Perception of Quality of Life among Patients with Peripheral Arterial Disease in Jordan

Mona A Shuriquie[*], Mohammad H. Bani-Khaled, Raed M. Shudifat Eman H. Shaqdih, Amal Ramadneh

Abstract

Objective: Peripheral arterial disease is a common chronic cardiovascular disease that influences different aspects of quality of life.

Methods: This study aimed to explore the perception of quality of life of Jordanian patients with peripheral arterial disease who attended vascular clinics.

Material and Methods: This study was conducted in Vascular Clinic of King Hussein Medical center, Amman, Jordan, which is a 650 – bed referral hospital in Jordan during March 2014. Cross sectional research design was used to recruit 96 vascular patients who had intermittent claudication due to peripheral arterial disease. Data were collected using the Arabic translation of the Australian Vascular Quality of Life index.

Results: The majority of patients (n=65, 67.7%) were male patients. Their age ranged from 35 to 81 (mean 59±15.6). The results indicated that overall the patients in this study had fair quality of life. The total mean score obtained on the Australian Vascular Quality of Life index was 46.9 (±20.54). Patients who underwent surgical interventions scored more than patients who did not on the general health perception domain, the function, mobility and pain domain, and total quality of life. The only statistically significant difference was in the general health perception domain (t=2.17, p 0.034).

Conclusions: Jordanian patients with peripheral arterial disease reported fair quality of life. This might be due to the chronic nature of the illness which pervades all aspects of their life. The patients who underwent surgical intervention had significantly better general health perceptions. Further research examining various influences on perception of quality of life of peripheral arterial disease patients is needed.

Keywords: Peripheral arterial disease, quality of life, AUSVIQUOL, Jordanian patients.

(J Med J 2016; Vol. 50 (3):135-143)

Received	***Accepted***
Jan. 11, 2016	*May 29, 2016*

Introduction

Peripheral arterial disease (PAD) is a common chronic cardiovascular disease which causes significant impairment in function and reduces health-related quality of life.[1,2,3] Incidence and prevalence goes up with increasing age, especially rising to above 10% in the sixth and seventh decades of life.[4] There is an increased prevalence of peripheral arterial disease in individuals with diabetes mellitus, hypercholesterolemia, hypertension

1. Assistant Professor, Princess Muna College of Nursing, Mu'tah University.

**** Correspondence should be addressed to:***

Mona A Shuriquie PhD, RN; Princess Muna College of Nursing, Mu'tah University, Jordan.
P. O. Box: 143516, Amman 11814, Jordan
E-mail: mona_nsour@yahoo.com

and cigarette smokers.[5]

Atherosclerosis, causing chronic narrowing of arteries, is considered the leading cause of occlusive arterial disease of the extremities.[6] Narrowing of the arteries causes a reduction in blood flow which is not evident until there is an increase in the flow demands by the limb muscles. Exercise tolerance is reduced, with 10-35% of patients complaining of pain on exertion in the form of intermittent claudication and around 50% having a typical symptoms that limit exercise.[6] Intermittent claudication is characterized by pain sensation, cramps, fatigue, and walking difficulties.[7] Resulting pain has vast impact on activities of daily living and on the quality of life (QOL) of patients requiring adjustment to restrictions on their activities.[8] Indeed, patients with intermittent claudication in the general population have been reported to have lower QOL related to physical functioning when compared with those with no claudication.[9]

The goals of treatment in patients with PAD include not only management of the disease itself but also targets improving their QOL by helping them to live a productive and satisfying life.[10] The American Heart Association stresses the importance of measuring patient reported health status and goes on to explain that the assessment of health related quality of life (HRQoL) is a central component of health status.[11] This explanation is based on Wilson and Cleary's conceptual quality-of-life model which proposes that patient health status has three principal components: symptom burden, functional status, and HRQoL which all reflect how an individual perceives their functional limitations and overall impact of their health on their well-being.[12]

Notably, there is disagreement between inferred QOL status and actual QOL as perceived by patient. The health care team focuses more on physiological abnormality that may lead to disease and discomfort while the patient is more concerned with their overall sense of QOL which is only partially related to their clinical status.[10] Additionally, the symptoms and functional limitations of the disease and medical therapies impact the individual's well being in a different ways.[11] Therefore, in order to enhance our understanding of the outcomes of PAD and its treatment, it might be crucial to obtain information relating to HRQoL by patient self-report.

