Robib and Telemedicine

June 2003 Telemedicine Clinic in Robib

Report and photos submitted by David Robertson

On Tuesday, June 10, 2003, Sihanouk Hospital Center of Hope nurse Koy Somontha gave the monthly Telemedicine examinations at the Robib Health Clinic. David Robertson transcribed examination data and took digital photos, then transmitted and received replies from several Telepartners physicians in Boston and from the Sihanouk Hospital Center of Hope (SHCH) in Phnom Penh.

The following day, all patients returned to the Robib Health Clinic. Nurse "Montha" discussed advice received from the physicians in Boston and Phnom Penh with the patients.

Following are the e-mail, digital photos and medical advice replies exchanged between the Telemedicine team in Robib, Telepartners in Boston, and the Sihanouk Hospital Center of Hope in Phnom Penh:

Date: Mon, 9 Jun 2003 01:20:44 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Cambodia Telemedicine, June 10th, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, "Dr. Srey Sin" <012905278@mobitel.com.kh>,
aafc@forum.org.kh, Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Please reply to dmr@media.mit.edu

Dear All:

A quick reminder the next Telemedicine clinic in Robib, Cambodia is still scheduled for this Tuesday, 10 June 2003.

We'll have the follow up clinic at 8:00am, Wednesday, 11 June (9:00pm, Tuesday, 10 June in Boston.) Best if we could receive your e-mail advice before this time.

Thanks again for your assistance.

Sincerely,

David

Date: Tue, 10 Jun 2003 01:19:49 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient #1: SAO PHAL, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,

Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Telemedicine Clinic in Robib, Cambodia – 10 June 2003

Patient #1: SAO PHAL, female, 55 years old, follow up patient

Chief complaint: Still has dizziness and sometimes sweating in the morning.

Subject: Patient's condition is stable. Has no chest pain, has shortness of breath on exertion, has dizziness, no headache, has upper abdominal pain, has hiccups, and has burning sensation on soles.

Object: Looks well.
BP: 110/50
Pulse: 90
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.
Lungs: Clear.
Heart: Regular rhythm, no murmur

Abdomen: Has upper abdominal pain, no mass, soft, flat, not tender, and has positive bowel sound.

UA: Negative.

Neuro exam: Has good orientation to person, date, and place. Sensation by vibration intact but decreases with light touch. Able to tell sharpness and dullness. Motor and reflex intact. Has dorsal pulse and strong.

Assessment: DMII (controlled) and Peripheral neuropathy. Hypertension (stable.) Dyspepsia due to aspirin.

Plan: We want to continue with the same medications suggested by Sihanouk Hospital Center of Hope:

- **Diamecrom, 80 mg daily (hold)**
- **Nifedipine, 20mg daily**
- **Aspirin, 75mg daily**
- **Ranitidine, 40 mg daily before bed**
- **Amitriptilline, 12.5mg, three times per day**

Please give me any other ideas.

Note: I want to hold Diamecrom because UA was negative; otherwise she gets sweatiness and has dizziness very often. Will observe her condition next time, especially her blood sugar. Please give me any other ideas.

From: sihosp@online.com.kh
Date: Tue, 10 Jun 2003 17:10:08 +0700
To: dmr@media.mit.edu
Cc: davidrobertson1@yahoo.com
Subject: Telemedicine replies

Dear Gentlemen:

Hi, This is Jennifer answering the telemedicine questions for SHCH. I hope you are both well. Here are my comments about the patients that you have seen thus far:

#1-Sao Phal, 55F

One thing that you should let us know about is her current diet. How often and what is she eating? Do her periods of dizziness and sweating occur during the evening hours or when? Does she do anything to help her symptoms, like take food? Has she had changes in her weight over the past several weeks? After you know the diet history and activity level, you may decide just to decrease the Diamecrom to 40mg daily instead of stopping it entirely. This depends on the history. When is the patient getting blood sugars and how often? I am sorry that I have not been in the Telemedicine Clinic for a while, so I don't know this patient. One thing to add to your case presentations, especially on diabetics is what was the last few blood sugars, if known and how long have they been on medication, diet history, and other interventions. For this patient, I would just take a more extensive history and then adjust the medication as needed. The other medications can stay the same.

From: "Rithy Chau" <tmed_rithy@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>

Cc: "Bunse Leng" <tmed1shch@bigpond.com.kh>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>

Subject: RE: Patient #1: SAO PHAL, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 07:07:47 +0700

Dear Montha and David,

Since this a follow-up patient (#1 Sao Phal) I think it may be better for those who has seen her case before in giving treatment. My suggestion is if the ASA causes her to have dyspepsia, then I would hold off for a while until resolves. Does she has any indication for heart problem to have the ASA treatment? If her dyspepsia worsens, I would increase her ranitidine 2 po qhs (are you sure it's ranitadine 40mg not Ranitindine 150mg or is it famotidine 40mg?). In any case I would increase to twice the dosage. You can also give some metoclopramide 5mg po q6hrs prn for her hiccup (if bothersome to her). For managing her DM II, I would find away to get her blood check maybe every two months not solely relying on the dipstick--can you get her blood to Kampong Thom Hospital to do this? About her SOB, how far does she have to go or how much work has she done before SOB? Remeber she is 55 yo.

Thanks,

Rithy PA-C

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "David Robertson (davidrobertson1@yahoo.com)" <davidrobertson1@yahoo.com>,
"David Robertson (dmr@media.mit.edu)" <dmr@media.mit.edu>
Subject: FW: Patient #1: SAO PHAL, Cambodia Telemedicine, June 10, 2003
Date: Tue, 10 Jun 2003 14:42:01 -0400

Hello David:

Please see the comments of Dr. Tan inserted into the 'case presentation' section.

