Robib and Telemedicine

December 2003 Telemedicine Clinic in Robib

Report and photos submitted by David Robertson

On Wednesday, December 10, 2003, Sihanouk Hospital Center of Hope nurse Koy Somontha gave the monthly Telemedicine examinations at the Robib Health Clinic. David Robertson transcribed examination data and took digital photos, then transmitted and received replies from several Telepartners physicians in Boston and from the Sihanouk Hospital Center of Hope (SHCH) in Phnom Penh.

The following day, all patients returned to the Robib Health Clinic. Nurse "Montha" dispensed medication to the patients and discussed advice received from the physicians in Boston and Phnom Penh.

Following are the e-mail, digital photos and medical advice replies exchanged between the Telemedicine team in Robib, Telepartners in Boston, and the Sihanouk Hospital Center of Hope in Phnom Penh:

Date: Sun, 7 Dec 2003 22:36:15 -0500
From: David Robertson <dmr@media.mit.edu>
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>, robibtech@yahoo.com
Subject: Reminder, Cambodia Telemedicine, Robib, 10 December 2003

Please reply to David Robertson dmr@media.mit.edu

Dear All:

A quick reminder that the December Telemedicine clinic in Robib, Cambodia is still scheduled for Wednesday, 10 December 2003.

We'll have the follow up clinic at 8:00am, Thursday, 11 December (8:00pm, Wednesday, 10 December in Boston.) Best if we could receive your e-mail advice before this time.

Thanks again for your kind assistance.

Sincerely,

David

PS Vansoeurn, we will drive from Phnom Penh to Robib on Tuesday, 9 December, hopefully arriving by 5pm.

Date: Wed, 10 Dec 2003 08:32:53 -0500
From: David Robertson <dmr@media.mit.edu>
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine" <KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>
Subject: Patient #1: SOM THOL, December 2003 Telemedicine, Robib, Cambodia

Please reply to David Robertson <dmr@media.mit.edu>

Our follow up clinic is at 8:00am on Thursday, 11 December 2003 (8:00pm on Wednesday, 10 December 2003 in Boston.)

It is most helpful if we can get your advice by this time.

Thanks again for your kind assistance.

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #1: SOM THOL, male, 50 years old, Follow up patient

Subject: 50-year-old male returned for his follow up visit of DMII, PNP and dyspepsia. No new symptoms, decreased leg numbness from the knee down, is thirsty, decreased urination, no fever, no cough, no chest pain, no weight loss, decreased burning sensation on epigastric pain, no nausea, no vomiting, and no bloody stool.

Object: BP: 100/50, **Pulse:** 80, **Resp.:** 20, **Temp:** 36.5, **Weight:** 52 kg

- No oropharyngeal lesions, no skin rashes
- Lungs clear both sides, full breath sound, no crackle, no Rhonchi,
- Heart regular rhythm without murmur.
- Abdomen, mild tenderness on the epigastric area, no HSM, has bowel sound in all four quadrants
- Legs the same color, left calf still mild pain but no edema, has strong pedal pulses bilaterally.

Assessment:

1. **DMII.**
2. **PNP**
3. **Dyspepsia**
4. **Muscle spasm due to Neuropathy?**

Plan: Prescribe the following meds for one month:

- **Diamecron, 80 mg, ½ tablet, three times per day**
- **Amitriptilline, 25 mg, one tablet, two times per day**
- **Famotidine, 40 mg, one tablet daily**
- **Multivitamin, one tablet daily**
- **Paracetemol, 500 mg, four times daily as needed (for ten days)**

Patient will follow up at next month's clinic on 06 January 2004. May I draw his blood for lytes, Bun, creatinine, blood sugar & CBC to do at Sihanouk Hospital Center of Hope? Kampong Thom Provincial Hospital can't do lytes, Bun, creatinine. Please give me any ideas.

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "'David Robertson'" <dmr@media.mit.edu>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>
Subject: RE: Patient #1: SOM THOL, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 11:39:33 -0500

Patient #1: SOM THOL, male, 50 years old, 12/10/03 Follow up

This man is unfortunately dealing with severe uncontrolled Type 2 diabetes, and will be a real challenge for you. As you know, prolonged hyperglycemia damages the retina of the eye, the kidneys, the nerves, and the blood vessels and he can expect that the following are likely to occur:

- Damage to the retina from diabetes (diabetic retinopathy) leading to blindness
- Damage to the kidneys from diabetes (diabetic nephropathy) and eventual kidney failure
- Further foot wounds and ulcers, which frequently lead to foot and leg amputations.
- Damage to the nerves in the autonomic nervous system can lead to paralysis of the stomach (gastroparesis), chronic diarrhea, and an inability to control heart rate and blood pressure with posture changes.
- The formation of fatty plaques inside the arteries putting him at high risk for heart attack, stroke, and decreased circulation in the arms and legs.

His leg pain may be due in part to this, but strong pedal pulses suggest otherwise. Does he have worsening pain with walking a short distance? If so consider that he may have peripheral vascular disease and intermittent claudication. If untreated, peripheral vascular disease can develop complications:

- Permanent numbness, tingling, or weakness in legs or feet
- Permanent burning or aching pain in legs or feet
- Gangrene

Remember also, serious short-term problems to expect in patients like him

include:

- Infections of any kind
- Hypoglycemic episodes from too much oral hypoglycemics

- Hyperglycemia leading to dangerous episodes: visual changes, altered mental status (agitation, extreme lethargy, or confusion), coma, seizures

The main thing for him now is to do whatever he can to maintain a normal blood sugar. I know this is difficult without the ability to monitor his blood sugar.

I'd recommend the following:

1. Continue to educate him about his disease and the importance of preventing further damage
2. Lifestyle: For example, no smoking/alcohol, low fat diet,
3. Medications:

a. Increase his Diamecron if it appears that he is taking it as you have directed but glucose remains elevated. (For example increase to 80 mg, 1 tablet, three times per day).

b. Note that this medication may eventually not be effective and insulin may be needed. Insulin however may not be a realistic option for him.

4. Tests: I'd recommend that you get the labs you suggested. Lytes, BUN, Creatinine, CBC. His urine could also be checked for protein. These will be helpful in assessing the presence of any kidney damage from his DM. The random glucose can give us a snapshot of his glucose control as well.

5. Ideally, having his eyes checked with a retinal exam, but this may not be considered critical as you weigh the cost to benefit.

6. Regular follow-up

Best of luck with this unfortunate and very challenging patient.

Paul Heinzelmann, MD

Massachusetts General Hospital

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>,
"Gary Jacques" <gjacques@bigpond.com.kh>,
"Jennifer Hines" <sihosp@bigpond.com.kh>,
"Rithy Chau" <tmed_rithy@online.com.kh>
Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,
"Bernie Krisher" <bernie@media.mit.edu>
Subject: RE: Patient #1: SOM THOL, December 2003 Telemedicine, Robib, Cambodia
Date: Thu, 11 Dec 2003 11:12:55 +0700

Dear David and Montha,

Good that his leg numbness, his urinary frequency and epigastric burning

pain improve.

