Robib *Telemedicine* Clinic

Preah Vihear Province

M A R C H 2 0 0 9

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

On Monday, March 02, 2009, SHCH staff, PA Rithy, Driver and Nurse Peng Sovann traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following two days, Tuesday and Wednesday (mornings), March 03 & 04, 2009, the Robib TM Clinic opened to receive the patients for evaluations. There were 8 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, March 04 & 05, 2009.

On Thursday, replies from SHCH in Phnom Penh and Partners Telemedicine in Boston were downloaded. Per advice from Boston, SHCH and PA Rithy 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 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: Feb 23, 2009 8:15 AM
Subject: Schedule for Robib TM Clinic March 2009
To: Rithy Chau; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Cornelia Haener
Cc: Bernie Krisher; Dan Liu; Thero Noun; Laurie & Ed Bachrach; Peou Ouk; Sochea Monn; Sam Oeurn Lanh

Dear all,

I would like to inform you that Robib Telemedicine clinic March 2009 will be starting from 02 March to 06 March 2009.

The agenda for the clinic is as following:

1. On Monday 02 March 2009, PA Rithy, driver and I will be starting the trip from Phnom Penh to Rovieng, Preah Vihea.
2. On Tuesday 03 March 2009, the clinic opens to see the patients for the whole morning, and the patients' information will be typed up into computor in the afternoon then send to both partners in Boston and Phnom Penh.
3. On Wednesday 04 March 2009, the activity is the same as on Tuesday.

4. On Thursday 05 March 2009, download all the answers replied from both partners and the treatment plan will be made accordingly then the medicine will be prepared for the patients in the afternoon.
5. On Friday 06 March 2009, draw blood from the 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: Mar 3, 2009 8:54 PM
Subject: Robib TM Clinic March 2009, case#1, Horm Somaly, 25F (Thnal Keng Village)
To: Rithy Chau; Kruy Lim; Cornelia Haener; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

For first day of Robib TM clinic March 2009, there are three new cases and this is the case number one, Horm Somaly, 25F 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: Horm Somaly, 25F (Thnal Keng Village)

Chief Complaint (CC): Right breast mass x 4y

History of Present Illness (HPI): 25F, primary school teacher, in 2004, noticed a small mass about 1x1cm on right breast without pain, swelling, erythema so she didn't seek medical care or consultation. In 2009 she noticed the mass became bigger and pain when she touch it so she went for ultrasound at private clinic in province. She came to consult with us today and denied of swelling, discharge, trauma, weight loss.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Single, primary school teacher

Current Medications: None

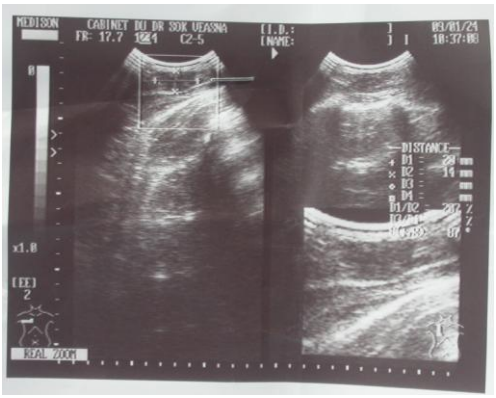
Allergies: NKDA

Review of Systems (ROS): prolong of menstrual period (35-40d), no change of discharge volume, menstruation last in 3-4d

PE:

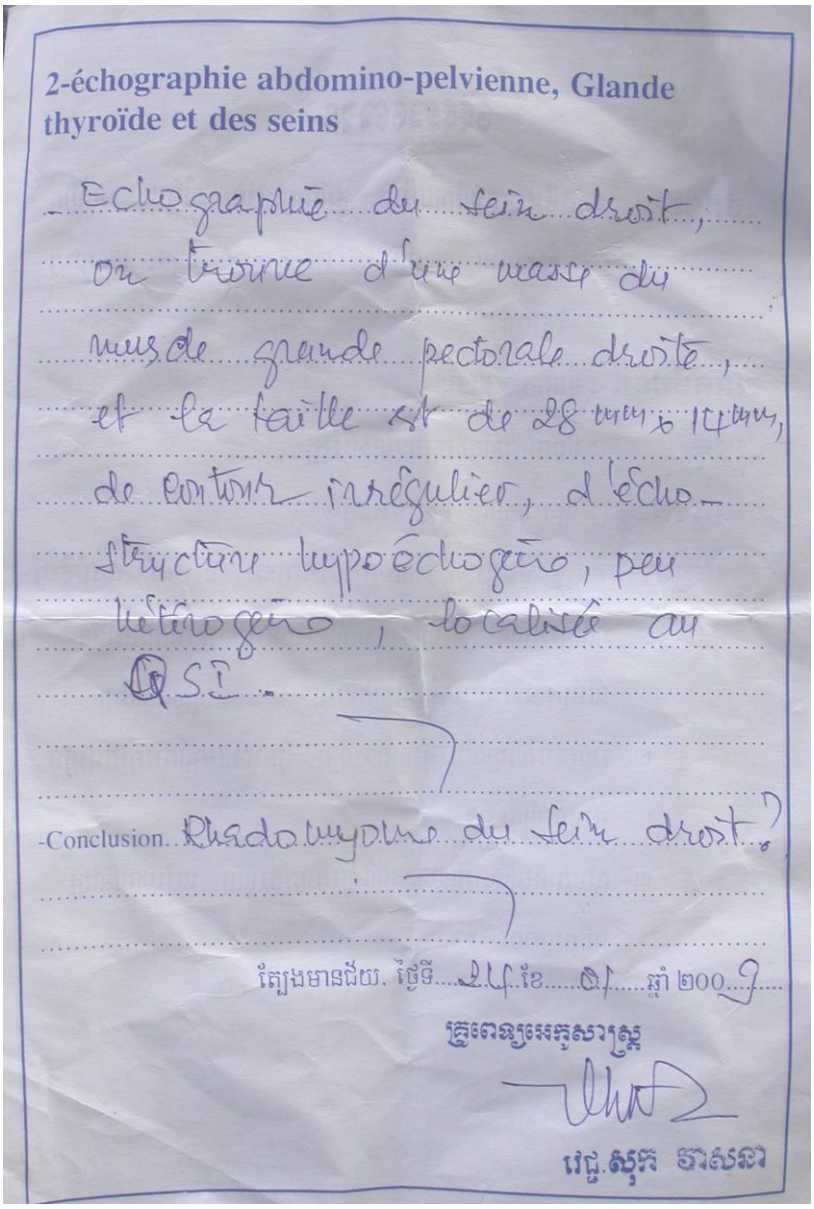
Vitals: **BP: 110/60** **P: 86** **R: 20** **T: 37°C** **Wt: 36Kg**

General: Look stable



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

Breast: Normal appearance of both breasts; Right breast present with two masses about 2x3cm at 2h and 4x4cm, firm, mobile, regular border, tender on palpation, Left breast a mass about 1x1cm 2h, mobile, firm, regular border; no swelling, no erythema, no nipple retraction, no discharge, no axillary lymph node palpable



2-échographie abdomino-pelvienne, Glande thyroïde et des seins

Echographie du sein droit, on trouve d'une masse du muscle grande pectorale droite, et la taille est de 28 mm x 14 mm, de contour irrégulier, d'écho-structure hypoéchogène, peu hétérogène, localisée au Q S I.

