Telemedicine Clinic
Rattanakiri
Referral Hospital
May 2006

Report and photos compiled by Rithy Chau, SHCH Telemedicine

On Tuesday, May 30, 2006, Rattanakiri Referral Hospital (RRH) staff began their TM clinic. 3 new and 6 follow-up patients 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, Wednesday May 31, 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: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Friday, May 26, 2006 3:35 PM
To: 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'gjacques@online.com.kh'; 'kruylim@yahoo.com'
Cc: 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Sovann Nop'
Subject: May 2006 TM Clinic at Rattanakiri Referral Hospital

Dear All,

Ly Channarith has asked me to send this message for him since the satellite service from Thailand is being switched to a different operation causing the internet service in Banlung to be inoperable during this week. An IT person from AAfC will be traveling to install the new system to be used in Rattanakiri soon by the time of TM next week:

Dear All,
Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Tuesday, May 30, 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, Wednesday, May 31, 2006.The patients will be asked to return to the hospital that afternoon on Wednesday 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: Tuesday, May 30, 2006 4:26 PM
To: Rithy Chau; Rithy Chau; Cornelia Haener; Ruth Tootill; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital TM clinic patient PS#00171

Dear All,

There are 3 new cases for this month TM clinic. Here is the first case patient PS#00171 and her photos.

Best regards,

Channarith

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

Patient: PS#00171, 14F, Village IV

Chief Complaint: a mass developing (4x5 em) on her neck x 1.5 y

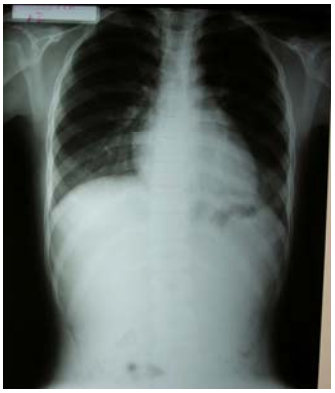
HPI: her complains of a mass developing on her neck, low appetite and palpitation off and on, weight loss : 4 kg (last six months), extremities tremor off and on, moderate fever, left occipital pain radiated to the whole Head , she felt the difficult swallowing when the taking the meal , occasionally dizziness and insomnia ,and common cold x 2- 3 times/ months.

PMH/SH: operated the mass on her left calf x from augus to November /2005

Social Hx: none

Allergies: none

Family Hx: none



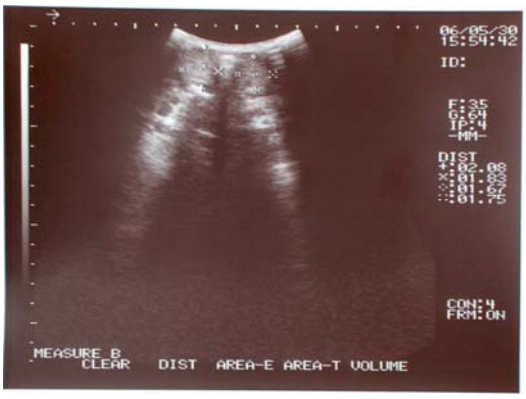
ROS:

PE:
Vital Signs: BPR:70/30 L:60/20 P 48 R 20 T: 37.6 Wt

General: look stable

HEENT: rhinopharyngitis , lymph nod under left jaw , no bruit , mobile by swallowing , size : 4x5 em , no ptosis.

Chest: lungs :clear both sides
Heart : no murmur ,



Abdomen: active BS, no organolmegaly, no mass .

