

Experience from Malaysia During the COVID-19 Movement Control Order



SUMMARY

COVID-19 pandemic has caused an unprecedented impact to the whole world. Many countries had made the difficult decision to lockdown their countries in order to curb the infection and mortality rate. Malaysia was among the first country to implement Movement Control or Restriction Order in the South East Asia Region following the recent worsening of COVID-19 outbreak. This correspondence describes our experience and the impact of the movement control order to our services and training.

SITUATION IN MALAYSIA

In 29 December 2019, China reported first 4 cases of “pneumonia of unknown origin” linked to a seafood market in Wuhan, caused by a novel coronavirus - which is now well-known as COVID-19.¹ The virus spread rapidly to every continent in the world and the World Health Organization declared the outbreak a pandemic on 11 March 2020. Malaysia reported its’ first confirmed case on 25 January 2020. This was a Chinese tourist from Wuhan, who had travelled from Singapore to Johor Bahru on 22 January 2020. There were only 22 positive cases during the first wave, of which all were discharged well. Following 11 days of zero reported case, the second wave of outbreak started on February 27, with a surge to 553 positive cases by March 16. These cases were related to the Tabligh gathering cluster, held at Sri Petaling from 27 February to 3 March 2020, which was attended by approximately 16,000 people.² To reduce the spread of infection, the Malaysian government decided to implement a nationwide Movement Control Order (MCO) effective from 18 March 2020 to 31 March 2020. After 2 weeks of enforcement of the MCO, new cases continued to increase with occasional plateauing, hence the MCO was extended from 1st April until 28th April 2020. Since the implementation of the MCO, all public hospitals in Malaysia have implemented changes at all level, aimed to conserve the limited resources for the battle against this pandemic.

This correspondence shares our experience from both tertiary public hospital (Hospital Serdang) and university hospital (Hospital Universiti Putra Malaysia), describing the impact of MCO on urology services and challenges after the MCO.

IMPACT OF MCO ON UROLOGY SERVICES AND TRAINING

The Department of Urology consists of 4 consultant urologists, 3 specialists and 11 medical officers (MO), providing services to both Hospital Serdang (620 beds) and Hospital UPM (400 beds). These 2 hospitals serve the southern part of Klang Valley and the state of Negeri Sembilan, covering about a population of 1.7 million. During the MCO period, some of the MOs were deployed to the screening centre in the hospital.

Our outpatient clinics normally receive a total of 250-300 patients per week. Following the implementation of MCO, we drastically reduced the number to about 30-40 patients per week, seeing only the immediate post-operative patients and those who need urgent intervention that is, obstructive uropathy requiring stenting and newly diagnosed cancer. Patients with nonurgent conditions for example, BPE, nonobstructive urolithiasis, treated / stable cancer were rescheduled to later date (ranging 1-6 months), with prescriptions given for pickup at pharmacy, drive-thru service or sent by delivery services.

All nonurgent daycare procedure for example, flexible cystoscopy, prostate biopsy, daycare surgery (eg, circumcision, orchidectomy, vasectomy), ESWL and 50% of ureteric stent change were postponed to later dates. Ureteric stenting for obstructive uropathy and change of expiring stents continued with standard COVID precautions and PPE.

Many wards including Urology ward had been converted to COVID wards. Multidisciplinary wards are currently being shared by all specialties with daily update on bed occupancy status by the ward sisters. Only minimum number of essential personnel was involved in the daily ward rounds. Grand ward rounds were cancelled and elective admissions were minimized. Inpatient transfers from other referring hospitals were also reduced. If interventions are needed and if the essential equipments are available in the referring hospitals, our surgeons will travel and perform the procedure there. Our on-call surgeons have travelled to these hospitals to perform: ureteric stenting for obstructive uropathy with sepsis, nephrectomy for emphysematous pyelonephritis.