Many thanks,

Kathy Fiamma

Patient #1: SAO PHAL, female, 55 years old, follow up patient

Diamecrom, 80 mg daily (hold)

==Was the urine glucose negative in the morning? Could you confirm hypoglycemia by a fingerstick blood glucose? It seems unusual for her to be hypoglycemic in the morning. When she takes Diamecrom in the morning, you'd expect her to be at risk for hypoglycemia in the afternoon. Certainly dizziness and sweating suggests hypoglycemia, but could she have orthostatic hypotension from diabetic autonomic neuropathy or anemia as an explanation? What about the shortness of breath? Since she has no heart failure, cardiomegaly or lung disease to explain this, how about anemia?

Nifedipine, 20mg daily

==Lisinopril 20 mg qd will be a better alternative for hypertension in diabetics to protect kidneys.

Aspirin, 75mg daily

==If you think aspirin is causing dyspepsia, perhaps stopping aspirin will confirm the diagnosis. Then you can decide whether it's worthwhile to restart it. Have you excluded other causes? Helicobacter pylori serology or UGI endoscopy for gastritis, peptic ulcer disease or gastroesophageal reflux disease? If ranitidine stops the pain, but it recurs, perhaps one could make a case for empiric treatment with bismuth subsalicylate 525 mg qid, metronidazole 500 mg qid, tetracycline 500 mg qid for 2 weeks and ranitidine 300 mg qd for 4 weeks for H. pylori gastritis if testing is not available.

Ranitidine, 40 mg daily before bed

Amitriptilline, 12.5mg, three times per day

Date: Tue, 10 Jun 2003 01:22:31 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient #2: SOM THOL, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Telemedicine Clinic in Robib, Cambodia – 10 June 2003

Patient #2: SOM THOL, male, 50 years old, follow up patient

Chief complaint: Both soles still have burning sensation.

Subject: Patient's condition is stable. Has a headache, has dizziness, has blurred vision, has lower back pain, no chest pain, has upper abdominal

pain, has diarrhea, and has burping sometimes. His foot wound has fully healed.

Object: Looks well.
BP: 110/60
Pulse: 80
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.

Neck: No JVD, no goiter, and no lymph node.

Lungs: Clear.

Heart: Regular rhythm, no murmur

Abdomen: No HSM, no mass, soft, no pain, and has positive bowel sound.

Limbs: No stiffness, no wound, and no edema.

Neuro exam: Has good orientation with place, time, and person. Decreasing sensation on both legs, unable to feel sharpness or vibration. Motor intact. Decreasing reflex on both legs. Has dorsal pulse.

Assessment: DMII and peripheral neuropathy. Dyspepsia? (new assessment)

Plan: Should we keep him on the same medication?

- **Diamecrom 80mg, 1 tablet daily**
- **Amitriptilline, 25mg, ½ tablet daily**
- **Tums, 1 gram twice daily**

Please give me any other ideas. The case was sent in brief as it's a repeat follow up case.

From: sihosp@online.com.kh
Date: Tue, 10 Jun 2003 17:10:08 +0700
To: dmr@media.mit.edu
Cc: davidrobertson1@yahoo.com
Subject: Telemedicine replies

Dear Gentlemen:

Hi, This is Jennifer answering the telemedicine questions for SHCH. I hope you are both well.

Here are my comments about the patients that you have seen thus far:

#2-Som Thol, 50M

In this patient, the dose of amitriptylline may not be adequate for him. We are very limited in the medications that we use for peripheral neuropathy. I would consider increasing the dose of the amitriptylline to a full tablet at night or 1/4-1/2 tablets during the day in additional to the current dose at night. All else is fine.

From: "Rithy Chau" <tmed_rithy@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>

Cc: "Bunse Leng" <tmed1shch@bigpond.com.kh>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>

Subject: RE: Patient #2: SOM THOL, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 07:27:55 +0700

Dear Montha and David,

For this patient #2 (Som Thol), continue his meds as usual and to stress the foot care instruction for him so as to not have another DM wound problem to care for. If he has diarrhea, I would expect for him to have abdominal symptoms of bloating, burping, flatus, mild tenderness, etc. How long has the diarrhea been and to what extent, with blood or/and mucous, how often a day for loose bowel movents, has he used any meds to self-treat? I would focus on treating diarrhea due to bacterial infection or parasitic infection rather giving him a dx of dyspepsia. Tum is good, but can also give Loperamide 2mg after each loose BM for maybe max dose of 10-12mg. If you think this infective in nature use something like Cotrim 480mg 2 po bid x 7d for stool without blood or mucous or for parasitic use metronidazole 250mg 2 po tid (tell him no alcohol with metronidazole).

Thanks,

Rithy

From: dsands@bidmc.harvard.edu
To: KKELLEHERFIAMMA@PARTNERS.ORG, dmr@media.mit.edu
Subject: RE: Patient #2: SOM THOL, Cambodia Telemedicine, June 10, 2003
Date: Tue, 10 Jun 2003 12:21:00 -0400

It sounds like the patient is suffering from diabetic neuropathy and likely his diabetes is poorly controlled, as well.

1. Type II Diabetes.

He should have a glucose checked, although his continued blurred vision and glycosuria last visit suggests continued poor control. In addition, he is dizzy and blood pressure has dropped, which suggests volume depletion.

Dr. Kedar had suggested increasing Diamecrom to 120 mg/day. It sounds like this was not done. Please verify either elevated blood glucose or persistent glucose in urine. Then increase Diamecrom to 160 mg per day (rather than 120 mg). Also, have him greatly increase his fluid intake. Educate him that he will need to take diabetes medication for the rest of his life and if he doesn't he will continue to have terrible foot pain and other terrible problems with his feet, eyes, and other parts of his body.