We would have some suggestions:

1. Left caft still tender. According to the attached picture, we see left caft bigger than right. Last month, deep palpation caused tenderness. Good that the pulses at the feet are strong. Does he has claudication? Does stretching his leg cause tenderness? - suggest to bring to Kg. Thom for US + XRay of Left leg, arterial vs veinous clots, ?mass - the concerns are the risks of stroke, pulmonary embolism. Agree with paracetamol for the moment.

Would add ASA 500mg 1/4tab a day.

2. For reason of compliance - Would do twice daily Diamicron. Glycemia needs to be done. If FBS>200 mg/dL, then would give Diamicron 80 mg BID. We think finger stick should be promoted. It can be brought to the site.

3. Amitriptylline - would give the 2 tabs at bedtime.

Regards,

Jennifer/Bunse

Date: Wed, 10 Dec 2003 07:00:16 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #2: PEN VANNA, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine" <KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #2: PEN VANNA, female, 37 years old, follow up patient

Subject: 37-year-old female returned for follow up visit for her hypertension, DMII and GERD. She complained of sweating on and off, sometimes dizziness, has dry mouth, has headache, no blurred vision, no cough, decreased central chest tightness after a meal, decreased epigastric pain, no nausea, no bloody stool, no extremity numbness, decreased urination.

Object: BP: 150/90, **Pulse:** 86, **Resp.:** 20, **Temp:** 36.5, **Weight:** 60 kg

- Hair, Eyes, Ears, Nose and Throat: Okay
- Neck: No JVD, no lymph node
- Lungs clear both sides, no crackle, no wheezing
- Heart regular rhythm without murmur.
- Abdomen: Soft, flat with mild burning sensation at epigastric pain, has bowel sound in all four quadrants
- Extremities have no edema and no tremor
- She checked blood sugar two days ago at Preah Vihear Provincial Hospital.

BS = 90mg/dl

Assessment:

1. **DMII (controlled.) Hypoglycemia?**
2. **Hypertension**
3. **GERD**
4. **Tension Headache**

Plan: Continue with:

- **Hydroclorothiazide, 50mg, ½ tablet daily**
- **Stop Diamecrom because she often gets sweating**
- **Famotidine, 40 mg twice daily**
- **Paracetemol, 500 mg, one tablet four times daily as needed**
- **Diet sugar and salty food. Exercise.**

Please give me any other ideas.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #2: PEN VANNA, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 16:52:29 -0500

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

From: Cusick, Paul S.,M.D.

Sent: Wednesday, December 10, 2003 3:28 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #2: PEN VANNA, December 2003 Telemedicine, Robib, Cambodia

Her BP is not optimally controlled. her target BP is 130/80.

Her dizziness may be from diuretic or from hypoglycemia.

Doing a set of orthostatic blood pressure and pulse readings may help to determine if she is dehydrated. She should drink at least 2 liters of water daily to preserve a well hydrated state.

I would check orthostatic BP and HR.

I would see if the sweating and dizziness gets better off of the diamecrom.

If she is still having these symptoms after one month off the medication, then it is likely due to dehydration.

Her GERD is controlled.

Optimally, when the source of her dizziness/sweating is clear, her blood pressure needs to be lowered.

Good luck,

Paul Cusick

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #2: PEN VANNA, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:18:47 +0700

Dear David and Montha,

1. Still uncontrolled HTN 150/90, is she on HCTZ 25 mg/day? (recommendation from Dr. Gary on Nov 2003). If you would like to increase to 50 mg/day, this may not do much, and even is not a good option because of her diabetes (risk of cardiovascular diseases - UpToDate 8.3). We suggest to keep 25 mg/day of HCTZ and add whether atenolol 25 mg/day (first option), or ACE inhibitors (for ACE-I lisinopril is good choice because of availability and once daily, but the use is complicated - need to stop HCTZ a few days first with ACE-I, then add later). May add ASA 500 mg 1/4 tab a day.

2. Because of low dose Diamicron 40 mg/day and she expereinces hypoglycemic symptoms weith BS = 90 mg/dL, we agree with you to stop diamicron, but also want to know when the episodes of hypoglycemia occurs and her diets. Continue diet, exercices and lowering weight. Have her recheck her BS at Preah Vihear (or you have your One-Touch) next time. If high BS > 200 mg/dL, may consider metformin.

3. Good that dyspepsia better. Agree to keep same famotidine.

Regards,

Jennifer/Bunse

Date: Wed, 10 Dec 2003 08:42:58 -0500
From: David Robertson <dmr@media.mit.edu>
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>
Subject: Patient #3: NGET SOEUN, December 2003 Telemedicine, Robib, Cambodia

Please reply to David Robertson dmr@media.mit.edu

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #3: NGET SOEUN, male, 56 years old, follow up patient

Subject: 56-year-old male returned for follow up visit for his Cirrhosis and Ascitis. His previous symptoms are much improved. Has headache, has blurred vision, has shortness of breath, no chest pain, no fever, no cough, no abdominal distension, no edema on both legs, has weakness, has good appetite, no loss of weight, no bloody or black stool.

Object: BP: 90/60, **Pulse:** 68, **Resp.:** 20, **Temp:** 36.5, **Weight:** 42 kg

- Hair, Eyes, Ears, Nose and Throat: Okay
- Neck: Not icteric, no oropharyngeal lesions, no JVD, and no lymph node.
- Lungs bilateral crackle at lower base
- Heart regular rhythm without murmur.
- Abdomen: Soft, flat, no HSM, has bowel sound in all four quadrants
- Extremities have no edema and no tremor

Assessment:

1. **Cirrhosis.**
2. **Ascitis due to Cirrhosis**
3. **Pulmonary congestion due to Cirrhosis?**

Plan: Continue with the same medications.

- **Spironolatone, 50mg, 1/2 tablet twice daily for 30 days**
- **Furosemide, 40 mg, 1/2 tablet daily for 30 days**
- **Propranolol, 40 mg, 1/4 tablet twice daily for 30 days**
- **Multivitamin, one tablet daily for 30 days**
- **Encourage him to eat two bananas per day**

Return next month for follow up. Do you agree?

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #3: NGET SOEUN, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 14:55:36 -0500

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

From: Tan, Heng Soon,M.D.

Sent: Wednesday, December 10, 2003 2:36 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #3: NGET SOEUN, December 2003 Telemedicine, Robib, Cambodia

I'm glad to hear that he remains stable on his current medications. Were any of my

recommendations from last month carried out? Specifically: 1. Serum electrolytes to check sodium, potassium, urea and creatinine to monitor renal response.

2. Was it alcoholic, viral hepatitis or cryptogenic cirrhosis?

3. Has he received appropriate hepatitis A and B vaccination to prevent superinfection?

Heng Soon Tan, M.D.

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>,
"Gary Jacques" <gjacques@bigpond.com.kh>,
"Jennifer Hines" <sihosp@bigpond.com.kh>,
"Rithy Chau" <tmed_rithy@online.com.kh>
Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,
"Bernie Krisher" <bernie@media.mit.edu>
Subject: RE: Patient #3: NGET SOEUN, December 2003 Telemedicine, Robib, Cambodia
Date: Thu, 11 Dec 2003 11:19:08 +0700

Dear David and Montha,

We agree with your management, great job!

We are unclear why he has crackles bilateral lower part of the lungs. Could you help him do a CXR at Kg. Thom and send us the picture?

