

论著·公共卫生

医养结合综合干预对上海郊区老年慢性肾脏病患者生活质量和精神状态的影响

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[摘要] **目的**·探索医养结合综合干预对上海郊区老年慢性肾脏病患者生活质量和焦虑/抑郁症状的影响。**方法**·选取居住在上海市青浦区2家养老机构的老年慢性肾脏病患者, 分别用广泛性焦虑量表 (Generalized Anxiety Disorder Scale-7, GAD-7) 评估其焦虑状态, 用老年抑郁量表 (The Geriatric Depression Scale, GDS) 评估其抑郁症状, 用健康调查简表 (The Mos 36-item Short Form Health Survey, 又称SF-36量表) 评估其生活质量。根据患者是否有焦虑/抑郁症状, 分为有精神症状组 (A组) 和无精神症状组 (B组); 再随机将A组分为医养结合干预组 (A1组) 和非医养结合干预组 (A2组)。A1组采用医养结合工作模式, B组及A2组采用传统慢病管理模式 (非医养结合工作模式)。分析GAD-7评分及GDS评分与SF-36量表8个维度评分的相关性。多因素Logistic回归分析老年慢性肾脏病患者生活质量的独立危险因素。干预6个月后进行效果评价, 再次分别用上述3个量表评估其焦虑/抑郁症状及生活质量, 比较医养结合干预前后焦虑/抑郁症状和生活质量的差异。**结果**·共纳入80例老年慢性肾脏病患者, 其中A组54例 (67.5%), B组26例 (32.5%), 焦虑和抑郁症状的发生率分别为37.5%和30.0%; A组中A1组27例, A2组27例。GAD-7评分及GDS评分与生活质量6个维度评分 (生理功能、生理职能、一般健康状况、精力、情感职能、精神健康) 均呈负相关 (均 $P<0.05$)。Logistic回归分析结果提示焦虑/抑郁症状是影响老年CKD患者生活质量的独立危险因素。A1组患者医养结合综合干预6个月后, 与干预前比较焦虑/抑郁状态评分显著降低 (均 $P<0.05$); 而A2组干预前后评分比较, 差异无统计学意义。干预前, A1、A2组的8个生活质量维度评分均显著低于B组 (均 $P<0.05$), A1组和A2组间差异无统计学意义; 医养结合干预6个月后, A1组6个维度评分显著高于A2组以及干预前的A1组 (均 $P<0.05$), 生理职能、社会功能无明显变化。**结论**·上海郊区老年慢性肾脏病患者的焦虑/抑郁症状会降低其生活质量; 医养结合综合干预可改善该群体的焦虑/抑郁症状, 提高其生活质量。

[关键词] 医养结合; 慢性肾脏病; 生活质量; 焦虑; 抑郁

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Effect of combination of medical care and nursing on the quality of life and mental state of elderly patients with chronic kidney disease in Shanghai suburbs

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[Abstract] **Objective**·To explore the effect of the combination of medical care and nursing on the quality of life and the anxiety/depression symptom of the elderly patients with chronic kidney disease (CKD) in Shanghai suburbs. **Method**·The elderly patients with CKD living in two nursing homes in Qingpu District, Shanghai were selected. The anxiety symptom was assessed by Generalized Anxiety Disorder Scale-7 (GAD-7), the depression symptom was assessed by The Geriatric Depression Scale (GDS), and the quality of life was assessed by The MOS 36-item Short Form Health Survey (SF-36). According to whether they had anxiety/depression symptom, they were divided into one group with mental symptoms (group A) and the other group without mental symptoms (group B). Then, the patients in group A were randomly divided into medical care and nursing-combined intervention

