Robib *Telemedicine* Clinic

Preah Vihear Province

N O V E M B E R 2 0 0 8

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

On Monday, November 03, 2008, 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), November 04 & 05, 2008, the Robib TM Clinic opened to receive the patients for evaluations. There were 7 new cases and one follow up case seen during this month, and the patients were examined and their data were transcribed along with digital pictures of the patients, then transmitted and received replies from their TM partners in Boston and Phnom Penh on Wednesday and Thursday, November 05 & 06, 2008.

On Thursday, replies from SHCH in Phnom Penh and Partners Telemedicine in Boston were downloaded. Per advice from Boston, SHCH, and PA Rithy on side, 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: Oct 27, 2008 9:30 AM
Subject: Schedule for Robib TM Clinic November 2008
To: Rithy Chau; Kathy Fiamma; Joseph Kvedar; Kruy Lim; "Paul J. M.D. Heinzelmann"; Cornelia Haener
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach; Peou Ouk; Dan Liu; Sam Oeurn Lanh; Sochea Monn

Dear all,

I would like to inform you that Robib TM Clinic November 2008 will be stating on November 03 and coming back on November 07, 2008.

The agenda for the trip is as following:
1. On Monday 03 November 2008, we start the trip from Phnom Penh to Rovieng, Preah Vihea province.
2. On Tuesday 04 November 2008, the clinic opens to see the patients for the whole morning and type up the patients' information into case then send to partners.
3. On Wednesday 05 November 2008, we do the same on Tuesday.
4. On Thursday 06 November 2008, download all the answers replied from both partners then make treatment plan and prepare the medicine for the patients in the afternoon.
5. On Friday 07 November 2008, 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 this project.

Best regards,
Sovann

From: Robib Telemed
Date: Nov 4, 2008 7:46 PM
Subject: Robib TM Clinic November 2008, Case#1, Chhit Khian, 67M (Trapang Teum 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,

For Robib TM Clinic for November 2008, There are four new cases and one follow up case. This is case number 1, Chhit Khian, 67M 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: **Chhit Khian, 67M (Trapang Teum Village)**

Chief Complaint (CC): Polyuria and fatigue x 5months

History of Present Illness (HPI): 67M presented with symptoms of fatigue, polyphagia, polyuria and noticed the ants come around his urine so he went to Kg Thom referral hospital, U/A show gluc 3+ and diagnosed with DM, treated with Diamicron 30mg 1t po qd and other two medicines at afternoon and evening. Now he became better and denied of fever, cough, extremity numbness/tingling, hematuria, dysuria, edema.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Smoking 5cig/d; no alcohol drinking

Current Medications:

1. Diamicron 30mg 1t po qd
2. Two kinds of medicine

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 143/82 P: 69 R: 20 T: 37°C Wt: 48Kg

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, no scar

Extremity/Skin: No edema, no rash, no foot wound

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

Lab/study: Done today November 4, 2008

RBS: 123mg/dl; U/A protein 2+

Assessment:

1. DMII

Plan:

1. Glibenclamide 5mg 1t po qd for one month
2. Captopril 25mg 1/4t po qd for one month
3. ASA 300mg 1/4t po qd for one month
4. Draw blood for CBC, Lyte, BUN, Creat, gluc, HbA1C at SHCH

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

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

Examined by: Nurse Sovann Peng **Date: November 04, 2008**

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

From: Tan, Heng Soon,M.D.
Sent: Tuesday, November 04, 2008 1:48 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic November 2008, Case#1, Chhit Khian, 67M (Trapang Teum Village)

I agree he has diabetes by symptoms and glucosuria. Diamicron had been effective in reducing symptoms and lowering random blood sugar to 123 mg/dl. However blood pressure is slightly high at 143/82, and 2+ proteinuria is present. I would use a higher dose of captopril perhaps 1/2 tab 25 mg bid to lower blood pressure and proteinuria. Renal function and A1c testing is good. Clinical exam should include evaluation for cataracts and retinopathy. Perhaps learning to use an opthalmoscope would be a useful skill to learn. Mention should be made of carotid and pedal pulses

to exclude carotid and peripheral vascular disease. An EKG would be useful as a baseline to exclude preexisting silent coronary artery disease. Glibenclamide and aspirin are fine but glibenclamide dose will need monitoring. I assume patient education for self care has been provided regarding regular exercise and physical activity and the importance of a diabetic diet.

HS

From: Robib Telemed
Date: Nov 4, 2008 7:49 PM
Subject: Robib TM Clinic November 2008, Case#2, Keo Sreng, 61M (Rovieng Tbong Village)
To: Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma
Cc: Bernie Krisher Thero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 2, Keo Sreng, 61M 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: **Keo Sreng, 61M (Rovieng Tbong Village)**

Chief Complaint (CC): Joint pain x 6 years

History of Present Illness (HPI): 61M presented with recurrent metatarsal joint pain, swelling, erythema, no stiffness, it developed to ankle and knees. Sometimes the pain developed on both joints at the time or one side. He got only one time steroid injection in two years ago and never took any pain killer or other medicine just massage to relieve pain. In these two years, he presented with extremity tremor, paresthesia, HA, neck tension but he never seek care. He has normal appetite, normal bowel movement, normal urination.

Past Medical History (PMH): Mandible fracture because of tooth retraction in 1977 at admitted to hospital in Phnom Penh, complete healed

Family History: None

Social History: Drinking alcohol 1/4L/d every day for over 20y, smoking 5cig/d

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: (L) 170/104, (R) 160/103 P: 88 R: 20 T: 37^{o}C Wt: 45Kg

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, no scar

Extremity/Skin: Both hands tremor, no joint swelling, erythema, stiffness

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

Lab/study:
Done today November 4, 2008
FBS: 94mg/dl

Assessment:

1. Alcoholism
2. HTN
3. Arthritis

Plan:

1. Smoking and alcohol drinking cessation
2. HCTZ 12.5mg 2t po qd for one month
3. Paracetamol 500mg 1t po qid prn pain for one month
4. MTV 1t po qd for one month
5. FeSO4/Folic acid 200/0.25mg 1t po qd for one month
6. Draw blood for CBC, Lyte, BUN, Creat, gluc at SHCH

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

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

Examined by: Nurse Sovann Peng **Date: November 04, 2008**

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

No answer replied

From: Robib Telemed
Date: Nov 4, 2008 7:51 PM
Subject: Robib TM Clinic November 2008, Case#3, Kim Cham, 72F (Bakdoang 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 3, Kim Cham, 72F 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: **Kim Cham, 72F (Backdoang Village)**

Chief Complaint (CC): HA and neck tension x 4y

History of Present Illness (HPI): 72F presented with symptoms of HA, neck tension, dizziness, she went to private clinic BP: 180/? and diagnosed with HTN, treated with antihypertensive 1/2t qd prn. Her symptoms seem not better so her family bought other kind of antihypertensive from Phnom Penh taking 1t po qd for two years. She became stable so she stopped taking antihypertensive for a year then she presented with HA, dizziness and BP checked 200/? and take antihypertensive 1t. This week, she developed suprapubic pain, dysuria, frequency, urgency and bought medication from pharmacy taking three times (Ciprofloxacin 500mg 1t, Metronidazole 250mg 1t, Paracetamol 500mg 1t, Phloroglucinol 1t).

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Chewing tobacco, no alcohol drinking

Current Medications:

1. Cirofloxacin 500mg 1t
2. Metronidazole 250mg 1t
3. Phloroglucinol 80mg 1t
4. Paracetamol 500mg 1t

Allergies: NKDA

Review of Systems (ROS): epigastric pain, burping with burning sensation after eating

PE:

Vitals: BP: (L) 201/116, (R) 195/115 P: 80 R: 20 T: 37°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, no murmur

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

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

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

Lab/study: FBS: 95mg/dl, U/A protein 2+

Assessment:

1. HTN
2. Dyspepsia
3. Parasititis

Plan:

1. HCTZ 12.5mg 2t po qd for one month
2. Famotidine 10mg 2t po qhs for one month
3. Mebendazole 100mg 5t po qhs once
4. GERD prev education
5. Draw blood for CBC, Lyte, BUN, Creat, gluc, tot chol, TG 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: November 04, 2008**

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

From: Crocker, J.Benjamin,M.D.
Sent: Tuesday, November 04, 2008 12:59 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic November 2008, Case#3, Kim Cham, 72F (Bakdoang Village)

This sounds fine, though would be really helpful to know what kind of BP meds she has been taknig over last 2 years. She is obviously at risk for stroke and cardiac complications (CHF, CAD) as a results of likely longstanding hypertension, so should be aggressive at getting BP lower. Watch electrolytes and renal function on thizide. Other options to add to thiazide (once it's been titrated to at least 25mg/day) includes betablocker or ace-inhibitor.

