Telemedicine Clinic
Rattanakiri
Referral Hospital
March 2006

Report and photos compiled by Rithy Chau, SHCH Telemedicine

On Monday, March 27, 2006, Rattanakiri Referral Hospital (RRH) staff began their TM clinic. Two new 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, Tuesday, March 28, 2006, 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, March 22, 2006 2:07 PM
To: Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Rithy Chau; Cornelia Haener; Ruth Tootill
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: March TM clinic at Rattanakiri Referral Hospital

Dear All,

Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Monday, March 27, 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, Tuesday, March 28, 2006.The patients will be asked to return to the hospital that afternoon on Tuesday 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: Monday, March 27, 2006 5:32 PM
To: Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital Patient MS#00165

Dear All,
There are two new cases of this month.Here is the first case patient MS#00165 and her Photos.
Best regards,
Channarith

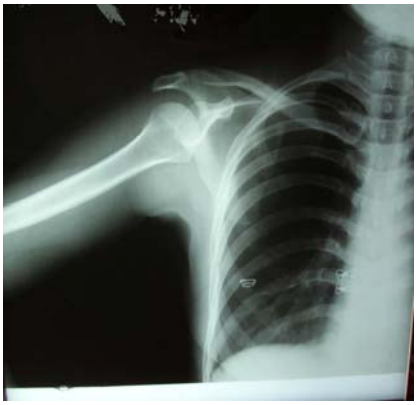
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: MU#00165, 34F, Villge Vi

Chief Complaint: right upper arm pain x one year

HPI: She presented with right upper arm pain is likely the muscle cramping associated with right upper arm joint pain and seemed atrophy of muscle of upper arm and She treated with unknown medication at private clinic and her symptoms did not get better .her complaint of burning joint pain which located only, cramping pain of upper arm muscle associated with pitching muscle pain , and her atrophy muscle of deltoide which drop down from joint a little bid , and she is difficulty to bend the back and upward , malaise , low appetite , dizziness off and on , no vo/ n .

PMH/SH: Gastritis



Social Hx: unremarkable

Allergies: none

Family Hx: unremarkable

ROS:

PE:
Vital Signs: **BP90/40mmhg P 65 R20 T36.5 Wt** 49kg

General: alerted and oriented

HEENT: unremarkable

Chest: lungs:clear both sides
heart: no murmur ,

Abdomen: soft, active BS, No mass.

Musculoskeletal: atrophy muscle of deltoid,

Neuro: weakness of motor of right upper arm , active sensory , cannot bend the back and difficult to upward , the a bit difficult to carry the thing and .

GU:

Rectal:

Previous Lab/Studies:

Lab/Studies Requests: x_ray of right shoulder , ca2+:11.1mg/dl, Na+:129.4mmd/dl, k+:3.4mmol/dl , M/S:negative, wbc 4600/mm3, Hb:38%, differential counting : 04%, 60%, 35%, 01%, 0%

Assessment: 1.artritis of right upper arm 2. nevralgia ?

Plan:
1. ibuprofen 400mg 1 ta bid po x 10 d
2. Vit B1 1 tab po qd x 15 d
3.cimitidine 400mg 1 tab po x bid x 1 month

Comments/Notes: please ,give a good idea

Examined by: San **Date: 27/03/06**

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: Tuesday, March 28, 2006 4:59 AM
To: kirihospital@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: FW: Rattanakiri Referral Hospital Patient MS#00165

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Monday, March 27, 2006 4:54 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri Referral Hospital Patient MS#00165

The key to this patient's problem is in the physical examination of her shoulder. She has difficulty with active abduction and extension. Could the shoulder be passively moved in all ranges of motion: flexion-extension, abduction, internal and external rotation?

If the shoulder joint is both actively and passively restricted, then I would consider a chronic anterior dislocation of the shoulder. First she is young. Did she have a fall a year ago? The apparent atrophy of the deltoid muscle may be from the step off in the joint due to chronic dislocation. Dislocated shoulder could be painful at extremes of active restricted motion. Arm muscles could atrophy from disuse.

