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Poor patient adherence to medication is one of the major factors contributing to poor disease control, in particular in asymptomatic chronic diseases like hypertension and dyslipidaemia. The physical and economic burden on patients and the health care system as a result of non-adherence is great. It is estimated that poor adherence to hypertension medication accounts for as many as 7.1 million preventable deaths annually. Hence recognising and identifying non-adherence is the first step to addressing this problem. Medication adherence can be measured in various ways including self-report to electronic monitoring. In order to be more successful in managing non-adherence, attention must be paid to barriers to adherence, namely the interplay of patient factors, the health care providers themselves and the health care system itself. Taking these into account will probably have the greatest impact on improving medication adherence. Consequently, strategies to help overcome these barriers are of paramount importance. Some of these strategies will include education of patients, improving communication between patients and health care providers, improving dose scheduling, providing drugs with less adverse effects, and improving accessibility to health care. Poor medication adherence continues to be a huge challenge. While the patient is ultimately responsible for the taking of medication, good communication, involving the patient in decision making about their care and simplifying drug regimens go a long way in improving it.


Exercise-induced asthma (EIA) is a common condition affecting 12-15% of the population. Ninety percent of asthmatic individuals and 35-45% of patients with allergic rhinitis are afflicted by EIA, while 3-10% of the general population is also believed to suffer from this condition. EIA is a condition which is more prevalent in strenuous outdoor, cold weather and winter sports. The pathophysiology of EIA continues to intrigue medical physiologists. However, the water-loss hypothesis and the post-exertional airway-rewarming hypothesis are as yet the best accepted theories. EIA is best diagnosed by a good medical history and a free-run challenge test. A post-exertion decrease by 15% in FEV1 and PEFR is diagnostic of EIA. Sensitivity of exercise testing ranges from 55% to 80% while specificity is as high as 93%. EIA is a disorder that can be successfully treated by combining both non-pharmacological and pharmacological treatment options. Prompt diagnosis and treatment of this condition is vital if we hope to provide our patients with better overall health, better social life and a better self-image.


Chronic diseases are the major cause of death and disability in Malaysia, accounted for 71% of all deaths and 69% of the total burden of disease. The WHO in its report Preventing Chronic Disease: A Vital Investment has highlighted the inaction of most governments of the low and middle income countries in tackling the problem urgently, is clear and unacceptable. The acute care paradigm is no longer adequate for the changing pattern of diseases in today’s and tomorrow’s world. An evolution of primary health care system beyond the acute care model to embrace the concept of caring for long term health problems is imperative in the wake of the rising epidemic of chronic diseases and its crushing burden resulting in escalating healthcare costs. Compelling evidence from around the world showed that there are innovative and cost-effective community-based interventions to reduce the morbidity and mortality attributable to chronic diseases, but these are rarely translated into high quality population-wide chronic disease care. This paper describes the current situation of chronic disease management in the Malaysian primary care setting – to highlight the need for change, discuss the barriers to the implementation of effective chronic disease management programmes in the community, and consider fundamental solutions needed to instigate the change in our setting.


Qualitative data is often subjective, rich, and consists of in-depth information normally presented in the form of words. Analysing qualitative data entails reading a large amount of transcripts looking for similarities or differences, and subsequently finding themes and developing categories. Traditionally, researchers ‘cut and paste’ and use coloured pens to categorise data. Recently, the use of software specifically designed for qualitative data management greatly reduces technical sophistication and eases the laborious task, thus making the process relatively easier. A number of computer software packages has been developed to mechanise this ‘coding’ process as well as to search and retrieve data. This paper illustrates the ways in which NVivo can be used in the qualitative data analysis process. The basic features and primary tools of NVivo which assist qualitative researchers in managing and analysing their data are described.
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One thousand one hundred and sixty-nine (1169) patients were examined in the Eye Clinic of University of Malaya Medical Centre over a period of three weeks to determine the prevalence of eye diseases and visual impairment. Age, gender, race, visual acuity and diagnosis of patients were noted from the case records. Cataract (385, 32.9%) was the most common eye disease seen in our study followed by glaucoma (274, 23.4%). Refractive errors were seen in 126 (10.8%) while diabetic retinopathy was noted in 113 (9.7%) patients. One hundred and fifteen (9.6%) patients had visual impairment and 11 (0.9%) had blindness in our study according to WHO classification of visual impairment. Refractive errors are the most common causes of visual impairment in children, while cataract, glaucoma and diabetic retinopathy account for visual impairment in elderly people. All these eye diseases are treatable and the severe eye conditions may be potentially preventable with early diagnosis.

EBM COMMENTARY


The paper discusses the management of two individuals with asymptomatic hypertriglyceridemia, a common problem faces by Family Physicians in Malaysia. In such instances it is advisable to exclude an underlying disorder (e.g. metabolic syndrome) and take a pragmatic approach.

NEWS & VIEWS


Leadership in a huge and complex organisation like the Ministry of Health is important. The importance of leadership lies in the role it plays in defining the character, values and direction of an organization; and its relation to organizational performance. Leadership is a quality that must be embedded within an organization for the organization to be successful and meet its objectives. Good leaders can be developed through a continuous process of self-study, education, training and experience. This concept of leadership also highlights the importance of seeking people with leadership talent, developing their potential and providing opportunities for them to lead.


In 2006, I was awarded a scholarship from Universiti Sains Malaysia for Fellowship training at Monash University (MU) for one year. The objective of the training programme was to develop knowledge and skills in several areas, including androgen deficiency, male infertility, prostate disease, testicular tumours, sexual dysfunction and sexually transmitted diseases. The training programme consisted of attachments with clinical specialists, completion of a course work module and a research project. After completion of the training programme, I believe that Primary Care Physicians (PCPs) will benefit from undertaking the training programme that I had completed. It will enable PCPs to assume leadership roles in this multidisciplinary area. The ability of PCPs in handling sexual and reproductive health issues in men will definitely be a more cost effective form of care for patients, particularly as the number of specialists is limited, and even more importantly, it will be satisfying for the patient and the physician.


This paper illustrates the training program in the field of Addiction Medicine designed for primary care doctors by the Department of General Practice, School of Primary Care at Monash University in Melbourne. The nine month program was based around coursework, field visits and clinical observations. There were five modules that were completed and passed, twenty six Continuous Medical Education sessions attended, twenty nine field visits on Drug & Alcohol services, forty seven clinical visits and a total of three hundred and sixty clinical observations made. The comprehensive training program has benefitted the first author in several ways to improve the Drugs & Alcohol services in Malaysia.