From: Robib Telemed
Date: Nov 4, 2008 7:56 PM
Subject: Robib TM Clinic November 2008, Case#4, Srey Reth, 51F (Kampot Village)
To: Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 4, Srey Reth, 51F 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: **Srey Reth, 51F (Kampot Village)**

Chief Complaint (CC): Headache x 3y

History of Present Illness (HPI): 51F presented with throbbing HA on left temporal, the HA started from neck, getting worse with sunlight and cool weather, relieved with pain killer. The headaches sometimes associated with nausea, vomiting, palpitation, insomnia.
She sought treatment from local health care provider and traditional medicine but her HA has been relieved for a short time. She denied of any ear discharge, trauma to the head.

Past Medical History (PMH): Unremarkable

Family History: Father and sister with HA

Social History: Smoking 5cig/d stopped 4y; no alcohol drinking, 10 children

Current Medications: Traditional medicine

Allergies: NKDA

Review of Systems (ROS): 2y post menopause

PE:

Vitals: BP: 113/78 P: 81 R: 20 T: 37°C Wt: 58Kg

General: Look stable

HEENT: No oropharyngeal lesion, pink conjunctiva, no thyroid enlargement, no lymph node palpable, no lesion or rash on the scalp

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

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

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

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

Lab/study: None

Assessment:

1. Migraine HA

Plan:

1. Paracetamol 500mg 1t po qid prn for one month
2. Amitriptylin 25mg 1/2t po qhs for one month
3. Draw blood for CBC, Lyte, BUN, Creat, gluc, TSH at SHCH
4. Stop traditional medicine

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: November 04, 2008**

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

From: Tan, Heng Soon,M.D.
Sent: Tuesday, November 04, 2008 1:38 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic November 2008, Case#4, Srey Reth, 51F (Kampot Village)

Migraine headache is diagnosed clinically: recurrent stereotypical headaches usually one sided, sometimes preceded by visual aura [flashing lights, blurred central vision, associated with poor concentration], lasting minutes to hours, without any other neurological symptoms other than nausea, photophobia. In this particular case, she is not hypertensive. Neurological exam is normal. I would like to see more of the HEENT exam: fundoscopy showing normal optic disc and retina [to exclude optic neuritis, papilledema], normal anterior chamber and pupillary reaction [to exclude acute angle glaucoma, uveitis], normal nontender temporal arteries [to exclude temporal arteritis in patients over 60], nontender temporomandibular joints, normal ears [to exclude otitis media], supple neck [to exclude subarachnoid hemorrhage or chronic meningitis], nontender thyroid [to exclude thyroiditis]. I would also like to hear more of the

neurological exam: normal cranial nerves with normal visual fields [to exclude cerebral mass lesion], full eye movements without nystagmus [to exclude brainstem or cerebellar lesions], no facial asymmetry [to exclude a stroke].

Blood tests are not necessary unless done for other reasons.

Migraines can be triggered by hunger, foods, temperature changes certainly. Stress is also a common trigger. Is there any stress triggers in this patient? Depression and anxiety should be managed to remove migraine triggers.

Acetaminophen and ibuprofen are effective for mild headaches. Caffeine is commonly used but poses a risk of dependency and subsequent withdrawal headaches. Of course triptans are quite specific and effective to abort acute migraines, but are expensive. Avoid combination narcotics to avoid dependency and withdrawal headaches.

Amitriptyline is a good first choice even at low doses to prevent recurrent migraines: both for pain as well as to alleviate anxiety and depression. I would go up to 25 mg qhs before considering betablockers like propranolol as an alternative, again at low dose 20-80 mg at night.

Heng Soon Tan, MD

From: Robib Telemed
Date: Nov 4, 2008 8:00 PM
Subject: Robib TM Clinic November 2008, Case#5, Srey Dum, 65M (Damnak Chen 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 last case for first day of Robib TM Clinic November 2008, Case number 5, Srey Dum, 65M and photos. 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 in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note

Name/Age/Sex/Village: **Srey Dum, 65M (Damnak Chen Village)**

Subject: 65M come to follow up of Alcoholic cirrhosis?, Iron deficiency, Parasititis, Splenomegaly, he feel better than last month with normal appetite, normal bowel movement, normal urination but still complaint of palpitation, fatigue. Malaria smear done in last month with negative result.

Medication:

1. MTV 1t po bid for one month
2. FeSO4/Folic acid 200/0.25mg 1t po bid for one month
3. Famotidine 10mg 2t po qhs for one month
4. Mebendazole 100mg 5t po qhs once
5. Vit Bcomplex 10cc IV x 3d

Allergies: NKDA

Object:

PE:

Vitals: BP: 123/73 P: 81 R: 20 T: 37°C Wt: 51Kg

General: Look sick (better than last month)

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

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

Abd: Soft, no tender, no distension, (+) BS, no Hepatomegaly, (+) splenomegaly, no surgical scar

Extremity/Skin: No edema, no lesion

MS/Neuro: Unremarkable

Lab/study:

On October 10, 2008

WBC	=1.6	[4 - 11x10^9/L]	Na	=141	[135 - 145]	RBC
=2.0	[4.6 - 6.0x10^{12}/L]		K	=3.4	[3.5 - 5.0]	
Hb	=4.1	[14.0 - 16.0g/dL]	Cl	=109	[95 - 110]	
Ht	=14	[42 - 52%]	BUN	=1.4	[0.8 - 3.9]	
MCV	=72	[80 - 100fl]	Creat	=80	[53 - 97]	
MCH	=21	[25 - 35pg]	Gluc	=6.0	[4.2 - 6.4]	
MHCH	=29	[30 - 37%]	SGOT	=29	[<37]	
Plt	=81	[150 - 450x10^9/L]	SGPT	=19	[<42]	
Lym	=0.5	[1.0 - 4.0x10^9/L]				

Reticulocyte count =3.4 [0.5 – 1.5]
Hypochromic 3+
Elliptocyte 1+
Microcyte 2+
Ferritine =3 [0 – 300]

Done today (November 4, 2008)

Hb: 9g/dl

Assessment:

1. Pancytopenia
2. Iron deficiency
3. Splenomegaly

Plan:

1. Send to Kg Thom referral hospital for Abdominal U/S and CXR to r/o mass/tumor
2. Recheck CBC, Lyte, BUN, Creat, Gluc, Peripheral blood smear, Reticulocyte count at SHCH
3. MTV 1t po bid for one month
4. FeSO4/Folic acid 200/0.25mg 1t po bid for one month

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: November 04, 2008**

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

From: Crocker, J.Benjamin,M.D.
Sent: Wednesday, November 05, 2008 2:11 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic November 2008, Case#5, Srey Dum, 65M (Damnak Chen Village)

I agree with your assessment and plan, and would also suggest that he be tested for viral hepatitis B and C. Hemolysis lab evaluation would be helpful. Bone marrow biopsy might be indicated if peripheral smear does not suggest a hematoepoetic process.

From: Robib Telemed
Date: Nov 5, 2008 4:00 PM
Subject: Robib TM Clinic November 2008, Case#6, Iem Mala,14F (Chamback Phaem Village)
To: Cornelia Haener; Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

For second day of Robib TM Clinic November 2008, there are three new cases. This is case number 6, cintinued from yesterday, Iem Mala, 14F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

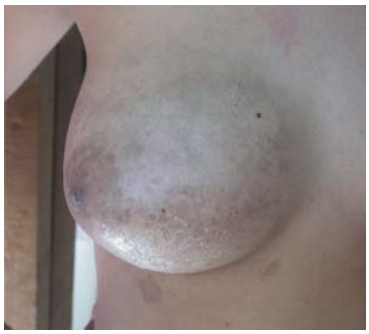
History and Physical

Name/Age/Sex/Village: Iem Mala, 14F (Chamback Phaem Village)

Chief Complaint (CC): Right breast mass x 6 months

History of Present Illness (HPI): 14F felt sharp pain on the right scapula region and a week later she noticed a small breast mass about little finger size without inflammation signs. The mass gradually developed bigger in six months. She got treatment with traditional medicine apply on the breast but it seems not better. She denied of trauma or insect bite to the area, fever, pain, discharge, or palpable lymph nodes. This mass has developed about 6 months after her menarche.

