Robib *Telemedicine* Clinic

Preah Vihear Province

M A R C H 2 0 1 2

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

On Monday, February 27, 2012, SHCH staffs Driver and Nurse Peng Sovann traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following two days, Tuesday and Wednesday (mornings), February 28 & 29, 2012, the Robib TM Clinic opened to receive the patients for evaluations. There were 8 new cases and 3 follow up 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, February 29 & March 1, 2012.

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 Sovann Peng at SHCH who compiled and sent for website publishing.

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

From: Robibtelemed
To: Rithy Chau ; Kruy Lim ; Cornelia Haener ; Kathy Fiamma ; Paul Heinzelmann ; Joseph Kvedar
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach ; Savoeun Chhun ; Robib School 1
Sent: Monday, February 20, 2012 7:31 AM
Subject: Schedule for Robib Telemedicine Clinic March 2012

Dear all,

I would like to inform you that Robib TM Clinic for March 2012 will be starting on February 27 - March 2, 2012.

The agenda for the trip is as following:

1. On Monday February 27, 2012, we will be starting the trip from Phnom Penh to Rovieng, Preah Vihear province.
2. On Tuesday February 28, 2012, the clinic opens to see the patients for the whole morning then the patients' information will be typed up into computer as the word file then sent to both partners in Boston and Phnom Penh.
3. On Wednesday February 29, 2012, the activity is the same as on Tuesday
4. On Thursday March 1, 2012, download all the answers replied from both partners then treatment plan will be made accordingly and prepare the medicine for the patients in the afternoon.
5. On Friday March 2, 2012, Draw blood from patients for lab test at SHCH then come back to Phnom Penh.

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

Best regards,
Sovann

From: Robibtelemed
To: Cornelia Haener ; Paul Heinzelmann ; Kathy Fiamma ; Joseph Kvedar ; Rithy Chau ; Kruy Lim
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Tuesday, February 28, 2012 5:00 PM
Subject: Robib TM Clinic February 2012, Case#1, Keum Kourn, 65F

Dear all,

There are four new cases and one follow up case for the first day of Robib TM Clinic March 2012. This is case number 1, Keum Kourn, 65F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

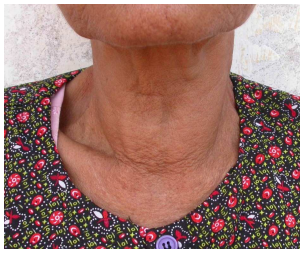
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Keum Kourn, 65F (Thkeng Village)**

Chief Complaint (CC): Neck mass x 6 months

History of Present Illness (HPI): 65F presented with anterior neck mass with progressive enlargement and symptoms of palpitation, tremor, heat intolerance, increased appetite, insomnia and weight loss. She got treatment from local health care worker with IV fluid and IM injection for a few days and became a bit better. She also took traditional medicine.



Past Medical History (PMH): Unremarkable

Family History: No goiter, no HTN, no Diabetes mellitus

SH: Chewing tobacco, no cig smoking, no EtOH

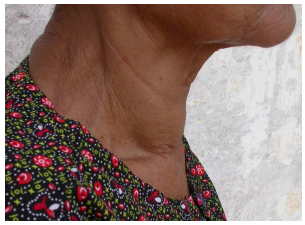
Current Medications: Traditional medicine

Allergies: NKDA

Review of Systems (ROS): Epigastric burning pain, flatus, burping on/off, no vomiting, no bloody/mucus stool, pulsatile abdominal mass in umbilical region

PE:

Vitals: BP: 126/68 P: 116 R: 20 T: 37°C Wt: 32Kg



General: Stable

HEENT: No oropharyngeal lesion, pink conjunctiva, neck mass about 3 x 5cm anteriorly, smooth surface, regular border, mobile on swallowing, no bruit

Chest: CTA bilaterally, no rales, no rhonchi; Heart tachycardia, RR, no murmur

Abd: Soft, no tender, no distension, (+) BS, no HSM, Pulsatile abdominal mass in umbilical area, no bruit, no surgical scar

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

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

Lab/study: None

Assessment:

1. Goiter
2. Hyperthyroidism?
3. Abdominal aortic aneurysm?
4. Dyspepsia

Plan:

1. Propranolol 40mg 1/4t po bid
2. Cimetidine 200mg 1t po qhs for one month
3. Draw blood for TSH and Free T4 at SHCH
4. Send patient to Kg Thom for Abdominal ultrasound

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: February 28, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Cornelia Haener' ; 'Kruy Lim'
Sent: Wednesday, February 29, 2012 9:35 AM
Subject: RE: Robib TM Clinic February 2012, Case#1, Keum Kourn, 65F

Dear Sovann,

Thanks for the cases this month.

For this patient, I agree with the goiter problem and dyspepsia and tx plan. For the "abdominal mass", I think because the patient is thin (I suspect from the wt given), sometimes one can feel the descending aorta pulsatile which is normal and usually presenting with bruit. You can send her to do neck US as well as abdominal US and specify to look at the descending aorta structure and if US confirms aneurysm, then proper referral deems necessary for her.

Rithy

From: Tan, Heng Soon,M.D.
Sent: Wed 2/29/2012 2:39 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic February 2012, Case#1, Keum Kourn, 65F

New thyroid toxic symptoms together with progressively enlarging thyroid gland suggests Grave's disease. Autoimmune [Hashimoto's] thyroiditis is possible but not usually associated with such a large thyroid gland. I would like for Graves associated ophthalmopathy: proptosis, lid retraction [though not evident in photo] and lid lag. Propranolol would reduce symptoms but I would double her dose. TSH, free T4 are appropriate..

The easily palpable aortic pulsation in a thin person with hyperthyroidism may be easily felt but if the diameter is not more than 5 cm [define the lateral edges with hands approaching deeply from both sides], it's unlikely to be an aneurysm. Without hypertension, an aneurysm is unlikely. I would skip the abdominal ultrasound.

I would like to rule out Helicobacter pylori gastritis in anybody with epigastric burning pain. Test for serology for H. pylori if available.

Heng Soon Tan, MD

From: Cornelia Haener
To: 'Robibtelemed' ; 'Paul Heinzelmann' ; 'Kathy Fiamma' ; 'Joseph Kvedar' ; 'Rithy Chau' ; 'Kruy Lim'
Cc: 'Bernie Krisher' ; 'Thero So Nourn' ; 'Laurie & Ed Bachrach'
Sent: Thursday, March 01, 2012 7:13 PM
Subject: RE: Robib TM Clinic February 2012, Case#1, Keum Kourn, 65F

Dear Sovann,
I agree with your plan.

Kind regards
Cornelia

From: Robibtelemed
To: Kathy Fiamma ; Joseph Kvedar ; Rithy Chau ; Kruy Lim ; Paul Heinzelmann
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Tuesday, February 28, 2012 5:02 PM
Subject: Robib TM Clinic March 2012, Case#2, Kheum Im, 42F

Dear all,

This is the case number 2, Kheum Im, 42F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

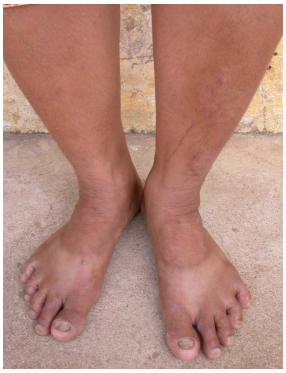
Sihanouk Hospital Center of HOPE and Partners Telemedicine
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Kheum Im, 42F (Thkeng Village)**

Chief Complaint (CC): Skin rash x 3y

History of Present Illness (HPI): 42F, farmer, presented with skin rash on the buttock with pruritus and became scaly in several days. The rash with well demarcate border progressively increased in size, no vesicle, no pustule. She got treatment with Antifungal orally and application (unknown name medication) bought from local pharmacy and the rash became better but not gone and reappeared again and again. Two years later, she presented with other rash on both ankle. She denied of contact with chemical.



Past Medical History (PMH): Unremarkable

Family History: Husband with the same lesion

SH: No cig smoking, no tobacco chewing, no EtOH

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: **BP: 108/60** **P: 64** **R: 20** **T: 37^{o}C** **Wt: 60Kg**

General: Stable

HEENT: No oropharyngeal lesion, pink conjunctiva, no icterus, 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, no surgical scar, no abdominal bruit

Extremity/Skin: Well demarcate macular rash with scalling on buttock and both ankles, no vesicle, no pustule

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

Lab/study: None

Assessment:

1. Eczema?
2. Tinea?

Plan:

1. Fluocinonide 0.1% apply bid until rash gone
2. Citirizine 10mg 1t po qhs

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

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

Examined by: Nurse Sovann Peng **Date: February 28, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Wednesday, February 29, 2012 9:47 AM
Subject: RE: Robib TM Clinic March 2012, Case#2, Kheum Im, 42F

Dear Sovann,

For this patient, the rash on her feet appeared more as tinea than eczema because it got the clearing center with well-demacated maculopapular lesions around. The pruritus and and scaly appearance are corresponding to tinea infection.

Don't give steroid, but can give clotrimazole or other antifungal cream to apply bid until rash gone and the 2 additional days after clearing. You can ask her to come back next month to check if any improvement. Ask her and her husband to both be treated at the same time; otherwise, they will continue to transmit to one another if only one is treated. Tell both to be constant in applying the cream twice a day and not to wear wet clothings for a prolong period of time (ie. keep area dry). Recommend also for them to be dewormed with Mebendazole 500mg single dose qhs.

