Robib *Telemedicine* Clinic
Preah Vihear Province
J U L Y 2 0 0 9

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

On Monday, July 6, 2009, SHCH staff Driver and Nurse Peng Sovann traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following two days, Tuesday and Wednesday (mornings), July 07 & 08, 2009, the Robib TM Clinic opened to receive the patients for evaluations. There were 6 new cases 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 Wednesday and Thursday, July 08 & 09, 2009.

On Thursday, replies from SHCH in Phnom Penh and Partners Telemedicine in Boston were downloaded. Per advice from Boston, and SHCH, 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 Peng Sovann 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 Telemed
Date: Jun 29, 2009 10:58 AM
Subject: Schedule for Robib TM Clinic July 2009
To: Rithy Chau; Cornelia Haener; Kathy Fiamma; Kruy Lim; "Paul J. M.D. Heinzelmann"; Joseph Kvedar
Cc: Bernie Krisher; Dan Liu; Thero Noun; Laurie & Ed Bachrach; Peou Ouk; Sochea Monn; Samoeurn Lanh

Dear all,

I would like to inform you all that the Robib TM Clinic for July 2009 will be starting on July 6 to 10, 2009.

The agenda for the trip is as following:
1. On Monday July 6, 2009, We will be starting the trip from Phnom Penh to Rovieng, Preah Vihear.
2. On Tuesday July 7, 2009, the clinic opens to see the patients for the whole morning, new
and follow up, then the patients' data will be typed up as Word file and send to both partners in Boston and Phnom Penh.
3. On Wednesday July 8, 2009, the activity is as on Tuesday
4. On Thursday July 9, 2009, download all the answers replied from both partners, then the treatment plan will be made accordingly and prepare the medicine for patients in the afternoon.
5. On Friday July 10, 2009, draw the blood from patients for lab test at SHCH then come back to Phnom Penh.

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

Best regards,
Sovann

From: Robib Telemed
Date: Jul 7, 2009 8:40 PM
Subject: Robib TM Clinic July 2009, Case#1, Prum Soeun, 53F (Thnout Malou Village)
To: Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Kathy Fiamma; Joseph Kvedar
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

For first day of Robib TM clinic July 2009, there are two new cases
and this is case number 1, Prum Soeun, 53F 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 Soeun, 53F (Thnout Malou Village)**

Chief Complaint (CC): Dizziness and palpitation x 1y

History of Present Illness (HPI): 53F, farmer, presented with symptoms of dizziness, palpitation, fatigue, HA, neck tension for a few weeks, she went to local clinic BP taken 160/? And treated with antihypertensive drug (unknown name) then she became better and took antihypertensive only when above symptoms presented. She came to see Telemedicine clinic in June 2009 with BP: 160/80, she was educate to eat low salt/fats diet, do regular exercise and come to check up in this months. She denied of chest pain, oliguria, dysuria, hematuria, edema.

Past Medical History (PMH): Unremarkable

Family History: Brother with HTN

Social History: No smoking, no tobacco chewing, no alcohol drinking

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Epigastric pain, retrosternal burning sensation, burping with sour taste after eating, radiate to the scapula, no vomiting, no stool with blood/mucus

PE:

Vitals: **BP: 152/84 (both arms)** **P: 80** **R: 20** **T: 37°C** **Wt: 61Kg**

General: Look stable

HEENT: No oropharyngeal lesion, pink conjunctiva, no neck mass, 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, some complete healed burning scar

Extremity/Skin: no edema, no rash, no foot wound, (+) dorsalis pedis pulse

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

Lab/study: On July 7, 2009
U/A Protein trace

Assessment:

1. HTN
2. GERD

Plan:

1. HCTZ 50mg 1/2t po qd
2. Ranitidine 300mg 1t po qhs for one month
3. Eat low salt/fats diet, no regular exercise
4. GERD prevention education
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: July 7, 2009**

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

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From: Rithy Chau
Date: Jul 8, 2009 10:52 AM
Subject: Robib TM Clinic July 2009, Case#1, Prum Soeun, 53F (Thnout Malou Village)
To: Robib Telemed
Cc: Kruy Lim; "Paul J. M.D. Heinzelmann"; Kathy Fiamma; Joseph Kvedar; Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear Sovann,

Thanks for the cases this month.

As for Prum Soeun, I agree with your assessment and treatment plan. You might want to add Metoclopramide 10mg 1 qhs for 15 days.

Rithy

From: Kreinsen, Carolyn Hope,M.D.,M.Sc.
Date: Jul 9, 2009 3:49 AM
Subject: Robib TM Clinic July 2009, Case#1, Prum Soeun, 53F (Thnout Malou Village)
To: "Fiamma, Kathleen M."; robibtelemed@gmail.com; rithychau@sihosp.org

Medical Consultation:

Hi Sovann,

Ms. S is a 53 yo woman who presents with a 1 year h/o intermittent dizziness, palpitations without chest pain or SOB, fatigue, headaches and neck stiffness. On exam close to 1 year ago, she was found to be hypertensive. Her symptoms resolved with antihypertensive therapy - unknown med. She has since been taking the medication on a PRN basis, whenever symptoms recur and seems to have relief of symptoms when she takes the med. When evaluated 1 month ago in the Telemedicine Clinic, she had systolic hypertension (160/80) and was treated conservatively with recommendations for lifestyle changes and was advised to f/u in 1 month.

On presentation at this visit, it's unclear whether she is still experiencing the dizziness and palpitations. She does have new symptoms of epigastric and retrosternal burning pain with radiation to the scapula, belching and a sour taste in her mouth. She has had no obvious upper or lower GI bleeding.

Examination was normal aside from bilateral arm hypertension with comparable readings in each arm.

Discussion:

1.) Hypertension: Ms. S. has a h/o documented and fairly stable hypertension for at least one year. She started to have associated symptoms one year ago, resolving - or at least improving - whenever she restarted the med. I'd be curious as to what the initial med was. Is there any way to find out? Regardless, it is encouraging to hear that symptoms responded to treatment, making it more likely that symptoms were at least in part due to the hypertension. Given her brother's history of hypertension, there may be a hereditary tendency. It's a bit concerning that there was some protein in her urinalysis. However, it's encouraging that there was no blood. I like your initial choice of lab tests! I think it might be helpful to check a TSH, as well, given her palpitations and hypertension. The education you provided was excellent. The HCTZ is a good choice as an initial antihypertensive. I'm always a little concerned for the farmers since they are out in the sun for long hours. As with my own patients, I think it would be helpful to let her know that she may sunburn more easily so should wear a hat, may be more prone to dehydration so should drink beverages frequently throughout the day and should be careful about including local available foods rich in potassium and magnesium in her diet. Keeping the potassium in the mid normal range also has a stabilizing effect on blood vessels, actually resulting in mildly lower blood pressure.

