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STATEMENT OF PROBLEM- A STUDY TO ASSESS THE QUALITY OF LIFE OF PATIENTS WITH MYOCARDIAL INFARCTION ATTENDING SELECTED OUTPATIENT DEPARTMENTS OF KOLKATA, WEST BENGAL

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ABSTRACT A descriptive survey was undertaken to evaluate the quality of life of patients after being diagnosed with myocardial infarction. The objectives of the study were to assess the quality of life of myocardial infarction patients and to find out the association of the quality of life with selected demographic variables. The conceptual framework adopted was based on Roy's Adaptation Model. Purposive sampling technique was used to select 100n patients. The Rand 36-Item Health Survey Questionnaire was employed to assess the quality of life. The findings revealed that the subjects experienced a moderate quality of life with the highest mean percentage in the concept of social functioning. There was significant association between the quality of life and selected demographic characteristics like sex and duration of illness. The study findings have several implications for nursing service and education.

KEYWORDS : quality of life, myocardial infarction

INTRODUCTION-
World Health Organization's (WHO's) Global Health Statistics 2008, the most recent health statistics for 200 member countries, reported that coronary artery disease will rank the number one killer disease in 2030, causing 14.2% of all deaths worldwide. According to recent estimates, cases of CVDs may increase from about 2.9 crores in 2000 to as many as 6.4 crores in 2015. By 2020, cases of CAD are expected to rise in India by 120% in women and 137% in men. 88 men of working age (35 – 64) out of a sample population of one lakh are likely to die due to CAD. With modernization, large proportions of people eat fatty foods, physical jobs for deskbound sloth and stressful city lifestyle leads to cardiac problem (4).

Myocardial Infarction (MI) or acute myocardial infarction, commonly known as a heart attack, is the interruption of blood supply to a part of the heart, causing heart cells to die. This is most commonly due to occlusion (blockage) of a coronary artery following the rupture of a vulnerable atherosclerotic plaque, which is an unstable collection of lipids (fatty acids) and white blood cells (especially macrophages) in the wall of an artery (9).

The incidences of acute myocardial infarction increase with age and 45% of all events occur before the age of 65. The targeted history and physical examination and a 12 lead ECG should be performed in the emergency department on all patients with suspected MI (11).

Lifestyle and diet modifications are indicated for implementation to reduce the burden of coronary artery disease in the urban population by Ashvaid (2004), where physical inactivity is termed as responsible co-factor (8).

Quality of life (QOL) is well known to convey an overall sense of well being including different blunt mental aspects. The individuals' subjective evaluation of disease, impairment and disability is what can be termed as quality of life. QOL depends on the person's physical health, psychological state, level of independence, social relationships and their relationships to salient features of the environment. Hence it is important to understand the impact of lifestyle behaviours on health status to control the negative effects on health (16).

Today, quality of life is becoming an important outcome measure after the initiation of treatment therapies of MI. The major therapeutic goal is to improve the functioning ability of these patients so that they can enjoy life to its fullest possible extent.

Operational definition-
Quality of life-
In this study Quality of life refers to the subjective satisfaction of life expressed by the myocardial infarction patients as measured by the RAND 36-Item Health Survey Questionnaire.

Myocardial infarction patients-
In this study it refers to the patients who are attending out patients department (OPD) for follow up after one month and not more than six months of the first attack of myocardial infarction and those who had undergone either medical intervention or surgical interventions like percutaneous transluminal coronary angioplasty (PTCA) or coronary artery bypass grafting (CABG).

Research Approach
Descriptive survey approach was adopted to collect data from the myocardial infarction patients.

Research Design
Descriptive survey design was adopted.

Variables of the study
The research variable under study was the quality of life of myocardial infarction patients.

The demographic variables were age, sex, education, occupation, monthly income, type of family, duration of illness, type of intervention, duration of undergoing treatment and follow-up, last clinic visit.

Population
Patients with myocardial infarction attending OPD for follow up after one month of diagnosis and not more than six months and also having medical/surgical interventions.