Rithy

From: Robibtelemed
To: Joseph Kvedar ; Rithy Chau ; Kruy Lim ; Paul Heinzelmann ; Kathy Fiamma
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Tuesday, February 28, 2012 5:03 PM
Subject: Robib TM Clinic March 2012, Case#3, Ngourn Sophorn, 37F

Dear all,

This is case number 3, Ngourn Sophan, 37F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

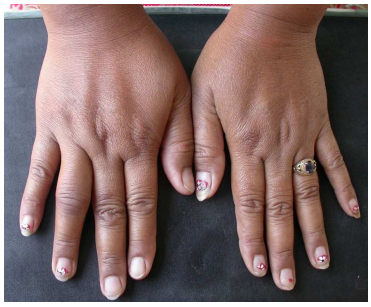
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Ngourn Sophorn, 37F (Ta Tong Village)**

Chief Complaint (CC): Joint pain x 2 months

History of Present Illness (HPI): 37F presented with symptoms of pain, warmth and morning stiffness of joint as DIP, PIP, Carpal joint, Elbow, Toe, Ankle, and shoulder joint. And noticed swelling of only PIP of right ring finger. The stiffness worse in morning and better with activity. She got treatment with Ibuprofen 200mg 2t po bid prn. She denied of skin lesion, fever, SOB, palpitation, nausea, bloody or mucus stool.



Past Medical History (PMH): Unremarkable

Family History: Father with arthritis

SH: No cig smoking, no tobacco chewing, no EtOH

Current Medications: Ibuprofen 200mg 2t po bid prn

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 130/81 P: 99 R: 20 T: 37°C Wt: 56Kg

General: Stable

HEENT: No oropharyngeal lesion, pink conjunctiva, no icterus, 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, no surgical scar, no abdominal bruit

Joint/Skin: swelling of right ring finger, no warmth, no swelling, full range of motion at all joints, no stiffness, no skin lesion

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

Lab/study: None

Assessment:

1. Rheumatoid arthritis

Plan:

1. Paracetamol 500mg 1-2t po qid prn
2. Draw blood for CBC, Lyte, Creat, ESR and RF 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: February 28, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Wednesday, February 29, 2012 10:03 AM
Subject: RE: Robib TM Clinic March 2012, Case#3, Ngourn Sophorn, 37F

Dear Sovann,

I would not jump into the conclusion of RA, since the episode only started 2 months ago and single swelling of the joint. The image you sent appeared to be erythematous for the right DIP joint of ring finger, but you reported no warmth. This may rule out septic joint, but could possibly be gouty arthritis as well. You can just do RF and uric acid level and no need for other lab tests for now. Ask her to get a hand x-rays AP and lat (with finger spreading) to assess the joint integrity.

I did not see any history of injury/trauma or the lack of. Can you ask her about this part?

She can continued to take Ibuprofen 200mg 3 tab po tid prn for pain because it would work better for anti-inflammation than paracetamol. She can buy on her own.

Rithy

From: "Fiamma, Kathleen M." <KFIAMMA@PARTNERS.ORG>
To: "Robib Telemed" <robibtelemed@gmail.com>
Cc: <rithychau@sihosp.org>
Sent: Friday, March 02, 2012 12:49 PM
Subject: FW: Robib TM Clinic March 2012, Case#3, Ngourn Sophorn, 37F

The patient is a 37-year-old woman with pain and stiffness of numerous joints including fingers, wrists, elbow, ankles and shoulders. The PIP joint of the right index finger was said to have been swollen. The photograph clearly shows enlargement with inflammation of the right index finger PIP joint.
This looks like arthritis of the index finger PIP joint. The patient has had joint symptoms without swelling elsewhere and we are not sure how long the index finger PIP joint has been swollen.

This looks like an inflammatory process like an inflammatory process and with a history of arthritis/arthralgias, rheumatoid arthritis is a possibility. I agree with the blood tests that were drawn. She probably would do better with ibuprofen or naproxen if it is available than with paracetamol.

George L. Cohen, M.D.

From: Robibtelemed
To: Rithy Chau ; Kruy Lim ; Paul Heinzelmann ; Kathy Fiamma ; Joseph Kvedar
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Tuesday, February 28, 2012 5:05 PM
Subject: Robib TM Clinic March 2012, Case#4, Panyi Sony, 13M

Dear all,

This is case number 4, Panyi Sony, 13M and photos.

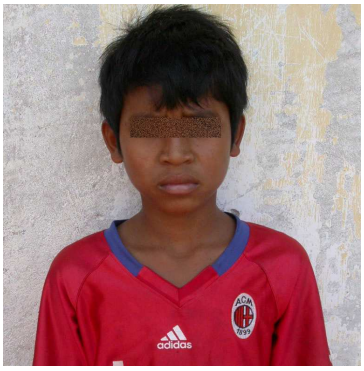
Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

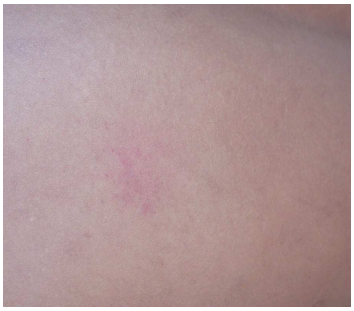
History and Physical



Name/Age/Sex/Village: **Panyi Sony, 13M (Thnal Keng Village)**

Chief Complaint (CC): Skin lesion x 2w

History of Present Illness (HPI): 13M, student, presented with light echymosis, macule skin rashs (see photo skin lesion 1), no itchy on the legs and several days, echymosis became dark with central clearing (see photo skin lesion 2) and to less echymosis (see photo skin lesion 3) and last with scaly skin (see photo skin lesion 4). He also presented with symptoms of fever, HA and dizziness but denied of cough, SOB, muscle pain, joint pain, abd pain, vomiting, diarrhea, animal contact, insect bite, trauma. The lesion disappeared in about two weeks and other lesion appeared. He reported of swimming in the pond of nearby house, no relative or neighboring with similar lesion. He got treatment with IV fluid 1L and no other treatment.



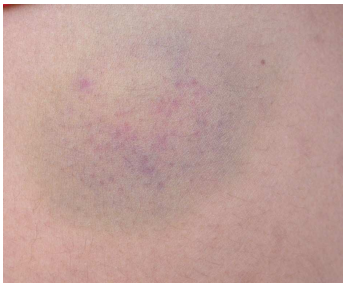
Past Medical History (PMH): Unremarkable

Family History: None

SH: No cig smoking, no tobacco chewing, no EtOH

Current Medications: None

Allergies: NKDA



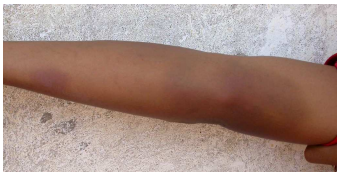
Review of Systems (ROS): Unremarkable

PE:

Vitals: **BP: 121/60** **P: 104** **R: 20** **T: 37^{o}C**

General: Stable

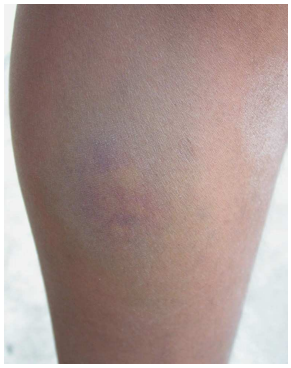
HEENT: No oropharyngeal lesion, pink conjunctiva, no icterus, no neck mass, no neck/axillary lymph node palpable, no JVD; ear examination with normal mucosa and intact TM



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

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

Skin: Slightly and dark echymosis on the legs, arms and body with macule, central clearing, and scale, no vesicle, no pustule

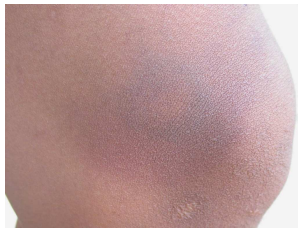


MS/Neuro: MS +5/5, motor and sensory intact, DTRs +2/4, normal gait

Lab/study: None

Assessment:

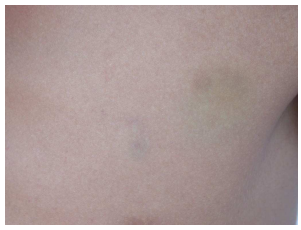
1. Purpura??
2. Coagulation dysfunction?



Plan:

1. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Peripheral blood smear, reticulocyte cound, ESR, LFT at SHCH

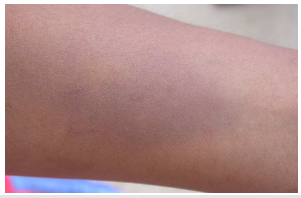
Labs available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, and Pregnancy Test



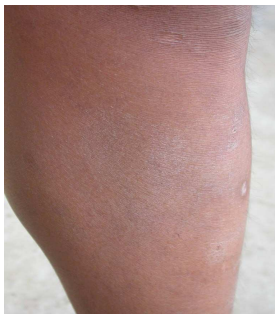
Specific Comments/Questions for Consultants: Do you agree with my assessment and plan?

Examined by: Nurse Sovann Peng **Date: February 28, 2012**

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



From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Wednesday, February 29, 2012 10:31 AM
Subject: RE: Robib TM Clinic March 2012, Case#4, Panyi Sony, 13M



Dear Sovann,

As for this patient, you mentioned that he denied animal contact, but did you ask if he got bitten by an animal like rat or rodent unintentionally (e.g. in his sleep)? Zoonotic infection could cause this kind of eccymoses acutely plus onset of fever initially and h/o swimming in a pond.

The ecchymoses images seemed to fit with the history that they were about 2 weeks since the bruises were becoming more yellowish and the dark brown/purple color is fading and I did not see any new lesion among all the images you sent. Can you investigate more whether there was any domestic abuse or school/boy fight (and this need more sensitive way to approach pt)? How about being exposed to chemical used in rice fields or gardening? Check his entire body for any bite marking especially small one that may not have noticed.

So under Assessment, I would suggest that you put Ecchymoses due to 1. Zoonostic infection? 2. Physical trauma? 3. Coagulopathy??? You can initiate treatment for zoonostic infection with Doxycycline (can buy at market cheaply) 100mg bid for 10-14d and paracetamol if any fever/pain. You can go ahead and draw blood for chem, creat, CBC and PTT.

Hope this is helpful.

