

The Relation between Life Quality and Angina Pectoris Patients in Hospitals in Kirkuk City

العلاقة بين نوعية الحياة والذبحة الصدرية للمرضى في مستشفيات مدينة كركوك

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الخلاصة

خلفية البحث: الذبحة الصدرية هي مرضيطلق للتعبير عن آلام الصدر أو عدم الراحة بسبب مرض القلب التاجي. الذبحة الصدرية هي عرض من أعراض حالة تسمى نقص تروية عضلة القلب. وهو يحدث عندما لا تحصل عضلة القلب على الكمية الكافية التي تحتاجها من الدم. يحدث هذا عادة بسبب تضيق أو انسداد في واحد أو أكثر من شرايين القلب (الأوعية الدموية التي تزود عضلة القلب بالدم).

الهدف: تقييم نمط حياة المرضى المصابين بالذبحة الصدرية في مستشفيات مدينة كركوك.

منهجية البحث: استخدمت الدراسة النمط الكمي (دراسة وصفية) ، أجريت في مستشفيات أزاوي التعليمي ومستشفى كركوك العام في مدينة كركوك لتقييم نوعية الحياة لمرضى الذبحة الصدرية. فترة الدراسة كانت من العشرين من تشرين الأول لسنة ٢٠١٥ إلى الخامس عشر من اب لسنة ٢٠١٦. وتكونت العينة عمدية من (١٠٠) مريض تم جمع (٧٢) عينة من مستشفى أزاوي تعليمي و (٢٨) من مستشفى كركوك العام في وحدة العناية المركزية. ولجمع معلومات الدراسة المطلوبة فقد بنى الاستبيان معتمدا على استمارة الاستبانة التابعة لمنظمة الصحة العالمية. يتألف الاستبيان من جزأين: تضمن الجزء الأول (٨) فقرات ركزت على الصفات الديموغرافية وتشمل (العمر، الجنس، السكن، الحالة الاجتماعية، المهنة، التحصيل الدراسي، فترة الإصابة بالذبحة الصدرية، والأمراض المزمنة المرافقة). والجزء الثاني تضمن (٥) فقرات رئيسية شملت (البدنية ، الاجتماعية ، النفسية، الاستقلالية و الروحية). وكان مجموع الفقرات (٩٠) فقرة، واستخدم مقياس يتألف من ثلاث إجابات معيارية في تقدير المقياس : الرقم (٣) دائما والرقم (٢) أحيانا، والرقم (١) أبدا. تم تحليل البيانات باستخدام الوسائل الاحصائية (التكرار ، النسبة المئوية،الوسط الحسابي ، الانحراف المعياري ، اختبار تائي ، اختبار انوفا).

النتائج: المجموعة العمرية (٤٠-٤٩ و اكثر من ٧٠) سنة تمثل النسبة المئوية الأعلى في مستشفيات بنسبة (٢٦ ٪). المرضى كانوا ذكورا أكثر في المستشفيات وتمثل بنسبة (٦٠ ٪). كذلك اظهرت النتائج بان بعض العوامل الديموغرافية وتشمل (العمر-الوظيفة و فترة الإصابة بالذبحة الصدرية) كانت أكثر تأثيرا على الفقرات الرئيسية وهي (البدنية ، الاجتماعية ، النفسية، الاستقلالية و الروحية).

الاستنتاج: استنتجت الدراسة ان عوامل العمر والحالة الزوجية والأمراض المزمنة كلها عوامل كان لها تأثير مباشر على جودة حياة مرضى الذبحة الصدرية. الجانب البدني من أكثر الجوانب المتأثرة بنمط حياة مرضى الذبحة الصدرية.

التوصيات: توصي الدراسة بأنشاء برامج رياضية وتعليمية لتحسين شعور المرضى وكذلك تعزيز الصحة وتقليل الاعراض بأنواع برامج وممارسات صحية وإدارة ترميضية مناسبة لمنع حدوث المضاعفات لدى مرضى الذبحة الصدرية .
الكلمة المفتاحية: نمط الحياة، الذبحة القلبية.

