Robib *Telemedicine* Clinic

Preah Vihear Province

O C T O B E R 2 0 0 8

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

On Monday, October 06, 2008, SHCH staff, driver and Nurse Peng Sovann traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following two days, Tuesday and Wednesday (mornings), October 07 & 08, 2008, the Robib TM Clinic opened to receive the patients for evaluations. There were 11 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, October 08 & 09, 2008.

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

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

From: Robib Telemed
Date: Oct 1, 2008 8:25 AM
Subject: Schedule for Robib TM Clinic October 2008
To: Rithy Chau; Kathy Fiamma; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kruy Lim; Cornelia Haener
Cc: Bernie Krisher; Dan Liu; Thero Noun; Laurie & Ed Bachrach; Peou Ouk; Sam Oeurn Lanh; Sochea Monn

Dear all,

I would like to inform you all that Robib TM Clinic for October 2008 will be starting from October 6 and coming back on October 10, 2008.

The agenda for the Trip is as following:
1. On Monday 6 October 2008, The driver and I start the trip from Phnom Penh to Rovieng, Preah Vihea.
2. On Tuesday 7 October 2008, the clinic opens to see the patients for the whole morning then type up the information into the computer and send to both partners in Boston and Phnom Penh.
3. On Wednesday 8 October 2008, we do the same as on Tuesday.
4. On Thursday 9 October 2008, download all the answers replied from both partners then make the treatment plan and prepare the medicine for the patients in the same day.
5. On Friday 10 2008, draw the blood from the patients for lab test at SHCH then come back to Phnom Penh.

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

Best regards,
Sovann

From: Robib Telemed
Date: Oct 7, 2008 8:05 PM
Subject: Robib TM Clinic October 2008, Case#1, Phach Phorn, 42F (Sre Thom 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,

Today is the first day for Robib TM Clinic October 2008. There are four new cases and one follow up case. This is case number 1, Phach Phorn, 42F 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: **Phach Phorn, 42F (Sre Thom Village)**

Chief Complaint (CC): HA, Palpitation and heat intolerance x 1y

History of Present Illness (HPI): 42F, farmer, presented with symptoms of palpitation, heat intolerance, tremor, insomnia, diaphoresis, fatigue and she bought medication (unknown name) from pharmacy without consultation and taking medicine for a week, it seem not help her so she stoped taking it. She denied of fever, cough, SOB, GI problem, oliguria, hematuria, edema, weight loss.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No alcohol drinking, no smoking, 2 children

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Regular period, LMP on Sept 26, 2008

PE:

Vitals: BP: 106/70 P: 76 R: 20 T: 37.5^{o}C Wt: 35Kg

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 lesion, no rash

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

Lab/study: None

Assessment:

1. Thyroid disorder

Plan:

1. Paracetamol 500mg 1t po qid prn HA for one month
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc and TSH, Free T4 at SHCH

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

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

Examined by: Nurse Sovann Peng **Date: October 07, 2008**

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

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From: Rithy Chau
Date: Oct 8, 2008 9:35 AM
Subject: Robib TM Clinic October 2008, Case#1, Phach Phorn, 42F (Sre Thom Village)
To: Robib Telemed <robibtelemed@gmail.com>

Dear Sovann,

I agree with your plan and may put in your differential dx of HA and anemia? Educate her on rich iron diet—leafy vegetable. Please check Hb and if lower than 10 draw a CBC; can draw TFT to rule out thyroid problem. But other lab unnecessary.

Hope this helps.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Tan, Heng Soon,M.D.
Sent: Tuesday, October 07, 2008 5:16 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic October 2008, Case#1, Phach Phorn, 42F (Sre Thom Village)

The symptoms do suggest a hyperthyroid state. Additional history could support this diagnosis: has she lost weight? is she more anxious? is she having more frequent bowel movements? does the fatigue include weakness climbing stairs? Sometimes hyperthyroidism may be associated with hypokalemic periodic paralysis when the patient becomes totally weak like she is paralyzed momentarily. The most common cause of hyperthyroidism is Graves disease, an autoimmune disorder. One would expect a thin habitus [she is thin], warm fine skin [not described], resting tachycardia around 100/m [she is only 76/m], a cardiac flow murmur [not present], an enlarged symmetrical thyroid with bruits [not described], possible lid retraction [she does not have a stare] and lid lag, mild proximal muscle weakness [not described], fine tremor of extended arms [not described], hyperreflexia [not present]. The one year history would support the diagnosis of Graves disease, since the second most common cause of thyroiditis is usually associated with a short lived period of hyperthyroidism before hypothyroid state develops. The third more rare cuase would be a toxic thyroid nodule. TSH and free T4 should confirm the hyperthyroid state. Ideally, radioactive I131 uptake and thyroid scan would distinguish between Graves disease [increased uniform uptake] vs thyroiditis [decreased heterogenous uptake]. If hyperthyroidism is confirmed, I would offer her methimazole 30 mg daily and taper down over the next 2 months to 5-15 mg daily to keep her euthyroid for 6-12 months before discontinuing. If that fails, radioactive iodine therapy could be offered if available. Propranolol betablocker may not be necessary if she does not have tachycardia.

Heng Soon Tan, MD

From: **Robib Telemed**
Date: Oct 7, 2008 8:08 PM
Subject: Robib TM Clinic October 2008, Case#2, Sam Yom, 60F (Chhnourn 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 2, Sam Yom, 60F 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: **Sam Yom, 60F (Chhnourn Village)**

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

History of Present Illness (HPI): 60F presented with symptoms of HA, neck tension, palpitaton, fatigue, muscle pain and went to seek care at local health center, BP: 160/? and she bought antihypertensive Amlodipine 5mg taking 1t po qd, It helped her more but still presented with HA, palpitation. She denied of fever, couhg, chest pain, oliguria, hematuria, edema.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No alcohol drinking, chewing tobacco

Current Medications:

1. Amlodipine 5mg 1t po qd

Allergies: NKDA

Review of Systems (ROS): Epigastric pain, burning sensation, burping with sour taste, radiated to right scapular andrelieved with antacid

PE:

Vitals: BP: 121/68 P: 65 R: 20 T: 37.5^{o}C Wt: 40Kg

General: Look stable

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

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

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

Assessment:

1. HTN
2. GERD
3. Parasititis

Plan:

1. HCTZ 12.5mg 2t po qd for one month
2. Famotidine 10mg 2t po qhs for one month
3. Mebedazole 100mg 5t po qhs once
4. GERD prevention education
5. Eat low Na+ diet, and do regular exercise
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

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

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

Examined by: Nurse Sovann Peng **Date: October 07, 2008**

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From: Danny Sands (dzsands) [mailto:dzsands@cisco.com]
Sent: Tuesday, October 07, 2008 5:26 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic October 2008, Case#2, Sam Yom, 60F (Chhnourn Village)

I agree with your assessment and plan.

- Danny

Daniel Z. Sands, MD, MPH

Beth Israel Deaconess Medical Center

Harvard Medical School

From: Rithy Chau
Date: Oct 9, 2008 8:39 AM
Subject: Robib TM Clinic October 2008, Case#2, Sam Yom, 60F (Chhnourn Village)
To: Robib Telemed <robibtelemed@gmail.com>

Dear Sovann,

I agree with your plan.

