Robib and Telemedicine

Robib Telemedicine Clinic November 2004

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

On Tuesday, November 2, 2004, SHCH staff, Nurse Koy Somontha, PA Rithy Chau, and Dr. Paul Heinzelmann (from Boston) traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic. Dr. Heinzelmann came to visit the project in Robib to perform need assessment for this TM project as well as bringing in a "lab in a box" in hope to faciliate the work of nurse Montha. He also investigated the idea of how IT could be used to improve the turn around time for Montha's assessment and management of his patients in relation to SHCH's and Boston's replies.

The following day, Wednesday, November 3, 2004, the Robib TM clinic opened to receive the patients for evaluations. There were 7 new cases and 6 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 Friday, November 5, 2004, replies from SHCH in Phnom Penh and the Partners Telemedicine in Boston were downloaded. Per advice from Boston, SHCH, Dr. Paul Heinzelmann and PA Rithy (on location), Nurse Montha managed and treated the patients accordingly. There were also 10 patients who came for refills of medications. 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, October 25, 2004 3:18 PM
To: Thero Noun; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Glenn Geeting; Paul J. M.D. Heinzelmann; Gary Jacques; Joseph Kvedar; Jack Middlebrook
Cc: Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Kiri; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: Robib TM for November, 2004

Dear all,

I am writing to inform you for Robib TM of November, 2004.

Here is the schedule for trip,

- On Tuesday (02/11/04) leave PP to the village.
- On Wednesday (03/11/04) clinic will be started at 8 am for full day.
- On Thursday (04/11/04) all patient's data will be sent to Telepartner in Boston and SHCH.
- On Friday (05/11/04) all data will be collected and also do treatment plan to follow the instructions, and then come back to PP.

Thank you very much for your strong cooperation.

Beast Regards,

Montha

-----Original Message-----
From: TM Team [mailto:tmrural@yahoo.com]
Sent: Wednesday, November 03, 2004 9:30 AM
To: Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar; Nancy Lugn; Cornelia Haener; Ruth Tootill; Rithy Chau; Glenn Geeting; Gary Jacques; Jack Middlebrook; bhammond@partners.org
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Robib TM Clinic November 2004

Dear All,

Please be informed that the Robib TM Clinic for November 2004 has begun today at 8AM Cambodian time. Mr. Rithy and Dr. Paul Heinzelmann from Boston are visiting. Please try to reply to all cases by Friday, November 5th, before 10AM Cambodian time.

Thank you for your cooperation.

Best Regards,

Rithy for Montha

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

Patient: Som Thol, 57M (Thnout Malou)

Subject: 57M, comes back for his follow up of DMII with PNP. He gets better so much with his previous symptoms by decreasing blurred vision, decrease numbness, no chest tightness, no fever, no cough, but gets SOB during long walking, (+) epigastric pain, (+) floating, no vomit, no diarrhea, no stool with blood.

Object:

VS: BP 140/50 P 100 R 22 T 36.5C Wt 58 kgs

HEENT: Unremarkable

Neck: (-) JVD, (-) lymphnode

Lungs: Clear both sides, no crackle, no wheezing

Heart: RRR, no murmur

Abdomen: soft, flat, no tender, (-) HSM, (+) BS

Limbs: (-0 peripheral edema, no deformity

Neuro Exam: unremarkable, but decrease reflex on the both knees and ankles

Previous Labs/Studies: None

Lab/Study Requests: BS= 146mg/ dl, Hgb= 13g/dl, UA (Negative)

Assessment:

1. DM II with PNP
2. Dyspepsia

Plan: I would like to cover him with the same medications like last month

1. Diamecron 80mg 1t po q8 for for one month
2. Amitriptilline 1t po q12 for one month
3. Captopril 25 mg 1/4t po qd for one month
4. Cimetidine 400mg 1t po q12 for one month
5. Feet care education

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

Examined by: Koy Somontha, RN **Date: 03/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 12:11 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient # 01 Som Thol, 57M (Thnout Malou)

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Thursday, November 04, 2004 11:52 AM
To: Fiamma, Kathleen M.
Subject: RE: Patient # 01 Som Thol, 57M (Thnout Malou)

I'm glad to hear he is feeling better. Diamicron could be given once a day, why 3 times a day? I would keep an eye on his blood pressure. If it still remains above 130/80 on followup, increase captopril dose for better control. Vitamin B complex tablets may help with his neuropathy.

Heng Soon Tan, M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 8:04 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn

Subject: RE: Patient # 01 Som Thol, 57M (Thnout Malou)

Dear Montha and team:

This patient's blood glucose appears to be well-controlled-- I agree with your plan to continue the Diamecron at the same dose.

There is no mention of whether his PNP is stable, better or worse. Does the dose of his amitryptline need to be changed?

A 57 year old diabetic male is at high risk of cardiovascular disease. A complaint of shortness of breath on exertion and epigastric pain must be taken seriously and investigated thoroughly to be sure it is not related to cardiac ischemia. Please take a good history and consider performing and ECG to evaulate the liklihood of ischemia.

I do not know what a complaint of "floating" means.

Best regards,

Jack

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

Patient: Moeung Srey, 42F (Taing Treuk)

Subject: 42F, returns for her follow up of stable HTN, and Anemia due to Iron deficiency. She still has no SOB, no head ache, no fever, no cough, no blurred vision, no chest pain, no stool with blood, no vomit, but still has mild epigastric pain, pain like dullness, and also radiating to chest.

Object: look stable

VS: BP 130/70 P 80 R 20 T 36.5C Wt 63 Kgs

HEENT: unremarkable

Neck: unremarkable

Lungs: clear both sides

Heart: RRR, no murmur

Abdomen: soft, flat no tender, (+) BS, (-) HSM

Limbs: No peripheral edema

Previous Labs/Studies:

Lab/Study Requests:

Assessment:

1. **Controlled HTN**

2. **Dyspepsia**

3. **Iron deficiency**

Plan: I would like to cover her with some medications

1.Captopril 25mg 1/2t po q12 for one month

2. Omeprazole 20mg 1t po q12 for one month

3. Fer 200mg 1t po qd for one month

4. Multivitamine 1t po qd for one month

5. do exercise

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

Examined by: Koy Somontha, RN Date: 03/11/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 12:12 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient # 02 Moeung Srey, 42F (Taing TreuK)

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Thursday, November 04, 2004 11:56 AM
To: Fiamma, Kathleen M.
Subject: RE: Patient # 02 Moeung Srey, 42F (Taing TreuK)

Perhaps it's time to offer her empiric treatment for H. pylori gastritis seeing that she has persistent dyspepsia despite omeprazole. Refer to Paul's note:

Finally, because of a high incidence of H. pylori, empirical treatment with triple/quadruple drugs may become a good option if the abdominal pain has been persistant [I am not certain how long she has had pain](eg amoxicillin 1 gram/clarithromycin 500mg/ and proton pump inhibitor(ie omeprazole 20mg) all BID for 2 weeks, OR 2. bismuth QID/tetracycline 500 QID/metronidazole 500mg TID/omeprazole 20 BID....or other combo)

Heng Soon Tan, M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 8:22 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie

Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient # 02 Moeung Srey, 42F (Taing TreuK)

Dear Montha and team:

A blood pressure of 130/70 is acceptable, but not ideal. While a height is not given, I suspect a weight of 63 kgs means that this patient might be overweight-- has she been counseled on strategies for weight loss? Frequently weight loss of even a few kgs can result in significant decreases in blood pressure.

