Evaluating the impact on patients of living with a leg ulcer

A qualitative study by Walsh (1995) investigated patients’ experiences of living with leg ulcers. Thirteen patients were interviewed in their own homes by the researcher using informal, unstructured interviews, which were tape-recorded and transcribed. Interviewees were randomly selected by district nurses and all had venous leg ulcers. Pilot interviews had been conducted before the study to ensure usefulness of the data gained.

This was a small study and those selected were mainly women and over 85. Interviews appeared to vary in length from 30 minutes to two hours. The dominating problem again was that of pain, which was described as having a profound effect on their lives. The researcher commented that the importance of pain is often not reflected in the literature concerning leg ulcer assessment and treatment, and recommended that care should aim to provide better comfort and symptom control.

Age and gender differences

Franks and Moffat (1998) examined health-related quality of life using the Nottingham Health Profile. This study included 758 patients. No age range was stated, but the average age was 74.6 years. Ulcers had lasted from two weeks to 59 years. The patients came from several trusts and this may have affected the results. The results were compared with ‘normal ranges’ based on an age/sex match, although manipulation of data to perform the comparison could have affected the results. In older patients the drop in health-related quality of life was greater in women than men. However, once the age/sex normal ranges were applied young men suffered most from having a leg ulcer. The main problems were mobility, pain and energy levels.

Patient experience

An Australian research team (Hyde et al, 1999) attempted to gain an insight into patients’ experiences of living with leg ulcers. The study involved 12 women aged 70–90, all of whom had had an ulcer for more than three years. Each woman was interviewed in depth, then had a follow-up interview. The two main problem areas were:

- Gaining and maintaining control over vulnerable limbs;
- Lifestyle consequences of chronic leg ulceration and impaired mobility (Hyde et al, 1999).

These areas were broken down into subgroups and again the overriding problem was pain, with leakage and odour also mentioned. In the authors’ experience these are all symptoms that nurses take to be a normal part of the patient experience of leg ulceration.

Douglas (2001) conducted a qualitative study of eight patients to explore their experiences of having a leg ulcer and to encourage their participation in care issues in accordance with government recommendations. The patients, six women and two men, were aged 65–94. No distinction was made on the type of leg ulceration.

Semi-structured interviews were recorded and transcribed as in previous studies. Although the study showed that pain was an overwhelming feature that had a profound effect on participants’ lives, it also showed that pain sometimes leads to non-compliance, which was seen as a problem associated with the nurse-patient relationship. The author suggested that if patients adopt a collaborative relationship with their district nurse they feel more in control of their lives and have improved self-esteem and better coping strategies (Douglas, 2001).

Nursing implications

In all the studies reviewed patients reported pain to be the main problem associated with leg ulceration – whether venous or arterial. Pain can also affect sleep and mobility. Odour and leakage can have a major effect on a patient’s psychological state and could lead to social isolation. Younger patients may find working difficult so there could be financial implications. All these factors can lead to low self-esteem and may affect healing rates.

These studies demonstrate the importance of undertaking a holistic assessment when caring for patients with leg ulcers. Nurses need up-to-date knowledge of different dressings to ensure they make an appropriate choice and they need to be familiar with the latest methods of management of leg ulcers – including dealing with exudates – to aid comfort. This in itself may increase patients’ self-esteem and improve sleep and mobility, enhancing their quality of life. An appropriate pain assessment tool should be incorporated into the nursing assessment to aid the monitoring of pain and the effectiveness of prescribed analgesia (Baker, 2002).

Nurses should be aware of the types of analgesia available. They should also monitor their effectiveness, initiating changes in dosage or to alternative medication following discussion with patients and their GPs.

Conclusion

In light of these studies pain assessment tools should be used to help nurses to ensure they minimise the pain experienced by patients and therefore reduce the negative impact of leg ulcers on their quality of life. This exercise has also highlighted the need for nurse education and training in the management of leg ulcers. By combining clinical knowledge and skills, and observing their effects on patients, more holistic treatment programmes can be tailored for each patient’s individual needs.