Thanks,

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Robib Telemed
Date: Oct 7, 2008 8:13 PM
Subject: Robib TM Clinic October 2008, Case#3, So Im, 55F (Thnout Malou 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 3, So Im, 55F 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: **So Im, 55F (Thnout Malou Village)**

Chief Complaint (CC): Extremity buring pain, skin color change x 1y

History of Present Illness (HPI): 55F, housewife, came to us complaining of extremity burning pain. She presented with medial side of foot skin became red color, about 3x6cm size, smooth skin, mild pruritus then change to brown color and rapidly developed upward to the calf in three months and also feeling of buring pain on both foot. She went to Dermatology center in Phnom Penh and treated with some oral medicine and application and follow in one follow. The medicine seems not help her and she didn't come for appointment at Phnom Penh. She also noticed some small red spots on the body chest and arm. She denied of contact to chemical or insect bite.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No alcohol drinking, no smoking, five children

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): 3y post menopause

PE:

Vitals: BP: 118/72 P: 73 R: 20 T: 37.5°C Wt: 65Kg

General: Look stable

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

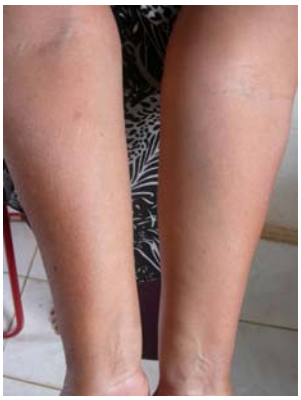
Chest: CTA bilaterally, no rales, no rhonchi; H RRR, no murmur

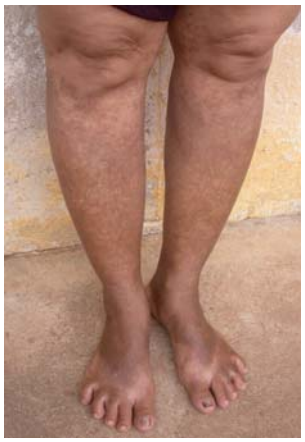
Abd: Soft, no tender, no distension, (+) BS, no HSM, no scar

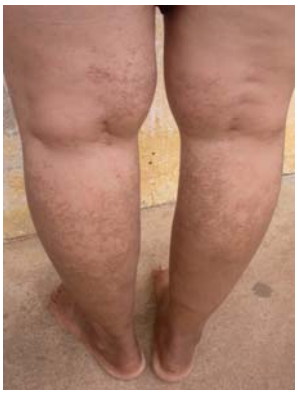
Extremity/Skin: brown color lesion with smooth skin from the foot to popliteal, some red color macules on the back, chest and arm

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

Lab/study: FBS: 102mg/dl







Assessment:

1. Hyperpigmented skin lesion

Plan:

1. Paracetamol 500mg 1t po qid prn pain 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: October 07, 2008**

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From: Kvedar, Joseph Charles,M.D.
Sent: Wednesday, October 08, 2008 8:37 AM
To: Fiamma, Kathleen M.
Subject: Re: Robib TM Clinic October 2008, Case#3, So Im, 55F (Thnout Malou Village)

This is a puzzling presentation. The most striking visual aspect is the pigmentation on the lower extremities. This brings to mind stasis dermatitis or possibly Schamberg's pigmentary purpura. Burning is more consistent with the former.

Therapeutically, I'd suggest adding topical triamcinolone or if not available, topical hydrocortisone to the regimen you have outlined, and a follow up in a month to see how she's doing.

--

Joseph C. Kvedar, MD
Director, Center for Connected Health
Partners HealthCare System, Inc.
Associate Professor of Dermatology
Harvard Medical School

From: Rithy Chau
Date: Oct 9, 2008 9:02 AM
Subject: Robib TM Clinic October 2008, Case#3, So Im, 55F (Thnout Malou Village)
To: Robib Telemed <robibtelemed@gmail.com>

Dear Sovann,

It seems that this patient has a benign problem at present time. Blood sugar is normal. Possibly, she has had an allergic dermatitis of some sort that caused the LE rashes up to her knees. The brown hyperpigmentation is probably part of the healing process of the skin and may stay like this for several months and sometimes years. Advise her not to use anything other medication at this point. She may benefit from proper diet and exercise to lose some weight which bears quite a bit by her LE. Did you check her LE pulses? If they are intact, then may not worry too much about vascular problem. Can you also ask her hx a little more on when this "burning" sensation comes—any particular time of day, how long it last, what she did to help, what made it worse, etc.? Read up on Raynaud's disease and ask her for sx for this problem or not. If she can afford, she may buy some vit B to take once a day for 3 months.

Dr. Kvedar from Boston may have a better idea to help you about her skin problem.

Hope this helps.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Robib Telemed
Date: Oct 7, 2008 8:21 PM
Subject: Robib TM Clinic October 2008, Case#4, So Putheara, 13M (Thnal Keng 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 4, So Putheara, 13M and photos.
Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

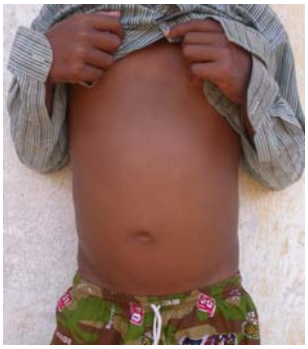
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **So Putheara, 13M (Thnal Keng Village)**

Chief Complaint (CC): Both legs edema x 2weeks

History of Present Illness (HPI): 13M, student, brought to us by his family complaining of both legs edema. He presented with symptoms of on/off epigastric pain after full eating and in these two weeks, developed with swelling of face, oliguria, dysuria, legs swelling, abdominal distension, fever, he was brought to private clinic in Preah Vihea and treated with three kind of medication (unknown name) but It seem not help him. He denied of sore throat, no nausea/vomiting, no stool with blood/mucus.



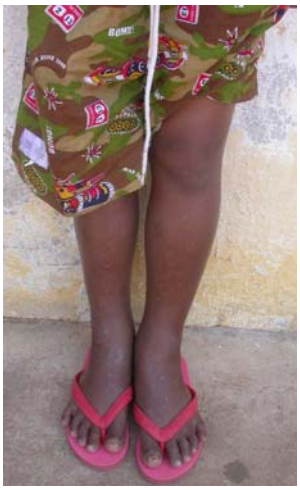
Past Medical History (PMH): Unremarkable

Family History: His sister with Nephrotic syndrome (our patient So Soksan)

Social History: grade 5 student

Current Medications:

1. Diuretic 2t po qd
2. Other two kinds 1t po qd



Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: **BP: 98/67** **P: 59** **R: 20** **T: 37^{o}C** **Wt: 40Kg**

General: Look sick, moon face

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, mild distended, (+) BS, no HSM, no scar, no abd dilated vein

Extremity/Skin: +2 pitting edema, no lesion, no rash

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

Rectal Exam: Good stincter tone, smooth, no mass palpable, neg colocheck

Lab/study: UA protein 4+, Blood 4+

Assessment:

1. Nephritis?
2. Nephrotic Syndrome?

Plan:

1. Should we start him on Prednisolone?
2. Furosemide 20mg 1t po qd for one week
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Albumin, protein, Tog chole 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: October 07, 2008**

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

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From: Fang, Leslie S.,M.D.
Sent: Tuesday, October 07, 2008 7:22 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic October 2008, Case#4, So Putheara, 13M (Thnal Keng Village)

Because of the nephritic sediment, I would think that the patient has a glomerulonephritis.

DDX:
Post-infectious GN
IgA nephropathy or Henoch Scholein Purpura with renal involvement primarily

This does not look like nephrotic syndrome of minimal change because of the 4+ heme in urine

Need to know renal function
Need to know the other 2 medications the patient is on

Leslie Fang, MD

From: Rithy Chau
Date: Oct 9, 2008 9:14 AM
Subject: Robib TM Clinic October 2008, Case#4, So Putheara, 13M (Thnal Keng Village)
To: Robib Telemed

Dear Sovann,

This patient may have Nephrotic Syndrome just like his sister. If no previous medication taken prior to these sx and pt is well nourished, then make sense to dx this. I would give Furosemide as you said but for two weeks, start prednisolone 1mg/kg/day and recheck next month. Also add ASA, Albendazole to prevent/cover hyperparasitemia, and low dose captopril for renal protection. I would also like to investigate and make a visit to their home next month I go there to see if any explanation why NS occurs in two members of this family already.

