June 2004 Telemedicine Clinic in Robib

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

On Monday, June 7, 2004, SHCH staff, Nurse Koy Somontha and PA Rithy Chau, traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following day, Tuesday, June 8, 2004, the Robib TM clinic opened to receive the patients for evaluations. There were 6 new cases and 8 follow-up patients. The patients were examined and their data were transcribed along with digital pictures of the patients, then transmitted and received replies from their TM partners in Boston and Phnom Penh on the next day.

On Thursday, June 10, 2004, replies from both the Sihanouk Hospital Center of HOPE in Phnom Penh and the Partners Telemedicine in Boston were downloaded. Per advice from these two locations, Nurse Koy Somontha managed and treated the patients accordingly. Finally, the data of the patient concerning final diagnosis and treatment/management would then be transcribed and transmitted to the PA Rithy Chau at SHCH who compiled and sent for website publishing.

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

-----Original Message-----
From: TM Team [mailto:tmrural@yahoo.com]
Sent: Monday, May 31, 2004 3:41 PM
To: Ruth Tootill; Heather Brandling Bennett; Rithy Chau; Cornelia Haener; Paul Heinzelmann; Jennifer Hines; Gary Jacques; Kathy Kelleher-Fiamma; Joseph Kvedar; Bunse Leang; Jack Middlebrook; thero@cambodiadaily.com
Cc: Kiri; Bernie Krisher; Nancy Lugn; peou@cambodiadaily.com; seda@cambodiadaily.com
Subject: Robib TM telemedicine date

Dear all,

I am writing to inform you about the next Robib TM visit. We set up the schedule for this month from 14th to 17th of June.

Hear is the detail agenda for visit of June 2004

- 14th June we leave PP for Robib
- 15th June Robib clinic will begin at 8.00AM
- 16th June Data entering and transmitting
- 17th June Downloading replies.

Patient treatment/management.

Return to PP.

Please, be advise that Mr. Rithy Chau will travel with me one more time to help facilitate in project. I would appreciate your patience with me. Please feel free to make comments on what will or will not work with this set up for Robib visit.

Thank you for cooperation and support.

Best regards,

Montha

-----Original Message-----
From: TM Team [mailto:tmrural@yahoo.com]
Sent: Thursday, June 03, 2004 10:12 AM
To: Ruth Tootill; Heather Brandling Bennett; Rithy Chau; Kathy Fiamma; Cornelia Haener; Paul Heinzelmann; Jennifer Hines; Gary Jacques; Joseph Kvedar; Bunse Leang; Jack Middlebrook; Thero Noun
Cc: Seda seng; Kiri; Bernie Krisher; Nancy Lugn; Peou Ouk
Subject: Reiform and ask for apolozise

Dear all,

I am so sorry about the wrong schedule of Robib Telemedicine. The date will be changed to next week on 7th to 10th of June. It is not from 14th to 17th of June.

Here is the detail agenda for visit of June 2004

- On 7th we leave PP to village.
- On 8th clinic will start from 8 o'clock.
- On 9th patient data will transmit to Center of Hope and Boston.
- On 10th all answers will collect, do management to follow the instruction and come back to PP.

Very thanks for your best patience with me.

Montha

-----Original Message-----
From: TM Team [mailto:tmrural@yahoo.com]
Sent: Wednesday, June 09, 2004 2:51 PM
To: Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Jennifer Hines; Joseph Kvedar; Bunse Leang; Jack Middlebrook
Cc: Somontha Koy; Bernie Krisher; Nancy Lugn; lauriebachrach@yahoo.com
Subject: Robib Telemedicine Cases for June

Dear all,

For this June of Robib Telemedicine, we have 14 cases. Please reply me on time by 9 o'clock tomorrow.

Best Regards,

Montha

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

Patient: Nong Hen, 31M, Farmer (Thnout Malou)

CC: Yellow eyes, mild fever and chill for 10 days.

HPI: 31M, farner. With 10 days of body weakness, mild fever, chill,

right upper abdominal pain, vomit after meal, and jaundice. He went to private pharmacy to buy some unknown drugs to release those symptoms. After taking those kinds of medicine for 7 days, his symptoms have still the same, just release only vomit and his urine become dark yellow from day to day but with normal amount.

PMH: had Malalria one time a year together in 1985,1986,1987. That time he was treated with modern medicine at health center.

SH: smoking for 20 years, just stop in the last 7 months ago. Drinking alcohol for 15 years.

FH: unremarkable

Allergies: NKA

ROS: loose weight one KG, no sore throat, no cough, has mild fever, no chest pain, no diarrhea, no stool with blood, no peripheral edema.

PE:

VS: BP 100/60 P 64 R 20 T37.5C Wt 53kgs

Gen: look stable

HEENT: no oropharyngeal lesion, conjunctiva is icteric . Neck no goiter enlarge, no JVD, no lymphnode

Chest: lungs: clear both sides. Heart: RRR, no murmur.

Abd: soft, flat, n tender, mild pain on the right quadrant during palpable, but HSM, has BS for all quadrants

MS/Neuro: not done

Other: lims: no deformity, no edema.

Previous Labs/Studies:

Lab/Study Requests: UA (Urobilinogen +2, Bilirubine +2). Blood Sugar = 100mg/ml

Assessment:

1. Hepatitis due to Etio?
2. Cholescystitis?
3. Parasitis?

Plan:

1. we would like to refer him to Kg Thom Hospital for reevaluation and do some paraclinic such as Abdominal Ultrasound, ans some blood work (BUN, Lytes, Creat, CBC, Liver function, and stool exam).

Comments: do you agree with my plan? Please, give me good idea.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Thursday, June 10, 2004 8:04 AM
To: 'tmed_project@online.com.kh'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_ruralcam@yahoo.com'
Subject: FW: June 04, Robib Telemedicine Patient 01, Nong Hen, 31M

> -----Original Message-----
> From: Fiamma, Kathleen M.
> Sent: Wednesday, June 09, 2004 8:37 AM
> To: Tan, Heng Soon,M.D.
> Subject: FW: June 04, Robib Telemedicine Patient 01, Nong Hen, 31M
>
> -----Original Message-----
> From: Tan, Heng Soon,M.D. [mailto:HTAN@PARTNERS.ORG]
> Sent: Wed 6/9/2004 8:43 AM
> To: Mak, Raymond Heungwing; 'cparanja@caregroup.harvard.edu'; Prasad, Paritosh
> Cc:
> Subject: FW: June 04, Robib Telemedicine Patient 01, Nong Hen, 31M
>
> -----Original Message-----
> From: Tan, Heng Soon,M.D.
> To: 'Mak, Raymond Heungwing'
> Cc: Fiamma, Kathleen M.
> Sent: 6/9/04 4:01 PM
> Subject: RE: June 04, Robib Telemedicine Patient 01, Nong Hen, 31M
>
> Ray,
> Excellent discussion. I forward this with some editorial comments.
> Heng Soon
>
> -----Original Message-----
> From: Mak, Raymond Heungwing
> [mailto:raymond_mak@student.hms.harvard.edu]
> Sent: Wednesday, June 09, 2004 3:17 PM
> To: Tan, Heng Soon,M.D.
> Subject: RE: June 04, Robib Telemedicine Patient 01, Nong Hen, 31M
>
> Hi Dr. Tan,
>
> I had a little bit of time to look at this case and put some of my thoughts together today. Please let me know if it's too short to be of use or if it's ok.
>
> Thanks,
>
> Ray
>
> In summary, a 31 M with a 15 year history of EtOH use presenting with a 10 day history of RUQ abdominal pain, jaundice, mild fevers, chills, vomiting, fatigue. Physical exam is notable for no fever, stable vital signs, scleral icterus, mild RUQ tenderness, no hepatosplenomegaly, and no peripheral edema. UA showed 2+ urobilinogen and 2+ bilirubin.
>
> Assessment and Plan:
>
> A 31 yo with a h/o significant alcohol abuse presenting with jaundice and RUQ abdominal pain would suggest primary hepatic disease by history alone. The acute nature of the patient's current symptoms is not consistent with chronic alcohol induced cirrhosis. Furthermore, on

physical exam, there was no evidence of anasarca that may be seen with depressed hepatic synthetic function (hypoalbuminemia). However, acute alcoholic hepatitis is a possibility.

Additionally, an acute viral hepatitis would also be on the differential. Some useful questions to ask the patient about include sexual activity, use of IV drugs, blood transfusions and other risk factors for viral hepatitis (A,B,C).
[Tan, Heng Soon,M.D.] I favor acute hepatitis A is this young person with a short history. Acute hepatitis B is a close second. I would send off serology tests for viral hepatitis.

