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An Investigation into the Effect of Treatment Adherence on Quality of Life in Glaucoma Patients

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Abstract

Background

Glaucoma requires lifelong topical therapy, making medication adherence a persistent clinical challenge. However, the sociodemographic and clinical factors that influence this relationship are not well established. This study evaluated the relationship between medication adherence and quality of life in glaucoma patients and to identify the clinical and sociodemographic factors influencing this relationship.

Methods

This cross-sectional study included 78 patients attending routine follow-up at the Glaucoma Unit of a training and research hospital in Istanbul between March 1 and April 30, 2025. Data were collected via face-to-face questionnaires including sociodemographic and clinical questions, the General Medication Adherence Scale (GMAS), and the Modified GlauQOL-17 Scale. Mann-Whitney U, Kruskal-Wallis, and Spearman correlation tests were used; significance was set at $p < 0.05$.

Results

The mean age was 64.47 ± 8.97 years; 64.1% were female. Mean GMAS and Modified GlauQOL-17 scores were 30.69 ± 3.13 and 55,14 ± 11.18, respectively. 76.9% of participants demonstrated high medication adherence. A moderate positive correlation was found between adherence and quality of life ($r = 0.374$, $p < 0.001$). Female gender ($p = 0.023$) and non-working status ($p = 0.010$) negatively affected quality of life. Educational level, income, age, and diagnosis duration showed no significant effects ($p > 0,05$).

Conclusion

A significant positive correlation exists between medication adherence and quality of life in glaucoma patients. However, moderate quality-of-life scores despite high adherence suggest adherence alone is insufficient. Psychosocial factors, particularly among female patients and those lacking retirement security, should be incorporated into holistic glaucoma management strategies.

INTRODUCTION

Glaucoma is a chronic optic neuropathy characterized by progressive optic nerve damage, most commonly associated with elevated intraocular pressure resulting from impaired aqueous humor dynamics [1]. Primary open-angle glaucoma (POAG), the most common form of glaucoma, has been referred to as the “silent thief of sight” as it usually does not show symptoms early on and irreversible

visual field loss is often not recognized by patients [1], [2]. Approximately 76 million people worldwide were living with glaucoma as of 2020, and this number is projected to reach 112 million by 2040 [3]. It is estimated that 50–80% of individuals with glaucoma remain undiagnosed, even in high-income countries, as the asymptomatic nature of the disease and the need for repeated assessment in suspicious cases can significantly delay diagnosis [4], [5]. Beyond vision loss, glaucoma imposes a broad burden encompassing physical limitations, depressive symptoms, and anxiety, all of which contribute to a substantially reduced quality of life [3], [6], [7]. While visual decline directly affects patients' daily functioning, the psychological toll of living with a chronic and progressive disease further compounds this burden and must be considered in comprehensive patient care [7].

The primary goal of glaucoma management is to reduce intraocular pressure. Topical and systemic pharmacological agents have formed the cornerstone of medical treatment for decades [8], [9]. However, long-term medication adherence remains a critical determinant of treatment success [7], [10]. Non-adherence rates among glaucoma patients range from 25% to 75% in the literature [2]. Inadequate adherence can lead to disease progression, accelerated vision loss, increased need for surgical intervention, and significant healthcare cost burdens [11].

The primary barriers to treatment adherence in glaucoma patients include insufficient disease awareness, difficulty managing eye drop administration and side effects, financial constraints, polypharmacy, and memory-related challenges [12]. As a chronic condition, glaucoma extends beyond physical health to encompass psychological and social functioning, placing patients at risk for significant challenges in daily living and reduced overall quality of life [13][6]. Despite this, the relationship between medication adherence and quality of life in glaucoma remains an understudied area in the literature.

This study aims to assess medication adherence and quality of life in glaucoma patients, examine the relationship between these two outcomes, and investigate the influence of sociodemographic and clinical factors on both. The findings are intended to inform the development of patient-centered care strategies for this population.

