Telemedicine Clinic
Rattanakiri
Referral Hospital
July 2006

Report and photos compiled by Rithy Chau, SHCH Telemedicine

On Wednesday, July 26, 2006, Rattanakiri Referral Hospital (RRH) staff began their TM clinic. Patients (4 new cases) were examined and the data were transcribed along with digital pictures of the patient, then transmitted and received replies from their TM partners in Boston and Phnom Penh.

The following day, Thursday July 27, 2006, 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: Thursday, July 20, 2006 3:22 PM
To: Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Rithy Chau; Cornelia Haener
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: July 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, July 26, 2006 beginning at 8:00am local time for one full day. We expect to enter and transmit the patient data to those of you at SHCH and at Partner in Boston that evening.

Please try to respond before noontime the following day, Thursday ,July 27, 2006.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
Rattanakiri Telemedicine Services
Rattanakiri Referral Hospital
Banlung, Rattanakiri Province, Cambodia

From: Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, July 26, 2006 10:17 AM
To: Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Rithy Chau; Cornelia Haener
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital TM clinic Patient TD#00180

Dear All,
There will be 4 new cases of this month for TM clinic at Rattanakiri.This is the first case of this month patient TD#00180 and her photos.

Best regards

Channarith

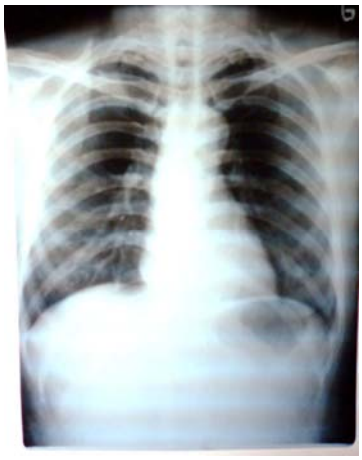
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: TD#00180, 43F, Village I

Chief Complaint: Weakness movement of both legs and numbness of both her legs x 7 days

HPI: 43 Woman, who complained of vertebral pain off and on x 10 years and She went to private clinic for pain, her symptoms could resolve .The last more than 10 days, her complain of vertebral pain associated with burning vertebral pain and radiated to her ribs , She treated at private clinic in Viet name and went to treat at private clinic in Kampong Cham province , like this : Rofedol 25mg 1 tab po qd , Cefixime 200mg 2 tab po bid , Domadol 1 tab po bid , Kalmeco 1 tab po bid , Doxi 100mg 2 tab po bid , Lansoprazol 1 tab po bid ,Metronidazol 250mg 2 tab po bid x 10 d , her symptoms can resolve slightly .
And now, her complaints of progressive vertebral pain with burning vertebral pain and radiated to the ribs , especially She has got up from bed is pain , weight loss , occasionally fever in afternoon , and this pain radiated to both hip ,both external lateral thigh , posterior calf, and ankles and She cannot walk herself and feel muscle weakness and numbness of both legs .

PMH/SH: HBsAG + (04/07/2005), Gastroduodenal ulcer (04/07/2005), Cervix inflammation .



Social Hx: no smoking and alcohol

Allergies: Cimetidine 200mg .

Family Hx: unremarkable

ROS:

PE:
Vital Signs: **BP110/80 mg** **P 70** **R20** **T36.5** **Wt** 48kg

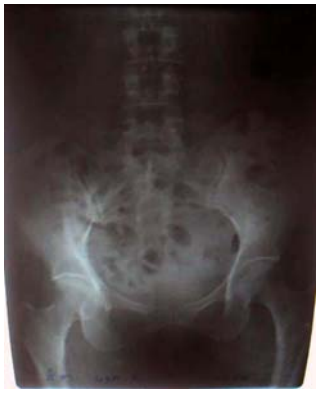
General: alerted and oriented

HEENT: unremarkable

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

Abdomen: soft, active BS, No mass.

Musculoskeletal: her gait can not walk on heel to toes, walk on heels , can walk hop on heel ,can walk herself ,all muscle are not hypotrophy, she can not bend her back to go down and turn the back or bend her body toward the sides .slightly ballooning of her vertebra when palpation.



