ABSTRACT
Objective: to analyze the quality of life (QOL) of people with Chronic Renal insufficiency (CRI) who are undergoing hemodialysis treatment compared to transplanted, with application of the SF-36. Method: quantitative study, descriptive, transversal, with 34 patients on dialysis and transplant unit 34 of Hemodialysis and Renal Transplantation outpatient clinic of a hospital of Florianópolis (Santa Catarina), randomly selected by the criteria: IRC carrier; over the age of 18 years; without restrictions on oral communication; who are undergoing hemodialysis or kidney transplanted. In the analysis of the data, we used descriptive statistics. The Research Ethics Committee, Protocol No. 2011/0033, has approved the research project. Results: scores of QOL of transplanted showed statistically significant differences in six areas: functional capacity, physical/social and emotional aspects, general health, vitality, compared to on dialysis. Conclusion: kidney transplant recipients have better QOL, in general health and limitations on physical aspects, compared to patients on dialysis. Descriptors: Quality of Life; Chronic Renal Failure; Hemodialysis; Kidney Transplant; SF-36.

RESUMO

RESUMEN
Objetivo: analizar la calidad de vida (CDV) de personas con Insuficiencia Renal Crónica (IRC) sometidos a tratamiento hemodiálisis comparado a de transplantados, con aplicación del SF-36. Método: estudio cuantitativo, descriptivo, transversal, con 34 pacientes en diálisis y trasplante 34 de la unidad de hemodiálisis y Trasplante Renal clínica ambulatoria de un hospital de Florianópolis (Santa Catarina), seleccionado al azar por los criterios: portador IRC; mayores de 18 años; sin restricciones en la comunicación oral; que se someten a hemodiálisis o riñón trasplantado. En el análisis de los datos se utilizó estadística descriptiva. El proyecto de investigación ha sido aprobado por el Comité de ética de la investigación, Protocolo n° 2011/0033. Resultados: puntuaciones de CDV de transplantados mostraron diferencias estadísticamente significativas en seis áreas: capacidad funcional, aspectos físico social y emocionales, salud general, vitalidad, en comparación con diálisis. Conclusión: receptores de trasplante renal tienen mejor CDV, en el estado general de salud y limitaciones en aspectos físicos, comparados con los pacientes en diálisis. Descriptores: Calidad de Vida; Insuficiencia Renal Crónica; Hemodiálisis; Transplante de Rínón; SF-36.

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INTRODUCTION

The increase in chronic non-communicable diseases fostered growing discussion on the quality of life (QOL) of people, due to the spread of preventive medicine, to greater awareness of the population, plus the increase in life expectancy and the technological advancement of diagnoses and treatments.1, 2

The chronic renal failure (CRF) is a chronic disease and a global public health problem because of its high morbidity and mortality.3, 4 The presents limitations and complications arising from their treatment, which affect the functional abilities of the carrier, its everyday activities, the QV and family life.1

Between these complications, include digestive and neurological changes, anemia, the loss or reduction of physiological functions, physical, sexual and cognitive incompetence; bone diseases; limitation of daily life activities and occupations; health care and constant dependence of dialisadora machine, which results in social deprivation.3, 4

Kidney transplantation is the best therapeutic option for patients with IRC, both from the medical point of view, as social or economic.3, 4 Renal transplant patients are able to return to normal diet and drink fluids regularly.5 May exercise everyday activities such as work, study, travel and practice physical exercises.6, 7 However, new routine in life due to the need of daily medication intake, in hard times, in addition to medical consultations and examinations.4

The option for kidney transplant occurs for various reasons, is the desire to avoid dialysis or improve your sense of well-being and the longing for a more regular life.6, 8 Kidney Transplantation offers patients in hemodialysis (HD) the chance of greater independence and better QOL.6, 9 The TX reduces, in most people, the risk of mortality, when compared to the 8/4/10 HD.

