Telemedicine Clinic
Rattanakiri
Referral Hospital
September 2005

Report and photos compiled by Rithy Chau, SHCH Telemedicine

On Wednesday, September 14, 2005, Rattanakiri Referral Hospital (RRH) staff began their TM clinic. PA Rithy Chau was not 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 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, Thursday, September 15, 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: Friday, September 09, 2005 4:14 PM
To: 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; Sovann Nop
Subject: September TM clinic at Rattanakiri Referral Hospital

Dear All,

Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Wednesday, September 14,2005 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, Thursday, September 15, 2005.The patents will be asked to return to the hospital that afternoon on Thursday to receive treatment along with a follow up plan or referral.

Thank you very much for your cooperation and service.

Best regards,

Channarith Ly

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

Patient: TS#00138,38M,Pakalan Village.

Chief Complaint: Left hip pain x 7 months

HPI: The first time he fell over the ground ,which affected the his knee and made slightly left hip pain and He took the modern medicines ,he didnot get better .And then he climbed the tree ,after climbing the tree He complaint of left hip pain and muscle pain of behind left thigh and calf and associated with muscle hypotrophy of a little bid thigh and calf and his walking is the left hip , behind muscle thigh and calf pain.He treated the Aternarine IV at private clinic , his symptoms didn't get better .And then, he came to the referral hospital and he was treated the indomethacin , Vit B1,B2 , B12 , Paracetamol x 5 days , his symptoms is still pain .no weigh loss , no fever .

PMH/SH: unremarkable

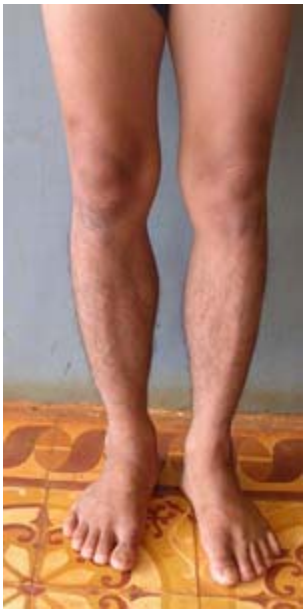
Social Hx: unremarkable

Allergies: none

Family Hx: none

ROS:

PE:
Vital Signs: **BP110/80** **P70** **R20** **T37** **Wt** 55kg



General: alerted and oriented

HEENT: unremarkable

Chest: Lungs: clear both sides
Heart : no murmur , regular rythme

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

Musculoskeletal: muscle hypertrophy of a little bid thigh and calf . join pain of left hip ,muscle thigh and calf (outward ,inward) . Bending the thigh and calf is a little pain , extension of his leg (upperward) is pain of left hip and pain in buttock and posterior thigh and calf .

Neuro: pitch on his leg sensory is normal .

GU: none

Rectal: none

Previous Lab/Studies:

Lab/Studies Requests: x-ray of femoral head and vertebral lumbar can not do (x _ray will send later),ca2+:15.1 ,Mg2+:2.2 ,potassium:4.3, Humatex ASLO :positive, hexagon TB: negative, WBC:12700/mm3,RBC:4895000/mm3 ,Eo:03%. Ne:70%,Ly:25%,Mono:02%,Ba:00%

Assessment: 1.sciatica 2.Femoral arthritis 3.pott's disease? 4.Arthritis TB?

Plan: 1.ibuprofen400mg 1tab po bid x7 2. anti TB drugs by national programme? 3.PNC 250mg 1 tab po tid x10 days

Comments/Notes: please ,give a good idea

Examined by: Dr San **Date: 14/9/05**

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

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, September 15, 2005 9:11 AM
To: 'Kiri Hospital'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient TS#00138

Dear Dr. San,

From the H&P you presented, the main problem for this gentlemen seemed to be sciatica. The photo of his legs did not show any gross abnormality nor appear to have any joint problem of LE. I agree with tx him with ibuprofen 400mg 1 po tid for 2-3 days and then prn—make sure he is not actively having dyspepsia or GI bleed. Paracetamol is an alternative if GI problem present. Massage and warm compress are also useful in recovery from sciatica. Please ask him not to do any strenuous exercise or contact sport or climbing for awhile (1-2 months) if pain still persists, but he can do light work and physical activities. If his daily activities involve standing or sitting for long time, ask him to move around every 1-2 hours to relieve some stress on the sciatic nerve.

