Оценивание якости життя паліативних хворих на хіміорезистентний туберкульоз легень в умовах спеціалізованої лікарні при виправній колонії

Оцінювання якості життя паліативних хворих на хіміорезистентний туберкульоз легень в умовах спеціалізованої лікарні при виправній колонії

Цель работы — оценить качество жизни паллиативных больных химиорезистентным туберкулёзом лёгких в условиях специализированной больницы исправительной колонии по показателям опросника MOS SF-36 и обосновать
Introduction. For today, according to the World Health Organization (WHO), Ukraine is included into the list of 30 countries with the worst situation of chemoresistance pulmonary tuberculosis (CRTB) [14]. In 2016, according to the Global report of WHO, efficiency of patients with multiresistant tuberculosis (MRTB) treatment in Ukraine made 39%.

Pulmonary CRTB belongs to clinical states when patients can need palliative care as antituberculous medicines (ATM) can not provide adequate treatment, and other clinical and social conditions make treatment of patient impossible [1]. Delivery of health care to palliative patients, including patients with pulmonary CRTB, is, first of all, in promoting improvement patients quality of life (QL) in process of disease progression and its rising to the terminal stage through the prevention and relief of patient suffering by early diagnosis and decrease of disease symptoms [2–4]. QL is an integrated indicator of the general human welfare [5].

In the different countries assessment of QL of TB patients is carried out by means of various questionnaires which have the criteria and rating scales [6–9]: a questionnaire of QL of WHO (Q of QL of WHO), a questionnaire of QL assessment of the European group of studying of QL (EUROQOL – Euro-QOL Group), the Nottingham profile of health (Nottingham Health Profile), the generalized scale of QL assessment (Overall Quality of Life Scale), etc.

Researchers of the International Centre of QL research (ICR of QL, St. Petersburg, RF) (1998) [14] created the Russian-language version of a questionnaire of Medical Outcomes Study-Short Form (MOS) SF-36 (the author is J. E. Ware, 1992 [15]) [10]. This version of a questionnaire of the MOS SF-36 is accepted for carrying out of QL population researches. It is recommended to use a questionnaire of the MOS SF-36 for QL assessment of healthy persons and at various diseases including at tuberculosis [11–13].

For today QL of TB patients is enough studied by means of questionnaires, both in an active phase, and with residual changes after tuberculosis. However, there are no data of QL research in palliative patients with pulmonary CRTB that is important for the differentiated approach of treatment and care, the warning of tuberculosis complications development, monitoring of these patients health state. The above makes the chosen subject urgent.

The purpose of the work is to estimate the quality of life of palliative patients with drug-resistant pulmonary tuberculosis in a specialized hospital penal colony in terms of the MOS SF-36 questionnaire and justify the appropriateness of its application for a differentiated approach in dependence of physical or mentally health components oppression, monitoring their health condition.

Materials and Methods

Assessment of QL was carried out among 95 patients with pulmonary CRTB who were on treatment in specialized hospital at Public Institution "Softyivka corrective labour colony (No. 55)" of the Ministry of Justice of Ukraine in the Zaporizhzhia region. There were 53 patients on palliative treatment in the main group and 42 patients in group of comparison received ATM in the supportive phase of chemotherapy.

There were no incurable patients among the palliative patients with CRTB (group 1). The most part of this group consisted of patients who did not require treatment.

To determine the norms of quality studied indicators in our region, we have formed a control group consisted of 40 healthy volunteers. All 3 groups of study subjects were males (100 %) as corrective labour colony was for men. Average age of healthy volunteers was (38.9±6.1), average age of patients of the main group was (35.0±1.1) and average age of comparison group was (36.3±2.3).

For QL assessment a questionnaire of the MOS SF-36 (ICR of QL, St. Petersburg, 1998) was used. There were estimated 8 scales according to the questionnaire of the MOS SF-36: Physical Functioning (PF) – physical functioning; Role-Physical (RP) – Influence of a physical state on role functioning; Bodily Pain (BP) – intensity of pain and its influence on ability to be engaged in daily activity; General Health (GH) – the general state of health; Vitality (VT) – viability; Social Functioning (SF) – social functioning; Role-Emotional (RE) – influence of an emotional state on role functioning; Mental Health (MH) – a self-assessment of mental health.