Your history notes that the patient has no chest pain, but then describes epigastric pain with radiation to the chest. The history should be much more detailed regarding these complaints-- a hypertensive patient with symtpoms like this should be considered for the possibility of ischemic heart disease and evaluated appropriately.

Best regards,

Jack

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

Patient: Pang Sidoeun, 31F (Thnout Malou)

Subject: 31F, comes backs for her follow up of HTN, and Headache. Now, she feels much improving with previous symptoms like decreasing headache, no SOB, no fever, no chest pain, no cough, no GI complains, but she feels poor sleep, mild palpitation, mild eye fatique

Object: looke stable

VS: BP (L) 170/90, (R) 180/100 P 108 R 20 T 37C
Wt = 35 Kgs

HEENT: unremarkable, but her conjunctiva is mild pale

Neck: (-) JVD, (-) lymphnode, no bruit

Lungs: clear both sides

Heart: RRR, (+) mild murmur at apex

Abdomen: Soft, flat, no tender, (+) BS, (-) HSM

Extremities: no o peripheral edema,

Previous Labs/Studies: none

Lab/Study Requests: Hgb= 11g/dl, UA (Specific gravity 1.005)

Assessment:

1. Uncontrolled HTN
2. Tension headache
3. Thyroide dysfunction?

4. Anemia?
5. VHD?
6. Anxiety?

Plan: we would like to change her HTN medications from HCTZ to Propranolol

1. Propranolo 40mg 1t po q12 for one month
2. Multivitamine 1t po qd for one month
3. ASA 300mg 1/4t po qd for one month
4. Paracetamol 500mg 1t po q6 for (PRN)
5. Encourage her to drink more water, vegetable, fruit, and exercise.
6. Dwaw her blood for TSH, T4, Lyts. Creat (These, will be sent to SHCH)

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

Examined by: Koy Somontha, RN Date: 03/11/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 8:24 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient # 03 Pang Sidoeun, 31F (Revieng Tbong)

Dear Montha and team:

I agree with your assessment and plan for evaluation of this patient, and agree that her hypertension requires much better control.

Why do you want to stop the HCTZ? I would continue it at the present dose (which would be helpful to include in your note) and add the propranolol-- most patients require more than one drug to acheive good control of blood pressure.

Best regards,

Jack

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

Patient: Nget Soeun, 56M (Thnout Malou)

Subject: 56M, comes back for his follow up of liver cirrhosis. He have no fever, no cough, no chest pain, no SOB, no GI complain, no peripheral edema, good appetite.

Object: look mild dehydrate

VS: BP 90/60 P 70 R 20 T 36.5C Wt 40kgs

HEENT: unremarkable

Neck: No goiter, no JVD, no lymphnode

Lungs: clear both sides

Heart: RRR, no murmur

Abdomen: Soft, flat, no tender, no HSM, (+) BS

Extremities: no peripheral edema

Skin: poor skin turgor

Previous Labs/Studies: none

Lab/Study Requests: UA (Specific gravity 1.030)

Assessment:

1. Liver Cirrhosis
2. Mild dehydration
3. Mulnutrition

Plan: I would like to cover her with some the following medications

1. Spironolactone 50mg 1/2t po qd for one month
2. Propranolol 400mg 1/4t po qd for one month
3. Multivitamine 1t po qd for one month
4. Encourage him to drink more water, vegetable and also fruit

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

Examined by: Koy Somontha, RN Date: 03/11/04

Please send all replies to tmrural@yahoo.com and cc: to

tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 12:08 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient # 04 Nget Soeun, 56M (Thnout Malou)

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Thursday, November 04, 2004 11:16 AM
To: Fiamma, Kathleen M.
Subject: RE: Patient # 04 Nget Soeun, 56M (Thnout Malou)

Seeing that he has no ascites or variceal bleeding, and if serum albumin could be tested and found to be above 3 g/dl indicating adequate liver synthetic function, he may be able to stop the spironolactone and propranolol. Avoid more than 3g Tylenol and other hepatotoxic drugs. If he has not been encephalopathic, he need not restrict dietary protein. Low salt and adequate protein intake should be emphasized.

Tan, Heng Soon,M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 8:26 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient # 04 Nget Soeun, 56M (Thnout Malou)

Dear Montha and team:

If would be helpful include the etiology of this patient's cirrhosis, if known.

I agree with your plan.

Jack

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

Patient: Sok Piseth, 12F (Kam pot)

CC: Fever, SOB, productive cough for 3 days

HPI: 12F, for 3 days she has high fever (39C), SOB, productive cough, and also accompany by headache, poor appetite, but she has no chest pain, no GI complain, no peripheral edema. When she gets these symptoms her grand mother gave her some drugs like Paracetamol 500mg 1/2t po q8 for 3 days, Amoxicilline 250mg 1t po q12 for 3 days, but her symptoms were released a little bit.

PMH: She was unconscious for 7 days when she was 7 years old

SH: Unremarkable

FH: Unremarkable

Allergies: NKA

ROS: no weight loose, (+) fever, (+) SOB, no sore throat, (+) productive cough, no chest pain, no GI complain, no peripheral edema.

Current medications: Paracetamol and Amoxicilline for 3 days

PE:

VS: BP 80/ 40 P 140 R 48 T 37C Wt 20 kgs

Gen: Look respiratory distress

HEENT: no oropharyngeal lesion, no pale,

Neck: no JVD, no lymphnode

Chest: Lungs: Wheezing all lobes, crackle at bilateral lower lobes. Heart: RRR, systolic murmur with Tachycardia

Abd: Soft, flat, no tender, no HSM, (+) BS

MS/Neuro: not done

Other: Limbs: no peripheral edema

Previous Labs/Studies: none

Lab/Study Requests: UA (Proteine +, Specific gravity 1.030)

Assessment:

1. Acute Asthma 2. Pneumonia?
3. Mild dehydration?
4. VHD? (RM?, MS?)

Plan: I discussed with Dr. Paul comes from Boston. He would recommends me to give her right the way of

1. Dexamethazone 12mg IV and then 30mg qd for 4 days later
2. Augmentine 750mg 1t q12 for 10 days

3. Multivitamine 1t po qd for one month

4. Encourage her to drink more water and also eat

Comments: I would like to refer her to KG Thom Hospital for CXR and EKG. Do you agree with my plan? Please, give me a god idea.

