Robib and Telemedicine

March 2004 Telemedicine Clinic in Robib

Report and photos submitted by David Robertson

On Tuesday, March 9, 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. Sihanouk Hospital Center of Hope physician assistant Rithy Chau was also present to observe and assist at the clinic.

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: Mon, 8 Mar 2004 01:16:29 -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, Thero <thero@cambodiadaily.com>,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Reminder, March 2004 clinic tomorrow, Robib, Cambodia, Telemedicine

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

Dear All:

A quick reminder that the March Telemedicine clinic for Robib is now scheduled for Tuesday, 9 March 2004.

We'll have the follow up clinic at 8:00am, Wednesday, 10 March 2004 (8:00pm, Tuesday, 9 March 2004 in Boston.)

Best if we could receive your e-mail advice before this time.

Thanks again for your kind assistance.

Sincerely,

David

Date: Tue, 9 Mar 2004 02:58:22 -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>,
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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,
Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #1: OUNG CHREB, March 2004 Telemedicine, Robib, Cambodia

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

Dear All:

We'll have the follow up clinic at 8:00am, Wednesday, 10 March 2004 (8:00pm, Tuesday, 9 March 2004 in Boston.)

Best if we could receive your e-mail advice before this time.

Thanks again for your kind assistance.

Sincerely,

David

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #1: OUNG CHREB, female, 40 years old, Staff at Robib medical clinic

History of present illness: Forty-year-old female. We saw this lady last year (December 2002, attached below.) We diagnosed her with Dyspepsia and anemia. We gave her Tums one gram twice daily, multivitamin one tablet per day, and Folic acid one tablet daily; all meds for one month. Her condition got a bit better and then she missed follow up. After feeling a bit better with these medications, three months later her condition got worse, all symptoms came up again presenting with epigastric pain, central chest tightness, throat burning, sometimes burping and excessive saliva in the morning like sour taste, dry cough, constipation, poor sleeping, and a slight headache on and off until now.

Past medical history: In the last two years she had an abortion.

Family history: No history of hypertension or diabetes and no heart disease.

Social history: Does not smoke or drink alcohol.

Allergies: None

Review of system: No weight loss, no fever, no productive cough, has shortness of breath, no stool with blood, and no limb edema.

Physical Exam: Looks stable. Alert and oriented x 3.

BP: 85/40
Pulse: 72
Resp.: 20
Temp. : 36.5
Weight: 44 kg

Eyes: Conjunctiva, mild pale, and no jaundice
Ears, nose, and throat: Unremarkable.
Neck: No lymph node and no goiter.
Lungs: Clear both sides.
Heart: Regular rhythm, no murmur
Abdomen: Soft, flat, not tender, no HSM, and has positive bowel sound.
Limbs: No edema and no deformity.

Assessment: GERD? Anemia. Parasitis. Low blood pressure.

Plan: May we cover her with these medications?

- **Omeprazole, 20 mg two tablets twice daily, for one month**
- **Multivitamin, one tablet daily, for one month**
- **Mebendazole, 100 mg, one tablet twice daily, for three days**
- **Metoclopramide, 10 mg, one tablet three times daily, for ten days**

Please give me any other ideas.

Telemedicine Clinic in Robib, Cambodia - 12 December 2002

Patient #6: OUNG CHREB, female, 37 years old, Staff at Robib medical clinic

Chief complaint: Abdominal pain and sometimes stool with black color on and off for nine months.

History of present illness: Nine months ago she got abdominal pain on and off around the umbilical area accompanied by black stool sometimes, with weakness and burping. She took some antacids but did not respond at all. So she came to see us.

Current medicine: None

Past medical history: Ten months ago she had an abortion and lost a lot of blood.

Social history: Unremarkable

Family history: Unremarkable

Allergies: None

Review of system: Has abdominal pain, no fever, no cough, no diarrhea, has black stool, has mild shortness of breath, has palpitations, has headache, has burping.

Physical exam

General Appearance: Looks stable.

BP: 90/40
Pulse: 84
Resp.: 22
Temp. : 36.5

Hair, ears, nose, and throat: Okay.
Eyes: Pale (mild)
Neck: No goiter, no lymph node, and no JVD.
Lungs: Clear both sides.
Heart: Regular rhythm, no murmur
Abdomen: Soft, flat, not tender, and positive bowel sound.
Limbs: Okay

Assessment: Chronic GI bleeding? Gastritis? Anemia secondary to abortion or GI bleeding? Parasitis?

Recommend: Can we try with:

- **Famotidine, 40mg, twice daily, for one month**
- **Mebendazole, 100mg twice daily, for three days**
- **Multivitamin, one tablet daily for one month**

Please give me any other ideas.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #1: OUNG CHREB, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 15:36:49 -0500

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

From: Tan, Heng Soon,M.D.
Sent: Tuesday, March 09, 2004 12:15 PM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #1: OUNG CHREB, March 2004 Telemedicine, Robib, Cambodia

I agree she has fairly severe reflux disease. What are the triggers? Is she facing some stress in her life? Does she eat late at night? She doesn't smoke or drink, so those are not contributing factors. Is she sensitive to fatty or spicy foods? She will benefit from omeprazole, but I would think 20 mg daily would suffice. After a month's course, she should be instructed to repeat 2 week courses of omeprazole if symptoms recur. If you suspect anemia or parasites, has that been confirmed by blood test or stool examination? Pallor may suggest anemia, but anemia is not necessarily always due to hookworms. I wouldn't worry about her low blood pressure if she is asymtomatic.

Heng Soon Tan, M.D.