According to the World Health Organization (who), QOL is the “individual’s perception about their position in life, in cultural context and value system of the place where he lives and in relation to your goals, expectations, standards and concerns.” 5, 1 When health-related QOL refers to the measure of the patient’s functioning, its physical-psycho-social well-being.8, 6, 10 In chronic renal patients is influenced by the disease and by the type of therapy used to replace renal function.6, 4

In relation to chronic diseases, information and measurement of QOL measurement are essential for the evaluation of assistance provided, as shall show the impact of the disease and treatment in their lives.14 This process occurs through the use of existing instruments and validated, based on concepts of health, being the main source of information the patient himself, assisting in decision-making by managers, clinicians and users of healthcare systems.6, 9

With this in mind, the present study aimed to analyze QOL of patients with chronic renal failure under hemodialysis treatment compared to transplant. He has been trying to perform a search that stating the improvement in QOL, serving as motivation for TX. The guiding question of this study involves the following problem: renal transplantation significantly improves QOL of patients with IRC that undergoing the procedure for HD.

METHOD

Article drawn from the monograph << quality of life of patients with Chronic Renal Failure hemodialysis-the kidney transplant >>, presented to the Nursing course of Estacio de Sá University Center of Santa Catarina. São José-SC, Brazil, 2011.

Study of non-experimental quantitative nature, exploratory and descriptive, comparative, cross, developed in HD and in renal transplant outpatient clinic of a large public hospital in the city of Florianopolis, State of Santa Catarina, Brazil.

The subjects of this study were people with IRC that do HD and TX renal patients. Participated in these research 34 patients on dialysis and transplant 34. The total number of patients enrolled in the HD and renal clinic TX determined this number of individuals. Decisive factor for participation in the study was the signature of informed consent (TFCC).

Data collection was developed in the months of August and September 2011. The patients were randomly selected, regardless of ethnicity, sex, education and marital status, taking into account the following inclusion criteria: carry IRC; be over the age of 18 years; do not have restrictions on oral communication; be capable of reading and understanding of the questionnaire; be performing HD or be transplanted renal agree to participate in the study; signing an informed consent (TFCC). Were considered as exclusion criteria: evidence or intellectual deficit (recorded in the medical record of patients); physical and organic problems (such...
Quality of life of patients with chronic renal...

The statistical analysis in this study had as objective to identify the variables that interfere with chronic renal patients QV. To this end, we used the instrument of SF-36 quality of life to measure possible differences of QOL in the group.

First was the calculation of the said questionnaire scores, turning the questions in domains. With this, so the eight domains of the questionnaire in two main groups: physical component (functional capacity, physical aspects, pain, and general health) and mental component (vitality, social, emotional and mental health issues).

In a second moment, became the value of previous issues in notes. The values of the fields varies from 0 (zero) to 100 (one hundred), which define 0 = the worst and 100 = the best score for each domain. Is called Raw Scale because the final figure shows no unit of measure.12

♦ General characteristics of the study population

The profile of the 68 participants of this research, in relation to the variable sex, male prevalence (65.6%-n = 42), 25 on dialysis and transplant about 17 female (40.6%-n = 26), transplanted and nine hemodialitics 17. The prevalent in both groups was age of 50 years or more.

With regard to marital status, it was found that there was a predominance of 25 (73.5%) patients in the transplant group and married, in the Group of patients on dialysis, single marital status prevailed with 16 (47.1%) individuals.

When it comes to education, there was a predominance of 17 subjects with intermediate (50.0%) in the transplant group and who are undergoing hemodialysis group, the fundamental level with 20 (58.8%) people.

♦ Clinics Characteristics

The main diseases that caused the IRC study groups are shown and compared in table 1.