Regards,

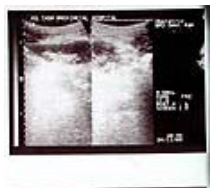
Jennifer/Bunse

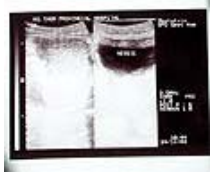
Date: Wed, 10 Dec 2003 07:05:09 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #4: SAO CHHOUN, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #4: SAO CHHOUN, male, 37 years old, follow up patient





Subject: 37-year-old male returned for follow up visit for his Splenomegalie, muscle strain and pneumonia? He was sent to Kampong Thom Provincial Hospital last month for some blood work, abdominal ultrasound, chest x-ray and AFB. The results as follows:

- Abdominal ultrasound: Showed normal per attached photo
- X-ray: Showed bronchitis per attached photo
- AFB: Negative
- Blood results: per attached photo

He still complains of left upper quadrant and epigastric pain, much improved from his previous symptoms. Has excessive saliva, no headache, no chest pain, no shortness of breath, has cough sometimes, no fever, has burning sensation after a meal, has a good appetite, no weight loss, no black or bloody stool, and has lower back pain.

Object: BP: 120/60, **Pulse:** 80, **Resp.:** 20, **Temp:** 36.5, **Weight:** 55 kg

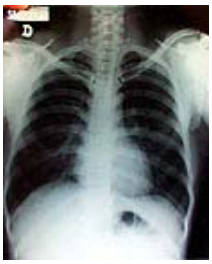
- Hair, Eyes, Ears, Nose and Throat: Okay
- Neck: No JVD, no lymph node
- Lungs clear both sides, no crackle, no wheezing
- Heart regular rhythm without murmur.
- Abdomen: Soft, flat, Splenomegalie about 3cm under costal margin, has bowel sound in all four quadrants
- Extremities have no edema and no tremor

Assessment:

1. Muscle strain.
2. Splenomegalie?
3. Chronic bronchitis?
4. GERD?

Plan:

- **Famotidine, 40 mg tablet daily, for one month**
- **Amoxycillin, 500 mg three times daily, for seven days**
- **Paracetemol, 500 mg, one tablet four times daily as needed, for seven days**



Please give me any other ideas.

From: "Crocker, J.Benjamin,M.D." <JBCROCKER@PARTNERS.ORG>

To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #4: SAO CHHOUN, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 13:46:29 -0500

Interesting case. I don't think I'd treat him w/ antibiotics at this point as I'm not convinced of a true bacterial bronchitis. Still no explanation for the splenomegaly. Differential diagnosis includes chronic infection (malaria, TB, kala azar, HIV), lymphoma/other malignancy, cirrhosis though less likely with reportedly "normal" ultrasound. Someone should verify the results of his lab work as I cannot be sure what I am looking at, but I presume that his CBC was normal.

I would:

1) plant PPD/mantoux skin test. if positive would obtain BM/other tissue culture to rule out active TB. AFB alone may not be sensitive enough.

2) check blood smear to see what his cells actually look like.

3) check malarial smear

4) check HIV test

5) check hepatitis serology testing for type B and C.

6) it would probably be too expensive to consider CT abdomen/chest but this would be something I'd recommend to folks here.

7) consider bone marrow biopsy for both microscopic evaluation and culture

for leishmaniasis (kala-azar) and TB.

hope this helps.

J. Benjamin Crocker, M.D.
Internal Medicine Associates 3
WACC 605
15 Parkman Street
Boston, MA 02114
Phone 617 724-8400
Fax 617 724-0331
Email jbcrocker@partners.org

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #4: SAO CHHOUN, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:19:48 +0700

Dear David and Montha,

1. LUQ abdominal pain with 3 cm splenomegaly below costal margin, and negative findings on abdominal US, CBC normal, CXR too dark to interprete. have cough but no fever. The DDx of LUQ abdominal pain could be MI, left lower lobe pneumonia, left lobe liver abscess, pyelonephritis, gastritis or splenic enlargement, ruptured or abscess. He is better compare to last month, so what is his current medications?

2. If current meds are what in the Plan list, then with his improvement + epigastric pain complaints would point towards gastritis. Would continue same famotidine.

3. Unlikely that liver abscess, pyelonephritis, splenic abscess due to 1 month without antibiotics.

4. Any abdominal trauma to the spleen, any anemia?

5. Agree with amoxicilline.

6. May empirically give Albendazole 400 mg BID for 5 days. Strongyloides can give epigastric pain.

Regards,

Jennifer/Bunse

Date: Wed, 10 Dec 2003 07:18:37 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #5: SUM SOKNA, female, 20 years old

Chief complaint: Pain on all finger, ankle, knee, wrist, and elbow joints for three months. Has had dry cough and sore throat on and off for one

year.

HPI: 20-year-old female presented with general joint pain all over the body, especially in the morning. Sometimes she can't walk; both knees have been swollen on and off as well. She also has a dry cough, has sore throat on and off, has mild fever, has nausea, has weight loss of about five kg over six months, has good appetite, has shortness of breath, no chest pain, no palpitations, and no black or bloody stool.

Past medical history: Unremarkable.
Family history: Unremarkable.
Social history: Does not smoke and does not drink alcohol.
Allergy: None known.
Current medicine: None.

Physical Exam:
BP: 120/60
Pulse: 86
Resp.: 20
Temp. : 37.3
Weight: 44 kg

Object: Alert and oriented x 3 (place, person, and time.)

Hair, eyes, ears, nose, and throat: Not icteric, has mild redness oropharyngeal but tonsil not enlarged, no lymph node enlargement, and no pus.

Lungs: Clear both sides, no crackle and no wheezing.

Heart: Regular rhythm, no murmur

Abdomen: Soft, flat, not tender, has positive bowel sound all four quadrants, no HSM.

Extremities: All joints no deformity, no stiffness, no edema, no redness, and has normal color.

Neuro exam: Unremarkable.

Assessment:

- **Poly Arthritis?**
- **Rheumatoid Fever?**
- **Chronic Pharyngitis.**

Plan: We would like to cover her with:

- **Amoxycillin, 500 mg three times daily, for seven days**
- **Ibuprofen, 400 mg, one tablet three times for 15 days**

Follow up at next month's clinic. If not better send her to Kampong Thom for some blood work like Rheumatoid Factor, CBC and ESR. Do you agree? Please give me any other ideas.

From: "Patel, Dinesh,M.D." <DGPATEL@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>

Subject: RE: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 18:23:19 -0500

Kathy,

I do not have any specific suggestions but question of Rheumatoid Arthrits does come in my mind She has pink cheeks so wonder if she also has some kind of skin disorder or secondary to rh fever or what Can they do the blood work before starting the treatment.

How about just give high dose of Ibuprofen 800mg three times a day and not give Amoxycillin antibiotics and see the response in 7 days.

Thanks

dinesh

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cam
bodia
Date: Wed, 10 Dec 2003 19:21:01 -0500

Dear David,

I understand you have already received a response from another doctor.

I add mine as further consideration.

Paul

Patient #5: SUM SOKNA, female, 20 years old

Chief complaint: Pain on all finger, ankle, knee, wrist, and elbow joints for three months. Has had dry cough and sore throat on and off for one year

Thank you for this interesting case.

