135 - QUALITY OF LIFE AND THEIR CORRELATIONS IN PATIENTS WITH HEART DISEASE AND WITH RISK FACTORS FOR ATHEROSCLEROSIS

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INTRODUCTION

Cardiovascular diseases are the major cause of morbidity and mortality in Brazil and worldwide (1). Its clinical manifestations usually occurs in the form of acute myocardial infarction (AMI), cerebrovascular accident (stroke), angina or sudden death between 50 and 60 years in men and between 60 and 70 years in women, increasing progressively with age (2). According to the IBGE, cardiovascular diseases were the third leading cause of hospitalization and accounted for about 20% of in-hospital deaths occurred in Paraná in 2006. (3).

In recent years there has been an improvement of the medical and surgical treatment of heart disease, modifying thus the mortality associated with them (4). During this period new research on pharmacological and non-pharmacological treatments not only allowed greater survival but also improved their quality of life (QOL) (5).

Health professionals have increasingly recognized the need for consideration of other factors related to health improvement, beyond the quantification of survival. In this context, the use of instruments that can measure the QOL has been added to assessment in order to identify differences between groups or in the same person over time (6). The relationship between health and QOL is a multidimensional concept that involves the degree of satisfaction achieved in physical, emotional and social areas. It can be treated under a objective or subjective viewpoint, in both individual or collective (7), and with the objective of identifying how diseases affect patients' lives and how they face these situations (8).

According to Favarato and Aldrighi (9) various instruments, generic and specific, have been used to assess QOL in patients with the most diverse health problems. The generic questionnaires of QOL bring a broad concept, that can assesses aspects of function, dysfunction and physical and emotional discomfort. They are relevant for establishing whether patients can perform certain routine activities and how they feel when they are performing (9,10). In addition, they offer an advantage over specific questionnaires: the comparison of QOL with the general population and patients with other diseases (11).

The Medical Outcomes Study 36-item Short-Form Health Survey (SF-36) has been widely used to assess QOL in patients with heart disease: after acute myocardial infarction (12), with stable ischemic heart disease and after angioplasty (6), in postmenopausal women with heart disease (9), in cardiac pacemaker users (13), in heart transplant candidates (4) and in patients with congestive heart failure (11,14). This instrument is often used in research because it is compact, easily interpreted and validated in Portuguese from Brazil and other languages which allows for comparison with other studies (4).

Several authors agree that, once installed, cardiovascular disease has strong impact on the patient's life, which can be explained by physical limitations (such as fatigue and dyspnea) associated with psychological disorders (such as fear, insecurity and sadness)(15, 16,17). Therefore, evaluating the impact of heart disease is fundamental in clinical practice (13).

Therefore, the purpose of this study were: to identify the socio-demographic and clinical profile in cardiac patients and patients with risk factors for atherosclerosis, to assess quality of life according to the SF-36 questionnaire (overall and in different areas), and still, to test possible correlations between the aspects evaluated.

METHODS

This cross-sectional and prospective study included outpatients, of both sexes, with minimum age of 18 years, previously diagnosed with heart disease or risk factors for atherosclerosis. After initial explanation and signing an informed consent, the patients who met these inclusion criteria answered a specific test to evaluate their cognitive status (Mini Mental Status Examination - MMSE). Those patients with at least one year of schooling who obtained a score of 24 points or more, and non-literates who have attained a score of 20 points or more in this examination continued on research. (18).

Those who reached the expected score were interviewed to collect demographic (age, education, individual income) and clinical data (diagnostic of heart disease and/or risk factor, number of medications, number of symptoms, degree of dyspnea and disease associated), the latter being also obtained by chart review. Those who had acute or chronic comorbidities (not related to heart disease) that could interfere with the perception of quality of life (neurological disorders, orthopedic, rheumatic) were also excluded. Body weight and height were measured with a calibrated scale and calculation of body mass index (BMI) was performed by dividing the weight (kg) by height squared (m2).