Rithy

From: Kruy Lim
To: 'Robibtelemed' ; 'Rithy Chau' ; 'Paul Heinzelmann' ; 'Kathy Fiamma' ; 'Joseph Kvedar'
Cc: 'Bernie Krisher' ; 'Thero So Nourn' ; 'Laurie & Ed Bachrach'
Sent: Wednesday, February 29, 2012 12:22 PM
Subject: RE: Robib TM Clinic March 2012, Case#4, Panyi Sony, 13M

Dear Sovann,

The picture is looklike physical abuse rather than coagulopathy (if coagulopathy: should be disseminate to all body not only on hand, leg, not on the trunk,…) if rodent bite, it will not appear like this presentation such as leptospirosis, rikettio,…
Does it pain or not?

His facial is suspicious of abuse,….? You need to seek more info and query in counseling room rather in the open air,… make sure seeking for abuse or physical violation in his childhood or at swimming poor,….

If no fever according to your note, no jaundice, clinically is pretty well, I will not give any antibiotic.

Thanks
Kruy

From: Paul Heinzelmann
To: Fiamma, Kathleen M. ; Robib Telemedicine ; Rithy Chau
Sent: Thursday, March 01, 2012 2:40 AM
Subject: Re: FW: Robib TM Clinic March 2012, Case#4, Panyi Sony, 13M

I believe this child may have Idiopathic Thrombocytopenic Purpura (ITP) - also known as Immune Thrombocyopenic Purpura...

ITP can happen in any age, but more common in boys aged 2-10 years old. Usually 1-2 weeks after a viral illness. Mild bumps to arms and legs result in easy bruising.

Typically platelets drop to < 20K

Though it often has smaller petchiae rather than true purpura, it can present with either.

Physical abuse appears this way too, so that should be ruled out first. Bone marrow problems can cause a similar picture, so ITP is often a "diagnosis of exclusion"... I would not do a bone marrow biopsy on this child though.

The presence of petechiae inside the mouth can help exclude abuse as the cause.

Do CBC and look at platelets at the very least.

In adults its often treated with prednisone, but child usually self resolve.

If it persists > 10 days, consider other causes.

Thanks

Paul
Paul Heinzelmann, MD

From: Robibtelemed
To: Kruy Lim ; Rithy Chau ; Kathy Fiamma ; Paul Heinzelmann ; Joseph Kvedar
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Tuesday, February 28, 2012 5:08 PM
Subject: Robib TM Clinic March 2012, Case#5, Say Soeun, 72F

Dear all,

This is the last case of first day of Robib TM Clinic March 2012, case number 5, Say Soeun, 72F and photo.

Please waiting for other cases which will be sent to you tomorrow. Thank you very much for your cooperation and support in this project.

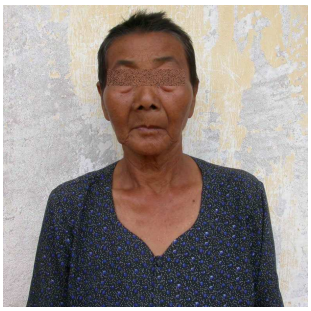
Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note



Patient Name & Village: Say Soeun, 72F (Rovieng Chheung Village)

Subjective: 72F came to follow up of uncontrolled HTN (BP: 200/100 since June 2011), DMII and renal insufficiency. In December 2011, she developed leg edema and admitted to provincial referral hospital and keep observe with the same treatment given by Telemedicine and discharged in 4d. Now She dose not have any complaint (no HA, no neck tension, no dizziness, no SOB, no chest pain, no palpitation, no legs edema).

Current Medications:

1. Glibenclamide 5mg 1t po bid
2. Metformin 500mg 1t po bid
3. Enalapril 5mg 1t po bid
4. Nifedipine 20mg 1t po qd
5. Atenolol 50mg 1t po qd
6. MTV 1t po qd
7. FeSO/Folate 200/0.4mg 1t po qd

Allergies: NKDA

Objective:

VS: BP: 201/104 P: 87 R: 20 T: 37 Wt: 42kg

PE (focused):

General: Look sick

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

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

Abd: Soft, no tender, no distension, (+) BS, no HSM, no abd mass palpable, no abd bruit

Skin/Extremity: No edema, no rash, no foot wound, dorsalis pedis and posterior tibial pulse palpable

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

Labs/Studies:

Lab result on October 7, 2011

WBC	=6.8	[4 - 11x10^9/L]	Na	=142	[135 - 145]
RBC	=3.6	[3.9 - 5.5x10^{12}/L]	K	=3.9	[3.5 - 5.0]
Hb	=9.3	[12.0 - 15.0g/dL]	Cl	=101	[95 – 110]
Ht	=29	[35 - 47%]	Creat	=159	[44 - 80]
MCV	=82	[80 - 100fl]	AST	=18	[<31]
MCH	=26	[25 - 35pg]	ALT	=15	[<32]
MHCH	=32	[30 - 37%]			
Plt	=335	[150 - 450x10^9/L]			
Lym	=1.8	[1.0 - 4.0x10^9/L]			
Mxd	=0.6	[0.1 - 1.0x10^9/L]			
Neut	=4.4	[1.8 - 7.5x10^9/L]			

Lab result on January 6, 2012

Creat	=213	[44 - 80]
T. Chol	=7.8	[<5.7]
TG	=1.7	[<1.71]
HbA1C	=6.6	[4.8 – 5.9]

Today February 28, 2012
U/A: glucose 1+, Protein 1+, no leukocyte, no ketone

Assessment:

1. Uncontrolled HTN
2. DMII
3. Renal insufficiency

Plan:

1. Refer to SHCH for evaluation of uncontrolled hypertension
2. Glibenclamide 5mg 1t po bid
3. Metformin 500mg 1t po bid
4. Enalapril 5mg 1t po bid
5. Nifedipine 20mg 1t po qd
6. Atenolol 50mg 1t po qd
7. MTV 1t po qd
8. FeSO/Folate 200/0.4mg 1t po qd

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: February 28, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Thursday, March 01, 2012 9:49 AM
Subject: RE: Robib TM Clinic March 2012, Case#5, Say Soeun, 72F

Dear Sovann,

You can refer her to our facility, but let her know that there is no guarantee for her to get into the hospital system right away and may have to wait until MD at SHCH select her. Or else she can seek care somewhere else. Again, if the patient condition became severe and cannot be followed in TM program, you must make clear to the patient that she needs to seek care at a higher level facility and staff to care for her instead of relying on our monthly visit.

Rithy

From: chaurithy
To: kruylim@sihosp.org
Cc: Robib Telemedicine
Sent: Wednesday, February 29, 2012 10:34 AM
Subject: FW: Robib TM Clinic March 2012, Case#5, Say Soeun, 72F

Dear Bong,

Can you help to answer this case and especially for us to consider referring her to better evaluate at SHCH? Please let me know your decision.

Thanks,
Rithy

From: "Cusick, Paul S.,M.D." <PCUSICK@PARTNERS.ORG>
To: "Fiamma, Kathleen M." <KFIAMMA@PARTNERS.ORG>; <robibtelemed@gmail.com>
Cc: <rithychau@sihosp.org>; "Cusick, Paul S.,M.D." <PCUSICK@PARTNERS.ORG>
Sent: Monday, March 05, 2012 7:54 AM
Subject: RE: Robib TM Clinic March 2012, Case#5, Say Soeun, 72F

I have read the case presentation and the original opinion by my colleague Dr. Smulders-Meyer on 6/21/11.

She has uncontrolled hypertension. She has severe hypertension with a systolic of 201 but does not have any symptoms to suggest damage to her eyes,brain, heart at the present.

Her diabetes control is better by her lower A1c. Great job!!

Her chronic kidney is worse with an increase in her Cr from 159 to 213.

Her progressively worsening renal failure is likely the result of the chronic uncontrolled hypertension and diabetes and elevated cholesterol.

She needs better blood pressure control.

In addition to refering her to the regional hospital, you can increase her atenolol from 50 to 100mg daily as her heart rate is 87 and she can likely tolerate more beta blocker.

Her HCT and HGB are also lower. This anemia could be from gastrointestinal (GI) blood loss, infection, anemia of chronic disease or a decrease in her erythropoietin from chronic kidney failure.

It would be helpful if stool guaiac cards could be done to detect any GI bleeding

Thanks for the consult and best of luck

Paul Cusick

From: Robibtelemed
To: Cornelia Haener ; Rithy Chau ; Kruy Lim ; Kathy Fiamma ; Paul Heinzelmann ; Joseph Kvedar
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Wednesday, February 29, 2012 2:50 PM
Subject: Robib TM Clinic March 2012, Case#6, Thy Ponlork, 22M

Dear all,

There are four new cases and one follow up case for second day Robib TM Clinic March 2012. This is case number 6, continued from yesterday, Thy Ponlork, 22M and photos.

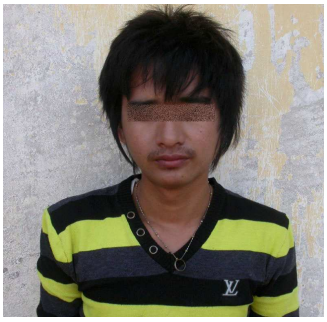
Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

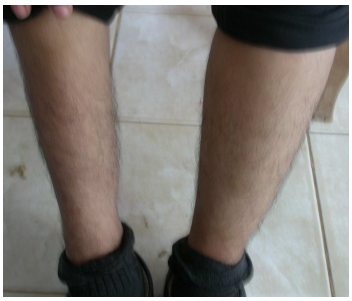


Name/Age/Sex/Village: **Thy Ponlork, 22M (Taing Treuk Village)**

Chief Complaint (CC): Right foot wound x 50days

History of Present Illness (HPI): 22M, student, had injury with the wood then it became inflamed with swelling, erythema, warmth and pain. Several days later it became pus formation with foul odor, no sensation around the wound and got treatment by cleaning and taking Penicillin 500mg 1t po tid. He came to Telemedicine in early of February 2012 and treated with Augmentin and Cotrimoxazole and daily wound cleaning. The wound became better with no swelling, no foul odor, no pain, no pus drainage.