From: hopestaff@online.com.kh
Date: Wed, 10 Mar 2004 08:00:51 +0700
To: David Robertson <dmr@media.mit.edu>

Cc: 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>,
"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, Thero <thero@cambodiadaily.com>,
Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Re: Patient #1: OUNG CHREB, March 2004 Telemedicine, Robib, Cambodia

Dear all,

I would suggest to take a deeper history concerning the constipation. Is this a new fact, change of stool habits? Could a rectal exam be done to rule out a rectal cancer? If no suspicion of colorectal malignancy, try Omeprazole, if no improvement till next month, consider sending her for a gastroscopy.

Thanks

Dr. Cornelia Haener

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>, <tmed_montha@online.com.kh>,
"'Rithy Chau'" <tmed_rithy@online.com.kh>
Cc: "'Gary Jacques'" <gjacques@bigpond.com.kh>,
"'Jennifer Hines'" <sihosp@bigpond.com.kh>,
"'Bernie Krisher'" <bernie@media.mit.edu>
Subject: RE: Patient #1: OUNG CHREB, March 2004 Telemedicine, Robib, Cambodia
Date: Wed, 10 Mar 2004 08:59:33 +0700

Dear David, Rithy and Montha,

The patient had black stool and responsed to famotidine, then did not showed up to the clinic at follow-up. The symptoms again reappeared, but no black stool. Mild pallor conjunctiva on exam. BP similar to months ago SBP 85 to 90 mmHg, HR 72. Agree with your management of omeprazole, metoclopramide, mebendazole and multivitamine. We would give her 2 months of medication just in case she missed follow-up again, add FeSO4/folic acid also 2 months. Check her Hgb if possible. If low, we would like to work-up this anemia.

Regards,

Bunse

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #1: OUNG CHREB, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 20:37:53 -0500

Hello David:

Here are some additional comments from the medical students working with Dr. Tan, along with his edits.

Kathy

> -----Original Message-----
> From: Tan, Heng Soon,M.D.
> Sent: Tuesday, March 09, 2004 5:29 PM
> To: 'Prasad, Paritosh '
> Cc: Kelleher-Fiamma, Kathleen M. - Telemedicine
> Subject: RE: Patient #1: OUNG CHREB, March 2004 Telemedicine, Robib, Cambodia

>
> Kathy:
> Here are the student's [edited] comments.
> HS
>
> Hi Dr. Tan,
>

> Again, thanks for the cases. The current presentation seems pretty
> consistent with GERD. The prior reports of black stools and anemia are
> concerning for an upper GI bleed (peptic ulcer), though at a dose of
> 20mg BID Omeprazole will treat both conditions. With long standing GERD,
> we might worry about erosive esophagitis as well, though there doesn't
> appear to be a history of hematemesis. Is it possible to get an O&P on
> her stool? [I support that--HS] While it appears she has been treated in the
> past with Mebendazole, it doesn't look like a specific parasite was ever
> identified. Hookworm's lifecycle from the intestines to the lungs and down the
> esophagus could give the abdominal discomfort as well as the
> cough, but I think GERD is a more likely etiology [agree--HS]. I'm not sure
> if empirical treatment with Mebendazole is a good idea without identification
> of the parasite this time, considering she's been treated previously and
> symptoms have recurred [agreed--HS]; Mebendazole will also probably make her
> constipation and headache worse in the short term (both are side effects of
> Mebendazole). And holding off on the antihelminthic while we push the GERD
> therapy might help us determine the cause of her symptoms. In the mean time we
> could ask her to think about possible sources of reinfection? [Endemic if she
> works barefeet in the fields--HS]
>

> Thanks,
> tosh

Date: Tue, 9 Mar 2004 03:04:11 -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>,

Bernie Krisher <bernie@media.mit.edu>
Cc: "Lugn, Nancy E." <NLUGN@PARTNERS.ORG>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
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Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #2: PEN SAMADY, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #2: PEN SAMADY, male, 36 years old, follow up patient

Chief complaint: Patient still complains of sore throat.

Subject: 36-year-old male came for his follow up of Pharyngitis. He still has mild sore throat and difficulty in swallowing, sometimes dry cough, and an itchy feeling all over his body. No palpitations, no fever, no shortness of breath, no chest pain, no abdominal pain, and no stool with blood.

Object: Looks stable, alert and oriented x 3.

BP: 120/80, **Pulse:** 84, **Resp.:** 20, **Temp:** 36.5, **Weight:** 66kg

Eyes, Ears, Nose & Throat: Okay. Conjunctiva, pink color.**Neck:** No goiter and no lymph node.

Lungs: Clear both sides

Heart: Regular rhythm and no murmur.

Abdomen: Soft, flat and not tender.

Limbs: Okay.

Assessment: Post Pharyngitis syndrome. Rhinitis by allergy. Hives.

Plan: We would like to cover him with some medications:

- **Nabumetone, 750 mg, one tablet per day, for ten days**
- **Acetaminophen/Diphenidramine, 500 mg/25mg, one tablet twice daily, for ten days**

Please give me any other ideas.

From: dsands@bidmc.harvard.edu
To: KKELLEHERFIAMMA@PARTNERS.ORG, dmr@media.mit.edu
Subject: RE: Patient #2: PEN SAMADY, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 11:49:43 -0500

I would like more information about how his skin looks. Does he have a rash? Does he have hives? Dry skin?

Also, does he have any thrush?

