Telemedicine Clinic
Rattanakiri
Referral Hospital
July 2005

Report and photos compiled by Rithy Chau and Nurse Somontha Koy, SHCH Telemedicine

On Tuesday, July 19, 2005, Rattanakiri Referral Hospital (RRH) staff began their TM clinic. PA Rithy Chau was present during this month clinic. The patients were examined and the data were transcribed along with digital pictures of the patient, then transmitted (except for a few follow-up patients who came for medication refills and/or further instruction on referring to PP) and received replies from their TM partners in Boston and Phnom Penh.

The following day, Wednesday, July 20, 2005, the TM clinic opened again to receive the same 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, July 13, 2005 9:28 AM
To: Rithy Chau; jmiddleb@camnet.com.kh; Cornelia Haener; Ruth Tootill; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Sovann Nop; Ed & Laurie Bachrach; HealthNet International; Bernie Krisher; Noun SoThero; Fil B. Tabayoyong
Subject: July TM clinic at Rattanakiri

Dear All,

Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Tuesday, July 19,2005 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, July 20, 2005.The patents 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

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 6:25 PM

To: Rithy Chau; jmiddleb@camnet.com.kh; Cornelia Haener; Ruth Tootill; 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 July 2005 Patient SR#00125

Dear All,

Welcome to Rattanakiri TM Clinic. We have 8 new cases present to you for July 2005.

Here is the first case and photo.

Best Regards,
Channarith/Rithy

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

Patient: SR#00125, 3F, Ochum Village

Chief Complaint: a small bulging mass on forehead

HPI: she presented a small puffing mass and pus flowing on forehead since delivery .her mother took her to German clinic at Rattanakiri province .And then she was referred to kantabopha hospital with treating and making the surgery there .At the last two years , her symptoms has appears the left hand and leg are restless movement association with any which can not speak , and both eyes displace up to down ,weakness of right leg and arm and the puffing on forehead is still.no fever , no coma .

PMH/SH: surgery of head at katabopha hospital in Phnom Penh

Social Hx: none

Allergies: none

Family Hx: none

ROS:

PE:
Vital Signs: **BP100/80** **P80/** **R30** **T36** **Wt** 10kg

General:

HEENT: pupils unable to view because she moved her eyeballs too quickly,well healed scar on forehead extending to her upper nose , no cleft palate, normal teeth growth .no lymphadenopathy.no neck bruit.

Chest: CTA, HRRR , no murmur

Abdomen: unremarkable

Musculoskeletal: restless spastic movement of left arm and leg, right leg and arm can bend by active and can extent , abduction and adduction by active

Neuro: DTR : 2+elbows, 2+ wrists, 3+ knees,1+ankles, both Babanski -,

GU:

Rectal:

Previous Lab/Studies:

Lab/Studies Requests:

Assessment:

1.Hydrocephalus
2.congenital abnormal disease
3 congenital bulging forehead bulging

Plan:

1.To refer to surgery
2.CT Scanning of head

Comments/Notes: please give a good idea

Examined by: Kok San **Date: 19/7/05**

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

From: Heinzelmann, Paul J.,M.D. [mailto:PHEINZELMANN@PARTNERS.ORG]
Sent: Wednesday, July 20, 2005 9:09 AM
To: Fiamma, Kathleen M.
Cc: kirihospital@yahoo.com; tmed_rithy@online.com.kh
Subject: RE: Rattanakiri TM Clinic July 2005 Patient SR#00125

Dear Dr San

This looks a bit like an encephalocele that was treated by an ineffective surgery. A MRI would be ideal, but A CT scan would very useful at this point to look at the structures. Do you have previous imaging studies? Be very cautious about surgery as an option however, unless you have an experienced neuro or plastic surgeon. If you can get good digital images of the CT scan, we might be able to have a surgeon here give their impression.

Paul Heinzelmann, MD

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 7:54 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'
Subject: RE: Rattanakiri TM Clinic July 2005 Patient SR#00125

Dear Dr. San:

I agree with your assessment-- I think the patient has a congenital defect.My best advice is that she should follow-up at Kuntha Bopha; they may still have her medical record with the surgical notes and diagnosis, and they will have pediatricians who can best treat her..

Jack

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 7:04 PM
To: Rithy Chau; jmiddleb@camnet.com.kh; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar

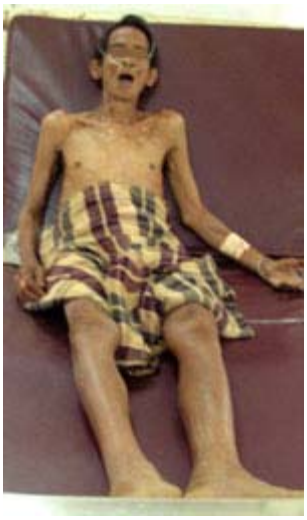
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach; HealthNet International; Fil B. Tabayoyong
Subject: Rattanakiri TM Clinic July 2005 Patient SS#00126

Dear All,

Here is the next case SS#00126 and photos.

Best Regards,
Channarith/Rithy

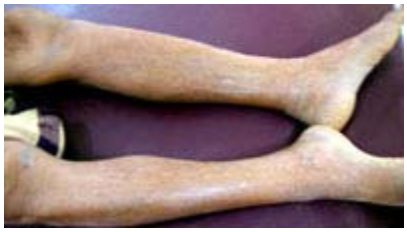
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine



Patient: SS#00126, M67 y.o, Village KET

Chief Complaint: Dyspnea intense, fatigue

HPI: 5 months ago he felt fatigue, dyspnea, headache, no fever 2 months ago he come to the Rattanakiri hospital he felt dyspnea, vertigo, cough with sputum his BP 110/60mmHg, pulse 110/min, RR 30/mi. He was treated for pulmonary edema caused by cardiac failure during 10 days he became better and continued with digoxine0,25mg 1 tablet qd when he returned home, but 7 days before he came to RTK hospital again he don't have any medicine and one day before he came our hospital on 14/07/2005 and he felt dyspnea, cough with sputum, oliguria, and I treated him with Furosemid 80mg IV, Digoxine 0,25mg slow IV bid, oxygen, one day after he became better



