

Adherence to treatment: a major problem in the control of arterial hypertension

Adesão ao tratamento: um grande problema no controle da hipertensão arterial

Adherencia al tratamiento: un problema importante para controlar la presión arterial alta

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Abstract

Arterial hypertension (AH) is a polygenic syndrome and comprises several pathophysiological aspects such as genetic predisposition, where heredity plays a considerable role in the origin of the increase in blood pressure levels. AH is the most frequent disease in Brazilian society, and its exact prevalence is not known throughout the country, and it contributes significantly to a high rate of cardiovascular mortality throughout the country. The evaluation of a patient with AH includes confirmation of the diagnosis, suspicion and identification of a secondary cause, in addition to checking the risk of a cardiovascular attack. Non-adherence to treatment can also be linked to the undesirable effects of antihypertensive drugs, financial barriers, lack of motivation of the patient to treat an asymptomatic disease, long-term treatment, influence on quality of life, inadequate relationship with the health team, among other diverse factors. Thus, the present study aims to search the scientific literature to analyze data on the impact on individual health of patients considered hypertensive who do not adhere to the treatment of arterial hypertension. A bibliographic survey of publications related to studies on arterial hypertension and treatment adherence through the data platform on Google Scholar, Scielo and LILACS was carried out between the years 1990 to 2020. Analyzing the information present in several articles researched in the literature, it is I need to recognize that the patient is not just hypertensive, but consider that he is inserted in a socio-cultural context and that he has his particularities.

Keywords: Blood pressure; Cardiology; Medication adherence; Patient acceptance of health care.

Resumo

A hipertensão arterial (HA) é uma síndrome poligênica e compreende vários aspectos fisiopatológicos como a predisposição genética, onde a hereditariedade desempenha um papel considerável na origem do aumento dos níveis pressóricos. A HA é a doença mais frequente na sociedade brasileira, não tendo sua prevalência exata conhecida em todo o país, sendo que contribui significativamente para uma elevada taxa de mortalidade cardiovascular em todo território nacional. A avaliação de um paciente com HA inclui a confirmação do diagnóstico, a suspeição e a identificação de causa secundária, além da verificação do risco de um ataque cardiovascular. A não adesão ao tratamento pode também estar ligada aos efeitos indesejáveis dos anti-hipertensivos, barreiras financeiras, falta de motivação do paciente em tratar uma doença assintomática, tratamento de longo prazo, influência na qualidade de vida, relacionamento inadequado com a equipe de saúde, dentre outros diversos fatores. Desta forma, o presente trabalho tem por objetivo uma pesquisa na literatura científica, para analisar dados sobre o impacto na saúde individual de pacientes considerados hipertensos que não aderem ao tratamento de hipertensão arterial. Foi realizado um levantamento bibliográfico de publicações referentes a estudos sobre hipertensão arterial e a adesão do tratamento através da plataforma de dados no Google Acadêmico, Scielo e LILACS entre os anos de 1990 a 2022. Analisando as informações presentes em diversos artigos pesquisados na literatura, é preciso reconhecer que o paciente não é apenas um hipertenso, mas considerar que o mesmo está inserido em um contexto sócio cultural e que possui suas particularidades.

Palavras-chave: Pressão arterial; Cardiologia; Adesão à medicação; Aceitação pelo paciente de cuidados de saúde.

Resumen

La hipertensión arterial (HA) es un síndrome poligénico y comprende varios aspectos fisiopatológicos como la predisposición genética, donde la herencia juega un papel considerable en el origen del aumento de los niveles de presión arterial. La HA es la enfermedad más frecuente en la sociedad brasileña, su prevalencia exacta no se conoce en todo el país y contribuye significativamente para una alta tasa de mortalidad cardiovascular en todo el territorio nacional. La evaluación de un paciente con HA incluye confirmar el diagnóstico, sospechar e identificar una causa secundaria, además de evaluar el riesgo de sufrir un infarto. La no adherencia al tratamiento también puede estar relacionada con los efectos indeseables de los medicamentos antihipertensivos, barreras financieras, falta de motivación del paciente para tratar una enfermedad asintomática, tratamiento a largo plazo, influencia en la calidad de vida, relación inadecuada con el equipo de salud, entre otros. varios factores. Así, el presente trabajo tiene como objetivo investigar la literatura científica para analizar datos sobre el impacto en la salud individual de los pacientes considerados hipertensos que no adhieren al tratamiento de la hipertensión arterial. Se realizó un levantamiento bibliográfico de publicaciones referentes a estudios sobre hipertensión arterial y adherencia al tratamiento a través de la plataforma de datos en Google Scholar, Scielo y LILACS entre los años 1990 al 2020. Analizando la información presente en varios artículos investigados en la literatura, se encuentra es necesario reconocer que el paciente no es sólo hipertenso, sino considerar que está inserto en un contexto sociocultural y que tiene sus propias particularidades.