I hope this will help.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: **Robib Telemed**
Date: Oct 7, 2008 8:27 PM
Subject: Robib TM Clinic October 2008, Case#5, Prum Pat, 67M (Trapang Reusey 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 the last case number 5, Prum Pat, 67M and photos. The other cases will be send 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 in Telemedicine
Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note

Patient Name & Village: Prum Pat, 67M (Trapang Reusey Village)

Subjective: 67M, was seen in January 2006 with diagnosis of severe HTN and left side stroke with right side weakness, came to us complaining of headache, neck tension, muscle pain, epigastric pain, burning sensation after full eating, no radiation, no nauea/vomiting. During missed appointment, he bought antihypertensive medication taking prn when he presented with very worse symtoms. He denied of fever, cough, chest pain, oliguria, dysuria, edema.

Current Medications: None

Allergies: NKDA

Objective:

VS: BP: 180/128 (both sides) P: 81 R: 20 T: 37
Wt: 47kg

PE (focused):

General: Look sick

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

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

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

Skin/Extremity: No edema, no rash, unable to stretch the fingers of right hand

MS/Neuro: MS +4/5 on right hand and right leg, sensory intact, walking with assistance

Lab/Study: UA protein 1+

Assessment:

1. Severe HTN
2. Left side stroke with right side weakness
3. Dyspepsia
4. Parasititis

Plan:

1. HCTZ 12.5mg 2t po qd for one month
2. ASA 300mg 1/4t po qd for one month
3. Mg/AL(OH)3 250/125mg 2t chew bid prn for one month
4. Mebendazole 100mg 5t po qd once
5. MTV 1t po qd for one month
6. Regular exercise on weak side
7. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Tot Chole, TG at SHCH

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

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

Examined by: Nurse Peng Sovann **Date: October 7, 2008**

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

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From: Rithy Chau
Date: Oct 9, 2008 9:48 AM
Subject: Robib TM Clinic October 2008, Case#5, Prum Pat, 67M (Trapang Reusey Village)
To: Robib Telemed

Dear Sovann,

Please change your tx to the followings:

1. Captopril 25mg ½ po now and recheck BP in an hour and if effective, then can prescribe ½ bid
2. ASA 300mg 2 po qd chew

Hope this helps.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Robib Telemed
Date: Oct 8, 2008 9:06 PM
Subject: Robib TM Clinic October 2008, Case#6, Sin Sokunthearak, 7F (Thnout Malou Village)
To: Cornelia Haener; Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Kathy Fiamma; Joseph Kvedar
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

Today is the second day for Robib TM Clinic October 2008. There are seven new cases. This is the case number 6, continued from yesterday, Sin Sokunthearak, 7F and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

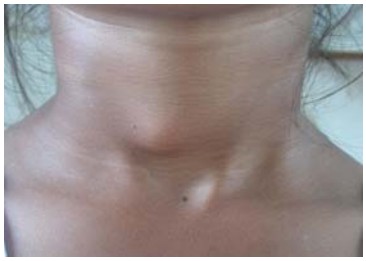
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Sin Sokunthearak, 7F (Thnout Malou Village)**

Chief Complaint (CC): Neck mass x 3y

History of Present Illness (HPI): 7F brought to us by her father complaining of neck mass. The mass presented about 0.5cm size, no swelling, no warmth, no pain, it became bigger from year to year so he bring her to us for consultation. She has normal bowel movement, normal urination, no dysphagia.



Past Medical History (PMH): Dengue fever in 2006

Family History: None

Social History: Grade 2 student

Current Medications: None

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 98/50 P: 89 R: 20 T: 36.5^{o}C Wt: 20Kg

General: Look stable

HEENT: No oropharyngeal lesion, pink conjunctiva, a small mass about 1x1cm size, smooth, regular border, mild hard, no tender, mobile on swallowing, 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 lesion

Assessment:

1. Subcutanous Cyst?
2. Thyroid Cyst?

Plan:

1. Should we refer her to SHCH or Pediatric hospital in Siem Reap for surgery consultation

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: October 08, 2008**

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

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From: **Rithy Chau**
Date: Oct 9, 2008 10:28 AM
Subject: RE: Robib TM Clinic October 2008, Case#6, Sim Sokunthearak, 7F (Thnout Malou Village)
To: Robib Telemed

Dear Sovann,

Yes, I think she may have a cyst on ant neck and it is benign. If no sx of obstruction or problem to daily living, then I suggest to observe. You can draw blood for a TSH, but very unlikely to be goiter problem but will help to emphasize the benign matter of this problem in conveying to the family. If family can afford, can have an US done and bring back result to us next month.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: cornelia_haener
Date: Oct 9, 2008 1:34 PM
Subject: Robib TM Clinic October 2008, Case#6, Sim Sokunthearak, 7F (Thnout Malou Village)
To: Robib Telemed; Rithy Chau; Kruy Lim; "Paul J. M.D. Heinzelmann"; Kathy Fiamma; Joseph Kvedar
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

It looks like a right thyroid mass. I would suggest referring her to Angkor Hospital for Children. A thyroid cancer is a probability.

Kind regards

Cornelia

From: Barbesino, Giuseppe,M.D.
Date: Oct 9, 2008 11:53 PM
Subject: Robib TM Clinic October 2008, Case#6, Sim Sokunthearak, 7F (Thnout Malou Village)
To: "Fiamma, Kathleen M." <KFIAMMA@partners.org>
Cc: robibtelemed@gmail.com, tmed_rithy@online.com.kh

This young girl has a slowly growing cervical mass, almost on the midline. The etiology of this mass is most likely thyroidal, as most non thyroidal masses in children (lymphadenopaties, branchial cleft cysts) are more lateral usually. The differential diagnosis includes a benign colloid nodule, a Thyroglossal duct cyst and thyroid cancer as well. A slow growth rate does not rule-in or out any of the above. Thyroid nodules are most often benign, but the risk of malignancy is increased in young children with thyroid nodules. I believe that the best course is measuring thyroid function tests (TSH), and neck ultrasound, followed by fine needle aspiration biopsy of the mass. If the biopsy cannot be done, then surgical removal should be considered only if the mass is not cystic on ultrasound. I do hope in a good outcome for this young girl and I would be glad to review ultrasound images if available.

GB

From: Robib Telemed
Date: Oct 8, 2008 9:11 PM
Subject: Robib TM Clinic October 2008, Case#7, Sok Tith, 71M (Boeung Village)
To: Cornelia Haener; 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 Tith, 71M and photos.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

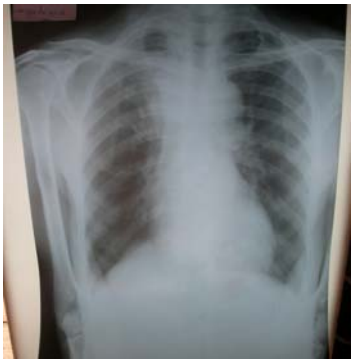
History and Physical

Name/Age/Sex/Village: **Sok Tith, 71M (Boeung Village)**

Chief Complaint (CC): Right arm pain x 2 months

History of Present Illness (HPI): 71M, farmer, came to us complaining of right arm pain. The pain started from the scapula with movement, radiate to the should, arm and four fingers except little finger, no inflammatory sign, and difficult to raise the right arm up. He also noticed a mass on right lateral neck, tender on palpation. He went to provincial hospital, has CXR and told he had lung problem and treated with some four medicine bid for a weeks. The medicine seems not help him with the pain. He denied of any trauma.