QOL is considered as one of the important indicators of health and well-being, it helps in evaluation of the effectiveness of treatment, the decisions on the priority of distribution of resources, and the development of policies[13]. Many components of QOL, such as social functioning and satisfaction, cannot be directly observed and therefore require special techniques drawn from the field of psychology and statistics. QOL questionnaires typically include generic questions about how patients are feeling or what they are experiencing. Examples to such tools are the SF-36,[14] QOL5[15] and Nottingham Health Profile.[16] QOL is a broad concept that reflects an individuals' perspective on the level of life satisfaction experienced in a variety of situations, including housing, health, recreation and environmental conditions. Whereas, HRQoL specifically refers to the impact of health and illness on physical, social functioning and psychological wellbeing, and is affected by mutable physical and psychosocial factors.[17] Disease-specific quality of life questionnaires are able to explore a particular range of problems and experiences met by patients suffering from a common condition such as PAD.[10]

Further research exploring the QOL of

patients with PAD and its related factors might be important for the delivery of patient centered care. Caring for the PAD patient is potentially a concern of the health care team and requires understanding of patients living with this chronic illness. Pain is a major concern for people with PAD and it negatively impacts the patients' mobility leading to limitations on their daily life which in turn might negatively affect their health related quality of life.[18]

Although, no studies were found in Jordan that address QOL of patients with peripheral vascular disease, there were few studies that studied QOL of patients with other diseases, such as cardiac diseases,[19] End Stage Renal Disease (ESRD),[20] and patients in medical surgical wards.[21] The findings of these studies indicated that patients had low[20] to moderate[19] QOL. Two of these studies reported that men have statistically significant higher QOL than women[19,21] while another study reported no statistically significant differences.[20]

This study was performed to explore the perception of QOL of Jordanian patients with PAD who attended vascular clinics and to identify if there were changes in the perception of QOL attributable to gender and surgical intervention. Findings of this study might support the health care team's understanding of various influences of PAD on patients' perception of QOL. Furthermore, this will help healthcare providers in delivering patient-centered care by providing information that might be used in designing strategies and policies targeting the improvement of QOL of PAD patients.

Materials and Methods

This study was conducted in the vascular clinic of King Hussain Medical Center, Amman, Jordan, which is a 650 – bed referral hospital during March 2014. Cross sectional research design was used to recruit 96 vascular patients (65 males and 31 females) who had intermittent claudication due to PAD and attended the vascular clinic at King Hussein Medical Center. The inclusion criteria were all patients who had claudication secondary to PAD. Patients who had communication problems due to organic brain disease were excluded from the study. A minimum sample of 82 patients was needed based on G*Power 3.1.7 software to achieve 80% power in detecting significant differences in the independent t test at significance level of .05 assuming a medium effect size (0.3). [22]

Descriptive comparative research design was used for conducting this study. Data collection was performed through face to face structured interviews. The items of this interview were composed of demographic questions and the Arabic translation of the Australian Vascular Quality of life index (AUSVIQUOL).[23] This instrument was designed specifically for vascular disease patients and is most appropriate for studying patients with intermittent claudication.[23] It includes three domains: general health perceptions (3 questions); function, mobility and pain (5 questions); and psycho-social aspects (2 questions). The whole questionnaire is composed of 10 questions with 5 choices for each question with total possible score ranging from zero (significant impairment in QOL within all dimensions) to 100 (no impairment in QOL). QOL categories of the AUSVIQUOL include: excellent 100, very good 80-99, good 55-79, fair 21- 54, and poor 0-20. Factor and regression analyses were used to compare the AUSVIQUOL and SF-36 scores; finding indicated that the validity of the AUSVIQUOL was similar to that of the SF-36.[23,24] AUSVIQUOL according to Cronbach's Alpha which revealed a good level of internal

consistency (Alpha = 0.8702) and demonstrated evidence of test-retest reliability.[23]

Permission to use and translate the instrument into the Arabic language was obtained from the authors of the AUSVIQUOL (Smith et al., 2007). The translation was done by two independent bilingual translators. The translated version was validated by a panel of three experts in the field of vascular specialty. Cronbach's Alpha of the translated tool demonstrated good internal consistency for the whole instrument (Alpha = 0.823) and Alpha was 0.798; 0.817 and 0.783 for general health perceptions; function, mobility and pain; and psycho-social aspects subscales respectively. Approval from the ethical committee of the Royal Medical Services in Jordan was obtained. The purpose of the study was explained to the prospective patients to ensure their voluntary participation. They were told that they have the right to participate or decline to participate in the study and that this would not affect their care in any way. Moreover, they had the right to withdraw from the study at any time. Promise of confidentiality was ensured throughout the whole course of the study. Before the questionnaire was used, a pilot study was carried out on 10 patients from the same population to pre-test the questionnaire. No modifications were needed.