Table 1. Distribution of patients in the study according to the etiology of IRC. Florianopolis (SC), Brazil, 2011.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Transplanted</th>
<th>On Dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 34 %</td>
<td>N = 34 %</td>
<td></td>
</tr>
<tr>
<td>The IRC-causing diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>14 (41.2)</td>
<td>15 (44.1)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8 (23.5)</td>
<td>4 (11.8)</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>5 (14.7)</td>
<td>3 (8.8)</td>
</tr>
<tr>
<td>Polycystic kidneys</td>
<td>4 (11.8)</td>
<td>2 (5.9)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (8.8)</td>
<td>10 (29.4)</td>
</tr>
</tbody>
</table>

Magalhães ACL, Coelho GD, Azevedo MA de et al.

as hearing impairment and chronic neurodegenerative diseases) that do not allow the application of the questionnaire.

In addition, this study was approved by the ethics on Research Committee of the Hospital Celso Ramos-Florianopolis/SC under the Protocol/0033 and 2011 developed in line with the resolution No. 196, October 10, 1996, Regulatory Standards and guidelines for research involving Human beings of the National Health Council, respecting the principles of beneficence, non-maleficence, justice and autonomy.11

Data collection was performed by applying an instrument auto populated, developed specifically for this study, containing demographic questions (age, gender, marital status, education, monthly income), both for patients in HD, as for kidney transplant patients. For the analysis of QOL was applied the generic SF-36 instrument, translated and validated in Portuguese. The average time used in every interview was 30 minutes.

The SF-36 questionnaire, evaluates the perception of QOL which the patient has health-related. Is a multidimensional questionnaire consisting of 36 items, with eight scales or components: functional capacity, physical aspects, pain, general health, vitality, social, emotional and mental health aspects.

To get the score of QV, the numeric values present in the questionnaire were transformed into a scale percentage 0% to 100% for each dimension, according to the manual for use and correction of the SF-36, so that high scores indicate better QOL in the parsed dimension.

The data were categorized, descriptive statistical analysis made and stored in a database tabulated in Microsoft Excel 2007. From this analysis, descriptive statistics were generated as mean, standard deviation, maximum and minimum percentage of variables. For the analyses were used three statistical tests, being the average differences test, correlation analysis and analysis of variance (Anova).

The statistical analysis in this study had as objective to identify the variables that interfere with chronic renal patients QV. To this end, we used the instrument of SF-36 quality of life to measure possible differences of QOL in the group.

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♦ Clinics Characteristics

The main diseases that caused the IRC study groups are shown and compared in table 1.
Quality of life of patients with chronic renal...

**Particular characteristics of transplanted group**

When approached about origin of the transplanted organ, 19 patients (55.9%) stated they were from donors, while 15 corpses (44.1%) claimed to be living donors. In relation to the waiting time by organ, 15 (44.1%) patients waited for 30 days to 6 months.

When investigated the TX time, 70.6% held the TX of 1 to 3 years, 14.7% of 4 to 7 years and 8.8% over 8 years. To be covered on the occurrence of graft rejection, 82.4% did not present any kind of rejection opposed to 17.6%.

How to receive guidance and education for self-care by nursing staff, 30 (88.2%) of respondents claimed that they were prepared and that perform continuous care while four (11.8%) claimed not to have received.

In relation to the improvement of QOL after TX, all transplant patients were unanimous in saying a significant improvement.

**Particular characteristics on dialysis group**

The particular characteristics of the Group of patients who perform HD are addressed in table 2.

