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Original Article

Impact of Coronary Artery Diseases on the Quality of Life and Psychological Well-Being

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ABSTRACT

Background: Globally, the major source of morbidity and mortality is Coronary Artery Disease (CAD). In addition to its direct physiological effects, CAD has a significant effect on people's psychological well-being and Quality of Life (QoL), influencing several areas of functioning and adjustment. **Materials and Methods:** A cross-sectional observational study on 100 patients was done to examine the impact of CAD on QoL and psychological well-being. Qol was assessed using WHOQOL BREF, and psychological well-being was assessed using the PSS scale in the medicine ward. **Results and Discussion:** A total of 100 patients were selected for the study (61% females and 39% males; 14% <40 years and 86% >40 years). Subjects that were elders of the age group of > 40 had lower HRQoL scores in the domains of psycho, social, and environmental than those in the age group of <40 (69.67±15.12, 64.20±26.59, and 62.91±16.72, respectively). As per WHOQOL BREF, the environmental domain has the highest mean score, and the psychological domain has the lowest. Females have lower QoL and have more retarded psychological well-being than males. Participants >40 years reported much higher mean scores of PSS as compared to those under 40. Males also showed substantially higher mean scores (146.2±13.03) than females (98.8±8.96). **Conclusion:** CAD patients, especially females, have poor Qol and psychological well-being.

Keywords: CAD, QoL, PROM, PSS, WHOQOL.

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INTRODUCTION

Coronary Artery Disease (CAD), a leading global cause of mortality and morbidity characterized by inflammatory atherosclerotic pathogenesis, manifests as stable or unstable angina, Myocardial Infarction (MI), or sudden cardiac death due to plaque-induced obstruction causing myocardial oxygen demand-supply mismatch (Bottardi *et al.*, 2024; Shahjehan *et al.*, 2024). Its prevalence exhibits significant geographical, ethnic, and gender disparities (Malakar *et al.*, 2019). Extensive epidemiological research, including the Framingham study, identifies key non-modifiable risk factors (age, genetics including homocystinuria) and modifiable factors: hypertension (strongly associated with CAD events, particularly in women), dyslipidemia (elevated LDL, low HDL), diabetes mellitus (conferring CAD risk equivalent to prior MI in non-diabetics), cigarette smoking (including second-hand and smokeless tobacco, RR 1.4-6.3), obesity (especially visceral adiposity, RR >5 for BMI>40), physical inactivity (independent of weight), and psychosocial stress (Brown *et al.*, 2025). Within the US, CAD prevalence increases with age (projected 17.3 million cases by 2040), driving substantial healthcare costs ($126.2 billion in 2010) (Duggan *et al.*, 2022). While some US risk factors show declining trends (smoking, hypertension, dyslipidemia, inactivity), others like age, diabetes, and obesity are increasing (Duggan *et al.*,2022). Management necessitates understanding these multifactorial risks, adopting preventive lifestyle modifications (diet, exercise), and utilizing evidence-based pharmacotherapy like statins, crucial for reducing the significant global burden of this atherosclerotic cardiovascular disease (Malakar *et al.*, 2019).

CAD profoundly diminishes Health-Related Quality of Life (HRQoL), independently associated with greater fatigue and reduced exercise capacity, even after controlling for CAD severity and mental distress symptoms like depression and anxiety (Staniute *et al.*, 2014). Specifically, multivariate analyses reveal that higher Multidimensional Fatigue Inventory (MFI-20) scores (indicating greater fatigue) independently correlate with poorer scores across various Short Form-36 (SF-36) HRQoL domains: general fatigue with overall HRQoL (global SF-36 score), physical fatigue with physical functioning and pain, and mental fatigue with mental health (Foxwell *et al.*, 2013). Reduced exercise capacity primarily impairs physical HRQoL domains (e.g., physical functioning), not mental health aspects (Foxwell *et al.*, 2013). Psychosocial factors significantly influence the broader

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Quality of Life (QoL) in CAD patients. Hope exhibits a substantial positive correlation with QoL, while older age predicts lower QoL. Additionally, better social support and financial stability (e.g., family/government income source) improve it (Soleimani *et al.*, 2022). This deterioration in HRQoL/QoL, linked to physical limitations, social isolation, and psychological burden, increases hospitalization and mortality risk.

As far as we can tell, there are only a few studies comparing QOL and psychological health in patients who have CHD. The main objective is to investigate the impact of coronary artery disease on quality of life and psychological well-being. The study will explain the mental health aspects of CAD among patients, and by doing so, the healthcare providers will be able to manage mental health challenges.

MATERIALS AND METHODS

Sample and setting

A cross-sectional observational study was used to explore the 100 CAD patients in the ICU of the Medicine Ward, M.M. Institute of Medical Sciences and Research Hospital, Mullana, Ambala, for 6 months. The patients diagnosed with CAD were identified through the medical records, covering various age groups (18-80 years) of both genders, and were willing to provide informed consent. They were included in the study. Patients from other wards and those affected by severe medical or pandemic conditions that could confound the results will be excluded. The institutional ethics committee has approved the study for implementation (IEC No. 2740).

