



CODEN [USA]: IAJ PBB

ISSN: 2349-7750

**INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES**<http://doi.org/10.5281/zenodo.2609215>Available online at: <http://www.iajps.com>

Research Article

**ANALYSIS OF EFFECTS OF ATTITUDE TOWARDS DISEASE
ON QUALITY OF LIFE IN PATIENTS WITH BONE TUMORS
IN PAKISTAN**¹Dr Ahmad Bilal, ¹Dr Ghazala Dawood Abbasi, ¹Dr Manal khan¹Islamic International Medical College Rawalpindi (RIU)**Article Received:** January 2019**Accepted:** February 2019**Published:** March 2019**Abstract:**

Introduction: Extremity soft tissue and bone sarcomas are a rare heterogeneous group of bone and connective tissue tumors. Their growth behavior and the biological grade of malignancy differ markedly between the histological subtypes.

Aims and objectives: The main objective of the study is to analyze the effects of attitude towards disease on quality of life in patients with bone tumors in Pakistan.

Methodology of the study: This study was conducted in Islamic International Medical College Rawalpindi (RIU) during September 2018. This study was done for the analysis of quality of life of bone tumor patients in Pakistan. The data were collected through a prepared questionnaire. Participants were given a toll-free number for technical support and to ask any questions regarding the study. All participants provided written consent upon arrival for their physician appointments.

Results: The data were collected from 100 patients of both genders. To develop the propensity score model, we used a multinomial logistic regression of the nominal three-category quality of life variable. The age, SF-12, education, sex, and race terms were entered into the model using restricted cubic splines for age, SF-12 PCS, and SF-12 MCS and interactions of sex with age and education.

Conclusion: It is concluded that patients with less cancer-related distress were more likely to favor quality of life over length of life. The direction of causation in this relationship cannot be inferred from these data.

Corresponding author:**Dr. Ahmad Bilal,**

Islamic International Medical College Rawalpindi (RIU)

QR code



Please cite this article in press Ahmad Bilal et al., *Analysis of Effects of Attitude towards Disease on Quality Of Life in Patients with Bone Tumors in Pakistan.*, Indo Am. J. P. Sci, 2019; 06(03).

INTRODUCTION:

Extremity soft tissue and bone sarcomas are a rare heterogeneous group of bone and connective tissue tumors. Their growth behavior and the biological grade of malignancy differ markedly between the histological subtypes. The prognosis and therapy options depend on the entity of the tissue. Fast histological diagnosis and grading are therefore essential for treatment decisions and improvement of patient's outcome [1]. The first line therapy for soft tissue sarcomas consists of wide margin surgery followed by radiotherapy, especially in the case of a primary high grade tumor in a respectable area. Patients with advanced cancer exist in a unique medical context in which they are facing mortality and may be considering treatment options that have significant potential for toxicity [2]. In addition, therapeutic choices are characterized by uncertain outcomes, and may be varied and complex, including supportive care alone, standard treatments (e.g. chemotherapy, radiation, biologic), and investigational approaches [3]. Quality patient decision making requires an adequate patient understanding of treatment options, including potential benefit and harm. The physician serves as the primary source of medical information for cancer patients as such, the communication between doctor and patient is of critical importance to quality decision making [4].

Adequate communication about the impact of treatment on quality of life is of particular importance given that patient preference for either quality of life or length of life can influence patient treatment decision making [5]. For example, among cancer patients with advanced disease, an individual's preference for length of life over quality of life is associated with treatment preference for chemotherapy over watchful waiting. Further, a number of socio demographic factors are associated with preference for quality or length of life. Preference for quality of life is associated with older age, and having no children [6]. In contrast, preference for length of life is associated with being young, having children, and good functional health status. Despite its

importance for cancer patient treatment decision making, few studies have explored how individual preference for quality or length of life influences the way in which patients wish their doctors to present prognostic and treatment-related information [7].

Aims and objectives

The main objective of the study is to analyze the effects of attitude towards disease on quality of life in patients with bone tumors in Pakistan.