Results

A total number of 96 patients with PAD participated in the study, more than two thirds (n=65, 67.7%) were male patients. Their age ranged from 35 to 81 (mean 59 ± 15.6). The majority of them were married (n=66, 68.8%), not working (n=82, 85.4%) and more than two thirds of the patients had a certain type of surgical intervention (n= 71,74%) as shown in Table 1.

Table 1. Sample Characteristics (n=96)

Sample Characteristics		N (%)
Sex	Male	65 (67.7)
	Female	31 (32.3)
Marital Status	Single	8 (8.3)
	Married	66 (68.8)
	Widowed	19 (19.8)
	Divorced	3 (3.1)
Work	Working	14 (14.6)
	Not Working	82 (85.4)
Diagnosis	FemPop bypass	35 (36.4)
	Femoral artery repair	16 (16.7)
	Popliteal artery repair	5 (5.2)
	Aortobifemoral bypass	15 (15.6)
	Embolectomy	2 (2.1)
	Lower limb ischemia	23 (24.0)
Duration since Diagnosis	Less than 6 months	28 (29.2)
	Between 6 months and 1 year	14 (14.6)
	Between 1 and 2 years	14 (14.6)
	Between 2 and 4 years	11 (11.5)
	Between 4 and 6 years	15 (15.6)
	More than 6 years	14 (14.6)
Surgical Intervention	Yes	71 (74.0)
	No	25 (26.0)

The results indicated that overall the patients in this study had fair QOL. The total mean score obtained on the AUSVIQUOL was 46.9 (±20.54) (see Table 2). There were no statistically significant differences between male and female patients on the three domains of QOL as well as on the total QOL (see Table 3).

Table 2. Patients' mean scores on the three domains of AUSVIQUOL scale and total QOL

Domains of QOL	Mean (SD)	Possible Range
General Health Perceptions	12.8 (±7.0)	0 -30
Function, Mobility and Pain	24.5 (±11.9)	0-50
Psycho-Social Aspects	9.6 (± 6.7)	0-20
Total QOL	46.9 (± 20.5)	0-100

Table 3. Comparison between male and female patients' scores on the three domains of AUSVIQUOL scale and total QOL

Domains of QOL	Male N =65 Mean (SD)	Female N =31 Mean (SD)	t	P value
General Health Perceptions	12.7 (± 7.3)	13.7 (±6.4)	-.725	.472
Function, Mobility and Pain	24.6 (± 11.5)	24.4 (±13.0)	.083	.934
Psycho-Social Aspects	9.7 (± 7.0)	9.4 (± 5.9)	.166	.869
Total QOL	46.7 (± 20.6)	47.5 (±21.0)	-.135	.893

Patients who underwent surgical interventions scored more than patients who did not on the general health perception domain, the function, mobility and pain domain, and total QOL. Patients, who did not undergo surgery, obtained a higher mean score on the psycho-social aspects domain. The only statistically significant difference was in the general health perception domain (t=2.17, p 0.034) (see Table 4).

Table 4. Differences between patients who underwent surgery and subject who did not

Domains of QOL	Operation Done N =71 Mean (SD)	Not Operated N =25 Mean (SD)	t	P value
General Health Perceptions	13.9 (± 6.8)	9.6 (± 6.8)	2.17	0.034*
Function, Mobility and Pain	25.3 (±11.6)	22.3 (± 12.8)	.829	.415
Psycho-Social Aspects	9.11 (± 6.1)	10.9 (± 7.4)	-.853	.403
Total QOL	48.4 (± 19.0)	42.9 (± 24.0)	.815	.424

*P < 0.05

Discussion

The majority of patients presenting to the vascular clinic at King Hussein Medical Center were seen previously and most of them had experienced a surgical intervention or embolectomy. Literature indicates that patients

with PAD are referred to vascular clinics when there is advanced atherosclerosis causing chronic narrowing of arteries, which might precipitate with acute thrombotic events.[6] The PAD spectrum ranges from intermittent claudication resulting in calf pain when walking to severe, chronic leg ischemia requiring arterial bypass.[10] This was represented in our sample, in which the majority of the patients recruited have had vascular interventions in the past (n=71, 74 %).