To start, I think we can deal with these as two separate problems for now, realizing they may be related.

1. Chronic cough
2. Chronic polyarthritis

1. Chronic cough

In a patient with cough, fever, SOB, wt loss- we need to consider TB as a possibility.

To evaluate for this, she needs to have sputum checked for acid-fast bacilli and ideally a chest x-ray. (TB can affect joints, but usually just one such as a hip or knee)

Other important causes of chronic cough with fever, wt loss which can also be seen on an x-ray include lung abscess, paragonimiasis (endemic in Cambodia), fungal infection (histoplasmosis, and less commonly thoracic actinomycosis). A rare cause, nocardia, can also affect the joints, and is seen mostly in patients that are immune deficient such as HIV. These admittedly are less likely but offered as causes to consider should she need further work up.

More than likely, her sore throat is secondary to the chronic cough.

2. Chronic polyarthritis

Your thoughts about checking for RA, CBC and ESR are good, as we can evaluate for more significant rheumatologic/connective tissue disease (rheumatoid arthritis, systemic lupus erythematosus, etc) many of which may include pulmonary symptoms.

Infectious arthritis seems less likely as her symptoms have been present for 3 months - a long time.

In summary, I agree with your plan. I might add an ANA blood test, if available, and would do a chest x-ray to evaluate for some serious causes of chronic cough. The amoxicillin is of very limited benefit in my opinion.

Thank you for this interesting case.

Paul Heinzelmann, MD

Massachusetts General Hospital

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:21:55 +0700

Dear David and Montha,

We have some questions. Does she have hair loss? Does she have skin rashes over her cheeks (sorry the picture is not clear)? Any skin hyperpigmentation at sun exposed areas? Her mental is OK?

We agree with your management. We would suggest not to wait to see improvement until next month, please send her for tests to Kg. Thom, so that next month we have results and we could give recommendations. Beside CBC (complete blood count, not the NFL as in case # 4), ESR, RF, we

would add UA, urine microscopy, CXR, and both hand X-Ray AP.

Regards,

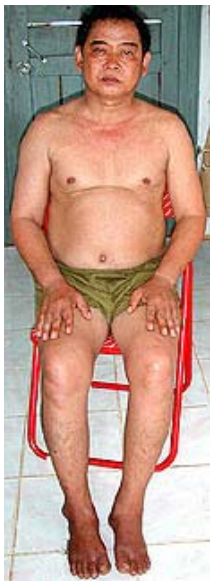
Jennifer/Bunse

Date: Wed, 10 Dec 2003 07:21:49 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #6: DOURNG SUNLY, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine" <KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

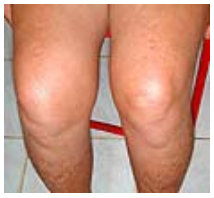
Patient #6: DOURNG SUNLY, male, 49 years old



Chief complaint: Patient complains of general joint pain, especially both knees and both ankles, on and off for three years.

HPI: 49-year-old male, district official, presented with general joint pain on and off for three years. It originally started from both ankles and then progressed to both knees, after that radiating to all joints. Joints are swollen on and off, and accompanied by burning feeling in knees and ankles, sometimes with redness, and he cannot walk. In January 2002 he went to Preah Vihear Provincial Hospital for consultation and was admitted for 12 days. He was diagnosed with arthritis; they gave him Benzatine, Penicillin and some painkillers and during that time his symptoms improved greatly. One month later all the symptoms reappeared and continue on and off until now. Now he has severe pain on both knee joints and both ankles, mild swelling on both knee joints and both ankles, and mild fever and blurred vision sometimes.

Past medical history: He was admitted to Preah Vihear Provincial Hospital for 12 days in January 2002.

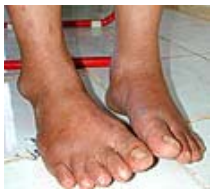


Family history: Unremarkable.

Social history: Has smoked one pack of cigarettes per day for 30 years. He drank alcohol for 25 years but stopped two years ago.

Allergy: None known.

Current medicine: Trankal (type of painkiller,) 1+ per day



Review of system: No sore throat, no weight loss, has shortness of breath, no cough, has chest pain sometimes, no abdominal pain, and no black or bloody stool.

Physical Exam:
BP: 110/50
Pulse: 80
Resp.: 28
Temp. : 36.5
Weight: 70 kg

Hair, eyes, ears, nose, and throat: Not icteric and no lymph node enlargement.

Lungs: Clear both sides, full breath sound

Heart: Regular rhythm, no murmur

Abdomen: Soft, big belly, has positive bowel sound all four quadrants, no pain.

Extremities: Both knees and both ankles mildly swollen, strong pain during bending, no redness, has normal color, is warm to touch, other extremities okay, has bilateral pedal pulse.

Neuro Exam: Unremarkable

Assessment: Poly arthritis?

Plan: I would suggest referring him to Kampong Thom Hospital for some blood work like CBC, ESR, Aslo, Rheumatoid Factor, lytes, creatinine, Bun, blood sugar, uric acid, and x-ray both knees and ankles.

Please give me any other ideas.

Note: I gave him one gram of Paracetemol to take now.

From: "Patel, Dinesh,M.D." <DGPATEL@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #6: DOURNG SUNLY, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 18:16:07 -0500

Kathy,

I have reviewd the case , historyu and pictures

It does sound like Synovits of undetermined itiology

I would do what has been propsed

Perhaps aspiration of knee joint fluid and evaluation can be of some value as well

Some times it is difficult to come to specific diagnoses so one may have to treat the synovitis

I would prefer that he should be started on aspirin small dose to high dose if stomach does not bother

him and see the response.

Perhaps local support to the joint as a form of rest can be of value as well.

His feet and hands are red distally so wonder if he has also Reynaulds' or some kind of vascular condition as well.

Let me know what one finds

Thanks

dinesh

Dinesh Patel M.D.
Mass.Gen.Hospital
ACC 510 15 Parkman Street
Boston Mass 02114
617 726 3555
617 726 5349 fax
dgpatel@partners.org

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #6: DOURNG SUNLY, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:22:19 +0700

Dear David and Montha,

We agree with the paracetamol. He may take it regularly 500-1000 mg qid. Also agree with the lab tests at Kg. Thom. He is obesis and (?used to be) drinkers + his left foot picture looked like goutty arthritis.

Date: Wed, 10 Dec 2003 07:27:23 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #7: SAO PHAL, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"

<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #7: SAO PHAL, female, 56 years old, follow up patient

Subject: 56-year-old female returned for follow up visit for DMII, hypertension and GERD. She has improved much from the previous symptoms but still has dizziness, has blurred vision, has shortness of breath, has muscle pain, no fever, no cough, decreasing epigastric pain, no chest pain, no stool with blood, has good appetite, has gained two kg of weight, and has increased sensation in feet.

Object: BP: 120/50, **Pulse:** 80, **Resp.:** 20, **Temp:** 36.5, **Weight:** 60 kg

- Hair, Eyes, Ears, Nose and Throat: No oropharyngeal lesions
- Neck: No JVD, no enlarged lymph node
- Lungs clear both sides
- Heart regular rhythm without murmur.
- Abdomen: Soft, flat, not tender, has bowel sound in all four quadrants
- Extremities Unremarkable
- Neuro exam: Unremarkable.

