Robib and Telemedicine

Telemedicine Clinic in Robib, Cambodia – May 2001

Report submitted by David Robertson

Date: Fri, 18 May 2001 09:16:49 -0700 (PDT)

From: David Robertson <davidrobertson1@yahoo.com>

Subject: Cambodia Telemedicine Clinic - 18 May

To: "Kvedar, Joseph Charles,M.D." <JKVEDAR@PARTNERS.ORG>,

KKELLEHER@PARTNERS.ORG, sihosp@bigpond.com.kh

Cc: bernie@media.mit.edu, aafc@forum.org.kh,

Graham Gumley <ggumley@bigpond.com.kh

Dear Kathy / Telepartners:

The following patients were seen today in Robib, Cambodia by Sihanouk Hospital Center of Hope nurse Koy Somontha. SHCH Director Dr. Graham Gumley was also in Robib observing and advising the project today.

Ideal for us would be to receive any recommendations from Boston by the end of Friday, May 18, 6pm Boston time. That will be May 19, 7am in Robib, and we will be having another clinic from 8am-noon where we could follow up with these patients and arrange hospital transport if recommended by the doctors in Boston.

Any recommendations that come in later will still be quite helpful and appreciated and will be discussed with the patients during our next Robib Telemedicine clinic on June 14 & 15.

Attached is text. Next several messages I will try to attach photos as long as our generator continues to run (getting late and generator is low on gas.)

Sincerely,

David

Telemedicine Clinic in Robib, Cambodia – 18 May 2001

Morning:

Patient #1: Som Tol, male, 48 years old

Chief complaint: Feel burning on both soles and palms, palpitation, frequency of urination, blurred vision. Last 6 months chest pain.

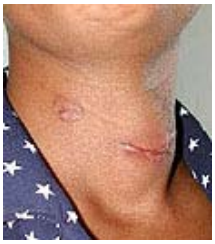
BP: 100/60
Pulse: 104
Resp.: 20
Temp. : 37.0

Past history: not significant
Lungs: clear both sides
Heart: regular rhythm, no murmur
Abdomen: soft, flat, not tender
Bowel sound: positive
Skin: warm to touch, no edema
Limbs: numbness and feel burning in all limbs
Urinalysis: Glucose: ++++, Ketone: +, Protein: +

Assessment: DMII (Diabetic Militus Type II) and Peripheral Neuropathy, Ruled out Ischamic Heart Disease

Recommend: Blood tests, EKG, and chest x-ray. Sihanouk Hospital Center of Hope's Dr. Gumley was present for examination and recommends referral to Kompong Thom Provincial Hospital.

Patient #2: Meas Phary, female, 36 years old



Chief complaint: Mass on the anterior neck for over ten years. Weakness, chest palpitations on and off for five years.

BP: 90/40
Pulse: 84
Resp.: 20
Temp. : 37.0

Past history: One month ago was admitted to Preah Vihear Provincial Hospital for 15 days for goiter.

Lungs: clear both sides
Heart: regular rhythm, no murmur
Abdomen: soft, flat, not tender
Bowel sound: positive
Skin: warm to touch, no edema
Neck: Mass size 4 x 6 cm, positive mobile

Assessment: Simple goiter? Ruled out parasitis.

Recommend: Blood tests (TSH, T3, T4,) neck ultrasound, stool microscopic. Dr. Gumley suggests patient go to Phnom Penh by herself for blood tests.

Patient #4: Ngoun Kim, female, 44 years old

Chief complaint: Difficult to swallow and has mass on anterior neck for seven years. Palpitations and dizziness on and off for one year. Edema all over both feet on and off for one year.

BP: 120/80
Pulse: 88
Resp.: 20

Temp. : 36.5

Past history: not significant

Lungs: clear both sides
Heart: regular rhythm, no murmur
Abdomen: soft, flat, not tender
Bowel sound: positive
Skin: warm to touch, no rash, no dehydration
Limb: no edema
Neck: Mass size 3 x 3 cm, postive mobile
Urinalysis: urobilinogen: ++, blood: +

Assessment: Simple goiter?

Recommend: Blood tests like TSH, T3, T4 and neck ultrasound. Dr. Gumley suggested patient go by herself to Phnom Penh for these tests.

Patient #5: Say Heang, female, 54 years old

Chief complaint: Mass on anterior neck size 6 x 5 cm for approx. ten years. Headache and sometimes chest tightness for one year.

