Telemedicine Clinic
Rattanakiri
Referral Hospital
August 2008

Report and photos compiled by Rithy Chau and Sovann Peng, SHCH Telemedicine

On Tuesday and Wednesday August 26 - 27, 2008, Rattanakiri Referral Hospital (RRH) staffs began their TM clinic. Patients 3 new cases and 1 missed-follow up case were examined, and the data were transcribed along with digital pictures of the patients, then transmitted and received replies from their TM partners in Boston and Phnom Penh. PA Rithy Chau saw 35 patients extra for minor illnesses without transmitting the data.

The following day, Thursday August 28, 2008, the TM clinic opened again to receive the same patients and other follow-up patients for further evaluation, treatment and management. Finally, the data for treatment and management would then be transcribed and transmitted to Nurse Peng Sovann 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: Hospital Rattanakiri Referral
Date: Aug 19, 2008 9:38 AM
Subject: August TM clinic at Ratanakiri Referral Hospital
To: Chau Rithy; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; "Kathleen M. Kelleher"; Kruy Lim; Cornelia Haener
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach

Dear All,
Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Wednesday, August 27, 2008 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, August 28, 2008.The patients 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

From: Hospital Rattanakiri Referral <kirihospital@gmail.com>
Date: Aug 27, 2008 4:56 PM
Subject: Rattanakiri TM Clinic August 2008, Case#1, OS#00282, 43M (Village III)
To: Chau Rithy; Chau Rithy; Kruy Lim; "Paul J. M.D. Heinzelmann"; "Kathleen M. Kelleher"; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach

Dear all,

Rattanakiri TM clinic for the August 2008, there are three new cases and one follow up. This is the case number 1, OS#00282, 43M and photo.

Best regards,
Sovann

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

Patient: OS#00282 43y male Village III

Chief Complaint: Headache, blurred vision, Neck tension and swelling of upper eyelid and tension of both feet on and off for 5month

HPI: 43year old man presented with the headache, neck tension, blurred vision and swelling upper eyelid and tension of both feet. He was examined BP= 160/100mmHg and protein (+++). He was treated with atenolol 50mg 1t qd, furosemid 20mg 1/2t bid, KCl 600mg1t bid for 15day at private clinic,nowaday he has presented with swelling of upper eyelid and tension of both feet, his symptoms are slighly relieved, no coma, no syncope, no fever.

PMH/SH: Unremarkable.

Social Hx: No smoking, no alcohol drinking

Allergies: NKDA

Family Hx: Unremarkable.

ROS: Unremarkable

PE:
Vital Signs: BP: 150/100mmHg P: 88/mn R: 20/mn T: 37 Wt: 80kg

General: look stable

HEEN: No oropharyngeal lesion, pink conjunctiva, no itching

Chest: CTA billateraly, no rale, no ronchis, HRRR, no murmur

Abdomen: Soft, no distension, (+) BS

MS/Neuro: MS+5/5, motor and sensory intact, DTRs+2/4

Previous Lab/Studies:

On August 1, 2008
UA: Protein+++

Lab/Studies Result on 25/8/2008:

A. UA:
1- Glucose negative

2- Protein +

B. Biochemistry:

1-Calcium=7.6mg/dl [8.1-10.4]
2- Total cholesterol = 221.5mg/dl [< 200mg/dl]
3- Creatinine =0.8mg/dl [0.6- 1.1mg/dl]
4- Glycemia =100.9mg/dl [75-115mg/dl]
5- Triglycerides=283.6mg/dl [60-165mg/dl]
6- CBC(WBC=7000/mm3,differencial counting; Eo=03,Ne=67,Ly=27,Mo=03

Assessment:

1. HTN

Plan:

1- HCTZ 25mg 1tb qd for 2 months
2- Do regular exercise
3- Draw blood for CBC, Lyte, BUN, Creat, Gluc, GT, Tot cholesterol at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

Specific Comments/Questions for Consultants: Do you agree with my assessment and plan?

Examined by: Dr Leng Sreng **Date: August 27, 2008**

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

From: Tan, Heng Soon,M.D.
Sent: Wednesday, August 27, 2008 3:03 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri TM Clinic August 2008, Case#1, OS#00282, 43M (Village III)

This 43 year old man presents with moderately severe hypertension, facial and ankle swelling for 5 months associated with normal renal function, proteinuria without hematuria, elevated lipids and normal blood sugar.

