Hrvat. čas. zdr. znan. 2026; 6: 21-28
https://doi.org/10.48188/hczz.6.1.4

Izvorni rad
Original articles

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EFFECT OF A STRUCTURED PATIENT EDUCATION PROGRAM ON SELF-CARE AND COMPRESSION THERAPY ADHERENCE IN VENOUS LEG ULCER PATIENTS: A PROSPECTIVE REPEATED-MEASURES STUDY

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Aim: To examine attitudes of patients with chronic venous leg ulcers toward compression therapy and self-care, and to assess the effect of a structured educational intervention on changes in attitudes and behaviours, particularly adherence to compression therapy.

Participants and Methods: A prospective repeated-measures study was conducted at three time points in the Phlebology Outpatient Clinic of the Department of Dermatology and Venereology at the University Hospital Centre Split, from July 2024 to April 2025. Nineteen adult patients with chronic venous leg ulcers were included. Two structured questionnaires were used to assess wound self-care behaviours and attitudes toward compression therapy, and the Dermatology Life Quality Index was administered. The wound area was measured using a transparent film with a millimetre grid. The educational intervention was delivered individually by a nurse, using verbal instruction and demonstration of wound care and the correct application of compression therapy. Data were analysed using the Friedman test, McNemar test, and post hoc Wilcoxon signed-rank test with Bonferroni correction ($p<0.05$).

Results: The sample included 11 men (58%) and 8 women (42%), with a median age of 67 years (43-87). Independent wound dressing increased from 21% to 74% at 90 days ($p=0.002$). Wound irrigation increased from 42% to 100% at 90 days, with a shift toward using tap water ($p<0.001$). Dressing changes "as needed" increased from 16% to 74% ($p=0.001$), and regular skin care from 10% to 84% ($p<0.001$). Use of compression therapy increased from 32% before education to 100% at 90 days ($p<0.001$), and the proportion of participants who believed compression should be continued after wound healing increased from 31.6% to 100% at 90 days ($p<0.001$). Median pain decreased from 7 to 0 at 90 days ($p<0.001$), and median wound area from 15 cm² to 0 cm² ($p<0.001$). Wound healing was observed in 63% of participants at 90 days.

Conclusion: Structured, individualised nurse-led education was associated with improved attitudes and behaviours related to wound self-care and a marked increase in adherence to compression therapy. Along with behavioural changes, clinically relevant improvements in pain, wound area, and quality of life were observed. These findings support incorporating structured education into standard care for patients with chronic venous leg ulcers. The larger studies with longer follow-up are needed to assess long-term sustainability and prevention of recurrence.

Keywords: CHRONIC VENOUS LEG ULCER, COMPRESSION THERAPY, PATIENT EDUCATION, ADHERENCE, QUALITY OF LIFE

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Introduction

A chronic wound is defined as a wound that fails to heal within six weeks despite appropriate treatment (1, 2). The burden of chronic wounds in the general population is considerable, with an estimated prevalence of approximately 1.08% and an incidence of around 1.33%. Their occurrence increases with age, affecting 1-3% of the elderly population, with a higher prevalence observed among women (3). Among chronic wounds of the lower extremities, venous leg ulcers predominate, accounting for approximately 60-80% of cases and representing the most common form encountered in clinical practice (1, 3, 4).

Venous leg ulcers are frequently associated with pain, functional impairment, and a diminished quality of life, and typically require prolonged management (1, 4). Their treatment necessitates a comprehensive, multimodal approach encompassing local wound care and appropriate dressing selection, pharmacological and surgical interventions, nu-

tritional support, and the promotion of physical activity (4, 5). Compression therapy constitutes the cornerstone of management, as the application of controlled mechanical pressure reduces venous hypertension and facilitates conditions conducive to wound healing. However, its effectiveness depends largely on the correct application and sustained patient adherence, both of which are key determinants of clinical outcomes (1, 4). It is estimated that 60-70% of patients do not adhere consistently to compression therapy, most commonly due to difficulties related to the application and removal of compression devices. Moreover, venous leg ulcers are prone to recurrence, with rates ranging from 30% to 58% within the first year after healing (1, 4). In this context, structured patient education on compression therapy and self-care in patients with venous leg ulcers represents a practical approach to improving patient knowledge and skills and promoting sustained adherence. However, evidence regarding its effect on patient attitudes and behaviours in routine clinical practice remains limited (6).

