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Prevalence of Psychiatric Morbidity and Quality of Life in Patients with Ischemic Heart Disease in A Tertiary Care Hospital

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Abstract

Aims and Objectives: The point of the investigation is to survey the mental horribleness and QOL in coronary heart condition (IHD) Materials and *Methods:* This cross-sectional examination was administrated at Department of therapeutic claim to fame, Mamata general medical clinic, Khammam, Telangana from may 2018 to December 2018. 130 patients with IHD were assessed for psychiatrical horribleness and QOL. Instruments utilized were SCID 1, Euro QOL-5D, and Socio demographic information sheet. *Results:* Mental indications, either burdensome or tension were available in the majority of the patients (n = 75, 75%). Burdensome manifestations were seen in 42 (42%) patients though tension side effects were available in 48 (48%). With respect to mental finding significant burdensome issue was available in 27 (27%) patients. Uneasiness issue was analyzed in 33 (33%). Fifteen patients announced both tension issue and burdensome issue. None of patients announced maniacal issue. Forty (40%) patients revealed that they were not able perform common exercises and 13 (13%) patients announced no issue in action. Larger part (n = 47, 47%) detailed a few challenges. Just 16 (16%) patients announced hindrance in versatility and 15 (15%) detailed no impedance in portability and 69% revealed some disability in portability. Number of patients with great QOL were more (n = 27, 27%) in self-care space. 16 (16%) patients detailed poor QOL in the equivalent. Higher pace of poor QOL was noted in the nervousness/discouragement area (n = 48, 48%). Torment and uneasiness space uncovered high-level of good personal satisfaction (n = 42, 42%). *Conclusion:* The discoveries of our investigation uncover a high-pace of psychiatrical bleakness and impeded QOL in IHD Patients.

Keywords: Anxiety; Cardiovascular; Depression; Ischemic heart disease.

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Introduction

Ischemic coronary illness (IHD) is never again kept by land region or by age, sex, or financial limits. Coronary illness has just arrived at pestilence extents in less fortunate nations. Of the 45.0 million grown-up passings announced worldwide in 2002, three-quarters (32 million) were because of noncommunicable infections. All around, IHD was the main executioner in the age bunch ≥ 60 years, and, with 1 332 000 passings in grown-ups matured 15–59 years.[1]

Asian Indians living in various nations have higher paces of frequency, hospitalization, pervasiveness, grimness, mortality, and case casualty from IHD than individuals of other ethnicity.[2,3]

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Mental issues related with IHD have been examined including the pervasiveness of mental issue, their indicators, and personal satisfaction. Complex multidimensional connections exist among discouragement and IHD. Sadness is perceived as a free hazard factor for the advancement of IHD just as a huge indicator of higher grimness and mortality in patients with symptomatic IHD.[4]

The outcomes showed a high predominance of mental dreariness (44.8%) in patients with cardiological pathology as opposed to another investigation utilizing a comparable philosophy (prevalence = 35%).[5]

During the previous three decades, personal satisfaction (QOL) has developed as a significant trait of clinical result and patient consideration. A study has endeavored to recognize clinical, statistic, and psychosocial attributes of patients at confirmation that were autonomous indicators of QOL a half year and 1 year after intense myocardial infarction.[6]

Another study assessed the relationship between a past filled with sadness and patient revealed angina recurrence, physical restriction, and QOL 7 months after release from the medical clinic for intense coronary syndrome.[7]

The nearness of melancholy at passage point as an amazing indicator of QOL among overcomers of myocardial localized necrosis was accounted for by different examinations also.[8,9] Apart from gloom, impact of uneasiness on QOL in patients hospitalized for intense myocardial dead tissue was additionally considered. One such study announced that manifestations of tension and gloom predicted QOL among the individuals who lived to a year after intense myocardial infarction.[10]

Mental and psychosocial factors assume significant jobs in the etiology course and result of IHD. The significance of mental elements was much progressively obvious when endeavors were made to restore IHD patients. Changes in mental factors in patients with IHD have been seen as significant determinants for development. The illness can straightforwardly influence the psychological capacity and result in incessant debilitation in mental capacity. By up until now, the most generally announced passionate results related with IHD are discouragement, nervousness, certain psychosocial work qualities, informal organizations and social help, and type-A character conduct in addition to hostility.[11]

These psychosocial parts are significant in the auxiliary anticipation of IHD separated from their job in essential and primordial counteractive action. Understanding the transaction between psychosocial elements and IHD is essential in comprehension QOL in IHD.[12]

Aims and Objectives

To assess prevalence and patterns of psychiatric morbidity in patients with IHD;

- To assess health related QOL in patients with IHD;
- To assess the relationship among socio-demographic and clinical factors, psychiatric morbidity, and health related QOL in patients with IHD.

Materials and Methods

Place of study: This cross-sectional study was carried out at Department of Cardiology, Mamata General Hospital, Khammam, Telangana.

Study period: The study undertaken during may 2018 to December 2018.

Study design: Cross sectional.

