

Disease understanding in patients with intermittent claudication: A qualitative study

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The aim of our qualitative study was to investigate the understanding of patients with intermittent claudication (IC) regarding the etiology and atherosclerotic nature of their disease. Patients were recruited from participants of the SUPER study, a randomized trial comparing angioplasty and supervised exercise therapy for alleviation of IC owing to an iliac artery obstruction. Patients were submitted to explorative, semistructured, in-depth interviews that were fully transcribed, coded, and categorized. We interviewed 19 patients. The majority of respondents (79%) recognized smoking as a major risk factor contributing to the etiology of IC. However, nearly one-half (47%) underestimated the effects of unhealthy dietary and exercise patterns. In contrast, a substantial number of respondents (42%) overestimated the contribution of genetics to the etiology of their disease. Most respondents (79%) were unaware of the fact that IC implies systemic atherosclerosis. This study shows that the patients' interpretation of the etiology and nature of IC was mostly incorrect. Therefore, we suggest that health care providers enhance counseling about etiologic factors and the systemic nature of IC to optimize outcomes of lifestyle adjustments. (J Vasc Nurs 2015;33:112-118)

Peripheral arterial disease (PAD) is a common disorder, with a worldwide prevalence of 2.5%-18.8%, increasing markedly with age.¹ The most common manifestation of PAD is intermittent claudication (IC), which is characterized by exercise-induced pain in the leg caused by ischemia. IC owing to PAD is a local manifestation of underlying systemic atherosclerosis. Treatment of patients with IC is aimed at improving the patient's pain-free walking distance and quality of life, and secondary prevention of cardiovascular morbidity and mortality through lifestyle modification and medication.

Patients require sufficient understanding regarding the etiology and pathophysiology of their disease for successful lifestyle modification.² Explorative research in patients with myocardial ischemia, a condition comparable with IC, indicated that they experience their disease as "fixed" after angioplasty and regard their disease as "acute" rather than "chronic."^{3,4}

These thoughts have negative implications for successful lifestyle modification.

So far, little qualitative research has been done regarding the disease understanding of patients with IC. The aim of our study was to investigate the disease understanding of patients with IC regarding the etiologic factors and systemic nature of their disease to evaluate whether the transfer of information between patient and health care practitioner needs to be improved.

MATERIALS AND METHODS

Study design

This prospective study was carried out from March to May of 2013. Participants were interviewed on how they perceive the etiology and nature of their disease by means of semistructured interviews guided by a topic list. A semistructured interview allows respondents to give diverse answers and to determine the course of the conversation, while the interviewer warrants that all topics are discussed. Therefore, a semistructured interview is especially useful for the exploration of patients' views regarding a particular topic without restricting the range of possible answers.⁵ The outcome of such interviews is not submitted to statistical analysis, but should be considered as a global overview of ideas prevalent in the patient population.

Sample

We selected patients with IC from participants in the SUPER study (clinicaltrials.gov, NCT01385774). This is a multicenter randomized, controlled trial (RCT) in which patients with IC owing to iliac obstructions are randomly allocated to either percutaneous transluminal angioplasty (PTA) or supervised exercise therapy (SET).⁶ The inclusion and exclusion criteria of the SUPER study are summarized in [Appendix A](#). We used this cohort for purposes of convenience. Patients were invited to participate through a telephone call, after which they received a letter disclosing the details of the interview.

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To ensure diversity, patient selection was based on gender and the allocated intervention in the SUPER study. In addition, we selected patients from different hospitals to ensure diversity in counseling by specialists. Inclusion was restricted to patients who had received their therapy between 6 and 18 months previously, to ensure that all respondents had indeed completed treatment and that patients allocated to SET had concluded their program.

Interviews

We conducted in-depth semistructured individual interviews. Each topic was initiated with an open-ended question, after which the respondent's answers determined the course of the interview. Interviewers made use of a checklist containing all topics that had to be discussed (see [Appendix B](#)).

Because this was a short, 1-time interview, the medical ethics committee of the Academic Medical Center exempted the study from ethical approval. Patients were guaranteed full confidentiality and were asked for permission for the digital recording of the interviews.

Procedure

Two investigators (J.L. and P.H.) conjointly conducted the interviews and interchangeably were interviewer and observer. The first 4 interviews were conducted in a face-to-face conversation, and served as a pilot to obtain interviewing experience with this population. The remaining interviews were conducted by telephone to improve efficiency for both interviewers and patients. In a qualitative survey, saturation is the determinant of sample size, that is, the number of respondents is sufficient if the interviews do not yield any new topics.⁵

Analysis

Recorded interviews were transcribed in verbatim. Interview fragments containing the patients' perceptions regarding ad hoc specified topics were identified and coded from each interview. All interviews were independently coded by both interviewers. Coding discrepancies were resolved through discussion. As an additional check for intercoder consensus, the first 6 interviews were independently coded by 4 investigators (J.L., P.H., A.C., and P.N.), after which additional discrepancies were resolved through discussion. Individual codes were compiled in a thematic matrix, using the mind-mapping freeware *FreeMind*, version 0.9.0, to establish an overall view of the results. The matrix was presented to, and interpreted by, the research group to receive feedback about the plausibility of the conclusions. Finally, codes were sorted and described per topic and notable results were quantified.

RESULTS

Patients were selected from one academic center and 5 general medical centers. One of the 20 patients that invited to this study refused to participate for unspecific reasons. In accordance with the research group, saturation was achieved after 19 interviews. The interviews lasted an average of 30 minutes. Baseline characteristics of the patients are shown in [Table 1](#). The mean age of our sample was 60.8 years old.

Etiology

The majority of respondents indicated that their smoking habits were, in their case, an important etiologic factor (79%; 15/19) and smoking was often the first factor that came to mind.

There's only 1 cause, and it's definitely smoking.

—Patient 18

The minority of respondents who did not appoint smoking as a major risk factor did so on personal empirical basis:

Although I'm a smoker, I strongly disagree with the idea that smoking is the leading cause. My mother never smoked and had 5 occluded arteries.

—Patient 16

Aside from smoking, few patients regarded their lifestyle as etiologic factor. About one-half of the respondents (47%; 9/19) disagreed with the idea that either unbalanced diet or insufficient exercise attributed to their disease:

In the past I used to do a lot of sports. I did gymnastics; I used to go hiking ... At work I am very busy and I move around all the time. ...So, it can't be caused by lack of exercise.

—Patient 9

If I take a look at the people around me, it seems that we, my wife and I, fit the description of unhealthy eaters. On the other hand, all our friends eat healthy and, when compared to us, suffer more from illness and ailments!

—Patient 13

The remainder of respondents either named lack of exercise, unhealthy diet or both as etiologic factors:

Well, I don't watch what I eat, so I probably ate too much of the wrong kind of lipids, that sort of stuff... I eat whatever I want and I don't exercise at all.

—Patient 15

A substantial part of the respondents believed that their disease was caused at least partly by genetics (42%; 8/19). The respondents usually provided ≥ 1 examples involving their first-degree relatives to support this statement.

I think it's because of my high cholesterol that I inherited... that might be the reason, but I'm no doctor.

—Patient 10

You see, my father had the same issues, so it must be partly hereditary.

—Patient 17

Other, less frequently mentioned causative factors included stress, hypertension, diabetes, alcohol, medication for comorbidity, gynecological surgery, and impact trauma.

It could be hereditary; it could be caused by stress... it can be caused by anything! By smoking... just by bad luck.

—Patient 16

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