# Telemedicine Clinic
## *Rattanakiri*
## Referral Hospital
## January 2008

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

On Tuesday and Wednesday January 21-25, 2008, Rattanakiri Referral Hospital (RRH) staffs began their TM clinic. Patients 3 new cases 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.

The following day, Thursday January 24, 2007, 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 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:** Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
**Sent:** Wednesday, January 16, 2008 10:15 AM
**To:** Rithy Chau; Cornelia Haener; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Kruy Lim
**Cc:** Ed & Laurie Bachrach; Cora; HealthNet International; Bernie Krisher; Noun SoThero
**Subject:** January 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, January 23, 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 ,January 24, 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:** Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
**Sent:** Wednesday, January 23, 2008 3:50 PM
**To:** Rithy Chau; Kruy Lim; Paul J. M.D. Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
**Cc:** Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach
**Subject:** Rattanakiri TM Clinic January 2008, Case#1, HY#00264, 22M (Village I)

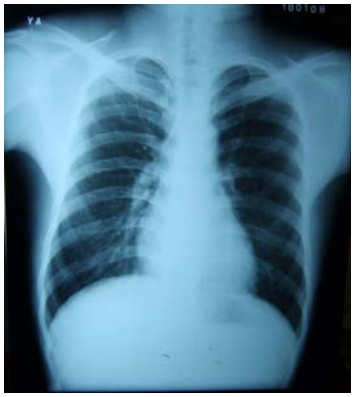
Dear all,
For Rattanakiri TM Clinic January 2008, there are three new cases. This is case number 1, HY#00264, 22M and Photos.
Best regards,
Sovann/Dr. Sreng/Koh Polo

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

**Patient: HY#00264, 22M (Village I)**

**Chief Complaint:** Epigastric pain x 5y

**HPI:** 22M presented with on/off epigastric pain x 5y and seek treatment at private clinic and he was told he had gastritis and treated with some unknown medicine. In this year, the pain became worse with burning sensation, burping sour taste and bloating. The pain became more severe after eating, relived about one hour after eating, and radiated to right shoulder and scapula. He got abd ultrasound conclusion Cholecystitis at private clinic then he was admitted to provincial hospital on January 18, 2008, and treated with Penicillin 2million tid IV, Viscerazine, Cimetidine, metochlopramide. He denied of headache, dyspnea, sore throat, dysphgia, vomiting, stool with blood or mucus, hematuria, dysuria, no icterus, no jaundice.



**PMH:** Unremarkable

**Family Hx:** Father with HTN

**Social Hx:** No smoking, drinking alcohol casually, single

**Medication:**
1. Penicillin 2million tid IV
2. Viscerazine 1t po tid
3. Cimetidine 400mg 1t po bid
4. Metochlorpramide 1t po bid IM

**Allergies: Ceftriazone cause skin rash**

**ROS:** 6kg wt loose during one year

**PE:**
**Vital Signs: BP: 110/ 60 P: 110 R: 20 T: 37$^{o}$C Wt: 48Kg**

**General:** Look stable

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

**Chest:** CTA bilaterally, no rales, no rhonchi; H Tachycardia, RR, no murmur

**Abdomen:** Soft, no tender, no distension, (+) BS, no HSM, no surgical scar, murphy's sign negative

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

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

**Previous Lab/Studies done:**
On January 14, 2008
Ag-HBs negative
Ac-HCV negetive

RTV negative

On January 13, 2008
Abd Ultrasound conclusion: Cholecystitis

**Lab result done today:**

On January 22, 2008
UA normal, colocheck is not available due to no material
WBC =7600/$mm^3$
RBC =4400000/$mm^3$
Hb =13.9mm
Ht =44%
$Na^+$ =161 [135 – 155]
$K^+$ =3.0 [3.6 – 5.5]
Gluc =73.2 [75 – 115]
$Ca^{2+}$ =8.1 [8.1 – 10.4]
SGOT =39.1 [<37]
SGPT =44.5 [<42]

