# April 2004 Telemedicine Clinic in Robib

**Report and photos compiled by Rithy Chau, Telemedicine Physician Assistant at SHCH**

On Monday, April 5, 2004, SHCH staff, Nurse Koy Somontha and PA Rithy Chau, traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic. David Robertson finished his contract with this TM project last month and Mr. Chau was sent to facilitate and train Mr. Montrha to run the clinic on his own in the near future.

The following day, Tuesday, April 6, 2004, the Robib TM clinic opened to receive the patients for evaluations. There were 10 new cases and three follow-up patients. The patients were examined and their data were transcribed along with digital pictures of the patients, then transmitted and received replies from their TM partners in Boston and Phnom Penh on the next day.

On the following day on April 8, 2004, replies from both the Sihanouk Hospital Center of HOPE in Phnom Penh and the Partners Telemedicine in Boston were downloaded. Per advice from these two locations, Nurse Koy Somontha managed and treated the patients accordingly. Finally, the data of the patient concerning final diagnosis and treatment/management would then be transcribed and transmitted to the PA Rithy Chau at SHCH who compiled and sent for website publishing.

The followings detail e-mails and replies to the medical inquiries communicated between Robib TM Clinic and their TM partners in Phnom Penh and Boston :

-----Original Message-----
**From:** Montha Koy [mailto:monthakoy@yahoo.com]
**Sent:** Wednesday, March 31, 2004 2:22 PM
**To:** tmed1shch@online.com.kh; tmed_rithy@online.com.kh; bernie@media.mit.edu; hopestaff@online.com.kh; Gary Jacques; Joseph Charles M.D. Kvedar; ruth_tootill@online.com.kh; sihosp@online.com.kh; kfiamma@partners.org; nlugn@partners.org
**Cc:** thero@cambodiadaily.com; Tith Vansourn; seda@cambodiadaily.com
**Subject:** Inform about Robib Telemedicine Trip

Dear All,

I am writing to inform youabout the next Robib TM visit. Since Mr. David Rbertson has ended his conract to work in this project, I taking over his former task as well as handling everything which I useed to do the past. There will be some changes in schedule of each of the visit from now onward. The first day wil involve traveling from PP to Robib, the second day for patient consultation, the third day for entering and transmitting data and for the fort day for collecting replies and returning to PP. Please be advise that Mr. Rithy Chau will travel with me the first few months to help facillitate the changes in this project. I would appreciate your patience with me. Please feel free to make comments on what will or will not work with this new set up for the Robib visit.

Here is the agenda for the next visit of April 2004:

5 April  Leave PP for Robib

6 April  Robib clinic will begin at 8:00 AM

7 April  Data entering and transmitting

8 April  Downloading replies, patient treatment/management, and return to PP

Best Regards,

Montha

-----Original Message-----
**From:** Montha Koy [mailto:monthakoy@yahoo.com]
**Sent:** Wednesday, March 31, 2004 2:22 PM
**To:** tmed1shch@online.com.kh; tmed_rithy@online.com.kh; bernie@media.mit.edu; hopestaff@online.com.kh; Gary Jacques; Joseph Charles M.D. Kvedar; ruth_tootill@online.com.kh; sihosp@online.com.kh; kfiamma@partners.org; nlugn@partners.org
**Cc:** thero@cambodiadaily.com; Tith Vansourn; seda@cambodiadaily.com
**Subject:** Inform about Robib Telemedicine Trip

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5 April  Leave PP for Robib

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7 April  Data entering and transmitting

8 April  Downloading replies, patient treatment/management, and return to PP

Best Regards,

Montha

-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Tuesday, April 06, 2004 7:58 AM
**To:** Cornelia Haener; Ruth Tootill; Rithy Chau; Jennifer Hines; Gary Jacques; Somontha Koy; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Kiri; Bernie Krisher; KuntheaK; SoThero Noun; Seda; Sovan; Ty
**Subject:** Reminder

Dear all,

I am in Robib right now and would like to inform you that be have a new yahoo address for our TM clinic communication. Please reply by Thursday April 8th by 9 AM to this address and CC: to tmed_rithy@online.com.kh.

If this new yahoo mailbox overload please send to an alternative mailbox with the address of tmed_ruralcam@yahoo.com. Use this mailbox only if the first yahoo mailbox can not receieve your reply any more.

Thank you your cooperation.

Sincerely,

Montha

-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Tuesday, April 06, 2004 7:58 AM
**To:** Cornelia Haener; Ruth Tootill; Rithy Chau; Jennifer Hines; Gary Jacques; Somontha Koy; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Kiri; Bernie Krisher; KuntheaK; SoThero Noun; Seda; Sovan; Ty
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If this new yahoo mailbox overload please send to an alternative mailbox with the address of tmed_ruralcam@yahoo.com. Use this mailbox only if the first yahoo mailbox can not receieve your reply any more.

Thank you your cooperation.

Sincerely,

Montha

-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 8:14 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 1, Chan Sokny, 24F

Dear All,

Greetings from Rovieng and thank you for helping with this project.

There will be a total of 12 cases being sent today. Some will be sent this morning and the rest will be sent later in late afternoon or evening. All three new cases will be sent along with a few of the follow up cases. Please try to reply by 9 am tomorrow (Thursday, April 8).

Here is the first case, Chan Sokny, 24F, with 2 photos.

Regards,

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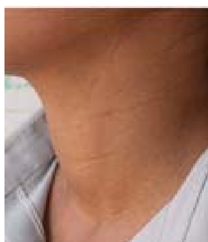
**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient:** **Chan Sokny, 24F, Thnout Malou Village**

**Subject:** Pt returned for f/u visit from two months ago (Feb) for her mild thyroid dysfunction (low TSH and normal free T4). She still c/o HA, dizziness, neck tension, palpitation. Appetite increased and sleeping well. No CP, no syncope, no GI or GU c/o. She stopped breastfeeding her baby 3 months already because "I did not feel well enough."

**Object:**

**VS:** BP 110/60 P 100 R 20 T 36.5 Wt 55kg



Exam showed no changed in thyroid gland size bilat. (5cmx6cm?), other exams WNL.

**Previous Labs/Studies:** 11/02/04 TSH=0.20 (0.47-5.01 uIU/ml), free T4=12 (9-25pmL/L)

**Lab/Study Requests:**

**Assessment:**

1. Low TSH
2. Anxiety?

**Plan:**

1. Give same meds (MTV and folate)
2. Recheck TSH again in 3-6 months?

**Comments:** F/u in June 04.

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]

**Sent:** Wednesday, April 07, 2004 9:56 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Bernie Krisher'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'
**Subject:** RE: Robib TM Clinic April 04, Patient 1, Chan Sokny, 24F

Dear Montha and Rithy,

The patient has palpitation with heart rate of 100 and she stops breast-feeding because she doesn't feel well. I think she is symptomatic. If no fever, no anemia, no arrhythmia, no medications known to cause tachycardia, I would put her on low dose propranolol 10 mg BID and check her T4. Hope propranolol helps her palpitation and her anxiety from her hyperthyroidism.