Assessment:

1. **DMII (controlled)**
2. **PNP**
3. **Hypertension (controlled)**
4. **GERD**

Plan: Continue same medication for another month:

- **Diamecrom, 80 mg, ½ tablet daily**
- **Amitriptilline, 25mg, ½ tablet twice daily**
- **Famotidine, 40 mg twice daily**
- **Hydroclorothiazide, 50mg, ½ tablet daily**
- **Aspirin, 500mg, ¼ tab daily**

Patient to return next month for follow up. Do you agree?

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>

To: '"dmr@media.mit.edu"' <dmr@media.mit.edu>
Subject: FW: Patient #7: SAO PHAL, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 15:19:02 -0500

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Wednesday, December 10, 2003 3:06 PM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #7: SAO PHAL, December 2003 Telemedicine, Robib, Cambodia

Diabetes

Can you monitor glycosylated hemoglobin or fingerstick fasting blood sugar, otherwise how would you know that the diabetes is well controlled? She looks slightly overweight and may be gaining weight because of excessive caloric intake. Has she received dietary advice on keeping food intake to 1800 calories a day, adjusted to the level of physical activity? Perhaps switching from diamicron to metformin 500 mg bid or metformin XL 1g qd may continue to control diabetes without further weight gain.

Hypertension

Does she really have hypertension? The blood pressure looks very good. You may want to monitor her without meds for a month. If she does need hypertensive meds, lisinopril, an ACE inhibitor, will control blood pressure and protect kidneys from progression to diabetic renal failure.

Blurred vision

Is there any obvious cataract on direct illuminination examination of the eye lens? Can she read the vision chart? If the blurred vision is chronic, I would suspect cataract or visual refraction problem. If it is transient, it may be related to hyperglycemia. Can her fingerstick fasting blood sugar be measured? As for treatment, are you able to perform refraction to prescribe eye glasses?

GERD

If GERD is controlled, famotidine 40mg qd will suffice and be better for compliance.

Peripheral neuropathy

Amitriptyline can be given 25 mg once a day will be better for compliance.

Heng Soon, M.D.

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #7: SAO PHAL, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:23:06 +0700

Dear David and Montha,

Like in patient # 1, we would do amitriptylline at bedtime only (2 tab), HCTZ maximum 25 mg a day in

DM II (so decrease it), ASA 500mg 1/4tab daily, and check her BS.

About dyspepsia, the treatment is 2 months, unless frequent relapse. Would stop famotidine.

We are not sure why SOB. Could you help her having EKG and CXR at Kg. Thom?

Regards,

Jennifer/Bunse

Date: Wed, 10 Dec 2003 07:31:38 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #8: EM SOKLEY, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine" <KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #8: EM SOKLEY, female, 25 years old

Chief complaint: Patient complains of epigastric pain for two months, diarrhea on and off for two months.

HPI: 25-year-old female farmer gets epigastric pain, like a burning sensation, especially after a meal. She feels something come up to her chest and then excessive saliva and nausea in the morning. She also has diarrhea on and off, comes at the same time as epigastric pain and is accompanied by weakness and palpitations. At the beginning of the symptoms two months ago she bought some antacid medicine at the local pharmacy; it helped her for four days but because of lack of finances she could not afford to buy any more and stopped using it, now all the symptoms have returned.

Past medical history: Unremarkable.

Family history: Has three children; her husband is a farmer.

Social history: Does not smoke and does not drink alcohol.

Allergy: None known.

Current medicine: Use traditional medicine for more than one month.

Review of system: No sore throat, weight loss of about three kg, no cough, no fever, no chest pain, has palpitations, has epigastric pain, and no black or bloody stool.

Physical Exam: Alert and oriented x 3 (place, person, and time.)

BP: 110/60, **Pulse:** 90, **Resp.:** 20, **Temp:** 37, **Weight:** 40 kg

Hair, eyes, ears, nose, and throat: No oropharyngeal lesions, not icteric

Neck: No JVD, and no enlarged lymph node

Heart: Regular rhythm, no murmur

Lungs: Clear both sides, no crackle and no wheezing.

Abdomen: Soft, flat, not tender, has positive bowel sound all four quadrants.

Extremities: No edema, no deformity

Assessment:

- **Dyspepsia**
- **Parasitis?**
- **Malnutrition**

Plan: Should we cover her with some medications like:

- **Tums, 1 gram twice daily for one month**
- **Multivitamin, one tablet daily for one month**
- **Mebendazole, 100 mg twice daily, for three days**

Please give me any other ideas.

From: "Crocker, J.Benjamin,M.D." <JBCROCKER@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: EM Sokley, Patient #8 12/03
Date: Wed, 10 Dec 2003 13:22:22 -0500

presumptive dx: GERD with possible PUD.

I am concerned with the 3 kg wt loss considering she only weighs 40 kg, and this should be monitored carefully. The post prandial pain may be indicative of ulcer disease. An H2 blocker (like zantac) or proton pump inhibitor (like omeprazole) would be best in this situation. If CBC to rule out anemia and liver enzymes are available, they should be checked. If H. Pylori status is not known or cannot be done (antibody test), she could even be treated empirically for H. Pylori eradication (if medicaiton available) w/ omeprazole 20mg bid, amoxicillin 500mg bid, clarithromycin 500mg bid for 10 days to 2 wks. If symptoms persist would consier Barium UGI series or endoscopy for further evaluation of peptic ulcer disease. She should elevate the head of her bed at night and avoid caffeinated beverages, even hot beverages before bed, and other foods which may exacerbate GERD symptoms.

If parasitic infection is of concern, would check stool O&P prior to treating.

hope this helps.

J. Benjamin Crocker, M.D.
Internal Medicine Associates 3
WACC 605
15 Parkman Street
Boston, MA 02114
Phone 617 724-8400
Fax 617 724-0331
Email jbcrocker@partners.org

Date: Thu, 11 Dec 2003 10:07:33 +0700

From: ruth_tootill@online.com.kh

To: David R <dmr_cambodia@yahoo.com>

Subject: Re: Patient #8: EM SOKLEY, December 2003 Telemedicine, Robib, Cambodia

Dear David,

I think your management plan is appropriate.

Ruth

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #8: EM SOKLEY, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:23:20 +0700

Dear David and Montha,

We agree with your management, follow-up next month. If better continue Tums one more month to complete 2 months total. If not better switch to Famotidine.

Regards,

Jennifer/Bunse

Date: Wed, 10 Dec 2003 07:34:12 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #9: REAM SREY BORN, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #9: REAM SREY BORN, female, 23 years old

Chief complaint: Patient complains of fever and abdominal pain on and off for one month.

HPI: 23-year-old female farmer has abdominal pain, especially around umbilical area, pain radiating to chest, especially after a meal. During the start of abdominal pains she also had a fever of around 39-40 degrees accompanied by headache, stool with mucus, abdominal distension as well. She went to a private local clinic and was treated with some unknown medication that didn't help her at all and her symptoms still appear.

Past medical history: Unremarkable.

Family history: Has one child.

Social history: Does not smoke and does not drink alcohol.

Allergy: None known.

Current medicine: None.

Review of system: No sore throat, no weight loss, no cough, has a fever, no chest pain, has pain in umbilical area, no black or bloody stool, has poor appetite, and has nausea.

