Telemedicine Clinic
Rattanakiri
Referral Hospital
October 2005

Report and photos compiled by Rithy Chau, SHCH Telemedicine

On Tuesday, October 18, 2005, Rattanakiri Referral Hospital (RRH) staff began their TM clinic. PA Rithy Chau was present during this month clinic. The patients were examined and the data were transcribed along with digital pictures of the patient, then transmitted (except for follow-up patients who came for medication refills and/or further instruction on referring to PP) and received replies from their TM partners in Boston and Phnom Penh.

The following day, Wednesday, October 19, 2005, the TM clinic opened again to receive the same 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: Wednesday, October 12, 2005 4:03 PM
To: 'Kiri Hospital'; 'Cornelia Haener'; 'Ruth Tootill'; 'Brian Hammond'; 'Paul Heinzelmann'; 'Kathleen M. Kelleher'; 'Joseph Kvedar'
Cc: 'Ed & Laurie Bachrach'; 'HealthNet International'; 'Bernie Krisher'; 'Noun SoThero'; 'Fil B. Tabayoyong'
Subject: RE: September TM clinic at Rattanakiri Referral Hospital

Dear All,

Channarith has asked me via telephone to send this message of correction due to his mistake and him unable to operate internet from his location. Just beware that the TM clinic this month may be slower with many interruption due to satellite malfunction from the severe thunderstorm and lightning last week.

Correction for the date for the next TM in Rattanakiri is as follow:
Please change the date to read October 18 and 19 instead of September in the message below.

Regards,
Rithy

F

rom: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, October 11, 2005 5:11 PM
To: Rithy Chau; Cornelia Haener; Ruth Tootill; Brian Hammond; Paul Heinzelmann; Kathleen M. Kelleher; Joseph Kvedar

Cc: Ed & Laurie Bachrach; HealthNet International; Bernie Krisher; Noun SoThero; Fil B. Tabayoyong
Subject: September TM clinic at Rattanakiri Referral Hospital

Dear All,

Please be informed that the next TM clinic at Rattanakiri Referral Hospital will be held on Tuesday, September 18,2005 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, September19, 2005.The patents 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: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, October 18, 2005 5:05 PM
To: 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 Referal Hospital patient KL# 00141

Dear all,

This is the patient KL # 00141and her photos.

Best regards,

Channarith/Rithy

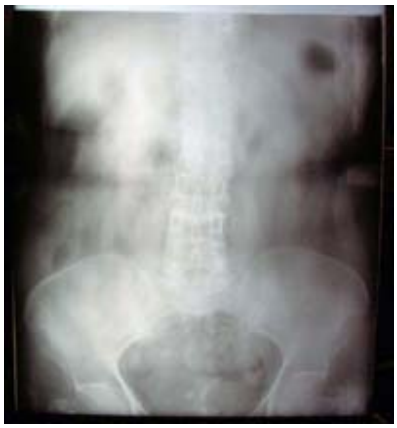
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: KL#00141, 56F, Village II

Chief Complaint: Back bone pain x 2 years

HPI: 56 F with PMH of PTB in 1980 presented with back bone pain x 2 y off and on with generalized joint pain of her body (less severe) exception of femoral head joint pain and toes; she went to have treatment at the private clinic in Kampong Cham and Kandal Provinces with unknown medications. Her symptoms did not resolve. She has complaint of back bone pain which locates in L1-L5 and unable to bend down to reach her toes and has difficulty to move her body to the right or left. Also both anterior thigh muscle pain off and on. No radiation pain, no numbness, no tingling, walking without assistance, not able to carry or lift >5kg, denied fever, cough, sputum production, cardiopulmonary problem; no trauma, no accident, no surgery, no GU c/o. She said she developed gastritis/dyspepsia after she took the unknown medications for her back. no blood in stool, no melena, no n/v, normal BM.

PMH/SH: injection of Streptomycin(1g) X 6M for PTB since 1980; Gastritis, HTN? (unknown med taken prn)



Social Hx: none EtOH, no smoke

Allergies: none

Family Hx: none

ROS: upset stomach

PE:
Vital Signs: BP: 130/90(L) 120/80(R) P 75 R20 T37.5 Wt

General: Alerted and oriented

HEENT: unremarkable

Chest: Lungs:clear both sides; HRRR no murmur

Abdomen: soft, active BS, no organomegaly, no tenderness

Musculoskeletal: ROM at hip caused L1-L 5 location pain,unable to bend her body forward due to pain of back. good tone.