**Assessment:**

1. GERD
2. Parasititis
3. Hypernatremia
4. Hypokalemia

**Plan:**

1. Omeprazole 20mg 2t po qhs for one month
2. Metochlorpramide 10mg 1t po qhs for 15d
3. Mebendazole 500mg 1t po qhs once
4. KCL 600mg 2t po tid for one week
5. Eat two bananas per day
6. Eat low $Na^+$ diet for a week
7. GERD prevention education
8. Draw blood for Lyte and Mg2+ at SHCH

**Comments/Notes: Do you agree with my assessment and plan?**

**Examined by: Nurse Sovann Peng** **Date: January 23, 2008**

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


**From:** Smulders-Meyer, Olga,M.D. [mailto:OSMULDERSMEYE@PARTNERS.ORG]
**Sent:** Thursday, January 24, 2008 1:25 AM
**To:** tmed_rithy@online.com.kh
**Subject:** RE: Rattanakiri TM Clinic January 2008, Case#1, HY#00264, 22M (Village I)

-----Original Message-----
**From:** Smulders-Meyer, Olga,M.D.
**Sent:** Wednesday, January 23, 2008 1:24 PM
**To:** Fiamma, Kathleen M.; ',tmed_rithy@online.com.kh'

**Cc:** 'kirihospital@yahoo.com'
**Subject:** RE: Rattanakiri TM Clinic January 2008, Case#1, HY#00264, 22M (Village I)

**Patient: HY#00264, 22M (Village I)**

**Chief Complaint:** Epigastric pain x 5years.

The patient is a 22-year-old male with a 5 year history of epigastric symptoms most consistent gastroesophageal reflux disease, or gastritis. Recently he had an exacerbation of his pain, as well as radiated pain to the right shoulder and scapula consistent with cystitis.

The patient will need to be treated for both conditions.
For his esophageal reflux, I would favor switching him to omeprazole 20 mg p.o. b.i.d.. The patient used to be advised that he could not not drink alcohol or caffeine. He needs to eat small bland meals 5 times a day.
You could consider testing him for Helicobacter pylori infection, which causes chronic gastritis. We usually treat this with a two-week course of Amoxicillin 500 mg q.i.d., Biaxin 500 mg b.i.d. and omeprazole 20 mg b.i.d.. If you do not have this test available, you could consider just treating him for two weeks and see if symptoms improve. The patient has had a significant weight loss and so this may be worth trying in order to get him comfortable enough to eat again properly.

In terms of his cholecystitis, this needs to be cooled down with the proper antibiotics. Usually we prescribe ciprofloxacin 500 b.i.d. as well as metronidazole 500 b.i.d.(for anaerobic coverage) and amoxicillin 500 mg q.i.d.

From your report it is not clear whether the patient has gallstones. However, an acalculous cholecystitis is rare, and occurs only in 10% of patients with gallbladder infections. Usually these patients are very sick, in the ICU, or with other severe medical problems.
I therefore wonder if this patient really doesn't have any gallstones to begin with. You may want to repeat the ultrasound of his gallbladder in a few weeks. As If he does, he will need removal of his gallbladder once the infection has completely cleared in 6 to 8 weeks.
If the patient has persistent symptoms, after he has been treated for Cholecystitis, you need to worry about complications. and pancreatitis.

Complications — Left untreated, symptoms of cholecystitis may abate within 7 to 10 days. However, complications can occur at alarmingly high rates. The most common complication is the development of gallbladder gangrene (up to 20 percent of cases) with subsequent perforation (2 percent of cases) [19].

Gangrene — Gangrenous cholecystitis is the most common complication of cholecystitis, particularly in older patients, diabetics, or those who delay seeking therapy [19]. The presence of a sepsis-like picture in addition to the other symptoms of cholecystitis should suggest the diagnosis, but gangrene may not be suspected preoperatively.

Perforation — Perforation of the gallbladder usually occurs after the development of gangrene. It is often localized, resulting in a pericholecystic abscess. Less commonly, perforation is free into the peritoneum, leading to generalized peritonitis. Such cases are associated with a high mortality.

