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Quality of Life at Patients with Malignancies

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Abstract: The subject of this research is the quality of life at patients with Myeloma Multiplex at diagnosis and during therapy within 6 to 12 months. The research aims to analyze patients to be able to continue activities which will contribute for improving their quality of life as a priority task for patient, his family, health institutions and social environment. This research was conducted at the University Clinic for Hematology, period from 2009 to 2012. It covers patients with multiple myeloma. Total of 80 patients, using the EORTC QLQ C30 ver. 3.0 standardized questionnaires for quality of life that analyzed the physical, cognitive, emotional, personal and social functions related to the patients. It also analyzed and general health and quality of life. Physical functioning at diagnosis is 27.5 during treatment 59.5, significantly improved. Personal functioning at patients at the diagnosis is 17.9, during therapy -36.4. Emotional functioning at patients at diagnosis is 39.9, during the therapy over 73.3. Cognitive functioning was at diagnosis 55.2, during treatment 72.5. Social functioning was 26.2 at the diagnosis; during the treatment 50.8. Financial difficulties were at diagnosis's 76.2 and 72.5 during treatment. Overall health and quality of life has a value of 23.9, and during therapy 58.8.Quality of life at patients with myeloma multiplex was significantly improved as a result of on time diagnosis and treatment with modern medicaments and the role of social worker with the application of certain social skills, continuous counseling, guidance and education for their reintegration in the community.

Keywords: Quality of life, Patient, Health

Introduction

The quality of life is defined as the perception of the individual for his own position in life in the context of the culture and the system of values in which he lives, and as well as according to his goals, expectations, standards and interests that hi will archive. It is a wide concept that constitutes the physical health of the individual, psychological status, material independence, social relations and their significant relationships and characteristics with the external environment. (WHO, 1995).

In scientific literature we come across a different understanding of the concept of quality life. There are also several theories and standardized questionnaires for its measurement, but there is still no harmonization of the definition or a universally accepted standards for its measurement.

The models and definitions of quality of life differ between themselves in their psychological aspects, which is the different considerations of individuals. However, although there are individual views, the establishment of a unique terminology for achieving uniformity in scientific research and the application of quality-of-life models in practice is further consistently pursued. It is based on a detailed assessment of the similarities and differences within values, considerations, and behavior for what quality of life means. According to the European Quality of Life Surveys methodology, there are four components for life satisfaction: access to material resources, social support, social affiliation and work difficulties (work complexity).

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The first component is directly related to the economic sphere, which is the quality level of the organization's system, while the other components have a social category, and the fourth is being related to the living standard or the need for additional professional engagement.

The quality of life is a concept that includes the emotional, physical, mental, behavioral, and social components, a sense of total satisfaction from life, based on the mental readiness of the individual whose life is valued. The quality of life is a multi-layered structure system that encompasses the behavior and cognitive capacity of the individual, the emotional well-being and the abilities needed to achieve the family, professional and social role.

There are objective versus subjective indicators of quality of life and it has been shown that objective measures (socioeconomic status assessment) are not sufficient for an explanation of the quality of life, and therefore it is necessary to include the subjective assessment. Objective measures are normative indicators for reality, while subjective ones indicate the differences of the individual in the observing and experiencing the real living conditions. If the basic needs of the individual are met, the increase in material goods does not have a significant impact on the subjective measure of quality of life. On the other hand, these indicators fail to measure how people perceive their own lives and therefore the conclusion cannot be given solely based on objective indicators. A certain level of satisfaction of living needs that is considered as necessary but not enough for quality living conditions.

There are many different approaches for measuring the quality of life. Hence, from the way it is measured, the definition depends and what is measured also. Depending on the objectives and the subject, research on measuring or assessing the quality of life can be quite different. The assessment is developed based and depending on the methodological approach of different disciplines in the context of their objective and philosophical views.

Today there is a whole industry that deals with measuring the quality of life, in the literature it is said that there are about 1200 different assessment instruments, especially in the last 20 years. Although they are numerous, they can be divided into specific in terms of disease, generic, individual, and others. Regardless of which instruments are applied, they should contain levels that will explain the objective state of operation and the subjective nature. Quality of life is associated with modern medicine from the bio psychosocial aspect because it provides ethical progress in the methods of clinical evaluation. It is based on the health care, including medical care and promotion of health, the subjective well-being of the individual or group, the impact of disability and mental health on the quality of life. Reforms of the social and health care system, especially in the Western countries, lead to an increase in the needs of the individual, and the use of quality of life as an indicator of the satisfaction of the services.