<table>
<thead>
<tr>
<th>Variables</th>
<th>On Dialysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transplanted</td>
<td>On Dialysis</td>
</tr>
<tr>
<td></td>
<td>N = 34</td>
<td>N = 34</td>
</tr>
<tr>
<td>HD time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 6 months</td>
<td>15 (44.1)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Of 6 months to 1 year</td>
<td>12 (35.3)</td>
<td>4 (11.8)</td>
</tr>
<tr>
<td>Above 1 year</td>
<td>7 (20.6)</td>
<td>20 (58.8)</td>
</tr>
<tr>
<td>Self-care guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15 (44.1)</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Not</td>
<td>19 (55.9)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>His submission to the TX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12 (35.3)</td>
<td>4 (11.8)</td>
</tr>
<tr>
<td>Not</td>
<td>22 (64.7)</td>
<td>18 (52.9)</td>
</tr>
<tr>
<td>Waiting list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14 (41.2)</td>
<td>14 (41.2)</td>
</tr>
<tr>
<td>Not</td>
<td>20 (58.8)</td>
<td>18 (52.9)</td>
</tr>
<tr>
<td>Better quality of life With TX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27 (79.4)</td>
<td>27 (79.4)</td>
</tr>
<tr>
<td>Not</td>
<td>7 (20.6)</td>
<td>7 (20.6)</td>
</tr>
</tbody>
</table>

**Analysis of quality of life**

The first issue of the SF-36 instrument quizzed about which the individual would refer your health: If excellent, very good, good, bad or very bad.

The second issue of the SF-36 wondered about what the individual would say if sort your health today compared to a year ago: much better, somewhat better, about the same, somewhat worse.
Quality of life of patients with chronic renal... (mean ± standard deviation), minimum and maximum values among transplant groups and who are undergoing hemodialysis.

Table 5 presents the comparison of average values in scores of eight domains of the SF-36

Table 5. Comparison of scores obtained in the eight domains of the SF-36 questionnaire in the transplant group and on dialysis group. Florianópolis (SC), Brazil, 2011.

<table>
<thead>
<tr>
<th>Domains</th>
<th>On dialysis (N = 34)</th>
<th>Transplanted (n = 34)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average ± SD</td>
<td>Minimum</td>
</tr>
<tr>
<td>C. Functional</td>
<td>57.50 ± 32.28</td>
<td>0</td>
</tr>
<tr>
<td>The Physical.</td>
<td>23.51 ± 34.82</td>
<td>0</td>
</tr>
<tr>
<td>Pain</td>
<td>70.71 ± 28.20</td>
<td>10</td>
</tr>
<tr>
<td>And General health.</td>
<td>52.29 ± 27.64</td>
<td>5</td>
</tr>
<tr>
<td>Vitality</td>
<td>57.79 ± 16.78</td>
<td>25</td>
</tr>
<tr>
<td>The Social.</td>
<td>58.81 ± 23.84</td>
<td>0</td>
</tr>
<tr>
<td>The Emotional.</td>
<td>65.68 ± 31.36</td>
<td>33.33</td>
</tr>
<tr>
<td>N. Mental</td>
<td>61.65 ± 15.34</td>
<td>20</td>
</tr>
</tbody>
</table>

**DISCUSSION**

**General characteristics of the study population**

The average age of the Total population was of 50 years, and is in line with others, which had all samples with the average age of 53.1 years, ranging between 18 and 81 years.3-5

There was male prevalence (65.6%) about the feminine (40.6%), corroborating with the data collected in the Census 2011 dialysis, the Brazilian society of Nephrology, which point out that there has been in recent years an increase of chronic diseases in men (57.3%) in women’s expense (42.7%).9

With regard to civil status, the prevalence of married patients in the transplant group and, in the Group of patients on dialysis, single marital status prevailed. This result matches the located in the literature, as a greater number of married patients.9-13

According to some studies, appropriate social support (family, friends and companions) affects differently the health of these individuals and consequently their QOL, resulting in better physical and mental conditions, considering the emotional resources that it gets, the better to counter the disease and treatment adherence.1-4

There is better QOL of people with marital and family relationships positives at the expense of greater dissatisfaction with life in those divorced, separated or widowed.3

We highlight that the behavior changes that are submitted individuals, directly reflect on the commitment of QOL.14 The way these patients react to those changes and the coping mechanisms they use are closely related to family support.13 The family involvement is essential, since it assumes roles and socialization of its members.1 The family, as a unit, develops a system of values, beliefs and attitudes in relation to health and disease that are expressed and demonstrated through health-disease behaviors of its members.14

