

Mini Review

Evaluation of the Quality of Life of Chronic Kidney Patients: Generic or Specific Instrument?

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Health and Quality of Life (QOL) are two competing magnitudes, since for a good quality of life, health must also be considered satisfactory. Currently, quality of life is seen as a multidimensional construct, in which researchers agree on the inclusion of physical aspects such as functional capacity, social interactions, affective and emotional behavior and mental health; thus adding to the various aspects of human life. Several researchers point out that they agree with the fact that only the individual can evaluate or qualify his or her life [1].

It is interesting to understand the concept of quality of life, especially since it is a term used in several aspects in the health area and by the change of morbimortality profile that indicates the increase in the prevalence of chronic-degenerative diseases, such as chronic kidney disease. Thus, investigations in patients diagnosed with this disease undergoing hemodialysis are of paramount importance in order to direct improvements in the care and quality of survival of these patients, since they generally deal with a great challenge that involves changes in their routine and life habits related to diet, physical activities, continuous medications and dependence on people and devices, as well as side effects, which also interfere with the physical capacity necessary for engagement in their occupational roles and improvement of the quality of life [2].

Patients with chronic kidney disease, a multicausal condition, treatable in many ways, are usually treated with hemodialysis, as this metabolic disorder leads to accumulation of metabolic products in the blood. This type of treatment is costly and several factors are related to its efficacy, such as time, disease severity, comorbidities that accompany it and even, due to the complications of its use, mortality risk. In this sense, even with all the support of the medical team, advanced techniques of treatment to increase patient survival, patients with this disease present impairments in quality of life, especially in physical and psychosocial aspects [3].

There are other treatment modalities for chronic kidney disease (continuous peritoneal dialysis, automated peritoneal dialysis and renal transplantation), but as to the choice of the ideal method that the patient will be treated, the choice must be individualized, considering the clinical, psychic and socioeconomic aspects of the patient, considering that chronic renal disease is

controllable, but without cure and with a high morbidity and mortality rate. Thus, hemodialysis has often been the method of choice, since in addition to the reversal of uremic symptoms, this treatment seeks, in the long term, to reduce complications, reduce mortality risk, improve quality of life and the social reintegration of the patient [2].

Since chronic kidney disease is a high prevalence index, it is considered of great value studies that value the individual aspects, in order to obtain indicators that can guide the professional action in the search for the quality of care, as well as the identification of the factors associated with quality of life of chronic renal patients on hemodialysis. Studies worldwide have identified some of these factors, such as gender, age, schooling, socioeconomic level, occupation, hemodialysis time, comorbidities, and malnutrition [4].

Several instruments are used to evaluate the quality of life in patients with chronic renal failure, however, it is recommended to use instruments with reliability and validity. In this context the Kidney Disease Quality of Life Short-Form questionnaire (KDQOL-SF) is the most used because it is complete and validated in several languages. This protocol includes the SF-36 and its questions are specific about renal disease, being an indicator of health in order to point out the real deficits related to the patients' health, verifying which of these cause a greater impact on the quality of life. KDQOL-SF is therefore a tool that contributes to the follow-up of interventions that influence quality of life, whether physical or medicinal [3].

The results obtained through the KDQOL-SF scores should be analyzed separately, so in obtaining the final score the data of each dimension are converted into a scale of 0 to 100. The higher scores reflect a better quality of life [5]. In the evaluation of the physical component the determination of the score is given by the dimensions: physical functioning and physical function, but also by pain, general health and energy/fatigue. For the mental component score the emotional function dimension has greater weight, followed in descending order by emotional well-being, social function, energy/fatigue and general health [4].

On the other hand, another instrument widely used to evaluate patients' quality of life is WHOQOL-Bref. This questionnaire was prepared by the World Health Organization Quality of Life Working Group (WHOQOL- Group) [6,7] in 1997 and validated in Brazil in 2003 and is currently the most widely used questionnaire worldwide to assess the quality of life of patients with specific diseases or groups (In this study, the results were compared with the results obtained in the WHOQOL group).

The WHOQOL-Bref protocol, short version of WHOQOL-100 [8], is generally chosen because it is easy to apply and understand, requiring little time to fill it. This protocol has satisfactory psychometric characteristics and has 26 questions distributed among 4 domains: Physical, Psychological, Social Relations and

Environment, generating indicators for the quality of life from the final score of the interview in each domain, the higher the score better the perception of QoL [9,10].

Castro, Driusso and Oishi [11] emphasize the need to consider which aspects of quality of life are of interest to the study that they propose, in order to choose one or another instrument. These authors compared the reliability and convergent validity of the WHOQOL-BREF and the SF-36 from the application of both instruments with 278 elderly people from São Carlos (SP), verifying that the two questionnaires have acceptable internal consistency, but with poor correlation between them [12,13]. The WHOQOL-BREF may be more relevant to assess changes in quality of life in healthy elderly people because it prioritizes responses to the aging process and avoids focusing on their disability.

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