The quality of life in the context of health implies functional ability, degree and quality of social interaction, psychological balance, somatic sensations, or satisfaction in life. In conditions of living and good health, a person is able to maintain the subjective quality of life, which is adaptive and functional, but in situations where there is a negative impact on the functioning of the individual, there is a disturbance of the homeostasis and a declining in the quality of life.

Measuring the quality of life related to health is based on health questionnaires that have their own characteristics, formulated and standardized with a specific scientific methodology.

Medical advances allow the application of a variety of targeted therapeutic approaches to the treatment of malignant diseases, which are basically characterized by long-term treatment of the patient, frequent hospitalization, complications that are symptomatic of various organ systems. It should be noted that today's therapy results in these patients report prolonging the survival time and improving the quality of life. This fact directs the interest not only in the effectiveness of the methods and the treatment, but also on the bio psychosocial factors in the treatment of diseases and living with the malignant nature of the disease.

Data reporting on the success achieved in the treatment of malignant diseases, beside the different therapeutic approaches, have a common feature that connects all patients, which is the timely diagnosis of malignant disease. The best results of therapy and the highest patient survival rates are achieved only in a situation of early detection of malignant disease and early onset (starting) of treatment.

The focus of this paper is hematological malignancies that disrupt the function of the hematopoietic system, which can lead to the emergence of multisystem symptomatology, which is often fatal for the patient. Hematological diseases are 9.5% of the total number of malignant diseases at the human population. Multiple myeloma is a malignant hematological disease and belongs to the group of lymph proliferative disorders. Multiple myeloma represents about 1% of all malignant diseases and over 10% of total malignant hematological diseases. The incidence of this disease is about 3 cases per 100,000 inhabitants per year. The etiology of this disease is unknown. Causes can be multifactorial. Multiple myeloma manifests itself most often at the age of 50 to 70 years, with a peak incidence in the seventh decade of life, slightly more in the male population. Modern statistics show an increase in the incidence of this disease at younger age groups. Although MM is a bone marrow disease in which pathological plasmocytes are proliferated, the clinical picture of this disease in the diagnosis may be different, depending on the stage of the disease and the disorders caused by the disease.

The most common symptom of the diagnosis is pain localized in the chest and back, very rarely in the bones of the limbs. The pain is emphasized by the movement, which is due to the lytic changes, primarily in the splenic bones.

Initially, the pain is "rheumatic" and has a migratory character; it can be strong in a certain time frame or followed by long painless periods, with progression to be constant and very pronounced. There are other symptoms that are considered as major criteria in the diagnosis of this disease.

For this reason, one of the main objectives of the health systems in many countries should be the programs for the prevention of these diseases, the screening programs for the at-risk populations defined by modern research for epidemiology, the incidence and prevalence of malignant diseases.

Working methods

The following methods are used in this research:
- Descriptive method
- Comparative method
- Analytical-explicit method

The descriptive method is applied in the analysis of the patient's medical documentation, which enables us to describe and determine the health status of patients with MM at the beginning and during treatment. Based on this method, we came to knowledge of the health condition of patients with MM, based on the results contained in the health records.

The comparative method allowed us to examine and determine the health status of patients with MM at the beginning of the treatment and during treatment, and at the same time to determine the similarities and differences in their quality of life.

We used the analytical-explicative method in order to analyze, explain and present the theoretical basis of the problem that we are investigating which works with the purpose of the research.

Sample of the survey

In this study, 80 patients with malignant hematological disease- myeloma multiplex were analyzed. In this study we have a quota sample. With a quota sample, 80 patients with MM who have been diagnosed and treated have been selected at the PHI University Clinic for Hematology - Skopje.

Research instruments

In accordance with the research techniques in this paper, the following instruments were applied:
Standardized questionnaire for interviewing patients with MM with an assessment scale and record lists of medical documentation for recording data on the health condition of patients with MM. The instruments are intended for patients with MM who are treated at the PHI University Clinic for Hematology in Skopje.

The EORTC QLQ C30 questionnaire of the European Organization for Research and Treatment of Cancer (the section on quality of life research) has been translated and validated in 81 languages and has been used in more than 3,000 studies worldwide.

Today, all new research uses version 3.0 (EORTC QLQ-C30 version 3.0), which is applied in this research. The questionnaire contains specific models' parts for specific malignant diseases. The questionnaire contains closed-type questions with previous assertions (not at all, a little, often and more often) from one to four (1-4), and the respondents having the task of declaring one of these four claims in accordance with their views and considerations. The questions are related to their physical activity, emotional, cognitive, family, social and financial conditions, as well as the impact of therapy on their quality of life. The questionnaire is divided into 5 categories. The introductory part of the questionnaire contains the following general data: sex, age, place of residence (city, village), education level, marital status, working status (employees, unemployed, and pensioners), income (salary, no, and help from a third person). In the second category are the functional abilities: physical functioning, emotional, cognitive, social functioning. The third categories cover issues related to the symptoms associated with the disease and are the result of the impact of the therapy. The fourth category refers to the financial difficulties of patients. The fifth category provides data on the general health and quality of life. The general health and quality of life at the beginning and during treatment were measured with the scale of assessment where patient had a task of ranking the response from 1 to 7 (from very poor to excellent).

