
Analysis of Quality of Life in Studies in Patients with Chronic Viral Hepatitis C

Ismailova Nilufar Bahodirovna, Yusupova Moyigul Jamolbek qizi
Urgench State University Masters students in Psychology

Annotation: The article discusses the history and content of the emergence of the concept of quality of life in medicine, the analysis of the quality of life of patients with hepatitis C in psychological research.

Keywords: chronic hepatitis C, quality of life (QOL), psychological, physical, social and spiritual well-being, nosology, asthenia, dysfunction, neurocognitive disorders.

The impact of chronic hepatitis C (CHC) infection on health-related quality of life (HRQoL) has been the subject of scientific research as a problem for the past decade. An analysis of the complexity of the disease, its chronic effects, and aspects of quality of life (QOL) that may affect treatment has shown that QOL can affect and alter the outcome of the disease [1].

The history of research on the concept of quality of life began to emerge in the late nineteenth century. Its origin is reflected in the principle "Treat the patient, not the disease" developed by the medical professor of the military academy SP Batkin [2, 72p].

The term "quality of life" (QOL) first appeared in Western philosophy. He then quickly entered various fields of science. The history of QOL research in medicine began in 1949 with the publication of Prof. D.A. Karnovsky's article "Clinical Assessment of Patient Status" [p. 3,67]. This work was the beginning of a comprehensive study. The term was officially recognized in medicine in 1977 [4,140b]. In the 1980s and 1990s, the study of quality of life began in various nosologies (part of medicine that studies the criteria used to diagnose disease, describing and studying disease for classification) [5,6,473-478p]. Analyzing the social context of the emergence of the category of "quality of life", it can be seen that its emergence is associated with a change in the type of social development and the position of the individual in society.

Currently, the quality of human life is being studied in various fields of science. is to bring it closer to the level of healthy people in practice. In psychology, special attention is paid primarily to the affective and cognitive components of quality of life [7,1-34p], in economics - the level of well-being and security, and in ecology - the state of the environment. In this regard, the quality of life is defined differently.

According to Russian authors, health-related quality of life is a psychological, social, including life-sustaining conditions and health status that allows for physical, mental, social well-being and self-awareness. is a complex of physical and spiritual well-being [8,245-258p].

A.A. Nakov describes quality of life as an integral feature of physical, psychological, emotional, and social activity based on the subjective perception of a healthy or sick person (Novik A.A. et al., 1999). V.N. Bobkov, on the other hand, interprets quality of life as the level of development and satisfaction of a highly developed set of needs and interests of

people. He considers quality of life as a socio-economic category [9,487p].

Quality of life encompasses all aspects of human life. Local scientist A.I. Subbeto defines quality of life as a system of spiritual, material, socio-cultural, ecological and demographic components of life. In this system, the level of a person's general strength, the creative meaning of his life is revealed [10,416p].

Researchers in the Department of Quality of Life at the University of Toronto describe quality of life as "the degree to which a person enjoys important opportunities in their own lives."

According to WHO experts, quality of life is "a position in society in the context of an individual culture and value system, a society in which the individual's goals, plans, capabilities and overall level of deterioration. Qol criteria and their components are:

- physical (strength, energy, fatigue, pain, discomfort, sleep, rest);
- Psychological (positive emotions, feelings, thinking, learning). memorization, concentration, self-esteem, appearance, negative experiences
- degree of independence (daily activities, ability to work, treatment and dependence on drugs);
- social life (personal relationships, social values, sexual activity);
- environment (welfare, safety, life, safety, availability and quality of medical and social security, access to information, opportunities for training and development, leisure, ecology) [12,29p]. Its components can include psychological well-being, social well-being, physical well-being, and spiritual well-being.

Thus, this concept is subjective and multidimensional, encompassing physical and professional functions, psychological state, social interactions, and somaticity. [13,11-23p].

There are various general and disease-specific scales for measuring HRQoL in patients with chronic hepatitis C. These include SF-36, Hepatitis Quality of Life Survey (HQLQ), Chronic Liver Disease Survey (CLDQ), Liver Disease Quality of Life Survey (LD QOL), and Liver Disease Symptoms Index 2.0 (LDSI 2.0). These instruments assess HRQoL from a patient perspective. They include time-consuming questionnaires and are more widely used in research than in clinical settings. In hepatitis C, quality of life, including the physical, mental, and social effects of the disease, is measured by a somatic assessment of symptoms: psychological state, social relationships, physical, cognitive, and psychosocial activities, feelings of well-being, and emotional states [14,227-234p]. In particular, the study of the quality of life of patients with hepatitis C from different perspectives allows to determine the patient's outlook on life. An objective material study of the quality of life, which allows us to consider the biological, physical and material aspects of quality of life, the functional side, with the help of which man interacts with socio-economic, cultural and ecological "spaces" allows assessment in terms of needs and abilities; structural-social, reveals the quality of the "spaces" themselves (material, spiritual and social) (Subbeto A.I., 1994).