Abstract

Background: Angina pectoris is disease for chest pain or discomfort due to coronary heart disease. Angina is a symptom of myocardial ischemia. It occurs when the heart muscle (myocardium) doesn't get as much blood as it needs. This usually happens because one or more of the heart's arteries (blood vessels that supply blood to the heart muscle) is narrowed or blocked.

Objectives: The aim of the study was to assess the quality of life in angina pectoris patients

Methodology: Quantitative design (Purposive study) was used in the study, the study was conducted at Azadi Teaching Hospital and Kirkuk general hospital in Kirkuk city to assess quality of life toward Angina pectoris patients. The period of the study was carried out from 20th of October in 2015 to 15th of August in 2016. A nonprobability (purposive) sample was selected. It consisted of (100) patients (72) sample was collected from Azadi teaching hospital and (28) Kirkuk general hospital from the units of critical care. In order to collect the data required a questionnaire was constructed depending on the criteria of WHO scale. It consists of two parts; part one included (8) items which focused on the client demographic characteristics which include (age, gender, residence, marital status, occupation, educational level, duration of the angina and Concomitant chronic diseases). Part two is composed of (5) domains that covered physical, social, psychological, level of independence and spiritual domains. The overall questions included (90) items. 3-likert scale options was used in the rating scale as: (Always = 3) , (Sometimes = 2) , (Never = 1) .

Result: The result of present study revealed that high percent (26%) the study sample at age (40-49 and >70) years old. In relation to gender, the majority of the patients are males and account (60%). The data analysis show that some demographic data include (age, occupation and duration of angina) are more common significant (effected) on the physical, social, psychological, independence and spiritual domains.

Conclusion: Age, married, chronic disease and monthly income variables are the most socio-demographic variables that were associated with direct effect on quality of life among angina pectoris patients. Physical domain is the most aspects of life among angina pectoris patients that were associated with many socio-demographic variables.

Recommendation: Exercise training results in improvement of symptoms, increase in the threshold of ischemia, and improvement of patients' sense of well-being. However, before enrolling a patient in an exercise-training program, perform an exercise tolerance test to establish the safety of such a program. Promoting best health practices and early optimal nursing management of angina pectoris to minimize damage and prevent complications.

Keyword: Quality of life, Angina pectoris.

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Introduction

Angina pectoris is a cardiac-induced pain arising from a lack of myocardial oxygen, not only do 10.2 million Americans have this condition and approximately 500,000 new cases of angina occur each year, but ischemic heart disease is the leading cause of death in the United States. Moreover, the lifetime risk of developing coronary artery disease (CAD) after 40 years of age is estimated at 49% for men and 32% for women⁽¹⁾.

Angina results when there is an imbalance between the heart's oxygen demand and supply. This imbalance can result from an increase in demand (e.g., during exercise) without a proportional increase in supply (e.g., due to obstruction or atherosclerosis of the coronary arteries). However, the pathophysiology of angina in females varies significantly as compared to males. Non-obstructive coronary disease is more common in females⁽²⁾.

The risk factors for angina pectoris include; Age (≥ 45 years for men, ≥ 55 for women), cigarette smoking, Diabetes mellitus, dyslipidemia, family history of premature cardiovascular disease (men <55 years, female <65 years old), hypertension, Kidney disease (microalbuminuria or $GFR < 60$ mL/min), Obesity (BMI ≥ 30 kg/m²), Physical inactivity and Prolonged psychosocial stress⁽³⁾.

Angina pectoris can be quite painful, but many patients with angina complain of chest discomfort rather than actual pain: the discomfort is usually described as a pressure, heaviness, tightness, squeezing, burning, or choking sensation. Apart from chest discomfort, angina pains may also be experienced in the epigastrium (upper central abdomen), back, neck area, jaw, or shoulders, also patients suffering from insistent quality shortness of breath, pallor diaphoresis, dizziness, light, headiness, nausea, and vomiting⁽⁴⁾.

Complication of angina pectoris is Acute pulmonary edema, heart failure, cardiogenic shock, dysrhythmias and cardiac arrest, myocardial infarction. Diagnosing angina pectoris; the provider will do a physical exam and check your blood pressure. The provider may hear abnormal sounds, such as a heart murmur or irregular heartbeat, when listening to your chest with a stethoscope⁽⁵⁾.