Thanks for the case,

Bunse

-----Original Message-----
**From:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Sent:** Wednesday, April 07, 2004 8:16 AM
**To:** List, James Frank,M.D.,Ph.D.
**Subject:** FW: Robib TM Clinic April 04, Patient 1, Chan Sokny, 24F

Good Morning Dr List:

Here is a follow up case from Feburary. If you need the previously presented material and your response, please let me know.

Best regards,

Kathy

-----Original Message-----
**From:** List, James Frank,M.D.,Ph.D. [mailto:JLIST@PARTNERS.ORG]
**Sent:** Thursday, April 08, 2004 5:27 AM
**To:** 'tmrural@yahoo.com'; 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'; 'tmed_ruralcam@yahoo.com'
**Cc:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Subject:** RE: Robib TM Clinic April 04, Patient 1, Chan Sokny, 24F

The patient has a goiter in the setting of a slightly suppressed TSH and a normal free T4 level. She has subclinical hyperthyroidism. Her thyroid overactivity is mild and unlikely to explain her symptoms. I agree with the plan to follow her thyroid function tests over time. If her free T4 climbs to above the normal range and/or her TSH falls below 0.1, there may then be need to initiate treatment for hyperthyroidism.

The patient continues to experience HA, dizziness, neck symptoms, and palpitations. This may, indeed, be depression or anxiety. A basic hematology and chemistry lab panel, if not already done, would be a good idea to screen for anemia, renal disease, and diabetes.

James F. List, M.D., Ph.D.

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-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 8:21 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 2, Em Kheav, 42F

Dear All,

Here is the second case, Em Kheav, 42F, with 2 photos.

Regards,

Montha/Rithy

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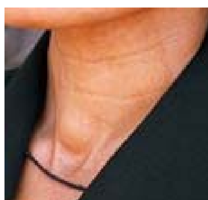
**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient: Em Kheav, 42F, Thnal Keng Village**



**CC:** Palpitation and SOB x 5 years

**HPI:** 42F presented w/ SOB, palpitation, HA, blurred vision, and dizziness intermittently x 5 years. Also, sometimes w/ chest tightness and neck tension. Last year, she noticed there was a mass enlarging progressively on her neck. No wt loss, no cough, no fever. She began to felt some difficulty to swallow accompanied by eye fatigue and insomnia. She was admitted at Preah Vihear Referral Hospital for 10 days this past February and was dx as having goiter. She was treated with some unknown oral medications for 7 days and sx seemed to be unresolving. She did not return to see the physician at the referral hospital and only bought paracetamol for her HA at local pharmacy. Her sx still persisted.

**PMH:** Goiter? 2/04, malaria 5 yrs ago

**SH:** No smoke, no EtOH

**FH:** unremarkable

**Allergies:** NKDA

**ROS:** other other problems

**PE:**

**VS:** BP 100/70 P 104 R 20 T 36.5 Wt 39kg

**Gen:** A&Ox3

**HEENT:** No oropharyngeal lesions, no exophthalmos, good visual acuity, no jaundice, pink conjunctiva, no JVD, no lymphadenopathy, bilateral thyroid enlargement 3cm x 3cm, diffuse, mobile when swallowed, no bruit

**Chest:** clear BS bilaterally w/o rale or rhonchi; HR mildly elevated and

RR w/o murmur

**Abd:** unremarkable

**MS/Neuro:** Normal DTRs, motor and sensory intact, mild extremity tremor, no edema

**Other:** None

**Previous Labs/Studies:** None?

**Lab/Study Requests:** T4, TSH and CBC, chem. And creat at SHCH?, CXR and EKG at K. Thom (if patient could afford it)

**Assessment:**

1. Hyperthyroidism ?
2. Tension HA ?
3. r/o Anemia
4. r/o Cardiac problem

**Plan:**

1. Paracetamol 500mg 1 po q6h prn HA
2. Blood work at SHCH and K. Thom?

**Comments:**

**Examined by:** Koy Somontha, RN **Date:** 6/4/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Wednesday, April 07, 2004 10:19 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'; 'Bernie Krisher'; tmed_project@online.com.kh
**Subject:** RE: Robib TM Clinic April 04, Patient 2, Em Kheav, 42F

Dear Montha and Rithy,

The patient has goiter with fine extremities tremor and 5 years of SOB, palpitation and sometime chest tightness. I agree with your management of checking TSH, T4, CBC, CXR

and EKG. If she is anemic, I would add peripheral blood smear and reticulocytes count with her requested CBC.

Her blurred vision and eyes fatigue needs to see ophthalmologist/optician at Kg. Thom also. Does she has difficulty opening her eyes or chewing? Just to rule out a possible myasthenia gravis!

Thanks for the case,

Bunse

-----Original Message-----
**From:** Kelleher-Fiamma, Kathleen M. - Telemedicine [mailto:KKELLEHERFIAMMA@PARTNERS.ORG]
**Sent:** Thursday, April 08, 2004 3:54 AM
**To:** 'tmrural@yahoo.com'
**Cc:** 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
**Subject:** FW: Robib TM Clinic April 04, Patient 2, Em Kheav, 42F

-----Original Message-----
**From:** Smulders-Meyer, Olga,M.D.
**Sent:** Wednesday, April 07, 2004 4:50 PM
**To:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Subject:** RE: Robib TM Clinic April 04, Patient 2, Em Kheav, 42F

Mrs. Kheav, 42 years old

The patient complains of palpitations and shortness of breath present for 5 years.

Her physical examination is remarkable for he fact that she is underweight, tachycardic and tachypneic.

She has a mass notable in the base of her neck, most consistent with a thyroid mass.

First, one has to establish whether the patient is hyperthyroid or not. Given her vital signs she might well be hyperthyroid. Hypothyroidism is very unlikely. It is important to obtain both a T4 as well as a T3, as she could be hyperthyroid due to overproduction of either one of them. A TSH will confirm whether she is hyperthyroid or not.

If she is hyperthyroid, you need to establish the cause of her hyperthyroidism . To differentiate Graves Disease from toxic adenoma and toxic multinodular goiter.

Since there is a large, palpable, almost superficial mass, that it quite amendable to fine needle aspiration, I would highly recommend that this procedure is done. first, as it is simple and yields a high sensitivity .

If you are dealing with a hot nodule, an autonomously functioning adenoma, your best option would be to treat her with radioactive iodine, and start thyroid replacement therapy once she starts to become hypothyroid soon after that, for life.

If she is not hyperthyroid, the lesion definately needs to be biopsied. to ensure she does not have a primary malignancy, a thyroid cancer or a lymphoma. It is ensuring that the patient has had stable symptoms for a prolongued period of time suggesting a non progressive illness, which does not seem to behave like a malignancy, which is invariably progressive.

If she is not hyperthyroid, it is unclear why she is tachycardic, and a cardiac work up including an EKG and cardiac ultrasound are . I agree with a chest xray to exclude any masses in her lung, given her shortness of breath .

Olga Smulders-Meyer, MD

-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 8:26 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 3, Ke Ourn, 47F

Dear All,

Here is the third case, Ke Ourn, 47F, with 2 photos. More photos will follow.