Physical Exam: Alert and oriented x 3

BP: 100/60, **Pulse:** 90, **Resp.:** 20, **Temp:** 38, **Weight:** 44 kg

Hair, eyes, ears, nose, and throat: Not icteric and no oropharyngeal

lesions.

Neck: No JVD, and no enlarged lymph node

Lungs: Clear both sides, no crackle and no wheezing.

Heart: Regular rhythm, no murmur

Abdomen: Soft, flat, not tender, has mild pain on umbilical area, has positive bowel sound all four quadrants and much more active, no HSM.

Extremities: Unremarkable

Malaria test: Negative on 6 December 2003.

Assessment:

- **Typhoid Fever?**
- **GERD?**
- **Parasitis?**

Plan: We would like to cover her with:

- **Gatifloxacine, 40 mg once daily, for ten days**
- **Famotidine, 40 mg once daily, for 30 days**
- **Mebendazole, 100 mg twice daily, for three days**
- **Paracetemol, 500 mg, one tablet four times daily as needed, for five days**

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #9: REAM SREY BORN, December 2003 Telemedicine, Robib , Cambodia
Date: Wed, 10 Dec 2003 19:57:16 -0500

Patient #9: REAM SREY BORN**,** female, 23 years old

Thank you for this interesting patient.

Your thought of Typhoid fever seems appropriate as fever, headache and abdominal distention are typical - particularly in the abscence of diarrhea. As you know, this can become quite serious.

Blood and/or stool culture/smear may not be practical at this, in which case, simply treating it for possible Typhoid seems reasonable. Cipro 500 BID for ten days is reasonable but gatifloxacin may be good alternative. (other option azithromycin 1 5 po qd x 5 days)

The mebendazole would treat intestinal worms such as ascaris.

Finally, GERD , or H. pylori are important considerations.

I would concur and agree with your plan, but be prepared to consider other causes if diarrhea develops or symptoms worsen. (ie Giardiasis, etc.)

Thank you for this interesting patient.

Paul Heinzelmann, MD

Massachusetts General Hospital

Date: Thu, 11 Dec 2003 10:04:59 +0700

From: ruth_tootill@online.com.kh

To: David R <dmr_cambodia@yahoo.com>

Subject: Re: Patient #9: REAM SREY BORN, December 2003 Telemedicine, Robib, Cambodia

Dear David,

Thanks for your letter.

I think your management is appropriate. The temperature is more against GERD.

The only other possible diagnosis I would think of is a liver abscess - probably amebic. However, your treatment would cover this, but may need to be prolonged for three weeks.

Yours sincerely,

Ruth Tootill

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #9: REAM SREY BORN, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:25:09 +0700

Dear David and Montha,

We have some questions. Does she have dysuria? Does she have tenesmus? Does she have vaginal discharge? Any vaginal exam?

We agree with your management. If tenesmus or vaginal discharge, we would add metronidazole 500 mg TID for 5 days.

Regards,

Jennifer/Bunse

From: "Ryan, Edward T., M.D." <ETRYAN@PARTNERS.ORG>

To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>

Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>

Subject: RE: Patient #9: REAM SREY BORN, December 2003 Telemedicine, Robib, Cambodia
Date: Thu, 11 Dec 2003 09:39:04 -0500

Sorry for delay in responding. was unable to get to email yesterday afternoon. Agree typhoid possible. would also rule out pregancy/ectopic/PID. Agrre with regimen. Doubt the mebendazole will do much. Good luck,

Edward T. Ryan, M.D., DTM&H
Tropical & Geographic Medicine Center
Division of Infectious Diseases
Massachusetts General Hospital
Jackson 504
55 Fruit Street
Boston, Massachusetts 02114 USA

Administrative Office Tel: 617 726 6175
Administrative Office Fax: 617 726 7416
Patient Care Office Tel: 617 724 1934
Patient Care Office Fax: 617 726 7653
Email: etryan@partners.org or ryane@helix.mgh.harvard.edu

Date: Wed, 10 Dec 2003 07:37:28 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #10: THO CHANTHY, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #10: THO CHANTHY, female, 36 years old, follow up patient

Subject: 36-year-old female came to follow up her hyperthyroidism. Her previous symptoms have improved a lot. Now she has less blurred vision,

decreased shortness of breath, decreased palpitations, no tremors, better appetite, weight gain of one kg, and better sleeping as well.

Object: BP: 100/60, **Pulse:** 68, **Resp.:** 20, **Temp:** 36.5, **Weight:** 53 kg

Hair, eyes, ears, nose, and throat: Has exophthalsis (bilateral,) other areas okay.

Neck: Same size as before, has enlarged thyroid.

Lungs: Clear both sides.

Heart: Regular rhythm, no murmur

Abdomen: Soft, flat, no HSM, has positive bowel sound all four quadrants.

Extremities: No edema and no tremor

Assessment: Hyperthyroidism.

Plan: Continue with same medications for another month:

- **Carbimazole, 5mg, one tablet three times daily**
- **Propranolol, 40mg, 1/4 tablet twice daily**
- **Aspirin, 300mg, 1/4 tablet daily**
- **Multivitamin, one tablet daily**

Draw her blood for both TSH and T4 to test at SHCH.

Do you have any other ideas or comment?

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #10: THO CHANTHY, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 16:34:55 -0500
Importance: high

-----Original Message-----
From: Crocker, Jonathan T., M.D.
Sent: Wednesday, December 10, 2003 4:14 PM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #10: THO CHANTHY, December 2003 Telemedicine, Robib, Cambodia
Importance: High

Good Morning,

It would be helpful to know what her presenting symptoms were and what the presumed diagnosis was. For example do you think this was classic Graves' disease? Does she have multiple nodules on exam. Is there any reason that she could not have a radioactive iodine uptake scan (ie is she breast feeding or is she pregnant, available, cost)? It would help confirm your diagnosis as to what's causing the hyperthyroidism. I would suggest checking T3 levels and T4 levels. If you have piror T3 and T4 levels, sometimes calculating their ratio can help suggest a cause -- ie Graves' disease you see ratio T3:T4 > 20 ng/dl or ug/dl or > 0.3 molar.

Patients should have thyroid funciton tested each 4-6 weeks. Initial TSH for several months may be misleading becasue it is suppressed by hyperthyroidism, so it's important to follow T4 and T3 during the first several months. When the TSH rises to the normal range, then follow only the T4 and TSH,

no need to measure T3. Usually have to treat for several years with thionamide therapy, but can be stopped anytime if pt proceeds with radioiodine treatment or surgery.

Best regards,

Dr. Crocker

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #10: THO CHANTHY, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:25:45 +0700

Dear David and Montha,

Good, patient improves. Agree with T4 check (no need TSH) in SHCH. No need MTV.

Regards,

Jennifer/Bunse

Date: Fri, 12 Dec 2003 06:37:25 -0500

From: David Robertson <dmr@media.mit.edu>

To: "Dr. Srey Sin" <012905278@mobitel.com.kh>

Cc: "Bernie Krisher" <bernie@media.mit.edu>, seda@bizdaily.forum.org.kh, aafc@camnet.com.kh

Subject: Robib Telemedicine patients admitted last night

Please reply to David Robertson dmr@media.mit.edu

Dear Dr. Srey Sin,

The following two attachments are the Telemedicine patient notes
from Nurse Montha, and the return advice of the physicians in Boston
and Phnom Penh, for the two patients we brought to Kampong Thom
Provincial Hospital last night.

