Telemedicine Clinic
Rattanakiri
Referral Hospital
April 2006

Report and photos compiled by Rithy Chau, SHCH Telemedicine

On Tuesday, April 25, 2006, Rattanakiri Referral Hospital (RRH) staff began their TM clinic. PA Rithy and Nurse Sovann were present during this month clinic. 4 new and 2 follow-up patients were examined and the data were transcribed along with digital pictures of the patient, then transmitted and received replies from their TM partners in Boston and Phnom Penh.

The following day, Wednesday and Friday, April 26 and 28, 2006, the TM clinic opened again to receive the same patients and other follow-up patients for further evaluation, treatment and management. Finally, the data for treatment and 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 TM clinic at RRH and their TM partners in Phnom Penh and Boston :

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, April 19, 2006 10:16 AM
To: Rithy Chau; Cornelia Haener; Ruth Tootill; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International; Sovann Nop
Subject: April TM clinic at Rattanakiri Referral Hospital

Dear All,
Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Tuesday, April 25, 2006 beginning at 8:00am local time for one full day. We expect to enter and transmit the patient data to those of you at SHCH and at Partner in Boston that evening.

Please try to respond before noontime the following day, Wednesday, April 26, 2006.The patients will be asked to return to the hospital that afternoon on Wednesday to receive treatment along with a follow up plan or referral.

Thank you very much for your cooperation and service.
Best regards,

Channarith Ly

----- Original Message ----
From: Rithy Chau <tmed_rithy@online.com.kh>
To: Kiri Hospital <kirihospital@yahoo.com>; Cornelia Haener <cornelia_haener@online.com.kh>; Ruth Tootill <ruth_tootill@online.com.kh>; Brian Hammond <bhammond@partners.org>; Paul Heinzelmann <ph2065@yahoo.com>; Kathleen M. Kelleher <kfiamma@partners.org>; Joseph Kvedar

<jkvedar@partners.org>
Cc: Bernie Krisher <bernie@media.mit.edu>; Noun SoThero <thero@cambodiadaily.com>; Fil B. Tabayoyong <docfil@yahoo.com>; Ed & Laurie Bachrach <lauriebachrach@yahoo.com>; HealthNet International <healthni@camintel.com>; Sovann Nop <sovanrural@yahoo.com>; Chas Taplin <ctaplin@online.com.kh>
Sent: Thursday, April 20, 2006 2:14:48 AM
Subject: RE: April TM clinic at Rattanakiri Referral Hospital

Dear All,

I would like to inform you that our new SHCH TM staff, Nurse Peng Sovann, will be traveling with me to Rattanakiri for the TM clinic next week.

Thank you for your cooperation and support for the TM project.

Best Regards,
Rithy

P.S. Happy Khmer New Year! And wishing you all well into the next year.

From: Paul Heinzelmann, MD [mailto:pheinzelmann@partners.org]
Sent: Friday, April 21, 2006 7:44 AM
To: Rithy Chau
Subject: Re: April TM clinic at Rattanakiri Referral Hospital

Happy New Year and welcome to Peng Sovann!
Paul

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, April 25, 2006 9:19 PM
To: Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; kruylim@yahoo.com
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach; HealthNet International; Fil B. Tabayoyong
Subject: Rattanakiri Telemedicine Clinic April 2006 Patient KC#00167

Dear all,

Today we have four new cases and two follow up cases. Here is the first case and photos.

Best Regards,
Rithy/Sovann/Channarith

Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: KC#00167, 30F, TAHEY Village , KON MUM

Chief Complaint: a small mass developing of neck x d size:3x 4 em

HPI: she complaints with the dry cough x 3 d , and associated with chest pain , moderated fever , headache off and on ,and then a small mass developing of neck radiated to the right neck , no dizziness , no exopthalmia , no extremities, no palpitation .

PMH/SH: unremarkable

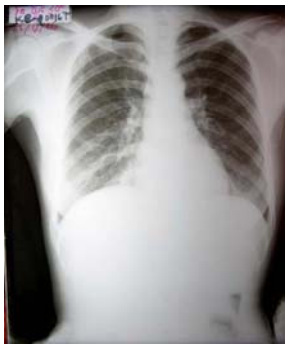
Social Hx: smoking x long time, slightly smoking .

Allergies: none

Family Hx: unremarkable

ROS:

PE:
Vital Signs: BP100/90P60 R 23 T 37.5



General: alerted and oriented

HEENT: size 3x 4 em, mobile mass when swallowing , no solid, soft , no bruit, no running nose , burning nose no rhinopharingitis ,.

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

Abdomen: soft, active BS, no organomegaly , no mass.

Musculoskeletal: unremarkable

Neuro: sensory and motor are intact

GU: none

Rectal: none

Previous Lab/Studies:

Lab/Studies Requests: CBC, CXR, Ultrasound ,

Assessment: 1.thyroide TB
2.Goiter
3.Bronchitis

Plan: 1.AFB
2.Paracetamol 500mg 1tab x qid x prn
3. check free T4 and TSH at SHCH

Comments/Notes: Please give a good idea

Examined by: San **date 25/4/06**

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

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, April 26, 2006 6:57 PM
To: kirihospital@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: FW: Rattanakiri Telemedicine Clinic April 2006 Patient KC#00167

-----Original Message-----
From: Barbesino, Giuseppe,M.D.
Sent: Tuesday, April 25, 2006 1:55 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri Telemedicine Clinic April 2006 Patient KC#00167

This 30 y/o woman with a newly developed neck mass seems to have a right side thyroid nodule. The h/o suggests a rapidly forming thyroid cyst or hemorrage in a preexisting thyroid nodule, but cancer remains a concern. There is tracheal deviation on the CXR whoch may explain the cough
Suggest: TSH and ultrasound. If TSH is low, nuclear medicine thyroid scan should be done. If nodule is hot, best management would be raioiodine or surgery. If TSH is not low, she should have a fineneedle aspiration biopsy. If biopsy benign, follow-up or surgery depending on persistence of compressive symptoms and content of the nodule (if it is fluid a FNA could drain it, avoiding need for surgey). If malignant or suspicious or indeterminate, surgery should be considered.