Neuro: DTR2+, Sensory and motor are intact

GU: none

Rectal: none

Previous Lab/Studies: 14/10/05 ASLO (negative), RF test (negative), exagon TB test (negative), gluc=0.97g/l, H. pylori (postive)

Lab/Studies Requests: x-ray of back bone, chest x- ray (to r/o TB lesions)

Assessment: 1. PUD 2. Muscle pain/LBP due to disc compression 3. Arthritis? 4. Parasititis 5. HTN?

Plan:
1. H. pylori eradication
2. Mebendazole 500mg chew 1 po once
3. Paracetamol 2 tab qid x prn pain
4. Carisoprodol 350mg 1 po bid prn severe pain
5. B-complex 1 po qd

Comments/Notes: Please give a good idea

Examined by: Dr san **Date: 18/10/05**

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

From: Ruth Tootill [mailto:ruth_tootill@online.com.kh]
Sent: Wednesday, October 19, 2005 8:47 AM
To: Kiri Hospital; 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 Referal Hospital patient KL# 00141

Dear Channarith,

I think this lady probably has degenerative disease of her spine. Clinically she seems to have no sciatic nerve compression. The anterior thigh pain may be due to higher compression L1/L2, does she have any sensory loss in this area or pain on hyperextension of the hip, while lying prone? The AP x-ray shows osteophytes and some degree of wedging of her lumber vertebrae. However, it is difficult to see all the pedicles and therefore, difficult to occlude destruction of the vertebral bodies due to some other process such as metastases or infection. It would also be good to have a lateral view of the lumber spine as this would also give us more details about the vertebral bodies and the disc spaces. Two views are better than one!

I would suggest performing a lateral lumber spine xray and perhaps a trial of a nonsteriodal anti-inflammatory as you plan to protect her stomach already.

Thanks
Ruth

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, October 26, 2005 5:43 AM
To: tmed_rithy@online.com.kh; kirihospital@yahoo.com
Cc: Heinzelmann, Paul J.,M.D.
Subject: FW: Rattanakiri Referal Hospital patient KL# 00141

The critical data is the lumbar sacral spine, but the resolution on my computer screen is not good enough for me to make out details. L3 vertebra looks foreshortened suggesting vertebral collpase. A lateral view would be helpful to clarify findings. There is no vertebral sclerosis to suggest past or active TB osteomyelitis or metastatic disease of bone. She has no perimenopausal osteoporosis that could contribute towards vertebral fractures.

The history of back pain with stiffness suggests ankylosing spondylitis, however back pain was not progressive. Furthermore this condition would be unusual in a woman. The spine xray did not show sclerosis of sacroiliac joints or

calcification of longitudinal ligament. Intermittent back pain suggests facet joint arthritis. Stiffness could be from deconditioning and disuse with loss of functional movement. However xray did not show obvious facet joint sclerosis though the L5-S1 facet joints look sclerotic. Again this interpretation is limited by screen resolution and absence of laterval view of LS spine. There is no sciatica to suggest a prolapsed vertebral disc. Radiation of pain to anterior thighs can be associated with facet joint arthritis.

Mild lumbar sclerosis is present and may be a contributing factor to low back pain, but is not severe enough to explain back pain completely by itself. There is no congenital spina bifida or other variation like lumbarization of S1 or fusion of L5-S1 that may be associated with back pain. A lateral view could rule out congenital spondylolisthesis.

So to summarize: get a lateral LS spine view, send both AP and lateral films for radiological reading and diagnosis. Clinical diagnosis is likely facet joint arthritis of L5-S1 joint.

As for management:start with ibuprofen 600 mg tid on full stomach for pain. Carisopodol for spasm is OK. Review with her physical therapy including proper back posture, protection of back during movement, back stretching and strengthening exercises to improve functionality. In Boston, we would later consider referral to physiatrist for facet joint steroid injection to relieve pain if she does not improve.

Heng Soon Tan, M.D.

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, October 18, 2005 10:15 PM
To: 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: Rattanakkiri Referal Hospital patient ST #00142

Dear all,

This is the patient ST #00142 and her photos.

Best regards,

Channarith/Rithy

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

Patient: ST#00142, 29F, TMEY Village

Chief Complaint: a small mass on neck x 1yr

HPI: Postpartum of last child, she presented with the palpitation off and on and tremor of extremities off and on and a small mass developing on neck for one year with headache, weight loss x7kg/yr, she complaint of burning epigastric pain and regurgitation, nausea in early morning. +low appetite, difficulty sleeping, malaise; denied fever, diaphoresis, hot flashes, edema, CP, SOB, cough, dysphagia, change in vision, tinnitis. The mass stay the same size without progression. Never seek tx for the neck mass.

