# Robib and Telemedicine

## February 2004 Telemedicine Clinic in Robib

***Report and photos submitted by David Robertson***

On Tuesday, February 10, 2004, Sihanouk Hospital Center of Hope nurse Koy Somontha gave the monthly Telemedicine examinations at the Rovieng Health Center. 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 Rovieng Health Center. Nurse "Montha" discussed advice received from the physicians in Boston and Phnom Penh with the patients.

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, 8 Feb 2004 21:51:52 -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>,
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>,
Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Dr. Srey Sin" <012905278@mobitel.com.kh>, tmed_montha@online.com.kh,
Ruth_tootill@online.com.kh, hopestaff@online.com.kh,
aafc@camnet.com.kh, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>, robibtech@yahoo.com
Subject: Reminder, February 2004 clinic tomorrow, Robib, Cambodia, Telemedicine

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

Dear All:

A quick reminder that the February Telemedicine clinic is still scheduled for Tuesday, 10 February 2004.

We'll have the follow up clinic at 8:00am, Wednesday, 11 February 2004 (8:00pm, Tuesday, 10 February 2004 in Boston.) Best if we could receive your e-mail advice before this time.

Thanks again for your kind assistance.

Sincerely,
David

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Date: Tue, 10 Feb 2004 02:35:15 -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>,
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>,
Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"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,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #1: SUM SOKNA, February 2004 Telemedicine, Robib, Cambodia

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

Dear All:

A quick reminder we'll have the follow up clinic at 8:00am, Wednesday, 11 February 2004 (8:00pm, Tuesday, 10 February 2004 in Boston.) Best if we could receive your e-mail advice before this time.

Thanks again for your kind assistance.

Sincerely,

David

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# Telemedicine Clinic in Robib, Cambodia – 10 February 2004

**Patient #1: SUM SOKNA**, female, 20 years old, follow up patient

**Chief complaint:** Still painful on both ankles, knees, and wrists during cold weather.

**Subject:** 20-year-old female returned for follow up of her Polyarthritis. Two months ago, we sent her to Kampong Thom Hospital for evaluation of her joint pain. The doctors there also diagnosed her with Polyarthritis and recommended her to use Penicillin V 250mg two tablets three times daily for three months and Ibuprofen 400mg one tablet twice daily. So far she was covered with those medicines for two months and is feeling better, but has pain on both knees, wrists, and ankles during cold weather, has a dry cough, palpitations, increased weight of two kg, no swollen joints, no fever, no shortness of breath, and no abdominal pain.

**Physical Exam:**

**BP:** 105/60
**Pulse:** 88
**Resp.:** 20
**Temp. :** 36.5
**Weight:** 46 kg

**Object:** Looks stable

**Hair, eyes, ears, nose, and throat:** Okay, skin not pale, no jaundice. Neck: No thyroid enlargement.

**Lungs:** Clear both sides, no crackle and no wheezing.
**Heart:** Regular rhythm, no murmur
**Abdomen:** Soft, flat, not tender, and no HSM.
**Limbs:** Not swollen, no stiffness, and no deformity.

**Assessment: Polyarthritis**

**Plan: May we cover her with these medications?**

- **Penicillin V, 250 mg two tablets three times daily, for one month**
- **Nabumetone, 750 mg, one tablet twice daily as needed, for one month**

**Please give me any other ideas.**

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From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #1: SUM SOKNA, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:09:19 +0700

Dear Montha and Dave,

Thanks for the case. We did not see this patient previously and the data given this time is not enough to say that she has polyarthritis or RA. She has no pharyngitis or throat infection to say that she needs treatment for rheumatic fever. We think, it is not necessary for her to be covered with Pen V, but you can give her the Relafen (nabumetone) 750mg 1 tab po qd prn.

You can give her 15-20 tablets since this is also NSAIDs which can give stomach problem also.

Thanks,

Rithy/Jack

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From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@MGHIHP.EDU>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Subject: RE: Patient #1: SUM SOKNA, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 18:39:24 -0500

Recommendation

Thank you for this follow up patient. This is a difficult case. As long as she is improving somewhat I would continue the current regimen of penicillin and return for follow up next month. It appears to me that that the doctors at Kampong Thom may think she has an infectious arthritis. In that case continuing Penicillin and Nabumetone is a good plan, particularly if they suspect infectious arthritis from sexually transmitted gonorrhea. (Note:some gonorrhea is resistant to penicillin). If no improvement in one month, review the other possible causes below. (I do recall her having a chronic cough and weight loss in the

past, so TB remains on the list.). Depending on her social history, an HIV test might be useful too.

If you have ANY labs or test results from her hospital stay please pass those on. Please let us know how she is in the next month.

Paul Heinzelmann, MD

Review the following:

1. Infectious arthritis overview:

This is more common in people with other disease such as diabetes, severe kidney disease, immune deficiency, some forms of cancer, abnormal heart valve, or drug or alcohol abuse problems. This can be caused by bacteria, viruses or fungi.

To differentiate these as possibilities, consider the following.

Bacterial infection: (Gonorrhea, other non-gonococcal bacteria)

- Generally located in one place or area, but not always
- Usually accompanied by fever and shaking chills initially
- Usually begins quite suddenly
- Usually cured by taking antibiotics

Mycobacteria (TB)

- may spread from a pulmonary focus and infect a joint.
- Mycobacterium marinum should be suspected in individuals exposed to aquatic or marine environments.