Giuseppe Barbesino, MD
Thyroid Associates
Massachusetts General Hospital-Harvard Medical School
Wang ACC 730S
55 Fruit St
Boston MA, 02114
FAX 617-726-5905
TEL 617-726-7573

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, April 25, 2006 9:29 PM
To: Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; kruylim@yahoo.com
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach; HealthNet International; Fil B. Tabayoyong
Subject: Rattanakiri Telemedicine Clinic April 2006 Patient RR#00166

Dear all,

Here is the second case RR#00166 and photos.

Best Regards,
Rithy/Sovann/Channarith

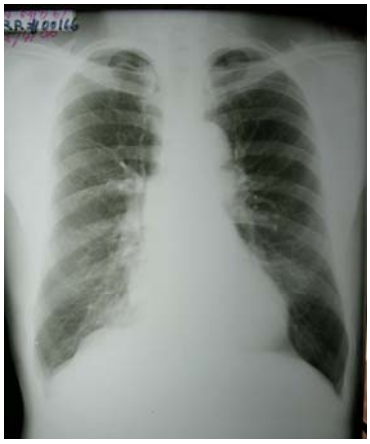
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: RR#00166, 61M, Village III

Chief Complaint: productive cough x one year and sob on exertion

HPI: He treated unknown drugs at Ratanakiri hospital .his symptoms got better .his complaints of sob on exertion , productive cough association with chest pain , dizziness and HA off and on, running nose , itching nose and stuffed-up nose occasionally .no fever , no loss weigh , bleeding cough .

PMH/SH: unremarkable



Social Hx: no alcohol ,smoking cigarette x more than 30 year

Allergies: none

Family Hx: unremarkable

ROS:

PE:
Vital Signs: BP120 R 70 T 37.5

General: alerted and oriented

HEENT: no lymph nodes , no tinnutis , stuffed –up nose , running nose off and on , HA off and on , no itching eye .

Chest: -Lungs: clear both sides , no crackle .
-Heart : no murmur , rhythm regular

Abdomen: soft, active BS, no organomegaly

Musculoskeletal: unremarkable

Neuro: sensory and motor are intact

GU: none

Rectal: none

Previous Lab/Studies:

Lab/Studies Requests: CXR, CBC ,

Assessment: 1.sinutis
2.Bronchitis
3 COPD

4.pneumonia?
5.PTB?

Plan: 1. AFB
2.paracetamol 500mg 2 tab qid x prn pain
3.clarithromicine 500 mg 1 tab po x bid x 7 d
4.albutrol spray 1 puff qd

Comments/Notes: please , give a good idea

Examined by: san date: 25/04/06

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

From: Kreinsen, Carolyn Hope,M.D. [mailto:CKREINSEN@PARTNERS.ORG]
Sent: Thursday, April 27, 2006 12:32 AM
To: Fiamma, Kathleen M.; ", kirihospital"@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: RE: Rattanakiri Telemedicine Clinic April 2006 Patient RR#00166

Case Summary:

This 61 year old man presents with a productive cough of one year duration, currently with associated chest pain. He has dyspnea on exertion and has been a smoker for over 30 years. At some time over the past year, he was evaluated and treated at Ratanikiri Hospital with symptomatic improvement for some time after the therapy. Details with regard to diagnosis and type of treatment are unknown. He currently has concerns with intermittent headaches and dizziness, rhinorrhea, and waxing and waning nasal congestion, as well. He denies fever, weight loss and hemoptysis. He has no known preexisting health problems.

On examination, he appears relatively well. He has a low grade temperature of 37.5. Respiratory rate and diastolic BP are not documented. Systolic blood pressure and heart rate are within normal range. HEENT exam appears unremarkable. There is no cervical adenopathy. Lungs are clear to auscultation and cardiac exam shows regular rate and rhythm with no appreciable murmurs. Abdominal exam is benign. There is no note of any rash or peripheral edema.

Chest x-ray shows cardiomegaly with increased vascular markings and some cephalization. There is a poorly defined right cardiac border and a probable small right pleural effusion with blunting of the costophrenic angle. The hilar region appears somewhat full.

1. Productive Cough: This has been ongoing for one year. The patient denies fevers, weight loss and hemoptysis. I agree with your assessment of probable underlying COPD with a more than 30 year history of smoking. He may have associated chronic bronchitis, asthma and sputum production associated with that at baseline. Superimposed, he seems to have another problem. His chest x-ray is concerning. The poor definition of the right cardiac border raises the strong possibility of an infectious process/pneumonia. This could also represent a mass/neoplasm. The pleuritic/chest wall pain would be consistent with either. The clarithromycin is a very good idea as initial intervention. It is broad spectrum and will address bacterial sources of pneumonia and sinusitis. If possible, I'd extend that treatment to 500 mg po BID x 14 days, rather than 7 days, given the duration of his symptoms and the fact that treatment should be geared toward pneumonia rather than bronchitis. The albuterol inhaler is also an excellent intervention. He could use that more frequently, 1-2 puffs every 6 hours PRN, as long as it does not cause jitteriness or palpitations. He might benefit from a steroid inhaler as well, fluticasone, 1-2 puffs every 12 hours for 10-14 days, if that is available to you. I always find it helpful to remind patients using steroid inhalers to rinse their mouths with water after usage and to spit the water out to avoid any thrush. It would be useful, if possible, to touch base with the hospital to find out what his diagnosis and treatment regimen were when he was seen there. That would be helpful in guiding treatment, especially since the patient seemed to respond to the therapy they provided. He should have a chest CT to evaluate further for neoplasm, pulmonary infection and other pathology,

given the duration of his symptoms and the appearance of his chest x-ray. I agree with the testing for TB. Primary TB can have an atypical appearance on chest x-ray, including right perihilar/right middle lobe involvement. The chronic persistent cough with pleuritic pain and dyspnea could certainly be consistent with TB. Other non-bacterial sources of infections should be considered if his TB testing is negative and if he does not respond to the clarithromycin. It would be helpful if the patient can monitor his temperature and report any night sweats. This patient also has evidence of probable cardiomegaly and congestive heart failure on his chest x-ray. Those could contribute to a chronic cough. CBC should provide helpful information regarding infection, inflammation and anemia. If would be good to get a differential, if possible, to check for bandemia, abnormalities in polys and lymphocytes, and to ascertain if there is an elevation in the eosinophils. It would be helpful to check the patient's pulse oximetry today. He also would benefit from smoking cessation counselling.

