Telemedicine Clinic
Rattanakiri
Referral Hospital
May 2010

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

On Tuesday May 25 and Wednesday May 26, 2010, Rattanakiri Referral Hospital (RRH) staffs began their TM clinic. Patients 4 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 May 27, 2009, 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: Fri, May 21, 2010 at 3:29 PM
Subject: May TM clinic at Rattanakiri Referral Hospital
To: Chau Rithy; Kruy Lim; Cornelia Haener; Joseph Kvedar; "Paul J. M.D. Heinzelmann"; "Kathleen M. Kelleher"; Brian Hammond
Cc: Bernie Krisher; Ed & Laurie Bachrach; Noun SoThero

Dear All,

Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Wednesday, May 26, 2010 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, May 27, 2010.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: **Kiri Hospital Telemedicine**
Date: Wed, May 26, 2010 at 10:16 AM
Subject: Rattanakiri TM Clinic Case TP#00335, 38F
To: rithychau@sihosp.org, Lim kruy; kfiamma@partners.org, Paul Heinzelmann; jkvedar@partners.org
Cc: bernie@media.mit.edu, thero@cambodiadaily.com, "Lauriebachrach@Yahoo. Com"

Dear all,

There are four new cases for Rattanakiri Telemedicine May 2010 and this is case TP#00335, 38F and photos.
Best regards,
Koh Polo

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

Patient: **PT#00335, 38F (Pong Village, Veun Sai commune)**

Chief Complaint: Palpitation x 1y

HPI: 38F, farmer, presented with symptoms of palpitation feeling her heart beating so fast on exertion (working, walking 100m) and got better with resting. The palpitation is also associated with dyspnea, fatigue and denied of chest pain, PND, dizziness, edema. She got treatment form local heal worker with IV fluid D5% 1L and Vitamin C injection then became a bit better and got this treatment once per month. In this year, she presented with epigstric pain, burning sensation, burping with sour taste, became worse with spicy food and got Antacid for 3d then stop because she feel a bit better.

PMH/SH: Sore throat in the past two years

Social Hx: No cig smoking, drinking alcohol post partum about 3L/each child, 5 children

Family Hx: None

Medication:

1. Antacid prn
2. Vitamin C

Allergies: NKDA

ROS: Regular menstrual period, no heavy vaginal bleeding, no PND, no chest pain, no edema

PE:

Vital Signs: BP: 94/63 P: 91 R: 20 T: 37^{o}C Wt: 38kg

General: Skinny

HEENT: No oropharyngeal lesion, mild pale conjunctiva, no thyroid enlargement, no neck lymph node palpable, no neck bruit, no JVD

