OBSTETRICS

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Elective Report

Introduction

I carried out my elective in Sarawak General Hospital (SGH) in Kuching, Malaysia. This 765 bed hospital is the largest hospital in the state of Sarawak, situated in East Malaysia. My initial impression of the hospital was that it was very large and rather intimidating! I was surprised at how similar it looked to hospitals in the UK, although the wards were much larger with a greater number of patients. The atmosphere however, seemed very different to what I was used to in the UK and despite this much higher turnover of patients it generally felt much more relaxed and friendly. All of the doctors and the nurses were English-speaking, making it easy to follow ward rounds. Although they communicated to patients in Malay they would summarise patients in English ensuring key learning points were covered.

Objectives

How does the prevalence and management of obstetric complications differ in Malaysia/SGH when compared to the UK?

The labour ward in Sarawak General Hospital was very similar to those I have seen in the UK. A notable difference however was that there seemed to be more people present in the labour room at any one time than I had ever seen in the UK. There was generally less emphasis placed on privacy and this was reiterated when one of the doctors informed me of a birth that was taking place and said I could go straight in without asking permission. After this initial difference, everything that followed in terms of the delivery and active management of the third stage was the same as I had seen before.

There was a slight difference in the pain management of patients during labour. As in the UK, entonox and pethidine are the main agents used in SGH for pain relief. However, whilst in the UK epidurals are offered quite readily to women, there is a very low rate of use in SGH and probably other hospitals in Malaysia. One of the doctors explained that this is because they have a very high turnover of patients and as epidurals can result in prolonged labour it is not encouraged.

The rate of obstetric complications was similar to those in the UK with complications such as cord prolapse being just as rare. However gestational diabetes mellitus appeared to be much more common and required increased monitoring every two weekly. If there are complications, patients are sent for Caesarean section early so the rate of emergency caesarean section is low.

How do services in SGH such as antenatal care differ from those offered in the UK?

Following a positive pregnancy test, women register at the Mother Child Clinic (MCC). They are given a tetanus injection intramuscularly and routine blood tests are carried out. This is similar to protocol in the UK however there is a difference in the tests requested. In Malaysia they are tested for blood group, HIV, and syphilis status however there is no triple testing. In the UK, triple testing is carried out to identify those women who are at high risk of having a baby with a genetic abnormality e.g. Down's syndrome. Following triple testing, if the risk is deemed high enough, couples are offered diagnostic testing such as amniocentesis to confirm or refute the diagnosis.

On discussion with some of the doctors about why triple testing is not offered in Malaysia many points were raised. We discussed the financial implications of offering the test but our discussions also led us onto the abortion law in Malaysia. During my obstetrics and gynaecology

placement in the UK, I witnessed couples undergo triple testing and then diagnostic testing, following which the option of abortion was often discussed. In Malaysia, which is an Islamic country, abortion is illegal. Therefore, even if triple testing and diagnostic testing were available in Malaysia it would not alter the outcome of the pregnancy i.e. the women would still continue with the pregnancy as opposed to in the UK where the option of termination is available.

In SGH, women are referred to the antenatal clinic if they have complications such as type 2 diabetes mellitus. In this case women are referred for a more detailed scan whereas normally they will only have a dating scan at 12 weeks. They are then seen every two weeks in the antenatal clinic.

In summary it appeared that antenatal care in Malaysia did differ in terms of the testing that was offered but was similar in regard to high risk women being referred to and followed up in the antenatal clinic with more regular monitoring. Also, the role of the MCH appeared to be similar to that role carried out by General Practitioners in the UK.

What is the level of post-natal care offered to new mothers and new born babies e.g. 6week health check, immunisations etc.

Following delivery, the babies were put together in incubators to keep warm whilst the mother was tended to. The mother's length of stay in hospital generally depended on two things; parity and the mode of delivery. A primigravida undergoing a normal vaginal delivery is required to stay in hospital for 12 hours, whilst a multigravida in the same position is only required to stay for 6 hours. If there have been complications during the pregnancy e.g. gestational diabetes or in the case of an instrumental delivery the mother is monitored for at least 48hours. Every baby is given a vitamin K injection and a BCG vaccine after birth.

In the UK, the mother and baby are seen a few days after discharge in the community by a health visitor. This visit is mainly to ensure that mother and baby are both well and to provide extra support with matters such as breastfeeding if required. At this visit the baby is also weighed and this is noted in their red book. In Malaysia, there is no visit by the health visitor and the mother and baby are first seen 4 weeks after discharge in the MCH. Whilst in the UK people are registered with their local GP within their catchment area, in SGH many women travel from far just to deliver the baby and then return home making it impractical to visit these patients in the community.

There was an equivalent of the red book in Malaysia and this was a record given to the parents on which the immunisation schedule was printed. Of note, at birth the babies are also given their first dose of the Hepatitis B vaccine. I found this very interesting as in the UK this vaccine is only given to those at high risk of contracting the virus e.g. healthcare professionals. On discussion as to why this is so, I discovered that Hepatitis B used to be very prevalent in Malaysia in the range of 10-13%, prior to universal vaccination which was introduced in 1989. The risk of vertical transmission is real and vaccination at birth does help to reduce the incidence in the younger generation. The first of the 1989 vaccinated babies would now be 22 years old and some of them may well be parents already. Subsequently, the prevalence of hepatitis B has dropped to single digit & is expected to drop to rates similar to developed countries in another generation.

In summary, I felt that because of the high turnover of patients and the fact that many patients travelled from far to give birth, it is not feasible to have a stringent postnatal care protocol in place as there is in the UK.

Summary

I thoroughly enjoyed my elective placement at Sarawak General Hospital and would definitely recommend it to others. An advantage of carrying out my placement in such a large hospital was that there was always a vast range of clinics I could attend. Also, many of the patients presented with much more advanced disease and florid clinical signs than in the UK. This was partly due to the fact that many people have to travel from a distance to gain access to healthcare resulting in delayed presentation. In the gynaecology clinic I was able to examine large abdominal masses caused by very advanced ovarian tumours and also saw patients with vaginal carcinoma which are both conditions I had not encountered before. The abundance of patients with clinical signs, in combination with friendly and helpful staff makes SGH an ideal location for elective students.