# Robib *Telemedicine* Clinic

## Preah Vihear Province

## A P R I L 2 0 1 0

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

On Wednesday, March 31, 2010, SHCH staff PA Rithy Chau, Driver and Nurse Peng Sovann traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following six days, Thursday April 1 until Tuesday 6, 2010 (mornings), the Robib TM Clinic opened to receive the patients for evaluations. There were 21 new cases and 1 follow up case seen during this month, and the patients were examined and their data were transcribed along with digital pictures of the patients, then transmitted and received replies from their TM partners in Boston and Phnom Penh on Friday 2 to Thursday 7 April, 2010.

On Thursday, replies from SHCH in Phnom Penh and Partners Telemedicine in Boston were downloaded. Per advice from Boston, SHCH, and PA Rithy and Dr. Lim Kruy on site, Nurse Sovann managed and treated the patients accordingly. There were also patients who came for refills of medications. Finally, the data of the patient concerning final diagnosis and treatment/management would then be transcribed and transmitted to Nurse Sovann Peng at SHCH who compiled and sent for website publishing.

The followings detail e-mails and replies to the medical inquiries communicated between Robib TM Clinic and their TM partners in Phnom Penh and Boston:

**From:** Robib Telemedicine
**To:** Rithy Chau ; Cornelia Haener ; Kruy Lim ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kathy Fiamma >
**Cc:** Bernie Krisher ; Kevin O' brien ; Sothero Noun ; Laurie & Ed Bachrach ; Peou Ouk ; Sochea Monn ; Eang Tea ; Samoeurn Lanh
**Sent:** Monday, March 29, 2010 8:14 AM
**Subject:** Schedule for Robib Telemedicine Clinic April 2010

Dear all,

I would like to inform you that schedule for Robib Telemedicine Clinic will be starting from Wednesday March 31, 2010 with Japaenese NHK Television crew to do possibly home visit and patients interview until Moday 5 April, 2010.

On Tuesday 6 April, 2010, The clinic opens to see the patients for the whole morning, and patients' information will be typed up into computor as Word file then send to both partners in Boston and Phnom Penh.
On Wednesday 7 April, 2010, the activity is the same as on Tuesday
On Thursday 8 April, 2010, download all the answers replied from partners then the treatment plan will be made accordingly and distribute medication to the patients in the afternoon.
On Friday 9 April, 2010, draw blood from patients for lab tests at SHCH then come back to Phnom Penh.

Thanks you very much for your cooperation and support in this project.

Best regards,
Sovann

**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 5:51 PM
**Subject:** Robib Telemedicine Clinic April 2010, Khorn Davy, 20F (Backdaong Village)

Dear all,

There are 15 new cases and 1 follow up case which will be sent to you for Robib Telemedicine April 2010.

Case number 1 (follow up), Khorn Davy, 20F and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

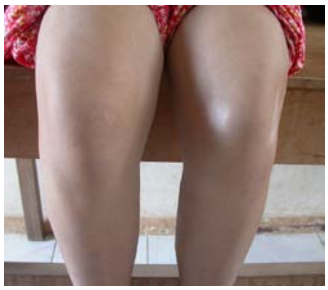
## Sihanouk Hospital Center of HOPE and Partners in Telemedicine

### Rovieng Commune, Preah Vihear Province, Cambodia

*SOAP Note*

**Name/Age/Sex/Village: Khorn Davy, 20F (Backdoang Village)**

**Subjective:** 20F come to follow up of arthritis? Because she presented with symptoms of pain, warmth, stiffness on lower back joint, shoulder, elbow, wrist, knee and ankle without swelling, erythema, deformity. The pain and stiff is worse in morning and better in afternoon and frequently on left knee and both shoulder. She had x-ray of joint done in the previous time but it is too old and can't be interpreted so she was advised to have other CXR and knee x-ray done in Kg Thom referral hospital. The left knee x-ray showed distal femoral fracture and asking further previous history, her father said she had felled down from the house (2m height) when she was 3 years old but denied of fracture symptoms (swelling, echymosis, pain, deformity) and she presented with joint problem until she was 15 years old.



On March 8, 2010, she was brought to consult in Khmer-Russian Friendship hospital in Phnom Penh and got treatment with Esomeprazole 40mg 1t po bid, Diclofenac 50mg 1t po bid, Paracetamol + Codein 500/8mg 1t tid and Amitryptylin 25mg 1t po qhs. She said her joint problem became better with these medications.

**Allergies:** NKDA

**Objective:**

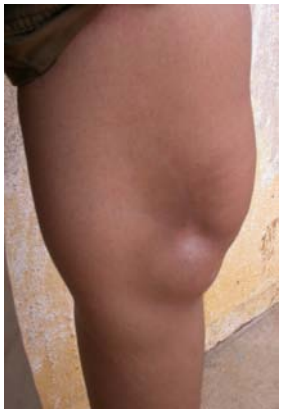
**VS: BP: 120/83 P: 110 R: 20 T: 37 Wt: 46kg**

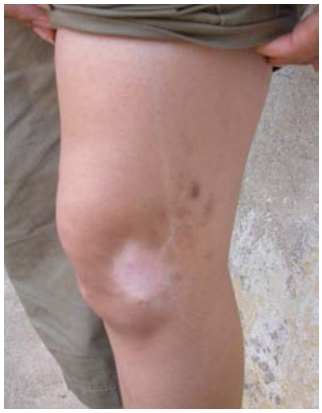
**PE (focused):**
**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM



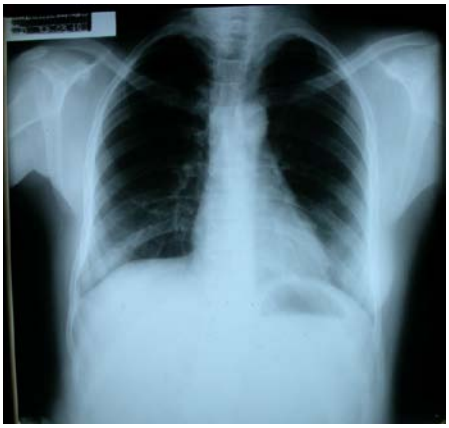


**Extremity/Skin:** All joints are normal, crepitus, no erythema, no swelling, no stiffness, no

**Lab/study:**

**Lab result on January 8, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =5.2 | [4 - 11x$10^9$/L] | Na | =140 | [135 - 145] |
| RBC | =4.9 | [3.9 - 5.5x$10^{12}$/L] | K | =3.3 | [3.5 - 5.0] |
| Hb | =10.8 | [12.0 - 15.0g/dL] | Cl | =113 | [95 - 110] |
| Ht | =34 | [35 - 47%] | BUN | =1.2 | [0.8 - 3.9] |
| MCV | =70 | [80 - 100fl] | Creat | =70 | [44 - 80] |
| MCH | =22 | [25 - 35pg] | Gluc | =6.1 | [4.2 - 6.4] |
| MHCH | =32 | [30 - 37%] | Uric acid | =254 | [140 – 340] |
| Plt | =338 | [150 - 450x$10^9$/L] | RF | = negative | |
| Lym | =1.7 | [1.0 - 4.0x$10^9$/L] | | | |



**On 22 March 2010**

CXR

Left knee x-ray (AP and Lateral): show fracture line on distal femoral

**Assessment:**

1. Traumatic arthritis?
2. Left distal femoral neck fracture?

**Plan:**

1. Paracetamol 500mg 1t po qid prn pain
2. Naproxen 220mg 1t po bid prn severe pain
3. Refer to SHCH for further evaluation of other joints (which is having pain) and possible femoral fracture reconstruction

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 1, 2010**

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

From: <rithychau@sihosp.org>
To: "Robib Telemedicine" <robibtelemed@gmail.com>
Cc: "Cornelia Haener" <corneliahaener@sihosp.org>
Sent: Thursday, April 01, 2010 5:36 PM
Subject: Re: Follow up case, Khorn Davy, 20F (Bakdoang Village)

Dear Sovann,

I will let Dr Cornelia reply to this. The x-ray clearly shows a fracture and whether reconstruction is possible or not, I am sure the surgeon will reply you on this.

Rithy

**From:** Cornelia Haener
**To:** 'Robib Telemedicine' ; 'Rithy Chau'
**Sent:** Friday, April 02, 2010 5:33 PM
**Subject:** RE: Follow up case, Khorn Davy, 20F (Bakdoang Village)

Dear Sovann and Rithy,

It sounds like a case of polyarthritis. Looking at her face and looking at her knee X-ray, she looks like Cushing syndrome due to steroids. The X-ray shows severe osteoporosis and most likely a new pathological fracture. It would be best to refer her to us, and I hope the medical department will receive her as well for her polyarthritis.
Please send the case to Dr. Kruy as well to keep her informed.

Kind regards
Cornelia

**From:** Lim kruy
**To:** Robib Telemedicine
**Cc:** Cornelia Haener ; Rithy Chau
**Sent:** Wednesday, April 07, 2010 8:01 AM
**Subject:** Re: Please help to give recommendation on this patient, Khorn Davy, 20F

Dear Rithy, Sovann and Cornelia,

Thanks, I do not this is related to MD, of course I had other question to confirm the RA DDX.

We need to fix her fracture, if really need us then I will see her at SHCH.

Attach is file for other question related

Thanks a lot

Kruy

**From:** Cusick, Paul S.,M.D.
**To:** Fiamma, Kathleen M. ; robibtelemed@gmail.com
**Cc:** rithychau@sihosp.org
**Sent:** Thursday, April 08, 2010 2:55 AM
**Subject:** RE: Robib Telemedicine Clinic April 2010, Khorn Davy, 20F (Backdaong Village)

Thank you for your consultation.

I asked one of my orthopedic consultants about the knee fracture/pain and this was his reply....

Actually, this type of fracture is very concerning to me for representing a possible pathologic fracture. Transverse fractures, especially in young adults, are exceedingly rare without some kind of stress riser such as a tumor, infection, or previous fracture/non-union. I would assume that MRI is not an option, nor is CT. Only other option is an open biopsy. If she is 20 years old now, this particular fracture couldn't have happened at 3 y.o. Pieces don't add up…

Therefore, she should seek orthopedic consultatation at a regional hospital for her knee.

In terms of the other joint pains, she could have seronegative rheumatoid arthritis or other forms of inflammatory arthritis.
While the current treatment is controlling her pain, we still do not have a diagnosis and would stronly suggest that a rheumatological consultation in the regional hospital would be helpful.

Thanks again,

Paul Cusick MD

From: rithychau@sihosp.org [mailto:rithychau@sihosp.org]
Sent: Thursday, April 08, 2010 5:24 AM
To: Cusick, Paul S.,M.D.
Cc: Fiamma, Kathleen M.; robibtelemed@gmail.com; kruylim@sihosp.org
Subject: RE: Robib Telemedicine Clinic April 2010, Khorn Davy, 20F (Backdaong Village)

Dear Dr Paul,

Thanks for your reply.

Actually, the patient told us when we probed more into this fracture and she said that she had a motorbike falling on top of her left leg (where fx seen) about 2-3 months ago because she could not hold on to the bike when she was trying to get on it to ride. She did remember to tell us because she thought it was a minor thing. This may explain the fx and became more clear that it was a traumatic fx , not a pathological fx. Do you agree?

Rithy/Sovann

From: "Cusick, Paul S.,M.D." <PCUSICK@PARTNERS.ORG>
To: <rithychau@sihosp.org>
Cc: "Fiamma, Kathleen M." <KFIAMMA@PARTNERS.ORG>; <robibtelemed@gmail.com>; <kruylim@sihosp.org>
Sent: Thursday, April 08, 2010 8:19 PM
Subject: RE: Robib Telemedicine Clinic April 2010, Khorn Davy, 20F (Backdaong Village)

This is helpful as this makes a pathological fracture less likely. She still needs orthopedic consultation for her knee fracture and rhuematological consultation for her inflammatory polyarthritis.

Paul

**From:** Robib Telemedicine
**To:** Cornelia Haener ; Kruy Lim ; Rithy Chau ; Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Joseph Kvedar
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 5:56 PM
**Subject:** Robib TM Clinic April 2010, Case#2, Chan Top, 49F (Thkeng Village)

Dear all,

This is case number 2, Chan Top, 49F and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

## Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Chan Top, 49F (Thkeng Village)**

**Chief Complaint (CC):** RUQ pain x 10 months

**History of Present Illness (HPI):** 49F, farmer, presented with symptoms of RUQ pain, stable like, radiate to the scapular and asked local health care worker to see her, told she had Liver problem and treated with IV fluid and other medicine injection (unknown name) for 5 days, she became better, but still presented with mild RUQ pain. She denied of fever, nausea, vomiting, light stool, stool with mucus/blood, yellow eye, oliguria, dysuria, leg edema.

**Past Medical History (PMH):** No history of malaria infection, blood transfusion

**Family History:** None

**SH:** No cig smoking, no alcohol drinking

**Current Medications:**

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals:** **BP: 128/81** **P: 80** **R: 20** **T: 37$^{o}$C** **Wt: 54Kg**

**General:** Stable

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

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

**Abd:** Soft, mild tender on RUQ, hepatomegaly, neg Murphy's sign, no distension, (+) BS, no splenomegaly, no surgical scar, abdominal bruit

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

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

**Lab/study:** None

**Assessment:**

1. Liver abscess?

**Plan:**

1. Send to Kg Thom referral hospital for abdominal U/S

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 5, 2010**

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



**From:** Cornelia Haener
**To:** 'Robib Telemedicine' ; 'Kruy Lim' ; 'Rithy Chau' ; 'Paul J. M.D. Heinzelmann' ; 'Kathy Fiamma >' ; 'Joseph Kvedar'
**Cc:** 'Bernie Krisher' ; 'Sothero Noun' ; 'Laurie & Ed Bachrach'
**Sent:** Tuesday, April 06, 2010 9:37 AM
**Subject:** RE: Robib TM Clinic April 2010, Case#2, Chan Top, 49F (Thkeng Village)

Dear Sovann,

Thanks for submitting this case. As the patient has had symptoms for over ten months, we should include other differential diagnosis like chronic hepatitis or cholecystolithiasis. How is the pain characterized? Colicky and related to food intake or dull constant pain.

It is certainly important to send her for an ultrasound to Kg Thom.

Regards
Cornelia

From: Crocker, J.Benjamin,M.D.
Sent: Monday, April 05, 2010 12:00 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic April 2010, Case#2, Chan Top, 49F (Thkeng Village)

Hello,

agree with need for ultrasound imaging -- want to rule out gallstones, cholecystitis, tumor. Would also request labs -- Is there any way to get hepatitis screening (for Hep B and C)? I can't tell from picture but her conjunctiva do not appear pink, would check liver enzymes if possible (eval for hyperbilirubinemia and get a sense of her underlying liver synthetic function). Can you give any more history as to when she develops RUQ pain, and what the aggravating/excacerbating and relieving factors are (ie, does food make it better or worse? how often after eating does pain come? How big is her hepatomegaly (can you measure it by palpation or percussion)? Is there a history of weight loss? Anyone else in her household with liver disease, jaundice, hepatitis?

All the best,
J. Benjamin Crocker, MD

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**From:** Robib Telemedicine
**To:** Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Joseph Kvedar ; Kruy Lim ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 5:58 PM
**Subject:** Robib Telemedicine Clinic April 2010, Case#3, Nong Khon, 59F (Thkeng Village)

Dear all,

This is case number 3, Nong Khon, 59F and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Nong Khon, 59F (Thkeng Village)**

**Chief Complaint (CC):** Fatigue x 1y

**History of Present Illness (HPI):** 59F, farmer, presented with symptoms of fatigue, dizziness, palpitation, and diaphoresis. She went to local health center, BP checked 170/? and told she had HTN and asked to buy Antihypertensive medicine from local pharmacy. She bought and took Chinese Antihypertensive 1t po qd and she became better but the symptoms still presented for sometimes why she come to consult with Telemedicine. She denied of cough, SOB, oliguria, dysuria, edema.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** No cig smoking, no alcohol drinking

**Current Medications:**

1. Chinese Antihypertensive 1t po qd

**Allergies:** NKDA

**Review of Systems (ROS):** Epigastric pain, burning sensation, radiate to the back, the pain frequently occurs after full eating, no burping, no stool with mucus/blood

**PE:**

**Vitals: BP: 157/112 (both arms) P: 76 R: 22 T: 36.5$^{o}$C Wt: 46Kg**

**General:** Stable

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

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

**Abd:** Soft, no tender, no distention, (+) BS, no HSM, no surgical scar

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

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

**Lab/study:**
**On April 5, 2010**
U/A: normal
BS: 97mg/dl

**Assessment:**

1. HTN
2. Dyspepsia

**Plan:**

1. HCTZ 50mg 1/2t po qd
2. Ranitidine 150mg 1t po qhs for one month
3. Mebendazole 100mg 5t po qhs once
4. Eat low salt diet, do regular exercise
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 5, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Cc:** Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Joseph Kvedar ; Kruy Lim ; Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Tuesday, April 06, 2010 3:52 PM
**Subject:** Re: Robib Telemedicine Clinic April 2010, Case#3, Nong Khon, 59F (Thkeng Village)

Dear Sovann,

I agree with your plan.

Rithy

**From:** Tan, Heng Soon,M.D.
**Sent:** Monday, April 05, 2010 5:23 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib Telemedicine Clinic April 2010, Case#3, Nong Khon, 59F (Thkeng Village)

Post prandial dyspepsia is an older person is more worrisome. Chronic dyspepsia could suggest H. pylori gastritis. Dyspepsia with pain radiating to back may be associated with chronic H. pylori peptic ulcer disease, gastric cancer in an older person, pancreatitis complicating peptic ulcer disease or pancreatic cancer. Weight loss would be concerning for a more serious diagnosis. Gall stones remain a possibility especially if fatty meals precipitate epigastric pain. The history is not quite typical for gastroesophageal reflux. I would check serology for H. pylori, liver and pancreatic enzymes. Ultrasound of liver would exclude gallstones. Ideally an UGI endoscopy to confirm the diagnosis should be done before starting treatment, but under the present conditions, you are left with empiric therapeutic trial. I would treat for presumptive H. pylori with amoxicillin 500 mg bid, metronidazole 500 mg bid and omeprazole 20 mg bid for 2 weeks. If she is not better, I recommend UGI endoscopy or barium series.

Fatigue, dizziness, diaphoresis may reflect menopausal state. When was her last period? Did symptoms begin around time of menopause?

