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Quality of life in patients with colorectal cancer in the Slovak Republic: A pilot study

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ABSTRACT

The aim of the study was to determine the level of QoL (quality of life) satisfaction/dissatisfaction in patients with colorectal cancer in eight health concepts in the study and control group. In this cross-sectional study, the standardized questionnaire MOS of the 36-Item Short Form Health Survey (SF-36) was used. The study group consisted of patients who were diagnosed with colorectal cancer ($n = 18$, 83.3% males; mean age 62.3 ± 15.9 years). The control group consisted of patients who were diagnosed with other diseases but not cancerous ones ($n = 34$, 58.8% males; mean age 50.6 ± 8.2 years). In the study group the highest rate of patient QoL dissatisfaction (expressed as a mean score) was observed in the subcategory of role limitations due to physical health (6.9 ± 11.5), whereas in the control group one of the highest rate of patients QoL satisfaction was achieved in this category (69.1 ± 39.9 ; $P = 0.000$). A similar high significant result was observed in the subcategory of role limitations due to emotional problems: there was a very low score in the study group and a high score in the control group (7.4 ± 18.3 and 71.6 ± 37.7 , respectively; $P = 0.000$). The highest rate of patients QoL satisfaction in the study group and the control group was observed in the subcategory of pain (31.7 ± 15.6 and 77.6 ± 13.9 , respectively; $P = 0.000$). Our results are the argument for intervention aimed at understanding the QoL experienced by colorectal cancer patients. This is essential for evaluating the full impact of the illness on individuals, their families and their communities.

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Introduction

Colorectal cancer is the second leading cause of cancer-related mortality and the fourth most prevalent malignant

disease in many developed countries. Colorectal cancer and its treatment can have an adverse effect on social functioning, including employment, living a productive life; relationships with friends, relatives, and partners; and other social

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activities and interests [1]. Several studies dealing with colorectal cancer prevention and/or patient nursing care have been performed [2–4].

Colorectal cancer incidence and mortality do differ significantly between European countries, even between countries that are close to one another geographically. Southern Europe has the lowest incidence and mortality, while Central and Eastern Europe have the highest (Slovakia, Hungary, Czech Republic), probably due to differences in lifestyle, stage at which it is diagnosed, and treatment. Similarly, there are significant intersexual differences too: males have a higher incidence and mortality than females, relating to differences in screening participation, medical attention seeking behaviour, and lifestyle. These variations suggest that country policy and societal norms play a large role in colorectal cancer development and ultimately the cancer burden [5].

Despite the continuous stabilization and decrease of this cancer in high-risk countries from the late 1970s, an unexpected and gradual rise of incidence rates of colorectal cancer was recorded in Slovakia. During the period studied, incidence rates rose by an annual mean percent change of 4.2 (males) and 2.8 (females) in colon cancer, and 2.2 (males) and 1.0 (females) in rectal cancer [6]. In 2014 in Slovakia, the colorectal cancer incidence was 2347 in males and 1616 in females [7]. Slovakia has the highest colorectal cancer incidence (in men) in the world, followed by Hungary and the Republic of Korea [8].

Quality of life (QoL) is a multidimensional, dynamic, subjective approach centred on the patient; it comprises physical, functional, emotional, and social/family well-being. Quality of life is a subjective, patient-rated concept. However, the lack of a “gold standard” instrument is reflected in the wide range of available instruments, generic or disease-specific [9].

Currently, there are several therapeutic modalities for cancer treatment, such as surgery (curative and palliative) and chemotherapy. An increasing number of researches assess the QoL of colorectal cancer patients going through different treatment types [10].

Cancer patients often experience distress. More than half of the patients are forced to leave work, while 35% show an increase in their liability for emotional stress and lack of energy due to various disorders. Even family members of the affected patients reduce their job activity, and this has a negative impact on the physical and emotional status of patients [11].

It is important to be able to measure the perception of the health of the population to assess the benefit of healthcare interventions and to target services. Different data collection instruments are used in the colorectal cancer studies – the measurement of health related quality of life (HR-QOL) questionnaire, the gastrointestinal quality of life index (GIQLI), the functional assessment of cancer therapy-colorectal (FACT-C), the inflammatory bowel disease questionnaire (IBDQ), and/or the 36-item short-form (SF-36) questionnaire.

A 36-item short-form (SF-36) questionnaire was constructed to survey health status in the Medical Outcomes Study (MOS). The SF-36 includes one multi-item scale that assesses eight health concepts: (i) limitations in physical activities because of health problems; (ii) limitations in usual activities because of physical health problems; (iii) limitations in social activities because of physical or emotional problems; (iv) general mental health (psychological distress and

well-being); (v) bodily pain; (vi) limitations in usual activities because of emotional problems; (vii) vitality (energy and fatigue); and (viii) general health perceptions [12].

The aim of the study was to determine the level of QoL (quality of life) satisfaction/dissatisfaction in patients with colorectal cancer in the eight health concepts mentioned above in the study and control group.

Materials and methods

In this cross-sectional study, the standardized questionnaire MOS of the 36-Item Short Form Health Survey (SF-36) was used [12]. The questionnaire itself was preceded by several questions regarding basic demographic data. The standardized questionnaire SF-36 consists of 36 statements focusing on QoL. The statements are divided into the following subcategories: physical functioning (10 questions), role limitations due to physical health (4 questions), role limitations due to emotional problems (3 questions), energy/fatigue (4 questions), emotional well-being (5 questions), social functioning (2 questions), pain (2 questions), general health (5 questions), health change (1 question) and overall satisfaction (all of the 36 questions).

The numeric values in the questionnaire are recoded as per the scoring key of the RAND Health Policy Institute [13]. The mean score in each subcategory is transformed into a percentage-like expression on a 0–100 scale, with a higher score being better. This means that a strong agreement with the statement represents the lowest level of QoL satisfaction. Answers to some questions where strong agreement means the maximum satisfaction with the QoL had to be rescaled to obtain a unified QoL score: 0 = maximum dissatisfaction with the QoL, 100 = maximum satisfaction with the QoL. Particular groups of answers reflecting the degree of QoL satisfaction were evaluated as mean scores for each subcategory. Level of satisfaction (in percentages) is identical to the mean score in each subcategory. The highest average value means the highest level of QoL satisfaction.

The study sample was made up of patients (during illness) attending gastroenterological surgery in the capital of Slovakia. Questionnaires were collected from July 2015 to July 2016. The selection criteria for patients' inclusion in the study were: being after the first symptoms detection and positive family anamnesis, the length of the illness being more than one month, and voluntary participation in the study. The location of the colorectal cancer, the stage of the illness and therapeutic procedures were not considered. Incomplete questionnaires were rejected. In total, 52 completed questionnaires were collected. All participants signed an informed consent before participating in the study. This study was approved by the University Hospital Ethics Committee of the Faculty of Medicine of the Comenius University in Bratislava (in accordance with the Helsinki Declaration and guidelines).

The study group consisted of patients who were diagnosed with colorectal cancer ($n = 18$, 83.3% males; mean age 62.3 ± 15.9 years). The control group consisted of patients who were diagnosed with other gastrointestinal but not cancerous diseases (ulcer diseases, celiac diseases, ulcerative

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