MATERIALS AND METHODS

Study Design and Sample

This cross-sectional study examined medication adherence and quality of life among glaucoma patients the relationship between medication adherence and quality of life. The study population consisted of patients who attended the glaucoma unit of a teaching and research hospital in Istanbul for routine outpatient follow-up between March 1 and April 30, 2025. Based on the population size (N ≈ 600) obtained from outpatient clinic data for two months, we estimated the sample size to be 130 with 50% prevalence, 5% margin of error, and 80% confidence interval. Participants were recruited using a convenience sampling method; all eligible patients attending the clinic during the study period were

consecutively invited to participate. During the study period, 78 patients completed the survey. The study population was not sized to the desired sample size, as each patient had to fill out a face-to-face interview and the survey was done in a relatively long period of time. The study results also showed that some patients waiting for evaluation were not selected because they did not want to wait in the outpatient clinic and so the evaluation of patients did not start until late. The glaucoma outpatient clinic only operates for two days a week and the data collection process was limited to eight days (which also put a limit on the sample size). However, a post-hoc power analysis using the G*Power program with n = 78 and α = 0.05 showed that the statistical power of the study is 92.3% based on the correlation coefficient (r = 0.37). This indicates that the current sample size is sufficient to make a good statistical check for the relationship between the variables.

Participants were included in the study if they were 40 years of age or older; had a glaucoma diagnosis with active outpatient follow-up; were using topical antiglaucoma medication; could speak Turkish and were willing to participate in the study. We excluded patients with cognitive impairment or who were not able to complete the questionnaire due to difficulty in communicating.

Data Collection Tools

A 48-item questionnaire with sociodemographic characteristics and a glaucoma clinical history and two scales were used to obtain data.

General Medication Adherence Scale (GMAS): It is an 11-item, 4-point Likert-type scale developed by Naqvi et al. and translated to Turkish by Karadamar in 2022. The scale is composed of three subscales: non-adherence to patient behavior, non-adherence to comorbidity and polypharmacy, and non-adherence to financial constraints [14], [15]. Based on the scores from the scale, the medication adherence levels of patients are as follows: 0–10 points: “poor adherence”, 11–16 points: “low adherence”, 17–26 points: “partial adherence”, 27–29 points: “good adherence”, 30–33 points: “high adherence”. Generally, we believe that as the score on the scale increases, so does the patient’s medication adherence level. Cronbach’s alpha coefficient was reported as 0.81 in the Turkish adaptation study.

Modified GlauQOL-17 Glaucoma Quality of Life Scale: Originally developed by Rouland and colleagues as a 17-item short form, the scale was subsequently adapted into Turkish by Çelik and colleagues, with the addition of four new items, bringing the total to 21 items [16], [17]. The scale consists of seven subscales: daily life, driving, anxiety, self-assessment, psychology, feeling under pressure, and taking ownership. The minimum possible score is zero and the maximum possible score is 72. A higher score indicates a better quality of life. It is reported in the Turkish adaptation study that Cronbach's alpha coefficient was 0.88.

Cronbach's alpha reliability coefficients were calculated to evaluate the internal consistency of the scales used in this study. The Cronbach's alpha coefficient was 0.68 for the GMAS and 0.73 for the Glaucoma-Specific Modified Quality of Life Scale (Modified GlauQOL-17).

Data Collection Process and Ethical Considerations

From March 1 to April 30, 2025, questionnaires were administered in person to patients attending the outpatient clinic for their scheduled appointments, either before or after their examination. To minimize data loss due to visual impairment or low literacy, all questions were read aloud and responses were recorded by the researchers. The study was approved by the Marmara University Faculty of Medicine Ethics Committee (protocol no. 09.2024.1351) and with institutional permission from the relevant hospital. All participants gave informed consent and the Declaration of Helsinki was followed throughout the study.

Data Analysis

The data were analyzed using the SPSS 26.0 software package. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were calculated to evaluate the participants' sociodemographic characteristics, clinical data, medication adherence, and quality of life. The normality of the data distribution was examined using the Shapiro-Wilk test and visual analyses (histogram and Q-Q plot). Since the data were not normally distributed, the Mann-Whitney U test was used for pairwise group comparisons and the Kruskal-Wallis test was used for multiple group comparisons when analyzing scale scores according to the patients’ demographic and clinical characteristics. Spearman's correlation analysis was applied to examine relationships between variables. A p-value of less than 0.05 was considered statistically significant.