Results and Discussion

Regarding the distribution of patients by age, larger part, that is, 33.75% are classified in the group from 51-60 years, while 27.5% in the age group 61-70 years. The analysis of the demographic characteristics group of patients in this paper showed that the majority, that is, 80% live in an urban environment, while 20% live in a rural environment. The research group of patients, 53% are pensioners, 23% are employed and 16% unemployed.

At diagnosing - Problems with physical functioning were "more often" in 58.3% of the respondents, while "often" in 15% of the respondents. The patient response rates range from 0 to 86.7. The level of physical functioning of the respondents is 27.5, which represents a low level of physical functioning.

During the treatment- therapy - problems with physical functioning were “more often” in 18.3% of the respondents, while "often" in 22.8% of the respondents. The patient response rates range from 13.33 to 100. The level of physical functioning of the patients is 59.5, which represents the intermediate level of physical functioning. At diagnosing - Problems with personal functioning were "more often" in 70.0% of the respondents, while "often" in 13.3% of the respondents. The level of personal functioning of the respondents is with a value of 17.91, which represents a low level of personal functioning.

During the treatment – Problems with personal functioning were “more often” at 40.0% of the respondents, and "often" in 22.5% of the respondents. The level of personal functioning of the respondents is 36.46, which represents a low level of personal functioning. At diagnosis – Problems with emotional functioning were “more often” at 34.4% of the respondents and "often" in 18.1% of the respondents. The level of emotional functioning among the examinees was with a value of 39.91, which represents a low level of emotional functioning.

During treatment - Problems with emotional functioning were “more often” in 3.8% of the respondents, while "often" in 12.8% of the respondents. The patient response rates range from 13.33 to 100. The level of emotional functioning of the patients is 73.34, which represents a high level of emotional functioning. At diagnosing - 19.4% of respondents had problems with cognitive function “more often”, while "often" at 20% of respondents. The level of cognitive functioning of the examinees is with a value of 55.21, which shows an intermediate level of cognitive functioning.

During therapy - Problems with cognitive function "more often" are absent among the examinees, while "often" in 25% of the examinees. The patient response rates range from 33.33 to 100. The level of cognitive functioning of the subjects is 72.5, indicating a high level of cognitive function. At diagnosing - Problems with social functioning were "more often" in 49.4% of the respondents, while "often" in 23.8% of the respondents. The level of social functioning among the respondents is with a value of 26.25, which represents a low level of social functioning.

During the treatment - 12.5% of the respondents had problems with social functioning “more often”, while "often" at 31.9% of the respondents. The values of patient responses range from 0 to 100. The level of social functioning of the respondents is 50.83, which represents an intermediate level of social functioning.

The symptom group includes those symptom's that appears as a direct consequence of the disease and its destructive effects on the rest of the organic systems, or if after the treatment with chemotherapy appear as side effects of the used medicaments.

In the analysis of non-specific symptoms (fatigue, loss of appetite) that can certainly be considered like determinants that contribute to disorder the quality of life at patients, a significant improvement is confirmed in the direction of reducing the level of their expression, which also leads into improving the social functioning of patients and the occurrence of a subjective feeling of improved health. This altered and improved condition is observed in the larger group of patients under analysis when assessing the characteristics of their quality of life. The extent of the therapeutic response achieved leads to a proportional dependence on the elimination of the severity of these symptoms.

From the investigated group of patients in the category of financial difficulties, there was no significant difference, following them from the beginning at diagnosis and during the treatment. The general health and quality of life of this researched group of patients are very difficult to describe numerically. The attitudes and considerations of the patients made it easier to assess the characteristics of their disease. However, although a multidimensional approach to data analysis is applied, it is clear that these components represent a synthesis of the full evaluation of the health status, including parameters that define the disease and the quality of life parameters of the researched group of patients with multiple myeloma.

Conclusion

According to the results of the research, the general hypothesis confirms that the quality of life changes from the period of diagnosis of the disease, during the treatment and in the further course of the disease. Specific hypotheses have been confirmed with a significant difference in the physical, emotional, personal and social functioning of patients with MM during diagnosis and during therapy for a period of 6 to 12 months, as well as the application of appropriate therapy that changes the quality of life.

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