Cholecystoenteric fistula — A cholecystoenteric fistula may result from perforation of the gallbladder directly into the duodenum or jejunum. Fistula formation is more often due to long standing pressure necrosis from stones than to acute cholecystitis [20].

Gallstone ileus — Passage of a gallstone through a cholecystoenteric fistula may lead to the development of mechanical bowel obstruction, usually in the terminal ileum (gallstone ileus)

Emphysematous cholecystitis — Emphysematous cholecystitis is caused by secondary infection of the gallbladder wall with gas-forming organisms (such as Clostridium welchii) Other organisms that may be isolated include Escherichia coli (15 percent), staphylococci, streptococci, Pseudomonas, and Klebsiella

Hopefully however, he will just recover on this current bout of Cholecystitis. He will have to be watched closely though.

I hope this is helpful to you.
Many kinds regards,

Olga Smulders-Meyer MD

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**From:** Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
**Sent:** Wednesday, January 23, 2008 3:56 PM
**To:** Rithy Chau; Kruy Lim; Paul J. M.D. Heinzelmann; Joseph Kvedar; Kathleen M. Kelleher
**Cc:** Bernie Krisher; Noun SoThero; Ed & Laurie Bachrach
**Subject:** Rattanakiri TM Clinic January 2008, Case#2, BS#00265, 51M (Village VI)

Dear all,

This is case number 2, BS#00265, 51M and photo.

Best regards,
Sovann/Dr. Sreng/Koh Polo

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

**Patient: BS#00265, 51M (Village VI)**

**Chief Complaint:** Dizziness and extremity numbness on/off x 1y

**HPI:** 51M presented with dizziness, extremity numbness, polyphasia, polydypsia, and polyuria. He was examined at private clinic, Glucose 218mg/dl and treated with chlorpropramide 250mg 1t po qhs for 22d and now he presented with symptoms of cough, runny nose and headache, dizziness so he came to see us. He denied of fever, sore throat.

**PMH:** 10y complete healed left tibia fracture

**Family Hx:** Unremarkable

**Social Hx:** Smoking 1pack of cig per day over 20y, drinking alcohol casually

**Medication:**
1. Chlorpropramide 250mg 1t po qhs

**Allergies:** NKDA

**ROS:** Unremarkable

**PE:**
**Vital Signs: BP: 90/ 70 P: 100 R: 22 T: 37$^{o}$C Wt: 48Kg**

**General:** Look stable

**HEENT:** No oropharyngeal lesion, pink conjunctiva, no icterus

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

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

**Extremity/Skin:** No edema, no skin rash, no foot wound

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

**Previous Lab/Studies done:**

On December 31, 2007
UA: Gluc 4+

| | | |
|---|---|---|
| Gluc | =218mg/dl | [75 – 115] |
| TG | =90.8 | [60 – 165] |

**Lab result done today:** On January 22, 2008

| | | |
|---|---|---|
| WBC | =4500/mm$^3$ | |
| RBC | = 4500000/mm$^3$ | |
| Hb | =15mm | |
| Ht | =45% | |
| Gluc | =352 | [75 – 115] |
| Creat | =5.7 | [0.6 – 1.1] |
| TG | =324 | [60 – 165] |
| Tot chole | =209 | [200] |

**Assessment:**

1. DMII
2. Allergic Rhinitis

**Plan:**

1. Glibenclamide 5mg 1t po qd for one month
2. Allergra 180mg 1t po qd
3. Smoking and alcohol drinking cessation
4. Diabetic diet education, regular exercise and foot care
5. Draw blood for Lyte, BUN, Creat, Gluc, TG, Tot chol, HbA1C at SHCH

**Comments/Notes: Do you agree with my assessment and plan?**

**Examined by: Dr. Sreng Leng** **Date: January 23, 2008**

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



**From:** Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
**Sent:** Thursday, January 24, 2008 2:24 AM
**To:** Rattanakiri Referral Hospital; Rithy Chau
**Subject:** FW: Rattanakiri TM Clinic January 2008, Case#2, BS#00265, 51M (Village VI)