RESULTS

The mean age of the 78 glaucoma patients included in the study was 64.47 ± 8.97 years, and the mean duration since receiving a glaucoma diagnosis was 9.88 ± 7.20 years. Of the sample, 64.1% (n = 50) were female, 75.6% (n = 59) were married, and 53.8% (n = 42) had completed primary school. 16.7% (n = 13) of the participants were illiterate. Regarding employment status, 52.6% were retired, and 41% were unemployed. In terms of economic status, 51.3% of the participants reported that their income was less than their expenses, and 48.7% stated that their income was equal to or greater than their expenses. Additionally, 89,7% of patients lived with their families, 89.7% had social security coverage, and nearly all participants (98.7%) lived in the city center (Table 1). The analysis conducted to describe the sample profile in greater detail revealed no statistically significant relationship between employment status and income levels (p = 0.714).

Table 1
Sociodemographic Findings

Variables		**Mean**	**SD (Min-Max)**
Age (Years)		64.47	8.97 (44–93)
Duration of Diagnosis (Years)		9.88	7.20 (1–31)
		Number (n)	**Percentage (%)**
Gender	Female	50	64.1
	Male	28	35.9
Educational Status	Illiterate	13	16.7
	Elementary School Graduate	42	53.8
	High School Graduate or Higher	23	29.5
Marital Status	Married	59	75.6
	Not Married (Single/Widowed/Divorced)	19	24.4
In-Household Social Support	Available (Living with family/spouse/children)	70	89.7
	None (Living alone)	8	10.3
Income Level	Low Income	40	51.3
	Middle-High Income	38	48.7
Social Security	Available	70	89.7
	None	8	10.3
Employment Status	Active	5	6.4
	Retired	41	52.6
	Not working	32	41
Place of Residence	City	77	98.7
	Rural	1	1.3

SD: Standard Deviation, Min: Minimum, Max: Maximum

The clinical characteristics of the participants regarding glaucoma and the treatment process are presented in Table 2. It was reported that 21.8% of the patients (n = 17) had a family history of glaucoma, while 75.6% (n = 59) had a concomitant chronic disease. Of the participants, 38.5% (n = 30) experienced medication side effects and 11.5% (n = 9) reported hand tremors when data regarding the treatment

process was examined. Additionally, 84.6% (n = 66) of patients administered their own eye drops without assistance.

Table 2
Clinical Characteristics of Participants Regarding Glaucoma and the Treatment Process

Variables		**Number (n)**	**Percentage (%)**
Family History of Glaucoma	Present	17	21.8
	No	61	78.2
Coexisting Chronic Condition	Present	59	75.6
	None	19	24.4
Experience with Drug Side Effects	Yes	30	38,5
	None	48	61.5
Hand Tremor	Present	9	11.5
	No	69	88.5
Administration Method	Self-administered	66	84.6
	Receives assistance	12	15.4

The mean GMAS score was 30.69 ± 3.13. Of participants, 76.9% demonstrated high adherence, 15.4% good adherence, and 7.7% partial adherence; no patients had poor or low adherence. The mean Modified GlauQOL-17 score was 55.14 ± 11.18, indicating moderate-to-high quality of life with considerable variability (Table 3).

Table 3

Findings from the General Medication Adherence Scale and the Modified GlauQOL-17 Scale

General Medication Adherence Scale (Total)	**Mean**	**SD**	**Min-Max**
	30.69	**3.13**	**17–33**
Sub-dimension 1: Patient Behavior	13.87	1.78	6–15
Subdimension 2: Comorbidities and Medication Burden	11.46	1.35	3–12
Sub-dimension 3: Financial Constraints	5.36	1.18	1–6
Modified GlauQOL-17 Scale (Total)	**55.14**	**11.18**	**16–71**
Subscale 1: Daily Life	13.13	3.80	0–16
Sub-Dimension 2: Driving	6.95	1.68	0–10
Subscale 3: Anxiety	8.79	3.39	0–12
Subscale 4: Self-Assessment	12.62	2.75	4–16
Sub-Dimension 5: Psychology	6.05	2.58	0–8
Sub-Dimension 6: Feeling Under Pressure	6.10	1.62	2–8
Subscale 7: Taking Responsibility	1.50	2.15	0–8

No significant relationships were found between medication adherence and gender, marital status, income, education, social support, social security, family history of glaucoma, medication side effects, comorbidities, hand tremors, or method of eye drop administration ($p > 0.05$). Similarly, glaucoma-specific quality of life showed no significant association with marital status ($p = 0.870$), education ($p = 0.164$), social support ($p = 0.824$), income ($p = 0.240$), social security ($p = 0.140$), or clinical characteristics including family history ($p = 0.947$), side effects ($p = 0.309$), comorbidities ($p = 0.903$), hand tremors ($p = 0.078$), or self-administration ($p = 0.102$).