2. Diabetic Neuropathy. Increase amitriptyline to 25 mg at bedtime. If you can get it, capsaicin cream rubbed in to soles of feet three times per day. Tell him it will burn at first but then he will have relief with continued and regular use.

- Danny

Date: Tue, 10 Jun 2003 01:25:31 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient #3: MUY VUN, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,

KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Telemedicine Clinic in Robib, Cambodia – 10 June 2003

Patient #3: MUY VUN, male, 36 years old, teacher, follow up patient

Chief complaint: Patient still has weakness and sometimes dizziness. We follow up with this patient every month.

Subject: Patient condition is stable. Has no headache, no dizziness, no palpitations, decreasing shortness of breath, no chest pain, no abdominal pain, no cough, and no fever, weight has increased 2 kg in the last month.

Object: Looks well.
BP: 100/50
Pulse: 84
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.
Skin: Normal color.
Neck: No JVD, no goiter, and no lymph node.
Lungs: Clear.
Heart: Irregular rhythm, no murmur.
Abdomen: No HSM, soft, not tender, and has abdominal pain.
UA: Negative.
EKG: Done in Siem Reap on 13 May 02, shows Afib with IRRR = 66, T invert on Lead V4, and AVR many P wave on Leads V1, V2, V3, and others not clear P wave.

Assessment: Afib due to valvular heart disease (MS? MR?)

Plan: We have covered this patient with Digoxin 0.25 mg ½ per day and Aspirin 300 mg, ¼ per day. We followed Dr. Hines's advice from Sihanouk Hospital Center of Hope. May I give the same meds and dose and follow up with him next month? Please give me any other ideas.

Note from David: The patient went on his own to Calmette Cardiology a few months ago. The patient said the doctors there recommended a valve replacement, but the patient cannot afford the $3,000 fee Calmette Cardiology requested. (The Director at Calmette told me recently they've had to cut back on free care, even for the poor, and only 10% of their services are free to the poorest and sickest patients.) This patient says he's willing to sell property that might raise $1,000 toward this operation.

From: sihosp@online.com.kh
Date: Tue, 10 Jun 2003 17:10:08 +0700
To: dmr@media.mit.edu
Cc: davidrobertson1@yahoo.com
Subject: Telemedicine replies

Dear Gentlemen:

Hi, This is Jennifer answering the telemedicine questions for SHCH. I hope you are both well.

Here are my comments about the patients that you have seen thus far:

#3-Muy Vun, 36M

What is the nature of this man's valvular heart disease? You did not state this in the presentation. I do not remember this patient, but I think that he may have mitral disease. Many of our heart patients are similar to this one, in that, they may not have irreversible heart damage from the valve problem right now and thus would be a good candidate for a valve replacement. His exam and history show that he has tolerated being on Digoxin and not needed more treatment for heart failure. I would continue this measure and would discourage this patient from selling his property. He should be on a fluid restriction (1-1 1/2 liters/day) and watch activity in the heat.

From: "Rithy Chau" <tmed_rithy@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>

Cc: "Bernard Krisher" <bernie@media.mit.edu>,

"Bunse Leng" <tmed1shch@bigpond.com.kh>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>

Subject: RE: Patient #3: MUY VUN, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 07:48:08 +0700

Dear Montha and David,

For this patient #3 (Muy Vun), he appeared very stable from your report. I would continue with his previous meds. In your PE, you wrote that his abdomen exam is without tenderness but has abdominal pain? What exactly do you mean by this? My advice is for his to not sell his property because I don't think he nedd to have this valvular surgery at the moment. He is very stable with the medication isn't he? Maybe in the meanwhile, try to get a better cardiovascular history and perform a more thorough exam including all his data from Calmette evaluation with labworks, 2D echo result, and pictures of his EKG readings. Please reassure the patient that his condition is a chronic problem and needs more follow-up before deciding whether to have this surgery or not (that is, even if he has enough money for surgery, I still would not recommend it right now). What is his renal function (chemistries, BUN, Creat)? You may want to regularly check these lab values for him to continue with Digoxin.

Thanks,

Rithy

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "David Robertson (davidrobertson1@yahoo.com)" <davidrobertson1@yahoo.com>,
"David Robertson (dmr@media.mit.edu)" <dmr@media.mit.edu>
Subject: FW: Patient #3: MUY VUN, Cambodia Telemedicine, June 10, 2003
Date: Tue, 10 Jun 2003 09:59:20 -0400

-----Original Message-----
From: Sadeh, Jonathan S.,M.D.
Sent: Tuesday, June 10, 2003 9:53 AM

To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #3: MUY VUN, Cambodia Telemedicine, June 10, 2003

Since the AF is related to the valve abnormality (I assume MS) a valve replacement is the best solution and the only long-term solution. If an operation cannot be done now, the only thing you can do is rate control, and try to prevent stroke and development of heart failure. If you don't have coumadin available, aspirin is the next best thing but I would give a higher dose--325mg/day has been shown to be better than 81mg for stroke prevention. He also may need a bit of lasix since the 2kg weight gain may be related to fluid retention.

Jonathan Sadeh, M.D.

Date: Tue, 10 Jun 2003 01:27:39 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient #4: NGET SOK NEN, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Telemedicine Clinic in Robib, Cambodia – 10 June 2003

Patient #4: NGET SOK NEN, female, 23 years old

Chief complaint: Still has dizziness and both legs feel numbness.