Nephrotic syndrome is defined as loss of more than 3.5 g protein in urine daily. It is associated with low serum albumin, elevated blood lipids causing body edema. However, if hypertension is present, a glomerulonephritis is likely to be present as well. Although the urine dipstick did not show any blood, urine microscopy would be important to look for red cells or white cell casts to rule out an active glomerulonephritis.

Minimal change disease is a common primary cause of nephrotic syndrome in children but less so in adults. Once hypertension is present together with nephrotic syndrome, one should consider post streptococcal glomerulonephritis in both children and adults. Was his illness preceded by a sore throat? Other primary glomerulonephritis that can cause hypertension and nephrotic syndrome would be focal segmental glomerulosclerosis, membranous glomerulonephritis or membranoproliferative glomerulonephritis though the latter would be associated with impaired renal function.

Of the secondary causes of nephrotic syndrome and hypertension, diabetes nephropathy is common, though unlikely in this patient because his blood sugar is normal. Membranous GN may be associated with chronic hepatitis B, systemic lupus [more commonly in women], sarcoidosis, syphilis and drugs/toxins. Has he been using herbal medicines? Focal segmental GN may be associated with HIV infection, diabetes, hypertension. Minimal change nephropathy may be associated with lymphoma. Other secondary causes include Henoch Scholein vasculitis and amyloidosis.

His work up should include serum albumin, fasting blood sugar, ESR, urine microscopy, 24 hour urine for protein, ASO titers and throat culture for recent streptococcal infection, Hepatitis B antigen, HIV, ANA anti-nuclear antibody, RPR for syphilis. Renal ultrasound can exclude large kidneys from amyloidosis.
Chest x-ray may exclude pulmonary sarcoidosis. What he really needs is a renal biopsy to confirm glomerulonephritis.

Moderately severe hypertension with nephrotic syndrome needs to be treated initially with furosemide 20 mg, KCL 20 meq and lisinopril 10 mg daily. A high protein diet may reduce edema. Once glomerulonephritis is confirmed, prednisone may be considered for the steroid responsive glomerulonephritis.

HS

From: Hospital Rattanakiri Referral
Date: Aug 27, 2008 5:03 PM
Subject: Rattanakiri TM clinic August 2008, Case#2, SM#00283, 39F (Village VI)
To: Chau Rithy; Kruy Lim; "Paul J. M.D. Heinzelmann"; "Kathleen M. Kelleher"; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach

Dear all,

This is case number 2, SM#00283, 39F and photo.

Best regards,
Sovann

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

Patient: SM#00283 39F Village VI

Chief Complaint: general Itching of body and polyuria on and off for 2years

HPI: 39y femal present with general itching of body and polyuria. She was examed the blood show triglyceride 321mg/dl and she was treated with Lipanthyl 300mg 1tb bid for 20day, Cetirizine 10mg 1tb qd, Genta creame, metronidazol 250mg 2tb bid for 5day , ketoconazol 200mg 1tb bid 5day, nowaday she came to us with symptom red scratched itching with swelling on skin and epigastric pain on and off.

PMH/SH: unremarkable

Social/ Hx: no smoking , no alcohol drinking

Allregies: NKDA

Family Hx: unremarkable

ROS: Red scratched itching with swelling on skin

PE:
Vital signs: BP: 80/60mmHg P: 80/mn R:20/mn T: 37 Wt:51.5kg

General: look stable

HEEN: no oropharyngeal lesion, pink conjunctiva, no itching

Chest: CTA bilaterally, no rale, no ronchis, HRRR no murmur

Abdomen: soft, no distension, (+)BS

MS/Neuro: MS +5/5 , motor and sensory intact, DTRs +2/4

Lab/studies Requests:

On August 25, 2008

Gluc	=98.8	[75 – 115]
Creat	=0.8	[0.5 – 0.9]
Calcium	=8.0	[8.1 – 10.4]
Total chole	=130.7	[>200]
SGPT	=33.5	[<32]
SGOT	=20.9	[<31]

Assessment:

1. Urticaria
2. Dyspepsia

Plan:

1. Cetirizine 10mg 1tab qd for one week
2. Al(OH)3 500mg 1tab qd for one week

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

Specific Comments/Questions for Consultants: Do you agree with my assessment and plan?