PMH/SH: unremarkable

Social Hx: no EtOH, no smoke, started to drink coffee this year

Allergies: none

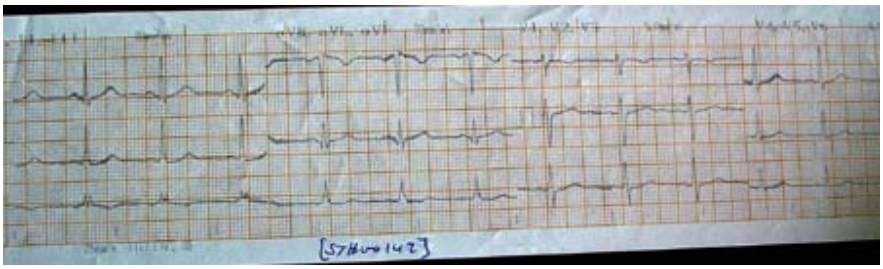
Family Hx: none

ROS: No GU complaint

PE:
Vital Signs: **BP 90/60** **P70** **R20** **T37.** **Wt** 48kg

General: alert and oriented

HEENT: PERRLA and EOMI, good acuity, no oropharyngeal lesions, no lymphadenopathy, smooth round mass about 1cm diameter, mobile when swallowing, no tenderness, no bruit.



Chest: Lungs:clear both sides; HRRR no murmur

Abdomen: unremarkable

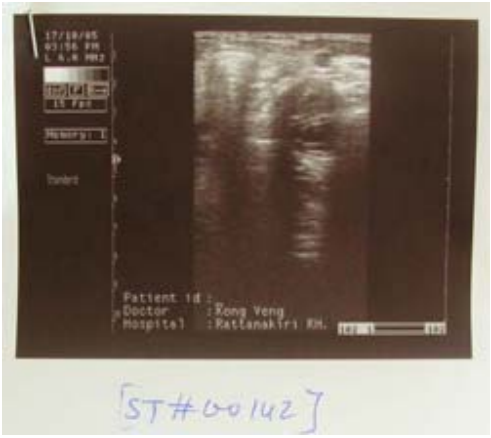
Musculoskeletal: unremarkable

Neuro: DTRs normal, sensory and motor are intact, no tremor

GU: no exam

Rectal: not exam

Previous Lab/Studies:



Lab/Studies Requests: ultrasound of mass of neck , EKG

Assessment: 1. thyroid cyst? vs. goiter 2. Dyspepsia 3. Parasititis

Plan: 1. Check free T4 and TSH at SHCH
2. MgAlOH3 250/120mg chew 2tab qid prn
3. Mebendazole 500mg chew 1 po qhs

Comments/Notes: give a good idea

Examined by: Dr San **Date: 18/10/05**

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, October 19, 2005 2:55 AM
To: Kiri Hospital
Cc: tmed_rithy@online.com.kh
Subject: FW: Rattanakkiri Referal Hospital patient ST #00142

This young lady appears to have a thyroid mass/nodule, 1 cm in size. Some symptoms suggest hyperthyroidism, but physical exam does not. Unfortunately I cannot see well the ultrasound. So I am not sure whether this is a nodule or a diffuse goiter, which would suggest Graves' disease or postpartum thyroiditis.
First step would be measuring TSH. If TSH is low, a thyroid scan would be indicated for likely "hot" nodule or other causes of hyperthyroidism.
If TSH not low, thyroid scan can be omitted as a "cold" nodule could be suspected. A non-emergent biopsy (fine needle) of the nodule should be done in this case, as in all palpable thyroid nodules that are cold. I will be glad to follow-up if further information accumulates.

Thank you.

Giuseppe Barbesino, MD
Thyroid Associates
Massachusetts General Hospital-Harvard Medical School

From: Ruth Tootill [mailto:ruth_tootill@online.com.kh]
Sent: Wednesday, October 19, 2005 8:35 AM
To: Kiri Hospital; 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: Rattanakkiri Referal Hospital patient ST #00142

Dear Channarith/Rithy,

I think your investigations of her thyroid are appropriate. The ultrasound suggests that the mass is not a cyst.

I am slightly concerned about her weight loss and general symptoms. However, if the period of weight loss covers her immediate post-partum time, and her weight is now more stable this would be less concerning.