History of present illness: We saw this patient last month and she was diagnosed with mild hypertension (BP 160/100) and Vitamin B deficiency after partum. The doctors in Phnom Penh and Boston suggested covering her with Propranolol (10-20mg twice a day) and Vitamin B1 250mg daily.

Subject: Has no headache, has dizziness, has weakness, no chest pain, no cough, and no fever, has mild neck tenderness, decreasing palpitations and decreasing shortness of breath.

Object: Looks well.
BP: 110/60
Pulse: 80
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.
Neck: No JVD, no goiter, and no lymph node.
Lungs: Clear both sides.
Heart: Regular rhythm and no murmur.
Abdomen: Soft, flat, not tender, and positive bowel sound.
Limbs: No edema but mild numbness on both legs (under and below knees.)

Has leg weakness when she walks a long distance.

Neuro exam: Good orientation (place, time and person.) Good sensation, motor and reflex intact.

Assessment: Hypertension (stable.) Vitamin B1 deficiency.

Plan: Should we continue with the same medication as last month?

- **Propranolol, 20mg daily**
- **Vitamin B1, 250mg daily**

Follow up again next month. Please give me any other ideas.

From: sihosp@online.com.kh
Date: Tue, 10 Jun 2003 17:10:08 +0700
To: dmr@media.mit.edu
Cc: davidrobertson1@yahoo.com
Subject: Telemedicine replies

Dear Gentlemen:

Hi, This is Jennifer answering the telemedicine questions for SHCH. I hope you are both well.

Here are my comments about the patients that you have seen thus far:

#4-Sok Nen, 23F

I think that you mean Vitamin B12 deficiency in this patient. This deficiency is supported by signs of peripheral neuropathy, namely, loss of joint position sense and vibratory sense. These are not documented in your presentation, although I know that you likely did state this part of the neuro exam in the past. I do not have anything else to add for this patient.

From: "Rithy Chau" <tmed_rithy@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>

Cc: "Bunse Leng" <tmed1shch@bigpond.com.kh>,

"Bernard Krisher" <bernie@media.mit.edu>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>

Subject: RE: Patient #4: NGET SOK NEN, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 08:02:17 +0700

Dear Montha and David,

Usually, a diagnosis of HTN can be done after three readings of at least two separate times unless the BP is extremely high. Then with the diagnosis, one can start the patient on appropriate medication. Since you started the tx for this patient already, maybe to reduce the propranolol 20mg to 10mg instead and watch her on this and maybe wean her off if her BPs become stable in the future. For her palpitation and SOB, rule out any domestic and social issues that may lead to such symptoms which can be mistaken for a medical problem. You can still give B1 for several more weeks.

Thanks,

Rithy

From: "List, James Frank,M.D.,Ph.D." <JLIST@PARTNERS.ORG>
To: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
Cc: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: RE: Patient #4: NGET SOK NEN, Cambodia Telemedicine, June 10, 2003
Date: Tue, 10 Jun 2003 14:12:17 -0400

To review, the patient is a 23 year-old woman who developed headache, dizziness, tachycardia, hypertension, neck tenderness, and symmetric distal paresthesias post partum. Treatment with propranolol and vitamin B1 has led to resolution of headache, improvement of palpitations, and improvement in blood pressure and heart rate. Dizziness, neck tenderness, and symmetric distal paresthesias remain, and the patient reports weakness. Neurological examination has been normal throughout.

It is difficult to tie everything together with one diagnosis. Some of the symptoms could have been explained by post-partum thyroiditis. TSH was recommended, which, if it was normal while the patient was tachycardic, rules this out as a cause of symptoms (was TSH normal?).

Post-partum hypocalcemia, though rare, could explain some symptoms including the paresthesias and would be important not to miss in this presumably nursing mother. I would recommend checking the calcium and albumin levels. If hypocalcemia is present, other desirable labs would be a phosphate level, magnesium level, 25-hydroxyvitamin D level, and a parathyroid hormone level. Alternatively, one could treat empirically with calcium (500 mg elemental calcium as calcium carbonate TID, vitamin D 800 units per day, and magnesium and see if there is an improvement in paresthesias.

In a thin 23 year-old, hypertension is unusual. One must continue to consider other causes of hypertension. Given the classic triad for pheochromocytoma, it was recommended that if the TSH is normal, urine metanephrines should be checked (were metanephrines normal?). Also, a test of renal function would be wise.

In summary, labs to check, if not already checked, are:
TSH, electrolytes, BUN, creatinine, glucose, calcium and albumin
If above are all normal, then consider urine metanephrines

Continued treatment with vitamin B1 seems prudent. Treatment with propranolol seems to have helped, though some of the current dizziness and weakness could now be secondary to this medication. Would continue propranolol for now, but would taper if patient has hypotension or orthostatic symptoms. You may wish to try empiric treatment with calcium for the paresthesias.

James F. List, M.D., Ph.D.
Molecular Endocrinology
Endocrine Associates
Massachusetts General Hospital

Date: Tue, 10 Jun 2003 01:31:02 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient #5: PEN VANNA, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Telemedicine Clinic in Robib, Cambodia – 10 June

2003

Patient #5: PEN VANNA, female, 38 years old, teacher, follow up patient

Chief complaint: She still has dizziness and shortness of breath sometimes.

History of present illness: This patient was diagnosed with hypertension (initial BP 180/120) and DMII. She was covered with Propranolol 20mg twice daily and Diamecrom 80mg daily, prescribed by Dr. Hines of Sihanouk Hospital Center of Hope six months ago. We keep giving her these meds every month after observing her vital signs and checking UA and sometimes blood sugar.