I would not recommend giving TB drugs since no hx or indication from his sx that he has TB.

Regards,
Rithy

From www.spine-health.com :

What you need to know about sciatica

Overview of sciatica causes and symptoms
Sciatica—pain along the large sciatic nerve that runs from the lower back down the back of each leg—is a relatively common form of low back pain and leg pain.

Sciatica is usually caused by pressure on the sciatic nerve from a herniated disc (also referred to as a ruptured disc, pinched nerve, slipped disk, etc.). The problem is often diagnosed as a **"radiculopathy"**, meaning that a disc has protruded from its normal position in the vertebral column and is putting pressure on the radicular nerve (nerve root), which connects with the sciatic nerve.

Understanding sciatica pain
For some people, the pain from sciatica can be severe and debilitating. For others, the pain from sciatica might be infrequent and irritating, but has the potential to get worse. Usually, sciatica only affects one side of the lower body, and the pain often radiates from the lower back all the way through the back of the thigh and down through the leg. Depending on where the sciatic nerve is affected, the pain may also radiate to the foot or toes.

One or more of the following sensations may occur as a result of sciatica:

- Pain in the rear or leg that is worse when sitting
- Burning or tingling down the leg
- Weakness, numbness or difficulty moving the leg or foot
- A constant pain on one side of the rear
- A shooting pain that makes it difficult to stand up

While sciatica can be very painful, it is rare that permanent nerve damage (tissue damage) will result. Most sciatica pain syndromes result from inflammation and will get better within two weeks to a few months. Also, because the spinal cord is not present in the lower (lumbar) spine, a herniated disc in this area of the anatomy does not present a danger of paralysis.

Symptoms that may constitute a medical emergency include progressive weakness in the legs or bladder/bowel incontinence. Patients with these symptoms may have cauda equina syndrome and should seek immediate medical attention.

Any condition that causes irritation or impingement on the sciatic nerve can cause the pain associated with sciatica. The most common cause is lumbar **herniated disc**. Other common causes of sciatica include **lumbar spinal stenosis, degenerative disc disease,** or **isthmic spondylolisthesis**.

Typical sciatica treatments
Nerve pain is caused by a combination of pressure and inflammation on the nerve root, and treatment is centered on relieving both of these factors. Typical sciatica treatments include:

- **Manual treatments for sciatica** (including physical therapy and osteopathic or chiropractic treatments) to help relieve the pressure.
- **Medical treatments for sciatica** (such as NSAID's, oral steroids, or epidural steroid injections) to help relieve the inflammation.
- **Surgery for sciatica** (such as microdiscectomy or lumbar laminectomy) to help relieve both the pressure and inflammation may be warranted if the sciatic nerve pain is severe and has not been relieved with appropriate manual or medical treatments.

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, September 16, 2005 12:27 AM
To: kirihospital@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: FW: Rattanakiri Referral Hospital TM clinic Patient TS#00138

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Wednesday, September 145, 2005 11 0:54 AM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient TS#00138

The history is unclear. I'll try to reconstruct the story and point out where further clarification of the history and physical examination can be helpful. He fell 7 months ago. How did he fall? Did he trip and fall? Did he fall from a height? Did he fall because of pain and weakness in the hip? Did he have any hip or back pain before the fall? How did he land? The left knee and hip hurt after the fall. The knee pain cleared but hip pain persisted and worsened after climbing a tree. Hip pain radiated posteriorly and down to behind knee and calf.