Participants and Methods

A prospective repeated-measures study was conducted at the Outpatient Clinic, University Hospital of Split, Croatia, between July 2024 and April 2025. Participants with venous leg ulcers were eligible for inclusion, with the diagnosis established by a specialist in dermatology and venereology based on clinical assessment and evaluation of peripheral arterial perfusion by measurement of the ankle-brachial index. Additional inclusion criteria were age ≥18 years, the ability to provide informed consent, absence of cognitive impairment, and no prior participation in a structured educational program focused on venous leg ulcers. A total of 25 participants were enrolled, of whom 19 completed follow-up. Three participants did not attend the second visit, two were unavailable despite repeated telephone contact, and one was diagnosed with a malignant disease during the study and was therefore excluded from further follow-up and analysis. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki and was approved by the Ethics Committee of the University Hospital of Split (Class: 520-03/24-01/91; Reg. No.: 2181-147/01-06/LJ.Z.-24-02). All participants provided written informed consent prior to inclusion.

Data were collected using two structured questionnaires (Questionnaire 1 and Questionnaire 2), adapted from an instrument used in a randomised controlled trial by Žulec et al. assessing the effect of an educational intervention on self-care in patients with venous leg ulcers (7). The questionnaires captured sociodemographic characteristics, wound duration and recurrence, and attitudes toward compression therapy, as well as self-care practices. Attitudes toward compression therapy were assessed using a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree), whereas self-care practices were evaluated using multiple-choice questions. Wound healing was objectively assessed by measuring wound surface area using transparent film with a millimetre grid at each follow-up visit. All measurements were performed by the same investigator and expressed in cm². Quality of life was assessed using the validated Dermatology Life Quality Index (DLQI), which measures the impact of venous leg ulcers on physical, emotional, and social functioning (8). The DLQI comprises 10 items scored from 0 to 3. Total scores range from 0 to 30, with higher scores indicating greater impairment of quality of life. The educational intervention was delivered individually by the same nurse to all participants, using a combination of verbal instruction and demonstration tailored to the participants' level of health literacy. The intervention was structured and included an explanation of the pathophysiology of chronic venous disease and the mechanisms underlying the development of venous leg ulcers, with emphasis on appropriate hygiene practices in the home setting. A standardised wound care procedure was demonstrated, including cleansing with lukewarm water and neutral soap, care of the perilesional skin, and correct application of prescribed dressings. The central component of the educational intervention focused on the proper use of elastic compression, with emphasis on consistent and continuous application to achieve therapeutic benefit. Compression therapy was implemented according to the prescribed regimen, and the type and level of compression were documented in the medical records. Participants were also provided with recommendations on lifestyle modifications relevant to risk factor control and prevention of recurrence, including regular physical activity, elevation of the affected limb at rest, a balanced diet, and avoidance of risk behaviours.

Following diagnosis, patients were referred to the nurse responsible for the educational intervention and were informed about the study objectives and protocol. After providing written informed consent, participants completed the baseline questionnaire (Questionnaire 1) and the DLQI, and baseline wound surface area was measured. An individual education session was then scheduled and conducted. Follow-up assessments were performed at 30 and 90 days after the intervention. At the first follow-up visit, participants completed Questionnaire 2 and the DLQI, and wound surface area was re-measured. They also demonstrated wound care procedures and the application of compression therapy, and additional instruction was provided as needed. At the second follow-up visit, participants again completed Questionnaire 2 and the DLQI, and the final wound surface area was measured. At the end of the study protocol, education was individualised according to clinical status. Participants with persistent ulcers received additional instruction on wound care and compression therapy. In those with complete healing, emphasis was placed on secondary prevention of recurrence through adherence to compression therapy, physical activity, and avoidance of risk behaviours.

Statistical analysis was performed using SPSS software (version 19 for Windows, SPSS Inc., Chicago, IL, USA). Categorical variables were presented as frequencies and percentages, and continuous variables as medians with ranges. The Friedman test and McNemar test were used for analysis. Post hoc pairwise comparisons were performed using the Wilcoxon signed-rank test with Bonferroni correction. A p-value <0.05 was considered statistically significant.