Thank you for helping these patients.

Best regards,

David Robertson

Following patient is from Robib village and was admitted to Kampong Thom Provincial Hospital on 11 December 2003:

Date: Wed, 10 Dec 2003 07:18:37 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cambodia
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine" <KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

Patient #5: SUM SOKNA, female, 20 years old

Chief complaint: Pain on all finger, ankle, knee, wrist, and elbow joints for three months. Has had dry cough and sore throat on and off for one year.

HPI: 20-year-old female presented with general joint pain all over the body, especially in the morning. Sometimes she can't walk; both knees have been swollen on and off as well. She also has a dry cough, has sore throat on and off, has mild fever, has nausea, has weight loss of about five kg over six months, has good appetite, has shortness of breath, no chest pain, no palpitations, and no black or bloody stool.

Past medical history: Unremarkable.

Family history: Unremarkable.

Social history: Does not smoke and does not drink alcohol.

Allergy: None known.

Current medicine: None.

Physical Exam:
BP: 120/60

Pulse: 86

Resp.: 20

Temp. : 37.3

Weight: 44 kg

Object: Alert and oriented x 3 (place, person, and time.)

Hair, eyes, ears, nose, and throat: Not icteric, has mild redness oropharyngeal but tonsil not enlarged, no lymph node enlargement, and no pus.

Lungs: Clear both sides, no crackle and no wheezing.

Heart: Regular rhythm, no murmur

Abdomen: Soft, flat, not tender, has positive bowel sound all four quadrants, no HSM.

Extremities: All joints no deformity, no stiffness, no edema, no redness, and has normal color.

Neuro exam: Unremarkable.

Assessment:

- **Poly Arthritis?**
- **Rheumatoid Fever?**
- **Chronic Pharyngitis.**

Plan: We would like to cover her with:

- **Amoxycillin, 500 mg three times daily, for seven days**
- **Ibuprofen, 400 mg, one tablet three times for 15 days**

Follow up at next month's clinic. If not better send her to Kampong Thom for some blood work like Rheumatoid Factor, CBC and ESR. Do you agree? Please give me any other ideas.

From: "Patel, Dinesh,M.D." <DGPATEL@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 18:23:19 -0500

Kathy,

I do not have any specific suggestions but question of Rheumatoid Arthrits does come in my mind

She has pink cheeks so wonder if she also has some kind of skin disorder or secondary to rh fever or what

Can they do the blood work before starting the treatment.

How about just give high dose of Ibuprofen 800mg three times a day and not give Amoxycillin antibiotics and see the response in 7 days.

Thanks

dinesh

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cam bodia
Date: Wed, 10 Dec 2003 19:21:01 -0500

Dear David,

I understand you have already received a response from another doctor.

I add mine as further consideration.

Paul

Patient #5: SUM SOKNA, female, 20 years old

Chief complaint: Pain on all finger, ankle, knee, wrist, and elbow joints for three months. Has had dry cough and sore throat on and off for one year Thank you for this interesting case.

To start, I think we can deal with these as two separate problems for now, realizing they may be related.

1. Chronic cough
2. Chronic polyarthritis

1. Chronic cough

In a patient with cough, fever, SOB, wt loss- we need to consider TB as a possibility.

To evaluate for this, she needs to have sputum checked for acid-fast bacilli and ideally a chest x-ray. (TB can affect joints, but usually just one such as a hip or knee)

Other important causes of chronic cough with fever, wt loss which can also be seen on an x-ray include lung abscess, paragonimiasis (endemic in Cambodia), fungal infection (histoplasmosis, and less commonly thoracic actinomycosis). A rare cause, nocardia, can also affect the joints, and is seen mostly in patients that are immune deficient such as HIV. These admittedly are less likely but offered as causes to consider should she need further work up.

More than likely, her sore throat is secondary to the chronic cough.

2. Chronic polyarthritis

Your thoughts about checking for RA, CBC and ESR are good, as we can

evaluate for more significant rheumatologic/connective tissue disease (rheumatoid arthritis,

systemic lupus erythematosus, etc) many of which may include pulmonary symptoms.

Infectious arthritis seems less likely as her symptoms have been present for 3 months - a long time.

In summary, I agree with your plan. I might add an ANA blood test, if available, and would do a chest x-ray to evaluate for some serious causes of chronic cough. The amoxicillin is of very limited benefit in my opinion.

Thank you for this interesting case.

Paul Heinzelmann, MD

Massachusetts General Hospital

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #5: SUM SOKNA, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:21:55 +0700

Dear David and Montha,

We have some questions. Does she have hair loss? Does she have skin rashes over her cheeks (sorry the picture is not clear)? Any skin hyperpigmentation at sun exposed areas? Her mental is OK?

We agree with your management. We would suggest not to wait to see improvement until next month, please send her for tests to Kg. Thom, so that next month we have results and we could give recommendations. Beside CBC (complete blood count, not the NFL as in case # 4), ESR, RF, we would add UA, urine microscopy, CXR, and both hand X-Ray AP.

Regards,

Jennifer/Bunse

Following patient lives outside Robib village and was admitted to Kampong Thom Provincial Hospital on 11 December 2003. Unfortunately we cannot support any costs associated with this patient's treatment. The patient agrees to this but hopes that because he is poor, that you will help him. He is a local government district official in Rovieng.

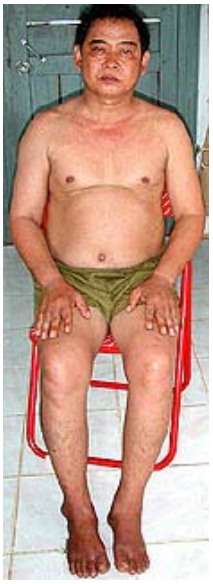
Date: Wed, 10 Dec 2003 07:21:49 -0800 (PST)
From: David R <dmr_cambodia@yahoo.com>
Subject: Patient #6: DOURNG SUNLY, December 2003 Telemedicine, Robib, Cambodia

To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine" <KKELLEHERFIAMMA@PARTNERS.ORG>,
"Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, dmr@media.mit.edu
Cc: "Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
tmed_montha@online.com.kh, Ruth_tootill@online.com.kh,
hopestaff@online.com.kh, aafc@camnet.com.kh,
Bernie Krisher <bernie@media.mit.edu>

Please reply to David Robertson <dmr@media.mit.edu>

Telemedicine Clinic in Robib, Cambodia – 10 December 2003

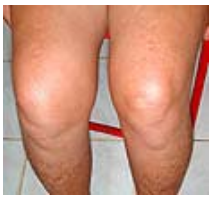
Patient #6: DOURNG SUNLY, male, 49 years old



Chief complaint: Patient complains of general joint pain, especially both knees and both ankles, on and off for three years.