Authors of a questionnaire of the MOS SF-36 recommended to carry out an assessment of a physical component of health in a complex according to 1–4 scales (PF, RP, BP,
Table 1. Assessment of a physical component of health according to scales of questionnaire of the MOS SF-36 (M±SD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Control (n=40)</th>
<th>Main group (n=53)</th>
<th>Comparative group (n=42)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>90.6±0.7</td>
<td>58.1±2.4</td>
<td>63.6±2.7</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>RP</td>
<td>88.4±2.3</td>
<td>20.8±3.3</td>
<td>56.5±3.2</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>BP</td>
<td>85.1±2.2</td>
<td>49.1±2.3</td>
<td>59.1±2.0</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>GH</td>
<td>74.6±0.9</td>
<td>48.4±2.2</td>
<td>53.7±2.6</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Physical component of health, points</td>
<td>85.0±0.9</td>
<td>43.6±1.7</td>
<td>58.2±1.5</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Fig. 1. Comparison of the scales of questionnaire MOS SF-36 among the groups.

Results of the study were processed by the modern methods of the analysis on the personal computer with statistical packet of the license program STATISTICA® for Windows 6.0 (Stat Soft Inc., No. AXXR712 D833214FANS). Normality of distribution of the quantitative signs was analyzed by Shapiro–Wilkie’s test. Parameters had normal distribution and were presented in the form of an arithmetic average and a standard deviation (M±SD). Comparison of indices in groups was made using Student’s t-test. Statistically significant considered a difference according to p<0.05. All tests were double-sided. For the purpose of correlations between scales of questionnaire of the MOS SF-36 in palliative pulmonary CRTB detection, correlation analysis was carried out by calculation of grade correlation coefficients between the quantitative signs – Pearson’s r.

Results and Discussion

Assessment of questionnaires results according to health physical component scales (Table 1, Fig. 1) showed that at patients with pulmonary CRTB both palliative and who received ATM in the supportive phase indicators according to all 4 scales were (p<0.05) much lower in comparison with scales of healthy volunteers. In general the scale of physical violations role in restriction of palliative patients activity was 1.9 times less in comparison with the scale of healthy volunteers (43.6±1.7 against 85.0±0.9; p<0.05) and 1.3 times less in comparison with the patients receiving ATM in the supportive phase (43.6±1.7 against 58.2±1.5; p<0.05) that testified about more expressed restriction of daily activity at these persons under the influence of main disease without antimycobacterial treatment. Assessment of physical state influence on role functioning (RP) scale paid attention to 2.7 times less in palliative patients with pulmonary CRTB, than in patients receiving ATM in the supportive phase (20.8±3.3 against 56.5±3.2; p<0.05).

The analysis of interrelations between scales of health physical component in patients with pulmonary CRTB was carried out. It has been established that decrease of the BP scale was directly connected with decrease of the PF scale (r=0.401; p<0.01) that directly influenced considerable decrease of the GH scale (r=0.324; p<0.05). And in patients with pulmonary CRTB received ATM in the supportive phase only direct link between decrease of the RP and PF scales (r=0.410; p<0.01) was defined.

Thus, increase of pain intensity among palliative patients with pulmonary CRTB promoted restriction of physical functioning, and as a result, disorders of health general state. While patients with pulmonary CRTB received ATM in the supportive phase had only physical state influence on role and physical functioning.

Assessment of health mental component (Table 2, Fig. 1) has established that it was similar to physical component scales in patients with pulmonary CRTB, regardless of treatment type, indicators of all 4 scales were (p<0.05) much lower in comparison with scales of healthy volunteers. But there were 2 important moments in palliative patients with pulmonary CRTB. Firstly, the scale of emotional functioning (RE) in these patients was clearly lowered to (28.9±3.1) of standard units, that was 2.8 times less, than healthy volunteers (p<0.05) and 1.9 times less, than in persons of the 2 group (p<0.05). Secondly, limitations of social contacts were defined in comparison with healthy volunteers and patients of the 2 group (1.4 and 1.2 times respectively; p<0.05). In general the expressed changes of mental health scale were defined among palliative patients, that was shown by its decrease 1.7 times in comparison with the scale of healthy volunteers (43.4±1.8 against 73.8±1.3; p<0.05) and 1.3 times in comparison with the patients received ATM in the supportive phase (43.4±1.8 against 56.9±1.4; p<0.05).