Thanks for such a complete evaluation.

Ruth

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, October 18, 2005 3:12 PM
To: 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 OS#00143

Dear All,

This is the first case of this month Patient OS#00143 and her photos.

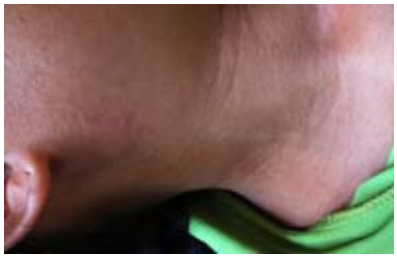
Best regards,

Channarith/Rithy

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

Patient: OS#00143, F 48y.o, Village Thmey

Chief Complaint: Palpitation, Dyspnea x 1year
HPI: One year ago she felt sore throat, fever, cough, no dyspnea, she went to buy the medicine from the pharmacy and she became better but about a haft month after she felt dyspnea, dizziness, fatigue, papitation, cough from time to time she was treated with unknown modern medicine but can help her from time to time in addition 6 or 7 days before she came to hospital dyspnea increasing until she can go up only 5 or 6 stairs



PMH/SH: no surgery no accident
Social Hx: no smoking and drinking alcohol, regular period

Family Hx: none

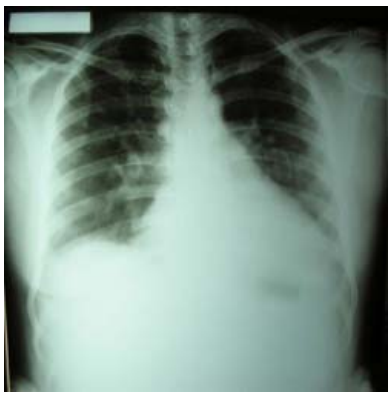
ROS:
PE:
Vital Signs: **BP 140/80 mmHg** **P 6/min** **R 22/min** **T 36 C** **Wt 60/kg**

General: normal consciousness, looks well, anxiety, no cough, no sputum, fatigue, anorexia

HEENT: Head normal, jugular venous distention, no bruits no thyromegaly, conjuncitiva no cyanosis no pallor, ENT normal neck soft no enlarged LN

Chest: normal breath sound, no crackle no wheezees, Heart systolic crescendo 2/4 murmur pulmonic area

Abdomen: no hepatosplenomegaly, positve BS, no abdominal pain, no tenderness



Musculoskeletal: no swelling on his both feet

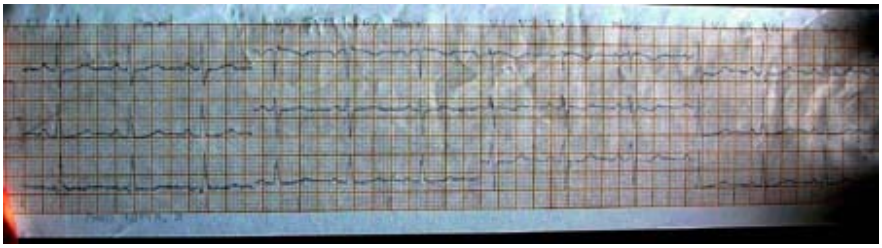
Neuro: Eye ball movement normal, corneal reflex normal, pupils 3mm, face no paralysis, reflex normal, motor and sensory normal both sides

GU: unremarkable

Rectal: not examined

Previous Lab/Studies: 18.10.2005 Chest X ray, abdominal ultrasound, EKG
Hb:14g/dl
Urine test: BS 90 mg/dl, UA normal

Lab/Studies Requests: Total cholesterol, creatinine, glucose, potassium, triglycerides, BUN, sodium



Assessment: congestive heart failure
Valvular heart Dz

Plan: Digoxine 0,25 mg bid
Furosemid 40mg qd
Kcl 600mg qd

Comments/Notes:

Examined by: Dr Sovitha **Date: 18.10.2005**

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

-----Original Message-----
From: Hutter, Adolph M.,Jr.,M.D. [mailto:AHUTTER@PARTNERS.ORG]
Sent: Wednesday, October 19, 2005 3:48 AM
To: kirihospital@yahoo.com
Cc: Fiamma, Kathleen M.
Subject: Correction opf Typo on consult reply

I have reviewed the data is sent to me. This lady has symptoms of congestive heart failure and physical findings of jugular venous distention with a 2/4 systolic murmur at the left sternal border compatible with aortic stenosis. The chest x-ray does show left ventricular enlargement. The EKG does not show left ventricular hypertrophy. I think this lady clearly needs further evaluation to include an echocardiogram and probably a catheterization. Therefore she should be sent into an appropriate facility with these things can be carried out. She may need aortic valve replacement if indeed she does have symptomatic significant aortic stenosis.