Other causes of an acute hepatitis include ingestion of hepatotoxic substances (e.g. acetaminophen, large quantities of alcohol, carbon tetrachloride). Since the patient took "unknown drugs" and has a history of alcohol use, it may be useful to find out what kind of medication the patient took and whether he combined it with alcohol.
[Tan, Heng Soon,M.D.] Even 4g of acetoaminophen in a previously compromised liver could precipitate acute hepatitis.

Checking for asterixis [Tan, Heng Soon,M.D.] and mental status on physical exam may have been useful to confirm the absence of hepatic encephalopathy. I agree with your plan to send the patient for blood work (liver function tests). If the ALT and AST are markedly elevated, viral hepatitis and toxic ingestion would be most likely. Moderately elevated LFTs (ALT, AST <500) with an AST to ALT ratio of 2.0 would support a diagnosis of alcoholic hepatitis.

Other things on the differential for jaundice include extrahepatic biliary obstruction. The urinalysis was helpful, since it points to the preservation of hepatic function. The presence of urobilinogen in the urine suggests that the patient's liver is conjugating bilirubin, and furthermore that there is not a complete obstruction of the biliary tree currently (urobilinogen is form when excreted conjugated bilirubin has been exposed to bowel flora). However, there is the possibility for a partial or transient obstruction of the biliary tree. Causes includes cholelithasis, cholangiocarcinoma, and parasitic disease (e.g. liver fluke). In light of the acute nature of his RUQ abdominal pain, jaundice and associated symptoms of fevers and chills, there is also a concern for acute cholecystitis and ascending cholangitis. Although his abdominal pain and fever are mild, it is appropriate to send him to a health center with the capabilities for abdominal ultrasound and surgical interventions.
[Tan, Heng Soon,M.D.] Acute cholelithiasis presents more with pain rather than jaundice. Chronic biliary obstruction would have been more insidious. Generally liver tests showing obstructive pattern with high alk phosphatase and relatively normal hepatic enzymes would suffice to exclude this possibility.

The differential for jaundice also includes hemolytic disease. With the patient's history of repeated bouts of malaria and current systemic symptoms, it would be useful to evaluate if he has had a recurrence or been re-infected. A CBC, hemolysis labs (LDH, direct and indirect bilirubin, haptoglobin), and a peripheral blood smear may be useful as well.
[Tan, Heng Soon,M.D.] Chronic malaria with vivax can present with chronic anemia and hemolysis, less likely to do so with jaundice.

Ray Mak

HMSIII

-----Original Message-----
From: Bunse LEANG [mailto:tmed1shch@online.com.kh]
Sent: Thursday, June 10, 2004 7:27 AM
To: 'TM Team'; 'Rithy Chau'
Cc: 'Somontha Koy'; 'Jack Middlebrook'; 'Bernie Krisher'; Jennifer Hines; Gary Jacques
Subject: RE: June 04, Robib Telemedicine Patient 01, Nong Hen, 31M

Dear Montha and Rithy,

31 M with 15 years drinking alcohol. 10 days mild fever, jaundice, vomiting, RUQ pain, HSM, no ascites, 100/60, HR 64, UA urobilinogen+2, bilirubine +2.

DDx:

Alcohlic hepatitis

Viral hepatitis - usually when we see jaundice the patient should feel better

Liver abscess - amebic often have low grade fever

Cholecystits, cholangitis - these should give tachycardia

Biliary stone, ascaris

Liver cirrhosis - should be seen by US

Hepatocellular carcinoma - should be seen by US

Pancreatic tumor - should be seen by US

Hemolysis

Malaria

Sepsis - this should give tachycardia

Hepatotoxic drugs - but it sound like he did not take drugs prior to jaundice

Plan: agree with your plan to refer to Kg Thom for the test. Just add reticulocytes count, malaria smear, bilirubin unconjugate and conjugate, agree not to check Hep B/C since we can not offer anything to him. In the mean time advice/counseling to stop alcohol, give pain killer codein 30 mg q 6, multivit, albendazole 400 mg single dose for possible ascaris. The sensitivity of a stool micro is 30%, and it is cost effective to treat than to screen.

Thank for the case,

Bunse

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

Patient: Mey Moeun, 47M, farmer (Bakdeung)

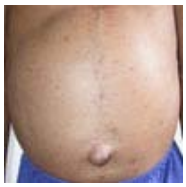
CC: abdominal pain and distension, SOB x for 20 days

HPI: 47M, farmer, in last 20 days he start having the whole abdominal pain and distention. Abdomen becomes gradually bigger and bigger and also accompany with some sings like SOB, mild fever and loose weight approximately 4 kgs, body weakness, palpitation, pass urine in small amount, both legs edema. He went to local pharmacy to buy some diuretic to take 3 or 4 tablets/ day for 10 days and also use traditional medicine for his symptoms. Symptoms were released by increasing urine out put, and decreasing both legs edema.

PMH: last year he had liver problem. He was told by Kg Thom doctor by conforming with abdominal ultrasound and some blood work.

SH: drinking alcohol for 8 years with 200ml/day and also stop in the last 5 years. No smoking.

FH: unremarkable



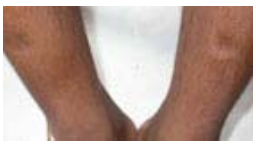
Allergies: NKA

ROS: loose weight 4kgs, mild fever, no chest pain, no cough, has abdominal distention, but no diarrhea or stool with blood, pitting edema on the both legs for +2

PE:

VS: BP 100/60 P 120 R 24 T 37c Wt = 56kgs

Gen: look sick and skinny



HEENT: no oropharyngeal lesion, mild conjunctiva icteric and pale. Neck no JVD, no lymphnode. Skin generalize body petichiae except face and lower extremities.

Chest: Lungs: crakle and decrease BS at bilateral lower lobes. Heart: RRR, no murmur.

Abd: distention, but soft, have BS for all the quadrants, have few varicose vein on abdomen, protruded embilicus.

MS/Neuro: not done

Other: +2 of pitting edema on the both legs.

Previous Labs/Studies:

Lab/Study Requests: Urobillinogen +1, Proteine +1

Assessment:

1. Ascitis due to etio?
2. Cirrhosis?
3. Hepatitis?
4. CRF?
5. Bilateral pleural effusion?
6. Lungs congestion?

7. Mulnutrition

Plan:

1. We would suggest to refer him to Kg Thom hospital for reevaluation and do some paraclinic such as abdominal ultrasound, CXR, Para synthesis, Urine microscopic, and some blood test like (Bun, Creat, Lytes, CBC, Liver function

Comments: do you agree with my plan? Please, give me a good idea.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Thursday, June 10, 2004 8:22 AM
To: 'tmed_project@online.com.kh'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_ruralcam@yahoo.com'
Subject: FW: June 04, Robib Telemedicine Patient 02, Mey Moeun, 47M

-----Original Message-----
From: Fiamma, Kathleen M.
Sent: Wednesday, June 09, 2004 8:16 AM
To: Tan, Heng Soon,M.D.
Subject: FW: June 04, Robib Telemedicine Patient 02, Mey Moeun, 47M

-----Original Message-----
From: Tan, Heng Soon,M.D.
To: Fiamma, Kathleen M.
Cc: 'Mak, Raymond Heungwing'; 'cparanja@caregroup.harvard.edu'; 'Prasad, Paritosh'
Sent: 6/9/04 5:12 PM
Subject: RE: June 04, Robib Telemedicine Patient 02, Mey Moeun, 47M

47 year old man presents with ascites, pitting leg edema and dyspnea suggestive of fluid overload. Diuresis confirms that impression. It is surprising that neck veins were not elevated when arm veins were distended, pulmonary veins were congested with possible pleural effusion, abdomen was protuberant and bilateral pitting edema was present. One concludes that he has hypoalbuminemia given the anasarca and accumulation of fluid in third spaces. One would need more than trace proteinuria to postulate nephrotic syndrome as the cause of anasarca.

Distended abdominal varicose veins could suggest superior or inferior vena caval obstruction, however distended arm veins rule out IVC obstruction, and pitting ankle edema rules out SVC obstruction. Portal hypertension with reversal of flow in umbilical vein is the likely diagnosis. Hypersplensim from enlarged spleen in portal hypertension explains petechiae from thrombocytopenia. Wasted muscles go along with dietary malnutrition and anorexia from chronic alcoholism with liver disease.