Past Medical History (PMH): In 2006, Motor accident with knee joint trauma and have several times of knee surgery and Achilee tendon reconstruction at Kantha Bopha in Siem Reap

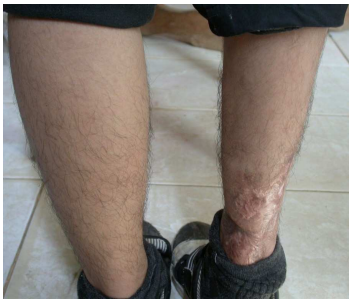


Family History: Father with HTN, and Gout

SH: Grade 11 student, No cig smoking, no EtOH

Current Medications:

1. Augmentin 600mg/5cc 10cc bid
2. Cotrimoxazole 960mg 1t po bid



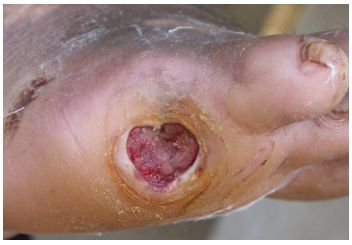
Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 119/69 P: 94 R: 20 T: 37^{o}C

General: Stable

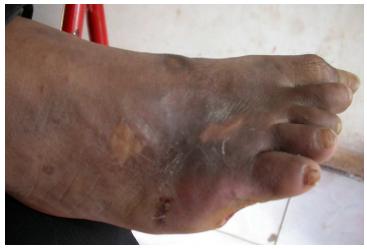


HEENT: No oropharyngeal lesion, pink conjunctiva, no icterus, no neck mass, no lymph node palpable, no JVD

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

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

Extremity/Skin: Wound on the lateral edge of the right foot with exudate, erythema, no pus, no foul odor, decreased sensation with touch around the wound site, darkening of skin of back of foot, scaring on posterior of ankle (see photos); atrophy of right calf



Lab/study: None

Assessment:

1. Infected wound due to bacterial infection (Melioidosis?) or poor blood supply

Plan:

1. Augementin 600mg/5cc 10cc bid for one month
2. Cotrimoxazole 960mg 1t po bid for one month
3. Daily wound cleaning with NSS
4. Send patient to Kg Thom Hospital for X-ray of Right foot

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: February 29, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim' ; Cornelia Haener
Sent: Thursday, March 01, 2012 9:05 AM
Subject: RE: Robib TM Clinic March 2012, Case#6, Thy Ponlork, 22M

Dear Sovann,

If he has been on Augmentin for a month already, you can discontinue this and still continue with Cotrim tx for several more months. Good practice of wound care is always the best to get the healing to go faster. Sending him for an x-ray is a good idea to rule out any fomite embedding that may cause chronic infection or any other problem that may require surgical intervention. I hope Dr. Cornelia will reply and help you with this case.

Rithy

From: Danny Sands (dzsands) [mailto:dzsands@cisco.com]
Sent: Wed 2/29/2012 3:33 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic March 2012, Case#6, Thy Ponlork, 22M

Sounds like a reasonable plan, but it's not clear from your history why he has calf atrophy. If from prior trauma then I understand, otherwise it needs investigation.

He may have osteomyelitis, so I think the x-ray is an excellent idea.

- Danny

From: Cornelia Haener
To: 'Robibtelemed' ; 'Rithy Chau' ; 'Kruy Lim' ; 'Kathy Fiamma' ; 'Paul Heinzelmann' ; 'Joseph Kvedar'
Cc: 'Bernie Krisher' ; 'Thero So Nourn' ; 'Laurie & Ed Bachrach'
Sent: Thursday, March 01, 2012 7:59 PM
Subject: RE: Robib TM Clinic March 2012, Case#6, Thy Ponlork, 22M

Dear Sovann,
It would be good to get some tissue, put it in NSS and bring it to our lab to confirm or rule out Melioidosis.

Thanks
Cornelia

From: Robibtelemed
To: Kruy Lim ; Kathy Fiamma ; Paul Heinzelmann ; Joseph Kvedar ; Rithy Chau
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Wednesday, February 29, 2012 4:30 PM
Subject: Robib TM Clinic March 2012, Case#7, Som Laty, 7F

Dear all,

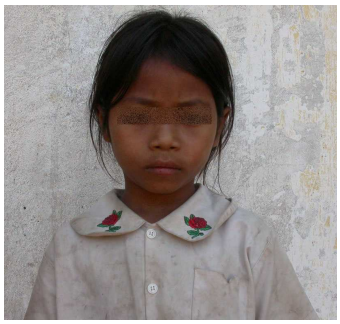
This is case number 7, Som Laty, 7F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

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

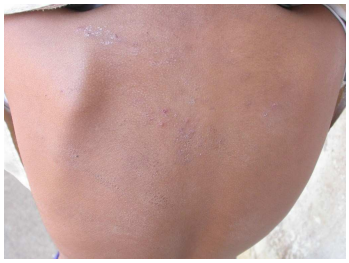
History and Physical



Name/Age/Sex/Village: **Som Laty, 7F (Doang Village)**

Chief Complaint (CC): Skin rash x 2y

History of Present Illness (HPI): 7F presented with itchy on the head, she scratch on it which then became exudate and pustule and got treatment with application cream (unknown name) but not better. She also report of some rashes on the extremities but not developed to exudative/pustule formation. No fever, no palpable lymph node.



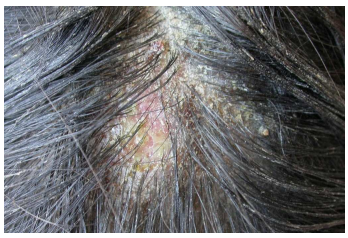
Past Medical History (PMH): Unremarkable

Family History: No family member with skin lesion/rash

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable

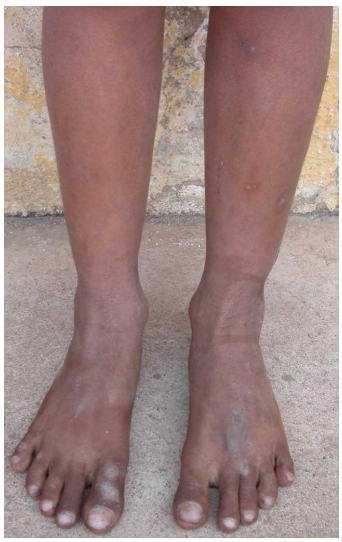


PE:

Vitals: **BP:** **P: 120** **R: 24** **T: 37^{o}C** **Wt: 20Kg**

General: Stable

HEENT: Lesions with pustule and few other lesion with crust on head; A lot of louse eggs on the hairs; the No oropharyngeal lesion, pink conjunctiva, no icterus, no lymph node palpable; ear examination with normal mucosa and intact TM



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

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

Skin: papular rash with scaly skin on the back and legs

Lab/study: None

Assessment:

1. Staph infection due to poor hygiene

Plan:

1. Augmentin 125mg/5cc 10cc bid for 10d
2. Keep the hair and body clean by having shower with shampoo and soap

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: February 29, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Thursday, March 01, 2012 9:18 AM
Subject: RE: Robib TM Clinic March 2012, Case#7, Som Laty, 7F

Dear Sovann,

I agree with the presentation that pointed toward poor hygiene and secondary infection in developing impetigo. Also, I would add a deworming medication (like Albendazole for 5d).

Concerning the lice, she needs to use soap/shampoo regularly, but once the head wounds are healed, she can use a lice comb to help rid of the lice more or have a head shave to help rid of the louse as last resort to having no medication to treat. Remember family members must be treated also to prevent recurrent transmission.

You may also need to consider scabies as another ddx with poor hygiene condition. If you strogly suspected scabies, then give them some benzoyl benzoate soln for the whole family to do after the head is healed and do thorough cleaning, drying out in the sun and soaking in hot water of all mat, mattress, linen, clothes, etc.

Rithy

From: Kroshinsky, Daniela,M.D.
Sent: Wed 2/29/2012 9:41 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic March 2012, Case#7, Som Laty, 7F

It appears that the child has eczema that may have become superinfected when she scratched it. I did not see actual eggs but a lot of scale on the scalp- it is possible that the photos were not close enough, but I suspect she has either seborrheic dermatitis or tinea capitis of the scalp. If she has no occipital lymphadenopathy, tinea capitis is less likely.

I would keep her showers to no more than 5-10 minutes with warm, not hot, water and moisturizer should be applied twice a day. Do we have access to topical steroids? If so, I would apply to the areas of rash twice a day for a week. A liquid steroid once a day to the scalp will help with scale and itch. Any open sores can be treated with a topical antibiotic but if she has already received augmentin this will cover her as well.

Hope this helps, please let me know how she does.
Best,
Daniela Kroshinsky, MD

From: Robibtelemed
To: Kathy Fiamma ; Paul Heinzelmann ; Joseph Kvedar ; Rithy Chau ; Kruy Lim
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Wednesday, February 29, 2012 4:32 PM
Subject: Robib TM Clinic March 2012, Case#8, Som Theara, 14F

Dear all,

This is case number 8, Som Theara, 14F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

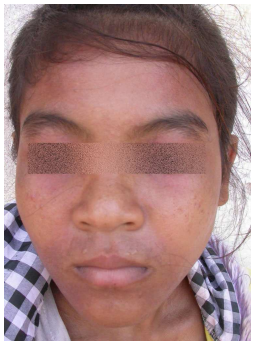
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Som Theara, 14F (Pal Hal Village)**

Chief Complaint (CC): Skin rashes x 2y

History of Present Illness (HPI): 14F, student, bitten by Ants, she scratched then it became exudative lesion with pustule formation and got treatment from local pharmacy with cream application (unknown name) but not better so she had Steroid injection IM which control the lesion from flare up then became crust (see photos). In these several days, she developed plague lesion on the face and neck with itchy, no vesicle, no pustule. She didn't get treatment for that yet and come to consult with Telemedicine today. She denied of chemical contact, insect bite, fever, lymph node enlargement.