Past Medical History (PMH): No trauma



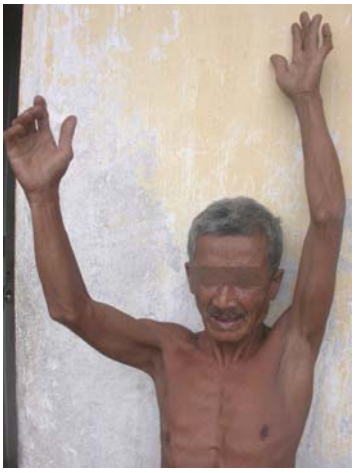
Family History: None

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

Current Medications: Three kinds of medicine po qd and traditional medicine

Allergies: NKDA

Review of Systems (ROS): Unremarkable



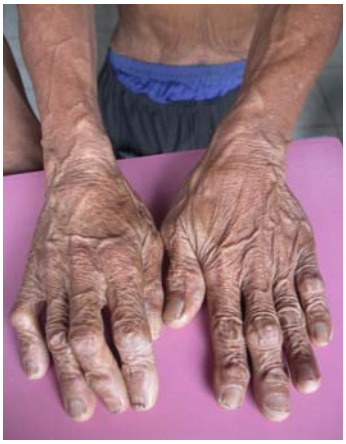
PE:

Vitals: BP: 93/66 P: 79 R: 20 T: 37^{o}C Wt: 43Kg

General: Look sick, cachexia

HEENT: No oropharyngeal lesion, pink conjunctiva, a mass about 2x3cm on right subclavicular in anterior triangle region, mild hard, irregular border, slightly tender, no lymph node palpable

Chest: Right lung fine crackle on exspiration, clear on the left; H RRR, no murmur



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

Extremity/Skin: finger joint deviation, no tender, no swelling,

Shoulder exam: Limited raising of right arm with pain, mild tender with percusion on right scapular, +4/5 MS on right arm, no swelling, no warmth

Assessment:

1. Brachial Plexus nerve compression by tumor
2. Pneumonia
3. PTB?

Plan:

1. Clarithromycin 500mg 1t po bid for 10d
2. Paracetamol 500mg 1-2t po qid prn pain for one months
3. Do AFB smear in local HC
4. Send to Kg Thom for x-ray of Right should joint

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: October 08, 2008**

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From: Rithy Chau
Date: Oct 9, 2008 10:11 AM
Subject: Robib TM Clinic October 2008, Case#7, Sok Tith, 71M (Boeung Village)
To: Robib Telemed <robibtelemed@gmail.com>

Dear Sovann,

I agree that he needs to be tx for pneumonia and getting AFB is the right move according to his CXR. R/o any hx of trauma or injury. May have nerve compression syndrome or possible Pott's dz if positive AFB. I do think he needs to go to K Thom for shoulder x-ray bilaterally but also evaluating the mass on US as well especially for nerve compress problem. It may also benefit to do a lat CXR since the hilar area seems enlarged. If the patient is poor and have difficulty financially, then may consider referring him to SHCH for a fuller workup. Wait for reply from the surgical doctor whether good idea to refer him or not. I agree with your tx plan.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: cornelia_haener
Date: Oct 9, 2008 1:40 PM
Subject: Robib TM Clinic October 2008, Case#7, Sok Tith, 71M (Boeung Village)
To: Robib Telemed; Rithy Chau; Kathy Fiamma; Joseph Kvedar; Kruy Lim; "Paul J. M.D. Heinzelmann"
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear Sovann,

Thanks for presenting this case. Its sounds like a malignant disease with invasion of the plexus. As differential diagnosis, a chronic inflammatory process is possible. I am rather thinking about melioidosis than TB. It might be worthwhile to bring him to P.P. for a FNA of the cervical mass.

Kind regards

Cornelia

From: Warner, Jon J.P.,M.D.
Sent: Thursday, October 09, 2008 9:46 AM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic October 2008, Case#7, Sok Tith, 71M (Boeung Village)

Dear Kathleen:

I have reviewed the history and the radiographs. I do not see any obvious mass either with the radiographs of the clinical photos. I do think that an MRI of the shoulder would help not only to rule out a mass in vicinity of the plexus but

also show if this man has a rotator cuff tear which is more likely the cause of weakness and pain. I do not know availability of MRI but if not available then CT arthrogram is also helpful. Also, a more detailed evaluation is needed from standpoint of any neurologic deficit as we do not know specific weakness and areas of decreased sensation.

I hope this is of value.

Regards,

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

From: Robib Telemed
Date: Oct 8, 2008 9:20 PM
Subject: Robib TM Clinic October 2008, Case#8, Meas Kong, 55F (Rovieng Tbong 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 the case number 8, Meas Kong, 55F 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: **Meas Kong, 55F (Rovieng Tbong Village)**

Chief Complaint (CC): Polyuria, and fatigue x 1y

History of Present Illness (HPI): 55F presented with symptoms of fatigue, polyuria, polydypsia, polyphagia, numbness, tingling, itchy of both foot, she scratched on it and it became the lesion about 1x1cm, black color. In last two month, she went to Preah Vihea hospital, Urinalysis showed gluc 4+, diagnosed with DMII and treated with Glibenclamide 5mg 1t po bid. Her symptoms seem not better. She denied of fever, cough, SOB, GI problem, oliguria, hematuria, edema, weight loss.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No alcohol drinking, no smoking, 7 children

Current Medications:

1. Glibenclamdie 5mg 1t po bid

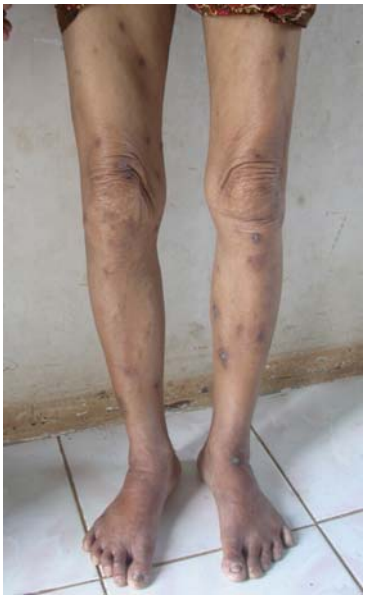
Allergies: NKDA

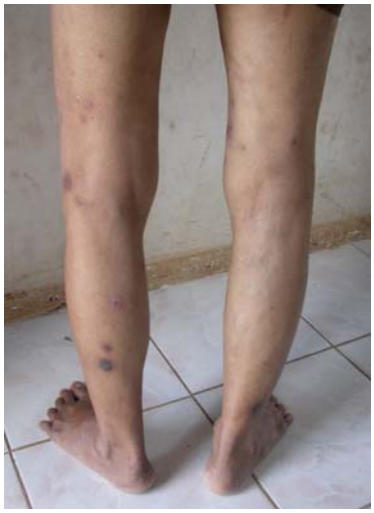
Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 205/101 (both side) P: 89 R: 20 T: 37°C Wt: 50Kg

General: Look stable





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

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

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

Extremity/Skin: (+) dorsalis pedis and post tibial pulse, some lesion, necrotic tissue, round shape about 1x1cm size, no vesicle, no pustule on both legs

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

Lab/study: U/A protein 4+, gluc 4+; RBS: 411mg/dl

Assessment:

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

Plan:

1. Glibenclamide 2t po qAM for one month
2. Metformin 500mg 1t po qhs for one month
3. Captopril 1/2t po bid for one month
4. ASA 300mg 1/4t po qd for one month
5. Amitriptylin 25mg 1/2t po qhs for one month
6. Educate on diabetic diet, do regular exercise and foot care
7. Draw blood for CBC, Lyte, BUN, Creat, Gluc, HbA1C at SHCH

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

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

Examined by: Nurse Sovann Peng **Date: October 08, 2008**

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From: Rithy Chau
Date: Oct 9, 2008 10:21 AM
Subject: Robib TM Clinic October 2008, Case#8, Meas Kong, 55F (Rovieng Tbong Village)
To: Robib Telemed

