DIFFICULTIES OF ELDERLY PEOPLE IN ACCESSION TO THE TREATMENT OF BLOOD HYPERTENSION

DIFICULDADES DE IDOSOS NA ADESÃO AO TRATAMENTO DA HIPERTENSÃO ARTERIAL DIFICULTADES DE LOS ANCIANOS EN LA ADHESIÓN AL TRATAMIENTO DE LA HIPERTENSIÓN ARTERIAL

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ABSTRACT

Objective: to analyze the difficulties of the elderly in adherence to the treatment of Systemic Arterial Hypertension. **Method:** a qualitative, descriptive study with 17 hypertensive elderly patients in a Basic Health Unit. Data were obtained through a semi-structured interview and submitted to the Content Analysis Technique in the Thematic Analysis modality. **Results:** most of the elderly reported that they follow the recommendations of health professionals for the treatment of hypertension. It has been shown that forgetfulness, fear of drug interactions and lack of family and social support interfere with adherence to drug therapy. In addition, it was identified that the diet was the most accepted non-pharmacological care and that the practice of physical activity still needs to be advanced. **Conclusion:** it was observed that socio-demographic aspects, changes in emotional state, lack of accessibility and support network, absence of symptoms of hypertension and urban violence influenced the adherence to therapy by the elderly. It is hoped that this study will serve as a subsidy to guide the care of these patients in the primary care setting, prioritizing holistic care. **Descriptors:** Hypertension; Aged; Therapeutics; Primary Health Care; Drug Therapy; Nursing.

RESUMO

Objetivo: analisar as dificuldades de idosos na adesão ao tratamento da Hipertensão Arterial Sistêmica. **Método:** estudo qualitativo, descritivo, realizado com 17 idosos hipertensos em uma Unidade Básica de Saúde. Os dados foram obtidos mediante entrevista semiestruturada e submetidos à Técnica de Análise de Conteúdo na modalidade Análise temática. **Resultados:** a maioria dos idosos relatou que segue as recomendações dos profissionais de saúde para o tratamento da hipertensão arterial. Evidenciou-se que o esquecimento, o medo de interações medicamentosas e a falta de apoio familiar e social interferem na adesão à terapia medicamentosa. Além disso, identificou-se que a dieta foi o cuidado não farmacológico mais aceito e que a prática de atividade física ainda precisa avançar. **Conclusão:** observou-se que os aspectos sociodemográficos, as alterações do estado emocional, a falta de acessibilidade e rede de apoio, a ausência de sintomatologia da hipertensão arterial e a violência urbana influenciaram a adesão à terapêutica por parte dos idosos. Espera-se que este estudo sirva de subsídio para nortear a assistência a esses pacientes, no âmbito da atenção primária, priorizando o cuidado holístico. **Descritores:** Hipertensão; Idoso; Terapêutica; Atenção Primária à Saúde; Tratamento Farmacológico; Enfermagem.

RESUMEN

Objetivo: analizar las dificultades de los ancianos en la adhesión al tratamiento de la Hipertensión Arterial Sistémica. **Método:** el estudio cualitativo, descriptivo, realizado con 17 ancianos hipertensos en una Unidad Básica de Salud. Los datos fueron obtenidos mediante entrevista semiestructurada y sometidos a la Técnica de Análisis de Contenido en la modalidad Análisis temático. **Resultados:** la mayoría de los ancianos relató que sigue las recomendaciones de los profesionales de salud para el tratamiento de la hipertensión arterial. Se evidenció que el olvido, el miedo a las interacciones medicamentosas y la falta de apoyo familiar y social interfieren en la adhesión a la terapia medicamentosa. Además, se identificó que la dieta fue el cuidado no farmacológico más aceptado y que la práctica de actividad física todavía necesita avanzar. **Conclusión:** se observó que los aspectos sociodemográficos, las alteraciones del estado emocional, la falta de accesibilidad y red de apoyo, la ausencia de sintomatología de la hipertensión arterial y la violencia urbana inflaron la adhesión a la terapéutica por parte de los ancianos. Se espera que este estudio sirva de subsidio para orientar la asistencia a esos pacientes, en el ámbito de la atención primaria, priorizando el cuidado holístico. **Descriptores:** Hipertensión; Anciano; Terapéutica; Atención Primaria de Salud; Tratamiento Farmacológico; Enfermería.