Past Medical History (PMH): Unremarkable

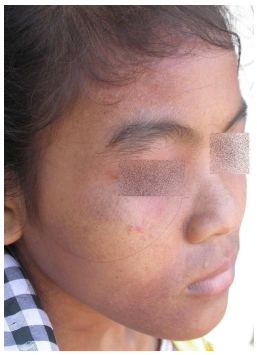
Family History: Father with skin lesion but unknown what kind

SH: Grade 6 student, no cig smoking, no EtOH

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable



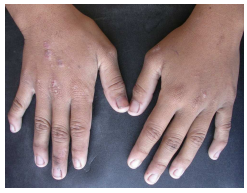
PE:

Vitals: **BP: 120/60** **P: 96** **R: 22** **T: 37^{o}C** **Wt: 37Kg**

General: Stable

HEENT: No oropharyngeal lesion, pale conjunctiva, no icterus, no neck mass, no lymph node palpable, no JVD; ear examination with normal mucosa and intact TM

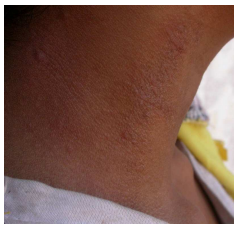
Chest: CTA bilaterally, no rales, no rhonchi; H RRR, no murmur



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

Skin: On foot and palm, plague with crust, no vesicle, no pus; on face and neck, erythematous papular with unclear border, no exudate, no vesicle,

no pustule, no scale (see photos)

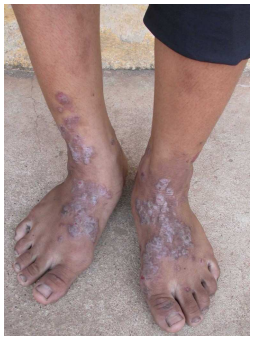


MS/Neuro: MS +5/5, motor and sensory intact, DTRs +2/4, normal gait

Lab/study: None

Assessment:

1. Eczema?
2. Dermatitis?



Plan:

1. Fluocinonide 0.1% apply bid
2. Cetirizine 10mg 1t po qhs prn itchy

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: February 29, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Thursday, March 01, 2012 9:23 AM
Subject: RE: Robib TM Clinic March 2012, Case#8, Som Theara, 14F

Dear Sovann,

I agree with your assessment. The periorbital discoloration may be an allergic sx that corresponds with the dx of eczema.

Rithy

From: Peter Schalock [mailto:schalock@gmail.com]
Sent: Wed 2/29/2012 3:56 PM
To: Fiamma, Kathleen M.
Subject: Re: FW: Robib TM Clinic March 2012, Case#8, Som Theara, 14F

Hi Kathleen,

This is a challenging case.That is a dermatoses in need of a diagnosis. From the photos I am in favor of lichen planus, but it certainly needs a work-up.

Unfortunately my recommendation would be to make the trek to Phnom Penh. She can continue with the current tx for now.

Best,
Peter Schalock, MD

From: Robibtelemed
To: Paul Heinzelmann ; Joseph Kvedar ; Rithy Chau ; Kruy Lim ; Kathy Fiamma
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Wednesday, February 29, 2012 4:34 PM
Subject: Robib TM Clinic March 2012, Case#9, Sourn Visal, 3M

Dear all,

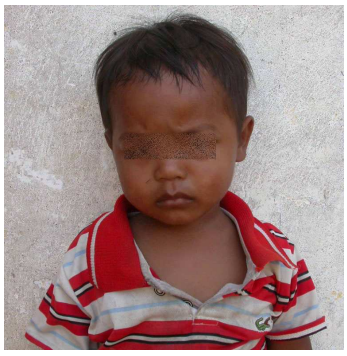
This is case number 9, Sourn Visal, 3M and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

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

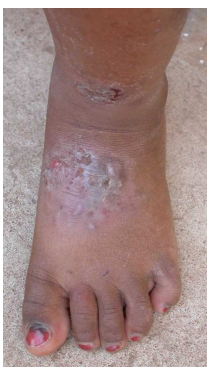
History and Physical



Name/Age/Sex/Village: **Sourn Visal, 3M (Thnout Malou Village)**

Chief Complaint (CC): Skin rash x 10 months

History of Present Illness (HPI): 3M was brought to Telemedicine by his mother complaining of 10 months of maculopapular rash on foot with itchy. He scratch on the rash which became exudate and pustule and was treated with traditional medicine application but not better. His mother brought him to consult with private clinic and treated with oral and cream application but not heal. His mother denied of chemical contact, insect bite.



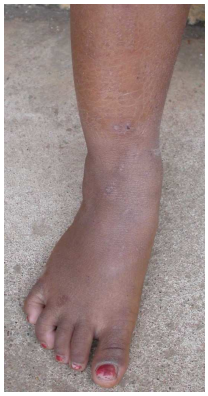
Past Medical History (PMH): Admitted to Kantha Bopha hospital in Siem Reap due to respiratory infection in 2009

Family History: No family member with skin lesion/rash

Current Medications: Cream application (unknown name)

Allergies: NKDA

Review of Systems (ROS): Unremarkable



PE:

Vitals: BP: P: 120 R: 26 T: 37°C Wt: 14Kg

General: Stable

HEENT: No oropharyngeal lesion, pale conjunctiva, no icterus, no lymph node palpable; ear examination with normal mucosa and intact TM

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

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

Skin: On left foot, erythema with some exudate lesion and crust (see photos)

Lab/study: None

Assessment:

1. Eczema?
2. Dermatitis?
3. Secondary infection?

Plan:

1. Augmentin 125mg/5cc 5c bid for 10d
2. Bacitracine zinc cream apply on the lesion bid

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

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

Examined by: Nurse Sovann Peng **Date: February 29, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Thursday, March 01, 2012 9:29 AM
Subject: RE: Robib TM Clinic March 2012, Case#9, Sourn Visal, 3M

Dear Sovann,

I agree with your plan. You can also give some antihistamine to help with the itching and clean the wound and put on sterile dressing will help to prevent the kid from scratching over the wound and help to heal better. NSAIDs will help with the inflammation and recheck next month.

Rithy

From: Peter Schalock [mailto:schalock@gmail.com]
Sent: Wed 2/29/2012 4:12 PM
To: Fiamma, Kathleen M.
Subject: Re: FW: Robib TM Clinic March 2012, Case#9, Sourn Visal, 3M

Hi,

Another challenging case. I would be concerned about a secondary infection - more likely deep fungal or bacterial. I'm less inclined to call it eczema, but it is itchy.
I would recommend trying a fluocinonide cream or ointment twice daily for 2 weeks. If it improves then it is more likely eczematous. If it worsens, it should be biopsied and tissue cultured. Likely another trip to Phnom Penh...

Best,
Peter

From: Robibtelemed
To: Joseph Kvedar ; Rithy Chau ; Kruy Lim ; Kathy Fiamma ; Paul Heinzelmann
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Wednesday, February 29, 2012 4:38 PM
Subject: Robib TM Clinic March 2012, Case#10, Chum Chet, 64M

Dear all,

This is the last case of Robib TM Clinic March 2012, Case#10, Chum Chet, 64M (follow up case) and photos. Please reply to the cases before Thursday afternoon then treatment plan can be made accordingly.

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

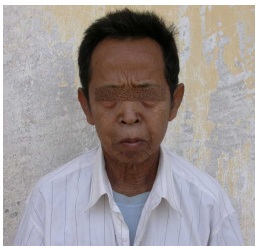
Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

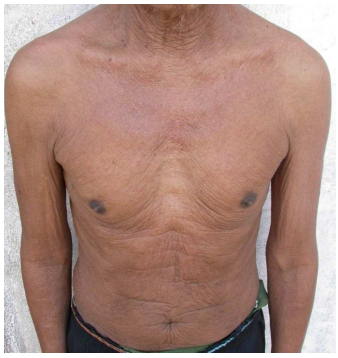
Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note



Patient Name & Village: Chum Chet, 64M (Koh Pon Village)

Subjective: 64M has been diagnosed with HTN, Osteoarthritis and renal insufficiency and treated with Atenolol 50mg 1/2t po bid, Amlodipine 5mg 1t po qd, MTV 1t po qd and Paracetamol 500mg 1t po qid prn pain. Since January this year, he presented with maculopapular skin rash with itchy, especially at night all over the body and extremity without vesicle, pustule and was treated with Citirizine 10mg 1t po qhs, which control a bit with itchy. He denied of fever, cough, SOB, palpable lymph node, contact with chemical.



Allergies: NKDA

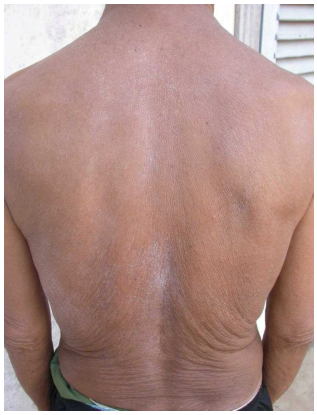
Objective:

VS: **BP: 122/63** **P: 72** **R: 20** **T: 37**
Wt: 49kg

PE (focused):

General: Look stable

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



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

Abd: Soft, no tender, no distension, (+) BS, no HSM, no abd mass palpable, no abd bruit

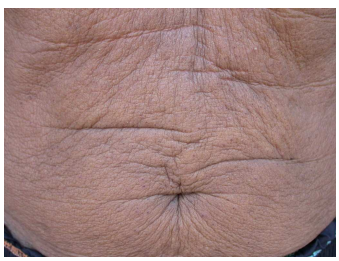
Skin: Generalized maculopapular rash over the body and extremity, no exudate, no vesicle, no pustule (see photos).

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

Labs/Studies:

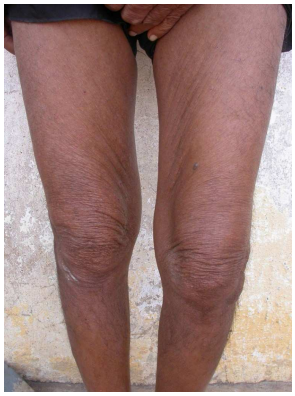
Lab result on February 10, 2012

Na	=138	[135 - 145]
K	=5.1	[3.5 - 5.0]
Cl	=107	[95 - 110]
Creat	=284	[53 - 97]



Done today on March 29, 2012

U/A: protein trace, no glucose, no leukocyte, no ketone



Assessment:

1. HTN
2. Osteoarthritis
3. Renal insufficiency
4. Generalized urticaria

Plan:

1. Atenolol 50mg 1/2t po bid
2. Amlodipine 5mg 1t po qd
3. Paracetamol 500mg 1t po qid prn pain
4. MTV 1t po qd
5. Prednisolone 5mg 8t po qd for 7d
6. Cemetidine 200mg 1t po bid for 10d
7. Albendazole 200mg 2t po bid for 5d

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 29, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Thursday, March 01, 2012 9:37 AM
Subject: RE: Robib TM Clinic March 2012, Case#10, Chum Chet, 64M

Dear Sovann,

His rashes seemed to be an allergic dermatitis of some sort. You may want to find out about exposure to chemical, detergent, soap, rice husk, etc., for him to avoid if possible. You can give him some calamine lotion to apply qid and if can find some lotion to apply to help with his dry skin.