Regards,

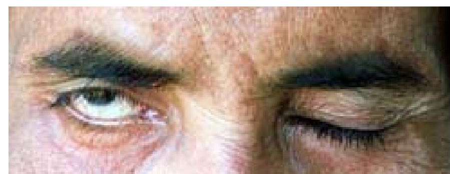
Montha/Rithy

---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient: Ke Ourn, 47F, Thnal Keng Village**

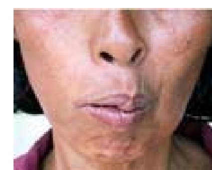
**CC:** Right facial droop x 5 years



**HPI:** 47F with remote h/o malaria infection presented with right facial droop and partial numbness x 5 years. Before this facial droop incidence, pt. said that she was down with "severe" malaria infection and was treated and got recovered from this. One month later, she came down with a high fever during the night that her family said that she "loss conscience" unable to wake her up from sleep for several hours. The next morning g she woke up with right facial weakness, numbness and droop and persisted until today. She said that her right side of the face never seemed to improve much at all. She was initially treated with some unknown modern and traditional medicine which helped slightly. She worried about her condition and came to our TM clinic today.

**PMH:** Malaria 5 yrs ago, FUO? 5 yrs ago

**SH:** no smoke, +EtOH postpartum x 2 years



**FH:** unremarkable

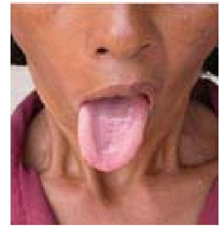
**Allergies:** NKDA

**ROS:** no other problem

**PE:**

**VS:** BP 110/50 P 100 R 18 T 37 Wt 34

**Gen:** A&Ox3, look stable, no pale

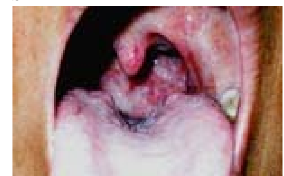


**HEENT:** PERRLA & EOMI, mildly pale conjunctiva, no oropharyngeal lesions, right facial weakness; right face: no crease marks on raising eyebrows, unable to shut right eye when closing, puffing of right cheek when blowing out air through mouth, no deviation of tongue or uvula, right lip droop; left side of face normal. No LN or thyroid enlargement. (see photos attached).

**Chest:** clear BS bilat., HRRR w/o murmur

**Abd:** unremarkable

**MS/Neuro:** Normal gait, normal DTRs, motor and sensory intact, point-to-point intact, tandem walk/tip-toe/heel-walking normal, - Romberg's, no tremor, no ext. weakness, no edema, no skin lesions



**Other:** None

**Previous Labs/Studies:** None

**Lab/Study Requests:** CBC (if she can afford it)

**Assessment:**

1. Bell's palsy
2. Cachexia
3. Parasitic infection

**Plan:**

1. MTV 1 po qd
2. Mebendazole 100mg 1 po bid x 3d
3. Paracetamol 500mg 1 po qd
4. B-complex 1 po bid

**Comments:**

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

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*computer.*

-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Wednesday, April 07, 2004 11:14 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'; 'Bernie Krisher'; tmed_project@online.com.kh
**Subject:** RE: Robib TM Clinic April 04, Patient 3, Ke Ourn, 47F

Dear Montha and Rithy,

The patient has isolated right facial nerve palsy, lower motor neuron, now 5 years. The most frequent cause is Bell's palsy, which is idiopathic and 10% of this illness leaves neurological sequel. The treatment at this point would be supportive, i.e. physiotherapy though after 5 years it is less likely to help. Ask the patient to blow several time a day with fingers helping to close her mouth. She should use adhesive to help close her eyes during her sleep if she cannot completely close her eyes.

I would also try to rule out other causes of isolated facial nerve palsy: HIV, lyme disease, sarcoidosis, acoustic neuromas, Ramsay Hunt syndrome...So I would check if there is vesicular eruption in pharynx, external ear canals, ask if she has joints pain, check if there is poor hearing, and also request HIV test, CXR.

Greetings,

Bunse

-----Original Message-----
**From:** Paul [mailto:ph2065@yahoo.com]
**Sent:** Thursday, April 08, 2004 9:00 AM
**To:** tmrural@yahoo.com; kkelleherfiamma@partners.org
**Cc:** tmed_rithy@online.com.kh; tmed_project@online.com.kh
**Subject:** Patient 3, Ke Ourn, 47F

I apologize for the delay. I have had troubles sending the case..Facial droop is usually caused by stroke, bell's palsy, or tumor compressing the 7th cranial nerve. In her case it appears that she had a case of cerebral malaria. In 3-10% of cases of those who survive there is some kind of neurological deficit. She was lucky to survive the malaria, but unfortunately without this paralysis of her 7th cranial nerve. Sometimes early treatment with steroids can help, and there have been anecdotal reports of benefit from acupunture or massage, but it has been five years so I think it is too late, and that she will have this problem indefinitely.

Thank you,

best wishes

Paul Heinzelmann, MD

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-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 8:42 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 4, Lay Neung, 35F

Dear All,

Here is the next case with photo.

Regards,

Montha/Rithy

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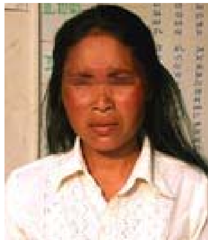
**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient:** **Lay Neung, 35F, Sleing Toul Village**



**CC:** Body weakness and palpitation x 2 years

**HPI:** 35F without PMH presented with intermittent palpitation, chest tightness, body weaknes, dizziness, HA, back pain, SOB and insomnia x 2 years. These sx worsen with daily activities and she bought some medications at local pharmacy (paracetamol and unknown med) for her palpitation and chesttightness without any relief. She has never seek any medical help at HC or hospital. No cough, no fever, wt loss; no GI complaint; no dysuria, no ext. edema. No major changes in BM except occasional "muddy" stool. No black or bloody stool.

**PMH:** unremarkable

**SH:** no smoke; EtOH during postpartum x 2

**FH:** unremarkable

**Allergies:** NKDA

**ROS:** no wt loss, no fever, no

**PE:**

**VS:** BP 110/60 P 90 R 20 T 36.5 Wt 47kg

**Gen:** Look stable, not pale, not tachypneic

**HEENT:** No oropharyngeal lesions, pink conjunctiva, no JVD, no thyroid enlargement, no lymphadenopathy, no bruit.

**Chest:** clear BS bilaterally no rale, no rhonch; Reg HR, irreg rhythm with missing beat every 4-5 beats, no murmur. No thrill.

**Abd:** Soft, flat, +BS in all 4 Q's, nontender, no HSM, no bruit

**MS/Neuro:** normal DTRs, motor and sensory intact, no clubbing, no cyanosis, no edema, good cap refill

**Other:** unremarkable

**Previous Labs/Studies:** None

**Lab/Study Requests:** EKG, CXR, CBC, lytes, BUN, creat, gluc

**Assessment:**

1. PVC?
2. Heart block?

**Plan:**

1. ASA 300mg ¼ tab po qd
2. Send her to K. Thom for labs and studies (patient can afford to do this on her own)

**Comments:** Any other idea about this lady?

**Examined by:** Koy Somontha, RN **Date:** 6/4/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Wednesday, April 07, 2004 11:28 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'; 'Bernie Krisher'; tmed_project@online.com.kh
**Subject:** RE: Robib TM Clinic April 04, Patient 4, Lay Neung, 35F

Dear Montha and Rithy,

The patient has 2 years of palpitation, SOB, dizziness, poor sleep with PE reveals missed beat. I agree with your ASA and your requests EKG, CXR, CBC, BS, lytes, creat at Kg. Thom.