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INTRODUCTION

It is revealed that population aging is a growing world reality, which requires a reorganization of public policies, social programs, family dynamics and, especially, health systems due to the increase of Non-Communicable Chronic Diseases such as Systemic Arterial Hypertension (SAH).¹ Thus, early diagnosis and adherence to treatment are essential to ensure control of blood pressure and to reduce hospitalizations and the consequences of untreated disease.²

Define-se a HAS por níveis elevados e sustentados de pressão arterial maior ou igual a 140/90 mmHg. Frequentemente, está associada com o aumento do risco de eventos cardiovasculares graves como o Infarto Agudo do Miocárdio, a Insuficiência Cardíaca Congestiva e o Acidente Vascular Encefálico.³ Apesar da alta prevalência no Brasil, com o acometimento de 75% na população idosa com mais de 70 anos, a HAS apresenta baixas taxas de controle.⁴

Severe consequences are caused by discontinuation of treatment when the patient does not associate the effect of continuous therapy with the maintenance of blood pressure levels as a result of the increased risk of cardiovascular diseases.⁵ According to the World Health Organization), approximately 600 million people are affected by SAH annually and 7.1 million deaths are caused by this disease.⁶

Blood pressure control is achieved in values lower than 140/90 mmHg in less than a quarter of individuals with SAH. In Brazil, effective blood pressure control rates are between 10% and 57%. Although there is scientific evidence to prove the benefits of pharmacological and non-pharmacological treatments, in addition to expanding access to health services and the Hyperdia Program, effective control of hypertension is still a challenge.⁷

Physical, psychological, social, cultural and behavioral aspects are involved in adherence to therapy. This process requires shared decisions and co-responsibility between the person living with the disease, the family, the professionals, the health service and the social support network.⁸

It is added that the patients with SAH tend to accept the disease and this justifies the high prevalence of abandonment. Thus, quality of care, comprehensive care, and motivation strategies for adherence to therapy are listed as critical for effective control of blood pressure in the elderly.⁹

OBJECTIVE

- To analyze the difficulties of the elderly in adherence to the treatment of Systemic Arterial Hypertension.

METHOD

It is a qualitative, descriptive study, developed in a Basic Health Unit (BHU) in the city of Teresina, Piauí, Brazil. This research was linked to the Institutional Program of Scholarships of Scientific Initiation of the State University of Piauí.

The study of 17 elderly people with Systemic Arterial Hypertension enrolled in the Hyperdia Program of a micro-area of the Family Health Strategy was constituted. Inclusion criteria are: patients aged 60 years or older and diagnosed with hypertension for more than six months. The elderly who presented cognitive disorders and speech problems were excluded from the research.

The data were obtained through a semi-structured interview script containing closed questions about the sociodemographic aspects (age, sex, skin color, schooling, marital status and income) and open about the knowledge about the treatment of the disease, related difficulties adherence to treatment and the challenges and experiences of users regarding adherence to medication and non-drug treatment. The data production was performed in the months of August to October 2016.

The responses were recorded on an mp3 player type audio device with the consent of the caller. Subsequently, they were transcribed in full. To maintain anonymity, the participants were coded by letter "A" with sequential arabic numeration.

The data were related to the closed answers by arranging them in a table with simple frequency. The open answers were submitted to thematic analysis in three phases: pre-analysis, material exploration and treatment of results and interpretation. In the pre-analysis, we performed the floating reading of the interviews. In the exploration of the material, the thematic categories were elaborated. In the treatment of the results and interpretation, the nuclei of signification were grouped in the thematic categories.¹⁰

This study was approved, in compliance with the ethical precepts of Resolution 466/2012 of the National Health Council, by the Research Ethics Committee of the State University of Piauí with CAAE 55557216.0.0000.5209 and opinion No.