Examined by: Nurse Sovann Peng **Date: August 27, 2008**

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

From: Fiamma, Kathleen M.
Date: Aug 28, 2008 7:54 PM

Subject: FW: Rattanakiri TM clinic August 2008, Case#2, SM#00283, 39F (Village VI)
To: kirihospital@gmail.com
Cc: tmed_rithy@online.com.kh

39 year old woman has recurrent generalized body itching for 2 years with normal blood sugar, liver and kidney function. She is taking fenofibrate for elevated trigylcerides. Did the itching start after she started fenofibrate therapy? The facial skin was erythematous, looking possibly like a photosensitivity reaction. If fenofibrate [Lipanthyl] is a possible cause, discontinue the drug. Based on the available history, exam and photo, I can't arrive at any specific diagnosis.

The rash is not described as urticaria. Certainly idiopathic urticaria is a common cause of recurrent generalized pruritus associated with an urticarial rash. If the rash is a scaly rash, then atopic dermatitis should be considered. Pruritus without a rash is most commonly due to dry skin or ichthyosis, but more serious less common causes of itch without rash include renal failure, thyroid disorders, cutaneous or systemic lymphoma or polycythemia vera.

I enclose a few tables for your reference.

HS

- Drug reaction
- Allergy
- Renal failure
- Sunburn
- Dry skin
- Dermatitis
- www.wrongdiagnosis.com/sym/**generalized_pruritus**.htm

Skin Disorders Associated With Pruritus*		
Inflammatory	**Infections and Infestations**	**Neoplastic**
Urticaria	Scabies	Cutaneous T-Cell lymphoma (Mycosis fungoides)
Dermatitis herpetiformis	Pediculosis	
Pemphigoid	Dermatophytosis	
Lichen planus		
Atopic eczema		
Irritant contact dermatitis		
Allergic contact dermatitis		
Asteatoic dermatitis (dry skin)		
Mastocytosis (urticaria pigmentosa)		
Lichen simplex chronicus		
Psoriasis		
Miliaria		

Table 3:

Systemic Causes of Generalized Pruritus

Systemic Causes of Generalized Pruritus	Other Disease/Conditions Associated With Pruritus
• Uremia • Cholestasis • Hodgkin's disease • Other lymphomas • Hyperthyroidism	• Hypothyroidism • Iron deficiency anemia • Systemic carcinoma • Diabetes mellitus (questionable; perhaps localized) • Leukemia • Polycythemia vera • HIV infection • Brain abscess • Multiple sclerosis • Drug hypersensitivity • Psychogenic • Pregnancy • Aging (senile pruritus) • Postmenopause • Multiple myeloma • Sjogren's syndrome • Carcinoid syndrome • Dumping syndrome

www.clevelandclinicmeded.com/diseasemanagement/dermatology/**pruritus/pruritus**.htm

The most frequent internal diseases associated with generalized pruritus are shown in Table 1. Dry skin (asteatosis, xerosis) as well as excessive bathing may provoke pruritus, especially in old individuals. In such cases the itch can be triggered by mechanical or osmotic mechanisms (26,27). Pruritus is a frequent and important symptom of various systemic disorders (28-30). Skin disorders characterized by itching are beyond the scope of this review.

Table 1. Conditions associated with pruritus

Chronic renal failure	Sclerosis multiplex
Patients on hemodialysis	Stroke
Intrahepatic cholestasis	Psychogenic states
Posthepatic cholestasis	Delusion of parasitosis
Pregnancy	Lymphoma
Drug-induced cholestasis	Mastocytosis
Polycythemia vera	Brain tumors
Iron-deficiency anemia	AIDS
Hyperthyroidism	Systemic parasitosis
Myxedema	Sjögren's syndrome
Diabetes mellitus	Drug eruptions

From: Hospital Rattanakiri Referral
Date: Aug 27, 2008 5:06 PM
Subject: Rattanakiri TM clinic August 2008, Case#3, SL#00284, 38F (Village VI)
To: Chau Rithy; Kruy Lim; Cornelia Haener; "Paul J. M.D. Heinzelmann"; "Kathleen M. Kelleher"; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach

Dear all,

This is case number 3, SL#00284, 38F and photos.