Subject: Patient condition is stable. She has no headache, no chest tightness, no dizziness, has sweating sometimes, has no chest pain, no cough, has shortness of breath, no fever, has upper abdominal pain, has nausea, and her weight is stable.

Object: Looks well.
BP: 130/90
Pulse: 74
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.
Neck: No JVD, no goiter, and no lymph node.
Lungs: Clear both sides.
Heart: Regular rhythm, no murmur
Abdomen: Soft, flat, has upper abdominal pain, has positive bowel sound.
Limbs: Not significant.
Neuro exam: Good orientation, good sensation, good motor and reflex intact.
Urinalysis: Negative.

Assessment: Hypertension (stable) and DMII.

Plan: Could we cover her with the same meds for another month?

- **Propranolol, 20mg twice daily**
- **Diamecrom, 80mg daily**

Follow up again next month. Please give me any other ideas.

From: sihosp@online.com.kh
Date: Tue, 10 Jun 2003 17:10:08 +0700
To: dmr@media.mit.edu
Cc: davidrobertson1@yahoo.com
Subject: Telemedicine replies

Dear Gentlemen:

Hi, This is Jennifer answering the telemedicine questions for SHCH. I hope you are both well.

Here are my comments about the patients that you have seen thus far:

#5-Pen Vanna, 38F

I think that it would be nice to change BP meds at this point, to an ACE inhibitor like captopril or similar. The dosing could be captopril 12.5mg twice day (1/2 25mg tablet). This is good as primary prophylaxis for renal impairment due to DM. It would be nice to get a baseline creatinine and/or follow-up creatinine in a month or so. In our setting at SHCH, this patient would also be on 1/4 tablet of Aspirin daily because of her risk for heart disease. I would recommend this unless there is a problem with taking the aspirin.

Thank, guys. I will hear from you later. Jennifer

From: "Rithy Chau" <tmed_rithy@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>

Cc: "Jennifer Hines" <sihosp@bigpond.com.kh>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Bernard Krisher" <bernie@media.mit.edu>,

"Bunse Leng" <tmed1shch@bigpond.com.kh>

Subject: RE: Patient #5: PEN VANNA, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 08:13:04 +0700

Dear Montha and David,

For patient #5 (Pen Vanna), please continue with her usual meds as Dr. Hines prescibed. For conderation of dizziness of amny of your patients, make sure that the dizziness does not come from low fluid intake per day. It is very common among people living in a hot climate like Cambodia. In general advice your patients to drink about 1.5-2.0L of boil or clean water each day.

Thanks,

Rithy

From: "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>

To: 'David Robertson' <davidrobertson1@yahoo.com>

Cc: dmr@media.mit.edu, "Kelleher-Fiamma, Kathleen M. - Telemedicine"

<KKELLEHERFIAMMA@PARTNERS.ORG>

Subject: RE: Patient #5: PEN VANNA, Cambodia Telemedicine, June 10, 2003

Date: Tue, 10 Jun 2003 17:41:26 -0400

Hi,

This patient has several problems.

1. Dizziness. The differential diagnosis is broad. As a start I would check orthostatics to see if she is volume depleted. She may also be anemic, and I would check a hematocrit. Autonomic dysfunction is also possible in a diabetic.
2. Shortness of breath. The differential diagnosis is also broad here, and includes pulmonary causes such as asthma or COPD (less likely given her age). Anemia could also cause shortness of breath. The differential also includes myocardial dysfunction, but lungs are clear which argues against heart failure. Anxiety is also possible, but this is a diagnosis of exclusion.

I would check a hematocrit as above, and get a chest x-ray.

3. Hypertension. Much better controlled, her blood pressure is now borderline. As I stated previously, a beta-blocker can mask the symptoms of hypoglycemia, and you may want to change to a diuretic or ace inhibitor.
4. Diabetes. Blood sugar not given. Continue diamecrom.
5. Dyspepsia. I would start with Tums. Likely causes include GERD, h. pylori, parasite infection. May want to consider empiric treatment for parasite infection or h. pylori if this problem persists.

Have her follow-up next month.

Sincerely,

Iris Kedar, M.D.

From: "Cusick, Paul S.,M.D." <PCUSICK@PARTNERS.ORG>
To: "'dmr@media.mit.edu'" <dmr@media.mit.edu>
Subject: FW: Patient #5: PEN VANNA, Cambodia Telemedicine, June 10, 2003
Date: Wed, 11 Jun 2003 14:18:02 -0400

I would continue current medications and encourage a low salt and no concentrated sweets diet.Would try to check fingerstick weekly before next clinic.

bp is improved on propanolol.

goal for bp is <120/80 given DM2.

Paul Cusick

Date: Tue, 10 Jun 2003 03:33:51 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient #6: CHAN HIM, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Telemedicine Clinic in Robib, Cambodia – 10 June 2003

Patient #6: CHAN HIM, female, 56 years old

Chief complaint: Patient complains of neck tenderness and headache on and off for two months.

History of present illness: Two months ago she got neck tenderness and severe headache on and off, sometimes accompanied by blurred vision, dizziness, and chest tightness. She went to a private clinic and bought some anti-hypertension medication to take like Nifedipine 20mg per day. She takes this drug only during increased blood pressure. When she takes this medication, she feels better. Just recently she stopped the

medication and all the symptoms reappeared so she came to see us.

Current medicine: Has taken Nifedipine, 20mg per day, on and off for last two months. This morning she took Nifedipine 10mg.

Past medical history: Has known she's had hypertension for two years.

Social history: Unremarkable

Family history: Unremarkable

Allergies: None

Review of system: Has neck tenderness, has headache, has dizziness, no chest pain, no fever, no cough, and no stool with blood.