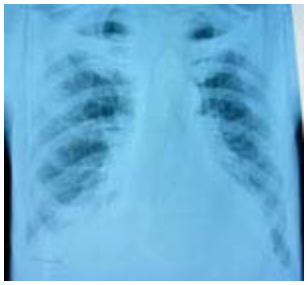
PMH/SH: no surgery, no accident

Social Hx: smoking and drinking alcohol

Allergies: none

Family Hx: none

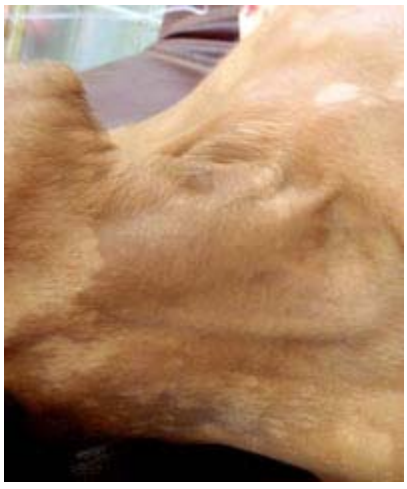
ROS: none



PE:
Vital Signs: **BP 110/70mmhg** **P 90/min** **R 26/min** **T36,5C** **Wt**

General: normal consciousness, cough with sputum fatigue, anorexia

HEENT: Head normal, cyanosis, conjunctiva fairly pallor, ENT: normal, neck soft, no enlarged LN , + bilateral neck bruits; +JVD



Chest: crackle bilateral, wheezees, Heart regular rhythm with systolic crescendo +2/4 murmur pulmonic and triscupid areas

Abdomen: hepato-splenomegely?? positive BS, no abdominal pain, fairly tenderness and dullness

Musculoskeletal: moderate swelling on his both feet

Neuro: Eye ball movement normal, corneal reflex normal, pupils 4mm, face no paralysis, reflex normal, motor and sensory normal both sides

GU: unremarkable

Rectal: not examined

Previous Lab/Studies: 19.07.2005 EKG, Chest X-ray

Abdominal ultrasound: foie image hyperéchogène bord irrégulier présente des liquides sous hépatique= Conclusion Cirrhose du foie

15/07/2005: Calcium 4,4mg/dl, Creatinine 0,7 mg/dl, Glucose 121,4 mg/dl, Potassium 3,5mmol/l, Sodium 80,9 mmol/l

18/07/2005: WBC 4100/mm3, RBC:3700.000/mm3, Ht 38%, Platelet 300 000/mm3, Malaria negative

Lab/Studies Requests:

Assessment:

1. Cardiac insufficiency
2. Valvular Heart Dz

Plan:

1. Digoxine 0,25mg qd
2. Furosemid 40mg qd
3. KCL 600mg qd

Comments/Notes:

Examined by: Dr Sovitha **Date: 19.07.2005**

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

From: Guiney, Timothy E.,M.D.
Sent: Tuesday, July 19, 2005 2:41 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri TM Clinic July 2005 Patient SS#00126

This 67-year-old man appears to have decompensated congestive cardiac failure. He initially responded to digitalis and diuretics but ran out of medications and is now in trouble again.

The description of the physical examination he has a loud basal systolic murmur and carotid bruits suggests that the underlying problem is that of aortic stenosis. This needs to be confirmed with an echocardiogram. The electrocardiogram did not transmit and I cannot read it.

His blood work appears to be fairly normal with normal renal function and only very mild anemia. It would be helpful to know the status of his liver function tests and in particular a serum albumin because he is so edematous

In the meantime he needs to be on a daily program of digoxin, furosemide and potassium replacement. Since he has abdominal and leg edema which is unusual with isolated aortic stenosis, and since the abdominal ultrasound suggests hepatic cirrhosis, he might be helped by the addition of either spironolactone or metolazone to his furosemide.

No mention is made of scleral icterus. We do not know the specific cause of his cirrhosis and it could either be on the basis of alcohol consumption or possibly could be cardiac cirrhosis from tricuspid insufficiency.

He has some areas of depigmentation on his skin which I cannot explain except that they are not at all likely to be related to his heart failure.

It will be important to attempt to define more fully the cause of his heart failure which is apparent on the chest x-ray which reveals no cardiomegaly and interstitial edema as well as pleural effusions. This will require an echocardiogram and if left

ventricular function is good, and the cirrhosis is not related to alcohol, he should probably be referred to our Center where cardiac catheterization and surgery could be done.

Timothy E. Guiney M.D.

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 9:37 AM
To: 'Kiri Hospital'; '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: RE: Rattanakiri TM Clinic July 2005 Patient SS#00126

Dear Dr. Sovitha:

I agree with your plan.

Jack

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 7:10 PM
To: Rithy Chau; jmiddleb@camnet.com.kh; 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 July 2005 Patient HH#00127

Dear All,

Here is the next case HH#00127 and photos.

Best Regards,
Channarith/Rithy

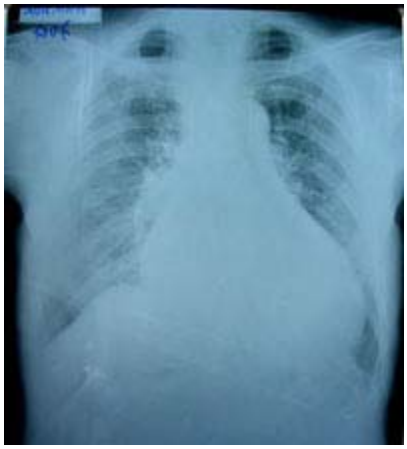
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: HH#00127, M 70y.o, Village I

Chief Complaint: Dyspea, Cough with green sputum

HPI: 6 months ago he felt fatigue, dyspnea, anorexia, swelling his both feet, oliguria and he came to Rattanakiri hospital 3 times ago for treatment and his symptoms were better but one week before he came to Rattanakiri hospital all symptoms happen again so he decide come to Rattanakiri hospital on 18.07.2005

