**OP 44: Factors affecting the quality of life of lymphoedema patients in the Western Province of Sri Lanka**

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**Background:** Information on the impact of lymphoedema, an important consequence of bancroftian

filariasis, on the quality of life (QOL) of Sri Lankans is limited. The Dermatological Life Quality Index

(DLQI) is a validated tool that can be used to monitor QOL.

**Objectives:** To study the factors affecting QOL of lymphoedema patients in the Western Province

of Sri Lanka.

**Methods:** Lymphoedema patients attending two filariasis clinics (Colombo and Kiribathgoda) and

the Outpatients Dept of the Colombo North Teaching Hospital, were studied. Lymphoedema was

graded using recommended criteria. QOL was assessed using the DLQI, modified to focus on

lymphoedema, and scored from 0 (normal) to 30 (affects QOL severely). A semi-structured

questionnaire was used to assess the patient's socio-economic status, frequency of acute

adenolymphangitis attacks (ADLA) and measures to alleviate morbidity.

**Results:** Ninety one patients (62 females, 29 males, mean age 50.4 years) were studied. A single

lower limb, both lower limbs and a single upper limb were affected in 78 (85.7%), 10 (10.9%) and 3

(3.2%) patients respectively. Severity of lymphoedema ranged from Grades 1 (mild) to 6 (severe);

87.5% were in Grades 1-3. The mean DLQI was 8.2 (SD5.2, range 1-20). DLQI correlated significantly

with lymphoedema, number of ADLA attacks and age (correlation co-efficients of 0.69,0.39 and -0.1

respectively). There was no significant association between DLQI and socio-economic status or

type of treatment practiced.

**Conclusions:** Increasing disease severity, frequency of ADLA and early onset lymphoedema

significantly worsens quality of life for patients with filarial lymphoedema.

**OP 45: Defaulter rate and predictors of defaulting of patients on anti-tuberculosis treatment**

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**Objective:** To determine the defaulter rate and risk factors of defaulting of patients on anti-
tuberculosis treatment. -

**Methods:** All consenting patients with a confirmed diagnosis of tuberculosis admitted to a unit at Chest Hospital, Welisara were recruited from April 2001 to April 2002 for follow up. Personal and follow up data were recorded in a pre-tested questionnaire and data sheet respectively. A defaulter was defined as a patient who interrupted treatment for more than two consecutive months before the end of the course of treatment.

**Results:** Of the 892 patients recruited, 770 were new cases and 122 were relapses. Defaulter rate was 10.3%(95%CI:8.3%-12.6%) and 30.3% (95% CI:22.7%-38.1%) among new cases and re-treatment cases respectively in the intensive phase of treatment and 10.9 % (95% CI:8.7%-13.3%) and 16.5% (95% CI: 9.7- 25.5) respectively in the continuation phase. 90% of new cases and 94% of re-treatment cases were sputum positive at diagnosis. Altogether 205 (22.9%) defaulted treatment (95% CI: 20.3%-25.8%).

**Age, sex, occupational status, family income, regular alcohol consumption, current smoking and substance abuse were independently significantly associated (p<0.05) with defaulting. Defaulters were significantly different (p<0.05) from compliers with regard to the site of the lesion, being in new or re-treatment category (type), acid-fast bacilli in sputum and extent of lung involvement. Using logistic regression analysis, a regular smoker (OR=1.9), a smear positive defaulter (OR=2.4) and a patient having involvement of more than 3 zones of the lung on chest x-ray examination (OR=0.5) was more likely to default as compared to a patient who did not smoke regularly, a smear positive patient who had relapsed after taking the full course of treatment and a patient with less lung involvement, respectively. Of the occupational categories, skilled and unskilled labourers were most likely to default (OR=2.03) followed by sales personnel (OR=2.00) as compared to those unemployed or home-bound.**

Conclusions: **A high defaulter rate of 23% was observed among the study participants. Smoking status, occupation, type of patient, and extent of lung involvement are predictors of defaulting.**