-Conclusion: Rhadomyome du sein droit?

ត្បែងមានជ័យ, ថ្ងៃទី ..21.. ខែ 01 ឆ្នាំ ២០09

គ្រូពេទ្យអេកូសាស្ត្រ

ជួ.សុក ទាសនា

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:
Right breast ultrasound with conclusion: Rhabdomyoma of right breast?

Assessment:

1. Bilateral breast tumor (adenoma?)

Plan:

1. Refer to SHCH for surgical consultation for mammography and possible biopsy

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: March 3, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Cornelia Haener
Date: Mar 4, 2009 9:46 AM
Subject: Robib TM Clinic March 2009, case#1, Horm Somaly, 25F (Thnal Keng Village)
To: Robib Telemed; Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear Sovann,

Thanks for this case. I agree with your plan. She certainly needs a surgical consultation and probably excision of the fibroadenomas.

Kind regards

Cornelia

From: Robib Telemed
Date: Mar 3, 2009 8:59 PM
Subject: Robib TM Clinic March 2009, Case#2, Khim Khem, 57F (Chhnourn Village)
To: "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Rithy Chau
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,
This is case number 2, Khim Khem, 57F 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: Khim Khem, 57F (Chhnourn Village)

Chief Complaint (CC): Epigastric pain x 4y

History of Present Illness (HPI): 57F, farmer, complaining of epigastric pain, burning sensation before and after eating, the pain radiated to the scapula, burping with sour taste. She went to Siem Reap hospital and told she had GI problem and treated with some kinds of IV medicine (unknown name) for a few days then continued with oral medicine at home, she became better for a while then above symptoms appeared again since then she got treatment by local pharmacist when she presented with the symptoms. She denied of vomiting, disphagia, stool with blood or mucus.

Past Medical History (PMH): PTB with complete treatment in 1998

Family History: None

Social History: Chewing tobacco, alcohol drinking about 2L/delivery, 6 children

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): 10y post menopausal

PE:

Vitals: BP: 100/62 P: 76 R: 20 T: 36.5^{o}C Wt: 35Kg

General: Look stable

HEENT: No oropharyngeal lesion, pale 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: 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, no mass palpable, neg colocheck

Lab/study:

Done on March 3, 2009
Hb: 10g/dl

Assessment:

1. GERD
2. Anemia due to iron def

Plan:

1. Omeprazole 20mg 1t po qhs x 1m
2. Metoclopramide 10mg 1t po qd x 10d
3. FeSO4/Folic acid 200/0.25mg 1t po bid x 1m
4. MTV 1t po qd x 1m
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: March 3, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Danny Sands (dzsands)
Sent: Tue 3/3/2009 6:35 PM
To: Fiamma, Kathleen M.
Subject: Robib TM Clinic March 2009, Case#2, Khim Khem, 57F (Chhnourn Village)

I am quite concerned about her:

a. She is drinking quite a bit of alcohol.

b. She is anemic.

Therefore, I suspect she has something more serious than GERD.

* Is she really iron deficient? How do we know that? What is her MCV? She needs iron studies if her MCV is normal or low.

* If she is iron deficient, we just determine the cause. You must ask her about dysfunctional uterine bleeding. One negative stool guaiac does not mean she did not having GI bleeding (it can be intermittent). And also she could have it

from an upper or a lower GI source. Ideally, she needs a colonoscopy and an endoscopy if she is iron deficient. If these are normal this could be nutritional.

* If she is not iron deficient, does she have a folate or B12 deficiency? Send these tests if the MCV is normal or elevated. If she's folate deficient she needs a higher dose than what you have prescribed.

* She may have only GERD, since her symptoms are typical, but based on the results of endoscopy you may need to treat for H. pylori, as well.

I agree with the rest of your plan.

- Danny

Daniel Z. Sands, MD, MPH

Beth Israel Deaconess Medical Center

Harvard Medical School

617-667-9600

dsands@bidmc.harvard.edu <mailto:dsands@bidmc.harvard.edu>

From: Robib Telemed
Date: Mar 3, 2009 9:05 PM
Subject: Robib TM Clinic March 2009, Case#3, Lorn Sophon, 20M (Thnal Keng 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 the last case for Robib TM Clinic March 2009, Lorn Sophon, 20M and photo. Please wait for other cases 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: **Lorn Sophon, 20M (Thnal Keng Village)**

Chief Complaint (CC): SOB x 1y

History of Present Illness (HPI): The local villager used the explosive to break the stone to make the well and while he was in the well to get the land out of the well, the land falls onto him and he was help out with unconsciousness and treated in local health center with IV fluid and some medicine. Since then he frequently developed with symptoms of SOB especially exposure to smoke, fever, productive cough, with slightly yellow sputum, chest discomfort, He didn't get treatment just come to consult with us. He denied of weight loss, hemoptysis, edema.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Grade 10 student, single, no smoking, no alcohol drinking

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: **BP: 118/68** **P: 73** **R: 20** **T: 37.5^{o}C** **Wt: 55Kg**

General: Look stable

HEENT: Pink conjunctiva, normal ear, White patches on the throat, no pustule, no lymph node palpable

Chest: Rhonchi bilaterally with coarse crackle on lower lobes; 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: None

Assessment:

1. Pneumonia
2. PTB?

Plan:

1. Clarithromycin 500mg 1t po bid x 7d
2. Do AFB smear in local health center

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: March 3, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Tan, Heng Soon,M.D.
Sent: Tuesday, March 03, 2009 3:25 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic March 2009, Case#3, Lorn Sophon, 20M (Thnal Keng Village)

I wonder whether he could have aspirated dirt into his lungs leaving him with a partial obstruction of a terminal bronchus, collapsed segment and chronic post obstructive pneumonia with abscess? Other possibility is chronic bronchiectasis arising from foreign body aspiration and subsequent chronic bronchitis? A persistent localised wheeze, or rales on chest exam may support this hypothesis. Ideally a chest x-ray to look for segmental collapse would confirm the diagnosis. Bronchiectasis may appear as localized thickened parallel interstitial markings. More subtle findings would only be apparent on a chest CT scan. Of course he could always have TB, but he looks quite healthy with no weight loss or hemoptysis. Besides a sputum AFB, sputum culture may suggest bronchiectasis or chronic lung abscess/pneumonia if some abnormal pathogen like Klebsiella or Pseudomonas is found.

Heng Soon Tan, MD

From: Robib Telemed
Date: Mar 4, 2009 8:30 PM
Subject: Robib TM Clinic March 2009, Case#4, Som Vynn, 26F (Rom Chek Village)
To: "Paul J. M.D. Heinzelmann"; Cornelia Haener; Kathy Fiamma; Joseph Kvedar; Kruy Lim; Rithy Chau
Cc: Thero Noun; Laurie & Ed Bachrach

Dear all,

Today is the second day for Robib TM clinic March 2009, there are 5 new cases and this is case number 4, continued from yesterday, Som Vynn, 26F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

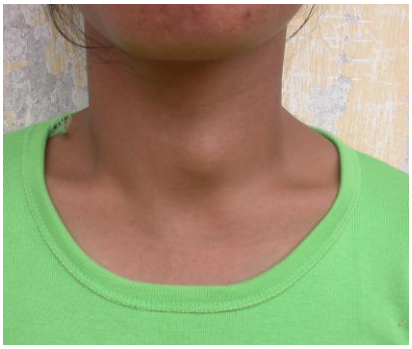
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: Som Vynn, 26F (Rom Chek Village)

Chief Complaint (CC): Neck mass x 3y

History of Present Illness (HPI): 26F, farmer, presented with a small mass about little finger size on anterior of the neck without any symptoms. After she had delivery of her baby, she felt palpitation, insomnia, heat intolerance, hair loss, constipation and the neck mass a bit bigger. She denied of tremor, fever, dysphagia, voice change.



