Robib *Telemedicine* Clinic

Preah Vihear Province

A P R I L 2 0 0 6

Report and photos compiled by Rithy Chau and Somontha Koy, SHCH Telemedicine

On Monday, April 03, 2006, SHCH staff, P.A. Chau Rithy, Nurse Somontha Koy, and Nurse Peng Sovann traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following two days, Tuesday and Wednesday (mornings), April 04&05, 2006, the Robib TM Clinic opened to receive the patients for evaluations. There were 6 new cases and 9 follow-up patients. 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, April 05&06, 2006.

On Thursday, replies from SHCH in Phnom Penh and Partners Telemedicine in Boston were downloaded. Per advice from Boston and SHCH with advice from PA Rithy on site, Nurses Montha and 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 the PA Rithy Chau 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: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Monday, March 27, 2006 12:08 PM
To: Rithy Chau; Rithy Chau; Gary Jacques; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Cornelia Haener
Cc: Bernie Krisher; Laurie & Ed Bachrach; Thero Noun; Seda Seng; Peou Ouk; Kiri
Subject: Robib Telemedicine for April 2006.

Dear all,

I am writing to inform you about Robib Telemedicine for April 2006.

Here is my agenda for trip:
- On Monday (03/April/2006) we will leave phnom Penh to Robib village
- On Tuesday (04/April/2006) clinic will be started at 8 o'clock am for whole morning to receive some new cases and in afternoon we will send pattents' data to Telepartner in Boston and Sihanouk Hospital Center of Hope in Phnom Penh.
- On Wednesday (05/April/2006) we Will do the same process like Tuesday but most of of follow up patients will be seen.
- On Thursday (06/April/2006) we will download all answers from both sides of Telepartner (Boston and SHCH) and also do treatment/management plan for all patients.
- On Friday (07/April/2006) we will return back to Phnom Penh.

I also would like to inform all of you that this is a final trip for me for Robib TM Project. New nurse named Pang Sovann will come to replace me onward for Robib TM Project. Please be aware that this trip P.A. Chua Rithy, Pang Sovann and me will go up to the Robib village together

Thank you very much for your strong cooperation for Robib Telemedicine.

Best regards,
Montha

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 04, 2006 9:06 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Cornelia Haener; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case # 01, Rin Ren,9F (Ta Tong)

Dear all,

we are here for Robib TM April 2006. Today we have five new cases. Here is case number one with pictures.

Best regards
Montha/Sovann (New Robib TM nurse)

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Patient Name (or identifier) and village: Rin Ren, 9F (Ta Tong)

Date: 04/04/06

Chief Complaint (CC): Abscess on the right neck for more than month

History of Present Illness (HPI): 9F, student, for this more than one month she gets small abscess on the right neck with high fever and sever pain, poor appetite. Abscess gets bigger and bigger from day to day and also all symptoms she has are getting worse like increase quality of pain until she could not sleep well and persistent fever. She gets theses symptoms she doesn't use any medication at all just use traditional medication to stick on abscess to release pain, she just comes to see us today

Past Medical History (PMH): unremarkable

Social History: unremarkable

Review of Systems (ROS): no weight lose, no sore throat, no ear discharge, no headache, (+) fever, no cough, no GI complain, no peripheral edema.

Current Medications: none

Allergies: NKA

Physical Exam (PE):

- Look skinny
- V/S BP 90/50 P n120 R 20 T 38C WT: 18kgs
- HEENT: no oropharyngeal lesion, (+)pink color on conjunctiva
- Neck: no lymphnode palpable, but has one abscess on the right side of neck, soft and warm to touch with size about 2x2 cm, (+) pain during palpable
- Lungs: clear both sides
- Heart: RRR, no murmur
- Abdomen: soft, flat, no tender, (+) BS, no HSM
- Extremities: nremarkable

Labs/Studies:

Previously completed: none
Completed today none

Assessment: Right Neck Abscess

Plan: I would like to cover her with some medication as the following

- Cephalexine 250 mg 1t po q8h for 10 days
- Metronidazole 250 mg 1 t po q8h for 7 days
- Diflunisal 500 mg ½ t po q12h prn for pain
- Similac powder 350 mg q12h
- Incision abscess to drain pus out (Procedure will do in Robib TM clinic) with properly clean wound everyday.

Specific Comments/Questions from RN to consultants:

Do you agree with my plan? please give me a good idea.

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

Examined by: Koy Somontha, RN **Date: 04/04/06**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: "Cornelia haener" <Cornelia_Haener@online.com.kh>
To: "'Telemedicine Cambodia'" <robibtelemed@yahoo.com>
Subject: RE: Case # 01, Rin Ren,9F (Ta Tong)
Date: Wed, 5 Apr 2006 07:59:57 +0700

Dear all,
I agree with your plan of incision and drainage. Please get some material for gram stain and culture, also some of the abscess wall for histology. I am wondering if it could be an infection with Nocardia or anthrax. I would add SMP (Bactrim) to your antibiotics in case it is Nocardia.
Thanks
Cornelia

From: Heinzelmann, Paul J.,M.D. [mailto:PHEINZELMANN@PARTNERS.ORG]
Sent: Friday, April 07, 2006 2:46 AM
To: Fiamma, Kathleen M.; robibtelemed@yahoo.com; tmed_rithy@online.com.kh
Subject: RE: Case # 01, Rin Ren,9F (Ta Tong)

If she has ear canal swelling, consider a mastoid abscess, which can be serious and lead to meningitisis or brain abscess if left untreated.

If she doesn't have the option of having this done by a surgeon, then perform the I & D locally.

Avoid doing the incision too far anteriorly, which comes close to vital neck structures.

She will need close follow up however, and formulate a plan if her condition worsens. (i.e IV antibiotics, to SHCH)

Paul Heinzelmann, MD

-----Original Message-----

From: Rithy Chau [mailto:tmed_rithy@online.com.kh]
Sent: Fri 4/7/2006 4:45 AM
To: Heinzelmann, Paul J.,M.D.
Cc: Fiamma, Kathleen M.; robibtelemed@yahoo.com; 'Bernard Krisher'; thero@cambodiadaily.com; 'Laurie & Ed Bachrach'
Subject: RE: Case # 01, Rin Ren,9F (Ta Tong)

Dear Paul,

We just got back from Robib. As for this girl, she truly has abcess without any complication, just neglect to seek care from HC or medical practitioner.
It ruptured before Montha lancing it and during the next 2-3 days of cleaning, the abcess reduce inflammation dramatically and no more pus forming, no fever and of course less pain which meant she could sleep better.