On examination, measurement of the thigh and calf muscle circumference will reveal whether he has muscle hypertrophy [bigger] or atrophy [smaller]. The text was confusing on this point, but a measurement will settle the issue. With chronic hip pain, I would expect muscle atrophy. On examination, no mention was made of back tenderness, posture and flexibility. I presume the lumbar spine was normal. On the hip examination, one should comment on whether there was anterior hip joint [or iliopsoas bursa tenderness] on direct palpation and whether the hip hurt on rolling the leg [suggestive of hip arthritis]. Flexion of hip caused pain suggesting hip arthritis. Did forced abduction of the hip [testing for greater trochanteric bursitis] and forced adduction and flexion of the hip [testing for iliopsoas bursitis] increase the pain? Straight leg raising caused posterior leg pain. If pain is restricted to hamstrings, it could be because of tight hamstrings. If pain radiated from posterior buttocks down to ankle, then it's sciatica.

Without back pain and the predominant hip pain, he is more likely to have a hip problem. It's unusual for a young man with no previous hip pain [suggestive of hip dysplasia] to develop hip arthritis when there is no previous traumatic fracture. So it's important to consider tuberculosis of the hip. He may not be febrile or have a red hot joint, but there should be joint swelling and localized tenderness. The elevated white count may suggest an infection. An elevated ESR sedimentation rate could be supportive of the diagnosis. Normal chest xray does not rule out diagnosis, but negative PPD skin test is against diagnosis. Hip xrays in tuberculosis may show perisynovial erosions, periarticular osteopenia and eventually joint space narrowing. If the hip joint has an effusion, aspiration for cell count typically 20,000 leucocytes with 50% polymorphs, AFB smear [30% positive likelihood] and culture [80% likelihood] will yield a quick diagnosis.

Heng Soon Tan, M.D.

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, September 14, 2005 4:26 PM
To: 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: Rattanakiri Referral Hospital TM clinic Patient BM#00139

Dear All,

This is patient BM#00139 and his photos.

Best regards,

Channarith

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

Patient: BM#00139,15M,Kalan Village, VEN SEY

Chief Complaint: Scare Contracture of Left hand x 15 years

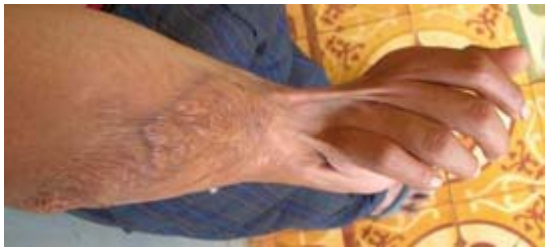
HPI: He burned the petrol lamp on his right hand and forearm since he aged 2 months ,and his mother took him to RH and treated there. And his scare progressively has developed by his age .the character of scare contracture are attached from the figure (middle , ring and little figure) to the forearm and formed the form of right hand which is different from the left hand . no hand join pain , no fever ,no convulsion .

PMH/SH: unremarkable

Social Hx: none

Allergies: none

Family Hx: none



ROS:

PE:
Vital Signs: **BP100/70** **P70** **R 24** **T37** **Wt** 30kg

General: alerted and oriented

HEENT: none

Chest: Lungs: clear both sides
Heart: no murmur ,no galop's sign

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

Musculoskeletal: scare contracture on right forearm and hand and scare on forearm .no hypothropy of forearm and hand muscle .no join pain on right forearm and hand

Neuro: **a little bid** numbness of scare on right forearm and hand and motor is intact

GU:

Rectal:

Previous Lab/Studies:

Lab/Studies Requests:

Assessment: 1.Scare contracture by petrol lamp

Plan: 1.Surgery of the scare

Comments/Notes: Please, give a good idea

Examined by: Dr San **Date: 14/9/05**

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

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, September 15, 2005 9:23 AM
To: 'Kiri Hospital'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient BM#00139

Dear Dr. San,

Yes, this young man needs a surgical operation on his hand to release the contracture. I suggest that you contact either Kean Kleing or Kheng Sisary, Senior Lecturer at CSPO (behind Calmette Hospital next to French Embassy) at 023-427-067/427-090 or 012-492-361. Ms. Sisory told me that they also have certain fund for at least transportation to/from the province for children and women. Please ask such patient like him to drop by to see me at SHCH while in PP and/or to return to see you after operation done.