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group (group A1) and conventional group (group A2). Except group A1, group A2 and group B both adopted the traditional chronic disease management mode. The correlations of the scores of SF-36 in 8 dimensions with the GAD-7 score and the GDS score were analyzed. Multivariate Logistic regression analysis was used to analyze the independent risk factors of life quality of elderly patients with CKD. The mental symptoms and the quality of life before and after the 6-month interventions were compared to evaluate the combination of medical care and nursing. **Results**·A total of 80 elderly patients with CKD were enrolled, including 54 cases (67.5%) in group A and 26 cases (32.5%) in group B, whose incidences of anxiety symptom and depression symptom were 37.5% and 30.0%, respectively. Group A included 27 cases in group A1 and 27 cases in group A2. The GAD-7 score and the GDS score were negatively correlated with the scores of 6 dimensions of quality of life (physiological function, role-physical, general health, vitality, role-emotional, and mental health), respectively ($P<0.05$). Logistic regression analysis showed that anxiety/depression symptom was an independent risk factor of the quality of life of elderly CKD patients. After the combined intervention of medical care and nursing for 6 months, the scores of GAD-7 and GDS in group A1 were significantly lower than those before intervention ($P<0.05$), while there was no statistical difference in the scores before and after the intervention in group A2. Before intervention, the scores of 8 dimensions of quality of life in group A1 and A2 were significantly lower than those in group B ($P<0.05$), and there was no significant difference between A1 and A2 groups. After 6 months of intervention, the scores of 6 dimensions in group A1 were significantly higher than those in group A2 and those in group A1 before the intervention ($P<0.05$), and there were no obvious changes in role-physical and social functioning. **Conclusion**·The anxiety/depression symptom of elderly patients with CKD in Shanghai suburbs can reduce their quality of life; the combination of medical care and nursing can improve the anxiety/depression symptom of these patients and their quality of life as well.

[Key words] medical care and nursing; chronic kidney disease (CKD); quality of life; anxiety; depression

慢性肾脏病 (chronic kidney disease, CKD) 发病率在全球逐年攀升, 是一类影响人类健康的重大慢性疾病, 给国家、社会和家庭造成沉重的经济负担^[1]。中国是一个发展中的人口大国, 随着人们生活方式的改变, 以及人口老龄化, 糖尿病和高血压等疾病发生率的迅速上升, CKD 的发病率有逐渐升高的趋势。王海燕教授领衔的一项中国多中心横断面 CKD 研究结果显示, 中国 CKD 的患病率为 10.8%^[2-3], 正严重影响人们的健康。受疾病引起的躯体不适、医疗费用支出增加以及社会角色转变等因素的影响, CKD 患者常常会出现情绪低落、悲观消极、沉默抑郁等表现, 导致其治疗依从性下降, 影响疾病的整体预后, 甚至引发焦虑/抑郁等严重的心理疾患^[4-6]; 该现象在老年人群中尤为突出。如何对患者进行有效管理, 更好地整合现有医疗资源, 延缓疾病的进展, 改善患者的心理状态, 使 CKD 患者更好地回归社会, 也是社会日益关注的问题。

医养结合是一种医疗机构与养老机构合作的新模式^[7], 能够有效整合现有医疗和养老资源, 为老年人提供医疗服务、健康教育、生活照护、保健康复、体育锻炼、文化娱乐等服务, 是集预防、治疗、护理为一体的整体养老服务体系^[8]。医养结合作为一种新型的老年照护模式, 将是未来的主要养老模式。近年来, 多项研究^[9-10]证实医养结合在慢病管理方面

有积极作用, 可有效延缓疾病的进展, 改善患者的情绪, 节约患者的平均费用等。本研究团队认为, 医疗机构主要关注老年 CKD 患者的身体健康; 养老机构主要负责这类患者的生活起居, 两者互为补充。为了解该模式对老年 CKD 患者焦虑/抑郁状态及生活质量的影响, 复旦大学附属中山医院青浦分院与养老机构开展合作, 进行研究探索。

1 对象与方法

1.1 研究对象

于 2020 年 1 月—2020 年 12 月选取上海市青浦区 2 家养老机构中生活的老年 CKD 患者作为研究对象。这 2 家机构均为非营利性质的养老机构, 可容纳的床位数约 300 张; 均有两人间、三人间、四人间等多种居住条件可供选择; 配备的护理人员数与入住人员的比例相近, 约为 1:7; 每月所需费用相近, 为 6 000~8 000 元/月。

研究对象纳入标准: ① 年龄 ≥ 60 岁。② 认知能力正常。③ 参照肾脏病预后质量指南 (Kidney Disease Outcome Quality Initiative, K/DOQI) 诊断和分期, 符合 CKD 的诊断, 即肾脏损伤或估算肾小球滤过率 (eGFR) ≤ 60 mL/(min \cdot 1.73m²) 持续 3 个月及以上^[11]。④ 入住养老机构时间 ≥ 1 年。⑤ 签署知情同意书。排除标准: 有精神障碍史; 近期使用过镇静