Palabras clave: Presión arterial; Cardiología; Cumplimiento de la medicación; Aceptación de la atención de salud.

1. Introduction

Arterial hypertension (AH) is a polygenic syndrome and comprises several pathophysiological aspects, such as genetic predisposition, where heredity plays a considerable role in the origin of the increase in blood pressure levels (Zardeto-Sabec et al., 2018). According to Nobre (2013), environmental factors, such as changes in habits in genetically predisposed individuals, contribute to the genesis of AH. For the same author, the excess of sodium in the individual's diet, with the inability of the kidneys to excrete the high demand, induces an increase in blood pressure (BP), caused by the increase in cytoplasmic volume, preload and, consequently cardiac output.

According to the Hypertension Guideline of the Brazilian Society of Hypertension (SBH) (2019) HA, it is characterized as a multifactorial condition pointed out by an increase in blood pressure levels equal to or greater than 140 x 90 mmHg. For Malachias et al. (2016), changes in blood pressure levels are associated with functional and / or structural abnormalities of target organs such as heart, brain, kidneys and blood vessels and metabolic changes such as dyslipidemia, abdominal obesity, glucose intolerance and diabetes mellitus (DM), which cause fatal and non-fatal cardiovascular problems, such as sudden death, stroke (stroke), acute myocardial infarction (AMI), heart failure (HF), peripheral arterial disease (PAD) and chronic kidney disease (CKD).

In order to make the diagnosis, it's necessary to measure the patient's BP, as most hypertensive patients are

asymptomatic. By detecting high and sustained BP levels, it's possible to diagnose AH (Maynarde et al., 2017). For studies authors (Tacon et al., 2010), the increase in blood pressure levels is responsible for the high frequency of hospitalizations with high socioeconomic costs. According to Malachias et al. (2016) the treatment with BP control has shown great efficiency in reducing the occurrence of complications resulted from AH, as well as mortality.

The assessment of a patient with AH includes confirmation of the diagnosis, suspicion and identification of a secondary cause, in addition to checking the risk of a cardiovascular attack (Zardeto-Sabec et al., 2019). This assessment includes the investigation of injuries and target organ and associated diseases. BP measurement in or out of the office, using appropriate equipment and techniques, medical history (personal and family), physical examination and clinical and laboratory investigation, are part of this assessment (Nobre et al., 2013; Malachias et al., 2016).

According to Rodrigues (2016), adherence to treatment is defined as the degree to which a person's behavior matches and agrees with the recommendations of a doctor or other health professional, represented by the intake of medication, the follow-up of the diet, lifestyle changes. When it comes to AH, adherence to treatment includes the degree to which the therapies are indicated, whether they are medicated or not, are followed in order to maintain BP at normal levels.

For De Gusmão e Junior (2006), when it comes to AH, patient compliance and commitment to treatment is what guarantees the quality and success of the regulation of BP levels. For the same authors, adherence would be a complex behavioral process, strongly influenced by the environment, health professionals and medical care. The individual's non-commitment, that is, non-adherence is an impediment to reaching the established therapeutic objectives, constituting a source of frustration for health professionals. Thus, the present study aims to search the scientific literature to analyze data on the impact on individual health of patients considered hypertensive who do not adhere to the treatment of arterial hypertension.

2. Methodology

A bibliographic survey of publications related to studies on arterial hypertension and treatment adherence was performed through the data platform on Google Scholar®, Scientific Electronic Library Online (SciELO) and Latin American and Caribbean Literature in Health Sciences (LILACS). Portuguese, English and Spanish articles were used between 1990 to 2022. The descriptors used, concomitantly, were: hypertension; adherence and treatment.