Since he had been drinking heavily, one suspects that he stopped drinking 5 years ago because he developed chronic liver disease and may have been advised medically then to stop drinking.

One has to be on the lookout for complications of the underlying condition. Mild fever raises possibility of acute peritonitis but soft nontender abdominal exam does not support that. Low blood pressure, palpitations, tachycardia and low urine output suggests intravascular hypovolemia associated with portal hypertension and ascites, and one has

to worry about the development of hepatorenal syndrome with renal failure. Urine urobilinogen is consistent with hepatocellular disease and not obstruction. When alcoholic liver disease worsens, one has to exclude a precipitating event--development of hepatocellular carcinoma presenting as a hepatic mass, acute viral hepatitis A, B or C, drug induced hepatitis from overuse of acetoaminophen, portal vein thrombosis. Pallor warrants workup for anemia from GI blood loss from possible esophageal varices that could result in exsanguination or hepatic encephalopathy.

In summary, he has chronic alcoholic liver cirrhosis with portal hypertension and anasarca from hypoalbuminemia. The acute precipitaing event is not obvious from the history and exam. Workup should include stool guaiac to exclude GI bleed. Lab tests should include CBC [check anemia, exclude leucocytosis, confirm thrombocytopenia], liver tests [to exclude acute hepatitis], prothrombin time, albumin [to confirm chronic status], BUN, Cr [to exclude hepatorenal disease], serum ammonia [to exclude potential for encephalopathy], serology for viral hepatitis A, B and C. CXR will confirm pulmonary venous congestion and pleural effusion. Liver ultrasound will exclude hepatic masses and confirm enlarged spleen. Paracentesis will exclude peritonitis. UGI endoscopy can exclude gastritis and esophageal varices.

Heng Soon

-----Original Message-----
From: Bunse LEANG [mailto:tmed1shch@online.com.kh]
Sent: Thursday, June 10, 2004 7:27 AM
To: 'TM Team'; 'Rithy Chau'; 'Jack Middlebrook'
Cc: 'Somontha Koy'; 'Bernie Krisher'; 'Jennifer Hines'; Gary Jacques
Subject: RE: June 04, Robib Telemedicine Patient 02, Mey Moeun, 47M

Dear Montha and Rithy,

41 M with history of drinking and liver disease, having 20 days of abdominal distension and pain, SOB. Jaundice, pale, no JVD, collateral circulation seen on abdominal wall, lungs crackles bilateral basilar, protruded ombilicus, pedal edema, 100/60, 120, UA urobili +1, protein +1, trunk petechiae.

DDx/problems list:

Liver cirrhosis

Rule out cardiac

Rule out SBP

Pallor

Plan: agree with your plan to refer to Kg. Thom for tests as suggested. Add reticulocytes count and peripheral blood smear to work-up his pallor. If he cannot afford, may treat as liver cirrhosis with spironolactone 25 mg BID, furosemide 20 mg BID, propranolol 10 mg BID.

Thanks for the case,

Bunse

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

Mean Visay (face)

Patient: Mean Visay, 25M farmer (Bakdorng)

CC: Epigastric pain and excessive saliva for 30 days.

HPI: 23M, farmer, present with symptoms of epigastric pain, pain like burning sensation and radiating to both upper sides of abdomen. He gets this symptom and also accompany by having some saliva in the morning, bur and head ache. He went to private pharmacy to buy some antacide drugs to take on off (taking only sever symptoms happening). It helps a little bit.

PMH: unremarkable

SH: drink alcohol occasionally, but no smoking.

FH: unremarkable

Allergies: NKA

ROS: no loose weight, no sore throat, no fever, has slight headache, no chest pain, no cough, no diarrhea, no stool with blood.

PE:

VS: BP 120/50 P 80 R 20 T 36.5 C Wt =64 kgs

Gen: look sable

HEENT: no oropharngeal lesion, no pale. Neck: no lymphnode no JVD

Chest: Lungs: clear both sides. Heart: RRR, no murmur.

Abd: soft, flat, not tender, have BS all 4 quadrants, no HSM

MS/Neuro: dot done

Other: limbs, left leg amputation in 1998 because of mine explosion

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

1. Gerd?
2. Tension Headache
3. Parasitis?

Plan:

1. H pylori eradication for 10 days

2. Paracetamol 500mg 1tab po q 6 (PRN) for 10 days

3. Mebendazole 100mg 1tab po q12 for 3 days

Comments: do you agree with my plan? Please, give me good idea.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, June 09, 2004 9:34 PM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
Subject: FW: June 04 Robib Telemedicine, Patient 03, Mean Visay, 25M
Importance: High

-----Original Message-----
From: Fiamma, Kathleen M.
Sent: Wednesday, June 09, 2004 8:37 AM
To: Crocker, Jonathan T., M.D.
Subject: FW: June 04 Robib Telemedicine, Patient 03, Mean Visay, 25M

-----Original Message-----
From: Crocker, Jonathan T., M.D.
Sent: Wednesday, June 09, 2004 8:45 AM
To: Fiamma, Kathleen M.
Subject: RE: June 04 Robib Telemedicine, Patient 03, Mean Visay, 25M
Importance: High

Goodmorning,

Thanks for allowing me to participate in this gentleman's care.

I generally agree with your outlined plan. I would make sure that he has had a rectal exam to exclude occult blood loss, though I suspect he has GERD. I would actually hold off on H. pylori eradication treatment unless you can document he has H.pylori infection, especially since this is the first time he is presenting with dyspeptic symptoms. I agree with deparasitization if not done recently. For initial treatment of GERD, I would generally suggest initial lifestyle modification (elevate head of bed, no coffee, alcohol, spicey foods, eat 3-4 hours prior to lying down etc) and Ranitidine 150mg PO BID for 4-6 weeeks. If symptoms don't improve or cease, then you could try a proton pump inhibitor like Omeprazole 20mg BID for 4 weeks. If that did not then take care of things, then you might test for H.pylori Ab in the serum (and or send for EGD) or, not unreasonably, empirically treat to eradicate depending on what services are available. Keep in mind there is resistance emerging of H. pylori to some of the antibiotics used in eradciation treatment.

Paracetamol is a good choice for his headaches.

Thank you very much, I hope he does well.

Jon Crocker, M.D.

-----Original Message-----
From: Bunse LEANG [mailto:tmed1shch@online.com.kh]
Sent: Thursday, June 10, 2004 7:27 AM
To: 'TM Team'; 'Rithy Chau'
Cc: 'Somontha Koy'; 'Jennifer Hines'; 'Jack Middlebrook'; 'Bernie Krisher'; Gary Jacques
Subject: RE: June 04 Robib Telemedicine, Patient 03, Mean Visay, 25M

Dear Montha and Rithy,

His dyspepsia symptom was better a bit with antacid, so he may have gastritis or PUD. Since this is the first episode, I would try only omeprazole 20 mg daily and not doing H.pylori eradicate yet.

Agree with Paracetamol and mebendazole.

Thank for the case,

Buns

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

Patient: Eam Neut, 54F housekeeper (Taing Treuk)

CC: Both soles burning, left knee join pain for one month.

HPI: 54F, housekeeper. In 1 month present with both soles pain, pain like burning especially in the morning, but no numbness. She also gets left knee pain, has crepitation, sometimes. Pain increases during walking, but no swelling. She went to buy some paracetamol for her pain, it just helps her for a while.

PMH: unremarkable

SH: unremarkable

FH: unremarkable

Allergies: NKA

ROS: no weight loose, no fever, no cough, no chest pain, has headache, no GI complain, have both legs burning sensation.

PE:

VS: BP R=150/90, L= 160/100 P 80 R 20 T 36.5 Wt 57kgs

Gen: look stable

HEENT: no oropharyngeal lesion, no pale. Neck: no lymphnode, no JVD, no goiter enlargement.

Chest: Lungs: clear both sides. Heart: RRR, no murmur

Abd: Soft, flat, not tender, have BS for all quadrants

MS/Neuro: not done

Other: Limbs: no deformities, left knee pain, but no swelling, normal to touch.