Thanks for the advice. She is being advised to wash wound at local HC every day and she also was looked after by her mom and an expat teacher in Rovieng.

Rithy

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 04, 2006 9:22 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: case #02, Srey Thouk, 56F (Taing Treuk)

Dear all,

This is case number two with picture.

Best regards,
Montha/Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Patient Name (or identifier) and village: Srey Thouk, 56F (Taing Treuk)

Date: 04/04/06

Chief Complaint (CC): Neck tension and headache on and off for to years

History of Present Illness (HPI): 56F, housekeeper, has know for HTN for two year with BP around 160/? with anti HTN use (Unknown name) during BP increase. She gets headache, (+) mild dizziness during stand up quickly, (+) neck tension, (+) blurred vision for some time, these symptoms happens to her on and off and can be better as long as she use Anti HTN. She never goes to consult with any doctor or medical person just come to see us right the way.

Past Medical History (PMH): known HTN for two years

Social History: unremarkable

Review of Systems (ROS): no weight lose, no sore throat, no SOB, no fever, (+) neck tension, (+) headaches, no cough, no chest pain, no GI complain, no frequency of urination, no peripheral edema.

Current Medications: Use HTN drug on and off while BP increase

Allergies: NKA

Physical Exam (PE):
- Look: obesity
- V/S BP 170/80 P 80 R 20 T 36.5C WT: 63 kgs
- HEENT: no oropharyngeal lesion, (+) pink color on conjunctiva
- Neck: no JVD, no lymphnode palpable, no giter glance enlargement
- Lungs: clear both sides
- Heart: RRR without murmur
- Abdomen: soft, flat, no tender, no HSM, (+) BS
- Extremities: no peripheral edema, no deformities

Labs/Studies:

Previously completed: none

Completed today:
- UA (Protein +3, blood +2)
- BS 112 mg/dl

Assessment:

- HTN
- CRF?

Plan: I would like to cover and manage her as the following

- Lisinopril 5 mg 1 t po q12h for one month
- Aspirine 81 mg 1 t po qd for one month
- Do regular exercise for every morning
- fatty and salty food diet
- Chest X Ray will send to Kampong Thom Hospital
- Draw blood for some tests like BUN, Lytes, Creat, Cholesterol and CBC

Specific Comments/Questions from RN to consultants: do you agree with my plan? please give me a good idea.

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

Examined by: Koy Somontha, RN **Date: 04/04/06**
Please send all replies to robibtelemed@yahoo.com and cc: to tmed_rithy@online.com.kh.

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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.
Sent: Wednesday, April 05, 2006 9:58 PM
To: Fiamma, Kathleen M.
Subject: RE: case #02, Srey Thouk, 56F (Taing Treuk)

Please forward this reply.

She has 3 problems.

Hypertension. She needs treatment for this. However, we do not know what her kidney function is like. I would probably start her on a beta blocker medication to treat her hypertension until we know that her kidney function is normal (she would need a blood urea nitrogen(BUN) , creatinine, potassium, bicarbonate (HCO3) and sodium and chloride blood tests
Starting her on lisinopril (an ACE inhibitor) could further compromise her kidney function.

Neck pain: this sounds like mechanical musculoskeletal neck pain and will respond to warm/hot wet towel for 20-30 minutes 3-4 times daily and acetominophen 500mg 4 times daily as needed for pain.

Urine she has protein and blood in her urine. There are many causes of protein and blood in the urine.
she could have a urinary tract infection. She could have her menstrual cycle. She could have secondary effects of uncontrolled hypertension on her kidneys causing proteinuria. She could have primary kidney disease causing her high blood pressure.
I would repeat the urine sample at the next visit to see if there is persistent protein and blood in the urine to see if we need to investigate further.

Good luck

Paul Cusick

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 04, 2006 9:32 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #03, Prom Pri, 52M (Rovieng Chheung)

Dear all,

This is case number three with pictures.

Best regards,
Montha/Sovann

History and Physical

Patient Name (or identifier) and village: Prum Pri, 52M (Rovieng Tbong)

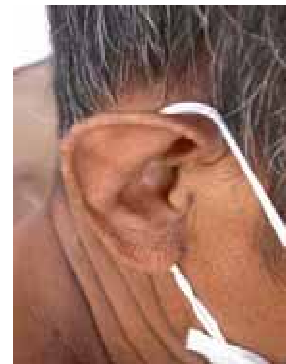
Date: 04/04/06

Chief Complaint (CC): SOB and cough on and off for one month

History of Present Illness (HPI): 52M, farmer, with this one month, presents with SOBeven sitting and lying down, (+) productive cough with mild fever, (+) pitting edema on the both legs but some time cover all on the body and edema gone while he use traditional medicine. He is also accompanies by another symptoms like poor appetite, poor urine out put. These symptoms get worse from day to day without searching any treatment from any doctor or medical person because of money support; he just uses home traditional medication for his edema and just comes to see us today

Past Medical History (PMH): Leprosy in last three years ago with properly treatment.

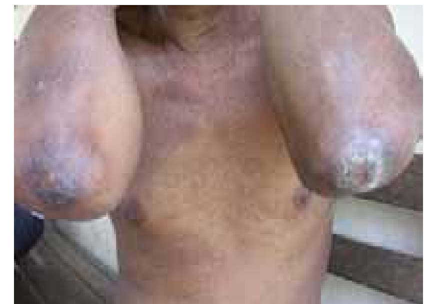
Social History: (+) smoking 4 or 5 cigarette per day and (+) alcohol drinking about 200 ml per day for 15 years but both just stopped for one month



Review of Systems (ROS): (+) weight lose about five kgs, no sore throat, (+) SOB, (+) mild fever, (+) headache, (+) neck tension, (+) palpitation, (+) chest pain on apex area without radiating to somewhere else for some time, (+) cough, (+) GI complain, +2 peripheral edema, (+) less urine out put.

Current Medications: traditional medication for one month for his edema

Allergies: NKA

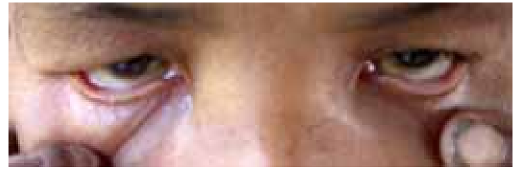


Physical Exam (PE):

- Look: sick
- V/S BP (L) 140/112, (R) 150/120 P 80 R 34 T 38C
  O2 sat 98%RA
- HEENT: no oropharyngeal lesion, (+) pale and mild yellow on conjunctiva, (+) deformity both

ears.