So she has hypertension perhaps even accelerated hypertension with a reading of 157/112. Fatigue, dizziness, palpitations occur in accelerated hypertension with progressive high elevation of blood pressure that may lead to headaches, lightheadedness, blurred vision, nausea, palpitations, chest pain, ankle edema of malignant hypertension. Do we know the time sequence of onset and progresson of her symptoms and whether it is correlated with her elevated blood pressure? In assessing severe hypertension, assess target organs as well: check fundus for papilledema, vessel narrowing, retinal exudates, EKG and CXR for LVH, urine for proteinuria or cells, palpate abdominal aorta for aneurysm, check pulses and bruits in carotids and feet for peripheral vascular disease, neuro exam to exclude previous stroke. Electrolytes, renal function tests and urine microscopy would be useful. A low potassium may suggest renal artery stenosis as cause of

hypertension. In that situation, the ratio of aldosterone and renin could be diagnostic. At her age, it is less likely for us to consider pheochromocytoma as cause of hypertension and symptoms. HCTZ would not be sufficient to treat this degree of hypertension. She should start on captopril 50 mg bid and titrate up to 100 mg tid if necessary.

If she had erosive gastritis, peptic ulcer disease or malignant gastric ulcer, she may bleed and become anemic. That could also account for fatigue, dizziness, palpitations. CBC and stool guaiac test will rule out that possibility.

General remarks: make more time based observations in the history taking. Example: one year ago, diagnosed with hypertension. Took Chinese medicine for 3 months. Symptoms recurred in past 6 months, etc.

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**From:** Robib Telemedicine
**To:** Rithy Chau ; Kruy Lim ; Kathy Fiamma > ; Joseph Kvedar ; Paul J. M.D. Heinzelmann
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 5:59 PM
**Subject:** Robib Telemdicine Clinic April 2010, Prum Tong, 48M (Thnout Malou Village)

Dear all,

This is case number 4, Prum Tong, 48M and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
**Rovieng Commune, Preah Vihear Province, Cambodia**

## History and Physical

**Name/Age/Sex/Village:** **Prum Tong, 48M (Thnout Malou Village)**

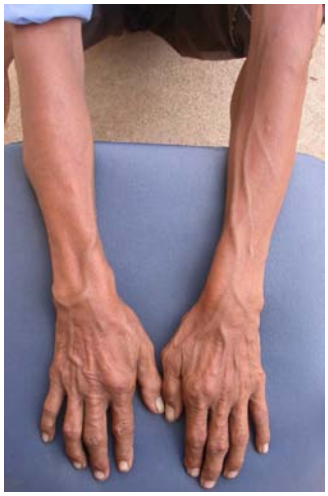
**Chief Complaint (CC):** Joint pain x 10y

**History of Present Illness (HPI):** 48M, farmer, presented with symptoms of pain, swelling, warmth, stiffness of joint. The symptoms first presented on toe then developed to ankle, knee, elbow, wrist, and finger joint. He also complained of slurred voice and difficult to breath. He bought medicine from local pharmacy but it helps him with symptoms just for a while. In this year, he noticed the present of nodule on both arms. He has never sought medical consultation. He denied of pain on the back, abdominal problem, oliguria, dysruia, chest pain, fever.

**Past Medical History (PMH):** Unremarkable

**Family History:** Father with arthritis

**SH:** Smoking 5cig/d; drinking alcohol 1/4L/d, stopped 2y



**Current Medications:**

1. Antiinflammatory medicine (unknown name)

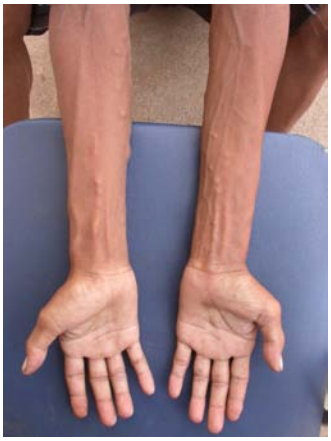
**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 128/83 P: 77 R: 20 T: 37$^{o}$C Wt: 40Kg**

**General:** Stable



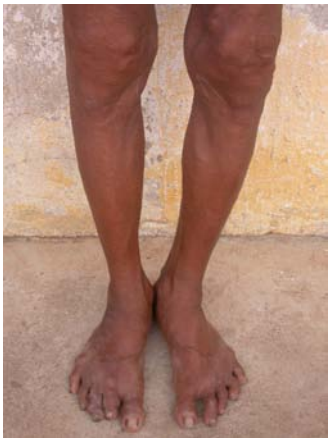
**HEENT:** No oropharyngeal lesion, pink conjunctiva, no thyroid enlargement, no lymph node palpable, no JVD

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Joint exam:** mild tender with joint movement, limited ROM of some joints as finger joint, elbow, ankle and knee, subcutaneous nodule on both arms, no joint swelling, no redness,

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



**Lab/study:** None

**Assessment:**

1. Polyarthritis

**Plan:**

1. Naproxen 220mg 1t po bid
2. Paracetamol 500mg 1t po qid prn
3. Send to Kg Thom referral hospital for x-ray of arm and legs
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc, ESR, RF, Uric acid at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 5, 2010**

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

**From:** Rithy Chau
**To:** Robib Telemedicine
**Cc:** Kruy Lim ; Kathy Fiamma > ; Joseph Kvedar ; Paul J. M.D. Heinzelmann ; Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Tuesday, April 06, 2010 4:05 PM
**Subject:** Re: Robib Telemdicine Clinic April 2010, Prum Tong, 48M (Thnout Malou Village)

Dear Sovann,

Can you describe his slurred speech abit more--when, where, how it happened? aggravating/alleviating factors...etc.? Same goes for his SOB. The joint pain and subcutaneous lesions H&P are not thorough enough for me to give clear feedback. I will call to discuss about this case later with you.

Rithy

**From:** Cohen, George L.,M.D.
**Sent:** Monday, April 05, 2010 4:36 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib Telemdicine Clinic April 2010, Case #4 Prum Tong, 48M (Thnout Malou Village)

I reviewed the report and photographs.

This 48 year old man has involvement of many joints. The photographs of his extremities are suggestive of inflammatory joint disease such as rheumatoid arthritis or psoriatic arthritis.The tests ordered are appropriate and may be helpful.
The nodules are numerous and appear on the extensor surface of the forearms, hands, feet and elsewhere. These are not rheumatoid nodules or tophi. I don't know what they represent. Depending on how long they have been present, these could be associated with hyperlipidemia, neurofibromatosis, etc. A biopsy would be simple and very interesting. X-rays of the hands and feet are recommended and are being done.
For now, I would continue naproxen, but double the dose to 2-220 mg tablets twice a day. Please let us know when additional information is available.

George L. Cohen, M.D.

---

**From:** Robib Telemedicine
**To:** Joseph Kvedar ; Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Kruy Lim ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:01 PM
**Subject:** Robib TM Clinic April 2010, Case#5, Prum Yet, 46F (Bos Village)

Dear all,

This is case number 5, Prum Yet, 46F and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village: Prum Yet, 46F (Bos Village)**

**Chief Complaint (CC):** Fatigue and palpitation x 6 months

**History of Present Illness (HPI):** 46F, farmer, presented with symptoms of fatigue, polyphagia, palpitation, tremor, insomnia, and weight loss, she bought medicine from local pharmacy but her symptoms seems not better. In the past two weeks, she went to private clinic in Kg Thom province and told she had GI problem and treated her with Lansoprazole and other two medicine (unknown name) but she still presented with above symptoms so she come to consult with Telemedicine. She denied of cough, SOB, chest pain, nausea, vomiting, stool with blood/mucus, oliguria, dysruia, edema.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** Chewing tobacco, no alcohol drinking

**Current Medications:**

1. Lansoprazole 1t po qd
2. Other two medicine (unknown name)

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 132/84 P: 104 R: 20 T: 37$^{o}$C Wt: 46Kg**

**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Extremity/Skin:** Hand tremor, no rashes, no lesion

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

**Lab/study:**
**On April 5, 2010**
FBS: 159mg/dl

**Assessment:**

1. Hyperglycemia
2. Thyroid dysfunction

**Plan:**

1. Recheck FBS tomorrow
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc, TSH, Free T4 at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 5, 2010**

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



**From:** Barbesino, Giuseppe,M.D.
**To:** Fiamma, Kathleen M.
**Cc:** rithychau@sihosp.org ; robibtelemed@gmail.com
**Sent:** Tuesday, April 06, 2010 1:48 AM
**Subject:** RE: Robib TM Clinic April 2010, Case#5, Prum Yet, 46F (Bos Village)

The presentation of this case is suggestive of hyperthyroidism (tachycardia and tremor, weight loss). The reported duration of her symptoms (six months), if accurate, allows to rule-out all transient forms of hyperthyroidism. So in case her thyroid function tests confirmed hyperthyroidism, then Grave's disease would be the likely diagnosis and patient could be treated with either radioactive iodine (if available), or methimazole/carbimazole. I typically counsel my patients on methimazole that they can have a rash or joint pains or bad taste with the medication (10% or so). They can also develop agranulocytosis (1/200 to 1/400). To prevent ongoing agranulocytosis I advise patients to stop the medication, call and get CBC with any high fever and symptoms of infection (faringodynia, mouth ulcers) in the oral region or anywhere else.

Giuseppe Barbesino, MD
Thyroid Associates
Massachusetts General Hospital
Harvard Medical School
Wang ACC 730S
15 Parkman Street-Boston MA 02114
Tel 617-726-7573

**From:** Rithy Chau
**To:** Robib Telemedicine
**Cc:** Joseph Kvedar ; Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Kruy Lim ; Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Tuesday, April 06, 2010 4:14 PM
**Subject:** Re: Robib TM Clinic April 2010, Case#5, Prum Yet, 46F (Bos Village)

Dear Sovann,

Yes I agree with your assessment. If her FBS is still high, start her on Metformin and check her HbA1C as well. If she is diagnosed with DM II and her SBP is above 120 or +proteinuria, then start low dose captopril also.

Rithy

---

**From:** Robib Telemedicine
**To:** Kruy Lim ; Rithy Chau ; Joseph Kvedar ; Paul J. M.D. Heinzelmann ; Kathy Fiamma >
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:03 PM
**Subject:** Robib TM Clinic April 2010, Case#6, Be Samphorn, 73M (Rovieng Cheung Village)

Dear all,

This is case number 6, Be Samphorn, 73M and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village: Be Samphorn, 73M (Rovieng Cheung Village)**

**Chief Complaint (CC):** Palpitation x 10y

**History of Present Illness (HPI):** 73M, retired teacher, presenting with symptoms of heart beating so fast and strong, dizziness and HA, neck tension, BP checked 170/? and told he had HTN and treated with Antihypertensive (unknown name). He took it only when he presented with above symptoms. In the past two years, he presented with above symptoms even he took Antihypertensive so he went to private clinic in Kg Thom province and told he had HTN and should take Antihypertensive regularly not when symptoms presented and prescribe him Amlodipine 5mg 1/2t qd.
In these few months, he presented with symptoms of fatigue, polydypsia, pholyphagia, polyuria, so he come to consult with Telemedicine clinic.

**Past Medical History (PMH):** Unremarkable

**Family History:** None
**SH:** Smoking 20cig/d, casually alcohol drinking, stop both for 10y

**Current Medications:**

1. Amlodipine 5mg 1/2t po qd

**Allergies:** NKDA

**Review of Systems (ROS):** No fever, no cough, no SOB, no Chest pain, no abdominal problem, no edema, no oliguria, no dysuria

**PE:**

**Vitals: BP: 137/81 P: 68 R: 20 T: 36.5$^{o}$C Wt: 67Kg**

**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM, no abdominal bruit

**Extremity/Skin:** No edema, no lesion, no foot wound, (+) dorsalis pedis and posterior tibial pulse

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

**Lab/study:**
**On April 3, 2010**
U/A: protein trace, gluc 2+
RBS: 180mg/dl

**Assessment:**

1. HTN
2. DMII

**Plan:**

1. Amlodipine 5mg 1/2t po qd
2. Metformin 500mg 1t po bid
3. Rechecked FBS tomorrow
4. Educate on diabetic diet, Do regular exercise and eat low salt diet, and foot care
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Tot chole, TG and HbA1C at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 3, 2010**

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

**From:** Rithy Chau
**To:** Robib Telemedicine
**Sent:** Monday, April 05, 2010 12:15 PM
**Subject:** Re: Case Be Samphorn, 73M (Rovieng Cheung Village)

Dear Sovann,

I agree.
Rithy

**From:** Tan, Heng Soon,M.D.
**Sent:** Tuesday, April 06, 2010 1:23 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib TM Clinic April 2010, Case#6, Be Samphorn, 73M (Rovieng Cheung Village)

He has 3 problems: palpitations, hypertension and diabetes mellitus.

Heart beating fast and strong indicate a tachyarrhythmia. He felt dizzy with headaches but no syncope, so ventricular arrhythmia is unlikely. Palpitations occurred in spells consistent with paroxysmal tachycardia over a 10 year period. Paroxysmal supraventricular tachycardia [PSVT] is likely if the palpitations were fast and regular, paroxysmal atrial fibrillation is likely if palpitations were irregular. Patient should be asked to clarify and confirm if the tachycardia was regular or irregular [skipped beats, irregular rhythm]. He could be taught valvsalva maneuver to break paroxysmal supraventricular tachycardia since that maneuver could confirm the diagnosis. A resting EKG could show EKG changes of pre excitation if delta waves and short PR interval shorter than 12 milliseconds is present. This condition is associated with PSVT. If EKG is normal, then a portable EKG recording would be the only other way to determine the nature of the palpitations.

His hypertension **137/81** appears relatively well controlled on low dose amlodipine 2.5 mg daily. However if he had PSVT, a beta blocker may not only treat hypertension, but could prevent PSVT or slow down the ventricular response. So metoprolol 50 mg bid could be considered instead of amlodipine. On the other hand with diabetes mellitus, lisinopril [ACE inhibitor] would be a good choice for blood pressure control because it protects the diabetic kidney. He would benefit from low doses of both medicines if blood pressure is easily controlled.

Diabetic diet, exercise and metformin therapy are good starts to manage diabetes. I agree with blood sugar, lipids and A1c.

Heng Soon Tan, MD

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From: **Robib Telemedicine**
Date: Mon, Apr 5, 2010 at 6:04 PM
Subject: Robib TM Clinic April 2010, Chum Chet, 63M (Koh Pon Village)
To: "Kathy Fiamma >"; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kruy Lim; Rithy Chau
Cc: Bernie Krisher; Sothero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 7, Chum Chet, 63M and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village: Chum Chet, 63M (Koh Pon Village)**

**Chief Complaint (CC):** Joint pain x 9y

**History of Present Illness (HPI):** 63M, farmer, presented with symptoms of pain, warmth, swelling, and morning stiff of both ankles, he got treatment with traditional medicine and pain killer from local pharmacy, which help him for a while. The symptoms of ankle joint attack recurred in a few months. In the last year, he presented with pain, warmth, swelling, and stiffness on both knees and this year with shoulders pain but no swelling, no stiffness. He denied of other joints attack as fingers, toes joint, wrist, elbow, back. In the last week, he presented with knee swelling, pain, warm and stiffness, so he bought Diclofenac 50mg and Paracetamol 500mg 1t bid then his condition became better now.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** Smoking 10cig/d, casually alcohol drinking

**Current Medications:**

1. Diclofenac 50mg 1t po bid
2. Paracetamol 500mg 1t po bid

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 175/99 (both arms) P: 103 R: 20 T: 37$^{o}$C Wt: 50Kg**

**General:** walking with stick due to joint pain

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Joint exam:** Ankle and Knee joint, warmth, slightly swelling, no stiffness, full ROM except left knee, full extension unless with passive movement, mild pain; other joint intact

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

**Lab/study:**
**On April 4, 2010**
U/A protein trace

**Assessment:**

1. Osteoarthritis?
2. HTN

**Plan:**

1. Naproxen 220mg 1t po bid prn pain
2. Atenolol 25mg 1t po qd
3. Do X-ray of ankle and knee at Kg Thom referral hospital
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc, ESR at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 4, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Sent:** Monday, April 05, 2010 12:03 PM
**Subject:** Re: Case Chum Chet, 63M (Koh Pon Village)

Dear Sovann,

I agree with your assessment. Can you do a colochaeck because he looks a bit pale from the photo and tx if positive.

Rithy

**From:** Cohen, George L.,M.D.
**Sent:** Monday, April 05, 2010 8:59 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib TM Clinic April 2010, Chum Chet, 63M (Koh Pon Village)

This gentleman had inflammation of both ankles that improved and then recurred. He later developed pain and swelling in both knees. He also had shoulder pain. Small joints of the hands or feet were not involved. In the past week, one or both knees had recurrent pain and swelling. On examination, there was pain and ? decreased motion of the left knee.

Osteoarthritis of the knees is very common but osteoarthritis infrequently involves ankles and shoulders. If the episodes are acute and are associated with swollen warm joints, this could be gout or a similar condition known as pseudogout. Another possibility is inflammatory joint disease such as rheumatoid arthritis.

Lab studies that could be helpful are ESR, uric acid, rheumatoid factor. X-rays of the knees are being done. Would recommend adding a chest x-ray. Sarcoid arthritis may present as painful swelling of the ankles and elsewhere and chest x-ray would show hilar lymphadenopathy.

Tretament with an NSAID such as naproxen sodium 2-220 mg tablets twice a day is appropriate. Please let us know the results of any x-rays and tests and how he does.

George L. Cohen, M.D.

---

From: **Robib Telemedicine**
Date: Mon, Apr 5, 2010 at 6:06 PM
Subject: Robib TM Clinic April 2010, Case#8, In Ly, 65M (Chan Lorng Village)
To: "Kathy Fiamma >"; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Rithy Chau; Kruy Lim
Cc: Bernie Krisher; Sothero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 8, In Ly, 65M and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village: In Ly, 65M (Chan Lorng Village)**

**Chief Complaint (CC):** SOB x 3y

**History of Present Illness (HPI):** 65M, farmer, with previous remote history of PTB and got complete treatment. In the past three years, he presented with symptoms of fever, cough and SOB with wheezing sound on breathing so he got treatment with traditional medicine and Aminophylin injection, which make him better. He got attacked of above symptoms 4 to 5 times per years. His condition is better now because he just got treatment with Aminophylin injection in the past four days.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** Smoking 10cig/d, no alcohol drinking

**Current Medications:** Aminophylin injection in the past four days

**Allergies:** NKDA

**Review of Systems (ROS):** Normal bowel movement, normal urination

**PE:**

**Vitals: BP: 140/82 P: 81 R: 24 T: 37$^{o}$C Wt: 40Kg O2sat: 95%**

**General:** Stable, cachexia

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

**Chest:** Bilateral wheezing, no rhonchi; H RRR, no murmur

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

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

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

**Lab/study:** None

**Assessment:**

1. Asthma
2. Cachexia

**Plan:**

1. Salbutamol Inhaler 2 puffs bid
2. MTV 1t po qd
3. Do CXR at Kg Thom referral hospital
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 4, 2010**

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

**From:** Rithy Chau
**To:** Robib Telemedicine
**Sent:** Monday, April 05, 2010 12:08 PM
**Subject:** Re: Case In Ly, 65M (Chan Lorng Village)

Dear Sovann,

I think this man has COPD from his heavy smoking. Tell him to stop or find a way to cut down until stop. I agree with the tx, if he has exacerbation, you can add steroid inhaler as well. Does he have productive cough? If yes, can do AFB smears for him, tx if pos.