Past Medical History (PMH): Unremarkable



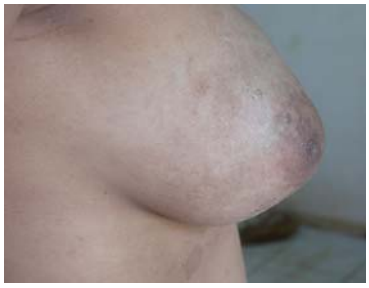
Family History: None

Social History: Grade 9 student, single

Current Medications: Traditional medicine apply on the breast

Allergies: NKDA

Review of Systems (ROS): Regular, normal menstrual periods



PE:

Vitals: BP: 98/66 P: 85 R: 20 T: 37^{o}C Wt: 45Kg

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

Right Breast: mass about 6 x 8cm on superior-medially, bumpy, semi-hard, slightly warmth, mild tender on palpation, mobile, no discharge, no nipple retraction, no axillary lymph node palpable

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

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

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

Lab/study: None

Assessment:

1. Right breast tumor (benign/malignant??)
2. Right mammary gland inflammation?

Plan:

1. Should we refer her to SHCH or Angkor hospital for children for surgical consultation?
2. Do FNA for cytology at SHCH
3. Augmentin 875mg 1t po bid x 7d
4. Naproxen 375mg 1t po bid prn pain
5. Paracetamol 500mg 1t po qid prn pain

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: November 05, 2008**

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

From: Cornelia Haener
Date: Nov 6, 2008 2:14 PM
Subject: Robib TM Clinic November 2008, Case#6, Iem Mala,14F (Chamback Phaem 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,

Thank you so much for this case. I would suggest either referring her to Angkor Hospital for Children or bringing her to the SHCH for surgical consultation, whatever is easier for the patient and the family. I agree with you that this breast mass is very suspicious for malignancy.

Kind regards

Cornelia

From: Tan, Heng Soon,M.D.
Sent: Wednesday, November 05, 2008 5:23 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic November 2008, Case#6, Iem Mala,14F (Chamback Phaem Village)

This teenage girl has developed a large firm mobile right breast mass that is slightly warm and tender without nipple discharge or axillary lymphadenopathy over 6 months. A focal right breast mass implies that this is not a developmental abnormality like macromastia. The long duration without signs of inflammation is against an acute process like mastitis or breast abscess, so I would not feel obliged to start antibiotics. The firmness favors juvenile fibroadenoma rather than a breast cyst, though a breast ultrasound could resolve that issue if necessary. Mammogram in a young person with dense breast to look for microcalcification may not be that effective. I would refer her to medical facility where a biopsy can be done to confirm the diagnosis of fibroadenoma. Excision should be considered because of its large size. Breast cancer would be unusual at her age but not impossible.

HS

Here is a useful reference:
http://www.patient.co.uk/showdoc/40024648/
Benign Breast Disease

Any lump in the breast causes natural and perhaps not inappropriate anxiety, but by no means all lumps are breast cancer. After history of breast lumps and breast examination the problem is differentiation:

- A benign mass is usually three-dimensional, mobile, and smooth, has regular borders, and is solid or cystic in consistency.

- A malignant mass is usually firm in consistency, has irregular borders, and may be fixed to the underlying skin or soft tissue.

There may also be skin changes or nipple retraction.
Differentiation is often still not easy and to err on the side of safety is wise.

When an adult woman presents with a lump in her breast and the doctor thinks it may be malignant, then a referral should be made.[1]

A retrospective study of over 300 referrals in Sheffield found that the ages of the women ranged from 16 to 85 years with a mean and median age of 45 years:[2]

- 200 women (66%) presented with a lump or lumpiness
- 42 women (14%) presented with pain
- 29 women (10%) had a skin and/or nipple problem
- 31 women (10%) were concerned about their family history or reported other symptoms

Only 23 women (8%) were diagnosed as having cancer, 180 (60%) were diagnosed as having benign breast disease, and 99 (33%) were diagnosed as normal.
Of the 23 women with cancer:

- 22 were over 40 years of age
- 21 women presented with a lump
- One presented with pain
- One presented with metastatic disease

Surgeons assessed the appropriateness of GPs' referrals for 257 cases and judged that 122 (47%) could have been managed by a GP.

Premature thelarche

Early breast growth in girls or some growth of breast tissue in males is quite common. The breasts are the first of the secondary sexual characteristics to develop at puberty and there may be some early activity in quite young girls:

- Very early development may be asymmetrical and apparently unilateral, but examination will usually show some contralateral development too.
- Unless there are features of true precocious puberty (such as premature pubic hair) then just reassurance is required.
- Note height and weight on a centile chart, as early puberty often accompanies obesity.

Breast lumps in males

Boys may also display some breast development in the hormonal turmoil around puberty. Again reassurance is required at this time of great personal insecurity. It is more likely to happen in Klinefelter's syndrome, but is by no means diagnostic.

- Gynaecomastia may accompany a number of diseases such as cirrhosis or be produced by a number of drugs.
- Male breast cancer does occur, but is rare.

Fibrocystic disease

This is a term that is now regarded by many as redundant. Formerly, the term used to be used to describe all benign breast conditions, but this caused confusion in distinguishing between normal physiological changes and pathological ones. There are now 2 different classifications that are used. One is based on clinical and the other pathological findings. The clinical system seems more appropriate for clinicians:

- **Physiological swelling and tenderness**

- **Nodularity**
- **Breast pain** is not usually associated with malignancy
- **Palpable breast lumps**
- **Nipple discharge including galactorrhoea**
- **Breast infection and inflammation** - usually associated with lactation

The sections that are covered elsewhere will not be considered further.

Physiological swelling and tenderness

The breasts are active organs that change throughout the menstrual cycle and some degree of tenderness and nodularity in the premenstrual phase is so common that it may be considered as normal, affecting perhaps 50 or 60% of all menstruating women. It rapidly resolves as menstruation starts. It is also called mammary dysplasia and cystic mastopathy.

- Affected women tend to be between 30 and 50.
- It is less frequent in association with combined oral contraceptives and rare after the menopause.
- Oral contraceptives reduce the risk of benign breast disease generally.[3]
- It may recur with HRT.

Recommended management has included:

- Reduction or avoidance of caffeine
- Vitamin E
- Pyridoxine
- Evening primrose oil

However, good RCTs with placebo control seem few:

- The placebo response may be as high as 20%.
- A review found little evidence to support dietary intervention.[4]
- Advising a good, well supporting bra may be the best advice.[5]

Breast cysts

Discrete cysts that are clearly palpable may be safely treated by needle aspiration:[6]

- After some local anaesthetic is injected an ordinary green hub needle attached to a 10 ml syringe is inserted and the cyst is aspirated.
- It disappears beneath the examiner's fingers and both doctor and patient are reassured.
- Failure to aspirate, especially if it appears to be a solid lesion, requires urgent referral to a breast clinic.

Nodularity

Nodularity is also a normal, hormonally mediated change with lumpiness of the breast and varying degrees of pain and tenderness:

- The symptoms are greatest about 1 week before menstruation and decrease when it starts.
- Examination may reveal an area of nodularity or thickening, poorly differentiated from the surrounding tissue and often in the upper outer quadrant of the breast.
- If the changes are bilaterally symmetrical, they are rarely pathological. If there is asymmetry it is acceptable to review the patient after one of two menstrual cycles, seeing her mid-cycle.
- If symptoms persist then referral should occur.
- Mammography is often used in older patients, but for younger ones with denser breasts, ultrasound is usually better.
- Treatment is analgesia and a good bra.

Other possible treatments are considered under the heading of Breast Pain.