剂、麻醉剂和其他可能影响精神状态的药物;近3个月内接受过手术治疗;正在参与其他干预性临床试验者。

1.2 研究方法

1.2.1 焦虑/抑郁症状评估与分组 为判定患者是否存在焦虑/抑郁症状,本研究采用广泛性焦虑量表(Generalized Anxiety Disorder Scale-7, GAD-7)^[12-13]和老年抑郁量表(The Geriatric Depression Scale, GDS)中文版^[14-16],在医护人员的指导下由患者填写完成。GAD-7评分 ≥ 5 分判定为焦虑状态,GDS评分 >10 分判定为抑郁状态;评分越高,焦虑/抑郁症状严重程度越高。首先根据有无焦虑/抑郁症状将入选的CKD患者分为有精神症状组(A组)和无精神症状组(B组),然后将A组的患者随机均分为医养结合干预组(A1组)和非医养结合干预组(A2组)。GAD-7及GDS筛查的结果均及时真实地告知研究对象及其所在养老机构,并建议具有焦虑/抑郁症状的A1组和A2组患者及时至医院专科就诊。

1.2.2 生活质量评估 采用健康调查简表(The MOS 36-item Short Form Health Survey, 又称SF-36量表)对老年CKD患者的生活质量进行评估。该量表作为生活质量评估的重要量表,已得到广泛认可和应用^[17-18]。患者均在医护人员的指导下填写完成。SF-36量表共有36个条目,分为8个维度[生理功能(physical functioning)、生理职能(role-physical)、躯体疼痛(bodily pain)、一般健康状况(general health)、精力(vitality)、社会功能(social functioning)、情感职能(role-emotional)、精神健康(mental health)]。8个维度中前4个属于生理方面的内容,后4个属于心理方面的内容^[19-20]。该量表每个维度评分为0~100分,分值越高表示研究对象生活质量越好,反之则表示越差。此外,该量表还包括1项健康变化(reported health transition)条目,用于评价过去1年内健康状况的总体变化情况。

1.2.3 干预手段 所有纳入对象均由养老机构为其提供基本生活养护服务,包括:①提供平衡力训练、关节活动度训练、中频脉冲电治疗等康复锻炼服务,增强老年人的体质、体能,提高其生活质量。②指定专人负责老年人生活起居。③每天安排1 h有氧运动,包括有氧健身操、太极拳、散步等自主运动。

④定期安排兴趣娱乐活动,例如书画、棋牌、唱歌、电影会等。

A1组采用医养结合工作模式:A1组在养老机构为其提供生活养护服务的基础上,由复旦大学附属中山医院青浦分院肾内科提供医疗保健服务。医疗保健服务包括:①为老年CKD患者进行系统健康评估,建立个性化的健康随访档案,制定诊疗及日常康复方案。②派遣医护人员为老年CKD患者进行定期查房(2次/月),并根据患者的病情及时调整治疗方案。③通过科普小视频、公众号科普文等形式进行健康科普宣传;对于无法观看科普视频、阅读科普文章的部分患者,由陪护人员播放视频、朗读文章。④进行健康教育科普小讲课。⑤对危重患者及时开通绿色通道实行转诊。

B组及A2组采用传统慢病管理模式(非医养结合工作模式):①养老机构派专人陪同CKD患者定期至复旦大学附属中山医院青浦分院肾内科进行复诊随访,2次/月。②接诊医师根据病情及时调整患者的治疗方案。

干预6个月后,使用GAD-7、GDS、SF-36量表对3组对象的焦虑/抑郁症状及生活质量再次进行评估。

1.3 统计学分析

使用SPSS 22.0统计软件对数据进行统计分析。定量资料用 $\bar{x} \pm s$ 表示,3组间比较采用方差分析,同组前后比较采用配对 t 检验,组间两两比较采用LSD- t 检验;定性资料组间比较采用 χ^2 检验;2个连续变量之间关系检验采用Pearson相关性分析;生活质量影响因素的分析采用非条件Logistic回归。 $P < 0.05$ 表示差异具有统计学意义。

2 结果

2.1 一般资料比较

共纳入80例老年CKD患者,其中男43例,女37例,年龄60~94岁,平均年龄(74.1 \pm 10.2)岁;其中A组54例(67.5%),B组26例(32.5%);A1组和A2组各27例。A1、A2、B组患者的人口学资料、机构分布比例、慢性合并症及CKD分期之间差异均无统计学意义(均 $P > 0.05$),3组之间具有可比性(表1)。