Rithy

From: "Cusick, Paul S.,M.D." <PCUSICK@PARTNERS.ORG>
To: "Fiamma, Kathleen M." <KFIAMMA@PARTNERS.ORG>; <robibtelemed@gmail.com>
Cc: <rithychau@sihosp.org>
Sent: Wednesday, April 07, 2010 7:59 AM
Subject: RE: Robib TM Clinic April 2010, Case#8, In Ly, 65M (Chan Lorng Village)

Thank you for the consultation.

His history could be consistent with asthma or emphysema(chronic obstructive disease) from smoking.
It is clear that he is worse in the past few days and improved after the injection with aminophylline. It is not clear why he is worse. It does not sound as if he is having an infection. No symptoms of angina or cardiac ischemia.

His weight loss is concerning as well for a chronic infection or cancer.

I agree with the therapeutic use of sambuterol.

He should be strongly encouraged to quit smoking.

A chest xray and blood studies are appropriate.

Best of luck.

Paul Cusick MD

---

**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:08 PM
**Subject:** Robib TM Clinic April 2010, Ke Sim, 77M (Thnout Malou Village)

Dear all,

This is case number 9, Ke Sim, 77M and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village: Ke Sim, 77M (Thnout Malou Village)**

**Chief Complaint (CC):** Dizziness x 1y

**History of Present Illness (HPI):** 77M, farmer, presented with symptoms of dizziness, HA, neck tension, and palpitation, he took traditional medicine without seeking medical care but it did not help him. The dizziness frequently occurred on exertion (walking or working for a while) then he sat down for a while to prevent fell down. He denied of fever, cough, SOB, chest pain, abdominal problem, oliguria, dysuria, edema.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** Smoking 5cig/d; casually alcohol drinking, stop for 10y

**Current Medications:** Traditional medicine

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: Lt: 156/82 Rt: 160/84 P: 60 R: 20 T: 37$^{o}$C Wt: 44Kg**

**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM, no abdominal bruit

**Extremity/Skin:** No edema, no lesion, (+) dorsalis pedis and posterior tibial pulse

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

**Lab/study:**
**On April 3, 2010**
U/A: normal

**Assessment:**

1. HTN

**Plan:**

1. HCTZ 50mg 1/2t po qd
2. Do regular exercise and eat low salt diet
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 3, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Sent:** Monday, April 05, 2010 12:13 PM
**Subject:** Re: Ke Sim, 77M (Thnout Malou Village)

Dear Sovann,

I agree with your assessment. Also ask him to stop smoking.

Rithy

**From:** Smulders-Meyer, Olga,M.D.
**To:** Fiamma, Kathleen M. ; rithychau@sihosp.org
**Cc:** robibtelemed@gmail.com
**Sent:** Wednesday, April 07, 2010 3:45 AM
**Subject:** RE: Robib TM Clinic April 2010, Ke Sim, 77M (Thnout Malou Village)

**Dear Sovann Peng,**

**I agree with your impression that it is his elevated blood pressure that might be causing his symptoms of dizziness, and I agree with starting a low dose diuretic and advising him to eat a low salt diet to improve his BP. he should be followed every few weeks for a BP check.**

**Also he is 77 years old and he has a history of smoking, as well as HTN and so you do need to keep in mind that he is at great risk and may well have significant coronary artery disease, so he would benefit from taking at least 81 mg of Aspirin a day. He is very light, only 44 kilos so that might be an adequate dose for him. If you have a chance it might be a good idea to check an EKG and see if he has had an MI in the past and if there are any changes in the EKG that suggest long standing hypertension. If that is the case you may want to switch to an Ace inhibitor such as Lisinopril which can be taken on a daily basis, to decrease the after load and improve the function of the heart.**

**I would also check a CBC to make sure he is not anemic which could also mimic this feeling of lightheadedness. I agree with checking a fasting glucose to rule out Diabetes.**

**Hope this was helpful.**

**Warm regards,**

**Olga Smulders- Meyer MD**

---

**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:09 PM
**Subject:** Robib TM Clinic April 2010, Kim Choeun, 45F (Thkeng Village)

Dear all,

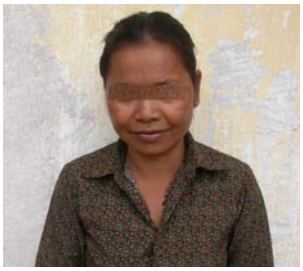
This is case number 10, Kim Choeun, 45F and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical



**Name/Age/Sex/Village: Kim Choeun, 45F (Thkeng Village)**

**Chief Complaint (CC):** Foot wound x 20d

**History of Present Illness (HPI):** 45F, farmer, was bitten by dog of her neighbor on the ankle area. She went to local health center and treated with Ampicillin 500mg 1t pot id and Paracetamol 500mg 1t pot id and asked her to cleaned wound by her own at home. The wound on lateral site of ankle heal well but the one on anterior ankle became infected with pus drainage, pain so she came to consult with Telemedicine clinic. She has normal appetite, normal bowel movement, normal urination.

**Past Medical History (PMH):** Unremarkable

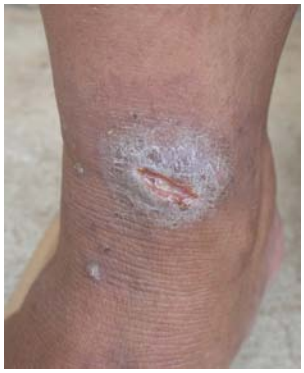
**Family History:** None

**SH:** Casually alcohol drinking, no cig smoking, 7 children

**Current Medications:**

1. Ampicillin 500mg 1t po tid

2. Paracetamol 500mg 1t po tid



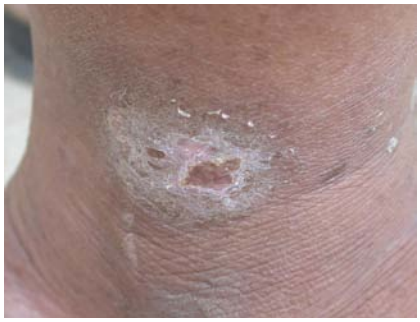
**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 96/60 P: 66 R: 20 T: 37$^{o}$C Wt: 60Kg**

**General:** Stable



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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Right ankle:** Wound on anterior of ankle about 2cm, pus inside and crust around the edge; lateral ankle wound completely healed with some crust, (+) dorsalis pedis and posterior tibial pulse

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

**Lab/study:** None

**Assessment:**

1. Infected wound on right ankle

**Plan:**

1. Cloxacillin 500mg 1t po tid x 5d
2. Naproxen 220mg 1t po bid x 5d
3. Clean wound every day with NSS and dressing with concentrated sugar solution

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 3, 2010**

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



**From:** Cornelia Haener
**To:** 'Robib Telemedicine' ; 'Rithy Chau'

**Sent:** Monday, April 05, 2010 8:45 AM
**Subject:** RE: Case Kim Choeun, 45F (Thkeng Village)

Dear Sovann,
Thanks for submitting this case. Unfortunately, I did not get the email before leaving my office on Friday, and I have no internet at home anymore.
I agree with cleaning of the wound and sugar pack, but would like to suggest Augmentin as treatment for five days according to recommendations from our ITM advisor.

Kind regards
Cornelia

**From:** Sheridan, Robert L., Burn Unit
**Sent:** Tuesday, April 06, 2010 3:29 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib TM Clinic April 2010, Kim Choeun, 45F (Thkeng Village)

I guess I'd just clean it with soap and water daily and apply a bland antibiotic ointment and hope it would heal in a couple of weeks.

Rob Sheridan, MD

---

**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:12 PM
**Subject:** Robib TM Clinic April 2010, Phim Sam An, 27F (Ta Tong Village)

Dear all,

This is case number 11, Phim Sam An, 27F and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
Rovieng Commune, Preah Vihear Province, Cambodia

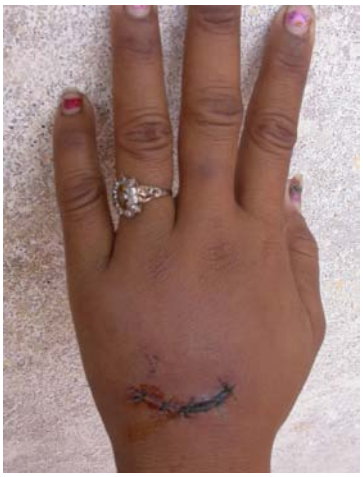
## History and Physical

**Name/Age/Sex/Village:** **Phim Sam An, 27F (Ta Tong Village)**

**Chief Complaint (CC):** Wound on left hand x 4d

**History of Present Illness (HPI):** 27F, housewife, presented with laceration on the dorsum of left hand due to motor and car accident. The laceration was about 3cm and was cleaned and sutured with 5 stitches by local health center staff, treated with Amoxicillin 500mg 1t po tid and Paracetamol 500mg 1t po qid. One day after, the sutured laceration became swelling, redness around and pain so she comes to consult with Telemedicine clinic.

**Past Medical History (PMH):** Unremarkable



**Family History:** None

**SH:** No alcohol drinking, no cig smoking, 2 children

**Current Medications:**

1. Amoxicillin 500mg 1t po tid
2. Paracetamol 500mg 1t po tid

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 106/67 P: 78 R: 20 T: 37$^{o}$C Wt: 52Kg**

**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Left hand dorsum:** Lesion about 3cm long, redness around, swelling, tender on palpation, no pus, no drainage, no fluctuation

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

**Lab/study:** None

**Assessment:**

1. Infected lesion on left hand dorsum

**Plan:**

1. Augmentin 875mg 1t po bid x 5d
2. Naproxen 220mg 1t po bid x 5d
3. Clean wound every day with NSS

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 2, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Cc:** Cornelia Haener
**Sent:** Friday, April 02, 2010 4:52 PM
**Subject:** Re: Case Phim Sam An, 27F

Dear Sovann,

As for this patient, I suggest that you remove the suture and let the wound heal openly with thorough cleaning and sterile dressing. If opening the wound, yous see pus, then I would would use glucose concentrate solution to add on the dressing to help expedite the healing of the wound. Amox does not work so well with skin structure infection. Either use Cloxacillin or Augmentin and for NSAID to help reduce swelling and pain as you suggested.

Rithy

**From:** Cornelia Haener
**To:** 'Rithy Chau' ; 'Robib Telemedicine'
**Sent:** Friday, April 02, 2010 5:28 PM
**Subject:** RE: Case Phim Sam An, 27F

Dear Sovann,
I agree with Rithy. She needs AB (cloxacillin) only if she has signs of infection higher up like lymphangitis or enlarged painful axillary lymph nodes. Opening the wound, cleaning and sugar pack or honey pack might be sufficient.

Did she get any tetanus vaccination (toxoid and/ or immunoglobuline)? If not, it would be good to refer her to a health center for that.

Thanks
Cornelia

**From:** Crocker, J.Benjamin,M.D.
**Sent:** Tuesday, April 06, 2010 12:43 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib TM Clinic April 2010, Phim Sam An, 27F (Ta Tong Village)

I agree with assessment, but would avoid over-cleaning with NSS daily -- just let the wound/scab form on its own, and keep the hand clean (but do not soak the area -- this will soften and break up the scab which is a natural protective barrier). It's the swelling/redness, or any sign of pus or drainage from the wound that are more concerning at this point. If she develops fever, chills, further swelling or redness spreading up the wrist or arm, she should seek immediate medical attention for intravenous antibiotics and consideration of surgical exploration of the wound.

J. Benjamin Crocker, MD

**From:** Robib Telemedicine
**To:** Rithy Chau
**Sent:** Thursday, April 01, 2010 4:15 PM
**Subject:** Case Say Phiroth, 10M (Thnal Keng Village)

Dear all,

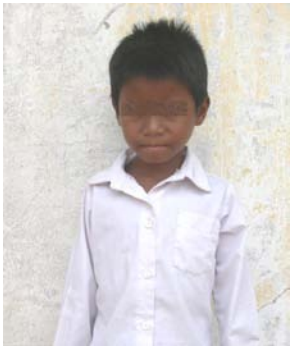
There are one new case and one follow up case for today of Telemedicine April 2010. Say Phiroth, 10M and photo.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical



**Name/Age/Sex/Village:** **Say Phiroth, 10M (Thnal Keng Village)**

**Chief Complaint (CC):** Fever and HA x 1d

**History of Present Illness (HPI):** 10M, 4 grade student, brought to Telemedicine clinic complaining of one day fever, HA. His mother thought he had a cold so she bought medicine (Paracetamol, Amoxicillin and other two kinds of medicines) from local pharmacy for him but the fever seems better only 1 – 2h after taking medicine. The patient also reported of having sore throat when swallowing. The patient and his mother denied of runny nose, nasal congestion, cough, SOB, abdominal pain. Malaria smear result is negative this morning.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**Current Medications:**

1. Paracetamol 500mg 1t po qid
2. Amoxicillin 250mg 1t po bid
3. Other two kinds of medicine (unknown name) 1t each bid

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals:** **BP: 84/40** **P: 113** **R: 26** **T: 38$^{o}$C** **Wt: 17Kg**

**General:** Stable

**HEENT:** One small aphthous ulcer on soft palate next to uvular, redness around; ear exam normal ear lobule, normal ear canal mucosa, no discharge, intact tympanic membrane, no neck lymph node palpable.

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

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

**Lab/study:** None

**Assessment:**

1. Aphthous stomatitis

**Plan:**

1. Paracetamol 250mg 1t po qid prn
2. Naproxen 220mg 1/2t po bid x 5d
3. Drink plenty of water

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 1, 2010**

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



From: <rithychau@sihosp.org>
To: "Robib Telemedicine" <robibtelemed@gmail.com>
Cc: <kruylim@sihosp.org>
Sent: Thursday, April 01, 2010 5:33 PM
Subject: Re: Case Say Phiroth, 10M (Thnal Keng Village)

Dear Sovann,

Thank you for the cases sent today.

For this 10M, I agree with your assessment. Since he was taking Amox already I would let him continue for 5 days but increase to tid instead. You can either give him Para or Naproxen but not both. Naproxen may help with the inflammation and pain better that para. Tell him to drink a lot of water or juice. If he is not better (esp with fever) in 2-3 days, he needs to come back for reevaluation.

I hope this helps.

Rithy

**From:** Robib Telemedicine
**To:** Rithy Chau
**Sent:** Friday, April 02, 2010 4:18 PM
**Subject:** Case Sim Y, 32F

Dear all,

This is case Sim Y, 32F and photos.

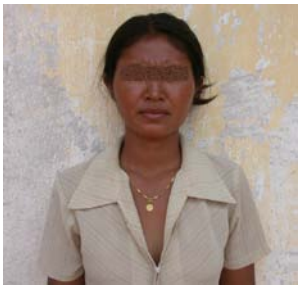
Best regards,
Sovann

# Robib Telemedicine Clinic

## Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical



**Name/Age/Sex/Village:** **Sim Y, 32F (Thkeng Village)**

**Chief Complaint (CC):** Dyspnea on exertion x 3y

**History of Present Illness (HPI):** 32F, farmer, in one month after delivery, she presented with symptoms dyspnea on exertion, dry cough, diaphoresis, and cold extremity and increased salivary secretion. She went to provincial referral hospital and got treatment with a few kinds of medicine (unknown name) for 10 days, then she became a bit better but she said she easily presented with dypnea with daily activity as caring her child, water and do farming. The other symptoms as diaphoresis, cold extremity, increased salivary secretion frequently developed along with dyspnea. She denied of fever, chest pain, abdominal problem, oliguria, dysuria, leg edema.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** Casually alcohol drinking, no cig smoking, 2 children

**Current Medications:** Injective contraceptive

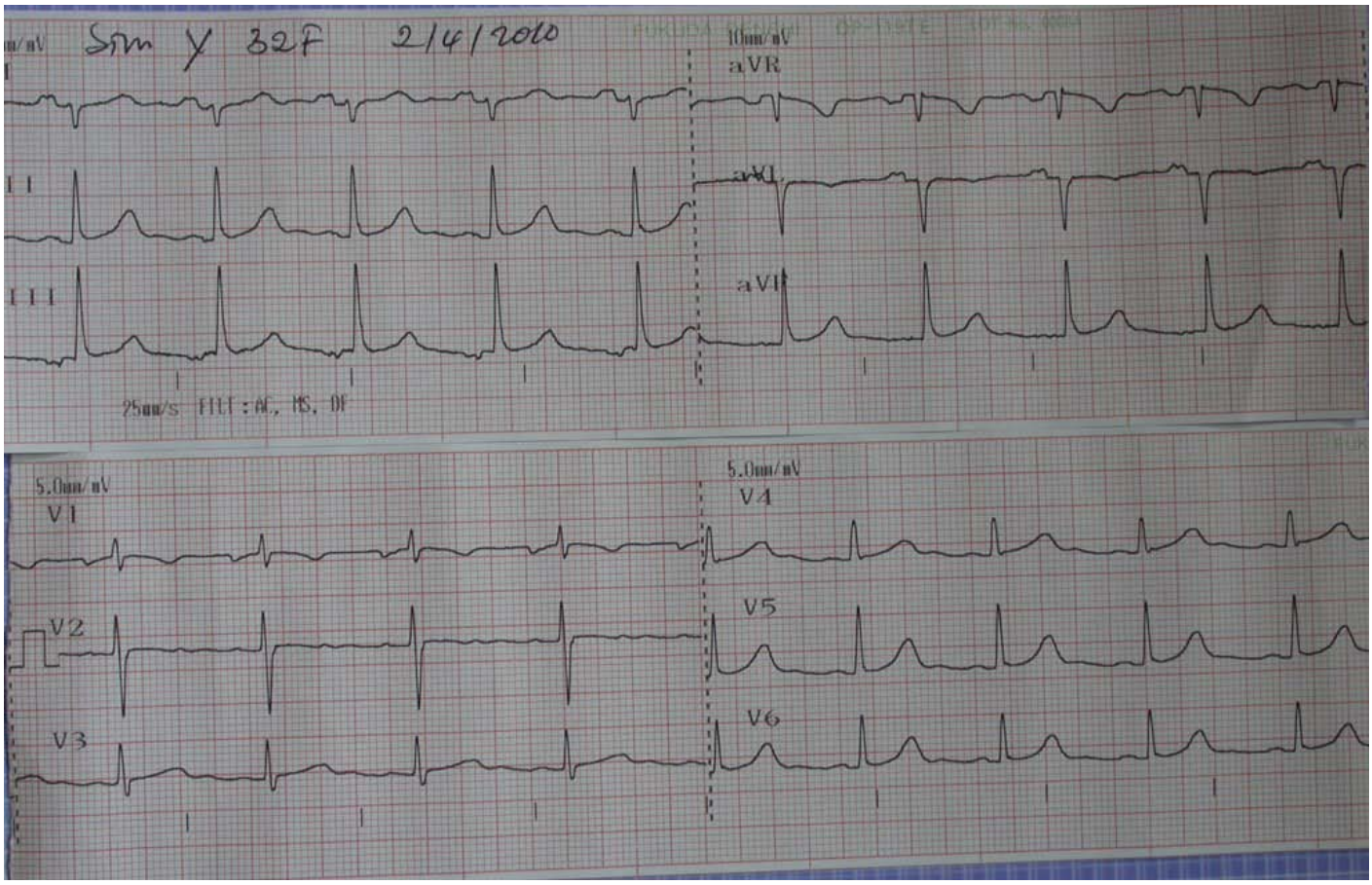
**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals:** **BP: 97/62** **P: 77** **R: 20** **T: 37$^{o}$C** **Wt: 51Kg**

**General:** Stable




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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM, abdominal bruit

**Extremity/Skin:** No edema, no lesion, no rash, + dorsalis pedis and posterior tibial pulse

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

**Lab/study:**
**On April 2, 2010**
EKG attached

**Assessment:**

1. CHF??

**Plan:**

1. Draw blood for CBC, Lyte, BUN, Creat, Gluca and TSH at SHCH
2. Do CXR at Kg Thom referral hospital

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 2, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Sent:** Friday, April 02, 2010 5:03 PM
**Subject:** Re: Case Sim Y, 32F

Dear Sovann,

According to the hx and assessment, this patient does not seem to have CHF or any heart condition, but more likely GERD. See if you can get more history for the GI problem because increased in salivating may be due to reflux acid from her stomach content. Also, you can try to have her walk for about 10 mins and then repeat ECG. If she can afford, a CXR may help to see if any cardiomegaly or not.

