NEUROLOGY

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SSC 5C: Elective

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Objectives:

1) *What are the prevalent neurological conditions in KL and how do these compare to the UK?*

A study published in 1996 revealed that there was indeed a shortage of neurologists in Malaysia; these in turn was resulting in the fact that all neurological patients were not able to see a neurologist and were managed by general physicians. The study involved six neurologists from Malaysia who made a record of patients presenting conditions. Epilepsy was the main condition comprising 13.9% of the weeks encounters, second was headaches and migraines (13.6%), followed by CVD at 9.1%. it was interesting to see that acute meningoencepahlitis was responsible for 3.5% of patients and 3.5% of patients presented with TB or cryptococcal meningitis. The study showed that only 0.9% of patients presented with Multiple sclerosis. [1] All these findings were based on the patients that could afford to come to hospital. In Malaysia there is a government sector and a private sector health care. Within government sector there are 3 classes and depending on the level of service required different fees are charged. Most charges may seem minimal to those that are financially stable but to those who aren't financially stable, going to hospital may seem challenging. This fact needs to be kept in focus when evaluating any study done. The study in question was done in 1996 and it can't be taken as a true representative of neurological profiles as some patients with neurological conditions never present to hospital.

During my stay at HKL I have seen a very different profile of patients. Clinics have generally comprised of epilepsy, headaches and stroke and on the ward the vast majority of patients have been young patients from low socio-economical status with encephalitis or meningitis. There have also been a few patients with Multiple Sclerosis.

During my placements in the UK the patients presenting in clinical have been somewhat similar to those in KL; epilepsy and headache. However in the UK meningitis or encephalitis is not so prevalent. This may be a reflection of lifestyle habits that make citizens of Malaysia more prone to brain infections and UK citizens more prone to stroke.
The age of patients presenting has also varied between the two countries. The average life expectancy in the UK is 80.4 whereas in Malaysia it is 76.1 years. The difference is not huge but it has to be noted that the age is an average. In the UK the average is reliable as even though there are differences in living standards everyone has access to good health care. However in Malaysia there is a vast difference between living standards so even though the average is 76.1

years there are people that die much younger and there are some that live on till much later. In the UK medicine is generally for the elderly as we are living in an aging population. Hence conditions encountered often are those of the elderly, for example Parkinson disease and dementia. However in Malaysia most of the patients I came across were young patients with infective causes or Multiple sclerosis.

All conditions, regardless of specialty will be under reported in Malaysia due to some difficulty accessing healthcare. It is worrying that the lack of neurologists serving Malaysia will seriously affect the lives of many Malays. This assumption is based on the fact that the number of cases of neurological disease is expected to rise in the next 10 years (by 2016), making this the second leading cause of morbidity and mortality after heart disease in Malaysia. [2]

2) UK places a great emphasis on rehabilitation following a neurological insult. How does Malaysia manage patient's post-neurological insult?

According to the World Health Organisation every year, as many as 15 million people suffer from a stroke. This is considered to be the single leading cause of disability in adults worldwide. Of these cases, approximately 5 million die and 5 million become permanently disabled. In Malaysia, there are approximately 10,000 new stroke cases each year; 70% of patients who recover stop taking part in social activities, 30% need assistance coping with daily life, and 15% die within one month. [3] Stroke related motor deficits can be rehabilitated to a greater degree compared to deficits resulting from other neurological disorders and traumatic brain injuries. [4] At present physiotherapy is the key to rehabilitation.

In the UK rehabilitation is essential; it helps patients regain as much independence as possible. A multi disciplinary team is involved in the care of the patient. The team is led by a doctor alongside other professionals to provide holistic care. Depending on the deficit in question different professionals are involved, for example physiotherapists, occupational therapists, social workers, counselors and doctors. There are often wards within the hospital that are dedicated solely to rehabilitation. These wards have gyms so that patients can regain their strength. If patients are unable to cope at home with their activities of daily living the occupational therapist can assess the home and adapt it for ease if possible. If the patient is still unable to cope then a care package can be put in to practice so a carer can visit during the day to assist.

