Quality of life and hospital re-admission in patients with chronic obstructive pulmonary disease

L M Osman, D J Godden, J A R Friend, J S Legge, J G Douglas

Abstract

Background — There is some evidence that quality of life (QOL) in patients with chronic obstructive pulmonary disease (COPD) may predict clinical outcomes and use of resources. This study examined whether QOL scores could prospectively predict re-admission for COPD or death within 12 months of an original admission, and whether QOL scores predicted home nebuliser provision.

Methods — The study was carried out in all acute medical wards of Aberdeen Royal Infirmary, Woodend and City Hospitals, Aberdeen over 12 months. A total of 377 patients admitted with an exacerbation of COPD were identified in this time, 111 of whom were not included in the study because they refused the interview or died before discharge. The remaining 266 patients completed the St George’s Respiratory Questionnaire (SGRQ). Information on spirometric parameters, nebuliser provision at discharge, provision of domiciliary oxygen, and re-admission within 12 months was collected from patient notes.

Results — The mean age of the patients was 68 years and 53% were men. The mean (SD) forced expiratory volume in one second (FEV1) was 38.8 (18.0)% predicted and forced vital capacity (FVC) was 58.9 (23.8)% predicted. Higher (worse) scores on the SGRQ were significantly related to re-admission for COPD in the next 12 months (difference = 4.8, 95% CI 1.6 to 8.0). Patients who were re-admitted and died from COPD did not differ in SGRQ scores from those who were re-admitted and survived for more than 12 months. Re-admission was not related to sex, age, or pulmonary function. One hundred and thirty eight patients did not have a home nebuliser before admission. Of these, 14 were provided with a home nebuliser at discharge. Patients provided with nebulisers had significantly worse SGRQ scores and worse FVC. The 41 patients given domiciliary oxygen did not differ in SGRQ or spirometric parameters. Logistic regression analysis of the three SGRQ subscales (Symptom, Impact and Activity), adjusting for lung function, age and sex, showed that all three subscales were significantly related to hospital re-admission and that Impact scores were related to nebuliser provision. Women did not differ from men in Symptom scores on the SGRQ but differed markedly on the Activity and Impact scales.

Conclusions — It is concluded that poor scores on the SGRQ, a QOL scale which measures patient distress and coping, are associated with re-admission for COPD and use of resources such as nebulisers, independent of physiological measures of disease severity.

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Keywords: chronic obstructive pulmonary disease, hospital admission, quality of life.

Quality of life (QOL) scales assess the impact of illness and experience of health among individuals. These scales include general “well being” measures such as the Sickness Impact Profile (SIP) and the General Health Survey (SF-36) and measures especially designed for respiratory disease such as the Chronic Respiratory Questionnaire (CRQ) and the St George’s Respiratory Questionnaire (SGRQ). Respiratory QOL measures focus on the patient’s experience of symptoms, how far symptoms such as breathlessness limit daily life activity, and how much distress the disease causes the patient. Jones et al argue that QOL measures are particularly relevant to the management of patients with chronic obstructive pulmonary disease (COPD) because much of this care is palliative and directed to improving patients’ experience of health and well being.

Studies have found that QOL of patients with COPD improves after intervention such as taking part in pulmonary rehabilitation programmes. However, improvement in QOL does not correlate very strongly with changes in physiological indicators. The relation of QOL to improvement in exercise tolerance has varied in different studies. Wijkstra found that, while both QOL and exercise tolerance improved after rehabilitation, the improvements were not correlated. These weak relationships between QOL and physiological measures raise the question of whether QOL scores have real clinical significance. However, Traver found that, among patients with severe COPD, those who used more acute services had significantly higher QOL scores.
Table 1 Target population: all patients admitted over 12 months to Aberdeen hospitals with a diagnosis of COPD