Physical exam

General Appearance: Looks okay.
BP: 160/80
Pulse: 60
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.
Skin: Warm to touch and not pale.
Neck: No JVD, no lymph node and no goiter.
Lungs: Clear both sides.
Heart: Regular rhythm, no murmur

Abdomen: Soft, flat, not tender, has positive bowel sound, and no abdominal pain.
Limbs: Okay
Neuro exam: Sensation, orientation, motor, and reflexes are good.

Assessment: Mild hypertension. Tension headache.

Recommend: May we cover her with:

- **Nifedipine, 20mg, ½ tablet twice daily**
- **Aspirin, 300mg, three times daily**

Please give me any other ideas.

From: "Jennifer Hines" <jghines@hotmail.com>
To: dmr@media.mit.edu
Cc: davidrobertson1@yahoo.com
Subject: Telemedicine replies from SHCH; part. 2
Date: Tue, 10 Jun 2003 18:19:37 -0500

Dear Gentlemen:
I hope that you received my other email. I saw and commented on 5 patient cases on the previous email and I have only received one more at this time.

#6-Chan Him, 56F

This lady has systolic hypertension, which is fairly commonly seen in this age group here in Cambodia. I am a bit concerned about using Nifedipine because she can have a rebound hypertension that may make her more symptomatic when she does not take it every day.

Compliance with any of these medications is very important. She should not miss any dosing of her regimen even if she feels well.

You could also consider a diuretic, like HCTZ, if you find that she will not stay on a medication that she has to take more than once a day. Diuretics is a common first line drug for older people who have systolic HTN, in combination with an ACE inhibitor. If you feel that she will not be consistent with the Nifedipine, I would consider HCTZ 50mg, ½ tablet a day with the ASA and follow-up in one month.

From: "Rithy Chau" <tmed_rithy@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>

Cc: "Bunse Leng" <tmed1shch@bigpond.com.kh>,

"Bernard Krisher" <bernie@media.mit.edu>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>

Subject: RE: Patient #6: CHAN HIM, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 08:38:45 +0700

Dear Montha and David,

For this patient #6 (Chan Him), remember there quite a number of patients who would come in and see you as clinician and already have a diagnosis on their mind already. You as a clinician must decide whether the information they are given you is correct or not based on your observation and examination of the patient. In this case, you mentioned that she has been (self?) diagnosed with HTN for two years and only the past two months that she was looking for TX by herself and took the medication whenever she felt bad? So, she came in yesterday for you to make her feel better. Again, you need to make a diagnosis based on the information you gathered--you need three readings on at least two separate times. Did she have her BP done at least a week ago somewhere else and what was the reading? Was it with medication or without her taking any medication? How long ago did take medication before the BP was measured? Your exam showed that that her BP was 160/80. From this are you highly suspected of her having HTN? If yes, go ahead start her on nifedipine 20mg but only qd. However, if you can wait until next visit to check her BP again (maybe two more times at least 15 minutes apart resting) to make a diagnosis would better in not rushing to treat patient in such stable condition. Also, watch for the ASA because some of your patients later develop dyspepsia from this. Maybe try Paracetamol instead for pain tx.

Thanks,
Rithy

From: "Rithy Chau" <tmed_rithy@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>

Cc: "Bunse Leng" <tmed1shch@bigpond.com.kh>,

"Bernard Krisher" <bernie@media.mit.edu>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>

Subject: RE: Patient #6: CHAN HIM, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 09:39:20 +0700

Dear Montha and David,

Here is an additional note after having discussed this case with Drs. Bunse and Gary. Wait for next visit to check her BP x2 as I wrote before to make a diagnosis of HTN on this patient. Do not give any HTN medication yet this time. If she is dx with HTN on next visit start her on either HTCZ 12.5mg po qd or Propranolol 40mg po bid, whichever more affortable (propranolol may help with the HA also if she has HA persistently). For this time, just give Para prn.

Thanks,

Rithy

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "David Robertson (davidrobertson1@yahoo.com)"
<davidrobertson1@yahoo.com>,
"David Robertson (dmr@media.mit.edu)"
<dmr@media.mit.edu>
Cc: "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>
Subject: FW: Patient #6: CHAN HIM, Cambodia Telemedicine, June 10, 2003
Date: Tue, 10 Jun 2003 14:09:20 -0400

-----Original Message-----
From: Smulders-Meyer, Olga,M.D.
Sent: Tuesday, June 10, 2003 1:46 PM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #6: CHAN HIM, Cambodia Telemedicine, June 10, 2003

It is not a good idea to give her high dose daily Aspirin. She might well start internal bleeding on this dose, and she will become dependent on this medication and you will be unable to take her off this, for she will always develop a rebound headache when she does not take her medication. Avoid daily anti headache medications at all times.

I would increase her Nifedipine. She is currently on a very low dose. I would increase it to 10 mg TID, three times a day, and see her back in one week for a bloodpressure check. if necessary you can increase it to 20 mg TID, or switch her to the long acting Nifedine 30 mg XL if this is available.

Her headaches are most likely related to her Hypertension , so treat that first, until she becomes normotensive .I would also advise her to take a walk for 45 minutes every day to release some stress, if you feel this is a stress headache.

If her neck pain persisits, she might needs imaging of the thyroid, but for now your physical examination of the neck seems normal.

All the best,

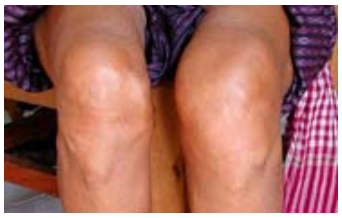
Olga Smulders-Meyer, MD

Date: Tue, 10 Jun 2003 03:36:00 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient #7: SOM DEUM, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,

KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Telemedicine Clinic in Robib, Cambodia – 10 June 2003

Patient #7: SOM DEUM, female, 63 years old, follow up patient



Chief complaint: Still has general joint pain, especially on the left knee.