- Neck: (+) JVD, no lymphnode palpable, no bruise, no goiter glance enlargement.
- Lungs: Crackle at left lower lobe, others are clear
- Heart: RRR, (+) murmur at apex
- Abdomen: soft, flat, no tender, (+) BS, no HSM, no pain during palpable
- Extremities: (+) mild yellow skin, +2 pitting edema on both legs but (+) dorsal pulses, (+) deformity all finger on right hand, (+) dry ulcer on left elbow.

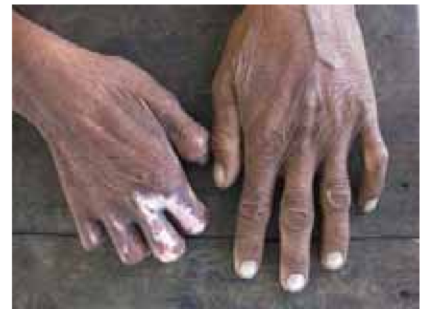


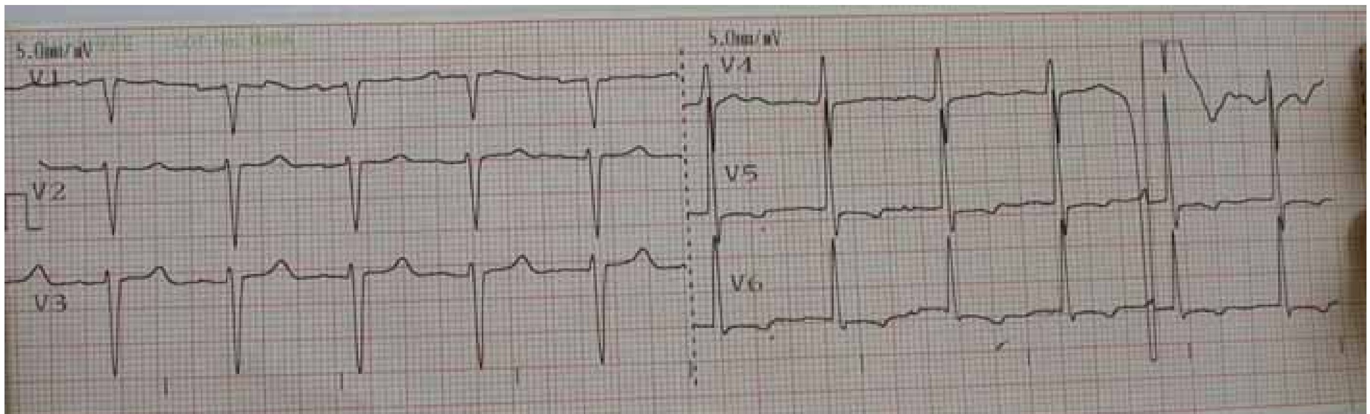
Labs/Studies:

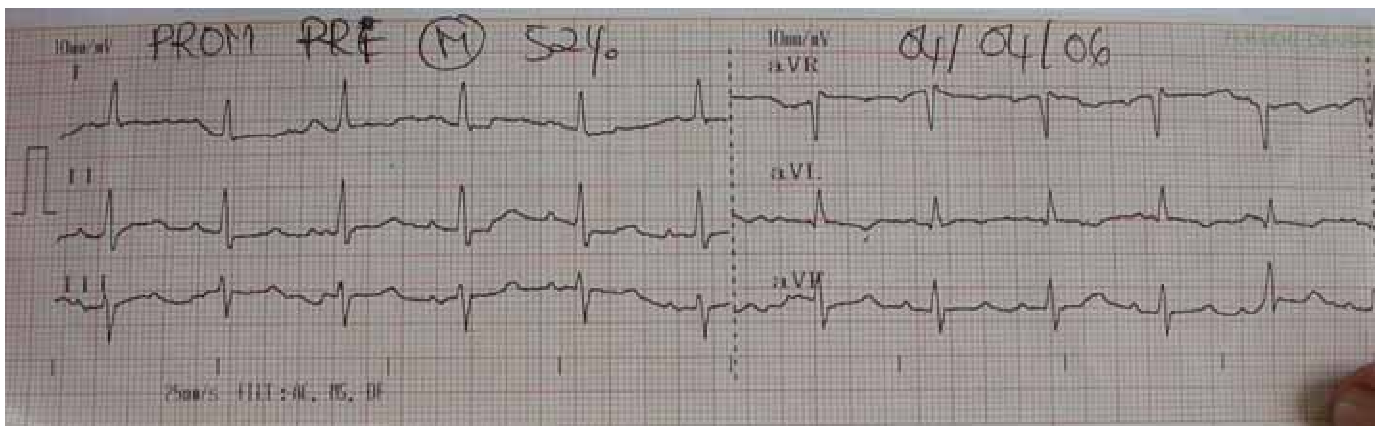
Previously completed: none

Completed today: UA (+3 protein, +1 blood hemolysis), Hgb 9g/dl,

FBS =146 mg/dl, EKG as we attached file.







Assessment:

- Valvulo Heart Disease (MR?) with CHF
- Pneumonia
- PTB?
- Anemia due to Vit/Iron deficiency/Parasititis?
- right elbow ulceration
- Hepatitis?

Plan:

- Lisinopril 5 mg 1 t po q12h for one month
- Furosemide 40 mg ½ t po q12h for one month
- MTV 1 t po q12h for one month
- Feso4/Folic 200/0.25 mg 1 t po qd for one month
- Augmentin 500 mg 1 t po q12h for 10 days
- Mebendazole 100 mg 1 t po q12h for three days
- Sent to Kampong Thom for CXR
- Draw blood for some tests like Lytes, Creat, BUN, CBC, liver function, Chelesterol, Peripheral blood smear, Retycolocyte.
- AFB check in local health center
- Fatty and salty diet, water restriction less than 1L per day, and also less activity.
- Will be send for heart ultrasound in next visit

Specific Comments/Questions from RN to consultants:

do you agree with my plan? Please give me a good idea.

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

Examined by: Koy Somontha, RN **Date: 04/04/06**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Thursday, April 06, 2006 11:30 AM
To: Kreinsen, Carolyn Hope,M.D.; Fiamma, Kathleen M.
Cc: tmed_rithy@online.com.kh; Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: RE: Case #03, Prom Pri, 52M (Rovieng Chheung)

Dear Dr. Carolyn,

Thank you for your thorough reply. It is nice to see reply with summary of what you read in our case presentation and replied to each problem to assist us in better managing the patient. Please do not hesitate to give us more information on each of the problem presented so as to help our nurse for Ribib TM project to improve his knowledge of medicine in order to care for the patients here better.