Results

A total of 19 participants with venous leg ulcers were included in the analysis. The sample comprised 11 men (58%) and 8 women (42%), with a median age of 67 years (range 43-87). Six participants (32%) lived alone, 6 (32%) lived with a spouse, and 7 (36%) lived with a spouse and children. Most participants were retired (n=12, 63%), while 3 (16%) were employed and 4 (21%) were unemployed. A previous episode of a venous leg ulcer was reported by 11 participants (58%). The median time since the first occurrence of a venous leg ulcer was 120 months (range 3-588), whereas the median duration of the current ulcer was 4.5 months (range 1-588). Among participants with previous episodes, one prior episode was most common (n=6). Two participants reported three previous episodes, while one participant each reported four and six previous episodes. Regarding sources of information on wound management, 18 participants (95%) identified healthcare professionals, including physicians and nurses, as their primary source, while one participant (5%) reported other sources. Table 1 presents participants' responses to items from Questionnaire 1 and Questionnaire 2, assessing attitudes and behaviours related to wound care before the educational intervention and at 30 and 90 days after the intervention.

At 30 and 90 days after the intervention, a progressive improvement in self-care behaviours was observed. Statistical analysis was based on comparisons between baseline and the 90-day assessment. The proportion of participants performing independent wound dressing increased from 4 (21%) at baseline to 10 (53%) at 30 days and 14 (74%) at 90 days, with a statistically significant difference at 90 days (p=0.002, McNemar test). Independent wound cleansing increased from 8 (42%) to 16 (84%) at 30 days and to 19 (100%) at 90 days. This was accompanied by a shift toward the use of tap water, from 4 (21%) at baseline to 14 (74%) at 30 days and 17 (90%) at 90 days (p<0.001, McNemar test). The proportion of participants changing dressings as needed increased from 3 (16%) to 6 (32%) at 30 days and to 14 (74%) at 90 days (p=0.001). Regular skin care increased from 2 (10%) at baseline to 14 (74%) at 30 days and 16 (84%) at 90 days (p<0.001, McNemar test). Appropriate

Table 1.
Participant responses regarding wound care at baseline and at 30 and 90 days after the educational intervention.

Question	Response	Baseline N (%)	30 days N (%)	90 days N (%)
Who performs your wound dressing?	Self	4 (21)	10 (53)	14 (74)
	With assistance	15 (79)	9 (47)	5 (26)
If not self, why?*	Fear	1 (7)	9 (100)	5 (100)
	Trust in others	14 (93)	-	-
Do you cleanse your wound?	Yes	8 (42)	16 (84)	19 (100)
	No	11 (58)	3 (16)	-
What do you use to cleanse the wound?	Saline	15 (79)	5 (26)	2 (10)
	Tap water	4 (21)	14 (74)	17 (90)
How often do you change dressings?	Every 3 days	16 (84)	13 (68)	5 (26)
	As needed	3 (16)	6 (32)	14 (74)
When do you apply skin care?	When the skin is dry	17 (90)	5 (26)	3 (16)
	Regularly	2 (10)	14 (74)	16 (84)
What position do you adopt at rest?	Supine	8 (42)	3 (15,8)	2 (10,5)
	Supine with legs elevated	11 (58)	16 (84,2)	17 (89,5)
Do you disinfect your hands before dressing?	Yes	18 (95)	19 (100)	19 (100)
	No / Do not know	1 (5)	-	-
Do you disinfect your hands before dressing?	Yes	17 (90)	17 (90)	17 (90)
	No / Do not know	2 (10)	2 (10)	2 (10)
Do you use gloves during dressing?	Yes	12 (63)	14 (74)	17 (90)
	No / Do not know	7 (37)	5 (26)	2 (10)

*Applies only to participants not performing self-care

rest with leg elevation was reported by 11 participants (58%) at baseline, 16 (84.2%) at 30 days, and 17 (89.5%) at 90 days (p=0.031, McNemar test). The use of gloves during dressing changes increased from 12 (63%) to 14 (74%) at 30 days and 17 (90%) at 90 days, showing a positive trend that did not reach statistical significance (p=0.063, McNemar test).

