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BRIEF REPORT

QUALITY OF LIFE IN HEART FAILURE

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Heart failure (HF) is expanding at an alarming rate with an estimated global prevalence of more than 37.7 million individuals.¹ Global incidence of HF ranges from 100 to 900 cases per 100,000 person, mainly depending on the diagnostic criteria used.²

Incidence and prevalence rates may present geographical variations according to the source of data and the methodology used, however they increase with advancing age, worldwide.³ In terms of risk factors, high blood pressure and body mass index at all ages may lead to higher lifetime risks.⁴ HF diagnosis relies on medical history, clinical examination and symptoms (shortness of breath, fatigue and swelling in the ankles and legs). Survival estimates are 50% and 10% at 5 and 10 years, respectively, after diagnosis.²

During recent decades, quality of life (QoL) has come to the forefront of clinical practice largely due to better understanding of HF pathophysiology and treatment. QoL reflects patients' perceptions about the multidimensional impact of this clinical syndrome on their lives. Measurement of QoL including physical, mental or social functioning is a significant tool in daily practice for assessment of HF treatment or effectiveness of interventions. Furthermore, systematic administration of standardized QoL instruments may provide valuable information to improve HF management.^{5,6}

Interestingly, efficacy of treatment is evaluated by several indices such as laboratory findings which ignore patients' needs which adversely affect QoL. It is not rare that physicians' prediction about patients' health perception and patients own health perception, frequently differ.⁷ According to patients' view, the main determinants of QoL include current health state, social integration, spirituality, perceived support, self care behaviors, sleep disorders and emotional burden.⁸

Notably, poor QoL in HF is associated with frequent hospitalizations and increased mortality rates.⁷ Specifically more, over 80% of HF patients have enormous burden of symptoms such as dyspnea, fatigue, edema, sleeping difficulties, and chest pain which adversely affects QoL.⁷

Contrariwise, medication adherence has a positive relationship with QoL among HF patients.⁹ In terms of Greek hospitalized patients, the more adherent a patient was the better QoL had.⁸ Relevant studies in Greece among HF outpatients, showed that when fatigue¹⁰ or anxiety¹¹ increases also deteriorates QoL while depression negatively influences QoL.¹²

Moreover, among 300 hospitalized HF patients (167 men and 133 women) worse QoL had patients taking antidepressants and anxiolytics, those suffering from 6 to 10 years, those with prior hospitalization and those who had not retired or were not absent from work because of their heart problem.¹³

The same study also showed that worse QoL in physical state had patients suffering from other diseases whereas worse mental state had those reporting poor relations with the medical and nursing staff. Low communication between health professionals and patients or misunderstandings about treatment may be an obstacle to patients' effective self-care, thus minimizing QoL. Indeed, patients need careful listening and provision of accurate information while clinicians are often reluctant to disclose the poor prognosis.¹³

Erceg et al.,¹⁴ who also explored hospitalized HF patients showed depression, high NYHA class, low income, and long duration of the disease as independent predictors of poor QoL. It is noteworthy, that depression is five times more prevalent in HF patients when compared to general population while major depression in chronic HF accounts for 20–40% of cases.¹⁵

Regarding symptoms, mainly fatigue and edema adversely

affects quality of life.¹⁶ Last but not least, HF patients experience several financial difficulties such as loss of their jobs or increase in medical expenses, which negatively affect their QoL.⁷

Measuring QoL in HF patients is important for both clinical practice and research. In general, QoL is a challenge for nurses involved in HF care as each patient has a unique way to confront with this clinical syndrome.

Recognizing factors associated with QoL in HF, on the one hand will significantly help health professionals to provide holistic care while on the other hand may prompt HF patients to continue their biological and psychological struggle.

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