Dear Sovann,

I agree with your ddx and because of her DM she develops infection easily from scratch or cut. Please ask her to avoid scratching. Give her some antihistamine for this. Also, go ahead and give Glibenclamide 2 po bid and hold off on the metformin. Can increase Captopril to 1 tab pot id (give 1 tab first and recheck BP in 1 hr, if not effective can give me a call). ASA can be given higher dose for all your cardiovascular and DM patients to 300mg po qd. Check her TG and tot chol also. Be strict with her diet and exercise as well as foot care instruction.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Fang, Leslie S.,M.D.
Sent: Saturday, October 11, 2008 8:12 AM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic October 2008, Case#8, Meas Kong, 55F (Rovieng Tbong Village)

Appears to have diabetes with diabetic nephropathy
The lesions do not look vasculitic on the photos: some actually look like excoriated skin
Agree with regimen but believe that she will need more captopril than prescribed

Leslie S.T. Fang, MD PhD

From: Robib Telemed
Date: Oct 8, 2008 9:30 PM
Subject: Robib TM Clinic October 2008, Case#9, Men Namsear, 56F (Chambak Phaem 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 the case number 9, Men Namsear, 56F 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: **Men Nam Sear, 56F (Chambak Phaem Village)**

Chief Complaint (CC): Left side weakness x 6months

History of Present Illness (HPI): 56F brought to us by her family complaining of left side weakness. While walking, she was trapped by the wood and falled down forwardly and unable to get up for a while then she tried to go home and noticed her left side of the body became weak, drop of the right eyelid, mouth deviation, ear ringing and feel like something in her head, she can walk by herself with the stick. One month later, her problem seems worse with unable to keep the balance, choking when eating/drinking, snoring during sleep. She didn't find care just buy medicines from pharmacy for pain, and taking traditional medicine. She has normal bowel movement, urination.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No smoking, no alcohol drinking

Current Medications: Pain killer and traditional medicine

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 113/85 P: 60 R: 20 T: 37^{o}C Wt: 70Kg

General: Look sick

HEENT: No oropharyngeal lesion, pink conjunctiva, 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 lesion, unable to completely stretch the left fingers

MS/Neuro:
CN I, II, III, IV, V, VI: intact
CN VII
Unable to blow out cheeks, can close the eyes, rais the eyebrow
CN VIII
whisper, Weber, and Rinne tests (not done)
CN IX, X
Decrease gag reflex
CN XI
Strength of trapezius and sternocleidomastoid muscles intact
CN XII
Able to protrude tongue, no deviation

Unable to stand up by herself

Assessment:

1. CN VII, IX, X defect

Plan:

1. MTV 1t po qd for one month
2. Paracetamol 500mg 1t po qid prn pan for one month
3. Do the physiotherapy on the weakness side

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: October 08, 2008**

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From: Rithy Chau
Date: Oct 9, 2008 11:28 AM
Subject: Robib TM Clinic October 2008, Case#9, Men Namsear, 56F (Chambak Phaem Village)
To: Robib Telemed

Dear Sovann,

I believe this lady suffered from a stroke and need tx for post-stroke management. Please give her ASA 300mg 1 daily, MTV and para use prn is fine. She needs someone who live with her to help with certain PT ROM and needs soft-liquid food that maybe taken by straw (if possible) and sleep with head of bed up on two brick blocks to prevent from aspirated pneumonia. Getting her to be mobile as much as possible during daytime and if possible to turn her once or twice nighttime to prevent bedsore development.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Robib Telemed
Date: Oct 8, 2008 9:34 PM
Subject: Robib TM Clinic October 2008, Case#10, Sek Ok, 65M (Bosan Thouk Village)
To: Rithy Chau; "Paul J. M.D. Heinzelmann"; Joseph Kvedar; Kathy Fiamma; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach

Dear all,

This is the case number 10, Sek Ok, 65M 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: **Sek Ok, 65M (Bosan Thouk Village)**

Chief Complaint (CC): Both legs edema x 2months

History of Present Illness (HPI): 65M, farmer, presented with symptoms of lower back pain, low grade fever, pass small amount of urine, both legs swelling and fatigue. He went to the local health center and treated with three kinds of medications (unknown name) bid for a week. Now he became better with less legs edema, pass much amount of urine. He denied of cough, sore throat, chest pain, stool with blood or mucus, hematuria, dysuria.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: Heavy smoking over 20y, alcohol drinking casually

Current Medications: Three kinds of medicine

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 145/81 P: 74 R: 20 T: 37°C Wt: 54Kg

General: Look stable

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

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

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

Extremity/Skin: 2+ pitting edema, + dorsalis pedis and post tibial pulse, no lesion

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

Assessment:

1. Nephritis?
2. Nephrotic Syndrome?
3. Renal failure?

Plan:

1. Furosemide 40mg 1/2t po qd for 7d
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Albumin, protein, Tot chole 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: October 08, 2008**

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From: Rithy Chau
Date: Oct 9, 2008 10:53 AM
Subject: Robib TM Clinic October 2008, Case#10, Sek Ok, 65M (Bosan Thouk Village)
To: Robib Telemed

Dear Sovann,

His BP is elevated and did you recheck again (both arms) and still elevated? Any hx of HTN? Make sure you really find out from this person that his drinking is more than socially or his "social" is quite frequent and in large quantity—sometimes pt hid this from you because of shame or stigmatism in the medical setting. Alcoholism can lead to other systemic problems that cause his edema—cardiovascular dz, DM, liver prob,

etc. I did not see you reporting a UA. Did you do one? You need to do this get result before suspecting such problem as NS or nephritis ot renal dysfn. If he is HTN, then would tx with HCTZ 25mg qd and f/u next month. Was there any medication that he was taking prior to having edema? Some medication esp traditional may lead to edema problem and will go away when he stop and so will the alcohol consumption if no severe damage to his system.

I would not draw for Alb, prot, tot chol if no real indication for NS (unlikely in this case). Can draw for LFT though. Also can give furosemide as suggested, MTV and Albendazole to cover any parasite infection since endemic in this area.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Fang, Leslie S.,M.D.
Sent: Saturday, October 11, 2008 8:11 AM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic October 2008, Case#10, Sek Ok, 65M (Bosan Thouk Village)

We definitely need more information
At the very least, a urinalysis now while awaiting the remainder of the blood tests to return

Leslie S.T.Fang, MD PhD

From: Robib Telemed
Date: Oct 8, 2008 9:38 PM
Subject: Robib TM Clinic October 2008, Case#11, So Sary, 65F (Koh Pon 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 11, So Sary, 65F 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: **So Sary, 65F (Koh Pon Village)**

Chief Complaint (CC): Fatigue and neck tension x 1y

History of Present Illness (HPI): 65F presented with symptoms of patigue, neck tension, HA, dizziness more often, she went to local health center, BP:170/? and bought antihypertensive from pharmacy taking 1t po qd then she became better. Since then she take antihypertensive when she presented with above symptoms. In these two months her symptoms became worse so she went to Preah Vihea proincial hosptial and treated with three kinds of medicine for two weeks. She denied of fever, cough, SOB, GI problem, oliguria, hematuria, edema.

Past Medical History (PMH): Unremarkable

Family History: None

Social History: No alcohol drinking, chewing tobacco, 5 children

Current Medications:

1. Antihypertension (unknown name) 1t po qd

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 167/89 P: 71 R: 20 T: 37^{o}C Wt: 47Kg

General: Look stable

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

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

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

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

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

Lab/study: U/A protein 2+

Assessment:

1. HTN

Plan:

1. HCTZ 12.5mg 2t po qd for one month
2. Eat low Na+ deit and do regular exercise
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

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

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

Examined by: Nurse Sovann Peng **Date: October 08, 2008**

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

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From: Cusick, Paul S.,M.D.
Date: Oct 9, 2008 9:01 AM
Subject: Robib TM Clinic October 2008, Case#11, So Sary, 65F (Koh Pon Village)
To: "Fiamma, Kathleen M."; robibtelemed@gmail.com
Cc: tmed_rithy@online.com.kh

thank you for this consultation

It is not clear to me why she is fatigued and dizzy.
She is certainly hypertensive.