Palpable breast lumps

Many breast lumps are benign, especially in younger patients:

- The Canadian Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer produced guidelines for the management of benign lumps too.[7]
- Most benign lumps will be either cysts or fibroadenoma.

Fibroadenoma

This is a benign tumour that is common in young women, mostly under 40. It is composed of stromal and epithelial elements and probably represents increased sensitivity to oestrogens:

- Complex and multiple fibroadenomas are associated with a two-fold increase in the risk of breast cancer.[8,9]
- They represent a hyperplasia or proliferation of a single terminal duct unit.
- Most stop growing at about 2 or 3 cm, but they can enlarge rather further.
- About 10% disappear each year.
- They tend to regress after the menopause.
- They occur in about half of women who receive ciclosporin after renal transplant.
- They are the commonest tumour of the breast under 30 years old, but overall they are second to breast cancer.
- Juvenile fibroadenomas can occur in teenage girls.

Both mammography and ultrasound may be used to examine the lump:

- Ultrasound tends to be preferred in younger women with dense breasts as mammograms are more difficult to interpret in this group. Routine mammography as a population screening tool, is not performed below the age of 50.
- Imaging studies may fail to give a firm diagnosis and biopsy or excision may be required for peace of mind of both the patient and doctor.
- If there is confidence in the diagnosis then inactivity may lead to spontaneous regression, but the patient must be advised to check the lump regularly and to return if it starts to enlarge.
- Assessment often includes examination, imaging studies and fine needle aspiration.

Phyllodes tumour

This is a rare tumour that tends to occur in women between 40 and 50.

- They may be benign, borderline or malignant.
- A benign tumour may re-appear after excision and may become malignant.
- Treatment is wide excision, including some normal breast tissue.
- Mammograms should be performed every 2 years thereafter.

Duct ectasia and periductal mastitis

Duct ectasia affects women approaching the menopause. Smoking increases the risk.[10]

- The ducts behind the nipple become dilated and may be get blocked with fluid, leading to a discharge from the nipple and it may be bloody. The epithelium of the duct may become ulcerated and lead to pain and infection.
- A lump may develop and the nipple may become retracted.
- A bloody discharge may also suggest intraduct carcinoma and a retracted nipple may suggest malignancy so referral to a breast clinic is required.
- Excision of the duct is advised to establish the diagnosis and treat the condition. [11,12]

Periductal mastitis affects younger women than duct ectasia, but the symptoms are similar, as is management.

Intraduct papilloma

It is a benign, warty lesion just behind the areola:

- A small lump may be noticed or a sticky, possibly blood-stained discharge.
- Women in their 40s are more likely to have just one, but younger women may have multiple lesions.
- Fine needle aspiration or core biopsy may be used.

Atypical hyperplasia

Benign hyperplasia can occur in the ducts or the lobes:

- Lobular carcinoma-in-situ may develop.
- Even this does not merit immediate operation, but annual mammograms are recommended.
- Risk is increased with a positive family history of breast cancer.

Sclerosing adenosis

This is a benign condition of sclerosis within the lobules:

- It may cause pain or be found on routine assessment.
- It can be very difficult to distinguish from malignancy and biopsy is often advised.

Fat necrosis

It tends to be large, fatty breasts in obese women that have this problem:

- It usually follows trauma.
- The lump is usually painless and the skin around it may look red, bruised or dimpled.
- Biopsy may be required, but if the diagnosis is confirmed, no further management is indicated.

Infection or mastitis

This may be associated with lactation or, more rarely, occur at other times:

With lactation

Breast ducts become blocked with engorged milk, and bacteria enter from cracks in the nipple.

- An abscess develops in the peripheral part of the breast tissue.
- There may be engorgement of the breast and axillary lymphadenopathy.
- Warm compresses and paracetamol may give some relief.
- Encourage the patient to continue breast-feeding with the unaffected breast, and once letdown occurs in the affected breast, feed with the affected breast until it is completely empty.
- A 10 days course of a penicillinase-resistant antibiotic such as flucloxacillin is required.
- A localised abscess will require incision and drainage.
- Swabs should be sent for culture.

Without lactation

Spontaneous peripheral abscesses in non-lactating women are often associated with diabetes and immune compromise.

- Non-lactational mastitis produces periareolar abscesses, usually resulting from obstruction with cellular debris and lipid-laden material. Bacteria enter from the skin and produce periductal inflammation and abscess formation.

- There is a chronic recurrent course with noncyclical mastalgia, nipple discharge or retraction, periareolar abscess, subareolar mass or cellulitis of overlying skin.

NB: Inflammatory breast cancer causes pain, redness and induration of the skin, usually affecting the dependent portion of the breast. Symptoms progress very rapidly, and within a month the breast may have the peau d'orange appearance. **Any patient in whom presumed mastitis does not resolve completely after 1 month of treatment with antibiotics needs referral to exclude inflammatory breast cancer.**

From: Robib Telemed
Date: Nov 5, 2008 4:11 PM
Subject: Robib TM Clinic November 2008, Case#7, Sok Som, 70F (Tourl Rovieng Village)
To: Rithy Chau; Kathy Fiamma; Joseph Kvedar; Kruy Lim; "Paul J. M.D. Heinzelmann";
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is case number 7, Sok Som, 70F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

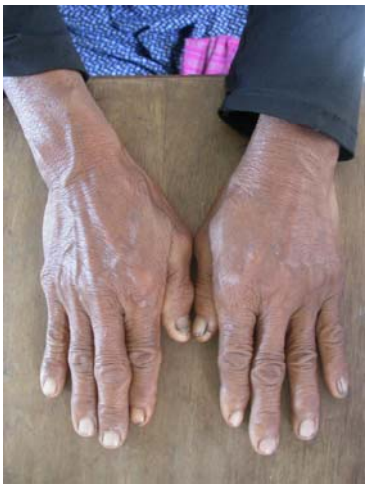
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Sok Som, 70F (Tourl Rovieng Village)**

Chief Complaint (CC): Right arm pain and stiffness x 4y

History of Present Illness (HPI): 70F presented with symptoms pain of dorsal surface of right arm and right shoulder, with swelling, redness, stiffness, she took traditional medicine for a month and inflammation signs have gone but she still felt pain on shoulder with rotation, and finger with extension/flexion. Sometimes when she carried thing, it get off from her hand. She denied of any trauma to that area.



Past Medical History (PMH): Unremarkable

Family History: None

Social History: Chewing tobacco, no alcohol drinking

Current Medications: Traditional medicine

Allergies: NKDA

Review of Systems (ROS): Epigastric pain, burping with burning sensation after full eating

PE:

Vitals: BP: 104/65 P: 71 R: 20 T: 37^{o}C Wt: 39Kg

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, no scar

Right hand: No inflammation sign on the hand;
Right arm when extension or flexion of finger causes pain but no tender with palpation to that area
Right shoulder: ask patient to rotate shoulder joint cause pain
Non tender on palpation to area, which has pain with movement, sensory intact, no mass palpable

Left hand: intact

Neuro: DTRs +2/4, normal gait

Lab/study: None

Assessment:

1. Brachial plexus neuritis
2. Dyspepsia
3. Parasititis

Plan:

1. Naproxen 375mg 1t po bid prn pain for one month
2. Paracetamol 500mg 1t po qid prn pain for one month
3. Famotidine 10mg 2t po qhs for one month
4. Mebendazole 100mg 5t chew qhs once
5. GERD prev education

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: November 05, 2008**

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

From: Warner, Jon J.P.,M.D.
Sent: Thursday, November 06, 2008 9:59 AM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic November 2008, Case#7, Sok Som, 70F (Tourl Rovieng Village)

I am happy to help but the enclosed images and history do not give much insight into what this might be. Better examination of the shoulder and perhaps MRI would be needed to say for sure . Sounds like a rotator cuff tear though, which would be common. Also, not sure if infection, but images don't look like this. JPW

Jon JP Warner
Chief, The Harvard Shoulder Service
55 Fruit Street
Yawkey Center for Outpatient Care
Suite 3200, 3rd Floor, 3G, Room 3-044
Boston, MA 02114
JWarner@partners.org
(617) 724-6592 (direct)
(617) 724-7300 (office)
(617) 724-3846 (fax)

From: Robib Telemed
Date: Nov 5, 2008 4:15 PM
Subject: Robib TM clinic November 2008, Thoang Tey, 72F (Rovieng Cheung 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 November 2008, Thoang Tey, 72F and photos.