1,634,299. authorized by the Municipal Health Foundation of Teresina.

RESULTS

Table 1 shows that the majority of hypertensive elderly patients presented age

equal or superior to 76 years (35.3%), female (58.8%), brown (64.7%), with incomplete primary education (82.4%), married (41.2%) and income from one to two minimum wages (88.2%).

Table 1. Sociodemographic characterization of hypertensive elderly in a Family Health Strategy. Teresina (PI), Brazil, 2016.

Variables	n	%
Age		
60 to 65 years	5	29.4
66 to 70 years	1	5.9
71 to 75 years	5	29.4
≥ 76 years	6	35.3
Sex		
Female	10	58.8
Male	7	41.2
Skin color		
Brown	11	64.7
White	4	23.5
Black	2	11.8
Education		
Illiterate	2	11.8
Incomplete elementary school	14	82.4
Complete elementary school	1	5.9
Marital status		
Married	7	41.2
Single	5	29.4
Widow	5	29.4
Income		
< 1 minimum wage	2	11.8
1 to 2 minimum wages	15	88.2

After the analysis, two categories were identified: knowledge of hypertensive elderly patients regarding pharmacological treatment and difficulties of the elderly to adhere to therapy.

◆ Knowledge of hypertensive elderly in relation to pharmacological and non-pharmacological treatment

It is recommended that, for adherence to pharmacological and non-pharmacological treatment, it is indispensable that the patients have knowledge and recognition of the therapeutic measures. It was observed that the majority had sufficient understanding about the treatment.

Since I started the treatment, I always go to the hospital and everything is ok, I continue to take the medicine and my food is healthy [...]. (A 1)

It is eating little fat, little salt, is taking medication, Enalapril, there are many remedies here that I take.(A10)

Just what the doctor gives me, take the medicine at the right time, eat at the right time, avoid fatigue, avoid worries, eat normal and pay attention to weight. (A16)

It is noted, however, that some patients did not have basic information to maintain adequate blood pressure levels.

I do not know anything about it (treatment), I take the pills for what the doctor says,

[...] I do not know anything, I just know that my pressure goes up suddenly. (A8)

The doctor, how does he do such a business? He explained that it was to take the pills, but did not explain that it was for me to take as long as life had, he did not explain, so I thought taking that one there had healed. (A1)

Because, for me, it was not an illness, because I did not feel anything, I did not feel pain. So I did not consider, did not follow the recommendations. I did this surgery (saphenous bridge), and so I started taking the medicine properly. (A15)

The antihypertensive treatment was also associated only with the medications.

It's just the remedies I take at the Health Clinic. When I'm taking the medication, I do not feel anything, but when I stop taking it, it's dizziness. (A5)

It's just the pills. When I'm calm, until the pressure does not rise a lot, but when I'm impatient, it rises too much, rises, rises even though I'm bad. (A9)

It was identified that the higher the time of treatment and schooling, the greater the information about the importance of health care.

My treatment, [...] since the doctor passed me, I'm very careful about that. [...] And the food is healthy, I eat chicken and fish. Red meat I eat, but it is rare (A1)

If the pressure rises too much, many things can happen: it gives a stroke, a heart attack. It's the right medicine at the right time. (A13)

It is pointed out that, regarding pharmacological treatment, most knew the type, the dosage and the schedules of the medications. However, some patients depended on caregivers.

The remedy I take is three times a day, one in the morning, one noon, and the other at night. (A13)

I take Methyldopa and Propranolol. Seven o'clock in the morning, eleven o'clock in the day and seven o'clock in the evening. (A7)

It's just the remedies I shot here. They are two qualities of remedies. Now, I do not know the name. (A5)

It's my daughter who gives me the pills, you know? She lives with me. She knows the time and all. (A9)

My wife reminds me. It's time! You've already touched your medicines? (A17)

Another strategy was used - the technological aid of the alarm function of the cellular apparatus - by one of the interviewees.

Sometimes even oblivion happened. Now, I have a cell phone that rings an alarm when it's seven o'clock, when it's time to take the medicine. (A13)

It is understood that, when there is no family and social support, following the goals obtaining the effectiveness of the treatment becomes complicated, as shown below.