In relation to the level of education, the elementary school need among all populations of this research, also in accordance with study.15 The predominance of middle level in the Group of patients and transplant recipients, who are undergoing hemodialysis group, the fundamental level. Different results were found in the literature, with incomplete basic prevalence in both groups.15

Information about the educational level of the patients are useful to health professionals as an instrument to assist communication in the sense of using a compatible and easy to understand language of guidelines, education and prevention of complications arising from the treatment.4-7

The low education level can affect in a negative way the understanding of the disease, the formulation of concepts of self-care and adherence to treatment.4 The QOL of patients under hemodialysis treatment has a relationship between the emotional aspects and the education, suggesting that people with higher education have cognitive resources capable of generating a better emotional adaptation to the IRC and who are undergoing hemodialysis treatment.1

**Clinical characteristics**

In relation to the leading causes of chronic kidney disease, it is possible to point out that the main cause if binds to the systemic arterial hypertension (SAH), followed by diabetes mellitus and multifactorial Association HAS. Some studies found in the literature also point out these diseases as the main etiologies of IRC.16 This fact is justified because the DM and the HA are silent diseases, because not always show signs and symptoms.4,14,15

Urinary tract infection, polycystic kidneys, preeclampsia, Glomerulonephritis and Alport...
renal TXs. Currently, episodes of acute rejection occur in 20 to 30% of transplant patients.18

When asked if they received guidance and education for self-care by nursing staff, 30 (88.2%) of respondents claimed that they were prepared and that perform continuous care while four (11.8%) claimed not to have received guidelines on this subject.

Papers found emphasize the risks of rejection involved after renal transplantation are great making the completion of nursing follow-up, in order to prepare these patients for self-care, preventing complications that could endanger the patient and graft survival.20

A study argues that self-care has two orientations: external and internal. From observation or subjective information, singly or together, nurses can identify what type of action orientation,20 according to the guidance, the identification and collation of self-care, let the nurse, analyze and judge to help individuals to meet the requirements of their therapeutic self-care.20

It is important to note that the patient and family should be properly guided about self-care.4 the nurse is responsible for providing guidance on diet, exercise, medications, infection prevention and identifying signs and symptoms of rejection that are extremely important for the success of kidney transplantation.2

The family, when targeted on the care, provides an opportunity to recognize the needs and self-care of the individual, in order to develop abilities through experience to be educated by others within the family.14

In relation to the improvement of QOL after TX, all transplant patients interviewed claimed that there was significant improvement. These give the information found in the literature, where studies point out that a successful kidney TX releases the patient from dialysis and interference in daily life, renal transplant becomes an option that improves the QOL of patients undergoing renal TX.1

In the case of recurrent urinary infection (3.5%), polycystic kidneys (2.7%), preeclampsia (1.3%), and Alport syndrome (1%) were found in the literature as a percentage too small and insignificant.17

The carriers of these diseases may be unaware that have, or are aware of them, but do not adhere to treatment by judge it unnecessary, since there are no major clinical manifestations.15 thus, the monitoring and not the inappropriate treatment of these diseases, over the years, will slow and progressive kidney damage, which can lead to IRC.16 contrary to these findings, some studies reveal Glomerulonephritis as the main cause of the IRC.17–18

♦ Characteristics of transplanted group

In this study, there was predominance of donated organs from corpses. This information match Central funding, notification and distribution of organs and tissues of Santa Catarina, as were carried out in Santa Catarina 148 kidney donors with organ TXs corpses and 26 with live donors.8 Against this data, surveys indicate that there is prevalence in donors living with renal TXs.18