Otherwise tx her as GERD. No need for lab test and wait for CXR result.

Rithy

**From:** Smulders-Meyer, Olga,M.D.
**To:** Fiamma, Kathleen M. ; robibtelemed@gmail.com
**Cc:** rithychau@sihosp.org
**Sent:** Wednesday, April 07, 2010 4:55 AM
**Subject:** RE: Robib TM Clinic April 2010, Sim Y, 32F (Thkeng Village)

This is a very puzzling case. I was wondering if she has been working with chemicals in the field, such as organophosphates. This material can cause increased salivation and diaphoresis and also a cough and dyspnea.
Is she taking any other OTC meds? Medications prescribed by other local MDs??

I think you need to start with the basics: Obtain a chest x-ray and make sure she has no infiltrate.
Check a CBC and a TSH to assess her thyroid function.
I doubt that she has CHF because her lungs are clear to auscultation, but we cannot rule out cardiomyopathy and decreased EF. Her EKG shows that she has not had an MI.
If the CXR is normal, consider getting a cardiac ultrasound if the dyspnea seems really real to you.

You need to explore her mental state as well.
I am not so sure about this case, so let me know what the outcome is of your work up.

Warmly,

Olga Smulders-Meyer MD

**From:** Gregory, Shawn A,M.D.
**Sent:** Wednesday, April 07, 2010 4:53 PM
**To:** Smulders-Meyer, Olga,M.D.
**Subject:** RE: Robib TM Clinic April 2010, Sim Y, 32F (Thkeng Village)

Hi Olga,
Sorry for the delay. I would read this one as Right axis deviation and left atrial enlargement. She does have counter clockwise rotatation and all of this might suggest right ventricular hypertrophy. Around these parts, an ECHO would be a good place to go with her.
Things to look for would be mitral stenosis, a congenital lesion, and/or some form of pulmonary hypertension.
Let me know how it turns out
Shawn Gregory, MD

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**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:18 PM
**Subject:** Robib TM Clinic April 2010, Sun Ronakse, 40F (Sre Thom Village)

Dear all,

This is case number 14, Sun Ronakse, 40F and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

## Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Sun Ronakse, 40F (Sre Thom Village)**

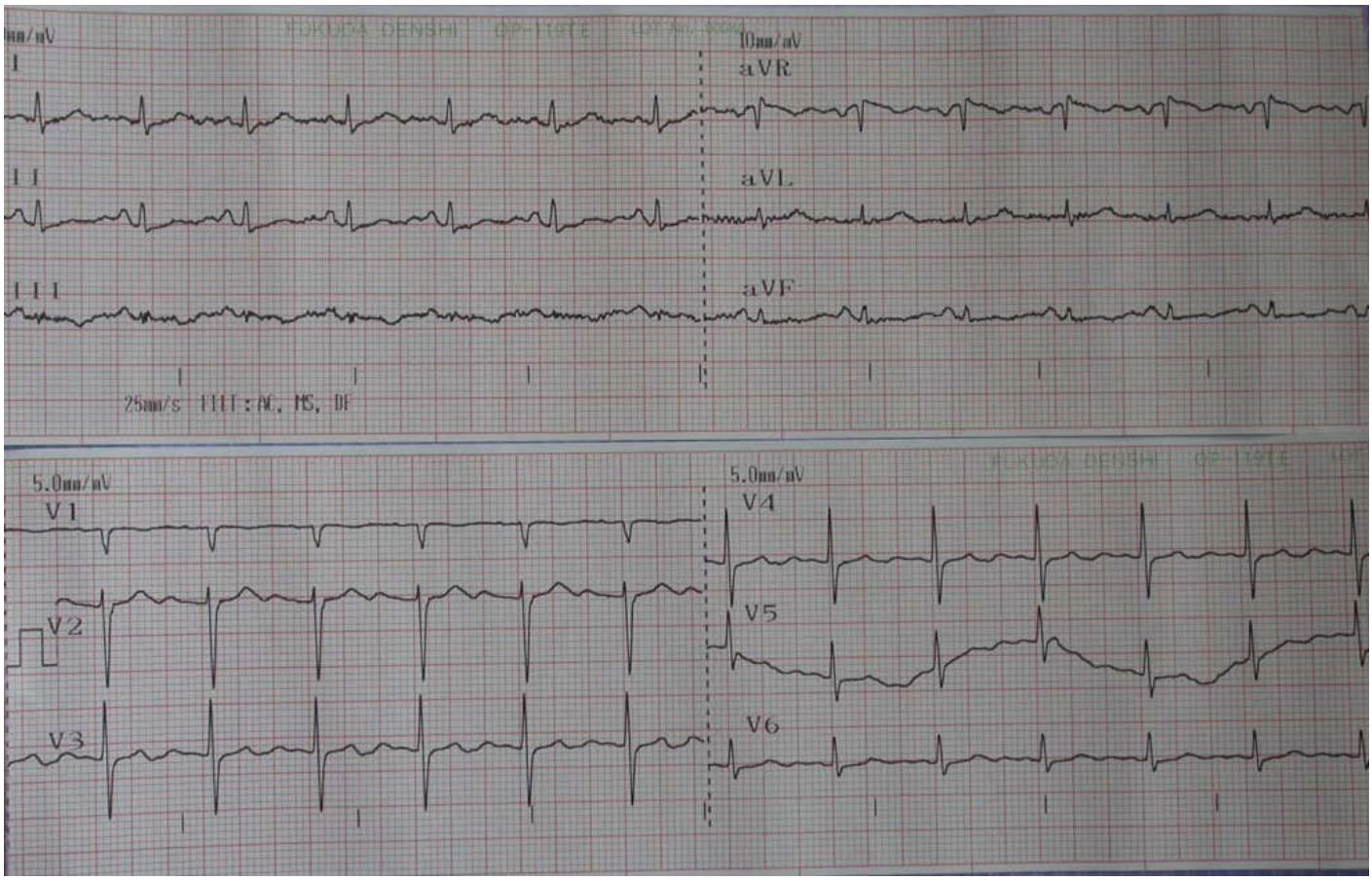
**Chief Complaint (CC):** Palpitation x 2 years

**History of Present Illness (HPI):** 40F, farmer, presented with symptoms of palpitation, fatigue, HA, neck tension. Her palpitation is like beating really fast with sensation of stop beating sometimes and happened frequently when hearing loud voice, it also make her difficult going to sleep. She went to local health center, checking BP: 170/? and treated with antihypertensive (unknown name) which help her better but the symptoms developed a few days after stop taking medicine. She denied of cough, SOB, orthopnea, Paroxysmal nocturnal dyspnea, edema, abd problem and oliguria, dysuria.

**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** No alcohol drinking, no cig smoking, 7 children




**Current Medications:**

1. Injective contraceptive (every three months injection)

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 158/87 P: 62 R: 20 T: 37°C Wt: 40Kg**

**General:** Stable

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

**Chest:** CTA bilaterally, no rales, no rhonchi; H RR, S3 galoop, no murmur

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

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

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

**Lab/study:**

On April 2, 2010

EKG attached

**Assessment:**

1. HTN
2. VHD??

**Plan:**

1. HCTZ 50mg 1/2t po qd
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH
3. Do CXR at Kg Thom referral hospital

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 2, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Sent:** Friday, April 02, 2010 5:22 PM
**Subject:** Re: Case Sun Ronakse, 40F

Dear Sovann,

For ths patient, it seems that she has a heart problem that may relate to valvular problem. You recorded that her HR as 62, yet her ECG showed more tha 100 bpm. Is her HR varied that much? I don't resally see an A-fib or flutter on the ECG, nor any block. She is definitely HTN, but has this sx correlated to her using the Depo for contraception or not?

Please send her for CXR and 2D echo at SHCH as well as blood work. You may want to consult Dr Kruy who is going next week to your location for 2nd opinion. Meanwhile, you can go ahead with the HCTZ to control her BP since hx in past. Please check HR again a couple times for confirming if varied greatly as reported or not.

Rithy

From: Guiney, Timothy E.,M.D.
Sent: Wed 4/7/2010 10:53 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic April 2010, Sun Ronakse, 40F (Sre Thom Village)

This 40 year old woman, mother of seven, has hypertension and rapid heart action.

Her examination is normal, but we don't know about weight loss or other symptoms to suggest hyperthyroidism.

The electrocardiogram is normal.

Suggest drawing a TSH and free T4.

In the meantime a beta blocker such as propanolol or metoprolol could be tried.

She should be told NOT to stop the medicine when her supply runs out. It will need to be taken on a long term (permanent) basis.

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**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim ; Rithy Chau
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:20 PM
**Subject:** Robib TM Clinic April 2010, Case#15, Tith Sokhem, 18months Female (Kam Pot Village)

Dear all,

This is case number 15, Tith Sokhem, 18months Female and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Tith Sokhem, 18 months Female (Kam Pot Village)**

**Chief Complaint (CC):** Abscess on scalp x 1 month

**History of Present Illness (HPI):** 18months old female brought by her mother complaining of an abscess on the scalp. At first, she presented with a small nodule on the scalp and progressively became bigger from day to day with redness around, pain, fever. Her mother thought that it was an abscess and applied on it with traditional medicine and in a few days, it became fluctuated then burst out with pus drainage. The abscess reoccurred in the same place four times in this one month. It just drained out the pus in the past two days that make her less pain, no fever.

**Past Medical History (PMH):** Unremarkable

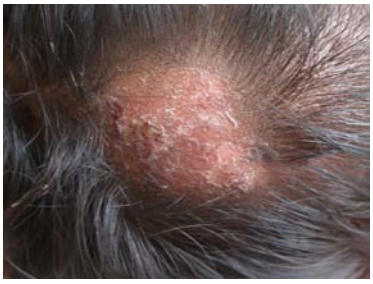
**Family History:** None

**SH:** Complete national vaccination

**Current Medications:** applied Traditional medicine

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable



**PE:**

**Vitals: BP: P: 130 R: 32 T: 37$^{o}$C Wt: 9Kg**

**General:** Stable

**HEENT:** On the scalp, lesion about 2 x 2cm, redness around, no fluctuation, no pus drainage, no oropharyngeal lesion, no neck lymph node palpable

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

**Abd:** Soft, no tender, no distension

**Lab/study:** None

**Assessment:**

1. Scalp abscess

**Plan:**

1. Augmentin 875mg 1/4t po bid x 7days

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 3, 2010**

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



**From:** Cornelia Haener
**To:** 'Robib Telemedicine' ; 'Rithy Chau'
**Sent:** Monday, April 05, 2010 8:49 AM
**Subject:** RE: Case Tith Sokhem, 18months Female

Dear Sovann,

Thanks for submitting this case.

The cheek lesion looks like a sebaceous cyst. I am wondering if the scalp lesion is a sebaceous cyst as well. It is hard to tell from the digital image. If the scalp lesion is still fluctuant, it would be good to incise and drain it. It it is a sebaceous cyst, the child would be better of with excision of the cyst, may be at Angkor Hospital for Children.

Kind regards
Cornelia

**From:** Watson, Alice J., M.D.
**Sent:** Tuesday, April 06, 2010 1:48 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Derm case from Cambodia

This story would make me suspicious of a fungal kerion. This is frequently misdiagnosed as a bacterial scalp abscess and recurs leading to multiple courses of antibiotics / surgeries.

If possible, skin scrapings and plucked hairs should be sent to mycology. The treatment is three months of oral griseofulvin microsize suspension 125 mg/5 ml at a dose of (10-15 mg/kg).

Alice Watson, MD

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**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Rithy Chau ; Kruy Lim
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Monday, April 05, 2010 6:23 PM
**Subject:** RobibTM Clinic April 2010, Ung Set, 52F (Sam Reth Village)

Dear all,

This is case number 16, Ung Set, 52F and photos. Please waiting for other cases which will be sent to you tomorrow.

Thanks you very much for your cooperation and support in this project.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

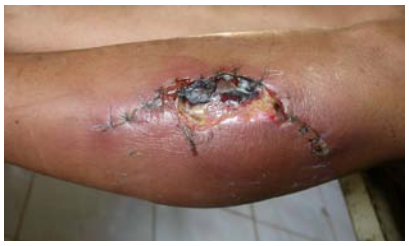
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Ung Set, 52F (Sam Reth Village)**

**Chief Complaint (CC):** Wound on both legs x 12d

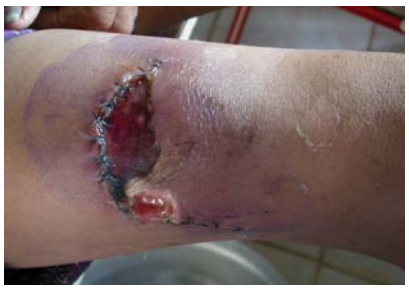
**History of Present Illness (HPI):** 52F, farmer, was bitten by her pig causing big laceration on right thigh and left calf. She was brought to local health center and the laceration cleaned and sutured about 10 stitches on each and treated with Amoxicillin 500mg 1t po tid and Paracetamol 500mg 1t po tid. The wound has been cleaned every day in the local health center but it seems not better with redness, swelling, severe pain and pustule discharge.



**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** No cig smoking, no alcohol drinking, 1 child

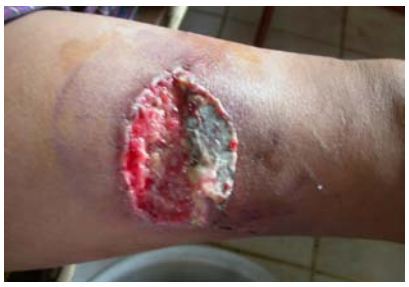


**Current Medications:**

1. Amoxicillin 500mg 1t po tid
2. Paracetamol 500mg 1t po tid

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable



**PE:**

**Vitals:** **BP: 117/77** **P: 76** **R: 20** **T: 37$^{o}$C** **Wt: 44Kg**

**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Extremity:** Right thigh, the sutured wound about 10cm with redness, swelling, tender, and pustule discharge; on left calf, sutured wound about 12cm with redness, swelling, tender (see photos), no inguinal lymph node, (+) posterior tibial and dorsalis pedis pulse

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

**Lab/study:** None

**Assessment:**

1. Infected wound on Right thigh and left calf

**Plan:**

1. Remove all suture then clean with NSS, apply with sugar solution every day
2. Augmentin 875mg 1t po bid
3. Naproxen 220mg 1t po bid

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 4, 2010**

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



**From:** Cornelia Haener
**To:** 'Robib Telemedicine' ; 'Rithy Chau'
**Sent:** Monday, April 05, 2010 8:59 AM
**Subject:** RE: Case Ung Set, 52F (Sam Reth Village)

Dear Sovann,

Thanks for submitting this case and for removing all the sutures.
I agree with your plan.

Kind regards
Cornelia

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**From:** Robib Telemedicine
**To:** Cornelia Haener ; Kruy Lim ; Rithy Chau ; Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Joseph Kvedar
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Tuesday, April 06, 2010 7:49 PM
**Subject:** Robib TM Clinic April 2010 Case number 17, Kim Chenda, 28F (Ta Tong Village)

Dear all,

Today there are three new cases which will be sent to all of you for today of Robib TM Clinic April 2010.

Case number 17, continued from Yesterday, Kim Chenda, 28F and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

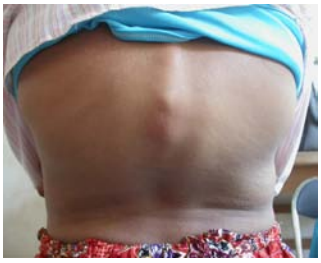
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Kim Chenda, 28F (Ta Tong Village)**

**Chief Complaint (CC):** Vaginal discharge x 2y

**History of Present Illness (HPI):** 28F was seen by Telemedicine clinic in 2001 with suspected TB due multiple neck masses and spine fracture causing spine deformity after falling from tree in the past 15 years. Now she complained of 2y history of vaginal discharge, white color with bad swelling, lesion on vulva with severe pain. She got treatment from local health care worker with Metronidazole but not better. In the past two weeks, her pain became worse so she got pelvic exam by local HC staff and advised to get treatment with injection medicine. She got Ceftriaxone injection 1g bid x 5 day then her symptoms became better.