*Kathy Fiamma*
*617-726-1051*

-----Original Message-----
**From:** Crocker, J.Benjamin,M.D.
**Sent:** Wednesday, January 23, 2008 10:43 AM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Rattanakiri TM Clinic January 2008, Case#2, BS#00265, 51M (Village VI)

Sounds good EXCEPT I can't tell if this patient's RENAL FUNCTION is vastly deteriorated (given your normal values in parentheses) or whether this is a typo. PLEASE REPEAT RENAL FUNCTION as the sulfonylurea that he is taking may put him at higher risk of hypoglycemia if he has renal failure.

Thanks,
BC

**J. Benjamin Crocker, M.D.**
**Internal Medicine Associates 3**
**WACC 605**
**15 Parkman Street**
**Boston, MA 02114**
**Phone 617 724-8400**
**Fax 617 724-0331**
**Email jbcrocker@partners.org**

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**From:** Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
**Sent:** Wednesday, January 23, 2008 4:21 PM
**To:** Rithy Chau; Kruy Lim; Paul J. M.D. Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
**Cc:** Bernie Krisher; Noun SoThero; Bunse Leng
**Subject:** Rattanakiri TM clinic January 2008, case#3, SL#00266, 27M (Village VI)

Dear all,

This is case number 3, SL#00266, 27M and photos . Please reply to the case before Thursday afternoon in Cambodia time. Thank you very much for your support and cooperation in this project.

Best regards,
Sovann/Dr. Sreng/Koh Polo

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

**Patient: SL#00266, 27M (Village VI)**

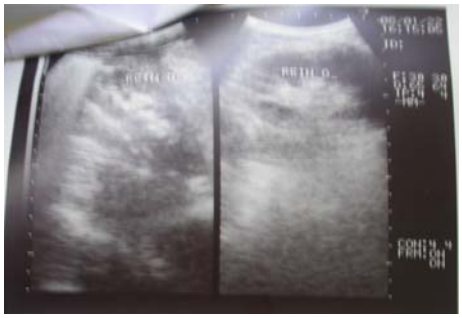
**Chief Complaint:** lumbar pain on and off for 2 years

**HPI:** 27y Male presented with lumbar pain and radiated to his back, neck behind and red color urine. He was examined at private clinic that confirmed Urinary tract infection. He was treated with Cefixime 200mg 1tab bid, Diclofenac 50mg tid and furosemide 40mg 1 tab qd for 4days. His symptoms got better When he take this medicine, and now he presented with red color urine and lumbar pain no fever, no dysuria no polyuria . He came to us.

**PMH:** Unremarkable

**Family Hx:** Unremarkable

**Social Hx:** smoking 1pocket/day
drinking for 8years

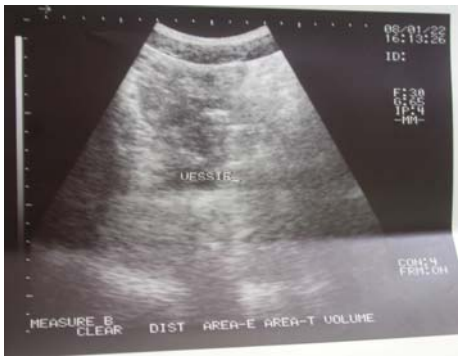


**Medication:** Above medicine

**Allergies: NKDA**

**ROS:** Unremarkable

**PE:**
**Vital Signs: BP: 100/ 70 P: 82 R: 26 T: 37°C Wt: 57Kg**




**General:** Look stable

**HEENT:** No oropharyngeal lesion, pink conjunctiva, no icterus

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

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

**Musculoskeletal:** Unremarkable

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

**Previous Lab/Studies done:**

**Lab result done today:**

On January 22, 2008

UA: blood ++; Abd ultrasound conclusion: Unremarkable

WBC =8600/$mm^3$

| | |
|---|---|
| Eosinophil | =0.4% |
| Neutrophil | =51% |
| Lymphocytes | =42% |
| Monocyte | =0.3% |