Thank you,
Rithy

"Kreinsen, Carolyn Hope,M.D." <CKREINSEN@PARTNERS.ORG> wrote:

Case Summary:

This 52 year old man presents with a one month history of worsening dyspnea on exertion and at rest, cough, palpitations, left anterior chest pain, pitting edema primarily in the lower extremities, weight loss and low grade fever. He has used a traditional medicine with some intermittent relief of the edema. His appetite and urine output have decreased. He has a past medical history of leprosy, treated within the past 3 years. Until one month ago, he was a regular heavy consumer of alcohol and also smoked. He is a farmer by trade.

On examination, he appears ill with scleral icterus and minor jaundice. He is febrile without notable tachycardia but with moderate to advanced hypertension. He is quite tachypneic with good room air pulse oximetry of 98%. There are JVD, left lower auscultated crackles, auscultated (?) mitral valve murmur and bilateral leg pitting edema. Ascites, hepatosplenomegaly and bruising are not noted. There are sequelae of leprosy infection with nodularity of the rims of the ears, missing digits on the right hand and some focal changes in skin coloration. There is a dry ulceration on the left extensor elbow.

Marked proteinuria with minor microscopic hematuria is evident on dipstick. The patient is quite anemic with a hemogobin of 9 g/dl and has an elevated blood sugar of 146mg/dl. 12 lead EKG did not transmit well and interpretatuion is therefore limited. There is a very wavy baseline. Rate is in the 80's and regular. P waves appear to vary but that may be the EKG. there is borderline 1st degree AV block with QRS and QT intervals within normal range. T waves are flattened in leads I and V4 and inverted in leads V5 and V6. There is 1mm ST segment depression in V5, nearly 1 mm in V6. There is poor R wave progression leads V1-V3.

1. Congestive Heart Failure: I agree with your assessment of CHF. His situation is quite complicated. He has many concerning findings, most notably shest pain and shortness of breath with ischemic changes in the lateral and possibly the anterolateral leads on EKG . It is uncertain whether his murmur is old or new. It could represent papillary muscle dysfunction with ischemia. This patient has been a long-term smoker and may well have elevated lipids, especially in the context of probable nephrotic syndrome. He has worrisome hypertension of unknown duration. He appears to be diabetic, duration of that unknown, as well. He has multiple cardiac risk factors, ischemic changes on EKG and evidence of debilitating CHF. He has a history of long-term alcohol usage, possibly affecting heart muscle function. He is quite anemic, placing further strain on his heart. If possible, he should be treated in an acute hospital setting at this time since potential for myocardial infarction and other complications is high. He really requires the echocardiogram, cardiac monitoring and further testing as soon as possible. There is a possibility of subacute bacterial endocarditis (SBE) with the open ulceration on the elbow, fevers and his other symptoms. other symptomatology. He is more prone to infection, given probable nephrotic syndrome. he should have blood cultures drawn. The lisinopril is an excellent idea for several reasons. It will help with the CHF, improve cardiac function, reduce his blood pressure and protect his kidneys in the context of diabetes and nephrotic syndrome. It would be optimal for that to be started in hospital so that his renal function and potassium levels can be watched, allowing for the dosage to be increased more quickly than as an outpatient. He will definitely require diuresis and the furosemide is a good choice. Again, he may show some resistance to the furosemide and require higher dosages. Other medications, possibly beta blockers or long acting nitrates, would complement the lisinopril and furosemide.

2. Nephrotic Syndrome: This patient has proteinuria, peripheral edema and hypertension. The labs you ordered will provide a good foundation from which to proceed. Again, the lisinopril and furosemide are both excellent choices for treating this. The initial labs you suggested will allow for calculation of his glomerular filtration rate(GFR) to assess his kidney function. It would be helpful to check blood tests for Hepatitis B and C (especially given his jaundice) and also syphilis to start looking at possible underlying causes. I would suggest a urinalysis with sediment and a differential with the blood count, if possible. Most likely, albumin is part of the LFT panel. If not, I would recommend obtaining that. Thyroid testing is advisable. Hypertension, diabetes and heavy alcohol use could certainly contribute to nephrotic syndrome. Further testing for possible autoimmune causes and also malignancies (especially with his weight loss) might be necessary. Renal ultrasound would be a helpful first imaging study to evaluate the kidneys. The sodium restricted diet is very important - 2 to 3 Gm per day. It's unclear whether some of his meds taken for leprosy may have impaired his renal function at a subclinical level....

3. Anemia: This is most likely multifactorial. The CBC, reticulocyte count and blood smear should provide a good initial assessment. I'd recommend a rectal exam to check for blood. This patient is a farmer and at risk for helminthic infection, possible schistosomiasis and malaria (jaundice and fever). I would expect to see elevated eosinophils on his white blood cell count differential if the source is parasitic or helminthic infection. The

mebendazole should address the first. He has heart disease and kidney disease; it's unclear how much of the anemia is due to chronic disease. The chest x-ray should help to rule out lung cancer in addition to pneumonia/infection. the iron, folic acid and multivitamin will be very helpful.

4. Fever: Again, a number of different problems may underlie this, including pneumonia, SBE, parasitic or other infection, or malignancy. Your initial lab tests and the chest x-ray should help give some indication of the source. The Augmentin is a good drug for community acquired pneumonia. If the GFR is low, the dosage of Augmentin might require lowering. I think the 500 mg dosage should be fine.

5. Diabetes: This may be an underlying reason for the slow healing of the elbow ulceration and could certainly make this patient more prone to all of the above disorders. If possible, I would recommend a hemoglobin A1C to assess his average blood sugar status over 3 months.

I hope this is not too lengthy and is helpful!

Take care,

Carolyn K

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 04, 2006 9:50 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #04, Tem Sophea, 18M (Trapaing Reusey)

Dear all,

This is case number four with pictures.