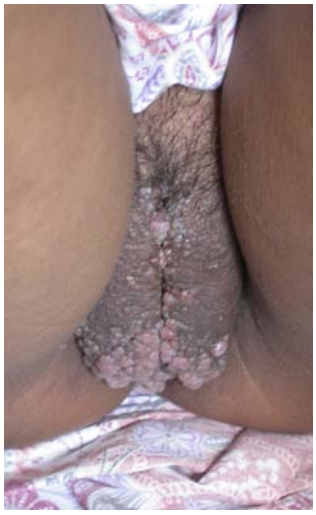
**Past Medical History (PMH):** Unremarkable

**Family History:** Not known family history of STDs

**SH:** Single, no sexual intercourse, share cloths history

**Current Medications:**

1. Ceftriaxone 1g bid for 5d (two weeks ago)



**Allergies:** NKDA

**Review of Systems (ROS):** She is on menstruation

**PE:**

**Vitals:** **BP: 108/88** **P: 88** **R: 20** **T: 37$^{o}$C** **Wt: 42Kg**

**General:** Stable

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

**Chest:** CTA bilaterally, no rales, no rhonchi; H RRR, no murmur, spine bulging with Kyphosis appearance due to spine fracture

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Extremity:** No edema, no lesion

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

**Pelvic exam:** Nodular lesion on the vulva (see photo); speculum exam not done

**Lab/study:** None

**Assessment:**

1. Genital wart

**Plan:**

1. Refer to SHCH for surgical consultation, possible lesion removal

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 6, 2010**

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



**From:** Cornelia Haener
**To:** 'Robib Telemedicine' ; 'Kruy Lim' ; 'Rithy Chau' ; 'Paul J. M.D. Heinzelmann' ; 'Kathy Fiamma >' ; 'Joseph Kvedar'
**Cc:** 'Bernie Krisher' ; 'Sothero Noun' ; 'Laurie & Ed Bachrach'
**Sent:** Wednesday, April 07, 2010 11:42 AM
**Subject:** RE: Robib TM Clinic April 2010 Case number 17, Kim Chenda, 28F (Ta Tong Village)

Dear all,

Has this patient ever been worked up for HIV?
She certainly has condylomata accuminata and needs surgical removal, but we will have to work her up first.

Please refer her to us.

Thanks
Cornelia

**From:** Lim kruy
**To:** Cornelia Haener ; Rithy Chau ; Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Joseph Kvedar ; Robib Telemedicine
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Wednesday, April 07, 2010 8:47 AM
**Subject:** Re: Robib TM Clinic April 2010 Case number 17, Kim Chenda, 28F (Ta Tong Village)

Dear Sovann,

Thanks, I do agree to refer to SHCH for surgical removal because this is a extensive warts.

If she did not have any sexual abuse. we need to ask for other question related to WHIM syndrome. (attach is

the question)

Does it occurs during the first menstruation period??

Best Regards

Kruy

From: "Goodman, Anne Kathryn, M.D." <AGOODMAN@PARTNERS.ORG>
To: "Fiamma, Kathleen M." <KFIAMMA@PARTNERS.ORG>
Cc: <robibtelemed@gmail.com>; <rithychau@sihosp.org>
Sent: Wednesday, April 07, 2010 7:50 AM
Subject: RE: Robib TM Clinic April 2010 Case number 17, Kim Chenda, 28F (Ta Tong Village)

Dear Nurse Sovann Peng ,

Thank you for your query about your patient, Kim Chenda.

To summarize her story: She is a 28 year old G0P0 who is not sexually active. She presents with a two year history of vulvar pain and vaginal discharge. Her medical history is significant for tuberculosis related boney disease and lymphadenopathy. Treatment for her gyn discomfort has included flagyl which did not help and Ceftriaxone which helped a little.

The photograph of her vulva is remarkable for diffuse swelling of both right and left labia. There are numerous small papules and bumps within the swellings on both labia. The majority of these papules are in the dependent area of the vulva. This condition looks chronic. I suspect that to palpation the whole vulva feels hard and indurated. I am curious whether she has inguinal adenopathy. My suspicion is that she must.

This does not look like human papillomavvirus related lower genital tract disease. This is not a classic look for condyloma. Additionally condylomas are not associated with pain nor are they associated with diffuse, symmetric swelling.

This does not look like cancer but a vulvar biopsy is reasonable.

I wonder if she has obstructed lymphatics causing chronic swelling and lymphedema of the vulva. The cause of obstructed lymphatics could be infectious , a noninfectious inflammatory condition, or a malignancy.

She has previously had swollen lymph nodes in her neck from tuberculosis. Is it possible that the vulva is a manifestation of progressive TB?

Another possibility is elephantiasis from lymphatic filariasis. Three kinds of round worms cause elephantiasis filariasis: Wuchereria bancrofti, Brugia malayi, and Brugia timori. Of these three, W. bancrofti makes up about 90% of the cases. Man is the only known host of W. bancrofti.

Culex, Aedes, and Anopheles mosquitoes are the carriers of W. bancrofti. Anopheles and Mansonia mosquitoes are the carriers of B. malayi. In addition, Anopheles mosquitoes are the carriers of B. timori.

The only sure way to diagnose lymphatic filariasis is by detecting the parasite itself, either the adult worms or the microfilariae.

Microscopic examination of the person's blood may reveal microfilariae. But many times, people who have been infected for a long time do not have microfilariae in their bloodstream. The absence of them, therefore, does not mean necessarily that the person is not infected. In these cases, examining the urine or hydrocele fluid or performing other clinical tests is necessary.

Collecting blood from the individual for microscopic examination should be done during the night when the microfilariae are more numerous in the bloodstream. (Interestingly, this is when mosquitoes bite most frequently.) During the day microfilariae migrate to deeper blood vessels in the body, especially in the lung. If it is decided to perform the blood test during the day, the infected individual may be given a "provocative" dose of medication to provoke the microfilariae to enter the bloodstream. Blood then can be collected an hour later for examination.

Detecting the adult worms can be difficult because they are deep within the lymphatic system and difficult to get to. Biopsies usually are not performed because they usually don't reveal much information.

Treatment is with one of the following drugs: with diethylcarbamazine, iverectin, albendazole, or doxycycline. Treatment with doxycycline would involve a 6 week course of 200 mg per day.

While less likely, a noninfectious inflammatory condition could cause this picture. Women with inflammatory bowel disease such as ulcerative colitis or Crohn's disease can have vulva manifestations that look very similar. In that case, managing the bowel disease will treat the vulvar swelling.

Suggestions:

1. Examine her inguinal region to evaluate for adenopathy
2. If she has swollen lymph nodes, she needs to be evaluated for active tuberculosis. She may need a lymph node biopsy.
3. A vulvar biopsy is reasonable.
4. I do not recommend a vulvectomy. If this is infectious or due to bowel disease, her vulva will never heal.
5. You could try an empiric course of doxycycline.

Respectfully

Annekathryn Goodman, MD.

**From:** Robib Telemedicine
**To:** Cornelia Haener ; Kruy Lim ; Rithy Chau ; Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Joseph Kvedar
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Tuesday, April 06, 2010 7:54 PM
**Subject:** Robib TM Clinic April 2010, Case#18, Om Samen, 36F (Thnout Malou Village)

Dear all,

This is case number 18, Om Samen, 36F and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

## Sihanouk Hospital Center of HOPE and Partners Telemedicine

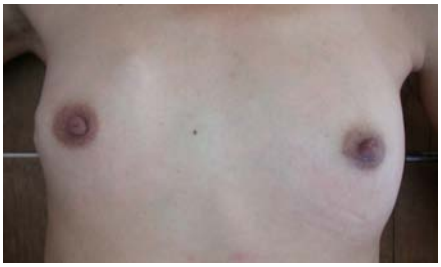
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Om Samen, 36F (Thnout Malou Village)**

**Chief Complaint (CC):** Bilateral breast masses x 3months

**History of Present Illness (HPI):** 36F, farmer, presented with a few masses on both breasts. First she feels a mass about 1x2cm on right breast without pain, swelling, and in a few days later she noticed the other mass on the same breast and a few on the left side also, and 5kg weight loss in these 3 months. She denied of discharge from breast, trauma, insect bites. She has not sought medical consultation or treatment and just come to consult with Telemedicine today



**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** No cig smoking, no alcohol drinking

**Current Medications:** None

**Allergies:** NKDA

**Review of Systems (ROS):** Epigastric pain, burning sensation after eating and during hungry, radiation to the back

**PE:**

**Vitals:** **BP: 113/76** **P: 106** **R: 20** **T: 36.5$^{o}$C** **Wt: 35Kg**

**General:** Stable

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

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

Breast: Right breast, two masses (one about 1x1cm at 2 O'clock, other one about 3x4cm at 10 O'clock); Left breast, two masses about 1x2cm at 4-5 O'clock and 7-8 O'clock; all masses are firm, mobile, no tender, no nipple retraction, no discharge, no axillary lymph node palpable

**Abd:** Soft, no tender, no distension, (+) BS, no HSM

**Extremity:** No edema, no lesion

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

**Lab/study:** None

**Assessment:**

1. Multiple masses on bilateral breasts
2. Dyspepsia

**Plan:**

1. Refer to SHCH for surgical consultation, possible biopsy or mass excision
2. Ranitidine 150mg 1t po qhs for one month
3. Mebendazole 100mg 5t po qhs once

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 6, 2010**

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



**From:** Cornelia Haener
**To:** 'Robib Telemedicine' ; 'Kruy Lim' ; 'Rithy Chau' ; 'Paul J. M.D. Heinzelmann' ; 'Kathy Fiamma >' ; 'Joseph Kvedar'
**Cc:** 'Bernie Krisher' ; 'Sothero Noun' ; 'Laurie & Ed Bachrach'
**Sent:** Wednesday, April 07, 2010 11:45 AM
**Subject:** RE: Robib TM Clinic April 2010, Case#18, Om Samen, 36F (Thnout Malou Village)

Dear Sovann,

Thanks for submitting this case. The masses are most likely multiple fibroadenomas.
I agree with your plan.

Kind regards
Cornelia

**From:** Hughes, Kevin S.,M.D.
**Sent:** Tuesday, April 06, 2010 11:36 AM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib TM Clinic April 2010, Case#18, Om Samen, 36F (Thnout Malou Village)

I agree with the plan for surgical assessment, with biopsy and/or excision

**Kevin S. Hughes, M.D., FACS**
**Surgical Director,Breast Screening**
**Co-Director, Avon Comprehensive Breast Evaluation Center**
**Massachusetts General Hospital**
**55 Fruit Street, Yawkey 7**
**Boston, Massachusetts 02114**

**Associate Professor of Surgery**
**Harvard Medical School**

**Medical Director**
**Bermuda Cancer Genetics and Risk Assessment Clinic**

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**From:** Robib Telemedicine
**To:** Paul J. M.D. Heinzelmann ; Kathy Fiamma > ; Joseph Kvedar ; Rithy Chau ; Kruy Lim
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Tuesday, April 06, 2010 7:57 PM
**Subject:** Robib TM Clinic April 2010, Kaem Seam, 51M (Kam Pot Village)

Dear all,

This is case number 19, Kaem Seam, 51M and photos. Please waiting for other cases which will be sent to you tomorrow.

Thank you very much for your cooperation and support in this project.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

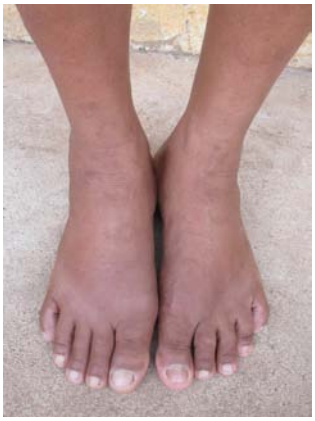
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village: Kaem Seam, 51M (Kam Pot Village)**

**Chief Complaint (CC):** Pain on big toe joint x 7 days

**History of Present Illness (HPI):** 51M, farmer, presented pain, swelling, warmth and stiffness on left big toe joint in 2007 and got treatment with medicine bought from local pharmacy for three days then the symptoms has gone. In 2008, the above symptoms presented on the same joint and got treatment with medicine from local pharmacy x 10d then the symptoms gone. In last week, he presented of pain, swelling, warmth and stiff of right bit toe and a few days to right ankle. The pain got worse at night and after activity. He denied of other joint attack as knee, hip, shoulder, elbow, wrist and finger.



**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** No cig smoking, casually alcohol drinking

**Current Medications:** Medication for pain (unknown name)

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 133/82 P: 96 R: 20 T: 37$^{o}$C Wt: 60Kg**

**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM, no surgical scar

**Joint exam:** Warmth, mild tender with movement on right big toe and ankle, no stiffness, no swelling, no skin rashes

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

**Lab/study:** None

**Assessment:**

1. Gouty arthritis?
2. Osteoarthritis?

**Plan:**

1. Naproxen 220mg 1t po bid
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc, ESR and Uric acid at SHCH

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 6, 2010**

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



**From:** Cohen, George L.,M.D.
**Sent:** Tuesday, April 06, 2010 12:53 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib TM Clinic April 2010, Kaem Seam, 51M (Kam Pot Village)

Gout is the most likely diagnosis in a 51 year old man with recurrent episodes of acute joint pain especially when the the base of the great toe has been involved.These episodes will usually respond to treatment with NSAIDS especially if started as soon as possible after the pain begins. The earlier treatment is started, the quicker the acute pain and swelling will resolve. Usually doses need to be somewhat on the high end such as ibuprofen 600 mg three times a day or naproxen 500 mg twice a day.

Serum uric acid level should be elevated. Most patients with elevated uric acid level and bouts of acute gout should be treated indefinitely with allopurinol or probenecid to lower the uric acid and to prevent future attacks.

George L. Cohen, M.D.

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**From:** Robib Telemedicine
**To:** Kruy Lim ; Rithy Chau ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kathy Fiamma >
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Wednesday, April 07, 2010 4:25 PM
**Subject:** Robib TM Clinic April 2010, Case#20, Teng Korng, 38M (Ta Tong Village)

Dear all,

Today is the last day for Robib TM Clinic April 2010, three new cases will be sent to you.

Continued from yesterday, this is Case number 20, Teng Korng, 38M and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Teng Korng, 38M (Ta Tong Village)**

**Chief Complaint (CC):** Body rashes x 2y

**History of Present Illness (HPI):** 38M, soldier, presented with skin rashes on the lower abdomen and back, with vesicle and pruritus, he got treatment from local health care worker with one IM injection and oral medicine but the skin rash seems not better. In these few months, the rashes presented on both forearms and elbows. He denied rashes on the head, neck, and lower extremities.

**Past Medical History (PMH):** Remote malaria

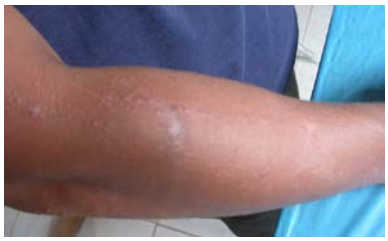
**Family History:** None

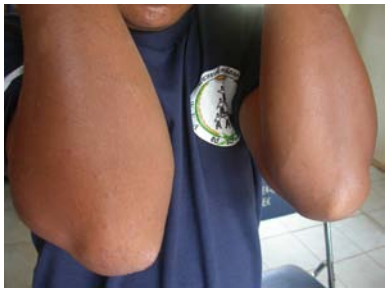
**SH:** No cig smoking, casually alcohol drinking

**Current Medications:** None

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable



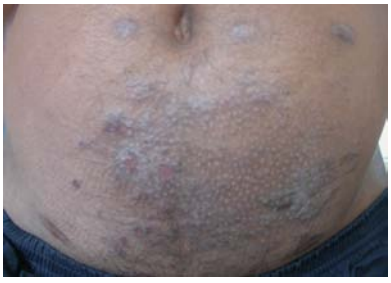


**PE:**

**Vitals:** **BP: 122/75** **P: 62** **R: 20** **T: 37°C** **Wt: 65Kg**

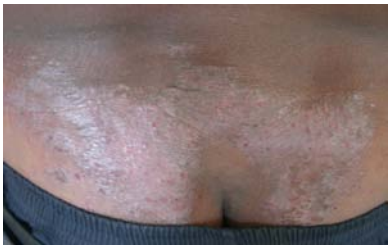
**General:** Stable

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



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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM, few completed healed burning scar, no abdominal bruit



**Extremity/Skin:** Maculopapula rashes, patches appearance (see photos) on the lower abdomen and lower back, and papule rashes on forearm and elbow

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

**Lab/study:** None

**Assessment:**

1. Contact dermatitis?
2. Eczema?

**Plan:**

1. Fluocinonide cream 0.1% apply bid on the lesion until the rashes gone
2. Diphenhydramine 25mg 1t po qhs

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 7, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Cc:** Kruy Lim ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kathy Fiamma > ; Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Wednesday, April 07, 2010 5:07 PM
**Subject:** Re: Robib TM Clinic April 2010, Case#20, Teng Korng, 38M (Ta Tong Village)

Dear Sovann,
I agree with your plan.
Rithy

From: Kvedar, Joseph Charles,M.D.
Sent: Wed 4/7/2010 9:24 PM
To: Fiamma, Kathleen M.
Cc: Watson, Alice J., M.D.
Subject: Re: Robib TM Clinic April 2010, Case#20, Teng Korng, 38M (Ta Tong Village)

I favor eczema and I would recommend a trial of triamcinolone 0.1% ointment and a follow up in a month.

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**From:** Robib Telemedicine
**To:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Rithy Chau ; Kruy Lim
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Wednesday, April 07, 2010 4:27 PM
**Subject:** Robib TM Clinic April 2010, Case#21, Hem Lonh, 31M (Kam Pot Village)

Dear all,

This is case number 21, Hem Lonh, 31M and photos.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

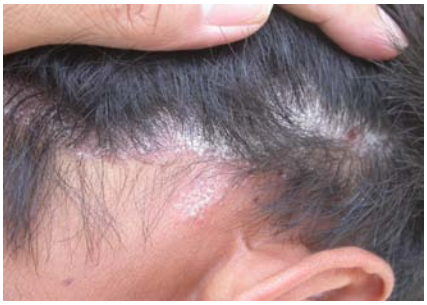
Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village: Hem Lonh, 31M (Kam Pot Village)**

**Chief Complaint (CC):** Lesion on scalp x 1y

**History of Present Illness (HPI):** 31M, farmer, presented lesion on the scalp with white scale, pruritus, no vesicle, no pustule. He denied of lesion affect on body or extremity. He got treatment from local health care worker with cream and oral medicine (unknown name) but the lesion did not get better so he didn't get any more treatment. He has normal appetite, normal bowel movement, normal urination.

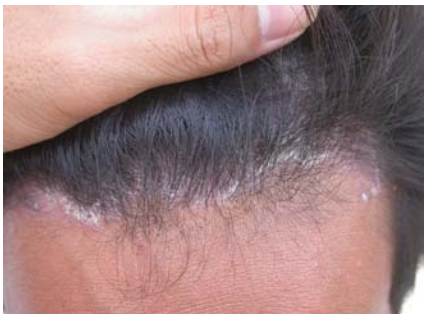


**Past Medical History (PMH):** Unremarkable

**Family History:** None

**SH:** Smoking 10cig/d, casually alcohol drinking

**Current Medications:** None



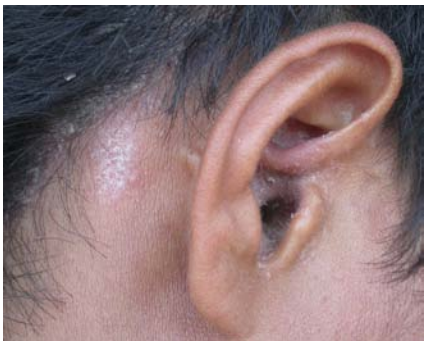
**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals: BP: 105/68 P: 67 R: 20 T: 37$^{o}$C Wt: 50Kg**

**General:** Stable



**HEENT:** White scale lesion with regular border on the scalp and ear canal, no macule, no papule, no vesicle, no pustule, normal tympanic membrane.