Examined by: Koy Somontha, RN Date: 03/11/04

Note: This morning on 04/11/40 she comes to meet us again for evaluation. Her condition is getting better by decreasing SOB, decreasing wheezing, no fever, but still cough.

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 1:46 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh.'
Subject: FW: Patient number 05, Sok Piseth 12F (Kam Pot)

-----Original Message-----
From: Haver, Kenan E., M.D.
Sent: Thursday, November 04, 2004 1:27 PM
To: Fiamma, Kathleen M.
Subject: RE: Patient number 05, Sok Piseth 12F (Kam Pot)

The wheezing and response to steroids makes me strongly consider asthma, especially since it sounds like she has had similar episodes in the past. The fever may be due to an infection that triggered her asthma. She may also have pneumonia. Given the duration TB is unlikely but worth considering. Why was she unconscious for 7 days?

1. change to prednisolone 20 mg twice per day

2. start albuterol 2 puffs q 4h and then as needed, up to every 4 hours

3. place a PPD and control

4. continue antibiotics

If she improves on steroids and bronchodilators the CXR is not immediately necessary. If not, I would agree that one could be helpful

Kenan Haver, M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 8:45 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie

Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient number 05, Sok Piseth 12F (Kam Pot)

Dear Montha and team:

I am glad the patient is better. If her improvement is significant, I do not think it is necessary to refer her to the hospital. The most important part of the plan for her would be to start her on inhaled beta agonists; for example, albuterol MDI or salmeterol MDI. She should be closely followed-up (within a few days intially) and if her symptoms are not controlled, she should be started on an inhaled steriod MDI. Chronic oral steroids have severe side effects and should not be considered unless all other options have failed.

Asthma requires significant patient and family education about triggers and mangement, and should be started on her visit today.

Best regards,

Jack

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

CC: Neck tension at the back, blurred vision on and off foe 3 years. Epigastric pain on and off for 2 years.

HPI: 58F, farmer, she has known HTN for 3 years. She feels having neck tension at the back, blurred vision during her BP comes up, malaise, SOB during heavy work, but she has no fever, no cough, no chest pain, no headache. She took drugs for HTN on and off only during her BP increase as well.

She has another complaint about abdominal pain on and off on epigastric area. Pain likes dullness, radiating to chest, it gets worse after meal, but she has no nausea, no vomiting, no stool with blood. She used to take some stomach upset medications also during her epigastric pain get more pain, drugs helps her a lot but she just took it for as few days and then stop.

PMH: Unremarkable

SH: unremarkable

FH: her mother has HTN

Allergies: NKA

ROS: no wieght loose, no fever, no cough, no chest pain, no dizziness, (+) SOB on heavy work, (+) epigastric pain, no stool with blood, no peripheral edema.

Current medication: Unknown Anti HTN for last 3 days

PE:

VS: BP (R) side 180/100, (L) side 190/90 P 80 R 20 T 36.5C Wt 45 Kgs

Gen: look stable

HEENT: no oropharyngeal lesion, no pale on conjunctiva

Neck: no JVD, no lymphnode, no goiter seen

Chest: Lungs: clear both sides. Heart: RRR, (+) murmur at pulmonic area

Abd: Soft, flat, (-) HSM, no tenderness, (+) BS

MS/Neuro: not done

Other: limbs: no peripheral edema, no numbness

Previous Labs/Studies: none none

Lab/Study Requests: UA (Negative), Colo check (Negative), Hgb= 11g/dl

Assessment:

1. Severe HTN

2. Dyspepsia

3. VHD?

Plan: I would like to cover her with some drugs as the following

1. Propranolol 40mg 1/2t po q12 for one month

2. H. pylory treatment and go on with Omeprazole 20mg 1t po qhs for 1 month

3. Distriction spicy food, coffee, fatty food.

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

Examined by: Koy Somontha, RN Date: 03/11/04

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Thursday, November 04, 2004 10:45 PM
To: 'tmrural@yahoo.com'

Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient # 06 Sam An, 58F (Thnout Malou)

-----Original Message-----
From: dsands@bidmc.harvard.edu [mailto:dsands@bidmc.harvard.edu]
Sent: Thursday, November 04, 2004 8:58 AM
To: Fiamma, Kathleen M.
Subject: RE: Patient # 06 Sam An, 58F (Thnout Malou)

I am concerned about this patient's heart-she may have ischemic heart disease. Her intermittently blurred vision and weakness are also consistent with diabetes mellitus.

I would recommend:

* ECG and (after her BP is better controlled) a stress test

* Blood glucose (or at least urine for glucose as a crude measure)

I agree with your plan to treat her dyspepsia.

For her blood pressure, if you treat her with regular (short-acting) propranolol, it should be given three times per day. I'd give her 20mg three times per day to start. A better treatment would be hydrochlorothiazide 25 mg once daily. Either way, BP needs to be reassessed in one month.

- 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

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 8:49 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient # 06 Sam An, 58F (Thnout Malou)

Dear Montha and team:

I agree with your assessment and plan.

Best regards,

Jack

Patient: Svay Tevy, 40F, Farmer (Thnout Malou)

CC: Frequency for urination, thirsty for one year and burp, epigastric pain on and off for 1 year as well.

HPI: 40F, farmer, she, herself has known DMII for 1 years. Now she has frequency of urination, thirsty, very hungry, mild headache, muscle pain, but no chest pain, no fever, no SOB, no cough. She also has epigastric pain, pain like dullness, pain gets better after meal, but she has nausea, sour test after burping, excessive saliva in the morning as well. She has regular period.

PMH: Unremarkable

SH: unremarkable

FH: unremarkable

Allergies: NKA

ROS: (-0 weight loose, no fever, no cough, no SOB, no dizziness, no chest pain, (+) epigastric pain, no stool with blood, no peripheral edema, has regular period.