**Assessment:**

1. Urinary Tract infection
2. Kidney stone (micro)

**Plan:**

1. Ciprofloxacin 500mg 1t po bid for a week
2. Drink water 3L/day

**Comments/Notes:** Please, give good idea

**Examined by: Dr. Sreng Leng** **Date: January 23, 2008**

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



**From:** Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
**Sent:** Thursday, January 24, 2008 8:22 PM
**To:** Rattanakiri Referral Hospital; Rithy Chau
**Subject:** FW: Rattanakiri TM clinic January 2008, case#3, SL#00266, 27M (Village VI)

Kathy Fiamma
617-726-1051
-----Original Message-----
**From:** Tan, Heng Soon,M.D.
**Sent:** Wednesday, January 23, 2008 4:32 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Rattanakiri TM clinic January 2008, case#3, SL#00266, 27M (Village VI)

I am unable to interpret the abdominal ultrasound. If a renal stone is suspected, shouldn't a renal ultrasound be more appropriate?
I doubt that he has an infection. It is not pyelonephritis since he has no fever or costovertebral angle tenderness. It is not an infected stone or cystitis without dysuria or white cells/nitrites in urine dipstick. Renal stone is a likely diagnosis with recurrent lumbar pain and bloody urine in a young man. A KUB xray as well as renal ultrasound may confirm the diagnosis. In that case, tramadol for severe pain, increased oral fluids to 3 liters a day and straining the urine with a cotton cloth to retrieve a stone should be recommended. If the stone does not pass, he needs to consult a urologist for further management.
If he has recurrent stones, a metabolic work up to check serum and 24h urine for calcium, creatinine and uric acid to rule out hypercalcemia, gout or hypercalciuria as a cause of recurrent stones.
If hematuria is gross blood in urine, I would be concerned about renal or bladder tumors even though he is a young man, though a young man who smokes. Could he have been exposed to organic chemicals in his occupation? Cystoscopy and renal ultrasound to rule out a renal or bladder tumor will be necessary.
Papillary necrosis is less likely without chronic pyelonephritis, overuse of NSAIDs or diabetes.

Heng Soon Tan, MD

# Thursday, January 24, 2008

## Follow-up Report for Rattanakiri TM Clinic

There were 3 new patients seen during this month TM clinic at Rattanakiri Referral Hospital (RRH). The data of 3 cases was transmitted and received replies from both Phnom Penh and Boston, 4 patients seen by PA Rithy for minor problem and other 19 patients came for follow up and refill medication. 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 January 2008

**1. HY#00264, 22M (Village I)**
**Diagnosis:**

1. PUD
2. Parasititis
3. Hypernatremia
4. Hypokalemia

**Treatment:**

1. Omeprazole 20mg 1t po bid for two weeks
2. Metronidazole 250mg 2t po bid for two weeks
3. Amoxicilline 500mg 2t po bid for two weeks
4. Metochlorpramide 10mg 1t po qhs for 15d
5. Mebendazole 500mg 1t po qhs once
6. KCl 600mg 2t po tid for 5d
7. MTV 1t po qd for one month
8. Eat two bananas per day
9. Eat low $Na^+$ diet for a week
10. GERD prevention education
11. Draw blood for Lyte and Mg2+ at SHCH

**Lab result on 25 January 2008**

| | | |
|---|---|---|
| $Na^+$ | =139 | [135 - 145] |
| $K^+$ | =3.8 | [3.5 - 5.0] |
| $Cl^-$ | =103 | [95 - 110] |
| $Mg^{2+}$ | =0.81 | [0.8 – 1.0] |

**SHCH Recommendation: Continue medication as plan and follow up next month**

**2. BS#00265, 51M (Village VI)**
**Diagnosis:**

1. DMII
2. Allergic Rhinitis

**Treatment:**

1. Glibenclamide 5mg 1t po qd for one month
2. Captopril 25mg 1/4t po bid for one month
3. ASA 500mg 1/4t po qd for one month
4. Allegra 180mg 1t po qd
5. Smoking and alcohol drinking cessation
6. Diabetic diet education, regular exercise and foot care
7. Draw blood for CBC, Lyte, BUN, Creat, Gluc, TG, Tot chol, HbA1C at SHCH