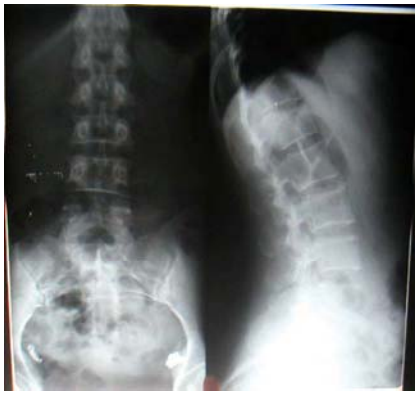
Neuro: 4/4: motor. cotton touch on sensory are slightly intact, DTR :+2

GU: none

Rectal: none

Previous Lab/Studies: chest x -ray, vertebral x-ray

Lab/Studies Requests: x_ray of vertebra:lesion on L1-T11 and shadow small tumor
ASLO:negative , WBC: 900/mm3, Ht:40%, RBC:4300000/mm3
differential counting : 03%, 57%, 38%, 02%, 0%,Platelet counting:225000



Assessment:

1. Vertebral TB
2. Neurogetic Pathology
3. Osteoporose?
4. a small tumor pressure ?

Plan:

1. Naproxen 220mg 1 tab bid po x 10 d
2. B-complex 1 tab po qd
3. Should give her anti drugs TB ?
4. Add to Vit B12 1 tab po bid ?(HBsAg +)
5. Omeprazol 20mg 1 tab po bid (GDU)

Comments/Notes: please, give a good idea

Examined by: San **Date: 25/07/06**

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

From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]
Sent: Thursday, July 27, 2006 3:46 AM
To: Fiamma, Kathleen M.; kirihospital@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient TD#00180

this patient sounds like she has chronic low back pain. She has some symptoms of radicular pain to her legs.
she has no neurological deficits to suggest that she has a nerve root impingement.
She has had no trauma to cause a fracture.
She is young (43) and likely pre menopausal so osteoporosis is less likely.

I cannot detect the lesion at T11-L1 that is reportedly seen on the xray.

She could also have a neuropathy from folate, b12 deficiency. Diabetes can produce neuropathic pain and checking a blood sugar would be helpful.

chronic Hep B antigenemia can cause malaise and fever but not neuropathy.

While her symptoms could be from extrapulmonary TB, I would like to have further studies of the "small tumor" and the "vertebral lesion" with a CT scan of the area.

Treating with rest, heat and antiinflammatories (naproxen) is fine initially as long as she does not have GI upset. Omeprazole is a good choice for gastric protection.

I would not commit her to TB therapy until we know what is going on in her Thoraco Lumbar spine.

vitamin B and B12 can't hurt.

Hope that this helps.

Paul

From: Rithy Chau [mailto:chaurithy@yahoo.com]
Sent: Thursday, July 27, 2006 2:40 PM
To: Rattanakiri TM
Cc: Brian Hammond; Paul Heinzelmann; Joseph Kvedar; Cornelia Haener; Kruy Lim; Kathy Fiamma; Bernie Krisher; So Thero Noun; Ed & Laurie Bachrach; Fil - Jr. Tabayoyong
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient TD#00180

Dear Dr. San,

As for this patient TD#00180, you mentioned CXR but I did not see any CXR image sent. Any injury or trauma in the past? Past surgical procedure? Where along the spine (at what level) was the most painful? To me it may possibly be a sciatica problem, but would rule out any spinal lesion and Pott's dz.

Dr. Cornelia said that she could not see the lumbar spine x-ray well esp. L5 area. Can you send down the spine x-rays and CXR films to us in PP to see or else if pain not so severe, can do this next month? However, if positive lesion of TB on CXR, please do not wait to send us the image and/or film so and would go ahead and do an AFB sputum smears for TB and begin tx if positive. Can you do colocheck and check her CBC? You can give her para and diflunasal to use interchangeably and she can buy omeprazole 20mg qhs to use for 1-2mo if she still experienced dyspeptic sx when taken NSAIDs. B-complex is optional. Warm compress and massage maybe useful with pain relief. As her to do some light back stretching exercise as tolerated and if problem leans toward sciatica, then ask to not sit or stand for a long period in one place, but to be mobile instead.