Because heart disease is often the cause of most forms of angina, you can reduce or prevent angina by working on reducing heart disease risk factors By: Quitting smoking, Monitoring and controlling other health conditions, such as high blood pressure, high cholesterol and diabetes, Eating a healthy diet low fat and salt, maintaining a healthy weight, Reducing stress level⁽⁶⁾.

QOL is multidimensional evaluation of individual's current life circumstances in the context of the culture in which they live and the values they hold. QOL is primarily a subjective sense of wellbeing encompassing physical, psychological, and social and spiritual dimensions. In some circumstances, objective indicators may supplement or, in

the case of individuals unable to subjectively perceive, serve as proxy assessment of QOL (7).

Objectives of the study:

1. To assess the quality of life for patients with Angina pectoris according to physical, social, psychological, independence and spiritual domains.
2. Identifying the relationship between some characteristics of patients with angina pectoris diseases and the quality of life after angina pectoris patients.

Methodology:

Quantitative design (Purposive study) was used in this study; the study was conducted at Azadi Teaching Hospital and Kirkuk general hospital in Kirkuk city to assess quality of life toward Angina pectoris patients. The period of the study was carried out from 20th of October in 2015 to 15th of August in 2016. A nonprobability (purposive) sample was selected. It consisted of (100) patients (72) sample was collected from Azadi teaching hospital and (28) Kirkuk general hospital from the units of critical care. A questionnaire was constructed depending on the criteria of WHO scale (9), questionnaire and related literature review. It consists of two parts:-

1. **Part I: Demographical Data Form:** This part was concerned with the determination of the demographic characteristics of the patients through a designated sheet which consists of (7) items.
2. **Part II: Quality of Life Questionnaire:** This part was developed from the quality of life scale which was constructed by the World Health Organization (9). It consists of (5) domains and (16) sub-domains.

Rating scale as :(Always = 3), (Sometimes = 2) , (Never = 1).

Data were analyzed through the application of descriptive statistical data analysis approach (frequency, percentage, mean, Standard deviation) and inferential statistical analysis (Independent t-test and Analysis of variance (ANOVA)). Statistical Package for Social Science (SPSS) version (20) was used for data analysis and the significance level was (P. value \leq 0.05).

Results:

Table(1):Distribution of the Socio-Demographic Characteristic of the Study Sample. N:100

Variables		Frequency	Percentage
Age	20-29 years	2	2.0
	30-39 years	5	5.0
	40-49 years	26	26.0
	50-59 years	25	25.0
	60-69 years	16	16.0
	> 70 years	26	26.0
Gender	Male	60	60.0
	Female	40	40.0
Residence	Urban	59	59.0
	Rural	41	41.0
Marital status	Single	4	4.0
	Married	64	64.0
	Divorced	15	15.0
	Widowed	17	17.0
Level of education	Illiterate	20	20.0
	Read and write	28	28.0
	Primary school graduate	14	14.0
	Secondary school graduate	21	21.0
	Institution graduate	15	15.0
Occupation	College and above graduate	2	2.0
	Retired	10	10.0
	Civil work	11	11.0
	jobless	31	31.0
	Housewife	34	34.0
	Employed	14	14.0
Concomitant with Chronic disease	DM	9	9.0
	Hypertension	26	26.0
	Asthma	2	2.0
	Renal disease	4	4.0
	None	29	29.0
Duration of angina	More than two disease	30	30.0
	< 1 year	28	28.0
	1-2 years	45	45.0
	3-5years	23	23.0
Hospital	> 6 years	4	4.0
	Kirkuk	28	28.0
	Azadi	72	72.0
Total		100	100%

This table indicated the socio-demographic characteristics of the whole study sample. The table shows that the highest percentage of age groups is between (40-49 years and > 70 years) and constituted (26.0%), and according to gender, the high percent was of males and constituted of (60%). With regard to residence (59.0%) were living in urban areas, most of the patients were married and constituted (64.0%), (28.0%) of the sample were to read and write, with regard to occupation, (34.0%) patients were housewife. One-third of the patients had more than two chronic diseases and constituted (30.0 %). With respect to the duration of angina, most of the sample (45.0 %) had a period of angina (1-2) year

Table (2): Variance for the Differences among angina Patient's QoL Domains, Sub-Domains in respect to their Age.