Musculoskeletal: unremarkable

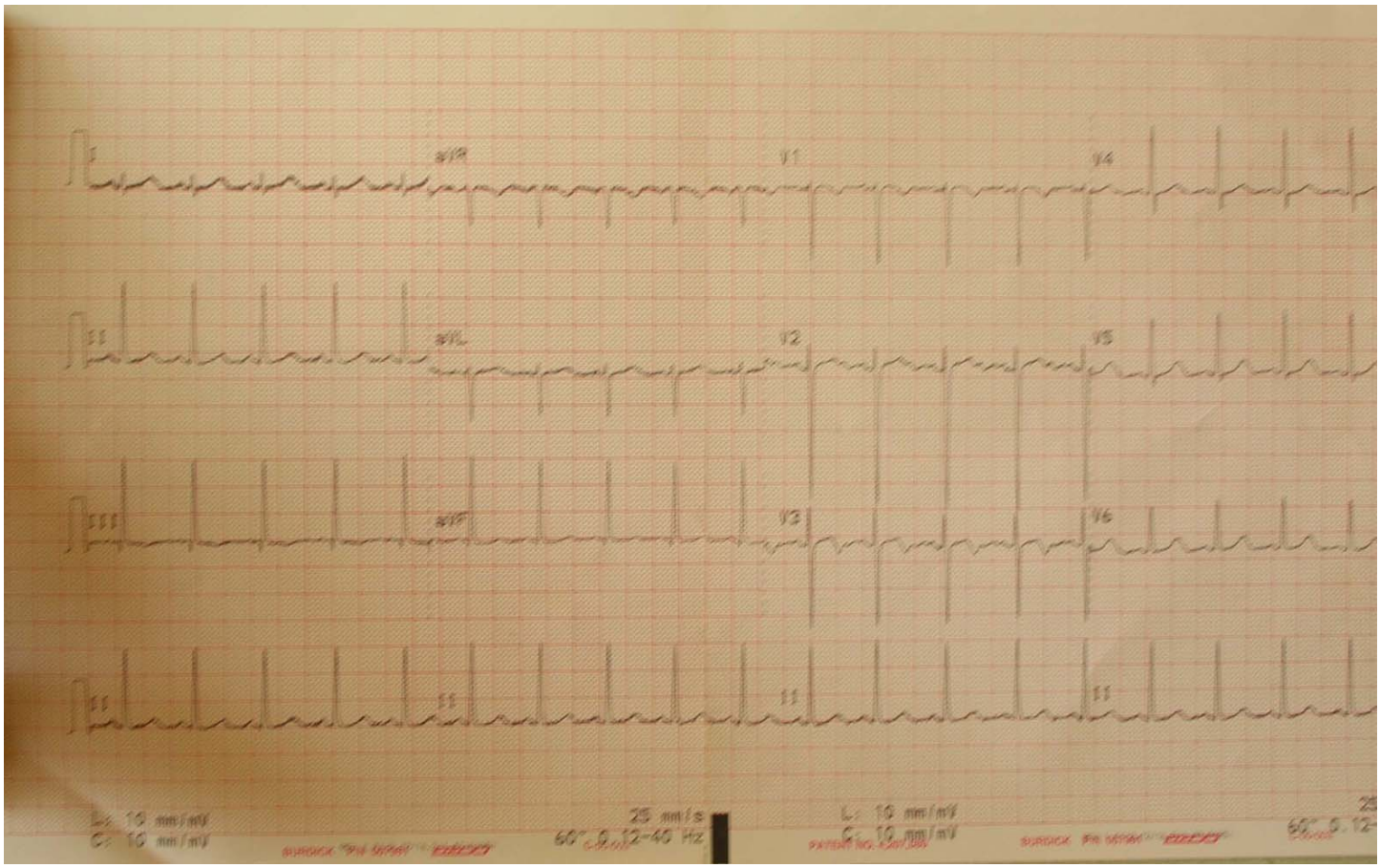
Neuro: motor and sensory are intact

GU:

Rectal:

Previous Lab/Studies:

Lab/Studies Requests: ultrasound of neck, chest x ray, EKG .