The mean age of the sample in this study was 59 years. This is relatively lower than the mean age of samples of other studies which looked at QOL and pain among PAD patients. For example Smith et al.[23] reported a mean age of ~73 years in Australia, and similarly Dumbille et al.[9] reported a mean age of ~ 76 years in UK, while Pedrosa et al.[25] reported a mean age of ~65 years in Brazil. The lower mean age in our study group may indicate that patients who attend the vascular clinics in Jordan are relatively younger. Indeed, evidence indicates that cardiovascular disorders affect younger age groups in the Middle East and North Africa. For example, more that 29% of men and 24% of women struck by ischemic heart disease were found to be less than 50 years old[26] in this region and on average died younger than most other regions in the world.[27]

No statistically significant differences between men and women in the general health perception domain, the function, mobility and pain domain, and total QOL were found in this study. The small sample size of women in this study might contribute to the absence of statistically significant differences between men and women patients. However, other studies found that women reported decreased physical functioning, more bodily pain, greater mood disturbances,[28] more walking impairment and lower general health[29] when compared to men. Moreover, studies which assessed QOL of patients with different diseases reported inconsistent findings; one study reported similar findings to the present study,[20] while two other studies reported that men have statistically significant higher QOL life women.[19, 21] .In this study, only a third of the sample was female and it is possible that a larger sample would have been needed in order to identify significant gender differences.

The results of this study indicated that patients had fair overall QOL. Previous studies which used the same scale to assess QOL reported that Australian vascular patients had good overall QOL and higher score in all the subscales than patients in this study.[23, 24] In the present study the patients' QOL related to function, mobility and pain domain had the highest score compared with other domains, this was explained by the fact that the majority of the patients in this study underwent a surgical intervention in order to improve blood flow to the limbs and treat intermittent claudication or limb ischemia. This finding supports previous evidence indicating that QOL parameters were higher among patients who underwent limb salvage surgery as compared to pre operative patients because peripheral arterial disease causes severe impairment of the QOL and arterial reconstructive surgery improves the QOL.[30]

Moreover, patients in this study who had undergone surgical intervention had higher mean scores in the total QOL and scored significantly higher in the general health perceptions domain than patients who did not have surgical procedures (p=0.034). This finding is likely the result of surgical

interventions having succeeded in reducing claudication and the accompanying ischemic pain previously experienced by patients hence the improved QOL and general health perceptions. This finding was supported by Dumville et al.[9] who point out that patients who are free from claudication have better health-related quality of life in the domain of physical health than those with intermittent claudication.

The results of this study indicate that Jordanian patients with PAD have fair scores in the three domains of QOL. All the three domains are interrelated with each other. Liles et al. found that patients with PAD have significant impairment in walking distance, functional status and the ability to complete activities of daily living and are at risk for emotional and social impairments such as depressive symptoms and impaired social role function.[10] Indeed, at the beginning of the disease the patient starts to complain of intermittent claudication which affects function and mobility domains, which will in turn influence the psycho-social domain and finally negatively impact QOL. Scoring fair scores on the AUSVIQUOL by our patients is in agreement with previous studies which indicate that PAD patients have lower QOL compared to the general population.[9,29] The low QOL among PAD patients may be attributed to many factors such as the nature of the disease, the poor prognosis, the absence of a complete cure and the loss of function or loss of limb.

Conclusion

The QOL of persons with PAD is affected by a number of interrelated factors. The results of this study indicated that patients with PAD have fair QOL. There were no statistically significant differences related to sex, work or marital status. The only statistical significance was found in the domain of general health perception between patients who underwent surgical intervention and patients who did not. Moreover, patients who underwent surgical intervention scored higher than patients who did not in the total QOL, but this difference was not statistically significant.

The results of this study have many implications for nurses in Jordan. Jordanian nurses need to assess the factors that reduce the QOL for patients with PAD and to implement measures that assist in enhancing patients' perception of QOL. These interventions must aim to the proper pain management, health education and encouraging the family's role in providing emotional and social support. It is recommended to replicate this study on a larger sample to enhance the generalizability of the findings. Recruitment of a larger sample with better female representation would enable better comparison in order to distinguish gender differences in QOL. Further research examining various influences on perception of QOL of peripheral arterial disease patients is needed.

References

1. de Graaff JC, Ubbink DT, Kools EJC, Chamuleau SAJ, Jacobs MJHM. The impact of peripheral and coronary artery disease on health-related quality of life. Ann Vasc Surg 2002; 16:495-500.
2. Issa SM, Hoeks SE, Scholte op Reimer WJ, et al. Health-related quality of life predicts long-term survival in patients with peripheral artery disease. Vasc Med 2010;15:163-9.