Best regards,
Sovann

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

Name/Age/Sex/Village: SL#00284, 38F (Village VI)

Chief Complaint (CC): Neck mass x 5y

History of Present Illness (HPI): 38F came to us complaining of neck mass. Five years ago after her third baby delivery, she noticed a small mass about 2x3cm on anterior neck and neck tension, palpitation. She went to Kampong Cham hospital and diagnosed her with thyroid problem and treated her with some medicine (unknown name) for her fast heart beat and her thyroid problem for a week. She didn't go for follow up and bought medicine from pharmacy when the symptoms presented. She denied tremor, heat intolerance, weight loss, constipation, diarrhea.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No smoking, drinking alcohol during delivery, 3 children

Current Medications: None

Allergies: NKDA

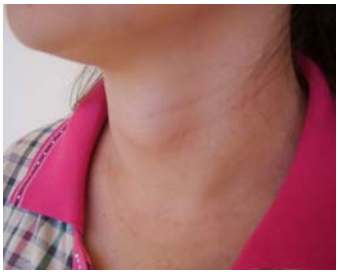
Review of Systems (ROS): Normal appetite, no fever, no cough, no chest pain, Regular period, Last menstrual period on August 12, 2008

PE:

Vitals: BP:116/78 P: 91 R: 20 T: 37^{o}C Wt: 54Kg

General: Look stable

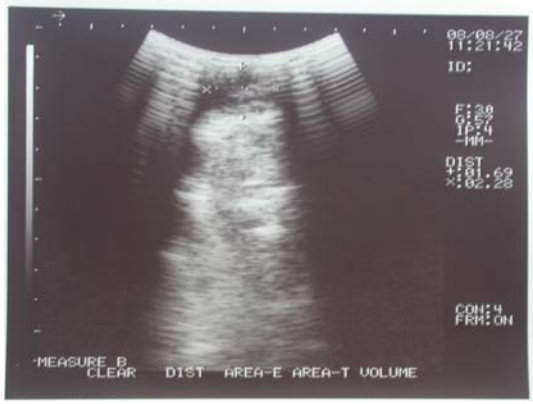
HEENT: No oropharyngeal lesion, pink conjunctiva, a mass on anterior neck about 3x4cm, smooth, regular border, no bruit, no tender, mobile on swallowing, no lymph node palpable, no JVD



Chest: CTA bilaterally, no rales, no rhonchi; H RRR, no murmur

Abd: Soft, no tender, no distension, (+) BS, no HSM, no surgical scar

Extremity/Skin: No edema, no rash, no lesion



MS/Neuro: MS +5/5, motor and sensory intact, slightly tremor on upper extremity, DTRs +2/4, normal gait

Lab/study: Neck mass ultrasound photo attached
Conclusion: Nodular goiter

Assessment:

1. Thyroid cyst
2. Nodular goiter

Plan:

1. Draw blood for THS and Free T4 at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

Specific Comments/Questions for Consultants: Do you agree with my assessment and plan?

Examined by: Nurse Sovann Peng **Date: August 27, 2008**

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

From: Cusick, Paul S.,M.D.
Date: Aug 28, 2008 5:57 AM
Subject: RE: Rattanakiri TM clinic August 2008, Case#3, SL#00284, 38F (Village VI)
To: "Fiamma, Kathleen M."; kirihospital@gmail.com
Cc: tmed_rithy@online.com.kh

I agree with your assessment and management.
It is reassuring that she does not have any symptoms or enlarged lymph nodes.
Clinically, this is not active at this time.

TSH and T4(thyroxine) would be helpful in guiding management.
Endocrine consultation may be necessary after reviewing blood results.

Graves disease and Hashimoto's thyroiditis are the most likely diagnosis in this case.

Thank you for the opportunity to assist

Paul

From: Hospital Rattanakiri Referral
Date: Aug 27, 2008 5:12 PM
Subject: Rattanakiri TM clinic August 2008, Case#4, SP#00081, 54F (Village III)
To: Chau Rithy; Kruy Lim; "Paul J. M.D. Heinzelmann"; "Kathleen M. Kelleher"; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach

Dear all,

This is the last case for Rattanakiri TM Clinic August 2008, Case number 4, SP#00081, 54F (Follow up patient, seen in 2004) and photo. Please reply to the cases before Thursday afternoon. Thank you very much for your cooperation and support in this project.