PE:

VS: BP 130/80 P 80 R 20 T 36.5 C Wt 60 kgs

Gen: look stable

HEENT: no oropharyngeal lesion, no pale on conjunctiva

Neck: no goiter seen, no JVD, no lymphnode palpable

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

Abd: Soft, flat, no tender, (+) BS, no HSM

MS/Neuro: unremarkable

Other: Limbs: no peripheral edema, no disformity

Previous Labs/Studies: none

Lab/Study Requests: UA (Glucose +4), BS = 249mg/dl, microalbuminuria (Negative)

Assessment:

1. DMII
2. GERD?

Plan: I would like to cover her with some medications as the following

1. Diamecron 80mg 1/2t po qd for one month
2. Omeprazole 20mg 1t po q12 for one month
3. Do exercise and reduce sugar in diet

4. DM education

5. Follow up next trip for BS checking

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

Examined by: Koy Somontha, RN **Date: 03/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 12:09 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient # 07 Svay Tevy, 40F (Thnout Malou)

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Thursday, November 04, 2004 11:33 AM
To: Fiamma, Kathleen M.
Subject: RE: Patient # 07 Svay Tevy, 40F (Thnout Malou)

GERD can be treated with just once a day omeprazole just before the time of greatest symptoms. It can be increased to twice a day only if symptoms breakthrough 12h later.

She has uncontrolled diabetes. Perhaps you should develop a short course on understanding diabetes in the form of an illustrated brochure or checklist that can be shared with patients newly diagnosed with diabetes so they understand the importance of a diabetic diet [restricted total calories, distributed evenly through the day, and not just avoidance of sweets or carbohydrates], weight control, and effects of exercise on blood glucose.

Heng Soon Tan, M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 8:51 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient # 07 Svay Tevy, 40F (Thnout Malou)

Dear Montha and team:

I agree with your plan.

Jack

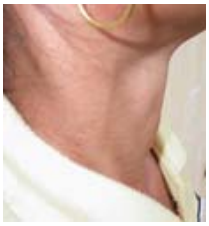
Robib Telemedicine Clinic
Sihanouk Hospital Center of HOPE and Partners in Telemedicine Rovieng Commune, Preah Vihear Province, Cambodia

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

Subject: 41F, farmer, comes back for her follow up of Low THS with normal T4. She has been covered with Iron + folic Acide and also Multivitamine for 4 months already. She still has palpitation, SOB on exertion during climbing step, neck tightness, but she has no headache, no fever, no peripheral edema.

Object: look stable

VS: BP 136/70 P 94 R 20 T 36.5C Wt 42Kgs



HEENT: unremarkable

Neck: goiter enlarge diffusely, none tender, goiter's size 5 cm

Lungs: clear both sides

Heart: RRR, no murmur

Abdomen: soft, flat, no tender, (+) BS, (-) HSM

Limbs: no peripheral edema

Previous Labs/Studies: T4= 15pml/l, TSH=0.21 microIU/ml

Lab/Study Requests: none

Assessment:

1. Euthyroide
2. Anxiety?

Plan: I would like to cover her with some medications as the following

1. Propranlol 40mg 1/4t po qd for one month
2. Multivitamine 1t po qd for one month
3. Recheck TSH at SHCH

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

Examined by: Koy Somontha, RN **Date: 03/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 12:10 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient # 08 Chhay Chanthy, 41F (Thnout Malou)

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Thursday, November 04, 2004 11:46 AM
To: Fiamma, Kathleen M.
Subject: RE: Patient # 08 Chhay Chanthy, 41F (Thnout Malou)

I don't have the reference range for your thryoid profile, but I presume from the text that the thyroid numbers represent low TSH and normal T4. Clinically she could be thyrotoxic with enlarged thryoid, tachycardia and dyspnea. In the history, does she have weight loss, fatigue, change in behavior, easy sweating and feeling excessively warm, tremors, menstrual changes, frequent bowel movements? On exam, does she have a bruit at the thyroid gland? She does not have proptosis, but does she have lid retraction, lid lag, tremors, warm skin, and hyperreflexia? If she is clinically thyrotoxic, perhaps she has T3 thyrotoxicosis with normal T4 levels. I suppose one could consider a month's trial with methimazole to monitor response if T3 cannot be tested. Positive TPO thyroid antibody test would make you favor thyrotoxicosis. Besides anxiety, the differential diagnosis includes anemia. I see that she is not in heart or lung failure, and presumably not in renal failure, but a BUN/creatinine test would confirm that.

Tan, Heng Soon,M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 9:00 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient # 08 Chhay Chanthy, 41F (Thnout Malou)

Dear Montha and team:

A women with shortness of breath and neck tightness on exertion must be considered for cardiovascular disease-- please perform an appropriate evaluation by history and possibly ECG.

Is propranolol a new medication for her? If so, what is the indication? It is not an appropriate treatment for anxiety alone. Otherwise, I agree with your plan.

Best regards,

Jack

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

Patient: Prum Savoeun, 36F, Farmer (Thnout Malou)

Subject: 36F, farmer, comes back for her follow up of Anemia due to Malaria

infection. She has much improving with previous symptoms by increasing appetite, increase weight for 3 Kgs, no dizziness, no SOB, no headache, n fever, no cough, but she complain about pain on epigastric area, pain like dullness, radiatingting to the chest, it can be subsided by taking medication like CImetidine, in the meanwhile, she has no burp, no nausea, no vomiting, no dark stool.

Object: look stable

VS: BP 100/50 P 80 R 20 T 37C Wt 50kgs

HEENT: Unremarkable

Neck: no JVD, no lymphnode, no goiter seen

Lungs: clear both sides

Heart: RRR, no murmur

Abdomen: soft, flat. tender, no pain during palpable, (+) BS, (-) HSM

Limbs: no peripheral edema

Previous Labs/Studies: none

Lab/Study Requests: none

Assessment:

1. Dyspepsia
2. Anemia due to Malaria

Plan: I would like to cover her with some medications as the following

1. Cimetidine 400mg 1t po q12 for one month
2. Multivitamine 1t po qd for one month

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

Examined by: Koy Somontha, RN **Date: 03/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 1:44 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh.'
Subject: FW: Patient # 09 Prum Savoeun, 36F (Thnout Malou)

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

From: Ryan, Edward T.,M.D.
Sent: Thursday, November 04, 2004 12:30 PM
To: Fiamma, Kathleen M.
Subject: RE: Patient # 09 Prum Savoeun, 36F (Thnout Malou)

Yes, I agree with cimetidine.

If the symptoms persist, would treat for helicobacter pylori.

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: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 9:07 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient # 09 Prum Savoeun, 36F (Thnout Malou)

Dear Montha and team:

Was the patient's stool ever tested for occult blood? In addition to malaria, her epigastric pain could be a symptom of a chronically bleeding gastric ulcer that might be contributing to her anemia. If so, iron studies could be useful to determine if she requires iron supplementation.

Otherwise, I agree with you plan.