**Lab result on 25 January 2008**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =5.5 | [4 - 11x10$^9$/L] | Na | =136 | [135 - 145] |
| RBC | =6.2 | [4.6 - 6.0x10$^{12}$/L] | K | =3.8 | [3.5 - 5.0] |
| Hb | =14.3 | [14.0 - 16.0g/dL] | Cl | =104 | [95 - 110] |
| Ht | =46 | [42 - 52%] | BUN | =2.0 | [0.8 - 3.9] |
| MCV | =75 | [80 - 100fl] | Creat | =85 | [53 - 97] |
| MCH | =23 | [25 - 35pg] | Gluc | =15.4 | [4.2 - 6.4] |
| MHCH | =31 | [30 - 37%] | T. Chol | =6.3 | [<5.7] |
| Plt | =169 | [150 - 450x10$^9$/L] | TG | =3.8 | [<1.71] |
| Lym | =1.3 | [1.0 - 4.0x10$^9$/L] | HbA1C | =17.1 | [4 – 6] |

**SHCH Recommendation: Increase Glibenclamide 5mg 1t po bid and follow up next month**

**3. SL#00266, 27M (Village VI)**
**Diagnosis:**

1. Urinary Tract infection
2. Kidney stone (micro)

**Treatment:**

1. Ciprofloxacin 500mg 1t po bid for a week
2. Paracetamol 500mg 1t po qid prn
3. Drink water 3L/day

## 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 qd (#100)
2. Propranolol 40mg ¼t po bid
3. Draw blood for Free T4 at SHCH

**Lab result on 25 January 2008**

Free T4=16.2 [9.2 – 23.9]

**SHCH Recommendation: Continue medication as plan and check Free T4 in three months**

**2. NH#00010, 53F (Village III)**

**Diagnosis:**

1. HTN
2. DMII
3. LVH
4. Aortic Insufficiency?
5. Aortic Stenosis?

**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. Fenofibrate 100mg 1t po qd (buy)

**3. NS#00089, 17F (Village I)**

**Diagnosis:**

1. Euthyroid goiter

**Treatment:**

1. Draw blood for Free $T_4$ in April 2008

**4. UP#00093, 52F (Village III)**

**Diagnosis:**

1. Euthyroid goiter

**Treatment:**

1. Carbimazole 5mg 1t po qd (#100)
2. Propranolol 40mg 1/4t po bid
3. Draw blood for Free T4 at SHCH

**Lab result on 25 January 2008**

Free T4=16.3 [9.2 – 23.9]

**SHCH Recommendation: Continue medication as plan and check Free T4 in three months**

**5. MS#00144, 52M (Thmey Village)**

**Diagnosis:**

1. DMII

**Treatment:**

1. Glibenclamide 5mg 1tab po bid (#200)
2. Metformin 500mg 1t po qhs (#100)
3. Captopril 25mg ¼ tab po qd (#25)
4. ASA 300mg 1/4t po qd (#25)

**6. PO#00148, 67F (Village III)**

**Diagnosis:**

1. HTN
2. DMII with PNP

**Treatment:**

1. Captopril 25mg ¼t po bid (#25)
2. Metformin 500mg 1t po qhs (#100)
3. Glibenclamide 5mg 1t po bid (#200)

4. ASA 300mg ¼t po qd (#25)
5. Amitriptylin 25mg ½t po qhs (#50)
6. Draw blood for Gluc and HbA1C in next month

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

1. Euthyroid Goiter

**Treatment:**

1. Carbimazole 5mg 1t po qd
2. Draw blood for Free T4 at SHCH

**Lab result on 25 January 2008**

Free T4=14.5 [9.2 – 23.9]