Previous Labs/Studies: none

Lab/Study Requests: UA (Negative), BS= 78mg/dl

Assessment:

1. Mild HTN
2. Left knee pain
3. PNP

Plan: we want to use with

1. HTCZ 50mg 1/2tab po qd for 1 month
2. Nabumetone 75mg 1 tab po bid (PRN)
3. Becomplex 1 tab po qd for 1 month
4. Try to observe foe next trip

Comments: do you agree with my plan? Please, give me a good idea.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, June 09, 2004 9:49 PM
To: 'tmrural@yahoo.com'
Cc: 'tmed_project@online.com.kh'; 'tmed_rithy@online.com.kh'
Subject: FW: June 04 Robib Telemedicine, Patient 04, Eam Neut, 54F

-----Original Message-----
From: Fiamma, Kathleen M.
Sent: Wednesday, June 09, 2004 8:26 AM
To: Patel, Dinesh,M.D.
Subject: FW: June 04 Robib Telemedicine, Patient 04, Eam Neut, 54F
Importance: High

Hello Dr. Patel:

Are you available to opine on this case?

-----Original Message-----
From: Patel, Dinesh,M.D.
Sent: Wednesday, June 09, 2004 8:35 AM
To: Fiamma, Kathleen M.
Subject: RE: June 04 Robib Telemedicine, Patient 04, Eam Neut, 54F

Thank you for referring this patient to me for a management opinion.

It appears that this patient has, based on what I read, the following:

1 Patella chondromalacia

2 Early medial compartment arthrtits

Plans

1 Avoid squatting

2 Exercises to make thigh muscles stronger

3 Hot packs to knee

4 Pillow under the knee at night time and if still persists knee brace with patella hole or ace bandage when she is working

5 Ibuprofeen 200 mg twice a day for 10 days as last resort

6 If things persists have standing xrays and let me see

Wish her the best.

Thanks

Dinesh Patel, M.D.

-----Original Message-----
From: Bunse LEANG [mailto:tmed1shch@online.com.kh]
Sent: Thursday, June 10, 2004 7:27 AM
To: 'TM Team'; 'Rithy Chau'
Cc: 'Somontha Koy'; 'Jennifer Hines'; 'Jack Middlebrook'; 'Bernie Krisher'; Gary Jacques
Subject: RE: June 04 Robib Telemedicine, Patient 04, Eam Neut, 54F

Dear Montha and Rithy,

Sole pain - the most common cause is plantar fasciitis. We should check for point tenderness by toes dorsiflexion while palpating along planta fascia from heel to forefoot. 15% is associated with gout, rheumatoid arthritis or ankylosing spondylitis.

Knee pain in a housekeeper with crepitation, worse at walk, no swelling, no hot, no redness. Sound like osteoarthritis.

High BP - Does she have high BP at several measurements? Does she have history of HTN? - if the answer if no, I would try low salt diet, weight reduction and exercise first.

Agree with your pain killer to take with food.

Thank for the case,

Bunse

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

Patient: Bong Sophin, 27F, farmer (Ta Tong)

CC: Epigastric pain on and off for 2 months.

HPI: 27F, farmer, in 2 month present with epigastric pain, pain like burning and radiating to left side of abdomen. She gets this symptome and also accompany by nausea, and dizziness. During this time she has taking Aluminium Hydroxide 2tab po qd on and off,but al the symptoms still not completely disappear.

PMH: unremarkable

SH: unremarkable

FH: unremarkable

Allergies: NKA

ROS: no weight loose, no sore throat, no fever, no cough, no stool with blood, no diarrhea, no peripheral edeme.

PE:

VS: BP 100/50 P 80 R 20 T 36.5 Wt= 44kgs

Gen: look stable

HEENT: no oropharyngeal lesion. Neck: no JVCD, no lymphnode

Chest: Lungs: clear both sides. Heart: RRR, no murmur

Abd: soft, flat, no tender, have BS for all the quadrants, no HSM

MS/Neuro: not done

Other: Lims ok

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

1. Dyspepsia?
2. Parasitis?

Plan:

1. Tums 1g 1tab po bid for 2 months
2. Mebandazole 100mg 1 tab po qd for 3days

Comments:

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, June 09, 2004 9:42 PM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
Subject: FW: June 04 Robib Telemedicine, Patient 05, Bong Sophin, 27F

-----Original Message-----
From: Fiamma, Kathleen M.
Sent: Wednesday, June 09, 2004 9:03 AM
To: Ryan, Edward T.,M.D.
Subject: FW: June 04 Robib Telemedicine, Patient 05, Bong Sophin, 27F

-----Original Message-----
From: Ryan, Edward T.,M.D.
Sent: Wednesday, June 09, 2004 10:00 AM
To: Fiamma, Kathleen M.

Subject: RE: June 04 Robib Telemedicine, Patient 05, Bong Sophin, 27F

I agree that this could be parasites, but sounds like peptic ulcer disease. The latter is often driven by helicobacter gastritis. Would consider amoxicillin 500 mg po bid, flagyl (metronidazole) 500 mg po bid and bismuth 4 xs a day for 10-14 days.

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

-----Original Message-----
From: Bunse LEANG [mailto:tmed1shch@online.com.kh]
Sent: Thursday, June 10, 2004 7:27 AM
To: 'TM Team'; 'Rithy Chau'
Cc: 'Somontha Koy'; 'Jennifer Hines'; 'Jack Middlebrook'; 'Bernie Krisher'; Gary Jacques
Subject: RE: June 04 Robib Telemedicine, Patient 05, Bong Sophin, 27F

Dear Montha and Rithy,

Her dyspepsia was better with antacid. Agree with your Tums.

Good lucks,

Bunse

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

Patient: Pheng Roeung, 58F farmer (Thnout Malou)

Note:

This patient has been dinognosed with Hyperthyroidism by SHCH and also has been covered with some drugs such as:

- **Carbimarzole 5mg 1 tab po bid**
- **Propranolol 40mg ¼ tab po bid**

After getting better PA. Rithy and Dr. Lou Loy decided to refer her to Robib TM by asking Dr. Jennifer for advice, because we want to

help TM account.

Subject: She decrease palpitation, mild tremor, decrease SOB, no chest pain, but feel mild chest tightness, no GI complain.

Object:

Look stable

VS: BP 130/70 P 84 R 20 T 36.5 Wt= 44kgs

HEENT: no oropharyngeal lesion, no exophlalmosis. Neck: no JVD, thyroide gland mild enlarge.

Lungs: clear both sides. Heart: RRR, no murmur.

Abdomen: soft, flat, no tender, + BS, no HSM

Extremities: mild tremor.

Previous Labs/Studies:

HerThyroide function test done on 10/01/04(TSH less than 0.02 micro IU/ml, and T4= 23pml/l)

Her CBC done on 17/03/04 (WBC= 4, RBC=4, Hgb= 11.1, Hct= 32, MCV= 81, MCH 28, MCHC= 35, platelet= 122)

Lab/Study Requests: none

Assessment:

4. Euthyroide

Plan: Keep the same dose of previous drugs

2. Carbomarzole 5mg 1 tab po bid for one month
3. Propranolol 40mg ¼ tab po bid for one month

Comments: do you agre with m plan? Please, give me good idea.

Examined by: Koy Somontha, RN **Date:**

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

-----Original Message-----
From: Fiamma, Kathleen M.
To: List, James Frank,M.D.,Ph.D.
Sent: 6/9/04 8:38 AM
Subject: FW: June 04 Robib Telemedicine, Patient 06, Pheng Roeung, 58F

-----Original Message-----
From: List, James Frank,M.D.,Ph.D. [mailto:JLIST@PARTNERS.ORG]
Sent: Wednesday, June 09, 2004 9:32 PM
To: 'tmrural@yahoo.com'; Fiamma, Kathleen M.
Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'; 'tmed_ruralcam@yahoo.com'
Subject: RE: June 04 Robib Telemedicine, Patient 06, Pheng Roeung, 58F

The patient is a 58 year-old female who had thyrotoxicosis diagnosed in January with a low TSH and an elevated T4. She has been treated with propranolol and carbimazole with improvement of her symptoms.

The possible causes of her thyrotoxicosis are Graves' disease, toxic multinodular goiter, or subacute thyroiditis. The first two choices require continued therapy with carbimazole unless the patient receives definitive therapy with radioactive iodine or by surgical thyroidectomy. The third choice (thyroiditis) does not required continued therapy.

In addition, the patient has complaints of chest tightness. This may reflect coronary artery disease, which can become symptomatic in the setting of thyrotoxicosis because of the increase oxygen consumption of the heart in this state. With this in mind, I would continue therapy with a beta blocker (propranolol) until she is free of chest pressure or until you are confident that the chest pressure does not reflect cardiac disease. At that point, you can taper the propranolol to off.