Study procedure

The study collected data from patients admitted to the Medicine Ward between December 2023 and April 2024. The study was explained to each participant, and the subject signed an informed consent form in both English and Hindi. The collected data included demographic details (name, age, gender, and IPD number), prescription information (including the final diagnosis), and a history of adverse events documented during follow-ups. Quality of life was assessed using the WHOQOL-BREF questionnaire, while psychological well-being was evaluated using the Perceived Stress Scale (PSS).

Table 1: Demographics of the study participants included 100 subjects.

Description	Frequency	Percentage (%)
Gender		
male	39	39
female	61	61
Age		
<40 years	14	14
>40 years	86	86

Assessment of QOL using World Health Organisation Quality of Life (WHOQOL BREF)

The WHOQOL-BREF is a widely used 26-item tool assessing Quality of Life (QoL), derived from the WHOQOL-100. It measures four domains: Physical (7 items), Psychological (6), Social (3), and Environmental (8), and two general items (Vahedi *et al.*, 2010; Thompson *et al.*, 2015). The response scale for each item is a 5-point Likert scale. The item scores within a respective domain are summed and then divided by the number of items in that domain to obtain the domain scores. The next step involves multiplying these raw scores by four to standardise them, resulting in scores that range from 4 to 20. Furthermore, we use a similar form to obtain individual scores for each of the two general items (Bujang *et al.*, 2023).

Assessment of Psychological Well-being using PSS

The Perceived Stress Scale (PSS) is a tool designed for measuring the extent to which people perceive events in their lives as stressful (Harris *et al.*, 2023). When first formulated, the PSS was made up of 14 items and later on was pared down to a 10-item version, more efficient and containing 6 items framed negatively and 4 items framed positively (Pretorius *et al.*, 2023).

Statistical analysis

SPSS version 26.0 was used to do statistical analysis. After compilation, the information was displayed as Mean±Standard Deviation (SD), numbers, and percentages (%). A p-value of $p<0.05$ was considered significant.

RESULTS

Table 1 gives the demographic profiles of the participants involved in the study (n=100). More participants were male (61%). About 86% of all participants were over 40, and 14% were under 40 years old.

Table 2 shows the means and the standard deviation of the four WHOQOL-BREF and HRQoL domains among the respondents. HRQoL scores were consistently higher than WHOQoL scores across all domains. Environment had the highest scores, while Psychological had the lowest.

Table 3 represents the distribution of WHOQOL BREF components on the basis of age and gender. Scores varied substantially by age and gender. All domains are elevated in

Table 2: Mean scores for all four domains of WHOQOL-BREF and HRQOL.

Domains	WHOQoL Scores (Mean±SD)	HRQoL Scores (Mean±SD)
Physical	12.18±15.96	51.125±15.96
Psychological	11.71±16.11	48.187± 16.11
Social	11.87±27.06	49.187± 27.06
Environment	13.06±17.58	56.625± 17.58

Table 3: Distribution of WHOQOL BREF based on Age and gender.

Domains	Age < 40	Age > 40	Male	Female
Physical	11.3±1.8	12.0±2.5	12.6±1.4	11.4±2.5
Psychological	10.6±2.2	11.6±1.7	11.8±1.7	11.0±2.3
Social	11.7±1.2	11.7±2.0	12.2±0.8	11.7±2.0
Environment	12.2±1.1	12.4±1.7	12.4±1.5	12.1±1.6

Table 4: HRQOL mean scores among different groups in the sample.

	Physical	Psychological	Social	Environmental
Gender				
Male	61.22±16.45	67.83±17.05	63.51±25.93	60.95±18.13
Female	61.31±15.78	68.91±15.71	63.57±27.60	63.59±17.31
p-value	0.952	0.1583	0.984	0.217
Age				
< 40 years	41.85±7.71	41.16± 3.80	43.00±2.16	44.12± 6.17
≥ 40 years	51.57±8.41	53.33±10.40	53.33±6.94	81.37±24.03
p-value	0.094	0.086	0.546	0.853

Table 5: Distribution of Perceived Stress Scale items' response (*n*=100).

Stress	Number (*n*=100)	Percentage (%)
Low	2	2
Moderate	97	97
High	1	1

people over 40 years of age, and males showed an increase in WHOQOL domains compared to females. The largest differences appeared in the Environment domain.

Table 4 displays the HRQOL mean scores among different groups. Subjects that were above 40 years had lower HRQoL scores in the domains of psycho, social, and environment than those in the age group of less than 40.

Table 5 shows each respondent's score for every item of the questionnaire (PSS).

Table 6 depicts the mean value and standard deviation on the basis of Age and gender, among the PSS questionnaire. PSS scores differed significantly by age and gender. Participants under 40 years reported much higher mean scores compared to those above 40. Males also showed substantially higher mean scores than females ($p<0.05$).

DISCUSSION

The objective of this study was to use validated measures like WHOQOL-BREF and the PSS to find out how CAD affects patients' QoL and mental health. This is one of the studies that considered the quality of life among patients with CAD; the information about this comparative aspect is limited. Our results show that CAD has a big effect on both the physical and mental health of patients, with mental health being the most affected. A notable outcome of our study was the fact that patients aged <40 years had a poorer QOL as compared to patients with CAD >40 years.