Categories	S.O.V.	Sum of Squares	D.F	Mean Square	F	Sig.
Physical domain	Between Groups	481.050	5	96.210	4.239	0.002
	Within Groups	2133.700	94	22.699		
	Total	2614.750	99			
Social domain	Between Groups	44.833	5	8.967	0.884	0.495
	Within Groups	954.007	94	10.149		
	Total	998.840	99			
Psychological domain	Between Groups	183.084	5	36.617	2.559	0.032
	Within Groups	1345.276	94	14.311		
	Total	1528.360	99			
Independence domain	Between Groups	263.566	5	52.713	1.396	0.233
	Within Groups	3549.474	94	37.760		
	Total	3813.040	99			
Spiritual domain	Between Groups	112.198	5	22.440	2.649	0.028
	Within Groups	796.162	94	8.470		
	Total	908.360	99			

(S.O.V.: Source of Variance)(D.F: Degree of freedom)(F:Frequency)(sig: significant)

Table (2) demonstrates that there is significant difference in physical, psychological and spiritual domains with respect to the patient's age at P. Value ≤ 0.05 .

Table (3): Association of QoL Domains, Sub-Domains of angina Patients in regard to their Gender.

Categories	Mean Difference	t-value	df	Sig.	95% of C.I. Lower	Upper
Physical domain	1.54167	1.478	98	0.961	-0.52776	3.61110
Social domain	0.97500	1.514	98	0.764	-0.30337	2.25337
Psychological domain	1.17500	1.474	98	0.561	-0.40726	2.75726
Independence domain	0.35833	0.282	98	0.786	-2.16739	2.88405
Spiritual domain	0.67500	1.093	98	0.312	-0.55081	1.90081

Table (3) indicates that there are no significant differences in all domains with respect to the patient's gender at P. Value ≤ 0.05 .

Table (4): Association of QoL Domains, Sub- Domains of angina Patients in regard to their Residence .

Categories	Mean Difference	t-value	df	Sig.	95% of C.I.
Physical domain	-0.25482	-0.237	95	0.849	-2.39145 1.88180
Social domain	-0.03114	-0.048	95	0.115	-1.32461 1.26233
Psychological domain	-0.4868	-0.059	95	0.413	-1.68444 1.58708
Independence domain	-1.29211	-1.002	95	0.498	-3.85155 1.26734
Spiritual domain	-0.21184	-0.136	95	0.991	-1.03940 1.46308

Table (4) indicates that there are no significant differences in all domains with respect to the patient's residence at P. Value ≤ 0.05 .

Table (5): One-way Analysis of Variance for the Differences among angina Patient's QoL Domains, Sub- Domains in regard to their marital status.

Categories	S.O.V.	Sum of Squares	D.F	Mean Square	F	Sig.
Physical domain	Between Groups	200.597	4	50.144	1.973	0.054
	Within Groups	2414.153	95	25.412		
	Total	2614.750	99			
Social domain	Between Groups	109.547	4	27.387	2.926	0.039
	Within Groups	889.293	95	9.361		
	Total	998.840	99			
Psychological domain	Between Groups	96.499	4	24.125	1.601	0.131
	Within Groups	1431.861	95	15.072		
	Total	1528.360	99			
Independence domain	Between Groups	37.974	4	9.494	2.39	0.825
	Within Groups	3775.066	95	39.738		
	Total	3813.040	99			
Spiritual domain	Between Groups	27.664	4	6.916	746	0.404
	Within Groups	880.696	95	9.290		
	Total	908.360	99			

Table (5) presents that there are significant differences in physical and social domains in regard to the patient's marital status at P. Value ≤ 0.05 .

Table (6): One-way Analysis of Variance for the Differences among Angina Patients QoL Domains, Sub-Domains in Respect to Level of education.