Jack

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

Patient: Tienn Sin, 65F, Doang Village

Chief complaint: Fever, cough, weight loss, right-sided upper and lower extremity weakness

HPI: 65 yo female was brought to our attention by her son,

the vice superintendent of local school system who requested a home visit. According to her son and other family members, the patient's condition began to deteriorate most notably two weeks ago with an apparent bought of painful herpes zoster involving her right lateral chest wall. Several days after appearance of the rash, her condition worsened with intermittent fevers, decreasing appetite, cough, dysphagia, non-verbal communication or response and right-sided weakness. She became unable to ambulate and care for herself; family members began assisting with ADLs such as feeding and bathing.

A "nurse" assisted with home visits including IV fluids and unknown IV antibiotics. Over the past three days, her PO intake has become almost non-existent and occasionally choking on spoon feedings of milk-based foods. Her mental status has deteriorated, and is non-verbal, but does occasionally follow simple commands upon repeated request.

Yesterday, a local traditional healer performed some treatments that included a small burn on skin of abdomen.

Husband was diagnosed with active TB in 1981, treated and recovered. Over the past year, he has had a intermittent cough with sputum production.

[note: history obtained from family members]

PMH: uncertain

Allergies: NKDA

SH: tobacco (snuff) for many years, ETOH

ROS: intermittent fevers and cough over the past year, notable WT loss over past month

PE:

General: very lethargic, cachetic (see photo)

Glasgow CS: 8 (Motor 4, Verbal 1, Eye opening 3)

Vitals: Pulse 110, BP 94/60, R 24, Temp: 37.5, WT: est 35 kg

HEENT: PERRLA, EOMI, no nystagmus observed (+ arcus senilus bil)

OP: Dry mucous membranes, + oral thrush on tongue/buccal mucosa/throat

Neck: supple, no bruits

Lungs: rhonchi noted bilaterally (ant & post) toward central chest

Decreased breath sounds R upper post chest

Heart: tachycardic, reg rhythm, no murmur

Abdomen: flat, +BS, several small (1-3 cm) mobile, soft masses were palpable subcutaneously, no HSM; Faint aortic pulsations palpable

Skin: + tenting on dorsum of hands and abdomen (see photos)

Prominent periumbilical vessels

Dry, flaking skin on abdomen

2 Pressure ulcers noted on sacrum: 2x3 cm, pick not draining (see photo)

Extremeties: Flaccid R UE & LE , but distal motor function present

Rectal: Poor tone, no gross visable blood, soft dark yellow stool passed involuntarily right after DRE

Neuro: + gag reflex

+ response to sternal rub decreased sensation to pinprick on R LE, but present distally approx 5 cm above lat malleolus

patella reflexes: +1 B

Babinski reflexes: downward bil

Psych: lethargic, non-verbal, follows simple commands on repeated reques

Labs: Glucose: 285 (pt on D10 upon arrival)

Hemoglobin: 9 (est. with color test) estimated HCT: 27 (HGB x3)

Stool guaic: + occult blood U/A: WNL

Assessment:

1. Severe dehydration and cachexia – secondary to decreased PO intake
2. CVA with R-sided flaccid paralysis of UE & LE?
3. Sacral Pressure ulcers
4. Oral thrush; probable esophogitis?
5. Chronic cough intermittant– consider TB, lung CA
6. GI bleeding – upper vs lower – consider gastritis, ulcer, GI CA
7. Anemia - may be multifactorial including:
    i. Iron deficiency anemia
        1. GI bleeding
    ii. B12/Folate deficiency
    iii. Anemia of chronic disease

Plan:

1. IV fluids upon arrival pt was noted to be on slow IV drip of D10. Patient was transferred to the health center, IV fluids were given by bolus (.5 L of LR, .5 D5/NS).

   Maintainance IV fluids LR given overnight and continued 1 more liter next day

2. B vitamin IV
3. Repositioning every 2 hours and dressing change
4. PO challenge with soft milk-based food

5. Ceftriaxone 1g IV qd x 10d

6. Re-assess in am and consult MDs through telemedicine for referral to SHCH in Phnom Penh

Follow up:

Subjective: Pt remained stable overnight. Was able to take small amounts of milk-based food PO without choking/aspiration. Patient with + urine output and bowel movement. Increased distal motor movement in upper and lower extremeties.

Lab/Study Requests: Referral to another tertiary center SHCH For further workups—other blood works, CXR, abd U/S.

Comments: If you agree to have her sent to SHCH (Phnom Penh), can we send her by taxi on Saturday? Please provide clinical and any valuable educational pearls in the management of this case.

Examined by: Dr. Paul Heinzelmann and Rithy Chau, PA-C **Date: 3/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 1:21 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient number 10 Tienn Sin, 65F (Doang)

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Thursday, November 04, 2004 12:22 PM
To: Fiamma, Kathleen M.
Subject: RE: Patient number 10 Tienn Sin, 65F (Doang)

She is quite ill. It does sound like there is an underlying serious illness that presented with weight loss, fever and coughing earlier. Tuberculosis would be a good bet given the environmental exposure. She used snuff tobacco but did not smoke and had no hemoptysis, but lung cancer should also be considered. The history of herpes zoster and candidal esophagitis/mucositis suggest immunosuppression, differential diagnoses include AIDS or underlying cancer. In any case, she very likely aspirated and developed pneumonia, though most aspiration pneumonia tend to be in the right middle lobe, though it could occur in superior segment of right lower lobe. I'm impressed by the lethargy that could be delirium or metabolic encephalopathy from the acute illness. I'm not sure whether the flaccid hemiparesis represents a stroke. You could have flaccid hemiparesis acutely after a stroke but after 2 weeks I would expect some spasticity with abnormal Babinski reflexes. I wonder whether she could have a tuberculous or malignant meningoencephalitis related to the underlying illness. In any case, she needs to be hospitalized, and if taxicab transport is the only mode available, then she has to travel by taxi. I agree with IV fluids and ceftriaxone. Further therapy will be determined by results from blood testing, sputum cultures for bacteria and AFB, CXR and perhaps lumbar puncture.

Heng Soon Tan, M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 9:17 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar; Cornelia Haener
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient number 10 Tienn Sin, 65F (Doang)

Dear Paul and Rithy:

This woman sounds like she would benefit from admission. At the very least, she should be assessed for aspiration pneumonia, and for evaluation and management of her swallowing/nutritional status and decubitus ulcers. Family teaching will be key.

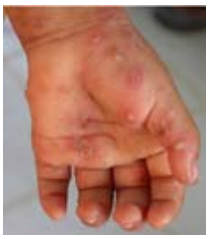
Please let me know when we can expect her to arrive so that a bed can be made available.

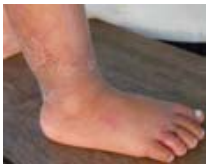
Thanks!