Past Medical History (PMH): Unremarkable

Family History: None

Social History: Drinking alcohol casually, no smoking, 1 child

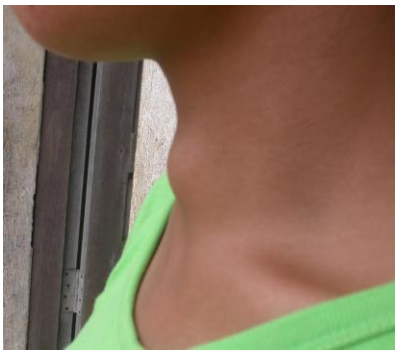
Current Medications: Traditional medicine

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 83/55 P: 85 R: 20 T: 37°C Wt: 48Kg



General: Look stable

HEENT: No oropharyngeal lesion, pink conjunctiva, a small mass about 2x2cm anterior of the neck, firm, smooth, regular border, mobile on swallowing, no bruit, 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: None

Assessment:

1. Thyroid cyst?

Plan:

1. Draw blood for TSH and 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: March 4, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Barbesino, Giuseppe,M.D.
Sent: Wed 3/4/2009 1:33 PM
To: Fiamma, Kathleen M.
Cc: 'robibtelemed@gmail.com'; 'tmed_rithy@online.com.kh'
Subject: Robib TM Clinic March 2009, Case#4, Som Vynn, 26F (Rom Chek Village)

This 26 y/o woman presents with new anterior neck mass of moderate size and symptoms suggesting hyperthyroidism. I do agree with tests of thyroid function to rule-out hyperthyroidism. I do suspect though that the neck or thyroid mass is unrelated as it was present prior to the onset of symptoms. Moreover, her exam is not consistent with hyperthyroidism, as she has normal heart rate and no reported tremor. Her mass should be worked-up with ultrasound and possibly fine needle aspiration biopsy if the mass turns out to be entirely or partially solid. If hyperthyroidism is confirmed, then a thyroid scan is usually done to understand whether the nodule is responsible for the hyperthyroidism, or simply incidental. If the nodule is "hot" on scan, then biopsy is not necessary.

Giuseppe Barbesino, MD

From: Cornelia Haener
Date: Mar 5, 2009 12:21 PM
Subject: Robib TM Clinic March 2009, Case#4, Som Vynn, 26F (Rom Chek Village)
To: Robib Telemed; "Paul J. M.D. Heinzelmann"; Kathy Fiamma; Joseph Kvedar; Kruy Lim; Rithy Chau
Cc: Thero Noun; Laurie & Ed Bachrach

Dear Sovann,
Thanks for this case. I agree with your plan.In case of hyperthyroidism, I suggest treatment till T3 and T4 normal, then surgical treatment.

Kind regards
Cornelia

From: Robib Telemed
Date: Mar 4, 2009 8:33 PM
Subject: Robib TM Clinic March 2009, Case#5, Chou Vandy, 42F (Ton Laep 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 case number 5, Chou Vandy, 42F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

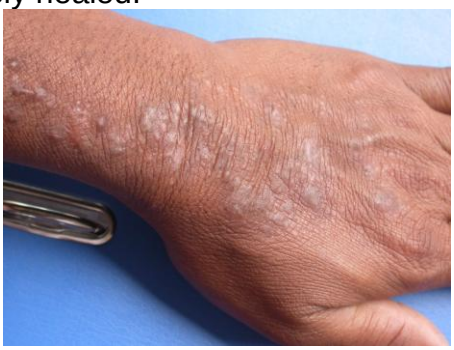
Sihanouk Hospital Center of HOPE and Partners Telemedicine
Rovieng Commune, Preah Vihear Province, Cambodia

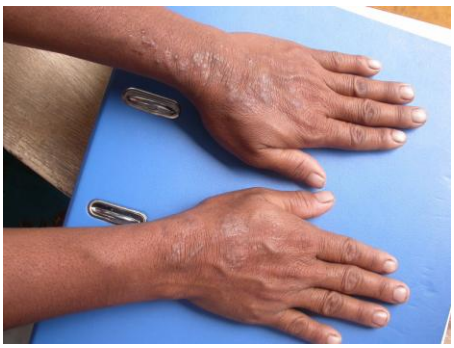
History and Physical

Name/Age/Sex/Village: **Chou Vandy, 42F (Ton Laep Village)**

Chief Complaint (CC): Skin rash x 3y

History of Present Illness (HPI): 42F, farmer, presented with macula skin rash with severe pruritus on both hand and foot, she scratched on it then it became redness, fluid come out, she bought medicine from local pharmacy, taking about 1m then the rash has gone. The rash usually attacked her in Oct –Jan (when finishing her farming) and presented only on uncovered area as hand, foot and face, no on the body and thigh. Now her skin rash almost completely healed.





Past Medical History (PMH): Unremarkable

Family History: None

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

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:
Vitals: BP: 105/67 P: 80 R: 20 T: 37^{o}C
Wt: 47Kg

General: Look 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

Skin: some almost complete healed scar on both hands, no erythema, no vesicle, no pustule and complete healed scar on the face and foot, no rash or scar of rash on the covered area

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

Lab/study: None

Assessment:

1. Eczema

Plan:

1. Loratidine 5mg 1t po qd prn bruritus

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: March 4, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Fiamma, Kathleen M.
Date: Mar 6, 2009 1:42 AM
Subject: FW: Derm case from Cambodia--Please
To: robibtelemed@gmail.com
Cc: Rithy Chau

This is a scarred process. Could be eczema, but there are other possibilities. Lichen planus is one.

I suggest adding a topical steroid, say triamcinolone 0.1% cream,

Joseph C. Kvedar, MD

Center for Connected Health

Partners Healthcare

Department of Dermatology

Massachusetts General Hospital

From: Robib Telemed
Date: Mar 4, 2009 8:37 PM
Subject: Robib TM clinic March 2009, Case#6, Sem Sarun, 68F (Trapang Toem Village)
To: "Paul J. M.D. Heinzelmann"; Kathy Fiamma; Joseph Kvedar; Kruy Lim; Rithy Chau
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 6, Sem Sarun, 68F 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: Sem Sarun, 68F (Trapang Toem Village)

Chief Complaint (CC): Dyspnea x 3y

History of Present Illness (HPI): 68F presented with symptoms of fever, productive cough, diaphoresis, weight loss, and progressive dyspnea so she went to Kg Thom hospital, CXR done, and told she had lung and GI problem. She got treatment with TB drug in 2006 then her symptoms became better. In these 6 months, she presented with symptoms of fever, palpitation, productive cough, white sputum, dyspnea on exertion (walking 10m or when eating rice), orthopnea (better sleeping in hammock), she went to private clinic in Kg Thom and got treatment with 8 kinds of medicine (unknown name) taking bid. After taking these medicines, she became a bit better and noticed that her face became swollen, belly became distended, increased weight, and echymosis on the hands and body. She denied of chest pain, hemoptysis, stool with blood/mucus, edema, hematuria, dysuria, oliguria.