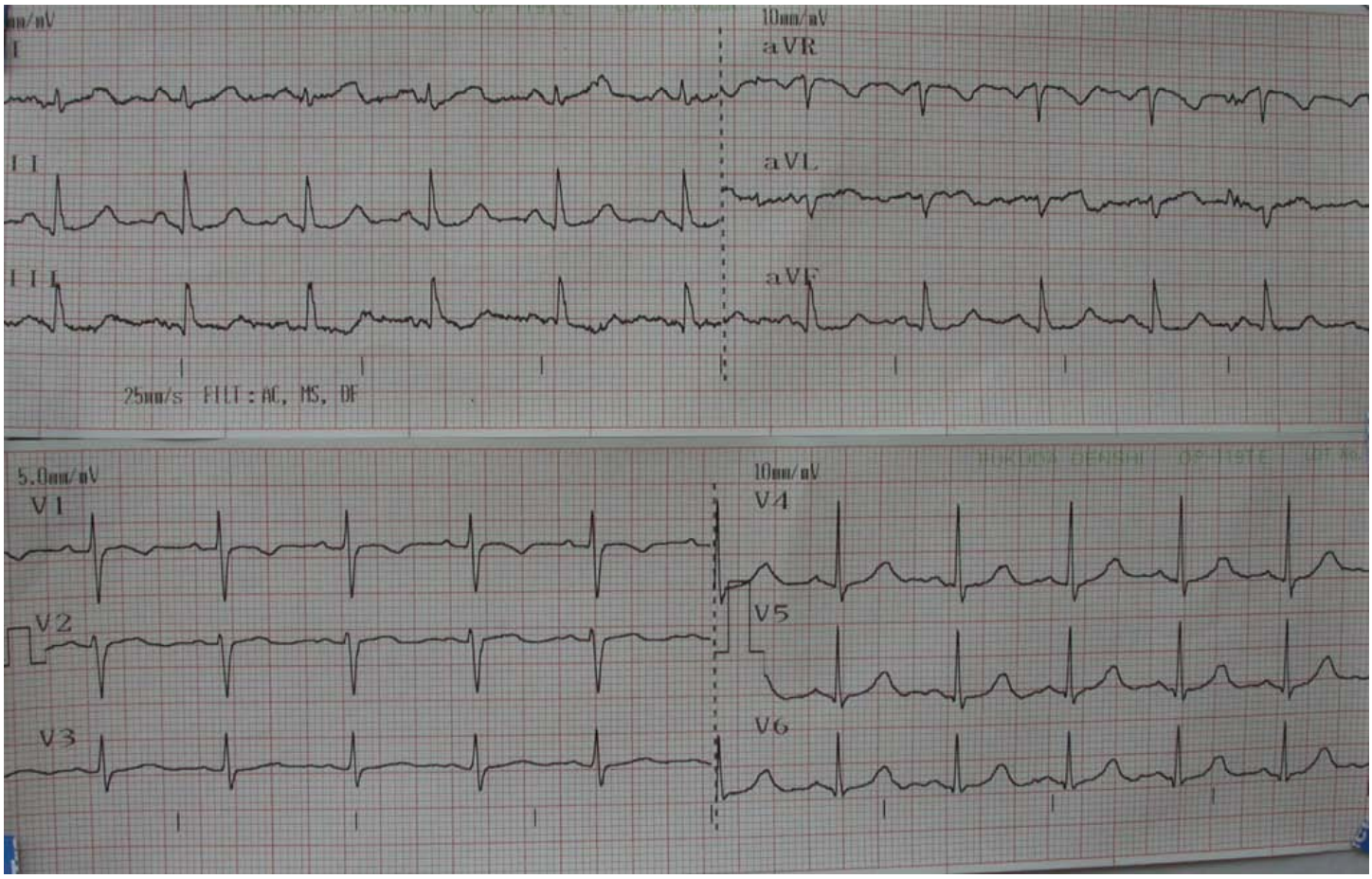
Chest: CTA bilaterally, no rales, no rhonchi, H RRR, 3+ crescendo systolic murmur, loudest at pulmonic area

Abdomen: Soft, no tender, no distension, (+) BS, no HSM, no abdominal bruit, no surgical scar

Extremity/Skin: No leg edema, no skin rash, (+) dorsalis pedis and posterior tibial pulse

Rectal Exam: good sphincter tone, no mass palpable, neg colocheck

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



Lab/Studies:
On May 25, 2010
Finger stick Hb: 11g/dl, RBS: 95mg/dl

EKG attached

Assessment:

1. VHD (PS?)
2. GERD

Plan:

1. Ranitidine 300mg 1t po qhs
2. Mebendazole 100mg 5t po qhs once
3. MTV 1t po qd
4. FeSO4/Folate 200/0.25mg 1t po qd
5. GERD prevention education
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

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

Examined by: Nurse Sovann Peng **Date: May 26, 2010**

Please send all replies to kirihospital@gmail.com and cc: to rithychau@sihosp.org

From: **Kiri Hospital Telemedicine**
Date: Wed, May 26, 2010 at 10:58 AM
Subject: CXR of Case TP#00335, 38F
To: rithychau@sihosp.org, Lim kruy; Paul Heinzelmann; jkvedar@partners.org, kfiamma@partners.org
Cc: bernie@media.mit.edu, thero@cambodiadaily.com, "Lauriebachrach@Yahoo. Com"

Dear all,

This is the CXR of Case TP#00335, 38F.

We will also plan to refer her to SHCH for 2D echo of the heart.

Best regards,
Koh Polo

From: **rithy chau** <rithychau@sihosp.org>
Date: Thu, May 27, 2010 at 9:44 AM
Subject: FW: CXR of Case TP#00335, 38F
To: radiologyexchange@gmail.com
Cc: Kiri Hospital Telemedicine <kirihospital@gmail.com>

Dear Dr. Gary,

I am forwarding the CXR from our TM Clinic in Rattanakiri for May 2010. There will be 2 cases in total. Please reply ASAP within today if possible.

Best,
Rithy/Polo

From: Garry Choy [mailto:garryc@gmail.com]
Sent: Thursday, May 27, 2010 9:56 AM
To: rithy chau
Cc: radiologyexchange@gmail.com; Kiri Hospital Telemedicine
Subject: Re: FW: CXR of Case TP#00335, 38F

Dear all,
I reviewed the following chest x-rays:

TP#00335 - 38F - There are streaky opacities in the right lower lung zone which may be due to possible pneumonia if clinical symptoms support this. However, the heart is otherwise borderline in size. No pulmonary edema.