I hope this helpful.

Regards,
Rithy

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, September 16, 2005 12:30 AM
To: tmed_rithy@online.com.kh; kirihospital@yahoo.com
Subject: FW: Rattanakiri Referral Hospital TM clinic Patient BM#00139

-----Original Message-----
From: Sheridan, Robert L., Burn Unit
Sent: Wednesday, September 14, 2005 11:04 AM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient BM#00139

I think this could be improved greatly with release and graft and post-op physical therapy. We would be happy to do it here if you would like.

Rob Sheridan, M.D.

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, September 14, 2005 4:14 PM
To: 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: Rattanakiri Referral Hospital TM clinic Patient CT#00140

Dear All,

There are three new cases of this month . This is patient CT#00140 and her photos.

Best regards,

Channarith

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

Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of Hope and Telepartners

Patient: CT# 000140 from Village I, Labanseak Commune, Banlung District, Ratanakiri Province

Chief of Complain: Back pain and chest tightness about a years

HPI: 34 F PMH of back pain and chest tightness at the same time about a year, the pain is always getting worse in night time and cold weather and when she has back pain the chest tightness occurs at the same time.

PMH/SH: back pain and treated with non-steroid and antibiotic drugs

Social Hx: Married, no children, no smoke, no drink

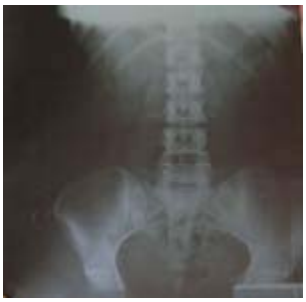
Allergies: non

Family Hx: no one in her family has TB

ROS: insomnia because back pain getting worse at night time, no weight loss, no cough, no sweating at night, no fever, no SOB

PE:

Vital Sighs: BP 90/70mmhg P 84/mn R 16/mn T 36.5 Wt 57kg



General: look stable

HEENT: unremarkable

Chest: lung: clear both sides, heart: no murmur, RRR

Abdomen: soft, flat, no tender, + BS all quadrants

musculoskeletal: feeling pain at lower back(L1-L5) when anteflexion, no tumor anything strange to notice.

Neuro: motor: alert, sensory: intact, reflex: + 5/5

GU: not done

Rectal: note done

Previous Lab/Studies:

Lab/Studies Requests: Hexagon TB: Negative, Humatex ASLO: Negative

Assessment: Pott Disease?

Plan: Ibuprofen 400mg bid

Comments/Notes: please give me any idea

Examined by: Dr. Sam Baramey **Date: 14/09/2005**

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

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, September 15, 2005 9:53 AM
To: 'Kiri Hospital'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Fil B. Tabayoyong'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient CT#00140

Dear Dr. Baramey,

Please give more detail on hx concerning the character of her CP and back pain, additional associating symptoms, alleviating/aggravating factors, etc. I will send to you the H&P supporting information I made earlier based on top 10 common complaints for our use again and please read the one on chest pain. Please have Channarith or Dr. San print out a copy to keep for your record and use in the future fro helping you with H&P writing on TM cases.

From little detail you gave me, I agreed that she may have muscle pain, though not sure of the etiology of her problem. Her lumbosacral x-ray showed no obvious lesion or deformity of the bony structures. Since no sx of TB with wt loss, night sweat, cough, sputum production and TB lab test negative, etc., I would not give a dx of Pott's dz, but dx of muscle pain. Possibly, seek out hx on UTI or kidney stone also—any CVA tenderness? FYI, deep tendon reflex (DTRs) is graded by 0-4 and +2 being normal relex at each area in proper examination, muscle strength (MS) is graded from 0-5 and +5/5 being normal in strength. Please review physical examination from Bates textbook on neuromuscular exam.