BP: 160/80
Pulse: 80
Resp.: 20
Temp. : 36.5

Past history: not significant

Lungs: clear both sides
Heart: regular rhythm, no murmur
Abdomen: soft, flat, not tender
Bowel sound: positive
Skin: warm to touch, no edema, no rash
Neck: Has mass on the left anterior, size 6 x 5 cm.

Assessment: Simple goiter, mild hypertension. Ischaemic heart disease?

Recommend: Blood tests, EKG and x-ray. Dr. Gumley suggests referral to Kompong Thom Provincial Hospital.

Patient #7, Bun Sarak Mony, female, 5 years old

Chief complaint: Can't speak, very panicky for five years

BP: -
Pulse: 100
Resp.: 25
Temp. : 36.5

Past history: When she was five months old, she had a high fever (temp. over 40,) had small convulsions.

Lungs: clear both sides
Heart: regular rhythm, no murmur
Abdomen: soft, flat, not tender
Bowel sound: positive

Skin: warm to touch, no edema
Other observations: Eye contact normal, muscle tone normal, normal crying, little walking (weak but not sticky,) is able to stand, can listen to someone, can hear.

Assessment: Neurological dysfunction.

Recommend: Neurological assessment and physical therapy.

Patient # 8: Chhay Channa, female, 31 years old

Chief complaint: vaginal discharge, yellow color and bad smell, on and off for seven years. Painful all on the body, especially right arm and upper back on and off for eight years.

BP: 90/60
Pulse: 112
Resp.: 20
Temp. : 37.7

Past history: not significant

Lungs: clear both sides
Heart: regular rhythm, no murmur
Abdomen: pain on both lower quadrants
Bowel sound: positive
Skin: warm to touch, no edema

Assessment: vaginitis? Salphangitis? Muscle pain.

Recommend: Need culture for vaginal discharge. Go to meet gynecologist.

Patient #9, Ny Hom, male, 62 years old

Chief complaint: Dry cough and ear ringing, blurred vision for one year.

BP: 130/70
Pulse: 74
Resp.: 20
Temp. : 36.5

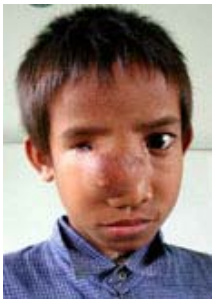
Past history: smokes cigarettes a lot

Lungs: clear both sides, breath sound decreases on both base.
Heart: regular rhythm, no murmur
Abdomen: soft, flat, not tender
Bowel sound: positive
Skin: warm to touch, no edema
Ears: close to deaf in both ears.
Eyes: Opacity both eyes.

Assessment: Cataract, rule out chronic obstruction pulmonary disease (COPD.)

Recommend: Meet opthamologist. Dr. Gumley suggests he go to next "eye camp."

Patient #10: Tann Hoeum, male, 9 years old



Chief complaint: Soft mass on the nose since birth.

BP: -
Pulse: 100
Resp.: 22
Temp. : 36.5

Past history: not significant

Lungs: clear both sides
Heart: regular rhythm, no murmur
Abdomen: soft, flat, not tender
Bowel sound: positive|
Skin: warm to touch, no edema
Nose: soft mass, size 3 x 3 cm

Assessment: Tumor? Mengiosele?

Recommend: Refer patient to Kantha Bhopa Children's Hospital.

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "David Robertson (E-mail)" <davidrobertson1@yahoo.com>

Subject: FW: Cambodia Project Patient #7

Date: Fri, 18 May 2001 16:25:10 -0400

Patient #7

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

From: MacCollin, Mia,M.D.

Sent: Friday, May 18, 2001 4:27 PM

To: Kelleher, Kathleen M., PHS - Telemedicine

Subject: Re: Cambodia Project Patient #7

Hi Kathy.

I agree that a formal neurological consultation with a complete exam would be helpful, along with physical therapy and speech therapy. I also think it might be worthwhile to consider an EEG and a cranial MRI scan.

Hope this is helpful.

Let me know if there is anything else I can do . . . . .

****

Dear. Dr. MacCollin:

Thank you very much for your interest in this program. Feel free to call with any questions.

Kathy

****

Patient #7, Bun Sarak Mony, female, 5 years old

1196, 1197, 1198 jpg

Chief complaint: Can't speak, very panicky for five years

Assessment: Neurological dysfunction.

Recommend: Neurological assessment and physical therapy.

Mia MacCollin, M.D.

Neuroscience Center, MGH--East

Bldg 149, 13th St.

