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DEPRESSIVE DISORDER INFLUENCE ON THE QUALITY OF LIFE OF THE PATIENT WITH DEGENERATIVE PATHOLOGY

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ABSTRACT. In chronic rheumatic diseases, we frequently follow the physical dimension of the disease and less the mental and social dimension of it. In the recent years, there has been a great interest in measuring the quality of life reflecting together all these three dimensions. The aim of this study was to assess and compare the perception of pain, quality of life of the patients with depression respectively without depression, using assessment tests recognized and accredited in Romania. We conducted an observational study on a group of 20 patients (n=20). The subjects were randomized of the patients hospitalized at *,,Avram Iancu''* Clinical Hospital, Oradea, over a period of 2 weeks(in January-February 2016).All the cases were staged according to current criteria approved in Romania. Data collection was prospective and was made directly by examining the patients. Assessment methods are standardized in order to limit as much as possible the influence of systematic error. Initial evaluation and monitoring the patients consisted of physical examination, muscular and articular consultations, assessment of the pain, and depression and quality. We observe higher incidence of depression among women, 70% in the studied group. We assessed the pain expressed by the patients objectively on the VAS pain scale. The mean values of pain were as follows: group I- initially3.8, at the end of treatment1.4; the second group - initially 6.2 and finally 4. The initial average values of the pain were lower in the group without depression and also the treatment response and mean values in group I were significantly superior to of the second group. From the analysis of the data obtained we observe that the average quality of life of the patients from group I is 1.81 and increases after treatment with a percentage of 41.4%.The average value of HAQ score in the group of patients with depressive disorder is 2.03, decreasing to 1.37 after treatment. That means an improvement of 32.17%. The number of women that addresses for recovery treatment is higher. We observe a higher incidence of depression among women, 70% in the study group. The average value of the pain of the patients from group I is lower both initially and at the end of the study than the average pain of the patients from group II, result otherwise expected because the perception of pain is higher at patients with depression and treatment response it is more modest. In the case of first group, the mean value of the pain decreases by 63.15%, while for the second group the decrease is 30.64%. From the analysis of the obtained data we observe that the average quality of life of the patients from group I is 1.81 and increased after treatment with a percentage of 41.4%. The average value of the HAQ score in the group of patients with depressive disorder is 2.03, this dropped to 1.37 after treatment. That means an improvement of 32.17%.
KEYWORDS: chronic rheumatic diseases, quality of life**,** depressive disorder.

INTRODUCTION

In chronic rheumatic diseases, we frequently follow the physical dimension of the disease and less the mental and social dimension of it.In the recent years, there has been a great interest in measuring the quality of life reflecting together all these three dimensions.

The aim of this study was to assess and compare the perception of pain, quality of life of the patients with depression respectively without depression, using assessment tests recognized and accredited in Romania.

Depression is an important mental disorder of the third age.Depressive disorder in the elderly is extremely widespread, the prevalence rate being higher at elders in retirement homes (15-25%) and primary care clinics (5%), decreasing to less than 3% at the elderly that have chronic physical disorders (especially those disorders that limit daily activities).

The decrease of psychomotor performances begins at the age of 25-35 years, with prolongation of the intellectual possibilities even over 70 years. Organ damages are unequal. Aging changes predominate at the

level of cardiovascular, respiratory and locomotor systems. Within certain limits, aging-related changes belong to a normal aging.

The changes that occur along with aging are: the decrease of visual and auditory activity, weakening voice, muscle weakness, sleep diminishing, constipation, edentation, skin and appendages changes etc. Depressive disorder associates a state of negative mood, loss of self-confidence, impaired concentration and memory, decreased interest in social life, loss of attachment, increased dependency, psychomotor slowness, physical fatigue, agitation, anorexia and weight loss, shortness of breath, sweating, headache, arthralgia, and awakening insomnia.

Among the most important tests used for depression evaluation are the following: Hamilton Depression Rating Scale, Scale Montgomery - Asberg Depression Rating, Beck Depression Inventory, Zung depression self-assessment scale etc.

MATERIAL AND METHOD

We conducted an observational study on a group of 20 patients (n=20).

The subjects were randomized of the patients hospitalized at ,,*Avram Iancu''*Clinical Hospital, Oradea, over a period of 2 weeks(in January-February 2016).All the cases were staged according to current criteria approved in Romania. The patients included in the study were aged between 65 and 83 years, the average age being 71.15 years.

We divided the 20 patients into two groups of 10 people. The first group presented degenerative pathology, without depressive disorder being present. In the second group were the patients with degenerative pathology in association with depressive disorder.

The average age in group I was 72.63, and in group II was 69.6 years.

We included in the study patients with coxarthrosis, and primitive and secondary gonarthrosis, cervical dorsolumbar spondylodiskarthrosis, n = 20.