PMH/SH: no surgery, no accident



Social Hx: smoking and no drinking alcohol but he drank when he was young

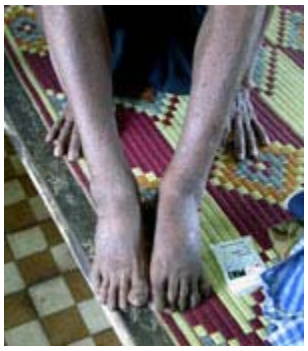
Allergies: none

Family Hx: none

ROS: none

PE:
Vital Signs: BP 130/70mmhg P 90/min R 28/min T36,5C
Wt 56 kg

General: normal consciousness, cough with sputum fatigue, anorexia

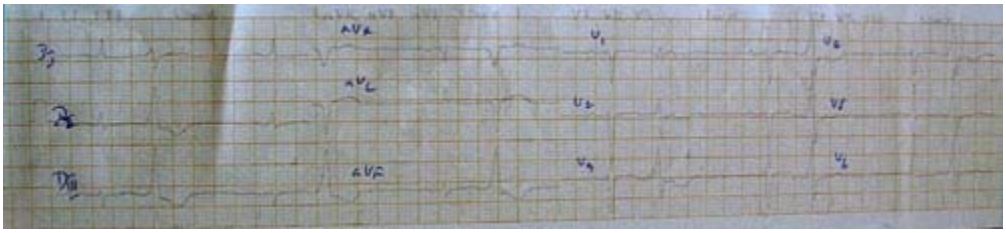


HEENT: Head normal, no cyanosis, conjunctiva fairly pallor, ENT: normal, neck soft, no enlarged LN no bruit

Chest: crackle bilateral, Heart irregular rhythm with systolic crescendo +2/4 murmur on the 4 areas

Abdomen: hepato-splenomegely, positive BS, no abdominal pain, fairly tenderness and dullness

Musculoskeletal: moderate swelling on his both feet



Neuro: Eye ball movement normal, corneal reflex normal, pupils 4mm, face no paralysis, reflex normal, motor and sensory normal both sides

GU: unremarkable

Rectal: unremarkable

Previous Lab/Studies: 19.07.2005
EKG, Chest X-ray
Abdominal ultrasound: hépatomegalie, voie billaire de paroi epaisseur, augmentation de volume, présence d'un image hyperéchogène 45mmx40mm, cavité abdominal présence des liquides= Conclusion: Ascite + calcul de vésicules billaire
19.07.2005: Calcium6,8mg/dl, Creatinine 0,4mg/dl, Glucose 85,7 mg/dl, K 3,4 mmol/l, Sodium 115mmol/l, SGOT 64,2 U/l, SGPT 42,3 U/l, Malaria negative, WBC 5500/mm3, RBC 4100000/mm3, Ht 43%, Platelet 85 000/mm3
Lab/Studies Requests:

Assessment:

1. Cardiac insufficiency
2. Valvular Heart Dz

Plan:

1. Digoxine 0,25mg bid
2. Furosemid 40mg qd
3. KCL 600mg qd

Comments/Notes:

Examined by: Dr Sovitha **Date: 19.07.2005**

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

From: Smulders-Meyer, Olga,M.D.
Sent: Tuesday, July 19, 2005 5:26 PM
To: Fiamma, Kathleen M.
Cc: 'kirihospital@yahoo.com'; ': tmed'
Subject: RE: Rattanakiri TM Clinic July 2005 Patient HH#00127

The patient is a 70 yr old gentleman who presents with several issues:

1. Congestive Heart Failure: he is symptomatic with shortness of breath, tachypnea and a productive cough. On physical examination he has crackles bilaterally and he has pulmonary congestion on his chest xray, as well as cardiomegaly. He has both left and right sided failure as he has shortness of breath as well as pedal edema.
His heart rate is 90, he is normotensive.

His chest xray shows a large heart and all chambers seem to be huge, suggestive of longstanding increasing cardiomegaly, which has now become symptomatic. The cause cannot be known at this point, but his history of alcohol in the past may well have contributed to the development of cardiomegaly..
We do not know if he has a history of Hypertension, or whether he may have had prior cardiac infarcts. . Most likely he has a very low Ejection Fraction, a bad pump, and needs circulatory support. A cardiac ultrasound would asses the heart function best, but I am not sure whether you have this tool available where you are right now.

I agree he needs to be diuresed and it is prudent to start with Lasix 40 mg, and supplement him with an equal amount of Potassium 40 Meq. He has fluid in his lungs, in his abdomen and in his legs, but intravascularly he is most likely quite dry, thus one must carefuly monitor his Bun/Creatinine, as they may rise when you diurese him too agressively, and thus create another problem, namely pre renal ATN.
Strict salt restrictions should be started, and urine output monitored.

He is normotensive, and it might be helpful to add a low dose Ace inhibitor, such as Captopril 25 mg and slowly titrate this upwards until his bloodpressure begins to fall. This will decrease after load for the heart, and thus promote the pump function of the heart, and thus decrease the left sided failure. Usually we might also add low dose Atenolol, but his

heartrate is so low right now that I would wait until the worst failure has been resolved, after diuresis, and see if his rhythm normalises.

he needs to be ruled out for MI and consider SL NTG prn worsening shortness of breath, as he might have continuing ischaemia.

The patient EKG shows an irregular rhythm with very wide, ventricular rhythm, that is slow as well as some junctional escape beats. Be careful that one monitors the Digoxin level. Here we might start a person on Digoxin 0.125 mg first.
He clearly needs to be on a heart monitor and might need to get a Holter once he is out of failure. If his rhythm remains this slow, he might need a pacer.

The patient is thin, and older and one worries about a malignancy. His Calcium is low, which is often associated with a malignancy, but his Hct is in normal range.
I fear with such amount of cardiomegaly his prognosis is not very good, and the treatment for now is supportive inn order to improve forward flow and decrease failure.

His Biliairy stone is insignificant.

Olga Smulders-Meyer, MD

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 9:51 AM
To: 'Kiri Hospital'; '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: RE: Rattanakiri TM Clinic July 2005 Patient HH#00127

Dear Dr. Sovitha:

I agree with your assessment and plan for furosemide and KCl.

On EKG, the patient appears to have bigeminy which is the most common arrthythmia caused by digoxin. It is also a sign of digoxin toxicity. For this reason, I recommend to stop digoxin.

Jack

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 6:48 PM
To: Rithy Chau; jmiddleb@camnet.com.kh; Cornelia Haener; Ruth Tootill; 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 July 2005 Patient ST#00128

Dear All,

Here is the next case ST#00128 and photos.