Past Medical History (PMH): Unremarkable

Family History: None

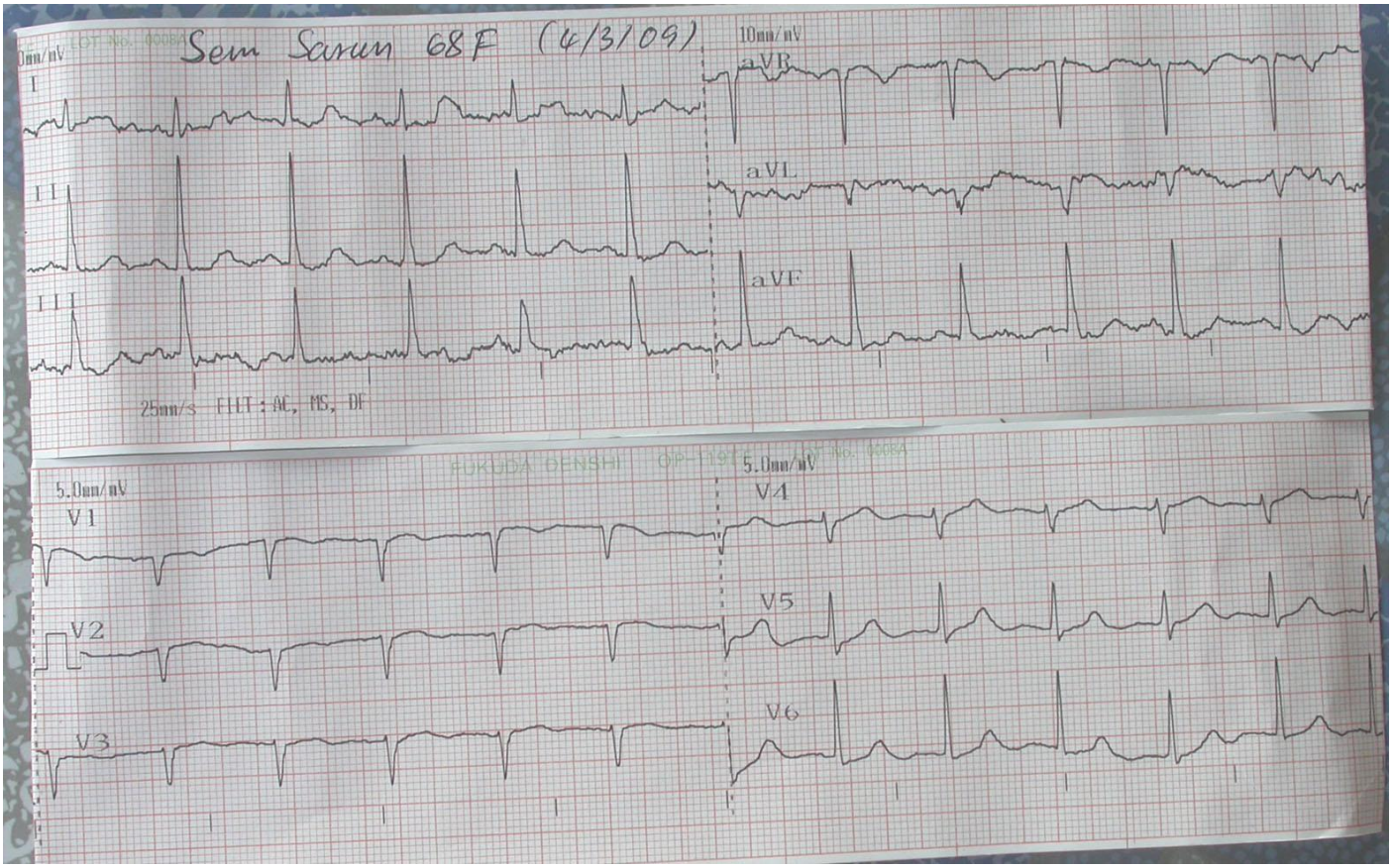
Social History: Drinking alcohol 1/2L/d, smoking 1pack of cig/d

Current Medications: 8 kinds of medicine 1t po bid x 5m

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:



Vitals: BP: 128/87 P: 87 R: 32 T: 36.5^{o}C Wt: 44Kg O2sat: 90%

General: Look tachypnea, orthopnea (asked to lie down with the head of bed elevate 45^{O}), dyspnea became better with sitting up

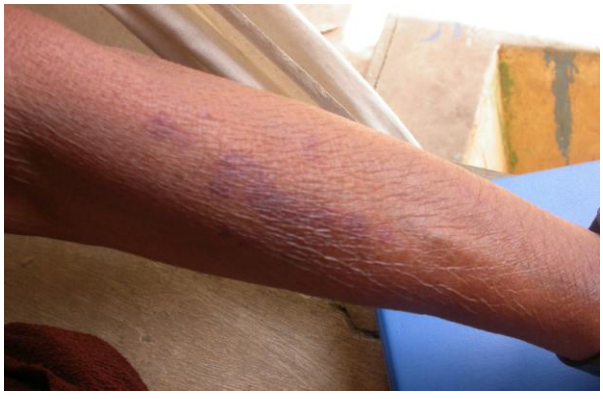
HEENT: No oropharyngeal lesion, pink conjunctiva, no thyroid enlargement, no lymph node palpable, no JVD

Chest: Decreased lung expansion, dullness to percussion, decreased breath sound with wheezing, Egophony bilaterally; H RRR, no murmur

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

Skin: Some echymosis on both hands and body, no edema

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



Lab/study:
Done on March 4, 2009
U/A normal,
EKG obtained when patient in sitting position

Assessment:
1. COPD with acute exacerbation
2. Pleural effusion?

3. PTB?

Plan:

1. Salbutamol inhaler 2puffs qid
2. Clarithromycin 500mg 1t po bid x 10d
3. Paracetamol 500mg 1t po qid prn
4. Send to Kg Thom for CXR

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: March 4, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Cusick, Paul S.,M.D.
Date: Mar 6, 2009 7:52 PM
Subject: Robib TM clinic March 2009, Case#6, Sem Sarun, 68F (Trapang Toem Village)
To: "Fiamma, Kathleen M."; robibtelemed@gmail.com
Cc: tmed_rithy@online.com.kh.

THanks for the opportunity to consult.

This patient has a history of tobacco abuse and alcohol abuse.
She also has a history of pulmonary TB.

Her presentation sounds like she initially had a respiratory infection with an exacerbation(worsening) of suspected emphysema. She does not endorse symptoms of angina. Her EKG does not show acute ischemia. However, the lack of an R wave in V1 and V2 raise the possibility of previous ischemic disease.

Her bloating and bruising after starting medication may be related to one of the medications that she received at KG Thom hospital (possibly prednisone) for a emphysema flare with respiratory infection.

Alternatively, the bruising could be from thrombocytopenia from liver disease if she has cirrhosis from alcohol consumption and splenic sequestration of platelets.