Viral infection:

- Ache all over
- Usually mild or no fever
- Not cured by antibiotics
- Usually goes away on its own over weeks

Fungal infection:

- May be in one area or throughout the body
- May have low-grade fever or none at all
- Usually begins quite slowly, over weeks or months
- Usually treated with anti-fungal medication
- Occurs more often in people who are near bird or chicken droppings

2. Reactive Arthritis overview:

'Reactive arthritis' occurs after an infection and creates joint pain for months. Explore whether she has had a recent infection such as sexually transmitted disease (chlamydia), dysentery (Salmonella), throat infection, or even HIV. Does she have a history of dysuria or painful intercourse, dysentery, or possibly throat infection?

Reactive arthritis often lasts for months, and does not migrate between joints. (It can sometimes also affect other organs than the joints, such as the eyes, mouth, skin, kidneys, heart, and lungs.) A rash or conjunctival inflammation is often present.

If her history is more like this, then treatment should focus on the area that is problematic. (For example, if you suspect urethritis the antibiotic doxycycline would be the best.) There is no singular lab test used to diagnose reactive arthritis, but the sedimentation rate is often elevated and the rheumatoid factor (RF), (which is typically present in rheumatoid arthritis), is usually negative in reactive arthritis. Did she have any of these tests in Kampong Thom?

Reactive arthritis is diagnosed based upon recognition of the combination of arthritis with inflammation of the eyes, and the genital, urinary, and/or gastrointestinal systems. Although it is more common in men, women get it too.

Treatment is to use NSAIDs or even prednisone.

3. Rheumatic fever

The type of arthritis associated with rheumatic fever typically affects large joints and migrates from joint to joint, each joint being affected for only two to three days, and lasts overall for three weeks. There is often a rash. This can be treated with penicillin, but this doesn't fit her history in my opinion.

Thank you

Paul Heinzelmann, MD

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Date: Tue, 10 Feb 2004 02:37:57 -0500
From: David Robertson <dmr@media.mit.edu>
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
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"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
Gary Jacques <gjacques@bigpond.com.kh>,
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Bunse Leng <tmed1shch@bigpond.com.kh>,
Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"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,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #2: THORN KHUN, February 2004 Telemedicine, Robib, Cambodia

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

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**Patient #2: THORN KHUN**, female, 38 years old, follow up patient

**Chief complaint:** Still has headache and neck tenderness.

Subject: 38-year-old female returned for follow up visit for her hyperthyroidism. She said that she has a mild headache, neck tenderness, blurred vision, no fever, no cough, no chest tightness, decreasing palpitations, decreasing shortness of breath, no extremity tremors, no limb edema, and no abdominal pain.

**Object: BP:** 120/70, **Pulse:** 100, **Resp.:** 20, **Temp. :** 36.5, **Wt.:** 57 kg

Looks stable.

**Hair, eyes, ears, nose, and throat:** Okay, skin not pale, no jaundice.

Neck: Her thyroid gland is the same size, no exophthalmos.

**Lungs:** Clear both sides

**Heart:** Normal

**Abdomen:** Unremarkable

**Extremities:** No edema, no tremor.

Assessment:

1. Hyperthyroidism.
2. Tension headache.

**Plan: Continue following meds for one month:**

- **Multivitamin tab once daily**
- **Feso4/folic 200/25mg, one tab per day**

**Add Paracetemol 50mg one tablet four times daily as needed.**

**Recheck her Thyroid function test next month. Please give me any other ideas.**

**Note: Her baby is healthy.**

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From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #2: THORN KHUN, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:11:29 +0700

Dear Montha/David,

We agreed with your plan.

Rithy/Jack

---

Reply-To: "Hope Staff" <hopestaff@online.com.kh>
From: "Hope Staff" <hopestaff@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>, <JKVEDAR@PARTNERS.ORG>,
"Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
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"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>,
"Bernie Krisher" <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
<tmed_montha@online.com.kh>, <Ruth_tootill@online.com.kh>,
<aafc@camnet.com.kh>, "Sing Seda" <seda@cambodiadaily.com>,
"David Robertson" <dmr@media.mit.edu>
Subject: Re: Patient #2: THORN KHUN, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 22:30:31 +0700

Is the patient still on treatment for hyperthyroidism? If yes, for how long? You do not write, if you want to continue treatment of hyperthyroidism.

Thanks

Dr. Cornelia Haener

Surgeon, SHCH

---

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@MGHIHP.EDU>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Subject: RE: Patient #2: THORN KHUN, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 19:35:05 -0500

Patient #2: THORN KHUN, February 2004 Telemedicine, Robib, Cambodia

Thank you for this follow up case. Again, I recommend checking her thyroid function (TSH, T4) and repeatinhg a CBC now as it has been at least 6-8 weeks since her delivery. Please send those results when they become are available.

Please also send the normal range of values you are using for the thyroid tests). I suspect that she remains hyperthyroid.

Her persistant headache with blurred vision is somewhat troubling. She would benefit from an ophthalmic exam to look at her optic nerves for papilledema.

Which if present suggests increased intracranial pressure. (This would raise the suspicion of such conditions as pseudotumor cerebri, which is more frequesnt in patients with thyrotoxicosis. It often presents with nausea).

