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Background.

Aseptic necrosis of the femoral head is a chronic polyetiologial disease with a prevalence of 1.4–3.0 per 100,000 adults worldwide [1]. This progressive disease is characterized by severe pain syndrome and joint dysfunction, resulting in the patients' disability [2]. Aseptic necrosis of the femoral head (ANFH) is 2–3 times more common in younger men than in women. The problem of interaction between ANFH and mental disorders is of interest according to modern research [3-6]. It has been found that in ANFH, altered brain activity is detected in the areas associated with pain, emotion, and consciousness [7], which proves the impact of joint disease on the formation of non-psychotic mental disorders (NMD). Objective evaluation of the results of treatment of hip joint diseases should be based not only on clinical indicators, but also include subjective information from patients with the study of the quality of life [8]. Health-related quality of life (QL) is an important primary endpoint in the care of patients with chronic diseases. Health-related QL can be used to assess health quality, diagnose the nature, severity, and prognosis of a disease, and evaluate treatment outcomes [9].

The purpose of the study. To examine the quality of life in patients with ANFH and non-psychotic mental disorders.

Materials and methods.

During this study, one hundred and thirty-seven patients diagnosed with ANFH, who received treatment at the MI "Dnipropetrovsk Regional Clinical Hospital named after I.I. Mechnikov DRC" from February 2016 to December 2018 were initially examined. The study was approved by the DSMU ethics committee, and patients gave written consent.

Patients diagnosed with ANFH at the age of 18 years were the subject of the study. The exclusion criteria were as follows: acute and/or chronic somatic and/or neurological diseases, mental disorders of the psychotic register, age under 18 years, refusal of the patient to be examined by a psychiatrist. A total of 137 patients were included in the study, 96 (70%) of whom completed the study and 41 (30%) dropped out due to refusal to continue participation in the study. Patients in the first clinical group (39.6%) included participants with up to 5 years of ANFH; those in the second (60.4%) had more than 5 years.

Patients diagnosed with ANFH and NMD were examined using the Beck Depression Inventory (BDI-II) and the Beck Anxiety Inventory (BAI) to confirm the leading syndrome. The cut-off point for depression was 21 points; for anxiety it was 14 points. Quality of life was assessed using the SF-12v2 quality of life survey. The SF-12 survey is constructed with questions taken from each of the 8 measures of the SF-36 interviewee examination. It is designed to have similar characteristics to the SF-36 survey, but it takes much less time to fill. As a result, the SF-12 survey provides two final scores: the Mental Component Summary (MCS) and the Physical Component Summary (PCS). The average score on both subscales is 50 points with a standard deviation of 10 points.

Patients were compared on the basis of non-psychotic mental disorders associated with ANFH duration up to 5 years and ANFH duration over 5 years. To form a rational attitude to the existing disease in patients with ANGSK, taking into account the general principles of psychotherapy as the primary method of psychotherapeutic influence, we used the forms of individual rational psychotherapy. In our opinion, the advantage of this technique is the ability to achieve significant positive changes within a short time and a small number of sessions. At the inpatient stage of treatment, a course of rational psychotherapy with elements of psychoeducation was prescribed. The course of treatment consisted of 2 sessions of psychotherapy using the technique of rational behaviour-oriented therapy lasting up to 40 minutes. In individual rational psychotherapy, we used methods of clarification, persuasion, distraction, and directive techniques involving the doctor's charisma and knowledge. Patients received treatment in stage 3-4 ANFH when they needed hip arthroplasty.

The original research data were transferred to an electronic database. Statistical analysis was performed using the STATISTICA software for Windows 6.1. During statistical processing, the results did not correspond to a normal distribution. The distribution type was assessed using the Shapiro-Wilk test. In calculating statistical variables, we calculated the median (Me) and 1-3 quartiles (Q1-Q3). To estimate the probability of the difference between the median values the Mann-Whitney test was used. Statistical significance in differences between qualitative and ordinal features was determined by Pearson's chi-square test (χ2), in particular with Yates' correction for continuity, or by Fisher's exact test. Differences associated with the indicators were assessed using the Wilcoxon test. To assess the probability of the difference, the generally accepted in biomedical research level of probability (p) – p<0.05 was taken into account.

Results and discussion.

The first clinical group consisted of 38 patients with ANFH duration up to 5 years (mean age 45.9±11.3), among whom men predominated (26 persons, 68.4%). The second main clinical group consisted of 58 patients with ANFH duration of more than 5 years (mean age 54.6±10.2), among whom men dominated (37 people, 63.8%). The demographic features of the patients are shown in Table 1.

The examined patients were diagnosed with the following syndromic variants of non-psychotic mental disorders: anxiety-
phobic – 17.7% (17/96), anxiety-depressive – 30.2% (29/96), depressive-hypochondriac – 16.7% (16/96), astheno-depressive – 18.7% (18/96) and astheno-apathetic syndrome – 16.7% (16/96). The characteristics of mental disorders in groups are presented in Table 2.