All elective surgeries were cancelled. As we have limited resources that is, facemask, PPE, anaesthetists and ICU beds, effort have been made to conserve these limited resources. The cancelled elective cases were screened and triaged by the consultants. Patients who really require surgery especially oncological cases were admitted and posted as semi-emergency surgery. The limited ICU beds and ventilators are some of our major challenges to proceed with most of these semi-emergency surgeries. Emergency surgeries such as ureteric stenting for obstructive uropathy, scrotal exploration, trauma surgery continued

during this period. The MOH issued a guideline which instructed all patients to undergo COVID-19 diagnostic tests via RT-PCR prior surgery with nasopharyngeal or throat swabs. The Urology MOs received training to take the swabs via online video using Zoom and small group training by our microbiology colleagues. In dire emergent situations where the COVID-19 status cannot be ascertained within limited time, the surgery will proceed with enhanced precautions as per COVID-positive cases. In order to ensure faster surgery (to prevent unnecessary waste of OT time) and minimize OT personnel to conserve resources like PPE, only consultant or specialist performed the surgery. Hence, the surgical skills training for trainees had significantly reduced during this period.

Another challenge we faced during the initial stage was patients who lied about their COVID risks. Some hospitals were closed for disinfection and doctors were quarantined as patients intentionally hid their travel and exposure history.³ In view of that, all patients were requested to sign the “COVID-19 Risks Declaration Form” at every level of encounter in all healthcare facilities. Patients were reminded that legal actions will be taken against them if they intentionally lied about their risks and travel history. Since the implementation of this measure, the number of reported dishonesties has reduced as well.

Weekly Uro-Radiology Conference, CMEs, hospital meetings, medical students’ clinical attachment were all cancelled. Undergraduate and postgraduate tutorial / lectures were conducted online using video recordings and meeting platforms for example, Zoom, Skype and etc.

MOVING FORWARD AFTER MCO

By 10th April 2020, 4346 positive cases and 70 deaths had been reported in Malaysia.² There is high possibility that the MCO might be extended further if the curve is not flattening. Catching up and clearing these backlogs will be a challenging task not only to our department but all the affected public hospitals in Malaysia. With 1.5 month of MCO, on a rough estimation, we have lost approximately 240 hours of daycare procedure and 180 hours of elective OT time. We have postponed about 1560 clinic appointments to later dates (1-6 months). This means that over the next 6 months, on top of the existing scheduled cases, we have to increase our resources to cater for: (1) 40 hours/month for daycare (2) 30 hours/month for elective surgery (3 full days’ list) and (3) 65 outpatient consultations/week. The additional elective OT time will be challenging as we will have to compete with the other surgical disciplines. All these will ultimately cause more stress to our overburdened elective surgery list (e.g. average waiting time for PCNL is about 12 months). And if the MCO is going to be extended further, the burden will increase proportionally. In addition, the negative economical impact to many in the middle-class will eventually diverts more patients to the government-subsidized public hospitals, and further increasing stress to the already overburdened health system.

One important aspect which we can learn from this pandemic is the potential of telemedicine in our clinical practice. Although telemedicine is rapidly growing in the healthcare industry especially in the developed countries, its use in urology and developing countries like Malaysia is still in the infancy stage.⁴ Connor et al. proposed a targeted virtual clinic approach for high-risks cancer patients in UK during the COVID-19 outbreak.⁵ As what Marilyn Monroe said: “Within crisis, are the seeds of opportunity.” Perhaps, this crisis could serve as a primer for the development of telemedicine for the urology services and training in Malaysia.

This unprecedented global crisis undoubtedly has a significant impact on all walks of life. The long-term implications of the reduction in clinical activity in Urology are currently unknown, as it is impossible to determine how long the crisis will last for.

Vincent Khor,
Arun Arunasalam,
Saiful Azli,
Mohd Ghani Khairul-Asri, and
Omar Fahmy

Hospital Pengajar Universiti Putra Malaysia,
Selangor, Malaysia
Hospital Serdang, Ministry of Health Malaysia,
Selangor, Malaysia

E-mail: khorweisheng@upm.edu.my (V. Khor).

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Does Surgical Method Affect Cognitive Disorders After Prostatectomy?



To the Editor:

We read with great interest the recent article by Beck et al¹ comparing cognitive function after 2 surgical approaches for radical prostatectomy. Although their findings have