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM, no surgical scar

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

**Lab/study:** None

**Assessment:**

1. Tinea capitis

**Plan:**

1. Clotrimazole cream 1% apply bid until the lesion gone

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 7, 2010**

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



**From:** Neel, Victor A., M.D.
**Sent:** Wednesday, April 07, 2010 12:09 PM
**To:** Fiamma, Kathleen M.
**Subject:** RE: Robib TM Clinic April 2010, Case#21, Hem Lonh, 31M (Kam Pot Village)

31 y/o with scaly eruption on hair bearing scalp and ears. Currently using a topical antifungal with no effect.
Obj: asian male, thick micaceous scale and erythema on scalp an \d on anterioir surface of ears.
A/P: scalp psoriasis - discontinue antifungals. Would use the strongest topical steroid available, if possible in a liquid form. For example, triamcinolone 0.1% solution or clobetasol 0.1% solution. Use 15-20 drops a day to wet scalp. This is a chronic problem and may wax and wane.

If he has access to tar-based shampoos that would help too.

**From:** Rithy Chau
**To:** Robib Telemedicine
**Cc:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim ; Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Wednesday, April 07, 2010 5:25 PM
**Subject:** Re: Robib TM Clinic April 2010, Case#21, Hem Lonh, 31M (Kam Pot Village)

Dear Sovann,

It does not look to me like a simple tinea capitis. It looks more like a psoriasis. I would suggest that you treat him with a 2-3 month course of antifungal like griseofulvin 100mg qd with cream application of mid-strength steroid (triamcinolone or betamethasone or mometasone) and Whitfield's oint in between to keep moist for the healing part. Antihistamine can be used for helping with pruritus.

Rithy

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**From:** Robib Telemedicine
**To:** Rithy Chau ; Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Wednesday, April 07, 2010 4:31 PM
**Subject:** Robib TM Clinic April 2010, Bon Phon, 64F (Thkeng Village)

Dear all,

This is the last case for Robib TM Clinic April 2010, Case number 22, Bon Phon, 64F and photos. Please try to reply the cases before Thursday afternoon then the treatment plan can be made accordingly.

Thank you very much for your cooperation and support in this project.

Best regards,
Sovann

# Robib Telemedicine Clinic

**Sihanouk Hospital Center of HOPE and Partners Telemedicine**

Rovieng Commune, Preah Vihear Province, Cambodia

## History and Physical

**Name/Age/Sex/Village:** **Bon Phon, 64F (Thkeng Village)**

**Chief Complaint (CC):** Epigastric pain x 10y

**History of Present Illness (HPI):** 64F, farmer, presented with symptoms of epigastric burning pain, radiation to the back, burping with sour taste, the pain getting worse with full eating and hungry. She got treatment medicine bought from local pharmacy and got abdominal U/S done at Kg Thom referral hospital and told she had GI problem and treatment with a few medicines (unknown name) but her symptoms presented a few weeks after stopping medicine. In this year, she developed with symptoms of fatigue, polyphagia, polyuria and dizziness without seeking for medical consultation just come to Telemedicine and blood sugar checked

On 5 April 2010, RBS: 186mg/dl
On 6 April 2010, FBS: 214mg/dl
On 7 April 2010, RBS: 178mg/dl

**Past Medical History (PMH):** Remote malaria

**Family History:** None

**SH:** No cig smoking, no alcohol drinking

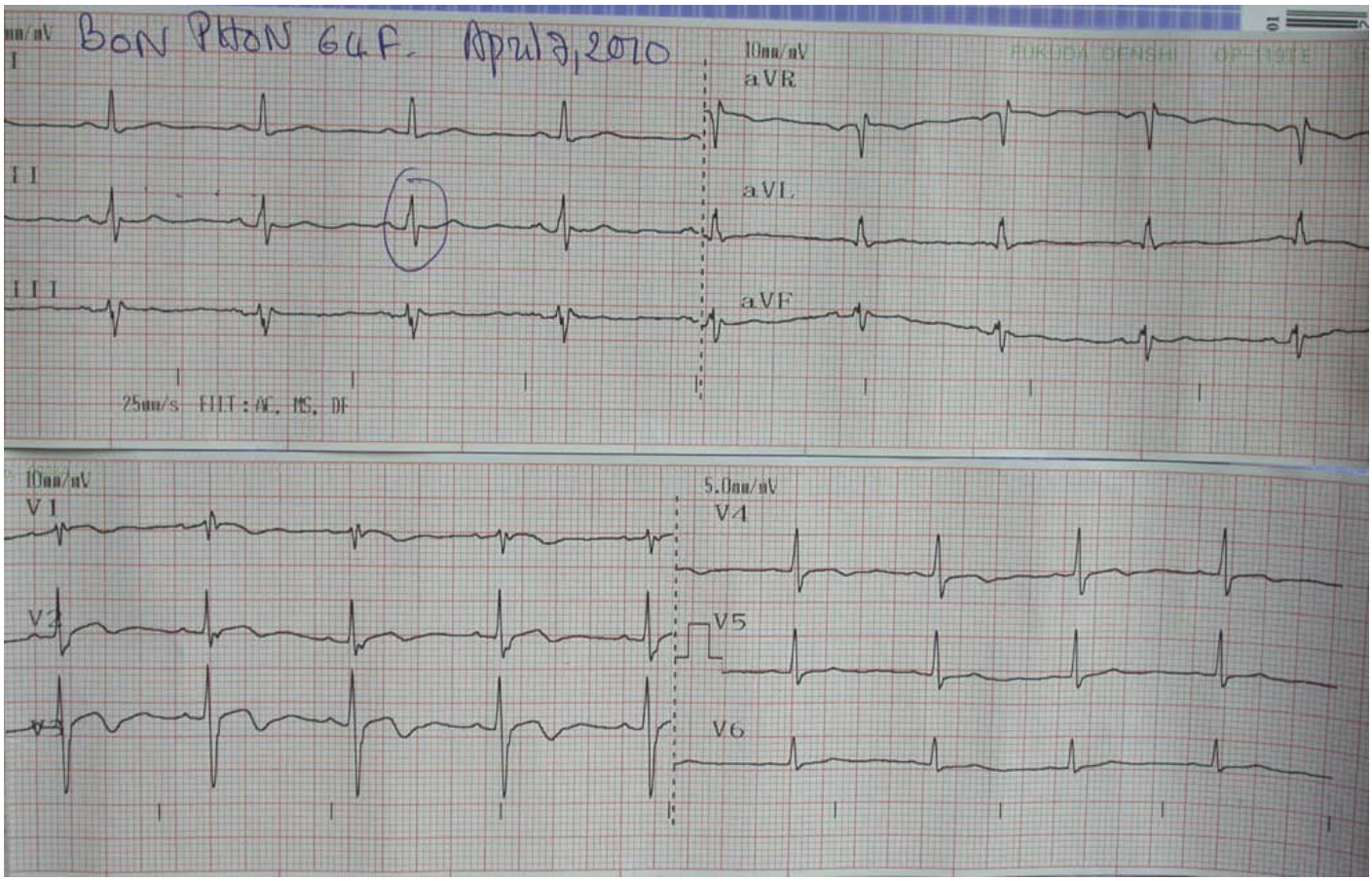
**Current Medications:** Antacid during epigastric pain

**Allergies:** NKDA

**Review of Systems (ROS):** Unremarkable

**PE:**

**Vitals:** **BP: 104/68** **P: 81** **R: 20** **T: 37$^{o}$C** **Wt: 40Kg**




**General:** Stable

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

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

**Abd:** Soft, no tender, no distension, (+) BS, no HSM, pulsation mass about 2cm on midline of abdomen, below umbilicus, no bruit

**Extremity:** No edema, no rashes, no lesion, no foot wound

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

**Lab/study:**
**On April 7, 2010**
U/A normal

**Assessment:**

1. DMII
2. Abdominal Aortic aneurysm
3. Dyspepsia

**Plan:**

1. Glibenclamide 5mg 1t po qd

2. Atenolol 25mg 1/2t po qd
3. ASA 300mg 1/4t po qd
4. Ranitidine 150mg 1t po qhs for one month
5. Mebendazole 100mg 5t po qhs once
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc and HbA1C at SHCH
7. Send to SHCH for 2D echo of abdomen

Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test

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

**Examined by: Nurse Sovann Peng** **Date: April 7, 2010**

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



**From:** Rithy Chau
**To:** Robib Telemedicine
**Cc:** Kathy Fiamma > ; Paul J. M.D. Heinzelmann ; Joseph Kvedar ; Kruy Lim ; Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach
**Sent:** Wednesday, April 07, 2010 5:39 PM
**Subject:** Re: Robib TM Clinic April 2010, Bon Phon, 64F (Thkeng Village)

Dear Sovann,

On PE, the AAA usually presented with pulsatile mass above umbilicus, not below. Was this a typo? If yes then I agree with your plan.

Thanks for your hard work.

Rithy

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**From:** Robib Telemedicine
**To:** Kathy Fiamma >
**Cc:** Bernie Krisher ; Sothero Noun ; Laurie & Ed Bachrach ; Rithy Chau
**Sent:** Friday, April 09, 2010 12:50 PM
**Subject:** Robib TM Clinic cases received

Dear Kathy,

I have received the reply of 18 cases from you and these are received cases:
Case#1, Khorn Davy, 20F
Case#2, Chan Top, 49F
Case#3, Nong Khon, 59F
Case#4, Prum Tong, 48M
Case#5, Prum Yet, 46F
Case#6, Be Samphorn, 73M

Cae#7, Chum Chet, 63M
Case#8, In Ly, 65M
Case#9, Ke Sim, 77M
Case#10, Kim Choeun, 45F
Case#11, Phim Sam An, 27F
Case#13, Sim Y, 32F
Case#14, Sun Ronakse, 40F
Case#15, Tith Sokhem, 18 months Female
Case#17, Kim Chenda, 28F
Case#18, Om Samen, 36F
Case#19, Kaem Seam, 51M
Case#20, Teng Korng, 38M

I have not yet received reply of these four cases
Case#12, Say Phiroth, 10M
Case#16, Ung Set, 52F
Case#21, Hem Lonh, 31M
Case#22, Bon Phon, 64F

Thanks alot for the reply to the Robib TM Clinic cases in this month of April 2010.

Best regards,
Sovann

# Thursday, April 8, 2010

## Follow-up Report for Robib TM Clinic

There were 21 new and 1 follow up patients seen during this month Robib TM Clinic, other 50 patients came for medication refills only, and 297 new patients seen by PA Rithy Chau for minor problem without sending data. The data of all 22 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 and PA Rithy Chau on site, the following patients were managed and treated as follows:

NOTE: [Please note that some blood works was drawn and done at SHCH at no cost and others including studies such as x-rays, U/S, EKG, etc. were done at Kompong Thom Referral Hospital with patients paying on their own. Robib TM clinic STILL pays for transportation, accommodation, and other expenses for the patients visiting the clinic IF they are from Thnout Malou Village. For those patients who were seen at SHCH previously and remained stable with medications, the clinic will continue to provide them with appropriate medications from SHCH at no cost for the duration of their illnesses or while supplies lasted. The clinic still provided free medications for all "poor" patients. Some patients may be listed below if they came by for refills of medications.]

### Treatment Plan for Robib Telemedicie Clinic April 2010

**1. Khorn Davy, 20F (Backdoang Village)**
**Diagnosis:**

1. Left distal femoral neck fracture?
2. Traumatic arthritis?

**Treatment:**

1. Paracetamol 500mg 1t po qid prn pain (#30)
2. Naproxen 220mg 1t po bid prn severe pain (#30)
3. Refer to SHCH for further evaluation of femoral fracture reconstruction

**2. Chan Top, 49F (Thkeng Village)**
**Diagnosis:**

1. Liver abscess?
2. Chronic hepatitis?
3. Cholecystolithiasis?

**Treatment:**

1. Send patient to Kg Thom referral hospital for abdominal U/S

**3. Nong Khon, 59F (Thkeng Village)**
**Diagnosis:**

1. HTN
2. Dyspepsia

**Treatment:**

1. HCTZ 50mg 1/2t po qd (#20)
2. Ranitidine 150mg 1t po qhs for one month (#30)
3. Mebendazole 100mg 5t po qhs once (#5)
4. Eat low salt diet, do regular exercise
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =3.7 | [4 - 11x10$^{9}$/L] | Na | =139 | [135 - 145] |
| RBC | =4.3 | [3.9 - 5.5x10$^{12}$/L] | K | =3.2 | [3.5 - 5.0] |
| Hb | =11.3 | [12.0 - 15.0g/dL] | BUN | =2.0 | [0.8 - 3.9] |
| Ht | =36 | [35 - 47%] | Creat | =102 | [44 - 80] |
| MCV | =85 | [80 - 100fl] | Gluc | =5.6 | [4.2 - 6.4] |
| MCH | =27 | [25 - 35pg] | | | |
| MHCH | =31 | [30 - 37%] | | | |
| Plt | =109 | [150 - 450x10$^{9}$/L] | | | |
| Lym | =1.1 | [1.0 - 4.0x10$^{9}$/L] | | | |
| Mxd | =0.6 | [0.1 - 1.0x10$^{9}$/L] | | | |
| Neut | =2.0 | [1.8 - 7.5x10$^{9}$/L] | | | |

**4. Prum Tong, 48M (Thnout Malou Village)**
**Diagnosis:**

1. Polyarthritis

**Treatment:**

1. Naproxen 220mg 1t po bid (#30)
2. Paracetamol 500mg 1t po qid prn (#30)
3. Send to Kg Thom referral hospital for x-ray of arm and legs
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc, ESR, RF, Uric acid at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =8.2 | [4 - 11x10$^{9}$/L] | Na | =144 | [135 - 145] |
| RBC | =3.4 | [4.6 - 6.0x10$^{12}$/L] | K | =4.7 | [3.5 - 5.0] |
| Hb | =8.2 | [14.0 - 16.0g/dL] | BUN | =5.6 | [0.8 - 3.9] |
| Ht | =26 | [42 - 52%] | Creat | =173 | [53 - 97] |
| MCV | =78 | [80 - 100fl] | Gluc | =3.9 | [4.2 - 6.4] |
| MCH | =24 | [25 - 35pg] | Uric Aci | =871 | [200 - 420] |
| MHCH | =31 | [30 - 37%] | RF | = Negative | |
| Plt | =259 | [150 - 450x10$^{9}$/L] | | | |

| | | |
|---|---|---|
| Lym | =1.7 | [1.0 - 4.0x10$^{9}$/L] |
| Mxd | =0.8 | [0.1 - 1.0x10$^{9}$/L] |
| Neut | =5.7 | [1.8 - 7.5x10$^{9}$/L] |
| | | |
| ESR | =80 | [0 – 15] |

**5. Prum Yet, 46F (Bos Village)**
**Diagnosis:**

1. Hyperglycemia
2. Thyroid dysfunction

**Treatment:**

1. Draw blood for CBC, Lyte, BUN, Creat, Gluc, TSH, Free T4 at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =5.1 | [4 - 11x10$^{9}$/L] | Na | =139 | [135 - 145] |
| RBC | =4.2 | [3.9 - 5.5x10$^{12}$/L] | K | =2.6 | [3.5 - 5.0] |
| Hb | =12.4 | [12.0 - 15.0g/dL] | BUN | =0.6 | [0.8 - 3.9] |
| Ht | =37 | [35 - 47%] | Creat | =86 | [44 - 80] |
| MCV | =86 | [80 - 100fl] | Gluc | =3.7 | [4.2 - 6.4] |
| MCH | =29 | [25 - 35pg] | TSH | =0.005 | [<5.7] |
| MHCH | =34 | [30 - 37%] | Free T4 | =34.36 | [12.00 – 22.00] |
| Plt | =225 | [150 - 450x10$^{9}$/L] | | | |
| Lym | =2.3 | [1.0 - 4.0x10$^{9}$/L] | | | |
| Mxd | =1.0 | [0.1 - 1.0x10$^{9}$/L] | | | |
| Neut | =1.8 | [1.8 - 7.5x10$^{9}$/L] | | | |

**6. Be Samphorn, 73M (Rovieng Cheung Village)**
**Diagnosis:**

1. HTN
2. DMII

**Treatment:**

1. Amlodipine 5mg 1/2t po qd (#20)
2. Metformin 500mg 1t po bid (#70)
3. Captopril 25mg 1/4t po qd (#10)
4. Educate on diabetic diet, Do regular exercise and eat low salt diet, and foot care
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Tot chole, TG and HbA1C at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =6.2 | [4 - 11x10$^{9}$/L] | Na | =143 | [135 - 145] |
| RBC | =4.9 | [4.6 - 6.0x10$^{12}$/L] | K | =3.5 | [3.5 - 5.0] |
| Hb | =14.2 | [14.0 - 16.0g/dL] | BUN | =2.4 | [0.8 - 3.9] |
| Ht | =41 | [42 - 52%] | Creat | =112 | [53 - 97] |
| MCV | =84 | [80 - 100fl] | Gluc | =4.9 | [4.2 - 6.4] |
| MCH | =29 | [25 - 35pg] | T. Chol | =4.6 | [<5.7] |
| MHCH | =35 | [30 - 37%] | TG | =2.6 | [<1.7] |
| Plt | =131 | [150 - 450x10$^{9}$/L] | HbA1C | =8.1 | [4 – 6] |
| Lym | =2.1 | [1.0 - 4.0x10$^{9}$/L] | | | |
| Mxd | =1.8 | [0.1 - 1.0x10$^{9}$/L] | | | |
| Neut | =2.3 | [1.8 - 7.5x10$^{9}$/L] | | | |