Please reply to the cases before Thursday afternoon. Thnak 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

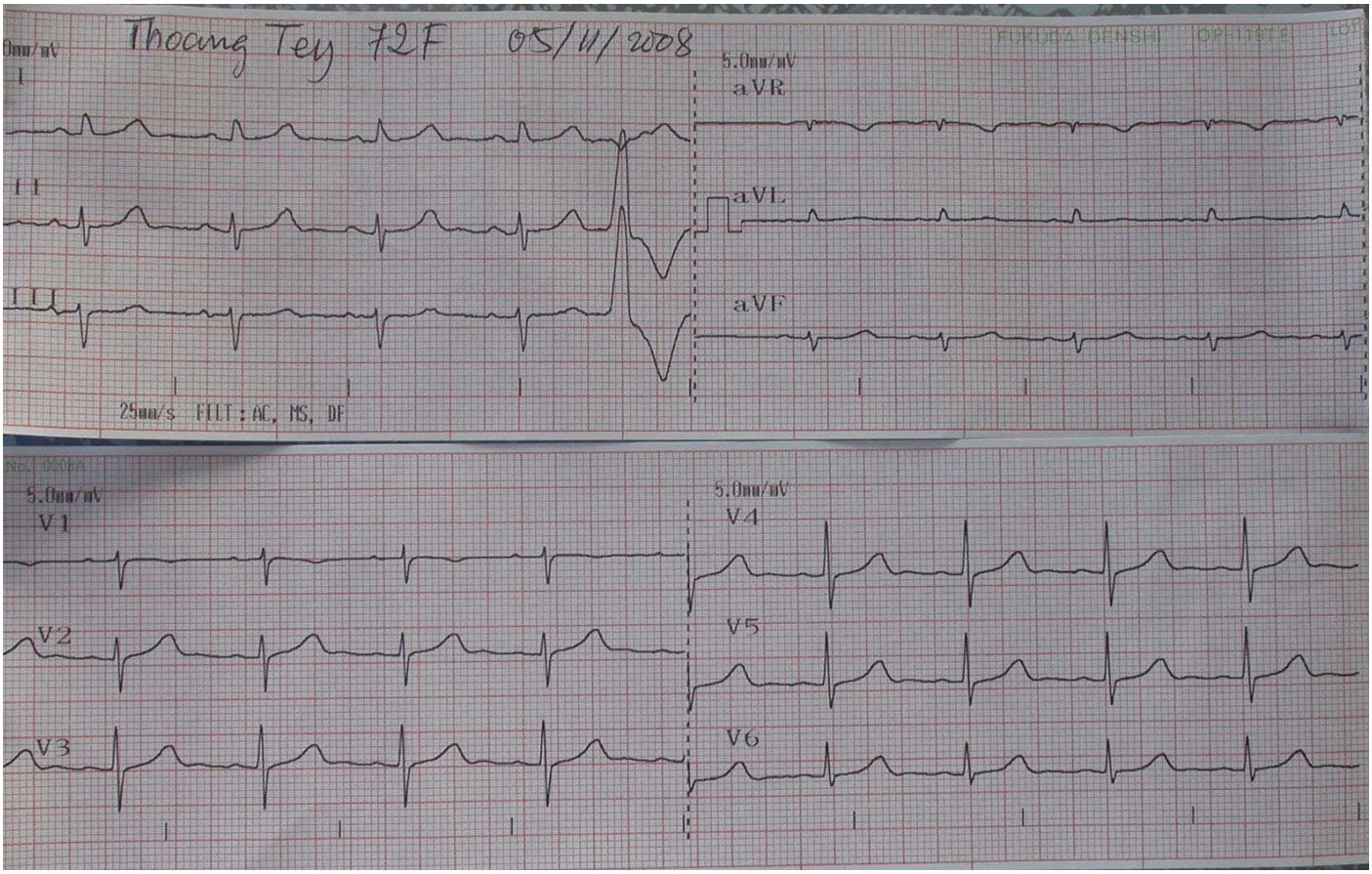
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Thoang Tey, 72F (Rovieng Cheung Village)**

Chief Complaint (CC): Fatigue and neck tension x 2 months

History of Present Illness (HPI): 72F, farmer, presented with symptoms of fatigue, neck tension, HA, palpitation, insomnia, she asked local health care provider give her IV fluid and injection of medicine (unknown name). She became better for a month then her symptoms presented again. She denied of chest pain, orthopnea, cough, edema, stool with blood/mucus, hematuria, oliguria.



Past Medical History (PMH): Unremarkable

Family History: None

Social History: Chewing tobacco, no alcohol drinking, 7 children

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Epigastric pain, burping with burning sensation after full eating

PE:

Vitals: BP: 148/88 P: 80 R: 20 T: 37^{o}C Wt: 42Kg

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+ pre-systolic murmur, loudest in tricuspid area

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

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

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

Lab/study: EKG attached

Assessment:

1. VHD (TR/TI??)
2. HTN
3. Dyspepsia
4. Parasititis

Plan:

1. HCTZ 12.5mg 2t po qd for one month
2. Famotidine 10mg 2t po qhs for one month
3. Mebendazole 100mg 5t chew qhs once
4. GERD prev education
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

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

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

Examined by: Nurse Sovann Peng **Date: November 05, 2008**

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

entities other than the intended recipient is prohibited. If you received this e-mail in error, please contact the sender and delete material from any computer.

From: Cusick, Paul S.,M.D.
Date: Nov 6, 2008 5:28 AM
Subject: Robib TM clinic November 2008, Thoang Tey, 72F (Rovieng Cheung Village)
To: "Fiamma, Kathleen M." <KFIAMMA@partners.org>, robibtelemed@gmail.com
Cc: tmed_rithy@online.com.kh

Thank you for the opportunity to participate.

SHe does not sound like she has a meningitis causing headache or neck strain

She is mildly hypertensive and the diuretic is OK.

She has reflux symptoms and famotidine is OK

Treating for parasities is fine.

Await lab test results

Would apply heat to neck muscles to see if this helps out

Best of luck

Paul

From: Robib Telemed
Date: Nov 6, 2008 8:06 PM
Subject: Robib TM Clinic November 2008 cases received
To: Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach; Rithy Chau

Dear Kathy,

I have received answer of four cases from you. Below are the case received:
Case#3, Kim Cham, 72F
Case#4, Srey Reth, 51F
Case#5, Srey Dum, 65M
Case#8, Thoang Tey,

Please send us the answer of remaining cases. Thank you very much for reply to cases in this month.

Best regards,
Sovann

Thursday, November 06, 2008

Follow-up Report for Robib TM Clinic

There were 7 new patients and one follow up patient seen during this month Robib TM Clinic , other 46 patients came for medication refills only, and 15 patients seen by PA Rithy Chau 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 own 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, especially if they are from Thnout Malou Village. Some patients may be listed below if they came by for refills of medications.]