2. Chest Pain: This seems to occur when he coughs. As noted above, it is most likely pleuritic or chest wall in nature. Pleuritic or chest wall pain would be consistent with a persistent pneumonia/infection or possibly with a mass. If the pain is parasternal, he may have costochondritis/costochondral cartilage inflammation due to the stress on his chest wall structures of chronic coughing. If he has been coughing hard or spasmodically, he may have sustained a rib fracture. I would expect that pain to be quite focal and palpable on exam. Heat application for 20 minutes several times per day in addition to the paracetamol should be helpful in decreasing the discomfort. The presence of cardiomegaly and possible CHF on the chest x-ray, along with the patient's age and smoking history, raises the question of ischemia. It would be advisable to check a 12-lead EKG today when the patient returns.

3. Possible CHF: This patient should have a 2D echo ordered to evaluate his cardiac status. He appears to have cardiomegaly. That with the increased vascular markings would raise the question of CHF. His chest x-ray raises the question of mass or infection. Pericardial effusion must be ruled out, as well. It would be helpful today to obtain baseline lipids, electrolytes, BUN, creatinine, blood sugar, TSH (thyroid) and liver function tests. I would recommend that he start low dosage furosemide, 20 mg each day, for possible CHF. That may help to alleviate some of his dyspnea on exertion. It would be advisable to check for JVD and peripheral edema when you see him back today. With the furosemide, he should eat potassium containing foods each day. An orange or a banana each day would be great. It would be good to get a baseline weight and to recheck his blood pressure today. He will need follow-up. He might benefit from a beta blocker such as atenolol or an ACE inhibitor such as lisinopril, once test results are back.

4. Rhinorrhea: It sounds as though this patient may have some degree of seasonal or environmental allergies. It would be helpful to explore any new possible exposures to allergens at work or at home and ways to minimize those. I'm not certain what antihistamines are available to you. Benadryl 25 mg is sedating but might be helpful at bedtime.

I Hope this is helpful!

Have a great day,

Carolyn K

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, April 25, 2006 9:43 PM
To: Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; kruylim@yahoo.com
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach; HealthNet International; Fil B. Tabayoyong
Subject: Rattanakiri Telemedicine Clinic April 2006 Patient SY#00168

Dear all,

Here is the third case SY#00168 and photos.

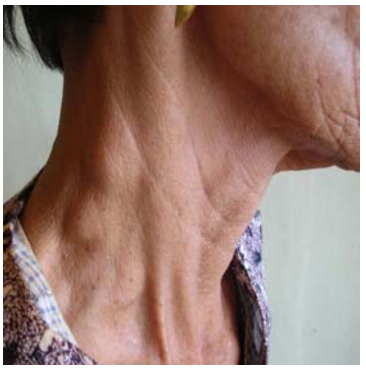
Best Regards,
Rithy/Sovann/Channarith

Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: SY#00168, 78F, Village I

Chief Complaint: in Pol Pot regime , this lymph nod appeared on right neck , she treated with traditional drugs, this lymph nod disappeared . the last 3 months , 2006 , she complaints of a small lymph nod developing on neck , that reappears on right and left of her neck , and she went to treat at private clinic , her mass did not relieve .no fever , no pain , no bleed cough .

PMH/SH: unremarkable



Social Hx: no alcohol and cigarette

Allergies: none

Family Hx: none

ROS:

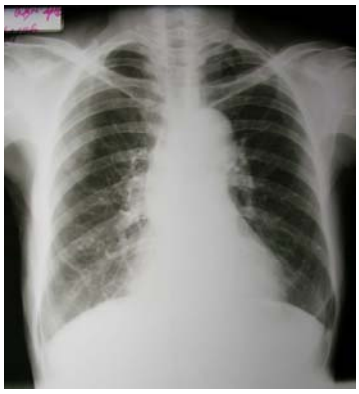
PE:

Vital Signs: **BP100/80** **P60** **R23** **T**36.5 **Wt** 37

General:

HEENT: soft ,mobile , no pain , no hot , no solid , no tinnutis , no rhinopharingitis , no adherence,.

Chest: Lungs: clear both sided Heart : no murmur, rhythm regular



Abdomen: soft, active BS, no mass, no organomegaly

Musculoskeletal: unremarkable

Neuro: sensory and motor are intact

GU:

Rectal:

Previous Lab/Studies:

Lab/Studies Requests: CX R

Assessment: 1.Lymph nod TB
2.Adnitis

Plan: 1. give TB drugs by protocol
2.cephalexin 500 mg 1 tab bid x 7 d
3.aspiration of lymph nod

Comments/Notes: please give a good idea

Examined by: san **Date: 25/4/06**

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

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, April 26, 2006 6:56 PM
To: kirihospital@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: FW: Rattanakiri Telemedicine Clinic April 2006 Patient SY#00168
-----Original Message-----
From: Cusick, Paul S.,M.D.
Sent: Tuesday, April 25, 2006 9:20 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri Telemedicine Clinic April 2006 Patient SY#00168

The patient has painless lymphadenopathy. She needs a lymph node biopsy to evaluate for TB, other infections or cancer.

The chest xray does not look like it has any active pneumonia or tuberculosis.
I agree with the TB protocol drugs until the aspiration returns.
I do not understand why she is getting cephalexin.