表1 3组患者一般资料比较

Tab 1 Comparison of baseline characteristics among the three groups

Item	Group A1 (n=27)	Group A2 (n=27)	Group B (n=26)	P value
Male/n (%)	12 (44.4)	15 (55.6)	16 (61.5)	0.684
Age/year	74.1±10.2	72.4±8.4	73.6±8.2	0.721
Nursing home (A/B)/n	12/15	14/13	12/14	0.702
Marital status (married/divorced/widowed)/n	17/3/7	15/5/7	15/5/6	0.801
Smoking/n (%)	10 (37.0)	9 (33.3)	9 (34.6)	0.412
High school or above/n (%)	11 (40.7)	10 (37.0)	10 (38.5)	0.891
Hypertension/n (%)	14 (51.9)	13 (48.1)	12 (46.2)	0.109
Diabetes/n (%)	9 (33.3)	8 (29.6)	8 (30.8)	0.531
Coronary heart disease/n (%)	7 (25.9)	8 (29.6)	6 (23.1)	0.682
Hyperuricemia/n (%)	17 (63.0)	18 (66.7)	17 (65.4)	0.711
Cerebral stroke/n (%)	6 (22.2)	5 (18.5)	5 (19.2)	0.752
CKD stage/n (%)				0.669
Stage 1-2	4 (14.8)	2 (7.4)	3 (11.5)	
Stage 3	9 (33.3)	8 (29.6)	11 (42.3)	
Stage 4	11 (40.7)	13 (48.1)	9 (34.6)	
Stage 5	3 (11.1)	4 (14.8)	3 (11.5)	
Dialysis mode/n (%)				0.672
Non-dialysis	25 (92.6)	24 (88.9)	25 (96.2)	
Haemodialysis	1 (3.7)	2 (7.4)	1 (3.8)	
Peritoneal dialysis	1 (3.7)	1 (3.7)	0 (0)	

2.2 A组患者生活质量与焦虑/抑郁症状相关性分析

干预前A组患者焦虑评分(GAD-7)与生理功能、生理职能、一般健康状况、精力、情感职能、精神健康这6项生活质量维度指标评分呈负相关,其中与精力、精神健康2项维度的相关性较大($P<0.01$,表2)。干预前A组患者抑郁症状评分(GDS)也与上述生活质量6个维度指标评分呈负相关($P<0.05$),其中与精力、精神健康2项维度相关性较大($P<0.01$,表2)。

表2 A组SF-36量表各维度评分与焦虑/抑郁症状评分的相关性分析(r)Tab 2 Correlation analysis between SF-36 dimensions and anxiety/depression symptom scores of group A (r)

Dimension of SF-36	GAD-7 score	GDS score
Physical functioning	-0.362 ^①	-0.291 ^⑥
Role-physical	-0.442 ^②	-0.378 ^⑦
Bodily pain	0.092	0.117
General health	-0.421 ^③	-0.391 ^④
Vitality	-0.492 ^④	-0.481 ^④
Social functioning	0.045	0.049
Role-emotional	-0.418 ^⑤	-0.268 ^⑧
Mental health	-0.501 ^④	-0.582 ^④

Note: ^① $P=0.021$, ^② $P=0.008$, ^③ $P=0.004$, ^④ $P=0.000$, ^⑤ $P=0.013$, ^⑥ $P=0.029$, ^⑦ $P=0.017$, ^⑧ $P=0.025$.

2.3 老年CKD患者生活质量危险因素分析

以SF-36量表反映总体健康情况的“健康变化”指标为因变量(≥ 50 分认为生活质量较好, <50 分认为生活质量较差),采用多因素Logistic回归分析,结果发现,影响老年CKD患者生活质量的危险因素包括女性、高龄、较低的文化程度、糖尿病、处于透析状态,以及有焦虑或抑郁症状(表3)。

表3 多因素Logistic回归分析老年CKD患者生活质量的相关因素

Tab 3 Multivariate Logistic regression analysis of relative factors of life quality of elderly CKD patients

Factor	OR (95%CI)	P value
Gender (female=0/male=1)	0.877 (0.318-0.956)	0.006
Age (every 1 year added)	1.189 (1.024-3.073)	0.000
Educational level (junior high school or below=0/high school or above=1)	0.993 (0.498-0.998)	0.018
Diabetes (no=0/yes=1)	1.652 (1.102-3.834)	0.020
Dialyses (no=0/yes=1)	3.154 (1.496-8.887)	0.000
Anxiety/depression symptom (no=0/yes=1)	2.134 (1.019-5.883)	0.002

2.4 医养结合综合干预对患者精神状态的影响

80例老年CKD患者中,有焦虑症状者共30例(37.5%),GAD-7基线评分为(13.46±3.6)分;有抑郁症状者共24例(30.0%),GDS基线评分为(21.36±4.01)分。