Let me know if there are specific questions! Please send more cases if you need help anytime,

Garry

From: **Kiri Hospital Telemedicine** <kirihospital@gmail.com>
Date: Wed, May 26, 2010 at 10:19 AM
Subject: Rattanakiri TM Clinic Case ES#00336, 21F
To: Paul Heinzelmann <paul.heinzelmann@gmail.com>, jkvedar@partners.org, kfiamma@partners.org, Lim kruy <kruylim@yahoo.com>, rithychau@sihosp.org
Cc: bernie@media.mit.edu, thero@cambodiadaily.com, "Lauriebachrach@Yahoo. Com" <lauriebachrach@yahoo.com>

Dear all,

This is case ES#00336, 21F and photos.

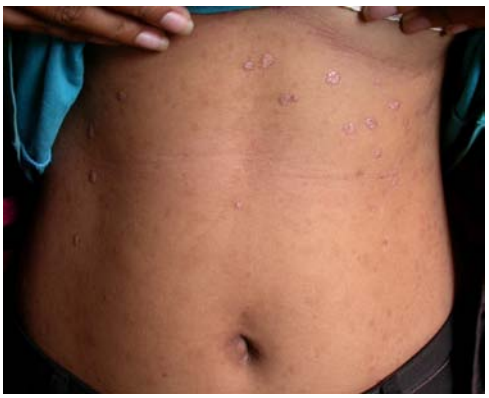
Best regards,
Koh Polo

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

Patient: ES#00336, 21F (Village IV, LBS commune)

Chief Complaint: Skin rashes x 1y

HPI: 21F, housewife, presented with plague skin rashes, less than 1cm in size on the back, no itchy, no vesicle, no pustule, the scale pealed out with scratching. In a few months, the rashes developed to the whole body, and extremities. She got treatment from local hospital staff with injection on the rash (Triamcinolone??) and apply with Gentamycin + Betamethasone + Clotrimazole creamthen then the rashes became completely healed with black scar remaining then the injected area became atrophy. She also treated with traditional medicine. Now the rashes became much better but the scar of rashes still presented.



PMH/SH: She said her mother told she had this type of skin lesion when she was 5 yeas old and got treatment from provincial hospital staffs and all lesions gone.

Social Hx: No cig smoking, no alcohol drinking, 3y married with three times pregnancy, now 45 days of third pregnancy. Two times of spontaneous abortion in first trimester.

Family Hx: No family member with skin rash

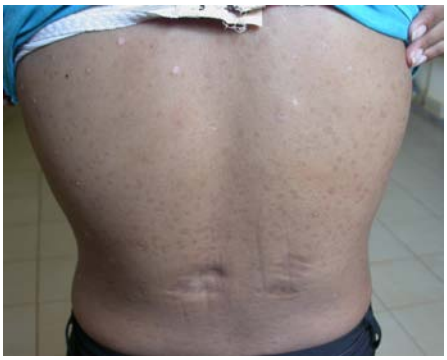
Medication: None

Allergies: NKDA

ROS: Unremarkable

PE:
Vital Signs: BP: 102/75 P: 87 R: 20 T: 37°C Wt: 44kg

General: Stable

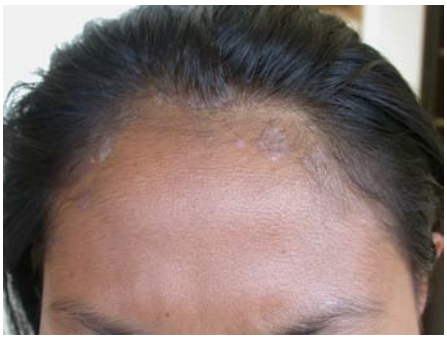


HEENT: No oropharyngeal lesion, pink conjunctiva, no thyroid enlargement, no neck lymph node palpable

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

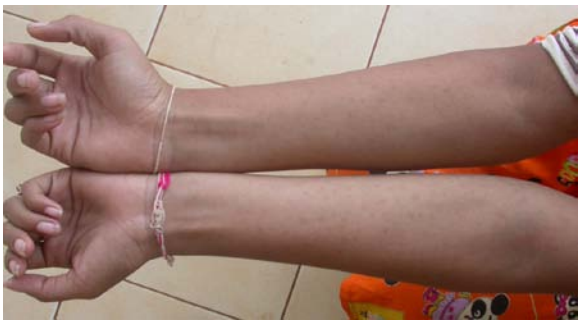
Abdomen: Soft, no tender, no distension, (+) BS, no HSM

Skin: Plague rash with silvery, defined border, rough surface, no vesicle, no pustule, no erythema on the anterior body, back, and scalp; black scar on the extremities; pitted skin on the lower back (due to Triamcinolone injection), spare on the palm, sole, elbow, knee, and face.