Charlestown, MA 02129

phone: (617) 726-5725

FAX: (617) 724-9620

Apathy is a dominant gene. Mutate.

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "David Robertson (E-mail)" <davidrobertson1@yahoo.com>

Subject: FW: Patient #9, PHENG Roeung

Date: Mon, 18 Jun 2001 10:02:19 -0400

From Dr. Paul Cusick of MGH

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

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

Sent: Friday, June 15, 2001 6:48 AM

To: Kelleher, Kathleen M., PHS - Telemedicine

Subject: RE: Patient #9, PHENG Roeung

Goiter needs evaluation w/ thyroid function testing and ultrasound/thyroid scan . Tachycardia requires EKG and rhythm strip. HTN needs to be treated and controlled. If chest pain is due to Afib, then that would require treatment. However, given age and likely postmenopausal status, ishemic workup needs to be considered. PSC

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "David Robertson (E-mail)" <davidrobertson1@yahoo.com>

Subject: FW: Cambodia Project Patient #2 - Meas Phary, female, 36 years old

Date: Fri, 18 May 2001 14:56:56 -0400

Hi David:

Here is the response for patient #2. It was completed by Dr. Gilbert Daniels,

Co-Director of Thyroid Associates at Massachusetts General Hospital.

Kathy

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

From: Daniels, Gilbert H.,M.D.

Sent: Friday, May 18, 2001 2:52 PM

To: Kelleher, Kathleen M., PHS - Telemedicine

Subject: RE: Cambodia Project Patient #2

This is not typical for patients whom we see. The skin over the thyroid nodule is red and apparently warm. If we saw a patient such as this we would also draw thyroid blood tests as noted, do an ultrasound as noted, but would immediately do a thyroid aspiration (FNA) to see if there is an infection in the nodule Best Gil.

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "David Robertson (E-mail)" <davidrobertson1@yahoo.com>

Subject: FW: Cambodia Project Patient #4

Date: Fri, 18 May 2001 14:58:18 -0400

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

> From: Smulders-Meyer, Olga,M.D.

> Sent: Friday, May 18, 2001 2:56 PM

> To: Kelleher, Kathleen M., PHS - Telemedicine

> Subject: RE: Cambodia Project Patient #4

>

> Ngou Kim, a 44 yr old woman, with a neck mass. The fact that she has had it

> for 7 years, makes a malignancy less likely. Still given the size of the

> growth, she really needs to be seen by an endocrinoloigist and have a fine

> needle aspiration to look at the pathology. She needs to have a TSH as well a

> test for thyroid antibodies, to confirm or rule out Hashimoto's thyroiditis

> and hypothyroidism. If her TSh is depressed she may need a thyroidscan to rule

> out a hot nodule, and Graves disease.

> of all these tests the FNA is the most important.

> She was noted to have Hematuria, and I would repeat a urinalysis in the

> hospital. The patient is 44 and could still be menstruating.

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "David Robertson (E-mail)" <davidrobertson1@yahoo.com>

Subject: FW: Cambodia Project Patient #5

Date: Fri, 18 May 2001 15:17:50 -0400

Recommendations for patient #5 are listed below.

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

> From: Smulders-Meyer, Olga,M.D.

> Sent: Friday, May 18, 2001 3:11 PM

> To: Kelleher, Kathleen M., PHS - Telemedicine

> Subject: RE: Cambodia Project Patient #5

>

> Say Heang, 54 year old woman has mild systolic hypertension that should

> just be treated medically with a Betablocker, Ace inhibitor or a Diuretic.

> The patient should be counselled on weight and excercise. Once she is

> normotensive, and still has symptoms of chest discomfort with exertion,

> one might consider a sterss test. This woman is still young, and CAD is

> less likely. Also check her fasting cholesterol.

>

> In terms of her thyroid mass, she needs a TSH, a thyroid ultrasound and a

> fine needle aspiration. Differential diagnosis of a solitary nodule

> include: benign adenoma, thyroidcarcinomas, and lymphoma.

> If in fact, there might be multiple nodules present, then Hashimoto'

> thyroiditis, multinodular goiter.are most likely.

> The consensus is, that of all nodules ,only about 10-20 % are

> malignancies, all others are benign lesions mentioned above.

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "'David Robertson (E-mail)'" <davidrobertson1@yahoo.com>

Subject: FW: Cambodia Project Patient #88 - Chhay Channa, female, 31 years old

Date: Fri, 18 May 2001 15:31:21 -0400

Hi David:

Response for patient #8 is below.