Sincerely yours,

Adolph M. Hutter Jr. M.D.
Professor of Medicine
Harbor Medical School
Massachusetts General Hospital

From: Kiri Hospital [mailto:kirihospital@yahoo.com]
Sent: Tuesday, October 18, 2005 3:59 PM
To: 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 MS#00144

Dear All,

This is Patient MS#00144 and his photos.

Best regards,

Channarith/Rithy

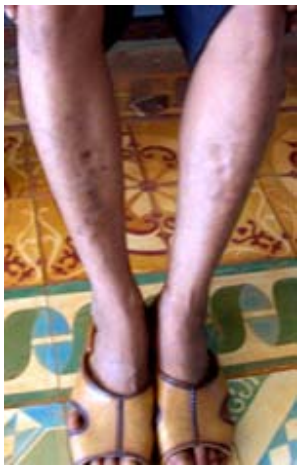
Rattanakiri Provincial Hospital Telemedicine Clinic
with
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Patient: MS#00144,M 52 y.o, Village Thmey

Chief Complaint: Dyspnea, Weight loss x 1 year

HPI: One year ago he felt headache, chill, oliguria, fatigue, anorexia, thirst, left chest pain, both legs swollen and he went to private clinic for check blood, His blood result are AgHBs positive, malaria negative and he was treated with unknown moderns medicines for about 3 months he became better(no headache no chill) but his both leg swollen increasing so he went to check urine at the same clinic and his result is glucose in urine + and he was treated with Chlopropamide250mg 2 tablets qd and traditional medicine and now he felt fatigue decreased, polyuria, thirst and leg swollen decreasing, weight loss about 8 kg and dyspnea

PMH/SH: no surgery, no accident



Social Hx: smoking no drinking alcohol

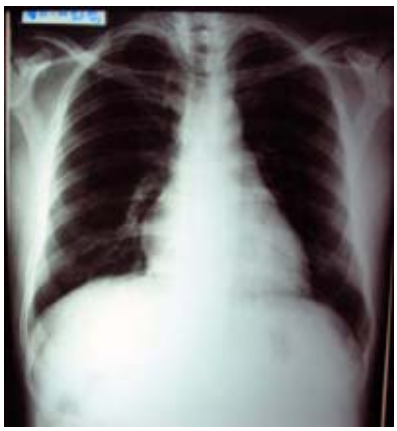
Allergies: none

Family Hx: none

ROS:

PE:
Vital Signs: **BP100/60mmHg** **P72/min** **R26/min** **T36,5C Wt73kg**

General: looks well, appetite normal, no fever, no chills no fatigue, no night sweets, normal consciousness, no cough no sputum



HEENT: Head normal, conjunctiva no pallor, no cyanosis, visual acuity normal, neck soft no enlarged LN , no throat pain

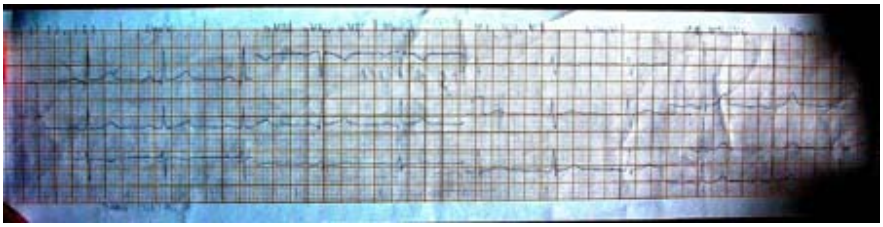
Chest: normal breath sound, no murmur, no crackle, heart regular rhythm

Abdomen: positive BS, no abdominal tenderness, no abdominal pain, no hepato-splenomegaly

Musculoskeletal: moderate swelling on his both feet

Neuro: Eye ball movement normal, corneal reflex normal, pupils 4mm, face no paralysis, reflex normal, motor and sensory normal both sides