Thanks for the case,

Bunse

-----Original Message-----
**From:** Kelleher-Fiamma, Kathleen M. - Telemedicine [mailto:KKELLEHERFIAMMA@PARTNERS.ORG]
**Sent:** Thursday, April 08, 2004 12:52 AM
**To:** 'tmrural@yahoo.com'
**Cc:** 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
**Subject:** FW: Robib TM Clinic April 04, Patient 4, Lay Neung, 35F

-----Original Message-----
**From:** Guiney, Timothy E.,M.D.
**Sent:** Wednesday, April 07, 2004 1:00 PM
**To:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Subject:** RE: Robib TM Clinic April 04, Patient 4, Lay Neung, 35F

This sort of collection of symptoms is fairly common among young women. The studies requested will uncover any of the usual causes except thyroid disese. Suggest obtaining a screening TSH for completeness.

She is probably having some atrial or ventricular premature beats, and is overreacting to their presence.If the ECG shows only extrasystoles,would suggest a lot of reassurance that she does not have a dangerous or lethal condition.You might also ask her to eliminate coffee,tea and caffeinated beverages.

This is usually accompanied by anxiety and may be the result of family or other personal problems, or the palpitations themselves may be the cause of anxiety. This should be looked into.

Timothy Guiney, M.D.

---

-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 8:47 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 5, Muy Vun, 37M

Dear All,

Here is the next case with photo.

Regards,

Montha/Rithy

---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient: Muy Vun, 37M, Thnout Malou Village**

**Subject:** Pt returned for f/u visit for VHD problem. He felt increasing palpitation, dizziness for the past month intermittently; no SOB, no cough, no CP, no ext edema, no fever; c/o burping, nausea, epigastric pain in AM; no rad pain, no bloodyn or black stool.

**Object:**

**VS:** BP 100/60 P 120 R 22 T 36.5 Wt 62kg

Look stable, exam remarkable for tachycardic, irreg rhythm, no murmur; no edema, no JVD

**Previous Labs/Studies:**

**Lab/Study Requests:**

**Assessment:**

1. VHD
2. A-fib
3. Dyspepsia

**Plan:**

1. Increase to Digoxin 0.25g ½ tab po bid
2. ASA 300mg ¼ qd
3. Add Ranitidine 75mg 2 tab po bid

**Comments:** F/u next month

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

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-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Wednesday, April 07, 2004 11:54 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'; 'Bernie Krisher'; tmed_project@online.com.kh
**Subject:** RE: Robib TM Clinic April 04, Patient 5, Muy Vun, 37M

Dear Montha and Rithy,

Follow-up patient with MS/MR and Afib. No SOB, no extremity edema. He had episode of hemoptysis diagnosed as pneumonia previous month. I wonder whether he has pulmonary congestion needed diuretics, does he have orthopnea, how many pillows he sleep with, how many meters can he walk without SOB? I would like to see his CXR too.

I think we need to send him to Phnom Penh heart center to evaluate his VHD for a possible free cardiac surgery.

I agree with your ASA and ranitidine. I would use Digoxin 0.25 mg q D.

Thanks for the case. Good jobs!

Bunse

-----Original Message-----
**From:** Kelleher-Fiamma, Kathleen M. - Telemedicine [mailto:KKELLEHERFIAMMA@PARTNERS.ORG]
**Sent:** Thursday, April 08, 2004 1:23 AM

**To:** 'tmrural@yahoo.com'
**Cc:** 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
**Subject:** FW: Robib TM Clinic April 04, Patient 5, Muy Vun, 37M

-----Original Message-----
**From:** Sadeh, Jonathan S.,M.D.
**Sent:** Wednesday, April 07, 2004 2:03 PM
**To:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Subject:** RE: Robib TM Clinic April 04, Patient 5, Muy Vun, 37M

As I said before, this young man is at very high risk for an embolic stroke and now also needs better rate control. The periods of palpitations and dizziness are likely related to rapid AF which he seems to be in when you examined him. I would again encourage him to go to a hospital for evaluation of his valvular disease and possible correction of it. In the mean time I would give him a full ASA a day for anticoagulation. I would give him digoxin at a higher dose than what he was given before but you should give it all once a day; a small dose of a beta blocker (lopressor, atenalol) would also help in rate control, if they are available. On his next visit check an ECG again.

The epigastric pain may be related to reflux and trying an H2 blocker like ranitidine is a good idea.

Jonathan Sadeh,M.D.

---

-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 8:55 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 6, Nget Soeun, 57M

Dear All,

Here is the next case with photos.

Regards,

Montha/Rithy

---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient: Nget Soeun, 57M, Thnout Malou Village**

**Subject:** Pt returned for his f/u visit for his problem of liver cirrhosis. He has been improving tremendously. No SOB, no cough, no fever, no jaundice, no abd distension, no edema; occasional HA and blurred vision. No new c/o.

**Object:**

**VS:** BP 90/60 P 70 R 20

T 36.5    Wt 40kg

Pt. appeared stable. PE unremarkable for new problem or recurrent sx of cirrhosis.

**Previous Labs/Studies:** None

**Lab/Study Requests:** None

**Assessment:**

1. Cirrhosis (resolving sx)

2. Slight Cachexia (malnutrition)

**Plan:**

1. Continue w/ same meds: spironolactone 50mg ½ qd, propranolol 40mg ½ qd, MTV.

2. Encourage pt to eat more green veg, fruits, and meat.

**Comments:** He can f/u every 2-3 months from now on.

**Examined by:** Koy Somontha, RN    **Date:** 06/04/04

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-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Wednesday, April 07, 2004 12:05 PM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'; 'Bernie Krisher'; tmed_project@online.com.kh
**Subject:** RE: Robib TM Clinic April 04, Patient 6, Nget Soeun, 57M

Dear Montha and Rithy,

Patient with liver cirrhosis. Good jobs, the patient is improving a lot. I agree with your management, and his propranolol is BID, e.g. 10 mg BID, instead of once daily.

Have a nice day at Preah Vihear,

Bunse

P.S. Dr. Jack with help me to reply the next 6 cases.

-----Original Message-----

From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]

Sent: Thursday, April 08, 2004 4:20 AM

To: 'tmrural@yahoo.com'

Cc: 'tmed_rithy@online.com.kh'; Kelleher-Fiamma, Kathleen M. -

Telemedicine; 'tmed_project@online.com.kh.'

Subject: Patient: Nget Soeun, 57M, Thnout Malou Village

I am glad to hear that he is feeling well.

continue present management and followup plans and abstain from alcohol.

thank you

Paul Cusick

---

----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 8:59 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 7, Pen Vanna, 38F

Dear All,

Here is the next case with photo.

Regards,

Montha/Rithy

---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient: Pen Vanna, 38F, Thnout Malou Village**

**Subject:** 38F, returned for her follow up of Stable HTN, Gerd, DMII? her previous symptoms much improve, no SOB, no chest pain, no dizziness, no neck tender, but still have epigastric pain, (+) burp, (+) nausea in tha morning, no stool with blood, decrease frequency urination, (+) headache.