Sometimes I forget and I'll take it at another time. [...] when I do not take it, I feel a reaction, I start to feel bad, the pressure goes up, it has already reached 23. (A7)

It's a bad thing to live alone. Sometimes, the person wants to have tea or eat a different food and does not have money at the time, there, ready. (A11)

We have demonstrated difficulties in the discipline with the schedules of medication by the economically active elderly in the labor market.

No. Sometimes I forget. The doctor explained that it is for me to take the medicine. Sometimes I get here at eight o'clock, but it's supposed to be right at six o'clock. If I forget, there, ready. (A11)

As for non-pharmacological measures, eating habits and physical activity.

It is to take the medicines, to control the feeding, not to exaggerate, not to eat salty, salt I do not even want to see salt, it has to be very little, I make walk. (A17)

Fat I love, but it's not every day, it's once a month. Sometimes I have to go hiking, but I'm lazy and I'm not going. Even more now,

in this heat everything. Early in the morning, I'm too lazy to get up.. (A2)

It was found that when the patient presented complications, such as acute myocardial infarction and stroke, there was a greater concern with health and better adherence to therapy.

Because, when I walked through the valley of the shadow of death, I was afraid. I had heart trouble. I had my saphenous bridge surgery about ten years ago. (A1)

Rain or shine, I take my medicine. I'm too scared to have another stroke. I am taking care of myself. (A3)

♦ Difficulties of the elderly in adhering to therapy

It was evidenced that the fact that arterial hypertension is a silent disease negatively influences adherence to treatment.

Sometimes I do not take it because I'm not feeling anything, I forget. (A5)

It was not a disease because I did not feel anything, I did not feel pain, I did not feel anything. (A15)

It was reported, however, that when they forget to take the medication and begin to feel some symptoms, they are already aware that the blood pressure is high.

Sometimes, when I forget, I feel weak and dizzy, I already know that it has increased. (A4)

When she's 18, I'm starting to vomit, fever, everything. [...] I begin to feel that she is high. (A8)

There was a strong relation to non-adherence to treatment, forgetfulness, fear of drug interactions and lack of a network of family and social support.

I forget. I do not take the pills at night because the problem is that I take remedy for knee pain too, so I do not want to mix. (A5)

Because we lost some things, I have no money, it's bad for people to live alone. (A13)

Adherence to therapy can be influenced by the relationship between the health professional and the patient, the availability of medications, financial resources and accessibility to the health post.

Difficult for the elderly to get off here (Health Post) at that time. In the old days, they gave the drugs to us to take three months straight. Now, we have to come every month to get the pills. When there is no remedy here, I buy. (A17)

It was observed that most of the users presented knowledge about the practices of healthy habits for the quality of life, but following the recommendations of the health professionals is still a challenge.

I do not eat fat and I do not like salt. Like enough fruit. Not as mass. Not like noodles. Not like rice. (A3)

When I was with my high blood pressure, the doctor said, "Take a walk! "But I've come a long way. I'm not going to walk anymore. (A4)

I do not walk because I have to look at my grandchildren. (A10)

I even like hiking. It is very good for health, but where I live is very violent. Then I get scared! (A11)

Another important aspect about the alterations of the emotional state and its implications in the control of the arterial pressure was evidenced.

In term of food, I follow quite properly. What makes the pressure high is anger, it's stress, I believe. (A8)

The doctor passes me to avoid worries, but it is very difficult to avoid. (A16)

DISCUSSION

It is highlighted that hypertension is the disease that affects the elderly population the most, emphasizing the need for professionals to use strategies to minimize the factors that negatively influence the treatment. One research identified that age, sex, personal, social and demographic conditions; factors inherent to the disease; drug schedules; the institutional conditions of the Brazilian health services and the interaction with the professional team are factors that interfere in the adherence to the therapeutics.¹¹

It is added that low education and common sense also influence adherence to therapy. One study has shown that some low-education elderly people have repeatedly replaced drug therapy with alternative therapeutic methods, such as bottles and medicinal teas, and substitution of therapy on their own without consulting the physician may potentiate cardiovascular risks.¹²

The predominance of females is justified because women are more likely to seek health services compared to males. This is a worrying fact, since hypertension is a silent disease and, when untreated, increases the risk of cardiovascular diseases. In addition, it is worth mentioning that sexual dysfunction in men, caused by antihypertensive drugs, is one of the causes of treatment abandonment.¹³⁻⁴ This shows the importance of public policies aimed at the health of the man aiming at the integrity of the assistance to this population.