Best regards,
Montha/Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

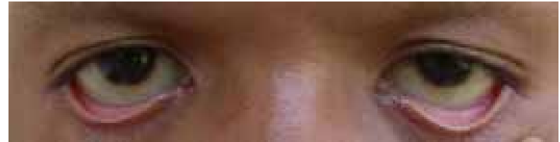
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: Tem Sophea, 18M (Trapang Reausey)

Chief Complaint (CC): diarrhea with mucus on and off for 3 months

History of Present Illness (HPI): 18 M, monk has diarrhea with mucus on and off about 3 months with symptoms of abdominal pain, N/V, headache, fever, chill, myalgia; loose stool with mucus, no blood; he went to local health center and checked for malaria test and it was negative; but he took the malaria drug (artesunate with mefloquine for 3d) anyway. He still experienced fever/chill every other day around 11AM with HA and sometimes N/V/D. No cardiopulmonary c/o. +weight loss?, decreased appetite, malaise, dizziness (esp during fever). No dysuria.



Past Medical History (PMH): none

Current Medication: Malarin (Artesunate+Mefloquine)

Allergies: NKDA

Social History: no alcohol, smoking on and off; being a monk, he ate only breakfast and lunch, no dinner

Review of Systems (ROS): unremarkable

PE:

Vitals sign: BP=98/60 P=86 R=20 T=36.5
General: stable
HEENT: no oropharyngeal lesion, no sore throat, mild pale conjunctiva
Neck: no mass, no lymph node palpable
Lungs: CTA bilaterally, no rale, no rhonchi
Heart: RRR, no murmur
Abdomen: soft, flat, no tender, (+) bowel sound, no HSM, neg colocheck
Back: unremarkable
Skin: no jaundice
Extremities: no edema
Neuro: unremarkable
Psych:NA

Assessment:

1. Dysentery
2. Parasititis

3. Malaria? (vivax)
4. Anemia due to (2) and (3) or low nutrition

Plan:

1. Metronidazole 250 mg 2tab PO TID x 14days
2. Mebendazole 100 mg chew 1tab PO BID x 3days
3. Metochlopramide 10 mg 1tab PO BID x 15days
4. Chloroquine 250 mg 2tab PO qd x 2days then 1tab PO qd x 1day
5. Paracetamol 500 mg 1tab PO q6 PRN (headache, fever)
6. MTV 1tab PO BID x 1 month
7. FeSO4/Folic acide 250/0.25 mg 1tab PO bid x 1month
8. Check CBC at SHCH

Lab/Study Requests: CBC
Done today: Hb=10g/dL, gluc=109mg/dL

Labs now available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, Pregnancy Test, AFB sputum smears, malaria smear

Specific Comments/Questions for Consultants:

Examined by: Nurse Peng Sovann/PA Chau Rithy **Date: 04/04/06**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: Crocker, J.Benjamin,M.D.
Sent: Tuesday, April 04, 2006 8:32 PM
To: Fiamma, Kathleen M.
Subject: RE: Case #04, Tem Sophea, 18M (Trapaing Reusey)

Where is his abdominal pain when he experiences it? The differential diagnosis in this case includes infectious and inflammatory causes of diarrhea. The mucousy stools make me think more of a colonic (large bowel) infection. Bacterial (typhoid, cholera, coliform infection) and parasitic (amebiasis, giardiasis, helminthiasis) causes would need to be considered. I would also even consider tubercular (TB) regional enteritis. A stool specimen for culture, ova and parasite examination and leukocytes would be helpful. A Mantoux (PPD) test and blood cultures would also be helpful. Inflammatory colitis would also need to be considered, but is generally a diagnosis made by colonoscopy or sigmoidoscopy and biopsy. This does NOT sound typical of malaria with the abdl pain and mucousy stools -- however, repeat blood smears to look for malaria would be indicated. I don't think he needs the metochlopramide so would stop this.

Hope this is helpful.

J. Benjamin Crocker, MD

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 04, 2006 10:03 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #05, Ros Yoeu, 29M (Taing Treuk)

Dear all,

This is case number five with pictures. Please waiting for more follow up or new cases which will be sent from Robib TM tomorrow.

Thank you very much for your support in this project.

Best regards,
Montha/Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

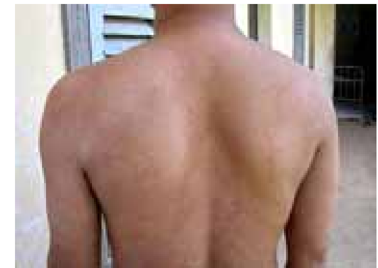
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Ros Yoeun, 29 M (Taing Treuk)**

Chief Complaint (CC): Epigastric pain 2 months

History of Present Illness (HPI): 29 M, come with symptom of epigastric pain burning before eating and better after eating no radiation, headache, dizziness, ear ringing, increased burping for about 2 months. Pt felt nausea, no vomiting in the morning and he went to the local HC and received tx with B-1 vit and another unknown med. But sx still persisted, so he came to us for check up. BM normal without blood or mucus; no dysuria.



Past Medical History (PMH): dyspepsia two years ago, tx and recovered, malaria in remote past

Current Medications: Vit B1 1tab PO q8h x 3 d and herbal skin applicant solution for ringworms

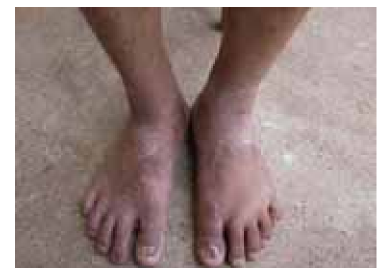
Allergies: NKDA

Social History: Drink alcohol on and off casually; smoking 1-2 cig/day for 8 years and stopped about 10 years until now

Review of Systems (ROS): rashes on body

PE:

Vitals: BP=130/90 P=84 R=20 T=37°c weight= 70kg



General: Stable
HEENT: no orolaryngeal lesion, pink conjunctiva
Neck: no lymph node palpable, no mass
Lungs: CTA bilateral no rale, no rhonchi
Heart: RRR, no murmur
Abdomen: soft, flat, no tender, (+) BS, no HSM
Skin/Extremity: rashes on all the body sparing face and scalp, palms and soles, (+) maculo-papular, lesion 0-1mm diameter, scaly border with central clearing, pitting nail all finger of right hand and all toes of both feet
Neuro: unremarkable
Psych: NA

Assessment:

5. Dyspepsia
6. Parasititis
7. Tinea (corporis & cruris)
8. Onychomycosis

Plan:

1. Famotidine 40 mg 1tab PO qhs x 1 month
2. Mebendazole 100 mg chew 1tab q12h x 3days
3. Griseofulvin 500 mg 1tab PO q12 x 1 month
4. Check CBC, LFT at SHCH
5. Patient can continue to use herbal solution for external application for ringworms

Lab/Study Requests: CBC, LFT
Done today: Hb=11g/dL, BS=117mg/dL

Labs now available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, Pregnancy Test, AFB sputum smears, malaria smear