<table>
<thead>
<tr>
<th>Description</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>St George’s interview</td>
<td>266</td>
</tr>
<tr>
<td>Refused interview</td>
<td>61</td>
</tr>
<tr>
<td>Not interviewed (deaf or confused)</td>
<td>12</td>
</tr>
<tr>
<td>Died during admission</td>
<td>38</td>
</tr>
<tr>
<td>Not identified during first 48 hours of admission</td>
<td>104</td>
</tr>
<tr>
<td>Total</td>
<td>478</td>
</tr>
</tbody>
</table>

Methods

The study was carried out during a 12 month audit (March 1991 to February 1992) of care of patients admitted with an exacerbation of COPD to any acute medical ward of hospitals in Aberdeen. Two respiratory nurses identified patients with COPD by contacting wards (in the respiratory unit and eight non-respiratory units) after their receiving days. From hospital computer records 478 patients had a primary discharge diagnosis of COPD during the study, of whom 101 were not identified during the first 48 hours of their hospital stay and not approached for interview. They did not differ from those studied in pulmonary function, age, or outcome over the following 12 months. The remaining 377 (79%) patients were identified for the study during their stay in hospital, 266 of whom completed the SGRQ (61 patients refused the interview, 12 were unable to be interviewed because of deafness (7) or confusion (5), and 38 patients died during their admission and were excluded from the analysis (table 1). This non-interviewed group also did not differ from those studied in pulmonary function, age, or outcome over the following 12 months. Data were collected from patient notes on spirometric indices, provision of nebuliser and domiciliary oxygen before admission and at discharge, and follow up after discharge. After one year all case records were re-examined for re-admissions and deaths.

The SGRQ contains 76 items which ask patients to review the past 12 months for frequency of respiratory symptoms, impact or distress caused to them by symptoms, and limitations of activity because of symptoms. Answers to SGRQ items are weighted and total SGRQ score and scores on the three subscales (Symptom frequency, Impact, and Activity) are calculated by adding these weights.17 Scores are then converted to percentages by dividing the weighted score obtained by the total possible weighted score. The higher the score the poorer the quality of life. A difference of 4% is taken to be clinically significant on the total or subscales. The results of the SGRQ were not made known to doctors during the study.

Statistical analysis was carried out using SPSS-PC. SGRQ scores were normally distributed and t tests were used to compare group means. Spearman correlation coefficients were calculated. Logistic regression was used to establish odds ratios for re-admission and nebuliser provision, adjusting for age, sex, and lung function (where patients did not have spirometric results mean substitution was used).

Results

The mean (SD) age of the 266 patients was 68 (9.1) years (range 44–92); 141 (53%) were men. There were 50 current smokers (19%), 194 former smokers (73%), 20 (8%) had never smoked, and for two patients this item was not answered. One hundred and eighteen patients (44%) were in the care of respiratory medicine consultants during their initial hospital admission and 148 in the care of consultants in...
other specialties. Spirometric tests were performed by 168 patients, mainly those in the care of respiratory specialists. The mean (SD) forced expiratory volume in one second (FEV₁) was 38.8 (18.0)% predicted and forced vital capacity (FVC) was 58.9 (23.8)% predicted. The mean (SD) SGRQ score was 52.7 (13.1), range 10.9–80.5 (table 2). COPD related causes) and those not re-admitted. The mean (SD) FVC (% pred) was 58.9 (23.8)% predicted. Scores for the three subscales showed that symptoms did not vary significantly more symptoms (table 6).

Seventeen patients were admitted to hospital and died from COPD in the 12 months following the audit. There was no significant difference in SGRQ score between these patients and those re-admitted for COPD who survived for 12 months (difference = 1.1, 95% CI 0.0 to 2.3, p = 0.01). These 17 deaths from COPD were grouped with the 92 COPD re-admissions as “re-admitted for COPD or COPD death in 12 months”. Another 23 patients either died from non-COPD causes (five cardiac failure, three carcinomas, one gastrointestinal haemorrhage) or died without a hospital re-admission in the following 12 months and with no stated cause of death in their notes. These patients had a better score on the SGRQ than all other groups (difference = 7.4, 95% CI 1.5 to 13.4, p = 0.01).