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

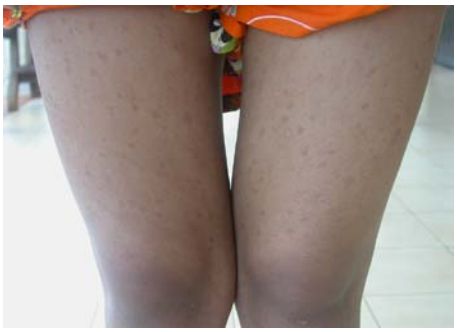
Lab/Studies: None



Assessment:
1. Psoriasis?

Plan:
1. Clotrimazole and Betamethasone dipropionate cream apply bid

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



Examined by: Nurse Sovann Peng **Date: May 26, 2010**

Please send all replies to kirihospital@gmail.com and cc: to rithychau@sihosp.org

From: **Kiri Hospital Telemedicine**
Date: Wed, May 26, 2010 at 10:30 AM
Subject: Rattanakiri TM Clinic Case BY#00337, 48M
To: jkvedar@partners.org; kfiamma@partners.org; Paul Heinzelmann; Lim kruy; rithychau@sihosp.org
Cc: rithychau@sihosp.org, thero@cambodiadaily.com, "Lauriebachrach@Yahoo. Com"

Dear all,

This is case BY#00337, 48M and photos.

Best regards,

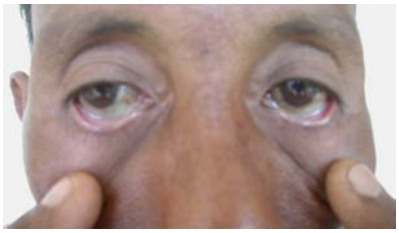
Koh Polo

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

Patient: BY#00337, 48M, KALAN Village, VOEUN SAY.

Chief Complaint: SOB. chest pain and palpitation for one year

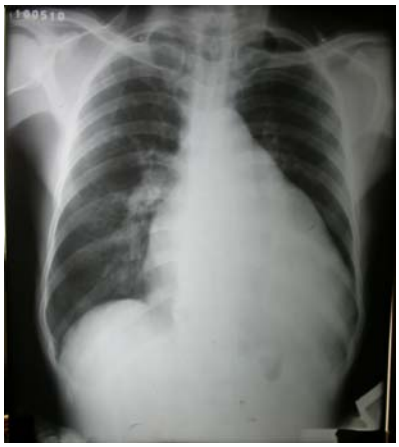
HPI: 48M, presented with symptoms of SOB on exertion, chest pain, fatigue, poor appetite, weight loss and got treatment from local health care worker and traditional medicine his condition not better and his SOB increased even at rest so he went to provincial hospital and he was examined and CXR done and diagnosed with CHF and treated with Digoxin 0.25mg 1t po qd, Aspirin 300mg 1/4t po qd, his condition became a bit better.