Treatment Plan for Robib TM Clinic November 2008

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

1. DMII

Treatment:

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

Lab result on November 07, 2008

WBC	=7.7	[4 - 11x10^9/L]	Na	=143	[135 - 145]
RBC	=3.5	[4.6 - 6.0x10^{12}/L]	K	=4.9	[3.5 - 5.0]
Hb	=10.1	[14.0 - 16.0g/dL]	Cl	=107	[95 - 110]
Ht	=31	[42 - 52%]	BUN	=5.8	[0.8 - 3.9]
MCV	=88	[80 - 100fl]	Creat	=170	[53 - 97]
MCH	=29	[25 - 35pg]	Gluc	=6.3	[4.2 - 6.4]
MHCH	=32	[30 - 37%]	HbA1C	=15.2	[4 – 6]
Plt	=513	[150 - 450x10^9/L]			
Lym	=2.1	[1.0 - 4.0x10^9/L]			

2. Keo Sreng, 61M (Rovieng Tbong Village)
Diagnosis:

1. HTN
2. Arthritis

Treatment:

1. Smoking and alcohol drinking cessation
2. HCTZ 12.5mg 2t po qd for one month (#80)
3. Paracetamol 500mg 1t po qid prn pain for one month (#30)

4. MTV 1t po qd for one month (#40)
5. FeSO4/Folic acid 200/0.25mg 1t po qd for one month (#40)
6. Draw blood for CBC, Lyte, BUN, Creat, gluc at SHCH

Lab result on November 07, 2008

WBC	=4.9	[4 - 11x10^{9}/L]	Na	=146	[135 - 145]
RBC	=3.8	[4.6 - 6.0x10^{12}/L]	K	=3.8	[3.5 - 5.0]
Hb	=10.9	[14.0 - 16.0g/dL]	Cl	=110	[95 - 110]
Ht	=34	[42 - 52%]	Creat	=118	[53 - 97]
MCV	=89	[80 - 100fl]	Gluc	=4.1	[4.2 - 6.4]
MCH	=28	[25 - 35pg]	T. Chol	=3.7	[<5.7]
MHCH	=32	[30 - 37%]	TG	=1.2	[<1.71]
Plt	=156	[150 - 450x10^{9}/L]			
Lym	=2.0	[1.0 - 4.0x10^{9}/L]			

3. Kim Cham, 72F (Backdoang Village)
Diagnosis:

1. HTN
2. Dyspepsia
3. Parasititis

Treatment:

1. HCTZ 12.5mg 2t po qd for one month (#80)
2. Famotidine 10mg 2t po qhs for one month (#60)
3. Mebendazole 100mg 5t po qhs once (#5)
4. GERD prev education
5. Draw blood for CBC, Lyte, BUN, Creat, gluc, tot chol, TG at SHCH

Lab result on November 07, 2008

WBC	=6.3	[4 - 11x10^{9}/L]	Na	=147	[135 - 145]
RBC	=4.6	[3.9 - 5.5x10^{12}/L]	K	=4.7	[3.5 - 5.0]
Hb	=11.3	[12.0 - 15.0g/dL]	Cl	=116	[95 - 110]
Ht	=35	[35 - 47%]	Creat	=256	[44 - 80]
MCV	=75	[80 - 100fl]	Gluc	=4.0	[4.2 - 6.4]
MCH	=25	[25 - 35pg]	T. Chol	=4.5	[<5.7]
MHCH	=33	[30 - 37%]	TG	=2.5	[<1.71]
Plt	=249	[150 - 450x10^{9}/L]			
Lym	=1.8	[1.0 - 4.0x10^{9}/L]			
Mxd	=0.7	[0.1 - 1.0x10^{9}/L]			
Neut	=3.8	[1.8 - 7.5x10^{9}/L]			

4. Srey Reth, 51F (Kampot Village)
Diagnosis:

1. Migraine HA

Treatment:

1. Paracetamol 500mg 1t po qid prn for one month (#30)
2. Amitriptylin 25mg 1/2t po qhs for one month (#20)
3. Draw blood for CBC, Lyte, BUN, Creat, gluc, TSH at SHCH
4. Stop traditional medicine

Lab result on November 07, 2008

WBC	=7.8	[4 - 11x10^{9}/L]	Na	=143	[135 - 145]
RBC	=4.6	[3.9 - 5.5x10^{12}/L]	K	=4.1	[3.5 - 5.0]
Hb	=11.9	[12.0 - 15.0g/dL]	Cl	=107	[95 - 110]
Ht	=38	[35 - 47%]	Creat	=53	[44 - 80]

MCV	=84	[80 - 100fl]	Gluc	=4.3	[4.2 - 6.4]
MCH	=26	[25 - 35pg]	TSH	=0.22	[0.49 – 4.67]
MHCH	=31	[30 - 37%]			
Plt	=234	[150 - 450x10^9/L]			
Lym	=3.6	[1.0 - 4.0x10^9/L]			

5. Srey Dum, 65M (Damnak Chen Village)
Diagnosis:

1. Pancytopenia
2. Iron deficiency
3. Splenomegaly

Treatment:

1. Send to Kg Thom referral hospital for Abdominal U/S and CXR to r/o mass/tumor
2. Recheck CBC, Lyte, BUN, Creat, Gluc, Peripheral blood smear, Reticulocyte count at SHCH
3. MTV 1t po bid for one month #80
4. FeSO4/Folic acid 200/0.25mg 1t po bid for one month (#80)

Lab result on November 07, 2008

WBC	=3.7	[4 - 11x10^9/L]	Na	=143	[135 - 145]
RBC	=3.6	[4.6 - 6.0x10^{12}/L]	K	=3.6	[3.5 - 5.0]
Hb	=8.4	[14.0 - 16.0g/dL]	Cl	=104	[95 - 110]
Ht	=30	[42 - 52%]	BUN	=1.7	[0.8 - 3.9]
MCV	=83	[80 - 100fl]	Creat	=105	[53 - 97]
MCH	=24	[25 - 35pg]	Gluc	=6.2	[4.2 - 6.4]
MHCH	=28	[30 - 37%]			
Plt	=125	[150 - 450x10^9/L]			
Lym	=0.9	[1.0 - 4.0x10^9/L]			
Mxd	=0.6	[0.1 - 1.0x10^9/L]			
Neut	=2.2	[1.8 - 7.5x10^9/L]			
Reticulocyte	=7.3	[0.5 – 1.5]			

RBC morphology
Macrocyte 2+
Poikilocytosis 1+
Elliptocyte 2+
Hypocromic 2+
Microcyte 3+

6. Iem Mala, 14F (Chamback Phaem Village)
Diagnosis:

1. Right breast tumor (benign/malignant??)
2. Right mammary gland inflammation?

Treatment:

1. Should we refer her to SHCH or Angkor hospital for children for surgical consultation?
2. Do FNA for cytology at SHCH
3. Augmentin 875mg 1t po bid x 7d (#14)
4. Naproxen 375mg 1t po bid prn pain (#30)
5. Paracetamol 500mg 1t po qid prn pain (#30)

Lab result on November 07, 2008

WBC	=5.5	[4 - 11x10^9/L]	Na	=141	[135 - 145]
RBC	=5.2	[3.9 - 5.5x10^{12}/L]	K	=4.6	[3.5 - 5.0]
Hb	=11.5	[12.0 - 15.0g/dL]	Cl	=105	[95 - 110]
Ht	=37	[35 - 47%]	Creat	=66	[44 - 80]
MCV	=72	[80 - 100fl]	Gluc	=5.1	[4.2 - 6.4]
MCH	=22	[25 - 35pg]			

MHCH	=31	[30 - 37%]
Plt	=219	[150 - 450x10^9/L]
Lym	=2.3	[1.0 - 4.0x10^9/L]
Mxd	=0.6	[0.1 - 1.0x10^9/L]
Neut	=2.6	[1.8 - 7.5x10^9/L]

7. Sok Som, 70F (Tourl Rovieng Village)
Diagnosis:

1. Brachial plexus neuritis
2. Dyspepsia
3. Parasititis

Treatment:

1. Naproxen 375mg 1t po bid prn pain for one month (#30)
2. Paracetamol 500mg 1t po qid prn pain for one month (#30)
3. Famotidine 10mg 2t po qhs for one month (#60)
4. Mebendazole 100mg 5t chew qhs once (#5)
5. GERD prev education

8. Thoang Tey, 72F (Rovieng Cheung Village)
Diagnosis:

1. VHD (TR/TI??)
2. HTN
3. Dyspepsia
4. Parasititis

Treatment:

1. HCTZ 12.5mg 2t po qd for one month (#80)
2. Famotidine 10mg 2t po qhs for one month (#60)
3. Mebendazole 100mg 5t chew qhs once (#5)
4. GERD prev education
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Lab result on November 07, 2008

WBC	=7.9	[4 - 11x10^9/L]	Na	=143	[135 - 145]
RBC	=5.1	[3.9 - 5.5x10^{12}/L]	K	=3.8	[3.5 - 5.0]
Hb	=10.4	[12.0 - 15.0g/dL]	Cl	=106	[95 - 110]
Ht	=34	[35 - 47%]	Creat	=71	[44 - 80]
MCV	=66	[80 - 100fl]	Gluc	=4.6	[4.2 - 6.4]
MCH	=20	[25 - 35pg]	T. Chol	=5.5	[<5.7]
MHCH	=31	[30 - 37%]	TG	=2.9	[<1.71]
Plt	=285	[150 - 450x10^9/L]			
Lym	=2.7	[1.0 - 4.0x10^9/L]			