Good luck
Paul S Cusick MD

From: Cornelia haener [mailto:Cornelia_Haener@online.com.kh]
Sent: Thursday, April 27, 2006 10:11 AM
To: 'Kiri Hospital'; 'Ruth Tootill'
Cc: 'Rithy Chau'
Subject: RE: Rattanakiri TM Clinic April 2006 Patient SY#00168

Dear all,
I agree to the suspicion of lymph node TB, as the right hilus on the chest X-ray is more voluminous. However, I suggest that we have a diagnosis before we expose this old lady to a long treatment. Other infectious diseases are possible as well. Do you want to aspirate the LN to see if there is pus and do a ZN staining on it? A negative result would of course not rule out TB, but a positive result would confirm it. If the puncture is negative, you would have to consider a LN biopsy. You could bring the specimen down to Phnom Penh for pathology work up.
Regards
Cornelia Haener

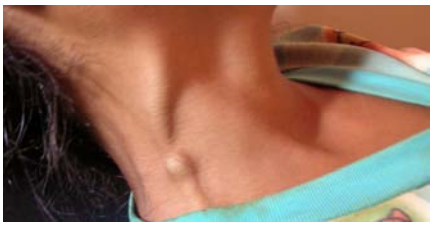
From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, April 25, 2006 10:02 PM
To: Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; kruylim@yahoo.com
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach; HealthNet International; Fil B. Tabayoyong
Subject: Rattanakiri Telemedicine Clinic April 2006 Patient CK#00102

Dear all,
Here is the forth case CK#00102 and photos.
Best Regards,
Rithy/Sovann/Channarith

Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

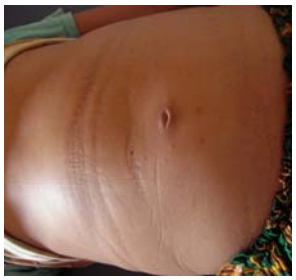
Patient: CK#00102, 20F, Village IV

Subject: 20F came for follow up for her PMH of Cardiac insufficiency (MR, AR), anemia. The patient was briefly seen at the Feb06 TM clinic and 6 months prior to that, she said that because she was feeling better and thus did not want to come to refill her medication until she was not feeling right in 02/06. Her symptoms of SOB on exertion, palpitation, productive cough white color, dyspnea on bed rest, edema on both legs, poor appetite, weight lose?, icterus, jaundice on the face persisted and her abdomen became increasingly distended with both leg edema during the past month; no fever, no chest pain, no diaphoresis, no syncope, no dysuria, but +oliguria—she said that she drank less than 1L day. She has been taking her meds regularly and live in remote area of the province.

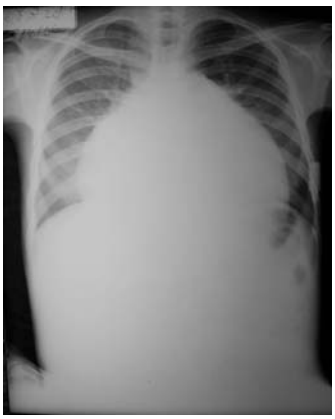


Current Med:

Lisinopril 5mg 1/2t po qd
MTV 1t po q12h
FeSO4/Folic Acid 200/0.25mg 1t po q12h
Furosemide 40mg ½ t po qd



Object:
Vital Signs: BP=84/56 P=120 R=24 T=35.6 Wt=
General: Sick, slight tachypneic
HEENT: no oropharygeal lesion, icterus on the eyes, (+) JVD, no lymph node palpable
Chest: CTA except in bilateral lower lobes, heart rate is fast and irregular rhythm, no murmur
Abd: soft, tender on right upper quadrant, moderate distension, hypoactive bovel sound, hepatomegaly, no splenomegaly, fluid wave (+)
Skin/Extremity: warm, jaundice on the face, +3 pitting edema on both legs
Neuro: unremarkable



Previous Lab/Studies: 2D cadiac echo: EF=80%, cardiac insufficiency (MR, AR)

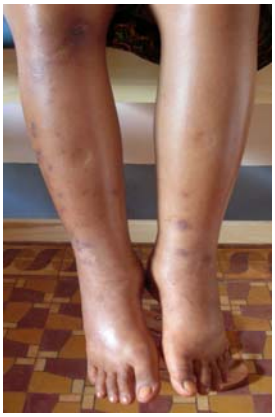
Lab/Studies Requests: U/A proteine2+, RBC trace, Ketone1+, BS= 133mg/dl, Hb=12g/dl, request for CBC, lyte, BUN, creatinine, LFT, Abd U/S, CXR

Assessment:

1. CHF
2. Artrial Fibrillation
3. Cardiac Insufficiency (MR, AR)
4. Cardiomegaly
5. Anemia
6. Ascites

Plan:

1. Captopril 25 mg 1t po qd
2. Furosemide 20mg 1t po q12h
3. MTV 1t po q12h
4. FeSO4/ Folic Acid 200/0.25mg 1t po q12h
5. Add Digoxin 0.25 mg 1/2t po qd
6. ASA 300mg ¼ tab po qd



Comments/Notes:

Examined by: Nurse Peng Sovann/PA Rithy Chau **Date: 25/4/2006**

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

No reply received from Boston.

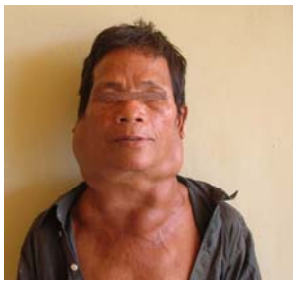
From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, April 25, 2006 10:15 PM
To: Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; kruylim@yahoo.com; Cornelia Haener; Ruth Tootill
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach; HealthNet International; Fil B. Tabayoyong
Subject: Rattanakiri Telemedicine Clinic April 2006 Patient NB#00164

Dear all,

Here is the fifth case NB#00164 and photos.