My recommendations

1. Check TSH and T4 now. Report values and normal ranges to us when they are recieved.
2. CBC

3. Ophthalmologic eye exam to check for papilledma
4. Continue the multivitamins as long as she is breast feeding
5. Continue paracetemol if it helps with headache

Thank you

Paul Heinzelmann, MD

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Date: Tue, 10 Feb 2004 02:40:21 -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>,
Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
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Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"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,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #3: CHAN SOKNY, February 2004 Telemedicine, Robib, Cambodia

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

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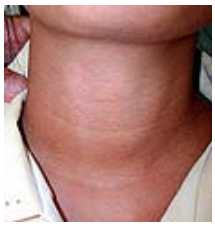
# Telemedicine Clinic in Robib, Cambodia – 10 February 2004



**Patient #3: CHAN SOKNY**, female, 24 years old

**Chief complaint:** Neck tightness, palpitations, and shortness of breath for four months.

**HPI:** 24-year-old female presented with neck tightness, palpitations, shortness of breath, and slight headache for four months since she was in month nine of pregnancy. She went to a private clinic last month to consult with a doctor who gave her some vitamins to take for probably about one week, but her symptoms remain the same. Sometimes she feels hypersensitive with sunlight and cold water, and also has chest tightness.

**Past medical history:** Nine months ago she had cholescystitis. She was admitted to Kampong Cham Hospital for five days and then discharged in stable condition. She delivered a healthy baby two months ago.

**Social history:** None.

**Family history:** None.

**Allergy:** None.

**Current medication:** None.

**Review of system:** No weight loss, no fever, no cough, no

exosphthalmos, no sore throat, has shortness of breath, has palpitations, no abdominal pain, and no stool with blood.

**Physical Exam:** Looks stable, alert and oriented x 3 (time, place, and person.)

**BP:** 120/80, **Pulse:** 90, **Resp.:** 20, **Temp:** 36.5, **Weight:** 54 kg

**Hair, Eyes, Ears, Nose and Throat:** No oropharyngeal problem, no lymph node enlargement.

**Neck:** Thyroid gland mildly enlarged, size about 12 x 8 cm.

**Skin:** Not pale, no jaundice, warm to touch.

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

**Heart:** Regular rhythm, no murmur.

**Abdomen:** Unremarkable.

**Limbs:** No tremor, no edema, and no deformity.

**Neuro exam:** Unremarkable.

**Assessment: Hyperthyroidism?**

**Plan: I would like to suggest drawing her blood to do a thyroid test like TSH, T4, and also use the following meds for one month:**

- **Multivitamin tab once daily**
- **Feso4/folic 200/25mg, one tab per day**

**Follow up next month.**

**Please give me any other ideas or comments.**

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From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #3: CHAN SOKNY, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:14:59 +0700

Dear Montha/David,

We agreed with your plan.

Rithy/Jack

---

Reply-To: "Hope Staff" <hopestaff@online.com.kh>
From: "Hope Staff" <hopestaff@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>, <JKVEDAR@PARTNERS.ORG>,
"Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
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"Bunse Leng" <tmed1shch@bigpond.com.kh>,
"Bernie Krisher" <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
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<aafc@camnet.com.kh>, "Sing Seda" <seda@cambodiadaily.com>,
"David Robertson" <dmr@media.mit.edu>
Subject: Re: Patient #3: CHAN SOKNY, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 22:21:18 +0700

DDx Hyperthyroidism Euthyroid goiter due to iodine deficiency in pregnancy

Any history of tachycardia or arrhythmia? Or other symptoms of hyperthyroidism?

I would suggest to check TSH and T4 as well.

If serious signs of hyperthyroidism, consider giving Propranolol. If no symptoms, then your suggestion is good.

Kind regards

Dr. Cornelia Haener

Surgeon SHCH

---

From: "List, James Frank,M.D.,Ph.D." <JLIST@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>,
"'dmr@media.mit.edu'"
<dmr@media.mit.edu>
Subject: RE: Patient #3: CHAN SOKNY, February 2004 Telemedicine, Robib, Ca
mbodia
Date: Tue, 10 Feb 2004 12:53:06 -0500

In summary, the patient is a 24 y/o female two months post-partum with neck tightness, chest tightness, shortness of breath, palpitations and goiter.

Thyrotoxicosis could explain these symptoms and signs. As a starting point, a TSH should be checked, and, if low (or if an older TSH test is used), a T3, T4 and free T4 level should be checked (at a minimum a T4 level).

In the post-partum patient, thyrotoxicosis would most commonly be from post-partum thyroiditis. This resolves over time, and is treated with beta blockers such as propranolol for symptom relief. The thyrotoxic phase of this can be followed by a hypothyroid phase, so monitoring TSH over ensuing months can be helpful.

Post-partum thyroiditis, however, does not typically cause much in the way of neck symptoms. If the patient's goiter is new, as is suggested by her symptom of neck tightness, then Graves' disease is the most likely etiology. The treatment for Graves' disease would be to initiate antithyroid medications such as carbimazole, and titrate the dose to normalize the patient's thyroid function tests. It is important to note that these medicines can have side effects including rash, hives, arthritis and arthralgias, cholestatic jaundice, and, importantly, agranulocytosis. If the patient develops signs of infection while on the medicine such as fever, we typically check a complete blood count to make sure the patient has a normal complement of leukocytes. Again, beta blockerscan be used for control of symptoms until

the thyroid hormone levels are within the normal range. Some patients achieve a remission after a year of treatment.