It is noted that the VII Brazilian Guideline for Hypertension emphasizes that black people are more prone to this disease.¹⁵

However, the prevalence of brown-colored elderly in this study can be explained by the fact that 64% of the population of Piauí self-declare brown.¹⁶

It was revealed in the speeches that the marital status was related to adherence to treatment. Corroborating this finding, a survey conducted in a city in southern Brazil found that married individuals were twice as likely to control blood pressure levels as singles. This is due to the involvement of a family member becoming a facilitating component for adherence to therapy presenting emotional support in difficult times.¹⁷

In accordance with this study, we consider a study carried out in Rio Grande do Sul, highlighting that 37.3% of the patients had income between one and two minimum wages. Given the precariousness of pharmacies in public health services and the frequent lack of medication, low income is a factor of vulnerability, since the lack of financial resources hinders access to medicines and, therefore, contributes to the lack of control of the levels blood pressure.¹³

The Hiperdia program was implemented in primary care to provide holistic, continuous and accessible care for patients with hypertension in order to control blood pressure levels, reduce morbidity and mortality rates and improve the quality of life of these patients.¹⁸ Even with the expansion of this program and health services, some elderly in this study reported difficulty access due to distance from the Basic Health Unit.

It is recorded that the Family Health Strategy nurse must develop skills such as leadership, bonding, attendance and teamwork. Thus, stratification of cardiovascular risk, monitoring of blood pressure levels, investigation of socio-familial factors that interfere with therapy, and the active search of patients who abandon treatment are actions that need to be reinforced in the routine care of patients with hypertension.³

It is inferred that most had important information to control blood pressure levels. These results corroborate a study on the perception of the elderly about the educational activities of the Hiperdia program in which it is emphasized that access to information reflects positively on the treatment, however, putting the recommendations of health professionals in practice is still problematic.¹⁹ In contrast, another study pointed out that the lack of adequate treatment is a challenge to be overcome.²⁰

Hypertension therapy is only associated with drug treatment by a large number of patients. It is known that the development and degree of severity of this disease are influenced by a number of factors related to the individual's life habits.²¹ A study that aimed to evaluate the effect of a lifestyle modification program on the Risk Score Cardiovascular Global of Framingham identified a significant reduction of systolic blood pressure in the group that practiced physical activity concomitantly with the nutritional control emphasizing the importance of the association of the healthy habits to the drug therapy in patients with SAH.²²

It is understood that most of the elderly knew the type and the dosage of the antihypertensive medications, however, some presented difficulty in taking multidoses with varied medications. Thus, the therapeutic regimen of arterial hypertension takes into account the severity of the disease, and monotherapy is adopted for less severe cases. Because of the multifactorial characteristic of hypertension, treatment usually requires the combination of two or more antihypertensive agents of the six classes (diuretics, beta-blockers, central acting sympatholytics, calcium channel antagonists, angiotensin converting enzyme inhibitors, and angiotensin II).¹⁸

It is worth noting that in this study, some elderly patients presented little concern with the therapy, but the absence of control of arterial hypertension is a risk factor for acute myocardial infarction, stroke, renal failure, congestive heart failure, hypertensive cardiopathy and aortic dissection.²³ In addition, one study found that non-adherent patients are 4.5 times more likely to develop coronary heart disease compared to those who follow therapy.²⁴

It is reported that hypertension is a silent chronic disease and the onset of late symptomatology may be indicative of systemic damage to target organs (brain, heart, kidneys, retina and peripheral vessels).¹⁵ Thus, failure to perceive symptoms, emphasized by some patients, is the main justification for not taking the medication and a negative factor for the early diagnosis of the disease constituting as an aggravating factor for cardiovascular risk.