Best Regards,
Rithy/Sovann/Channarith

Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine



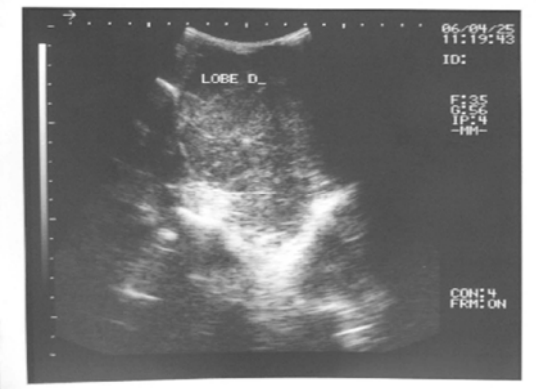
Patient: NB#00164, 53M, Tompong Roeung Village

Subject: 53M came for follow up of big mass around the neck, patient still has the symptoms of fever, productive cough, white color, dysphagia and could only swallow liquid food, SOB on exertion, poor appetite, good urine output, no edema, no tinnitus, no N/V and he is getting the TB drugs at the hospital DOT ward even though his sputum smears were negative and no CXR done. Now the mass became larger in size and the hospital wanted to discharge him home, but TM staff requested that he stayed for further evaluation and FNA for cytology at SHCH.

Object:

Vital Signs: BP 100/70 P 100 R 22 T36.6 Wt 42kg

General: look sick, skinny
HEENT: Uvular swelling, pale on conjunctiva, the mass is hard irregular border, fixed, slightly tender, slight erythema, no thrush, 1 right axillary lymph node about 2x2 cm palpable without tenderness (see images)
Chest: decrease breath sound on bilaterally lower lobes, no rales, no rhonchi, HRRR, NO Murmur
Abd: soft, no tender, no distention, (+) BS on 4Q, no HSM, no mass palpable
Extremity/Skin: good tugor, no rash, no edema
Neuro: unremarkable



Previous Lab/Studies:

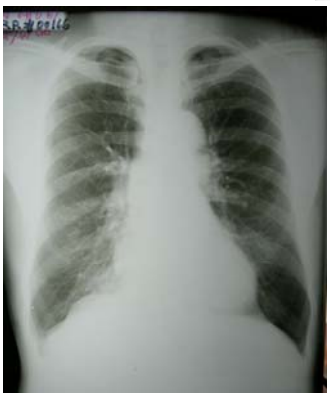
Lab/Studies Requests: Hb 11g/dl, request for CBC, lyte, BUN, Creatinine, glucose; CXR and neck mass U/S as attached

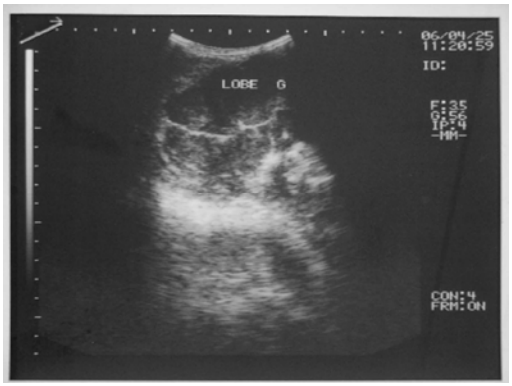
Assessment:

1. Lymphoma?
2. Neck/parotid Cancer?
3. PTB???
4. Malnutrition
5. Cachexia

Plan:

1. Paracetamol 500mg 1t po q6h PRN (pain)
2. Multivitamin 1t po q12h
3. Similac Cereal 3scips/180cc water q12h





4. Find needle Aspiration sent for cytology at SHCH

Comments/Notes:

Examined by: Nurse Peng Sovann/PA Chau Rithy **Date: 25/4/2006**

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

From: Cornelia haener [mailto:Cornelia_Haener@online.com.kh]
Sent: Wednesday, April 26, 2006 7:49 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; kruylim@yahoo.com; 'Ruth Tootill'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'
Subject: RE: Rattanakiri Telemedicine Clinic April 2006 Patient NB#00164

Dear all,
I agree with your DDx malignant lymphoma towards ENT cancer. However, I do not think that this is a benign disease. Whatever it is, there is no cure, but the patient needs some palliation due to his dysphagia. I would suggest starting him on Prednison 20 mg qD after HIV and Hep B/C are ruled out. You can try a FNA. However, if the fixation is not according to the guidelines of our laboratory, the diagnostic value will be low.
Thanks
Cornelia

No reply received from Boston.

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, April 25, 2006 11:01 PM
To: Kruy Lim; Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach; HealthNet International; Fil B. Tabayoyong
Subject: Rattanakiri TM Clinic April 2006 Patient TS#00169

Dear All,

Here is the last patient for this month. Thank you and we look forward to your replies.

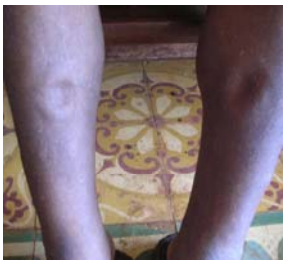
Best Regards,
Rithy/Sovann

Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: TS#00169, 59M, Village III

Chief Complaint: SOB on exertion since August 2005

HPI: 59M with PMH of DM II, HTN and a self-dx "asthma" presented with c/o SOB after climbing 10 steps, dizziness, fatigue with symptoms of feverish, dry cough, dyspnea so his family bring him to the Refferal Hospital in emergency room in August 05 and in Feb06 and April06 he started that symptoms again his family brought him to hospital to get treatment due to his BP elevated to about 260/?. Now he came here to the TM clinic. Pt took HTN med (Nifedipine) prn, DM II meds as follow: glibenclamide 5mg 1 po bid (but stopped past few month because it made "my legs swell"), gliclazide 80mg 1 po bid, traditional medicaine for DM since 1994, and used hydrocortisone IV(?) prn when "I have attacks with my high BP." Most of the medications taken were self treated from friends' advices. +extremity numbness and burning sensation and pitting edema. No polydipsia, no polyuria, but polyphagia. He developed an ulcer of his right foot from the shoes he wore.