2.) Palpitations: It sounds as though these responded to blood pressure treatment in the past. Again, it makes me wonder if she perhaps received a beta blocker like atenolol for treatment. I think that it would be helpful to obtain an EKG and rhythm strip at this point. Further work-up is probably not necessary now if her labs are normal and her symptoms resolved with HCTZ. However, the palpitations could indicate anemia, electrolyte disorders or a thyroid problem. You are checking for those and they would require further investigation. A cardiac source of her symptoms should be investigated if her palpitations continue. It would be good to ask her to come back once again in a month just to monitor that situation closely. Women with cardiac problems can often have GI symptoms rather than the more typical chest pain that men tend to have.

3.) GI: I'd be interested to know when the GI symptoms started. The radiation through to her back makes me a bit concerned about an ulcer in addition to GERD. She may get a little more benefit from the ranitidine if she splits up her dosage to 150 mg twice a day, taking the first before breakfast and the second before supper. However, given that she is a farmer, that might be difficult logistically. The benefit of a single dosage is that it is an easier regimen to follow. If she is willing, I'd advise Ms. S to cut back on tea (or coffee if she drinks it) for the time being since those may worsen her symptoms. Again, it would be good to see her again in a month. If her symptoms are not substantially better, she may need a stronger medicine such as omeprazole, or may need to see a GI specialist. It would be good to do a rectal exam at this visit to check for any occult blood. Again, I always worry when women have GI symptoms that they may be having heart problems. I think the EKG at this time would be helpful.

4.) Dizziness: It would be interesting to explore this symptom a little more with Ms. S. Does she feel as though the room is spinning - vertigo? Does she feel as though she might faint - presyncope? Does she simply feel weak? It also may be helpful to find out if her vision changes when she gets dizzy or if she has numbness or tingling in her arms and legs when she feels dizzy. Another good question would be to see if it happens more with positional change.

Sovann,

I think your assessment is excellent. I hope my thoughts are helpful for you as you sort out this woman's health problems. Please let me know if you have any questions.

Have a great day!

Carolyn K

From: Robib Telemed
Date: Jul 7, 2009 8:45 PM
Subject: Robib TM Clinic July 2009, Case#2, Tith Pov, 70F (Taing Treuk Village)
To: Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 2, Tith Pov, 70F and photo. Please waiting for other cases which will be sent to you tomorrow.

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 Pov, 70F (Taing Treuk Village)

Chief Complaint (CC): Numbness and tingling on extremity x 6 months

History of Present Illness (HPI): 70F, in previous 3y, presented with symptoms of polydypsia, polyphagia, polyuria, fatigue, dizziness, she went to private clinic in province Blood sugar 177mg/dl, treated with traditional medicine but not better she bought Antihyperglycemic drug (Chinese medicine) taking 2t bid and traditional medicine, her symptoms became better. In these 6 months, she presented with numbness and tingling on both feet up to the thigh and both arms, she tried to apply herbal traditional medicine on the extremities but it is not better. She denied of palpitation, chest pain, abdominal pain, stool with blood/mucus, oliguria, hematuria, edema.

Past Medical History (PMH): Unremarkable

Family History: Brother with DMII

Social History: No smoking, no alcohol drinking

Current Medications:

1. Chinese Antihyperglycemic drug 2t bid

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 123/81 P: 91 R: 20 T: 37°C Wt: 48Kg

General: Look 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: no edema, no rash, no foot wound, (+) dorsalis pedis pulse

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

Lab/study: On July 7, 2009
U/A Protein trace; RBS: 224mg/dl (4 hours after breakfast)

Assessment:

1. DMII with PNP

Plan:

1. Recheck FBS tomorrow
2. If FBS >200mg/dl, start Glibenclamide 5mg 1t po bid, stop Chinese and traditional medicine
3. Captopril 25mg 1/4t po bid
4. ASA 300mg 1/4t po qd
5. Amitriptyline 25mg 1/2t po qhs
6. Educate on diabetic diet, foot care and do regular exercise
7. Draw blood for CBC, Lyte, BUN, Creat, Gluc, 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: July 7, 2009**

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

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From: Rithy Chau
Date: Jul 8, 2009 10:59 AM
Subject: RE: Robib TM Clinic July 2009, Case#2, Tith Pov, 70F (Taing Treuk Village)
To: Robib Telemed
Cc: Kruy Lim; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma; Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear Sovann,
I agree with your plan. You can start the Amitriptyline 1/4 po qhs for one month and then can increase to 1/2 if not improved. Also try to get all DM II patients' BP syst below 130 and diastolic below 80.

Rithy

From: Robib Telemed
Date: Jul 8, 2009 9:10 PM
Subject: Robib TM Clinic July 2009, Case#3, Has Samith, 58F (Koh Pon Village)
To: Rithy Chau; Kathy Fiamma; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

There are four new cases for second day of Robib TM clinic July 2009 and this is case number 3, continued from yesterday, Has Samith, 58F 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: Has Samith, 58F (Koh Pon Village)

Chief Complaint (CC): Epigastric pain x 6months

History of Present Illness (HPI): 58F, farmer, presented with symptoms of epigastric pain, burning sensation, radiated to the scapular and left arm and the pain became worse with full eating, burping with sour taste. She denied of vomiting, stool with blood/mucus and got treatment with Cimetidine 40mg 1t qd, Ofloxacin 500mg 1t bid, Paracetamol 500mg 1t po qd and. She became better but the above symptoms presented in a few days after stopping medicine.