Definitive therapy can be achieved with thyroidectomy or radioactive iodine treatment.

Another, less likely, possible cause of thyrotoxicosis in this case would be toxic nodule(s) of the thyroid. Such nodules can lead to thyrotoxicosis, especially following an iodine load such as the administration of iodinated intravenous contrast. Treatment is similar to treatment of Graves' disease. True remission does not occur, but thyroid function can return to normal after an iodine load is excreted.

If the patient's thyroid function tests are normal, then other possible causes, of these symptoms include a variety of diseases such as severe anemia, thromboembolic pulmonary disease, cardiomyopathy, and asthma.

As for a multivitamin, folate, and iron, these are reasonable to give as well.

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

Molecular Endocrinology, Massachusetts General Hospital

---

Date: Tue, 10 Feb 2004 02:44:12 -0500
From: David Robertson <dmr@media.mit.edu>
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
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"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
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Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #4: SOM THOL, February 2004 Telemedicine, Robib, Cambodia

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

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## Telemedicine Clinic in Robib, Cambodia – 10 February 2004

**Patient #4: SOM THOL**, male, 50 years old, Follow up patient

**Chief complaint:** Small wound and mild swelling on the right ankle for two weeks.

**Subject:** 50-year-old male returned for his follow up visit of DMII, PNP and dyspepsia. All symptoms are getting better; decreased numbness, decreased thirst, decreased urination, decreased blurred vision, no cough, no chest pain, no weight loss has mild epigastric pain, and no nausea. Two weeks ago, during his activities at home, he got a sprained left ankle and a small wound on the right foot near his big toe. Symptoms accompanie

by pain but he can walk.

**Object:** Looks stable and oriented x 3 (place, person, and time.)

**BP:** 120/80, **Pulse:** 80, **Resp.:** 20, **Temp:** 36.5, **Weight:** 54 kg

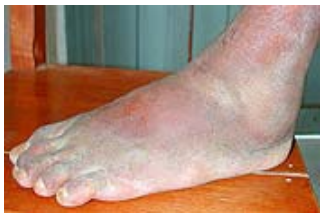
**Hair, Eyes, Ears, Nose and Throat:** Unremarkable

**Neck:** No lymph node and no JVD.

**Skin:** Not pale, warm to touch and no jaundice.

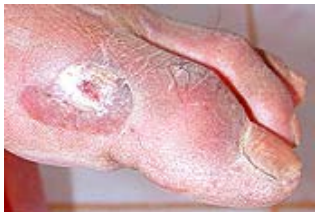
**Lungs:** Clear both sides.

**Heart:** Regular rhythm, no murmur.



**Abdomen:** Soft, flat, not tender and no HSM.

**Limbs:** Mild swelling on the left ankle and foot, swelling and mild pain when moving. Also has one small wound near the big toe, pink color, no redness around it. Positive pedal pulse both sides.



**Assessment:**

1. **DMII & PNP**
2. **Dyspepsia**
3. **Infected wound on the left foot.**

**Plan: Continue with the following meds for one month:**

- **Diamecron, 80 mg, ½ tablet, three times per day**
- **Amitriptilline, 25 mg, one tablet, two times per day**
- **Ranitidine, 75 mg, one tablet twice daily**
- **Aspirin, 300 mg, 1/4 tablet daily**
- **Paracetemol, 500 mg, four times daily (for seven days.)**
- **Velocef, 500 mg, one tablet four times daily (for seven days.)**

**May I draw his blood for lytes, Bun, creatinine, blood sugar do at Sihanouk Hospital Center of Hope? Kampong Thom Provincial Hospital can't do lytes, Bun, creatinine. Do you agree? Please give me any ideas.**

---

From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Gary Jacques" <gjacques@online.com.kh>,
"Jennifer Hines" <sihosp@online.com.kh>
Subject: RE: Patient #4: SOM THOL, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:31:27 +0700

Dear Montha/David,

We think that with the hx of previous foot wound, this man may need a better shoe that can cover his feet better. Can TM help him to get get this as part of the management for his foot ca (maybe on your next visit)? We agreed with your plan except change the Velosef 500mg to 2 tab po bid x 14d and do the "ICE" for his ankle (i.e. use ice, compression (with elastic bandage and elevation of his affected foot). Check the labs as requested and if creatinine < 300 then m want to start him on an ACE-inhibitor (start low) to help prevent his diabetic nephropathy.

Rithy/Jack

---

Reply-To: "Hope Staff" <hopestaff@online.com.kh>
From: "Hope Staff" <hopestaff@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>, <JKVEDAR@PARTNERS.ORG>,
"Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@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>,
"Bernie Krisher" <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
<tmed_montha@online.com.kh>, <Ruth_tootill@online.com.kh>,
<aafc@camnet.com.kh>, "Sing Seda" <seda@cambodiadaily.com>,
"David Robertson" <dmr@media.mit.edu>
Subject: Re: Patient #4: SOM THOL, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 22:26:59 +0700

I would like to reply concerning the wound and the swollen ankle.

Suggest to cover the wound with dry dressing; elevate foot during the night; good shoes. Is there suspicion of ankle fracture? Would she need an X-ray of her ankle?