In the UK, patients often have a care package in place as they often live alone or wish not to burden their families. However I have noticed that this is not the case in Malaysia. Very few patients require social support as family play a vital role in looking after their family members. Apart from this social services issue in Malaysia, the rehabilitation program is similar to that in the UK. There is a gym on the ward as well as one for outpatient use. Physiotherapists play a key role on the neurological ward and also attend ward rounds so they have a clear

understanding of their patients. There is a National Stroke Association Malaysia (NASAM) that aims to provide information about stroke and the rehabilitation program so patients have a better understanding and have a portal to information. This is important; especially in Malaysia as it raises the awareness of exercise and changes that can be made to further reduce the risk of subsequent insults in a population whereby all citizens are not literate.

3) *To gain an understanding of how conditions related specifically to Asia affect patients' lives and how such conditions are managed compared to those found in the UK?*

The main difference between medical conditions in Malaysia and UK are tropical infections. In July/August 2010 there was an outbreak of Leptospirosis. This bacterial infection has steadily been on the rise in Malaysia. There were 1400 cases in 2009. [5] In the UK this infection is very low and during 1990-1995 only an average of 5 cases were reported. [6] They are managed in the same way in both countries but in Malaysia it is higher up on the differential list than it is in the UK.

Dengue fever is also prevalent in Malaysia, in 2010 14000 cases were reported and is caused by mosquitoes. There is currently no vaccination. This is rarely seen in the UK. [5]

The UK has good sewage and water systems, hence there are condition that are rarely seen in the UK but are in Malaysia, for example legionnaires disease and cholera.

Devic's disease is also known as neuromyelitis optica. It is more prevelant in the Africa and Far East Asia. It is an autoimmune condition affecting aquaporin 4. It is often confused with multiple sclerosis but the brain lesions are said to be different. However in Asia it has been proposed that neuromyelitis is a variant of MS in Asia and is known as Asian optic-spinal MS. This variant comprises 30% of MS in Japan. [7] The treatment options differ between the two variants, the classical western MS can be managed with IFN-1b but the Asian form cannot. Immunosuppressant's can be used for the Asian variant.

4) *Appreciate language barriers and cultural sensitivity and experience how health professionals overcome religious barriers in a clinical setting.*

Before commencing my elective in Malaysia I assumed there would be an enormous language and religious barrier, but to my surprise this was not the case. Malaysia is a country that consists mainly of Malays, Chinese and South Indians. Already there are three main languages but what allows them to communicate is English. Most doctors know at least 2 languages so

within the medical team there is always someone that can communicate with the patient. Also the vast majority of patients can speak English so there was no real language barrier. Studying in Whitechapel, London I have come across language barriers and this reflects how culturally diverse London really is.

The religious and cultural backgrounds are also separated three ways in Malaysia. Muslims, Hindus and Chinese all reside side by side with absolutely no issues. However, health professionals are culturally sensitive and appreciate their patients' backgrounds. For example all efforts are made to keep male and female patients separate and dignity is maintained at all times. I noted that during ward rounds curtains were not drawn for general history and examination but were drawn for sensitive examinations. Even though curtains were not drawn it did not feel as though the patients' privacy or confidentiality was compromised.
There is a mosque on site which can be used for praying and doctors are aware of how different patients pray and are aware of their needs.

Generally women do not have a problem with men examining them for medical purposes but if a female doctor is present they would prefer her. From my experience I have come across more women in the UK that have refused to be examined by a male, again this reflects the diversity of London and how the religion in question is the same but the attitude is different.

Being on a neurological firm there have been many lumber punctures refused by patients. There seems to be an understanding that a lumber puncture is potentially fatal and should not be done under any circumstances. This perception has led to many patients refusing consent. Doctors are sensitive to this understanding and try to make the patients understand the nature of the procedure without making them feel bad for refusing or coercing them in to making a decision.

It was nice to see that even though there are three different cultures/religions in Malaysia they all still live as one with no real cut. In the UK we do have a multi cultural society but I don't feel it is as liquid as Malaysia as in the UK it is more small communities within UK rather than one society. There is a lesson to be learnt by the Malaysians.

References

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