Gender was significantly associated with quality of life ($p = 0.023$); men had higher median scores than women (median = 62.50, IQR = 11.50 vs. median = 55.00, IQR = 13.25) (Fig. 1a). Employment status also significantly affected quality of life ($p = 0.010$), with retired individuals scoring higher than the non-working group (Fig. 1b).

Spearman's correlation analysis was used to examine the relationship between participants' age, duration of glaucoma diagnosis, and scale scores. The results showed that age was not significantly related to medication adherence ($r = 0.172$; $p = 0.131$) or glaucoma-specific quality of life ($r = 0.173$; $p = 0.130$). Similarly, no significant effect of disease duration on medication adherence ($r = -0.075$; $p = 0.514$) or glaucoma-specific quality of life ($r = 0.042$; $p = 0.718$) was detected. These findings suggest that age and disease duration did not significantly impact treatment adherence or quality of life among the study participants.

Within the scope of the main study hypothesis, the relationship between treatment adherence levels and glaucoma-specific quality of life was examined using Spearman's correlation analysis. The analysis revealed a positive and moderately significant correlation between GMAS scores and Modified GlauQOL-17 scale scores (r = 0.374; 95% CI [0.185, 0.534], p < 0.001). According to this finding, as patients' treatment adherence levels increased, their quality of life scores increased as well (Fig. 2).

The mean quality of life score was 57.8 ± 8.69 in patients with high treatment adherence, whereas in patients with partial or good adherence (n = 18) this score was 46.2 ± 13.77 (Table 4). There were no participants in the low or poor adherence groups. The partial and good compliance groups were combined and analysed together (Table 4).

Table 4
Distribution of Mean Glaucoma-Specific Quality of Life Scores According to Participants' Overall Medication Adherence Levels

	Modified GlauQOL-17 Scale Total Score			
General Medication Adherence Status*	Mean	SD	Min - Max	P-value
High Compliance (n = 60)	57.8	8.69	31–71	< 0.001
Partial and Good Fit** (n = 18)	46.2	13.77	16–71	

p: Mann-Whitney U test result; SD: Standard Deviation; Min: Minimum; Max: Maximum.

*Since no patients with low or poor fit levels were identified in the study, the analyses are presented based on the identified fit categories.

**The partial and good adherence groups were combined in the analyses.

Examining the relationships between scale subscales revealed that the 'feeling of pressure' subscale of the GlauQOL-17 scale showed positive, moderate, and highly significant correlations with the patient behavior subscale (r = 0.390; p < 0.001) and the burden of comorbidities and medications (r = 0.417; p < 0.001) of the GMAS. Additionally, there were statistically significant correlations between the GlauQOL-17 daily living subscale and the GMAS patient behavior subscale (r = 0.271, p = 0.016), as well as between the GlauQOL-17 anxiety subscale and the GMAS financial constraints subscale (r = 0.231, p = 0.042). No significant relationships were found among the other subscales (p > 0.05)(Table 5).

Table 5

Correlation Between the General Medication Adherence Scale and the Modified GlauQOL-17 Scale Subdimensions

Modified GlauQOL-17 Scale	**Patient Behavior**	**Comorbidities and Medication Burden**	**Financial Constraints**
Subscale 1: Daily Living	**0.271***	0.126	0.099
Sub-Dimension 2: Driving	0.213	0.038	-0.085
Subscale 3: Anxiety	0.107	0.104	**0.231***
Subscale 4: Self-Assessment	0.169	0.048	0.129
Sub-Dimension 5: Psychology	0.129	0.099	0.136
Sub-Dimension 6: Feeling Under Pressure	**0.390****	**0.417****	0.129
Sub-Dimension 7: Taking Responsibility	-0.003	-0.128	-0.037
Note: Correlation coefficients were calculated using the Spearman correlation test (r)			
*p < 0.05; ** p < 0.001			