### Table 5 Correlations between SGRQ scores, lung function, and age

<table>
<thead>
<tr>
<th></th>
<th>SGRQ Total</th>
<th>SGRQ Symptoms</th>
<th>SGRQ Impact</th>
<th>SGRQ Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEV₁ (% pred)</td>
<td>0.07</td>
<td>-0.00</td>
<td>0.09</td>
<td>0.03</td>
</tr>
<tr>
<td>FVC (% pred)</td>
<td>-0.01</td>
<td>-0.04</td>
<td>0.04</td>
<td>-0.12</td>
</tr>
<tr>
<td>Age</td>
<td>-0.17**</td>
<td>-0.10</td>
<td>-0.19**</td>
<td>-0.07</td>
</tr>
</tbody>
</table>

FEV₁ = forced expiratory volume in one second; FVC = forced vital capacity.

### Table 6 Relationship between SGRQ scores and sex

<table>
<thead>
<tr>
<th></th>
<th>Men (n = 123)</th>
<th>Women (n = 115)</th>
<th>Difference</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SGRQ</td>
<td>51.1</td>
<td>56.2</td>
<td>5.1</td>
<td>1.9 to 8.2</td>
<td>0.001</td>
</tr>
<tr>
<td>SGRQ Symptoms</td>
<td>77.7</td>
<td>79.7</td>
<td>2.0</td>
<td>-5.7 to 1.6</td>
<td>0.28</td>
</tr>
<tr>
<td>SGRQ Impact</td>
<td>42.1</td>
<td>47.9</td>
<td>5.8</td>
<td>1.7 to 9.7</td>
<td>0.005</td>
</tr>
<tr>
<td>SGRQ Activity</td>
<td>52.1</td>
<td>58.3</td>
<td>6.2</td>
<td>2.9 to 9.9</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Logistic regression analysis was used to establish odds ratios for the relation between SGRQ subscales and re-admission and nebuliser provision. Odds ratios were adjusted for age, sex, and current smoking status.
for effects of age, sex, and lung function. For adjusted odds ratios, Symptoms, Impact and Activity were all significantly related to re-admission and Impact was also related to nebuliser provision (table 7).

Over the 12 months following the audit 55% of patients with nebulisers were re-admitted compared with 45% of patients without nebulisers (p<0.01). This difference was no longer significant when SGRQ score was controlled for in a logistic regression analysis.

Patients in the care of respiratory physicians did not differ in Symptom QOL but had worse Impact QOL (difference = 4.1, p = 0.03) and worse Activity QOL (difference = 3.2, p = 0.05) and were more likely to be re-admitted (53% versus 40%, p<0.05).

Table 7 Estimated odds ratios for re-admission or nebuliser provision on the subscales of the SGRQ

<table>
<thead>
<tr>
<th>SGRQ subscale*</th>
<th>Re-admission within 12 months (n = 238)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unadjusted OR (95% CI)</td>
</tr>
<tr>
<td>Symptoms</td>
<td>1.13 (1.03 to 1.25)</td>
</tr>
<tr>
<td>Impact</td>
<td>1.12 (1.03 to 1.22)</td>
</tr>
<tr>
<td>Activity</td>
<td>1.10 (0.99 to 1.25)</td>
</tr>
</tbody>
</table>

* Odds ratios show the effect of a five point change on each scale.

Patients with a home nebuliser were more likely to be re-admitted to hospital over the following 12 months but when we controlled for SGRQ score the relationship between nebuliser and re-admission was no longer significant, showing that the greater number of admissions among patients with a home nebuliser was not due to provision of a nebuliser per se. This illustrates how a valid QOL measure can be used to correct for differences between patients when investigating differences in outcome.