Your treatments are appropriate for treating an infectious cause of worsening of her underlying emphysema.
If she does not improve with these treatments, you might consider adding a diuretic as she may be volume overloaded (she cannot lay flat in bed). However, the rest of your exam does not suggest that she has congestive heart failure (no edema or elevation of jugular venous pressure or rales on lung exam)

A chest xray would be helpful
A complete blood count and liver function tests and albumin would be helpful.

She needs to stop smoking and drinking to prevent worsening of her health.

Good luck.

Paul

From: Robib Telemed
Date: Mar 4, 2009 8:44 PM
Subject: Robib TM Clinic March 2009, Case number 7, Sok Khorn, 44M (Ton Laep 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,

This is the case number 7, Sok Khorn, 44M 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: Sok Khorn, 44M (Ton Laep Village)

Chief Complaint (CC): Cough and chest tighness x 1 month

History of Present Illness (HPI): 44M, farmer, presented with symptoms of chronic productive cough, white sputum, fever, night sweat, wt loss and hemoptysis (about a spoon) so he went to provincial hospital, CXR done and was treated with TB drugs x 6m, then his symptoms became better. In this month presented with productive cough, fever, diaphoresis, chest tightness, fatigue, dizziness, he bought medicine from local pharmacy but his symptoms seem not better; he denied of palpitation, chest pain, orthopnea, stool with blood/mucus, hematuria, dysuria, oliguria, edema.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Drinking alcohol 1/2L/d, smoking 10cig/d

Current Medications: None

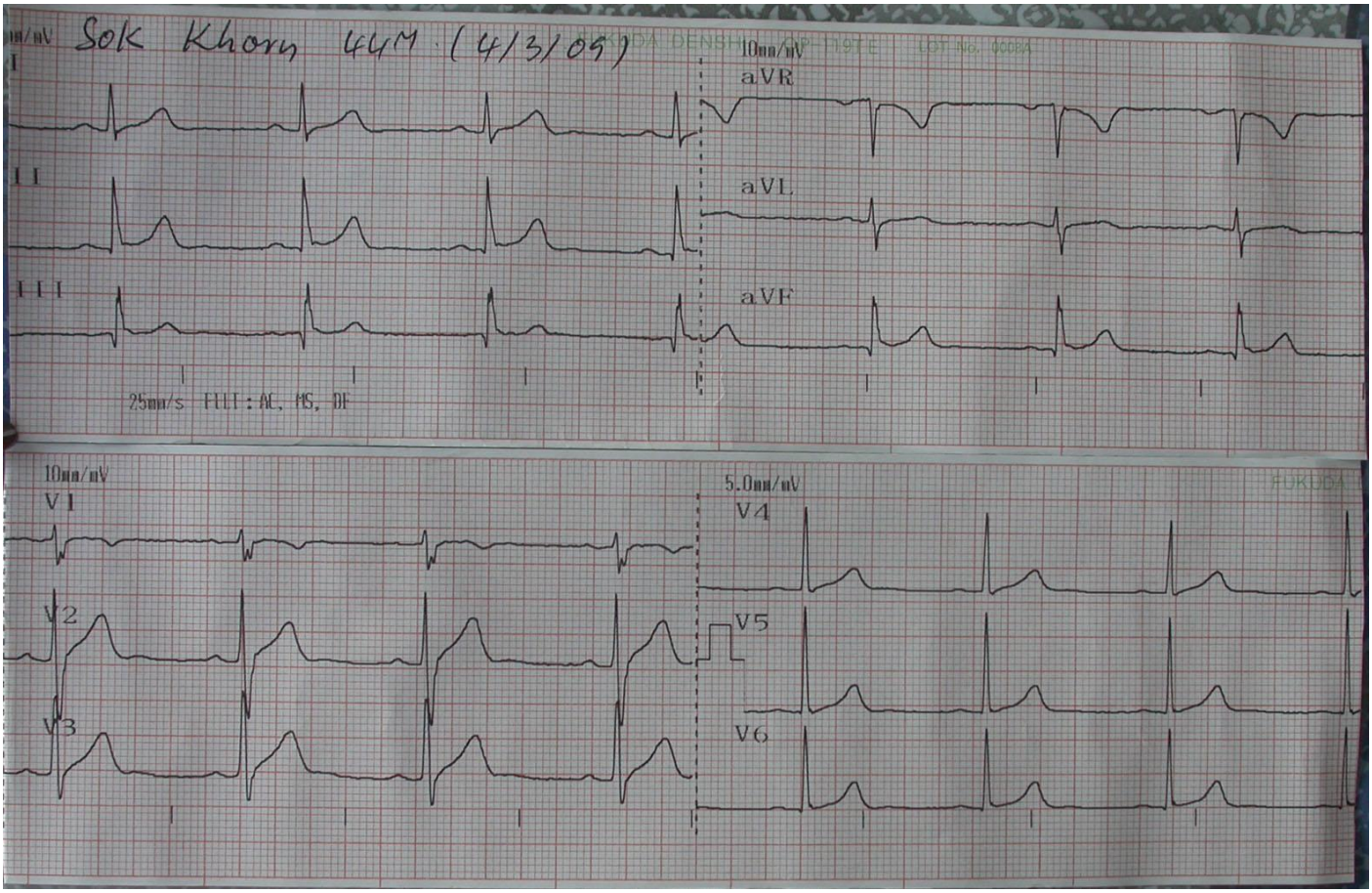
Allergies: NKDA

Review of Systems (ROS): epigastric pain, burning sensation, before and after meals, radiate to scapular and right arm

PE:

Vitals: BP: 121/79 P: 56 R: 20 T: 37^{o}C Wt: 62Kg

General: Look stable



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

Chest: CTA bilaterally, no rales, no rhonchi; H RRR, 2+ systolic murmur loudest at pulmonic area

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: EKG attached

Assessment:

1. VHD (PR/PS??)
2. Dyspepsia
3. Parasititis

Plan:

1. Famotidine 20mg 1t po qhs x 1m
2. Mebendazole 100mg 5t po qhs once
3. Send to SHCH for 2D echo of the heart

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: March 4, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Tan, Heng Soon,M.D.
Sent: Wed 3/4/2009 1:30 PM
To: Fiamma, Kathleen M.
Cc: Smart, Ryan
Subject: Robib TM Clinic March 2009, Case number 7, Sok Khorn, 44M (Ton Laep Village)

Discussion of chief complaint:
Question: how long ago did he complete TB treatment?
Fever and productive cough with chest tightness suggests a pneumonia; a bacterial pneumonia if acute, or relapsed tuberculosis if chronic. Do we know whether a sputum culture was done to rule out drug resistant Mycobacterium? The differential diagnosis for chronic pneumonia would include meloidosis due to Burkholderia pseudomallei, developement of bronchiectasis from previously treated tuberculosis. A chest x-ray will quickly clarify the diagnosis.

Why consider a parasitic infection? It's unlikely to be ascariasis with worms migrating through his lungs. That condition presents with cough but no fever.

The dyspeptic pain before and after meals make me wonder about H. pylori gastritis or peptic ulcer disease. There is now a fecal H. pylori antigen test that can confirm an active infection. Empirically it may be worthwhile to offer him standard H. pylori therapy: omeprazone 20 mg bid, metronidazole 500 mg bid and clarithromycin 500 mg bid for 2 weeks.