Best Regards,
Channarith/Rithy

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

Patient: ST#00128, M30y.o, Village TANG SE

Chief Complaint: Left severe flank pain + low back pain x 1 month

HPI: One month ago, he felt spine pain with radiation into left flank the pain progressively increasing until unbearable, he can't walk or sit and the pain decrease when he lie down so he decide to come to our hospital on 19.07.2005
PMH/SH: no accident, no surgery

Social Hx: smoking and drinking alcohol

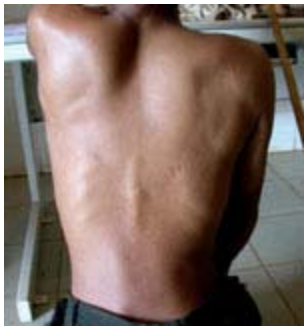
Allergies: none

Family Hx: none

ROS:
PE:
Vital Signs: BP 120/80mmhg P 76/min R 16/min T37C Wt

General: no cough no sputum, no fever normal consciousness, no weight loss

HEENT: Head normal conjunctiva no pallor, ENT normal, no enlarged LN, no bruit



Chest: normal breath sound, no crackle, no wheezes bilateral, HRRR, no murmur

Abdomen: BS positive, no tenderness, left flank pain, no tenderness, no hepato-splenomegaly

Musculoskeletal: lumbalgo when palate the spine and paraspinal muscle, pain increase when flexion, extension, lateral bending, rotation(impossible to do) when lie down no problem to do flexion or extension his leg, no tumor

Neuro: Eye ball movement normal, corneal reflex normal, pupils 4mm, face no paralysis, reflex normal, motor and sensory normal the 4 limbs.

GU: no bladder dysfunction, no urinary incontinence

Rectal: Stool normal

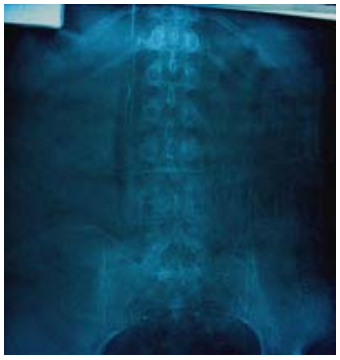
Previous Lab/Studies:

Lab/Studies Requests: Spinal CT-Scan

Assessment:

1. Pott's disease
2. Lumbar radiculopathy
3. Recurrent or prolonged pain

4. Malignancy suspected
5. Ruptured or herniated intervertebral disk



Plan:

1. Strict bedrest for 1-2weeks
2. Indométacine2mg tid
3. Vit bB1 B6 B12 1tablet tid
4. Paracétamol500mg 1 tablet tid

Comments/Notes:

Examined by: Dr Sovitha **Date: 19.07.2005**

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

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 8:43 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'
Subject: RE: Rattanakiri TM Clinic July 2005 Patient ST#00128

Dear Dr. Sovitha:

Thank you for your good evaluation of this patient. I think the patient most likely has simple low back pain from a muscle of ligament strain. Your plan for anti-inflammatories and paracetamol is good. It is not necessary for the patient to have strict bed rest; he should not do any heavy activities for a few weeks, but it is fine for him to walk and move around normally.

If you suspect Pott's diesease, I think a lateral X-ray of the spine would be a good next step. I do not think a CT spine is necessary, especially since the patient has no neurological signs or symptoms.

With best regards,

Jack

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From: Heinzelmann, Paul J.,M.D. [mailto:PHEINZELMANN@PARTNERS.ORG]
Sent: Wednesday, July 20, 2005 9:25 AM
To: Fiamma, Kathleen M.
Cc: kirihospital@yahoo.com; tmed_rithy@online.com.kh
Subject: RE: Rattanakiri TM Clinic July 2005 Patient ST#00128

Dr Sovita,

I think your differential diagnosis is good.  (Does he have a hstory of TB?) The
pain seems to be fairly localized and is not referred down the leg, but reflexes
would be helpful.  The x-ray is some dificult to interpret.  A urinalysis would
be helpful as well.
I would avoid excessive lifting, twisting, bending.  Strict bed rest may not be
necessary, however.  I agree with indomethacin but would not keep the patient on
for a prolonged period of time.

Paul Heinzelmann, MD
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From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 6:34 PM
To: Rithy Chau; jmiddleb@camnet.com.kh; Cornelia Haener; Ruth Tootill; 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 July 2005 Patient NS#00129

Dear All,

Here is the next case NS#00129 and photos.

Best Regards,
Channarith/Rithy

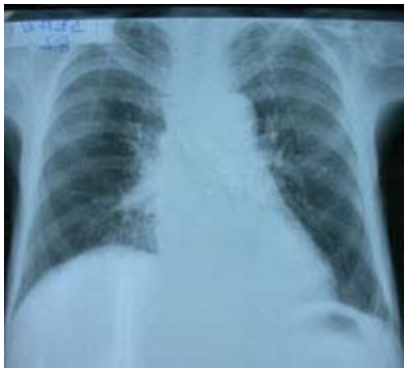
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: NS#00129, F82y.o, Village I
Chief Complaint: Abdominal pain, abdominal swelling x 6 months

HPI: 6 months ago he felt fever, headache, abdominal pain, icteric, cough from time to time she came to Rattanakiri hospital for treatment 3 times ago and she became better and she returned home but one week before she come to the hospital, progressive abdominal enlargement has gone noticed , weight loss, dyspnea, oliguria, cough, vertigo, itching, on his body so she decided to come to our hospital on 18.07.2005
PMH/SH: no surgery, no accident

Social Hx: no smoking and drinking alcohol but she drank a little when she was young

Allergies: none



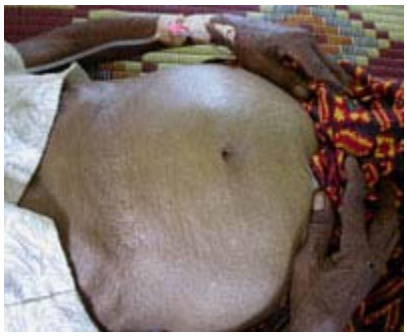
Family Hx: none

ROS: post menopause x 42 years

PE:
Vital Signs: BP 110/70mmhg P 70/min R 26/min T37,5C
Wt

General: normal consciousness, cough with yellow sputum, fatigue, anorexia, her mouth bad breath, dyspnea

HEENT: Head normal, conjunctiva jaundice pallor, ENT: normal, neck soft, no enlarged LN , no bruit



Chest: crackle bilateral, no wheezes, Heart regular rhythm no murmur

Abdomen: hepato-splenomegaly positive BS, abdominal pain on RLQ and LLQ, the umbilicus is flat, Schwartz's test positive