According to SBN (2011), the advantage of the living donor is the best patient and graft survival the cadaverous donor number available is much smaller than the number of urêmicos patients on the waiting list for TX. For these reasons, the renal TX is performed preferably with live donors. The use of cadaver donor, in addition to the difficulties in obtaining the organ, offers a smaller survival both for the patient and for the graft.13,14

In relation to the waiting time by organ, most waited of 30 days to 6 months. These results are similar to those found in the literature, that point the average wait time of 30 days to 6 months.17 This waiting period is variable and depends on the opportunity to be a donor that is accepted by TX and compatible with the receiver.10

When investigated the TX time, most reported having held the TX of 1 to 3 years, 14.7% of 4 to 7 years and 8.8% say more than eight TX us. To be covered on the occurrence of graft rejection, 82.4% claimed not to present any kind of rejection while 17.6% reported that presented.

These results are due to the technological advances of new immunosuppressive drugs, progressively more potent and selective, allowing a significant reduction in the incidence of acute and chronic rejection of
therapy, namely chronic kidney 19 (55.9%) are in therapy during this period, followed by 9 (26.5%) of 6 months to 1 year, and 6 (17.6%) respondents with up to 6 months in renal therapy substitution through HD, and as the findings of another study in which the time was predominantly of one to three years (31.8%).

The treatment time is an important factor in the worsening of Comorbidities, and these have been highlighted in several studies, as being instrumental in the survival of clients who are undergoing hemodialysis treatment.

All respondents claimed to have received guidance and education for self-care by nursing staff (about FAV care, food, water, medication and adhesion restriction blood pressure control). Be in the care involving dialysis treatment three times a week or daily peritoneal dialysis brings to re-chronic impact on contexts physical, emotional and social development of their lives.

Works found in the literature claim that the individual with CKD experience abrupt changes in your life, becoming dispirited, desperate and, often, because of this or because of a lack of a guidance, abandons the treatment leaving to care for the constant care to their QOL. Thus becomes essential to stimulate their abilities, skills and potential of human reaction, allowing it to adapt positively to new lifestyle and take control of your treatment.

Em uma unidade de hemodiálise é responsabilidade do enfermeiro a transmissão de conhecimentos que o paciente e seus familiares necessitam ter sobre a doença, auxiliando-os, para que aprendam a conviver melhor com essa doença crônica. Para tanto, torna-se necessário o desenvolvimento de competências e habilidades tanto para o enfermeiro como para o cliente quanto ao significado do viver com qualidade no enfrentamento da vida.

O paciente deve entender perfeitamente, desde o início do programa hemodiálise que sua negligência quanto ao tratamento, trar-á graves consequências. O enfermeiro terá de comunicar ao paciente as orientações corretas para que ele possa decidir adequadamente sobre suas responsabilidades.

A literatura ainda aponta que o doente renal crônico deve ser orientado sobre sua patologia e seu tratamento, as formas de terapia renal substitutiva e os riscos e benefícios associados a cada modalidade terapêutica, sobre a confecção precoce do acesso dialítico (fístula arteriovenosa ou cateter para diálise peritoneal), dieta, uso de medicamentos, controle da pressão arterial e da glicemia, ainda durante a fase de tratamento conservador.

This guidance is essential to reduce the initial stress, help in self-care, decrease the complications arising from the treatment and increase adherence to therapeutic scheme. Give an educational support at this stage of life is a way to stimulate the individual to take care, with the acquisition of new knowledge, prevents damage to health and well-being.

In relation to the desire to hold the TX, the majority of nephropathy 24 (70.6%), say that if wanted to submit to this procedure, it is worth mentioning that some patients do not want to make the TX, aware that it does not promote healing and brings with it other forms of restrictions.

It is to mention that small part of the population (14-41.2%) is entered on the waiting list for TX, while 20 (58.8%) of chronic kidney do not yet have your name on the waiting list for organ.

The number of active patients on the waiting list varies from 25 to 30% of patients with renal therapy substitutionary IRC. More than 42 million people are on the waiting list, including children who contract diseases whose only treatment is the kidney transplant. About 30% die before the transplant, and less than 10% receive a body every year.