DISCUSSION

This cross-sectional study examined the relationship between medication adherence and quality of life in glaucoma patients, along with the sociodemographic and clinical factors influencing this relationship. A positive and statistically significant association was found between medication adherence and glaucoma-specific quality of life, suggesting that regular medication use is linked to better intraocular pressure control and improved patient outcomes. Notably, patients with high treatment adherence demonstrated significantly higher quality of life scores compared to those with good adherence, underscoring the substantial role of medication adherence in treatment management. These findings are consistent with studies suggesting that adequate treatment adherence supports visual function preservation, which in turn may contribute to greater patient confidence and well-being [18], [19]. Although the majority of the participants showed good or good adherence, the average quality of life score was still quite low. Despite high adherence rates, mean quality of life scores remained moderate. The irreversible nature of glaucoma, chronic disease burden, and psychological distress associated with vision loss are key determinants of quality of life that operate independently of medication adherence [20]. As Odberg et al. note, a glaucoma diagnosis alone may negatively affect quality of life, regardless of adherence levels [21]. Moreover, the variety in quality of life scores in glaucoma-based clinical conditions suggests that glaucoma has different perceptions of the disease and different levels of limitations in daily living for patients. In the literature, the patients also have different experiences of the disease and the subjective quality of life, even if clinical stages are the same [20] .

The correlation patterns at the sub-dimension level indicate that glaucoma management is not merely a mechanical process of medication administration, but is directly shaped by the patient's psychological state and daily life experiences. The moderate-to-strong correlations between the 'feeling of pressure' quality of life subdimension and the 'patient behavior' and 'comorbidity and medication burden' subdimensions of medication adherence suggest that psychological burden may negatively influence treatment adherence. Due to the cross-sectional design of the study, the directionality and causality of this relationship could not be established; nevertheless, this finding suggests a meaningful association between patients' psychological experiences and their treatment behavior. This is consistent with the literature indicating that the emotional and psychological burden of chronic diseases such as glaucoma directly impacts disease management [20], [22]. The correlations between financial constraints and both anxiety and daily functioning further support the multidimensional nature of this relationship. Financial problems related to glaucoma can also negatively affect treatment adherence and psychological well-being [22], [23]. These findings are more significant when considered in combination with the socioeconomic profile of the sample. Although most participants had social security coverage, over half reported income below expenses, indicating that financial burden continues to affect treatment adherence despite adequate healthcare access. Notably, the economic cost of disease extends beyond direct treatment expenses, as financial uncertainty may also heighten anxiety and further complicate the overall treatment process, a finding consistent with the existing literature [23]

One of the key findings of this study is the significant role of gender in glaucoma-related quality of life. Men demonstrated a median quality of life score 12 points higher than women, consistent with similar studies [25], [26]. This disparity may partly reflect the caregiving roles traditionally assumed by women, as functional limitations imposed by glaucoma may further complicate these responsibilities. Women's longer life expectancy may also contribute to a greater cumulative disease burden over time [27]. Moreover, female patients are more psychologically affected by chronic diseases and face a higher risk of depression [28]. Taken together, these findings suggest that female glaucoma patients represent a vulnerable subgroup requiring gender-sensitive approaches in clinical care and follow-up.

Regarding employment status, retired individuals demonstrated significantly higher quality of life scores than non-working individuals. Notably, this difference was not attributable to income, as no significant association was found between employment status and income level. Rather, the quality of life advantage observed in retired individuals may be explained by access to social security benefits and greater flexibility in daily time management, both of which may facilitate treatment integration and healthcare utilization [29]. Non-working individuals, by contrast, may face greater caregiving and household responsibilities, leaving less time and energy for self-care. In this group, quality of life scores were particularly low among women, suggesting that the combined effect of gender and employment status warrants specific attention in clinical practice. Similar patterns have been reported in studies examining chronic disease management among women and non-working populations [30].