Regards,
Rithy

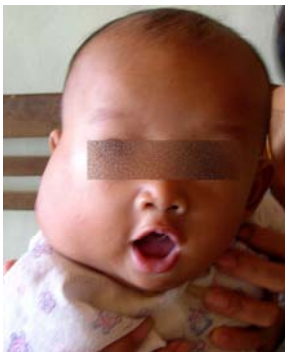
From: Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, July 26, 2006 10:29 AM
To: Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Rithy Chau; Cornelia Haener
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital TM clinic Patient VR#00181

Dear All,

This is the patient VR#00181 and her photos.

Best regards
Channarith

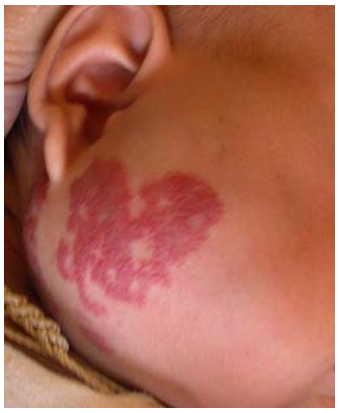
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine



Patient: VR#00181, 5M F, Village IV

Chief Complaint: a big mass developing on right face x 2 M

HPI: 5 M F, the first time, there was a small mass on right face with red nature spots after she was born, which developed progressively during 2 M associated with mild fever and burning mass ,she was taken to private clinic for treating her symptoms including antipyretic , antibiotic , and traditional drugs, she did not get better .
The last 3 months, a enlarge mass on right face , has progressively ballooned on right face with burning , associated with moderate fever , no cough, no v/n , no convulsion , appetite normal , no weigh loss.
PMH/SH: unremarkable



Social Hx:

Allergies: none.

Family Hx: unremarkable

ROS:

PE:
Vital Signs: **BP** **P** **R** **T** **Wt** 7kg

General: alerted and oriented

HEENT: very soft , no pain , mobile when palpation, warm when palpitation , no lymph node at all .no pharyngitis , no tonsillis .no otitis .

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

Abdomen: soft, active BS, No mass.

Musculoskeletal: unremarkable
Neuro: motor and sensory are intact

GU: none

Rectal: none

Previous Lab/Studies:

Lab/Studies Requests: WBC ,

Assessment: 1. Cervical lymphadenitis
2.viral respiratory infection
3.Mumps
4. lymphoma 5. TB

Plan: 1.Cephexine 250 1/ 2 tab po bid x 10 d
2.Para 500mg 1/ 4 tab prn pain
3.refer to other hospital ?

Comments/Notes: please ,give a good idea

Examined by: San **Date: 25/07/06**

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

From: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, July 27, 2006 3:12 PM
To: 'Rattanakiri Referral Hospital'
Cc: 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Cornelia Haener'; 'Lim kruy'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient VR#00181

Dear Dr. San,

This patient 5 mo old female baby has a right facial hemangiomas of infancy vs. cavernous hemangiomas. No need for medication tx for now but can refer this child to KB Children Hospital in PP for further evaluation. If it is a hemangiomas of infancy which progresses in size from 1 to 8 cm in diameter and grows rapidly during the first year, 50% presented on head/neck area, then usually it regresses or even disappears by the fifth year.

Hope this is helpful.

Regards,
Rithy

No reply from Boston

From: Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, July 26, 2006 10:46 AM
To: Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Rithy Chau; Cornelia Haener
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital TM clinic Patient CC#00182

Dear All,

This is the patient CC#00182 and his photos.

Best regards

Channarith

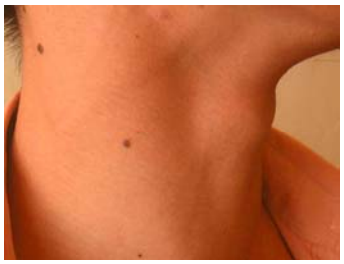
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: CC#00182,23M, TMEY Village , Ven Say

Chief Complaint: a developing mass on his anterior neck x 3 y size : 5x 25 em

HPI: 23 Man, who has complained of a developing mass on his anterior neck x 3 y associated with palpitation off and on, phobia, occasionally difficulty of swallowing saliva ,dyspnea on exertion, tremor of extremities off and on, weight loss , appetite normal , no exophthalmia, no v/ no , no dizziness, no convulsion, no ptosis.