Could you send digital pictures of the wound?

Thanks

Dr. Cornelia Haener

Surgeon, SHCH

---

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@MGHIHP.EDU>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Subject: RE: Patient #4: SOM THOL, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 18:56:48 -0500

Details about where his foot/ankle is tendet on palpation would be helpful in determining fracture from sprain.

I think that because of his PNP it is quite possible he has fractured his foot and not have the typical pain sensation. He may even have something called Charcot foot. In patients with Charcot foot, pain perception and the ability to sense the position of the joints in the foot are severely impaired and the muscles lose their ability to support the joint(s) properly. Loss of nerve functions allow minor traumas such as sprains and stress fractures to go undetected and untreated, leading to ligament laxity (slackness), joint dislocation, bone erosion, cartilage damage, and deformity of the foot can occur. The bones most often affected are the metatarsals and the tarsals, located in the forefoot and midfoot, respectively.

I believe he should get an x-ray, and have close monitoring of the wound which should be debrided, bandaged, and treated with antibiotics so that osteomyelitis is prevented.

I also repeat my recommendations from his last telemedicine clinic.

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, two to 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.

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 complicated patient.

Paul Heinzelmann, MD

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Date: Tue, 10 Feb 2004 02:46:27 -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>,
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>,
Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"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,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #5: SVAY SOPHEAK, February 2004 Telemedicine, Robib, Cambodia

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

---

## Telemedicine Clinic in Robib, Cambodia – 10 February 2004

**Patient #5: SVAY SOPHEAK**, male, 19 years old

**Chief complaint:** Patient complains of epigastric pain on and off for one year.

**Subject:** 19-year-old male presented with epigastric pain, usually after a meal and radiating to left or right sides of abdomen. He gets these symptoms accompanied by burping and excessive saliva in the morning. He also gets diarrhea very often but doesn't have blood or mucus. He hasn't ever consulted with a doctor or used any medicine.

**Past medical history:** Unremarkable.

**Family history:** None.

**Social history:** None.

**Allergy:** None known.

**Current medication:** None.

**Review of system:** No sore throat, no weight loss, no fever, no cough, no chest pain, no shortness of breath, no headache, and has mild epigastric pain.

**Object:** Looks stable, oriented x 3 (time, place, and person.)

**BP:** 100/60, **Pulse:** 80, **Resp.:** 20, **Temp:** 36.5, **Weight:** 53 kg

**Hair, Eyes, Ears, Nose and Throat:** Unremarkable.

**Lungs:** Unremarkable.

**Heart:** Unremarkable.

**Abdomen:** Mild epigastric pain during palpable, not tender, no HSM, has positive bowel sound.

**Limbs:** Okay.

**Assessment: Dyspepsia? Parasitis?**

**Plan: May we give him:**

- **Ranitidine, 75 mg, one tablet twice daily for one month**
- **Mebendazole, 100 mg, one tablet twice daily for three days**

**Please give me any other ideas.**

---

From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #5: SVAY SOPHEAK, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:35:27 +0700

Dear Montha/David,

We agreed with yoru plan.  You may want to give him some MgALOH3 2 chew q6h prn if you have any to help with abdominal complaint.

Rithy/Jack

---

Reply-To: "Hope Staff" <hopestaff@online.com.kh>
From: "Hope Staff" <hopestaff@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>, <JKVEDAR@PARTNERS.ORG>,
"Paul Heinzelmann, MD" <pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@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>,
"Bernie Krisher" <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
<tmed_montha@online.com.kh>, <Ruth_tootill@online.com.kh>,
<aafc@camnet.com.kh>, "Sing Seda" <seda@cambodiadaily.com>,
"David Robertson" <dmr@media.mit.edu>
Subject: Re: Patient #5: SVAY SOPHEAK, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 22:37:16 +0700

Another differential diagnosis would be giardiasis. This would well explain these symptoms. I would suggest adding 2 gr of Tinidazol single dose or seven days of Metronidazole.

Thanks

Dr. Cornelia Haener

Surgeon, SHCH

---

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #5: SVAY SOPHEAK, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 13:30:51 -0500

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

From: Crocker, Jonathan T., M.D.

Sent: Tuesday, February 10, 2004 12:24 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #5: SVAY SOPHEAK, February 2004 Telemedicine, Robib, Cambodia

Hi,

I think your ideas of deparasitization is good and agree with that empiric treatment.  Also treating him for severe dyspepsia is also warranted given Sx accompanied by burping and excessive saliva (?waterbrash).  However, I would recommend treating him with Ranitidine 150mg TWICE DAILY for a month, and then following up.  If you can, I'd check a CBC now to evaluate for anemia given his upper GI symptoms and concurrent diarrhea.  If in a

month he still had symptoms, you would want to further investigate for entities like severe gastritis, ulcers, or even H. Pylori infection and probably at least move him to a proton pump inhibitor like Prilosec. Also, if he was not improved you could check for UGI study +/- H. pylori Ab testing. If he was worse off and/or anemic, I'd recommend upper endoscopy for definitive evaluation.

Lifestyle interventions which may prove helpful now would be to avoid any of the following foods - caffeine, mints, hot spicey food, tea etc. - all of which can increase acid secretion.

I hope this helps.