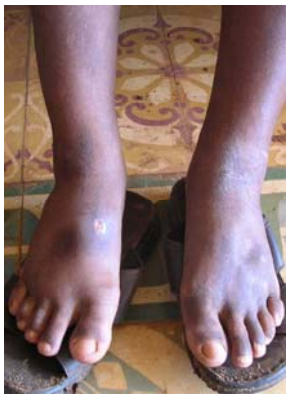


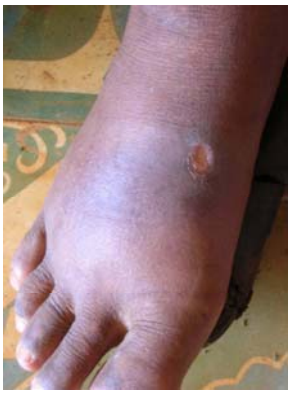
PMH/SH: Patient had Arthritis? in 1993, DMII in 1994, HTN in 2004 with HTN and DMII drug now

Social Hx: drink alcohol on and off, smoke 1 ppd about 10 ys stop 3 ys ago

Allergies: NKDA

Family Hx: none



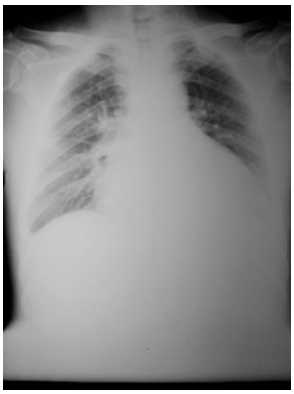


ROS: SOB on exertion, no weigh lose, no jaundice on conjunctiva, no GI complaint, no dysuria

PE:
Vital Signs: BP® 152/85, (L) 148/82 P ® 101, (L) 96 R 26 T 37^{o}C Wt 55Kg Ht 1.55m O2 sat 97% room air

General: look stable, slightly tachypneic

HEENT: no oropharyngeal lesion, slightly pale on conjunctiva no lymph node palpable, (+) JVD



Chest: CTA billateraly, no rale, no rhonchi, HRRR with 2+ crescendo systolic murmur loudest at tricuspid area.

Abdomen: soft, no tender, no distension, (+) BS on 4Q, no HSM

Musculoskeletal: +1 pitting edema bilateral lower extremity, good pedal pulses, 1cm foot ulcer on right dorsum of foot, slight callous on sole of both large toes

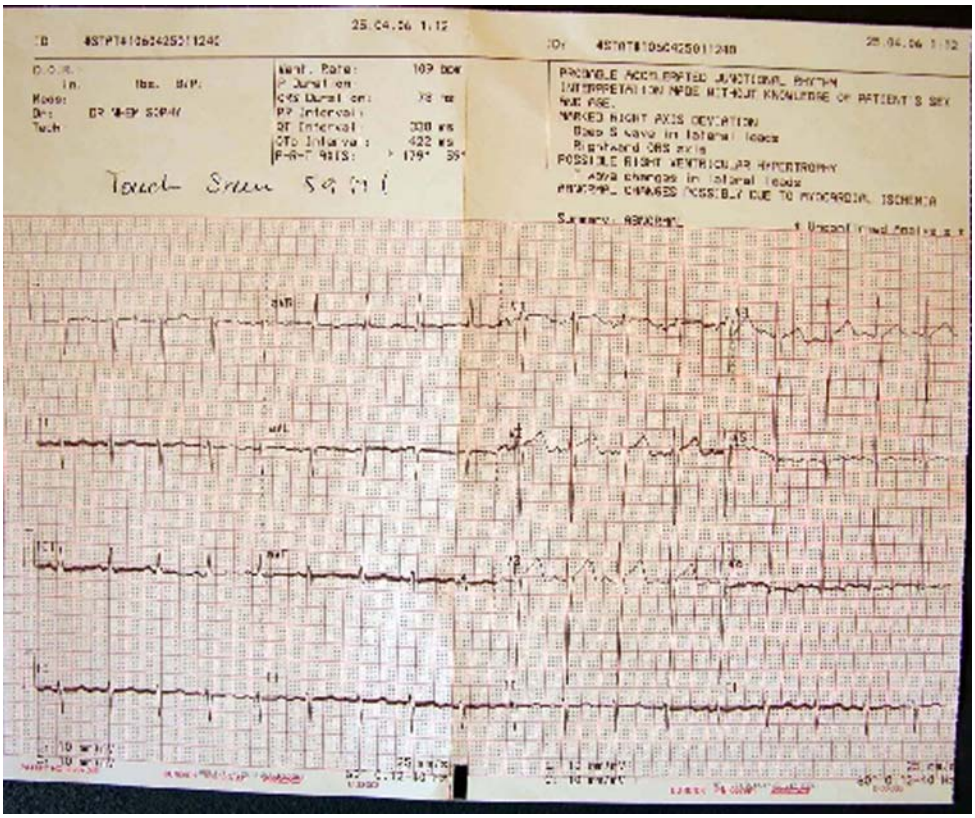
Neuro: DTRs +2/4 billaterally, motor in tact, +5/5 MS, sensory pin prick intact, but + stocking and glove pattern of numbness to light touch. Normal gait.

GU: NA

Rectal: good tone, no mass palpable, -hemocult

Previous Lab/Studies:

Lab/Studies Requests: U/A gluco 4+, blood 4+ hemolyte blood, protein 3+; BS >500mg/dl, request for CBC, lyte, BUN, Creatinine, LFT, glucose, CXR



Assessment:

1. DMII
2. HTN
3. CHF?
4. VHD?
5. UTI?
6. DM Foot ulcer

Plan:

1. Glibenglamide 5 mg 2t po bid
2. Lisinopril 5 mg 1t po qd
3. HCTZ 50 mg ½ t po qd
4. Ciprofloxacine 500 mg/5ml 500ml po q12h
5. Cephalexin 250mg 2 po tid x 14d
6. Desipramine 75mg ½ tab qhs
7. ASA 300mg ¼ tab po qd
8. Wound care/dressing
9. Refer for 2D echo at Calmette Cardiac center
10. DM foot care, low fat, low sugar, low salt diet, regular exercise, stop previous medication not prescribed here in current plan.