In order to assess the health-related QOL, the Medical Outcomes Study 36-item Short-Form Health Survey (SF-36) was administered by a trained evaluator (19). This questionnaire consists of eight dimensions or domains: functional capacity (FC), physical limitations (AF), bodily pain (DC), general health (EGS), vitality (VT), social aspects (AS), emotional aspects (AE) and mental health (SM), scored from 0 to 100, with the higher value indicating better function. Besides the scores of each domain, the mean total QOL (QOL total) was performed by the arithmetic mean of the 8 domains. Despite being a self-administered questionnaire, in this study was conducted a direct interview, applied by the same trained interviewer, so that the patient had no doubts in understanding the issues.

In the statistical analysis, the distribution of data was evaluated by the Kolmogorov-Smirnov test. The data were described by mean and standard deviation (since the data were normally distributed). Nominal data were presented by frequency. The correlation analyzes were performed by Pearson test. To perform the statistical analysis it was used the GraphPad Prism 3.0 program (San Diego, CA, USA) and statistical significance was set at 5%.

RESULTS

In this study 20 patients were included (7 men and 13 women), of whom 50% had risk factors for atherosclerotic disease (Hypertension, Diabetes Mellitus, dyslipidemia, sedentary lifestyle, smoking, obesity and/or stress), 15% had coronary artery disease, 10% had heart valve disease and 25% had other cardiac diseases. The characterization of all patients (n=20) are presented in Table 1.

Table 1. Description of sociodemographic contentsand BMI.

Age (years)		Absolute Number (n)	% of patients	Average and Standard Deviation
	Young adults (20-40)	3	15	32±4
	Adults (41-65)	13	65	53±8
	Aged (66-79)	2	10	72±6
	Aged above 80 years	2	10	81±0
	Total	20	100	54±15
BMI (kg/m^2)				
	Normal weight (18.5 -24.9)	3	15	23±4
	Overweight (25 -29.9)	11	55	27±3
	Obesity I (30-34.9)	4	20	32±2
	Obesity II (35-39.9)	1	5	35±0
	Obesity III (above 40)	1	5	41±0
	Total	20	100	28±5
Educational Level				
	Iliterates	2	10	
	Elementary School	4	20	
	Middle School	9	45	
	Higher Education	5	25	
	Total	20	100	
Monthly Income				
	Up to 1 minimum salary	4	20	
	1 to 3 salaries	6	30	
	Over 3 salaries	10	50	
	Total	20	100	

The overall quality of life for the sample was 65% on average. The values obtained in the different domains in the entire sample are shown in Table 2, with the highest rate in General Health (79%) and worse in Physical Aspect (54%).

Table 2. Measure of Quality of Life in each domain, described as percentage achieved.

Domain	Average	Standard Deviation
Functional Capacity	74	26
Physical Aspect	54	48
Pain	62	22
General Health	79	14
Vitality	58	19
Social Aspect	65	23
Emotional Aspect	62	44
Mental health	66	16
Total Quality of Life	65	17

Regarding the correlations between socio-demographic and clinical data, it was observed that the education and individual monthly income items had weak and inverse correlation with patient age. This means that older people were less educated (r= -0.45, p <0.05) and had lower income (r = -0.45, p <0.05). Factors such as the time of diagnosis, total symptoms, number of medications used per day and degree of dyspnea showed weak and direct correlations with age. That means that the elderly had longer diagnosis and treatment (r = 0.49, p <0.05), more symptoms related to heart disease / risk factor (r=0.47, p <0.05), more drugs used per day (r = 0.59, p <0.05) and higher level of dyspnea than young adults (r = 0.49, p <0.05).

About the correlations between symptoms and quality of life, the study showed that individuals with higher values in dyspnea scale, i.e. showing more breathlessness, had lower percentages in the field "Functional Capacity" (r = -0, 62, p <0.01), and those with a higher total number of symptoms, had lower scores in this same area (r= -0.65, p<0.01) as well as in the field "Physical Aspects" (r = -0.45, p<0.05).

There was no statistically significant correlation between the values of overall quality of life and other factors assessed, including age, BMI, gender, education, level of dyspnea, individual monthly income, time since diagnosis, total drugs and total symptoms.