HPI: 49-year-old male, district official, presented with general joint pain on and off for three years. It originally started from both ankles and then progressed to both knees, after that radiating to all joints. Joints are swollen on and off, and accompanied by burning feeling in knees and ankles, sometimes with redness, and he cannot walk. In January 2002 he went to Preah Vihear Provincial Hospital for consultation and was admitted for 12 days. He was diagnosed with arthritis; they gave him Benzatine, Penicillin and some painkillers and during that time his symptoms improved greatly. One month later all the symptoms reappeared and continue on and off until now. Now he has severe pain on both knee joints and both ankles, mild swelling on both knee joints and both ankles, and mild fever and blurred vision sometimes.

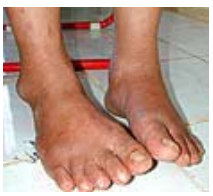
Past medical history: He was admitted to Preah Vihear Provincial Hospital for 12 days in January 2002.



Family history: Unremarkable.

Social history: Has smoked one pack of cigarettes per day for 30 years. He drank alcohol for 25 years but stopped two years ago.

Allergy: None known.



Current medicine: Trankal (type of painkiller,) 1+ per day

Review of system: No sore throat, no weight loss, has shortness of breath, no cough, has chest pain sometimes, no abdominal pain, and no black or bloody stool.

Physical Exam:
BP: 110/50
Pulse: 80
Resp.: 28
Temp. : 36.5
Weight: 70 kg

Hair, eyes, ears, nose, and throat: Not icteric and no lymph node enlargement.

Lungs: Clear both sides, full breath sound

Heart: Regular rhythm, no murmur

Abdomen: Soft, big belly, has positive bowel sound all four quadrants, no pain.

Extremities: Both knees and both ankles mildly swollen, strong pain during bending, no redness, has normal color, is warm to touch, other extremities okay, has bilateral pedal pulse.

Neuro Exam: Unremarkable

Assessment: Poly arthritis?

Plan: I would suggest referring him to Kampong Thom Hospital for some blood work like CBC, ESR, Aslo, Rheumatoid Factor, lytes, creatinine, Bun, blood sugar, uric acid, and x-ray both knees and ankles.

Please give me any other ideas.

Note: I gave him one gram of Paracetemol to take now.

From: "Patel, Dinesh,M.D." <DGPATEL@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #6: DOURNG SUNLY, December 2003 Telemedicine, Robib, Cambodia
Date: Wed, 10 Dec 2003 18:16:07 -0500

Kathy,

I have reviewd the case , historyu and pictures

It does sound like Synovits of undetermined itiology

I would do what has been propsed

Perhaps aspiration of knee joint fluid and evaluation can be of some value as well

Some times it is difficult to come to specific diagnoses so one may have to treat the synovitis

I would prefer that he should be started on aspirin small dose to high dose if stomach does not bother him and see the response.

Perhaps local support to the joint as a form of rest can be of value as well.

His feet and hands are red distally so wonder if he has also Reynaulds' or some kind of vascular condition as well.

Let me know what one finds

Thanks

dinesh

Dinesh Patel M.D.
Mass.Gen.Hospital
ACC 510 15 Parkman Street
Boston Mass 02114
617 726 3555
617 726 5349 fax
dgpatel@partners.org

From: "Bunse LEANG" <tmed1shch@online.com.kh>

To: "David R" <dmr_cambodia@yahoo.com>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@online.com.kh>

Cc: <tmed_montha@online.com.kh>, <aafc@camnet.com.kh>,

"Bernie Krisher" <bernie@media.mit.edu>

Subject: RE: Patient #6: DOURNG SUNLY, December 2003 Telemedicine, Robib, Cambodia

Date: Thu, 11 Dec 2003 11:22:19 +0700

Dear David and Montha,

We agree with the paracetamol. He may take it regularly 500-1000 mg qid. Also agree with the lab tests at Kg. Thom. He is obesis and (?used to be) drinkers + his left foot picture looked like goutty arthritis.

Follow up Report, Friday, 12 December 2003

Per e-mail advice of the physicians in Boston and Phnom Penh, two patients from this month's clinic agreed to go to the hospital:

Patient #5: SUM SOKNA, female, 20 years old, was taken to Kampong Thom Provincial Hospital by the Telemedicine team on Thursday, 11 December 2003. She has been admitted for tests.

Patient #6: DOURNG SUNLY, male, 49 years old, was taken to Kampong Thom Provincial Hospital by the Telemedicine team on Thursday, 11 December 2003. This patient was in a lot of pain by the time he arrived at the hospital and could not walk on his own so we moved him from the truck to the admitting area on a stretcher. This patient lives outside of Robib village and will take care of all of his own health care costs.

Per e-mail advice of the physicians in Boston and Phnom Penh, patients from this month's clinic and several follow up cases were given medication from the pharmacy in the village or medication that was donated by Sihanouk Hospital Center of Hope:

Patient #1: SOM THOL, male, 50 years old, follow up patient

Patient #2: PEN VANNA, female, 37 years old, follow up patient

Patient #3: NGET SOEUN, male, 56 years old, follow up patient

Patient #4: SAO CHHOUN, male, 37 years old, follow up patient

Patient #7: SAO PHAL, female, 56 years old, follow up patient

Patient #8: EM SOKLEY, female, 25 years old

Patient #9: REAM SREY BORN, female, 23 years old

Patient #10: THO CHANTHY, female, 36 years old, follow up patient

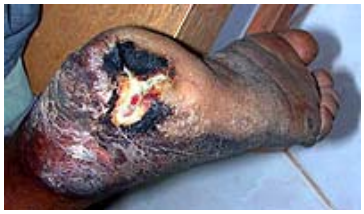
November 2003 Patient: MUY VUN, male, 36 years old

November 2003 Patient: THORN KHUN, female, 38 years old

October 2003 Patient: YEM PHALA, male, 55 years old

May 2003 Patient: SOM DEUM, female, 63 years old

November 2003 Patient CHHOURN SOKHON, male, 45 years old, returned to the Telemedicine clinic this month after last month's trip to Sihanouk Hospital. Nurse Montha inspected and cleaned the patient's wound. The patient was advised to keep cleaning the wound daily and to return to the Telemedicine clinic next month.



Transport arranged for 26 December 2003 follow up appointment at Sihanouk Hospital Center of Hope in Phnom Penh:

September 2001 Patient: PHENG ROEUNG, female, 58 years old

This patient will stay with one of her relatives in Phnom Penh.

Transport & lodging arranged for 2 January 2004 follow up appointment at Sihanouk Hospital Center of Hope in Phnom Penh. We have been following this patient's heart condition since the very first Telemedicine clinic:

February 2001 Patient: NOUNG KIM CHHANG, male, 50 years old

Transport & lodging was arranged last month for a 28 November 2003 follow up appointment at Kantha Bhopa Children's Hospital in Phnom Penh. Normally this child receives a penicillin injection for her polyarthritis condition and returns back to the village the next day but the doctors at Kantha Bhopa decided to admit her. She is still in the hospital as of this date:

June 2001 Patient: SENG SAN, female, 13-year-old child

Transport & lodging was arranged last month for a 28 November 2003 follow up appointment at Calmette Cardiology Hospital in Phnom Penh. We have been following this child's heart condition since the very first Telemedicine clinic. Previously too weak, and now three and a half years old, she just recently started walking:

February 2001 Patient: CHHEM LYNA, female, 3-year-old child

The next Telemedicine Clinic in Robib, Cambodia will be on Tuesday, January 7, 2004.