Best regards,
Sovann

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

Patient: SP#00081, 54F (Village III)

Subject: 54F was seen through our telemedicine clinic on June 2004 with diagnosis of HTN. She presented with symptoms of headaches, blurred vision, neck tension, polyuria, polydypsia, polyphagia and extremity numbness. In this one month, she was examined with BP: 200/120mmHg, protein 3+ and glucose 201mg/dl and was treated with Gliclazide 30mg 1t po bid, Lipanthyl 100mg 1t bid at private clinic. She also takes traditional medicine. She denied of fever, cough, chest pain, hematuria, oliguria, dysuria, edema.

Medication:

1. Gliclazide 30mg 1t po bid
2. Lipanthyl 100mg 1t po bid
3. Traditional medicine

Allergies: NKDA

Object:

Vital Signs: **BP: 170/110** **P: 96** **R: 23** **T: 37** **Wt: 52kg**

General: Look stable

HEENT: No oropharyngeal lesion, pink conjunctiva, no icterus, no neck mass, no lymph node palpable

Chest: CTA bilaterally, no rale, no rhonchi; H RRR, no murmur

Abdomen: Soft, no tender, no distension, (+) BS, no HSM

Extremity/Skin: No edema, no lesion, no foot wound

MS/Neuro: MS +5/5, motor and sensory intact, DTRs +2/4, normal gait

Previous Lab/Studies:

On August 25, 2008

WBC	= 4600/mm^3	
Eosinophil	= 0.3%	
Neutrophil	= 59%	
Lymphocyte	= 36%	
Monocyte	= 0.2%	
Urea	= 21.9	[10 – 50]
Creat	= 0.7	[0.5 – 0.7]
Glucose	= 201.2	[75 – 115]
Tot chole	= 161.5	[<200]
Calcium	= 7.2	[8.1 – 10.4]

On July 17, 2008
UA: Gluc 3+, protein 2+
RBS: 422mg/dl

Lab/Studies Requests:

Assessment:

1. HTN
2. DMII

Plan:

1. Glibenclamide 5mg 1t po qAM for one month
2. Metformin 500mg 2t po qhs for one month
3. Captopril 25mg ¼ po bid for one month
4. ASA 300mg ¼t po qd for one month
5. Educate on diabetic diet and foot care, exercise

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

Specific Comments/Questions for Consultants: Do you agree with my assessment and plan?

Examined by: Dr. Leng Sreng **Date: August 26, 2008**

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

From: Cusick, Paul S.,M.D.
Date: Aug 28, 2008 6:01 AM
Subject: Rattanakiri TM clinic August 2008, Case#4, SP#00081, 54F (Village III)

To: "Fiamma, Kathleen M."; kirihospital@gmail.com
Cc: tmed_rithy@online.com.kh

I agree that this patient needs more aggressive treatment for DM type 2 and htn complicated by proteinuria.

She needs dietary input as well.

You should follow up glucose and bp in a month and you will likely need to increase the captopril.

What are these medications? [Gliclazide 30mg 1t po bid, Lipanthyl 100mg 1t bid]

Thank you,

Paul

Thursday, August 28, 2008

Follow-up Report for Rattanakiri TM Clinic

There were 3 new patients and 1 missed-follow up seen during this month TM clinic at Rattanakiri Referral Hospital (RRH). The data of 4 cases was transmitted and received replies from both Phnom Penh and Boston, other 19 patients came for follow up and refill medication, and 35 patients seen by PA Rithy for minor problems. 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. Nearly all medications and some lab tests not available/done at RRH are provided by SHCH to TM patients at no cost]

Treatment Plan for Rattanakiri TM Clinic August 2008

1. OS#00282, 43M (Village III)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 25mg 1tb qd for 2 months
2. Do regular exercise

2. SM#00283 39F Village VI
Diagnosis:
1. Urticaria
2. Dyspepsia

Treatment:

1. Cetirizine 10mg 1tab qd for one week
2. Al(OH)3 500mg 1tab qd for one week

3. SL#00284, 38F (Village VI)
Diagnosis:
1. Thyroid cyst
2. Nodular goiter

Treatment:
1. Draw blood for THS and Free T4 at SHCH

Lab result on August 28, 2008

TSH	=0.21	[0.49 - 4.67]
Free T4	=12.71	[9.14 - 23.81]