**Object:** look stable

**VS:** BP 140/90 P 72 R 20 T36.5 Wt = 64kg

- HEENT: unremarkable

- Lungs: clear both sides, no crackle, no wheezing

- Heart: RRR, no murmur

- Abdomen: soft, flat, (-) tender, (+) BS, (+) epigastric pain.

- Limbs: unremakable

**Previous Labs/Studies:**

**Lab/Study Requests:** UA (negative)

**Assessment:**

1. HTN

2. Gerd

3. Tension Headache

4. DMII?

**Plan:** we would like to cover her with the same medications, but twitch from Ranitidine to Omeprazole

1. Increase HCTZ 50mg 1/2tab PO qBID for 1 month

2. ASA 300mg 1/4tab PO qD for 1 month

3. Omeprazole 20mg 2tab PO qHS for 1 month

4. Paracetamol 500mg 1tab PO q 6 (PRN) for 10 days

5. Advise her keep continuous on diet sweet and salty restriction

**Comments:** Please give me some idea and advice.

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----

From: Jack Middlebrooks [mailto:jmiddleb@eudoramail.com]

Sent: Wednesday, April 07, 2004 2:20 PM

To: tmrural@yahoo.com; tmed_rithy@online.com.kh;

tmed_project@online.com.kh

Cc: sihosp@online.com.kh; gjacques@online.com.kh; bernie@media.mit.edu;

tmed1shch@online.com.kh

Subject: Robib TM Case 7

Montha and Rithy:

RE: Case 7, Pen Vanna, 37 F

Why was this patient given a diagnosis of possible DMII? Has she had several elevated blood glucose measurements? She has neither glucose nor protein in her urine, which makes me think that if she does have DM, it is not very severe or longstanding. The diagnosis of DM is important because it affects the approach to both the epigastric pain and the hypertension.

The epigastric pain is not well-described. Is it constant or intermittent? Severe or mild? Associated with food? Associated with the nausea? A reasonable first step might be to stop the ASA and see if the pain resolves at the next follow-up visit. Since she complains of burping, if she has diarrhea or bloating I would consider Giardia and suggest a stool O&P if available, or just treat empirically with metronidazole. If she has symptoms or physical examination findings to suggest diabetic complications, I would consider diabetic gastroparesis as a possible diagnosis and suggest metoclopramide. If she has neither and the symptoms do not improve after a month of omeprazole, I would consider starting H. pylori eradication therapy.

How long has she had nausea in the morning? Could she be pregnant?

I agree that her HTN should be better controlled and agree with your increase in the HCTZ dose. If she were really diabetic, an ACEI would be a better choice because of the renal protective effects, but if she does not have DM, HCTZ alone is fine.

If her headache is not accompanied by other neurologic symptoms and her neurologic examination is normal, a trial of paracetamol is a good first choice for therapy.

Hope this is helpful.

Jack

-----Original Message-----

From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]

Sent: Thursday, April 08, 2004 4:26 AM

To: 'tmrural@yahoo.com'

Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh.';

Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: Patient: Pen Vanna, 38F, Thnout Malou Village

Her blood pressure is better controlled but can still improve. You can use 50mg

HCTZ in daily dose to increase compliance or 25mg bid for bp control.

Her lack of glucose on urinalysis argues against DM2.

It is reasonable to use prilosec to control GERD symptoms and to follow up in

clinic in one month.

Lifestyle and dietary changes are appropriate.

Best of luck,

Paul Cusick

---

----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 9:10 AM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun; tmed_project@online.com.kh
**Subject:** Robib TM Clinic April 04, Patient 8, Sao Phal,

Dear All,

Here is the next case and photo. The other four cases will be sent later today.

Regards,

Montha/Rithy

---

## Robib Telemedicine Clinic
## Sihanouk Hospital Center of HOPE and Partners in Telemedicine
## Rovieng Commune, Preah Vihear Province, Cambodia

**Patient: Sao Phal, 57F, Thnout Malou Village**

**Subject**: 57F, she turned for her follow up of DMII with PNP, HTN and Gerd. She feels much better with her previous symptoms, (-) SOB, (-) fever, (-) chest pain, (-) cough, (-) burp, decrease excessive, but still dizziness and blurred vision sometimes.

**Object:** look stable

**VS:** BP 120/60 P 80 R 20 T 36.5 Wt = 64kg

**HEENT:** no oropharyngeal lesion, no lymphnodenopathy, no JVD, no pale

**Lungs:** clear both sides, no crackle, no wheezing.

**Heart:** RRR, no murmur

**Abdomen:** soft, flat, no tender, (+) BS

**Limbs:** decrease numbness o extremities, no peripheral edema

**Previous Labs/Studies:** none

**Lab/Study Requests:** none

**Assessment:**

1. HTN ( stable)
2. DMII with PNP
3. Gerd

**Plan:** we would continuous with the same medications

1. Diamecron 80mg 1/2 tap PO qD
2. Amitriptilline 25mg 1 tab PO qD
3. HCTZ 50mg 1/2 tab PO qD
4. ASA 300mg 1/4 tap PO qD
5. Decrease Ranitidine 75mg 1tab PO qBID

All cover for one month

**Comments:** if you have any idea or commad, please give me.

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----

From: Jack Middlebrooks [mailto:jmiddleb@eudoramail.com]

Sent: Wednesday, April 07, 2004 3:26 PM

To: tmrural@yahoo.com; tmed_rithy@online.com.kh;

tmed_project@online.com.kh

Cc: sihosp@online.com.kh; gjacques@online.com.kh; bernie@media.mit.edu;

tmed1shch@online.com.kh

Subject: Robib TM Case 8

Montha and Rithy:

RE: Case 8, Sao Phal, 57 F

It sounds like this patient is feeling much better, except for the dizziness and blurred vision. How does the patient describe her dizziness-- does she feel like she is going to faint? Is the room spinning around her? Is it worse in certain positions? Is it worse if she stands up suddenly?

In an older patient on anti-hypertensives, it is common for then to feel dizzy (like they are going to faint) if they stand up quickly because of orthostatic hypotension caused by the medication. History and orthostatic vital signs would help make this diagnosis more clear; if so, you might consider discontinuing the HCTZ for one month if the dizziness is really bothersome, and re-evaluating at her next follow-up. Other common causes of dizziness include benign positional vertigo, which is induced by changes in position- usually while lying flat- and viral URTI's, which she has no symptoms of.

As for the blurred vision: does she have visible cataracts on physical exmaination? If so, referral to an ophthalmologist would be helpful. If it is associated with postural "dizziness" and orthostatic hypotension, decreasing the anti-hypertensive would be reasonable. And in a diabetic, retinopathy is always a possibility-- I don't know if there are treatment options available for this locally or not. If there are, referral to an ophthalmologist might again be a good idea.

Finally, there is no mention of a foot exam in your note-- something that should alway be performed in a diabetic. Good foot care is one of the easiest ways to prevent morbidity and mortality in diabetics.

Hope this is helpful!