Assessing patient coping and the impact of disease on patients is a normal part of the clinical interview and it is not surprising that poor quality of life should be related to decisions to admit to hospital or to provide support such as home nebulisers. QOL measures can reflect this clinical assessment, but at present such measures do not have great enough sensitivity to be used as determinants of clinical decisions. Guyatt, however, found that patients were more reluctant to volunteer information about the emotional impact of illness than about symptoms, and he has suggested that QOL scales should provide a way of eliciting areas of distress for patients.

Poor QOL in patients with COPD has previously been linked to greater use of health resources and the study by Cox et al suggests that, when QOL improves, even though lung function does not, consultations and hospital admissions decrease. The results of our study are compatible with those of Cox et al in showing that poor QOL is associated with a greater chance of admission and of nebuliser provision. Thus QOL outcomes, even when there is no physiological improvement, may be important in assessing the success of interventions in patients with COPD. The SGRQ appears to distinguish patients who cope relatively well, despite having high symptom levels, and to show that this good coping has clinical con-

Discussion

These results show that patients with poor QOL are at greater risk of hospital re-admission after an initial admission and that patients are also more likely to be provided with home nebulisers if they have poor QOL. The results also suggest that patients are likely to be referred to respiratory specialists if they have poor QOL. We did not find that percentage predicted FEV<sub>1</sub> or FVC was related to re-admission within 12 months among this group of patients. The results of this study suggest that, in patients whose range of lung function is restricted, differences in QOL are more significantly related to clinical decisions and use of resources than are differences in pulmonary function.

QOL scales are designed to measure psychological impact and subjective experience of patients, but all QOL scales also have a symptom component. It might be the symptom measure component of the total score which predicts risk of admission to hospital rather than the more subjective components measuring distress and daily life limitation. Because the SGRQ provides separate subscale scores for Symptoms, Impact and Activity we were able to test which aspects of QOL best discriminated differences in outcome between patients. Although all scales showed differences between patients, the Impact subscale showed the largest differences in re-admission to hospital and nebuliser provision. Among this group of patients with COPD, all of whom had quite high symptom scores, those with greater distress and poorer coping were more likely to be re-admitted and provided with nebulisers. This was so, even though the patients were under the care of a large number of consultants in both respiratory medicine and other specialties.

Activity limitation as assessed by the Activity subscale of the SGRQ subscale was relatively poorly related to re-admission to hospital or nebuliser provision. The Activity scores did show that significant differences in self-perceived activity limitation exist between men and women and older and younger patients. Women with COPD feel they are more limited in activities than do men, and women experience greater distress from their illness without reporting any worse levels of symptoms. The patients who were relatively younger also showed most signs of suffering from the psychological impact of their disease. The greater distress caused by COPD to these groups has been previously reported.

Patients with a home nebuliser were more likely to be re-admitted to hospital over the following 12 months but when we controlled for SGRQ score the relationship between nebuliser and re-admission was no longer significant, showing that the greater number of admissions among patients with a home nebuliser was not due to provision of a nebuliser per se. This illustrates how a valid QOL measure can be used to correct for differences between patients when investigating differences in outcome.

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sequences. This therefore offers the possibility of using QOL scales to identify patients who cope poorly and directing interventions to them.

Ketelaars et al have recently shown the complex relationship that exists between the subscales of the SGRQ and measures of coping and physical performance. They have commented that “longitudinal studies are needed to disentangle the cause and effect relationships suggested by (their) findings”. The present study shows that, in a longitudinal study, QOL is associated with hospital admission in patients with moderate to severe limitations in lung function. We do not yet know how strongly QOL would predict hospital admission among a milder group of patients, but the studies previously described suggest that poor QOL plays a part in increasing risk of hospitalisation at all levels of physiological impairment. We conclude that the results of this study suggest an important area of research into patient experience of COPD and its impact on clinical decision making and the use of resources.

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