If the shoulder passive movement is normal, then one could consider a nerve lesion. For instance a C5 nerve lesion could produce deltoid weakness and atrophy. However you should see other C5 innervated muscles weak as well, example, rhomboid muscles [weakness in pushing hand backwards while shoulder is internally rotated], pectoralis major [weakness in arm elevation above 90 degrees], supraspinatus [weakness in arm abduction], infraspinatus [weakness in arm external rotation], biceps [weakness in elbow flexion]. One could also experience a brachial plexus lesion affecting the lateral cord that could produce upper arm weakness associated with nerve pain. However being a young person, she is unlikely to have cervical spondylosis or diabetes related neuropathy, or Pancoast-type lung cancer at the lung apex.

So a throrough history and physical exam along these lines should help sort out whether it's shoulder joint dislocation or C5 root lesion or brachial plexus neuritis. For shoulder dislocation, you may need an axillary view to confirm anterior dislocation and a referral to orthopedics for reduction of chronic dislocation. A nerve lesion can be worked up with cervical spine xray and chest xray with apical view.

The serum calcium is high incidentally and requires repeat testing.
Heng Soon Tan, MD

From: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Tuesday, March 28, 2006 9:15 AM
To: 'Kiri Hospital'
Cc: 'Ruth Tootill'; 'Cornelia haener'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital Patient MS#00165

Dear San/Channarith,

Thank you for the cases for this month.

As for this patient, MS#00165, there was a lot of missing information on the history and PE needed to make a good assessment of her problem. You stated that she has pain for one year, but what happened initially to her right shoulder that led to this problem—was there an accident, injury, trauma? How long ago? What was she doing when the problem started? Besides pain medications, were there any other treatment or management of the problem? Any surgery done? Any previous x-ray? Any numbness or tingling and where? ROM of arm and limitation of daily activity with her right arm? Can you also get a lateral view of her right arm also? According to the images you sent, the most likely problem she has is right shoulder dislocation, but I have to have some more history and lat x-ray to make a clearer dx of this. From the face shot, her shoulder seemed asymmetrical with sloping/dropping of the right shoulder, but an image of her with shirt off exposing her shoulder bilaterally, frontal, right lateral and posterior views would help to give better dx also. Please give me a call on my hand phone to discuss further about this patient. Until then no tx for her except for para 500 mg 2 po qid prn pain. Her gastritis may have come from taking NSAIDs or steroid for her pain too frequently, you can give her some antacid like MgALOH3 to chew prn or cimetidine 400mg 1 po qhs for 1-2 months if this problem is chronic for her. I am cc: to our surgeon also for any other advice.

Hope to her from you soon.

Rithy

RITHY CHAU, MPH, MHS, PA-C
Physician Assistant, Telemedicine Project/EHC

From: Cornelia haener [mailto:Cornelia_Haener@online.com.kh]
Sent: Tuesday, March 28, 2006 1:26 PM
To: 'Rithy Chau'; 'Kiri Hospital'
Cc: 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital Patient MS#00165

Dear all,
The ap X-ray does not look like dislocation, but I agree that a lateral X-ray should be added. Does she have any neck problems? Limited movement? Pain when you palpate?
Thanks
Cornelia Haener

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Monday, March 27, 2006 5:37 PM
To: Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Cornelia Haener; Ruth Tootill
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital Patient NB#00164

Dear All,
Here is the last case patient NB#00164 and his photos.

Best regards,

Channarith

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

Patient: NB#00164, 53M, TaVeng District

Chief Complaint: a developing big mass on around of his neck x 3 months

HPI: The first time , he complaints of a small mass x one corn size on right neck , and then he scratching it which caused to develop the full of right neck x 1 months , and one month later , his mass appeared progressively on left neck .He was treated the antibiotic and steroid during 7 days , all symptoms did not get better .now , his complaint of a progressively developing mass on bilateral of neck and big mass on both clavicle and a small mass on both axillar , especially his HA come as from mass to his right temporal and slightly difficulty for food eating .no fever , no dizziness , no vo / n , no weigh loss .

