OPHTHACMOLOGY

2013 Elective report
Hospital Kuala Lumpur
(HKL)
Ophthalmology
Malaysia

I was fortunate enough to travel to Southeast Asia for my elective, namely Malaysia. I conducted my placement in the capital city of Kuala Lumpur at the infamous Hospital Kuala Lumpur, which is one of the largest hospitals in the region boasting a 2000 bed capacity.

I conducted the majority of my placement in the ophthalmology department,(although towards the end I was given the liberty to roam the hospital site and attend the A and E department also). This department was in the new building and I was amazed at the modern architecture of this building. The building itself was immaculate with glistening floors and numerous shops for public convenience. There was however, always a high demand for the lift service, and I found myself waiting a good 10 minutes before I could board one to arrive at the sixth floor where the ophthalmology department was based. From the outset, this helped me to appreciate that a large proportion of the population are using the healthcare service provided by the Malaysia government. The building was fully air conditioned and when sat in the consulting rooms it was very similar to the clinic rooms we have at the Royal London Hospital.

The ophthalmology department was extensive, with approximately 30 consulting rooms consisting of triage, A&E and sub-specialties including cornea, paediatric ophthalmology and strabismus, glaucoma, occuloplastic, vitreoretinal, cataract and comprehensive ophthalmology. Unlike the likes of Moorfields eye hospital, the hospital did not have patients separated according to the specialty by which they were being seen. Instead, there was one large waiting area designated to all ophthalmic patients. It was interesting to note, that each specialty was only assigned one day a week in which to perform operations, whilst all the other teams ran clinics. The slit lamps being used were similar to that used at Moorifelds, although limited in number. There were not many snellen charts available and visual acuity was not routinely measured; this is in stark contrast to the UK where snellen charts are available at each cubicle.

The hospital ophthalmic A&E offered an open door policy and saw all patients that came requesting aid, as is the Ministry Of Health's policy-Malaysia's equivalent to the NHS. All patients were required to pay a fixed fee of 1 Ringgit which is equivalent to 20pence for all services received, whilst the rest of their healthcare provision cost was provided for by the Ministry Of Health. Malaysia is able to provide such services through the government tax system which helps to pay healthcare costs of the general public, however, like the NHS, this system is overburdened and things are moving into the direction of privatisation. There is a significant demand for this sector and there are over 200 private hospitals in the country.

The A&E was simply one consulting room with two slit lamps, and it was staffed by and ST1and ST3 equivalent. During my time here I witnessed many cases of labourers coming in with foreign bodies due to the lack of protective wear utilised by builders in the region. During my stay here it was relatively quiet when comparing it to the eye casualty at Moorfields where you are expected to wait a minimum of three hours before being seen.

I was lucky enough to see a police case also be treated; this patient was under police custody for drug smuggling, a crime which the Malaysian authorities take extremely seriously so much so that you are warned of its implications when landing into the country on the aeroplane. This patient was requesting lorazepam and considering his background I would have taken caution when prescribing him such a drug, however the attending doctor simply complied with his request. Regardless they were very skilled at what they did.

The department has recently undergone change in structure allowing it to facilitate regular retinal screening programmes which I thought was a major development in preventing Diabetic related blindness in the region, something which is of paramount significance in both the UK and Malaysia due to the surge in incidence of diabetes. However, vitreo retinal services were not readily available at this hospital and I saw two patients who presented with retinal detachments. One of these still had their macula on so had to be transported to Sarawak for emergency surgery-there were very few vitreo-retinal surgeons in KL. This is in contrast to the UK where the same hospital will have an emergency theatre list dealing solely with retinal detachments.

The leading causes of visual impairment in Malaysian adults are cataracts, diabetic retinopathies and glaucoma. Although the above conditions account for UK adult blindness also, the fact that the UK has a higher life expectancy means that age related macular degeneration is actually a leading cause of visual impairment in the UK, accounting for 50.5% of severe sight loss, followed by glaucoma and then cataracts. Due to the prevalence of ocular trauma and subsequent microbial keratitis, significant corneal ulceration was also witnessed and identified to be a major cause of blindness in working adults. The lack of patient education in the area meant that a lot of the cases of cataracts and corneal ulcerations were presenting late and people were more keen to try home remedies before seeking medical help. In contrast to the UK, occupational hazards (building/farming) placed these individuals at risk of developing corneal ulcers whereas in the developed areas, contact lenses are the major culprit for corneal ulcers developing. Patient education is still being improved in Malaysia as we speak with regular patient information days being held, but due to the lack of funding available only so much can be done, and there is also a greater culture of risk taking behaviour here.

The cosmetics industry is increasingly rapidly in the country and many female patients wear coloured contact lenses for cosmetic purposes. This has consequently resulted in a high rise in female cases of bacterial related keratitis. Although a common procedure in the UK, phacoemulsification was not always used due to the high running and maintenance costs.

This experience has provided me with an appreciation of the similarities and differences between healthcare provision in Malaysia and the UK. It has been a valuable learning experience and I have learned to accept the differences in the presentations of ophthalmic disease. The experience has further compounded my desire to pursue a career in ophthalmology.