Musculoskeletal: moderate swelling on the both feet

Neuro: Eye ball movement normal, corneal reflex normal, pupils 4mm, face no paralysis, reflex normal, motor and sensory normal both sides

GU: not examined

Rectal: not examined

Previous Lab/Studies: 19.07.2005 Chest X-ray

Abdominal ultrasound: Hépatomegalie bord irrégulier voie biliaire dilatée, cavité abdominal et Douglas présentent des liquides abondant

19/07/2005: Calcium 6.3mg/dl, Creatinine 0,7 mg/dl, Glucose 94,4mg/dl, K 6,5 mmol/l, Sodium 65,5 mmol/l(blood error possible), SGOT 83,5 U/l, SGPT 58,1 U/l

AgHBs, AcHBS, AcHCV not jet received result

18/07/2005: WBC 38000/mm3, RBC:2000000/mm3, Ht 21%, Platelet 210000/mm3, Malaria negative

Lab/Studies Requests:

Assessment:

1. Cirrhosis with Ascites
2. Liver Tumor

Plan:

1. Infusion NSS 1000ml/day
2. Infusion Ciprofloxacine200mg bid
3. Furosemid 40mg 1 tablet bid

Comments/Notes:

Examined by: Dr Sovitha **Date: 19.07.2005**

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

From: Tan, Heng Soon,M.D.
Sent: Tuesday, July 19, 2005 4:42 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri TM Clinic July 2005 Patient NS#00129

Six months ago she presented with liver disease. Do we have hospital records to confirm that she had acute on chronic hepatitis or liver cirrhosis at that time?

On current presentation, she appears to have liver cirrhosis with ascites. It would be useful to have a more detailed clinical description of chronic liver disease. Were there telangiectasia on skin? She was alert, but was there asterixis to suggest elevated ammonia? She was afebrile and abdomen had ascites and was tender. Was it epigastric, umbilical or liver tenderness? It's hard to know whether there was bacterial peritonitis. Aspiration of ascitic fluid for white cell count and gram strain and culture for bacteria could clarify status.

The large spleen is consistent with chronic liver disease and portal hypertension. The large liver on the other hand is not consistent with just cirrhosis. It suggests an acute hepatitis or presence of liver mass or even Budd Chiari syndrome with thrombosis of hepatic veins. Abdominal ultrasound shows an enlarged liver but no mention of a mass. Alpha fetoprotein antigen could support diagnosis of liver cancer. Ideally a liver biopsy may be necessary to confirm diagnosis.

Viral hepatitis serology makes sense. If these are negative, one could screen for metabolic causes of chronic liver disease like ferritin or ceruloplasmin. Electrolytes likely reflect lab error. I notice she is anemic. A blood smear to look for hemolytic schistocytes could clarify whether hypersplenism is contributing to anemia. However the platelet count is normal, a point against severe hypersplenism. Stool guaiac test is necessary to rule out GI bleeding from gastritis or esophageal or rectal varices. Ferritin, folic acid and B12 levels will help categorize anemia. Further tests of prothrombin time, serum albumin and ammonia will confirm degree of impaired hepatic function.

I'm not sure I would use ciprofloxacin without confirmation of bacterial peritonitis. Furosemide is fine, but monitor serum potassium. It's always safer to start spironolactone as primary diurectic to conserve potassium and supplement with

smaller doses of furosemide. Low doses of propranolol to decompress portal hypertension may help. Monitoring renal function and electrolytes would be important during diuresis.

Adequate hydration, low protein high carbohydrte diet will prevent hepatic encephalopathy. She should avoid acetoaminophen and alcohol and other hepatotoxic chemicals.

Heng Soon Tan, M.D.

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 9:28 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'
Subject: RE: Rattanakiri TM Clinic July 2005 Patient NS#00129

Dear Dr. Sovitha:

I discussed this case with Dr. Cornelia (the surgeon at SHCH) and she thinks the patient most likely has a cholagiocarcinoma or pancreatic tumor, probably advanced. Because of the patient's age and advanced disease, surgery is unlikely to help.

Her high white count may be due to cholangitis, so we agree with your plan for antibiotics. The patient should also receive treatment for pain, if she has any.

Finally, I do not recommend giving IV fluid. Furosemide may be helpful for her edema and ascites.

I hope this is helpful.

Jack

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 6:29 PM
To: Rithy Chau; jmiddleb@camnet.com.kh; Cornelia Haener; Ruth Tootill; 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 July 2005 Patient SW#00130

Dear All,

Here is the next case SW#00130 and photos.

Best Regards,
Channarith/Rithy

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

Patient: SV#00130, M 17 y.o, Village VI

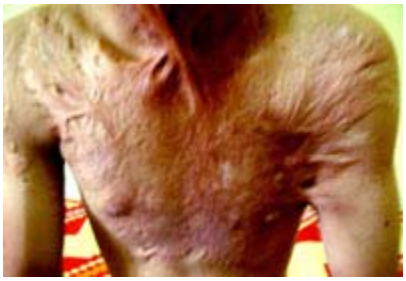
Chief Complaint: Retracted scar + neck hypertension difficulty because of burn

HPI: About 8 years ago the burn cause by petrol on his face, neck , chest and left upper limb. After the burn he was treated and clean at his house by his parents during about 2 weeks and retracted scar happened, make decrease movement his neck, mouth and left upper limb. 6 months after he go to calmette hospital Phnom Penh for doing plastic operation of his retracted scar on his neck during for 2 weeks and after that he don't do anything on his scar.

PMH/SH: Petrol burn 8 years ago and do plastic operation on his neck

Social Hx: no smoking and drinking alcohol

Allergies: none



Family Hx: none

ROS:
PE:
Vital Signs: BP 100/60mmhg P 80/min R 16/min T36,5C
Wt 50kg

General: normal consciousness, no cough no sputum

HEENT: conjunctiva no pallor, ENT normal, no enlarged LN, no bruit, no symmetrical mouth when open or close, retracted scar one his face until upper his chest, front neck area, left shoulder and axillary area

Chest: normal breath sound, no crackle, no wheezes bilateral, HRRR, no murmur

Abdomen: BS positive, no tenderness, no abdominal pain, no hepato-splenomegaly

Musculoskeletal: unremarkable

Neuro: Eye ball movement normal, corneal reflex normal, pupils 4mm, face no paralysis, reflex normal, motor and sensory normal both sides

GU: not examined

Rectal: not examined

Previous Lab/Studies:

Lab/Studies Requests:

Assessment:

1. Retracted scar caused by petrol burn

Plan:
Comments/Notes:

Examined by: Dr Sovitha **Date: 19.07.2005**

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

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 9:03 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'
Subject: RE: Rattanakiri TM Clinic July 2005 Patient SW#00130

Dear Dr. Sovitha:

Our best advice is to refer this patient to the Rose charity at Keang Klang for surgical evaluation for contracture release.