Assessment: 1.hypothyroidism 2.chronic bronchitis 3.Rhinopharyngitis

Plan:

1. check free T4 and TSH at SHCH
2. Cephalexin 500mg 1 tab bid x 10 d
3. Parac500 mg 1 tab po pain
4. propranol 40 mg ¼ tab qd

Comments/Notes: please give a good idea

Examined by: Dr San **Date: 30/5/06**

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

From: Barbesino, Giuseppe,M.D. [mailto:GBARBESINO@PARTNERS.ORG]
Sent: Tuesday, May 30, 2006 9:32 PM
To: Fiamma, Kathleen M.
Cc: kirihospital@yahoo.com; tmed_rithy@online.com.kh
Subject: RE: Rattanakiri Referral Hospital TM clinic patient PS#00171

This young girl presents with upper left neck mass (it seems from the exam that her thyroid is normal on exam, if not so, please describe**) and has some systemic symptoms which may or may not be consistent with hyperthyroidism. The mass is described as being 4-5 "em" which I assume means cm. If that is the case this is a large mass, which deserves attention. The differential diagnosis includes infection: tuberculosis would be a significant concern considering the duration and the associated symptoms, but also toxoplasmosis, HIV and**

others. One should also be worried about neoplastic causes such as lymphoma, thyroid cancer or salivary gland tumors given the location. A simple lateral cyst of the neck is also possible. On top of the tests offered, a PPD should be planted. However considering the size and persistence of the mass, it should be removed for diagnostic puproses. So my advice, based on the information available, is an excisional biopsy. Her heart rate and BP are distinctly low, so I suggest that Propranolol is quite CONTRAindicated in this case. I am not sure that antibiotics are needed at this point, in the absence of a clear diagnosis and with only low grade fever. Please provide follow-up.

Giuseppe Barbesino, MD
Thyroid Associates
Massachusetts General Hospital-Harvard Medical School
Wang ACC 730S
55 Fruit St
Boston MA, 02114
FAX 617-726-5905
TEL 617-726-7573

-----Original Message-----
From: Fiamma, Kathleen M.
Sent: Tuesday, May 30, 2006 10:15 AM
To: Barbesino, Giuseppe,M.D.
Subject: FW: Rattanakiri Referral Hospital TM clinic patient PS#00171

From: Ruth Tootill [mailto:ruth_tootill@online.com.kh]
Sent: Wednesday, May 31, 2006 8:56 AM
To: Rattanakiri Referral Hospital; Rithy Chau; Rithy Chau; Cornelia Haener; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Re: Rattanakiri Referral Hospital TM clinic patient PS#00171

Dear Channarith,

Thank you for refering this patient.

I am afraid that I cannot really see the mass on the photos. You say it is under her jaw. This would mean that a thyroid mass unlikely. It could be a submandibular gland mass or lymph nodes. Is there any abnormality in her mouth or her tonsils? Is her pharyngitis severe, with pus or tonsilar swelling?

For lymph nodes in the neck, we recommend skull x-rays AP and Lateral, assessment of larynx and lower pharynx. If these are normal, a FNA of the mass would be helpful. I think the thyroid assessment will also be useful to exclude an associated thyroid problem.

Her chest x-ray is a little dark. Does anyone think the right lower lung field is abnormal?

Best wishes,
Ruth

From: Rithy.Chau [mailto:tmed_rithy@online.com.kh]
Sent: Wednesday, May 31, 2006 11:55 AM
To: 'Rattanakiri Referral Hospital'
Cc: 'Rithy Chau'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'; kruylim@yahoo.com
Subject: RE: Rattanakiri Referral Hospital TM clinic patient PS#00171

Dear Dr. San/ Channarith,

For this patient PS#00171, 14F, your assessment and images pointed to a goiter as a dx for now and I agree with checking her TFT at SHCH. I would not start her on propranolol since no sx of tremor, palpitation and HR recorded here as 48 bpm (was this the correct HR?). Her BP seemed extremely low, did you use the right size BP cuff for her—you may need to use the pediatric cuff I left for you at TM clinic there.