Categories	S.O.V	Sum of Squares	D.F	Mean Square	F	Sig.
Physical domain	Between Groups	64.569	5	12.914	479	0.793
	Within Groups	2550.181	94	27.130		
	Total	2614.750	99			
Social domain	Between Groups	81.240	5	16.248	1.664	0.151
	Within Groups	917.600	94	9.762		
	Total	998.840	99			
Psychological domain	Between Groups	161.572	5	32.314	2.222	0.058
	Within Groups	1366.788	94	14,540		
	Total	1528.360	99			
Independence domain	Between Groups	207.188	5	41.438	1.080	0.376
	Within Groups	3605.852	94	38.360		
	Total	3813.040	99			
Spiritual domain	Between Groups	35.993	5	7.199	776	0.570
	Within Groups	872.367	94	9.280		
	Total	908.360	99			

Table (6) depicts that there are significant differences in psychological domain with regard to the patient's level of education at P. Value ≤ 0.05 .

Table (7): One-way Analysis of Variance for the Differences among Angina Patients QoL Domains, Sub- Domains in Respect to Patients Occupation.

Categories	S.O.V	Sum of Squares	D.F	Mean Square	F	Sig.
Physical domain	Between Groups	75.680	4	18.920	708	0.588
	Within Groups	2539.070	95	26.727		
	Total	2614.750	99			
Social domain	Between Groups	42.870	4	10.717	1065	0.378
	Within Groups	955.970	95	10.063		
	Total	998.840	99			
Psychological domain	Between Groups	107.438	4	26859	1.796	0.136
	Within Groups	1420.922	95	14.957		
	Total	1528.360	99			
Level of independence domain	Between Groups	30.532	4	7.633	192	0.942
	Within Groups	3782.508	95	39.818		
	Total	3813.040	99			
Spiritual domain	Between Groups	35.233	4	8.808	958	0.434
	Within Groups	873.127	95	9.191		
	Total	908.306	99			

Table (7) reveals that there is no significant difference in all domains in regard to the patient's occupation at P. Value ≤ 0.05 .

Table (8): One-way Analysis of Variance for the Differences among angina Patients QoL Domains, Sub- Domains in respect to Patients with Chronic Disease .

Categories	S.O.V	Sum of Squares	D.F	Mean Square	F	Sig.
Physical domain	Between Groups	403.762	5	80.752	3.433	0.007
	Within Groups	2210.988	94	23.521		
	Total	2614.750	99			
Social domain	Between Groups	59.658	5	11.932	1.194	0.318
	Within Groups	939.182	94	9.991		
	Total	988.840	99			
Psychological domain	Between Groups	150.546	5	30.109	2.054	0.078
	Within Groups	1377.814	94	14.658		
	Total	1528.360	99			
Independence domain	Between Groups	286.015	5	57.203	1.525	0.190
	Within Groups	3527.025	94	37.522		
	Total	3813.040	99			
Spiritual domain	Between Groups	111.824	5	22.365	2.639	0.028
	Within Groups	796.536	94	8.474		
	Total	808.360	99			

Table (8) demonstrates that there is significant difference in physical and spiritual domains in respect to the patient's chronic disease at P. Value ≤ 0.05 .

Table (9): One-way Analysis of Variance for the Differences among Angina Patients QoL Domains, Sub- Domains of angina in Respect to Patient's duration Angina.

Categories	S.O.V	Sum of Squares	D.F	Mean Square	F	Sig.
Physical domain	Between Groups	79.339	3	26.446	1.001	0.396
	Within Groups	2535.411	96	26.411		
	Total	2614.750	99			
Social domain	Between Groups	36.500	3	12.167	1.214	0.309
	Within Groups	962.340	96	10.024		
	Total	998.840	99			
Psychological domain	Between Groups	14.444	3	4.815	.305	0.821
	Within Groups	1513.916	96	15.770		
	Total	1528.360	99			
Independence domain	Between Groups	89.768	3	2.923	.772	0.513
	Within Groups	3723.272	96	38.784		
	Total	3813.040	99			
Spiritual domain	Between Groups	52.624	3	17.875	2.008	0.118
	Within Groups	854.736	96	8.904		
	Total	908.460	99			

Table (9) reveals that there is no any significant difference in all domains in regard to the patient's duration of angina at P. Value ≤ 0.05 .

