



## Original Research Article

## Self-rated health and associated factors in elderly patients with non-Hodgkin lymphoma

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## ABSTRACT

**Background:** Self-rated health is a useful indicator for understanding health issues in elderly populations and considered to be a predictor of adverse health outcomes in this group. This study aims to identify factors associated with self-rated health in elderly people with non-Hodgkin's lymphoma.

**Methods:** Cross-sectional study performed at a cancer referral hospital in Rio de Janeiro, Brazil, included 162 patients, aged 60 or more years. All patients received a Multidimensional Geriatric Assessment, including seven health dimensions, and socio-demographic, epidemiological and it were collected clinical data. Descriptive analyses were performed and prevalence ratios were calculated to assess associations between self-rated health and the independent variables. Multivariate analysis was performed using Poisson's regression, to a  $\leq 0.05$  level of statistical significance.

**Results:** The study population mean age was 68.8 (SD = 7.1) years; most were women, lived with a partner and had little education. Prevalence of fair/poor self-rated health was 33.6%. Being female, not living with a partner, functional dependence, depressive symptoms and nutritional risk/malnutrition showed associations with fair/poor self-rated health. In the multiple model, dependence in instrumental activities of daily living (PR 2.96; 95%CI 1.66-5.30) and presence of depressive symptoms (PR 1.78; 95%CI 1.15-2.75) remained associated with fair/poor health.

**Conclusion:** Variation in perceived health status supports the hypothesis that self-rated health is related to multiple issues, regardless of disease status. The risk profile for poor self-rated health identified may be a useful tool in care for older cancer patients, as it points to those at higher risk of adverse health outcomes.

## 1. Introduction

Self-rated (SRH) is a useful indicator for understanding health issues in elderly populations and is considered an independent predictor of adverse health outcomes in this group [1–4]. This measure represents a perception by subjects themselves, based on their interpretations of physical and mental status and their expectations and benchmarks for comparison [5].

Studies have shown many factors associated with SRH among the elderly, including socio-demographic variables, social support, lifestyle, health and access to health services [6–9]. Self-reported health is also believed to associate with populations' cultural values [10].

Although most studies in the literature on self-rated health consider overall health in community-dwelling elderly people, some studies do report on specific chronic diseases, including cancer [4,11–13]. Poor self-rated health was identified, over a seven-year follow-up period, as

an important predictor of treatment tolerance and mortality in elderly women with breast cancer [14]. It was also associated with an increasing number of comorbidities during treatment period among elderly patients with solid tumours or haematological cancer [4,13].

Non-Hodgkin's lymphoma is a frequent haematological neoplasm in the elderly. In 2012, mean age at diagnosis for non-Hodgkin's lymphoma in the United States was 67 years [15]. In the United Kingdom, individuals 60 or more years old constituted two thirds of cases diagnosed [16]. With advancing age, incidence of non-Hodgkin's lymphoma has been observed to increase constantly, independently of sex and race [17–19]. Although the literature demonstrates that world rates of incidence and mortality for various types of cancer have declined in recent decades, non-Hodgkin's lymphoma rates continues to show growth [17], for as yet unknown reasons [16].

This study aimed to identify factors associated with self-rated health in elderly people with non-Hodgkin's lymphoma in the city of Rio de

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Janeiro, Brazil.

## 2. Material and methods

This cross-sectional study was conducted at a cancer referral hospital in Rio de Janeiro, Brazil. From February to July 2013, 176 consecutive patients with non-Hodgkin's lymphoma, 60 or more years old and treated in the outpatient hematologic clinic were contacted, if able to answer a structured questionnaire. Of those, the 162 who agreed to participate in the study underwent a Multidimensional Geriatric Assessment (MGA), including functional capacity, comorbidity, nutrition, emotional condition, social support and use of medication. Data was also collected on socio-demographic and clinical variables.

The study was approved by the Research Ethics Committees of the National School of Public Health/Oswaldo Cruz Foundation and National Cancer Institute and was conducted in accordance to the principles of the declaration of Helsinki.