From your brief description of frequent common cold, she may be experiencing allergic rhinitis and only needs antihistamine, decongestant, and/or analgesic like para for HA/fever/pain to control her sx. My recommendation on using antibiotic for URTI is that when a patient have at least 2-3 of the following together:

1. Fever >38.5C
2. Swollen lymph nodes +/- tenderness
3. Exudate (pus) on pharynx/tonsil
4. Continuous discharge (nasal discharge or phlegm) of dark yellow-green color

Amoxicilllin should be first line drug for this if available and no allergy. In this case I do not think she benefits from antibiotic.

Hope this is helpful,
Rithy

From: Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, May 30, 2006 4:39 PM
To: Rithy Chau; Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital TM clinic patient KL#00170

Dear All,

This is the patient KL#00170 and her photos.

Best regards,

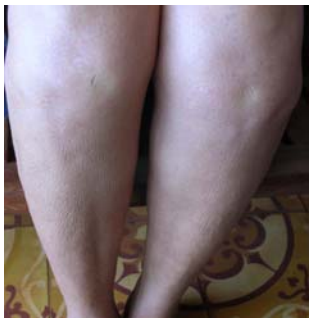
Channarith

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

Patient: KL#00170, 68F, Village I

Chief Complaint: edema of both legs and sob off and on x one months

HPI: she treated with unknown medication at Germany clinic X 4 one year , her symptoms was relief and she stopped the these drugs .she has treated with unknown drugs of antidiabets at private clinic .her complains of sob off and on , productive cough x 1 year, weight loss, low appetite , chest pain occasionally , numbness of both legs , weakness of both legs , edema of both legs , frequent urine .no fever , no coma .



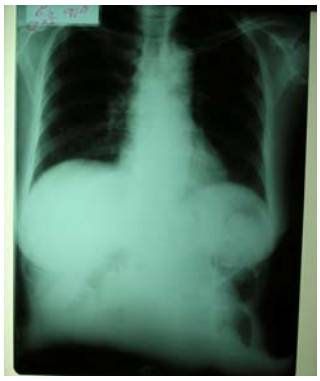
PMH/SH: none

Social Hx: none

Allergies: none

Family Hx: none

ROS:



PE:
Vital Signs: BP R:100/70 ,L:90/70 P 70 R 24 T 36.5 Wt

General: look very thin

HEENT: no HA, no ptosis , no rithopharyngitis , no facial droop .

Chest: Lungs: crackle on lower left part of lung .
Heart : no murmur , regular rythme .

Abdomen: soft, no mass , active BS .