I agree with continuing the carbimazole. Another check of the patient's TSH and T4 also would be helpful at this point to make sure the therapy is on target. If she is still biochemically thyrotoxic (i.e. low TSH, elevated T4), the dose can be increased. If she is euthyroid (i.e. normal TSH and normal T4), the dose should stay the same. And if she is hypothyroid (elevated TSH), the dose can be lowered, and the possibility should be considered that her thyroid problem was transient (i.e. thyroiditis).

James F. List, M.D., Ph.D.
Endocrinology
Massachusetts General Hospital

-----Original Message-----
From: Bunse LEANG [mailto:tmed1shch@online.com.kh]
Sent: Thursday, June 10, 2004 7:27 AM
To: 'TM Team'; 'Rithy Chau'
Cc: 'Somontha Koy'; 'Bernie Krisher'; 'Jennifer Hines'; 'Jack Middlebrook'; Gary Jacques
Subject: RE: June 04 Robib Telemedicine, Patient 06, Pheng Roeung, 58F

Dear Montha and Rithy,

Hyperthyroid goiter becoming euthyroid under carbimazole/propranolol.

Look like small goiter, agree with your plan if no tracheal compression.

She may need long term carbimazole and T4 level should be monitored from time to time.

Thanks,

Bunse

Patient: Nget Soeun, 57M farmer (Thnout Malou)

Subject: 57M, farmer comes for his follow up of Liver Cirrhosis. His symptoms have much improving. He has no SOB, no fever, no cough, no chest pain, no abdominal distension, no GI complain, has good appetite.

Object: Look stable

VS: BP 100/40 P 88 R 20 T 36.5 Wt 40kgs

Lungs: clear both sides

Heart: RRR, no murmur

Abd: soft, flat, n tender, no HSM, +BS

Limbs: no extremities edema

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

5. Liver Cirrhosis

Plan: Keep the same drugs and the same doses

4. Spironolactone 50mg ½ tab po qd for 1 month
5. Propranolol 40mg ½ tab po qd for 1month
6. Multivitamine 1 tab po qd for 1 month

Comments: do you agree with my plan? Please, give me a good idea.

Examined by: Koy Somontha, RN **Date:**

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

-----Original Message-----
From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]
Sent: Thursday, June 10, 2004 1:27 AM
To: Fiamma, Kathleen M.; 'tmrural@yahoo.com'; 'tmed_rithy@online.com.kh'
Subject: RE: June 04 Robib Telemedicine, Patient 07, Nget Soeun, 57M

What is the etiology of his cirrhosis (viral hepatitis or alcoholic hepatitis)

His management is excellent and you should continue current medications.

Thanks

Paul Cusick

-----Original Message-----
From: Bunse LEANG [mailto:tmed1shch@online.com.kh]
Sent: Thursday, June 10, 2004 7:27 AM
To: 'TM Team'; 'Rithy Chau'
Cc: 'Somontha Koy'; 'Bernie Krisher'; 'Jennifer Hines'; 'Jack Middlebrook'; Gary Jacques
Subject: RE: June 04 Robib Telemedicine, Patient 07, Nget Soeun, 57M

Hi Montha and Rithy,

Great, he is stable. Agree with your plan. May go for propranolol 10 mg BID, which has less effect on BP than 20 mg a day.

Have a nice day,

Bunse

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

Patient: Sao Phal, 57F farmer (Thnout Malou)

Subject: 57F, farmer, comes for her follow up of HTN, DMII and PNP. She still has slight headache, blurred vision, no frequency urination, no chest pain, no SOB, no fever, no cough, has stool with mucus for 3 days with abdominal pain.

Object: look stable

VS: BP 110/60 P 80 R 20 T 36.5 Wt 60kgs

Lungs: clear both sides.

Heart: RRR, no murmur

Abd: soft, flat, no tender, + BS for all quadrants, no pain during palpable.

Limbs: decrease numbness at both soles.

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

6. HTN (stable)
7. DMII with PNP
8. Dysentary

Plan:

7. Diamecron 80mg ½ tab po qd for one month
8. HCTZ 50mg ½ tab po qd for one month
9. Captopril 25mg ¼ tab po qd for one month
10. Amitriptilline 25mg 1 tab po qhs for one month
11. ASA 500mg ¼ tab po qd for one month
12. Metronidazole 500mg 1tab po tid for 7 days

Comments: do you agree with my plan? Please, give me a good idea.

Examined by: Koy Somontha, RN **Date: 08/06/04**

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

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Thursday, June 10, 2004 8:06 AM
To: 'tmed_project@online.com.kh'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_ruralcam@yahoo.com'
Subject: FW: June 04 Robib Telemedicine, Patient 08, Sao phal, 57F

-----Original Message-----
From: Tan, Heng Soon,M.D.
To: Fiamma, Kathleen M.
Sent: 6/9/04 5:22 PM
Subject: RE: June 04 Robib Telemedicine, Patient 08, Sao phal, 57F

If you have a microscope, you could check for fecal leucocytes before treating infectious diarrhea with antibiotics. Without fever and bloody stools and short history of diarrhea, chance of bacterial infection is quite low. She is more likely to have traveler's type diarrhea. I would prefer ciprofloxacin rather than metronidazole if I decide to treat for bacterial gastroenteritis.

Her blood pressure is very well controlled. Perhaps, you could stop HCTZ.

Heng Soon

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

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]

Sent: Wednesday, June 09, 2004 5:55 PM

To: TM Team; Heather Brandling Bennett; Rithy Chau; Kathy Fiamma; Paul

Heinzelmann; Jennifer Hines; Joseph Kvedar; Bunse Leang; Jack

Middlebrook

Cc: Somontha Koy; Bernie Krisher; Nancy Lugn; lauriebachrach@yahoo.com

Subject: Robib Patient 08

Robib Patient 08

Sao Phal, 57F farmer (Thnout Malou)

Dear Montha and Rithy:

Her HTN appears to be well-controlled. I would continue the same antihypertensive regimen.

Regarding her DM, it is difficult to assess her blood sugar control without a finger stick or urine dipstick. However, the fact that she does not complain of polyuria or polydipsia is somewhat reassuring. I would continue the same, management.

As for the abdominal pain with mucus in the stool, I would not be very worried so long as she does not have fever, blood in the stool or abdominal pain on exam. This symptom can be observed, and the patient instructed to seek care if any of the above develop. Metformin can cause bloating and diarrhea, but I would not expect this to be the cause if she has been on a stable dose for the last month.

Jack Middlebrooks, M.D.

Sihanouk Hospital Center of HOPE

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

Patient: Som Thol, 57M farmer (Bakdeung)

Subject: 57F, farmer, comes for his follow up of DMII and PNP. He still has muscle pain, waist pain, no fever, no cough, no chest pain, no SOB, no GI complain.

Object: look stable

VS: BP 100/60 P 90 R 20 T 36.5 C Wt= 56kgs

HEENT: ok

Lungs: clear both sides

Heart: RRR, no murmur

Abd: soft, flat, no tender, no HSM, +BS

Limbs: decrease numbness at both soles and palms, no edema

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

9. DMII with PNP

10. Muscle Pain

Plan: Keep the same drugs and the same doses

13. Diamecron 80mg 1.5 tab po qd for one month
14. Captopril 25mg ¼ tab po qd for one month
15. Amitriptilline 25mg 1 tab po qhs for one month
16. ASA 500mg ¼ tab po qd for one month
17. Paracetamol 500mg 1 tab po q6 (PRN) for 10 days
18. Do more exercise

Comments: do you agree with my plan? Please, give me a good idea.

Examined by: Koy Somontha, RN **Date: 08/06/04**

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

-----Original Message-----
From: Heinzelmann, Paul J.,M.D. [mailto:PHEINZELMANN@PARTNERS.ORG]
Sent: Thursday, June 10, 2004 4:38 AM
To: Fiamma, Kathleen M.; 'tmrural@yahoo.com'; 'tmed_project@online.com.kh'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_ruralcam@yahoo.com'
Subject: RE: June 04 Robib Telemedicine, Patient 09, Som Thol, 57M

Patient: Som Thol, 57M farmer (Bakdeung)

In March we were somewhat concerned about his elevated BUN, Creatinine, and potassium and we were concerned about dehydration and possible kidney failure - both likely due to poor control of diabetes.

His blood sugar was reported in March as as 9 mmol/l (162 mg/dl) Was this a fasting glucose? Is it possible to increase his Diamecron? If you decide not to, please let me know why you choose not to.