I hope this helpful and help you better assess your patient in the future.

Thanks,
Rithy

Effective coping strategies for chronic back pain

Introduction to chronic back pain
Those who treat chronic back pain now recognize that it is not merely a sensation, like vision or touch, but rather is strongly influenced by the ways in which the brain processes the pain signals.

Chronic back pain can provoke emotional reactions, such as fear or even terror, depending on what we believe it signals. In other cases, such as in sports, chronic back pain is a nuisance, a feeling to be overcome in order to continue in the competition.

First steps for managing chronic back and neck pain

Of course, the first step in coping with chronic back pain or chronic neck pain is to receive a medical evaluation to determine the cause of the chronic back pain.

- In some situations, such as a herniated disc in the spine, you may need to pay attention to the chronic back pain so that it can serve as a warning signal of impending damage.
- In other cases, especially when the back pain is chronic and the health condition unchangeable, you can try and keep the chronic back pain from being the entire focus of your life. Often patients "act as if" they do not have a chronic back pain problem. This can help "normalize" the person's activities and keep him or her out of the "sick role".

Whatever your medical condition, there are a number of effective strategies for coping with chronic back pain. These

techniques generally include **relaxation training, hypnosis, biofeedback** and **guided imagery.**

All of these techniques for coping with chronic back pain make use of four types of skills:

- Deep Muscle Relaxation
- Distraction: moving your attention away from chronic back pain signals
- Imagery: visual, sound or other pictures and thoughts that are pleasant and relaxing to you
- Dissociation: The ability to separate normally connected mental processes, leading to feelings of detachment and distance from the chronic back pain.

Coping techniques for chronic back pain begin with controlled deep breathing, as follows:

- Try putting yourself in a relaxed, reclining position in a dark room. Either shut your eyes or focus on a point.
- Then begin to slow down your breathing. Breathe deeply, using your chest. If you find your mind wandering or you are distracted, then think of a word, such as the word "Relax", and think it in time with your breathing...the syllable "re" as you breathe in and "lax" as you breathe out.
- Continue with about 2 to 3 minutes of controlled breathing.

By: Andrew R. Block, PhD
June 13, 2000

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Friday, September 16, 2005 12:31 AM
To: tmed_rithy@online.com.kh; kirihospital@yahoo.com
Subject: FW: Rattanakiri Referral Hospital TM clinic Patient CT#00140

-----Original Message-----
From: Cusick, Paul S.,M.D.
Sent: Wednesday, September 14, 2005 5:17 PM
To: Fiamma, Kathleen M.; 'kirihospital@yahoo.com'
Cc: 'tmed_rithy@online.com.kh'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient CT#00140

The patient is describing muscular pain. There is no mention of asthma or dyspnea to suggest a pulmonary cause (asthma) of this pain. There is no radicular element so that a nerve root impingement from disc herniation is unlikely.

PPD negative would likely rule out Potts disease. Xray does not reveal any bone abnormalities to my eye.

I would encourage hot towels to her back for 30 minutes at night for muscle relaxation and ibuprofen for pain relief.

a urinalysis would help to evaluate for hematuria due to possible renal stone disease.