Sample
In the present study sample comprised of the patients diagnosed as myocardial infarction attending OPD of selected hospitals for follow up after one month of diagnosis and not more than six months and also having medical/surgical interventions.

Sample Size
In the present study the sample size was 10 in pilot study and 100 in final study.

Sampling Technique
The selection of sample technique largely depended upon their availability. Therefore the sampling technique adopted for the present study was non- probability purposive method of sampling.

Data collection tools and techniques
Table 1Data collection tools and techniques

Sl. No	Tools	Variables to be measured	Technique
IA	Semi Structured interview schedule	Demographic data	interviewing
IB	Semi Structured interview schedule	Patient profile	interviewing
II	The RAND 36-Item Health Survey Questionnaire	Quality of life	interviewing

Major findings of the study
Majority (55%) of the subjects were male. Maximum respondents (68%) belonged to the age group 51-70. Maximum respondents (35%) completed primary education. Majority (61%) of the subjects had a monthly income of <Rs. 3000.

Majority (51%) of the respondents were suffering from their illness for

3 months to 6 months. Majority (68.29%) of the respondents had undergone PTCA as surgical intervention. Majority (51%) of the respondents were under treatment for the duration of 3 months to 6 months. Maximum respondents (32%) had a past history of hypertension.

Mean of total quality of life score was 1491.95 with median 1437.5 and standard deviation of 424.45 (Maximum possible score 3600 and minimum possible score 0).Majority of the respondents (64%) had perceived moderate level of quality of life. Majority of the respondents (81.67%) had perceived good quality of life in relation to the concept of social functioning.

Majority of the respondents (68%) of 51-70 years of age group had perceived average quality of life. Majority of the male respondents (55%) had perceived average quality of life. Majority of the respondents (51%) suffering from their illness for 3 months to 6 months had perceived average quality of life.

In case of findings related to Correlation and association between quality of life and selected variables, no correlation (0.0108) was found between age of the respondents and quality of life perceived by them. Chi square value (4.88) showed statistically significant association between quality of life and gender of subjects. Chi square value (1.26) showed no association between quality of life and education, occupation and monthly family income of the subjects. Chi square value (2.02) showed no association between quality of life and duration of illness of the subjects and types of intervention the subjects had undergone

DISCUSSION
In this present study it was revealed that majority (55%) of the subjects were male. Chi square value (4.88) showed significant association between quality of life and gender of subjects,at 0.05 level of significance. Similarly a case-control study was conducted by M. Baudet and colleagues, 2006with an objective to elicit risk factors for myocardial infarction among Southern Indians and to find out its association with body mass index in Chennai. The study results showed that the risk of developing myocardial infarction was significantly more in males.(27)

The overall quality of life was skewed towards moderate level of quality of life (64%) which was similar to the findings of the study by Nagaraju and colleagues, 2012 where it had shown that majority of the patients, (48.6%) had moderate quality of life. A statistically significant association was found between gender and quality of life of myocardial infarction outpatients and male myocardial infarction patients had better quality of life than female myocardial infarction patients. This indicated that the incidence of Myocardial infarction was on the rise and it affected the quality of life of the Indian population (37).

It was observed that majority of respondents (81.67%) had good score in the concept of social functioning. Similarly Choo and colleagues, 2007 evaluated the effects of an 8-week CRP on HRQOL and exercise capacity in myocardial infarction patients in Korea. After matching on gender, age, and left ventricular ejection fraction, 60 subjects with a first acute MI were allocated to either a CRP group (n=31) or a Control group (n=29) and social functioning and psycho/spiritual scores showed greater increases in the CRP group than the Control group (45).

Analysis of the present study highlighted that maximum respondents (32%) had a past history of hypertension. This finding was supported by the study of MenakshiSundaram R and her colleagues in 2010. The survey showed that prevalence of myocardial infarction continues to rise (at 4% per year) and driven by a persistently high prevalence of smoking and the rapid growth of diabetes, hypertension and hypercholesterolemia (21).

