

Introduction

The pathophysiology of frailty syndrome (FS) results primarily from metabolic imbalance and impaired functioning of the immune and endocrine systems. Disturbed cellular processes influence the development of frailty syndrome through changes in the functioning of organs and systems. It should be emphasized that frailty syndrome (FS) is not synonymous with the natural aging process. It can occur both earlier and later than typical old age. Frailty is increasingly recognized as an important and common geriatric syndrome. It is defined as a state of extreme susceptibility to endogenous and exogenous stressors leading to an increased risk of negative health outcomes, including falls, hospitalization, institutionalization, and mortality.

Objective

To demonstrate the relationship between the occurrence of frailty syndrome and the quality of life of chronically ill patients treated at a cardiology clinic.

Material and methods

The study was conducted among 147 patients of a selected cardiology clinic in Mszana Dolna. It was carried out using a diagnostic survey method with tools such as the Edmonton Frailty Scale questionnaire, the Yesavage Depression Scale – 15-point version, and the SF-36 Quality of Life Questionnaire. Statistical analysis was performed using the Chi2 test and Spearman's rank correlation, assuming a significance level of $p < 0.05$.

Results

The collected data enabled the assessment of the relationship between the level of frailty and the quality of life of patients in outpatient specialist care. Patients of the cardiology clinic show symptoms of frailty syndrome (FS) of varying severity (59.0%), which confirms the diversity of functional status in this group of patients. A significant correlation was found between the severity of FS and quality of life – the higher the level of frailty syndrome, the lower the subjectively assessed quality of life in terms of both physical and mental functioning ($p = 0.001$). The occurrence of frailty syndrome correlates significantly with increasing patient age ($p < 0.015$) and the number of medications taken ($p = 0.001$), which may indicate the importance of multimorbidity and polypharmacy as risk factors for FS. No significant association was found between FS and the severity of depressive symptoms, although approximately 28% of the study participants were found to have moderate or severe depressive symptoms.

Tabela 1: występowanie zespołu kruchości

	Skala Edmonton	
	n	%
fit (zdrowy)	41	28
wrażliwy	29	20
łagodna kruchość	33	22
umiarkowana kruchość	17	12
ciężka kruchość	27	18
Razem	147	100

Tabela 2: Jakość życia badanych (SF-36)

	Kwestionariusz Jakości Życia SF36	
	n	%
dobra jakość życia	53	36
średnia jakość życia	64	44
zła jakość życia	30	20
Razem	147	100

Tabela 3: Występowanie depresji

	Skala depresji wg Yesavage	
	n	%
brak objawów	106	72
depresja umiarkowana	32	22
depresja ciężka	9	6
Razem	147	100

Tabela 4: Zespół kruchości a jakość życia (Skala Edmonton i SF-36)

	Korelacja porządku rang Spearmana $p < 0,05$			
	N	R	t(N-2)	p
Zmienne				
skala Edmonton & kwestionariusz jakości życia SF36	147	0,677980	11,10622	0,001

Tabela 5: Zespół kruchości a występowanie depresji

	Korelacja porządku rang Spearmana $p < 0,05$			
	N	R	t(N-2)	p
Para zmiennych				
Skala Edmonton & Skala depresji	147	0,247516	6,011321	0,001

Tabela 6: występowanie depresji a jakość życia

	Korelacja porządku rang Spearmana $p < 0,05$			
	N	R	t(N-2)	p
Para zmiennych				
Skala depresji & Kwestionariusz Jakości Życia SF-36	147	0,566934	8,287322	0,001

Conclusions

The results obtained indicate the important role of early diagnosis of frailty syndrome and the need to implement measures tailored to the needs of chronically ill patients, especially those receiving cardiac care. The research tools used proved effective in assessing the severity of FS in everyday clinical practice, and the conclusions of the study may serve as a starting point for further analysis and improvement of care for older people undergoing treatment for cardiovascular diseases.