GU: unremarkable



Rectal: not examined

Previous Lab/Studies: 18.10.2005 Chest X ray,EKG,Abdomen ultrasound
WBC 7300/mm3, RBC 4300000/mm3, Platelet 285000/mm3, Hb 13, Ht 44%, Creatinine 1.4mg/dl, Glucose 160mg/dl, Urea 22.9mg/dl, SGOT 24.2U/l, SGPT 21.4U/l, HBs Ag positive
Urine check: BS fasting 164mg/dl
UA: SG 1.030, PH 5, Leukocyte +1, Nivite negative, prot negative, glucose +1,Ket negative,
uro normal, Bili negative, Blood negative
Lab/Studies Requests: Total cholesterol, potassium, sodium, triglycerides

Assessment: Diabetic
Cirrhosis
Renal failure
Cardiac failure
Plan: Glibenclamide 5mg qd

Comments/Notes:

Examined by: Dr Sovitha **Date: 18.10.2005**

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

From: Paul Heinzelmann, MD [mailto:pheinzelmann@partners.org]
Sent: Wednesday, October 19, 2005 7:02 AM
To: kirihospital@yahoo.com; tmed_rithy@online.com.kh; Kathleen M. Fiamma
Subject: Rattanakiri Referral Hospital TM clinic Patient MS#00144

Dr Sovitha,

Your assessment and plan seems reasonable. I agree with your plan top further assess cardiovascular risk factors. (cholesterol). It will be important to educate this patient about diabetes and the need for diet control (sugar, salt) in addition to medicine.

I dont see evidence of exacerbation of heart failure to explain the dyspnea, and I do have some difficulty reading the EKG due to light reflection. Did the ultrasound show anything?

He will need close follow up, and monitoring of his weight will be of value to assess fluid status.

Knowing his electrolytes (as you have suggested) will also be helpful -especially if you are considering a diuretic (furosemide), which should be done with caution.

Best,
Paul Heinzelmann, MD

Wednesday, October 19, 2005

Follow-up Report for Rattanakiri TM Clinic

There were 4 new and 8 follow up patients seen during this month TM clinic at Rattanakiri Referral Hospital (RRH). The data of all 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 (with advice from PA Rithy on location at RRH), 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 at RRH are provided by SHCH to TM patients at no cost]

Treatment Plan for Rattanakiri TM Clinic October 2005

New Cases

1. KL#00141, 56F, Village II
   Dx:
   1. Dyspepsia
   2. Osteoporosis?
   3. Parasititis

   Tx:
   1. MgAlOH3 (250/120) chew 2tab po qid prn upset stomach (50 tab)
   2. Calcium (600mg) 1tab po bid x one month
   3. MTV 1 tab po qd x one month
   4. Mebendazole (500mg) chew 1 tab po once

2. ST#00142, 29F, TMEY Village
   Dx:
   1. Goiter
   2. Dyspepsia
   3. Parasititis

   Tx:
   1. Check TSH and free T4 at SHCH
   2. MTV 1 tab po qd x one month
   3. MgAlOH3 (250/120) chew 2 tab po qid prn upset stomach (50 tab)
   4. Mebendazole (500mg) chew 1 tab po once

   Note: This patient did not show up at the clinic on 21/10/05 to receive tx.

3. 0S#00143, 48F, TMEY Village

Dx:

1. Cardiomegaly (CHF? VHD?)

Tx:

1. 2D Cardiac Echo at Calmette Heart Center
2. Request Creatinine, BUN,Tot cholesterol, glucose, CBC, electrolytes at SHCH
3. ASA (81mg) chew 1tab po qd x 100d

Note: This patient was able to come to Phnom Penh on her own to do 2D heart echo and also to have blood test done at SHCH.

4. MS#00144, 52M, TMEY Village

Dx:

1. DMII
2. UTI
3. Cardiomegaly (Right side heart disease?)
4. HBsAg(+)

Tx:

1. Glibenclamide(5mg) 1tab po qd x 100d (provided from SHCH)
2. 2D Cardiac Echo at Calmette Heart Center
3. Cipro (500mg/5cc) susp. 5cc po bid x 10d
4. ASA (81mg) chew 1tab qd x 100d
5. Captopril (25mg) ¼ tab po qd x 100 d (provided from SHCH)
6. DM education ,diet , exercise.
7. Request: Creatinine,BUN, tot cholesterol, glucose, CBC, Electrolytes.

Note: This patient was able to come to Phnom Penh on hisr own to do 2D heart echo and also to have blood test done and receive DM education at SHCH.