With best regards,

Jack and Cornelia

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 6:56 PM
To: Rithy Chau; jmiddleb@camnet.com.kh; Cornelia Haener; Ruth Tootill; 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 July 2005 Patient PS#00131

Dear All,

Here is the next case PS#00131 and photos.

Best Regards,
Channarith/Rithy

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

Patient: PS#00131,34,TROPEANG KRAHORME Village

Chief Complaint: yellow urine and both eyes for 2 months, RUG pain for one moth

HPI: 34M presented with a yellow urine and both eyes x2 m ,he treated the traditional drugs and cared a unknown medicines at private clinic ,and his symptoms did not get better association with RUG pain x 1month .At the last month , his complaint of development of both yellow eyes with yellow urine and loss weigh 6.5 kg in 2 month , and still RUG pain with constipation sometime ,asthenia , fever - ,coma -, headache -, v/n - .

PMH/SH: unremarkable

Social Hx: + smoking , alcohol up to ½ liter/ a day sometime x 10 years

Allergies: none

Family Hx: unremarkable

ROS:

PE:
Vital Signs: **BP98/72** **P72** **R20** **T36** **Wt** 55,5 kg

General: look stable

HEENT: pal conjunctivae , yellow both eyes , no sore throat , no lymph nod , no otitis , no rhinopharyngitis ,

Chest:Lung: clear both sides , no crepitation , no rhonchi
Heart: HRR normal , no murmur

Abdomen: soft , large liver = 19 cm , liver pain on palpation ,diarrhea off and on , active BS , abdominal vascular vein , regular liver border .

Musculoskeletal: intact motor

Neuro: intact sensory

GU: none

Rectal: rectum normal , + Hemoccult

Previous Lab/Studies: none

Lab/Studies Requests: ultrasound :hepatomegally ,echogen, homogen regular border ,urine analysis : ph :6., SG:1.02 ,track protein , - glucose , - ketones , urobullin + , bilirubin + 4 ,blood - , Hb 13 , leukocytes - , nitrites - ,
Assessment:

1. alcoholism cirrhosis
2. viral hepatitis
3. cirrhosis
4. Fillariosis

Plan:

1. Vit b 1 ,b6 , b 12 1tb pot id x 1 m
2. MTV 1 tab po qd x 1 m
3. Hepatic 1 tab po tid x 1m

Comments/Notes: give a good idea

Examined by: Kok San **Date: 19/7/05**

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

From: Tan, Heng Soon,M.D.
Sent: Tuesday, July 19, 2005 5:03 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri TM Clinic July 2005 Patient PS#00131

The history suggests acute on chronic alcoholic liver disease. Certainly concurrent viral hepatitis or use of hepatotoxic herbal medicines could cause flare of hepatitis, but the 2 month history suggests more chronic liver disease with continued insult from alcoholic [and herbal] intake. Chronic cirrhosis presents with small liver. A large liver suggests superimposed hepatitis [or liver cancer, but he is a young man]. He has guaiac positive stools so I would be concerned about alcoholic gastritis or even esophageal variceal bleeding.

Liver function tests including prothrombin time, albumin will define liver function. Alpha fetoprotein, viral hepatitis serology, ferritin and ceruloplasmin to rule out metabolic causes of liver disease could be considered.

He should abstain from alcohol, but may need benzodiazepines to treat withdrawal symptoms.

Heng Soon Tan, M.D.

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 8:55 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'
Subject: RE: Rattanakiri TM Clinic July 2005 Patient PS#00131

Dear Dr. San:

If possible, check viral hepatitis serologies. I agree with your assessment and plan. Please counsel the patient to avoid alcohol and paracetamol.

With best regards,

Jack

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, July 19, 2005 6:59 PM
To: Rithy Chau; jmiddleb@camnet.com.kh; 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 July 2005 Patient HV#00132

Dear All,

Here is the next case HV#00132 and photos.

Best Regards,
Channarith/Rithy

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

Patient: HV#00132, 2F, Village I

Chief Complaint: Low appetite and chronic diarrhea x 1 yr.

HPI: 2F was brought in to TM clinic by her mother seeking help for her since her daughter seems to have difficulty to thrive. She said that her child was born normally, sixth of the siblings, and was breastfed without any problem. However, about 1 yr ago, the child began to have fever, diarrhea, and vomiting every month or other month lasting about 3 days to one week per episode. She only sought treatment at local pharmacy and the medicine given seemed to help her daughter to "get through" each episode, but her sx did not resolve completely. Since her chronic diarrhea with fever and vomiting, the child seemed to become stagnant with the same weight and height ("from appearance"). She passed watery stool of yellow color with mucus without blood; markedly decreased appetite, and weakened (and now unable to walk on her own for the past few months). Last week, the child was brought to see a private doctor who treated her for URI because of the c/o yellow nasal d/c, fever, diarrhea with mucus, vomiting, and "noisy breathing." She became better but not totally resolving and thus came to RRH TM Clinic today. No cough, no sputum.

PMH/SH: Chronic diarrhea with mucus

Social Hx: parents do not smoke, sixth child

Allergies: NKDA

Family Hx: all siblings and parents are healthy

ROS: eat solid food, occasionally drink whole milk (when parents can afford it), mom said child can only say the words "ma" and "pa", able to walk about 2-3 months ago

PE:
Vital Signs: **BP** not done (no peds cuff) **P** 132 **R** 26 **T** 37C **Wt** 6kg **Ht** 67cm

General: Alert, somewhat playful, no words, cachetic, able to follow commands, slightly pale

HEENT: PERRLA & EOMI, no orpharyngeal lesions, shotty LN palp at right submandibular, pink conjunctiva, TMs clear, no jaundice

Chest: generalized coarse crackles with rhonchi bilaterally; HRRR no murmur

Abdomen: +BS, mod distension, look slightly irritative when doing deep palpation, no HSM

Neuro/MS: muscle tone slightly decreased, but more prominent at gluteal area, normal ROM, motor and sensory intact, DTRs ok, can stand normally, won't walk; good pulses.