Note: We saw her last month. Sihanouk Hospital Center of Hope's Dr. Jacques diagnosed her with Polyarthritis. He recommended that she use Aspirin 500mg three times daily and Cimetidine 400mg twice daily for one month.

Subject: All joints painful, has fever, no cough, no chest pain, no headache, no dizziness, no abdominal pain, no nausea, and no stool with blood.

Physical exam

Object: Looks mildly sick.
BP: 110/50
Pulse: 80
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.
Skin: Mild dehydration and not pale.
Neck: No JVD, no goiter and no lymph node.
Lungs: Clear both sides.
Heart: Regular rhythm, no murmur
Abdomen: Soft, flat, not tender, has positive bowel sound, and no abdominal pain.

Limbs: Mild deformity on the fingers, left knee joint still mildly swollen and hot to touch but with no redness and swelling size decreased from last month.

Assessment: Polyarthritis. Malnutrition.

Plan: Should we keep giving some medication that Dr. Jacques recommended last month?

- **Aspirin, 500mg, three times daily for one month**
- **Multivitamin, 1 tablet daily for one month**

Please give me any other ideas.

From: "Bunse Leang" <tmed1shch@bigpond.com.kh>
To: "David Robertson" <davidrobertson1@yahoo.com>, <JKVEDAR@PARTNERS.ORG>,

"Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
<KKELLEHER@PARTNERS.ORG>,
"Gary Jacques" <gjacques@bigpond.com.kh>,
"Jennifer Hines" <sihosp@bigpond.com.kh>,
"Rithy Chau" <tmed_rithy@bigpond.com.kh>
Cc: <dmr@media.mit.edu>, <aafc@forum.org.kh>,
"Bernie Krisher" <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>
Subject: RE: Patient #7: SOM DEUM, Cambodia Telemedicine, June 10, 2003
Date: Wed, 11 Jun 2003 08:25:00 +0700

SHCH reply,

Polyarthritis inflammatory according to the description hot, red (previous), swollen and complained of fever though temperature is normal. Is it symmetric? It affects the fingers as well. I would prefer a picture of her hands to see the deformity. It sounds like rheumatoid arthritis. Great that aspirin helps her (decrease redness and swollen) and no abdominal pain under cimetidine. In SHCH before methotrexate available, we tried chloroquine base 150 mg daily with succes in some patients, so if she does not have any symptoms related to vision I would add chloroquine above dose. It take some months for chloroquine to start to work, if after 6 months still not work then I would stop. Have her report any symptom related to vision. Any change of vision should stop choloroquine also.

Bunse Leang, M.D.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "David Robertson (davidrobertson1@yahoo.com)" <davidrobertson1@yahoo.com>,
"David Robertson (dmr@media.mit.edu)" <dmr@media.mit.edu>
Subject: FW: Patient #7: SOM DEUM, Cambodia Telemedicine, June 10, 2003
Date: Tue, 10 Jun 2003 10:18:19 -0400

-----Original Message-----
From: Sadeh, Jonathan S.,M.D.
Sent: Tuesday, June 10, 2003 10:06 AM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient #7: SOM DEUM, Cambodia Telemedicine, June 10, 2003

It is sounding more like osteoarthritis now but the reports of fevers are worrisome. A swolen, warm joint associated with fever should be tapped to make sure it's not infected, which would obviously change the management. If it isn't infected then the treatment would be NSAIDs with an anti-acid, as you are doing.

Jonathan Sadeh, M.D.

Date: Tue, 10 Jun 2003 03:48:25 -0700 (PDT)
From: David Robertson <davidrobertson1@yahoo.com>
Subject: Patient 8: SOEUNG PHOEUK, Cambodia Telemedicine, June 10, 2003
To: JKVEDAR@PARTNERS.ORG, "Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
KKELLEHER@PARTNERS.ORG, Gary Jacques <gjacques@bigpond.com.kh>,
Jennifer Hines <sihosp@bigpond.com.kh>,
Rithy Chau <tmed_rithy@bigpond.com.kh>,
Bunse Leng <tmed1shch@bigpond.com.kh>
Cc: dmr@media.mit.edu, aafc@forum.org.kh,
Bernie Krisher <bernie@media.mit.edu>,
"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,
"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Patient #8 is the last case being sent for the June Telemedicine Clinic in Robib.

Telemedicine Clinic in Robib, Cambodia – 10 June 2003

Patient 8: SOEUNG PHOEUK, female, 25 years old

Chief complaint: Upper abdominal pain for ten days.

History of present illness: We saw this patient in April 2003 and she was diagnosed with Dyspepsia and Parasitis. We gave her Famotidine 40mg daily for one and a half months and Mebendazole 100mg twice daily for three days following Dr. Jacques' advice. She missed following up with us last month and has now come to see us with upper abdominal pain, before or after a meal, pain like burning, has nausea, has excessive saliva, and sometimes burping.

Current medicine: None (but took Famotidine one month ago for one and a half months.)

Past medical history: Three years ago she had malaria.

Social history: Unremarkable

Family history: Unremarkable

Allergies: None

Review of system: Has no fever, no cough, has epigastric pain, no chest pain, no shortness of breath, no stool with blood, and has nausea.