A consistent shift toward more appropriate attitudes regarding compression therapy was observed at both follow-up points, with changes becoming more pronounced by day 90 (Table 2). The proportion of participants agreeing that compression therapy exerts pressure on the wound area increased from 11 (57.9%) at baseline to 12 (63.2%) at 30 days and 17 (89.5%) at 90 days, with a significant difference at 90 days (p=0.031, McNemar test). Agreement with the statement that compression therapy compresses blood vessels increased from 12 (63.2%) to 15 (78.9%) at 30 days and 17 (89.5%) at 90 days, although this change did not reach statistical significance (p=0.125, McNemar test). At the same time, there was a marked increase in the proportion of participants who correctly disagreed with incorrect statements. Disagreement with the statement that compression therapy should not be used while the ulcer is present increased from 9 (47.4%) at baseline to 15 (78.9%) at 30 days and 18 (94.7%) at 90 days (p=0.004, McNemar test). Disagreement with the statement that compression therapy can be applied at any time of day increased from 4 (21.1%) to 10 (52.6%) at 30 days and 18 (94.7%) at 90 days (p<0.001). Similarly, the proportion of participants who disagreed with the statement that compression therapy is not beneficial for their condition increased from 10 (52.6%) at baseline to 13 (68.4%) at 30 days and 17 (89.5%) at 90 days, with a significant improvement at 90 days (p=0.039, McNemar test). In contrast, attitudes toward the statement that rest promotes wound healing did not change significantly (p=0.289, McNemar test), with agreement reported by 11 (57.9%) participants at baseline, 10 (52.6%) at 30 days, and 11 (57.9%) at 90 days. The perceived usefulness of the educational intervention was high, with 18 participants (94.7%) at both follow-up points reporting that the intervention improved their understanding of wound treatment.

Table 2.
Participant responses to statements on compression therapy, physical activity, and education at baseline and at 30 and 90 days after the educational intervention.

Statement	Response	Baseline N (%)	30 days N (%)	90 days N (%)
	Strongly disagree/disagree	3 (15,8)	4 (21,1)	2 (10,5)
Compression therapy compresses the wound area.	Neither agree nor disagree	5 (26,3)	3 (15,8)	-
	Agree / strongly agree	11 (57,9)	12 (63,2)	17 (89,5)
	Strongly disagree/disagree	3 (15,8)	1 (5,3)	-
Compression therapy compresses blood vessels.	Neither agree nor disagree	4 (21,1)	3 (15,8)	2 (10,5)
	Agree / strongly agree	12 (63,2)	15 (78,9)	17 (89,5)
	Strongly disagree/disagree	9 (47,4)	15 (78,9)	18 (94,7)
Compression therapy should not be used while the ulcer is present.	Neither agree nor disagree	3 (15,8)	3 (15,8)	-
	Agree / strongly agree	7 (36,8)	1 (5,3)	1 (5,3)
	Strongly disagree/disagree	4 (21,1)	10 (52,6)	18 (94,7)
Compression therapy can be applied at any time of day.	Neither agree nor disagree	9 (47,4)	3 (15,8)	-
	Agree / strongly agree	6 (31,6)	6 (31,6)	1 (5,3)
	Strongly disagree/disagree	3 (15,8)	6 (31,6)	7 (36,8)
Rest promotes wound healing.	Neither agree nor disagree	5 (26,3)	3 (15,8)	1 (5,3)
	Agree / strongly agree	11 (57,9)	10 (52,6)	11 (57,9)
	Strongly disagree/disagree	10 (52,6)	13 (68,4)	17 (89,5)
Compression therapy is not beneficial for my condition.	Neither agree nor disagree	6 (31,6)	3 (15,8)	1 (5,3)
	Agree / strongly agree	3 (15,8)	3 (15,8)	1 (5,3)
	Strongly disagree/disagree.	-	-	-
The education I received improved my understanding of wound treatment*.	Neither agree nor disagree.	-	1 (5,3)	1 (5,3)
	Agree / strongly agree.	-	18 (94,7)	18 (94,7)

*Assessed only after the educational intervention

Table 3.
Use of compression therapy and related attitudes at baseline and at 30 and 90 days after the educational intervention.