**7. Chum Chet, 63M (Koh Pon Village)**
**Diagnosis:**

1. Osteoarthritis?
2. HTN

**Treatment:**

1. Naproxen 220mg 1t po bid prn pain (#30)
2. Atenolol 25mg 1t po qd (#40)
3. Do X-ray of ankle and knee at Kg Thom referral hospital
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc, ESR and RF at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =8.8 | [4 - 11x10$^{9}$/L] | Na | =147 | [135 - 145] |
| RBC | =3.9 | [4.6 - 6.0x10$^{12}$/L] | K | =4.5 | [3.5 - 5.0] |
| Hb | =8.7 | [14.0 - 16.0g/dL] | BUN | =6.3 | [0.8 - 3.9] |
| Ht | =29 | [42 - 52%] | Creat | =265 | [53 - 97] |
| MCV | =74 | [80 - 100fl] | Gluc | =4.1 | [4.2 - 6.4] |
| MCH | =23 | [25 - 35pg] | | | |
| MHCH | =30 | [30 - 37%] | | | |
| Plt | =375 | [150 - 450x10$^{9}$/L] | | | |
| Lym | =2.8 | [1.0 - 4.0x10$^{9}$/L] | | | |
| Mxd | =1.1 | [0.1 - 1.0x10$^{9}$/L] | | | |
| Neut | =4.9 | [1.8 - 7.5x10$^{9}$/L] | | | |
| | | | | | |
| ESR | =60 | [0 - 15] | | | |
| RF | = Negative | | | | |

**8. In Ly, 65M (Chan Lorng Village)**
**Diagnosis:**
1. COPD
2. Cachexia

**Treatment:**
1. Salbutamol Inhaler 2 puffs bid (#1)
2. MTV 1t po qd (#30)
3. Cig Smoking cessation
4. Do CXR at Kg Thom referral hospital
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =4.1 | [4 - 11x10$^{9}$/L] | Na | =135 | [135 - 145] |
| RBC | =4.0 | [4.6 - 6.0x10$^{12}$/L] | K | =3.0 | [3.5 - 5.0] |
| Hb | =10.6 | [14.0 - 16.0g/dL] | BUN | =2.8 | [0.8 - 3.9] |
| Ht | =33 | [42 - 52%] | Creat | =119 | [53 - 97] |
| MCV | =82 | [80 - 100fl] | Gluc | =3.7 | [4.2 - 6.4] |
| MCH | =27 | [25 - 35pg] | | | |
| MHCH | =32 | [30 - 37%] | | | |
| Plt | =294 | [150 - 450x10$^{9}$/L] | | | |
| Lym | =0.7 | [1.0 - 4.0x10$^{9}$/L] | | | |

**9. Ke Sim, 77M (Thnout Malou Village)**
**Diagnosis:**
1. HTN

**Treatment:**
1. HCTZ 50mg 1/2t po qd (#20)
2. Do regular exercise and eat low salt diet

**10. Kim Choeun, 45F (Thkeng Village)**
**Diagnosis:**
1. Infected wound on right ankle

**Treatment:**
1. Cloxacillin 500mg 1t po tid x 5d (#15)

2. Naproxen 220mg 1t po bid x 5d (#10)
3. Clean wound every day with NSS and dressing with concentrated sugar solution

**11. Phim Sam An, 27F (Ta Tong Village)**
**Diagnosis:**
1. Infected lesion on left hand dorsum

**Treatment:**
1. Cloxacillin 500mg 1t po tid x 5d (#15)
2. Naproxen 220mg 1t po bid x 5d (#10)
3. Clean wound every day with NSS

**12. Say Phiroth, 10M (Thnal Keng Village)**
**Diagnosis:**
1. Aphthous stomatitis

**Treatment:**
1. Naproxen 220mg 1/2t po bid x 5d (#10)
2. Drink plenty of water

**13. Sim Y, 32F (Thkeng Village)**
**Diagnosis:**
1. CHF??

**Treatment:**
1. Draw blood for CBC, Lyte, BUN, Creat, Gluc and TSH at SHCH
2. Do CXR at Kg Thom referral hospital

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =8.2 | [4 - 11x10$^9$/L] | Na | =140 | [135 - 145] |
| RBC | =4.7 | [3.9 - 5.5x10$^{12}$/L] | K | =4.1 | [3.5 - 5.0] |
| Hb | =12.1 | [12.0 - 15.0g/dL] | BUN | =1.2 | [0.8 - 3.9] |
| Ht | =36 | [35 - 47%] | Creat | =98 | [44 - 80] |
| MCV | =77 | [80 - 100fl] | Gluc | =5.3 | [4.2 - 6.4] |
| MCH | =26 | [25 - 35pg] | TSH | =2.01 | [0.27 – 4.20] |
| MHCH | =34 | [30 - 37%] | | | |
| Plt | =258 | [150 - 450x10$^9$/L] | | | |
| Lym | =1.8 | [1.0 - 4.0x10$^9$/L] | | | |
| Mxd | =3.3 | [0.1 - 1.0x10$^9$/L] | | | |
| Neut | =3.1 | [1.8 - 7.5x10$^9$/L] | | | |

**14. Sun Ronakse, 40F (Sre Thom Village)**
**Diagnosis:**
1. HTN
2. VHD??

**Treatment:**
1. HCTZ 50mg 1/2t po qd (#20)
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH
3. Do CXR at Kg Thom referral hospital

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =7.4 | [4 - 11x10$^9$/L] | Na | =143 | [135 - 145] |
| RBC | =5.1 | [3.9 - 5.5x10$^{12}$/L] | K | =3.7 | [3.5 - 5.0] |
| Hb | =12.8 | [12.0 - 15.0g/dL] | BUN | =1.5 | [0.8 - 3.9] |
| Ht | =41 | [35 - 47%] | Creat | =89 | [44 - 80] |
| MCV | =81 | [80 - 100fl] | Gluc | =4.1 | [4.2 - 6.4] |
| MCH | =25 | [25 - 35pg] | | | |

| | | |
|---|---|---|
| MHCH | =31 | [30 - 37%] |
| Plt | =271 | [150 - 450x$10^9$/L] |
| Lym | =3.5 | [1.0 - 4.0x$10^9$/L] |

**15. Tith Sokhem, 18 months Female (Kam Pot Village)**
**Diagnosis:**
1. Scalp abscess

**Treatment:**
1. Cloxacillin 500mg 1/4t po qid x 7days (#7)

**16. Ung Set, 52F (Sam Reth Village)**
**Diagnosis:**
1. Infected wound on Right thigh and left calf

**Treatment:**
1. Remove all sutures then clean with NSS, apply with sugar solution every day
2. Augmentin 875mg 1t po bid x 10d (#20)
3. Naproxen 220mg 1t po bid x 10d (#20)

**17. Kim Chenda, 28F (Ta Tong Village)**
**Diagnosis:**
1. Genital wart

**Treatment:**
1. Refer to SHCH for surgical consultation
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Differential count, Reticulocyte, Protein electrophoresis, Peripheral blood smear at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =4.8 | [4 - 11x$10^9$/L] | Na | =142 | [135 - 145] |
| RBC | =4.5 | [3.9 - 5.5x$10^{12}$/L] | K | =3.6 | [3.5 - 5.0] |
| Hb | =11.4 | [12.0 - 15.0g/dL] | BUN | =2.1 | [0.8 - 3.9] |
| Ht | =36 | [35 - 47%] | Creat | =97 | [44 - 80] |
| MCV | =80 | [80 - 100fl] | Gluc | =4.9 | [4.2 - 6.4] |
| MCH | =25 | [25 - 35pg] | | | |
| MHCH | =31 | [30 - 37%] | | | |
| Plt | =193 | [150 - 450x$10^9$/L] | | | |
| Lym | =0.9 | [1.0 - 4.0x$10^9$/L] | | | |

**Differential count**

| | | |
|---|---|---|
| Neut | =75 | [36 – 66] |
| Lym | =20 | [24 – 44] |
| Eo | =3 | [0 – 3] |
| Mono | =2 | [0 – 4] |

**RBC morphology**

| | |
|---|---|
| Microcyte: | 1+ |
| Hypocromic: | 1+ |

| | | |
|---|---|---|
| Reticulocyte | =2.5 | [0.5 – 1.5] |

**18. Om Samen, 36F (Thnout Malou Village)**
**Diagnosis:**
1. Fibroadenoma on bilateral breasts
2. Dyspepsia

**Treatment:**
1. Refer to SHCH for surgical consultation, possible biopsy or mass excision

2. Ranitidine 150mg 1t po qhs for one month (#30)
3. Mebendazole 100mg 5t po qhs once (#5)

**19. Kaem Seam, 51M (Kam Pot Village)**
**Diagnosis:**

1. Gouty arthritis?
2. Osteoarthritis?

**Treatment:**

1. Naproxen 220mg 1t po bid (#20)
2. Draw blood for CBC, ESR at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| WBC | =7.6 | [4 - 11x$10^9$/L] |
| RBC | =4.8 | [4.6 - 6.0x$10^{12}$/L] |
| Hb | =12.8 | [14.0 - 16.0g/dL] |
| Ht | =39 | [42 - 52%] |
| MCV | =82 | [80 - 100fl] |
| MCH | =27 | [25 - 35pg] |
| MHCH | =33 | [30 - 37%] |
| Plt | =233 | [150 - 450x$10^9$/L] |
| Lym | =3.5 | [1.0 - 4.0x$10^9$/L] |
| | | |
| ESR | =70 | [0 – 15] |

**20. Teng Korng, 38M (Ta Tong Village)**
**Diagnosis:**

1. Contact dermatitis?
2. Eczema?

**Treatment:**

1. Fluocinonide cream 0.1% apply bid on the lesion until the rashes gone (#2)
2. Diphenhydramine 25mg 1t po qhs (#30)

**21. Hem Lonh, 31M (Kam Pot Village)**
**Diagnosis:**

1. Psoriasis

**Treatment:**

1. Griseofulvin 250mg 1t po qd (#40)
2. Mometasone cream apply bid (#3)
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc, LFT at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =6.0 | [4 - 11x$10^9$/L] | Na | =141 | [135 - 145] |
| RBC | =5.4 | [4.6 - 6.0x$10^{12}$/L] | K | =3.7 | [3.5 - 5.0] |
| Hb | =14.5 | [14.0 - 16.0g/dL] | BUN | =1.2 | [0.8 - 3.9] |
| Ht | =45 | [42 - 52%] | Creat | =101 | [53 - 97] |
| MCV | =83 | [80 - 100fl] | Gluc | =3.4 | [4.2 - 6.4] |
| MCH | =27 | [25 - 35pg] | SGOT | =29 | [<37] |
| MHCH | =32 | [30 - 37%] | TG | =13 | [<42] |
| Plt | =264 | [150 - 450x$10^9$/L] | | | |
| Lym | =1.3 | [1.0 - 4.0x$10^9$/L] | | | |

**22. Bon Phon, 64F (Thkeng Village)**
**Diagnosis:**

1. DMII
2. Abdominal Aortic aneurysm

3. Dyspepsia

**Treatment:**

1. Glibenclamide 5mg 1/2t po qd (#20)
2. Atenolol 25mg 1/2t po qd (#20)
3. ASA 300mg 1/4t po qd (#10)
4. Ranitidine 150mg 1t po qhs for one month (#30)
5. Mebendazole 100mg 5t po qhs once (#5)
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc and HbA1C at SHCH
7. Send to SHCH for 2D echo of abdomen

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =5.0 | [4 - 11x10$^{9}$/L] | Na | =141 | [135 - 145] |
| RBC | =4.4 | [3.9 - 5.5x10$^{12}$/L] | K | =3.6 | [3.5 - 5.0] |
| Hb | =8.8 | [12.0 - 15.0g/dL] | BUN | =1.9 | [0.8 - 3.9] |
| Ht | =28 | [35 - 47%] | Creat | =110 | [44 - 80] |
| MCV | =63 | [80 - 100fl] | Gluc | =4.4 | [4.2 - 6.4] |
| MCH | =20 | [25 - 35pg] | HbA1C | =5.9 | [4 – 6] |
| MHCH | =32 | [30 - 37%] | | | |
| Plt | =238 | [150 - 450x10$^{9}$/L] | | | |
| Lym | =3.2 | [1.0 - 4.0x10$^{9}$/L] | | | |

## Patients who come for follow up and refill medicine

**1. Bun Kry, 39M (Bakdoang Village)**
**Diagnosis:**

1. Epilepsy

**Treatment:**

1. Phenytoin 100mg 2t po qd for one month (#70)

**2. Chan Him, 60F (Taing Treuk Village)**
**Diagnosis:**

1. HTN

**Treatment:**

1. HCTZ 50mg 1/2t po qd for three months (# 45)
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Tot chol, TG at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =10.1 | [4 - 11x10$^{9}$/L] | Na | =142 | [135 - 145] |
| RBC | =5.0 | [3.9 - 5.5x10$^{12}$/L] | K | =3.1 | [3.5 - 5.0] |
| Hb | =12.6 | [12.0 - 15.0g/dL] | BUN | =2.9 | [0.8 - 3.9] |
| Ht | =39 | [35 - 47%] | Creat | =106 | [44 - 80] |
| MCV | =79 | [80 - 100fl] | Gluc | =6.4 | [4.2 - 6.4] |
| MCH | =25 | [25 - 35pg] | T. Chol | =5.9 | [<5.7] |
| MHCH | =32 | [30 - 37%] | TG | =2.3 | [<1.71] |
| Plt | =270 | [150 - 450x10$^{9}$/L] | | | |
| Lym | =3.5 | [1.0 - 4.0x10$^{9}$/L] | | | |

**3. Chan Khut, 64F (Sre Thom Village)**
**Diagnosis:**

1. HTN

**Treatment:**

1. HCTZ 50mg 1/2t po qd for one month (#20)
2. ASA 300mg 1/4t po qd for one month (#10)

3. Eat low Fats/Salt diet, do regular exercise

**4. Chan Oeung, 57M (Sangke Roang Village)**
**Diagnosis:**

1. HTN
2. Osteoarthritis (Diffuse PIP, DIP, MIP, Wrist and shoulder)

**Treatment:**

1. HCTZ 50mg 1t po qd for three months (#40)
2. Calcium gluconate 1t po qd (#30)
3. FeSO4/Folate 200/0.4mg 1t po qd (#90)
4. Naproxen 220mg 1t po bid prn severe pain for three months (# 30)
5. Paracetamol 500mg 1t po qid prn pain for three months (# 30)
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc, tot Chole, TG, Uric acid and RF at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =8.8 | [4 - 11x10$^9$/L] | Na | =143 | [135 - 145] |
| RBC | =4.3 | [4.6 - 6.0x10$^{12}$/L] | K | =3.5 | [3.5 - 5.0] |
| Hb | =12.2 | [14.0 - 16.0g/dL] | BUN | =4.1 | [0.8 - 3.9] |
| Ht | =38 | [42 - 52%] | Creat | =292 | [53 - 97] |
| MCV | =88 | [80 - 100fl] | Gluc | =5.5 | [4.2 - 6.4] |
| MCH | =29 | [25 - 35pg] | T. Chol | =4.3 | [<5.7] |
| MHCH | =32 | [30 - 37%] | TG | =2.6 | [<1.7] |
| Plt | =273 | [150 - 450x10$^9$/L] | Uric Aci | =852 | [200 - 420] |
| Lym | =1.1 | [1.0 - 4.0x10$^9$/L] | RF | = Negative | |
| Mxd | =0.8 | [0.1 - 1.0x10$^9$/L] | | | |
| Neut | =6.9 | [1.8 - 7.5x10$^9$/L] | | | |

**5. Chea Kimheng, 34F (Taing Treuk Village)**
**Diagnosis:**

1. ASD by 2D echo on August 2008

**Treatment:**

1. ASA 300mg 1/4t po qd for three months (#24)
2. Atenolol 25mg 1t po qd for three months (#90)
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc, tot Chole, TG at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =5.4 | [4 - 11x10$^9$/L] | Na | =138 | [135 - 145] |
| RBC | =4.8 | [3.9 - 5.5x10$^{12}$/L] | K | =4.0 | [3.5 - 5.0] |
| Hb | =13.6 | [12.0 - 15.0g/dL] | BUN | =1.6 | [0.8 - 3.9] |
| Ht | =41 | [35 - 47%] | Creat | =90 | [44 - 80] |
| MCV | =85 | [80 - 100fl] | Gluc | =3.2 | [4.2 - 6.4] |
| MCH | =28 | [25 - 35pg] | T. Chol | =4.3 | [<5.7] |
| MHCH | =33 | [30 - 37%] | TG | =1.0 | [<1.71] |
| Plt | =193 | [150 - 450x10$^9$/L] | | | |
| Lym | =2.8 | [1.0 - 4.0x10$^9$/L] | | | |
| Mxd | =0.4 | [0.1 - 1.0x10$^9$/L] | | | |
| Neut | =2.2 | [1.8 - 7.5x10$^9$/L] | | | |

**6. Chourb Kimsan, 56M (Rovieng Tbong Village)**
**Diagnosis:**

1. HTN
2. Right Side stroke with left side weakness
3. DMII

**Treatment:**

1. Atenolol 50mg 1/2t po bid for three months (buy)
2. Captopril 25mg 1t po tid for three months (buy)
3. ASA 300mg 1/4t po qd for three months (#24)
4. Metformin 500mg 1t po bid for three months (#180)
5. Glibenclamide 5mg 1t po qd for three months (buy)

**7. Chhay Chanthy, 45F (Thnout Malou Village)**
**Diagnosis:**

1. Hyperthyroidism
2. Dyspepsia

**Treatment:**

1. Carbimazole 5mg 1t po bid for one month (#60)
2. Propranolol 40mg 1/4t po bid for one month (#20)
3. Raniditine 150mg 1t po qhs (#30)

**8. Chhim Paov, 50M (Boeung Village)**
**Diagnosis:**

1. GOUT
2. HTN

**Treatment:**

1. Captopril 25mg 1t po bid (#70)
2. Naproxen 220mg 1t po bid prn for three months (#50)
3. Paracetamol 500mg 1t po qid prn pain for three months (#50)
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc, tot Chole, TG and Uric acid at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =8.5 | [4 - 11x$10^9$/L] | Na | =145 | [135 - 145] |
| RBC | =3.6 | [4.6 - 6.0x$10^{12}$/L] | K | =3.5 | [3.5 - 5.0] |
| Hb | =11.3 | [14.0 - 16.0g/dL] | BUN | =2.9 | [0.8 - 3.9] |
| Ht | =34 | [42 - 52%] | Creat | =147 | [53 - 97] |
| MCV | =94 | [80 - 100fl] | Gluc | =4.2 | [4.2 - 6.4] |
| MCH | =32 | [25 - 35pg] | T. Chol | =7.5 | [<5.7] |
| MHCH | =34 | [30 - 37%] | TG | =4.0 | [<1.7] |
| Plt | =485 | [150 - 450x$10^9$/L] | Uric Aci | =729 | [200 - 420] |
| Lym | =2.2 | [1.0 - 4.0x$10^9$/L] | | | |
| Mxd | = | [0.1 - 1.0x$10^9$/L] | | | |
| Neut | = | [1.8 - 7.5x$10^9$/L] | | | |