Jack

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

Patient: San Daov, 18 mo. F, Taing Treuk





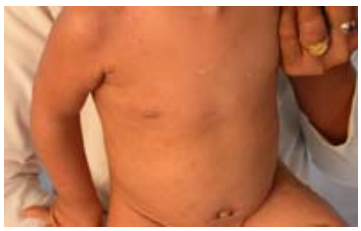
CC: Itchy rashes over body x 2 mo.

HPI: 18 month old female child was brought to the clinic by her aunt (who cared for her) and was told that she has itchy rashes all over the body with fever at the beginning of the episode 2 months ago. Small red rashes, some with pus covering entire body sparing facial area; one cluster of rashes on her right posterior scalp. No conjunctivitis, no cardiopulmonary c/o, no GI c/o; rashes covered her soles and palms as well (see photos). Used paracetamol and topical cream (steroid?); no new soap or perfume product; no new household product.

PMH: None

SH: unremarkable

FH: Mother lives in Phnom Penh City; separated with husband; mother without STD hx; Pt lives with her aunt.



Allergies: NKDA

ROS: drink milk

PE:

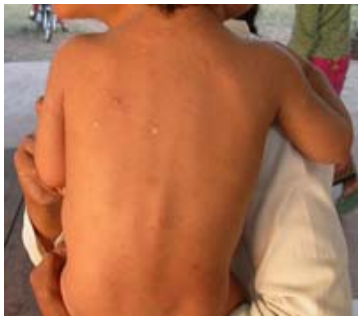
VS: BP P 100 R 18 T 37.45 Wt 8kg

Gen: Good looking, playful child,

HEENT: unremarkable

Chest: CTA bilat, HRRR no murmur

Abd: unremarkable



MS/Neuro/Skin: Genralized popular, macular rashes 0-1cm, some with pus, pruritus, involving palms and soles, groin and axillary, and scalp (with honey color crust on posterior aspect of her right parietal) but not face and ears. No lymphadenopathy, motor and sensory intact, good muscle strength, good turgor, warm to touch

Other: N/A

Previous Labs/Studies: none

Lab/Study Requests:

Assessment:

1. Eczema with secondary infection
2. Scalp impetigo
3. Viral exanthema
4. Erythema multiform??
5. Syphillis??

Plan:

1. Cephalexin 250mg 1tsp bid x 14d
2. Paracetamol/dihypheniramine 500/25mg ¼ tab po tid prn
3. Hydrocortisone cream 1% apply on affected areas (avoid face) bid x 1wk

Comments:

Examined by: Rithy Chau, PA-C **Date: 3/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

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

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 3:52 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: RE: Patient number 11San Daov, 18moF (Taing Treuk)

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

From: Kvedar, Joseph Charles,M.D.

Sent: Thursday, November 04, 2004 3:50 PM

To: Fiamma, Kathleen M.

Cc:

Subject: FW: Patient number 11 San Daov, 18moF (Taing Treuk)

Because of the chronic nature of this rash, differential diagnoses include:

Most likely it is Scabies with a super-infection

Other Possibilities:

Atopic Dermatitis with bacterial superinfection or bullous impetigo

There is no harm in treating her for scabies. Please ask the rest of the family if they have been having any itchy rashes, and if so the entire family needs to be treated. Getting rid of the mites is critical in the treatment of scabies. Everyone in the family or group, whether itching or not, should be treated at the same time to stop the spread of scabies.

Bedding and clothing must be washed. Do all the laundry with the hottest water possible. The mite is attracted to scent.

We recommend for treatment at this time:

1. Cephalexin 250mg 1tsp bid x 14d

2. Paracetamol/dihypheniramine 500/25mg ¼ tab po tid prn

3. **Triamcinolone Acetonide Cream** apply on affected areas (avoid face) bid x 1wk

4. **Permethrin 5% Cream- (for scabies)** applied to the skin from the neck down at bedtime and washed off the next morning. The cream should be applied to dry skin over the entire body (including the palms of the hands, under finger nails, soles of the feet, and the groin) and left on for 8 to 14 hours (overnight). A second treatment one week later may be recommended. Side effect of 5% percent permethrin cream includes mild temporary burning and stinging

   If Permethrin is not available-10% percent sulfur ointment and **crotamiton cream** may be used for infants.

Joseph C. Kvedar, M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 9:24 AM
To: TM Team
Subject: RE: Patient number 11San Daov, 18moF (Taing Treuk)

Dear Montha and Rithy:

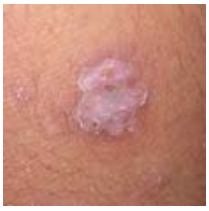
Not being a dermatologist, I'll let the folks in Boston handle this one, as well as case 12.

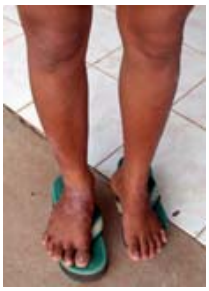
Best regards,

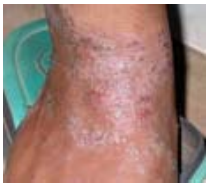
Jack

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

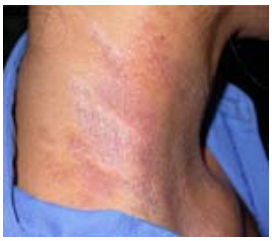
Patient: Teng Hem, 25F, Ta Tong Village



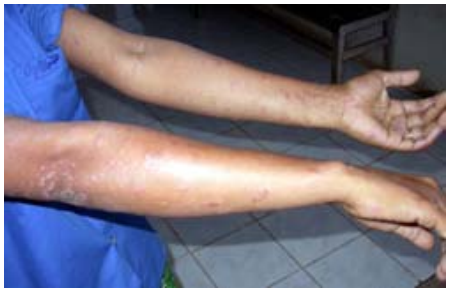




CC: Body rashes x 2 wks



HPI: 25F with no significant PMH presented with generalized pruritus rashes over her body sparing scalp, face, palms and soles. She said she used to have tendered LN on medial aspect of her upper arms bilaterally for a few days and now resolved. No fever, no other constitutional sx, no cardiorespiratory sx, no GI sx. No new household product or perfume or lotion used. No travel in the forest lately.