CONCLUSION
The study findings revealed that most of the patients after myocardial infarction experienced moderate quality of life. The findings also highlighted that there were few demographic characteristics which had impaction the quality of life. During monitoring the patients, quality of life is an important factor to take care of not only because it is a basic part of the concept of health but also because of its close relation with morbidity and mortality. Better quality of life has the potential to result in greater survival rate, better performance status and less morbidity.

REFERENCES
1. "Buddha-quotes" ,Sources of light - Insight and Action for Personal Effectiveness. [Place unknown][updated 2012 Jan 5 ; cited 2013Feb 10]. Available from http://sourcesofinsight.com/ Buddha-quotes/
2. Patricia, Morton G. Critical care nursing a holistic approach. 8th ed. Philadelphia: Lippincott Williams and Wilkins; 2005. 422-473.
3. World Health Organization. The world health report 2002- reducing risks, promoting healthy life. Geneva: WHO; 2002. [updated 2002 June 26; cited 2013 March 20] Available fromhttp://www.who.int/whr/2002/en/
4. Enas A.E., Kanan S. How to beat the heart disease epidemic among south asians- a prevention and management guide for Asian Indians and their doctors. 203-237:Advanced Heart Lipid Clinic .D.O.P: 2005 Nov [updated 2012 Jan cited 2013 Aug 21] : Available from http://www.amazon.com/Heart-Disease-Epidemic-Among-Asians/dp/0976995301
5. Jain P, Jain P. Introduction to Heart Disease,112-114: Voluntary health Associates of India. D.O.P :1998Oct [updated 2011Dec cited 2013 Aug 21]: Available from : http://www.ncbi.nlm.nih.gov/pubmed/9282636
6. Dr.Peeyush Jain. Coronary Heart Disease. Health for the Millions, New Delhi: 1999 May 15;2(3): 15 - 20.
7. World Health Organization. The world health report- risk factors of cardiovasculardisease .Geneva: WHO; 2008. [updated 2008 July 2; cited 2013 March 20] Available from:www.who.int/chp/knowledge/publications/adherence_full_report.
8. Ashavaid TF, Todur SP, Dherai AJ. Health Status of Indian population current scenario. J. Associate Physicians India [Internet]. 2004 June [cited 2013 March 20]:3(52): 359-61. Available from www.japi.org/march_2012/03_oa_a_survey_for.html
9. Joyce MB, Jane HH, Annabelle MK. Medical surgical nursing: Clinical management for positive outcomes. 7th ed. Pennsylvania: Saunders; 2005. 1579-81
10. Sathvik BS, Pathasarathi G, Narahair MG. An assessment of the quality of life in haemodialysis patients using WHOQOL- BREF questionnaire. Indian Journal of Nephrology. 2008 April; 18(4): 141-149.
11. Goldberg AC: Prevention and treatment of coronary artery disease in women, the elderly, and child: overview, coronary artery diseases.577-579: [updated 2003 May April 04 cited 2013 Feb 17]; Available from http://www.ncbi.nlm.nih.gov /articles/pubmed/1994008/
12. Heart disease facts and statistics.Centres for disease control and prevention.Chicago :,. 2004. [cited on Sep 24]; Available fromhttp://heart. bmj. com/ content/81/4/352.short
13. Al Eissa M, Al Sulaiman MM, Jondeby M, Karkar A, Barahmein M, Shaheen FA, et al. Factors affecting hemodialysis patients satisfaction with their dialysis therapy. International Journal of Nephrology. 2010 Dec; 14(2) :65-69.
14. Lewis SM, Collier IC, Heitkemper MM .Medical surgical Nursing .4th ed.ssSt. Louis: Mosby; 1996.
15. Leahey ,Wright , et.al. Exercise Training in Coronary Artery Disease and Circulation ; [updated 2007Feb 15; cited 2013 March 3] : Available from http:// onlinelibrary. wiley.com/doi/ 10.1046/j.1525-1497.2001.10102.x/full