**8. OT#00155, 45F (Bor Keo)**
**Diagnosis:**

1. HTN
2. DMII

**Treatment:**

1. Captopril 25mg 1/2t po bid
2. Metformin 500mg 2t qAM, 3t qPM
3. Glibenclamide 5mg 2t po bid
4. ASA 300mg ¼t po qd (buy)
5. Amitriptylin 25mg ½t po qhs
6. Citirizin 10mg 1t po qd

**9. KM#00158, 51F (Sre Ankrong Village)**
**Diagnosis:**

1. Euthyroid goiter

**Treatment:**

1. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Free T4 at SHCH
2. Refer to SHCH for surgery consultation on February 12, 2008

**Lab result on 25 January 2008**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =8.6 | [4 - 11x10$^{9}$/L] | Na | =141 | [135 - 145] |
| RBC | =5.1 | [3.9 - 5.5x10$^{12}$/L] | K | =4.4 | [3.5 - 5.0] |
| Hb | =11.1 | [12.0 - 15.0g/dL] | Cl | =108 | [95 - 110] |
| Ht | =36 | [35 - 47%] | BUN | =1.4 | [0.8 - 3.9] |
| MCV | =72 | [80 - 100fl] | Creat | =58 | [44 - 80] |
| MCH | =22 | [25 - 35pg] | Gluc | =5.5 | [4.2 - 6.4] |
| MHCH | =31 | [30 - 37%] | Free T4 | =10.3 | [9.2 – 23.9] |
| Plt | =308 | [150 - 450x10$^{9}$/L] | | | |
| Lym | =2.9 | [1.0 - 4.0x10$^{9}$/L] | | | |

**10. 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)

**11. OP#00161, 78M (Village I)**
**Diagnosis:**
1. COPD

**Treatment:**
1. Salbutamol Inhaler 2puffs po bid (#2)

**12. YM#00189, 16F (Village III)**
**Diagnosis:**
1. Asthma

**Treatment:**
1. Salbutamol Inhaler 2puffs bid prn (#2)

**13. EM#00193, 22F (Village I)**
**Diagnosis:**
1. Euthyroid goiter
2. Myopia

**Treatment:**
1. Seek opthalmologist for eye glasses
2. Paracetamol 500mg 1t po qid prn pain

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

**Treatment:**
1. Chlorpropramide 250mg 1t po qd (buy)
2. Metformin 500mg 1t po qhs (#100)
3. ASA 81mg 1t po qd (#25)
4. Draw blood for Gluc and HbA1C next month

**15. KK#00231, 45F (Village I)**
**Diagnosis:**
1. DMII

**Treatment:**
1. Chlorpropramide 250mg 1t po bid (buy)
2. Metformin 500mg 1t po qhs (#100)
3. Captopril 25mg 1/4t po qd (#25)
4. ASA 300mg 1/4t po qd (#25)
5. Draw blood for Gluc and HbA1C next month

**16. SV#00256, 43M (Village I)**
**Diagnosis:**
1. Phimosis circumcision
2. DMII

**Treatment:**
1. Glibenclamide 5mg 2t po qd (buy)
2. Metformin 500mg 2t po qhs (#100)

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

1. DMII

**Treatment:**

1. Glibenclamide 250mg 1t po qd (#100)
2. Diabetic diet, hypoglycemia sign, do regular exercise, foot care

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

1. DMII

**Treatment:**

1. Metformin 500mg 2t po qhs (#200 )
2. Glibenclamide 5mg 1t po qd (buy)
3. Review patient on diabetic diet and foot care
4. Draw blood for Gluc and HbA1C next month

**19. CV#00262, 37M (Village VI)**
**Diagnosis:**

1. DMII
2. Allergic Rhinitis
3. LLQ lipoma

**Treatment:**

1. Metformin 500mg 1t qhs for one month (#100)
2. Captopril 25mg 1/4t po qd for one month (buy)
3. ASA 500mg 1/4t po chew qd for one month (#25)
4. Diabetic education, foot care and do regular exercise

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# The next Rattanakiri TM Clinic will be Held on February 2008