PMH/SH: unremarkable

Social Hx: no smoking , no alcohol

Allergies: none

Family Hx: unremarkable

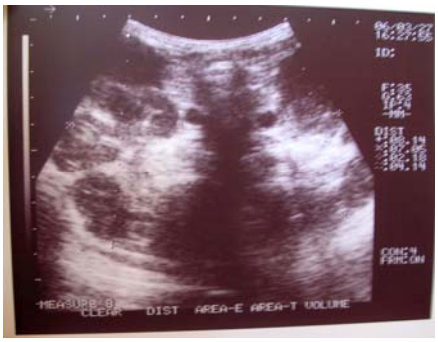
ROS:

PE:
Vital Signs: **BP 90/60 mmHg P 67 R 20 T 37.5 Wt** 42kg

General: alerted and oriented

HEENT: big mass on his neck characterized by solid , adherence from one to one , no mobile , more mass on bilateral of his neck ,and on both clavicle , a small mass on both axilar which characterized by solid , no mobile , no pain palpitation.

Chest: lungs :clear both sides , no crackle
heart: no murmur , rythme ragular.



Abdomen: soft , no mass , active BS , NO organomegally.

Musculoskeletal: unremarkable

Neuro: sensory and motor are intact

GU:

Rectal:

Previous Lab/Studies:

Lab/Studies Requests: ultrasound , ca2+:8.4mg/dl , Na+:124.4mmol/dl, CBC , K+:5.4mmol/dl, M/S=negative, WBC:4500/mm3, Htc:44%, Differential count : o5%, 56%, 38%, 01%, 0%, Platelet:317000.

Assessment:
1.Hodzhin's disease ?
2.lymphome ?
3.Sacoidosis ?
4.Primative cancer from Metastase ?
5.lymphe node of TB ?

Plan:
1.Penicilliine 1 g 1 vial q6h x 14 d
2.paracetamol 500mg 1 tab q6 h x prn x throat
3.biopsy , it is possible at PP

Comments/Notes: PLease , give a good idea

Examined by: San **Date: 27/3/06**

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

From: Barbesino, Giuseppe,M.D. [mailto:GBARBESINO@PARTNERS.ORG]
Sent: Tuesday, March 28, 2006 4:37 AM
To: Fiamma, Kathleen M.; kirihospital@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: RE: Rattanakiri Referral Hospital Patient NB#00164

This 53 years old man has what appears an extremely large bilateral lymphadenopathy of the neck, rapidly growing, and axillary suspicious lymphnodes as well. It is unclear whether a thyroid mass was also distinctly observed . CBC is normal and chemistry too. Primary diagnoses are lymphoma, anaplastic cancer of the thyroid (favor lymphoma because of symmetric disease, axillary involvment). Patient should have CT scan of the neck and chest and ENT evaluation for upper airway patency. Open biopsy of one of the masses with urgency should be done to clarify etiology and guide treatment. Fine needle biopsy may not be useful in this case and may only delay final diagnosis. If lymphoma is found, chemotherapy plus radiotherapy as directed by oncologist might be succesful in shrinking the mass. If this is anaplastic thyroid cancer, prognosis extremely poor given the size of masses. Please let me know what you find out.
Thanks

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: Barbesino, Giuseppe,M.D. [mailto:GBARBESINO@PARTNERS.ORG]
Sent: Tuesday, March 28, 2006 5:09 AM
To: Fiamma, Kathleen M.; kirihospital@yahoo.com
Cc: tmed_rithy@online.com.kh