4. SP#00081, 54F (Village III)
Diagnosis:
1. HTN
2. DMII

Treatment:
1. Glibenclamide 5mg 1t po qAM for one month
2. Metformin 500mg 2t po qhs for one month
3. Captopril 25mg ¼ po bid for one month
4. ASA 300mg ¼t po qd for one month
5. Educate on diabetic diet and foot care, exercise
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc and HbA1C at SHCH

WBC	=5.9	[4 - 11x10^9/L]	Na	=140	[135 - 145]
RBC	=4.5	[3.9 - 5.5x10^{12}/L]	K	=2.6	[3.5 - 5.0]
Hb	=13.0	[12.0 - 15.0g/dL]	Cl	=93	[95 - 110]
Ht	=41	[35 - 47%]	BUN	=0.8	[0.8 - 3.9]
MCV	=90	[80 - 100fl]	Creat	=51	[44 - 80]
MCH	=29	[25 - 35pg]	Gluc	=8.4	[4.2 - 6.4]
MHCH	=32	[30 - 37%]			
Plt	=112	[150 - 450x10^9/L]			
Lym	=2.8	[1.0 - 4.0x10^9/L]			
HbA1C	=11.0	[4 – 6]			

Patient who came for follow up and refill medication

1. NS#00006, 18F (Village I)
Diagnosis:
1. Euthyroid goiter

Treatment:
1. Carbimazole 5mg 1t po tid (#300tab)
2. Propranolol 40mg ¼t po bid
3. Draw blood for TSH and Free T4 at SHCH

Lab result on August 28, 2008

TSH	=2.92	[0.49 - 4.67]
Free T4	=6.28	[9.14 - 23.81]

2. NH#00010, 53F (Village III)
Diagnosis:
1. HTN

2. DMII
3. LVH
4. VHD (AR/AS??)

Treatment:

1. Atenolol 50mg 1t po bid (#200)
2. Chlorpropramide 1t po bid (buy)
3. ASA 300mg 1/4t po qd (#25)
4. Captopril 25mg 1t po tid (#300)
5. HCTZ 25mg 2t po qd (#200)
6. Draw blood for Gluc, HbA1C at SHCH

Lab result on August 28, 2008

Gluc =6.9 [4.2 - 6.4]
HbA1C =6.9 {4 - 6]

3. UP#00093, 52F (Village III)
Diagnosis:

1. Euthyroid goiter

Treatment:

1. Carbimazole 5mg 1t po qd (#100)
2. Propranolol 40mg 1/4t po bid

4. CL#00122, 34F (Village III)
Diagnosis:

1. Euthyroid goiter
2. BV

Treatment:

1. Clotrimazole vaginal cream 1% qd for 5d

5. PO#00148, 67F (Village III)
Diagnosis:

1. HTN
2. DMII with PNP

Treatment:

1. Metformin 500mg 2t po qhs (#200tab)
2. Glibenclamide 5mg 2t po bid (#400)
3. Captopril 25mg ¼t po bid (#50)
4. ASA 300mg ¼t po qd (#25tab)
5. Amitriptylin 25mg ½t po qhs (#50)
6. Simvastatin 5mg 1t po qhs (buy)
7. Draw blood for Tot Chole, TG, Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc =9.7 [4.2 - 6.4]
HbA1C =9.5 [4 - 6]
T. Chol =3.5 [<5.7]
TG =2.2 [<1.71]

6. PS#00149, 26F (Village I)
Diagnosis:

1. Euthyroid Goiter

Treatment:

1. Carbimazole 5mg 1t po qd (#100)

7. OT#00155, 45F (Bor Keo)
Diagnosis:
1. HTN
2. DMII

Treatment:
1. Metformin 500mg 2t qAM, 3t qPM (#500tab)
2. Glibenclamide 5mg 2t po bid (#400tab)
3. Captopril 25mg 1/2t po bid (#100tab)
4. ASA 300mg ¼t po qd (#25tab)
5. Amitriptylin 25mg ½t po qhs (#50tab)
6. Citirizin 10mg 1t po qd (buy)
7. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc =11.4 [4.2 - 6.4]
HbA1C =12.7 [4 - 6]

8. RH#00160, 67F (Village I)
Diagnosis:
1. HTN
2. OA

Treatment:
1. Captopril 25mgmg 1tab po qd (#100)
2. Amitriptylin 25mg ½ tab po qhs (#50)
3. ASA 300mg ¼tab po qd (#25)