PMH: None

SH: No smoke, no EtOH

FH: None

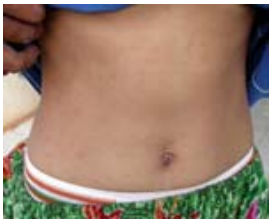
Allergies: NKDA

ROS: Used oral meds (unkown) from local pharmacy

PE:

VS: BP 104/80 P 80 R 20 T 37 Wt 44kg

Gen: stable



HEENT: unremarkable

Chest: CTA bilat; HRRR no murmur

Abd: unremarkable

MS/Neuro/Skin: Motor and sensory intact; good MS and tone, no lymphadenopathy; multiple, generalized plaque-like rashes, violatous lesions 1-2cm, some in clusters, scaly scabs over some lesion, excoriation with pus and scab formation. +erythema, mild tenderness with some infected lesions.

Other: N/A

Previous Labs/Studies: none

Lab/Study Requests: lesion bx

Assessment:

1. Eczema (allegic etiology)
2. Erythema nodosum?
3. Secondary infection of lesions (h/o swollen LN)
4. Psoriasis??
5. Saccoidosis???

Plan:

1. Triamcinolone cream or betametasone cream apply tid
2. Promethazine 25mg 1 po qid prn itching
3. Augmentin 875mg 1 po bid x 10d
4. Para 500mg 1 po qid prn

Comments: Please send some reference photos and/or article on what you think it is if rare dermatological disorder.

Examined by: Rithy Chau, PA-C **Date: 3/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

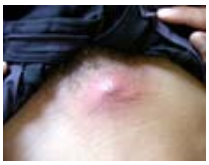
Advice on this patient was given per PA Rithy and Dr. Heinzelmann on location.

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

Patient: Pech Thanith, 22M, Taing Teuk Village

CC: Abcess on suprapubic area x 8-10d

HPI: 22M with previous episode of abcess on his posterior right thigh presented with abcess on the suprapubic area for more than a week ago, now increasing in pain and redness but has not yet perforated. Also c/o tenderness from swollen glands in both inguinal area. Low grade fever. No other lesion on body.



PMH: Abcess on right posterior thigh a few month ago, resolved without complications

SH: No smoke, occasional EtOH

FH: None

Allergies: NKDA

ROS: N/A

PE:

VS: BP P R T 36.8 Wt

Gen: Stable

HEENT: unremarkable

Chest: N/A

Abd: Soft, +BS, no HSM, abccess 4-5cm diameter, erythematous base with crusted scab in suprapubic region; + shotty, tender LN bilateral inguinal areas.

MS/Neuro: Normal

Other: ringworms on both groin areas

Previous Labs/Studies: none

Lab/Study Requests: None

Assessment:

1. Abcess (suprapubic area)
2. Tinea cruris

Plan:

1. I&D abcess was done AM 4/11/04 and used sterile dressing with triple abx ointment
2. Augmentin 875mg 1 po bid x 10d
3. Nabumetone 750mg 1 po bid prn pain
4. Ciclipirox cream apply bid until lesions gone and then use two more days
5. Keep area dry and clean, do not wear wet clothing for a prolong period of time
6. Return on 5/11/04 for change of dressing and teach pt to do this at home on his own.

Comments: Do you agree?

Examined by: Rithy Chau, PA-C **Date: 4/11/04**

Please send all replies to tmrural@yahoo.com and cc: to tmed_rithy@online.com.kh.

-----Original Message-----
From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, November 05, 2004 3:24 AM
To: 'tmrural@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: FW: Patient number 13 Pech Thanith, 22M (Tang Treuk)

-----Original Message-----
From: Williams, Christy M.,M.D.
Sent: Thursday, November 04, 2004 3:06 PM
To: Fiamma, Kathleen M.
Cc: Kvedar, Joseph Charles,M.D.
Subject: RE: Patient number 13 Pech Thanith, 22M (Tang Treuk)

I believe this patient most likely has a furuncle, which is a painful and inflammatory lesion typically caused by Staph aureus. Your current management is appropriate for this diagnosis. In many cases, spontaneous rupture will occur. In those that do not, surgical incision and drainage is recommended. Antibiotics, such as augmentin, should cover S. aureus. Other antibiotic possibilities would include dicloxacillin 500mg po every six hours, cephalexin 250mg po four times a day, and clindamycin 150mg po four times daily.

I would also recommend obtaining a CXR to assess for tuberculosis, which can also have this presentation.

Thanks,

Christy Williams, M.D.

-----Original Message-----
From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Friday, November 05, 2004 9:27 AM
To: TM Team; bhammond@partners.org; Rithy Chau; Kathy Fiamma; Paul Heinzelmann; Paul J. M.D. Heinzelmann; Joseph Kvedar; Cornelia Haener
Cc: Kiri; Thero Noun; Peou Ouk; Seda Seng; Laurie & Ed Bachrach; Montha Koy; Bernie Krisher; Nancy Lugn; Nancy E. Lugn
Subject: RE: Patient number 13 Pech Thanith, 22M (Tang Treuk)

Dear Rithy and team:

I agree with your plan.

Best wishes for safe travels back to Phnom Penh,

Jack

Friday, November 5, 2004

Follow-up Report for Robib TM Clinic

There were 13 patients seen during this month Robib TM Clinic (and 10 other patients came for medication refills 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 (as well as advices from Dr. Heinzelmann and PA Rithy), the following patients were managed and treated as follows:

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.]

Robib TM Treatment Plan for November 2004

I- Som Thol, 55M (Thnout Malou)

1)- Diagnosis
   a)- DMII with PNP

2)- Treatment plan
   a)- Diamecron 80mg 1t po q8h for one month
   b)- Amitriptyline 25mg 1t po q12h for one month
   c)- Multivitamin 1t po qd for one month

II- Moeung Srey, 42F (Taing Treuk)

1)- Diagnosis
   a)- HTN
   b)- GERD
   c)- Anemia?

2)- Treatment plan
   a)- Omeprazole 20mg 1 po qhs for one month
   b)- Captopril 25mg 1t po q12h for one month.
   c)- FeSO4 200mg 1t po qd for one month.
   d)- Mutivitamin 1t po qd for one month.
   e)- Reduce weight by doing exercise

III- Pang Sidoeun, 31F (Revieng Tbong)

1)- Diagnosis
   a)- HTN
   b)- Tension Headache
   c)- Anxiety?

2)- Treatment plan
   a)- HCTZ 50mg ½t po q12h for one month.
   b)- Multivitamin 1t po qd for one month.
   c)- Paracetamol 500mg 1t po q6h prn
   d)- Encourage her to eat and drink more.

IV- Nget Soeun, 56M (Thnout Malou)

1)- Diagnosis
a)- Liver Cirrhosis
b)- Malnutrition

2)- Treatment plan
a)- Aldactone 50mg ½t po qd for one month.
b)- Propranolol 40mg ¼t po qd for one month.
c)- Multivitamine 1t po qd for one month.

V- Sok Piseth, 12F (Kam Pot)

1)- Diagnosis
a)- Asthma
b)- Pneumonia?