A1组患者27例,其中男12例,女15例;年龄60~91岁,平均年龄(72.58±6.94)岁。其中有焦虑症状者16例,有抑郁症状者11例,无同时有焦虑与抑郁症状者。6个月后比较干预前后焦虑、抑郁状态评分,差异均有统计学意义(均 $P<0.05$,表4)。

表4 有焦虑/抑郁症状的老年CKD患者干预前后精神状态比较

Tab 4 Comparison of mental state of elderly CKD patients with anxiety/depression symptom before and after intervention

Group	GAD-7 score			GDS score		
	0 month	6 months	<i>P</i> value	0 month	6 months	<i>P</i> value
Group A1						
Patients with anxiety symptom (<i>n</i> =16)	13.14±3.28	7.81±3.09 ^①	0.000	—	—	—
Patients with depression symptom (<i>n</i> =11)	—	—	—	21.89±3.48	16.08±3.52 ^②	0.001
Group A2						
Patients with anxiety symptom (<i>n</i> =14)	14.02±3.04	14.19±2.11	0.893	—	—	—
Patients with depression symptom (<i>n</i> =13)	—	—	—	20.25±2.91	19.25±2.91	0.346

Note: ^① $P=0.000$, ^② $P=0.032$, compared with the corresponding patients in group A2.

2.5 3组患者生活质量的评估

干预前,A1组和A2组生活质量各维度指标均显著低于B组(均 $P<0.05$),但A1组和A2组间差异均无统计学意义(均 $P>0.05$);干预6个月后,A1组生活质量评价中的6个维度评分(生理功能、躯

A2组患者27例,其中男15例,女12例;年龄60~92岁,平均年龄(70.21±7.68)岁。其中有焦虑症状者14例,有抑郁症状者13例,无同时有焦虑与抑郁症状者。6个月后比较干预前后的焦虑、抑郁状态评分,差异均无统计学意义(均 $P>0.05$,表4)。

干预前,A1组与A2组焦虑、抑郁状态评分相比,差异均无统计学意义(均 $P>0.05$);干预6个月后,A1组与A2组焦虑、抑郁状态评分相比,差异均有统计学意义(均 $P<0.05$,表4)。

体疼痛、一般健康状况、精力、情感职能、精神健康)均较干预前显著提高(均 $P<0.05$),且显著高于同期A2组患者(均 $P<0.05$);仅生理职能和社会功能无明显变化(表5)。

表5 3组老年CKD患者干预前后SF-36量表各维度指标比较

Tab 5 Comparison of SF-36 dimensions before and after intervention in three groups of elderly CKD patients

Dimension of SF-36	0 month			6 months		
	Group A1	Group A2	Group B	Group A1	Group A2	Group B
Physical functioning	38.8±21.8 ^①	41.9±23.7 ^②	58.1±21.3	50.8±25.9 ^⑩	44.1±24.2 ^⑦	50.2±19.9
Role-physical	45.4±27.2 ^③	47.1±22.9 ^④	60.2±21.7	49.9±25.3	42.8±26.4	57.1±22.9
Bodily pain	50.4±27.2 ^①	47.1±26.8 ^②	73.1±16.8	67.9±18.5 ^⑩	49.8±20.4 ^⑧	71.2±18.4
General health	44.1±21.8 ^①	46.7±20.2 ^⑤	63.9±18.5	57.8±18.2 ^⑫	50.1±19.9 ^⑨	62.3±20.8
Vitality	39.2±24.1 ^①	38.1±20.4 ^②	59.2±14.6	53.2±24.9 ^⑩	40.2±19.5 ^⑧	60.1±20.8
Social functioning	31.2±19.1 ^①	33.1±20.9 ^②	40.3±19.8	30.2±17.1	35.2±20.2	42.1±15.9
Role-emotional	53.6±27.6 ^①	51.9±24.2 ^②	77.4±14.1	68.1±21.6 ^⑬	50.1±29.2 ^⑧	74.1±19.5
Mental health	51.2±26.1 ^①	50.4±24.8 ^⑥	70.1±18.6	66.8±19.1 ^⑭	52.4±20.1 ^⑨	72.4±21.8

Note: ^① $P=0.001$, ^② $P=0.000$, ^③ $P=0.008$, ^④ $P=0.015$, ^⑤ $P=0.024$, ^⑥ $P=0.017$, compared with Group B before intervention (0 month); ^⑦ $P=0.036$, ^⑧ $P=0.001$, ^⑨ $P=0.025$, ^⑩ $P=0.006$, compared with group A1 after intervention (6 months); ^⑪ $P=0.001$, ^⑫ $P=0.016$, ^⑬ $P=0.004$, ^⑭ $P=0.002$, compared with group A1 before intervention (0 month).