According to the analysis of correlations between scales of health physical component, lowering of the RE scale in palliative patients directly influenced lowering of the SF scale (r=0.318; p<0.05), lowering of the MH scale had a direct link with lowering of the SF (r=0.396; p<0.01) and VT (r=0.596; p<0.001) scales. While in patients with pulmonary CRTB received ATM in the supportive phase there was defined only a direct link between lowering of the MH and VT scales (r=0.491; p<0.001).

Thus, sharp emotional instability (depressions, mental tension and negative emotions) and restrictions of social activity of palliative patients with pulmonary CRTB promoted lowering of mental status self-assessment, and as a result, viability oppression. But patients with pulmonary CRTB received ATM in the supportive phase had only influence of mental status self-assessment lowering on viability suppression.
The average value of QL according to questionnaire of the MOS SF-36 scales (Fig. 2) in patients with pulmonary CRTB, regardless of a treatment type, was lower in comparison with the index of healthy volunteers: in the main group 1.8 times (43.5±1.5 against 79.4±0.9; p<0.05) and in the group of comparison 1.4 times (56.7±1.3 against 79.4±0.9; p<0.05). However, palliative patients with pulmonary CRTB had it 1.3 times lower, than the patients received ATM in the supportive phase (p<0.05) that was referred to sharp decrease of life quality in patients with pulmonary CRTB who didn’t receive antimycobacterial therapy.

Conclusions
1. Palliative patients with chemoresistance pulmonary tuberculosis quality of life significantly decreased by all parameters: physical functioning, physical status influence on role functioning, intensity of pain and its influence on ability to be involved in daily activities, general state of health, viability, social functioning, emotional status influence on role functioning, mental health self-assessment.
2. Increase of palliative patients with CRTB pain intensity promoted reduction of physical functioning and pronounced emotional instability (depressions, mental tensions and negative emotions), with restriction of social activity it promoted lowering of mental status self-assessment and as a result led to oppression of viability and general health problems.
3. Special attention should be given to patients who had significantly lower indices according to PF, VT and MN scales of life quality in comparison with patients with pulmonary CRTB received ATM in the supportive phase.

Use of the MOS SF-36 questionnaire for QL assessment among palliative patients with pulmonary CRTB is expedient for differentiated approach of assistance depending on oppression of health physical or mental components and monitoring of these patients health condition.

Perspectives of further scientific research. Further study of palliative patients with pulmonary CRTB quality of life according to scales of the MOS SF-36 questionnaire in conditions of specialized hospital of corrective labour colony in the course of revealed violations correction, general observation and monitoring.

References

Table 2. Assessment of mental component of health according to scales of the MOS SF-36 questionnaire (M±SD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Control group (n=40)</th>
<th>Main group (n=53)</th>
<th>Comparative group (n=42)</th>
<th>P&lt;0.05</th>
<th>P&lt;0.01</th>
<th>P&lt;0.001</th>
</tr>
</thead>
<tbody>
<tr>
<td>VT</td>
<td>61.0±1.2</td>
<td>37.0±2.9</td>
<td>45.6±3.0</td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SF</td>
<td>85.1±2.5</td>
<td>59.7±2.2</td>
<td>70.2±2.4</td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>RE</td>
<td>82.9±2.5</td>
<td>28.9±3.1</td>
<td>54.8±2.5</td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>MH</td>
<td>66.1±1.3</td>
<td>47.8±2.4</td>
<td>57.1±2.8</td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Psychological component of the health, points</td>
<td>73.8±1.3</td>
<td>43.4±1.8</td>
<td>56.9±1.4</td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Fig. 2. Average values of QL according to questionnaire of the MOS SF-36 scales among patients with pulmonary CRTB, standard units.

Conclusions
1. Palliative patients with chemoresistance pulmonary tuberculosis quality of life significantly decreased by all parameters: physical functioning, physical status influence on role functioning, pain intensity, of pain and its influence on ability to be involved in daily activities, general state of health, viability, social functioning, emotional status influence on role functioning, mental health self-assessment.
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