decision-making and in the search for strategies to involve other health professionals. For nursing, it is possible to consider welcoming with qualified and sensitive listening, emotional support and dialogue. Still, in view of the other health centers, the importance of psychological therapeutic accompaniment is considered.

We identified the trend of worse QoL for the elderly who did not have relapses, with current UV up to one-year, present pain and signs of infection. Thus, it is noteworthy that decisions about nursing interventions need to consider the patient and the family member so that they can understand and carry out the therapeutic process in a continuous and effective way, as well as avoid complications in relation to pain and wound infection through knowledge about the health condition.[18] Therefore, prevention and recovery measures lack investments in PHC. The importance of working with health

education in the individual approach to the elderly or through actions in health groups is highlighted, in order to prevent recurrences and complications, such as pain and signs of infection.

Pain was significantly associated with the domains Domestic Activities (p=0.048), Emotional State (p=0.034) and Total Score (p=0.022) of the CCUVQ, so that the elderly who reported pain had worse QoL compared to those who did not. The occurrence of pain is frequent in patients with UV and can cause effects such as delay in the healing process, irritability, insomnia and even social isolation, negatively affecting QoL.[3,12,22]

When investigating the occurrence of pain in people with UV, it was found that the least impact of pain on daily activities occurred in those who had a profession/occupation, who did not smoke/drink, used or received guidance on compressive therapy and elevation of lower limbs, with minor lesions, in the epithelialization phase and without signs of infection.[22]

The reduction of pain constituted a factor of change and improvement in the QoL of the elderly with UV. However, the relationship between pain and QoL should be further explored, as it still lacks constant assessment measures and interventions. It is reinforced that pain is characterized as one of the factors that affects the QoL of people with UV and is a gap in care. It is necessary that they receive care based on humanized welcoming, sensitive listening and that they have emotional and psychological support throughout the treatment, through health interventions aimed at the recovery and rehabilitation of these people and their families.[3,15]

Regarding the care variables, the worst QoL was identified for the elderly with UV who undergo treatment at home. It is noteworthy that the follow-up with the health professional, for example, the nurse, is fundamental for the treatment, opportune to evaluate the cognitive conditions of the patient, the care that is performed, the family support, adherence to the treatment and, mainly, to indicate the correct coverage since the inadequate use can lead to problems, such as pain, infections and hospitalizations.[23] The performance of the PHC health team can contribute to the planning, coordination and execution of measures to prevent injury aggravations, in addition to facilitating the clinical and hemodynamic evaluation of the progression and evolution of treatment.[24]

However, those undergoing treatment in the health service had higher medians in the domains Domestic Activities, Aesthetics and Emotional State. A significant difference was found between those who performed the dressing and the Emotional State (p=0.045), with better QoL of the elderly who performed their dressing when compared to those who made the dressing with the health professional. It is inferred that the search for professionals may be related to the aggravation of the injury.

In a study conducted in the interior of RS, it was identified that the search for care is related to the family and cultural context, and the therapeutic itinerary of the person with chronic venous ulcer is influenced by popular knowledge, family and spiritual support, in addition to relations with health services that did not act in an integrated and not always resolutive way. It evidenced important gaps in professional care, such as unpreparedness, fragmentation of the bond and humanization in health services, which contributed to the lack of adherence to treatment.[25]

Health care requires frequent revisions and re-evaluations of the therapeutic plan in addition to the practice of dressings. Thus, non-invasive and cost-effective intervention measures can be implemented. As an example, the effectiveness of an exercise intervention is cited as an adjunct to other treatments to aid in wound healing. In the case of people with UV, exercises that stimulate the gastrocnemius muscle are effective in improving the hemodynamics of the venous system and with favorable repercussions on QoL. However, ways are needed to improve their adherence to the exercise program as a complementary treatment to usual care.[6,26-27] Adherence to care, including rest, adequate nutrition and compressive therapy, may be a possibility for improving QoL.[6]