Effective glaucoma management requires lifelong eye drop administration, which demands adequate fine motor skills. Although hand tremors were not significantly associated with quality of life in this

study, the borderline p-value (p = 0.078) and the small number of affected patients (n = 9) suggest that the analysis may have been underpowered to detect a meaningful effect. Fine motor limitations are not merely a technical challenge; they may also undermine patients' sense of self-efficacy [31]. The need for external assistance with a basic self-care activity such as eye drop administration aligns with the concept of 'dependency burden' in the literature and may particularly affect psychosocial quality of life [32]. These considerations suggest that motor function and functional independence should be routinely assessed in glaucoma management.

In conclusion, these findings highlight the multidimensional nature of glaucoma management. While medication adherence is significantly associated with glaucoma-specific quality of life, sociodemographic factors including gender, employment status, and economic conditions, as well as physical limitations, independently shape patients' overall well-being. A comprehensive approach that integrates psychological, economic, and functional dimensions alongside clinical parameters is essential for optimizing patient outcomes.

LIMITATIONS AND STRENGTHS

This study has several limitations. First, its cross-sectional design precludes the establishment of causal relationships between variables. The single-center, relatively small sample size limits the generalizability of the findings. Most of the sample consists of urban residents with social security coverage, which may have resulted in limited sociodemographic variability and masked group differences. The absence of objective clinical severity measures such as visual acuity or visual field indices, as well as data on the number of medications, dosing frequency, and treatment complexity, limits the interpretability of findings. The sample comprises patients with regular outpatient follow-up and excludes those who discontinued treatment, which may have introduced healthy user bias and contributed to a ceiling effect in adherence scores. Medication adherence was assessed solely through self-report without objective verification such as pharmacy refill records or electronic monitoring, which may have introduced social desirability bias; similarly, some clinical variables were not verified against objective records. Finally, the small number of actively employed participants (n = 5) may have produced unstable estimates in subgroup comparisons and should be interpreted with caution. Furthermore, the exploratory nature of this study and the limited sample size precluded multivariate modeling; future studies should employ regression analyses to control for potential confounding variables.

This study also has notable strengths. The use of the Modified GlauQOL-17, a glaucoma-specific quality of life scale, enabled a more accurate assessment of disease impact on daily functioning and psychological well-being compared to generic scales. The simultaneous use of the GMAS ensured a multidimensional examination of the adherence-quality of life relationship. Face-to-face administration of all questionnaires by researchers minimized data loss, particularly among participants with visual impairment or low literacy. Although the targeted sample size was not reached, a post hoc power analysis confirmed that the achieved sample size provided sufficient statistical power (92.3%).

CONCLUSION

This study demonstrated a positive, statistically significant association between medication adherence and quality of life in glaucoma patients; however, adherence alone is not a sufficient determinant. Sociodemographic factors, including gender, employment status, and economic conditions, as well as clinical variables, significantly modulate this relationship. In clinical follow-up, a comprehensive evaluation encompassing the patient's psychological state, economic circumstances, and disease perception should complement biomedical parameters such as intraocular pressure. Female patients and those without stable employment should be prioritized for psychosocial assessment, while targeted support strategies should be considered for patients facing financial constraints. Patient education programs focusing on eye drop administration and self-care independence should also be incorporated into holistic glaucoma management. Future prospective, multicenter studies encompassing diverse socioeconomic backgrounds and patients with irregular treatment follow-up are warranted to enhance the generalizability of these findings.

Declarations

Funding not applicable

Conflicts of interest/Competing interests not applicable

Ethics approval : The study was approved by the Marmara University Faculty of Medicine Ethics Committee (protocol no. 09.2024.1351) and with institutional permission from the relevant hospital.

Consent to participate : Verbal informed consent was obtained from all individual participants included in the study. The use of verbal consent was approved by the Ethics Committee.

Written Consent for publication not applicable

Availability of data and material : The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Code availability not applicable

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Author contributions

All authors contributed to the study conception and design.

Material preparation and data collection were performed by Y.E.T., Z.T., E.T.Y., İ.Y., S.T., and Ş.M.Ş..

Data analysis and interpretation were conducted by Y.E.T. and Z.T..

The first draft of the manuscript was written by Z.T. and Y.E.T..

N.E.L. and B.İ.S.A. provided clinical and academic supervision, and performed the final critical revision of the manuscript for important intellectual content.

All authors commented on previous versions of the manuscript, read, and approved the final version for publication.