DISCUSSION

Regarding the profile of the patients, it can be observed that the mean age (54 ± 15 years) was consistent with the range of greater prevalence of cardiovascular diseases and risk factors in several studies in the literature (11,12,20, 21,22), however, there was a predominance of females (65%), unlike the majority of studies (4,10,12,13,20,23,24). The BMI was above normal in 85% of evaluated (mean 28 ± 5 kg/m2), with11 patients classified as overweight (55%) and 6 with different degrees of obesity (30%). Carneiro et al. (25) reported that, compared to normal weight individuals, those with high BMI have a higher risk of developing diabetes mellitus, dyslipidemia and hypertension, conditions which favor the development of cardiovascular disease.

When compared to the literature, there is a discrepancy in this study in relationship to schooling and income. In several studies, the population consisted of individuals with middle level education (like this study) but with lower income (10,24,26). The result of this study may have positively influenced the QOL scores. Minayo, Hartz and Buzz (7) state that income, health and education are fundamental aspects of quality of life of a population, and directly proportional to the scores.

In this study, as expected, overall QOL (65%) was lower than the scores found in healthy people (88%) (11). When domains were analyzed individually it was observed that the Physical Aspect showed lower score (54%), representing worst health perception in this regard, and General Health, was the area with the highest score (79%). In a study that assessed the QOL of 28 outpatients after acute myocardial infarction treated in a conventional manner, the authors obtained a score of 66% in overall QOL, 46% in Physical Aspect and 67% in General Health, for patients with a mean age similar to the current study (12). Despite the similarity between the overall QOL and EGS in both studies, the Physical Aspect study was lower in patients with AMI. The authors of that study emphasized the limitations imposed by the symptoms (and other aspects) of the disease to justify their findings. Based on this comparison, the current sample would be expected to score better in this domain, considering that most patients had no cardiac disease installed and that the cardiac risk factors cause few symptoms in most cases. The fact that this sample has shown 54% in the Physical Aspect domain reinforces the understanding that, because QOL is subjective and multidimensional, it should always be assessed by validated instruments and may not be inferred uniquely on the basis of

diagnosis.

Juenger et al., in 2002 (11), performed a study in Germany with a sample of 205 cardiac patients with Congestive Heart Failure (CHF) and compared the quality of life by SF-36, among these patients, healthy people and people with other chronic diseases. The authors concluded that people with CHF had a reduced score when compared to the healthy group, particularly in the domains "Physical Aspect", "Functional Capacity" and "Emotional Aspect", and showed the same pattern when compared with people on hemodialysis due to chronic renal insufficiency.

According to Helito et al. (4) various researchers evaluate the survival of patients with cardiovascular disease, however, remains the lack of studies in which QOL is discussed in view of its importance for the maintenance of human dignity. Thus, despite the small sample size, it is considered that this study has clinical relevance because it started to characterize the profile of patients with heart disease and risk factors in the study area.

CONCLUSION

In this sample - composed mostly of adult women, with middle-level education, income above 3 minimum salaries, overweighed, half of whom had heart disease installed and the other half had only cardiovascular risk factors - the quality of life proved to be reduced especially in the domain Physical Aspect. The total number of symptoms and level of dyspnea correlated inversely with quality of life (Functional Capacity domain), regardless of patient age. These data reinforce the view that, because QOL is subjective and multidimensional, it should always be assessed by validated instruments and may not be inferred uniquely on the basis of diagnosis.

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QUALITY OF LIFE AND THEIR CORRELATIONS IN PATIENTS WITH HEART DISEASE AND WITH RISK FACTORS FOR ATHEROSCLEROSIS

