Prediction of Mortality in Type 2 Diabetes From Health-Related Quality of Life (ZODIAC-4)  

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OBJECTIVE — To investigate the relationship between health-related quality of life (HRQOL) and mortality in type 2 diabetes.

RESEARCH DESIGN AND METHODS — In 1998, 1,143 primary care patients with type 2 diabetes participated in the Zwolle Outpatient Diabetes project Integrating Available Care (ZODIAC) study. At baseline, HRQOL was assessed with the RAND-36 and, after almost 6 years, life status was retrieved. Cox proportional hazards modeling was used to investigate the association between HRQOL (continuous data) and mortality with adjustment for selected confounders (smoking, age, sex, diabetes duration, A1C, renal function, BMI, blood pressure, HDL cholesterol, and macrovascular complications).

RESULTS — The Physical Component Summary of the RAND-36 was inversely associated with mortality (hazard ratio [HR] 0.979 [95% CI 0.966–0.992]), as were two separate RAND-36 dimensions.

CONCLUSIONS — This study found that HRQOL is an independent marker of mortality and emphasizes the importance of looking beyond clinical parameters in patients with type 2 diabetes.

A mong others, hypertension and dyslipidemia are well-known clinical risk factors in type 2 diabetes and should be treated accordingly (1). However, studies in nondiabetic populations have also found that factors like worse health-related quality of life (HRQOL) are associated with higher mortality (2–4). If this holds true for patients with type 2 diabetes, clinicians might have to give more attention to HRQOL and perhaps assess HRQOL routinely in these patients. This study is, to our knowledge, the first one investigating the relationship between HRQOL and mortality in type 2 diabetes.

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Abbreviations: HRQOL, health-related quality of life; PCS, physical component summary; ZODIAC, Zwolle Outpatient Diabetes project Integrating Available Care.

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the PCS score led to an increase of the hazard of mortality of 2.1%. A total of 145 (32.4%) of 448 patients with PCS scores below the median died vs. 69 of 449 (15.4%) with PCS scores above the median (a 2.1 ratio) (Fig. 1). The MCS score was not associated with mortality (1.008 [0.994–1.022]).

For separate RAND-36 dimensions, significant relationships were found for “physical functioning” (HR 0.989 [95% CI 0.982–0.996]) and “general health perception” (0.982 [0.971–0.994]).

For cardiovascular mortality, results remained significant for physical functioning (HR 0.987 [95% CI 0.977–0.996]). HRs for general health perception and PCS were 0.967 [95% CI 0.967–1.000] and 0.982 (0.964–1.001), respectively.

CONCLUSIONS — Worse HRQOL is associated with higher overall mortality in patients with type 2 diabetes in 6 year follow-up after taking potential confounders into account. Patients with low versus high HRQOL (PCS score) have a 2.1-fold increased mortality risk. Two separate RAND-36 dimensions, physical functioning and general health perception, were related to mortality. The former has questions about ability to perform physical activities, the latter questions about patients’ opinion about their health in general. Physical functioning was also associated with cardiovascular mortality.

Limitations of this study were that 25% of patients did not fill in or complete the questionnaire. However, this was strongly related to mortality and has therefore probably led to an underestimation of the effects of HRQOL on mortality (7).

Acknowledgments — This study was presented in abstract form at the 43rd Annual Meeting of the European Association for the Study of Diabetes, Amsterdam, the Netherlands, 17–21 September 2007 and published as an abstract in Diabetologia 50 (Suppl. 1): S71, 2007.

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