Patients who come for follow up and refill medication

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

1. Diffuse goiter
2. Hyperthyroidism

Treatment:

1. Propranolol 40mg 1/2t po bid for one months (# 30)
2. Carbimazole 5mg 2t po tid for one month (#180)
3. Draw blood for Free T4 at SHCH

Lab result on November 07, 2008

Free T4=16.06 [9.14 - 23.81]

2. Chin Thary, 27F (Rovieng Cheung Village)
Diagnosis:
1. DMII
2. Obesity

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

Lab result on November 07, 2008

Gluc =10.7 [4.2 – 6.4]
HbA1C=8.0 [4 – 6]

3. Chhin Chheut, 13M (Trapang Reusey Village)
Diagnosis:
1. Bilateral Lower extremity muscle weakness
2. Cachexia
3. Nephrotic Syndrome

Treatment:
1. Prednisolone 5mg 3t po qd for one month (#90)
2. MTV 1t po bid for one month (#60)

4. Em Thavy, 36F (Thnal Keng Village)
Diagnosis:
1. Diffuse Goiter
2. Hyperthyroidism

Treatment:
1. Carbimazole 5mg 2t po tid for one month (#180)
2. Propranolol 40mg 1/4t po bid for one month (#15)
3. Draw blood for Free T4 at SHCH

Lab result on November 07, 2008

Free T4=7.41 [9.14 - 23.81]

5. 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)
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Lab result on November 07, 2008

WBC =6.5 [4 - 11x10^9/L] Na =140 [135 - 145]

RBC	=4.6	[3.9 - 5.5x10^{12}/L]	K	=4.4	[3.5 - 5.0]
Hb	=12.0	[12.0 - 15.0g/dL]	Cl	=107	[95 - 110]
Ht	=37	[35 - 47%]	Creat	=81	[44 - 80]
MCV	=81	[80 - 100fl]	Gluc	=3.9	[4.2 - 6.4]
MCH	=26	[25 - 35pg]			
MHCH	=32	[30 - 37%]			
Plt	=233	[150 - 450x10^{9}/L]			
Lym	=2.2	[1.0 - 4.0x10^{9}/L]			

6. Kouch Be, 76M (Thnout Malou Village)
Diagnosis

1. HTN
2. COPD

Treatment

1. Nifedipine 10mg 1t po qd for three months (# 90)
2. Salbutamol Inhaler 2 puffs prn SOB for three months (# 3)

7. Kul Chheung, 78F (Taing Treuk)
Diagnosis:

1. HTN
2. COPD
3. Pneumonia

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (#180)
2. Salbutamol inhaler 2puffs prn SOB for three months (#3vials)
3. Clarithromycin 500mg 1t po bid for 10d (#20)

8. Lang Da, 45F (Thnout Malou Village)
Diagnosis:

1. HTN

Treatment:

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

9. Lay Lai, 28F (Taing Treuk Village)
Diagnosis:

1. Thyroid disorder??

Treatment:

1. Propranolol 40mg 1t po bid for one month (# 80)
2. Draw blood for CBC, TSH and Free T4 at SHCH

Lab result on November 07, 2008

WBC	=8.9	[4 - 11x10^{9}/L]
RBC	=4.9	[3.9 - 5.5x10^{12}/L]
Hb	=12.2	[12.0 - 15.0g/dL]
Ht	=37	[35 - 47%]
MCV	=76	[80 - 100fl]
MCH	=25	[25 - 35pg]
MHCH	=33	[30 - 37%]
Plt	=184	[150 - 450x10^{9}/L]
Lym	=2.5	[1.0 - 4.0x10^{9}/L]
TSH	=1.71	[0.49 - 4.67]
Free T4	=17.54	[9.14 - 23.81]

10. 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 two months (# 120tab)
2. ASA 300mg 1/4t po qd for two months (# 15tab)
3. MTV 1t po qd for two months (# 60tab)

11. Meas Kong, 55F (Rovieng Tbong Village)
Diagnosis:

1. DMII with PNP
2. HTN
3. Both leg lesion

Treatment:

1. Glibenclamide 2t po bid for one month (#140)
2. Metformin 500mg 2t po qhs for one month (#80)
3. Captopril 1t po tid for one month (#100)
4. ASA 300mg 1/2t po qd for one month (#15)
5. Amitriptylin 25mg 1/2t po qhs for one month (#15)

12. Meas Lone, 58F (Ta Tong)
Diagnosis

1. COPD

Treatment

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

13. 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)

14. Men Nam Sear, 56F (Chambak Phaem Village)
Diagnosis:

1. Stroke

Treatment:

1. MTV 1t po qd for one month (#30)
2. Paracetamol 500mg 1t po qid prn pan for one month (#30)
3. ASA 300mg 1/2t po qd for one month (#15)
4. Do the physiotherapy on the weakness side

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

1. HTN

Treatment

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

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

1. DMII

Treatment:

1. Glibenclamide 5mg 2t po bid for one month (# 160)
2. Metformin 500mg 2t po bid for one month (#160)
3. MTV 1t po qd for one month (# 30)

4. FeSO4/Vit C 120/500mg 1t po qd for one month (# 30)

17. Nhem Sok Lim, 59F (Thnout Malou Village)
Diagnosis:
1. DMII

Treatment:
1. Glibenclamide 5mg 2t po qd for three months (#180)
2. Metformin 500mg 2t po qhs for three months (#180)
3. Captopril 25mg 1/4t po bid for three months (#45)

18. Pang Sidoeun, 31F (Rovieng Tbong Village)
Diagnosis:
1. HTN

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

19. Phach Phorn, 42F (Sre Thom Village)
Diagnosis:
1. Tension HA

Treatment:
1. Paracetamol 500mg 1t po qid prn HA (#50)

20. Pheng Roeung, 61F (Thnout Malou Village)
Diagnosis:
1. HTN
2. Liver cirrhosis
3. Euthyroid

Treatment:
1. Atenolol 50mg 1t po qd for three months (# 90)
2. Spironolactone 25mg 1t po qd for three months (buy)
3. MTV 1t po qd for three months (#90)

21. 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 (#170)
3. Captopril 25mg 1/4t po bid for one month (#15)
4. ASA 300mg 1/4t po qd for one month (#10)
5. MTV 1t po bid for one month (#60)
6. Draw blood for CBC, Lyte, Creat, Gluc, HbA1C at SHCH

Lab result on November 07, 2008

WBC	=3.5	[4 - 11x10^9/L]	Na	=139	[135 - 145]
RBC	=2.9	[3.9 - 5.5x10^{12}/L]	K	=4.3	[3.5 - 5.0]
Hb	=4.9	[12.0 - 15.0g/dL]	Cl	=104	[95 - 110]
Ht	=20	[35 - 47%]	Creat	=52	[44 - 80]
MCV	=71	[80 - 100fl]	Gluc	=16.1	[4.2 - 6.4]

MCH	=17	[25 - 35pg]	HbA1C =9.1	[4 – 6]
MHCH	=24	[30 - 37%]		
Plt	=422	[150 - 450x10^9/L]		
Lym	=1.6	[1.0 - 4.0x10^9/L]		
Mxd	=0.1	[0.1 - 1.0x10^9/L]		
Neut	=1.8	[1.8 - 7.5x10^9/L]		

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

1. Euthyroid Goiter

Treatment:

1. Carbimazole 5mg 1/2t po tid for one month (#45)
2. Draw blood for Free T4 at SHCH

Lab result on November 07, 2008

Free T4=13.79 [9.14 - 23.81]

23. Prum Maly, 53F (Bakdoang Village)
Diagnosis:

1. Goiter
2. Dyspepsia
3. Parasititis

Treatment:

1. Famotidine 10mg 2t po qhs for one month(#60)
2. Mebendazole 100mg 5t po qhs once (#5)
3. Draw blood for TSH and Free T4 at SHCH

Lab result on November 07, 2008

TSH	=0.42	[0.49 - 4.67]
Free T4	=13.58	[9.14 - 23.81]