In this study, the elderly who used compressive therapy had better QoL and the presence of this type of treatment was a positive issue of care. Similarly, research has found that people who used compression therapy had lower pain intensity and less impact of pain on day-to-day activities.[22] The literature indicates that people using compressive therapy have benefits in general, such as lower pain intensity, reduction of edema and venous hypertension. It is considered that this therapeutic measure, when performed appropriately, can assist in the debridement of devitalized tissue due to the control of inflammation, contributing to the management of the amount of exudate and

to the improvement of healing, also presenting effectiveness in the prevention of recurrence.[21,24,28]

The use of compressive therapy was significantly associated with the Domestic Activities domain (p=0.031). It is presumed that the use of this treatment, especially Unna's boot, which was the therapy made available to the participants, gave them a sense of security and reduced edema. Unna's boot is a traditional and low-cost dressing when compared to other compressive techniques, such as multilayer bandage.[28]

The use of Unna's boot was considered easy because it did not require daily change and because it favored the healing process. The use of Unna's boot allows the reduction of pain and edema, but in some cases it can cause discomfort due to the treatment adherence and inelasticity, in addition to being able to cause embarrassment by the odor exhaled during its use and the difficulty for body hygiene.[28-29]

In the characteristics of care for the elderly with UV, statistically significant associations were verified between the number of consultations with an angiologist and the domains Social Interaction (p=0.033), Domestic Activities (p=0.033), Emotional State (p=0.025) and total score (p=0.030). The elderly who had more than three visits per year had better QoL. However, the focus on QoL cannot be restricted to medical care centered on the specialty, since this reality is considered a difficulty in the continuity of care in PHC services.[5,30] Therefore, the need for multidisciplinary and comprehensive follow-up in prevention, early diagnosis and care for the elderly with UV and their families is reinforced.

It is known that PHC needs to accompany the users enrolled in its unit, being a counter-reference of specialized services during treatment, contributing to the integrality and resolvability of the care provided by playing a significant role in the planning and implementation of actions and measures for the promotion of health and prevention of injuries, acting in the co-responsibility of the health and disease process.[12,14] However, these people were not cared for in order to follow the injuries. In the municipality under study, PHC units were not considered a reference for treatment, which was centralized in district units, considered to be of high cost.

The diagnosis and treatment of chronic wounds constitute an interdisciplinary challenge and should be guided on the standards of protocols. Although, most seniors

with UV received guidance on compressive therapies, many users were not being treated properly according to the guidelines.[21,24]

As a methodological limitation of this study, the cross-sectional design stands out, which prevents the evaluation of the behavior of the variables over time and the inference of causal relationships between them. In addition, due to the small sample size, the results cannot be generalized. New studies with a larger sample size, which investigate differences between elderly with UV from different regions of Brazil and with longitudinal designs should be conducted in order to better guide nursing actions with a focus on monitoring the elderly and promote interventions to improve the QoL of this population. It is also mentioned as a limitation of the study the absence of evaluation of the exudate and appearance of the dressing, which are aspects evidenced in the literature with an impact on the QoL of individuals with venous ulcers.

As contributions of the present study, the implications for health and nursing practice and the relevance of nurses working in the development of rehabilitation and health promotion programs through care, therapeutic and educational actions that can reflect on the improvement of QoL are highlighted. The establishment of a singular, comprehensive and continuous multiprofessional care plan can promote social reintegration, provide strategies for adaptation and encourage self-care, as well as the autonomy of the elderly and the participation of the family. In this sense, the prominent role of nursing in the context of PHC is pointed out when getting to know the elderly who are in its territory, in view of the increase in care needs in this group to add more years of life and with quality, from the appreciation of their cultural context and that health education actions can be implemented and feasible.

Conclusion

The QoL of the elderly with UV was compromised, mainly, in the Emotional State domain, and the evaluation of psychosocial factors presents contributions to the direction of care regarding a holistic, integral and resolutive approach. In this sense, the strategic role of the PHC health professional as an agent of emancipatory education in relation to the promotion of self-care, adherence to treatment and follow-up of the evolution of the VU, as well as the prevention of relapses, is highlighted.

Regarding the characteristics, statistically significant associations were identified with the variables: pain, who performs the dressing, making use of compressive therapy and number of medical consultations, confirming the emphasis on clinical and care characteristics. Therefore, the absence of pain, dressing, treatment with compressive therapy and three or more medical visits per year were the characteristics that favored the quality of life of this group.

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