Jack

-----Original Message-----
**From:** Kelleher-Fiamma, Kathleen M. - Telemedicine [mailto:KKELLEHERFIAMMA@PARTNERS.ORG]
**Sent:** Wednesday, April 07, 2004 9:32 PM
**To:** 'tmrural@yahoo.com'; Montha
**Cc:** 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
**Subject:** FW: Robib TM Clinic April 04, Patient 8, Sao Phal,

-----Original Message-----
**From:** Tan, Heng Soon,M.D.
**Sent:** Wednesday, April 07, 2004 9:47 AM
**To:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Subject:** RE: Robib TM Clinic April 04, Patient 8, Sao Phal,

Sounds great. How are we monitoring her diabetes?

Ranitidine can be given 75 mg qd once a day.

Heng Soon Tan, M.D.

---

-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 6:41 PM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun
**Subject:** Robib TM clinic, April 04, Patient 9, Som Doeum, 65F

Dear All,

Here is the next case and photos. One more photo will be sent next.

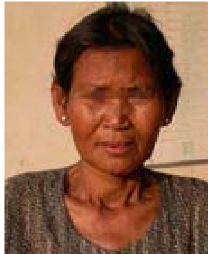
Regards,

Montha/Rithy

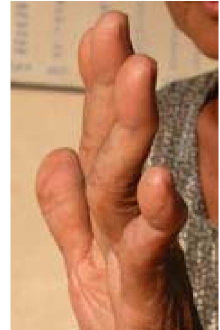
---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient:** **Som Doeum, 65F, Thnout Malou Village**



**Subject:** 64F, returned for her follow up visit of her Polyarthritis and Malnutrition. She still has pain on the both knees, warm to touch on bilateral sides of knees, but no swelling, no fever, no cough, no SOB, no GI complain, (+) body weakness.



**Object:** Look stable

**VS:** BP 110/70 P 80 R 20 T 37
Wt = 39kg

**HEENT:** no oropharyngeal lesion, no pale, no JVD, no thyroid enlargement

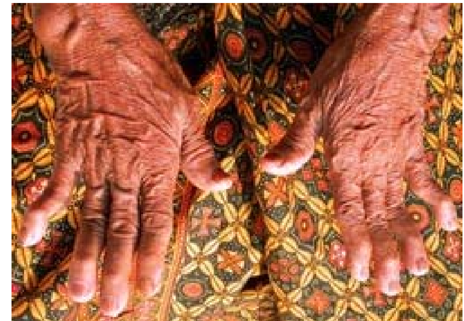
**Lungs:** clear both sides, no crackle, no wheezing

**Heart:** RRR, No murmur

**Abdomen:** soft, flat, no tender, (+) BS

**Limbs:** all her hand fingers are swan neck, but no pain.

**Previous Labs/Studies:** none



**Lab/Study Requests:** none

**Assessment:**

1. Polyarthritis
2. Mulnutrition

**Plan:** **w**e would like to cover her with same medication

1. Nabumetone 75mg 1tab PO q BID
2. Multivitamine 1 tab PO q D

All cover for 1 month

**Comments:** If you have any idea or command, please give me

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----
**From:** Kelleher-Fiamma, Kathleen M. - Telemedicine [mailto:KKELLEHERFIAMMA@PARTNERS.ORG]
**Sent:** Thursday, April 08, 2004 1:09 AM
**To:** 'tmrural@yahoo.com'
**Cc:** 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
**Subject:** FW: Robib TM clinic, April 04, Patient 9, Som Doeum, 65F

-----Original Message-----
**From:** Crocker, Jonathan T., M.D.
**Sent:** Wednesday, April 07, 2004 1:30 PM
**To:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Subject:** RE: Robib TM clinic, April 04, Patient 9, Som Doeum, 65F

Hello,

Regarding Pt Som Doeum, I think we should try and aim for a definitive diagnosis. I am more concerned about the possibility of Rhematoid arthritis given her fatigue and polyarthritis with other joints involved in the past and swan neck deformities evident on your photo. Do you know if she ever had the labs done recommended in January 2004? She should have a baseline CBC, ESR, Rheumatoid factor, and albumen, AST/ALT checked if this hasn't been done already. Check her for rheumatoid nodules on your exam. You should check xrays of the hands and wrists to evaluation for erosive changes and a baseline. If periarticular osteopenia, joint space narrowing, or bone erosions appear or worsen, then you may need to intensify your regimen.

If she is positive for RA, then you may want to consider treating with hydroxychloriquine if Nabumetone alone is not sufficing, as you have done in the past. Rheumatoid arthritis: 310-465 mg/day to start taken with food or milk; increase dose until optimum response level is reached; usually after 4-12 weeks dose should be reduced by 1/2 and a maintenance dose of 155-310 mg/day given

Joint rest, and active/passive range of motion is also important. I see that she has gained 5 kg since last year, that's a good thing!!

Thanks for letting me participate again in her care.

Dr. Jonathan Crocker

-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Thursday, April 08, 2004 8:28 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'; 'Bernie Krisher'
**Subject:** RE: Robib TM clinic, April 04, Patient 9, Som Doeum, 65F

Dear Montha and Rithy,

Dr. Jack is busy with GF meeting, so I continue the case discussion with you.

The patient has polyarthritis, sound like symmetric, inflammatory with morning stiffness, swelling and hot (knees). She has already swan neck deformities, I think she has more likely rheumatoid arthritis. Both hands X-ray with features such as (more than 6 months illness) juxta-articular osteoporosis, erosion and joints space narrowing add to diagnosis.

I agree with your nabumetone with food and MTV and add chloroquine 250 mg q day and monitor her vision monthly. If possible ask for both hands AP X-ray at Kg. Thom.

Thanks for the case.

Bunse

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-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 6:52 PM
**To:** Rithy Chau; Jennifer Hines; Gary Jacques; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun
**Subject:** Robib TM clinic, April 04, Patient 10, Som Thol, 51M

Dear all,

Here is the next case and photos,

Regards,

Montha/Rithy

---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient: Som Thol, 51M, Thnout Malou Village**

**Subject:** Pt returned for his f/u visit concerning his DMII with PNP and dyspepsia. He felt much better, only occasional HA. Extremity numbness has been much improved with medications. He got a good pair of shoes for the protection of his feet.

**Object:**

**VS:** BP 100/60 P 80 R 20 T 36.5 Wt 57kg

Exam showed no remarkable finding.

**Previous Labs/Studies:**

**Lab/Study Requests:** U/A=3+ gluc, BS (w/ breakfast)=394mg/dL

**Assessment:**

1.DMII

2.PNP

3.Dyspepsia (resolving)

**Plan:**

1. Same meds for two months (increasing Diamecron 80mg from ½ to 1 tab po id, amitriptyline 25mg 1 bid, ASA ¼ qd, Ranitidine 75mg 1 bid).

2. Pt education for foot care

3. Check fasting BS next visit, but f/u for med refill in 2 months.

**Comments:**

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----

From: Heinzelmann, Paul J.,M.D. [mailto:PHEINZELMANN@PARTNERS.ORG]

Sent: Thursday, April 08, 2004 2:48 AM

To: 'tmrural@yahoo.com'; 'kelleherfiamma@partners.org'

Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'

Subject: Som Thol, 51M, Thnout Malou Village

Som Thol, 51M, Thnout Malou Village

Greetings.

I am glad he appears to be improving. I assume his foot wound has improved since we dont have a photo.