Follow-up patients

1. UP#00093, 51F, Village I

Dx:

1. Hyperthyroidism

Tx:

1. Methimazole (5mg) 1tab po tid x 2 months more (has one month supply already)
2. Recheck TSH and free T4 .

2. NS#0006, 18F, Village I

Dx:

1. Hyperthyroidim

Tx:

1. Methimazole (10mg) ½ tab qd x 100d
2. Recheck thyroid panel at SHCH .

3. NS#00089, 16F, Village I

Dx:

1. Hypothyroidism

Tx:

1. L-Thyroxin 25mcg 1tab qd x 100d
2. Recheck thyroid panel at SHCH .

4. CL#00122, 33F, Village III

Dx:

1. Subclinical hyperthyroidism
2. Dyspepsia

Tx:

1. Methimazole (10 mg) ½ tab po tid x one month (52tab)
2. MgAlOH3 (250/120) chew 2 tab qid prn (30 tab)

5. PC#00113, 40F, Village I

Dx:

1. Pneumonia?
2. Goiter with Euthyroidism

Tx:

1. Clarythromycin (500mg) 1tab po bid x 7 d
2. ASA (81mg) chew 3 tab po tid prn fever
3. Spontaneous Abortion 13/10/05 tx at RRH

6. LH#00116, 59F, Village IV

Dx:

1. Hyperthyroidism
2. HTN
3. Nephritis? (resolved)
4. Cardiomegaly

Tx:

1. HCTZ (50mg) ½ tab po qd x 35 d
2. ASA(81mg) chew 1tab po qd x 35 d
3. Methimazole (10mg) ½ tab po qd x 35 d
4. Recheck free T4 and TSH at SHCH

7. LD#00134, 35F, Fang Village

Dx:

1. Hyperthyroidism

Tx:

1. Aspiration of neck mass at RRH 19/10/05 and send 6 slides to SHCH pathology lab

8. TR#00120, 34M, Village I

Dx:

1. Sciatica
2. Dyspepsia

Tx:

1. Ranitidine (300mg) 1tab po bid x one month

2. Naproxen (220mg) 2tab po bid prn pain
3. MTV 1 tab qd x one month

Follow-up Notes:

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Thursday, October 27, 2005 11:20 AM
To: 'Kiri Hospital'
Cc: Bernie Krisher (bernie@media.mit.edu); 'Gary Jacques'; So Thero Noun (thero@cambodiadaily.com); Fil - Jr. Tabayoyong (docfil@yahoo.com); Ed & Laurie Bachrach (lauriebachrach@yahoo.com); Bunse Leang (tmed1shch@online.com.kh)
Subject: Rattanakiri TM Clinic October 2005 Follow-up Report

Dear Dr. San and Channarith,

Here is the latest follow-up report for patients seen at October 05 TM clinic:

1. **NS#0006, 18F, Village I**

   Dx: Hyperthyroidism

TFTs on 21/10/05	TSH	<0.02	[0.49 – 4.67]
	Free T4	24.26	[9.14 – 23.81]

   Tx: Please increase her medication as follow ➔ Methimazole 10mg 1 tab po qd and recheck free T4 in 2 months. Since her goiter is nodular and at least grade II, she needs thyroidectomy when her free T4 becomes normalized consecutively for 6 months (i.e. when her free T4 is normal x3 with blood test 3 months apart).

2. **NS#00089, 16F, Village I**

   Dx: Hyperthyroidism 2nd to medication (initial dx hypothyroidism)

TFTs on 21/10/05	TSH	<0.02	[0.49 – 4.67]
	Free T4	48.16	[9.14 – 23.81]

   Tx: Please increase her medication as follow ➔ L-thyroxine 25mcg 1 tab po bid and recheck TSH in 2 months.

3. **UP#00093, 51F, Village I**

   Dx: Subclinical Hyperthyroidism

TFTs on 21/10/05	TSH	0.02	[0.49 – 4.67]
	Free T4	23.35	[9.14 – 23.81]

   Tx: Please keep her medication the same as follow ➔ Methimazole 10mg ½ tab po qd and recheck free T4 in 2 months.

4. **LH#00116, 59F, Village IV**

   Dx: 1. Subclinical Hyperthyroidism 2. HTN 3. Cardiomegaly (VHD/MS/CHF??)

   TFTs on 21/10/05 Free T4 15.54 [9.14 – 23.81]

   Tx: Please keep her medication as follow ➔
   1. Methimazole 10mg ½ tab po qd and recheck free T4 in 2 months.
   2. HCTZ 50mg ½ tab po qd
   3. ASA 81mg chew 1 tab po qd

4. Recommend to have 2D cardiac echo at Calmette Cardiac Center in Phnom Penh (let me know when she will be coming to PP and ask her to bring by the result for me to see before returning back to RK).