The study of quality-of-life indicators revealed that the examined patients have a lower quality of life compared to the average population indicator (50±10 points) [10]. While a lower index of the physical component of quality of life is predicted on the basis of the existing somatic symptoms, a decrease in the mental component of quality of life is an indicator of the influence of the NMD (Table 3). The obtained data indicate that quality of life deteriorates with increasing duration of ANFH, with the mental component more so than the physical one. This reflects the impact of a chronic illness on the mental life of an individual.

The obtained data are consistent with the results of Hampton et al. [4], who found that patients with ANFH experience a number of psychological problems that ultimately reduce their quality of life. Similar results were found in the study by Vardhan et al. who found that in patients with ANHF with unilateral lesions the mean SF-12 scores were 49.5±6.9 (PCS) and 47.4±11.5 (MCS), and with bilateral lesions – 46.5±7 and 39.6±12.5, respectively [11]. According to preliminary studies, it was found that the mental component of quality of life in patients with ANFH is also reduced and ranges from 38.9 to 45.3 [12,13], but these results were obtained using a similar but different measure, the SF-36. NMD even without existing somatic pathology have a negative impact on the quality of life [14]. Therefore, the combination of a severe somatic disease, usually manifested at working age and accompanied by a pronounced pain syndrome and a significant decrease in mobility (ability to move) and NMD has a cumulative impact on quality-of-life indicators [15]. This necessitates early intervention in NMD [16], since with increasing of ANFH duration professional functioning, self-care and independent functioning, ability and motivation for interpersonal communication deteriorate.

According to the data of the analysis of the dynamics of the quality-of-life indicators in patients with ANFH under the influence of the carried out NMD correction, the following features were revealed (Table 4). In the first main group, the physical component of quality of life improved by 3.25 points (p<0.05), the mental component changed positively by 6.4 points (p<0.05). In the second main group, the physical component of quality of life improved by 4.55 points (p<0.05), the mental component of quality of life changed positively by 10.55 points (p<0.05).

### Table 1. General characteristics of groups.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>MG1 Me (Q1-Q3) / n</th>
<th>%</th>
<th>MG2 Me (Q1-Q3) / n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>41.5 (37;55)</td>
<td>55.5 (50;61)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>68.4</td>
<td>37</td>
<td>63.8</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>31.6</td>
<td>12</td>
<td>36.2</td>
</tr>
<tr>
<td>Marital status</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>29</td>
<td>76.3</td>
<td>36</td>
<td>62.1</td>
</tr>
<tr>
<td>Single</td>
<td>7</td>
<td>18.4</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td>Divorced / widowed</td>
<td>2</td>
<td>5.3</td>
<td>20</td>
<td>34.5</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>7</td>
<td>18.4</td>
<td>6</td>
<td>10.3</td>
</tr>
<tr>
<td>Technical school</td>
<td>18</td>
<td>47.4</td>
<td>23</td>
<td>39.7</td>
</tr>
<tr>
<td>Higher</td>
<td>13</td>
<td>34.2</td>
<td>29</td>
<td>50.0</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>37</td>
<td>81.6</td>
<td>46</td>
<td>79.3</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>18.4</td>
<td>12</td>
<td>20.7</td>
</tr>
</tbody>
</table>

### Table 2. Non-psychotic mental disorders in patients with ANFH.

<table>
<thead>
<tr>
<th>Leading syndrome</th>
<th>MG1 (n)</th>
<th>%</th>
<th>MG2 (n)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>anxiety-phobic</td>
<td>14</td>
<td>36.8</td>
<td>3</td>
<td>5.2</td>
</tr>
<tr>
<td>anxiety-depressive</td>
<td>7</td>
<td>18.4</td>
<td>22</td>
<td>38.0</td>
</tr>
<tr>
<td>depressive-hypochondriac</td>
<td>3</td>
<td>7.9</td>
<td>13</td>
<td>22.4</td>
</tr>
<tr>
<td>astheno-depressive</td>
<td>8</td>
<td>21.1</td>
<td>10</td>
<td>17.2</td>
</tr>
<tr>
<td>astheno-apathetic syndrome</td>
<td>6</td>
<td>15.8</td>
<td>10</td>
<td>17.2</td>
</tr>
</tbody>
</table>

### Table 3. Quality of life indicators in the surveyed groups before treatment (M (SD)).

<table>
<thead>
<tr>
<th>Indicators</th>
<th>MG1</th>
<th>MG2</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCS</td>
<td>42.72 (8.16)</td>
<td>38.60 (6.86)</td>
<td>0.001</td>
</tr>
<tr>
<td>MCS</td>
<td>43.46(9.00)</td>
<td>36.55(10.34)</td>
<td>0.001</td>
</tr>
</tbody>
</table>
The dynamics of the quality of life depending on the chosen method of treatment are shown in table 5. A reliable increase in indicators of the physical and mental components of the quality of life before and after treatment was established, regardless of the selected method of treatment of NMD. The obtained data indicate that when combining pharmacotherapy and psychotherapeutic interventions in the provision of care to patients with NMD with ANFH, the mental component of quality of life improves more in comparison with pharmacotherapy alone.