I would recommend:

1. Saline gargles

2. Increased fluids

3. Pain relievers (acetaminophen and/or nabumetone)

4. If he definitely has hives, I would treat more aggressively with diphenhydramine 25-75 mg every 4-6 hours as needed to control itching

- Danny Daniel Z. Sands, MD, MPH V: (617) 667-1510

___/ Center for Clinical Computing F: (810) 592-0716

(__ Beth Israel Deaconess Medical Center

___) Harvard Medical School

http://cybermedicine.caregroup.harvard.edu/dsands

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: <tmed_montha@online.com.kh>, "'Gary Jacques'" <gjacques@bigpond.com.kh>,
"'Jennifer Hines'" <sihosp@bigpond.com.kh>,
"'Rithy Chau'" <tmed_rithy@online.com.kh>,
"'Bernie Krisher'" <bernie@media.mit.edu>
Subject: RE: Patient #2: PEN SAMADY, March 2004 Telemedicine, Robib, Cambodia
Date: Wed, 10 Mar 2004 09:00:35 +0700

Dear David, Rithy and Montha,

Chronic pharingitis, most likely is non-infectious in origin. Often cause is post-nasal drip from a sinusitis. Smoking could also be a cause a long with other chemical irritation. We would advise not to use antibiotics, just pseudoephedrine 60 mg P.O tid, chlorpheniramine 4 mg tid, paracetamol (or paracetamol/diphenhydramine 500/25 tid), salt water gargles for 10 days, quit smoking if he does.

Throat Pain when swallowing could be from the pharyngitis itself or esophageal herpes, candidiasis, malignancy....especially in immunocompromised patients. We would check whether he is immunocompromised such as diabetes or HIV.

Regards,

Bunse

Date: Tue, 9 Mar 2004 03:08:29 -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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Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #3: PRUM SOUR, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #3: PRUM SOUR, female, 53 years old, follow up patient

Subject: 53-year-old female came back for her follow up of pneumonia. Last month we sent her to Kampong Thom Provincial Hospital for chest x-ray and AFB check. The doctor told her that she has pneumonia and her AFB is negative. After discharging her from the hospital, the doctor asked her to buy some Amoxycillin, 500mg twice daily for ten days. But she only took medication for two and a half days. This was similar to last month when she did not take all her medication because she could not afford the full course of medication. Now her symptoms still are shortness of breath while working, headache, sometimes cough with slight sputum. She has no chest tightness, no fever, no abdominal pain, and no stool with blood.

Object: Looks stable and oriented x 3.

BP: 120/80, **Pulse:** 100, **Resp.:** 22, **Temp:** 36.5, **Weight:** 62 kg

Eyes, Ears, Nose and Throat: Okay. Conjunctiva, pink color, no jaundice.

Lungs: Slight wheezing on upper and lower lobes both sides.

Heart: Regular rhythm and no murmur.

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

Limbs: No edema and no deformity.

Assessment: Chronic Asthma? Allergy? Tension headache.

Plan: May we cover her with the following?

- **Albuterol Inhaler, two puffs four times daily as needed**
- **Acetaminophen/Diphenidramine, 500 mg/25mg, one tablet twice daily, for seven days**

Please give me any other ideas.

From: "Sadeh, Jonathan S.,M.D." <JSADEH@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"

<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #3: PRUM SOUR, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 15:55:43 -0500

My differential diagnosis now is bronchitis with reactive airways or cardiac etiology. When I first saw this case I thought a cardiac etiology is very likey; bronchitis and wheezing secondary to that is also possible. A chest x-ray (or a report of it) and an ECG would be very helpfull. I would give her an inhaler (albuterol) to use as needed/every 4 hours for shortness of breath but also give her some anti ischemic meds--if you have a nitrate (e.g. imdur) or even atenalol I would try that+ an aspirin a day. She isn't febrile so I wouldn't recommend acetaminophen.

Jonathan Sadeh.

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: <tmed_montha@online.com.kh>, "'Gary Jacques'" <gjacques@bigpond.com.kh>,
"'Jennifer Hines'" <sihosp@bigpond.com.kh>,
"'Rithy Chau'" <tmed_rithy@online.com.kh>,
"'Bernie Krisher'" <bernie@media.mit.edu>
Subject: RE: Patient #3: PRUM SOUR, March 2004 Telemedicine, Robib, Cambodia
Date: Wed, 10 Mar 2004 08:59:33 +0700

Dear David, Rithy and Montha,

The main complaint is shortness of breath on exertion. She has cough with sputum sometime. Her sputum AFB last month are negative. No chest pain, no fever. She was told she had pneumonia in Kg. Thom provincial hospital (by X-Ray???)last month. She is overweight by the picture.

We think she may have:

1. PTB - does she has weight loss, night sweat, low grade fever, neighbor has PTB? What is her CXR look like?.

2. CHF - Does she have cardiomegaly on CXR? Any chest tightness on exertion? Since she is overweight, we would like to look at her glycemia and also want to rule out IHD by EKG.

3. Asthma or COPD - does she have history of asthma? Does she smoke?

While waiting for CXR, glycemia and EKG, we would try low dose furosemide, say 20 mg AM. If no chest tightness on exertion and EKG is unremarkable, we may try albuterol and see if SOBOE and wheeze go away.

If CXR is suspicious, we will follow TB program protocol - repeat 3 more sputum AFB while putting her on Amoxicilline 500 mg tid for another 7 days.

Regards,

Bunse

Date: Tue, 9 Mar 2004 03:15:14 -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>,
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Bunse Leng <tmed1shch@bigpond.com.kh>,
Bernie Krisher <bernie@media.mit.edu>
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"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
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Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #4: SAO PHAL, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #4: SAO PHAL, female, 56 years old, follow up patient

Subject: 56-year-old female returned (last visit December 2003) for follow up visit for hypertension, DMII, and PNP. Her symptoms are improving a lot - no neck tenderness, no chest pain, no shortness of breath, but she has dizziness, and sometimes has epigastric pain radiating to sternal chest. She also has excessive saliva and burping in the morning, like a sour taste, and a dry cough at night. Patient gained 4 kg in the last three months.

Object: Looks stable.