PMH/SH: Unremarkable

Social Hx: cigarette ½ packet /day, casually alcohol drinking

Medication: Digoxine 0.25mg 1tab qd and Aspirine 300mg 1/4tab qd for 15 days



Allergies: NKDA

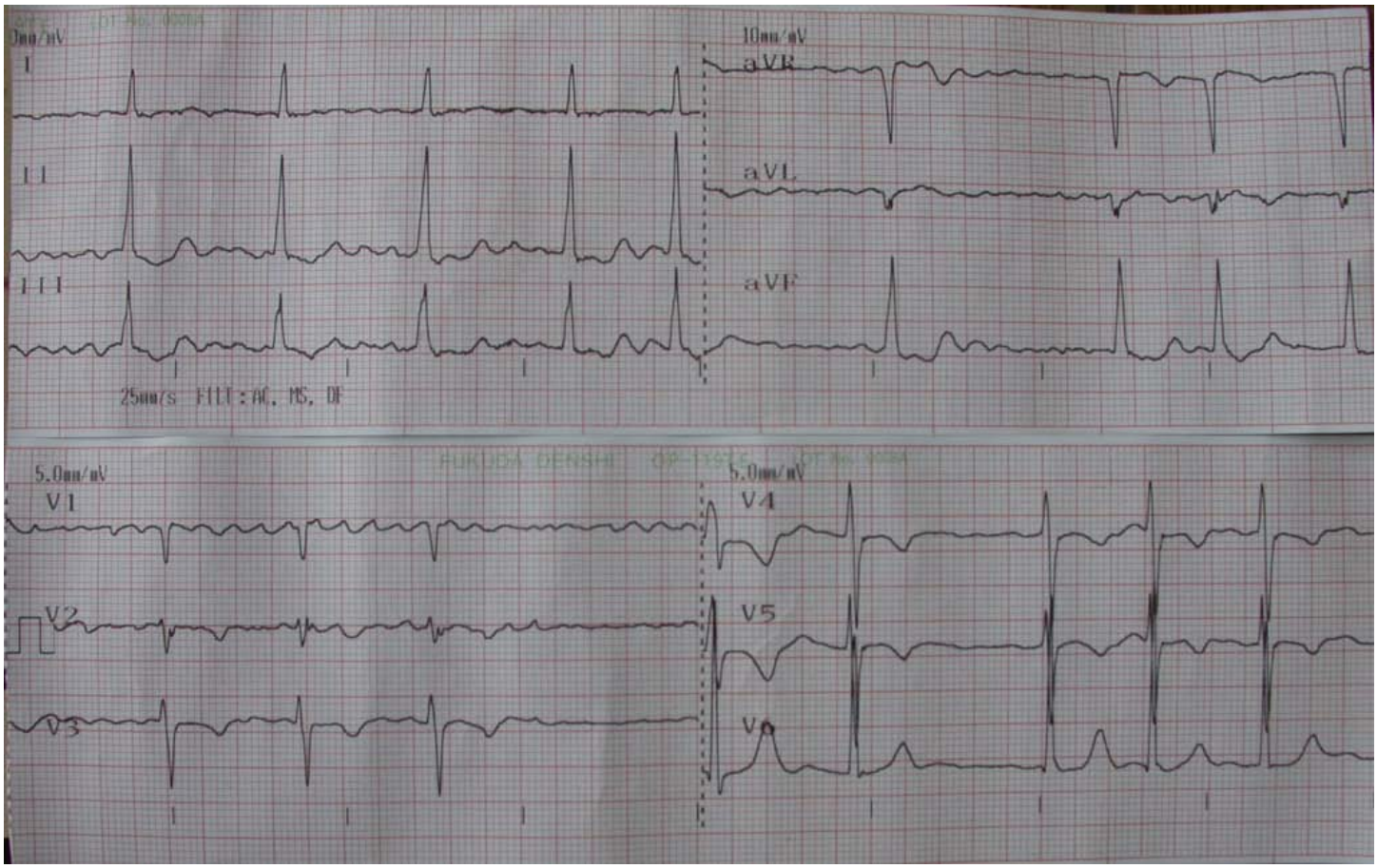
Family Hx: None

ROS: Unremarkable

PE:
Vital Signs: BP: 100/70 P: 67 R: 20 T: 36.5 Wt: 49kg
O2 sat: 98%

General: Alert and oriented x 3

HEENT: No icteric, mild pale conjuntiva, no oropharyngeal lesions, JVD +



Chest: Clear BS bilaterally, no crackle, no ronchi, H Irregular rate and rhythm, palpable thrill at apex

Abdomen: Soft, non tendered, active BS, no organomegaly

Musculoskeletal: no gross masses or lesions or rashes

Neuro: Normal DTRs, mortor and sensory intact

Previous Lab/Studies:

- Chest x-ray on 10/05/2010 show: Opacification and nodular lesion on R lung and (+) cardiomegaly.

Lab/Studies Requests: on 25/05/2010 – EKG show: irregular rhythm and rate within 40beat – 120beat/mn, Atrial fibrillation.

- K^+ 4.5mmol/l, glucose 112mg/dl, creatinine 1.1mg/dl, Urea 46 mg/dl , SGOT 10.7u/l , SGPT 19.5 u/l
- CBC : Hb 10.5 , WBC 4600/mm3, RBC 4970000, S m/s negative

Assessment:

1. A fib
2. VHD?
3. Cardiomegaly
4. TB pulmonary?

Plan:

1. Digxine 0.25mg ½ tab qd for one month
2. Aspirin 300mg 1/4 tab qd
3. Do sputum smear in local hospital
4. Refer to Phnom penh for 2D echo of the heart.