Subject: IMPORTANT ADDENDUM
Importance: High

THIS IS AN ADDENDUM TO THIS CASE. NOTICED SODIUM TO BE LOW AT 124. THIS MAY BE DUE TO VOLUME DEPLETION/DEHYDRATION BUT ALSO TO SIADH AS PARANEOPLASTIC SYNDROME OF EPITHELIAL (LUNG, LARYNGEAL) CANCER. THIS SHOULD BE EVLAUATED WITH SERUM OSMOLALITY, URINE OSOMLALITY AND SODIUM AND TREATED ACCORDINGLY.
PLEASE ACKOWLEDGE RECEIPT OF THIS MESSAGE.
This 53 years old man has what appears an extremely large bilateral lymphadenopathy of the neck, rapidly growing, and axillary suspicious lymphnodes as well. It is unclear whether a thyroid mass was also distinctly observed . CBC is normal and chemistry too. Primary diagnoses are lymphoma, anaplastic cancer of the thyroid (favor lymphoma because of symmetric disease, axillary involvment). Patient should have CT scan of the neck and chest and ENT evaluation for upper airway patency. Open biopsy of one of the masses with urgency should be done to clarify etiology and guide treatment. Fine needle biopsy may not be useful in this case and may only delay final diagnosis. If lymphoma is found, chemotherapy plus radiotherapy as directed by oncologist might be succesful in shrinking the mass. If this is anaplastic thyroid cancer, prognosis extremely poor given the size of masses. Please let me know what you find out.
Thanks

Giuseppe Barbesino, MD
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From: Cornelia haener [mailto:Cornelia_Haener@online.com.kh]
Sent: Tuesday, March 28, 2006 8:54 AM
To: 'Kiri Hospital'; 'Rithy Chau'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Ruth Tootill'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital Patient NB#00164

Dear all,
Does the patient have any ENT symptoms like bleeding from his nose or obstruction of one side of his nose? Another DDx would be nasopharyngeal carcinoma with lymph node metastasis. Did you do a chest X-ray? Any hint for lung cancer?
Otherwise, it is most likely a malignant lymphoma. Of course, histology would confirm the diagnosis. Easier and cheaper might be a fine needle aspiration cytology. Take the biggest needle you have and aspirate cells from the biggest lymph node, then spread it on four glass slides and keep it air dry. Pleasdo not use an alcohol spray to fix the slides. Bring it down to our lab at SHCH like that and we will stain it. Often, a good FNA already gives us a hint for lymphoma. If it is a lymphoma, the best treatment would be high dose steroid after excluding HIV, Hep B/C and Syphilis. Full chemotherapy is very expensive, around 300 USD per treatment at the oncology department at least, and the patient has to pay it himself. Prognosis in this age group is often not much better with chemotherapy.
Kind regards
Cornelia Haener

From: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Tuesday, March 28, 2006 10:10 AM
To: 'Kiri Hospital'
Cc: 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Cornelia Haener'; 'Ruth Tootill'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital Patient NB#00164

Dear San/Channarith,

For patient, NB#00164, he c/o neck mass developing progressively in 3 months period without fever, weight loss, pain and non-mobile? You did not mention productive cough or not, any GI problem except mild dysphagia (due to the neck mass), and no rectal exam, CXR, and abd US done. I would have like to have these information to help me advise better. The masses on bilateral neck with axillary and supraclvicular lymphadenopathy may point to either TB infection (very common in Cambodia) or malignancy from GI tract, lungs and other sources. Can he produce sputum to do AFB? If positive from AFB or indicated on CXR for TB lesion, then treat per national protocol. I will also wait for surgical opinion from Dr. Cornelia or Ruth as well on the next step to care for this patient. I do not think he need any medication at this point.

Please ask the two patients for this month to be follow-up next month as well since I will be there in Rattanakiri.

Hope this helps.