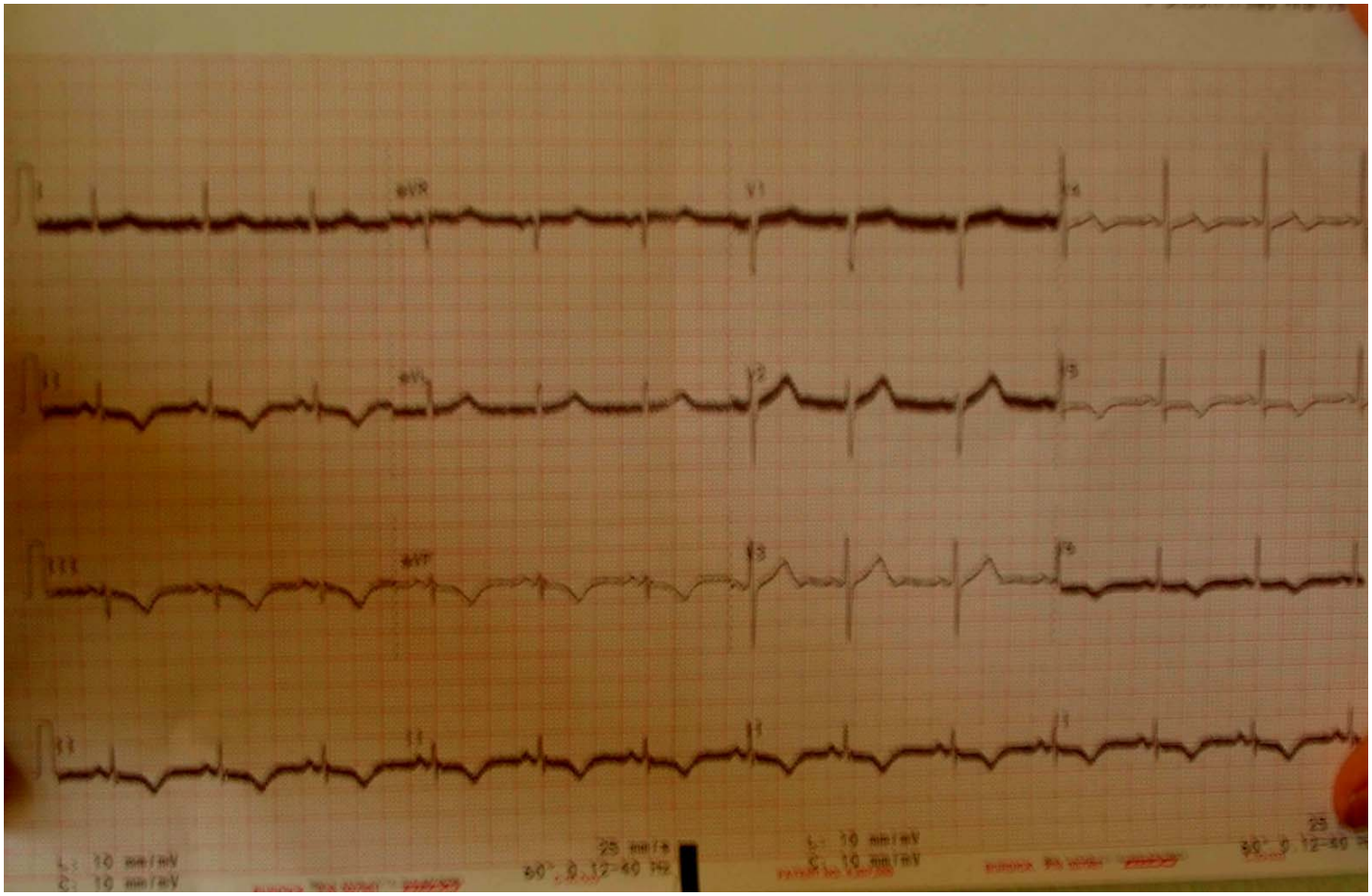
Musculoskeletal: edema of both legs and edema on both calf, no atrophy of muscle, godet's sign

Neuro: numbness of both foot by pinching tip of pen ,

GU:

Rectal:

Previous Lab/Studies:



Lab/Studies Requests: glucose:+4, protein : + 1, bilirubin + , ketone : normal , ph: 6, protein :trace, urobilirubin :normal , nitrate :+ , leucocyte : - , glucose finger :331,

Assessment: 1.DMI 2.PTB 3. pneumonia 4. UTI ? , 5. Malnutrition

Plan:

1. Glibenclamid 5mg 1 tab bid before meal x 100 d
2. Clarythromycine 500mg 1 tab bid x 14 d
3. MTV 1 tab bid x 100 d
4. ASP 1 tab qd x 100 d
5. vitamin B1 1tab qd
6. AFB

Comments/Notes: please give a good idea

Examined by: Dr San **Date: 30/5/06**

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: Wednesday, May 31, 2006 3:39 AM
To: kirihospital@yahoo.com

Cc: tmed_rithy@online.com.kh
Subject: FW: Rattanakiri Referral Hospital TM clinic patient KL#00170

Kathy Fiamma
617-726-1051
-----Original Message-----
From: Tan, Heng Soon,M.D.
Sent: Tuesday, May 30, 2006 4:35 PM
To: Fiamma, Kathleen M.
Subject: RE: Rattanakiri Referral Hospital TM clinic patient KL#00170