11. Given 2L of NSS IV at TM clinic today and encourage pt to drink more water..

Comments/Notes:

Examined by: Sovann/Rithy **Date: 25/4/2006**

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

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, April 26, 2006 3:13 AM
To: Kiri Hospital
Cc: Rithy Chau
Subject: RE: Rattanakiri TM Clinic April 2006 Patient TS#00169

Very nice assessment and plan.

This patient's major problems are:

1. Type II diabetes, poorly controlled

2. Diabetic nephropathy

3. Diabetic peripheral neuropathy

4. Diabetic foot disease, with ulcer

5. Peripheral edema, which may be due to CHF, tricuspid regurgitation, nephropathy, or some other problem

6. Valvular heart disease, likely tricuspid regurgitation.

Your plan is fine, but I don't think the HCTZ will work for him since I suspect some renal insufficiency. You might consider furosemide 20mg daily until you see him next. You should also emphasize the need for follow-up with you.

- Danny

Daniel Z. Sands, MD, MPH, FACP, FACMI
Assistant Clinical Professor of Medicine, Harvard Medical School
Faculty, Harvard-MIT Division of Health Sciences and Technology
Associate in Medicine, Beth Israel Deaconess Medical Center
Director, American Medical Informatics Association
Advisor, Center for Health Information and Decision Systems, Robert H. Smith School of Business, University of Maryland
Phone: 617-667-1510, 214-370-2267
Mobile: 617-256-4775
dsands@bidmc.harvard.edu

Kathy Fiamma
617-726-1051

Wednesday/Friday, April 26/28, 2006

Follow-up Report for Rattanakiri TM Clinic

There were patients seen during this month TM clinic at Rattanakiri Referral Hospital (RRH). The data of 4 new and 2 follow-up 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 PA Rithy on site, the following patients were managed and treated per local staff:

[Please note that in general the practice of dispensing medications at RRH for all patients is usually limited to a maximum of 7 days treatment with expectation of patients to return for another week of supplies if needed be. This practice allows clinicians to monitor patient compliance to taking medications and to follow up on drug side effects, changing of medications, new arising symptoms especially in patients who live away from the town of Banlung and/or illiterate. Medications and lab tests not available/done at RRH are provided by SHCH to TM patients at no cost]

Treatment Plan for Rattanakiri TM Clinic April 2006

New Cases

1. RR#00166, 61F, Village III
   Dx:
   1. Sinusitis
   2. Bronchitis?
   3. COPD?
   4. Pneumonia?
   5. PTB?

   Tx:
   1. Clarithromycin 500mg 1 tab po bid
   2. Para 500mg 1tab po qid prn pain
   3. Smoking cessation
   4. Check AFB

2. KC#00167, 30F, Taheng Village
   Dx:
   1. TB Lymphadenopathy?
   2. Goiter???
   3. Bronchitis?

   Tx:
   1. Clarithromycin 500mg 1tab po bid x 14d
   2. Para 500mg 2 tab po qid prn (20 tab)
   3. MTV 1 tab po qd (30 tab)
   4. Check AFB
   5. Check free TSH and T4 at SHCH

3. SY#00168, 76F, Village I
   Dx:

1. TB Lymphadenopathy?
2. Adenitis

Tx:

1. Cephalexin 250mg 2 tab po tid x 10d
2. Para 500mg 2 tab po qid prn
3. MTV 1 tab po qd

4. TS#00169, 59M, Villlage I

Dx:

1. DM II with PNP
2. HTN
3. CHF
4. VHD?
5. UTI
6. DM foot ulcer
7. Renal insufficiency

Tx:

1. Glibenclamide 5mg 2 tab bid
2. Furosemide 20mg 1 tab po qd
3. ASA 81 mg 1 tab qd
4. Metformin 500mg ½ tab bid
5. Amlodipine 5mg ½ tab qd
6. Cipro 500mg/5cc suspension 5cc po bid x 10d
7. Desipramine ½ tab po qhs
8. DM/HTN education and foot care
9. Para 500mg 2 tab po prn pain

Follow-up patients

1. CK#00102, 18F, Village IV

Dx:

1. CHF
2. Artrial Fibrillation
3. Cardiac insufficiency (MR, AR)
4. Cardiomegaly
5. Anemia
6. Ascites

Tx:

1. Captopril 25mg 1 tab po qd
2. Furosemide 20mg 1 tab po q12h
3. MTV 1 tab po q12h
4. Feso4/Folic Acid 200/0.25mg 1tab po q12h
5. Add Digoxin 0.25 mg ½ tab po qd
6. ASA 300mg ¼ tab po qd

2. KP#00153, 57F, Village III

Dx:

1. DMII
2. VHD
3. A-fib
4. HTN
5. ASD/VSD?

Tx:

1. Lisonopril 5mg 1tab po qd x 100d

2. Glibenclamide 5mg ½ tab po qd x 100d
3. Atenolol 50 mg ½ tab po qd x 100d
4. MTV 1 tab po qd x 100d
5. ASA 81 mg 1 tab po qd x 100d
6. Desipramine 75 mg ½ tab po x 100d

3. LH#00116, 59F, Village IV

Dx:

1. Hyperthyroidism?
2. HTN
3. Cardiomegaly

Tx:

1. HCTZ 50mg ½ tab po qdx 100d
2. ASA 81 mg 1 tab po chew qd x 100d
3. Methimazol 10mg ½ tab qd x 100d
4. Recheck free T4 and TSH

4. EB#00078, 41F, Village IV

Dx:

1. CHF
2. Incompleted RBBB

Tx:

1. Enalopril 5mg ½ tab po qd x 100d
2. Digoxin 0.25mg 1tab po qd x 100d
3. Furosemide 40mg 1 tab po bid x 100d
4. Spironolactone 25mg 2tab po bidx100d
5. MTV 1tab po bid x100d