In relation to the improvement of QOL after TX, most, 27 (79.4%) of respondents believe a significant improvement claims. These give the information found in the literature. There are many factors that affect physical and psychological aspects of substitution therapy patients, affecting thus their QOL. Cite among the main aspects, symptoms and complications arising from the disease and who are undergoing hemodiálisis treatment; the use of medications that are usually in large quantities and used to stabilize or prevent health complications; and, finally, the time that the neuropath remains in HD treatment.

♦ Analysis of quality of life

Comparison of quality of life on dialysis and transplant groups (Questions 1 and 2)

It can be observed through the results that most transplant patient’s claims that his health is excellent making a correlation to his life, prior to transplantation, suffering chronic
illness brought them and the feeling of better well-being offered by transplant.

The second issue of the SF-36 wondered about what the individual would say if sort your health today compared to a year ago. There was a statistically significant difference between the groups, 28 (82.4%) of transplanted considered their health “much better” compared with 12 (35.3%) on dialysis, 6 (17.6%) of transplanted and two (5.9%) on dialysis feel a little better now, whereas nine (26.6%) on dialysis reported almost the same thing and 11 (32.4%) of this same group consider a little worse now.

These results are similar to some studies, which show that the patient transplanted has better health in chronic renal patient relationship.4,5,8

- **Comparison of quality of life on dialysis and transplant groups (eight Scores domains)**

The domain functional capacity allows evaluating an individual's performance in daily activities such as dressing, bathing, climbing stairs, walking, among others. The average achieved by on dialysis in this area was considered a low score 57.50 compared to the result presented by transplanted (80.44).

In agreeing to these findings, the survey in the literature revealed that the functional incapacity makes it difficult to perform certain tasks considered normal and due to the severity of renal disease, some patients turn out to lead a sedentary lifestyle, a restricted and monotonous daily, which is considered a major cause of weakness, decreased QV and premature death of patients in HD.7,14

Their families can describe this failure as a difficulty to perform tasks that were once simple and routine, such as cleaning the House, washing clothes or take care of the garden.6 Many end up getting worse due to lack of confidence and a larger stimulus both as by himself.4-16

The continuous dependency of HD treatment interferes with the work and study of these patients, as well as the lack of energy and available during the day for symptoms and complications of this disease.16 In transplanted, this domain was high (80.44) not compromising daily activities.

The domain limitation by physical analyses the impact of physical health in the performance of daily activities and/or professionals. The average achieved by on dialysis was 23.53. It is worth mentioning that this was the lowest score achieved by patients on dialysis. This result highlights problems with daily activities and the resulting work of physical health, indicating prejudice in SOCIETY, but are consistent with studies which show similar values in this population.3,18

The low scores presented in these areas of this research can be explained by low aerobic capacity and muscle strength with patients who suffer from CKD undergoing hemodialysis, which carries low exercise tolerance, and is likely that they have trouble carrying out occupational activities and even activities of daily living.1,7

The IRC not only weakens the body, but also causes physical changes associated with the HD treatment, these are limiting factors of daily activities.6,13 In transplanted, and this area has kept the average 73.53, which does not compromise the regular daily activities of the individual and their work.14

The domain pain evaluates the intensity and pain interference in daily life activities of the individual. The average achieved by on dialysis, transplant was 70.71 and 76.12 respectively, and there is no relevant difference. This was the area where the average scores were approximate in both groups and where the highest score obtained on dialysis.