It is clear she has diabetes with peripheral neuropathy presenting as numbness and weakness of legs. She had diabetic neuropathy as well with presence of proteinuria. However proteinuria may be present during a urinary tract infection as well, so urinalysis should be repeated once infection has cleared. It is unusual for diabetic nephropathy to present with nephrotic syndrome and leg edema. Could she have some other glomerulonephritis? Checking renal function and urine sediment when free of infection would help. Could she be in heart failure? The heart appears normal size and the chest exam and xray do not show heart failure. The EKG showed inferior and lateral T wave inversion consistent with myocardial ischemia. There is an QS wave in V1 that may go with a previous anterior septal infarction. An echocardiogram could confirm heart size and myocardial contractility.

Cachexia and chronic cough could go with pulmonary tuberculosis. However rales at left lower lobe do not correlate with any pneumonia on CXR from what I can make out from the xray. Pulmonary tuberculosis usually present with upper lobe lesions, though apex of lower lobe may also be targeted. Of course cachexia could go along with uncontrolled diabetes, which is after all, a metabolically wasting disease that can present as malnutrition. Is she a smoker? Perhaps she is just having chronic bronchitis with shortness of breath? I don't see emphysematous changes on CXR.

Urinalysis show no ketones, so she is not in ketoacidosis, merely hyperglycemia. I wonder about the presence of bile. Does she have hepatitis too?

For workup, I would send off CBC to check for anemia, liver tests to rule out hepatitis, A1c to monitor diabetes, urine culture to confirm infection, repeat urinalysis when free of infection to check sediment and proteinuria, renal function tests for renal failure that could also present with leg edema. Sputum for culture and AFB will rule out pulmonary tuberculosis. Echocardiogram to check heart size and contractility may confirm coronary artery disease.

Clarithromycin will be fine for bronchitis but not for urinary tract infection. Perhaps Bactrim would have been a better choice to cover for both possibilities. With the amount of hyperglycemia, I would normally have initiated insulin therapy, but if that was not possible, glibenclamide would be a start. Diuretic therapy with small dose of furosemide 10-20 mg daily will be effective in reducing leg edema to make her more comfortable.

Good luck with her.

HS

From: Bernard Krisher [mailto:bernie@media.mit.edu]
Sent: Tuesday, May 30, 2006 6:13 PM
To: Rattanakiri Referral Hospital
Cc: EDBACHRACH@aol.com; Rithy Chau:
Subject: Re: Rattanakiri Referral Hospital TM clinic patient KL#00170

This should also be sent to Ed Bachrach

Best regards,

Bernie

Dear All,

This is the patient KL#00170 and her photos.

Best regards,

From: Rithy.Chau [mailto:tmed_rithy@online.com.kh]
Sent: Wednesday, May 31, 2006 11:35 AM
To: 'Rattanakiri Referral Hospital'
Cc: 'Rithy Chau'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'; kruylim@yahoo.com
Subject: RE: Rattanakiri Referral Hospital TM clinic patient KL#00170

Dear Dr. San/Channarith,

I agree with your assessment of DMII with PNP and treatment with Glibenclamide 5mg 1 po bid and desipramine 75mg or amitriptyline 25mg ¼ tab po qhs and reevaluate her FBS every week and adjust medication every two weeks until her FBS falls in 90-130 range. Please check her FBS, lytes, BUN, creat, CBC, tot chol, triglyceride. Please provide appropriate DM education and foot care.

With positive nitrite in U/A, I agree with considering UTI and tx with Cipro 500mg 1 tab po bid x 3d.

Even though EKG sent was blurred, there appeared to be T-inversion in leads II, III, and aVF for possible inferior MI and V5-V6 for lat MI. You can do a right side (reverse the leads as if heart pointing to right) EKG to look for posterior MI. Tx: Atenolol 50mg ¼ tab po qd, Isosorbide dinitrite 5mg 1 tab sublingual tid prn chest pain, ASA 300mg ¼ tab po qd. Can you redo the EKG and send a clearer image to me for publishing?