The inclusion criteria were: certain diagnosis, age over 65, the possibility of assessing the patient twice; patient consent for radiological investigation with magnetic resonance imaging or computed tomography; without a history of incompatibility with MRI (peace-Macker, claustrophobia).

Data collection was done according to medical ethics principles.

We evaluated the patients at admission and hospital discharge, namely after 10 days of balneary physiotherapy treatment, antialgic electrotherapy, paraffin, kinetotherapy, massage.

STUDY DESIGN

Data collection was prospective and was made directly by examining the patients. Assessment methods are standardized in order to limit as much as possible the influence of systematic error.

Initial evaluation and monitoring the patients consisted of physical examination, muscular and articular consultations, assessment of the pain, and depression and quality of life.

We mention that clinical examination, metrology and questionnaires were applied by the same investigator.

Evaluation of predictive factors: Predictive factors of structural severity depend on:

- demographic characteristics;
- clinical characteristics;
- radiological characteristics (these were not the subject of this study).

Demographic variables. All participants (n = 20) were questioned about the age, gender and duration since the disease onset, and area of origin: rural or urban. The basal data of patients included in the study were presented in a table.

Clinical variables. Comprehensive evaluation of patient progress requires reliable and credible measurements both in terms of functional status as well as clinical data, biological and radiological. At the patients of the studied group were followed the parameters as: *pain, functional impact, quality of life.*

a. Pain is defined by intensity and duration. Pain intensity was assessed with the Visual Analogue Scale of 100 mm. Thus, for clinical trials the pain> 40 mm is taken as the value of inclusion in the study. A minimum duration of the pain to define the clinical evolution that appears twice a month and lasts no more than a few hours does not reflect the same spurt of activity as a pain that occurs daily during the last 3 months. In the recovery activity and in clinical research patients present pain for at least 30 days during the last 3 months.

VAS is probably the most widely used instrument for measuring the pain intensity. It is considered a simple procedure, robust, sensitive and reproducible, a tool that allows the patient to express the severity of his pain, so that it can be given a numerical value. Its usefulness in the clinical trials was confirmed, the results vary from "no pain" to "worst pain possible". The notes ranged from 0 to 100.

We also tried to measure the spontaneous pain (pain intensity assessment at a precise moment), both at admission and hospital discharge.

b. We analyzed the patient's quality of life using the HAQ questionnaire. We made the assessment of the global functional capacity using the HAQ questionnaire (Stanford Healt Assessment Questionnaire), which measures the disability over the last week, including a total of 20 questions grouped into 8 categories from the ADL field: dressing, getting up from a sitting position and from supine, feeding, walking, hygiene, prehension and other activities in the occupational field.

Jurnal Medical Aradean (Arad Medical Journal)
Vol. XX, issue 2, 2017, pp. 5-8

RESULTS

The distribution by gender of the patients from the two studied groups, 13 women and 7 men, is represented in the chart below:

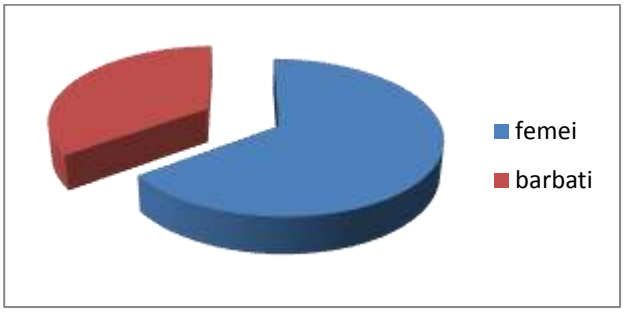

Chart no.1 The distribution of the patients by gender

We observe higher incidence of depression among women, 70% in the studied group (chartno.2).

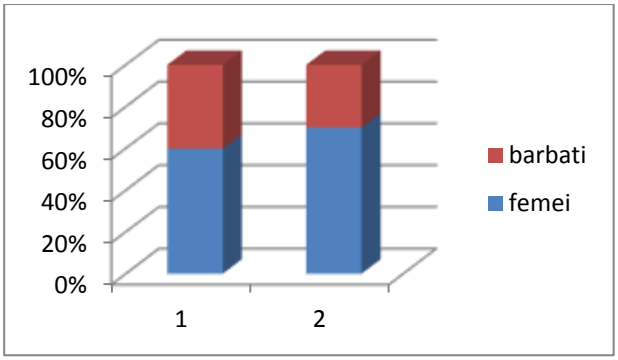

Chart no. 2 The incidence of depression

Another followed demographic parameter was the area of origin. The distribution according to the area of origin is represented in chart no.3.The study that we have conducted demonstrates the predominance of the patients from urban areas.