When analyzing the dynamics of indicators of the mental component of quality of life (Table 6) in the context of the available leading psychopathological syndrome, it should be noted that increasing the duration of the disease negatively affects the quality of life, and even persons with the leading astheno-apathetic syndrome, for whom a decrease in MCS is not typical with duration of ANFH up to 5 years, have corresponding problems (decrease is 31%). When analyzing MCS dynamics, it should be noted that not all patients were able to achieve average-population levels of QL; for example, with the duration of ANFH up to 5 years, patients with leading anxiety-phobic and astheno-depressive syndromes did not reach a score of 50±10. The situation is different in patients with more than 5 years duration of ANGBC disease. None of the variants of the leading psychopathological syndromes reached the average population level after treatment.

Treatment of presenting psychiatric symptoms in patients with pathologies of large joint is recommended by the National Institute for Health and Care Excellence (NICE) [17].

In general, positive dynamics of the characteristics of the quality of life after the correction of NMD was noted in both main groups. In this study, we confirm the findings of Mariconda et al. [13]: they found that patients after treatment of hip joint diseases have a worse than normal quality of life, but they still have a better functional level and work capacity than untreated patients.

Conclusions.
Patients with ANFH and NMD have a significant decrease in quality of life on all indicators. Longer duration of ANFH disease significantly impaired the mental component of quality of life. In the presence of anxious-depressive or depressive-hypochondriac syndromes, it is possible to restore the mental component of QL to a normal level. The developed intervention measures reliably improve the mental component of QL when ANFH duration is more than 5 years.

REFERENCES

Table 4. Dynamics of quality-of-life indicators in the course of treatment depending on the duration (M(SD)).

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Before treatment</th>
<th>After treatment</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>Q1-Q3</td>
<td>M (SD)</td>
</tr>
<tr>
<td>MG1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCS</td>
<td>43.46 (9.0)</td>
<td>36,94-46,47</td>
<td>49.89 (5.6)</td>
</tr>
<tr>
<td>PCS</td>
<td>42.72 (8.2)</td>
<td>40,37-48,8</td>
<td>45.97 (5.6)</td>
</tr>
<tr>
<td>MG2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCS</td>
<td>36.55 (10.3)</td>
<td>30,1-41,9</td>
<td>47.10 (6.1)</td>
</tr>
<tr>
<td>PCS</td>
<td>38.60 (6.9)</td>
<td>33,9-44,22</td>
<td>43.15 (5.0)</td>
</tr>
</tbody>
</table>

Table 5. The dynamics of quality-of-life indicators during treatment depending on the treatment method.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Before treatment</th>
<th>After treatment</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Me</td>
<td>Q1-Q3</td>
<td>Me</td>
</tr>
<tr>
<td>GP1 (n=53)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCS</td>
<td>40,16</td>
<td>35,62-46,71</td>
<td>49,07</td>
</tr>
<tr>
<td>PCS</td>
<td>41,80</td>
<td>34,28-47,06</td>
<td>44,08</td>
</tr>
<tr>
<td>GP2 (n=43)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCS</td>
<td>35,86</td>
<td>31,27-41,89</td>
<td>45,16</td>
</tr>
<tr>
<td>PCS</td>
<td>41,36</td>
<td>36,02-45,49</td>
<td>44,78</td>
</tr>
</tbody>
</table>

Table 6. Dynamics of indicators of the mental component of quality of life in the course of treatment depending on the leading syndrome.

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>MG1 Before</th>
<th>After</th>
<th>MG2 Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>anxiety-phobic</td>
<td>39.2±6.3</td>
<td>47.6±3.4*</td>
<td>45.3±4.2</td>
<td>46.8±1.1</td>
</tr>
<tr>
<td>anxiety-depressive</td>
<td>44.8±4.6</td>
<td>50.4±5.1</td>
<td>37.3±8.9</td>
<td>47.3±6.0*</td>
</tr>
<tr>
<td>depressive-hypochondriac</td>
<td>48.4±15.8</td>
<td>52.2±8.2</td>
<td>29.9±10.8</td>
<td>44.9±5.8*</td>
</tr>
<tr>
<td>astheno-depressive</td>
<td>39.3±6.1</td>
<td>47.3±3.9*</td>
<td>39.7±3.0</td>
<td>47.9±5.3*</td>
</tr>
<tr>
<td>astheno-apathetic syndrome</td>
<td>54.8±8.3</td>
<td>56.8±6.2</td>
<td>37.8±14.8</td>
<td>48.7±8.4*</td>
</tr>
</tbody>
</table>

Note: * - Reliable difference between patients until that time following the Wilcoxon criterion.
Note: + - Reliable difference between patients with the same syndromes depending on the duration of the disease (p<0.05 by Mann-Whitney test)