Two researchers read the summaries of the articles found in the search and applied the relevant inclusion and exclusion criteria. After the pre-selection made by each one, they met and the articles congruently inserted or taken from the composition of the present review were thus allocated. When there was disagreement between the decisions of the two researchers, both discussed the study exhaustively until it reached a decision by mutual agreement. When there was no agreed decision, a third researcher was consulted about the study.

The present study is a narrative review on the proposed theme (Estrela, 2018). Descriptive articles about the prevalence of hypertensive adults and their adherence to treatment were selected, as well as their non-adherence and consequences. After collecting these articles, abstracts of all studies were obtained; then, reading and evaluating its relevance for this review was promoted. Because it is a narrative review, the Qualis Capes analysis of the articles selected for the study was not performed.

3. Results and Discussion

3.1 Arterial hypertension (HA)

According to the new SBH hypertension guideline (2019), arterial hypertension is considered a syndrome, as it is most often associated with metabolic disorders, such as obesity, increased insulin resistance, diabetes mellitus and

dyslipidemia, among others. For Gus (2004), HA is one of the main causes of morbidity in developed and developing countries. For the same author, the control of hypertension shows a reduction in cardiovascular morbidity and mortality.

According to Brandão (2003), arterial hypertension (AH) is the most common disease in Brazilian society, and its exact prevalence is not known throughout the country. It is known as one of the major unique health problems, due to the great economic and financial impact generated on the public health system¹¹. For Manfroi (2006), the prevention of changes in BP levels can be controlled, requiring actions at individual and collective levels.

According to the SBH hypertension guideline (2019), hypertensive individuals are considered, whose Systolic Blood Pressure (SBP) reaches values equal to or greater than 140 mmHg and / or whose Diastolic Blood Pressure (DBP) is equal to or greater than 90 mmHg, in two or more situations, for adults, in the absence of antihypertensive medication.

For Tacon et al., (2010), in Brazil, about 32.5% of adult individuals suffer from AH, where 60% are elderly, and the increase in BP contributes to 50% of deaths from cardiovascular disease (CVD).

AH is a disease without alarms, which presents risk factors such as body mass (BMI), blood glucose and serum lipids, which are directly or indirectly associated with obesity, diabetes, dyslipidemia, physical inactivity, alcoholism, and can cause complications such as heart attack, stroke (stroke), AMI, in addition to chronic end-stage disease (Vital et al., 2011).

According to Woods (2005), some changes may be primarily responsible for AH, such as changes in the autonomic nervous system, in the renin - angiotensin - aldosterone system, in genetic variations, in the reabsorption of renal sodium and in insulin resistance. Still for the same author, some probable secondary causes can be grouped into pheochromocytoma, Cushing's syndrome, hyperthyroidism and hypothyroidism, chronic kidney disease, renovascular disorders, use of oral contraceptives, coarctation of the aorta and primary aldosteronism.

According to Rodrigues (2016), non-adherence to long-term treatments in the general population is around 50%. In a systematic review that compiled studies published in 50 years, authors (DiMatteo, 2004) identified an average rate of 24.8% of non-adherents to treatment or who are unaware that they are hypertension.

3.2 Diagnosis of arterial hypertension (AH)

AH in most cases is an asymptomatic and idiopathic disease, which can make the diagnosis of hypertension difficult, causing the individual not to adhere to the appropriate treatment, thus aggravating his clinical condition, compromising the proper functioning of the organism by delaying adherence to treatment (Brasil, 2006). In primary care, the individual's health must be exposed to a routine and mandatory practice of health centers, with their pressure levels measured. Thus, the health professional, already trained and qualified, can identify through the patient's life history and blood pressure levels the possibility of being hypertensive (Pierin et al., 2001).

The diagnosis of AH is obtained after several elevated and sustained BP measurements, and in different situations, which obey technical criteria, such as adequate patient preparation, the use of standardized techniques and properly calibrated equipment, paying attention to some factors aggravating factors such as age, obesity, pregnancy, among others (Nobre et al., 2013).

The auscultatory technique, performed with the aid of the mercury or aneroid sphygmomanometer or the oscillometric technique, performed by semiautomatic digital arm devices, are the most common methods for obtaining the measurement of BP levels. BP measurements are performed by the patient himself, or by a relative, if there is no person who understands basic information about these techniques, a home monitoring is carried out by health agents, aiming at the quality of the diagnosis of AH (Silva et al., 2010).