2)- Treatment plan
a)- Augmentin 875mg ½t po q12h for 10 days
b)- Dexamethasone 12mg IV at first day after that cover with Prednisolone 30mg
po qd for 4 days.
c)- Paracetamol 500mg 1t po q6h prn

VI- Som An, 58F (Revieng Tbong)

1)- Diagnosis
a)- HTN
b)- PUD

2)- Treatment plan
a)- Propranolol 40mg ½t po q12h for one month.
b)- H. Pylori treatment for ten days and then go on with Omeprazole 20mg 1t po qd
for one month.

VII- Svay Tevy, 40F, (Thnout Malou)

1)- Diagnosis
a)- DMII
b)- GERD

2)- Treatment plan
a)- Diamecron 80mg ½t po qd for one month
b)- Omeprazole 20mg 1t po qhs for one month
c)- DM education, foot care, and also do exercise & GERD prevention education.

VIII- Chhay Chanthy, 41F (Thnout Malou)

1)- Diagnosis
a)- Euthyroid
b)- Anxiety?

2)- Treatment plan
a)- Multivitamin 1t po qd for two months
b)- Paracetamol 500mg 1t po q6h prn

IX- Prum Savoeun, 36F (Thnout Malou)

1)- Diagnosis
a)- Dyspepsia
b)- Malnutrition

2)- treatment plan

a)- Cimetidine 1t po q12h for one month

b)- Mutivitamin 1t po qd for one month

X- Tienn Sin, 65F (Doung)

1)-Diagnosis

a) Severe dehydration and cachexia due to decreased PO intake
b) CVA with right side weakness?
c) PTB?
d) Lungs CA?
e) GI bleeding
f) Anemia due to GI bleeding, Iron defigency?

2)- Treatment plan

a) Maintainance IV fluid 5L of LR, D 5%NSS)

b) B vitamine IV

c) CTX 1g IV qd for ten days

d) Refer to SHCH for reevaluation

XI- Pech Thanith, 22M (Taing Treuk)

1)- Dignosis

a)- Abcess (Suprapubic area)

b)- Tinea cruris

2)- Treatment plan

a)- I&D abcess

b)- Augmentin 875mg 1t po q12h for 10 days

c)- Nabumetone 750mg 1t po q12h prn

d)- Ciclopirox cream apply q12h until lesion gone and then use two more days.

e)- Keep wound dry and clean

XII- Teng Hem, 25F (Ta Tong)

1)- Diagnosis

a)- Eczema (Allergic etiology)

b)- Erythema nodosum?

c)- Psoriasis?

d)- Saccoidosis?

2)- treatment plan

a)- Triacinolone cream apply q8h

b)- Promethazine 25mg po q6h prn during itching

c)- Augmentin 875mg 1t po q12h for 10 days

d)- Paracetamol 500mg 1t poq6h prn

XIII- San Daov, 18 mo (Taing Truek)

1)- Diagnosis

a)- Eczema with secondary infection

b)- Scalp impetigo

c)- Viral exanthema

d)- Erythema multiform?

e)- Syphillis?

2)- Treatment plan
a)- Cephalexin susp 250mg 1tsp q12h for 14 days
b)- Paracetamol/dihypheniramine 500/25mg ¼t po q8h prn itching
c)- Hydrocortisone cream 1% apply on affected areas (avoid face) q12h for 1 week.

Patients, who just come to refill medications.

I- Muy Vun, 38M (Thnout Malou)

1)- Diagnosis
a)- VHD (MR, MS)

2)- Treatment plan
a)- Digoxine 0.25mg 1t po qd for one month
b)- ASA 500mg ¼t po qd for one month

II- Tan Kim Horn, 56F (Thout Malou)

1)- Diagnosis
a)- DMII
b)- Dyspepsia

2)- Treatment plan
a)- Diamecron 80mg ½t po qd for one month
b)- Captopril 25mg ¼t po qd for one month
c)- Ranitidine 75mg 1t po qd for one month

I**II- Sao Phal, 55F (Thnout Malou)**

1)- Diagnosis
a)- DMII with PNP
b)- Stable HTN
c)- GERD
d)- Anemia

2)- Treatment plan
a)- Diamecron 80mg ½t po qd for one month
b)- HCTZ 50mg ½t po qd for one month
c)- Amitriptyline 25mg 1t po qhs for one month
d)- FeSO4 200mg 1t po qd for one month
e)- Omeprazole 20mg 1t po qd for one month

IV- Pheng Roeung, 58F (Thnout Malou)

1)- Diagnosis
a)- Euthyroid
b)- Dyspepsia

2)- Treatment plan
a)- Carbimazole 5mg 1t po q12h for two months
b)- Propranolol 25mg ¼t po qd for two months
c)- Tums 1g 1t po q12h for one month
d)- Multivitamin 1t po qd for one month **V- Chhim Siborn, 30F (Thnout Malou)**

1)- Diagnosis
a)- Dyspepsia
b)- Malnutrition

2)- Treatment plan

a)- Cimetidine 400mg 1t po qd for one month
b)- Multivitamin 1t po qd for one month

VI- Eam Neut, 53F (Taing Treuk)

1)- Diagnosis
a)- Stable HTN
b)- Left knee pain

2)- Treatment plan
a)- HCTZ 50mg 1t po q12h for two months
b)- Paracetamol 500mg 1t po q6h prn

VII- Thorng Khun, 39F (Thnout Malou)

1)- Diagnosis
a)- Hyperthyroidism with 7 month of feeding baby

2)- Treatment plan
a)- Multivitamine 1t po qd for two months
b)- FeSO4 200mg 1t po qd for two months

VIII- Lay Neung, 35F (Sleing Tourl)

1)- Diagnosis
a)- Euthyroid
b)- Anxiety?

2)- Treatment plan
a)- Propranolol 25mg ¼t po q12h for two months
b)- Multivitamin 1t po qd for two months

IX- Chum Phay, 54M (Ta Tong)

1)- Diagnosis
a)- Dyspepsia
b)- Anemia

2)- Treatment plan
a)- Tums 1g 1t po q12h for two months
b)- Multivitamin 1t po qd for two months
c)- FeSO4 200mg 1t po qd for two months

X- Yim Sokkin, 23M (Thnout Malou) (He used to be SHCH patient with hospital #03007057)

1)- Dignosis
a)- Liver Cirrhosis
b)- Anemia due to GI bleeding

2)- Treatment plan
a)- Furosemide 40 ½t po qd for one month
b)- Propranolol 40mg ¼t po q12h for one month
c)- Multivitamin 1t po qd for one month

The next Robib TM Clinic will be held on
November 30 – December 2, 2004