Past Medical History (PMH): In the previous 2y, she developed with HA, neck tension, dizziness, and blurred vision, BP checked 170/? Got treatment with prn Nifedipine 10mg 1t po qd, bought from local pharmacy until now

Family History: Sister with HTN

Social History: No cig smoking, no alcohol drinking

Current Medications:

1. Nifedipine 10mg 1t po qd
2. Cimetidine 40mg 1t po qd
3. Ofloxacin 500mg 1t bid
4. Paracetamol 500mg qd

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 128/83 P: 77 R: 20 T: 36.5°C Wt: 60Kg

General: Look 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: no edema, no rash, no lesion

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

Rectal exam: Good sphincter tone, smooth surface, no mass palpable, neg colocheck

Lab/study: None

Assessment:

1. GERD
2. Parasititis
3. History elevated BP

Plan:

1. Omeprazole 20mg 1t po qhs for one month
2. Metoclopramide 10mg 1t po qd x 10d
3. Mebendazole 100mg 5t chew qhs once
4. Hold Nifedipine and recheck BP in next month
5. Eat low salt/fats diet, do regular exercise
6. 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: July 8, 2009**

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

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From: Healey, Michael J.,M.D.
Date: Jul 8, 2009 10:49 PM
Subject: Robib TM Clinic July 2009, Case#3, Has Samith, 58F (Koh Pon Village)
To: "Fiamma, Kathleen M."; robibtelemed@gmail.com
Cc: rithychau@sihosp.org

Your plan sounds good. I would also suggest stool guiaic testing to see whether there may be gastritis or a peptic ulcer. If H. pylori testing or treatment is available, that may also be worthwhile. It seems reasonable to hold the Nifedipine, which it sounds like she has been taking prn, to get an accurate assessment of the blood pressure.

MJH

From: Rithy Chau
Date: Jul 9, 2009 7:59 AM
Subject: Robib TM Clinic July 2009, Case#3, Has Samith, 58F (Koh Pon Village)
To: Robib Telemed
Cc: Kruy Lim

Dear Sovann,

You can have her continue her medications (buy on her own), but she should stop the Ofloxacin--what was it for? You do not need to give medication for everyone you know only the ones who cannot afford. You can do her baseline lab work if not already done on her own in the past; but if she has no need to redo.

Rithy

From: Robib Telemed <robibtelemed@gmail.com>
Date: Jul 8, 2009 9:13 PM
Subject: Robib TM Clinic July 2009, Case#4, Pech Huy Keung, 48M (Rovieng Cheung Village)
To: Kathy Fiamma; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kruy Lim; Rithy Chau
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 4, Pech Huy Keung, 48M and photo.

Best regards,
Sovann

History and Physical

Name/Age/Sex/Village: Pech Huy Keung, 48M (Rovieng Cheung Village)

Chief Complaint (CC): Polydypsia and polyuria x 3 months

History of Present Illness (HPI): 48M presented with symptoms of polyphagia, polydypsia, polyuria, fatigue, dizziness and noticed the ants come around his urine. He denied of nausea, vomiting, abdominal pain, numbness/tingling. He has not got consultation or treatment, just come to Telemedicine clinic today.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Smoking cig 2pack/d, stopped 10y; casually alcohol drinking

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 140/92 P: 91 R: 20 T: 37°C Wt: 65Kg

General: Look 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: no edema, no rash, no foot wound

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

Lab/study:

On July 7, 2009
RBS: 443mg/dl

On July 8, 2009
FBS: 271mg/dl, U/A protein trace, gluc 3+

Assessment:

1. DMII

Plan:

1. Glibenclamide 5mg 1t po bid
2. Captopril 25mg 1/2t po bid
3. ASA 300mg 1/4t po qd
4. Educate on diabetic diet, foot care and do regular exercise
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc, 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: July 8, 2009**

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

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From: Rithy Chau
Date: Jul 9, 2009 8:04 AM
Subject: Robib TM Clinic July 2009, Case#4, Pech Huy Keung, 48M (Rovieng Cheung Village)
To: Robib Telemed
Cc: Kruy Lim

Dear Sovann,

Recheck his BP again in both arms and if still elevated about the same values you reported, then let him do some regular aerobic exercise and low salt diet and recheck next month again. I would only give him 1/4 Captopril bid for now.

Rithy

From: Fang, Leslie S.,M.D.
Sent: Wednesday, July 08, 2009 6:38 PM
To: Fiamma, Kathleen M.
Subject: Re: Robib TM Clinic July 2009, Case#4, Pech Huy Keung, 48M (Rovieng Cheung Village)

Agree with management
Need aggressive control of blood sugar

Leslie Fang, MD

From: **Robib Telemed**
Date: Jul 8, 2009 9:17 PM
Subject: Robib TM Clinic July 2009, Case#5, Pov Our, 64M (Sangke Roang Village)
To: "Paul J. M.D. Heinzelmann"; Kathy Fiamma; Joseph Kvedar; Rithy Chau; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 5, Pov Our, 64M 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: **Pov Our, 64M (Sangke Roang Village)**

Chief Complaint (CC): Palpitation x 3months

History of Present Illness (HPI): 64M presented with symptoms of fatigue, dizziness, diaphoresis, dyspnea on exertion and orthopnea, he went to private clinic in Phnom Penh blood test and CXR done and told he had heart disease with cardiomegaly, treated with some medicine (unknown name). His symptoms became better and he came for follow up with doctor at Preah vihear province and treated him with three to four kinds of medicine during each follow up. And In this month he was treated with Digoxin 0.25mg 1t po qd, Ibuprofen 400mg 1t po bid and other two kinds of medicine (unknown name). Now he feels stable and denied of dyspnea, orthopnea, chest pain, cough, dizziness, fatigue, palpitation, edema.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Smoking 5cig/d, stopped; casually alcohol drinking

Current Medications:

1. Digoxin 0.25mg 1t po qd
2. Ibuprofen 400mg 1t po bid
3. Other two types of drugs (unknown name) 1t po qd and bid

Allergies: NKDA

Review of Systems (ROS): Unremarkable

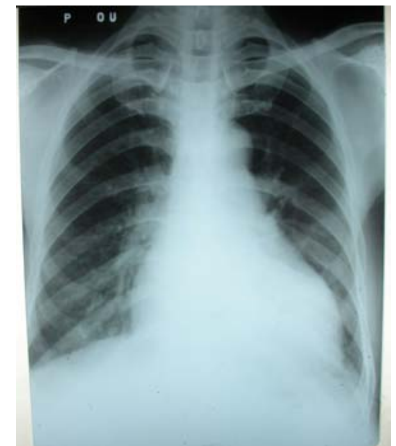
PE:

Vitals: BP: 86/45 (both arms) P: 44 R: 20 T: 37°C Wt: 52Kg

HR is less than 50/mm after asking patient to walk 5mn

General: Look stable

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



Chest: CTA bilaterally, no rales, no rhonchi; H bradycardia, RR, no murmur

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

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 May 2008

Na	=140	[135 - 145]
K	=3.4	[3.5 - 5.0]
Creat	=125	[62 - 120]
Gluc	=1.82	[0.74 - 1.10]

AD

គ្លីនិក ចិន្ត្រា

ផ្ទះលេខ 364-366 មហាវិថី ម៉ៅសេទុង

ក្រុងភ្នំពេញ ([illegible])

ទូរស័ព្ទលេខ : 023 88 39 29

វេជ្ជបណ្ឌិត [illegible]
ឯកទេសផ្នែកជំងឺទូរទៅ
ជំងឺសួត ជំងឺទឹកនោមផ្អែម និង
ជំងឺក្រពេញ

វេជ្ជបណ្ឌិត សុខ ដានី
ឯកទេសផ្នែកជំងឺទូរទៅ

វេជ្ជបណ្ឌិត [illegible]
ឯកទេស ផ្នែក រោគស្ត្រី សម្ភព
ជំងឺដោះ ស្ត្រីអត់កូន និង
អេកូសាស្ត្រ

វេជ្ជបណ្ឌិត មួល ប៊ុន
ឯកទេសផ្នែកថតកាំរស្មីអ៊ិច និង
អេកូសាស្ត្រ

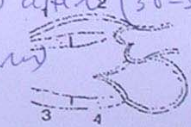
វេជ្ជបណ្ឌិត ឈី ប្រកប
ឯកទេសជំងឺទូរទៅ ជំងឺបេះដូង
អេកូសាស្ត្របេះដូង

LABORATOIRE D'ECHOCARDIOGRAPHIE-DOPPLER

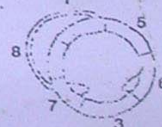
Nom et Prénom: POEU OU ,Age: 62 A,Sex: M
Date de l'examen: le 27-05-2008
Motif de l'exame: .
Provenance de service:
Demander par: **Dr Chea Savuth.**

ECHOCARDIOGRAPHIE MODE TM :
Diamètre de l'aort: 28 mm,Ecart intersigmoidien aortique: mm,OG: 40 mm
Diamètre VD télédiastolique: non dilaté
Diamètre VG télédiastolique: 66 mm,télésystolique: mm,FR: %,FE: 30-35 %.
Volume télédiastolique du VG: ml
Volume télésystolique du VG: ml
Stroke volume: ml
Epaisseur peroi posterieur télédiastolique: 7,00 mm.
Epaisseur paroi posterieur télésystolique : mm.
Epaisseur septal télédiastolique: 8,00 mm
Epaisseur septal télésystolique: mm
Valves mitrales et Aortique: non calcifié.

ECHOCARDIOGRAPHIE BIDIMENTIONNEL :
Cavités cardiaques: gauches très dilaté.
Surface télédiastolique du VG:
Surface télésystolique du VG:
Volume télédiastolique du VG:
Volume télésystolique du VG:
Fonction et sinétique segmentaire du VG: Hypokinésie de façon globale avec FEVG très altéré (30-35%).
Péricarde: libre
Valves: Rien
Veine cave inférieur: peu dilaté. (22 mm)
Aorte horizontale: mm



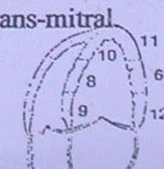
Parasternale grand axe



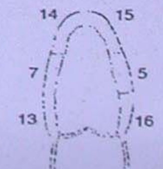
Parasternale petit axe

DOPPLER :
Rapport E/A en doppler pulsé trans-mitral.

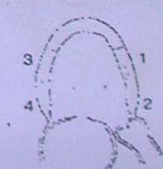
CONCLUSION :



Vue apicale 4 cavités



Vue apicale 2 cavités



Vue apicale 3 cavités

- Hypokinésie de façon global avec FEVG très altéré (30-35%) en faveur de cardiomyopathie dilaté.
- dilatation des cavités gauches (DTDVG 66 mm)
- VCI peu dilaté (22 mm).

INVESTIGATEUR.

Dr CHHY Prâkab

SGOT=35 [<37]
SGPT =25 [<40]
TSH =2.72 [0.4 – 6.2]
HBs Ag negative
HCV Ac positive

2D echo of the heart conclusion: Dilated cardiomyopathy with EF 30 – 35%
CXR attached

On July 8, 2009
EKG attached

Assessment:

1. Dilated cardiomyopathy by 2D echo
2. Bradycardia
3. Cardiomegaly by CXR

Plan:

1. Digoxin 0.25mg 1t po qd
2. Eat low salt/fats 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: July 8, 2009**

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

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From: Tan, Heng Soon,M.D.
Sent: Wednesday, July 08, 2009 2:52 PM
To: Fiamma, Kathleen M.
Cc: Allireza_Alloo@hms.harvard.edu
Subject: RE: Robib TM Clinic July 2009, Case#5, Pov Our, 64M (Sangke Roang Village)

This 64 year old man presented with symptoms of a low cardiac output state. Cardiomegaly on CXR and global hypokinesis with ejection fraction of 35 % on echocardiogram confirm the diagnosis of dilated cardiomyopathy.

The EKG has an unusual pattern with right axis deviation and a bundle conduction delay pattern with discordant T wave suggestive of right bundle branch block conduction. However there is no clinical basis for a right bundle branch block since he does not have right ventricular hypertrophy or pulmonary hypertension clinically. Dilated cardiomyopathy is more likely associated with a left bundle branch block and a leftward axis deviation. I wonder whether the leads were placed correctly.

In any case, the underlying rhythm is slow atrial fibrillation at a rate of just under 40 beats per minute. One wonders whether he is in complete heart block given such a slow rate, but if the baseline truly represents fibrillation waves rather than electrical noise interference, then he is indeed in slow atrial fibrillation. Digoxin would slow the heart, but not to this extent. If he were digoxin toxic, an accelerated regular junctional rhythm may appear. Slow atrial fibrillation or heart block are common in dilated cardiomyopathy. The rate is slow enough to warrant placement of a cardiac pacemaker given his low blood pressure and failure of heart rate to response to effort.

Voltages are not increased and, given the size of his heart, would be consistent with a dilated cardiomyopathy.

There are no clues in his history and physical exam to suggest an etiology of his dilated cardiomyopathy, presumably from some past viral myocarditis.

