



Hypertension in the Lebanese adults: Impact on health related quality of life

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Abstract Cardiovascular disease is a major cause of morbidity and mortality worldwide, hypertension being one of their most prevalent risk factors. Information on health related quality of life (QOL) of hypertensive individuals in Lebanon is lacking. Our objectives were to evaluate QOL of hypertensive patients compared with non-hypertensive subjects and to suggest possible predictors of QOL in Lebanon. We conducted a case control study among individuals visiting outpatient clinics. Quality of life was assessed using the eight item (SF-8) questionnaire administered face to face to the study population, applied to hypertensive ($N = 224$) and non-hypertensive control ($N = 448$) groups. Hypertensive patients presented lower QOL scores in all domains, particularly in case of high administration frequency and occurrence of drug related side effects. Among hypertensive patients, QOL was significantly decreased with the presence of comorbidities ($\beta = -13.865$, $p = 0.054$), daily frequency of antihypertensive medications ($\beta = -8.196$, $p < 0.001$), presence of drug side-effects ($\beta = -19.262$, $p = 0.031$), older age ($\beta = -0.548$, $p < 0.001$), female gender ($\beta = -21.363$, $p = 0.05$), lower education ($\beta = -22.949$, $p = 0.006$), and cigarettes smoked daily ($\beta = -0.726$, $p < 0.001$); regular sport activity ($\beta = 23.15$, $p < 0.001$) significantly increased quality of life. These findings indicate the necessity for health professionals to take these factors into account when treating hypertensive patients, and to tackle special subgroups with attention to their deteriorated QOL.

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1. Introduction

Cardiovascular disease (CVD) is a major cause of morbidity and mortality worldwide [1,2]. Globally, they account for approximately 17 million deaths

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a year [3]. Hypertension is considered a major cardiovascular risk factor with high prevalence in almost all countries, with a slow and silent progression [4]. Complications of hypertension are highly prevalent and account for 9.4 million deaths worldwide every year [5]. On another hand, the dramatic increase of longevity has brought attention that it should be accompanied with improvements in health-related quality of life (QOL). The World Health Organization (WHO) has summarized these concerns, stating that "adding years to life is an empty victory without adding life to years" [6]. Regardless of the condition type, patients' QOL is adversely affected by chronic illness [7]; this is an important consideration in the management of asymptomatic conditions such as hypertension [8].

With this regard, studies assessing the impact of hypertension on QOL had been carried out in various countries. For example, Roca-Cusachs et al. assessed the impact of QOL clinical variables and reported that hypertensive patients experienced a significant reduction in QOL when compared with normotensive individuals [9]. Li et al. studied the Chinese population and observed that QOL was higher in normotensive individuals [10]. Bardage and Isacson found that QOL scores were poorer in hypertensive patients than in general population [11].

As far as Lebanon is concerned, a population based study conducted in 2005 revealed that the overall prevalence of declared hypertension was 23.1% [13]. Compared to other Mediterranean countries, Lebanon has a lower prevalence of hypertension; however, compared to other countries, [14,15], Lebanon still has a high prevalence of hypertension. Nevertheless, no study has been performed regarding the health related quality of life of hypertensive patients and its correlates. The objective of this study was to evaluate QOL of hypertensive patients compared to non-hypertensive subjects in Lebanon and to suggest possible predictors of their QOL.

2. Material and methods

2.1. Study design

This is an observational case control study carried out in hypertensive patients undergoing treatment and non-hypertensive individuals. Patients were randomly selected from those visiting outclinics of two tertiary care hospitals (Hamoud and Raei Hospitals). The Institutional Review Board of both institutions waived the need for an official approval to perform this observational study, provided it

respected patients' autonomy and confidentiality. The patients were informed about the objectives of the study and asked to give an oral consent. Only those who gave their consent to participate in the study were enrolled. Data were collected from the 2nd of March till the 1st of June 2014.

2.2. Study population

Patients enrolled were of both genders, aged 18 years and older and divided into two groups: Hypertensive group consisting of patients diagnosed with hypertension and taking antihypertensive medication for at least three months, while the control group consisted of non-hypertensive individuals (blood pressure < 120/90 mmHg); the latter should be healthy or consulting for acute health related problems, such as urinary tract infections or otitis. Exclusion criteria were the presence of chronic or disabling diseases, including decompensated diabetes, cancer, pregnancy, sequelae of stroke, decompensated heart failure, chronic kidney disease, liver failure, acute myocardial infarction within the past six months and the use of antipsychotic drugs.

2.3. Data collection

Data were acquired through a structured face to face interview. The questionnaire was administered in Arabic and included different sections that evaluated: socio-demographic data including sex, age, educational level and marital status, monthly income, body mass index and lifestyle data including smoking status, involvement in sports activities, alcohol, caffeine consumption and salt intake. Detailed health history was also assessed, in relation with the onset of the hypertension, the presence of associated complications and co-morbidity. Clinical data related to hypertension classification (controlled or uncontrolled), pharmacological management (class and number of antihypertensive drugs used) as well as any drug side-effects experienced were obtained. Blood pressure was recorded. Accordingly, controlled blood pressure was defined as systolic blood pressure \leq 140 mmHg and diastolic \leq 90 mmHg [16]. We also assessed the patients' attitudes and knowledge about the severity of disease and the use of medication.

2.4. Quality of life measurement

We assessed the QOL using the SF-8 questionnaire. While one of the most widely used tools is the SF-36 generic QOL questionnaire, its derivative (SF-8) is an additional easier instrument used in

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