5. UP #00094, 51F, Village I

Dx:

1. Hyperthyroidism

Tx:

2. Propranolol 40 mg ½ tab po qd
3. Recheck free T4 and TSH at SHCH

6. OT# 0155, 45F, Village I

Dx:

1. DMII
2. HTN

Tx:

1. Lisinopril 5mg 1 tab po qd x 100d
2. Glibenclamide 5mg 2 tab po bid x 100d
3. Metformin 500mg 1 tab po bid x 100d
4. ASA 81mg chew 1 tab po qd x 100d
5. Desipramine 75mg 1 tab po ghs x 100d

7. OP#00161, 78M, Village I

Dx:

1. Emphysema/ COPD

Tx:

1. Albuterol inhaler 2 puffs bid prn SOB
2. MTV 1 tab po qd
3. Stop smoking

8. NB#00164, 53M, Tompong Roeung Village

Dx:

1. Lymphoma?
2. Neck/parotid cancer ?
3. PTB???
4. Malnutrition

Tx:

1. Para 500mg 1 tab po q12h PRN (pain)
2. MTV 1 tab po q12h
3. Similac Cereal 3 scips/180cc water q12h
4. Fine Needle Aspiration (FNA) to be sent for cytology at SHCH

9. OS#00143,48F, Thmey Village

Dx:

1. ASD
2. Right Atrium enlargement

Tx:

1. Furosemide 20mg ½ tab po qd x 100d
2. ASA 81 mg 1tab po qd x 100d

10. MS#00144, 52M, Thmey Village

Dx:

1. DM II

Tx:

1. Glibenclamide 5mg 2 tab po qd x 100d
2. Lisinopril 5mg ¼ tab po qd x 100d
3. ASA 81mg 1 tab po qd x 100d

11. CL#00159, 45F, Bafang Village

Dx:

1. Right breast cyst
2. HTN

Tx:

1. Paracetamol 500mg 1tab po qid prn pain
2. HCTZ 50mg ½ tab po qd

12. CL#00122, 33F, Village III

Dx:

1. Subclinical Hyperthyroidism

Tx:

1. Methimazol 10mg ½ tab po tid
2. Recheck free T4 and TSH at SHCH

13. TO#00152, 45M, Village II

Dx:

1. Left knee pain 2. HTN

Tx:

1. Diflunasol 500 mg 1 tab po bid
2. HCTZ 50mg ½ tab po qd
3. Para 500mg 2 tab po prn pain (50 tab)

14. KM#00158, 51F, Sre Ankrong Village

Dx:

1. Hyperthyroidism?

Tx:

1. Recheck free T4 and TSH at SHCH

From: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Wednesday, May 17, 2006 3:26 PM
To: 'Kiri Hospital'
Cc: 'Bernard Krisher'; 'Noun SoThero'; gjacques@online.com.kh; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Fil - Jr. Tabayoyong'; 'Ed & Laurie Bachrach'; 'Cornelia Haener'; 'Ruth Tootill'; kruylim@yahoo.com; 'Paul Heinzelmann'
Subject: RE: Rattanakiri TM April 2006 Lab Results

Dear Channarith/San,

Here is an additional note for lab result:

NB#00164, 53M, Tompong Roeung Village

Result from SHCH telepathology lab of FNA of neck mass for cytology on 28.04.06 was concluded on 09.05.06 as follow:

Dx: Matastasis of nasopharyngeal carcinoma

Tx: Palliative care with pain medication and MTV/Similac cereal

If you have any further question, please let me know. I will bring up with me copies of the lab results for your record on my next visit next month.

Best Regards,
Rithy

From: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, May 11, 2006 4:02 PM
To: 'Kiri Hospital'
Cc: 'Bernard Krisher'; 'Noun SoThero'; 'gjacques@online.com.kh'; 'Kathleen M. Kelleher'; 'Fil - Jr. Tabayoyong'; 'Ed & Laurie Bachrach'
Subject: Rattanakiri TM April 2006 Lab Results

Dear Channarith/San,

Here are the lab results done on 28/04/06 for patients from the April 2006 TM Clinic:

1. UP#00093, 53F

   - TSH 0.06 [0.49 – 4.67]
   - Free T4 41.57 [9.14 – 23.81]

   Dx: Hyperthyroidism

   Tx: Start Methimazole 10mg ½ tab po tid x 2mo and recheck her TFT again in 2 months

2. LH#00116, 59F

   - TSH 0.70 [0.49 – 4.67]
   - Free T4 17.24 [9.14 – 23.81]
   - Na = 144 [135 - 145], K = 3.2 [3.5 – 5.0], Cl = 110 [95 -110], Creat = 58 [44 – 80], glucose = 7.1 [4.2 – 6.4]

Dx: 1. Hyperthyroidism (euthyroid due to medication)

Tx: 1. Keep the same tx with Methimazole 10mg ½ tab po qd x 2mo and recheck her TFT again in 4 months

2. Do regular exercise and balance diet with less sweet

3. CL#00122, 33F

- TSH 24.88 [0.49 – 4.67]
- Free T4 7.93 [9.14 – 23.81]

Dx: Hypothyroidism (hyperthyroidism becoming hypothyroidism due to medication)

Tx: Stop her Methimazole and recheck her TFT again in 1 month

4. KM#00158, 51F

- TSH 1.42 [0.49 – 4.67]
- Free T4 11.61 [9.14 – 23.81]

Dx: Euthyroid goiter

Tx: No tx needed and recheck her TFT again in 6 months

5. KC#00167, 30F

- TSH 0.22 [0.49 – 4.67]
- Free T4 15.90 [9.14 – 23.81]

Dx: Subclinical Hyperthyroidism

Tx: No tx needed and recheck her TFT again in 2 months

If you have further question, please let me know.

Best Regards,

Rithy

The next Rattanakiri TM Clinic will be held on May 2006