As for the systolic murmur, that seems to be an incidental finding that is of no immediate clinical import. EKG is normal.
The only way to determine the nature of the murmur would be a comprehensive cardiac exam that answers the following questions:
is the murmur grade 2/6? is it a systolic ejection type murmur [pulmonic valve, aortic valve, ASD, asymmetric cardiomyopathy] or holosystolic mumur [VSD]? is there a click before the murmur [pulmonary stenosis]? does the murmur radiate to the apex [aortic] or to the carotid vessels [aortic]? does the murmur vary with respiration [pulmonary]? is there any diasolic murmur in the same location [aortic, pulmonic]? is there a precordial heave [pulmonary hypertension]? is there a thrill [VSD]? is the cardiac apex enlarged and displaced to suggest LVH [aoritc, asymmetric cardiomyopathy]? is S2 loud [pulmonary hypertension] or soft [pulmonic, aortic]?

Pulmonary flow mumur is likely because the murmur is localized and would expect respiratory variation without any other change in heart sounds intensity or EKG.

Atrial septal defect should be considered: may be a short systolic ejection murmur, with fixed splitting of S2, associated with mild RVH on EKG in early stages, and pulmonary hypertension in advanced stages.

Ventricular septal defect would be less likely given his age, would present with holosystolic mumur usually with a thrill. RVH may be present on EKG.
Aortic stenosis ejection type murmur would radiate to neck or apex, have a

softer S2.
Asymmetric septal hypertrophy may be between ejection type and holosystolic type murmur, louder with valsalva, softer with squating, may be associated with LVH.
EKG may show diffuse inverted T waves or Q waves in V1-2.

From: Robib Telemed
Date: Mar 4, 2009 9:04 PM
Subject: Robib TM Clinic March 2009, Case#8, Tenn Kheng, 46M (Ton Laep Village)
To: "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Rithy Chau
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is the last case for Robib TM Clinic March 2009, Tenn Kheng, 46M and photo. Please reply to 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: **Tenn Kheng, 46M (Ton Laep Village)**

Chief Complaint (CC): Numbness on lower extremity x 2y

History of Present Illness (HPI): 46M, farmer, presented with symptoms of numbness on extremity and felt like his foot became bigger, and something under his foot while he walked, and his skin became moist especially on the extremity, the symptoms became worse so he went to provincial hospital and admitted x 1m, treated with IV and oral medicine (unknown name) but his condition seem not better. He came back home and got treatment with medicine bought from local pharmacy and traditional medicine.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Drinking alcohol 1/2L/d, smoking 5cig/d, just stop when he became sick

Current Medications: Traditional medicine for numbness

Allergies: NKDA

Review of Systems (ROS): productive cough with white sputum, no fever, no hematuria, no dysuria, no stool with blood or mucus

PE:

Vitals: BP: 155/105 (both arms) P: 67 R: 20 T: 37^{o}C Wt: 50Kg

General: Look stable

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

Chest: Rhonchi bilaterally no lower lobe, clear on the upper; H RRR, no murmur

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

Extremity/Skin: no edema, no rash, no lesion, (+) post tibial and dorsalis pedis

MS/Neuro: MS +5/5, decreased sensitivity to brush touch on both feet, DTRs +3/4 on knee jerk, other reflex intact, normal gait

Lab/study: None

Assessment:

1. Numbness due to Vit deficiency/chronic Alcoholism
2. Pneumonia
3. Elevated BP?

Plan:

1. Vit B complex 10cc IV infusion x 3d
2. MTV 1t po qd
3. Clarithromycin 500mg 1t po bid x 7d
4. Recheck BP if still elevate, start him with HCTZ 12.5mg 1t po qd
5. Do regular exercise, eat low salt and fat diet
6. Alcohol and smoking cessation

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: March 4, 2009**

Please send all replies to robibtelemed@gmail.com and cc: to tmed_rithy@online.com.kh.

From: Danny Sands (dzsands) [mailto:dzsands@cisco.com]
Sent: Thursday, March 05, 2009 5:48 PM

To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic March 2009, Case#8, Tenn Kheng, 46M (Ton Laep Village)
Importance: High

I am terribly sorry I did not respond.—I was tied up with meetings.

I agree with most of the assessment and plan, except that I'm not sure he has pneumonia—he has no shortness of breath or fever. He could have a pleural effusion and/or malignancy. He needs a chest x-ray.

I recommend starting him on regular vitamin B1 (thiamine) and folate supplementation, since he likely won't quit using alcohol anytime soon.

I would also start him on BP medications today, since his BP is quite high.

- Danny

Daniel Z. Sands, MD, MPH

Beth Israel Deaconess Medical Center

Harvard Medical School

617-667-9600

From: Robib Telemed
Date: Mar 5, 2009 8:13 PM
Subject: Robib TM Clinic March 2009 Cases received
To: Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach; Rithy Chau

Dear Kathy,

I have received answer of 4 cases for Robib TM clinic March 2009 and below are the cases received:
Case#2, Khim Khem, 57F
Case#3, Lorn Sophon, 20M
Case#4, Som Vynn, 26F
Case#7, Sok Khorn, 44M

Please send me the answer of the remaining cases.

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

Best regards,
Sovann

Thursday, March 05, 2009

Follow-up Report for Robib TM Clinic

There were 8 new patients seen during this month Robib TM Clinic, other 48 patients came for medication refills only, and 10 patients seen by PA Rithy for minor problem without sending data. The data of all 8 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 March 2009

1. Horm Somaly, 25F (Thnal Keng Village)
Diagnosis:

1. Bilateral breast tumor (fibroadenoma?)

Treatment:

1. Refer to SHCH for surgical consultation

2. Khim Khem, 57F (Chhnourn Village)
Diagnosis:

1. GERD
2. Anemia due to iron def

Treatment:

1. Omeprazole 20mg 1t po qhs x 1m (#35)
2. Metoclopramide 10mg 1t po qd x 10d (#10)
3. FeSO4/Folic acid 200/0.25mg 1t po bid x 1m (#70)
4. MTV 1t po qd x 1m (#35)
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Peripheral smear at SHCH

Lab result on March 06, 2009

WBC	=6.8	[4 - 11x10^9/L]	Na	=141	[135 - 145]
RBC	=3.5	[3.9 - 5.5x10^{12}/L]	K	=4.6	[3.5 - 5.0]
Hb	=8.9	[12.0 - 15.0g/dL]	Cl	=109	[95 - 110]
Ht	=29	[35 - 47%]	BUN	=4.1	[0.8 - 3.9]
MCV	=82	[80 - 100fl]	Creat	=123	[44 - 80]
MCH	=25	[25 - 35pg]	Gluc	=4.0	[4.2 - 6.4]
MHCH	=31	[30 - 37%]			
Plt	=212	[150 - 450x10^9/L]			
Lym	=2.2	[1.0 - 4.0x10^9/L]			
Mxd	=1.6	[0.1 - 1.0x10^9/L]			
Neut	=3.0	[1.8 - 7.5x10^9/L]			
Hypochromic 2+					

Microcyte 2+

3. Lorn Sophon, 20M (Thnal Keng Village)
Diagnosis:

1. Pneumonia
2. PTB?

Treatment:

1. Clarithromycin 500mg 1t po bid x 7d (#14)
2. Paracetamol 500mg 1t po qid prn (#20)
3. Do AFB smear in local health center
4. Send to Kg Thom for CXR

4. Som Vynn, 26F (Rom Chek Village)
Diagnosis:

1. Thyroid cyst?

Treatment:

1. Draw blood for TSH and Free T4 at SHCH

Lab result on March 06, 2009

TSH	=1.05	[0.49 - 4.67]
Free T4	=10.46	[9.14 - 23.81]

5. Chou Vandy, 42F (Ton Laep Village)
Diagnosis:

1. Eczema

Treatment:

1. Loratidine 5mg 1t po qd prn bruritus (#30)
2. Mometasone lotion 0.1% apply bid (#3)

6. Sem Sarun, 68F (Trapang Toem Village)
Diagnosis:

1. COPD with acute exacerbation
2. Pleural effusion?
3. PTB?

Treatment:

1. Salbutamol inhaler 2puffs qid (#2)
2. Clarithromycin 500mg 1t po bid x 10d (#20)
3. Paracetamol 500mg 1t po qid prn (#30)
4. Send to Kg Thom for CXR

7. Sok Khorn, 44M (Ton Laep Village)
Diagnosis:

1. VHD (PR/PS??)
2. Dyspepsia
3. Parasititis

Treatment:

1. Famotidine 20mg 1t po qhs x 1m (#30)
2. Mebendazole 100mg 5t po qhs once (#5)

8. Tenn Kheng, 46M (Ton Laep Village)
Diagnosis:

1. Numbness due to Vit deficiency/chronic Alcoholism
2. Pneumonia
3. Elevated BP?

Treatment:

1. Vit B complex 10cc IV infusion x 3d
2. MTV 1t po qd (#30)
3. Clarithromycin 500mg 1t po bid x 7d (#14)
4. Paracetamol 500mg 1t po qid prn (#20)
5. Recheck BP if still elevate, start him with HCTZ 12.5mg 1t po qd
6. Do regular exercise, eat low salt and fat diet
7. Alcohol and smoking cessation

Patients who come for follow up and refill medication

1. Ai Lun, 75F (Rovieng Tbong Village)
Diagnosis:

1. Osteoarthritis
2. Dyspepsia

Treatment:

1. Paracetamol 500mg 1t po qid prn pain (#50)
2. Famotidine 20mg 1t po qhs for two months (#30)
3. Warm compression on joint with pain

2. Ban Lay, 34F (Koh Pon Village)
Diagnosis:

1. Diffuse goiter
2. Euthyroid goiter

Treatment:

1. Propranolol 40mg 1/2t po bid for two months (#60)
2. Carbimazole 5mg 1/2t po bid for two months (#70)

3. Be Kim Ke, 54M (Thnout Malou Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 1t po bid for two months (#120)
2. Metformin 500mg 1t po qhs for two months (#60)
2. Captopril 25mg 1/4t po qd for two months (#15)
3. ASA 300mg 1/4t po qd for two months (#15)

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

1. DMII
2. Obesity

Treatment:

1. Glibenclamide 5mg 1t po qAM for one month (# 40)
2. Metformin 500mg 2t po qPM for one month (# 70)
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 March 06, 2009

Gluc	=7.2	[4.2 - 6.4]
HbA1C	=8.1	[4 - 6]

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

1. DMII

Treatment:

1. Metformin 500mg 2t po qhs for one month (#60)
2. ASA 300mg 1/4t po qd for one month (#8)
3. Review on Diabetes diet, foot care and regular exercise
4. Draw blood for Gluc and HbA1C at SHCH

Lab result on March 06, 2009

Gluc	=10.3	[4.2 - 6.4]
HbA1C	=11.8	[4 - 6]

6. 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
2. Draw blood for Ca^{2+} and Mg^{2+} at SHCH

Lab result on March 06, 2009

Ca^{2+}	=1.02	[1.12 – 1.32]
Mg^{2+}	=1.7	[0.8 – 1.0]

7. 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)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on March 06, 2009

Gluc	=3.3	[4.2 - 6.4]
HbA1C	=8.4	[4 - 6]

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

Lab result on March 06, 2009

Gluc =8.7 [4.2 - 6.4]
HbA1C =10.3 [4 - 6]

9. 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 two months (#60)
2. Captopril 25mg 1t po bid for two months (#120)
3. ASA 300mg 1/2t po qd for two months (#30)
4. Metformin 500mg 2t po qhs for two months (#120)
5. Glibenclamide 5mg 1t po qd for two months (#60)
6. Review on diabetic diet, regular exercise and foot care

10. Chum Ly Voeung, 34F (Dam Nak Chen Village)
Diagnosis:

1. Anemia

Treatment:

1. FeSO4/Folate 200/0.25mg 1t bid for two months (#120)
2. MTV 1t po qd for two months (#60)
3. Draw blood for CBC, Peripheral smear and Reticulocyte count at SHCH

Lab result on March 06, 2009

WBC =6.9 [4 - 11x10^9/L]
RBC =5.4 [3.9 - 5.5x10^{12}/L]
Hb =10.0 [12.0 - 15.0g/dL]
Ht =35 [35 - 47%]
MCV =64 [80 - 100fl]
MCH =19 [25 - 35pg]
MHCH =29 [30 - 37%]
Plt =232 [150 - 450x10^9/L]
Lym =2.7 [1.0 - 4.0x10^9/L]
Mxd =1.0 [0.1 - 1.0x10^9/L]
Neut =3.2 [1.8 - 7.5x10^9/L]
Reticulocyte count = 1.1 [0.5 – 1.5]
Hypochromic 2+
Microcyte 2+
Poikilocytosis 1+
Elliptocyte 1+

11. Em Thavy, 36F (Thnal Keng Village)
Diagnosis:

1. Diffuse Goiter
2. Euthyroid

Treatment:

1. Carbimazole 5mg 1/2t po tid for two months (#100)
2. Propranolol 40mg 1/4t po bid for two months (#30)

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

1. Asthma

Treatment:

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

13. Keth Chourn, 55M (Chhnourn Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 12.5mg 2t po qd for three months (# 180)

14. Khoem Sokunthea, 40F (Rovieng Tbong Village)
Diagnosis:
1. Hypothyroidism

Treatment:
1. L-thyroxin 100mcg 1/2t po qd for one month (#20)

15. Kong Hin, 68F (Ton Laep Village)
Diagnosis:
1. HTN

Treatment:
1. Amlodipine 5mg 1t po qd (#40)
2. Eat low salt/fat diet and regular exercise

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

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

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

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

18. Meas Kong, 55F (Rovieng Tbong Village)
Diagnosis:
1. DMII with PNP
2. HTN

Treatment:
1. Glibenclamide 5mg 2t po bid for one month (#120)
2. Metformin 500mg 2t po bid for one month (#130)
3. Captopril 1t po tid for one month (#90)
4. ASA 300mg 1/2t po qd for one month (#15)
5. Amitriptylin 25mg 1/2t po qhs for one month (#15)

19. Meas Lone, 58F (Ta Tong)
Diagnosis
1. COPD

Treatment
1. Salbutamol Inhaler 2 puff prn SOB for four months (#3vial)

20. Meas Ream, 74F (Taing Treuk Village)
Diagnosis:

1. HTN
2. Left side stroke with right side weakness

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (# 180)
2. ASA 300mg 1/4t po qd for three months (# 24)
3. MTV 1t po qd for three months (# 90)

