RESPIRATORY MEDICINE

Obianulika Chukwu

Elective Report

Describe the pattern of COPD in Malaysia and discuss this in the context of global health.

In Malaysia, respiratory illness is the primary cause of visits to health clinics and outpatient hospital clinics. It is estimated that 50 percent of the male population smokes, with higher rates in the rural areas than the urban areas.
Based on the National Health and Morbidity survey in 1996, the Ministry of Health Malaysia reported that the smoking prevalence among those more than 18 years was 24.8%, with 49.2% males and 3.5% females. A national survey in 2000 found 4.64 million smokers, with 3.26 million (78.4%) males above 18, while another 11.2% of themwere 18 and below. More importantly, there were almost half a million female smokers,with 7.3% above 18 years, and 3.1% £ 18 years. Currently there are about 4.3 million smokers in Malaysia, each consuming an average of 14 cigarettes per day. It is estimated that 10,000 Malaysians die each year due to tobacco related illnesses, particularly cancer and cardiovascular disease. Tobacco is the number one preventable cause of premature death nationally and globally. Consistent with the findings of WHO Global Burden of Disease study both mortality and morbidity rates for COPD in the Asia-Pacific region were reported to be higher in men than in womenand increased with increasing age. COPD-related illness was higher in men, with rates of 32.6to 334 per 10,000 people, compared with rates of 21.2 to 129 per 10,000 for women. Chronic respiratory disease including COPD is responsible for 7% of the total Disability-Adjusted Life Years (DALYs) in Malaysia and is ranked fifth as the leading cause of disease burden. The burden of COPD in males is almost three times that of females. The per capita burden of disease increases with age both in males and females where it is predominantly due to COPD in males, while in females it is related to other respiratory diseases. In a survey by the Southeast Asia Tobacco Control Alliance (SEATCA) in Malaysia in 2006, 77% of the health economy burden with the highest growth projected health care cost (2004-2010) among the three major tobacco-related diseases in Malaysia is contributed by COPD.

Describe the pattern of health provision in Malaysia and contrast this with other countries, or with the UK

Health professionals are at the best position to promote smoking cessation. They understand the complexity of nicotine addiction that includes both physiological and psychological dependency, treatment and prevention. Physicians_ advice regarding the harmful effects of tobacco use on health has been shown to be the most effective when in motivating smokers to quit. A brief intervention employing the 5 A's method (Ask,Advise, Assess, Assist and Arrange for follow-up) should be employed at every encounter with patients. Pharmacological agents (e.g., nicotine replacement therapy, NRT) should be offered when appropriate. More intensive intervention could be provided by those trained in providing the service. The Ministry of Health (MOH) Malaysia has been running about 200 quit smoking clinics at various hospitals and health clinics in the country since late 1990's. This shows that help has been around for quite sometime. Thus, health professionals must ask all patients about their smoking status and refer them to the quit clinics. Health professionals should familiarize themselves with the clinical practice guideline (CPG) on _Treatment of TobaccoSmoking and Dependence_ that has been published by the MOH and Academy ofMedicine in September 2003 (available at: http://www.acadmed.org.my/).
Health professionals should also be actively involved in other aspects of tobacco control in line with the Framework Convention on Tobacco Control (FCTC). The FCTC is the worlds first public health treaty negotiated under the auspices of the World Health Organization (WHO) to reduce the global devastating health and economic impacts of tobacco. The FCTC outlines in its provisions measures to achieve effective tobacco control, including increasing price and tax, combating cross-border smuggling and illicit trade, placing pictorial health warnings on tobacco packaging, protecting non-smokers from exposure to tobacco smoke in workplaces, public transport and indoor public places, and banning any sort of promotion, advertising and sponsorship by tobacco industries. The existing health professional organizations should be more active in urging prompt ratification of the FCTC and also more importantly, its implementation.

Obianulika Chukwu

Personal/professional development goals. Must also include some reflective assessment of your activities and experiences.

After being told about this interesting case earlier in the morning I took the opportunity to take a full history from this patient. Upon discussing my findings with the consultant I realised I had large gaps in my knowledge. Subsequently I sat in a clinic with my consultant and came across patients with COPD as well as patients with other respiratory disorders such as lung cancer. From this I identified that my knowledge was weak in the area of staging and grading of tumours as well as differential diagnosis for haemoptysis and I set some personal goals. I was able to examine another patient with a COPD and later read up on the staging and grading of tumours. I discussed this with my consultant afterwards. The consultant supported my learning in this situation by asking me questions and encouraging me to reflect on my experiences. After the consultant had asked a question that I was unable to answer, he encouraged me to read up about it and then tested me again. This enabled me to consolidate my learning. This experience was not only useful for my own personal learning but highlighted useful methods of teaching. As an FY1 I will be involved in teaching other students and I will also be involved in student appraisals by encouraging them to reflect and identify learning goals, practice, seek further exposure and read further.