Dr. Jonathan Crocker

Bulfinch Medical Group

MGH

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Date: Tue, 10 Feb 2004 08:13:22 -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>,
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>, jmiddleb@eudoramail.com,
Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"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,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #6: SUN NARA, February 2004 Telemedicine, Robib, Cambodia

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

---

## Telemedicine Clinic in Robib, Cambodia – 10 February 2004

**Patient #6: SUN NARA**, female, 18 years old

**Chief complaint:** Patient complains of shortness of breath, chest tightness, and weakness on and off for one year.

**HPI:** 18-year-old female presented with shortness of breath, chest tightness, and weakness on and off for one year. All symptoms get worse during exertion. In the last two years she also had malaria. Her mother took her to a private clinic, they gave her some IV, IM or PO of medicines, and she was healed. One year later she had a mild fever and gradually with malaise, paleness, dizziness, plus with all the symptoms mentioned above.

**Past medical history:** In the last two years she had malaria.

**Family history:** Unremarkable.

**Social history:** None.

**Allergy:** None known.

**Current medication:** Used traditional medicine for four months for paleness.

**Review of system:** No sore throat, no weight loss, no fever, has shortness of breath, no cough, has chest tightness, has palpitations, no abdominal pain, no stool with blood, and no bleeding gums.

**Physical Exam:** Looks stable, alert and oriented x 3 (time, place, and person.)

**BP:** 110/60, **Pulse:** 120, **Resp.:** 20, **Temp:** 36.5, **Weight:** 45 kg

**Hair, Eyes, Ears, Nose and Throat:** Okay

**Neck:** No thyroid enlargement and no JVD.

**Skin:** Pale and warm to touch.

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

**Heart:** Regular rhythm, systolic murmur at mitral area.

**Abdomen:** Soft, flat, not tender, no HSM, and has positive bowel sound.

**Limbs:** No joint pain and no edema.

**Assessment: Anemia due to:**

- **Parasitis?**
- **Vitamin deficiency?**
- **Iron deficiency?**

**Valvular heart disease due to anemia?**

Plan: I would like to refer her to Kampong Thom Hospital for evaluation and some blood work like CBC, Reticulocyte, Bun., creat., lytes, a chest x-ray and an EKG. Do you agree? Please give me any ideas.

---

From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #6: SUN NARA, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:41:40 +0700

Dear Montha/David,

AT this point from your preasentation of this patient, it does not seem to us that she needs to be sent to KT for work up. We think that she may have some parasitic infection (especially worms) to cause her vague sx. The previous malaria infection though now recovered may also make her feel like your presentation for months afterward. You can give her some MTV and FeSO4/folate and some Para for HA if any. Ask her to come back next visit to reevaluate her condition.

Rithy/Jack

---

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #6: SUN NARA, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 12:07:21 -0500

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

From: Mudge, Gilbert Horton,Jr.,M.D.

Sent: Tuesday, February 10, 2004 12:04 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #6: SUN NARA, February 2004 Telemedicine, Robib, Cambodia

I think your plan is an appropiate beginning.

We will need to see a CBC, and EKG.

I would not resort to echocardiogram until this is addressed. If anemeic, full workup can follow.

Gilbert Mudge, M.D.

---

Date: Tue, 10 Feb 2004 08:17:55 -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>,
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>, jmiddleb@eudoramail.com,
Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"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,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #7: PRUM SOUR, February 2004 Telemedicine, Robib, Cambodia

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

---

## Telemedicine Clinic in Robib, Cambodia – 10 February 2004

**Patient #7: PRUM SOUR**, female, 53 years old, farmer
**Chief complaint:** Patient complains of chest tightness and productive

cough on and off for one month.

**HPI:** 53-year-old female presented with chest tightness and productive cough on and off for one month. All symptoms get worse during exertion. She also has a fever, shortness of breath, headache, and neck tenderness accompanying symptoms mentioned above. She went to a private pharmacy to buy some drugs like Amoxycillin to take for a few days in the last two weeks. The medicine helped her a little bit and then she stopped because of no money.

**Past medical history:** She has had malaria many times in her life, the last time being two years ago.

**Family history:** None.

**Social history:** None.

**Allergy:** None known.

**Current medication:** Amoxycillin, 500 mg three times daily for three days during the last two weeks.

**Review of system:** No sore throat, no weight loss, has mild fever, has shortness of breath, has cough, has chest tightness, no abdominal pain, and no stool with blood.

**Physical Exam:** Looks stable and oriented x 3 (time, place, and person.)

**BP:** 130/80, **Pulse:** 84, **Resp.:** 22, **Temp:** 37.5, **Weight:** 65 kg

**Hair, Eyes, Ears, Nose and Throat:** Okay

**Skin:** Not pale and warm to touch.

**Neck:** No goiter enlargement and no JVD.

**Lungs:** Crackle all over lobes.

**Heart:** Regular rhythm and no murmur.

**Abdomen:** Soft, flat, not tender, and has positive bowel sound.

**Limbs:** No edema and no deformity.

**Urinanalysis:** Negative.

**Assessment: Chronic pneumonia?**

**Plan: Should we cover her with the following for seven days?**

- **Gatifloxacine, 400 mg, 1 tablet per day**
- **Paracetemol, 500 mg, one tablet, four times per day**

Do you agree? Please give me any ideas.