ABSTRACT

Introduction: Physical limitations and psychological changes in patients with cardiovascular diseases can have a strong impact on the perceived quality of life (QOL). To provide a multidimensional approach to them is important that this aspect is evaluated in clinical practice. Objectives: To identify the socio-demographic and clinical profile in cardiac patients and in those with risk factors for atherosclerosis (FR), to assess quantitatively QOL and also test possible correlations between these aspects. Methods: This cross-sectional and prospective study included outpatients, of both sexes, with minimum age of 18 years, diagnosed with heart disease or FR and excluded patients with cognitive impairment and comorbid conditions that might interfere with QoL, as measured by the SF-36. Socio-demographic and clinical data were collected by interview and review of medical records. Results: The sample consisted of 20 patients, mostly women (65%), with income above 3 minimum wages, mean age 54 ± 15 years and a body mass index of 28 ± 5 kg/m2. Half of the patients had heart disease (15% coronary artery disease, 10% heart valve disease and 25% other cardiovascular diseases) and the other half had only FR. The total QOL (average of the 8 domains) was 65%, with the highest score obtained in the field General Health (79%) and worst in Physical Aspect (54%). Moderate and inverse correlations were observed between the total number of symptoms and level of dyspnea versus QOL (Functional Capacity domanin), regardless of patient's age. Conclusion: In this sample, despite the low level of clinical severity in most patients, QOL proved to be reduced, especially in the domain Physical Aspect (54%). These data reinforce the view that QOL, that issubjective and multidimensional, should always be assessed by validated instruments and may not be inferred uniquely on the basis of diagnosis.

KEYWORDS: Quality of life, Heart Diseases, Risk Factors.

QUALITÉ DE VIE ET LEURS CORRELATIONS CHEZ LES PATIENTS SOUFFRANT DE MALADIES CARDIAQUES ET PRESENTANT DES FACTEURS DE RISQUE D'ATHEROSCLEROSE

RÉSUMÉ

Introduction: Les maladies cardiovasculaires peuvent avoir un fort impact sur la qualité de vie (QOL) d'où est important que elle est évaluée en pratique clinique. Objectifs: identifier les aspects socio-démographiques et cliniques et les patients cardiaques ou présentant des facteurs de risque d'athérosclérose (FR), évaluer la QOL, et également tester les corrélations possibles entre ces différents aspects. Méthodes: Étude transversale et prospective a inclus les patients externes, des deux sexes, âge minimum de 18 ans, diagnostiqués avec les maladies cardiovasculaires ou FR et exclu les présentant des troubles cognitifs et les comorbides qui pourraient interférer avec la mesurée par le SF-36. Les socio-démographiques et cliniques données ont été recueillies par interview et examen des dossiers médicaux. Résultats: L'échantillon se composait de 20 patients, principalement des femmes (65%), dont le revenu était supérieur à 3 salaires minimums, âge moyen 54±15 ans et un indice de masse corporelle de 28±5 kg/m2. La moitié des patients avait une maladie cardiaque (15% coronaropathie, 10% valvules et 25% atteints d'autres maladies cardio-vasculaires) et l'autre moitié seulement FR. Le total la QOL (moyenne des 8 domaines) était de 65%. Le score le plus élevé a été obtenu dans la "Générale de la Santé" (79%) et le pire dans l'aspect physique (54%). Modérés corrélations inverses ont été observées entre le nombre total de symptômes et le niveau de la dyspnée avec la QOL (capacité fonctionnelle domaine), quel que soit l'âge du patient. Conclusion: Dans cet échantillon, malgré le faible niveau de gravité clinique dans la plupart des patients, la QOL s'est avérée être réduite, en particulier dans le domaine aspect physique (54%). Ces données renforcent l'idée que la QOL, car elle doit subjective et multidimensionnelle, doit toujours être évaluée par des instruments validés et ne peut être déduit uniquement sur la base en le diagnostic.