The fear of drug interaction was also listed as one of the reasons for not taking the medication. Thus, it is important that during the consultation, the nurse and the physician obey the pharmacodynamics of the drug in the patient's language, giving guidance on the

function, adverse effects and interactions of medications in use.

The forgetfulness and the self-care deficit common in the elderly population are considered to interfere negatively in the treatment of hypertension. In this context, it is important that the nurse be alert to identify these deficits and, when necessary, to suggest and instruct a caregiver.

It was found that economically active elderly patients reported difficulties in taking medications at the recommended times. However, this barrier can be solved if the patient takes the medications to work.²⁵ In addition, it was observed that one participant used the cellular alarm to take medication at the prescribed time, emphasizing that the technology could be an ally in the treatment of hypertension.

It is advisable to change lifestyle as a goal of health programs for the control of chronic non-communicable diseases. In that sense, a longitudinal study identified that sedentarism and feeding were the main predisposing factors for the early development of arterial hypertension in the population, highlighting that in the United States, 41% of hypertensive patients were aged between 45 and 54 years.²⁶

It is understood that physical activity can be aerobic, anaerobic or combined. Aerobics have a lower intensity and longer duration, such as walking, swimming, running and dancing, and are important in fat burning and increased cardiopulmonary capacity. The anaerobic is of high intensity, short duration and requires greater strength and power, like bodybuilding, having as benefits the development of mass and the increase of the physical resistance and the cardiorespiratory conditioning. The association of aerobics with anaerobic is also effective in reducing blood pressure levels. It is also emphasized that it is not recommended to perform intense physical activity in individuals with systolic blood pressure higher than 160 and / or diastolic greater than 105mmHg.³

It is important to emphasize the importance of health professionals to indicate that effective physical activity should be frequent and rhythmic, since many patients mistakenly believe that walking in daily activities is a substitute for regular physical activity. In addition, it has been shown that the increase in urban violence and the attribution of the role of caregivers of grandchildren to the elderly also contribute to non-adherence to the practice of physical activity.²⁷

A large part of the elderly was advised in relation to the reduction of salt and fat, and many have difficulties in reducing fat. Thus, it is necessary to demystify the idea that salt and fat are the only ingredients that flavor the food and encourage the use of natural seasonings.

The need to address mental health in the treatment of elderly with hypertension was identified, since stress, worry, fear and family conflicts influence the increase in blood pressure levels. In this sense, the importance of nurses to intervene to minimize these stressors and, when necessary, to request support from other professionals.²⁸

CONCLUSION

It was observed that the majority of the elderly presented 76 years or more, female, married, low schooling and income, and the increase in age interfered in adherence to treatment due to forgetfulness and the appearance of self-care deficits. Spousal support stood out as fundamental to adherence to therapy for providing emotional input and motivation. In addition, patients with higher educational level and time of treatment were more aware of the importance of care for the control of hypertension.

It was noticed that most of the elderly knew the type of medication and the posology, however, some reported fear in relation to the drug interactions and the economically active ones emphasized difficulty in adhering to the therapeutics. In addition, patients who were affected by SAH-related complications presented greater health concern and better adherence to treatment. Some elderly people have associated antihypertensive treatment only with medications, forgetting non-pharmacological treatment through healthy eating and physical activity.

It was identified that the relationship between professional and patient, the fact of SAH being a silent disease, lack of medication and support network and accessibility to health services interfered with adherence to therapy. Moreover, urban violence and the occupation of the elderly as caregivers of grandchildren are some of the obstacles to the practice of physical activity. The absence of management of changes in the emotional state in the elderly is also one of the challenges that hinder the control of blood pressure levels.

It is hoped, therefore, that this study will serve as a subsidy to guide the care of these

patients in primary care, prioritizing holistic care in order to solve the individual difficulties of each patient and ensure the effectiveness in the treatment of hypertension.

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Submission: 2018/04/14

Accepted: 2018/08/03

Publishing: 2018/10/01

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