Abstract :

Quality of life is now becoming a major issue in the field of health, it stems from taking into account the legitimate desire of the medical community to know how the patient deals with his illness. Diabetes is a chronic disease that affects patients' quality of life , therefore this study was done to evaluate the health-related QOL of the 106 type 1 and 2 diabetic patients followed in our department, hospitalized or coming for annual control within the exploration unit This health-related quality of life is influenced by several parameters and variables, either these are parameters linked to the patient himself or to his disease. This is a cross-sectional study carried out in the internal medicine department, from September 2016 to March 2017. We have collected from the studied population sociodemographic variables as well as parameters related to diabetes : type, disease duration, degenerative complications, comorbidity , antidiabetic treatment.

For this evaluation, a practical survey was chosen, it is the EQ5D (EuroQol 5 Dimensions), which measures 5 dimensions of health status: mobility, autonomy , current activity, pain, anxiety /depression.

This survey was evaluated and interpreted according to a health score of which 1 is the best quality of life and 0 is the poor quality. But we can have negative values marking the poorest qualities of life which french studies consider to be a state of health that's worse than death(16).

Our study involved 106 patients (70 women and 36 men). The mean age is 54.13 ± 17.93, 65.09% were married and 76.41% were urban origin people, 67.92% were unemployed. The average duration of diabetes was with extremes ranging from 2 months to 26 years, the majority of our patients had associated diseases (55.66%), 21.69% had degenerative complications, 33.01%

were on insulin, 34.90% on ADO, 30.14% on an insulin / ADO combination and only 1.8% (2 patients) were on diet only , as they were considered to be on ADO (since the next step of the therapeutic approach was to put them on ADO).

This study objectified an influence and a relationship between the state of health score and a marital status (P = 0.042). Comorbidity (P = 0.028), Degenerative complications (P = 0.018) while health status score is not influenced by age, sex, professional situation, urban or rural origin, type of diabetes , disease duration, anti-diabetic treatment. Concerning the 05 dimensions of the EQ5 survey, they are differently influenced by the variables linked to the patient and his diabetes. Mobility is influenced by sex (P = 0.01), by marital status (P = 0.01), professional activity (P = 0.003), age (P = 0), type of diabetes (P = 0), comorbidity (P = 0), they are not influenced by origin (p = 0.86), by disease duration (P = 0.3), the treatment of diabetes. Autonomy is related to comorbidity (P = 0.017) and the existence of degenerative complications (P = 0), while the other parameters of the EQ5D have no influence on autonomy.

The current activity depends on sex (P = 0.01), marital status (P = 0.02), professional activity (P = 0.006), comorbidity (P = 0.008), existence of degenerative complications (P = 0.002).

Pain is influenced by sex (P = 0.01), marital status (P = 0.01), professional activity (P = 0.03), age (P = 0.009), type of diabetes (P = 0.005), comorbidity(P= 0.013).

Anxiety / depression is not influenced by any parameter, it is marked in all the patients in our sample.

Our study has shown that certain parameters such as marital status, the existence of diseases associated and the degenerative complications, alter

significantly the quality of life of our patients, while some variables linked to the patient or his disease alter certain dimensions of the quality of life.

Current activity and age alter very significantly the perception of the quality of life of our patients either by the occurrence of various independent ailments of diabetes, or else age degrades the quality of life by itself which was described in different studies .

Married patients are patients who have a better quality of life than patients who have lost their spouses, as well as patients who are civil servants; they don't have issues with mobility, autonomy and current activity, the origin is not related to the perception of the quality of life.

The existence of an associated disease also alters the QOL of our patients, such as hypertension, our study found that 42.45% of our diabetic patients find that hypertension is a factor that alters the quality of life. In addition to diabetes, our patients are faced with polypharmacy and additional consultations. Regarding the antidiabetic treatment, when the patient gets to the point of treating himself with ADO + insulin, that means that he's having extreme problems, and he requires more care than usual, 87.9% of patients on ADO / insulin suffer from pain of which 21.2% have permanent pain.

The degenerative complications of diabetes significantly affect patients' quality of life , strokes, blindness, amputations and MI which limits the patient in his mobility, his autonomy and his daily activities.

To improve our patient's quality of life we need an early diagnosis, multiple management, close and regular checks, close monitoring and therapeutic education of patients and those around them, and above all, respect for hygieno-dietetic measures.