A systematic review of 15 recent studies comparing HRQoL in patients with HCV with healthy people has shown that HCV infection often impairs vitality, overall health, physical function, and social function. In patients with hepatitis C, QOL was significantly reduced globally, especially in the field of social relations, and the lowest rate in the social relations component in terms of quality of life was returned. Low quality of life in this area may reflect the impact of hepatitis diagnosis, as chronic infections such as hepatitis may limit social attitudes in some respects. There is a statistically significant correlation between these

figures, which means that low incomes and low levels of education are associated with poorer living standards. Together with such socio-demographic variables, diseases have a significant impact on the global living conditions of patients with hepatitis [15]. Recent research on social habits suggests that simultaneous consumption of tobacco and alcohol by patients with hepatitis C, especially depression, fatigue, difficulty sleeping, and loss of interest in sex, has a significant negative impact on their QOL. 'revealed the mystery [16,714-720p]. Patients diagnosed with liver disease were less likely to drink [17]. Sharing the experience of one's own illness by talking to other patients with CHC and the fact that those around the patient feel uncomfortable knowing his or her diagnosis of CHC also contribute to a decline in quality of life [18]. Hepatitis C virus disease is one of the most common complaints that have a profound effect on health-related quality of life (HRQoL) - fatigue, depression and neurocognitive deficits. HCV can directly affect cognitive impairment, although the mechanism is unknown. One possibility is that HCV can act on the central nervous system [19,307p] because the replicating virus is found in nervous system tissue [20,151p] and the brain is a suitable site for HCV replication. may have neurotoxic effects [21]. In previous studies, approximately 20 percent of patients with non-cirrhotic HCV showed cognitive deficits related to attention and concentration, psychomotor speed, mental flexibility, visual scanning, and observation, whereas nearly half of patients had excessive time to perform this task. demanded. about 30% of tasks and patients made multiple errors. Other symptoms of chronic hepatitis C that reduce HRQoL include sexual dysfunction [22]. Men with hepatitis are more likely to have sexual dysfunction than women. In a small study involving women, 22 women reported sexual dysfunction in 50% of patients compared to 43% in the general population. The most commonly reported problems were lack of sexual desire (55%) and difficulties with arousal (50%) and orgasm (59%). In patients with chronic HCV infection, the prevalence of sexual dysfunction in men can be up to 47%, and the rate of erectile dysfunction can be up to 39% [23,175-179p].

Even without liver disease, hepatitis C has a profound negative impact on physical and mental well-being. In a classical study to determine normative data for short form 36 (SF-36), the most widely used HRQoL assessment tool, 2489 out of 9332 respondents reported a long-lasting illness. Indicators of SF-36 in all eight areas of physical and mental health were approximately 10–20 points lower in patients with chronic disease than those without disease, indicating a persistent impairment of well-being as a result of chronic disease. [24, 67p]. We can compare this figure with other chronic diseases. In an international comparison of the effects of various chronic conditions on HRQoL, physical and general health indicators were significantly reduced by 7–12 points compared to arthritis, chronic lung disease, congestive heart failure, diabetes, and coronary heart disease, and mental health ranged from 2–5 points. Was a passer-by [25,283p]. It is known that HCV infection also has a significant effect on mental health, with the average mental health score decreasing by 10–12 points (mean decrease: 7–13 points) [26,806p].

Decreased energy, insomnia, suppression of emotional reactions, the impact of the disease on the daily lives of patients are the main reasons for the decline in quality of life. Also, often patients suffer from inability to do paid work (jobs) and participate in public life due to illness, inability to have a good rest, restriction of sexual life, etc. Studies on gender differences in patients with chronic hepatitis C have shown that women with infection have a lower quality of life than men. The main reasons for poor quality of life for women are: pain, emotional background, sleep, as well as social isolation. Women are more concerned about the need for regular treatment and activity restrictions. Also, physical health and physical activity in patients with hepatitis were better in men than in women. Social relationships were also better in men than in women. However, women scored higher on the SF-36 score in role

limitation due to physical health, emotional well-being, social activity, pain, and general health [28]. Due to the long duration of the virus in the body, the need for diet is also the most common cause of depression in patients with hepatitis C. In addition, poor general health and quality of life can lead to asthenia (Greek asthenia - helplessness) - nervous weakness; the patient is moody, tired, emaciated, sleep deprived, cries; autonomic nervous system function is impaired; it is a headache for a long time. It is one of the cases observed during the recovery period from infectious diseases), which leads to their social adaptation. This is confirmed by a decrease in social activity in the majority of patients with chronic hepatitis C.

Studies in the age-related features of the decline in quality of life of patients with hepatitis C show that adolescents and young people with chronic hepatitis C have less pronounced physical pain than older patients and are less likely to experience it on a daily basis. is distinguished by its secret. Decreased quality of life has been found to be more common in younger patients with social and psychological disruption. Also, the main criterion for deteriorating quality of life for young patients with an average age of 17-31 years with a disease duration of less than 5 years is associated with social isolation and restriction of sexual life, which in the social environment for young patients shows the importance of forming and establishing different relationships [29,56-59p]. Age-specific characteristics make it difficult to provide medical care to young patients The data obtained allow to recommend the involvement of social work specialists and psychologists in providing comprehensive care to patients of this age group. Unmet needs and stigmatizations for information and support also had a significant impact on patients 'quality of life. According to patients, this can be achieved by providing better education and information, raising awareness of the need for patient support, and raising awareness of liver disease among the general population to reduce misconceptions and stigma.

In conclusion, regardless of the etiology, the quality of life of patients with liver disease deteriorates. It is associated with the development of the disease, the presence of symptoms, response to treatment and anxiety, mental, physical and social factors such as confusion, joint disease and fatigue, as well as limitations in daily life, including loneliness, low income, stigmatization and treatment costs. may be related to factors [30]. We can take the basic rules of the concept of quality of life as a universal criterion for assessing the basic functional state of a person. This criterion, in turn, includes at least four components of well-being: physical, psychological, social, and spiritual. Here, the quality of life associated with health is the subjective assessment of people, the factors that determine their current health, health and efforts to improve it; is the ability to achieve and maintain a level of activity that allows people to achieve their life goals and reflects their level of well-being. (According to the 1995 concept of quality of life) [32,46-52b]. Hence, quantitatively, overall health contributes to the overall measure of physical health and vitality to the overall measure of mental health. Correspondence to the mental and physical components of overall health and vitality indicates a qualitative contribution of each to the overall dimension of the other scale [33,790–800].

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