By the way, I did not receive a clinical history or photos for patients #3 & #7.

Kathy

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

> From: Goodman, Annekathryn,Md

> Sent: Friday, May 18, 2001 3:21 PM

> To: Kelleher, Kathleen M., PHS - Telemedicine

> Subject: RE: Cambodia Project Patient #8

>

> Thank you very much for your consultation. This 31 year old woman complains

> of a malodorous vaginal discharge for seven years. I would be interested in

> obtaining some more history from her.

>

> Questions:

> -does she have any children?

> -if she has children, how did she deliver her children? When was the last

> child born? Did she experience any trauma from the delivery such as a perineal
> tear?
> -is she sexually active? What does she use for birth control?
> -has she been sexually or physically assaulted?
> -has she ever had any sexually transmitted infections?
> -has she had any abortions?
> -what medicines or home remedies has she used? Has she put anything in her
> vagina (medicines, douches, etc)
> -does she have any urinary problems?
> -does she have any problems having a bowel movement?
> -is she having monthly menstrual cycles? Has there been any change is her
> menstrual cycles?
> -Does she have any abnormal vaginal bleeding? Does she have any bleeding after
> sexual activity?
> -does she have any fevers, chills, night sweats?
>
> Work-up:
>
> -I would recommend obtaining a careful medical history with the questions
> outlined above.
> -In addition to a general physical examination, she needs a pelvic
> examination. This examination involves the following:
> -careful inspection of the vulva and perianal region. Look for signs of
> trauma, healing injuries, healing childbirth injuries.
> -look for ulcers or growths that may be secondary to infectious diseases
> such as herpes, chancroid, condyloma, or tumors
> -evaluate the vagina using a speculum. Look at the walls of the vagina.
> Look for discharge, ulcers, growths. Look at the exocervix. Evaluate the
> cervix for ulcers, bleeding, growths.
> -Acetic acid can be applied to the vagina and cervix. Premalignant

> lesions will look white after application of acetic acid.

> -take cultures of the cervix for gonorrhea and chlamydia.

> -do a wet prep of the vaginal discharge to look for yeast, "clue cells"

> (diagnostic for gardenerella vaginalis)

> -take a pap smear.

> -evaluate the vagina and cervix by bimanual examination. Feel for

> nodules, masses. Assess the size and shape of the cervix.

> -evaluate the uterus and ovaries by bimanual examination.

> -do a rectal examination. A rectovaginal examination is the best method

> of picking up ovarian masses in the cul de sac, evaluating the parametria for

> abnormalities that might suggest an advanced cervical cancer, and for

> evaluating the utero-sacral liga ments.

> -Her total body pain, right arm pain, and back pain may or may not be related

> to her gynecologic complaints. If she has an infectious disease, this may

> cause systemic symptoms. If she has an advanced infection with gonorrhea, she

> could develop gonococcal arthritis. Perhaps tuberculosis could cause these

> symptoms. We have seen several women from South East Asia who have had

> advanced TB with ascites and peritonitis.

>

> Please let me know if you have other questions.

>

> Sincerely yours,

>

> Annekathryn Goodman

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "David Robertson (E-mail)" <davidrobertson1@yahoo.com>

Cc: "Kvedar, Joseph Charles,M.D." <JKVEDAR@PARTNERS.ORG>

Subject: Telemedicine Clinic in Robib, Cambodia - 18 May 2001

Date: Fri, 18 May 2001 17:03:32 -0400

Dear David:

Here is a summary of today's activity:

Case #2 completed by Dr. Gilbert Daniels from MGH Department of Endocrinology

Case #4 completed by Dr. Olga Smulders-Meyer from MGH Department of Medicine

Case #5 completed by Dr. Olga Smulders-Meyer from MGH Department of Medicine

Case #7 completed by Dr. Mia MacCollin from MGH Department of Neurology

Case #8 completed by Dr. Anne Kathryn Goodman from MGH Department of Gynecologic Oncology

Case #1 will be completed by Dr. Lee Schwamm from MGH Department of Neurology

Case #9 will be completed by Dr. Neil Bhattacharyya from BWH Department of Otolaryngology

Case #10 will be completed by Dr. Jorge Arroyo from BWH Department of Ophthalmology

Photographs and clinical histories for case #3 and case #6 were missing from the document that you sent to me this afternoon so I am assuming that you decided not to send those two patients.