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Figures

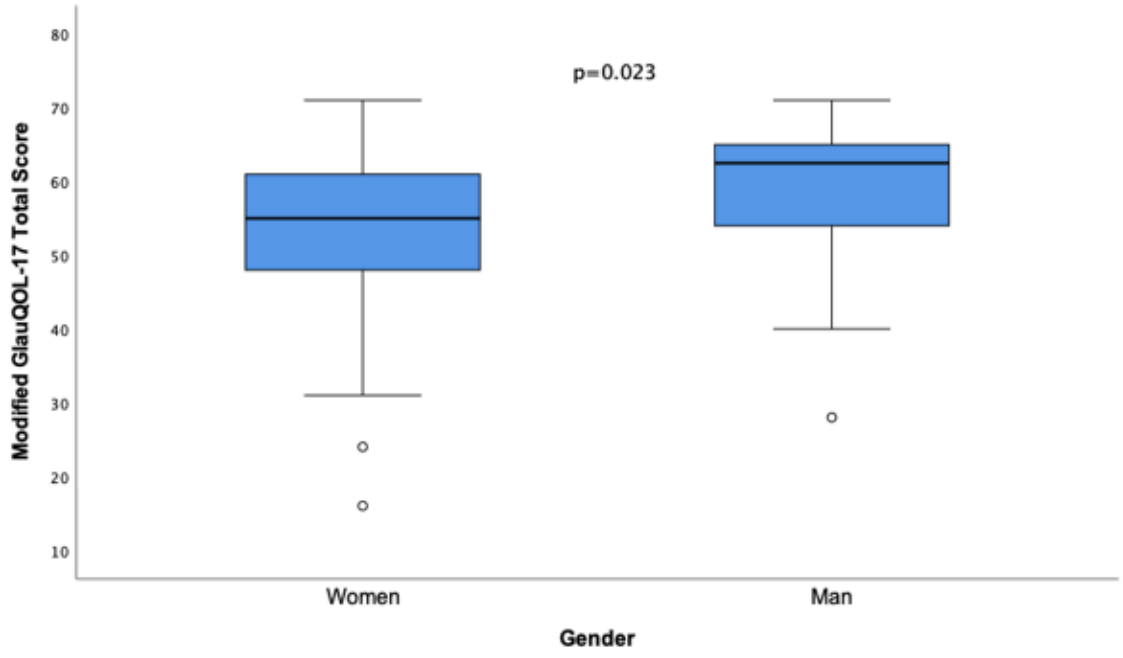


Figure 1a.

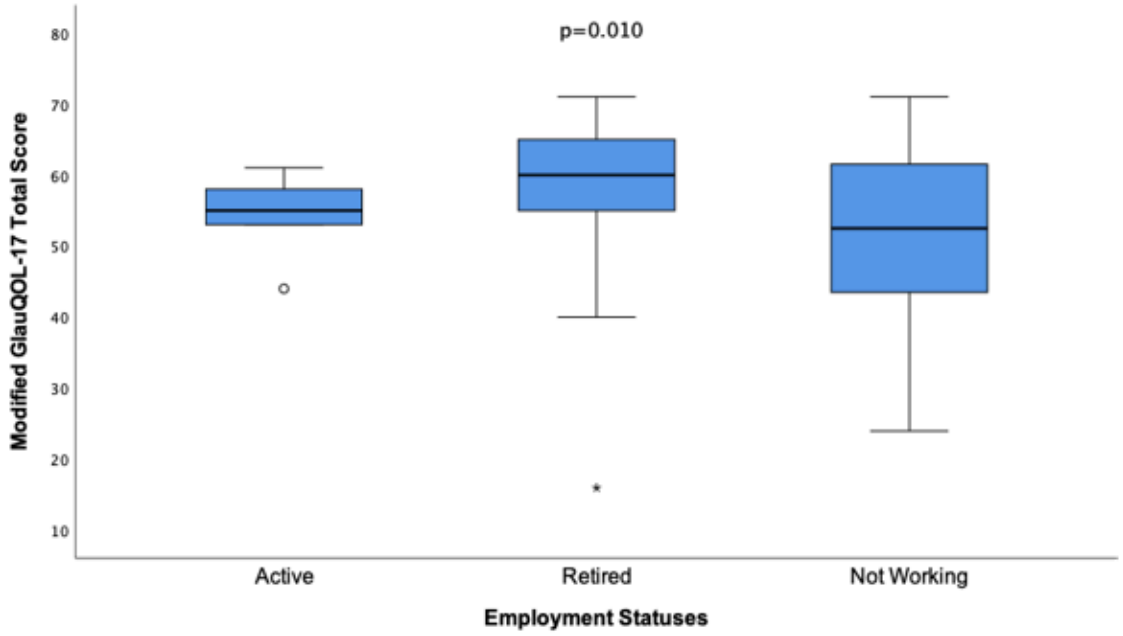


Figure 1b.