Besides digoxin and ibuprofen, he is likely taking a diuretic given the lowish potassium of 3.4 mmol/l to prevent congestive heart failure. The fourth medicine may be carvedilol, a beta blocker, used for off loading the heart to improve the low cardiac ejection fraction and improve effort tolerance. If he is not on the last 2 medicines, these could be prescribed to improve his functional status.

As noted above, a cardiac pacemaker to regulate and increase the heart rate will also improve functional status. In the best of worlds, he could be a candidate for heart transplantation later.

As for HCV Ac, I'm not sure what that refers to. If HCV Ac positive indicates positive antibody to hepatitis C then he needs further evaluation for hepatitis C.

Heng Soon Tan, MD

From: Rithy Chau
Date: Jul 9, 2009 8:19 AM
Subject: RE: Robib TM Clinic July 2009, Case#5, Pov Our, 64M (Sangke Roang Village)
To: Robib Telemed
Cc: Kruy Lim

Dear Sovann,

Please ask this patient to return immediately to Phnom Penh to his previous provider because with low HR and BP plus sx of dizziness is not good. Check for JVD. If no JVD give him some fluid challenge now 300cc of Lactate's IV fluid. Tell him to stop his Digoxin immediately! He can return for more advise from us next month if he wants to or else just remind him to check with his doctor regular about his condition in PP, better than waiting for us every month since he can afford. Don't let him wait for us.

Also, ask him to check his lytes, Ca, and TFT for hypothyroidism when he goes to PP.

Rithy

From: Robib Telemed
Date: Jul 8, 2009 9:22 PM
Subject: Robib TM Clinic July 2009, Case#6, Som Hon, 50F (Thnal Keng Village)
To: Rithy Chau; Kruy Lim; Kathy Fiamma; "Paul J. M.D. Heinzelmann"; Joseph Kvedar
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is the last case for Robib TM clinic July 2009, case number 6,
Som Hon, 50F and photo.

Please reply to the cases before Thursday afternonn 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: Som Hon, 50F (Thnal Keng Village)

Chief Complaint (CC): HA and dizziness x 5y

History of Present Illness (HPI): 50F, farmer, presented with symptoms of HA, neck tension, dizziness, palpitation, she went to Kg Thom hospital and was told having HTN, treated antihypertensive drug (unknown name) 1t po qd for a few weeks then above symptoms has gone then she stopped taking it. In this year, she developed with above symptoms and have BP checked at local clinic 170/? And treated with Nifedipine 10mg 1t po qd. Now she became better and denied of chest pain, dyspnea, oliguria, hematuria, stool with blood/mucus, edema.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No cig smoking, no alcohol drinking, 5 children

Current Medications:

1. Nifedipine 10mg 1t po qd

Allergies: NKDA

Review of Systems (ROS): Regular menstrual period, LMP on July 7, 2009

PE:

Vitals: BP: 166/114 P: 95 R: 20 T: 36.5°C Wt: 62Kg

General: Look 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: no edema, no rash, no lesion

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

Lab/study:

On July 8, 2009
U/A protein trace

Assessment:

1. HTN

Plan:

1. HCTZ 50mg 1/2t po qd
2. ASA 300mg 1/4t po qd
3. Eat low salt/fats diet, do regular exercise
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: July 8, 2009**

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

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From: Tan, Heng Soon,M.D.
Sent: Wednesday, July 08, 2009 2:50 PM
To: Fiamma, Kathleen M.
Cc: Allireza_Alloo@hms.harvard.edu
Subject: RE: Robib TM Clinic July 2009, Case#6, Som Hon, 50F (Thnal Keng Village)

She is still moderately hypertensive with BP: 166/114.

Physical exam should check for target organ dysfunction including fundoscopy to look for vessel changes or retinal hemorrhage, carotid and peripheral pulse examination to look for stenosis, a cardiac examination to determine cardiac apex size and location, and the presence of any S4 or S3 gallops. The urine is useful showing only trace proteinuria. Absence of an active sediment with cells and heavy proteinuria eliminates chronic glomerulonephritis as the etiology of the hypertension.

The planned renal function test will rule out renal impairment. Blood glucose or A1c testing to rule out diabetes is important to assess other cardiovascular risks. Blood lipids would similarly be indicated. After all the risk for strokes, heart and renal disease and subsequent organ failure could be reduced by normalizing blood pressure, sugar and lipids.

Since hypertension is a chronic disease, largely under self care, she needs to be well education on the nature of the condition: the importance of a low salt diet and regular exercise and avoidance of weight gain. She needs to understand that medications suppress the condition and does not cure it: hence the need for lifelong use of medications that has to be titrated according to the blood pressure response.

Given her high reading, besides adding HCTZ, I would double her dose of nifedipine to 10 mg twice a day. She should follow up monthly until her blood pressure reaches the target of below 130/80.

Good luck with her.

From: Rithy Chau
Date: Jul 9, 2009 8:25 AM
Subject: RE: Robib TM Clinic July 2009, Case#6, Som Hon, 50F (Thnal Keng Village)
To: Robib Telemed
Cc: Kruy Lim

Dear Sovann,

I agree with your plan.
Rithy

From: Robib Telemed
Date: Jul 9, 2009 8:29 PM
Subject: Robib TM Clinic July 2009 received cases
To: Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach; Rithy Chau

Dear Kathy,

I have received answer of 5 cases from you, except one case number 2, Tith Pov, 70F.

Thank you very much for the reply to the cases in this month.

Best regards,
Sovann

Thursday, July 09, 2009

Follow-up Report for Robib TM Clinic

There were 6 new patients seen during this month Robib TM Clinic, and other 51 patients came for medication refills only. The data of all 6 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, 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 July 2009

1. Prum Soeun, 53F (Thnout Malou Village)
Diagnosis:
1. HTN
2. GERD

Treatment:
1. HCTZ 50mg 1/2t po qd (#20)
2. Ranitidine 300mg 1t po qhs for one month (#30)
3. Metoclopramide 10mg 1t po qd x 15d (#15)
4. Eat low salt/fats diet, no regular exercise
5. GERD prevention education
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Lab result on July 10, 2009