9. CO#00188, 38F (Village I)
Diagnosis:
1. Euthyroid goiter

Treatment:
1. Draw blood for TSH, Free T4 at SHCH

Lab result on August 28, 2008

TSH =0.44 [0.49 - 4.67]
Free T4 =13.15 [9.14 - 23.81]

10. PN#00229, 45F (Village VI)
Diagnosis:
1. DMII

Treatment:
1. Chlorpropramide 250mg 1t po bid (buy)
2. Metformin 500mg 1t po qhs (#100tab)
3. ASA 300mg $^{1}/_{4}$t po qd (#25tab)
4. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc =7.3 [4.2 - 6.4]
HbA1C =8.9 [4 - 6]

11. OH#00230, 59F (Village III)
Diagnosis:
1. Euthyroid
2. HTN

Treatment:

1. Atenolol 50mg 1/2t po bid (#100)
2. Captopril 25mg 1/2t po bid (#100)
3. Draw blood for Lyte, Creat, Gluc, TSH and free T4 at SHCH

Lab result on August 28, 2008

Na	=150	[135 - 145]
K	=4.6	[3.5 - 5.0]
Cl	=112	[95 - 110]
Creat	=67	[44 - 80]
Gluc	=4.4	[4.2 - 6.4]
TSH	=0.57	[0.49 - 4.67]
Free T4	=14.62	[9.14 - 23.81]

12. KK#00231, 45F (Village I)
Diagnosis:

1. DMII

Treatment:

1. Chlorpropramide 250mg 1t po bid (buy)
2. Metformin 500mg 2t po qhs (#200)
3. Captopril 25mg 1/4t po qd (#25)
4. ASA 300mg 1/4t po qd (#25)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc	=8.3	[4.2 - 6.4]
HbA1C	=10.4	[4 - 6]

13. SV#00256, 43M (Village I)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 2t po qd (buy)
2. Metformin 500mg 2t po qhs (#200tab)
3. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc	=10.2	[4.2 - 6.4]
HbA1C	=10.6	[4 - 6]

14. SS#00258, 61F (Village III)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 250mg 1t po qd (#100tab)
2. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc	=12.1	[4.2 - 6.4]
HbA1C	=6.2	[4 - 6]

15. KC#00260, 44F (Village V)
Diagnosis:

1. DMII

Treatment:

1. Metformin 500mg 1t po qhs (#100tab)
2. Glibenclamide 5mg 1t po qd (buy)
3. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc =2.8 [4.2 - 6.4]
HbA1C =6.0 [4 - 6]

16. TV#00267, 55F (Village II)

Diagnosis:

1. DMII

Treatment:

1. Metformin 500mg 1t po qAM and 2t po qhs (#300)
2. Captopril 25mg 1/4t po bid (buy)
3. ASA 300mg 1/4t po qd (#25)
4. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc =7.1 [4.2 - 6.4]
HbA1C =9.6 [4 - 6]

17. VC#00268, 66M (Bey Srok Village)

Diagnosis:

1. DMII

Treatment:

1. Metformin 500mg 2t po bid (#400tab)
2. Glibenclamide 5mg 2t po bid (#buy)
3. Captopril 25mg 1/4t po qd (#25tab)
4. ASA 300mg 1/4t po qd (#25tab)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc =9.8 [4.2 - 6.4]
HbA1C =7.9 [4 - 6]

18. OE#00273, 65M (Village I)

Diagnosis:

1. DMII with PNP

Treatment:

1. Glibenclamide 5mg 2t po bid (#400tab)
2. Captopril 25mg 1/4t po qd (buy)
3. ASA 300mg 1/4t po qd (#25tab)
4. Amitriptylin 25mg 1/2t po qhs (#50tab)
5. MTV 1t po qd for one month
6. Draw blood for Gluc and HbA1C at SHCH

Lab result on August 28, 2008

Gluc =3.4 [4.2 - 6.4]
HbA1C =6.3 [4 - 6]

19. MP#00275, 10M (Village I)

Diagnosis:

1. Tinea Unguium (Onychomycosis)

Treatment:

1. Cephalexin 250mg 1t po tid for 7d
2. Cetirizine 5mg 1t po qd prn (#20tab)

The next Rattanakiri TM Clinic will be held in October 2008