3. Wilson WR, Fitridge RA, Weekes AJ, Morgan C, Tavella R, Beltrame JF. Quality of life of patients with peripheral arterial disease and chronic stable angina. Angiology 2012; 63:223-8.
4. Criqui M. and Aboyans V. Epidemiology of Peripheral Artery Disease. Circulation Research. 2015; 116(9):1509-1526.
5. Tabereaux.P.B. Peripheral vascular disease. NEJM 2005; 344:1608-1621.
6. Haas TL, Lloyd PG, Yang HT, and Terjung RL. Exercise Training and Peripheral Arterial Disease. Compr Physiol. 2012 October; 2 (4): 2933-3017.
7. Norgren L, Hiatt WR, Dormandy JA, et al. Inter-Society Consensus for the Management of Peripheral Arterial Disease (TASC II). J Vasc Surg 2007; 45(Suppl S): S5-67.
8. Pedrosa DF, Siqueira HB, Gomez RR, Saltareli S, da Silva Tde C, Sousa FA. Evaluation of the perception of chronic ischemic pain in humans with peripheral arterial disease. J Vasc Nurs. 2014 Sep; 32 (3): 82-7.
9. Dumville JC, Lee AJ, Smith FB, and Fowkes GR. The health-related QOL of people with peripheral arterial disease in the community. British Journal of General Practice 2004; 54: 826-831.
10. Liles DR, Michael BA, Kallen A, Petersen LA, and Bush RL. Quality of life and peripheral arterial disease. Journal of surgical research 2006;136(2): 294-301.
11. Rumsfeld J.S., Alexander KP, Goff DC et al. Cardiovascular Health: The Importance of Measuring Patient-Reported Health Status: A Scientific Statement From the American Heart Association. Circulation 2013; 127:2233-2249.
12. Wilson IB, Cleary PD. Linking clinical variables with health-related quality of life: a conceptual model of patient outcomes. JAMA. 1995; 273: 59-65.
13. Karen, L., Kevin T., Fred B., Domenic J., Margaret M., Denise M. (2008). Comparison of health-related quality of life measures for chronic renal failure: quality of well-being scale, short form 6D, and kidney disease quality of life instrument. Qual. Life Res., 17 (8), 1103-1115.
14. Ware JE, and Sherbourne CD. The MOS 36-Item Short-Form Health survey (SF-36). I. Conceptual framework and item selection. Med Care 1992; 30 (6): 473e483.
15. Lindholt JS, Ventegodt S, Henneberg EW. Development and validation of QOL5 clinical databases. A short, global and generic questionnaire based on an integrated theory of the quality of life. Eur. J. Surg. 2002; 168: 103-107.
16. Hunt S, McKenna S, McEwan J, Williams J, Papp E. Nottingham Health Profile: subjective health status and medical consultation. Soc Sci Med 1981; 15a: 221-9.
17. Krasner DL, Rodeheaver GT, Sibbald RG. Chronic wound care: A Clinical Source Book for Healthcare Professionals. H M P COMMUNICATIONS LLC. 4th edition. 2007.
18. Johnstone CC. Living with peripheral vascular disease: a review of the literature. Prof Nurse. 2003; 18:446449.
19. Abu Hasheesh MO, Almostafa OY, Ahmad MZ. Health Related Quality of Life among Cardiac Disease Patients at Queen Alia Heart Institute. Jordan Medical Journal. 2010, Vol. 44 (3): 282-289.
20. Shdaifat EA, Abdul Manaf MR. Quality of Life of Caregivers and patients Undergoing Haemodialysis at Ministry of Health, Jordan. International Journal of Applied Science and Technology. 2012, Vol. 2(3); 75-85
21. Ahmad MM, Al-Daken LI, Ahmad HM. Quality of Life for Patients in Medical-Surgical Wards. Clinical Nursing Research. 2015, Vol. 24 (4); 375-387.
22. Faul, F., Erdfelder, E., Lang, A., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral and biomedical sciences. Behavior Research Methods, 39, 175-191.
23. Smith MJ1, Borchard KL, Hinton E, Scott AR. The Australian Vascular Quality of Life Index (AUSVIQUOL): an improved clinical quality of life tool for peripheral vascular disease. Eur J Vasc Endovasc Surg.2007 Aug; 34 (2):199-205.
24. Borchard KLA, Hewitt PM, Wotherspoon S, Scott AR. Australian Vascular Quality of Life Index (AUSVIQUOL): A Pilot Study of a Disease-Specific Quality of Life Measure.
25. Pedrosa DF, HB Siqueira, Gomez RR, Saltareli S, da Silva TC, Sousa FA. Evaluation of the perception of chronic ischemic pain in humans with peripheral arterial disease. J Vasc Nurs 2014; 32:82-87.
26. Moran AE, Tzong KY, Forouzanfar MH, Rothy GA, Mensah GA, Ezzati M, Murray CJ, Naghavi M.Glob Variations in ischemic heart disease burden by age, country, and income: the Global Burden of Diseases, Injuries, and Risk Factors 2010 study. Heart. 2014 Mar; 9 (1): 91-9.