According to the findings of this study, the demographic characteristics reveal a predominance of male participants and a significant proportion over the age of 40, which aligns with existing literature that suggests CAD is more prevalent in older populations, particularly among men (Akhtar *et al.*, 2023; Lima *et al.,* 2023). In our study, the results of WHOQOL BREF indicate that while many participants reported positive health, certain domains, particularly physical and psychological, showed considerable inadequacies. Specifically, responses to questions regarding physical pain and daily activities reflect a troubling trend where patients experience significant limitations in their daily functioning. This finding is consistent with previous studies that have demonstrated a strong negative correlation between physical impairments due to CAD and overall QoL (Muhammad *et al.*, 2016; Lima *et al.,* 2023). The psychological domain yielded the lowest mean scores, suggesting that emotional and psychological challenges are a critical concern for CAD patients. This is consistent with research that shows psychological well-being as the determinant for cardiovascular health outcomes. Factors like positive emotional expectations and emotional intensity correspond to the lower chances of Coronary Heart Disease (CHD) (Vlachaki *et al.,* 2013; Sin *et al.,* 2016; Najafi *et al.*, 2013; Hussein *et al.*,2024). Furthermore, studies have indicated that interventions to enhance psychological well-being can improve cardiovascular health metrics (Su *et al.*,2025). Age and gender appeared to influence QoL outcomes. Patients aged over 40 years exhibited lower scores in psychological, social, and environmental domains compared to younger patients. Similarly, female patients

Table 6: Distribution based on Age and Gender among the PSS questionnaire.

Age	Mean±SD	Gender	Mean±SD
< 40	22.2±1.8	Male	28.5±8.0
> 40	20.7±3.6	Female	21.0±3.5
p value	0.08	*p* value	0.001

reported lower QoL scores than male patients. These trends are consistent with studies highlighting that older age and female gender are associated with diminished QoL in CAD populations (Frøjd *et al*., 2023; Lanini *et al*., 2024; Kasaudhan *et al.*, 2024). As per Singh *et al.*, the environmental domain performed relatively better. These findings imply that it is crucial to design some special interventions to address the problem of psychological and physical health in older patients with CAD (Singh *et al.*, 2022).

The results from the PSS indicate elevated stress levels among participants, which may further exacerbate their health outcomes. Previous research has established a link between high stress levels and poorer cardiovascular health, suggesting that managing stress could be a vital component of comprehensive care for CAD patients (Gao *et al.*, 2024; Malik *et al*., 2021). In our study, ICU patients showed high stress prevalence and poor mental well-being, and we observed no gender differences. Similarly, Kuhail *et al.* confirm that higher stress worsens CAD. A 9% increased risk of severe CAD for each point on a stress scale, with stronger effects in women, was found. Both studies highlight older patients as particularly vulnerable (Kuhail *et al.*, 2022). A study by Gupta *et al*., revealed high stress prevalence and impaired psychological well-being. However, while younger patients showed greater stress in this study, our CAD population exhibited worse quality of life among older individuals (>40 years) (Gupta *et al*., 2023). These findings collectively underline the need for routine psychological assessment in cardiac care while highlighting potential differences in psychosocial profiles between acute and chronic cardiovascular conditions that may warrant tailored intervention approaches (Gupta *et al.,* 2023). Unsar *et al.*, show CAD causes significant stress and reduces quality of life, especially in patients over 40, similar to our results. Our measured stress levels confirm previous reports of anxiety/depression. Both found that physical health is the most affected area, linking physical symptoms to psychological distress like diminished hope (Unsar *et al.*, 2007).

The study has several limitations. First, the sample size was small, which makes it hard to apply the results to larger groups of people. The study also used self-reported measures (WHOQOL-BREF and PSS), which might be affected by recall bias and social desirability bias.

CONCLUSION

This study highlights the complex relationship between CAD, psychological health, and QoL, significantly influenced by age. Patients under 40 reported better overall QoL but greater psychological distress, likely due to the shock of an early diagnosis. Conversely, patients over 40 experienced poorer QoL across all domains but showed fewer acute psychological issues, possibly due to developed coping strategies. The study's higher proportion of female participants warrants further investigation into gender differences in CAD experience and care.

ABBREVIATIONS

CAD: Coronary artery disease; **PTCA:** Percutaneous Transluminal Coronary Angioplasty; **QoL:** Quality of life; **WHOQOL-BREF:** World Health Organisation Quality of Life; **PSS:** Perceived Stress Scale; **ICU:** Intensive care unit.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHORS' CONTRIBUTION

All authors contributed significantly to the idea and design of the work, the collection of data, the analysis and interpretation of data, the drafting of the article or its critical revision for significant intellectual content

ETHICS STATEMENT

The study was performed after the Institutional Ethics Committee (IEC) approval (IEC No. 2740) of MM Institute of Medical Sciences & Research Hospital, Mullana-Ambala.

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