BP: 120/80, **Pulse:** 70, **Resp.:** 20, **Temp:** 36.5, **Weight:** 64 kg

Eyes, Ears, Nose and Throat: Unremarkable

Lungs: Clear both sides.

Heart: Regular rhythm and no murmur.

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

Limbs: Decreased numbness and no joint pain. No edema.

Urinanalysis: Normal

Assessment:

1. **Hypertension (stable)**
2. **DMII & PNP**
3. **GERD**

Plan: Continue same medication for another month plus add

some others:

- **Diamecrom, 80 mg, ½ tablet daily (for one month)**
- **Amitriptilline, 25mg, ½ tablet three times daily (for one month)**
- **Hydroclorothiazide, 50mg, ½ tablet daily (for one month)**
- **Aspirin, 300mg, ¼ tab daily (for one month)**
- **Ranitidine, 75 mg, two tablets twice daily (for one month)**
- **Metoclopramide, 10mg, one tablet twice daily (for ten days)**

Note: We would like to try the above for one month. If all symptoms not improving, we would like to switch to Omeprazole. Please give me any other ideas.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #4: SAO PHAL, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 15:42:40 -0500

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

From: Tan, Heng Soon,M.D.

Sent: Tuesday, March 09, 2004 12:58 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #4: SAO PHAL, March 2004 Telemedicine, Robib, Cambodia

I agree she has esophageal reflux disease. What are the triggers? Is she facing some stress in her life? Does she eat late at night? She doesn't smoke or drink, so those are not contributing factors. Is she sensitive to fatty or spicy foods?

If she coughs at night, propping up the head of the bed by 6 inches may avoid nocturnal reflux. She will benefit from ranitidine. 300 mg at night is an alternative way to dose her. After a month's course, she should be instructed to repeat 2 week courses of ranitidine if symptoms recur. Of course if response is incomplete, omeprazole will be more effective. With her diabetes, I would advise her not to gain any more weight.

Heng Soon Tan, M.D.

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: <tmed_montha@online.com.kh>, "'Gary Jacques'" <gjacques@bigpond.com.kh>,
"'Jennifer Hines'" <sihosp@bigpond.com.kh>,
"'Rithy Chau'" <tmed_rithy@online.com.kh>,
"'Bernie Krisher'" <bernie@media.mit.edu>
Subject: RE: Patient #4: SAO PHAL, March 2004 Telemedicine, Robib, Cambodia
Date: Wed, 10 Mar 2004 09:33:11 +0700

Dear David, Rithy and Montha,

Do you have any info on her blood sugar? We cannot comment on whether we should stay on same dose Diamicron.

I would be sleepy all day if I take amitripyline tid. For her PNP, bedtime should be OK.

We think she is on famotidine long enough and still not better, we would switch it now to omeprazole, if still not better after 1 month, she needs endoscopy. If better, continue another month. Metoclopramide should be tid or qid.

Have a nice day,

Bunse

Date: Tue, 9 Mar 2004 03:17:40 -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,
Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #5: SOM DEUM, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #5: SOM DEUM, female, 64 years old, follow up patient

Subject: 64-year-old female returned for follow up visit for her Polyarthritis and malnutrition. Her symptoms are improving a lot; less painful on all her joints, increased walking, no joint swelling, no shortness of breath, no fever, no abdominal pain, no stool with blood, no cough and her weight has increased 5 kg.

Object: Looks stable, alert and oriented x 3.

BP: 100/50, **Pulse:** 70, **Resp.:** 20, **Temp:** 36.5, **Weight:** 49 kg

Hair, Eyes, Ears, Nose and Throat: Unremarkable

Lungs: Clear

Heart: Regular rhythm and no murmur.

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

Joints: No swelling, no stiffness, but still has mild pain on both knees.

Assessment: Polyarthritis. Malnutrition.

Plan: May we continue with the following:

- **Nabumetone, 750mg, one tablet daily for one month**
- **Multivitamin, 1 tablet daily for one month**

Please give me any other ideas.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #5: SOM DEUM, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 15:44:10 -0500

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

From: Crocker, Jonathan T., M.D.
Sent: Tuesday, March 09, 2004 11:27 AM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #5: SOM DEUM, March 2004 Telemedicine, Robib, Cambodia

Re: Som DEUM

Fantastic! Glad to hear that response to NSAID has been good and tolerated well. Continue NABUMETONE with food daily, and if symptoms continue to improve, you might think about cutting back to AS NEEDED dosing. No other recommendations.

Best,

Jon Crocker, M.D.

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: <tmed_montha@online.com.kh>, "'Gary Jacques'" <gjacques@bigpond.com.kh>,
"'Jennifer Hines'" <sihosp@bigpond.com.kh>,
"'Rithy Chau'" <tmed_rithy@online.com.kh>,
"'Bernie Krisher'" <bernie@media.mit.edu>
Subject: RE: Patient #5: SOM DEUM, March 2004 Telemedicine, Robib, Cambodia
Date: Wed, 10 Mar 2004 09:47:38 +0700

Dear David, Rithy and Montha,

The patient is better on the treatment. We agree with your suggestion.

Keep taking NSAID with meal.

Regards,

Bunse

Date: Tue, 9 Mar 2004 03:20:40 -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,
Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #6: THORN KHUN, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #6: THORN KHUN, female, 38 years old, follow up patient

Subject: 38-year-old female returned for follow up visit for her hyperthyroidism and neck headache. Her symptoms are improving a lot; decreasing palpitations, decreasing shortness of breath, decreasing eye fatigue, but she still has slight neck tenderness.

Object: Looks stable, alert and oriented x 3.