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

Examined by: MA Koh Polo **Date: May 26, 2010**

Please send all replies to kirihospital@gmail.com and cc: to rithychau@sihosp.org

From: Danny Sands (dzsands) [mailto:dzsands@cisco.com]
Sent: Wednesday, May 26, 2010 12:31 PM
To: Fiamma, Kathleen M.
Subject: Re: Rattanakiri TM Clinic Case BY#00337, 48M

My comments:

Is the attached CXR from May 10? You only sent a single view (no lateral), but he appears to have a left pleural effusion, as well.

He clearly has atrial fibrillation. Does he have CHF? You said he had JVD but a clear chest. Did he have peripheral edema?

I agree that he needs an echo and sputum studies. Continuing aspirin and digoxin are fine. If he has fluid overload he'll need furosemide, as well.

I suggest also ordering both PA and lateral CXR, as well as a left lateral decubitus view to better evaluate his effusion.

He should follow up within a month.

- Danny

From: **rithy chau** <rithychau@sihosp.org>
Date: Thu, May 27, 2010 at 9:44 AM
Subject: FW: CXR of Case TP#00335, 38F
To: radiologyexchange@gmail.com
Cc: Kiri Hospital Telemedicine <kirihospital@gmail.com>

Dear Dr. Gary,

I am forwarding the CXR from our TM Clinic in Rattanakiri for May 2010. There will be 2 cases in total. Please reply ASAP within today if possible.

Best,
Rithy/Polo

From: Garry Choy [mailto:garryc@gmail.com]
Sent: Thursday, May 27, 2010 9:56 AM
To: rithy chau
Cc: radiologyexchange@gmail.com; Kiri Hospital Telemedicine
Subject: Re: FW: CXR of Case TP#00335, 38F

Dear all,
I reviewed the following chest x-rays:

BY#00337 - 48M - Cardiomegaly with marked left atrial enlargement. No pulmonary edema. Any comparison to prior imaging? There are some linear opacities in the right apex that could be due to prior infection (scarring vs. new finding?) - comparison with prior imaging can confirm.

Let me know if there are specific questions! Please send more cases if you need help anytime,

Garry

From: **rithy chau** <rithychau@sihosp.org>
Date: Thu, May 27, 2010 at 10:06 AM
Subject: RE: FW: CXR of Case TP#00335, 38F
To: Garry Choy <garryc@gmail.com>
Cc: radiologyexchange@gmail.com, Kiri Hospital Telemedicine <kirihospital@gmail.com>

Dear Garry,

Thanks for your prompt reply.

Is the quality of our images sent acceptable? Also, there was suggestion from Boston for us to do a lat and decubitus views on BY#00337 for finding pleural effusion. Do you think this necessary? (We tried to limit the orders on our patients mainly due to financial reason and limitation of resources available here, but if necessary, then we will do as suggested).

Best,
Rithy

From: **Garry Choy** <garryc@gmail.com>
Date: Thu, May 27, 2010 at 10:16 AM
Subject: Re: FW: CXR of Case TP#00335, 38F
To: rithy chau <rithychau@sihosp.org>
Cc: radiologyexchange@gmail.com, Kiri Hospital Telemedicine <kirihospital@gmail.com>

For case 00337 - I don't think there is a pleural effusion but if there is need to identify a pleural effusion that may change management, then you should do it. But if that doesn't change management, then I would say with relative confidence that there is unlikely a large pleural effusion.

However, I do think there should be a comparison to prior films regarding the right apex -- do you see the linear opacity I am looking at? I want to make sure it is sequela of prior infection and not a malignancy. That finding should be followed-up in the appropriate time interval you feel necessary to exclude any change to suggest a malignant process.

Garry

From: **rithy chau** <rithychau@sihosp.org>
Date: Thu, May 27, 2010 at 10:43 AM
Subject: RE: FW: CXR of Case TP#00335, 38F
To: Garry Choy <garryc@gmail.com>
Cc: radiologyexchange@gmail.com, Kiri Hospital Telemedicine <kirihospital@gmail.com>

Dear Garry,

We are asking the patient to AFB sputum smear done to rule out any infection or relapse of TB because it is quite common here. If negative, we may thing of looking for malignancy, but for now our assessment is unlikely for this problem.

Again thanks for your help.