Good luck

Paul Cusick

Follow-up Report for Rattanakiri TM Clinic

There were 3 new and 4 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 Clinic September 2005

1. TS#00138, 38M, Pakalan Village

   Dx: 1. Sciatica

   Tx: 1. Naproxen 220mg 1 tab po bid x 10days
   2. MTV 1 tab po qd x 10 days
   3. Massage and warm compression

2. BM#00139, 15M, Kalan Village

   Dx: 1. Scar contracture of right hand

   Tx: 2. Need a surgical operation on his hand (refer to PP)

3. CT#00140, 34F, Village I

   Dx: 1. Back muscle pain

   Tx: 1. Ibuprofen 400mg 1tab po bid x 5 day
   2. Warm compress and back stretching exercise

Follow-up patients:

1. PC#00113, 40F, Village I

   Dx: Euthyroid goiter

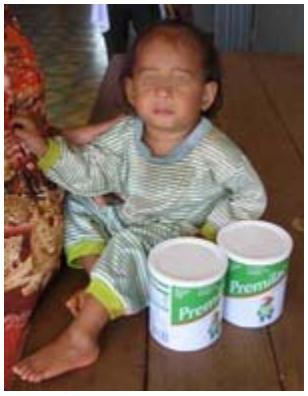
Tx: Check AFB, repeat CXR each month x 3, then return to SHCH for f/u appointment with surgeon

2. CL#00122, 33F, Village III

Dx: Subclinical hyperthyroidism

Tx: Methimazol 5mg 1tab po tid x 100 d

3. HV#00132, 2F, VillageI



Dx: Failure to thrive

Tx: Premilac2 put 8 leveled scoops in 240cc warm water po tid (2 cans) provided by SHCH at no cost

4. EB#00078, 41F, Village IV

Dx:
1. CHF
2. Incompleted RBBB

Tx:
1. Captopril 25mg ½ tab po bid x 100 d
2. Digoxin 0.25mg 1tab po qd x 100 d
3. Furosemide 40 mg 1tab po bid x 100d
4. MTV 1 tab po qd x 100 d
5. Spironolactone 25mg 2 tab po bid x 100 d

Follow-up Notes:

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Monday, September 05, 2005 3:12 PM
To: Rattanakiri TM
Cc: Bernie Krisher; Ed & Laurie Bachrach; Fil - Jr. Tabayoyong; Gary Jacques; HealthNet Rattanakiri; So Thero Noun
Subject: Lab Results from August 2005 TM Clinic

Dear Channarith/Dr. San,

Here are the lab results taken from patients during Rattanakiri TM Clinic August 2005 and the f/u plan:

1. UP#00093, 51F, Village I

TSH	<0.02	[0.49 - 4.67]
Free T4	20.65	[9.14 – 23.81]

- DDx
  - Subclinical Hyperthyroidism
- Tx
  - Please add methimazole 5mg 1 po tid and recheck TFT in 2 months.

2. LH#00116, 59F, Village IV

TSH	1.08	[0.49 - 4.67]
Free T4	12.18	[9.14 – 23.81]

- DDx
  - Euthyroidism (with medication)
- Tx
  - Please continue methimazole 5mg 1 po qd and recheck TFT in 2 months.

3. CL#00122, 33F, Village III

TSH	0.33	[0.49 - 4.67]
Free T4	11.41	[9.14 – 23.81]

- DDx
  - Subclinical Hyperthyroidism
- Tx
  - Please give methimazole 5mg 1 po tid and recheck TFT in 2 months.

4. LD#00134, 35F, Fang Village

TSH	0.94	[0.49 - 4.67]
Free T4	13.91	[9.14 – 23.81]

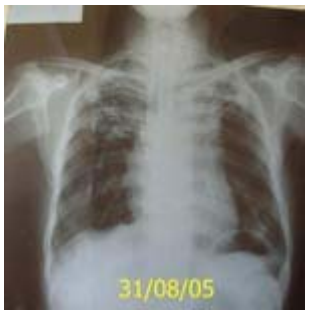
- DDx
  - Euthyroid goiter
- Tx
  - Please ask her to return in October for possible FNA of mass.

If you have any question concerning these lab results and plan for treatment, please contact me.