References


### SUMMARY POINTS

- Over one-third of patients cited pain as the worst thing about having an ulcer (Hamer et al, 1994).
- Pain results in sleep disturbance and impaired mobility (Hyde et al, 1999; Franks and Moffat 1998; Charles, 1995; Hyland et al, 1994).
- Care should aim to provide better comfort and symptom control (Walsh, 1995).
- Pain sometimes leads to non-compliance (Douglas, 2001).

### ABSTRACT


Much research has been undertaken into the cost-effectiveness of leg ulcer treatments, dressing selections and patient compliance. However, comparatively little research has investigated the effect of leg ulcers on patients’ quality of life. This article reviews the literature examining the quality of life of this patient group and the factors that have the greatest negative impact on them.

It is estimated that approximately one to two per cent of the population will develop a leg ulcer at some stage in their life (Laing, 1992), and that 100,000 people have a leg ulcer at any one time (Callam et al, 1985). Of these over 80 per cent will be cared for by district and practice nurses (Cornwall et al, 1986) at a cost of approximately £1,200 per patient per year (Callam et al, 1988). However, the financial implications for the NHS are not the only costs associated with leg ulcers.

### Quality of life

Ulcers have a negative effect on a patient’s quality of life and in order to minimise this it is important to understand which factors associated with leg ulceration have the greatest impact. Much research has investigated the cost-effectiveness of treatment, choice of dressings and patient compliance. However, comparatively few studies have considered how ulcers affect the quality of life of patients and the role of the primary health care team.

The Health of the Nation (Department of Health, 1993) states that health care providers should aim to reduce or minimise the adverse effects of illness and disability, in order that their patients live for more years free from ill health. The definition of health is an individual one and is therefore difficult to measure. Equally, perception of quality of life is complex and subjective, reflecting the individual’s status, life experiences and needs (Hayes, 1997).

### Associated pain

In order to provide quality health care it is necessary to understand how a disease affects the life of individuals or populations (Franks and Moffat, 1999). Hamer et al (1994) tried to gain a greater insight into patients’ perceptions of having chronic leg ulcers, using a structured questionnaire in a semi-structured interview. The study also included health measurement tools such as the Nottingham Health Profile and Gibbs Pain Questionnaire.

A total of 158 patients were interviewed: 88 with leg ulcers and 70 without. Subjects were randomly selected within certain criteria; all were over 65 years old. There were several interviewers, which could be seen as a weakness as their interview techniques may have varied. In addition no distinction was made between arterial and venous ulcers. The study was commercially sponsored, which could also have caused bias. Initial results showed over-one-third of patients felt that the worst thing about an ulcer was the associated pain (Hamer et al, 1994).

### Effects of pain

Hyland et al (1994) developed a disease-specific quality-of-life questionnaire for patients with leg ulcers. The questionnaire was developed using focus groups of patients with leg ulcers who were opportunistically selected by the district nurses. This type of sampling may not be completely representative and could affect the reliability of any results.

A pilot questionnaire was distributed to 33 patients, again opportunistically selected, after which a final questionnaire was issued and completed by 50 patients. This study also made no attempt to differentiate between arterial and venous leg ulcers. The small sample size could lessen the reliability of the results across all patients with leg ulcers. However, the study found that patients with leg ulcers experience pain and their quality of life is influenced by a variety of factors. Some of the factors are the direct result of pain, such as sleep disturbance and impaired mobility (Hyland et al, 1994).

A US study by Phillips et al (1994) investigated the impact of leg ulcers on patients’ quality of life by interviewing 73 patients attending hospital outpatient departments. The standardised interviews were broken down into sections covering physical, functional and psychosocial aspects. Some 65 per cent of patients reported severe pain. The study concluded that leg ulcers pose a substantial threat to a variety of dimensions of patients’ quality of life (Phillips et al, 1994). There was no indication of how the study results would be used to improve care.

A phenomenological study (Charles, 1995) was performed to attempt to understand the lived experience of having a leg ulcer. Due to the amount of data such studies generate just four patients were included, but selection criteria were absent. All interviews were conducted by the same interviewer to maintain consistency and were tape-recorded. The tapes were transcribed and given back to the participants to confirm accuracy. The study found that pain was the dominating factor for patients, and that it affected sleep patterns and mobility (Charles, 1995).

### Need for symptom control

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### REFERENCES


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