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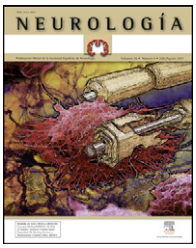

ORIGINAL ARTICLE

Psychopathological disorders and quality of life in patients with brain infarction☆,☆☆

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Abstract
Objectives: To study the influence of various factors on the health-related quality of life (HRQoL) of patients who have suffered a brain infarction (BI), with special attention to psychopathological disorders (PD).
Patients and methods: Prospective observational study on 45 patients admitted due to a BI, evaluated at 4, 12 and 26 weeks of the acute event. Social and demographic data, and medical history were collected; the SF-36 scale was used for the assessment of HRQoL, and the Neuropsychiatric Inventory (NPI), MMSE, Canadian Neurological Scale, Modified Rankin Scale and other instruments for assessing psychopathological, cognitive, neurological and functional status. A linear regression analysis was performed to identify potential predictors of the SF-36 scores at 26 weeks, introducing, as independent variables, medical and psychiatric history, demographic characteristics and the functional, neuropsychological and psychopathological assessments at 4 weeks.
Results: Valid predictive models for all the SF-36 domains were obtained, in which a history of pre-morbid depression, higher scores in the NPI and Rankin Scale, and lowest in the Canadian Neurological Scale were the main predictors of a worse HRQoL in the long term. Psychopathology related caregiver's distress (assessed with the NPI) was associated with a lower score in the social function index.
Conclusions: PDs and functional status were the main determinants of HRQoL in patients with BI.

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PALABRAS CLAVE
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Trastornos psicopatológicos y calidad de vida en el infarto cerebral

Resumen
Objetivos: Estudiar la influencia de diversos factores en la calidad de vida relacionada con la salud (CVRS) de los pacientes tras un infarto cerebral (IC), con especial atención a los trastornos psicopatológicos (TP).
Pacientes y métodos: Estudio observacional prospectivo sobre 45 pacientes ingresados por IC, evaluados a las 4, 12 y 26 semanas del evento agudo. Se recogieron antecedentes y datos sociodemográficos previos, se utilizó la escala SF-36 para la valoración de la CVRS, para la valoración psicopatológica, cognitiva, neurológica y funcional se utilizó el inventario neuropsiquiátrico (NPI), MMSE, escala de Canadá, escala de Rankin modificada y otras escalas. Para determinar los posibles factores predictivos de las puntuaciones del SF-36 a las 26 semanas se realizó un estudio de regresión lineal, introduciendo como variables independientes los antecedentes médicos y psiquiátricos, las características sociodemográficas y la evaluación funcional, neuropsicológica y psicopatológica a las 4 semanas.
Resultados: Se obtuvieron modelos predictivos válidos para todos los índices del SF-36, en los que el antecedente de depresión, las puntuaciones más altas en el NPI y la escala de Rankin, y más baja en la escala canadiense fueron los principales indicadores predictivos de una peor CVRS a largo plazo. El distrés del cuidador asociado a la psicopatología del paciente (medido a través del NPI) tuvo una influencia negativa sobre el índice de función social.
Conclusiones: Los TP y la situación funcional fueron los principales determinantes de la CVRS de los pacientes tras un IC.

Introduction

Health-related quality of life (HRQoL) is a key measure to assess the real impact of a disease on individuals. Cerebral stroke (CS) is an acute and severe neurological disorder that can result in sensory-motor, cognitive and psychopathological deficits that, along with the personal and social circumstances of patients, will determine their HRQoL.[1]

The measurement of HRQoL is complex because it is influenced by aspects such as previous experiences, expectations, beliefs and subjective perceptions. However, there is a consensus that at least 4 dimensions should be assessed: physical (physical symptoms), functional (basic and instrumental activities), psychological (cognitive and emotional function, life satisfaction, perceived health) and social (interaction of the subject with the environment).[2] The Short Form 36 (SF-36)[3] health survey is a generic instrument that covers all these aspects and is widely used for the study of HRQoL in stroke. In addition, its dissemination among the scientific community makes it possible to compare its results.

Previous studies have linked HRQoL of stroke patients with multiple factors, including the characteristics of the CS (location, extent or aetiology),[4–6] post-stroke depression,[7–9] cognitive impairment (CI)[4,6–10] and the coping strategies employed by patients.[11] However, in most studies the most determining factor for HRQoL is the functional status of patients.[5,9,12–14]

There are few studies that analyse the combined influence on HRQoL of the different areas affected after stroke (cognitive, sensory-motor, functional and psychopathological) or how to predict the long-term evolution of HRQoL from the history and clinical status of a patient.[15] Regarding psychopathological disorders (PD), most studies that have addressed this issue have focused on affective disorders, mainly depression.[7,8,13] While this is undoubtedly the most common PD in stroke patients, others such as apathy[16] are also frequent and greatly influence post-stroke recovery. Moreover, how global psychopathological status affects HRQoL has not been studied. Finally, most HRQoL studies in stroke patients group the cases with different types of stroke, including cerebral strokes and haemorrhages, and even transient ischaemic attacks,[13] despite their having different prognoses.[17]

The objectives of this study were to analyse the evolution of HRQoL in the 6 months following a CS, as well as to detect potential predictive indicators of HRQoL at 26 weeks after a vascular event, taking as a reference the history, location of CS and functional, cognitive and psychopathological status of each patient at 4 weeks following the stroke.

Patients and methods

Participants

A prospective study was conducted on a sample of 45 Caucasian patients consecutively admitted at the neurology unit of our hospital for probable ischaemic stroke. Patients were evaluated at 4 different times: upon admission and at 4, 12 and 26 weeks after the event. Patients were recruited between May 2007 and December 2008 from a sample of 55 patients included in a study of PD in CS,[18] of which 45 patients did not meet any of the exclusion criteria.