AWARD PAPER

Quality Of Life In Depressed Patients- A Strategic Marker Of Treatment Outcome

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Abstract : *Depressive patients experience difficulty with physical activities and their energy levels are reduced. Their sense of personal health is adversely affected including their abilities to interact socially, to work effectively and to manage their homes. The aim of our study was to study the correlation between clinical status and Quality of life in depressive patients and to assess response to treatment in patients with depression by using a validated instrument WHO-QOL-BREF scale. 30 depressive patients (moderate to severe category as per ICD-10) were assessed by demographic details, WHO-QOL-BREF scale and Beck depression inventory, Global assessment of functioning scale on day 1 and then on day 56 (8 weeks). Fluvoxamine was given in a flexible way (50-200 mg) with starting dose of 50 mg. The data was collected on above tools is analyzed using descriptive and inferential statistics using paired t-test and pearson correlation coefficient. Results revealed significant improvement with treatment which is the expected outcome and quality of life was also improved in all the domains and negative correlation was found between BDI score and QOL score.*

Key Words: *Quality of life, depression*

Quality of life is a broad concept that includes many aspects of living in addition to health. A common definition focuses on overall satisfaction with the life and general sense of well being. The concept has been developed to assess the overall impact of medical treatments from the patients' perspective.[1] World Health Organi-zation has defined quality of life as the condition of life resulting from the combination of the effect of complete range of the factors such as those determining health, happiness including comfort in physical environment and a satisfying occupation, education, social and intellectual attainments, freedom of actions, justice and freedom of expression.[2]

In patients with depression, health related quality of life reflects a treatment outcome beyond symptom improvement. During episodes of depression, these patients experience difficulty with physical activities, and their energy levels are reduced. Their sense of personal health is adversely affected including their abilities to interact socially, to work effectively and to manage their homes.[3] Thus, to fully evaluate the impact of treatment, it is important to assess the physical, social and psychological status of patients.[4]

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Traditional outcome measures in major depression include Hamilton rating scale for depression (HAM-D)[5], the Monotogomery Asberg Depression Rating scale[6] and Clinical Global impression.[7] These measures do not cover important domains of Health related QOL. One relies on HAM-D or MADRS to evaluate treatment outcome, the domains of inquiry will be limited (e.g. the presence or absence of quality of interpersonal relationships can not be examined) and there will be methodological inconsistencies.[8]

OBJECTIVES

To study the correlation between clinical status and quality of life in depressive patients.

To assess response to treatment in patient with depression.

MATERIAL AND METHODS

Study sample: It consists of 34 new patients of depression diagnosed as per ICD-10, attending a camp organized at Mansarovar, Jaipur on 10th April, 2005, for depressed patients after wide publicity with the help of NGO. Out of 34 patients, 4 patients dropped out in subsequent follow up hence excluded from analysis. Follow up was on day 14 (2 weeks), day 28 (4 wks), day 42(6 wks) and day 56 (8 weeks).

Inclusion Criteria

- Patients of either sex
- Age between 18-70 years
- Patient fulfilling criteria for depression as per diagnostic criteria. (ICD-I0)
- Current BDI score 16 or above.

Exclusion criteria

- Patients with any comorbid psychiatric disorders.
- Patients with any chronic physical illness, organic brain disorder or substance dependence.

Study medication

Fluvoxamine was given in a flexible way (50-200 mg) with starting dose of 50 mg. The investigator had the option to adjust the daily dose depending on individual patient's response. Therapy was given for 8 weeks.

Instruments

a) *Sociodemographic proforma:* it consists of structured format to record certain variables regarding the patient such as age, sex, marital status, education, occupation, religion, type of family; income etc. Clinical status was assessed by-

(b) *Beck depression inventory:* It is a self reporting scale for quantification of depression. Hindi adaptation[9], is used in present study. It contains 21 items, scores 0 to 3, of which 15 items deal with psychological symptoms and only 6 are concerned with somatic ones.

(c) *Global assessment of functioning scale:* it measures the level of functioning of patients, it was developed in early 1990 to rate Axis. V of DSM IV. It is a clinician rated 100 point scale based on all available information with clear description of 10 point interval.[10]

(d) Quality of life instrument (WHO QOL BREF Scale)[8]:

The WHOQOL-BREF is the 26-item abridged form of the WHOQOL-100 developed for studies requiring a concise, easily administered scale. It is a structured-self-report interview. It was developed by WHO, division of mental health. Its purpose is to assess quality of life of a person. It assesses patients under 4 domains, which are physical psychological, social, environmental.