PMH/SH: unremarkable



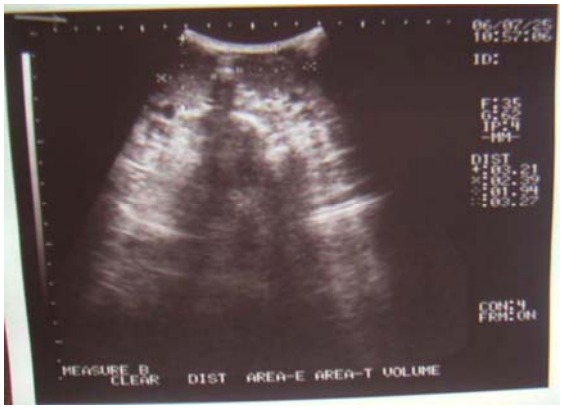
Social Hx: no smoking and alcohol

Allergies: none

Family Hx: unremarkable

ROS:

PE:
Vital Signs: **BP110/80** **P 70** **R20** **T 36.5** **Wt** 52 kg



General: look stable

HEENT: size : 5 x 25 em , mobile , soft, no bruit , no lymph node.

Chest: Lungs : clear both sides
heart : RRR normal

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

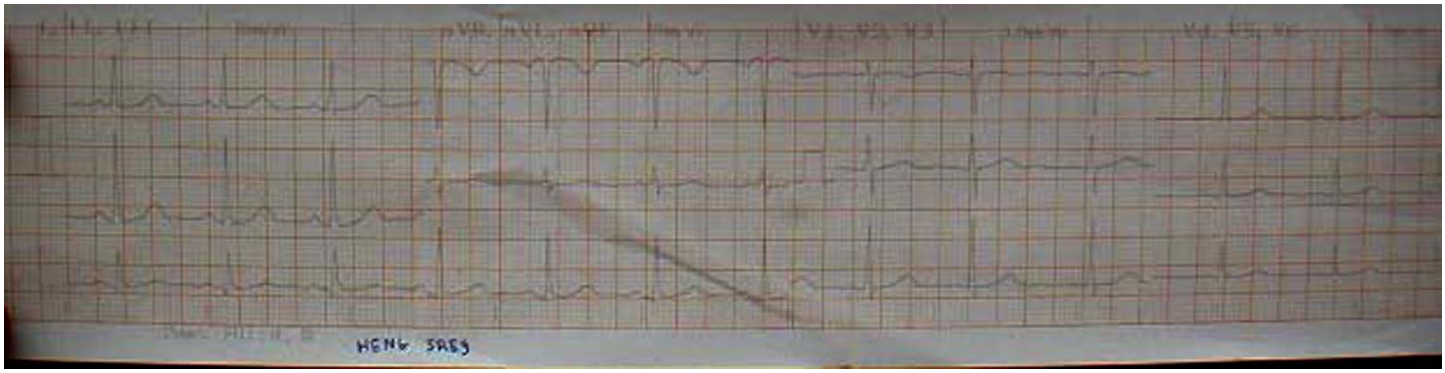
Musculoskeletal: unremarkable

Neuro: motor 5/5 , sensory are intact , DTR 2 +.

GU: none

Rectal: none

Previous Lab/Studies: none



Lab/Studies Requests: EKG normal, ultrasound of his neck

Assessment: 1 .GOITRE

Plan: 1. Check the TSH and T4 at SHCH

Comments/Notes: please , give a good idea

Examined by: San **Date: 25/7/06**

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

From: Cornelia haener [mailto:cornelia_haener@online.com.kh]
Sent: Wednesday, July 26, 2006 3:46 PM
To: 'Rattanakiri Referral Hospital'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Rithy Chau'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient CC#00182

Dear all,
It sounds like a hyperthyroidism. Does the ultrasound show a diffuse or a nodular goiter? Your plan of lab tests sounds good. I would add the T3 as some of the patients have t3 hyperthyroidism alone. If he is tachycardic I would suggest that you start him on propranolol already.
If he has a nodular goiter, he should have an operation as soon as his hyperthyroidism is controlled (T4 and T3 normal under treatment for at least 2 months.
Thanks
Cornelia

From: Rithy Chau [mailto:chaurithy@yahoo.com]
Sent: Thursday, July 27, 2006 2:46 PM
To: Rattanakiri TM
Cc: Brian Hammond; Paul Heinzelmann; Joseph Kvedar; Cornelia Haener; Kruy Lim; Kathy Fiamma; Bernie Krisher; So Thero Noun; Ed & Laurie Bachrach; Fil - Jr. Tabayoyong
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient CC#00182

Dear Dr. San,

Thank you for the cases for this month.