**9. Chhin Chheut, 13M (Trapang Reusey Village)**
**Diagnosis:**

1. Renal Rickettsia (per AHC in Siem Reap)
2. Cachexia
3. Nephrotic Syndrome

**Treatment:**

1. Ca/Vit $D_3$ 500/400 2t po qid

**10. Chhiv Sok Kea, 54F (Thnout Malou Village)**
**Diagnosis:**

1. DMII

**Treatment:**

1. Metformin 1000mg (extended release) 1t po qhs for one month (#30)
2. Captopril 25mg 1/4t po bid for one month (#15)
3. ASA 300mg 1/4t po qd for one month (#8)
4. Draw blood for Gluc and HbA1C at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =6.9 | [4.2 - 6.4] |
| HbA1C | =10.0 | [4 - 6] |

**11. Chin Thary, 27F (Rovieng Cheung Village)**
**Diagnosis:**

1. DMII

**Treatment:**

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

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =13.9 | [4.2 - 6.4] |
| HbA1C | =8.1 | [4 - 6] |

**12. Chin Thy Ren, 38F (Rovieng Cheung Village)**
**Diagnosis:**

1. DMII

**Treatment:**

1. Metformin 500mg 2t po bid (buy)
2. Glibenclamide 5mg 1t po qd (buy)
3. ASA 300mg 1/4t po qd (buy)
4. Draw blood for Gluc and HbA1C at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =3.5 | [4.2 - 6.4] |
| HbA1C | =6.2 | [4 - 6] |

**13. Chum Chey, 75M (Ta Tong Village)**
**Diagnosis:**

1. COPD

**Treatment:**

1. Salbutamol inhaler 2puffs po bid for one month (#1)

**14. Dourng Sunly, 50M (Taing Treurk Village)**
**Diagnosis:**

1. HTN
2. Gout

**Treatment:**

1. Captopril 25mg 1/2t po bid for three months (# 90)
2. ASA 300mg 1/4t po qd for three months (# 24)
3. Naproxen 220mg 1t po bid prn severe pain for three months (# 50)
4. Paracetamol 500mg 1t po 1q6h prn pain/fever for three months (# 50)

**15. Eam Neut, 54F (Taing Treuk)**
**Diagnosis**

1. HTN

**Treatment**

1. Atenolol 50 mg ½ t po bid

**16. Heng Chan Ty, 49F (Ta Tong Village)**
**Diagnosis:**

1. Hyperthyroidism

**Treatment:**

1. Carbimazole 5mg 1t po tid for one month (#100)
2. Propranolol 40mg ¼ t po bid for one month (#20)

**17. Heng Pheary, 30F (Thkeng Village)**
**Diagnosis:**

1. Asthma

**Treatment:**

1. Salbutamol Inhaler 2puffs po bid prn severe SOB for four months (# 2)

**18. Ke Narin, 24F (Chambak Phaem Village)**
**Diagnosis:**

1. VHD (PS/TR)??
2. Dyspepsia

**Treatment:**

1. Ranitidine 150mg 1t po qhs (#30)

**19. Keth Chourn, 55M (Chhnourn Village)**
**Diagnosis:**

1. HTN

**Treatment:**

1. HCTZ 50mg 1t po qd for two months (# 60)
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Tot chol, TG at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =7.9 | [4 - 11x$10^9$/L] | Na | =142 | [135 - 145] |
| RBC | =4.3 | [4.6 - 6.0x$10^{12}$/L] | K | =2.5 | [3.5 - 5.0] |
| Hb | =12.2 | [14.0 - 16.0g/dL] | BUN | =3.2 | [0.8 - 3.9] |
| Ht | =39 | [42 - 52%] | Creat | =89 | [53 - 97] |
| MCV | =92 | [80 - 100fl] | Gluc | =5.0 | [4.2 - 6.4] |
| MCH | =29 | [25 - 35pg] | T. Chol | =4.0 | [<5.7] |
| MHCH | =31 | [30 - 37%] | TG | =1.3 | [<1.7] |
| Plt | =256 | [150 - 450x$10^9$/L] | | | |
| Lym | =2.9 | [1.0 - 4.0x$10^9$/L] | | | |

**20. Kim Yat, 28F (Sre Thom Village)**
**Diagnosis:**

1. Anemia
2. Elevated BP

**Treatment:**

1. FeSO4/Folate 200/0.25mg 1t po bid for two months (#120)
2. MTV 1t po qd for tow months (#60)

**21. Kong Nareun, 34F (Taing Treuk Village)**
**Diagnosis:**

1. Moderate MS with severe TR
2. Atria dilation
3. Severe pulmonary HTN

**Treatment:**

1. Atenolol 25mg 1/2t po qd (#15)
2. Spironolactone 25mg 1t po qd (#30)
3. ASA 300mg 1/4t po qd (#8)

**22. Meas Lam Phy, 57M (Thnout Malou Village)**
**Diagnosis:**
1. DMII

**Treatment:**
1. Metformin 1000mg 1t po qhs for one month (#30)
2. Draw blood for Gluc, HbA1C at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =5.2 | [4.2 - 6.4] |
| HbA1C | =7.4 | [4 - 6] |

**23. Moeung Srey, 42F (Thnout Malou Village)**
**Diagnosis**
1. HTN
2. Anemia due to malaria

**Treatment**
1. Enalapril 5mg 1t po qd for one month (# 40)
2. MTV 1t po qd for one month (#30)
3. FeSO4/Folate 200/0.25mg 1t po for one month (#60)

**24. Nop Sareth, 38F (Kampot Village)**
**Diagnosis:**
1. Cardiomegaly
2. VHD (MS/TR)

**Treatment:**
1. Atenolol 50mg ½ t po qd for three months (# 45)
2. Captopril 25mg ¼ po bid for three months (# 45)
3. ASA 300mg 1/4t po qd for three months (# 24)

**25. Nung Bopha, 45F (Rovieng Cheung Village)**
**Diagnosis:**
1. DMII

**Treatment:**
1. Gliburide/Metformin 2.5mg/500mg 2t po bid for one month (#120)
2. Captopril 25mg 1/4t po bid for one month (#buy)
3. ASA 300mg 1/4t po qd for one month (#buy)
4. Draw blood for Gluc, HbA1C at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =7.1 | [4.2 - 6.4] |
| HbA1C | =9.8 | [4 - 6] |

**26. Pang Then, 51F (Thnal Keng Village)**
**Diagnosis:**
1. HTN

**Treatment:**
1. Enalapril 5mg 1t po qd for one month (#40)
2. HCTZ 50mg 1/2t po qd for one month (#20)
3. Eat low Fats/Salt diet, do regular exercise

**27. Phim Sichin, 35F (Taing Treuk Village)**
**Diagnosis:**

1. DMII with PNP
2. LVH
3. TR/MS
4. Thalassemia

**Treatment:**

1. Glibenclamide 5mg 2t po bid for two months (#240)
2. Metformin 500mg 3t qAM, 2t po qPM for two months (#300)
3. Captopril 25mg 1/4t po bid for two months (#30)
4. MTV 1t po bid for two months (#120)
5. Amitriptylin 25mg 1/2t po qhs for two months (#30)

**28. Prum Vandy, 49F (Taing Treuk Village)**
**Diagnosis:**

1. Hyperthyroidism

**Treatment:**

1. Carbimazole 5mg 1t po bid for two months (#120)
2. Propranolol 40mg 1/4t po bid for two months (#30)

**29. Roth Ven, 53M (Thkeng Village)**
**Diagnosis:**

1. DMII

**Treatment:**

1. Glibenclamide 5mg 1t po bid for three months (#180)
2. Metformin 500mg 1t po bid for three months (#180)
3. Captopril 25mg 1/4t po qd for three months (#24)
4. ASA 300mg 1/4t po qd for three months (#24)

**30. Sam Thourng, 29F (Thnal Keng Village)**
**Diagnosis:**

1. Cardiomegaly by CXR
2. Severe MS (MVA <1cm$^2$)

**Treatment:**

1. Atenolol 50mg 1t po qd for one month (#35)
2. ASA 300mg 1/2t po qd for one month (#20)
3. HCTZ 50mg 1/2t po qd for one month (#20)

**31. Seung Samith, 63M (Sre Thom Village)**
**Diagnosis:**

1. Gouty arthritis

**Treatment:**

1. Paracetamol 500mg 1t po qid prn pain (#30)
2. Naproxen 220mg 1t po bid prn severe pain (#30)
3. Eat low protein/salt/fats diet and do regular exercise

**32. So On, 80F (Thnout Malou Village)**
**Diagnosis:**

1. HTN
2. Osteoarthritis
3. Anemia

**Treatment:**

1. HCTZ 50mg 1/2t po po qd for three months (# 45)

2. Paracetamol 500mg 1t po qid prn pain/fever for three months (# 30)
3. MTV 1t po qd for three months (#90)
4. FeSO4/Folate 200/0.25mg 1t po qd for three months (#90)
5. Calcium gluconate 1t po qd (#30)
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Tot chol, TG at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =10.1 | [4 - 11x$10^9$/L] | Na | =141 | [135 - 145] |
| RBC | =3.9 | [3.9 - 5.5x$10^{12}$/L] | K | =3.2 | [3.5 - 5.0] |
| Hb | =9.3 | [12.0 - 15.0g/dL] | BUN | =2.1 | [0.8 - 3.9] |
| Ht | =29 | [35 - 47%] | Creat | =143 | [44 - 80] |
| MCV | =74 | [80 - 100fl] | Gluc | =4.2 | [4.2 - 6.4] |
| MCH | =24 | [25 - 35pg] | T. Chol | =5.1 | [<5.7] |
| MHCH | =32 | [30 - 37%] | TG | =2.3 | [<1.71] |
| Plt | =229 | [150 - 450x$10^9$/L] | | | |
| Lym | =3.6 | [1.0 - 4.0x$10^9$/L] | | | |
| Mxd | =2.4 | [0.1 - 1.0x$10^9$/L] | | | |
| Neut | =4.1 | [1.8 - 7.5x$10^9$/L] | | | |

**33. So Sary, 65F (Koh Pon Village)**
**Diagnosis:**
1. HTN

**Treatment:**
1. HCTZ 50mg 1/2t po qd for three months (#45)
2. Draw blood for CBC, Lyte, BUN, Creat, gluc, Tot chole, TG at SHCH

**Lab Result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =6.3 | [4 - 11x$10^9$/L] | Na | =142 | [135 - 145] |
| RBC | =3.7 | [3.9 - 5.5x$10^{12}$/L] | K | =3.9 | [3.5 - 5.0] |
| Hb | =9.7 | [12.0 - 15.0g/dL] | BUN | =3.3 | [0.8 - 3.9] |
| Ht | =31 | [35 - 47%] | Creat | =160 | [44 - 80] |
| MCV | =85 | [80 - 100fl] | Gluc | =3.8 | [4.2 - 6.4] |
| MCH | =27 | [25 - 35pg] | T. Chol | =6.0 | [<5.7] |
| MHCH | =31 | [30 - 37%] | TG | =1.4 | [<1.71] |
| Plt | =243 | [150 - 450x$10^9$/L] | | | |
| Lym | =2.3 | [1.0 - 4.0x$10^9$/L] | | | |

**34. Sok Tem Ra, 25M (Thnal Keng Village)**
**Diagnosis:**
1. Anemia

**Treatment:**
1. FeSO4/Folate 200/0.25mg 1t po bid (#120)
2. MTV 1t po qd (#60)

**35. Srey Hom, 62F (Taing Treuk Village)**
**Diagnosis:**
1. HTN
2. DMII with PNP
3. Renal Failure

**Treatment:**
1. Glibenclamide 5mg 1$^1/_2$t po bid for one month (# 90)
2. Nifedipine 20mg 1t po qd for one month (# 30)
3. ASA 300mg 1/4t po qd for one month (# 8)
4. Amitriptylin 25mg 1/2t po qhs for one month (# 15)
5. FeSO4/Folic Acid 200/0.25mg 1t po qd for one month (#30)

6. MTV 1t po qd for one month (#30)
7. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =7.4 | [4 - 11x$10^9$/L] | Na | =145 | [135 - 145] |
| RBC | =3.9 | [3.9 - 5.5x$10^{12}$/L] | K | =3.4 | [3.5 - 5.0] |
| Hb | =10.1 | [12.0 - 15.0g/dL] | BUN | =4.0 | [0.8 - 3.9] |
| Ht | =29 | [35 - 47%] | Creat | =500 | [44 - 80] |
| MCV | =74 | [80 - 100fl] | Gluc | =6.9 | [4.2 - 6.4] |
| MCH | =26 | [25 - 35pg] | | | |
| MHCH | =35 | [30 - 37%] | | | |
| Plt | =236 | [150 - 450x$10^9$/L] | | | |
| Lym | =2.8 | [1.0 - 4.0x$10^9$/L] | | | |
| Mxd | =1.6 | [0.1 - 1.0x$10^9$/L] | | | |
| Neut | =3.0 | [1.8 - 7.5x$10^9$/L] | | | |

**36. Srey Reth, 51F (Kampot Village)**
**Diagnosis:**
1. Migraine HA

**Treatment:**
1. Paracetamol 500mg 1t po qid prn for three months (#50)

**37. Srey Thouk, 56F (Taing Treuk Village)**
**Diagnosis:**
1. HTN

**Treatment:**
1. Atenolol 50mg ½ t po qd for four months (#60)
2. ASA 300mg 1/4t po qd for four months (#30)

**38. Tann Kim Horn, 51F (Thnout Malou Village)**
**Diagnosis**
1. DMII

**Treatment**
1. Glibenclamide 5mg 2t po bid (buy)
2. Metformin 500mg 2t po bid (buy)
3. Captopril 25mg 1/4t po qd (buy)
4. ASA 300mg 1/4t po qd for (buy)
5. Draw blood for Gluc, HbA1C at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =19.7 | [4.2 - 6.4] |
| HbA1C | =10.6 | [4 - 6] |

**39. Tep Tam, 74M (Bos Village)**
**Diagnosis:**
1. Dyspepsia
2. HTN

**Treatment:**
1. HCTZ 50mg 1/2t po qd for one month (#20)

**40. Tey Sophourn, 33F (Chambak Phaem Village)**
**Diagnosis:**
1. Dyspepsia
2. Stress

**Treatment:**

1. Ranitidine 150mg 1t po qhs for month (#30)
2. Stress release

**41. Thoang Korn, 38F (Ta Tong Village)**
**Diagnosis:**

1. HTN

**Treatment:**

1. HCTZ 50mg 1/2t po qd for one month (#20)

**42. Thorng Khun, 43F (Thnout Malou Village)**
**Diagnosis:**

1. Hyperthyroidsim
2. Sciatica
3. Vit Deficiency

**Treatment:**

1. Carbimazole 5mg 1t po bid (#70)
2. Paracetamol 500mg 1t po qid prn pain (#20)
3. MTV 1t po qd (#30)

**43. Tith Hun, 56F (Ta Tong Village)**
**Diagnosis:**

1. HTN

**Treatment:**

1. Enalapril 5mg 2t po qd for one month (# 70)
2. Atenolol 25mg 1t po bid for one month (# 70)

**44. Tith Pov, 70F (Taing Treuk Village)**
**Diagnosis:**

1. DMII with PNP

**Treatment:**

1. Glibenclamide 5mg 1t po bid for one month (#60)
2. Captopril 25mg 1/4t po bid for one month (#15)
3. ASA 300mg 1/4t po qd for one month (#8)
4. Amitriptyline 25mg 1/4t po qhs for one month (#8)
5. Draw blood for Gluc, HbA1C at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =8.1 | [4.2 - 6.4] |
| HbA1C | =6.5 | [4 - 6] |

**45. Touch Run, 61F (Thnal Keng Village)**
**Diagnosis:**

1. Dyspepsia

**Treatment:**

1. Ranitidine 150mg 1t po qhs (#30)

**46. Toun Keun, 23F (Bang Korn Village)**
**Diagnosis:**

1. VHD (Severe MS/TR/TS)
2. Mild MR with EF 45%

**Treatment:**

1. Digoxin 0.25mg 1t po qd for one month (#30)
2. Furosemide 40mg 1t po qd for one month (#30)
3. MTV 1t po qd for one month (#30)
4. FeSO4/Folate 200/0.25mg 1t po bid for one month (#60)

**46. Thoang Khoeun, 51F (Thnout Malou Village)**
**Diagnosis:**

1. Drug induced hepatitis
2. Premature artrial contraction
3. Thalassemia?

**Treatment:**

1. Omeprazole 20mg 1t po bid x 2w then 1t po qhs for one month (#30)
2. FeSO4/Folate 200/0.25mg 1t po bid for one month (#60)
3. Folic acid 5mg 1t po qd (#40)

**47. Um Sam Ol, 41M (Sleng Tuol Village)**
**Diagnosis:**

1. Liver cirrhosis

**Treatment:**

1. Spironolactone 25mg 1t po bid (#70)
2. Folic acid 5mg 1t po qd (#35)
3. Furosemide 40mg 1t po bid x 7d (#14)
4. Vit K 10mg S/C for 3days
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc, LFT at SHCH

**Lab result on April 9, 2010**

| | | | | | |
|---|---|---|---|---|---|
| WBC | =4.4 | [4 - 11x10$^9$/L] | Na | =137 | [135 - 145] |
| RBC | =4.2 | [4.6 - 6.0x10$^{12}$/L] | K | =3.0 | [3.5 - 5.0] |
| Hb | =12.7 | [14.0 - 16.0g/dL] | BUN | =1.6 | [0.8 - 3.9] |
| Ht | =38 | [42 - 52%] | Creat | =109 | [53 - 97] |
| MCV | =91 | [80 - 100fl] | Gluc | =2.4 | [4.2 - 6.4] |
| MCH | =31 | [25 - 35pg] | SGOT | =276 | [<5.7] |
| MHCH | =34 | [30 - 37%] | SGPT | =133 | [<1.7] |
| Plt | =77 | [150 - 450x10$^9$/L] | | | |
| Lym | =1.2 | [1.0 - 4.0x10$^9$/L] | | | |

**48. Un Chhourn, 40M (Taing Treuk Village)**
**Diagnosis:**

1. DMII

**Treatment:**

1. Glibenclamide 5mg 1t po bid for one month (#60)
2. Captopril 25mg 1/4t po qd for one month (#8)
3. ASA 300mg 1/4t po qd for one month (#8)
4. Draw blood for Gluc, HbA1C at SHCH

**Lab result on April 9, 2010**

| | | |
|---|---|---|
| Gluc | =7.9 | [4.2 - 6.4] |
| HbA1C | =6.7 | [4 - 6] |

**49. Vong Cheng Chan, 52F (Rovieng Cheung Village)**
**Diagnosis**

1. HTN

**Treatment**

1. Atenolol 50mg 1/2t po bid for three months (#90)

**50. Yin Hun, 72F (Taing Treuk Village)**
**Diagnosis:**

1. HTN

**Treatment:**

1. HCTZ 50mg 1/2t po qd for three months (#45)

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# The next Robib TM Clinic will be held on May 10 - 14, 2010