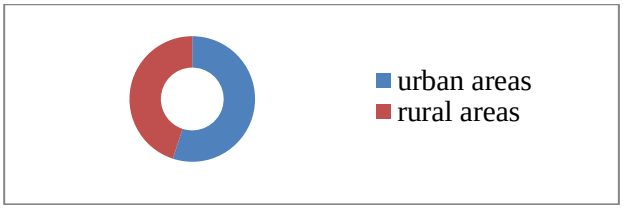

Chart no.3. The distribution of patients according to the area of origin

The assessment of the pain in the two groups of patients.

We assessed the pain expressed by the patients objectively on the VAS pain scale. The mean values of pain were as follows: group I- initially3.8, at the end of treatment1.4; the second group - initially 6.2 and finally 4.3 (chart 4).

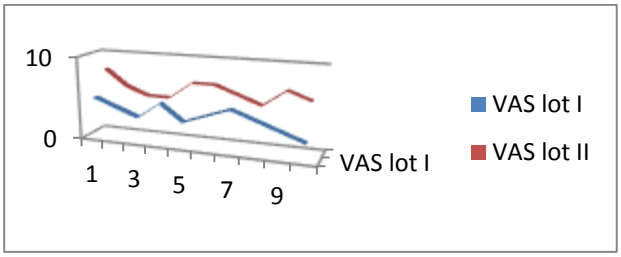

Chart no. 4 The comparative values of the pain group I vs. group II, at the first assessment

The initial average values of the pain were lower in the group without depression and also the treatment response and mean values in group I were significantly superior to of the second group (chart 5).

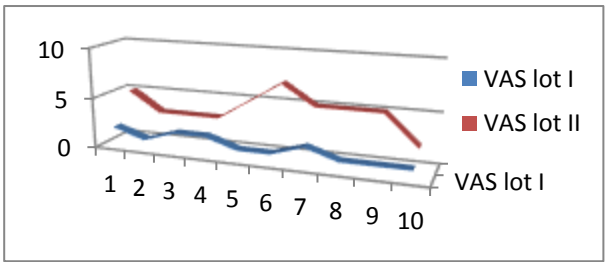

Chart no.5 The comparative values of the pain group I vs. group II, at the second assessment

The assessment of the quality of life of the patients in the two groups

The quality of life of patients of both groups was assessed using the HAQ questionnaire.

From the analysis of the data obtained we observe that the average quality of life of the patients from group I is 1.81 and increases after treatment with a percentage of 41.4%.The average value of HAQ score in the group of patients with depressive disorder is 2.03, decreasing to 1.37 after treatment. That means an improvement of 32.17%.

We also represented graphically the initial and the final values of the HAQ score, group I vs. group II. We notice from the graphic representation of the HAQ index, higher values in group I vs. group II, at the initiation of treatment as well as at end of treatment (chart no.6 and 7).

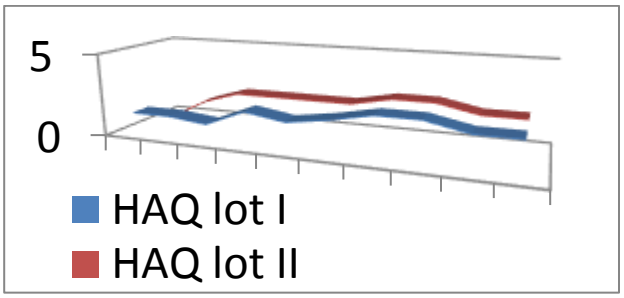

Chart no.6 The variation of the initial HAQ score in the two groups

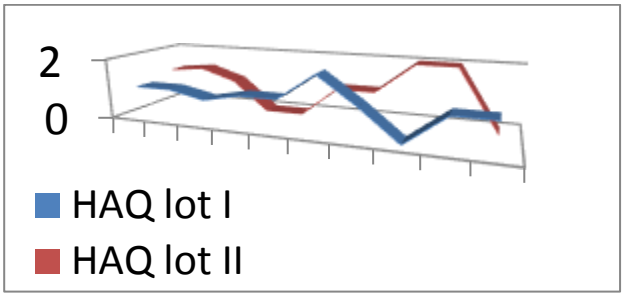

Chart no.7 The variation of the final HAQ score in the two groups

CONCLUSIONS

From the performed study result the following:

1.The number of women that addresses for recovery treatment is higher.

2.We observe a higher incidence of depression among women, 70% in the study group.

3.Increased incidence of hypertension, diabetes, ischemic heart disease among women, knowing that all these diseases are predisposing factors for depression.

4.The average value of the pain of the patients from group I is lower both initially and at the end of the study than the average pain of the patients from group II, result otherwise expected because the perception of pain is higher at patients with depression and treatment response it is more modest.

5.In the case of first group, the mean value of the pain decreases by 63.15%, while for the second group the decrease is 30.64%.

6.From the analysis of the obtained data we observe that the average quality of life of the patients from group I is 1.81 and increased after treatment with a percentage of 41.4%. The average value of the HAQ score in the group of patients with depressive disorder is 2.03, this dropped to 1.37 after treatment. That means an improvement of 32.17%.

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