GU: not done

Rectal: not done

Previous Lab/Studies: per verbal hx, no malaria

Lab/Studies Requests: CBC (WBC=9,000; RBC=2,700,000; Hb=8.2; Hct=27; E3, N55, L40, M2; Plt=180,000; K=5.0; Creat=1.0; gluc=85.5; Hb (f/s) = 11; CXR (difficult to read)

Assessment:

1. Dysentery (amoeba, giardia)
2. Parasititis (worms)
3. Pneumonia?
4. Failure to Thrive?? (under nourished)
5. Anemia?

Plan:

1. Metronidazole 250mg ½ tab po bid x 10d
2. Bactrim susp 120mg/5mL 1 tsp bid x 10d
3. Mebendazole 100mg 1 po bid x 3d
4. MTV w/ FeSO4 syrup 1 tsp po qd x 60d
5. Para 100mg po bid prn fever

Comments/Notes:

Examined by: Rithy Chau, PA-C **Date: 19/7/05**

Please send all replies to kirihospital@yahoo.com and cc: to tmed_rithy@online.com.kh .
The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any

From: Heinzelmann, Paul J.,M.D. [mailto:PHEINZELMANN@PARTNERS.ORG]
Sent: Wednesday, July 20, 2005 9:00 AM
To: Fiamma, Kathleen M.
Cc: kirihospital@yahoo.com; tmed_rithy@online.com.kh
Subject: RE: Rattanakiri TM Clinic July 2005 Patient HV#00132

Rithy,

Thanks for the very complete assessment. There are several things going on.

Diarrhea: the child may have what is sometimes refrred to as chronic non-specific diarrhea. This can be from a diet high in fluids, low in fat, and carbohydrate/sugar malabsorption from excessive fruit juice. You can determine this by diet history, which doesn't seem to entirely support this. Therefore, other things to consider are:
1. lactase deficiency and other enzyme deficiencies
2. giardia or cryptosporidium
3. malabsorption
4 gastroenteritis

A stool eval will be helful to rule out parasites - OR simply treat and see if the condition improves. As you suggested metronidazole (15mg/kg/d for 10 days) seems resonable. If things don't improve, consider the others on the list.

Course breath sounds/?pnumonia: This can be misleading in kids this young as upper airway noise is easily transmitted to the back on exam with stethoscope. Because of the lack of fever and lack of high respiratory rate, I would hold off in treating this as a pnuemonia. The antibiotics for treatment may also make the diarrhea worse. (Conversely, antibiotics may be useful in treating bacterial gastroenteritis)

Anemia/malnutrition: your CBC supports this diagnosis. Colochecking a stool

sample would be helpful to see if there is blood loss in the stool.
Malnutrition would also weaken the immune system and make the child more
susceptable to URIs and other illnesses. Fe supplementation seems reasonable.
Do we know the MCV?

Failure to thrive sounds likely and may be related to anemia/malnutrition....it
is defined as a child younger than 2 years of age below the 3rd or 5th
percentile on more than one occassion, or less than 80% of ideal body weight.
This sounds like it is likely as she seems to be developmentally delayed..ie
speech. The key is to get a very thorogh diet history and see how the parents
interact with the child and see if they seem to be neglectful.

If possible, I'd suggest having the child taken to SHCH and have thorough
evaluation there.

Hope this helps
Paul Heinzelmann, MD

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, July 20, 2005 10:02 AM
To: 'Kiri Hospital'; '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: RE: Rattanakiri TM Clinic July 2005 Patient HV#00132

Dear Rithy:

Thanks for the nice evaluation. Not being a pediatrician or a family practioner, I can't give much advice about growth problems in children. If the child was walking before, but has stopped walking in the last two months that seems very worrisome to me. If Partners doesn't submit a plan you feel is adequate, I think the child's best bet would be a consultation at Kuntha Bopha.

Jack

Wednesday, July 20, 2005

Follow-up Report for Rattanakiri TM Clinic

There were 8 new and 7 follow up patients seen during this month TM clinic at Rattanakiri Referral Hospital (RRH). The data of all new cases were transmitted and received replies from both Phnom Penh and Boston. Per advice sent by Partners in Boston and Phnom Penh Sihanouk Hospital Center of HOPE, the following patients were managed and treated 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.]

Treatment Plan for Rattanakiri TM July 2005

1. SR#00125, 3F, Ochum Village

   Dx: 1. Hydrocephalus

   Tx: 1. Refer to a Pediatric Hospital in PP

2. SS#00126, 67M, Key Village

   Dx: 1. CHF 2. Aortic Stenosis?

   Tx: 1. Digoxin 0.25 mg 1 tab po qd
   2. Furosemide 40 mg 1tab po qd
   3. KCl 600 mg 1tab po qd

3. HH#00127, 70M, Village I

   Dx: 1.CHF

   Tx: 1. Digoxin 0.25 mg 1tab po qd
   2. Furosemid 40 mg 1 tab po qd
   3. KCL 600 mg 1 tab po qd

4. ST#00128, 30 M, Tang Se Village

   Dx: 1. Muscle Strain 2. Pott's disease?

   Tx: 1. Indomethacine 25mg 1 tab po tid
   2. Paracetamol 500mg 1tab po tid

5. NS#00129, 82F, Village I

Dx: 1. Cholangiocarcinoma or Pancreatic Tumor ? 2. Cholangitis

Tx: 1. Ciprofloxacine 500mg 1 tab po bid
2. Furosemid 40 mg 1 tab po qd
3. KCL 600 mg 1 tab po qd

6. SV#00130, 17M, Village VI

Dx: 1. Scar contracture/Keloid

Tx: 1. Refer this patient to the Rose Charity at Keang Klang for surgical evaluation

7. PS#00131, 34M, Tropeang Krahorm Village

Dx: 1. Alcoholic liver disease 2 . liver cancer? 3.alcoholic gastritis

Tx: 1.clarythromycin 500mg 1tab po bidx14 day
2.Amoxicilline 500 mg 2 tab po bidx 14d
3.Omeprazol 20 mg 1 tab po bid x14d
4.MTV 1 tab po po x 1 month
5.vit b1,b6,b12 1tab po tid x 1month