Best,
Rithy

From: **Kiri Hospital Telemedicine** <kirihospital@gmail.com>
Date: Wed, May 26, 2010 at 10:30 AM
Subject: Rattanakiri TM Clinic May 2010 Case NL#00338, 43M
To: rithychau@sihosp.org, Lim kruy <kruylim@yahoo.com>, kfiamma@partners.org, Paul Heinzelmann <paul.heinzelmann@gmail.com>, jkvedar@partners.org
Cc: bernie@media.mit.edu, thero@cambodiadaily.com, "Lauriebachrach@Yahoo. Com" <lauriebachrach@yahoo.com>

Dear all,

This is the last case for Rattanakiri TM Clinic May 2010 Case NL#00338, 43M and photo.

Please try to reply to the cases before Thursday afternoon.

Thank you very much for your cooperation and support the project.

Best regards,
Koh Polo

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

Patient: **NL#00338, 43M (Village III, LBS)**

Chief Complaint: Blurred vision and polyuria, Weakness and Loss weight x 6 months

HPI: 43M presented with symptoms of blurred vision, polyuria, Asthenia, chest tightness, He sought consultation with private clinic (Blood sugar 500mg/dl), diagnosed with DMII and treated with three kind of medicine (unknown name) 1t qd for one month. He does not have money to buy medicine so he bought traditional medicine for the treatment for four months. He denied of SOB, nausea, vomiting, diarrhea, dysuria, hematuria, edema.
PMH/SH: Unremarkable

Social Hx: Casually alcohol drinking; smoking 5cig/d

Family Hx: None

Medication: None

Allergies: NKDA

ROS: Headache, Cough, runny nose, nasal Congestion, No abdominal pain, no stool with blood or black stool

PE:
Vital Signs: BP: 110/70 P: 60 R: 20 T: 36.5^{o}C Wt: 58kg

General: Look stable

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

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

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

Extremity/Skin: No edema, no lesion

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

Lab/Studies:
Request for : - Total cholesterol : 117 (200mg/dl)
- Creatinin : 2.2 (0.6-1.1)
- Glucose : 177 (75-115mg/dl)
- TG : 155.6 (60-165mg/dl)

U/A: gluco 4+

Assessment:
1. DMII
2. Common Cold

Plan:
1. Metformin 1t po qd x 1 month
2. Paracetamol 500mg 1t po tid prn x 3d
3. Chlorpheniramin 4mg 1t po tid x 3d
4. Educate on diabetic diet, do regular exercise, and foot care

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

Examined by: MA. Lok Vanthan Date: May 25, 2010

Please send all replies to kirihospital@gmail.com and cc: to rithychau@sihosp.org

Thursday, May 27, 2010

Follow-up Report for Rattanakiri TM Clinic

There were 4 new patients 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 13 patients came for follow up and refill medication only. 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 May 2010

1. PT#00335, 38F (Pong Village, Veun Sai commune)
Diagnosis:

1. VHD (PS?)
2. GERD

Treatment:

1. Ranitidine 300mg 1t po qhs (#60)
2. Mebendazole 100mg 5t po qhs once (#5)
3. MTV 1t po qd (#60)
4. FeSO4/Folate 200/0.25mg 1t po qd (#60)
5. GERD prevention education

2. ES#00336, 21F (Village IV, LBS commune)
Diagnosis:

1. Psoriasis?

Treatment:

1. Clotrimazole and Betamethasone dipropionate cream apply bid (#2)

3. BY#00337, 48M (KALAN Village, VOEUN SAY)
Diagnosis:

1. A fib
2. VHD?
3. Cardiomegaly
4. TB pulmonary?

Treatment:

1. Digxine 0.25mg ½ tab qd for one month (#50)
2. Aspirin 300mg 1/4 tab qd (#25)
3. Do sputum smear in local hospital
4. Refer to Phnom penh for 2D echo of the heart.

4. NL#00338, 43M (Village III, LBS)
Diagnosis:

1. DMII
2. Common Cold

Treatment:

1. Metformin 1t po qd x 1 month (#100)
2. Paracetamol 500mg 1t po tid prn x 3d (#10)
3. Chlorpheniramin 4mg 1t po tid x 3d
4. Educate on diabetic diet, do regular exercise, and foot care

Patients who come for follow up and refill medicine

1. NH#00010, 55F (Village III)
Diagnosis:

1. HTN
2. DMII
3. VHD (AI/MR)

Treatment:

1. Atenolol 25mg 2t po bid
2. Chlorpropramide 250mg 1t po bid
3. ASA 300mg 1/4t po qd
4. HCTZ 50mg 1t po qd
5. Enalapril 5mg 1/2t po qd

2. KY#00069, 61F (Village III)
Diagnosis:

1. DMII with PNP

Treatment:

1. Glibenclamide 5mg 1t po bid
2. Metformin 500mg 1t po bid
3. Captopril 25mg 1/2t po bid
4. ASA 300mg 1/4t po qd
5. Amitriptylin 25mg 1/2t po qhs
6. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=12.6	[4.2 - 6.4]
HbA1C	=11.7	[4 - 6]

3. SP#00081, 54F (Village III)
Diagnosis:

1. HTN

Treatment:

1. Enalapril 5mg 1/2t po qd
2. ASA 300mg ¼t po qd

4. MS#00144, 52M (Thmey Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 1tab po bid
2. Metformin 500mg 1t po bid
3. Captopril 25mg ¼ tab po qd
4. ASA 300mg 1/4t po qd
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=9.4	[4.2 - 6.4]
HbA1C	=9.4	[4 - 6]

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

1. HTN
2. DMII

Treatment:

1. Metformin 500mg 2t po bid
2. Captopril 25mg 1/2t po tid
3. ASA 300mg ¼t po qd
4. Amitriptylin 25mg 1/2t po qhs
5. Insulin NPH 20UI qAM
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc and HbA1C at SHCH

Lab result on May 28, 2010

WBC	=7.6	[4 - 11x10^9/L]	Na	=134	[135 - 145]
RBC	=4.8	[3.9 - 5.5x10^{12}/L]	K	=4.6	[3.5 - 5.0]
Hb	=11.6	[12.0 - 15.0g/dL]	BUN	=3.1	[0.8 - 3.9]
Ht	=36	[35 - 47%]	Creat	=78	[44 - 80]
MCV	=74	[80 - 100fl]	Gluc	=13.3	[4.2 - 6.4]
MCH	=24	[25 - 35pg]	HbA1C	=11.4	[4 - 6]
MHCH	=33	[30 - 37%]			
Plt	=360	[150 - 450x10^9/L]			
Lym	=2.6	[1.0 - 4.0x10^9/L]			

6. YM#00189, 16F (Village III)
Diagnosis:

1. Asthma

Treatment:

1. Salbutamol Inhaler 2puffs bid prn (#2)

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

1. DMII

Treatment:

1. Glibenclamide 5mg 1t po bid
2. Metformin 500mg 2t po bid
3. Draw blood for Lyte, BUN, Creat, Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Na	=139	[135 - 145]
K	=4.7	[3.5 - 5.0]
BUN	=3.4	[0.8 - 3.9]
Creat	=111	[53 - 97]
Gluc	=7.2	[4.2 - 6.4]
HbA1C	=8.7	[4 - 6]

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

1. DMII

Treatment:

1. Metformin 500mg 1t po qhs
2. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=9.4	[4.2 - 6.4]
HbA1C	=9.4	[4 - 6]

9. TV#00267, 55F (Village II)
Diagnosis:

1. DMII

Treatment:

1. Metformin 500mg 2t po bid
2. Glibenclamdie 5mg 1t po qd
3. Captopril 25mg 1/4t po bid
4. ASA 300mg 1/4t po qd
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=5.4	[4.2 - 6.4]
HbA1C	=8.1	[4 - 6]

10. VC#00268, 66M (Bey Srok Village)
Diagnosis:

1. DMII

Treatment:

1. Metformin 500mg 2t po qAM and 3t qPM
2. Glibenclamide 5mg 2t po bid
3. Captopril 25mg 1/4t po qd
4. ASA 300mg 1/4t po qd
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=12.2	[4.2 - 6.4]
HbA1C	=8.3	[4 - 6]

11. SS#00299, 46F (Thmey Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 2tab bid (#400)
2. ASA 300mg 1/4 tab qd (#25)
3. Fenofibrate 100mg 1tb qd (BUY)
4. Captopril 25mg 1/4 tab bid (#50)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=21.7	[4.2 - 6.4]
HbA1C	=11.6	[4 - 6]

12. NV#00306, 25M (Thmey Village)
Diagnosis:

1. DM

Treatment:

1. Glibenclamide 5mg 2t po bid
2. Captopril 1/4t po qd
3. ASA 300mg 1/4t po qd
4. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=6.3	[4.2 - 6.4]
HbA1C	=9.3	[4 - 6]

13. TS#00320, 51M (Village V)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 2t po bid
2. Draw blood for Gluc and HbA1C at SHCH

Lab result on May 28, 2010

Gluc	=13.2	[4.2 - 6.4]
HbA1C	=12.0	[4 - 6]

The next Rattanakiri TM Clinic will be held in 2010