Kathy Kelleher

Senior Remote Consultation Coordinator

Partners Telemedicine

Two Longfellow Place, Suite 216

Boston, MA 02114

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Page: 617-724-5700 x28976

http://telemedicine.partners.org

From: "Kelleher, Kathleen M., PHS - Telemedicine" <KKELLEHER@PARTNERS.ORG>

To: "David Robertson (E-mail)" <davidrobertson1@yahoo.com>

Subject: FW: Cambodia Project Patient #10

Date: Mon, 21 May 2001 12:27:55 -0400

Two more cases will follow shortly.

Best regards,

Kathy

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

> From: Bhattacharyya, Neil,M.D.

> Sent: Monday, May 21, 2001 7:19 AM

> To: Kelleher, Kathleen M., PHS - Telemedicine

> Subject: FW: Cambodia Project Patient #10

>

>

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

> From: Neil Bhattacharyya [SMTP:neiloy@massmed.org]

> Sent: Sunday, May 20, 2001 8:06 PM

> To: Bhattacharyya, Neil,M.D.

> Subject: RE: Cambodia Project Patient #10 - Tann Hoeum, male, 9 years old

>

> Dear Kathy,

>

> Attached is a Microsoft Word file with my evaluation of the Cambodian case

> listed above. Thank you. Let me know if you cannot read the file.

>

>

> Best regards,

>

> Neil

>

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

> From: Bhattacharyya, Neil,M.D. [mailto:NBHATTACHARYYA@PARTNERS.ORG]

> Sent: Sunday, May 20, 2001 12:30 PM

> To: @home -- Neil (E-mail)

> Subject: FW: Cambodia Project Patient #10

RE: Tann Hoeum

Cambodian Medical Project

The patient is a nine-year-old young boy from Cambodia. The history is quite limited, but he has had a soft mass present in the nasal dorsum since birth (congenital). A clinical photograph accompanies the limited clinical information. He has a lesion located along the nasal dorsum, somewhat to the right of midline. It appears to have produced some overlying skin change with increased redness. There is pseudo-hypertelorism due to the mass. The left eye appears to be normal. The mass has some impact on the right orbital volume in the single frontal view that is available. The forehead and brow region appear normal.

This appears to be a congenital lesion, as it was present from birth. I do not have any history as to whether or not it is expanding. Several important factors need to be considered in the evaluation of this patient. First, he should have an ophthalmology consultation to assess the status of the right eye. Second, the most important study, if available would be a magnetic resonance imaging study with contrast of the facial skeleton and head. If that is not available, then I would recommend a CT scan of the facial skeleton and head to further delineate the origin and boundaries of this mass. This will narrow the differential diagnosis considerably. Clinically, the patient should be assessed for the presence or absence of cerebrospinal fluid leak from the nose, the status of the nasal air flow, and his sense of smell. Also, the presence or absence of epistaxis should be determined.

The differential diagnosis in this case is somewhat vast. Given that the lesion is probably congenital, and is involving the skin with increased redness and thickening of the skin itself, I would consider arteriovenous malformation as a likely possibility. A cavernous hemangioma is less likely. Importantly, one must consider meningocele or meningoencephalocele. Each of these entities can be well distinguished from one another with MRI imaging. Also included in the differential diagnosis would be congenital lesions such as dermoid cyst and teratoma. As the mass has been present since birth, I think infectious etiologies are much less likely, but possible. These would include syphilitic type infections or other very slowly progressing infections. Finally, neoplastic etiologies should be also considered. These would include soft tissue tumors, angiofibroma, osseous tumors or extracranial meningioma. Given the duration of the lesion, these are also unlikely.

In summary, the patient likely has a lesion since birth, which is unlikely to be a neoplasm, but could likely be a malformation or a very slow growing tumor. The most important element of his evaluation will be the imaging studies. Also, and endoscopic examination of the nose should be performed, with potential biopsy. However, no biopsy should be undertaken until the possibility of a vascular lesion or meningocele has been excluded.

Thank you.

Sincerely,

Neil Bhattacharyya, MD, FACS

Assistant Professor of Otology and Laryngology

Harvard Medical School

Brigham and Women's Hospital

David Robertson, coordinator for the Telemedicine project (left) and Sihanouk Hospital Center of Hope nurse Koy Somontha (right) outside the Robib Health Clinic with patients waiting for transport to the hospital.

Nurse Montha helps the staff at Kampong Thom Provincial Hospital perform an EKG on a Robib village Telemedicine patient.