8.HV#00132,2F,village I

Dx: 1.Giardiasis 2.Parasitis 3.failure to thrive

Tx: 1.Metronidazol 250mg suspension ¼ po bid x10d
2.Mebendazol 100mg ½ po bid x 3d
3.MTV /Feso4 syrup 5 drops bid x3o d
4.returne for follow up next month
5. pediasric powder to be requested from SHCH

Follow-up patients for Rattanakiri TM Clinic July 2005

1.PN#0005,38F,villageI

Dx: 1.Asthma 2.allergic Rhinitis 3.GERD 4 .PUD

Tx: 1.Albuterol 2 puff twice prn
2.Azmacort 2 puff twice /d
3.claritin 10mg 1 sl qd prn

2.UP#00093,51F ,village I

Dx: 1.Hyperthoidism 2.osteochondritis

Tx: 1.carbimarzole 5mg 1tab po tidx100d
2.para 500mg 1 tab po prn pain
3.MTV 1 tab po qd

3.PC#00113,40F, Village I

Dx: 1.thyroid tumor 2. hyperthyroidism

Tx: 1.cytology at SHCH

4.KO#00100,33F,SRE ANKRONG Village.

Dx: 1.euthyroid cystic goiter

Tx: 1She was mad the surgery at SHCH

5. NS#0006, 18F, Village I

Dx: 1. Hyperthyroidism

Tx: 1. Methimazole 10mg ½ po tid x100d

6. NS#00089, 15F, Village I

Dx: 1. Hypothyroidism

Tx: 1. L-thyroxine25 mcg 2tab po qd x100d

7. HM#00123, 28M, Village I

Dx: 1. Anxiety 2. Tension HA.

Tx: 1. Naproxen 220mg 2tab bid prn HA

Follow-up Report from SHCH

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Tuesday, August 09, 2005 3:41 PM
To: Rattanakiri TM
Cc: Bernie Krisher; Cornelia Haener; Ed & Laurie Bachrach; Fil - Jr. Tabayoyong; Gary Jacques; HealthNet Rattanakiri; Jack Middlebrooks; Kathy Fiamma; Ly Channarith; Paul Heinzelmann; Paul Heinzelmann; Ruth Tootill; So Thero Noun
Subject: Follow-up Report for Rattanakiri TM Patients in July 2005

Dear Channarith and Dr. San,

The following is the follow-up report for three patients seen at the July 2005 TM Clinic at RRH:

1. NS#0006, 18F, Village I

22/07/05
Free T4 6.61 [9.14 – 23.81]

03/08/05

TSH	2.02	[0.49 – 4.67]
Free T4	3.77	[9.14 – 23.81]

Dx: Hyperthyroidism (now became hypothyroidism from medication)

Tx Plan: Please reduce her medication as follow→instead of giving methimazole 10mg ½ tab po tid, please give only ½ tab po qd and recheck her TFT in 6-8 weeks.

Note: Since it was unclear that the lab drawn on 22/07/05 may be confused between the two sisters with very similar names, a repeat of TFTs was done on 03/08/05 before changing the treatment plan.

2. NS#00089, 16F, Village I

22/07/05

TSH	0.07	[0.49 – 4.67]

03/08/05

TSH	< 0.02	[0.49 – 4.67]
Free T4	17.31	[9.14 – 23.81]
Tot T3	2.49	[0.78 – 2.50]

Dx: Hypothyroidism (now became hyperthyroidism from medication)

Tx Plan: Please reduce her medication as follow→instead of giving L-Thyroxine 25mcg 2 tab po qd, please give only 1 tab po qd and recheck her TFT in 6-8 weeks.

Note: Since it was unclear that the lab drawn on 22/07/05 may be confused between the two sisters with very similar names, a repeat of TFTs was done on 03/08/05 before changing the treatment plan.

3. PC#00113, 40F, Village I

From: Jack Middlebrooks [mailto:jmiddleb@camnet.com.kh]
Sent: Wednesday, April 27, 2005 7:50 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Cc: 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Bernie Krisher'; 'Nancy Lugn'; 'Noun SoThero'; 'Fil B. Tabayoyong'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient PC#00113

Dear Rithy and Channarith:

As a general principle for evaluating any patient with a chief complaint of dysphagia, it is helpful to ask if the problem is swallowing solids, liquids, or both. Often with a mass, the problem begins as difficulty swallowing solids, and over time, progresses to difficulty swallowing liquids. Does the patient ever have the sensation of food "getting stuck?" If so, asking the patient to indicate where the sticking sensation occurs can help localize the problem.

I agree with your assessment and plan. If the TSH is low, the patient should be treated until she is euthyroid; because she is having difficulty swallowing, I suspect our surgical department would be willing to consider resection of the mass once her TSH is normal. If her TSH is normal, I would suggest an ultrasound, and possibly a biopsy, for further evaluation. I will defer to Dr. Cornelia to comment on this possible surgical referral.

Best regards,

Jack

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, May 05, 2005 11:31 AM
To: Rattanakiri TM
Cc: Bernie Krisher; Ed & Laurie Bachrach; Fil - Jr. Tabayoyong; Gary Jacques; Jack Middlebrooks; Ly Channarith; So Thero Noun; HealthNet Rattanakiri
Subject: Lab Results for Rattanakiri TM Clinic April 2005

Dear Dr. San and Channarith,

The followings are lab results for the patients seen at TM clinic April 2005:

1. PC#00113, 40F
    a. Free T4 = 16.49 [9.14 - 23.81]
    b. TSH = 0.93 [0.49 – 4.67]

    Dx: Euthyroid Goiter
    Plan: May need to do FNA of neck mass (6 slides) and send to SHCH path lab for evaluation. Please contact Montha to facilitate this.

Result of FNA (4 slides) done on 21/07/08 and reported from SHCH telepathology lab on 05/08/05:

> **Conclusion:** Follicular adenoma (but could not exclude from follicular carcinoma)
> **Recommendation:** surgery and histology study for a more definitive diagnosis.

I will consult with Dr. Cornelia/Dr. Jack as to whether to refer this patient to SHCH surgical dept and when this may happen; I will let you know as soon as I get this information.

If you have any question or concern, please contact me.

Best Regards,
Rithy

The next Rattanakiri TM Clinic will be held on August 23-24, 2005