Test	Result	Normal range	Test	Result	Normal range
WBC	=7.5	[4 - 11x10^9/L]	Na	=143	[135 - 145]
RBC	=5.8	[3.9 - 5.5x10^{12}/L]	K	=4.1	[3.5 - 5.0]
Hb	=12.1	[12.0 - 15.0g/dL]	Cl	=109	[95 - 110]
Ht	=38	[35 - 47%]	BUN	=1.4	[0.8 - 3.9]
MCV	=66	[80 - 100fl]	Creat	=96	[44 - 80]
MCH	=21	[25 - 35pg]	Gluc	=4.6	[4.2 - 6.4]
MHCH	=32	[30 - 37%]			
Plt	=250	[150 - 450x10^9/L]			
Lym	=3.2	[1.0 - 4.0x10^9/L]			
Mxd	=2.1	[0.1 - 1.0x10^9/L]			
Neut	=2.2	[1.8 - 7.5x10^9/L]			

2. Tith Pov, 70F (Taing Treuk Village)
Diagnosis:
1. DMII with PNP

Treatment:

1. Glibenclamide 5mg 1t po bid (#70)
2. Captopril 25mg 1/4t po bid (#20)
3. ASA 300mg 1/4t po qd (#10)
4. Amitriptyline 25mg 1/4t po qhs (#10)
5. Educate on diabetic diet, foot care and do regular exercise
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc, HbA1C at SHCH

Lab result on July 10, 2009

WBC	=5.3	[4 - 11x10^{9}/L]	Na	=141	[135 - 145]
RBC	=4.6	[3.9 - 5.5x10^{12}/L]	K	=3.6	[3.5 - 5.0]
Hb	=13.2	[12.0 - 15.0g/dL]	Cl	=108	[95 - 110]
Ht	=39	[35 - 47%]	BUN	=1.7	[0.8 - 3.9]
MCV	=85	[80 - 100fl]	Creat	=66	[44 - 80]
MCH	=29	[25 - 35pg]	Gluc	=8.9	[4.2 - 6.4]
MHCH	=34	[30 - 37%]	HbA1C	=8.6	[4.0 – 6.0]
Plt	=284	[150 - 450x10^{9}/L]			
Lym	=2.6	[1.0 - 4.0x10^{9}/L]			

3. Has Samith, 58F (Koh Pon Village)
Diagnosis:
1. GERD
2. Parasititis
3. History elevated BP

Treatment:
1. Omeprazole 20mg 1t po qhs for one month (#30)
2. Metoclopramide 10mg 1t po qd x 10d (#10)
3. Mebendazole 100mg 5t chew qhs once (#5)
4. Eat low salt/fats diet, do regular exercise

4. Pech Huy Keung, 48M (Rovieng Cheung Village)
Diagnosis:
1. DMII

Treatment:
1. Glibenclamide 5mg 1t po bid (#70)
2. Captopril 25mg 1/4t po bid (#20)
3. ASA 300mg 1/4t po qd (#10)
4. Educate on diabetic diet, foot care and do regular exercise
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc, HbA1C at SHCH

Lab result on July 10, 2009

WBC	=6.0	[4 - 11x10^{9}/L]	Na	=143	[135 - 145]
RBC	=6.0	[4.6 - 6.0x10^{12}/L]	K	=3.5	[3.5 - 5.0]
Hb	=15.6	[14.0 - 16.0g/dL]	Cl	=109	[95 - 110]
Ht	=47	[42 - 52%]	BUN	=2.2	[0.8 - 3.9]
MCV	=77	[80 - 100fl]	Creat	=102	[53 - 97]
MCH	=26	[25 - 35pg]	Gluc	=16.5	[4.2 - 6.4]
MHCH	=33	[30 - 37%]	HbA1C	=13.7	[4.0 – 6.0]
Plt	=211	[150 - 450x10^{9}/L]			
Lym	=3.1	[1.0 - 4.0x10^{9}/L]			

5. Pov Our, 64M (Sangke Roang Village)
Diagnosis:
1. Dilated cardiomyopathy by 2D echo
2. Bradycardia
3. Cardiomegaly by CXR

Treatment:

1. Refer back to check up with doctor seen him in Phnom Penh

6. Som Hon, 50F (Thnal Keng Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 50mg 1/2t po qd (#20)
2. ASA 300mg 1/4t po qd (#10)
3. Eat low salt/fats diet, do regular exercise
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Lab result on July 10, 2009

WBC	=6.9	[4 - 11x10^9/L]	Na	=140	[135 - 145]
RBC	=4.6	[3.9 - 5.5x10^{12}/L]	K	=3.5	[3.5 - 5.0]
Hb	=12.0	[12.0 - 15.0g/dL]	Cl	=108	[95 - 110]
Ht	=35	[35 - 47%]	BUN	=2.3	[0.8 - 3.9]
MCV	=76	[80 - 100fl]	Creat	=92	[44 - 80]
MCH	=26	[25 - 35pg]	Gluc	=5.5	[4.2 - 6.4]
MHCH	=34	[30 - 37%]			
Plt	=280	[150 - 450x10^9/L]			
Lym	=2.1	[1.0 - 4.0x10^9/L]			
Mxd	=1.2	[0.1 - 1.0x10^9/L]			
Neut	=3.6	[1.8 - 7.5x10^9/L]			

Patients who come for follow up and refill medicine

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

1. HTN

Treatment:

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

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

1. HTN
2. Arthritis

Treatment:

1. HCTZ 50mg 1/2t po qd for three months (#45)
2. Ibuprofen 200mg 2t po bid prn severe pain for three months (# 50)
3. Paracetamol 500mg 1t po qid prn pain for three months (# 70)

3. 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 50mg 1/2t po qd for three months (#45)

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

1. GOUT
2. HTN

Treatment:

1. HCTZ 50mg 1/2t po qd for three months (# 45)
2. Ibuprofen 200 mg 2t po bid prn for three months (#50)
3. Paracetamol 500mg 1t po qid prn pain for three months (#70)

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

1. DMII
2. Obesity

Treatment:

1. Glibenclamide 5mg 1t po qAM for one month (# 30)
2. Metformin 500mg 2t po bid for one month (# 120)
3. Captopril 25mg 1/4t po qd for one month (# 8)
4. ASA 300mg 1/4t po qd for one month (# 8)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on July 10, 2009

Gluc =8.1 [4.2 – 6.4]]
HbA1C =7.3 [4 – 6]

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

1. DMII

Treatment:

1. Metformin 500mg 2t po bid for one month (#120)
2. Glibenclamide 5mg 1t po qd for one month (#30)
3. ASA 300mg 1/4t po qd for one month (#8)
4. Draw blood for Gluc and HbA1C at SHCH