Discussion:

The Socio-demographic data which presented in table (1) revealed that the age group of (40-49) years and (>70 years) considered the highest percentage (26%) of the sample. The reason of this finding may be caused by the impact of different life style and unhealthy behaviors and choices results in many of the chronic diseases in this age, our study agreement with Muslim and Shia (2014) they found that the majority of the sample were (40-49) years which form (88.5%)⁽¹⁰⁾. In relation to gender, the majority (60%) of the patients are males. The percentage of smoker male are higher compared to the women, lack of regular exercises, use of drug, coffee, obesity, stress, diet, family history, high levels of fat and cholesterol in the blood, high blood pressure, and a high level of sugar in the blood (due to insulin resistance or diabetes) can damage the coronary arteries. Also sedentary life style. The increase in heart disease among post-menopausal women could be due to a decline in estrogen. Estrogen appears to have a positive effect on the inner layer of the artery wall, keeping blood vessels flexible. This allows them to relax and expand to accommodate blood flow ⁽¹¹⁾.

The current study is agreement with another study of Farah and Mark (2009) who found that (71.0%) of Angina pectoris patients were male and (29.0%) of them were females ⁽¹²⁾.

With regard to residence, (59.0%) patients are living in urban areas, this because nature of urban as higher amount of pollution than rural, also increased factors which help to cause diseases (such as chemical, waste and air pollution, crowded area). Pollution is also believed to have inflammatory effects on the heart, causing chronic cardiovascular problems. Medical researchers are particularly concerned about pollution particles smaller than 2.5 microns, which are usually related to fuel combustion. Because they are so tiny, they aren't easily screened and more readily enter the human body. Then they begin to irritate the lungs and blood vessels around the heart. Data suggest that over time, pollutants aggravate or increase the process of disease in the arteries.

Concerning marital status, the majority of the patients were married and accounted for (64.0%) The disease can usually affect individuals between the age (40-49 and >70 years) when these individuals were already married, The Study show agreement with the study of Rusmita, et al,(2008) they found that the majority of patients were married (73.0%)⁽¹³⁾. With regard to educational level, most of the patients can read and write (28.0%). This finding is due to that education is considered the cornerstone for awareness of any disease which may have impact upon the patients understanding of the disease process, treatment and prognosis. Also, the importance of education for patients with Angina pectoris to understand the disease, control its pain and other symptoms, as well as decrease complications ⁽¹⁴⁾ This study is in agreement with Abdul-Rahman study (2013), who found that most of the Angina pectoris patients were able to read and write (29.2%)⁽¹⁵⁾. As for occupation, the majority of the patients were housewives and accounted (34.0%), this finding is due to the nature of the sample as females, suggest that women with cardiac disease are more likely to be confronted with continuing demands in the home environment than men, and may be more likely to neglect health care needs, The current study agrees with muslims and shia (2014) who found that housewife form higher percent (51.5%)⁽¹⁰⁾. In relation to concomitant chronic diseases the study shows that (30%) of patients had more than two chronic diseases, this result are in disagree with Abdul-Rahman study (2013), who's emphasized that (27%) of patients had Atherosclerosis⁽¹⁵⁾. As for the duration of the angina, most of patients (45.0%) have the disease since (1-2) years, this finding due to the time period represented the usual course through which the disease initiated its absolute effect upon the human body. To ascertain the absence or presence of association between socio-demographic characteristics of patients and the quality of life among them, the tables (2-9) demonstrates many significant statistical differences in some domains of the quality of life among patients in regard to some attributes of the patients. The study shows that there is a significant statistical association with physical domains in regard to the patient's age, patient's marital status at $P \leq 0.05$. They suffered from pain discomfort, energy and fatigue, sleep and rest, and health Care insufficient. The severity of Angina based on the precipitating activity and its effect on the activity of daily living ⁽¹⁶⁾, The disorder of sleep may be due to the Anxiety especially at night that the insomnia may be due to problem leads to inability to sleep especially at night make the patient so tired and Anxious⁽¹⁷⁾. Concerning insufficient health care, the finding may explained by the fact that health care services provided by the health care system are not efficient and do not take in consideration the needs of the patients, which is reflected in the health problem that occurred to them. Also, it was noticeable that the patients didn't gain the appropriate care that leads to the improvement of their quality of life. Our study findings reveals that there is a significant statistical association in regard to the patients marital status at $P \leq 0.05$ The reason is probably because of recurrent nature of disease and lack of appropriate control of symptoms⁽¹⁸⁾. Work disability starts early in the course of Angina pectoris as a result of functional impairment and fatigue. Patients seem to have greater impairment in areas of social and physical functioning, and general health perceptions, it may generate limits on their involvement in work, in social events and on being as an active family member in terms of initiating sexual relationship and household role, severe relative to stress and depression with a highly significant relationship with fear and anxiety. Angina disease can severely limit mobility and level of participation in activities; creating increased social stress. People may find themselves unable to function normally in everyday situations or unable to maintain the