The CXR looks clear of any problem or lesion and no cardiomegaly and no sign of congestion. Go ahead and do an AFB to rule out TB and give her Clarithromycin if you have strong suspicion of pneumonia esp. with fever and yellow-green sputum production.

She looked cachetic, so you can give her some MTV to take daily with meal. You can add iron supplement if her HB is low.

You can add Furosemide 40mg ½ tab po qd to help with the pitting edema which may result from her DM II condition. She has no hx of HTN and she is not on any HTN medication right now? Make sure she stops all other previous medications and starts taking the medications we prescribed regularly. Check her vital sign each time she visits for FBS check also.

I hope this is helpful.

Rithy

From: Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
Sent: Wednesday, May 31, 2006 2:36 PM
To: Rithy Chau; Rithy Chau
Subject: kl#00170

Dear Rithy
this is the result of the patients , KL#00170
-creatin:0.4
-glucose fasting : 530mg/dl
-wbc:9500
-RBC :4500000
-HB:14.5

-Htc :45
-eosinophil:04
-N :65
-lym :29
-Mono:02
-Baso:00

best reguards
san

From: Rattanakiri Referral Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, May 30, 2006 4:46 PM
To: Rithy Chau; Rithy Chau; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar
Cc: Bernie Krisher; Noun SoThero; Fil B. Tabayoyong; Ed & Laurie Bachrach; HealthNet International
Subject: Rattanakiri Referral Hospital TM clinic patient RN#00172

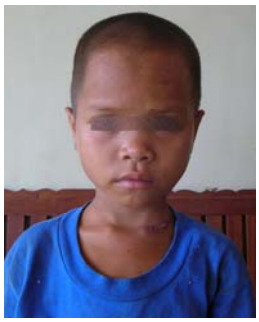
Dear All,

This is the last case patient RN#00172 and her photos.

Best regards,

Channarith

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

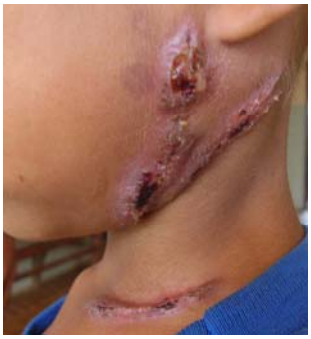


Patient: RN#00172, 4F, Paler Village .

Chief Complaint: ruptured lymph nod on her neck

HPI: the first time lymph nod appeared on left jaw x 3 months and other also occurred on under her left ear and over left clavicle and there are lymph nod on right neck from right jaw to the upper right clavicle.
The last two months, all lymph nod on her neck started to erupte pus and weight loss. No fever, no HA ,

PMH/SH: none



Social Hx: none

Allergies: none

Family Hx: none

ROS:

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

General: oriented and alerted

HEENT: lymph nod on her neck , which characterized by mobile , soft , ruptured , no pain , no otitis , no throat pain .

Chest: lungs :clear both sides
Heart : no murmur ,

Abdomen: active BS, no organolmegaly, no mass .

Musculoskeletal: unremarkable

Neuro: motor and sensory are intact

GU:

Rectal:

Previous Lab/Studies:

Lab/Studies Requests:

Assessment: 1. lymph nod TB
2. R/o cancer

Plan: 1. give her anti TB drugs by protocol of ministry of health.

Comments/Notes: please , give a good idea

Examined by: Dr San **Date: 30/5/06**

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: Wednesday, May 31, 2006 12:42 PM
To: 'Rattanakiri Referral Hospital'
Cc: 'Rithy Chau'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'; 'Ed & Laurie Bachrach'; 'HealthNet International'; kruylim@yahoo.com
Subject: RE: Rattanakiri Referral Hospital TM clinic patient RN#00172

Dear Dr. San/Channarith,

It is difficult to agree with your assessment since there was not enough information given in your H&P. Did you do a CXR? Was there any family hx of active TB, any people around him at school or village with this dz? Did you try to rule out other causes with dermatological or zoological problem? Did you do a culture of AFB yet?