These findings were similar to results in other studies.4,7, which observed that the average found in this population was 69 and 65, respectively. The approach of these scores, according to another survey, is related to the wear caused by IRC to the body occurred before the completion of TX.13

The general condition evaluates the health of subjects studied. The average was on dialysis and transplant was 81.41 52.29. We notice an exorbitant difference relative to the value obtained by groups. Studies corroborate with the data found here and claim that the chronic renal patient presents a very fragile health in relation to transplanted that despite the continuous administration of immunosuppressant, get sick less than the chronic nephropathy.3,15

The vitality evaluates the energy levels, stamina, desire and fatigue as exhaustion and tiredness.17 The average obtained by was on dialysis and transplant 71.03 57.79. It is worth mentioning that this was the lowest score achieved by transplant patients.

In a similar study, to search patients' QOL chronic renal hemodialysis observed that one of the areas with the lowest scores was the vitality.2 Claim that this is due to the long under hemodialysis treatment that causes the patient a physical feeling of discouragement and lack of energy.2,7

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**English/Portuguese**

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**Magalhães ACL, Coelho GD, Azevedo MA de et al.**

**Quality of life of patients with chronic renal...**

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Quality of life of patients with chronic renal...

With regard to social aspects that analyzes an individual's integration in social activities and define different levels of social activity (family, friends, neighbors or groups), we detected that the highest values are centered in the transplant group with an average of 77.15, demonstrating satisfaction in this area.

Similar to this research, a study also found higher score to the social dimension in transplanted (73.4) when compared to chronic kidney in treating HD (64.9). These authors consider this dimension of extreme relevance to chronic renal patient, due to the physical and emotional dependence that develop in the course of the disease process and maintenance of life.

The emotional aspects analyze problems like depression and anxiety. In this area, the average was higher than transplant (85.59) on dialysis (65.68). It is worth noting that this area was the highest score achieved by transplant patients.

A study found different results to this survey. The average found in this population was 75 and 70, respectively. In this respect, the authors realized that the average scores were approximate in both groups.

The mental health area examines the happiness, peace of mind and behavior changes, or emotional disarray as depression, nervousness and dismay. The average obtained by was on dialysis and transplant 72.85 61.65.

The survey of the literature showed that a large proportion of chronic renal patients presents commitment in this area, a fact attributed to addiction treatment and the limitations imposed by the condition of the chronicity of the disease, which usually leads the changes often difficult acceptance, and that produce feelings of sadness, anger, aggression and hostility.

It is observed that, in the transplant group, the values of the scores showed statistically significant differences in six areas: functional capacity, physical aspects, general health, vitality, social aspects and emotional aspects when compared with the Group of on dialysis. In pain and mental health, there was no significant difference between the groups.

The mental health component (vitality, emotional aspects, social aspects and mental health) presented values above 50 for all domains. Despite these data, works found in the literature show that emotional aspects and vitality mostly evaluate the performance in work activities and the lack of energy, experience symptoms in patients with IRC, since the vast majority of people with HD starts and stops working having symptoms of discouragement with the life. As a result, the vitality and emotional aspects are harmed in nephropathic.

According to these results, the SBN (2011) States that the TX would bring earnings, to the extent that some losses were repaired, resulting in better physical and mental health condition. This occurs because of the improvement of QOL of the patients, because it does not perform a treatment that restricts time in your daily routine, allowing the resumption of professional activities or in their homes so the TX can be characterized as an effective treatment for the physical and mental rehabilitation of the patient.

CONCLUSION

Considering the objectives proposed in this study, and the results achieved, it was found that the change causes the lives of kidney TX transplant patients, demonstrated by high rates of satisfaction in all areas involved, allowing them a normal life, with dreams and goals to be achieved.

This time, it can be affirmed that the TX qualitatively improve the lives of kidney patients with IRC that undergoing the procedure for HD.

This study presents some limitations, including the use of generic questionnaire for assessment of QOL, the small sample size and the cross-sectional delineation, which prevents the inference of causality. Even so, these findings will be useful for future investigations of hypotheses in Nephrology. There is a lack of studies that explore the knowledge about the property to invest in self-care orientation to customers affected by CKD, and especially those hemodialysis program participants.

REFERENCES