Table -I

Comparison of Quality of life and clinical status of patients before and after 8 weeks of treatment

N = 30

		Before and After	Mean	Std. Deviation	Std. Error Mean	t- test
Quality of life domains	Physical	Before Treatment	2.529	0.712	0.130	-5.64***
		After Treatment	3.657	0.833	0.152	
	Psychological	Before Treatment	2.283	0.607	0.111	-6.07***
		After Treatment	3.517	0.933	0.170	
	Social	Before Treatment	2.667	1.017	0.186	-4.81***
		After Treatment	3.867	0.912	0.167	
	Environmental	Before Treatment	3.238	0.809	0.148	-3.45**
		After Treatment	3.875	0.610	0.111	
Clinical status	General	Before Treatment	2.300	0.943	0.172	-5.01***
		After Treatment	3.600	1.062	0.194	
	BDI	Before Treatment	25.700	7.773	1.419	8.05***
		After Treatment	8.700	8.559	1.563	

*** P d" .001 ** P d" .05

Methodology

All patients were kept on regular follow up periodically. These patients are assessed by these tools on day 1 and then on day 56 (8 weeks). The data was collected on above tools is analysed using descriptive and inferential statistics using paired 't' test and Pearson correlation coefficient.

OBSERVATION

A total of 34 patients of depression were interviewed, 4 of the patients dropped out of this study on account of long distances and family reasons. All were treated as out patient basis.

Table I shows comparison of mean QOL score and BDI Score before and after 8 weeks of treatment in quality of life and in clinical status, significant improvement was found in all domains ($P< 0.05$). There is also significant improvement in global assessment of functioning after 8 weeks.

In table II, correlation was assessed among quality of life and clinical status using person correlation coefficient. Negative correlation was found between clinical status and quality of life.

DISCUSSION

Quality of life has become very fashionable in medical research and patient care as it takes account of improvements in function or distress that falls short of complete cure, it is holistic and takes account of a broad range of outcomes that are consistent with the complexities of human life, it focuses attention on the needs of the individual which is acceptable to patients and relatives' and it can be applied across disciplines to compare different interventions for different disorders using the same measure of outcome[12]. Quality of life also acts as an outcome measure of treatment.

Table II
Correlation between QOL domains 7 BDI (N=30)

QOL	1st Week	8th Week
Physical	- 0.74 **	-0.82***
Psychological	- 0.48**	-0.78**
Social	- 0.19	-0.88**
Environmental	-0.51**	-0.63**
General	-0.76**	-0.90**

***p<.001 **p<.05

In the present study WHO QOL BREF questionnaire was used to assess the quality of life of patients of depression receiving treatment as it assesses all 26 facets of WHO QOL scale. We compared our patients on different measures before and after the end of 8 weeks of treatment. Clinical status of all the patients showed significant improvement with treatment which is the expected out come and quality of life was also improved in all the domains.

The correlation between clinical status and quality of life, was found using Pearson's correlation coefficient. The mean BDI score of patients had negative correlation with QOL scores.

A comparison of "responders" (who experienced a reduction in symptoms of 50% or more) and non responders to several standard antidepressant treatments, as recorded in the natural practice database at the centre of addiction and mental health, Toronto revealed significant differences in SF 36 ratings before and after treatment. After 8 weeks, responders had significantly higher ratings for each measure of social function. The finding indicates that health related quality of life questionnaires can detect response to treatment in patients with depression. In this study there was also a significant correlation between changes in scores on 17 item HRSD scale and change in 5 of the 8 scales of SF-36 (physical role, vitality, social functioning, emotional role and mental health) ($P < 0.01$ in all cases).[8]

Turner et al. established that antidepressant therapy with sertraline was associated will all improvement in psychosocial functioning.[3] This study rated 400 patients with depression in clinical practice. After 6 weeks, there were significant improvements in all psychosocial -parameters ($P=0.001$).

Similarly, in a controlled comparative trial of fluoxetine and reboxitine, Healy used the social adaptation and self evaluation scale to evaluate health related QOL[13]. After 6 weeks of therapy, psychosocial function was significantly better for patients treated with reboxitine. Than for those who had received treatment with fluoxetine ($P < 0.05$).

Limitation

The sample size was small; hence generalization of the findings to all types of depressed patients is not possible.

Neither these measures address the heterogeneity of depressive syndromes (e.g., presence of atypical symptoms) nor do they cover patients' motivation and personal preference for different treatment modalities.

CONCLUSIONS

Health related quality of life measures have been beneficial in the assessment of antidepressant treatment. They are sensitive to change in status during treatment and have predictive value for outcome measures. QOL questionnaire also provide additional information about timelines for improvement in psychosocial functioning, which may occur at a different rate than changes in other depressive symptoms.

The use of health related quality of life questionnaires represents a step forward in the evaluation of treatment efficacy. These assessments can lead to better targeted interventions and more specific measures of response to treatment. They provide an important additional dimension with anti depressant medications.

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