For patient CC#00182, 23M, the H&P pointed toward anxiety disorder more than thyroid or cardiac problem. From the images you sent, I disagree that the neck mass actually measured to be 5x25cm→did you meant 5x2.5cm? You wrote

this measurement twice once in the history and once in your PE. I did not see a neck [mass] on both the anterior and lat views of the images; what did the interpretation of US state? I agree EKG appeared as NSR with HR=72 and no LVH or other abnormality, VS stable. Please look into his social and domestic history for psychosocial-related problem instead that led to this occasional palpitation and difficulty to swallow. Does this patient do any form of exercise, has balanced diet, function well for day-to-day living?

You can ask him to come back next month for TSH screening if concerning for thyroid dysfunction. Otherwise, reassurance for the patient is enough.

Note: Please always use the "Relevant Data" sheet for H&P provided by SHCH and Chan's "Current Clinical Strategies: History and Physical Examination" provided by Partners in Boston to follow as guidelines to write up a more thorough H&P presentation.

Regards,
Rithy

No reply from Boston

From: Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, July 26, 2006 10:52 AM
To: Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar; Rithy Chau
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital TM clinic Patient HS#00183

Dear All,

This is the patient HS#00183 and her photos.

Best regards

Channarith

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

Patient: HS#00183

Chief Complaint: Dizziness, Headache, Chest pain and Palpitation on and off

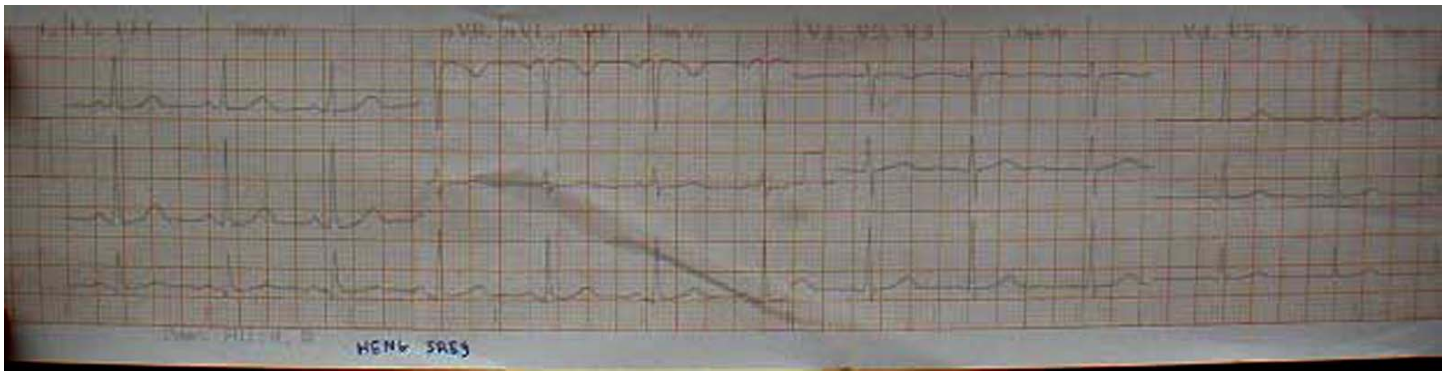
HPI: 45 F PMH of HTN about 4 years,
2 days ago she presented with,
- High PB 180/120mmhg
- Convulsion
- coma (GS= 9/15)
- treated with Hydralazine 100mg IV bid and Diazepam 10 mg IM bid

PMH/SH: - Had HTN since 2002
- Last year had Stroke (BP=220/160 mmhg) with right hemiplegia
- Have been treated only with Hydrochorodiazide 25mg gd since last 3 months
- Usual BP= 120/80mmg

Social Hx:

Allergies:

Family Hx: Her mother died for Stroke (HTN)