Lab result on July 10, 2009

Gluc =6.7 [4.2 – 6.4]]
HbA1C =6.2 [4 – 6]

7. 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 1t po qid

8. Choeung Thang, 62M (Thnout Malou Village)
Diagnosis:

1. DMII
2. HTN

Treatment:

1. Glibenclamide 5mg 1t po bid for one month (#60)
2. Metformin 500mg 2t po bid for one month (#120)
3. Captopril 25mg 1t po bid for one month (#60)
4. ASA 300mg 1/4t po qd for one month (#8)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on July 10, 2009

Gluc =5.6 [4.2 – 6.4]]
HbA1C =8.0 [4 – 6]

9. Chhit Khian, 67M (Trapang Teum Village)
Diagnosis:
1. DMII

Treatment:
1. Glibenclamide 5mg 1t po bid for one month (#60)
2. Metformin 500mg 1t po bid for one month (#60)
3. Captopril 25mg 1/4t po qd for one month (#8)
4. ASA 300mg 1/4t po qd for one month (#8)

10. Dourng Ponlork, 41F (Rovieng Cheung Village)
Diagnosis:
1. Bradycardia
2. GERD

Treatment:
1. GERD prev education
2. Draw blood for TSH at SHCH

Lab result on July 10, 09

TSH =1.75 [0.49 - 4.67]

11. Dourng Sunly, 50M (Taing Treurk Village)
Diagnosis:
1. HTN
2. Gout
3. Hyperlipidemia

Treatment:
1. Captopril 25mg 1/2t po bid for three months (# 90)
2. ASA 300mg 1/4t po qd for three months (# 24)
3. Ibuprofen 200mg 2t po bid prn severe pain for three months (# 60)
4. Paracetamol 500mg 1t po 1q6h prn pain/fever for three months (# 70)

12. Huy Yim, 55F (Backdoang Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 50mg 1/2t po qd for two months (#30)

13. Ing Em, 51F (Taing Treuk Village)
Diagnosis:
`
1. HTN
2. Right side stroke with left side weakness

Treatment:
1. Amlodipine 5mg 1t po qd for two months (#60)
2. ASA 300mg 1/2t po qd for two months (#30)
3. Eat low Salt/Fats diet and do regular exercise

14. Kaov Soeur, 63F (Sangke Roang Village)
Diagnosis:
1. HTN

Treatment:

1. HCTZ 50mg 1/2t po qd for two months (#30)

15. Keum Lourth, 62F (Thnout Malou Village)
Diagnosis:
1. Gum ulcer
2. Carcinoma of the oral cavity??

Treatment:
1. Ibuprofen 200mg 2t po bid prn severe pain for one month (#50)
2. Paracetamol 500mg 1t po qid prn pain for one month (#50)
3. Gargle the mouth with warmth salty water

16. Kim Sam, 84F (Rovieng Tbong Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 50mg 1/2t po qd for two months (#30)
2. ASA 300mg 1/2t po qd for two months (#30)

17. Kong Nareun, 31F (Taing Treuk Village)
Diagnosis:
1. Moderate MS with severe TR
2. Biatrium dilation
3. Severe pulmonary HTN

Treatment:
1. Atenolol 50mg 1/2t po bid for two months (# 60)
2. Furosemide 40mg 1/2t po bid for two months (# 60)

18. Kong Sam On, 53M (Thkeng Village)
Diagnosis:
1. DMII
2. HTN

Treatment:
1. Metformin 500mg 1t po bid for two months (#120)
2. Glibenclamdie 5mg 1t po bid for two months (buy)
3. Atenolol 50mg 1t po qd for two months (#60)
4. Captopril 25mg 1/2t po bid for two months (#60)
5. ASA 300mg 1/4t po qd for two months (#15)
6. Review on diabetic diet, low fats and salt, do regular exercise and foot care

19. Kor Khem Nary, 32F (Trapang Reusey Village)
Diagnosis:
1. Hyperthyroidism
2. Tachycardia

Treatment:
1. Carbimazole 5mg 1t po bid for one month (#60)
2. Propranolol 40mg 1/2t po bid for one month (#30)

20. Lay Lai, 28F (Taing Treuk Village)
Diagnosis:
1. Tachycardia

Treatment:
1. Propranolol 40mg 1t po bid for two months (# 120)

21. Moeung Srey, 42F (Thnout Malou Village)

Diagnosis

1. HTN

Treatment

1. Captopril 25mg 1t po bid for four months (# 240)

22. Neth Ratt, 37M (Otalauk Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 2t po bid for one month (# 120)
2. Metformin 500mg 2t po bid for one month (#120)
3. MTV 1t po qd for one month (# 30)
4. FeSO4/Folate 200/0.25mg 1t po qd for one month (# 30)

23. 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)

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

1. DMII
2. LVH
3. Cardiomegaly
4. TR/MS
5. Thalassemia
6. Cachexia

Treatment:

1. Glibenclamide 5mg 2t po bid for one month (#120)
2. Metformin 500mg 3t qAM, 2t po qPM for one month (#150)
3. Captopril 25mg 1/4t po bid for one month (#15)
4. MTV 1t po bid for one month (#60)

25. Pou Limthang, 42F (Thnout Malou Village)
Diagnosis:

1. Euthyroid Goiter

Treatment:

1. Carbimazole 5mg 1/2t po tid for three months (#140)

26. Prum Norn, 56F (Thnout Malou Village)
Diagnosis:

1. Liver cirrhosis with PHTN
2. HTN
3. Hypocromic Microcytic Anemia
4. Hypertrophic Cardiomyopathy
5. Renal Failure

Treatment:

1. Spironolactone 25mg 1t po qd for two months (#60)
2. FeSO4/Folate 200/0.25mg 1t po qd for two months (#60)
3. Folic acid 5mg 1t po qd for two months (#60)

4. MTV 1t po qd for two months (#60)

27. Rim Sopheap, 32F (Doang Village)
Diagnosis:
1. Dilated Cardiomyopathy with EF 32% with PR

Treatment:
1. Captopril 25mg 1/4t po bid for two months (#30)
2. ASA 300mg 1/4t po qd for two months (#15)
3. MTV 1t po qd for two months (#60)