METHODOLOGY OF THE STUDY:

This study was conducted in Islamic International Medical College Rawalpindi (RIU) during September 2018. This study was done for the analysis of quality of life of bone tumor patients in Pakistan. The data were collected through a prepared questionnaire. Participants were given a toll-free number for technical support and to ask any questions regarding the study. All participants provided written consent upon arrival for their physician appointments. These parameters were assessed with three items to determine the relative value that an individual assigns to quality of life (QOL) and quantity of life (LOL). This instrument, designed and refined based on prior research with the target population, asked participants to select from among 4 choices about whether QOL or LOL was more important.

Statistical analysis

We defined QOL and LOL preferences in two ways. We initially defined QOL vs. LOL preference based upon the single 4-point survey item that required patients to prioritize QOL and LOL.

RESULTS:

The data were collected from 100 patients of both genders. To develop the propensity score model, we used a multinomial logistic regression of the nominal three-category quality of life variable. The age, SF-12, education, sex, and race terms were entered into the model using restricted cubic splines for age, SF-12 PCS, and SF-12 MCS and interactions of sex with age and education.

Table 01: Relationship between communication preferences, distress, and LOL/QOL preference

	Total RIES	Adjusted Mean (SE)			p-value
	Correlation				
	p	QOL	Equal	LOL	p
I want the doctor to speak in a positive manner	0.096 p=0.040	3.65 (.09)	4.03 (.05)	4.19 (.09)	<.001
I want to hear general terms (for example, “the treatment is likely to work”) rather than statistics (for example, “the treatment has a 75% likelihood of working”).	0.034 p=0.468	3.22 (.12)	3.63 (.07)	3.76 (.12)	.002
I want the doctor to soften the blow when giving me bad news	0.321 p<0.001	2.17 (.10)	2.74 (.08)	2.93 (.16)	<.001
I want the doctor to speak to me in an emotionally supportive way	0.289 p<0.001	3.83 (.08)	4.15 (.04)	4.24 (.07)	<.001
I want to hear detailed statistics	0.074 p=0.112	3.87 (.10)	3.96 (.06)	3.81 (.10)	.358
I want the doctor to speak matter-of-factly (for example, give me the cold hard facts)	-0.217 p<0.001	3.92 (.10)	3.82 (.07)	3.88 (.10)	.721
I want to hear averages about people like me	0.034 p=0.463	4.05 (.07)	4.01 (.05)	4.01 (.10)	.910
I want to hear the doctor's opinion about my case in particular	-0.087 p=0.064	4.70 (.05)	4.66 (.04)	4.64 (.07)	.788

QOL, quality of life preferred; LOL, length of life preferred; Scores represent average responses, 1 = Strongly Disagree, 5 = Strongly Agree (standard deviation)

DISCUSSION:

There is great variability in cancer patients' preferences regarding the content and format of communication from their physicians. Matching communication to patient preferences contributes to quality patient decision making and satisfaction. Thus tools to assist physicians in identifying relevant patient preferences and guiding communication accordingly could improve clinical outcomes [8]. The data we present indicate that a values preference for length vs. quality of life may be simply measured, and is associated with a desire for more supportive and less pessimistic communication from the oncologist [9]. Communication skill in the cancer context is particularly critical given that patients are commonly facing mortality and “bad news,” treatment outcomes are characterized by uncertainty, and treatment is associated with significant potential for morbidity.

Previous reports have identified a variety of patient characteristics that bear on their wishes regarding physician communication. For example, women and patients with higher levels of educational attainment have been shown to want more detailed information about their prognosis [6]. Female gender is also associated with desire for a supportive communication style over a blunter approach, while patients with more education and older patients; have been shown to prefer a more fact-oriented style of communication) [10].

CONCLUSION:

It is concluded that patients with less cancer-related distress were more likely to favor quality of life over length of life. The direction of causation in this relationship cannot be inferred from these data. It is possible that increased distress is associated with

greater difficulty in processing quality of life issues when faced with a life-threatening illness, and therefore a focus on length of life is preferred.

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