BP: 100/70, **Pulse:** 80, **Resp.:** 20, **Temp. :** 36.5, **Wt.:** 55 kg

Hair, eyes, ears, nose, and throat: Unremarkable.

Neck: Her goiter the same size, not enlarged.

Lungs: Clear.

Heart: Regular rhythm and no murmur.

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

Limbs: No edema.

Assessment:

1. Hyperthyroidism with three months of breast-feeding baby.
2. Tension headache.

Plan: Continue with following meds:

- **Multivitamin tab once daily, for one month**
- **Feso4/folic 200/25mg, one tab per day, for one month**
- **Paracetemol, one tablet four times daily, for seven days**

We want to draw her blood in the village to recheck TSH of her Thyroid test at Sihanouk Hospital Center of Hope. Please give me any other ideas.

Note: Her baby is still healthy.

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "'dmr@media.mit.edu '" <dmr@media.mit.edu>
Cc: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Subject: Patient #6: THORN KHUN, female, 38 years old, follow up patient
Date: Tue, 9 Mar 2004 18:54:10 -0500

Patient #6: THORN KHUN, female, 38 years old, follow up patient

Thank you for the interesting case. I am happy to hear that she is improving somewhat. My advice remains the same as last month, so I have included that below with slight modification.

Best Wishes

Paul Heinzelmann, MD

PS. I might suggest that we develop some kind of unique medical record number for each patient. That will make archiving their cases a bit easier for us.

Just a suggestion.

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 repeating 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 has been hyperthyroid but is improving somewhat.

Her persistant headache with blurred vision is somewhat troubling. I assume that has improved as well? She would benfit from an ophthalmic exam to look at her optic nerves for papilledema if her headache persists with blurred vision.

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 if headache persists with blurred vision

4. Continue the multivitamins as long as she is breast feeding

5. Continue paracetemol if it helps with headache but dont ignore persistant headache

Thank you

Paul Heinzelmann, MD

From: "Bunse LEANG" <tmed1shch@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>
Cc: <tmed_montha@online.com.kh>, "'Gary Jacques'" <gjacques@bigpond.com.kh>,
"'Jennifer Hines'" <sihosp@bigpond.com.kh>,
"'Rithy Chau'" <tmed_rithy@online.com.kh>,
"'Bernie Krisher'" <bernie@media.mit.edu>
Subject: RE: Patient #6: THORN KHUN, March 2004 Telemedicine, Robib, Cambodia
Date: Wed, 10 Mar 2004 10:03:12 +0700

Dear David, Rithy and Montha,

Agree with TSH check, also would check her hemoglobin in order to stop MTV and FeSO4. Agree with Paracetamol for headache, inform her about her thyroid status noe so that she feels relieve.

Regards,

Bunse

Date: Tue, 9 Mar 2004 00:41:11 -0800 (PST)
From: Rithy Chau <chaurithy@yahoo.com>
Subject: Robib TM patient Pheng Roeun
To: Jennifer Hines <sihosp@online.com.kh>,
Bunse Leang <tmed1shch@online.com.kh>
Cc: Somontha Koy <tmed_montha@online.com.kh>,
Bernie Krisher <bernie@media.mit.edu>,
David Roberson <dmr@media.mit.edu>

Dear Jennifer/ Bunse,

About six cases were sent per David this afternoon and some more will be sent later. If you have time, you can go ahead and reply now. Here is a case which was follow up at SHCH, but I think that instead of having here returning to SHCH for more F/U she can receive medication from Montha here since he may have enough left over from another patient to give her until he return next month (i.e. if you agree with my plan below):

Pheng Roeun, 58F, from Robib TM clinic has been scheduled to returned to SHCH on 17/03/04 for follow-up on her hyperthyroid condition. She was lasted seen at SHCH on 27/01/03 per Dr. Lou Lay and since her free T4 was slightly elevated (T4=27) was was restarted on Carbimazole 5mg 1 po bid. Her past history at SHCH showed that she was dx and tx with Carbimazole 5mg 1 po tid since 27/09/01 and reduced to 1 po bid on 14/01/02 and 1 po qd on 23/09/02 and she was stopped due to medication ran out at SHCH on 25/10/02 and restarted back on 31/01/03.

Finally, the doctor stopped her carbimazole (and propranolol) on 19/08/03 due to free T4 = 17 (10/08/03). However, her sx recurred with BP 160/80 P 120 R 20 on 26/12/03.

Her T4 was checked on 20/01/04 again and found to be 27. Dr. Lay started her back on Carbimazole 5mg 1 po bid.

As for my opinion, this patient may need a maintanance dose of Carbimazole 5 mg 1 po qd is enough (plus Propranolol 40mg 1/4 po bid) and recheck her free T4 again in 1-2 months (total 3 mos after medication retstarted). Her vital sx is normal BP 120/60, P80, R22 and without any new sx. She said that she would be happy not to travel back to SHCH if she does not need to. What is your opinion on this?

Regards,

Rithy

From: "Jennifer" <sihosp@online.com.kh>
To: "'Rithy Chau'" <chaurithy@yahoo.com>,
"'Bunse Leang'" <tmed1shch@online.com.kh>
Cc: "'Somontha Koy'" <tmed_montha@online.com.kh>,
"'Bernie Krisher'" <bernie@media.mit.edu>,
"'David Roberson'" <dmr@media.mit.edu>
Subject: RE: Robib TM patient Pheng Roeun
Date: Tue, 9 Mar 2004 18:23:26 +0700

Dear Rithy:

This is the problem in treating any of these patients with chronic diseases so far away. We end up dealing with a woman who needs care there and not here and will be lost to follow up again when she cannot travel. When was her follow up down here supposed to be? I think that she should try and keep that appointment. You could keep her on Propranolol only for now and this drug she can buy in the private pharmacy up there when she runs low and chooses not to come back to SHCH for care. The carbimazole is harder to come by up there and maybe she could get away with just the beta blocker, given the mild elevation of T4 when she is off of all medications.