3 讨论

为了研究医养结合综合干预对老年CKD患者焦虑/抑郁症状的作用及其与生活质量的关系,本研究

选取了上海青浦区2家养老院的CKD患者作为研究对象,使用GAD-7、GDS及SF-36量表对80例老年CKD患者进行综合评估。既往有研究^[21]证实,约20%的CKD患者存在焦虑/抑郁。在本项研究中,老

年CKD患者抑郁/焦虑症状的检出率也较高,其中符合焦虑症状者30例(37.5%),符合抑郁症状者24例(30.0%),略高于先前的研究结果。

上海是全国第一个进入老龄化社会的城市。2020年,上海60岁以上老人已达500万人,其中80岁以上的将近100万人^[22-23]。由于部分子女无暇顾及老年人的生活照料、情感交流、社会参与等方面的需求,传统家庭照顾模式被削弱^[24],直接影响老年人的心理状态。而焦虑、抑郁等不良情绪直接影响着CKD患者疾病的发生、发展和预后^[25],在老年CKD患者中显得尤为突出,可能影响日常生活,降低生活质量。

既往研究^[26]表明,CKD患者的生活质量与其心理健康密切相关,伴有焦虑、抑郁症状患者的生活质量明显低于心理正常的患者,从而影响患者治疗的依从性,以及疾病的总体预后。本研究采用多因素Logistic回归分析法对影响老年CKD患者生活质量的危险因素作了分析,结果显示焦虑/抑郁症状是影响老年CKD患者生活质量的独立危险因素。此外,本研究对老年CKD患者的生活质量与其焦虑/抑郁症状的相关性作了分析,结果显示老年CKD患者焦虑、抑郁症状评分与生活质量的6个维度指标均呈负相关(与躯体疼痛、社会功能尚未发现相关性),其中与精力、精神健康2个维度的相关性较大。由此可见,老年CKD患者焦虑/抑郁症状的存在和严重程度均会影响其生活质量,特别在精力、精神健康这2项指标表现上,严重影响了患者的躯体健康、情感交流和自知感受。躯体疼痛这个维度,可能是因为老年CKD患者常合并高尿酸血症,甚至痛风等,可能由此引发的躯体疼痛发作的频率较高,程度较剧烈,与精神状态之间的关系较小,与疾病本身关系更大。此外,本研究的对象均为入住养老机构时间 ≥ 1 年的老年人,其社会活动可能普遍较少,这可能是社会功能与焦虑/抑郁症状无明显关联的原因。

本研究中,伴有焦虑/抑郁症状的老年CKD患者多项生活质量维度的评分较无焦虑/抑郁症状组明显下降,通过6个月医养结合综合干预后,A1组患者的焦虑、抑郁评分得到明显改善,通过SF-36量表再次评估后,A1组生理功能、躯体疼痛、一般健康状况、精力、情感职能、精神健康的评分均显著提高,提示该组患者生活质量得到提高。但与此同时,A1组的生理职能及社会功能这2个维度的评分较A2组

仍无明显变化,这可能与研究对象所处环境没有发生变化有关。

医养结合综合干预组的研究人员除了在医疗上对该组患者进行定期查房,及时调整治疗方案外,还通过科普文章、科普小视频、线下科普小讲课等方式,帮助患者正确认识疾病、学习如何日常调养及应对疾病的变化,从而帮助患者建立积极的心态。医养结合综合干预可能发挥了部分心理干预的作用,改善了老年CKD患者的精神状态,进而对提高其生活质量产生积极效益。

与传统慢病管理模式相比,医养结合综合干预确实会消耗医务人员更多的时间与精力,如何大规模地推广是个瓶颈问题。目前我国许多养老机构和医疗机构在一定程度上是相互分离的,如果通过“医联体”等方式将医疗和养老机构的资源有效地整合到一起,实现灵活的“双向转诊制”,既可以缓解综合性医院的医疗负担,又可以解决养老机构只养老不能治疗疾病的问题,实现双赢,从而使老年人在养老机构就能获得慢性病的诊疗和护理。

