



ORIGINAL ARTICLE

Gender differences in quality of life perception and cardiovascular risk in a community sample



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KEYWORDS

Cardiovascular risk factors;
Self-reported health;
Quality of life;
Gender

Abstract

Introduction: Self-reported health and quality of life is an independent predictor of overall and cardiovascular morbidity and mortality, and incident coronary heart disease. However, less is known regarding how gender differences in cardiovascular risk factors impact quality of life perception.

Methods: Primary healthcare users (n=261, 158 women) were screened for cardiovascular risk factors and completed the Medical Outcomes Study Short Form (SF-36).

Results: Women had significantly lower alcohol consumption, body mass index and exercise frequency than men, but more prevalent psychiatric history, depressive and anxiety symptoms, and negative affectivity. Prevalences of hypertension, diabetes, dyslipidemia and type D personality were similar between genders. Women reported significantly worse quality of life on most SF-36 subscales and gender differences were apparent in predictors of quality of life. Moreover, high negative affectivity was an independent predictor of worse general health for women, whereas high social inhibition and high anxiety had a comparable role for men.

Conclusion: Gender specifics in cardiovascular risk factors should be considered in prevention strategies. Women reported significantly worse quality of life, putting them at higher risk for cardiovascular morbidity and mortality. Therefore, gender differences in predictors of quality of life warrant further investigation.

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PALAVRAS-CHAVE

Fatores de risco cardiovascular;
Saúde auto-relatada;
Qualidade de vida;
Especificidades de gênero

Diferenças de gênero na percepção de qualidade de vida e risco cardiovascular numa amostra comunitária

Resumo

Introdução: A percepção de qualidade de vida é um preditor independente de mortalidade geral, morbidade e mortalidade cardiovascular, e incidência de doença cardíaca coronária. Contudo, permanece por esclarecer qual o impacto que as diferenças específicas de gênero nos fatores de risco cardiovascular têm na percepção de qualidade de vida.

Métodos: Duzentos e sessenta e um utentes dos cuidados primários (158 mulheres) foram rastreados para fatores de risco cardiovascular e preencheram a versão portuguesa do *Medical Outcomes Study Short Form (SF-36)*.

Resultados: As mulheres apresentaram um padrão de menor consumo de álcool, índice de massa corporal e frequência de exercício físico, mas maior prevalência de antecedentes psiquiátricos, sintomatologia depressiva e ansiosa, e afetividade negativa. As prevalências de hipertensão, diabetes, dislipidemia e personalidade tipo D foram semelhantes entre homens e mulheres. Globalmente, as mulheres apresentaram piores índices de qualidade de vida na maioria das subescalas do SF-36 e encontraram-se diferenças de gênero nos preditores de qualidade de vida. Enquanto nas mulheres, a elevada afetividade negativa foi um preditor independente de pior saúde geral, nos homens, esse efeito foi verificado para índices elevados de inibição social e ansiedade.

Conclusões: As especificidades de gênero nos fatores de risco cardiovascular devem ser tidas em consideração nas estratégias de prevenção primária. As mulheres apresentam qualidade de vida significativamente pior, o que as coloca em maior risco de morbidade e mortalidade cardiovascular, pelo que as diferenças de gênero nos preditores de qualidade de vida devem ser investigados.

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Introduction

Cardiovascular disease (CVD) remains the leading cause of premature death in Europe. Unhealthy lifestyles and psychosocial burden are commonly associated with CVD, and not surprisingly, most of its mortality is preventable through appropriate changes in lifestyle.¹ It is well established that psychosocial risk factors interact with biomedical vulnerabilities in the development of CVD, and approximately one third of the attributable risk of acute myocardial infarction can be related to major life events, depression or stress related to work, family or finances. Furthermore, when several psychosocial risk factors cluster in the same individual, the risk for both cardiac events and severe atherosclerosis is substantially increased.²

Men and women have similar biomedical risk factors for CVD, but their relative weight and impact on the pathophysiology of the disease differ markedly.³ Prevention strategies could benefit from taking these risk profile differences into account. Further, gender differences in both disease progression and impact of risk factors could explain why prevalence rates, symptom profiles and medical outcomes still have different prevalences between genders.^{4,5} Specifically, women with ischemic heart disease have worse outcomes than men regardless of age,⁴ but usually present much less severe anatomical obstructive lesions and better preserved systolic function.^{4,6} Clearly, other factors are at play in this apparent contradiction.

It is well established that psychosocial factors such as negative affect and personality traits can increase the risk

for CVD.² However, it is unknown whether they also impact cardiovascular health differentially by gender, thereby contributing to higher CVD morbidity and mortality among women. Specifically, depression is an established risk factor for both CVD patients and healthy individuals, increasing both cardiac morbidity and mortality,⁷⁻⁹ while anxiety has been identified as an independent risk factor for CVD in the community.^{10,11} Similarly, type D personality is a stable personality construct marked by negative affectivity and social inhibition that combine to produce sustained high levels of mental distress and increased physical symptoms in both CVD patients and healthy participants.¹²⁻¹⁴ Overall, these psychosocial factors have been consistently linked to CVD risk, but little progress has been made in examining their differential impact by gender.

Self-reported health is an independent predictor of overall and cardiovascular mortality in most studies, and individuals who assess their health as fair or poor have a higher mortality risk than those whose assessment is better.^{15,16} Moreover, after controlling for sociodemographic characteristics, health care access and risk factors, self-reported health is still a significant and independent predictor of both global morbidity onset¹⁵ and CVD incidence.^{17,18} Specifically, the Medical Outcomes Study Short Form (SF-36) has been shown to predict mortality in community samples.^{19,20} In particular, the physical component summary of the SF-36 (derived from the sum of scores obtained on the physical functioning, role-physical, bodily pain and general health subscales) exhibits a strong association with mortality, estimates being independent of other

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