---

Date: Tue, 10 Feb 2004 22:55:14 -0500
From: David Robertson <dmr@media.mit.edu>
To: "Dr. Srey Sin" <012905278@mobitel.com.kh>

Cc: tmed_montha@online.com.kh, Bernie Krisher <bernie@media.mit.edu>,
aafc@camnet.com.kh, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #7: PRUM SOUR, female, 53 years old, Robib, Cambodia, Telemedicine

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

Dear Dr. Srey Sin:

Per the recommendations of the doctors in Boston and Phnom Penh (copied below,) the following patient will be transported to your hospital today. We hope to arrive in Kampong Thom around 2:00pm.

Thanks again for your kind assistance.

Sincerely,

David

*ADVICE FROM SIHANOUK HOSPITAL CENTER OF HOPE IN PHNOM PENH:*

From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #7: PRUM SOUR, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:50:33 +0700

Dear Montha/David,

For this patient, we suspected that she may be having TB infection. We would like for you to send her to KT hospital for AFB sputum smears and a CXR. If CXR is positive for TB or pneumonia, then the DR. at KT will have to treat her appropriately according to their decision. You can give paracetamol with MTV and Mebendazole for now. Ask her to bring you the CXR and result from KT on your next visit to look at. If negative for CXR, then may consider COPD or asthma. Does she have any GERD sx? Does she smoke or live in a household who smoke around her? Does she wheeze during her SOB?

Rithy/Jack

---

*ADVICE FROM BOSTON:*

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #7: PRUM SOUR, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 15:44:23 -0500

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

From: Sadeh, Jonathan S.,M.D.

Sent: Tuesday, February 10, 2004 3:25 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #7: PRUM SOUR, February 2004 Telemedicine, Robib, Cambodia

My differential diagnosis to this case is pneumonia vs. heart failure. She certainly may be infected but after a month of essentially no treatment I would expect her to be much worse than she sounds. Heart failure is consistent with this presentation--chronic presentation, worse on exertion, associated with chest tightness; the PE finding of diffuse crackles is more likely to be heart failure than pneumonia. A chest x-ray would make the diagnosis easy. If you can look at her sputum under the microscope, that would help also.

I would treat her for pneumonia initially (gatifloxacin is good) since that is the potentially more serious condition. If no improvement in 5-7 days of antibiotics I would stop them and start her on lasix for presumed heart failure.

Jonathan Sadeh, MD

---

Date: Tue, 10 Feb 2004 08:22:32 -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>,
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>, jmiddleb@eudoramail.com,
Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"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,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #8: YEM PHALA, February 2004 Telemedicine, Robib, Cambodia

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

---

## Telemedicine Clinic in Robib, Cambodia – 10 February 2004

**Patient #8: YEM PHALA**, male, 55 years old, follow up patient

**Chief complaint:** Patient complains of still having pain on the left leg.

**Subject:** 55-year-old male returned for follow up visit of hypertension and nerve root pain on the left leg. A lot of symptoms are improving; less blurred vision, less headache, no shortness of breath, no chest pain, no abdominal pain, but still has pain on the left leg from waist to foot, sometimes painful during walking or bending.

**Object:** Looks stable and good oriented x 3..

**BP:** 140/70
**Pulse:** 86
**Resp.:** 20
**Temp. :** 36.5
**Weight. :** 77 kg

**Hair, eyes, ears, nose, and throat:** Okay.

**Lungs:** Unremarkable
**Heart:** Unremarkable
**Abdomen:** Unremarkable
**Limbs:** Left leg pain, but not swelling and not stiff.

Assessment:

1. Hypertension (Stable.)

2. Nerve root pain on left leg.

Plan: May we continue with the same drugs for another month?

- **Propranolol, 40 mg, 1/4 tablet twice daily**
- **Nabumetone, 750 mg, one tablet twice daily as needed**

**Do you agree? Please give me some ideas.**

---

From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #8: YEM PHALA, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 08:54:14 +0700

Dear Montha/David,

We agreed with your plan, but remember start any NSAIDs with a lower dose to prevent any GI side effect. For Relefan (nebumatome) you can give 750mg 1 po qd. This is a strong medication. The max dose is 2g qd.

Rithy/Jack

---

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: '"dmr@media.mit.edu"' <dmr@media.mit.edu>
Subject: FW: Patient #8: YEM PHALA, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 16:39:34 -0500

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

From: Tan, Heng Soon,M.D.

Sent: Tuesday, February 10, 2004 4:16 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #8: YEM PHALA, February 2004 Telemedicine, Robib, Cambodia

Sounds like he has chronic sciatica from prolapsed left L5-S1 disk. In the history it will be useful to know the duration of symptoms, whether there is a foot drop or numbness in the foot, and the progression of symptoms.

Neurological exam describing strength, sensation and reflexes will also provide additional information to confirm a radiculopathy. Most cases of sciatica will improve with rest when tired, proper posture while sitting or standing, avoidance of repeated bending and lifting of weights, use of NSAID and performance of back strengthening exercises. If symptoms are

getting worse, he should consider surgery to remove the disk.

Heng Soon Tan, M.D.