28. Ros Oeun, 50F (Thnout Malou Village)
Diagnosis:
1. HTN
2. DMII

Treatment:
1. Glibenclamide 5mg 11/2t po bid for two months (# 180)
2. Metformin 500mg 2t po bid for two months (# 240)
3. Captopril 25mg 1/2t po bid for two months (# 60)
4. ASA 300mg 1/4t po qd for two months (# 15)

29. Ros Yeth, 55M (Thnout Malou Village)
Diagnosis:
1. DMII

Treatment:
1. Metformin 500mg 2t po qhs for two months (# 120)
2. Glibenclamdie 5mg 1t po bid for two months (# 120)
3. Captopril 25mg 1/4t po qd for two months (# 15)

30. Sam Thourng, 29F (Thnal Keng Village)
Diagnosis:
1. Cardiomegaly by CXR
2. MR
3. Right kidney stone by ultrasound

Treatment:
1. Atenolol 50mg 1t po qd for two months (#60)
2. ASA 300mg 1/4t po qd for two months (#15)

31. Same Kun, 30F (Beung Village)
Diagnosis:
1. Tachycardia
2. Hyperthyroidism

Treatment:
1. Propranolol 40mg 1/2t po bid for one month (#30)
2. Draw blood for Thyroid panel at SHCH

Lab result on July 10, 09

TSH	= <0.02	[0.49 - 4.67]
Free T4	= >77	[9.14 - 23.81]
Free T3	= >30	[1.45 – 3.48]

32. Sem Sarun, 68F (Trapang Toem Village)
Diagnosis:
1. COPD

Treatment:
1. Salbutamol inhaler 2puffs bid for two months (#2)

33. Seng Kim Oeun, 56M (Thnout Malou Village)
Diagnosis:
1. HTN

Treatment:
1. Captopril 25mg 1t po qd for two months (#60)
2. ASA 300mg 1/4t po qd for two months (#15)
3. Eat low Na+ and fats diet and do regular exercise

34. So Sok San, 24F (Thnal Keng Village)
Diagnosis:
1. Nephrotic Syndrome
2. 5 months Pregnancy

Treatment:
1. Captopril 25mg 1/4t po bid for one month (#15)
2. MTV 1t po qd for one month (#30)
3. FeSO4/Folic Acid 200/0.25mg 1t po qd for one month (#30)

35. Som Thol, 57M (Taing Treuk Village)
Diagnosis:
1. DMII with PNP

Treatment:
1. Gliburide/Metformin 2.5mg/500mg 2t po bid for two months (#240)
2. Captopril 25mg 1/4t po qd for two months (#15)
3. ASA 300mg ¼t po qd for two months (# 15)
4. Amitriptyline 25mg 1t po qhs for two months (#60)
5. MTV 1t po qd for two months (#60)

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

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

37. So On, 80F (Thnout Malou Village)
Diagnosis:
1. HTN
2. Joint pain
3. Anemia

Treatment:
1. HCTZ 50mg 1/2t po po qd for two months (# 30)
2. Paracetamol 500mg 1t po qid prn pain/fever for two months (# 30)
3. MTV 1t po qd for two months (#60)
4. FeSO4/Folate 200/0.25mg 1t po qd for two months (#60)

38. So Sary, 65F (Koh Pon Village)
Diagnosis:
1. HTN
2. Dyspepsia

Treatment:
1. HCTZ 50mg 1/2t po qd for three months (#45)
2. Ranitidine 300mg 1t po qhs (#30)

39. Svay Tevy, 42F (Thnout Malou Village)
Diagnosis:
1. MDII

Treatment:
1. Glibenclamide 5mg 2t po bid for two months (# 240)
2. Metformin 500mg 2t po bid for two months (# 240)
3. Captopril 25mg 1/4t po qd for two months (# 8)
4. ASA 300mg 1/4t po qd for two months (# 8)

40. Tann Kin Horn, 51F (Thnout Malou Village)
Diagnosis
1. DMII

Treatment
1. Glibenclamide 5mg 2t po bid for one month (#120)
2. Metformin 500mg 2t po bid for one month (#120)
3. Captopril 25mg 1/4t po qd for one month (#8)
4. ASA 300mg 1/4t po qd for one month (#8)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on July 10, 2009

Gluc =8.6 [4.2 – 6.4]]
HbA1C =7.4 [4 – 6]

41. Tann Sopha Nary, 22F (Thnout Malou Village)
Diagnosis
1. Euthyroid Goiter

Treatment
1. Carbimazole 5mg 1/2t po bid for three months (# 90)

42. Tann Sou Hoang, 50F (Rovieng Cheung Village)
Diagnosis:
1. DMII

Treatment:
1. Metformin 500mg 2t po qhs 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 and HbA1C at SHCH

Lab result on July 10, 2009

Gluc =6.9 [4.2 – 6.4]]
HbA1C =7.3 [4 – 6]

43. Thoang Tey, 72F (Rovieng Cheung Village)
Diagnosis:
1. HTN

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

44. Thon Mai, 78M (Boeung Village)
Diagnosis:
1. DMII

Treatment:

1. Glibenclamide 5mg 1t po bid for three months (# 180)
2. Metformin 500mg 1t po qhs for three months (#90)
3. Captopril 25mg 1/4t po qd for three months (#24)
4. ASA 300mg1/4t po qd for three months (#24)

45. Thorng Khourn, 70F (Bak Dong Village)
Diagnosis:

1. Liver Cirrhosis
2. Hepatitis C
3. Hypochromic Microcytic Anemia
4. Euthyroid Goiter (Nodular)

Treatment:

1. Spironolactone 25mg 1t po qd for two months (# 90)
2. FeSO4/Folate 200/0.25mg 1t po qd for two months (# 90)
3. MTV 1t po qd for two months (# 90)

46. Tith Mann, 29F (Thnout Malou Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 2t po bid for one month (#120)
2. Metformin 500mg 1t po bid for one month (#60)
3. Educate on diabetic diet, foot care and do regular exercise

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

1. DMII

Treatment:

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

48. Un Chhorn, 45M (Taing Treuk Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 1t po qd for three months (# 90)

49. Vong Cheng Chan, 52F (Rovieng Cheung Village)
Diagnosis

1. HTN

Treatment

1. Atenolol 50mg 1/2t po bid for three months (#90)

50. Vong Yan, 72F (Boeung Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 50mg 1t po qd for two months (#60)

51. Yin Hun, 72F (Taing Treuk Village)
Diagnosis:

1. HTN

Treatment:

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

The next Robib TM Clinic will be held on August 03-07, 2009