21. Meas Thoch, 78F (Ta Tong Village)
Diagnosis:

1. HTN

Treatment:

1. Atenolol 50mg 1/2t po bid for four months (#120)
2. HCTZ 12.5mg 2t po qd for four months (#240)

22. Moeung Srey, 42F (Thnout Malou Village)
Diagnosis

1. HTN

Treatment

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

23. 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)

24. Nhem Sok Lim, 59F (Thnout Malou Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 2t po qd for two months (#120)
2. Metformin 500mg 2t po bid for two months (#240)
3. Captopril 25mg 1/2t po bid for two months (#60)

25. 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. ASA 300mg 1/4t po qd for one month (#8)
5. MTV 1t po bid for one month (#60)

26. Pin Chhourn, 62F (Thnal Keng Village)

Diagnosis:

1. HTN
2. Otitis media

Treatment:

1. Atenolol 50mg 1t po bid for one month (# 70)
2. ASA 300mg 1/4t po qd for one month (# 10)
3. Cefuroxime 250mg 1t po bid x 10d (#20)

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

1. Euthyroid Goiter

Treatment:

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

28. Prum Maly, 53F (Thnout Malou Village)
Diagnosis:

1. Euthyroid goiter

Treatment:

1. Draw blood for TSH and Free T4 at SHCH

Lab result on March 06, 2009

TSH	=0.46	[0.49 - 4.67]
Free T4	=11.21	[9.14 - 23.81]

29. Prum Moeun, 56M (Bakdoang Village)
Diagnosis:

1. HTN
2. PVC

Treatment:

1. Atenolol 50mg 1/2t po bid for three months (# 90)
2. ASA 300mg 1/4t po qd for three months (# 24)

30. 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 12.5mg 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)

31. Rim Sopheap, 32F (Doang Village)
Diagnosis:

1. Dilated Cardiomyopathy with EF 32% with PR
2. Dyspepsia

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)

4. Omeprazole 20mg 1t po qhs (#30)
5. Metoclopramide 10mg 1t po qhs (#10)

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

Treatment:
1. Metformin 500mg 2t po qd for one month (# 60)
2. Captopril 25mg 1/4t po qd for one month (#8)

33. Sam Yom, 60F (Chhnourn Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 12.5mg 2t po qd for three months (#180)

34. Sao La, 62F (Thnal Keng Village)
Diagnosis:
1. Gastritis
2. Elevated BP

Treatment:
1. Omeprazole 20mg 1t po qhs for one month (#30)
2. Recheck BP in next month

35. Sath Rim, 51F (Taing Treuk Village)
Diagnosis:
1. HTN
2. DMII with PNP
3. Renal Failure
4. Anemia

Treatment:
1. Glibenclamide 5mg 2t po bid for one month (# 120)
2. Atenolol 50mg 1t po bid for one month (# 60)
3. Nifedipine 20mg 1/2t po bid for one month (# 35)
4. Amitriptylin 25mg 1t po qhs for one month (# 30)
5. FeSO4/Folate 200/0.25mg 1t po qd for one month (# 30)
6. Folic Acid 5mg 1t po qd for one month (# 30)
7. ASA 300mg 1/4t po qd for one month (#8)
8. Draw blood for Lyte, BUN, Creat, Gluc, and HbA1C at SHCH

Lab result on March 06, 2009

Na	=144	[135 - 145]
K	=4.9	[3.5 - 5.0]
Cl	=118	[95 - 110]
BUN	=8.6	[0.8 - 3.9]
Creat	=606	[44 - 80]
Gluc	=7.1	[4.2 - 6.4]
HbA1C	=8.1	[4 – 6]

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

Treatment:

1. HCTZ 12.5mg 2t po po qd for two months (# 120)
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)

37. So Putheara, 13M (Thnal Keng Village)
Diagnosis:

1. Nephrotic syndrome

Treatment:

1. Prednisolone 5mg 2t po qd for one month (# 60)
2. Draw blood for Lyte, Creat, Gluc, Albu, Prot and Tot Chole, Ca2+, Mg2+ at SHCH

Lab result on March 6, 2009

Na	=134	[135 - 145]
K	=4.6	[3.5 - 5.0]
Cl	=106	[95 - 110]
Creat	=74	[53 - 97]
Gluc	=3.6	[4.2 - 6.4]
T. Chol	=5.1	[<5.7]
Albu	=43	[38 - 54]
Prote	=70	[66 – 87]
Ca2+	=1.06	[1.12 – 1.32]
Mg2+	=0.8	[0.8 – 1.0]

38. So Sok San, 24F (Thnal Keng Village)
Diagnosis:

1. Nephrotic Syndrome
2. Anemia

Treatment:

1. Prednisolone 5mg 1t po qd for two months (#60)
2. Captopril 25mg 1/4t po bid for two months (#30)
3. MTV 1t po qd for two months (#60)
4. FeSO4/Folic Acid 200/0.25mg 1t po qd for two months (#60)
5. Draw blood for Lyte, Creat, Gluc, Alb, protein, tot chole, Ca2+ and Mg2+ at SHCH

Lab result on 06 March, 2009

Na	=139	[135 - 145]
K	=3.3	[3.5 - 5.0]
Cl	=109	[95 - 110]
Creat	=67	[53 - 97]
Gluc	=4.4	[4.2 - 6.4]
T. Chol	=4.2	[<5.7]
Albu	=40	[38 - 54]
Prote	=67	[66 – 87]
Ca2+	=1.10	[1.12 – 1.32]
Mg2+	=0.7	[0.8 – 1.0]

39. Som Thol, 57M (Taing Treuk Village)
Diagnosis:

1. DMII with PNP

Treatment:

1. Glibenclamide 5mg 2t po qd
2. Metformin 500mg 2t po bid (#70)
3. Captopril 25mg 1/4t po qd

3. ASA 300mg ¼t po qd
4. Amitriptyline 25mg 1t po qhs
5. MTV 1t po qd (#35)

40. Sum Ra, 46F (Trapang Reusey Village)
Diagnosis:
1. GERD
2. Otitis media

Treatment:
1. Omeprazole 20mg 1t po qhs for one month (#35)
2. Metoclopramide 10mg 1t po qhs (#15)
3. Mebendazole 100mg 5t po qhs once (#5)
4. Paracetamol 500mg 1t po qid prn (#24)
5. Cefuroxime 250mg 1t po bid x 10d (#20)

41. 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 qhs 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)
5. Draw blood for Gluc and HbA1C at SHCH

Lab result on 06 March, 2009

Gluc	=13.3	[4.2 - 6.4]
HbA1C	=12.9	[4 – 6]

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

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

43. Teav Vandy, 63F (Rovieng Cheung Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 12.5mg 2t po qd for three months (# 180tab)

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. 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)

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

1. DMII

Treatment:

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

47. Um Yi, 55F (Rovieng Cheung Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 12.5mg 2t po qd for two months (#120)

48. Yi Seart, 53M (Rovieng Cheung Village)
Diagnosis:

1. HTN

Treatment:

1. Captopril 25mg 1t po bid for two months (#120)
2. ASA 300mg 1/4t po qd for two months (#15)

The next Robib TM Clinic will be held on April 06-10, 2009