ROS: poor sleeping, low urine, difficult to pass stool, feel nausea, poor appetite, no fever, no diarrhea, no abd pain

PE: July 25, 2006
Vital Signs: BP110/70mmhg P80/mnR18/mn T 36,5 Wt

General:

HEENT:

Chest: Lung: clear both sides, heart: rhythm rate irregular (75-90/mn), no murmur

Abdomen: unremarkable

Musculoskeletal: Hypotonia right hand and leg

Neuro: Right hand and leg:
- Motor: 3/5
- Sensibility: normal
- Reflex: 1/4

GU: not done

Rectal: not done

Previous Lab/Studies:

Lab/Studies Requests:

- Creatinin: 1.7mg/dl
- Glucose: 70.1mg/dl
- Potassium: 7.8mmol/l
- Triglyceride: 110.5mmol/dl
- Urea: 230,1mg/dl
- Uric acid: 5.7mg/di

Assessment: HTN, Heart Ischemia, Renal insufficiency

Plan: - Atenolol 25 mg gd
- Asp 100mg gd
- Furosemide 20 bid

Comments/Notes:

Examined by: Sam Baramey, MD **Date: July 25, 2006**

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

From: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, July 27, 2006 3:10 PM
To: 'Rattanakiri Referral Hospital'
Cc: 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Lim kruy'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient HS#00183

Dear Dr. Baramey,

Welcome back and thank you for participating in this month TM Clinic.

As for patient HS#00183, 45F, you reported that she has a PMH of controlled HTN and stroke with right side weakness (?). Was she admitted into RRH emergency room for elevated BP, convulsion, and mild GCS 4 days ago? On consultation on 25 July, 2006, she appeared stable with normal BP and EKG (NSR HR=85). Was this all the history you could get from her because in the HPI there was only the summary of what happened 4 days ago and no apparent diagnosis for her condition given and no other information except a few detail noted in ROS. Did you suspected that she has another stroke? The dose of hydralazine 100mg bid seemed a bit high (usually 25-50mg)—was this a national protocol for tx of

hypertensive emergency? Did you investigate further why this incidence occurred since her BP was reported to be controlled usually with HCTZ 25mg qd? Was she a smoker? Did she use oral contraception? Could you please tell me more about the symptoms (HA, CP, dizziness, palpitation) she complained in the report? Was there any leg or body edema? Cough or SOB? Could you also do a CXR to rule out any pulmonary problem and to assess heart size and also do a U/A, CBC and tot chol?

After discussing with SHCH senior physician, Dr. Lim Kruy, we agreed on the dx of possible hypertensive encephalopathy and a h/o HTN and ischemic stroke with right side weakness. We recommend giving her Atenolol 50mg ½ tab po qd, HCTZ 50mg 50mg ½ tab po qd and make sure she is hydrated properly. Please hold off the ASA for a few more days—usually, no ASA given to patient with new stroke for the first 5 days unless the physician can prove that the stroke is not of hemorrhagic in nature (i.e. by CT scan)--however, can be given about a week after dx of new stroke (which in this case we cannot rule out) and dosage given: ASA 500mg 1/6 tab po qd. Please stop hydralazine and furosemide. Furosemide20mg bid can be given if patient has any cardiopulmonary congestion. If CXR is clear for any pulmonary edema, then no need for furosemide because HCTZ will help with this problem in the long run.

The value of urea reported as 230.1mg/dL, was this reported correctly? This baffled us because Dr. Kruy said that even with severe dehydration or active hemorrhagic stroke BUN value should not go up this high, plus seemed not to correlate with the value of creatinin reported (141.6 = 1.7mg/dL). Can you explain this?

Please let us know if you have any other concern about caring for this patient.

Regards,
Rithy

-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Wednesday, July 26, 2006 3:33 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri Referral Hospital TM clinic Patient HS#00183

The labs seem quite unusual. She has renal insufficiency with creatinine 1.7 mg/dl, but urea of 230 mg/dl appears way too high for the creatinine of 1.7 mg/dl. Is this a typographical error? Serum potassium may be high in renal failure, but K 7.8 mmol/l would have sent her into a ventricular arrhythmia. Thought the pulse was described as irregular, the EKG shows sinus rhythm with no ventricular ectopy. The T waves are not peaked as you would expect with hyperkalemia, in fact, non specific T wave flattening is present [more in line with hypokalemia]. Lyzed blood samples may give a falsely raised potassium. In this situation, when the labs are not internally consistent, or compatible with the clinical picture. repeat blood testing is necessary to establish the true status of the patient.