This patient needs to have frequent lab testing to monitor his status. (glucose, potassium, BUN/creatinine, Hgb A1C...)

A hemoglobin A1C would be very valuable in this patient- at least twice a year, (it is typically done on a 3-month basis.)

Best of luck

Paul Heinzelmann, MD

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

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]

Sent: Wednesday, June 09, 2004 6:04 PM

To: TM Team; Heather Brandling Bennett; Rithy Chau; Kathy Fiamma; Paul

Heinzelmann; Jennifer Hines; Joseph Kvedar; Bunse Leang; Jack

Middlebrook

Cc: Somontha Koy; Bernie Krisher; Nancy Lugn; lauriebachrach@yahoo.com

Subject: Robib Patient 09

Patient 09

Som Thol, 57M farmer (Bakdeung)

Dear Montha and Rithy:

It is difficult to comment on this patient's muscle pain without a description of the distribution, the patient's symptoms or a neurologic or musculoskeletal exam. Is the muscle pain localized? Does he have weakness? Has he been working harder because it is rice planting season? (Is he bending over to plant seedlings and having waist pain later that night?) I would ask these questions before recommending increased exercise as the treatment.

I see no reason to change the treatment for his DM and PNP.

Jack Middlebrooks, M.D.

Sihanouk Hospital Center of HOPE

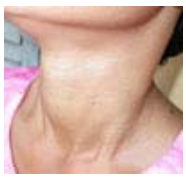
Robib Telemedicine Clinic
Sihanouk Hospital Center of HOPE and Partners in Telemedicine
Rovieng Commune, Preah Vihear Province, Cambodia

Patient: Chhay Chanthy, 41F farmer (Thnout Malou)

Note: This patient was dismissed from SHCH with Hyperthyroidm and became Euthyroide. Follow up PRN with SHCH.

Subject: Now she comes to see us, because she has slight chest tightness, increase SOB, increase palpitation, has neck tightness, has feeling hot, no cough, no fever, no GI complains.

Object: Look stable



VS: BP 120/70 P 88 R 22 T 36.5 Wt= 40kgs

HEENT: no oropharyngeal lesion, no exophlalmosis. Neck: no JVD, anterior neck mass diffuse no tender, no bruit.

Lungs: clear both sides

Heart: RRR, no murmur

Abd: soft, flat, no tender, no HSM, + BS

Limbs: no edema, no tremor

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

11. Relapsed Hyperthyoidism?

12. Anxiety?

Plan:

19. we would like to refer her back to SCHC for reevaluation or letting me draw her blood for Thyroide function and see her in the next trip.

Comments: do you agree with my plan? Please, give me a good idea.

Examined by: Koy Somontha, RN **Date: 08/06/04**

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

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, June 09, 2004 11:24 PM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh.'
Subject: FW: June 04 Robib Telemedicine, Patient 10, Chhay Chanthy, 41F
Importance: High

-----Original Message-----
From: Crocker, Jonathan T., M.D.
Sent: Wednesday, June 09, 2004 11:53 AM
To: Fiamma, Kathleen M.
Subject: RE: June 04 Robib Telemedicine, Patient 10, Chhay Chanthy, 41F
Importance: High

Goodmorning,

Thanks for letting me help care for this woman.

There are several key points that would be very helpful to know.

1) What was the nature of her prior hyperthyrodism? Grave's Disease? Did she have goiter in the past, nodules, multiple nodules?

2) How long ago was she hyperthyroid?

3) Was she treated with anything that made her Euthyroid or did this just happen on its own?

4) What were her prior most recent Thyroid function tests?

5) Has she ever had a thyroid ultrasound and what did it show?

Does her exam show any lymphadenopathy, hyperreflexia?

Is she a smoker or drinker or have any other risk factors for head and neck cancer?

There is nothing on exam suggesting a clinically hyperthyorid individual though her SOB, chest tightness and palpitations are concerning. Pleas make sure you listen over her trachea to make sure there is no stridor. Is there any SOB on exertion?

I would recommend finding the above information out, getting thyroid function tests (TFT, T3, T4, Free T4), CBC with diff, Chest xray and thyroid ultrasound to begin with. I'm concerned about her symptoms of SOB and neck mass and might even suggest that you have an ENT physician evaluate her, but that would depend on her functional status and you clincal assessment of her airway. You want to rule out a rapidly expanding mass or enlarging multinodular goiter. She may need a biopsy of potential thyroid mass and possible neck CT if things are more unclear.

I hope this helps.

Dr. Jonathan Crocker

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

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]

Sent: Wednesday, June 09, 2004 9:24 PM

To: TM Team; Heather Brandling Bennett; Rithy Chau; Kathy Fiamma; Paul

Heinzelmann; Jennifer Hines; Joseph Kvedar; Bunse Leang; Jack

Middlebrook

Cc: Somontha Koy; Bernie Krisher; Nancy Lugn; lauriebachrach@yahoo.com

Subject: Re: June 04 Robib Telemedicine, Patient 10, Chhay Chanthy, 41F

Patient 10

Chhay Chanthy, 41F farmer (Thnout Malou)

Dear Montha and Rithy:

It would be helpful to know more about her SOB and chest tightness. Is it related to exertion? How frequently does it occur? I also wonder about her palpitations: are they associated with activity or accompany the chest tightness? Are her reflexes normal?

I agree that her history and symptoms are concerning for a recurrence of her hyperthyroidism, and I would suggest that you draw her blood for a TSH and refer her back to SHCH-- that way we will have the results when she presents.

Jack Middlebrooks, M.D.

Sihanouk Hospital Center of HOPE

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

Patient: Tan Kim Horn, 55F farmer (Thnout Malou)

Subject: 55F, she comes for her follow up of DMII. She still has symptoms like weakness, poor sleep, frequency of urination, no fever, no cough, no chest pain, feeling hot in both eyes, has epigastric pain and diarrhea sometimes, no peripheral edema.

Object: look well

VS: BP 120/50 P 88 R 20 T 36.5 Wt= 59 kgs

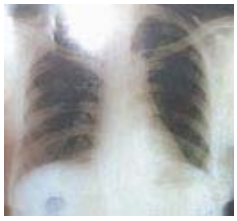
Lungs: clear both sides

Heart: RRR, no murmur

Abd: soft, flat, no tender, + BS for al quadrants, no HSM

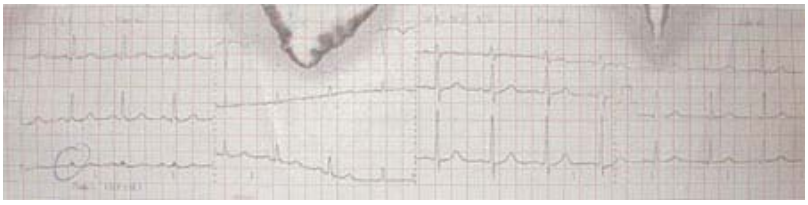
Neuro exam: unremarkable

Previous Labs/Studies: result of blood work done on 13/05/04 (Na 144 mmol/L, BUN 2.2 mmol/L, Creat 78umol/L, Glucose 12.3 mmol/L, SGOT 11UI/L, SGPT 18UI/L)



CX ray look normal, please see picture through attachment.

EGK (HR 88/mm, PR 0.16sec, QRS complex 0.04 sec, P to P regular, no Q wave, no T invert) so conclusion of EKG is normal



Lab/Study Requests: none

Assessment:

13. DMII
14. Dyspepsia
15. Parasitis?

Plan: we want to start using DM drugs

20. Diamecron 80mg ½ t po bid for one month
21. Captopril 25mg ¼ tab po qd for one month
22. Tums 1g 1tab po bid for one month
23. Mebendazole 100mg 1 tab po bid for 3 days
24. DM education

Comments: Do you agree with my plan? Please, give me a good idea.

Examined by: Koy Somontha, RN **Date: 08/06/04**

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

-----Original Message-----
From: Fiamma, Kathleen M.
Sent: Wednesday, June 09, 2004 9:45 AM
To: Cusick, Paul S.,M.D.
Subject: FW: June 04 Robib Telemedicine, Patient 11, Tan Kim Horn, 55F

Hello Dr. Cusick:

Here is another follow up case.

This is the last one. Sorry for all of the extra work today.

-----Original Message-----
From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]
Sent: Thursday, June 10, 2004 1:38 AM
To: Fiamma, Kathleen M.; 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
Subject: RE: June 04 Robib Telemedicine, Patient 11, Tan Kim Horn, 55F

She needs treatment for diabetes and starting with an oral hypoglycemic agent is a good start.