Specific Comments/Questions for Consultants:

Examined by: Nurse Peng Sovann/PA Chau Rithy **Date: 04/04/06**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 5:26 PM
To: Smulders-Meyer, Olga,M.D.; Fiamma, Kathleen M.
Cc: Bernie Krisher; Rithy Chau; Thero Noun; Laurie & Ed Bachrach
Subject: RE: Case #05, Ros Yoeu, 29M (Taing Treuk)

"Smulders-Meyer, Olga,M.D." <OSMULDERSMEYE@PARTNERS.ORG> wrote:
29y/o gentleman presented with two specific problems.
1) epigastric pain
Gastritis, GERD, and duodenal ulcer are most common cause of epigastric pain. He has no serious symptoms such as weight loss or bleeding, so we agree with treatment of H2 blocker for 8 weeks and see if these symptoms improve. He could be infected with H. pylori, so if he has recurrent symptoms, he should be treated for 2 weeks with the course of triple antibiotics. He should avoid coffee, alcohol, and smoking.

2) rash
Tinea corporis or psoriasis are suspected. In both cases, nails can be infected. We agree with Griseofulvin 500mg a day for 4 weeks, and the patient should apply miconazole cream topically over the affected area for 1 month twice a day. If there is no improvement, we should consider psoriasis because his nail has pitting and he has a lot of white scaling. We agree with liver function tests screening. We should discontinue herbal solution for ringworms.

Maki Ono, medical student
Olga Smulders-Meyer, MD

-----Original Message-----
From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 6:26 AM
To: Smulders-Meyer, Olga,M.D.; Fiamma, Kathleen M.

Cc: Bernie Krisher; Rithy Chau; Thero Noun; Laurie & Ed Bachrach
Subject: RE: Case #05, Ros Yoeu, 29M (Taing Treuk)

Dear Dr. Ono,

Thank you for your reply for this case. Just to let you know that this patient has used a very common herbal remedy--a type of green leaves in Cambodia--and is working well for him for the skin problem and that is why we are going to ask him to continue using it. To use topical miconazole may be too costly and hard to find around in this area. He worked as a gov't military cadet and does not earn enough money for trying to get the cream from the city.

Again thank you for your care for the people of Cambodia.

Best Regards,
Rithy

From: Smulders-Meyer, Olga,M.D. [mailto:OSMULDERSMEYE@PARTNERS.ORG]
Sent: Thursday, April 06, 2006 3:06 AM
To: Telemedicine Cambodia
Subject: RE: Case #05, Ros Yoeu, 29M (Taing Treuk)

I showed the pictures to one of the senior dermatologist;

This is wheat he had to say:

Possibly Tinea versicolor, but probably not tinea corporis. Other possibilities would be nummular eczema or even a subtle case of psoriasis.

Joseph C. Kvedar, M.D.

Director, Partners Telemedicine

Vice Chair, Dermatology, Harvard Medical School

Two Longfellow Place, Suite 216

Boston, MA 02114

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 8:49 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #06, Chhin Chheut, 12M (Trapang Reusey)

Dear all,

Today is the second day for Robib TM. we alos have 9 follow up cases and one new cases. We will send all of you one by one. This case number 06 with pictures continuous number from yesterday.

Best regards,
Montha

Robib Telemedicine Clinic

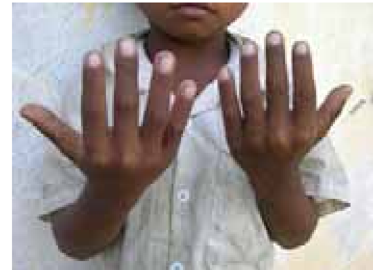
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note (Follow-Up)

Patient Name & Village: Chhin Chheut, 12M (Trapang Reusey)

Subjective: 12M, returns for his follow up of Valvular Heart disease (MR?), Anemia due to Vit/Iron deficiency and Mulnutrition. He feels much better with his previous symptoms like decreasing SOB, decrease palpitation, no fever, no cough, no chest pain, no GI complain and no peripheral edema. But he has frequency of urination with very hungry.

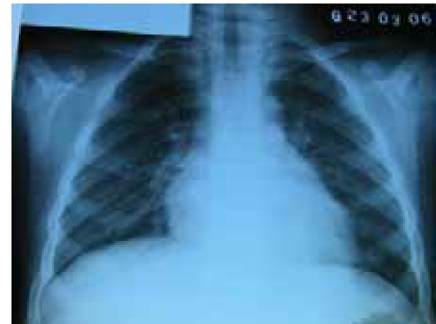


Objective:

Current Medications:

- MTV 1 t po qd
- Ferso4/Folic Acide 200/0.25mg 1 t po qd

Allergies: NKA



VS: BP 100/60 P 94 R 20 T 37C Wt 28 kgs O2sat 97% RA

PE (focused):

- Look stable
- HEENT: no oropharyngeal lesion, but still has mild pale on conjunctiva
- Neck: NO JVD, no lymphnode palpable
- Lungs: Clear both sides
- Heart: RRR, (+) systolic murmur
- Abdomen: Soft, flat, no tender, (+) BS, No HSM
- Extremities: no peripheral edema, no cyanosis

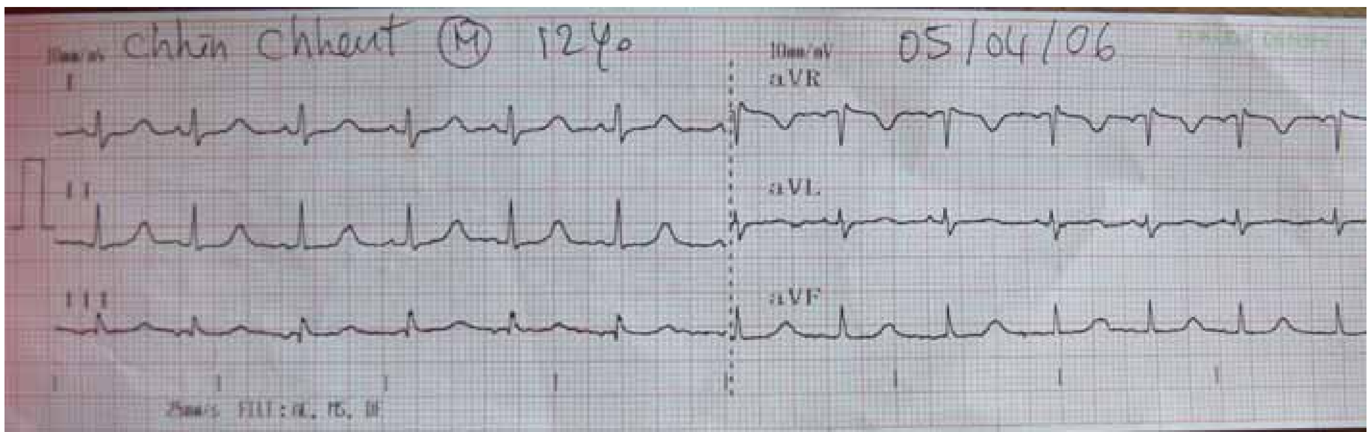
Labs/Studies:

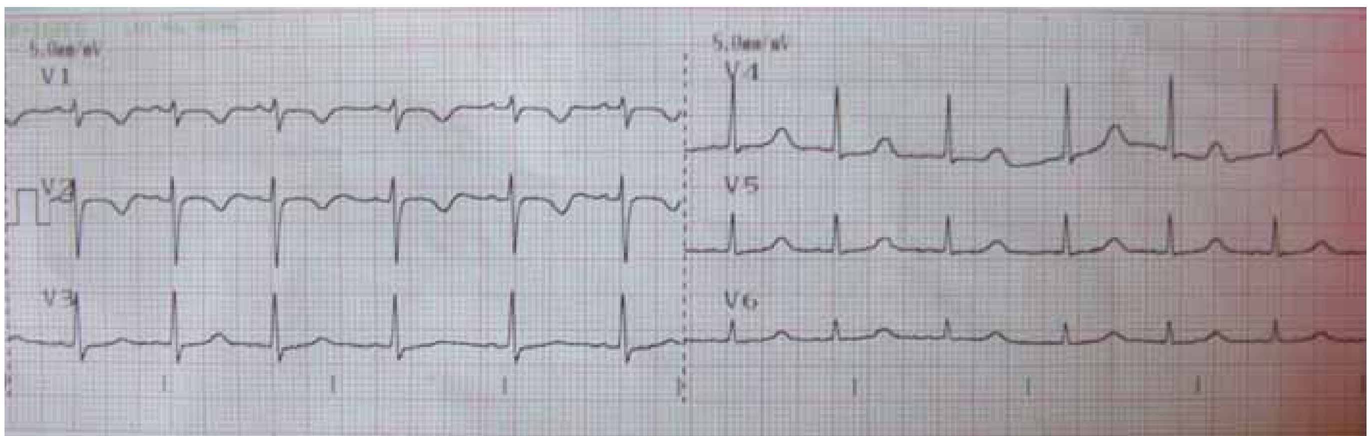
Previously completed: done on 10/03/2006

- Na+ 140	- K+ 4.8	- BUN 6.1	- Creat 440	- Glucose 10.2
- SGOT 88	- SGPT 39	- WBC 12	- RBC 3.1	- Hgb 7.4
- HCT 22	- MCV 75	- MCH 25	- MCHC 34	- Lym 2.6
- Platelet count 490	- Anisocytosis 2+		- Microcytes 2+	- Hypocromic 2+
- Reticulocyte count 1.7				

Completed today:

- EKG as we attached file
- Hgb 10.5 g/dl
- BS 146 mg/dl
- UA (Protein +3, blood +1, Glucose +2)
- CXR as we attached file





Assessment:

9. VHD (MR?)
10. Hypocromic Microcytic Anemia
11. DMI?
12. CRF? Nephritis?
13. Malnutrition

Plan: I would like to cover him with some medications as the following

1. MTV 1 t po qd for one month
2. Feso4/Folic Acide 200/0.25 mg 1 t po qd for one month
3. Start Lisinopril 5 mg ½ t po qd for one month
4. Similac 350g 3 spoons mix with glass of water q12h
5. Can we start prednisolon 5 mg 2 t po q12h for one month?
6. Wait to observe for his DM for next visit
7. Low salt and sweat diet
8. We also want to refer him to Pediatric Hospital for evaluation

Labs or Studies: Draw blood for rechecl Glucose, CBC, Lytes, Creat, BUN, Cholesterol, and total Protein.

Specific Comments/Questions for Consultants: do you agree with my plan? please give me a good idea.

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

Examined by: Koy Somontha, RN **Date: 05/04/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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.

No reply received for this patient from Boston.

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 8:58 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #07, Pou Limthang,42 (Thnout Malou)

Dear all,

This is case number 07 with pictures.

Best regards
Montha

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note (Follow-Up)

Patient Name & Village: Pou Lim Thang, 42F (Thnout Malou)

Subjective: 42F, return to us for her follow up of Hypertyroidism and become Euthyroide. She feels much better with her previous symptoms like no headache, no fever, no SOB, no palpitation, no blurred vision, no difficulty to swallow, no tremor, no GI complain, no peripheral edema.

Objective:

Current Medications:

- Methymazole 10 mg ½ t po q12h

Allergies: NKA

VS: BP 110/60 P 84 R 20 T 36.5C Wt 65kgs

PE (focused):

- HEENT: unremarkable
- Neck: No JVD, no lymphnode palpable, goiter gland not increase size 4x4cm, (+) mobile with smooth face,
- Lungs: Clear both sides
- Heart: RRR, no murmur
- Abdomen: normal
- Extremities: no tremor, no peripheral edema

Labs/Studies:

Previously completed: her thyroide function test became normal since last September

Completed today: none

Assessment:

14. Euthyroide

Plan: I would like to keep the same treatment

1. Methymazole 10 mg ½ t po q12h for four months

Labs or Studies: draw blood to re check T4 and THS

Specific Comments/Questions for Consultants: do you agree with my plan? Please give me a good idea.

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

Examined by: Koy Somontha, RN **Date: 05/04/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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.

No reply received for this patient from Boston.

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:06 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #08, Doung Sunly,50M (Taing Treuk)

Dear all,

This is case number 08 with pictures.

Best regards,
Montha

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note (Follow-Up)

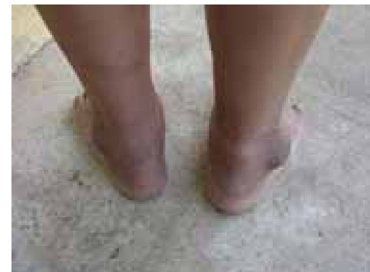
Patient Name & Village: Dourng Sunly, 50M (Taing Treuk)

Subjective: 50M, returns for his follow up of Gout, HTN and Dyspepsia. He feels much better with his previous symptoms like no SOB, no palpitation, no headache, no cough, no fever, no joint pain or swelling, be able to walk properly, no GI complain, no peripheral edema. But still has stabling chest pain without radiating to somewhere else for some times with sweating, pain lasts about 10 mn then will be subsided its own, he could not eat much.