综上所述,老年CKD患者的焦虑/抑郁症状与其生活质量下降有显著的相关性。医养结合综合干预可以改善老年CKD患者的焦虑/抑郁症状,提高其生活质量。此次研究中,医养结合工作模式由5条具体措施组成,但本次研究仅仅把医养结合作为一项综合干预手段对其进行研究分析。在接下来的工作中,可把5条具体措施进行拆分,横向比较这几条措施哪一项或哪几项对各量表评分的改善意义更为显著。此外,此次研究仅基于医养结合干预前后的对照,并且相对来说样本量有限,研究期限较短,后续可与社区居家养老相对照,更加科学客观地评价医养结合的干预价值。

利益冲突声明/Conflict of Interests

所有作者声明不存在利益冲突。

All authors disclose no relevant conflict of interests.

伦理批准和知情同意/Ethics Approval and Patient Consent

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All experimental protocols in this study were reviewed and approved by Qingpu Branch of Zhongshan Hospital, Fudan University (Approval Letter No. 2021-43). Consent letters have been signed by the research participants or their relatives.

作者贡献/Authors' Contributions

王亚琨、白寿军参与实验设计; 许佳瑞负责数据统计分析; 吴茜茜、张晓华、朱迎春参与问卷调查; 王亚琨、许佳瑞参与论文的写作和修改。所有作者均阅读并同意最终稿件的提交。

The study was designed by WANG Yakun and BAI Shoujun. The statistical analysis of data was completed by XU Jiarui. The questionnaire survey was completed by WU Qianqian, ZHANG