She needs to continue diabetes diet.

the chest xray and EKG appear to be normal on transmission

Tums are a good start to dyspepsia.

A short course of Mebendazole will kill parasites. Education in water purification with boiling or bleach is important to avoid further intestinal parasites.

Good luck

Paul Cusick

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Thursday, June 10, 2004 8:00 AM
To: TM Team; Heather Brandling Bennett; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Jennifer Hines; Joseph Kvedar; Bunse Leang
Cc: Somontha Koy; Bernie Krisher; Nancy Lugn; lauriebachrach@yahoo.com
Subject: Robib Patient 11

Patient 11

Tan Kim Horn, 55 F Farmer (Thnout Malou)

Dear Montha and Rithy:

Given the patient's polyuria and elevated blood glucose, I agree with your plan to start Diamecron. Adding captopril to prevent the renal complications of DMII is also a good idea.

It would be useful to have a more complete history for the epigastric pain and diarrhea. When did these symptoms start? How severe is the pain? What is the quantity of diarrhea? How frequent are these symptoms? Do they occur together or separately? Are they associated with eating? Relieved by eating? Tums is a reasonable first treatment for occasional GERD, but not for dyspepsia. Are you considering a peptic or duodenal ulcer? It is reasonable to give her a trial of mebendazole to see if it relieves her symptoms, but if not, I would suggest a more thorough history and possibly a trial of H. pylori eradication given the high prevalence in Cambodia.

Jack Middlebrooks, M.D.

Sihanouk Hospital Center of HOPE

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

Patient: Tho Chanthy, 37F farmer (Thnout Malou)

Subject: 37F, farmer, she comes for her follow up of Hyperthyroidism. She feels much improving with her previous symptoms like decreasing SOB, decrease SOB, decrease Palpitation, no fever, no cough, decrease tremor, has running nose, has epigastric pain, has nausea before meal time, no peripheral edema. She has normal period.

Object: look well

VS: BP 120/70 P 70 R 20 T 36.5 Wt 44kgs

HEENT: no oropharyngal lesion, eyes have mild exophlamosis. Neck: no JVD, goiter gland has the same size. It's around 36cm.

Lungs: clear both sides

Heart: RRR, no murmur

Abd: soft, flat, no tender, no HSM, + BS for all the quadrants

Limbs: decrease tremor, but no edema

Previous Labs/Studies: her thyroide testof T4 we did in the last 3 months ago

Lab/Study Requests: we want to recheck her thyoride tst of T4 for this month

Assessment:

16. Hyperthyroidism
17. Dyspepsia
18. Parasitis
19. Common cold

Plan:

25. Carbimarzole 5mg 1 tab po qd for one month
26. Decrase dose of Propranolol from 20mg dq to 10mg qd for one month
27. Stop ASA
28. Tums 1g 1 tap po bid for one month
29. Mebendazole 100mg 1 tab po bid for 3 days
30. Benadryl cold 500/25mg 1 tab po bid for 7 days

Comments: do you agree with my plan? Please, give me a god idea.

Examined by: Koy Somontha, RN **Date: 08/06/04**

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

-----Original Message-----
From: Fiamma, Kathleen M.
To: List, James Frank,M.D.,Ph.D.
Sent: 6/9/04 8:49 AM
Subject: FW: June 04 Robib Telemedicine, Patient 12, Tho Chanthy, 37F

-----Original Message-----
From: List, James Frank,M.D.,Ph.D. [mailto:JLIST@PARTNERS.ORG]
Sent: Wednesday, June 09, 2004 9:47 PM
To: 'tmrural@yahoo.com'; Fiamma, Kathleen M.
Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'; 'tmed_ruralcam@yahoo.com'
Subject: RE: June 04 Robib Telemedicine, Patient 12, Tho Chanthy, 37F

The patient is a 37 year-old female with thyrotoxicosis in the setting of diffuse goiter and exophthalmos. Her diagnosis is Graves' disease. She has been treated with beta blockers (propranolol) and anti-thyroid medication (carbimazole). Her symptoms have improved.

The goal at this point is to keep her thyroid hormone levels in the normal range. Another check of TSH and T4 would be in order, and the carbimazole dose adjusted accordingly. If the TSH is low and the T4 is elevated, I would add a second dose of 5 mg carbimazole (i.e. make it BID rather than Q day) as the next step.

Once the patient has normal thyroid function tests, the propranolol can be tapered to off, as you suggest.

The aspirin should be stopped, as it does not help Graves' disease and may be contributing to

her gastrointestinal symptoms. The mebendazole is fine to use if the prior likelihood of a parasitic infection in your community is high. Given that the patient has other issues and multiple medications, I would not recommend giving the Benadryl Cold formulation, as it may cause side-effects that are difficult to distinguish from worsening of the underlying disorders.

Finally, while the patient can be maintained indefinitely on carbimazole and may even have her Graves' disease go into remission after one to two years of carbimazole therapy, definitive cure would require a thyroidectomy or radioactive iodine therapy. As always, the patient must be aware that carbimazole can lead to many side effects including agranulocytosis, so that if she should develop fever or severe infection, she needs to have her white blood cell count checked.

James F. List, M.D., Ph.D.
Endocrinology
Massachusetts General Hospital

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Thursday, June 10, 2004 8:10 AM
To: TM Team
Subject: RE: June 04 Robib Telemedicine, Patient 12, Tho Chanthy, 37F

Patient 12

Tho Chanthy 37F

Dear Montha and Rithy:

I agree with your plan for the management of the patient's hyperthyroidism, including a re-check of her T4 level and decreasing the propranolol. I assume that you are not changing the dose of carbimazole. I would suggest that an examination of the patient's reflexes is a helpful part of the exam for someone with known or suspected thyroid disease.

Regarding her epigastric pain and nausea before meals, I would refer you to my comments on Case 11-- it is difficult to narrow down the diagnosis without a more complete history.

Jack Middlebrooks, M.D.

Sihanouk Hospital Center of HOPE

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

Patient: Pen Vanna, 38F teacher (Thnout Malou)

Subject: 38F, teacher, she comes for her follow up of HTN and Gastritis. She still has mild head ache, mild neck tender, no cough, no fever, no GI complains.

Object: Look stable

VS: BP 140/90 P 78 R 20 T 36.5C Wt 62kgs

HEENT: unremarkable

Lungs: clear both sides

Heart: RRR, no murmur

Abd: soft, flat, no tender, no HSM, + BS

Limbs: no peripheral edema

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

20. HTN (Stable)

21. Gastritis(Resolve)

Plan: Keep the same drugs of HTN

31. HCTZ 50mg ½ tab po bid for one month
32. ASA 500mg ¼ tab po qd for onr month

Comments: Do you agree with my plan

Examined by: Koy Somontha, RN **Date: 08/06/04**

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

-----Original Message-----
From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]
Sent: Thursday, June 10, 2004 1:43 AM
To: Fiamma, Kathleen M.; 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'; 'tmed_project@online.com.kh'
Subject: RE: June 04 Robib Telemedicine, Patient 13, Pen Vanna, 38F

Her blood pressure needs to be less than 140 systolic and less than 90 diastolic. If her blood pressure does not improve with diet and exercise and the diuretic, then she will need a second agent for blood pressure control.

Good luck,

Paul Cusick

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Thursday, June 10, 2004 8:20 AM
To: TM Team; Heather Brandling Bennett; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Jennifer Hines; Joseph Kvedar; Bunse Leang
Cc: Somontha Koy; Bernie Krisher; Nancy Lugn; lauriebachrach@yahoo.com
Subject: Robib Patient 13

Patient 13

Pen Vanna 38 F

Dear Montha and Rithy:

A blood pressure of 140/90 is still high; I would suggest increasing the dose of HCTZ or adding another agent, like a beta-blocker. Also, is the patient overweight? If so, I would counsel her on exercise and weight reduction, as this can frequently reduce the need for anti-hypertensives.

I would not give ASA to a patient with a recent history of gastritis.

Jack Middlebrooks, M.D.

Sihanouk Hospital Center of HOPE

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

Patient: Muy Vun, 38M teacher (Thnout Malou)

Subject: 38M, he comes for his follow up of A Fib, Valvulo Heart Disease, and Gastritis. He feels much improving with his previous symptoms like decreasing SOB, decreasing palpitation, gain weigh for 2 kgs, increase appetite, but still has abdominal pain and accompany by diarrhea sometimes, no peripheral edema.