The BP values for the identification of AH are arbitrary, as the blood pressure limit may vary according to some literature. BP values may also vary due to the effect of the "white coat", which defines the presence of HA, are the pressure

values corresponding to SBP greater than or equal to 140 mmHg and DBP greater than or equal to 90 mmHg, which they must be confirmed in at least three different situations, always under appropriate technical conditions (Pierin et al., 2001, Eslampanhah, 2016).

3.3 Risk factors for arterial hypertension

HA contributes significantly to a high rate of cardiovascular mortality in all regions of the country. Although blood pressure measurement is a simple, non-invasive and low-cost diagnostic method, studies show that many hypertensive patients do not know their condition (Gus et al., 2004).

Knowing the risk factors for AH is one of the strategies to reduce this major public health problem. The risk factors commonly investigated for this purpose are body mass (BMI), blood glucose and serum lipid levels, which are directly or indirectly associated with obesity, diabetes, dyslipidemia, physical inactivity, alcoholism, thus potentiating the effects of AH on risk cardiovascular (Eslampanah, 2016).

According to Rodrigues (2016) the patient's age (men over 55 and women over 65), premature family history of cardiovascular disease, excessive salt intake, genetic predisposition, socioeconomic factors and metabolic syndrome, which is described as a set of two or more risk factors that affect the same individual, are also considered risk factors that account for the vast majority of diseases and deaths from chronic non-communicable diseases, such as Arterial Hypertension.

The history and physical examination of the hypertensive patient, according to the Brazilian Society of Cardiology (SBC) (2019), must be obtained in full, giving relevance to risk factors such as:

- **Obesity:** High weight is related to the increase in blood pressure, so if the weight is out of the ordinary, a proposal for dietary reeducation should be initiated. Piegas et al. (2015), suggests that the Body Mass Index (BMI) be regularly measured, for an adequate relationship between weight and the patient's age range. The goal is to maintain a BMI between 20 kg / m² and 25 kg / m² to prevent overweight from triggering blood pressure. BMI is calculated using the following formula: BMI: weight / height (Nobre et al., 2013, Piegas et al., 2015).

- **Alcoholic beverages:** It is certain that the components in alcoholic beverages increase BP considerably. Thus, for patients suffering from hypertension it is better to avoid drinking alcoholic beverages. SBC (2019) advises to abandon or limit the daily consumption of alcohol to 30 ml of ethanol for men (720 ml of beer, 240 ml of wine and 60 ml of distilled drink) and to half of these quantities for women, this for the population that still do not show variations in blood pressure levels, as a preventive factor.

- **Food:** Limit salt in the diet. The reduction of salt levels in the diet prevents the oscillation of pressure levels. SBC guides a daily sodium intake between 2.4 g of sodium or 6 g of sodium chloride, including natural and manufactured foods. A daily intake of potassium between 2 to 4 g is recommended in a diet rich in fresh fruits and vegetables (SBC, 2019).

- **Sedentary lifestyle:** Inadequate physical exercise leads to serious blood pressure problems, in addition to high blood pressure, the risks of heart attack increase considerably. It is necessary to practice aerobic physical exercises, 30 to 45 minutes a day, three or more times a week (Zardeto-Sabec et al., 2019).

- **Smoking:** Raises blood pressure sharply and contributes to the development and complications of atherosclerosis. Its interruption decreases the risk of stroke, ischemic heart disease and peripheral arterial vascular disease, in addition to avoiding its other deleterious effects. Exposure to smoking (passive smoking) must also be controlled. Smoking is of great risk for patients with hypertension, since nicotine raises blood pressure considerably, and is also a risk factor for cardiovascular diseases (SBC, 2019).

- **Stress:** There is a relationship between high blood pressure under stress conditions, due to hormonal changes caused by behavioral changes guided by emotions (SBC, 2019).

Dyslipidemias: Hypercholesterolemia is one of the major cardiovascular risk factors. The serum total cholesterol (TC) level should be controlled below 200 mg / dl, with LDL cholesterol (low density cholesterol) below 130 mg / dl. Low HDL (high density cholesterol) cholesterol (less than 35 mg / dl) may increase in response to weight reduction, physical exercise and smoking restriction. The use of non-HDL, which represents the fraction of cholesterol in plasma lipoproteins, also serves as a parameter for assessing dyslipidemia, which can be obtained by subtracting the HDL value from the CT value (non-HDL = CT-HDL). This parameter can be used in the evaluation of dyslipidemic patients, especially in those with triglyceride concentrations above 400 mg / dL (Virani, 2011).