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参 · 考 · 文 · 献

- [1] JHA V, GARCIA-GARCIA G, ISEKI K, et al. Chronic kidney disease: global dimension and perspectives[J]. *Lancet*, 2013, 382(9888): 260-272.
- [2] LIYANAGE T, TOYAMA T, HOCKHAM C, et al. Prevalence of chronic kidney disease in Asia: a systematic review and analysis[J]. *BMJ Glob Health*, 2022, 7(1): e007525.
- [3] ZHANG L X, WANG F, WANG L, et al. Prevalence of chronic kidney disease in China: a cross-sectional survey[J]. *Lancet*, 2012, 379(9818): 815-822.
- [4] DUAN D F, YANG L, ZHANG M, et al. Depression and associated factors in Chinese patients with chronic kidney disease without dialysis: a cross-sectional study[J]. *Front Public Health*, 2021, 9: 605651.
- [5] GUERRA F, DI GIACOMO D, RANIERI J, et al. Chronic kidney disease and its relationship with mental health: allostatic load perspective for integrated care[J]. *J Pers Med*, 2021, 11(12): 1367.
- [6] ONISHI Y, UCHIDA HA, TAKEUCHI H, et al. Impaired mental health status in patients with chronic kidney disease is associated with estimated glomerular filtration rate decline[J]. *Nephrology (Carlton)*, 2019, 24(9): 926-932.
- [7] 王晓晓, 郭清. 基于CiteSpace的近几年我国医养结合研究热点及发展趋势分析[J]. *中国全科医学*, 2021, 24(1): 92-97.
WANG X X, GUO Q. Recent 10-year research hotspots and development trends of integrated medical and nursing care in China: a CiteSpace-based visual analysis[J]. *Chin Gen Pract*, 2021, 24(1): 92-97.
- [8] 张丽艳, 冯思思. 中国医养结合研究热点分析[J]. *中国老年学杂志*, 2021, 41(11): 2440-2443.
ZHANG L Y, FENG S S. Analysis of hot spots in the research of combination of medical care and health care in China[J]. *Chin J Gerontol*, 2021, 41(11): 2440-2443.
- [9] 王水莲, 陈丽敏, 张云逸. 医养结合型养老机构入住老人生存质量[J]. *中国老年学杂志*, 2021, 41(7): 1531-1535.
WANG S L, CHEN L M, ZHANG Y Y. Analysis of the quality of life of the elderly living in medical and nursing care institutions[J]. *Chin J Gerontol*, 2021, 41(7): 1531-1535.
- [10] 何海燕, 李琳, 罗涛, 等. 医养结合在老年人慢性病管理中的作用及经济学影响的初步研究[J]. *中华医学教育探索杂志*, 2021, 20(6): 741-744.
HE H Y, LI L, LUO T, et al. Impact of the medical burden under chronic disease management for the elderly based on the "combination of medical care and pension" model: a preliminary study[J]. *Chin J Med Edu Res*, 2021, 20(6): 741-744.
- [11] National Kidney Foundation. K/DOQI clinical practice guidelines for chronic kidney disease: evaluation, classification, and stratification[J]. *Am J Kidney Dis*, 2002, 39(2 Suppl 1): S1-S266.
- [12] GARCÍA-CAMPAYO J, ZAMORANO E, RUIZ M A, et al. Cultural adaptation into Spanish of the generalized anxiety disorder-7 (GAD-7) scale as a screening tool[J]. *Health Qual Life Outcomes*, 2010, 8: 8.
- [13] GONG Y Q, ZHOU H X, ZHANG Y, et al. Validation of the 7-item Generalized Anxiety Disorder scale (GAD-7) as a screening tool for anxiety among pregnant Chinese women[J]. *J Affect Disord*, 2021, 282: 98-103.
- [14] CASTELO M S, COELHO-FILHO J M, CARVALHO A F, et al. Validity of the Brazilian version of the Geriatric Depression Scale (GDS) among primary care patients[J]. *Int Psychogeriatr*, 2010, 22(1): 109-113.
- [15] MITCHELL A J, BIRD V, RIZZO M, et al. Diagnostic validity and added value of the Geriatric Depression Scale for depression in primary care: a meta-analysis of GDS30 and GDS15[J]. *J Affect Disord*, 2010, 125(1-3): 10-17.
- [16] SIU A L, BIBBINS-DOMINGO K, GROSSMAN D C, et al. Screening for depression in adults: US Preventive Services Task Force recommendation statement[J]. *JAMA*, 2016, 315(4): 380-387.
- [17] YARLAS A, BAYLISS M, CAPPELLERI J C, et al. Psychometric validation of the SF-36® Health Survey in ulcerative colitis: results from a systematic literature review[J]. *Qual Life Res*, 2018, 27(2): 273-290.
- [18] HAGELL P, WESTERGREN A, ÅRESTEDT K. Beware of the origin of numbers: standard scoring of the SF-12 and SF-36 summary measures distorts measurement and score interpretations[J]. *Res Nurs Health*, 2017, 40(4): 378-386.
- [19] VAN GENDEREN S, PLASQUI G, LACAILLE D, et al. Social Role Participation Questionnaire for patients with ankylosing spondylitis: translation into Dutch, reliability and construct validity[J]. *RMD Open*, 2016, 2(1): e000177.
- [20] MÖRCK B, PULLERITS R, GEIJER M, et al. Infliximab dose reduction sustains the clinical treatment effect in active HLAB27 positive ankylosing spondylitis: a two-year pilot study[J]. *Mediators Inflamm*, 2013, 2013: 289845.
- [21] STASIAK C E, BAZAN K S, KUSS R S, et al. Prevalence of anxiety and depression and its comorbidities in patients with chronic kidney disease on hemodialysis and peritoneal dialysis[J]. *J Bras Nefrol*, 2014, 36(3): 325-331.
- [22] 王蓓. 上海老龄化社会的特点、应对及其思考[J]. *中国老年学杂志*, 2015, 35(2): 532-534.
WANG B. Characteristics, countermeasures and thoughts of Shanghai's aging society[J]. *Chin J Gerontol*, 2015, 35(2): 532-534.
- [23] 严宇珺, 严运楼. 上海人口老龄化发展趋势及其影响因素: 基于GM(1,1)和主成分分析[J]. *中国老年学杂志*, 2021, 41(14): 3093-3098.
YAN Y J, YAN Y L. The trend of Shanghai's aging population and its influencing factors: based on GM(1,1) and principal component analysis[J]. *Chin J Gerontol*, 2021, 41(14): 3093-3098.
- [24] 黄佳豪, 孟昉. “医养结合”养老模式的必要性、困境与对策[J]. *中国卫生政策研究*, 2014, 7(6): 63-68.
- [25] HUANG J H, MENG F. Integrating pension service with medical service for the elderly: necessity, dilemmas and solutions[J]. *Chin J Health Policy*, 2014, 7(6): 63-68.
- [26] SCHOEVEERS R A, DEEG D J, VAN-TILBURG W, et al. Depression and generalized anxiety disorder: concurrence and longitudinal patterns in elderly patients[J]. *Am J Geriatr Psychiatry*, 2005, 13(1): 31-39.
- [27] BAIDER L, PERETZ T, HADANI P E, et al. Psychological intervention in cancer patients: a randomized study[J]. *Gen Hosp Psychiatry*, 2001, 23(5): 272-277.

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