Question	Answer	Baseline N (%)	30 days N (%)	90 days N (%)
Do you use compression therapy?	Yes	6 (32)	19 (100)	19 (100)
	No	13 (68)	0 (0)	-
	Bandage	3 (50)	7 (36,8)	9 (47,4)
	Compression stocking	2 (33)	5 (26,3)	3 (15,8)
	Multilayer system	1 (17)	5 (26,3)	4 (21)
	Adjustable inelastic compression system	-	1 (5,3)	-
	Other	-	1 (5,3)	3 (15,8)
Do you think compression therapy should be continued after wound healing?	Yes	6 (31,6)	15 (78,9)	19 (100)
	No	4 (21,1)	-	-
	I don't know	9 (47,3)	4 (21,1)	-

A marked increase in the use of compression therapy was observed following the educational intervention (Table 3). At baseline, compression therapy was used by 6 participants (32%), whereas at both 30 and 90 days, all participants reported its use (100%). The proportion of participants who considered that compression therapy should be continued after wound healing also increased, from 6 (31.6%) at baseline to 15 (78.9%) at 30 days and to 19 (100%) at 90 days. Comparison of baseline and 90-day measurements confirmed statistically significant changes for both outcomes (p<0.001, McNemar test).

Statistically significant changes in pain, wound surface area, and quality of life were observed across the three time points (Table 4). Pain intensity decreased significantly over time (χ^2=16.7, p<0.001, Friedman test), with the median decreasing from 7 (range 1-10) at baseline to 3 (range 0-10) at 30 days and to 0 (range 0-10) at 90 days. In post hoc analyses, the reduction in pain at 30 days was not statistically significant compared with baseline (p=0.123), whereas a significant reduction was observed at 90 days (p<0.001). The proportion of participants reporting no pain increased from 5/19 (26%) at 30 days to 10/19 (52%) at 90 days. Wound surface area also decreased significantly over time (χ^2=31.6, p<0.001, Friedman test), with the median decreasing from 15 cm² (range 1-100) at baseline to 1 cm² (range 0-24) at 30 days and to 0 cm² (range 0-16) at 90 days. Post hoc comparisons showed a significant reduction at both 30 days (p=0.001) and 90 days (p<0.001) compared with baseline. Consistent with these findings, complete wound healing was observed in 8/19 participants (42%) at 30 days and in 12/19 participants (63%) at 90 days. Quality of life, as measured by the DLQI, improved significantly over time (χ^2=15.88, p<0.001, Friedman test). The median DLQI score decreased from 10 (range 0-17) at baseline to 5 (range 0-19) at 30 days and to 2 (range 0-17) at 90 days (Table 4). In post hoc analyses, the change at 30 days was not statistically significant (p=0.105), whereas a significant improvement was observed at 90 days (p<0.001).

Discussion

This study aimed to evaluate the effect of a structured educational intervention in patients with venous leg ulcers on attitudes and behaviours related to self-care and the use of compression therapy, as well as on clinical outcomes, including pain, quality of life, and wound surface area. The age distribution of participants was consistent with the known epidemiological characteristics of chronic wounds, which predominantly affect older individuals (1-3). More than half of the participants reported a previous episode of a venous leg ulcer, indicating a recurrent and chronic disease course (1, 3, 4). The wide range in time since the first occurrence, including cases of long-standing ulcers, further supports the view that venous leg ulcers represent

Table 4.
Changes in pain intensity, wound surface area, and DLQI scores at baseline and at 30 and 90 days after the educational intervention.

Ishod	Baseline Median (range)	30 days Median (range)	90 days Median (range)	P*
Pain	7 (1-10)	3 (0-10)	0 (0-10)	<0,001
Wound surface area (cm²)	15 (1-100)	1 (0-24)	0 (0-16)	<0,001
DLQI	10 (0-17)	5 (0-19)	2 (0-17)	<0,001

*Friedman test

a persistent condition associated with a substantial burden for both patients and healthcare systems, and underscores the need for interventions aimed at improving education and adherence (1, 3, 4).

Baseline findings indicated a low level of independence in wound care, with only 21% of participants reporting that they performed dressing changes independently. Most relied on assistance from others. Following the intervention, independence increased to 53% at 30 days and 74% at 90 days. This suggests that structured, targeted education can support a more active patient role in daily wound management (6, 7, 9-11). Similar observations have been reported by Žulec et al., who found that patients often relied on informal observation rather than structured instruction (7). In our cohort, most participants received information from healthcare professionals, providing a basis for standardised education. However, as the quality of patient education depends on provider competence, previous studies emphasise the importance of continuous professional training to ensure consistent and evidence-based communication (6, 9).