Object: Look well

VS: BP 100/60 P 68 R 20 T 36.5 C Wt 63Kgs

HEENT: unremarkable

Lungs: clear both side

Heart: IRRR, no murmur

Abd: soft, flat, no tender, mild pain at epigastric area during palpable, + BS for all quadrants

Limbs: no edeme

Previous Labs/Studies: Blood result done on 10/05/04 (Na 146 mmol/L, Bun 2.3 mmol/L, Creat 93umol/L

Lab/Study Requests: none

Assessment:

22. Afib with Valvulo Heart Desease (MR,MS)
23. Gastritis
24. Parasitis?

Plan:

33. Digoxine 0.25mg 1tab po qd for one month
34. ASA 500mg ¼ tab po qd for one month
35. H pylory eradication for 10 days
36. Mebendazole 100mg 1 tab po bid for 3 days

Comments: Do you agree with plan? Please give me a good idea.

Examined by: Koy Somontha, RN **Date: 08/06/04**

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

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Thursday, June 10, 2004 8:20 AM
To: TM Team; Heather Brandling Bennett; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Jennifer Hines; Joseph Kvedar; Bunse Leang
Cc: Somontha Koy; Bernie Krisher; Nancy Lugn; lauriebachrach@yahoo.com
Subject: RE: June 04 Robib Telemedicine, Patient 14, Muy Vun, 38M

Patient 14

Muy Vun 38M

Dear Montha and Rithy:

It appears that the digoxin has done a good job in rate-controlling the patient's atrial fibrillation. The more difficult issue is what to do for anticoagulation in a patient with suspected gastritis. I agree with your plan for mebendazole and H. pylori eradication, but would suggest that the patient be continued on some sort of acid supression (H2 blocker or PPI) after his ten day regimen is completed, as this can help reduce the incidence of gastritis in patients on ASA.

Jack Middlebrooks, M.D.

Sihanouk Hospital Center of HOPE

Thursday, June 10, 2004

Follow-up Report for Robib TM Clinic

There were 14 patients seen during this month Robib TM Clinic (and 1 patient came for blood works only). The data of all cases were transmitted and received replies from both Phnom Penh and Boston. Per advice sent by Partners in Boston and Phnom Penh Sihanouk Hospital Center of HOPE, the following patients were managed and treated as follows:

CORRECTION FROM LAST MONTH'S NOTE: [Please note that some blood works was drawn and done at SHCH at no cost and others including studies such as x-rays, U/S, EKG, etc. were done at Kompong Thom Referral Hospital with patients paying own their

own. Robib TM clinic **STILL** pays for transportation, accommodation, and other expenses for the patients visiting the clinic **IF** they are from Thnout Malou Village. For those patients who were seen at SHCH previously and remained stable with medications, the clinic will continue to provide them with appropriate medications from SHCH at no cost for the duration of their illnesses or while supplies lasted. The clinic still provided free medications for all "poor" patients, especially if they are from Thnout Malou Village. Some patients may be listed below if they came by for refills of medications.]

1- Norng Hen, 31M, Thnout Malou

A- Diagnosis

1)- Hepatitis?

2)- Cholescystitis?

3)- Parasititis?

B- Plan

Refer to Kg Thom Hospital for reevaluation and also do some paraclinic like Abdominal Ultrasound, Stool exam, some blood work (Bun, Lytes, Creat, CBC, Liver function)

2- Mey Moeun, 47M, Bakdeung

A- Diagnosis

1)- Ascitis due to Etio?

2)- Cirrhosis?

3)- Hepatitis?

4)- Bilateral Pleural Effusion?

5)- PTB?

6)- Lung Congestion?

7- CRF?

8)- Mulnutrition

B- Plan

Refer him to Kg Thom Hospital for reevaluation or admission, and also for some paraclinic like Abdominal Ultrasound, CXR, Parasynthesis, Urine Microscopic, Blood Test (CBC, BUN, Lytes, Creat, Liver Function)**3- Mean Visay, 25M, Bakdeung**

A- Diagnosis

1)- GERD?

2)- Tension Headache

3)- Parasititis?

B- Plan

1)- Omeprazole 20mg qhs for one month

2)- Paracetamol 500mg 1t po q6h PRN for 10 days

3)- Mebendazole 100mg 1t po bid for 3 days

4)- GERD education.

4- Eam Neut, 54F, Taing Trork

A)- Diagnosis

1)- HTN

2)- Left Knee Pain (Osteoarthritis?)

3)- PNP?

B)- Plan

1)- Nabumetone 75mg 1t po bid PRN for 20 days

2)- HTN education (Low salt and fat diet, reduce weight by doing daily exercise)

5- Bong Sophin, 27F, Taing Trork

A)- Dignosis

1)- Dyspepsia

2)- Parasititis?

B)- Plan

1)- Tums 1g po bid for 2 months

2)- Mebendazole 100mg 1t po bid for 3 days

6- Pheng Roeung, 58F, Thnout Malou

A)- Diagnosis

1)- Euthyroid

B)- Plan

1)- Carbimazole 4mg 1t po bid for one month

2)- Propranolol 40mg ¼ t po bid for one month

7- Nget Soeun, 57M, Thnoout Malou

A)- Diagnosis

1)- Liver Cirrhosis

B)- Plan

1)- Spironolactone 50mg ½ t po qd for one month

2)- Propranolol 40mg ½ t po qd for one month

3)- Multivitamine 1t po qd for one month

8- Sao Phal, 57F, Thnout Malou

A)- Diagnosis

1)- HTN (Stable)

2)- DMII with PNP

B)- Plan

1)- Diamecron 80mg ½ t po qd for one month

2)- HCTZ 50mg ½ t po qd for one month

3)- Captopril 25mg ¼ t po qd for one month

4)- Amitriptilline 25mg 1t po qd for one month

5)- ASA 500mg ¼ t po qd for one month

9- Som Thol, 57M, Bak Kdeung

A)- Diagnosis

1)- DMII with PNP

2)- Muscle Pain

B)- Plan

1)- Diamecron 80mg 1 ½ t po qd for one month

2)- Captopril 25mg ¼ t po qd for one month

3)- Amitriptyline 25mg 1t po qhs for one month

4)- ASA 500mg ¼ t po qd for one month

5)- Paracetamol 500mg 1 t po q6h PRN for 10 days

10- Chhay Chanthy, 41F, Thnout Malou

A)-Diagnosis

1)- Hyperthyroidism (Relapse)?

2)- Anxiety?

B)- Plan

Draw her blood for her thyroid function test (free T4, TSH), these will be done at SHCH and also follow up in next visit.

11- Tan Kim Horn, 55F, Thnout Malou

A)- Diagnosis

1)- DMII

2)- Dyspepsia

3)- Parasititis

B)- Plan

1)- Diamecron 80mg ½ t po bid for one month

2)- Captoprile 25mg ¼ t po qd for one month

3)- Tums 1g 1 t po bid for one month

4)- Mebendazole 100mg 1 t po bid for 3 days

5)- DM education

12- Tho Chanthy, 37F, Thnout Malou

A)-Diagnosis

1)- Hyperthyroidism

2)- Dyspepsia

3)- Parasititis?

4)- Common Cold

B)- Plan

1)- Carbimazole 5mg 1 t po qd for one month

2)- Propranolol 40mg ¼ t po qd for one month

3)- Tums 1g 1 t po bid for one month

4)- Mebendazole 100mg 1 tpo bid for 3 days

5)- Benadril Cold 500/25mg 1 t po bid for 7 days

6)- Draw her blood for recheck her thyroid function, it will be done at SHCH.

13- Pen Vanna, 38F, Thnout Malou

A)-Diagnosis

1)- HTN (Stable)

2)- Gastritis (Resolved)

B)- Plan

1)- HCTZ 50mg 1 t po bid for one month

14- Muy Vun, 38M, Thnout Malou

A)- Diagnosis

1)- A-fib

2)- Valvular Heart Disease (MS, MR)

3)- Gastritis/PUD

4)- Parasititis?

B)- Plan

1)- Digoxine 0.25 mg 1 t po qd for month

2)- ASA 500mg 1/4 t po qd for one month

3)- PUD treatment for 10 days

4)- Mebendazole 100mg 1t po bid for 3 days

15- Chan Sokny, 25F, Thnout Malou (came only for blood works)

A)- Diagnosis

1)- Euthyroid

B)- Plan

Draw her blood to recheck her Thyroide function, it will be done at SHCH and also follow up next trip.

The next Robib TM Clinic will be held on
July 6-8, 2004