### 2.1. Measuring instruments

The MGA used comprised a set of selected instruments commonly used for health assessment in elderly populations. Functional capacity in Basic Activities of Daily Living (ADL), and in Instrumental Activities of Daily Living (IADL), were assessed on the Katz [20] and Lawton [21] scales, respectively. For both scales, individuals were “dependent” if they needed help or were unable to perform any activity. The Cumulative Illness Scale-Geriatric (CIRS-G) was used to investigate comorbidity [22], and individuals were classified using an adapted version of the classification proposed by Rodriguez et al. [23]: no comorbidity (0 points), mild comorbidity (1–2 points), moderate comorbidity (3–8 points) and severe comorbidity (> 8 points). Nutritional status was evaluated by the short version of the Mini Nutritional Assessment (MNA) [24] and patients were classified into no nutritional risk and nutritional risk/malnourished. The 15-item Geriatric Depression Scale was chosen to evaluate emotional condition [25]; a score of five or more was considered indicative of depressive symptoms. Polypharmacy was considered to be regular use of 4 or more medications [26].

The dependent variable was the answer to the question “Compared to other people your age, how is your health?”. Although this question had five possible answers (excellent, very good, good, fair and poor), these were aggregated into two categories (Excellent/Very good/Good and Fair/Poor), following the tendency observed in the literature, which indicates predominance of responses in the intermediate categories [27–29].

### 2.2. Data analysis

Descriptive analysis of the distribution of individuals into self-rated health response groups, by study co-variable, was conducted using measures of central tendency and dispersion for continuous variables, and frequency distributions for categorical variables.

Prevalence ratios (PR) were calculated to assess associations between self-reported health and the independent variables, and multivariate analysis was performed using Poisson regression, to a  $\leq 0.05$  level of statistical significance.

Statistical analyses were performed using the statistical software STATA, version 10.0 (StataCorp LP).

## 3. Results

Study population mean age was 68.8 (SD = 7.1) years, most were women (53.7%), lived with a partner and had little formal education. Self-rated health prevalences were 33.6% fair/poor (N = 51) and 66.4% good/very good/excellent (N = 101). Prevalence of dependence in Instrumental Activities of Daily Living (IADL) was high (47.5%),

**Table 1**

Characterisation of elderly patients with non-Hodgkin lymphoma, Rio de Janeiro, Brazil, 2013 (N = 162).

Variables		N	%
Self-rated health	Excellent	29	19.1
	Very good	18	11.8
	Good	54	35.6
	Fair	44	28.9
	Poor	7	4.6
Gender	Male	75	46.3
	Female	87	53.7
Marital Status	Married	91	56.2
	Living with partner	7	4.3
	Divorced/separated	18	11.1
	Widowed	31	19.1
	Single	15	9.3
Education level	Upper Secondary/Higher	52	32.5
	Lower Secondary	91	56.9
	Did not attend school	17	10.6
Functional Capacity in ADL	Independent	136	84.5
	Dependent	25	15.5
Functional Capacity in IADL	Independent	85	52.5
	Dependent	77	47.5
Severe Comorbidity	No	125	77.2
	Yes	37	22.8
Polypharmacy (4 or more regular medications)	No	108	66.7
	Yes	54	33.3
Depressive Symptoms	No depressive symptoms	113	74.8
	Mild depressive symptoms	29	19.2
	Severe depressive symptoms	9	6.0
Nutritional Risk	No nutritional risk	83	53.9
	At nutritional risk	53	34.4
	Malnourished	18	11.7

\*Differences between absolute numbers are due to missing values.

while 34.4% were at nutritional risk (Table 1).

Being female (PR 1.75; 95%CI 1.07-2.85), living without a partner, dependence in Activities of Daily Living (ADL) and in Instrumental Activities of Daily Living (IADL), presence of depressive symptoms and being at nutritional risk/malnourished all showed associations with fair/poor self-rated health (Table 2).

In the multiple model, functional dependence in IADL and presence of depressive symptoms were independent risk factors for self-rated fair/poor health (Table 3).

## 4. Discussion

Self-rated health proves to be an important marker of the diversity in aging and in the individual recognition of the concept of health at this stage in life. This is reflected in the results of this study, in which a population of elderly people with a diagnosis of haematological cancer, fewer than 34% classified their health adversely. A similar value was described in a study of 112 Canadians 65 years or more, with a diagnosis of solid (breast, colorectal or lung) tumours or haematological cancer (lymphoma or myeloma), in which only 38 patients (33.9%) rated their own health as poor [4]. In a study of 181 Australians with a diagnosis of advanced-stage cancer, mean age 62 years (SD 12 years), it was observed that 58% rated their own health as excellent, very good or good, 28% as fair and only 14% as poor [30].

In the literature on health and aging, individuals who rated their own health as fair or poor are observed to display a greater likelihood of illness and death, independently of their objective health status [1,3,31,32]. The claim appears to hold even when individuals with cancer are rated. In a United States study, designed to assess self-rated health as a variable indicative of health-adjusted life expectancy

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