Best Regards,
Rithy

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, September 08, 2005 3:13 PM
To: Rattanakiri TM
Cc: Bernie Krisher; Ed & Laurie Bachrach; Fil - Jr. Tabayoyong; Gary Jacques; HealthNet Rattanakiri; So Thero Noun; Bunse Leang
Subject: Follow-up Note for Rattanakiri TM Patient PC#00113

Dear Dr. San and Channarith,



Patient PC#00113, 40F from Village I, arrived and was consulted with SHCH surgeon on 31/08/05 and f/u on 06/09/05-07/09/05 was found to have 6 week pregnancy and suspected to have TB per CXR. The patient said that she has PMH of TB infection about 10 yrs ago and was tx for 3 months and she stopped going for tx. She still has dry cough off and on for 10 years without sputum production and no weight loss (and gain 1kg recently), no fever, no night sweat, no hemoptysis. She also stated that she wanted to have an abortion also for the reason that she has 6 children already, youngest being 7 yrs old. As a result, the surgeon at SHCH cannot operate on her goiter (and also doing a bx to find out whether it is malignant or not) for the two contraindication of possible TB infection and pregnancy. You will find in the note in her SHCH chart that Dr. Bunse, SHCH associate staff, recommended that with her having an abortion (her own decision), she can wait for 3 months to either confirm of no TB infection by initially doing a AFB sputum smears--if negative results, then repeat CXR every month for the next three months. If AFB smears + for TB, then treat accordingly and by the end of 3 months, surgical procedure may be performed. She is scheduled to come back for f/u consultation for possible surgical procedure at SHCH on 06/12/05. As a result, the patient asked to go back home (Rattanakiri) since all her children are there and her husband has to go back to work to feed the family. We agreed that she can do this and return in three month.

If somehow she changes her mind about abortion (i.e. she wants to keep the baby), please contact right away for further recommendation on managing her illness.

Also, please send me any progress note and images especially of the CXR series including the initial one done at SHCH on her.

Thank you for your dedication to serve the people of Rattanakiri through this project.

Best Regards,
Rithy

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Friday, September 09, 2005 4:36 PM
To: Rattanakiri TM
Cc: Bernie Krisher; Ed & Laurie Bachrach; Fil - Jr. Tabayoyong; Gary Jacques; HealthNet Rattanakiri; So Thero Noun
Subject: Follow Up Note on Patient KS#00133 from Rattanakiri TM

Dear Dr. San and Channarith,

Please be inform that the patient seen at our August 2005 Rattanakiri TM Clinic, KS#00133, 47F, Sre Ankrang Village, was referred to PP hospital (Norodom Hospital) and dx with uterine cancer (no documentation, per verbal by Ms. Samnang, her chaperone) which is inoperable due to high risk of mortality due to procedure complication. As a result, she will be sent home to Rattanakiri this evening. Ms. Samnang brought her by SHCH to see me and I explained to the patient about her prognosis and encourage her to enjoy what life comes for her and provide her some pain meds and supplement enough for at least 4-6 months. The list of medication given as follow:

1. Para 500mg 1 po qid prn pain (#300)
2. Codeine 30mg 1 po qid prn severe pain (#200)
3. Bisacodyl 5mg 1 po bid prn constipation (from medications above 1-2) (#30)

4. MTV 1 po bid (#200)
5. Pediasure powder 900g 5 scoops mix with 190cc water bid (#1 can) use when there is significant weight loss

Her daughter was there when I explained to her about using medications and ask her to go and see you once they reach Rattanakiri (mother may not be able to go to see you due to her pain?). I also told to seek help from you if there is any other health problem arise with the patient and to stay in contact with you to report about her health if possible.

Please let me know if there is anything else I can do from here to help you to care for our patients better. I will try to get other prescriptions fill next week and send via airmail to the other patients we follow. Thank you for you continuous support and practice in the TM project.

Best Regards,
Rithy

P.S. Is there an organization called “Douleur san Frontiere” in Rattanakiri? This group may be able to help us in managing pain for such and other patients—I heard they provide free medications for patients also.

The next Rattanakiri TM Clinic will be held on
October 18 - 19, 2005