27. Moran AE, Forouzanfar MH, Roth GA, Mensah GA, Ezzati M, Murray CJ, Naghavi M. Temporal trends in ischemic heart disease mortality in 21 world regions, 1980 to 2010: the Global Burden of Disease 2010 study. Circulation. 2014 Apr 8; 129 (14): 1483-92.
28. Oka RK, Szuba A, Giacomini JC, Cook JP. Gender differences in perception of PAD. Vascular Medicine 2003; 8: 89-94.
29. Collins TC, Suarez-Almazor M, Bush RL, Petersen NJ. Gender and peripheral arterial disease. J Am Board Fam Med.2006 Mar-Apr; 19 (2): 132-40.
30. Sechter M., Auslander G., Weinmann EE., and Bass A. Quality of life and social support following distal bypass in elderly patients. IMAJ 2003; 5: 322-325.

تصور جودة الحياة لدى مرضى الشرايين الطرفية في الأردن

منى عبد الحميد الشريقي، محمد هزاع بني خالد، رائد محمد شديفات، ايمان حسن شقديح، أمل رماضنة

كلية الأميرة منى للتمريض، جامعة مؤتة، الأردن

الملخص

خلفية: أمراض الشرايين الطرفية هي من أمراض القلب والأوعية الدموية الشائعة والمزمنة والتي تؤثر على مختلف جوانب جودة الحياة.

الهدف: هدفت هذه الدراسة إلى استكشاف تصور جودة الحياة لدى مرضى الشرايين الطرفية الذين يراجعون عيادات أمراض الأوعية الدموية.

الطريقة: أجريت هذه الدراسة في مستشفى تحويلي يحتوي على 650 سريراً في الأردن خلال شهر آذار 2014. تم استخدام التصميم البحثي المقطعي لإجراء الدراسة على 96 من المرضى الذين يعانون من العرج المتقطع الناتج عن أمراض الشرايين الطرفية. تم جمع البيانات باستخدام النسخة العربية من المقياس الاسترالي لجودة الحياة لمرضى الشرايين

النتائج:. غالبية المرضى كانوا من الذكور (ن=65, 67.7%). تراوحت أعمار المرضى ما بين 35-81 سنة (المعدل= 59±15.6). أظهرت النتائج بأن إجمالي المرضى في هذه الدراسة لديهم مستوى متوسط من جودة الحياة حيث كان متوسط جودة الحياة كان 46.9±20.54 حسب مقياس جودة حياة الشرايين الأسترالي. كما أظهرت النتائج بأن المرضى الذين خضعوا لتداخلات جراحية كان لديهم مستوى أعلى من جودة الحياة من المرضى الذين لم يخضعوا لتداخلات جراحية وذلك في مجال التصور العام للصحة, ومجال الوظيفة والحركة والألم وفي مقياس جودة الحياة الكلي إلا أن الفرق الوحيد الذي كان ذو دلالة إحصائية كان في مجال تصور الصحة العام (t=2.17, p 0.034).

الاستنتاجات: مرضى الشرايين الطرفية الأردنيون لديهم مستوى متوسط من جودة الحياة وقد يعزى ذلك إلى الطبيعة المزمنة لهذه الأمراض التي تتغلغل في جميع مناحي حياتهم. المرضى الذين خضعوا لتدخل جراحي لديهم تصور أفضل في مجال الصحة العام. هناك حاجة لإجراء مزيد من الدراسات لدراسة كافة المؤثرات التي قد تؤثر على جودة الحياة لدى مرضى الشرايين الطرفية.

الكلمات الدالة: أمراض الشرايين، أمراض القلب، الشرايين الطرفية، جودة الحياة، الأردن.