Rithy

RITHY CHAU, MPH, MHS, PA-C
Physician Assistant, Telemedicine Project/EHC

From: Cornelia haener [mailto:Cornelia_Haener@online.com.kh]
Sent: Tuesday, March 28, 2006 1:29 PM
To: 'Rithy Chau'; 'Kiri Hospital'
Cc: 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Ruth Tootill'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital Patient NB#00164

Dear all,
As mentioned in my first email, the most likely diagnosis is malignant lymphoma. Please rule out ENT and lung cancer. GI-tract cancer is unlikely. They usually only metastasis towards the left supraclavicular area (Virchow node) before the lymphatics enter the subclavian vein. I think it is wise to do sputums for AFB, because malignancies of the neck/lymphomas are risk factors for reactivation of TB.
Thanks
Cornelia

Tuesday, March 28, 2006

Follow-up Report for Rattanakiri TM Clinic

There were 2 new 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 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 March 2006

1. MS#00165, 34F, Village VI

   Dx:

   1. Gastritis
   2. Neuralgia?

   Tx:

   1. Paracetamol(500mg) 2 tab po qid prn pain
   2. MgALOH3 2 tab chew qid prn (50 tab)

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

   Dx:

   1. Lymphoma?

   Tx:

   1. Prenisolone 5mg 8 tab po qd x 2mo (on second month tx per RRH)
   2. FNA of mass and send to SHCH for cytology
   3. CX R and AFB sputum smears

Follow-up Patients

1. CL#00122, 33F, Village III

   Dx:

   1.Subclinical hyperthyroidism

   Tx:

   1. Methimazol 10mg ½ tab po tid
   2. Recheck TFT next month

2. PS#00149, 26F, Village I

Dx:

1. Hyperthyroidism

Tx:

1. Carbimazol 5mg ½ tab po qd
2. Propranolol 40mg ¼ tab po qd
3. MTV 1 tab po qd
4. Para 500mg 1 tab po qid prn

3. UP#00093, 51F, Village I

Dx:

1. Hyperthyroidism (became hypothyroidism per lab result possibly due to medication)

Tx:

1. Stop all medications and recheck TFT in 2-4 weeks

4. CK#00102,18F, Village IV

Dx:

1. Cardiac insufficiency
2. Anemia
3. Pulmonary HTN
4. Right + Left atrial enlargement

Tx:

1. Lisinopril 5mg ½ tab po qd x 100 tab
2. Furosemide 40mg ½ tab po qd x 100d
3. FeSo4/ folate200mg /0.25mg 1 tab po bid x 100d

5. RH#000, 67F, Village I

Dx:

1. HTN
2. DMII
3. OA?
4. PNP

Tx:

1. GLibenclamide 5mg 1 tab po qd x 100d
2. Lisinopril 5mg 1 tab po qd x 100d
3. ASA 81mg chew 1 tab po x 100d
4. Desipramine 100mg ½ tab po qhs x 100d

6. OT#00155, 45F, Village I (Borkeo District)

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. PN#00052, 53F, Ban Fang Village

Dx:

1. Hyperthyroidism

Tx:

1. Carbimazol 5mg 1tab po bid x 100d
2. Propranolol 40mg ¼ tab po bid x 100d

8. TV#00157, 53F, Phnom Kok Village

Dx:

1. Hyperthyroidism

Tx:

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

9. PO#00148, 67F, Village III

Dx:

1. DM II
2. HTN
3. PNP
4. GERD

Tx :

1. Metformin 500mg 1 tab po qhs x 100d
2. Glibenclamide 5mg 1 tab po qd AM half hour before eating x100d
3. Lisinopril 5mg 1tab po qd x 100d
4. Desipramine 75mg ½ tab po qhs x 100d
5. ASA 81mg chew 1tab po qd x 100d

10. KP#00153, 57F, Village III

Dx:

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

Tx:

1. Lisinopril 5mg 1tab po qd x 100d
2. Glibenclamide 5mg ½ tab po qd x 100d
3. Atenolol50mg ½ tab po x 100d
4. MTV 1 tab po x 100d
5. ASA 81mg 1 tab po qd x 100d
6. Desipramine 75mg ½ tab po qd x 100d

11. LH#00116, 59F, Village IV

Dx

1. Hyperthyroidism

Tx

1. Methimazol 5mg 1 tab po qd x 30 tab

The next Rattanakiri TM Clinic will be held on
April 24-28, 2006