My recommendation---put on propranolol 40 mg, 1/4 tab. PO BID x 30 days and ask her to follow up with us at SHCH, if she wants to or just stay on the beta blocker that she can buy up there in the future.

Thanks. Jennifer

Date: Tue, 9 Mar 2004 08:30:38 -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,
Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #7: NGET SOEUN, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #7: NGET SOEUN, male, 56 years old, follow up patient

Subject: 56-year-old male returned for follow up visit for his Cirrhosis. His previous symptoms are much improved. He has no shortness of breath, no palpitations, no cough, no chest tightness, no abdominal distension or pain, no stool with blood, has a good appetite, has no limb edema but has weakness sometimes.

Object: Looks stable

BP: 90/40, **Pulse:** 68, **Resp.:** 20, **Temp:** 36.5, **Weight:** 40 kg

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

Neck: Has no goiter, no JVD, and no lymph node.

Lungs: Clear both sides.

Heart: Regular rhythm without murmur.

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

Extremities: No edema, no deformity

Assessment: Cirrhosis

Plan: Continue with the same medications for another month.

- **Spironolatone, 50mg, 1/2 tablet daily**
- **Propranolol, 40 mg, 1/2 tablet twice daily**
- **Multivitamin, one tablet daily**
- **Furosemide, 40 mg, 1/2 tablet daily**

Please give me any other ideas.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #7: NGET SOEUN, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 15:45:52 -0500

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

From: Tan, Heng Soon,M.D.

Sent: Tuesday, March 09, 2004 1:02 PM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine

Subject: RE: Patient #7: NGET SOEUN, March 2004 Telemedicine, Robib, Cambodia

Congratulations on a good clinical response! He should be monitored with serum electrolytes, renal function tests every 3 months to avoid electrolyte imbalances that could cause weakness or cardiac arrhythmia.

Heng Soon Tan, M.D.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #7: NGET SOEUN, March 2004 Telemedicine, Robib, Cambodia

Date: Tue, 9 Mar 2004 20:41:24 -0500

> -----Original Message-----

> From: Tan, Heng Soon,M.D.

> Sent: Tuesday, March 09, 2004 5:32 PM

> To: 'Prasad, Paritosh '

> Cc: Kelleher-Fiamma, Kathleen M. - Telemedicine

> Subject: RE: Patient #7: NGET SOEUN, March 2004 Telemedicine, Robib,

> Cambodia

>

> Kathy:

> Here are the student's [edited] comments.

> HS

>

>

> Hi Dr. Tan,

>

> Again, thanks for the forwards. The pt in the case below seems to be

> doing well. He seems to be ascites free right now, so it probably

> wouldn't pay to change his diuretic regimen. But theoretically; what

> would you think about going up on the Spironolactone and down on the

> Furosemide[worth trying considering that he is on such low doses, he may very

> well continue to do well just on spironolactone alone. Furosemide could be

> used whenever needed to supplement diuretic action--HS]. Yes hyperkalemia

> might be a risk but we would better maximize on spironolactone's inhibition of

> the hyperaldosteronism of

> portal hypertension. Otherwise, besides salt and water restriction to

> minimize ascites, and protein restriction to minimize hepatic

> encephalopathy he seems to be well. (Has he ever had any signs of

> hepatic encephalopathy before?)[No--HS]. It would also be good to check his

> orthostatics just to make sure he's not intravascularly depleted. [Good

> suggestion. Checking BUN/Creatinine and electrolytes will be critical

> too--HS].

>

> thanks,

> tosh

>

From: "Jennifer" <sihosp@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>,
<hopestaff@online.com.kh>, <aafc@camnet.com.kh>,
"'Thero'" <thero@cambodiadaily.com>,
"'Sing Seda'" <seda@cambodiadaily.com>
Subject: RE: Patient #7: NGET SOEUN, March 2004 Telemedicine, Robib, Cambodia
Date: Wed, 10 Mar 2004 09:27:53 +0700

Dear Guys in the Province---

I will answer questions for patients 7-11 and Bunse will handle the first 6 for SHCH. I hope the weather is nice and that your time there is going well.

#7-Nget Soeun, 56 male---

This man has chronic cirrhosis and at this point, appears to be stable. The goal of all patients is to stabilize them on a medication regimen and then maintain them on the least amount of medications possible. In this case, I would stop the furosemide, which was needed when he was volume overloaded, but may not be needed now. I would continue Propranolol 40mg 1/2 po BID; spirolactone 50mg 1/2 po daily and MVI 1 po daily. Next month, you may want to access the need for propranolol at that dose. Changes in medications should be done in stages to allow the patient to get used to the change and so one will know what changes may affect the patient for the better or for worse.

Date: Tue, 9 Mar 2004 08:32:43 -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,
Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #8: PEN VANNA, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #8: PEN VANNA, female, 38 years old, follow up patient

Subject: 38-year-old female returned for follow up visit for her stable hypertension, dyspepsia, and DMII? Her symptoms have much improved, now decreased muscle pain, decreased dizziness, no blurred vision, no neck tenderness, has slight headache, no cough, but still feels burning on the sternal chest pushing up to the mouth, has excessive saliva and sour tasting burping in the morning, no abdominal pain, and has no stool with blood. Patient gained 4 kg since her last visit in December 2003.

Object: Looks stable.

BP: 140/90, **Pulse:** 70, **Resp.:** 20, **Temp:** 36.5, **Weight:** 64 kg

Hair, Eyes, Ears, Nose and Throat: Unremarkable

Lungs: Clear both sides.