Increasing his Diamecron seems like a good idea, and Im glad we're finally doing that. He needs to be advised, however, to watch for potential symptoms of hypoglycemia now that we're increasing this medication. These symptoms include:

sweating, shakiness, dizziness, hunger, vision disturbances, unsteadiness, tingling hands or lips, headache, and trouble with speech. As you mentioned, checking BS again will be important.

Best of luck with this patient.

Paul Heinzelmann, MD

-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Thursday, April 08, 2004 9:19 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Gary Jacques'; 'Jack Middlebrook'; 'Bernie Krisher'
**Subject:** RE: Robib TM clinic, April 04, Patient 10, Som Thol, 51M

Dear Montha and Rithy,

Great jobs! the wound was gone.

The patient takes Diamicron 80 mg 1/2 tab TID and his BS = 9 mmol/L and K = 6.3 (Feb 04), His BS now after breakfast = 394 mg/dl could be from large breakfast or from not taking medication regularly. I agree your with management to switch Diamicron to once daily in the morning (hope he then has better compliance). I would start 1.5 tab (120 mg) q AM and advise him on diet, small frequent diets and regular aerobic exercises.

Regarding his high Kalemia, DM itself can cause hyperkalemia (decrease potassium excretion) but I would ask him what does he eat everyday?. It is common here in Cambodia that people think if they have diabetes, something sour like orange, green mango... help metabolite the sugar. We do see patients who take regularly 10-20 oranges a day. Please help to educate that and other diet containing potassium. I would also recheck his electrolytes, BUN, creat. After that consider ACE inhibitor.

I would also use once daily at night of amitriptyline say 25 mg q HS.

Sincerely,

Bunse

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-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 7:15 PM
**To:** Rithy Chau; Jennifer Hines; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun
**Subject:** Robib TM clinic, April 04, patient 11, Tho Chanthy, 36F

Dear all,

Here is the next case and photos.

Regrads,

Montha/Rithy

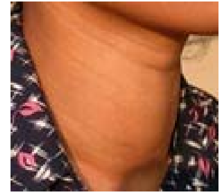
---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient:** **Tho Chanthy, 36F, Thnout Malou Village**

**Subject:** 36F, returned for her follow up of Hyperthyroidism. She still has

head ache, eyes fatigue, neck tightness, decrease palpitation, decrease SOB, No chest pain, positive muscle pain, no GI complain



**Object:** Look stable

**VS:** BP 100/60 P 80 R 20
T 36.5 Wt 55kg

- HEENT: no oropharyngeal lesion, no pale, no JVD, thyroid enlargement is the same size 10x18cm
- Lungs: clear both sides, no crackle, no wheezing.
- Heart: RRR, no murmur.
- Abdomen: soft, flat. no tender, (+) BS
- Limbs: no peripheral edema, no cyanosis

**Previous Labs/Studies:** Her result of Thyroid test done on 12/12/03. T4= 6pml/l (normal range 9 to 25 pml/l) and TSH 1.07microIU/ml (normal 0.47 to 5.01microIU/ml).

**Lab/Study Requests:** We would recheck her Thyroid function test at SHCH

**Assessment:**

Hyperthyroidism

**Plan:** we would continuous with same medications such as

1. Carbimazole 5mg 1tab PO qD
2. Propranolol 40mg 1/4tab PO qD
3. ASA 300mg 1/4tab PO qD

All cover for one month and follow up her for next trip

**Comments:** if you have any idea or command, please give me

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----
**From:** Kelleher-Fiamma, Kathleen M. - Telemedicine
[mailto:KKELLEHERFIAMMA@PARTNERS.ORG]
**Sent:** Thursday, April 08, 2004 1:51 AM

**To:** 'tmrural@yahoo.com'
**Cc:** 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
**Subject:** FW: Robib TM clinic, April 04, patient 11, Tho Chanthy, 36F

-----Original Message-----
**From:** Crocker, Jonathan T., M.D.
**Sent:** Wednesday, April 07, 2004 2:47 PM
**To:** Kelleher-Fiamma, Kathleen M. - Telemedicine
**Subject:** RE: Robib TM clinic, April 04, patient 11, Tho Chanthy, 36F

Hello,

Regarding pateint Tho Chanthy: Her thyroid function looks well controlled on the Carbimazole. Her headaches and muscle pains might be from the carbimazole, but it's hard to tell from your description. I would suggest discontinuing the Propranolol since her thyroid function is improved and she's no longer tachycardic or tremulous. Her headaches might go away when she's off the Propranolol. I'd also suggest she only take the Aspirin as needed, and not every day, if she doesn't need it for any particular reason. Continue following her TSH and T4 values as you have been doing. Is she practicing any contraception? It's important that she not become pregnant on the carbimazole.

Regarding her long term thyroid issues: She should be on the Carbimazole for 12-18 months. Some people then have a recurrence of their hyperthyroidism. You should speak with an endocrinologist for her long term care (ie, radioactive thyroid ablation vs thyroidectomy surgery in the future)...

Thanks again for letting me participate in the care of this woman.

Dr. Jonathan Crocker

-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Thursday, April 08, 2004 9:38 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Jack Middlebrook'; 'Bernie Krisher'; Gary Jacques
**Subject:** RE: Robib TM clinic, April 04, patient 11, Tho Chanthy, 36F

Dear Montha and Rithy,

She is euthyroid (Dec 03). Agree with your management of carbimazole 5 mg qD, though according to experience usually need BID, but it is OK we will follow her T4. You may increase propranolol to BID.

Thanks,

Bunse

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-----Original Message-----
**From:** TM Team [mailto:tmrural@yahoo.com]
**Sent:** Wednesday, April 07, 2004 7:22 PM
**To:** Rithy Chau; Jennifer Hines; Bunse Leang; Jack Middlebrook; Heather Brandling Bennett; Paul Heinzelmann; Kathy Kelleher-Fiamma; Joseph Kvedar; Nancy Lugn
**Cc:** Somontha Koy; Bernie Krisher; SoThero Noun
**Subject:** Robib TM clinic, April 04, patient 12, Torng Khun, 38F

Dear all,

Here is the last case and photos. THank you for participating in the April 04 TM clinic. Please do not forget to reply by 9AM tomorrow.

Regrads,

Montha/Rithy

---

**Robib Telemedicine Clinic**
**Sihanouk Hospital Center of HOPE and Partners in Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

**Patient:** **Thorng Khun, 38F, Thnout Malou Village**

**Subject:** Pt returned for f/u visit for hyperthyroidism, been feeling better with increasing appetite gaining 2kg since last month. No new or recurrent sx. 4 month healthy baby and still breastfeeding. Occasional HA.

**Object:**

**VS:** BP 90/50 P 80 R 20 T 36.5 Wt 57kg

Exam unremarkable for new finding. Goiter size about the same.

**Previous Labs/Studies:** 10/03/04 TSH<0.02

**Lab/Study Requests:**

**Assessment:**

1. Hyperthyroidism
2. HA

**Plan:**

1. Same meds (MTV and Iron)
2. Paracetamol 500mg 1 po qid prn HA

**Comments:** F/u in June 04.

**Examined by:** Koy Somontha, RN **Date:** 06/04/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh and tmed_project@online.com.kh. If unable to send to the first address, please send replies to tmed_ruralcam@yahoo.com as an alternative address.