As for secondary infection, you can give cephalexin 250mg 1 po tid and cotrim 480mg ½ po bid x 14d and reevaluate in 2 weeks and if not completely healed but improving can give another two weeks. For starting TB meds, you can follow national protocol with your best clinical judgement to dx her with TB LN.

I hope this helps.
Rithy

Wednesday, May 31, 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 3 new and 6 follow-up 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. Medications and lab tests not available/done at RRH are provided by SHCH to TM patients at no cost]

Treatment Plan for Rattanakiri TM Clinic May 2006

New Patients

1. KL#00170, 68F (Village I)

Diagnosis

1. DMII
2. Pneumonia
3. PTB
4. UTI
5. Vit Deficiency

Treatment

1. Glibenclamide 5mg 1t po bid
2. Desinopril 75mg 1/4t po qhs
3. Furosemide 20mg 1t po qd
4. ASA 300mg 1/4t po qd
5. Clarythromycin 500mg 1t po bid for 10d
6. Ciprofloxacin 500mg 1t po bid for 3d
7. MTV 1t po qd for 15d
8. Check FBS and Vital Sign every week
9. DMII education and foot care

2. PS#00171, 14F (Village VI)

Dignosis

1. Goiter?
2. Allergic Rhinitis

Treatment

1. Zyrtec 10mg 1t po qd for 5d
2. Cephalexine 500mg 1t po bid for 7d
3. Paracetamol 500mg 1t po tid prn HA
4. Draw blood for TFT at SHCH

3. RM#00172, 4F (Paler Village)

Diagnosis

1. Adenitis?
2. Lymph node TB?

Treatment

1. Cephalexin 250mg 1t po tid for 14d
2. Cotrimoxazole 480mg 1/2t po bid for 14d
3. MTV 1/2t po qd for 30d

Follow-up Patients

1. RR#00166, 61F (Village III)

Diagnosis

1. COPD
2. GERD

Treatment

1. MgAl(OH)3 500mg 2t chew bid for 30d
2. AFB sputum smears

2. PO#00148, 67F (Village III)

Diagnosis

1. DMII
2. PNP
3. HTN
4. GERD

Treatment

1. Metformin 500mg 1t po qhs for 100d
2. Glibenclamide 5mg 1t po qd for 100d
3. Lisinopril 5mg 1t po qd for 100d
4. ASA 81mg 1t po qd for 100d
5. Desipramine 75mg 1/2t po qhs for 100d

3. RH#00160, 67F (Village I)

Diagnosis

1. DMII
2. PNP

Treatment

1. Glibenclamide 5mg 1t po qd for 100d
2. Lisinopril 5mg 1t po qd for 100d
3. ASA 81mg 1t po qd for 100d
4. Desipramine 75mg 1/2t po qhs for 100d

4. OP#00161, 78M (Village I)

Diagnosis

1. COPD
2. Emphysema

Treatment

1. Albuterol Inhaler 2puffs bid prn SOB

5. NS#00006, 18F (Village I)

Diagnosis

1. Hyperthyroidism

Treatment

1. Carbimazole 5mg 1t po qd for 100d
2. Propranolol 40mg 1/4t po qd for 100d

6. KP#00153, 53F (Village III)

Diagnosis

1. DMII
2. VHD
3. A-fib
4. HTN
5. ASD/VSD?

Treatment

1. Glibenclamide 5mg 1/2t po qd for 100d
2. Lisinopril 5mg 1t po qd for 100d
3. Atenolol 50mg 1/2t po qd for 100d
4. Desipramin 75mg 1/2t po qhs for 100d
5. MTV 1t po qd for 100d

The next Rattanakiri TM Clinic will be held on June 20-23, 2006