---

Date: Tue, 10 Feb 2004 08:26:31 -0500
From: David Robertson <dmr@media.mit.edu>
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
<pheinzelmann@PARTNERS.ORG>,
"Kelleher-Fiamma, Kathleen M. - Telemedicine"
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Rithy Chau <tmed_rithy@online.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>, jmiddleb@eudoramail.com,
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Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #9: PEN SAMADY, February 2004 Telemedicine, Robib, Cambodia

This is the last case we will be sending from Robib this month.

Thanks again for your assistance.

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

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## Telemedicine Clinic in Robib, Cambodia – 10 February 2004

**Patient #9: PEN SAMADY**, male, 36 years old

**Chief complaint:** Patient complains of sore throat and throat tightness on and off for three weeks.

**HPI:** 36-year-old male presented with throat tightness and sore throat on and off for three weeks. In the last three weeks, he had a high fever, cough, headache, and severe sore throat. He could not eat anything. He went to the local pharmacy to buy some drugs like Amoxycillin to take, one gram/day for three days, and then stopped. Four or five days later, all the symptoms returned and became on and off up to now.

**Past medical history:** Unremarkable.

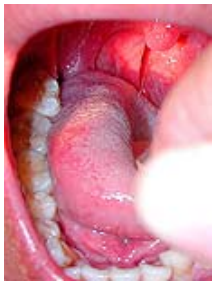
**Family history:** His father and sister have hypertension.

**Social history:** No smoking but drinks alcohol sometimes.

**Allergy:** None known.

**Current medication:** None.

**Review of system:** Has sore throat, no weight loss, has mild fever, no



shortness of breath, coughs occasionally, no chest tightness, no abdominal pain, and no joint pain.

**Physical Exam:** Looks stable, alert and oriented x 3 (time, place, and person.)

**BP:** 130/60, **Pulse:** 84, **Resp.:** 20, **Temp:** 37.5

**Hair, Eyes, Ears, Nose:** Okay

**Throat:** Has redness with hypervascularisation, few white spots on bilateral tonsil

**Neck:** No lymph node.

**Heart, Lungs, Abdomen:** Unremarkable.

**Limbs:** Okay.

**Assessment: Chronic Pharyngitis.**

**Plan: I would cover him with the following for seven days:**

- **Penicillin V, 250 mg, 1 tablet, four times per day**
- **Paracetemol, 500 mg, one tablet, four times per day**

Please give me some ideas.

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From: "Rithy Chau" <tmed_rithy@online.com.kh>
To: "David Robertson" <dmr@media.mit.edu>
Cc: "Jennifer Hines" <sihosp@online.com.kh>,
"Gary Jacques" <gjacques@online.com.kh>
Subject: RE: Patient #9: PEN SAMADY, February 2004 Telemedicine, Robib, Cambodia
Date: Wed, 11 Feb 2004 09:02:13 +0700

Dear Montha/David,

We agreed with pharyngitis (recurrence, not chronic). Since he took Amox already, let try him on Velosef 500mg 2 capsules bid x 10d instead. You can give Para for his HA and fever. Tell him to drink a lot of clean water (2L/day) and get some rest and if he felt better in two to three days with Velosef, he needs to finish off the medicine for 10 days and not stopearlier.

Again, thanks for letting us participate in the TM clinic at Robib.

Rithy/Jack

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From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #9: PEN SAMADY, February 2004 Telemedicine, Robib, Cambodia
Date: Tue, 10 Feb 2004 16:32:41 -0500

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

From: Tan, Heng Soon,M.D.

Sent: Tuesday, February 10, 2004 4:09 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #9: PEN SAMADY, February 2004 Telemedicine, Robib, Cambodia

The differential diagnoses for chronic pharyngitis include infectious mononucleosis, but he does not have lympahadenopathy. It is more likely to be one of the other non-Group A streptococcus. Penicillin is fine, but I would use a higher dose of 500 mg 3 times a day for 10 days.

Heng Soon Tan, M.D.

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# Follow up Report, Thursday, 11 February 2004

***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: SUM SOKNA**, female, 20 years old, follow up patient

**Patient #2: THORN KHUN**, female, 38 years old, follow up patient

**Patient #3: CHAN SOKNY**, female, 24 years old

**Patient #4: SOM THOL**, male, 50 years old, Follow up patient

**Patient #5: SVAY SOPHEAK**, male, 19 years old

**Patient #6: SUN NARA**, female, 18 years old

**Patient #8: YEM PHALA**, male, 55 years old, follow up patient

**Patient #9: PEN SAMADY,** male, 36 years old

**January 2004 Patient: NGET SOEUN**, male, 56 years old, follow up patient

**December 2003 Patient: SAO PHAL**, female, 56 years old, follow up patient

**December 2003 Patient: THO CHANTHY**, female, 36 years old, follow up patient

**December 2003 Patient: PEN VANNA**, female, 37 years old, follow up patient

November 2003 Patient: MUY VUN, male, 36 years old, follow up patient

***Per e-mail advice of the physicians in Boston and Phnom Penh, one patient from this month's clinic was transported to Kampong Thom Provincial Hospital by the Telemedicine team for a chest x-ray and other tests:***

**Patient #7: PRUM SOUR**, female, 53 years old

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**The schedule for the next Telemedicine Clinic in Robib:**

Tue. March 9 – Travel - Phnom Penh to Robib

Wed. March 10 - Clinic

Thu. March 11 - Morning follow up clinic. Travel - Robib to Phnom Penh with a stop at Kampong Thom Provincial Hospital.