5. OS#00143, 48F, Tmey Village

Dx: 1. ASD (Atrial Septal Defect) 2. Right Atrial Dilated

2D Cardiac Echo on 26/10/05 at Calmette Cardiac Center ➔ Conclusion: EF not given, right atrial dilated, ASD with second ostium diameter approx. 20mm shunting left to right, LV not dilated, paradoxical movement of ventricular septum, PAP = 45 mmHg

Repeated EKG done at SHCH on 26/10/05 ➔ NSR with HR = 84

Tx: Her medication was given at SHCH as follow ➔ add Furosemide 40mg ½ tab po qd x 100d, eat 2 bananas qd and to continue with ASA 81mg chew 1 po qd (given at RRH TM clinic; patient returned to RK on 27/10/05 and advised to meet Dr. Kok San upon arrival in the province. Follow-up next TM clinic.

6. MS#00144, 52M, Tmey Village

Dx: 1. DM II 2. UTI

Repeated EKG at SHCH on 26/10/05 ➔ NSR with HR = 91
Random BS (finger stick) = 293 mg/dL
U/A: Gluc +4, Ket +1
2D cardiac echo on 26/10/05 at Calmette Cardiac Center ➔ Conclusion: Normal with EF = 73%

Tx: His medications were given at SHCH as follow ➔ discontinue Chlorpropamide and start Glibenclamide 5mg 1 tab po qAM x 100d, Captopril 25mg ¼ tab po qd x 100d, and continue with ASA and Cipro provided at RRH TM clinic. DM education and foot care provided by SHCH Nurse Tol Bunna. Please check his fasting blood sugar (finger stick) with target goal between 90-130 mg/dL and U/A dipstick every week—**please report these results to Rithy each week for advice on management of this patient**. Follow-up next TM clinic.

Concerning SHCH Patient Pal Sinay, 26F, Village I, dx with subclinical hyperthyroidism and dyspepsia, tx with methimazole 10mg ½ tab po bid, propranolol 40mg ¼ tab po bid, and MgAlOH3 250/120mg chew 1 po tid x 2 mo., her physician at SHCH agreed for her to be follow-up at RRH and do not need to return to PP for her next appointment on 14/12/05. She can get her refill of medications (from SHCH) and medical care (as long as her thyroid condition is stable) through the TM clinic at RRH. Please inform her to come for follow-up at our TM clinic in December 2005.

If you have concern or queries for any of the above patients, please let me know.

Best Regards,

Chau Rithy
SHCH Physician Assistant

From: Rithy-chau [mailto:tmed_rithy@online.com.kh]
Sent: Friday, October 28, 2005 4:10 PM
To: 'Kiri Hospital'
Cc: Bernie Krisher; So Thero Noun; 'Gary Jacques'; Fil - Jr. Tabayoyong; 'Heinzelmann, Paul J.,M.D.'; Ed & Laurie Bachrach
Subject: More Lab Results for Patients Seen at Rattanakiri TM Clinic October 2005

Dear Channarith and Dr. Kok San,

Here are some more lab results on 26/10/05 at SHCH for the following patients from the October 05 TM Clinic:

1. **OS#00143, 48F, Tmey Village**

Dx: 1. ASD 2. Dilated Right Atrium

- Na 153 [135 – 145]
- K 3.8 [3.5 – 5.0]
- Creat 64 [44 – 80]
- BUN 1.2 [1.0 – 4.0]
- Gluc (random) 113 [90 – 130]
- Tot Chol 3.3 [mod risk = 5.7, high risk = 6.7]
- CBC Normal

Tx: Keep management the same.

2. **MS#00144, 52M, Tmey Village**

Dx: 1. DM II 2. UTI

- Na 152 [135 – 145]
- K 3.8 [3.5 – 5.0]
- Creat 48 [53 – 97]
- BUN 1.4 [1.0 – 4.0]
- Gluc (random) 318 [90 – 130]
- Tot Chol 4.7 [mod risk = 5.7, high risk = 6.7]
- CBC
    i. WBC 5 [4 – 11]
    ii. RBC 4.3 [4.6 – 6.0]
    iii. Hb 13.5 [14 – 16]
    iv. Hct 40 [42 – 52]
    v. MCV 93 [80 – 100]
    vi. Plt 68 [150 – 450]

Tx: Stop his ASA for now and recheck his CBC include platelet next month. Please let me know the results for next month also.

Best Regards,
Rithy

The next Rattanakiri TM Clinic will be held on
November 23 - 24, 2005