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-----Original Message-----

From: Heinzelmann, Paul J.,M.D. [mailto:PHEINZELMANN@PARTNERS.ORG]

Sent: Thursday, April 08, 2004 3:06 AM

To: 'tmrural@yahoo.com'

Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'

Subject: Patient: Torng Khun, 38F, Thnout Malou Village

Patient: Torng Khun, 38F, Thnout Malou Village

Greetings.

This patient with thyroid disease sounds to be doing fine clinically. As I have been stating in most of my replies that without a TSH or free T4 it is hard to know with certainty her status. It has been 6 months since her last TSH, so it really is worth repeating at some point.

Thank you for the update. I look forward to her next visit.

Best Wishes,

Paul Heinzelmann, MD

-----Original Message-----
**From:** Bunse LEANG [mailto:tmed1shch@online.com.kh]
**Sent:** Thursday, April 08, 2004 9:58 AM
**To:** 'TM Team'
**Cc:** 'Somontha Koy'; 'Rithy Chau'; 'Jennifer Hines'; 'Jack Middlebrook'; 'Bernie Krisher'; Gary Jacques
**Subject:** RE: Robib TM clinic, April 04, patient 12, Torng Khun, 38F

Dear Montha and Rithy,

Last case of this month.

Hyperthyroid goiter during pregnancy, off carbimazole after delivery. I would check T4 and CBC now. I wonder if she still need iron.

Greetings,

Bunse

**Thursday, April 8, 2004**

Follow-up Report for Robib TM Clinic

There were 12 patients seen during this month Robib TM Clinic. The data of all cases were transmitted and received replies from both Phnom Penh and Boston. Per advice sent by Partners in Boston and Phnom Penh Sihanouk Hospital Center of HOPE, the following patients were managed and treated as follows:

[Please note that some blood works was drawn and done at SHCH at no cost and others including studies such as x-rays, U/S, EKG, etc. were done at Kompong Thom Referral Hospital with patients paying own their own. Robib TM clinic no longer pays for transportation, accommodation, and other expenses for the patients visiting the clinic whether they are from Thnout Malou Village or not. For those patients who were seen at SHCH

previously and remained stable with medications, the clinic would continue to provide them with appropriate medications from SHCH at no cost for the duration of their illnesses or while supplies lasted. The clinic still provided free medications for all "poor" patients, especially if they are from Thnout Malou Village.]

**Patient Chan Sokny, 24F, Thnout Malou Village**

Final assessment: 1) Low TSH 2) Anxiety?

This patient was prescribed and treated with medications as follows:

1. Propranolol 40mg ¼ tab po bid x 1 mo

Next trip draw blood for TSH, free T4, CBC, Creat and BS.

**Patient Em Kheav, 42F, Thnout Malou Village**

Final assessment: 1) Hyperthyroidism 2) Tension HA 3) r/o Anemia 4) r/o Cardiac problem

This patient was prescribed and treated with medications as follows:

1. Paracetamol 500mg 1 tab po qid for 10d

Request TSH, free T4, CBC, Creat, lytes, BS at SHCH and send to K. Thom for CXR and EKG.

**Patient Ke Ourn, 47F, Rovieng Cheung Village**

Final assessment: 1) Bell's Palsy 2) Parasitic infection 3) Cachexia

This patient was prescribed and treated with medications as follows:

1. MTV 1 tab po qd x 1mo
2. B-complex 1 po qd x 1mo
3. Para 500mg 1 po qid x 7d
4. Mebendazole 100mg 1 po bid x 3d

Send to K. Thom for CXR and HIV test.

**Patient Lay Neung, 35F, Thnout Malou Village**

Final assessment: 1) PVC? 2) Heart Block?

This patient was prescribed and treated with medications as follows:

1. ASA 300mg ¼ po qd x 1mo

Send to K. Thom for CXR and EKG. Draw blood for Lytes, Creat, CBC.

**Patient Muy Vun, 37M, Thnout Malou Village**

Final assessment: 1) VHD 2) A-fib 3) Dyspepsia

This patient was prescribed and treated with medications as follows:

1. Digoxin 0.25mg 1 tab po qd x 1mo
2. ASA 300mg ¼ po qd x 1mo
3. Ranitidine 75mg 2 po bid x 1mo

Send to K. Thom for CXR and EKG.

**Patient Nget Soeun, 57M, Thnout Malou Village**

Final assessment: 1) Cirrhosis 2) Cachexia

This patient was prescribed and treated with medications as follows:

1. Spironolactone 50mg ½ po qd x 1mo
2. Propranolol 40mg ¼ tab po bid x 1mo
3. MTV 1 po qd x 1mo

**Patient Pen Vanna, 38F, Thnout Malou Village**

Final assessment: 1) HTN 2) GERD 3) Tension HA

This patient was prescribed and treated with medications as follows:

1. HCTZ 50mg 1 tab po bid x 1mo
2. Amox 500mg 2 po bid x 14d
3. Metronidazole 250mg 2 po bid x 14d
4. Omeprazole 20mg 1 po bid x 14d
5. Metochlopramide 10mg 1 po bid x 14d
6. GERD patient education

After 2 weeks of eradication, will continue omeprazole 20mg 1 po qhs for 1 mo.

**Patient Sao Phal, 57F, Thnout Malou Village**

Final assessment: 1) HTN (stable) 2) DM II 3) PNP 4) Dyspepsia

This patient was prescribed and treated with medications as follows:

1. Diamecron 80mg ½ tab po qd x 1mo
2. Amitriptyline 25mg 1 tab po qhs x 1mo
3. HCTZ 50mg ½ po qd x 1mo
4. ASA 300mg ¼ po qd x 1mo

5. Ranitidine 75mg 1 po bid x 1mo
6. Foot Care Education

**Patient Som Doeum, 65F, Thnout Malou Village**

Final assessment: 1) Polyarthritis 2) Vitamin deficiency

This patient was prescribed and treated with medications as follows:

1. Nabumetone 75mg 1 tab po bid x 1mo
2. MTV 1 po qd x 1mo
3. Chloroquine 250mg 1 po qd x 1mo

Send to K. Thom for hand x-ray.

**Patient Som Thol, 51M, Thnout Malou Village**

Final assessment: 1) DM II 2) PNP 3) Dyspepsia (resolving)

This patient was prescribed and treated with medications as follows:

1. Diamecron 80mg 1½ tab po qAM x 1mo
2. Amitriptyline 25 mg 1 po qhs x 1mo
3. ASA 300mg ¼ tab po qd x 1mo
4. Ranitidine 75mg 1 tab po bid x 1mo
5. Foot Care Education

Do fasting BS next trip.

**Patient Tho Chanthy, 36F, Thnout Malou Village**

Final assessment: 1) Hyperthyroidism

This patient was prescribed and treated with medications as follows:

1. Carbimazole 5 mg 1 tab po qd x 1mo
2. Propranolol 40mg ¼ tab po bid x 1mo
3. ASA 300mg ¼ po qd x 1mo

**Patient Thorng Khun, 38F, Thnout Malou Village**

Final assessment: 1) Hyperthyroidism 2) Tension HA

This patient was prescribed and treated with medications as follows:

1. MTV 1 po qd x 1mo
2. Fe/Folate 200/0.25mg 1 tab po qd x 1mo

**The next Robib TM Clinic will be held on**
**May 11-13, 2004**