Heart: Regular rhythm without murmur.

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

Limbs: Okay

Urinanalysis: Negative

Assessment:

1. **Stable Hypertension**
2. **GERD**
3. **DMII?**
4. **Tension headache.**

Plan: We would like to cover her with some medications for the next month like:

- **Hydroclorothiazide, 50mg, ½ tablet daily**
- **Aspirin, 500 mg, ¼ tablet daily**
- **Omeprazole, 20 mg twice daily**
- **Paracetemol, 500 mg, one tablet four times daily as needed**
- **Keep her on a restricted sweets and restricted salt diet.**

Please give me any other ideas.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #8: PEN VANNA, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 17:17:12 -0500

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

From: Cusick, Paul S.,M.D.
Sent: Tuesday, March 09, 2004 5:16 PM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #8: PEN VANNA, March 2004 Telemedicine, Robib, Cambodia

Thank you for the information.

She has stable bp (could be a bit better) with a low salt diet.

Sounds like brackish taste and symptoms are GERD. continue prilosec and a low acid diet (avoid orange juice, coffee.)

Thank you.

Paul Cusick, M.D.

From: "Jennifer" <sihosp@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>,
<hopestaff@online.com.kh>, <aafc@camnet.com.kh>,
"'Thero'" <thero@cambodiadaily.com>,
"'Sing Seda'" <seda@cambodiadaily.com>
Date: Wed, 10 Mar 2004 09:27:53 +0700

#8-Pen Vanna, 38F

This lady keeps getting the label of questionable diabetes. Why? What evidence do you have that she is or is not a diabetic? Many of our older patients with hypertension may be at risk of having impaired glucose tolerance (IGT) and would be at a higher risk of getting diabetes and atherosclerotic cardiovascular disease in the future. How does this patient fit that profile? What about this stomach problem? What does she eat in her diet, how often does she eat and how late does she eat in the day? Does she have burning in the chest after every meal or is it with certain foods or other circumstances? If she had gained weight, she may have a good appetite and not have problems that stop her from eating. GERD is certainly a possibility and using omeprazole empirically is a very common treatment to begin with. I agree to start omeprazole 20mg BID and I would hold the ASA, which can aggravate symptoms, possibly. I would also continue the HCTZ 25mg QD and the paracetamol, PRN.

Date: Tue, 9 Mar 2004 08:34:54 -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,
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Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #9: SOM THOL, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #9: SOM THOL, male, 50 years old, Follow up patient

Subject: 50-year-old male returned for his follow up visit of DMII, PNP, dyspepsia and left foot wound infection. His previous symptoms are improving; decreased frequency of urination, no chest pain, no dizziness, no fever, no cough, decreased epigastric pain, no diarrhea, has a weight gain of 3 kg, decreased numbness at extremities.

Results of blood test done last month at Sihanouk Hospital Center of Hope:

- NA+ 133 mmol/l
- K+ 6.3 mmol/l
- Bun. 1.3 mmol/l
- Creat. 69 umol/l
- BS = 9 mmol/l

Object: Looks stable

BP: 110/60, **Pulse:** 80, **Resp.:** 20, **Temp:** 36.5, **Weight:** 57 kg

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

Lungs: Clear both sides.

Heart: Regular rhythm, no murmur.

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

Limbs: Left foot wound healing and he's able to walk very well.

Assessment:

1. **DMII & PNP**
2. **Dyspepsia**
3. **Hyperkalemia (due to blood hemolisis)**
4. **Left foot wound completely healed**

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**
- **Aspirin, 300 mg, 1/4 tablet daily**
- **Ranitidine, 75 mg, one tablet twice daily**

From: "Heinzelmann, Paul J." <PHEINZELMANN@PARTNERS.ORG>
To: "'dmr@media.mit.edu '" <dmr@media.mit.edu>
Cc: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Subject: Patient #9: SOM THOL, male, 50 years old, Follow up patient
Date: Tue, 9 Mar 2004 19:50:16 -0500

Patient #9: SOM THOL, male, 50 years old, Follow up patient

Greetings. I am so happy to hear about his improvement with his foot and in general. I am surprised the wound is already healed, but that is reassuring. I assume he is not limping.

I suspect you had the BUN and creatinine values reversed. A BUN of 69 is a high and his creatinine is just outside normal range, so I would suspect at least some loss of kidney function due to his diabetes. (This is important to consider with a patient on any long term antibiotics.) We are assuming his hyperkalemia is due to hemolysis. Does he have any recent prior recorded potassium levels? In my opinion, it warrents re-checking. My suspician is that he now has diabetic nephropathy leading to his increased BUN, and his mildy elevated creatinine. This makes a high potassium less likely due to hemolysis If available, an easy way to see if a high potassium is real, is to look for peaked or tented T waves on an EKG.

Assessment:

1. DMII & PNP
2. Dyspepsia
3. Hyperkalemia (?hemolysis vs renal insufficiency)
4. Elevated BUN (dehydration? ....suggests diabetic nephropathy to me)
4. Left foot wound completely healed

Recommendations:

1. continue meds , but I would consider avoiding Aspirin if he has ongoing dyspepsia. It can also worsen any kidney problems. Risks may be greater than any benefit, and you should consider.

2. recheck Potassium (and/or get ECG and look for peaked or tented T waves to verify if elevated K is actually high)

3. If possible do UA dip and look for protein - this too suggests loss of kidney function.

4. If it hasnt been done, a rectal exam checking for occult blood and a CBC are needed in patients with dyspepsia, especially if on Aspirin.

5. Regular follow up

Best of luck with this complicated patient.