Improvements were also observed in other aspects of self-care. Independent wound cleansing became more frequent and was nearly universal by day 90. There was a shift toward the use of tap water for cleansing, in line with current recommendations (12). Additional improvements included more appropriate dressing changes, more consistent care of the perilesional skin, and more frequent limb elevation at rest (2, 4). Taken together, these findings indicate that structured education may lead to meaningful changes in patient behaviour, consistent with previous reports (9-11).

Patient attitudes toward compression therapy showed further changes. Although some baseline knowledge was present, likely due to prior experience, the intervention clarified misconceptions that directly influence treatment use. In particular, understanding of key principles of compression improved after the intervention (10, 11). Correction of the misconception that compression is unnecessary during active ulceration is clinically important, as this may lead to treatment interruption at a critical stage of healing (1, 4). Improved understanding of practical aspects, such as morning application before oedema develops, may also reduce barriers and facilitate adherence (10, 13, 15, 16). These findings suggest that structured education not only provides information but also shapes how patients interpret and apply treatment in daily life.

In contrast, attitudes regarding rest showed little change. This may reflect the complexity of the concept or limited responsiveness to short-term education. While rest with limb elevation may relieve symptoms, prolonged inactivity can impair venous return by reducing the effectiveness of the muscle pump, particularly in the absence of adequate compression (13, 14). It is therefore possible that patients do not clearly distinguish between beneficial elevation and harmful inactivity. Similar findings have been reported in the literature, where limited physical activity and low self-efficacy are common (13-16).

By contrast, perceptions of the personal benefit of compression therapy improved, suggesting increased confidence in the treatment. As perceived benefit and trust are known determinants of adherence, this may represent a mechanism through which education contributes to improved treatment consistency and outcomes (15, 16). The high proportion of participants reporting improved understanding further supports the role of structured education in routine care. Future interventions should place greater emphasis on clarifying the role of physical activity and distinguishing it from inactivity (13-16).

The effect of the intervention was most evident in the use of compression therapy. While participants initially recognised its general purpose, education contributed to a clearer understanding of compression as a continuous and essential component of treatment (1, 4, 10). Increased use was accompanied by greater variation in compression devices, suggesting improved individualisation based on patient needs and abilities (4, 10).

Importantly, participants showed improved awareness of the need to continue compression therapy after epithelialization, in line with current recommendations for secondary prevention of recurrence (17). This understanding may be critical for long-term disease control. Improvements in knowledge and attitudes were accompanied by reductions in pain and wound surface area, as well as improved quality of life, consistent with previous findings (11, 18).

Several limitations should be considered. The small sample size limits generalizability. The follow-up period was relatively short, restricting conclusions about long-term outcomes, particularly recurrence. Some outcomes were self-reported, and information bias cannot be excluded. The absence of a control group limits causal interpretation, as other factors may have influenced the results. Finally, although satisfaction with the intervention was high, future studies would benefit from including objective measures of knowledge acquisition. These limitations highlight the need for larger and more robust studies to further evaluate the effectiveness and sustainability of such interventions.

Conclusion

The findings of this study suggest that a structured educational intervention delivered by a trained nurse may have a multifaceted beneficial effect in the care of patients with venous leg ulcers. Following the intervention, improvements were observed in patients' knowledge and attitudes regarding the role and importance of compression therapy, accompanied by positive changes in self-care practices and increased adherence to recommended treatment measures. Clinically relevant improvements were also observed, including reductions in pain intensity and wound surface area, as well as improvements in quality of life, supporting the broader therapeutic value of structured education within an integrated care approach. In addition, the intervention was associated with better adoption of key hygiene and preventive practices, increased self-efficacy in wound care, and a more individualised approach to the selection and use of compression therapy. Importantly, patients demonstrated greater recognition of the need to continue compression therapy after wound epithelialization, which represents a key component of secondary prevention of recurrence. Despite the study limitations, these findings support the integration of structured educational interventions into routine care for patients with venous leg ulcers, particularly in secondary healthcare settings.

Future studies should include larger sample sizes and longer follow-up periods, as well as incorporate more objective measures of knowledge and behaviour, to further evaluate the effectiveness and long-term sustainability of such interventions, including their impact on recurrence rates.