Rithy

From: "Cusick, Paul S.,M.D." <PCUSICK@PARTNERS.ORG>
To: "Fiamma, Kathleen M." <KFIAMMA@PARTNERS.ORG>; <robibtelemed@gmail.com>
Cc: <rithychau@sihosp.org>; "Cusick, Paul S.,M.D." <PCUSICK@PARTNERS.ORG>
Sent: Monday, March 05, 2012 8:06 AM
Subject: RE: Robib TM Clinic March 2012, Case#10, Chum Chet, 64M

Thank you for the chance to participate in this consult.

Unfortunately, I cannot make out much detail of the rash on his chest/back/legs/abdomen.

Your description is helpful

It appears that the rash is not on his face, soles of his feet or his palms.

Therefore, it is not a rash related to sun exposure as his face is exposed to the sun

The rash sounds quite itchy and bothersome.

This rash may be from one of his medications, even if the medications are not new.

This rash may be related to his chronic kidney disease.

The rash may be from some contact dermatitis with a reaction to his clothes or to soap used to clean his clothes.

The zyrtec and prednisone should help the itching to improve. It may help to control the original cause of the rash and may help to reverse and eliminate the rash.

If his rash does not go away after prednisone, then you may have to stop his medications one at a time to see if any of his medications are causing the rash.

I am not aware that intestinal parasites can cause this kind of rash, but given that there is a great deal of intestinal parasites in Camodia, the albendazole makes sense.

Best of luck
Paul

From: Robibtelemed
To: Rithy Chau ; Kruy Lim ; Kathy Fiamma ; Paul Heinzelmann ; Joseph Kvedar
Cc: Bernie Krisher ; Thero So Nourn ; Laurie & Ed Bachrach
Sent: Wednesday, February 29, 2012 7:22 PM
Subject: Robib TM Clinic March 2012, Case#11, Dourng Sunly, 56M

Dear all,

There are one follow up case that is seen this evening. Case number 11, Dourng Sunly, 56M and photos.

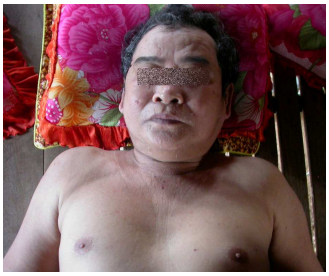
Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note

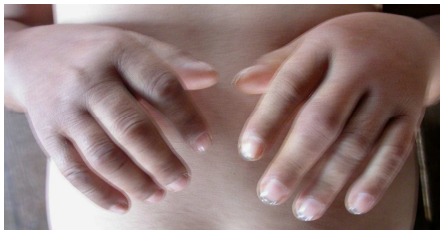


Patient Name & Village: Dourng Sunly, 56M (Taing Treurk Village)

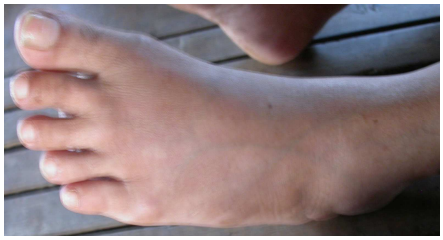
Subjective: 56M with past diagnosis of HTN, Gouty arthritis and hyperlipidemia presented with one months of symptoms pain, warmth, swelling, and stiffness of joint as DIP, PIP, MCP, wrist, elbow, toe joint, ankle and knees. The symptoms presented symmetrically and did not change in the day. The pain became worse with fever. He was treated by local health care worker with Diclofenac and Paracetamol injection, which help relieve the pain a little bit. He has been resting still with less activity due to severe pain. He report of on/off dyspepsia but denied nausea, vomiting, black or bloody stool. oliguria, hematuria, dysuria.

Current Medication

1. Captopril 25mg 1/2t po bid
2. ASA 300mg 1/4t po qd
3. Paracetamol 500mg 1t po qid prn pain/fever
4. Fenofibrate 1t po qd

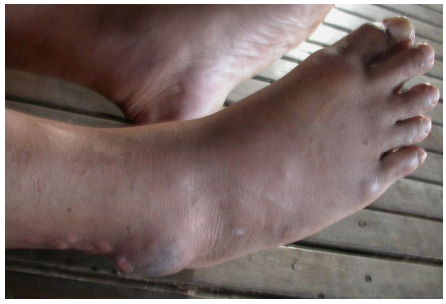


Allergy: NKDA



Objective:

VS: BP: 95/75 P: 92 R: 20 T: 37^{o}C
(Patient on Paracetamol and Sponge bath)
Wt: 74kg O2sat: 95%



PE (focused):

General: Look sick, resting with support pillow due to severe pain

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

Chest: CTA bilaterally, no rales, no rhonchi; HRRR, no murmur

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

Extremity: Warmth, swelling, stiffness with moderate tender of DIP, PIP, MCP, wrist, toes and ankle joint; mild tender with motion of elbow and knee joint

Labs/Studies: None

Lab result on October 7, 2011

T. Chol	=6.3	[<5.7]
TG	=2.2	[<1.7]
AST	=28	[<37]
ALT	=24	[<42]

Assessment:

1. Exacerbated gouty arthritis
2. Rheumatoid arthritis??
3. Septic arthritis
4. HTN
5. Hyperlipidemia

Plan:

1. Prednisolone 5mg 10t po qd for 10day
2. Captopril 25mg 1/2t po bid
3. ASA 300mg 1/4t po qd
4. Paracetamol 500mg 1t po qid prn pain/fever
5. Fenofibrate 1t po qd
6. Draw blood for CBC, Lyte, Creat, tot chole, TG, Uric acid, and RF 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: February 29, 2012**

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

From: chaurithy
To: 'Robibtelemed'
Cc: 'Kruy Lim'
Sent: Thursday, March 01, 2012 9:43 AM
Subject: RE: Robib TM Clinic March 2012, Case#11, Dourng Sunly, 56M

Sovann,

Patient like this need to seek help somewhere else as we discussed previously at a tertiary medical facility (e.g. in PP). Please ask him and his family to do this and you can help to follow him up when his sx are not as severe.

Rithy

Thursday, March 1, 2012

Follow-up Report for Robib TM Clinic

There were 8 new and 3 follow up patients seen during this month Robib TM Clinic, and other 64 patients came for medication refills only. The data of all 11 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 2012

1. Keum Kourn, 65F (Thkeng Village)
Diagnosis:

1. Goiter
2. Hyperthyroidism
3. Dyspepsia

Treatment:

1. Propranolol 40mg 1/4t po bid (#20)
2. Cimetidine 200mg 1t po qhs for one month (#30)
3. Draw blood for TSH and Free T4 at SHCH

Lab result on March 02, 2012

TSH	=<0.005	[0.27 - 4.20]
Free T4	=90.82	[12.0 - 22.0]

2. Kheum Im, 42F (Thkeng Village)
Diagnosis:

1. Tinea pedis

Treatment:

1. Clotrimazole cream apply bid (#1)
2. Cetirizine 10mg 1t po qhs (#30)
3. Mebendazole 100mg 5t po qhs (#5)

3. Ngourn Sophorn, 37F (Ta Tong Village)
Diagnosis:

1. Rheumatoid arthritis?

Treatment:

1. Ibuprofen 200mg 2t po bid prn pain (#30)
2. Draw blood for RF and uric acid at SHCH

Lab result on March 02, 2012

Uric acid =266 [140 - 340]
Rheumatoid factor= positive 1/8

4. Panyi Sony, 13M (Thnal Keng Village)
Diagnosis:

1. Purpura??
2. Coagulation dysfunction?

Treatment:

1. Draw blood for CBC, PT at SHCH

Lab result on March 2, 2012

Testing is not done due to clot specimen

5. Say Soeun, 72F (Rovieng Chheung Village)
Diagnosis:

1. Uncontrolled HTN
2. DMII
3. Renal insufficiency

Treatment:

1. Glyburide 2.5mg 2t po bid (#120)
2. Metformin 500mg 1t po bid (#60)
3. Enalapril 5mg 1t po bid (#60)
4. Nifedipine 20mg 1t po qd (#30)
5. Atenolol 50mg 1t po qd (#30)
6. MTV 1t po qd (#30)
7. FeSO/Folate 200/0.4mg 1t po qd (#30)

6. Thy Ponlork, 22M (Taing Treuk Village)
Diagnosis:

1. Infected wound due to bacterial infection (Melioidosis?) or poor blood supply

Treatment:

1. Cotrimoxazole 960mg 1t po bid for one month (#60)
2. Daily wound cleaning with NSS
3. Send patient to Kg Thom Hospital for X-ray of Right foot

7. Som Laty, 7F (Doang Village)
Diagnosis:

1. Impetigo

Treatment:

1. Augmentin 125mg/5cc 10cc bid for 10d (#2)
2. Albendazole 200mg 1t po bid for 5d (#10)
3. Keep the hair and body cleaned by having shower with shampoo and soap

8. Som Theara, 14F (Pal Hal Village)
Diagnosis:

1. Eczema?
2. Dermatitis?

Treatment:

1. Fluocinonide 0.1% apply bid (#2)
2. Cetirizine 10mg 1t po qhs prn itchy (#30)

9. Sourn Visal, 3M (Thnout Malou Village)
Diagnosis:

1. Eczema?
2. Dermatitis?
3. Secondary infection?

Treatment:

1. Augmentin 125mg/5cc 5c bid for 10d (#1)
2. Bacitracine zinc cream apply on the lesion bid (#1)
3. Clean and dressing on the affected foot

10. Chum Chet, 64M (Koh Pon Village)
Diagnosis:

1. HTN
2. Osteoarthritis
3. Renal insufficiency
4. Generalized urticaria

Treatment:

1. Atenolol 50mg 1/2t po bid (#30)
2. Amlodipine 5mg 1t po qd (#15)
3. Paracetamol 500mg 1t po qid prn pain (#20)
4. MTV 1t po qd (#30)
5. Prednisolone 5mg 8t po qd for 7d (#56)
6. Cemetidine 200mg 1t po bid for 10d (#20)
7. Albendazole 400mg 1t po bid for 5d (#10)

11. Dourng Sunly, 56M (Taing Treurk Village)
Diagnosis:

1. Exacerbated gouty arthritis
2. Rheumatoid arthritis??
3. Septic arthritis?
4. HTN
5. Hyperlipidemia

Treatment:

1. Prednisolone 5mg 10t po qd for 10day (#30)
2. Albendazole 400mg 1t po bid for 5d (#10)
3. Captopril 25mg 1/2t po bid
4. ASA 300mg 1/4t po qd
5. Paracetamol 500mg 1t po qid prn pain/fever
6. Fenofibrate 1t po qd

Patients who come for follow up and refill medicine

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

1. DMII
2. HTN

Treatment:

1. Metformin 500mg 1t po bid for four months (#200)
2. Amlodipine 10mg 1/2t po qd for for four months (#50)
3. Captopril 25mg 1/2t po bid for for four months (buy)

2. Chan Him, 63F (Taing Treuk Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 1t po qd for three months (# 90)

3. Chan Oeung, 60M (Sangke Roang Village)
Diagnosis:

1. Gouty arthritis
2. Osteoarthritis
3. Renal insufficiency

Treatment:

1. Paraetamol 500mg 1t po qid prn for two months (#40)
2. MTV 1t po qd for two months (#60)
3. Allopurinol 100mg 2t po qd for two months (buy)

4. Chan Rim, 59F (Ke Village)
Diagnosis:

1. HTN
2. Dyspepsia

Treatment:

1. Nifedipine 20mg 1/2t po qd for one month (#20)
2. Mg/Al(OH)3 200/125mg 2t chew qid prn (#30)

5. Chan Sem, 62M (Chambak Phaem Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 1t po qd for two months (#60)

6. Chan Sorya, 50F (Pal Hal Village)
Diagnosis:

1. HTN
2. Old stroke with right side weakness
3. Dyspepsia

Treatment:

1. HCTZ 25mg 1t po qd for two months (#60)
2. Cimetidine 200mg 1t po qhs (#30)

7. Chhay Chanthy, 47F (Thnout Malou Village)
Diagnosis:

1. Euthyroid goiter

Treatment:

1. Carbimazole 5mg 1t po bid for three months (buy)
2. Propranolol 40mg 1/4t po bid for three months (#45)

8. Chheng Yearng, 48F (Thkeng Village)
Diagnosis:

1. Tachycardia

Treatment:

1. Propranolol 40mg 1/4t po qd for two months (#15)
2. MTV 1t po qd for two months (#60)

9. Chhourn Khi, 51F (Trapang Teum Village)
Diagnosis:

1. DMII with PNP

Treatment:

1. Metformin 500mg 1t po bid for two months (#90)
2. Amitriptylin 25mg 1/4t po qhs for two months (#15)

10. Chourb Kim San, 57M (Rovieng Tbong Village)
Diagnosis:

1. HTN
2. Right side stroke with left side weakness
3. DMII
4. Gouty arthritis
5. Chronic renal failure

Treatment:

1. Atenolol 50mg 1/2t po bid for two months (#60)
2. Amlodipine 5mg 1t po qd for two months (buy)
3. ASA 300mg 1/4t po qd for two months (#15)
4. Metformin 500mg 1t po bid for two months (#120)
5. Glibenclamide 5mg 1t po bid for two months (buy)

11. Doeu Chetana, 6F (Bos Village)
Diagnosis:

1. Tourette syndrome

Treatment:

1. Didn't come to get medicine

12. Dourng Sopheap, 37F (Thnal Keng Village)
Diagnosis:

1. Hyperthyroidism

Treatment:

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

13. Ek Rim, 47F (Rovieng Chheung Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 1t po qd for one month (#30)

14. Heng Chan Ty, 50F (Ta Tong Village)
Diagnosis:

1. Hyperthyroidism

Treatment:

1. Carbimazole 5mg 1t po tid for two months (buy)
2. Propranolol 40mg ¼ t po bid for two months (#30)

15. Heng Naiseang, 63F (Taing Treuk Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 2t po qd for one month (#60)
2. Do regular exercise

16. In Kong, 68F (Bos Village)
Diagnosis:

1. HTN
2. Mouth ulcer

Treatment:

1. Nifedipine 20mg 1/2t po qd (#20)
2. Refer to hospital in Phnom Penh for evaluation

17. Kim Yat, 38F (Sre Thom Village)
Diagnosis:

1. Anemia
2. Tachycardia

Treatment:

1. Propranolol 40mg 1/4t po bid for one month (#15)
2. Draw blood for CBC, Peripheral blood smear and reticulocyte count at SHCH

Lab result on March 02, 2012

WBC	=5.29	[4 - 11x10^9/L]
RBC	=4.5	[3.9 - 5.5x10^{12}/L]
Hb	=9.6	[12.0 - 15.0g/dL]
Ht	=32	[35 - 47%]
MCV	=70	[80 - 100fl]
MCH	=21	[25 - 35pg]
MHCH	=30	[30 - 37%]
Plt	=266	[150 - 450x10^9/L]
Neut	=3.53	[2.0 - 8.0x10^9/L]
Lymph	=1.09	[0.7 - 4.4x10^9/L]
Mono	=0.31	[0.1 – 0.8x10^9/L]
Eosino	=0.34	[0.08 – 0.40]
Baso	=0.02	[0.02 – 0.10]

Peripheral blood smear

Microcytic	2+
Hypochromic	2+
Macrocytic	1+
Schistocytes	1+
Elliptocytes	2+
Poikolocytosis	2+

Reticulocyte cound =4.5 [0.5 – 1.5]

18. Kin Yin, 35F (Bos Pey Village)
Diagnosis:

1. Hyperthyroidism

Treatment:

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

19. Kong Nareun, 35F (Taing Treuk Village)
Diagnosis:

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

Treatment:

1. Atenolol 50mg 1/4t po qd for three months (buy)
2. Spironolactone 25mg 1t po qd for three months (#90)
3. ASA 300mg 1/4t po qd for three months (#23)

20. Kong Sam On, 55M (Thkeng Village)
Diagnosis:

1. HTN
2. DMII
3. Chronic renal failure
4. Hypertriglyceridemia
5. Arthritis

Treatment:

1. Glibenclamdie 5mg 2t po bid for one month (buy)
2. Metformin 500mg 1t po bid for one month (#60)
3. Enalapril 5mg 1t po qd for one month (#35)
4. Amlodipine 10mg 1/2t po qd for one month (#15)
5. ASA 300mg 1/4t po qd for one month (#8)
6. Fenofibrate 100mg 1t po qd for one month (buy)
7. Draw blood for CBC, Lyte, Creat, Ca2+, Mg2+, HbA1C at SHCH

Lab result on March 02, 2012

WBC	=6.83	[4 - 11x10^9/L]	Na	=137	[135 - 145]
RBC	=4.0	[4.6 - 6.0x10^{12}/L]	K	=3.9	[3.5 - 5.0]
Hb	=10.9	[14.0 - 16.0g/dL]	Cl	=104	[95 – 110]
Ht	=32	[42 - 52%]	Creat	=252	[53 - 97]
MCV	=82	[80 - 100fl]	Ca2+	=1.06	[1.12 – 1.32]
MCH	=28	[25 - 35pg]	Mg2+	=0.81	[0.66 – 1.07]
MHCH	=34	[30 - 37%]	HbA1C	=7.1	[4.8 – 5.9]
Plt	=235	[150 - 450x10^9/L]			
Neut	=3.42	[2.0 - 8.0x10^9/L]			
Lymph	=2.45	[0.7 - 4.4x10^9/L]			
Mono	=0.49	[0.1 - 0.8x10^9/L]			
Eosino	=0.43	[0.8 – 0.40]			
Baso	=0.04	[0.02 – 0.10]			

21. Kor Khem Nary, 33F (Trapang Reusey Village)
Diagnosis

1. Hyperthyroidism

Treatment

1. Carbimazole 5mg 1t po bid for two months (buy)
2. Propranolol 40mg 1/2t po bid for two months (#50)

22. Kouch Be, 80M (Thnout Malou Village)
Diagnosis

1. HTN
2. COPD
3. Dyspepsia

Treatment

1. Amlodipine 10mg 1/2t po qd for four months (#50)
2. Salbutamol Inhaler 2 puffs prn SOB for four months (#2)
3. Cimetidine 200mg 1t po qhs (#30)

23. Long Darith, 2M (Thnout Malou Village)
Diagnosis:

1. Impetigo
2. Eczema

Treatment:

1. Fluocinonide cream apply bid on the lesion (#1)

24. Mar Thean, 54M (Rom Chek Village)
Diagnosis:

1. DMII
2. Hyperlipidemia

Treatment:

1. Metformin 500mg 2t po bid for two months (#60)
2. Glyburide 2.5mg 2t po bid for two months (#240)
3. ASA 300mg 1/4t po qd for two months (#15)
4. Fenofibrate 100mg 1t po bid for two months (buy)

25. Meas Ream, 88F (Taing Treuk Village)
Diagnosis:

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

Treatment:

1. HCTZ 25mg 1t po qd for one month (# 30)

26. Meas Thoch, 85F (Ta Tong Village)
Diagnosis:

1. HTN
2. Dyspepsia

Treatment:

1. HCTZ 25mg 1t po qd for one month (#30)
2. MTV 1t po qd for one month (#30)
3. Cimetidine 200mg 1t po qhs (#30)

27. Moeung Phalla, 35F (Thkeng Village)
Diagnosis:

1. Tachycardia

Treatment:

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

28. Moeung Srey, 48F (Thnout Malou Village)
Diagnosis

1. HTN
2. Dyspepsia

Treatment

1. HCTZ 25mg 1t po qd for one month (#35)
2. Cimetidine 200mg 1t po qhs (#30)

29. Natt Wei, 55F (Thkeng Village)
Diagnosis:

1. Overweight
2. HA

Treatment:

1. Paracetamol 500mg 1t po qid prn HA (#30)
2. Regular exercise

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

1. HTN

Treatment:

1. HCTZ 25mg 1t po qd for three months (#90)

31. Nop Sareth, 41F (Kampot Village)
Diagnosis:

1. Cardiomegaly
2. VHD (MS/TR) with Pulmonary hypertension
3. Dyspepsia

Treatment:

1. Enalapril 5mg 1/4t po qd for one month (#8)
2. Furosemide 40mg 1t po bid for one month (buy)
3. ASA 300mg 1/4t po qd for one month (#8)
4. Mg/Al(OH)3 200/125mg 1-2t chew qid prn (#30)

32. Nung Chhun, 74F (Ta Tong Village)
Diagnosis:

1. HTN
2. DMII

Treatment:

1. Glyburide 2.5mg 2t po bid for one month (#120)
2. Metformin 500mg 1t po bid for one month (#60)
3. Captopril 25mg 1t po tid for one month (buy)
4. ASA 300mg 1/4t po qd for one month (buy)

33. Phim Sovann, 30F (Rovieng Tbong Village)
Diagnosis:

1. Anxiety

Treatment:

1. Amitriptylin 25mg 1/2t po qhs for one month (#15)
2. Paracetamol 500mg 1t po qid prn HA (#20)
3. Stress release

34. Phon Phorn, 68F (Bos Village)
Diagnosis:

1. Contact dermatitis

Treatment:

1. Cetirizine 10mg 1t po qhs for one month (#30)

35. Phork Vann, 60F (Bakdoang Village)
Diagnosis:

1. Vertiligo
2. Scleroderma

Treatment:

1. Cetirizine 10mg 1t po qd for pruritus (#30)
2. Clotrimazole cream apply bid

36. Preum Proy, 52M (Thnout Malou Village)
Diagnosis:

1. DMII
2. HTN
3. Hyperlipidemia

Treatment:

1. Glyburide 2.5mg 2t po bid for two months (#240)
2. Metformin 500mg 2t po bid for two months (#60)
3. Captopril 25mg 1/2t po bid for two months (buy)
4. ASA 300mg 1/4t po qd for two months (#15)
5. Simvastatin 10mg 1t po qhs for two months (buy)

37. Prum Chean, 50F (Sangke Roang Village)
Diagnosis:

1. DMII

Treatment:

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

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

1. HTN
2. Atrial fibrillation

Treatment:

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

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

1. Liver cirrhosis with PHTN
2. HTN
3. Anemia
4. Hypertrophic Cardiomyopathy
5. Renal Failure with hyperkalemia
6. Arthritis

Treatment:

1. Spironolactone 25mg 1t po qd for one month (#30)
2. FeSO4/Folate 200/0.4mg 1t po qd for one month (#30)
3. MTV 1t po qd for one month (#30)
4. Paracetamol 500mg 1t po qid prn pain (#30)
5. Furosemide 40mg 1/2t po bid for one month (#30)

40. Prum San, 42M (Thnal Keng Village)
Diagnosis:

1. Liver cirrhosis due to alcohol
2. Ascitis

Treatment:

1. Spironolactone 25mg 1t po bid for one month (#60)
2. Propranolol 40mg 1/4t po bid for one month (#15)
3. MTV 1t po qd for one month (#30)

41. Prum Sourn, 71M (Taing Treuk Village)
Diagnosis:

1. Heart Failure with EF 27%
2. LVH
3. VHD (MR, AR)
4. Renal Failure

Treatment:

1. Enalapril 5mg 1/2t po qd for one month (#20)
2. Furosemide 40mg 1t po bid for one month (#60)
3. ASA 300mg 1/4t po qd for one month (#8)

42. Prum Ty, 23M (Thnout Malou Village)
Diagnosis:

1. Epilepsy

Treatment:

1. Phenytoin 100mg 1t po bid for one month (#60)

43. Prum Vandy, 50F (Taing Treuk Village)
Diagnosis:

1. Hyperthyroidism

Treatment:

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

44. Ream Sim, 56F (Thnal Keng Village)
Diagnosis:

1. MDII
2. Osteoarthrtis

Treatment:

1. Metformin 500mg 2t po bid for one month (#100)
2. Paracetamol 500mg 1-2t po qid prn pain for one month (#30)
3. Review on diabetic diet, do regular exercise and foot care
4. Draw blood for HbA1C at SHCH

Lab result on March 02, 2012

HbA1C =6.7 [4.8 – 5.9]

45. Sam Bunny, 25F (Thnout Malou Village)
Diagnosis:

1. Nephrotic syndrome
2. Dyspepsia

Treatment:

1. Prednisolone 5mg 4t po qd for one month (#120)
2. Omeprazole 20mg 1t po qhs for one month (#30)
3. Draw blood for HBsAg, HCV Ab at SHCH

Lab result on March 02, 2012

HbsAg = Non-reactive
HCV antibody = Non-reactive

46. Sam Khim, 50F (Taing Treuk Village)
Diagnosis:
1. DMII

Treatment:
1. Metformin 500mg 2t po bid for one month (#120)
2. Glyburide 2.5mg 2t po bid for one month (#120)
3. Captopril 25mg 1/4t po bid for one month (buy)

47. Sam Thourng, 30F (Thnal Keng Village)
Diagnosis:
1. Cardiomegaly by CXR
2. Severe MS (MVA <1cm2)

Treatment:
1. Atenolol 50mg 1t po qd for three months (buy)
2. ASA 300mg 1/2t po qd for three months (#45)
3. HCTZ 25mg 1t po qd for three months (#90)

48. Sam Yom, 62F (Chhnourn Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 25mg 1t po qd for three months (#90)
2. MTV 1t po qd for three months (#90)

49. Sao Lim, 76F (Taing Treuk Village)
Diagnosis:
1. Right side stroke with left weakness

Treatment:
1. Xango po qd for prn (#1)

50. Seung Samith, 63M (Sre Thom Village)
Diagnosis:
1. Gouty arthritis
2. Renal insufficiency

Treatment:
1. Allopurinol 100mg 1t po bid for one month (buy)
2. Paracetamol 500mg 1t po qid prn pain for one month (#30)

51. Som Hon, 51F (Thnal Keng Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 25mg 1t po qd for three months (#90)

52. Som Ka, 61M (Taing Treuk Village)
Diagnosis:
1. DMII
2. Right side stroke with left side weakness

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

53. Sun Ronakse, 40F (Sre Thom Village)

Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 1t po qd for three months (#90)

54. Sun Yorn, 50M (Bos Village)

Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 2t po qd for one month (#60)
2. Amlopidine 5mg 1t po qd for one month (#30)

55. Svay Tevy, 46F (Thnout Malou Village)

Diagnosis:

1. DMII
2. HTN
3. Dyslipidemia

Treatment:

1. Glibenclamide 5mg 2t po bid for two months (#240)
2. Metformin 500mg 3t qAM and 2t po qPM for two months (#200)
3. Captopril 25mg 1/2t po bid for two months (buy)
4. ASA 300mg 1/4t po qd for two months (#15)
5. Fenofibrate 100mg 1t po bid (buy)

56. Tay Kimseng, 54F (Taing Treuk Village)

Diagnosis:

1. HTN
2. Obesity

Treatment:

1. Atenolol 50mg 1/2t po bid for two months (#60)
2. HCTZ 25mg 1t po qd for two months (#60)

57. Teav Vandy, 65F (Rovieng Cheung Village)

Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 1t po qd for three months (# 90)

58. Thoang Korn, 38F (Ta Tong Village)

Diagnosis:

1. HTN

Treatment:

1. HCTZ 25mg 1t po qd for three months (#90)

59. Tith Hun, 58F (Ta Tong Village)

Diagnosis:

1. HTN

Treatment:

1. Enalapril 5mg 1t po qd for two months (#60)
2. HCTZ 25mg 1t po qd for two months (#60)
3. Atenolol 50mg 1/2t po qd for two months (#30)

60. Tith Y, 56F (Ta Tong Village)

Diagnosis:

1. Frozen shoulder
2. HTN

Treatment:

1. Ibuprofen 200mg 2t po bid prn pain (#30)
2. HCTZ 25mg 1t po qd for one month (#30)

61. Un Rady, 49M (Rom Chek Village)
Diagnosis:

1. DMII

Treatment:

1. Metformin 500mg 2t po bid for three months (#180)
2. Captopril 25mg 1/4t po bid for three months (buy)
3. ASA 300mg 1/4t po qd for three months (#23)
4. Fenofibrate 100mg 1t po qd for three month (buy)

62. Yim Sok Kin, 31M (Thnout Malou Village)
Diagnosis:

1. Liver cirrhosis with PHTN

Treatment:

1. Propranolol 40mg 1/4t po bid for one month (#15)
2. Spironolactone 25mg 1/2t po bid for one month (#30)

63. Yin Chhengkorn, 58M (Rovieng Cheung Village)
Diagnosis:

1. Osteoarthritis

Treatment:

1. Paracetamol 500mg 1t po qid prn (#30)

64. Yin Hun, 74F (Taing Treuk Village)
Diagnosis:

1. HTN

Treatment:

1. Atenolol 50mg 1/2t po qd (#20)
2. HCTZ 25mg 1t po qd for one month (#30)
3. Draw blood for Lyte, Creat at SHCH

Lab result on March 2, 2012

Na	=134	[135 - 145]
K	=4.5	[3.5 - 5.0]
Cl	=100	[95 - 110]
Creat	= 106	[44 - 80]

The next Robib TM Clinic will be held on April 2 - 6, 2012