- Genetic factor: it is seen as a relevant risk factor, because heredity, that is, gene inheritance increases the chance of developing hypertension (SBC, 2019).

Approximately 65% of the elderly in Brazil have AH, and among women over 65, the percentage can reach 80%. According to Brandão (2003), the index of people with HA, in the country should increase, in 2025 there will be more than 35 million elderly people in the country. For the same author, in developed countries, cardiovascular diseases are the main responsible for half of the deaths, in addition, they have been causing high morbidity and mortality in the Brazilian population for over 30 years.

Among these diseases, AH is the most common worldwide, reported by high rates of morbidity and mortality, especially in old age. Due to the prevalence of chronic-degenerative diseases, the tendency to use medications tends to increase since the fourth decade of life. Thus, the elderly form the age group with the highest consumption of drugs in society (Zardeto-Sabec et al., 2019).

Other factors have been used to suggest cardiovascular risk factors, such as fasting glucose and abnormal glycated hemoglobin, abdominal obesity, pulse pressure greater than 65 mmHg (in the elderly), history of preeclampsia during pregnancy, family history of arterial hypertension . BP is directly related to age, and most individuals over 65 years old have AH (SBH, 2019).

According to Brandão (2003), physical activity has shown great efficiency in reducing the number of mortality and risks of cardiovascular diseases, thus elucidating the importance of combating sedentary lifestyle.

3.4 Treatment of arterial hypertension (AH)

The treatment is usually started with the implementation of an eating plan and physical exercise. If there is no normalization of glycemic levels in one to two weeks after adopting these measures, it is recommended to start pharmacological treatment, preferably with insulin, as it does not cross the placental barrier, and all types can be used, but human recombinant insulin has less immunogenic activity and should be preferred (Guedes et al., 2020).

The treatment can be carried out with medications or through care with food and changes in lifestyle, among others and will depend on the individual's blood pressure levels, the involvement or not of certain organs and the presence of other diseases (DiMatteo, 2004).

AH has no cure, but it can and should be treated, following the guidance of a doctor and changing lifestyle and eating habits, where the patient will avoid all blood pressure problems, leading a normal and healthy life (Gus et al., 2004).

3.5 Non-drug treatment

O The non-drug treatment of AH is carried out through some practices that depend directly on the patient, such as some lifestyle changes, including weight reduction, moderation in alcohol intake, adequate maintenance of physical activity, moderation in intake of sodium, maintenance of potassium intake and in addition to avoiding smoking (Lopes, Barreto-Filho & Roccio, 2003). For the same author, the non-drug treatment of AH consists of strategies that aim to change the lifestyle and

that can lead to a decrease in the dosage of the drugs or even to their dispensation.

Non-drug treatment has the main objective of decreasing cardiovascular morbidity and mortality through lifestyle changes that favor the reduction of blood pressure (Oliveira, 2011).

It is indicated for all hypertensive patients and individuals, even if normotensive, but at high cardiovascular risk.

The reasons that make lifestyle changes useful are:

- Low cost and minimal risk;
- Reduction of blood pressure, favoring the control of other risk factors;
- Increase in the effectiveness of drug treatment;
- Reduction of cardiovascular risk (SBC, 2019).

Studies demonstrate some lifestyle changes, such as those mentioned above, providing good cardiovascular health and quality of life. However, if blood pressure continues to fluctuate after three to six months of lifestyle change, drug therapy should be started (Lopes et al., 2003).

3.6 Drug treatment

Drug treatment is indicated by the doctor when non-pharmacological measures are not sufficient to control BP, however for all patients with HA in phases I or II, non-pharmacological treatment must be maintained (Santos Borges & Caetano, 2005).

According to Ortega et al. (2001) the treatment of Systemic Arterial Hypertension (SAH) has proven beneficial in several studies in the prevention of cardiovascular complications, when associated with the patient's adherence to treatment.