NOVČANA POTPORA/*FUNDING*
Nema/*None*

ETIČKO ODOBRENJE/*ETHICAL APPROVAL*
Nije potrebno/*None*

SUKOB INTERESA/*CONFLICT OF INTEREST*
Autori su popunili *the Unified Competing Interest form na www.icmje.org/coi_disclosure.pdf (dostupno na zahtjev)* obrazac i izjavljuju: nemaju potporu niti jedne organizacije za objavljeni rad; nemaju financijsku potporu niti jedne organizacije koja bi mogla imati interes za objavu ovog rada u posljednje 3 godine; nemaju drugih veza ili aktivnosti koje bi mogle utjecati na objavljeni rad./ *All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: no support from any organization for the submitted work; no financial relationships with any organizations that might have an interest in the submitted work in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work.*

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Ivana Mijalić et al. Effect of a structured patient... Hrvat. čas. zdr. znan. 2026; 6: 21-28

Sažetak

UČINAK STRUKTURIRANE EDUKACIJE BOLESNIKA S KRONIČNOM RANOM VENSKE ETIOLOGIJE NA SAMOSTALNU NJEGU I ADHERENCIJU KOMPRESIVNOJ TERAPIJI

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Cilj: Ispitati stavove bolesnika s kroničnom ranom venske etiologije o kompresivnoj terapiji i samostalnoj njezi rane te procijeniti učinak strukturirane edukativne intervencije na promjenu stavova i ponašanja, osobito adherencije prema kompresivnoj terapiji.

Ispitanici i metode: Provedeno je prospektivno istraživanje s ponovljenim mjerenjima u tri vremenske točke u Ambulanti za flebologiju Klinike za kožne i spolne bolesti KBC Split od srpnja 2024. do travnja 2025. godine. Uključeno je 19 odraslih bolesnika s kroničnom ranom venske etiologije. Primijenjena su dva strukturirana upitnika za procjenu ponašanja samostalne njege rane i stavova o kompresivnoj terapiji, te dermatološki indeks kvalitete života. Površina rane mjerena je prozirnom folijom s milimetarskom mrežom. Edukativna intervencija provedena je individualno od strane medicinske sestre, uz verbalnu i demonstracijsku poduku o njezi rane i pravilnoj primjeni kompresije. Za analizu su korišteni Friedmanov test, McNemarov test i post hoc Wilcoxonov test uz Bonferronijevu korekciju ($p<0,05$).

Rezultati: U uzorku je bilo 11 muškaraca (58%) i 8 žena (42%), uz medijan dobi od 67 godina (43-87). Samostalno previjanje rane poraslo je s 21% na 74% nakon 90 dana ($p=0,002$). Ispiranje rane poraslo je s 42% na 100% nakon 90 dana, uz pomak prema ispiranju tekućom vodom ($p<0,001$). Promjena obloga prema potrebi porasla je sa 16% na 74% ($p=0,001$), a redovita njega kože s 10% na 84% ($p<0,001$). Primjena kompresivne terapije porasla je s 32% prije edukacije na 100% nakon 90 dana ($p<0,001$), a udio ispitanika koji smatraju da kompresiju treba nositi i nakon cijeljenja rane porastao je s 31,6% na 100% nakon 90 dana ($p<0,001$). Medijan boli smanjen je sa 7 na 0 nakon 90 dana ($p<0,001$), a medijan površine rane s 15 cm^2 na 0 cm^2 ($p<0,001$). Cijeljenje rane zabilježeno je u 63% ispitanika nakon 90 dana.

Zaključak: Strukturirana individualna edukacija koju provodi medicinska sestra povezana je s poboljšanjem stavova i ponašanja vezanih uz samostalnu njegu rane te s izrazitim porastom adherencije prema kompresivnoj terapiji. Uz promjene u ponašanju zabilježena su i klinički relevantna poboljšanja boli, površine rane i kvalitete života. Nalazi podupiru uključivanje strukturirane edukacije u standardnu skrb za bolesnike s kroničnim ranama venske etiologije, uz potrebu za većim istraživanjima i duljim praćenjem radi procjene dugoročne održivosti učinaka i prevencije recidiva.

Ključne riječi: KRONIČNA RANA VENSKE ETIOLOGIJE, KOMPRESIVNA TERAPIJA, EDUKACIJA BOLESNIKA, ADHERENCIJA, KVALITETA ŽIVOTA

Primljeno/Received: 13. 1. 2026.
Prihvaćeno/Accepted: 8. 4. 2026.