Physical exam

General Appearance: Looks stable.
BP: 100/50
Pulse: 100
Resp.: 20
Temp. : 36.5

Hair, eyes, ears, nose, and throat: Okay.
Neck: No goiter and no lymph node.
Skin: Not pale and warm to touch.
Lungs: Clear both sides.
Heart: Regular rhythm, no murmur
Limbs: Okay.

Assessment: Dyspepsia.

Recommend: May we continue with Famotidine 40mg twice daily for one month? Please give me any other ideas.

From: "Bunse Leang" <tmed1shch@bigpond.com.kh>

To: "David Robertson" <davidrobertson1@yahoo.com>, <JKVEDAR@PARTNERS.ORG>,

"Kedar, Iris,M.D." <IKEDAR@PARTNERS.ORG>,
<KKELLEHER@PARTNERS.ORG>,

"Gary Jacques" <gjacques@bigpond.com.kh>,

"Jennifer Hines" <sihosp@bigpond.com.kh>,

"Rithy Chau" <tmed_rithy@bigpond.com.kh>

Cc: <dmr@media.mit.edu>, <aafc@forum.org.kh>,

"Bernie Krisher" <bernie@media.mit.edu>,

"Brandling-Bennett, Heather A." <HBRANDLINGBENNETT@PARTNERS.ORG>,

"Cataldo, Christine" <CCATALDO@PARTNERS.ORG>

Subject: RE: Patient 8: SOEUNG PHOEUK, Cambodia Telemedicine, June 10, 2003

Date: Wed, 11 Jun 2003 08:04:45 +0700

SHCH reply:

I do not know whether she got better the previous month with famotidine, the reason why she lost follow-up, or not. If she got better with it, she likely having dyspepsia, and I would put her back with 40 mg daily for 2 months, not BID since this 40 mg daily is already high dose. I also would palpate the epigastrium to see if there is any tender, and check if there is Murphy's sign.

Nausea, salivation and burping, probably due to dyspepsia or others. Could be morning sickness: is she married? How about her menses? Could we check urine pregancy test? If negative I would add metoclopramide 5 mg P.O TID or QID for some days. Could be strongyloides also: there was verbal report from MSF-Belgium in the field said about dyspepsia symptoms due to strongyloides infection, confirmed by stool microscopy and went away with thiabendazole. The prevalence of this parasite, according to one report, is around 20% in Loas and Thailand. Due to side effects of thiabendazole, I would give albendazole 400 mg BID for 5 days (cure rate 95%) and not do stool microscopy (sensitivity is only 30% per stool exam).

After this I would have her follow up in 2 months unless otherwise sicker, then she would refer.

Thanks alot for the case.

Bunse Leang,

SHCH, Telemedicine Coordinator.

From: "Kelleher-Fiamma, Kathleen M. - Telemedicine"
<KKELLEHERFIAMMA@PARTNERS.ORG>
To: "David Robertson (davidrobertson1@yahoo.com)" <davidrobertson1@yahoo.com>,
"David Robertson (dmr@media.mit.edu)" <dmr@media.mit.edu>
Subject: FW: Patient 8: SOEUNG PHOEUK, Cambodia Telemedicine, June 10, 2003
Date: Tue, 10 Jun 2003 10:17:05 -0400

-----Original Message-----
From: Sadeh, Jonathan S.,M.D.
Sent: Tuesday, June 10, 2003 10:16 AM
To: Kelleher-Fiamma, Kathleen M. - Telemedicine
Subject: RE: Patient 8: SOEUNG PHOEUK, Cambodia Telemedicine, June 10, 2003

Her symptoms are probably back because she stopped taking the pepcid. I would restart it again and talk to her about a few lifestyle modifications--avoid coffee, mints, smaller meals, not eat 3-4 hours before sleep. She can also use an anti-acid on top of pepcid. If she does not respond she should also be refered to a GI clinic because dyspepsia not responsive to the above therapy needs to be scoped (to r/o malignancy, mainly).

Jonathan Sadeh, M.D.

Follow up Report, Wednesday, 11 June 2003

Per e-mail advice of the physicians in Boston and Phnom Penh, the patients from this month's clinic and one follow up case were given medication from the pharmacy in the village or medication that was donated by Sihanouk Hospital Center of Hope:

March 2003 Patient: LAY SEUN, male, 34 years old

Patient #1: SAO PHAL, female, 55 years old

Patient #2: SOM THOL, male, 50 years old

Patient #3: MUY VUN, male, 36 years old

Patient #4: NGET SOK NEN, female, 23 years old

Patient #5: PEN VANNA, female, 38 years old

Patient #6: CHAN HIM, female, 56 years old

Patient #7: SOM DEUM, female, 63 years old

Patient # 8: SOEUNG PHOEUK, female, 25 years old

Transport & lodging arranged for July 4th follow up appointment at Sihanouk Hospital Center of Hope in Phnom Penh:

April 2003 Patient: PROM NORN, female, 52 years old

Transport & lodging arranged for July 7th follow up appointment at Sihanouk Hospital Center of Hope in Phnom Penh:

July 2002 Patient: YIN HUN, female, 66 years old

Still in the hospital:

June 2001 Patient: SENG SAN, female, 13 year old child, care for Polyarthritis, hospitalized at Kantha Bhopa Children's Hospital in Phnom Penh since March 13, 2003

PHIM SOPHAN, a 13-year-old boy and patient we have followed every month since the first Telemedicine clinic in February 2001, sadly passed away May 5th at Calmette Cardiology Hospital in Phnom Penh.

PHIM SOPHAN, 2nd from the right, with his friends outside his grandparents' home in Robib in the summer of 2001. Note the enlarged chest area due to his heart condition.

The next Telemedicine Clinic in Robib is scheduled for July 8 & 9, 2003.