Figure 1

a. *Relationship Between* Glaucoma-Specific *Quality of Life Score and Gender*

b. *Relationship Between* Glaucoma-Specific *Quality of Life Score and Employment Status*

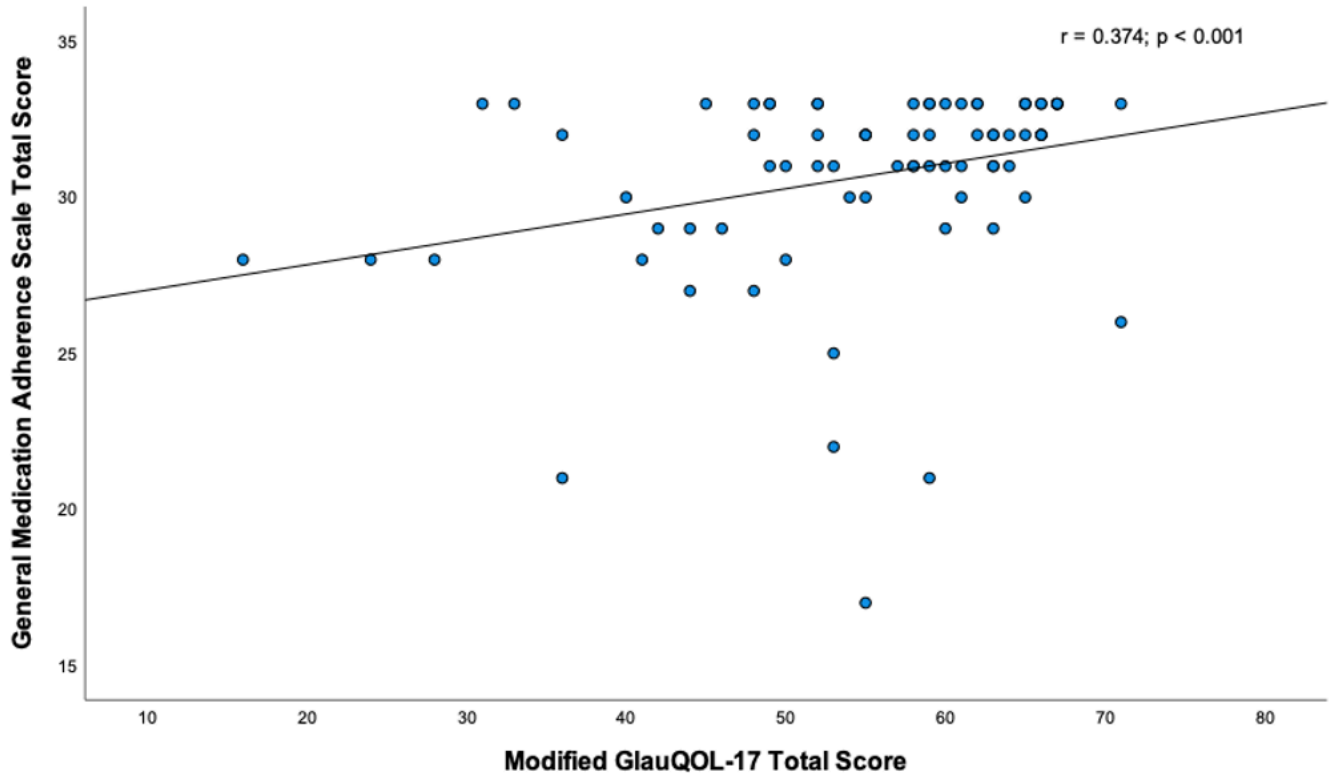


Figure 2

Correlation Between Overall Medication Adherence and Glaucoma-Specific Quality of Life