I agree with diuretic as a hypertensive.
She should try to limit sodium (less than 2gm per days)

I agree with the need to recheck her blood pressure and electrolytes.

Best of luck to you and to her.

Paul

From: Rithy Chau
Date: Oct 9, 2008 10:57 AM
Subject: Robib TM Clinic October 2008, Case#11, So Sary, 65F (Koh Pon Village)
To: Robib Telemed <robibtelemed@gmail.com>

Dear Sovann,

I agree with your assessment and plan.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Robib Telemed
Date: Oct 8, 2008 9:53 PM
Subject: Robib TM Clinic October 2008, Case#12, Srey Dum, 65M (Damnak Chen 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 last case for Robib TM Clinic October 2008, case number 12, Srey Dum, 65M and photo. Please reply to the case before Thursday afternoon then I can make treatment plan accordingly. Thank you very much for your cooperation and support in this project.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

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

Chief Complaint (CC): Pale and fatigue x 1y

History of Present Illness (HPI): 65M presented with symptoms of fatigue, abdominal dicomfort and distension, SOB on exertion, palpitation, black stool, he bought medicine from pharmacy and traditional medicine. He never seeks medical care at any place. He denied of nausea, vomitting, cough, oliguria, dysuria, hematuria, edema.

Past Medical History (PMH): Malaria in 2005

Family History: None

Social History: Heavy alcohol drinking, smoking 10cig/d

Current Medications: Traditional medicine

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 121/57 P: 86 R: 20 T: 37^{o}C Wt: 53Kg

General: Look sick

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

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

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

Extremity/Skin: No edema, no lesion

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

Rectal Exam: good sphincter tone, smooth, no mass palpable, neg cholocheck

Lab/study: U/A normal; RBS: 209mg/dl; Hb: 7g/dl

Assessment:

1. Severe Anemia
2. Hyperglycemia
3. Splenomegaly

Plan:

1. MTV 1t po qd for one month
2. FeSO4/Folic acid 200/0.25mg 1t po bid for one month
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Peripheral blood smear, Reticulocyte count 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: October 08, 2008**

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

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From: Rithy Chau
Date: Oct 9, 2008 11:38 AM
Subject: Robib TM Clinic October 2008, Case#12, Srey Dum, 65M (Damnak Chen Village)
To: Robib Telemed <robibtelemed@gmail.com>

Dear Sovann,

With severe anemia, splenomegaly, pale, it may be due to his alcoholism (Cirrhosis) and smoking. He can have gastric or peptic ulcer that give h/o black stool. It may be from a relapse malaria infection—please check malaria smear again and may treat him with Chloroquine even if negative. MTV and Iron supplement bid.

Get LFT and ferritin also. Tx with H2 Blocker or Omeprazole for 2 months, B-complex IV x 3d, Mebendazole and ask him to stop smoking and drinking. Stop the traditional med also. DDX: Malaria?, Alcoholic Cirrhosis?, Iron Deficiency?, Parasititis.

Rithy

Rithy Chau, MPH, MHS, PA-C
Director for Capacity Building and Telemedicine
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia
Mobile: 855-12-520-547/855-11-623-805

From: Robib Telemed
Date: Oct 9, 2008 8:41 PM
Subject: Robib TM Clinic October 2008 Cases received
To: Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach; Rithy Chau

Dear Kathy,

I have received 5 replies from you, and below are the received cases:

Case#1, Phach Phorn, 42F
Case#2, Sam Yom, 60F
Case#3, So Im, 55F
Case#4, So Putheara, 13M
Case#11, So Sary, 65F

Please send me the answer of the remaining cases.

Thank you very much for the answers to the cases in this month TM Clinic.

Best regards,
Sovann

Thursday, October 09, 2008

Follow-up Report for Robib TM Clinic

There were 11 new patients and one follow up patient seen during this month Robib TM Clinic , other 35 patients came for medication refills only, and one patient has been consulted with PA Rithy Chau by phone. The data of all 12 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 October 2008

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

1. Thyroid disorder

Treatment:

1. Paracetamol 500mg 1t po qid prn HA for one month (#30)
2. Draw blood for CBC, Lyte, BUN, Creat, Gluc and TSH, Free T4 at SHCH

Lab Result on Oct 10, 2008

WBC	=13.3	[4 - 11x10^9/L]	Na	=140	[135 - 145]
RBC	=5.2	[3.9 - 5.5x10^{12}/L]	K	=3.9	[3.5 - 5.0]
Hb	=12.0	[12.0 - 15.0g/dL]	Cl	=106	[95 - 110]
Ht	=38	[35 - 47%]	BUN	=1.6	[0.8 - 3.9]
MCV	=73	[80 - 100fl]	Creat	=50	[44 - 80]
MCH	=23	[25 - 35pg]	Gluc	=4.4	[4.2 - 6.4]
MHCH	=32	[30 - 37%]	TSH	=0.83	[0.49 – 4.67]
Plt	=242	[150 - 450x10^9/L]	Fre T4	=12.55	[9.14 – 23.81]
Lym	=2.5	[1.0 - 4.0x10^9/L]			

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

1. HTN
2. GERD
3. Parasititis

Treatment:

1. HCTZ 12.5mg 2t po qd for one month (#70)
2. Famotidine 10mg 2t po qhs for one month (#60)
3. Mebedazole 100mg 5t po qhs once (#5)
4. GERD prevention education
5. Eat low Na+ diet, and do regular exercise

6. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Lab Result on Oct 10, 2008

WBC	=4.3	[4 - 11x10^9/L]	Na	=143	[135 - 145]
RBC	=4.5	[3.9 - 5.5x10^{12}/L]	K	=3.5	[3.5 - 5.0]
Hb	=10.9	[12.0 - 15.0g/dL]	Cl	=109	[95 - 110]
Ht	=34	[35 - 47%]	BUN	=2.3	[0.8 - 3.9]
MCV	=77	[80 - 100fl]	Creat	=60	[44 - 80]
MCH	=24	[25 - 35pg]	Gluc	=4.6	[4.2 - 6.4]
MHCH	=32	[30 - 37%]			
Plt	=252	[150 - 450x10^9/L]			
Lym	=1.5	[1.0 - 4.0x10^9/L]			
Mxd	=0.9	[0.1 - 1.0x10^9/L]			
Neut	=1.9	[1.8 - 7.5x10^9/L]			

3. So Im, 55F (Thnout Malou Village)
Diagnosis:

1. Hyperpigmented skin lesion
2. Schamberg's pigmentary purpura

Treatment:

1. Hydrocortisone apply bid for one month (#2)
2. Paracetamol 500mg 1t po qid prn pain for one month (#30)

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

1. Nephritis?
2. Nephrotic Syndrome?

Treatment:

1. Prednisolone 5mg 6t po qd for one month (#250)
2. Furosemide 40mg 1/2t po qd for one month (#15)
3. Albendazole 200mg 1/2t po bid for 5d (#5)
4. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Albumin, protein, Tog chole at SHCH

Lab Result on Oct 10, 2008

WBC	=10.8	[4 - 11x10^9/L]	Na	=134	[135 - 145]
RBC	=6.0	[4.6 - 6.0x10^{12}/L]	K	=3.1	[3.5 - 5.0]
Hb	=15.4	[14.0 - 16.0g/dL]	Cl	=94	[95 - 110]
Ht	=48	[42 - 52%]	BUN	=3.7	[0.8 - 3.9]
MCV	=81	[80 - 100fl]	Creat	=55	[53 - 97]
MCH	=26	[25 - 35pg]	Gluc	=4.3	[4.2 - 6.4]
MHCH	=32	[30 - 37%]	T. Chol	=17.8	[<5.7]
Plt	=452	[150 - 450x10^9/L]	Prote	=41	[66 - 87]
Lym	=2.0	[1.0 - 4.0x10^9/L]	Albu	=18	[38 - 54]