Two days ago she presented with severe hypertension and convulsion. The picture shows a woman who is quite awake, presumably 2 days later. Malignant hypertension may present with headaches and even seizure with transient post-ictal coma. Severe renal failure may also present with seizures and come though she may not recover so quickly. The old stroke may be an epileptogenic focus. In any case, the blood pressure is currently controlled, she is awake, and renal failure status needs clarification.

I'm surprised that her current blood pressure is normal just on lasix and atenolol for someone with recent malignant hypertension. One always has to consider secondary causes like pheochromocytoma that may present with transient hypertensive spikes. Low normal blood sugar argues against diabetes. Besides repeat blood testing, urinalysis to look for primary renal disease, other blood testing to check for vasculitis [ESR] as a cause of hypertension may be useful.

Heng Soon Tan, MD

Thursday, July 27, 2006

Follow-up Report for Rattanakiri TM Clinic

There were patients seen during this month TM clinic at Rattanakiri Referral Hospital (RRH). The data of 4 new cases were transmitted and received replies from both Phnom Penh and Boston. Per advice sent by Partners in Boston and Phnom Penh Sihanouk Hospital Center of HOPE as well as advices from PA Rithy on site, the following patients were managed and treated per local staff:

[Please note that in general the practice of dispensing medications at RRH for all patients is usually limited to a maximum of 7 days treatment with expectation of patients to return for another week of supplies if needed be. This practice allows clinicians to monitor patient compliance to taking medications and to follow up on drug side effects, changing of medications, new arising symptoms especially in patients who live away from the town of Banlung and/or illiterate. 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 July 2006

1. **TD#00180, 43F (Village I)**
   Diagnosis
   1. Sciatica
   2. Pott's disease ?

   Treatment
   1. Diflunasal 500mg 1 tab po bid prn pain
   2. B-complex 1 tab po qd
   3. Omeprazol 20mg 1 tab po qd
   4. Para 500mg 1 tab qid prn pain
   5. Check AFB sputum

2. **VR#00181, 5 Mo F (Village IV)**
   Diagnosis
   1. Hemangioma

   Treatment
   1. Refer to KB Children Hospital in PP

3. **CC#00182, 23M (Ven Say Village)**
   Diagnosis
   1. Goiter

   Treatment
   1. Check free T4 and TSH at SHCH

4. **HS#00183, 45F (Village I)**
   Diagnosis
   1. HTN

   Treatment
   1. Captopril 25mg 1tab po qd

Follow up Patients:

1. **PN#00052, 53F (Ban Fang Village)**
   Diagnosis:
   1. Hyperthyroidism

   Treatment
   1. Carbimazol 5mg 1 tab po tid x 100d
   2. Propranolol40mg ¼ tab po bid x 100d

2. **TV#00157, 53F (Phnom kok Village)**
   Diagnosis:
   1. Hyperthyroidism

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

3. **UP#00093, 52F (Village III)**
   Diagnosis
   1. Hyperthyroidism

   Treatment
   1. Methimazol 10mg ½ tab po tid x 100d

4. **LH#00116, 59F (Village IV)**
   Diagnosis
   1. Hyperthyroidism
   2. Cardiomegaly

   Treatment
   1. Methimazol 10mg ½ tab po qd x 100d
   2. ASA 81 mg 1 tab po chew qd x 100d
   3. HCTZ 50mg ½ tab po qd x 100d

5. **MS#00144, 52F (Thmey Village)**
   Diagnosis:
   1. DMII
   2. Dyspepsia

   Treatment
   1. Glibenclamide 5mg 1tab po qd x 100d
   2. Lisinopril 5mg ¼ tab po qd x 100d
   3. MgAlOH3 2 tab chew po bid prn
   4. DM education

6. **OS#00143, 48F (Thmey Village)**
   Diagnosis
   1. Cardiomegaly (CHF, VHD)

   Treatment
   1. Furosemide 40mg ½ tab po qd x 20 tab

August 2006
Rattanakiri TM Clinic will be cancelled