Study sample:

Inclusion criteria

The sample comprised patients with coronary heart disease. The following diagnoses are included under the heading of coronary heart disease:

1. Myocardial infarction with ST segment elevation;
2. Myocardial infarction without ST segment elevation;
3. Chronic Stable angina, and
4. Unstable angina.

Information was gathered from the inpatient cardiology office at Mamata Medical College, Hospital, Khammam. Examiner visited the patients admitted to the coronary consideration unit every day. Conclusion of IHD affirmed with the guide of ECG and heart chemical investigations. Patients satisfying the incorporation criteria were chosen and were clarified about the idea of the investigation, and afterward educated assent was taken from every one of the patients. Chosen patients were met on third or fourth day of the confirmation rather than the day itself, in perspective on conceivable precarious ailment meddling with the meeting method.

Exclusion criteria

Subjects who had other mental sickness or physical disease. Subjects who are not ready to take an interest in study and who didn't gave composed assent.

Methods:

Patients were first administered the Mini Mental Status Examination (MMSE). Then the clinical proforma, Structured Clinical Interview for DSM-IV Axis I Diagnosis (SCID-I), and Health related quality of scale (EQ-5D) were administered.

Statistical Analysis:

The data obtained was analyzed using Statistical Package for the Social Sciences (SPSS), Version 20. The Chi-square test was used as needed.

Results

Psychiatric symptoms, either depressive or anxiety were present in most of the patients (n = 75, 75%). Depressive symptoms were noticed in 42 (42%) patients whereas anxiety symptoms were present in 48 (48%). With regard to psychiatric diagnosis major depressive disorder was present in 27 (27%) patients. Anxiety disorder was diagnosed in 33 (33%). Fifteen patients reported both anxiety disorder and depressive disorder. None of patients reported psychotic disorder (Table 1 and Fig. 1).

Chi-Square results from cross tabulation between Hr QOL items with psychiatric morbidity as well as socio-demographic and illness related variables have shown significant association for following items (i) activity, (ii) anxiety/depression, (iii) mobility, (iv) self-care (Table 2).

Discussion

Socio-demographic distribution

The sample comprised of dominatingly males (n = 73, 73%) contrasted with females (n = 27, 27%). Major share of the patients were married (n = 79), 8 were unmarried and 13 lost their life partners. 83 patients were from urban foundation while 17 spoke to rustic regions. The family structure revealed clients belonging to nuclear family represented 71 while 29 were from nonnuclear family. Most of the patients had formal education (49 were with school education and 43 had college education). 8 were illiterate. Larger part of the patients revealed money related issues and right around a comparative number of patients announced diminished productivity in work limit in the past 1 year.

Psychiatric morbidity

With the end goal of further investigation, patients were ordered into four gatherings: (1.) Major Depressive issue (MDD) (2.) Nervousness issue because of ailment, (3.) Those having both uneasiness issue and MDD, (4.) Those with no mental finding.

Psychiatric symptoms, either depressive or anxiety were present in most of the patients (n = 75, 75%). Depressive symptoms were noticed in 42 (42%) patients whereas anxiety symptoms were present in 48 (48%). With regard to psychiatric diagnosis major depressive disorder was present in 27 (27%) patients. Anxiety disorder was diagnosed in 33 (33%). Fifteen patients reported both anxiety disorder and depressive disorder. None of patients reported psychotic disorder (Fig. 1).