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

1. Severe HTN
2. Left side stroke with right side weakness
3. Dyspepsia
4. Parasititis

Treatment:

1. Captopril 25mg 1/2t po bid for one month (#35)
2. ASA 300mg 1t po qd for one month (#30)
3. Mg/AL(OH)3 250/125mg 2t chew bid prn for one month (#30)
4. Mebendazole 100mg 5t po qd once (#5)

5. MTV 1t po qd for one month (#30)
6. Regular exercise on weak side
7. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Tot Chole, TG at SHCH

Lab Result on Oct 10, 2008

WBC	=6.7	[4 - 11x10^9/L]	Na	=138	[135 - 145]
RBC	=6.8	[4.6 - 6.0x10^{12}/L]	K	=4.6	[3.5 - 5.0]
Hb	=12.0	[14.0 - 16.0g/dL]	Cl	=107	[95 - 110]
Ht	=40	[42 - 52%]	BUN	=2.1	[0.8 - 3.9]
MCV	=59	[80 - 100fl]	Creat	=103	[53 - 97]
MCH	=18	[25 - 35pg]	Gluc	=6.2	[4.2 - 6.4]
MHCH	=30	[30 - 37%]	T. Chol	=3.7	[<5.7]
Plt	=217	[150 - 450x10^9/L]	TG	=1.1	[<1.71]
Lym	=1.4	[1.0 - 4.0x10^9/L]			

6. Sin Sokunthearak, 7F (Thnout Malou Village)
Diagnosis:
1. Subcutanous Cyst?
2. Thyroid Cyst?

Treatment:
1. Refer to pediatric hospital in Siem Reap

7. Sok Tith, 71M (Boeung Village)
Diagnosis:
1. Brachial Plexus nerve compression by tumor
2. Pneumonia
3. PTB?

Treatment:
1. Clarithromycin 500mg 1t po bid for 10d (#20)
2. Paracetamol 500mg 1-2t po qid prn pain for one month (#30)
3. Do AFB smear in local HC
4. Send to Kg Thom for x-ray of Right should joint and neck mass U/S

8. 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 (#150)
2. Captopril 1t po tid for one month (#120)
3. ASA 300mg 1/2t po qd for one month (#20)
4. Amitriptylin 25mg 1/2t po qhs for one month (#20)
5. Educate on diabetic diet, do regular exercise and foot care
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc, HbA1C at SHCH

Lab Result on Oct 10, 2008

WBC	=7.7	[4 - 11x10^9/L]	Na	=139	[135 - 145]
RBC	=4.6	[3.9 - 5.5x10^{12}/L]	K	=5.0	[3.5 - 5.0]
Hb	=11.6	[12.0 - 15.0g/dL]	Cl	=107	[95 - 110]
Ht	=34	[35 - 47%]	BUN	=5.1	[0.8 - 3.9]
MCV	=77	[80 - 100fl]	Creat	=111	[44 - 80]
MCH	=26	[25 - 35pg]	Gluc	=15.2	[4.2 - 6.4]
MHCH	=34	[30 - 37%]	T. Chol	=6.0	[<5.7]

Plt	=166	[150 - 450x10^9/L]	TG	=3.6	[<1.71]
Lym	=3.1	[1.0 - 4.0x10^9/L]	HbA1C	=14.1	[4 - 6]

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

1. Stroke (CN VII, IX, X defect)

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 1t po qd for one month (#30)
4. Do the physiotherapy on the weakness side

10. Sek Ok, 65M (Bosan Thouk Village)
Diagnosis:

1. Nephritis?
2. Nephrotic Syndrome?
3. Renal failure?

Treatment:

1. Furosemide 40mg 1/2t po qd for 7d (#4)
2. MTV 1t po qd for one month (#30)
3. Albendazole 200mg 1t po bid for 5d (#10)
4. HCTZ 12.5 mg 2t po qd for one month (#70)
5. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Albumin, protein, Tot chole at SHCH

Lab Result on Oct 10, 2008

WBC	=7.5	[4 - 11x10^9/L]	Na	=138	[135 - 145]
RBC	=4.6	[4.6 - 6.0x10^{12}/L]	K	=5.7	[3.5 - 5.0]
Hb	=12.6	[14.0 - 16.0g/dL]	Cl	=115	[95 - 110]
Ht	=39	[42 - 52%]	BUN	=2.8	[0.8 - 3.9]
MCV	=85	[80 - 100fl]	Creat	=114	[53 - 97]
MCH	=27	[25 - 35pg]	Gluc	=6.9	[4.2 - 6.4]
MHCH	=32	[30 - 37%]	T. Chol	=5.0	[<5.7]
Plt	=295	[150 - 450x10^9/L]	Prote	=52	[66 - 87]
Lym	=2.4	[1.0 - 4.0x10^9/L]	Albu	=21	[38 - 54]
			SGOT	=118	[<37]
			SGPT	=96	[<42]

11. So Sary, 65F (Koh Pon Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 12.5mg 2t po qd for one month (#70)
2. Eat low Na+ deit and do regular exercise
3. Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH

Lab Result on Oct 10, 2008

WBC	=4.5	[4 - 11x10^9/L]	Na	=142	[135 - 145]
RBC	=3.5	[3.9 - 5.5x10^{12}/L]	K	=3.7	[3.5 - 5.0]
Hb	=9.7	[12.0 - 15.0g/dL]	Cl	=106	[95 - 110]
Ht	=31	[35 - 47%]	BUN	=3.6	[0.8 - 3.9]
MCV	=89	[80 - 100fl]	Creat	=118	[44 - 80]
MCH	=31	[25 - 35pg]	Gluc	=5.2	[4.2 - 6.4]
MHCH	=31	[30 - 37%]			
Plt	=218	[150 - 450x10^9/L]			
Lym	=1.6	[1.0 - 4.0x10^9/L]			

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

1. Alcoholic cirrhosis?
2. Iron dificiency
3. Parasititis
4. Splenomegaly

Treatment:

1. MTV 1t po bid for one month (#60)
2. FeSO4/Folic acid 200/0.25mg 1t po bid for one month (#60)
3. Famotidine 10mg 2t po qhs for one month (#60)
4. Mebendazole 100mg 5t po qhs once (#5)
5. Vit Bcomplex 10cc IV x 3d
6. Draw blood for CBC, Lyte, BUN, Creat, Gluc, Peripheral blood smear, Reticulocyte count at SHCH

Lab Result on Oct 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]			

Patients who come for follow up and refill medication

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

1. HTN

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (# 180)
2. ASA 300mg 1/4t po qd for three months (# 23)

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

1. HTN
2. Arthritis

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (#180)
2. Naproxen 375mg 1t po bid prn severe pain for three months (# 70)
3. Paracetamol 500mg 1t po qid prn pain for three months (# 70)

3. Chan Thoeun, 50F (Sralou Srong Village)
Diagnosis:

1. Mild to moderate Aortic regurgitation
2. Anemia

Treatment:

1. Captopril 25mg 1/4t po bid for two months (# 30tab)
2. ASA 300mg 1/4t po qd for two months (# 15tab)
3. FeSO4/Folate 200/0.25mg 1t po qd for two months (#60tab)
4. MTV 1t po qd for one month (#60tab)

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

1. ASD by 2D echo on August 2008

Treatment:

1. ASA 300mg 1/4t po qd for two months (#15)
2. Atenolol 50mg 1/2t po qd for two months (#30)

5. Chourb Kimsan, 54M (Rovieng Tbong Village)
Diagnosis:

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

Treatment:

1. Atenolol 50mg ½t po bid for three months (# 90)
2. Captopril 25mg 1t po qd for three months (#90)
3. ASA 300mg 1/2t po qd for three months (# 45)

6. Chum Heng, 69F (Damnak Chen Village)
Diagnosis:

1. Arthritis

Treatment:

1. Paracetamol 500mg 1t po qid prn pain (#70)

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

1. GOUT
2. HTN

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (# 180)
2. Naproxen 375 mg 1t po bid for three months (#70)
3. Paracetamol 500mg 1t po qid prn pain for three months (#70)

8. Chhim Bon, 71F (Taing Treuk Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 12.5mg 2t po qd for two months (#120)
2. Eat low Na+ diet and do regular exercise

9. 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. Captopril 25mg 1/4t po qd for one month (#8)
3. MTV 1t po bid for one month (#60)
4. Draw blood for Lyte, Creat, Gluc, Albu, Prote, Tot Chole at SHCH

Lab Result on Oct 10, 2008

Na	=141	[135 - 145]
K	=4.2	[3.5 - 5.0]
Cl	=117	[95 - 110]
Creat	=380	[53 - 97]
Gluc	=5.1	[4.2 - 6.4]
T. Chol	=9.2	[<5.7]
Prot	=63	[66 - 87]
Albu	=36	[38 - 54]

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

1. HTN
2. Gout
3. Hyperlipidemia

Treatment:

1. Captopril 25mg 1/2t po bid for three months (# 90)
2. ASA 300mg 1/4t po qd for three months (# 25)
3. Naproxen 375mg 1t po bid prn severe pain for three months (# 70)
4. Paracetamol 500mg 1t po 1q6h prn pain/fever for three months (# 70)

11. Kaov Soeur, 63F (Sangke Roang Village)
Diagnosis:

1. HTN
2. Arthritis

Treatment:

1. HCTZ 12.5mg 2t po qd for three months (# 180)
2. Paracetamol 500mg 1t po qid prn pain for three months (# 70)

12. Khi Ngorn, 63M (Rovieng Cheung Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 12.5mg 4t po qd for two months (#240)
2. Do regular exercise

13. Khiev Monn, 47M (Trapang Reusey Village)
Diagnosis:

1. Arthritis

Treatment:

1. Paracetamol 500mg 1t po qid prn pain (#50)

14. Leng Hak, 70M (Thnout Malou Village)
Diagnosis:

1. HTN
2. Stroke
3. Muscle Tension
4. CHF??

Treatment:

1. Nifedipine 10mg 1/2t po q8h for two months (# 90)
2. Atenolol 50mg 1t po q12h for two months (# 120)
3. HCTZ 12.5mg 2t po qd for two months (# 120)

4. ASA 300mg 1/4t po qd for two months (# 15)
5. MTV 1t po qd for two months (# 60)
6. Paracetamol 500mg 1t po qid prn for two months (# 60)

15. Meas Thoch, 78F (Ta Tong Village)
Diagnosis:
1. HTN

Treatment:
1. Atenolol 50mg 1/2t po bid (#30)
2. HCTZ 12.5mg 2t po qd (#60)

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

Treatment:
1. Glibenclamide 5mg 2t po bid for one month (# 120)
2. Metformin 500mg 2t po bid for one month (#120)
3. MTV 1t po qd for one month (# 30)
4. FeSO4/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 1t po qd for one month (#30)
2. Metformin 500mg 1t po qhs for one month (#30)
3. Captopril 25mg 1/4t po bid for one month (#15)
4. Draw blood for Gluc and HbA1C at SHCH

Lab result on Oct 10, 2008

Gluc =8.1 [4.2 - 6.4]
HbA1C =11.2 [4 – 6]

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

Treatment:
1. Atenolol 50mg ½ t po qd for two months (# 30)
2. Captopril 25mg ¼ po bid for two months (# 30)
3. ASA 300mg 1/4t po qd for two months (# 10)

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

Treatment:
1. Gliclazide 80mg 1t po bid for two months (buy)
2. Captopril 25mg 1/4t po bid for two months (#35)
3. ASA 300mg 1/4t po qd for two months (#15)
4. Review on diabetic diet, foot care and regular exercise

20. 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 2t po bid for one month (#120)
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)

21. Pin Chhourn, 62F (Thnal Keng Village)
Diagnosis:

1. HTN
2. Anemia

Treatment:

1. Atenolol 50mg 1/2t po bid for two months (#60)
2. MTV 1t po qd for two months (#60)
3. FeSO4 200mg 1t po qd for two months (#60)

22. Ros Im, 53F (Taing Treuk Village)
Diagnosis:

1. Euthyroid goiter
2. Dyspepsia

Treatment:

1. Famotidine 10mg 2t po qhs for one month (#60)

23. Ros Yeth, 55M (Thnout Malou Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 1t po qd for two months (# 60)
2. Captopril 25mg 1/4t po qd for two months (#15)

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

1. Nephrotic Syndrome
2. Anemia

Treatment:

1. Prednisolone 5mg 3t po qd for one month (#90)
2. Captopril 25mg 1/4t po bid for one month (#15)
3. MTV 1t po qd for one month (#30)
4. FeSO4/Folic Acid 200/0.25mg 1t po qd for one month (#30)
5. Draw blood for Lyte, BUN, Creat, Gluc, Albu, Prote, Tot Chole at SHCH

Lab result on October 10, 2008

Na	=140	[135 - 145]
K	=3.4	[3.5 - 5.0]
Cl	=108	[95 - 110]
Creat	=66	[44 - 80]
Gluc	=4.2	[4.2 - 6.4]
T. Chol	=6.1	[<5.7]
Prote	=73	[66 - 87]
Albu	=42	[38 - 54]

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

1. HTN
2. RI
3. Dyspepsia

Treatment:

1. Captopril 25mg 1/2t po bid for two months (# 120tab)
2. Atenolol 50mg 1/2t po bid for two months (# 60tab)

26. Teav Vandy, 63F (Rovieng Cheung Village)
Diagnosis:

1. HTN

Treatment:

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

27. Thon Mai, 78M (Boeung Village)
Diagnosis:

1. DMII

Treatment:

1. Glibenclamide 5mg 1t po bid for two months (# 120)
2. Metformin 500mg 1t po qhs for two months (#60)
3. Captopril 25mg 1/4t po qd for two months (#15)
4. ASA 300mg1/4t po qd for two months (#15)

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

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

Treatment:

1. Spironolactone 50mg 1/2t po bid for two months (# 60)
2. FeSO4/Vit C 500/105mg 1t po qd for two months (# 60)
3. MTV 1t po bid for two months (# 60)

29. Thorng Thun, 63M (Koh Pon Village)
Diagnosis:

1. Left foot wound

Treatment:

1. Naproxen 375mg 1t po bid prn pain (# 30tab)
2. Paracetamol 500mg 1t po qid prn pain (# 30tab)

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

1. DMII

Treatment:

1. Glibenclamide 5mg 1t po qd for one month (# 30tab)
2. Draw blood for Gluc and HbA1C at SHCH

Lab result on Oct 10, 2008

Gluc	=6.3	[4.2 - 6.4]
HbA1C	=6.1	[4 – 6]

31. Un Chhourn, 40M (Taing Treuk Village)
Diagnosis:
1. DMII

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

32. Uy Noang, 55M (Thnout Malou Village)
Diagnosis:
1. DMII

Treatment:
1. Glibenclamide 5mg 1t po bid for two months (#120)

33. Vong Cheng Chan, 52F (Rovieng Cheung)
Diagnosis
1. HTN

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

34. Vong Yan, 72F (Boeung Village)
Diagnosis:
1. HTN

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

35. Yin Hun, 72F (Taing Treuk Village)
Diagnosis:
1. HTN

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

The next Robib TM Clinic will be held on November 03-07, 2008