For Ortega et al. (2001) use of antihypertensive drugs has the objective not only to reduce BP, but also to prevent fatal and non-fatal cardiovascular events. Studies with thiazide diuretics (Chlortalidone, Hydrochlorothiazide, Indapamide), calcium channel blockers (Phenylalkylamines, Verapamil Retard, Benzothiazepines, Diltiazem SR or CD, Dihydropyridines, Anlodipine, Felodipino, Nipple, Ripidine, Nipple, Ripple, , Lercanidipino, Manidipino) beta-blockers (Atenolol, Bisoprolol, Metoprolol 50, Nadolol, Propranolol, Pindolol) and angiotensin-converting enzyme inhibitors (Captopril, Enalapril, Lisinopril, Benazepril, Fosinopril, Cilazapril, Ramipril, Quinapril, Trinapril, Trinapril, Perina, in morbidity and mortality. Still for the same author, the lower number of adverse effects caused by drugs recently developed by the pharmaceutical industry, has provided greater patient adherence to drug treatment. Only the doctor should evaluate and prescribe the antihypertensive medication for the patient.

3.7 Adherence to the treatment of arterial hypertension (AH)

Many literatures combine adherence to treatment with medication adherence, this term refers to several other specific health behaviors that go beyond the simple fulfillment of prescription medications and relate aspects related to the health system, socioeconomic factors, in addition to aspects directed to treatment , patient and the disease itself (Giroto, 2013).

Reis and Pereira (2014) describe adherence as the level at which an individual's behavior represented by medication intake, dietary follow-up, lifestyle changes corresponds and agrees with the guidelines of a doctor or other professional in the field. According to Figueiredo et al. (2010) treatment adherence is a way to reach an end, an evaluation for the maintenance or improvement of health, aiming to decrease the signs and symptoms of a disease.

In a more in-depth approach related to arterial hypertension, autors (Car, Pierin & Aquino, 1991) presents adherence as the level of compliance with the indicated therapeutic measures, whether they are medicated or not, with the objective of maintaining blood pressure at normal levels. It is noteworthy that the definitions of adherence must always cover and recognize the individual's willingness to participate and collaborate with his treatment, which is not addressed in some conceptions.

There are other terminologies used as synonyms for adherence such as adherence, observance, complacency, fidelity and complacency. Complacency would be the “active, participatory obedience of the patient to the medical prescription”, understood by the prescription not only of medications, but also of all other care or measures recommended by the doctor or other health professional (Figueiredo & Asakura, 2010).

For Pierin (2001) with regard to arterial hypertension, the terminology that best represents the follow-up of the proposed treatment is adherence. For these authors, there are different levels of adherence. At the highest level are adherents, individuals who follow treatment completely and, on the opposite side, are dropouts, who are those who abandon treatment. There are also persistent individuals, within the group of non-adherents, who are those individuals who even attend consultations, but do not follow treatment.

3.8 Factors that influence adherence to the treatment of arterial hypertension (HA)

Several factors contribute to treatment adherence and can be linked to the patient (sex, age, ethnicity, marital status, education and socioeconomic level); disease (chronicity, absence of symptoms and late consequences); health beliefs, lifestyle and cultural habits (perception of the seriousness of the problem, ignorance, experience with the disease in the family context and self-esteem); the treatment within which the quality of life is included (cost, undesirable effects, complex therapeutic schemes), the institution (health policy, access to the health service, waiting time versus service time); and, finally, to the relationship with the health team (Santos Borges & Caetano, 2005).

For Rodrigues (2016), adherence is a multidimensional phenomenon determined by the interaction of five factors called “dimensions”, such as health system and team, socioeconomic factors, factors related to treatment, factors related to disease and factors related to the patient, in which patient-related factors are only a determinant. The common view that patients are solely responsible for following their treatment is misleading and reflects the most common misconception of how other factors affect a person's behavior and ability to adhere to their treatment.

4. Conclusion

Analyzing the information present in several articles researched in the literature, it is necessary to recognize that the patient is not just a hypertensive patient, but consider that he is inserted in a socio-cultural context and that he has his particularities. It is extremely important to reflect on the influences of your beliefs, customs and perceptions not only regarding the disease. The health team is important in building new knowledge. The professionalism and dedication of the health worker are indispensable in the patient's adherence to treatment. Non-adherence to treatment can be linked to the undesirable effects of antihypertensive drugs, financial barriers, lack of motivation of the patient to treat an asymptomatic disease, long-term treatment, influence on quality of life, inadequate relationship with the health team, among several other factors.

Therefore, further studies on the subject are needed in order to make the patient aware of the importance of adherence to treatment and help health professionals to better guide patients in relation to this importance.

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