Sincerely,

Paul Heinzelmann, MD

From: "Jennifer" <sihosp@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>, <JKVEDAR@PARTNERS.ORG>,
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Date: Wed, 10 Mar 2004 09:27:53 +0700

#9 Som Thol, 50 male

It is very helpful to at least show us a picture of the healed foot wound and to continue to educate about closed toed shoes that don't fit tightly, inspecting and cleaning the feet with warm soap and water daily and to always walk around with foot protection. I agree with your treatment plan to continue all medications as before.

Date: Tue, 9 Mar 2004 08:37:49 -0500
From: David Robertson <dmr@media.mit.edu>
To: JKVEDAR@PARTNERS.ORG, "Paul Heinzelmann, MD"
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Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #10: KHUN NAVOEUN, March 2004 Telemedicine, Robib, Cambodia

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

Patient #10: KHUN NAVOEUN, female, 21 years old, follow up patient

Subject: 21-year-old female follow up case with lichen planus returned. She is improving a lot with Ciclopirox applied twice daily but still feels itchy in some places. She has no fever, no cough, no respiratory distress, no GI complaints and no secondary infection.

Object: Looks stable

Hair, eyes, ears, nose, and throat: Normal

Lungs, heart, abdomen: Normal

Skin: Old scars of lichen planus on both arms.

Assessment: Lichen planus.

Plan: Continue with the same drug for another month:

- Ciclopirox gel, 0.77%, increase dose and apply three times daily

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #10: KHUN NAVOEUN, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 20:35:52 -0500
Importance: high

I saw this lady in person when we were in Robib. I would suggest a more potent topical steroid. I am not sure what is available. Choices included fluocinonide, clobetasol or halobetasol. If only betamethasone is available, that is ok too. She should soak the skin in cool water for 20-30 minutes at night, apply the ointment to the lesions and wrap them for one hour with something occlusive like plastic food wrap.

By the way, I don't think there is any evidence for sarcoidosis in this case.

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#10 Khun Navoeun 21 female

Lichen Planus is a chronic condition, so when the patient is pretty much asymptomatic, she does not need to continue daily use of topical agents.

Only when symptomatic. I agree with increasing the use of Ciclopirox, as needed. These lesions will not likely disappear entirely, but can fade a bit when not excoriated. I defer to my dermatology colleagues in

Boston.

Date: Tue, 9 Mar 2004 08:40:35 -0500
From: David Robertson <dmr@media.mit.edu>
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Thero <thero@cambodiadaily.com>, Sing Seda <seda@cambodiadaily.com>,
David Robertson <dmr@media.mit.edu>
Subject: Patient #11: MUY VUN, March 2004 Telemedicine, Robib, Cambodia

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

Telemedicine Clinic in Robib, Cambodia – 9 March 2004

Patient #11: MUY VUN, male, 37 years old, follow up patient

Subject: 37-year-old male patient returned for follow up visit for his valvular heart disease (MS/MR Afib.) Last three weeks he has been coughing up blood, increased shortness of breath, increased

palpitations, and increased fever so he went to Kampong Thom to meet a doctor and they found he had pneumonia. They gave him some medication and now he is getting healed, all symptoms gone. He has no shortness of breath, no palpitations, no cough, no GI complaints and no edema on extremities.

Object: Looks stable.

BP: 100/60, **Pulse:** 84, **Resp.:** 20, **Temp:** 36.5, **Weight:** 61 kg

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

Neck: No JVD.

Lungs: Clear both sides.

Heart: Irregular rhythm, no murmur.

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

Limbs: No edema.

Assessment:

1. **Valvular heart disease (MS, MR) and A-fib.**

Plan: Continue following medications for another month:

1. Digoxin 0.25 mg ½ tablet per day
2. **Aspirin 300 mg ¼ tablet per day**

Please give me any other ideas.

From: "Sadeh, Jonathan S.,M.D." <JSADEH@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #11: MUY VUN, March 2004 Telemedicine, Robib, Cambodia
Date: Tue, 9 Mar 2004 16:02:33 -0500

Hemoptysis in the setting of MS in an ominous sign--it is related to increased pulmonary pressures and is a clear indication for a valve replacement.

Obviously, the best thing for this patient is to go to a hospital where this can be fixed. If that is not possible, I would STOP THE ASPIRIN and try to diuris with lasix to lower pulmonary pressures. It may be secondary to a pneumonia but the mortality from MS with hemoptysis is so high you have to have him evaluated in a hospital.

Jonathan Sadeh.

From: "Jennifer" <sihosp@online.com.kh>
To: "'David Robertson'" <dmr@media.mit.edu>, <JKVEDAR@PARTNERS.ORG>,
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#11-Muy Vun 37 male

For this gentleman, did he get a chest x-ray in the process of diagnosing the pneumonia? If he did, it is nice to document where the finding of pneumonia was seen. How long ago did he have this problem?

I agree with continuing his current medications as before.

That is it from me. Thanks. Jennifer

Follow up Report, Thursday, 11 March 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: OUNG CHREB, female, 40 years old, Staff at Robib medical clinic

Patient #2: PEN SAMADY, male, 36 years old, follow up patient

Patient #3: PRUM SOUR, female, 53 years old, follow up patient

Patient #4: SAO PHAL, female, 56 years old, follow up patient

Patient #5: SOM DEUM, female, 64 years old, follow up patient

Patient #6: THORN KHUN, female, 38 years old, follow up patient

Patient #7: NGET SOEUN, male, 56 years old, follow up patient

Patient #8: PEN VANNA, female, 38 years old, follow up patient

Patient #9: SOM THOL, male, 50 years old, follow up patient

Patient #10: KHUN NAVOEUN, female, 21 years old, follow up patient

Patient #11: MUY VUN, male, 37 years old, follow up patient

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

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

[English Version][Khmer Version]