MOTS-CLÉS: Qualité de vie, maladies cardiaques, facteurs de risque

CALIDAD DE VIDA Y SUS CORRELACIONES EN PACIENTES CON ENFERMEDAD DE CORAZÓN Y FACTORES DE RIESGO PARA ATEROSCLEROSIS

RESUMEN

Introducción: La enfermedad cardiovascular puede tener un fuerte impacto en la percepción de calidad de vida (QOL) y esta debe ser evaluada en la práctica clínica. Objetivos: Identificar los aspectos socio-demográficos y clínicos en pacientes cardíacos o con factores de riesgo para la aterosclerosis (FR), evaluar cuantitativamente la QOL, y probar las posibles correlaciones entre estos aspectos. Métodos: Estudio transversal y prospectivo de pacientes no hospitalizados, de ambos los sexos, mayores de 18 años, con diagnóstico de enfermedad cardiovascular o FR y se excluyeron los pacientes con deterioro cognitivo y trastornos comórbidos que pueden interferir con la QOL, medida por el SF-36. Los datos socio-demográficos y clínicos fueron recolectados por entrevistas y revisión de historias clínicas. Resultados: La muestra fue constituida por 20 pacientes, la mayoría mujeres (65%), con ingresos superiores a 3 salarios mínimos, edad media 54±15 años y un índice de masa corporal de 28±5 kg/m2. La mitad de los pacientes tenían enfermedad del corazón (15% enfermedad coronaria, 10% enfermedad valvular y 25% otras enfermedades cardiovasculares) y medio tenía solamente FR. El total de la QOL (promedio de los 8 dominios) fue del 65%. La mayor puntuación obtenida fue en el campo de la salud general (79%) y el peor en el aspecto físico (54%). Fueran demostradas moderadas correlaciones inversas entre el número total de síntomas y el grado de disnea con la QOL (dominio capacidad funcional), sin importar la edad del paciente. Conclusión: En este estudio, aunque del bajo nivel de gravedad clínica en la mayoría de los pacientes, la QOL demostró ser reducida, especialmente en el aspecto físico (54%). Estos datos refuerzan la información de que, dado que la QOL es subjetiva y multidimensional, siempre se debe evaluar esta mediante instrumentos validados e no se puede deducirse únicamente Basado en el diagnóstico.

PALABRAS CLAVE: Calidad de vida enfermedades cardíacas, factores de riesgo

QUALIDADE DE VIDA E SUAS CORRELAÇÕES EM PACIENTES COM DOENÇAS CARDÍACAS E COM FATORES DE RISCO PARA ATEROSCLEROSE

RESUMO

Introdução: As doenças cardiovasculares, na presença de limitações físicas e alterações psicológicas, podem ter forte impacto na percepção da qualidade de vida (QV). Para proporcionar uma abordagem multidimensional a estes pacientes é importante que esse aspecto seja avaliado na prática clínica. Objetivos: Identificar o perfil sócio-demográfico e clínico de cardiopatas e pacientes com fatores de risco para aterosclerose (FR), avaliar quantitativamente a QV, e ainda, testar possíveis correlações entre esses aspectos. Métodos: Nesta pesquisa transversal e prospectiva foram incluídos pacientes ambulatoriais, de ambos os sexos, idade mínima de 18 anos, portadores de cardiopatia diagnosticada ou FR e excluídos os pacientes com comprometimento cognitivo e comorbidades que pudessem interferir na QV, medida pelo questionário SF-36. Dados sócio-demográficos e clínicos foram coletados por entrevista e por análise de prontuário. Resultados: A amostra foi composta por 20 pacientes, em sua maioria mulheres (65%), com renda acima de 3 salários mínimos, média de idade de 54±15 anos e de índice de massa corporal de 28±5 Kg/m2. Metade dos pacientes tinha cardiopatia (15% coronariopatas, 10% valvopatas e 25% portadores de outras doenças cardiovasculares) e metade tinha somente FR. A QV total (média dos 8 domínios) foi de 65%, sendo o maior escore obtido no domínio Estado Geral de Saúde (79%) e o pior no Aspecto Físico (54%). Correlações inversas e moderadas foram observadas entre o número total de sintomas e o nível de dispnéia com a QV (no domínio Capacidade Funcional), independentemente da idade do paciente. Conclusão: Nesta amostra, apesar do baixo nível de gravidade clínica da maioria dos pacientes, a QV apresentou-se diminuída, especialmente no domínio Aspecto Físico (54%). Esses dados reforçam o entendimento de que a QV, por ser subjetiva e multidimensional, deve ser sempre avaliada por instrumentos validados, não podendo ser inferida unicamente com base no diagnóstico.

PALAVRAS-CHAVE: Qualidade de vida, Cardiopatias, Fatores de Risco.