24. 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 50mg 1/2t po qd for two months (#30)
2. FeSO4/Vit C 500/105mg 1t po bid for two months (#120)
3. Folic acid 5mg 1t po qd for two months (#60)
4. MTV 1t po qd for two month (#60)

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

1. HTN
2. PVC

Treatment:

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

26. Prum Pat, 67M (Trapang Reusey Village)
Diagnosis:

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

Treatment:

1. Captopril 25mg 1t po bid for one month (#80)
2. ASA 300mg 1t po qd for one month (#15)
3. MTV 1t po qd for one month (#30)

27. Prum Sourn, 65M (Taing Treuk Village)
Diagnosis:

1. CHF with EF 27%
2. LVH
3. VHD (MI, AI)
4. Renal Impairment

Treatment:

1. Captopril 25mg 1/4t po bid for three months (#45)
2. Furosemide 40mg 1t po qd for three months (#90)
3. ASA 300mg 1/4t po qd for three months (#25)
4. Draw blood for CBC, Lyte, Creat, Gluc at SHCH

Lab result on November 07, 2008

WBC	=4.7	[4 - 11x10^{9}/L]	Na	=143	[135 - 145]
RBC	=3.7	[4.6 - 6.0x10^{12}/L]	K	=4.3	[3.5 - 5.0]
Hb	=11.6	[14.0 - 16.0g/dL]	Cl	=109	[95 - 110]
Ht	=35	[42 - 52%]	Creat	=145	[53 - 97]
MCV	=95	[80 - 100fl]	Gluc	=4.1	[4.2 - 6.4]
MCH	=31	[25 - 35pg]			
MHCH	=33	[30 - 37%]			
Plt	=212	[150 - 450x10^{9}/L]			
Lym	=2.2	[1.0 - 4.0x10^{9}/L]			
Mxd	=0.8	[0.1 - 1.0x10^{9}/L]			
Neut	=1.7	[1.8 - 7.5x10^{9}/L]			

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

1. Dilated Cardiomyopathy with EF 32% with increase RHD
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. Draw blood for Lyte, Mg2+ anc Ca2+ at SHCH

Lab result on November 07, 2008

WBC	=6.1	[4 - 11x10^{9}/L]	Na	=143	[135 - 145]
RBC	=4.9	[3.9 - 5.5x10^{12}/L]	K	=3.8	[3.5 - 5.0]
Hb	=12.6	[12.0 - 15.0g/dL]	Cl	=109	[95 - 110]
Ht	=40	[35 - 47%]	Creat	=79	[44 - 80]
MCV	=81	[80 - 100fl]	Gluc	=4.7	[4.2 - 6.4]
MCH	=26	[25 - 35pg]	Ca2+	=1.14	[1.12 – 1.32]
MHCH	=32	[30 - 37%]	Mg2+	=1.0	[0.8 – 1.0]
Plt	=236	[150 - 450x10^{9}/L]			
Lym	=3.6	[1.0 - 4.0x10^{9}/L]			

29. Ros Oeun, 50F (Thnout Malou Village)

Diagnosis:

1. HTN
2. DMII

Treatment:

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

30. Sam Yom, 60F (Chhnourn Village)
Diagnosis:

1. HTN

Treatment:

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

31. Sao Lim, 73F (Taing Treuk Village)
Diagnosis:

1. HTN
2. Anemia

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (# 180)
2. ASA 300mg ¼ t po qd for three months (# 25)
3. MTV 1t po qd for three months (# 90)

32. Sao Ky, 71F (Thnout Malou Village)
Diagnosis

1. HTN

Treatment

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

33. Sao Phal, 57F (Thnout Malou)
Diagnosis:

1. HTN
2. Anxiety

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (# 180)
2. Amitriptylin 25mg 1t po qhs for three months (# 90)
3. Paracetamol 500mg 1t po qid prn pain/HA for three months (#50)

34. 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 10mg 1t po bid for one month (# 60)
4. Amitriptylin 25mg 1t po qhs for one month (# 30)
5. FeSO4/Vit C 500/105mg 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 CBC, Lyte, Creat, Gluc ans HbA1C at SHCH

Lab result on November 07, 2008

WBC	=9.5	[4 - 11x10^{9}/L]	Na	=144	[135 - 145]
RBC	=3.2	[3.9 - 5.5x10^{12}/L]	K	=5.1	[3.5 - 5.0]
Hb	=7.9	[12.0 - 15.0g/dL]	Cl	=114	[95 - 110]
Ht	=23	[35 - 47%]	Creat	=428	[44 - 80]
MCV	=72	[80 - 100fl]	Gluc	=12.7	[4.2 - 6.4]
MCH	=24	[25 - 35pg]	HbA1C	=10.1	[4 – 6]
MHCH	=34	[30 - 37%]			
Plt	=313	[150 - 450x10^{9}/L]			
Lym	=2.6	[1.0 - 4.0x10^{9}/L]			
Mxd	=1.8	[0.1 - 1.0x10^{9}/L]			
Neut	=5.1	[1.8 - 7.5x10^{9}/L]			

35. Sek Ok, 65M (Bosan Thouk Village)
Diagnosis:
1. HTN

Treatment:
1. HCTZ 12.5 mg 2t po qd for one month (#80)

36. Seung Savorn, 48M (Sre Thom Village)
Diagnosis:
1. HTN

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

37. 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 (# 120tab)
2. Paracetamol 500mg 1t po qid prn pain/fever for two months (# 30tab)
3. MTV 1t po qd for two months (#60tab)
4. FeSO4/Folate 200/0.25mg 1t po qd for two months (#60tab)

38. So Putheara, 13M (Thnal Keng Village)
Diagnosis:
1. Nephritis?
2. Nephrotic Syndrome?

Treatment:
1. Prednisolone 20mg 11/2t po qd for one month (#60)
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Albumin, protein, Tog chole at SHCH

Lab result on November 07, 2008

WBC	=18.3	[4 - 11x10^{9}/L]	Na	=139	[135 - 145]
RBC	=5.5	[4.6 - 6.0x10^{12}/L]	K	=4.5	[3.5 - 5.0]
Hb	=14.4	[14.0 - 16.0g/dL]	Cl	=103	[95 - 110]
Ht	=45	[42 - 52%]	Creat	=40	[53 - 97]
MCV	=82	[80 - 100fl]	Gluc	=3.9	[4.2 - 6.4]
MCH	=26	[25 - 35pg]	T. Chol	=10.9	[<5.7]
MHCH	=32	[30 - 37%]	Albu	=36	[38 - 51]
Plt	=518	[150 - 450x10^{9}/L]	Protein	=64	[66 - 87]

Lym =2.8 [1.0 - 4.0x10^9/L]

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

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

40. So Sok San, 24F (Thnal Keng Village)
Diagnosis:
1. Nephrotic Syndrome
2. Anemia

Treatment:
1. Prednisolone 5mg 2t po qd for two months (#120)
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)

41. Sok Thai, 69M (Taing Treuk Village)
Diagnosis:
1. Stroke

Treatment:
1. ASA 300mg 1/2t po qd for one month (# 20)
2. MTV 1t po qd for one month (#40)

42. Sok Tith, 71M (Boeung Village)
Diagnosis:
1. Brachial Plexus nerve compression by tumor

Treatment:
1. Naproxen 375mg 1t po bid prn for one month (#30)
2. Paracetamol 500mg 1-2t po qid prn pain for one month (#30)

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

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

Lab result on November 07, 2008

Gluc =10.6 [4.2 - 6.4]
HbA1C =10.7 [4 – 6]

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

Treatment
1. Carbimazole 5mg 1/2t po tid for one month (# 45)
2. Draw blood for Free T4 at SHCH

Lab result on November 07, 2008

Free T4=12.89 [9.14 - 23.81]

45. Thorng Phorn, 36F (Bakdoang Village)
Diagnosis:

1. Peripheral neuropahty due to Vit difficiency?
2. Pott's Disease?

Treatment:

1. MTV 1t po qd for two months (#60)
2. Paracetamol 500mg 1t po qid prn pain/fever (#50)

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

1. DMII

Treatment:

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

The next Robib TM Clinic will be held on December 08-12, 2008