level of functioning that they had previously been used. The chronic stress and pain may affect one's mind and body manifesting itself psychologically as depression, generalized anxiety disorder, panic attacks, fear, and decreased overall well being (18). The findings show that because the impact of different life style and unhealthy behaviors and can result results in many chronic diseases (19). Patients had making a conscious effort to reduce patterns of worrying thoughts. This was sometimes difficult thoughts as patients were returning home to manage the same stressful situations that they had left. In some ways this belief has the potential to shift the focus of control away from the victim. This may be a significant factor at a time when there is considerable emphasis on patient's successfully self-managing chronic conditions which requires considerable motivation. Patients may have fears that they may not be able to care for themselves or families. They may fear that nobody will love them. Friends and family will abandon, or they will become overwhelmed and alone. These changes and fears can lead to anxiety or depression. Also patients fear of death due to the high mortality of the disease and not having the sufficient medication for a complete treatment of the disease. Patients think about the progression and complications of the disease, economic state and loss of ability to do their usual activities of daily life, together with the lack of family support, social activity and emotional enforcement (19).The study findings reveal that there is no significant statistical association in all domains at $P \leq 0.05$ in angina pectoris patient's in the level of independence. This may not affect all of patients but some of them due to the nature of our sample and their age from (40-49) and (more than 70). The greatest problem was the variability is difficult to plan walking activity as part of one's daily routine. Also complained of physical symptoms which discouraged them from walking such as; breathlessness, swollen feet, dizziness and excessive tiredness. Moreover, sensory impairments limited their physical functioning. The study findings reveal that there is a significant statistical association in spiritual domains with regard to age and concomitant chronic disease at $P \leq 0.05$. Patients suffered from spiritual effect, hope and future problems. Poor mental and emotional health scores in patients with early Angina pectoris. They may be explained by greater dissatisfaction with the loss of life's roles. Because of a long term of medication in the life, the patients feel no hope to complete recovery from the illness. Also because there is low role in the society and with family due to the complication and progressive fear that pain may lead to MI or death. Presence of the spouse as a support can be effective in decreasing tension, disability and adaptation with the disease (20).

Conclusion:

1. The main age group of angina pectoris patients (40-49 years and more than 70).
2. Males to females ratio is 6:4.
3. Health problems related to quality of life of angina pectoris patients differ according to physical, social , psychological, Independence land spiritual domains with more effect on the quality of life of angina pectoris patients when compared to the angina patients.
4. Age, married, chronic disease and monthly income variables are the most socio-demographic variables that were associated with direct effect on quality of life among angina pectoris patients.
5. Physical domain are the most aspects of life among angina pectoris patients that were associated with many socio-demographic variables.

Recommendation:

1. Constructing of educational programs regarding health care, and health status can promote an appropriate body weight, regular physical activities to improve patients life adaptation and psycho - social support.
2. Offering psychological interventions (for example, relaxation, stress management and cognitive coping skills) to help people with angina pectoris adjust to living with their illness.
3. Providing patients with booklets containing information about angina pectoris, exercises' programs in the home and guidance's
4. healthy lifestyles, self-management and activities of daily living, to optimize health outcomes for people with angina pectoris.
5. providing posters , booklet to improve young adult individuals should be oriented about all factors which considered as a confirmed risk for (AP).

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