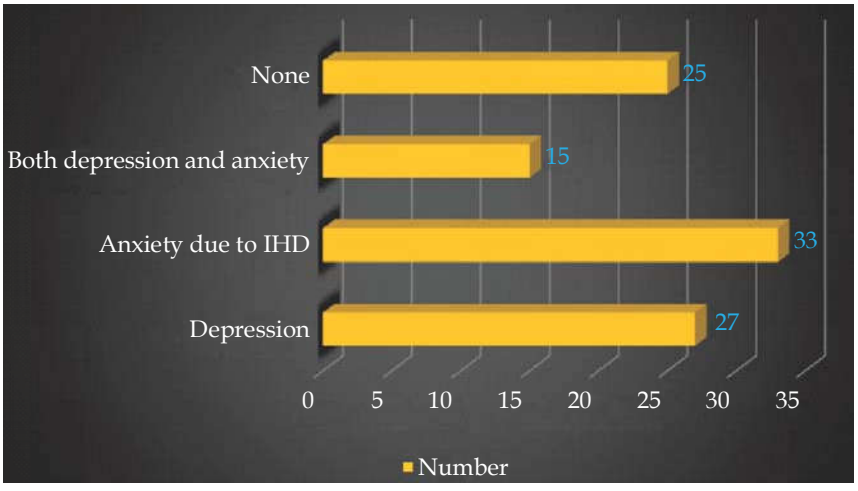

Fig. 1: Comparison of psychiatric morbidity with QOL domains

Table 1: Comparison of psychiatric morbidity with QOL domains

		Psychiatric morbidity					
		MDD	**Anxiety due to IHD**	**Both**	**None**	**Total**	***p* - value**
EQ-5D activity	No	2	2	1	8	13	Chi-square 19.1
	Some	12	14	6	15	47	
	Severe	13	17	8	2	40	*p* - value 0.003
	Total	27	33	15	25	100	
EQ-5D mobility	No	3	5	1	6	15	Chi-square 20.5
	Some	13	25	13	18	69	
	Severe	11	3	1	1	16	*p* - value 0.002
	Total	27	33	15	25	100	
EQ-5D anxiety/depression	No	1	4	1	6	12	Chi-square 15
	Some	11	14	2	13	40	
	Severe	15	15	12	6	48	*p* - value 0.019
	Total	27	33	15	25	100	
EQ-5D pain/discomfort	No	10	15	3	14	42	Chi-square 5.8
	Some	15	17	11	10	53	
	Severe	2	1	1	1	5	*p* - value 0.43
	Total	27	33	15	25	100	
EQ-5D self-care	No	6	9	1	11	27	Chi-square 14.9
	Some	15	21	8	13	57	
	Severe	6	3	6	1	16	*p* - value 0.02*
	Total	27	33	15	25	100	

Forty (40%) patients reported that they were unable to perform usual activities and 13 (13%) patients reported no problem in activity. Majority (n = 47, 47%) reported some difficulties. Only 16 (16%) patients reported impairment in mobility and 15 (15%) reported no impairment in mobility and 69% reported some impairment in mobility, shown as (Table 1).

Table 2: Frequency distribution-QOL domains

		n	%
EQ-5D activity	No	13	13%
	Some	47	47%
	Severe	40	40%
EQ-5D mobility	No	15	15%
	Some	69	69%
	Severe	16	16%
EQ-5D anxiety/depression	No	12	12%
	Some	40	40%
	Severe	48	48%
EQ-5D pain/discomfort	No	42	42%
	Some	53	53%
	Severe	5	5%
EQ-5D self-care	No	27	27%
	Some	57	57%
	Severe	16	16%

Number of patients with good QOL were more (n = 27, 27%) in self-care domain. 16 (16%) patients reported poor QOL in the same. Higher rate of poor QOL was noted in the anxiety/depression domain (n = 48, 48%). Pain and discomfort domain revealed high percentage of good quality of life (n = 42, 42%), shown in (Table 2).

Chi-square results from cross tabulation between Hr QOL items with psychiatric morbidity as well as socio-demographic and illness related variables have shown significant association for following items (i) activity (p = 0.003), (ii) anxiety/depression (p = 0.019), (iii) mobility (p = 0.002), (iv) self-care (p = 0.02).

Conclusion

In present study we observed that The discoveries of our investigation uncover a high pace of psychiatrical bleakness and impeded QOL in IHD Patients.

Limitations

This study has a few limitations. Small sample size, use of convenient sampling are some of the other limitations of the present study that needs to be taken into consideration before planning further research in this area.

Conflicts of Interest

There are no conflicts of interest.

References

1. World Health Organization (WHO). Facts and figures. The World Health report 2003–shaping the future [online] 2003. Available from: http:// www.who.int/whr/2003/en/Facts_and_Figures-en.pdf. [Last accessed on 2005 Feb 14].
2. Enas EA, Yusuf S, Mehta J. Meeting of International Working Group on Coronary Artery Disease in South Asians. Indian Heart J 1996;48:727-32.
3. Enas EA, Dhawan J, Petkar S. Coronary artery disease in Asian Indians: Lessons learnt and the role of lipoprotein. Indian Heart J. 1997 Jan-Feb;49(1):25–34.
4. Roose PS. Depression: Links with ischemic heart disease and erectile dysfunction. J Clin Psychiatry 2003;64(Suppl 10):26–30.
5. Lloyd GG, Cawley RH. Psychiatric morbidity after myocardial infarction. Q J Med. 1982;51(201):33–42.
6. Beck CA, Joseph L, Belisle P, et al. QOLAMI Investigators (Quality of life in acute myocardial infarction). Predictors of quality of life 6 months and 1 year after acute myocardial infarction. Am Heart J 2001;142:271–79.
7. Rumsfeld JS, Magid DJ, Plomondon ME, et al. History of depression, angina and quality of life after acute coronary syndromes. Am Heart J. 2003 Mar;145(3):493–99.
8. Conn VS, Taylor SG, Wiman P. Anxiety, depression, quality of life, and self-care among survivors of myocardial infarction. Issues Ment Health Nurs. 1991;12(4):321–331.
9. Mayou RA, Gill D, Thompson DR, et al. Depression and anxiety as predictors of outcomes after myocardial infarction. Psychosom Med. 2000 Mar-Apr;62(2):212–29.
10. Lane D, Carroll D, Ring C, et al. Mortality and quality of life 12 months after myocardial infarction: Effects of depression and anxiety. Psychosom Med. 2001 Mar-Apr;63(2):221–30.
11. Hemingway H, Marmot M. Psychosocial factors in the etiology and prognosis of coronary heart disease: Systematic review of prospective cohort studies. Br Med J 1993;318:1460–67.
12. Chaturvedi SK, Savithashri EV, Rajashekar K. Quality of Life: General concepts and research in India. In: Chaturvedi SK, Chandra PS, editors. Quality of life in health and disease. Bangalore: NIMHANS; 1999.