Objective:

Current Medications:

- HCTZ 50 mg ½ t po qd
- Diflunisal 500 mg 1 t po q12h
- Famotidine 40 mg 1 t po q12h

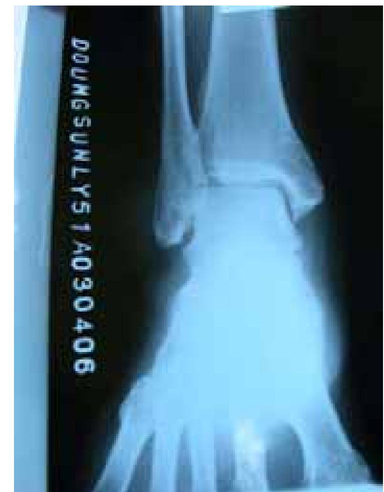


Allergies: NKA

VS: BP 120/60 P 80 R 20 T 36.5C Wt 67kgs

PE (focused):

- HEENT: unremarkable
- Neck: No JVD, no lymphnode palpable
- Lungs: Clear both sides
- Heart: RRR, no murmur
- Abd: Soft, flat, no tender, (+)BS, no HSM
- Extremities: no deformity, no peripheral edema

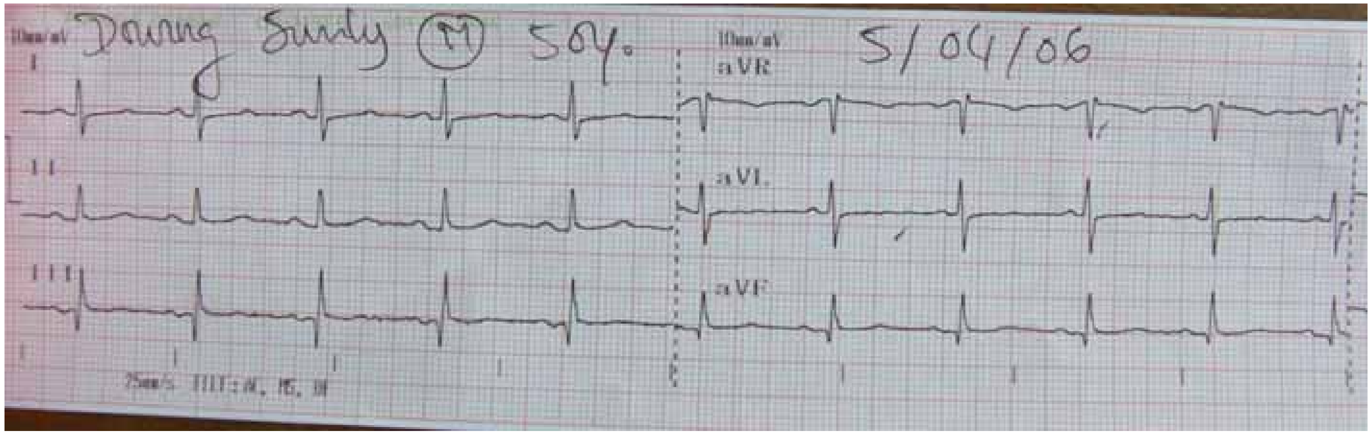


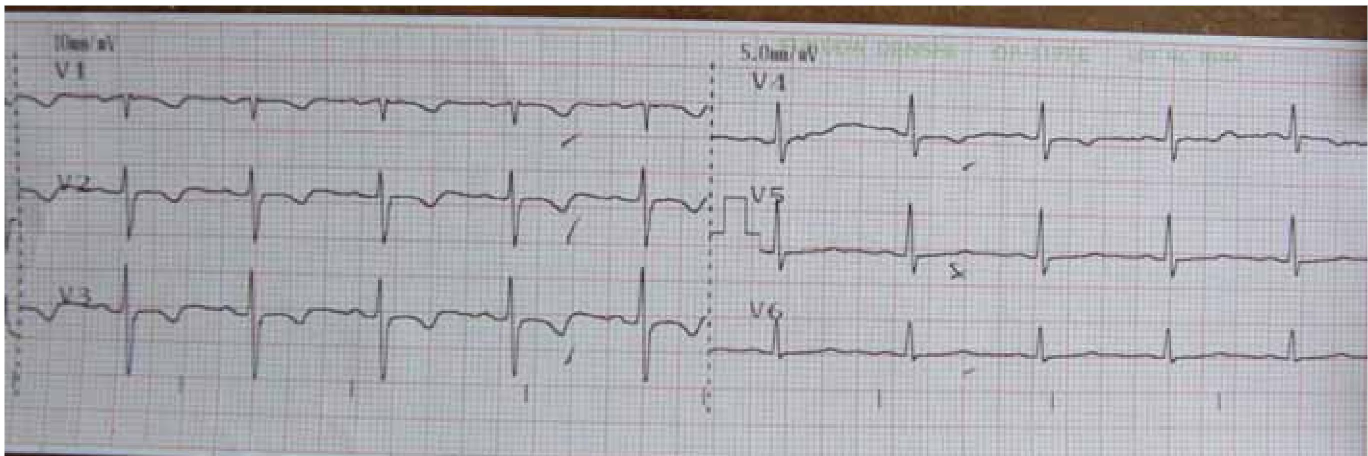
Labs/Studies:

Previously completed: not done last month

Completed today:

- **FBS 147 mg/dl**
- **Right ankle XR will attach**
- **EKG show HR 84/mn PR 0.16 secon QRS 0.04 secon Q wave on lead AVR & lead III T invert on V1, V2, V3, V4 and T flat on lead III and AVL**





Assessment:

15. GOUT
16. HTN
17. IHD (Lateral)
18. Dyspepsia
19. Hyper Glycemia

Plan: I would like to keep the same treatment but suggest to add Propranolol as the following

1. HCTZ 50 mg ½ t po qd for two months
2. Propranolol 40 mg ½ t po qd for two months
3. Diflunisal 500 mg 1 t po q12h prn for join pain
4. Famotidine 40 mg 1 t po q12h fo two months
5. Observe for his Hyperglycemie and manage for next trip
6. Low salt and fat diet and also avoid eating product food

Labs or Studies: re draw blood for Lytes, Creat, BUN, Cholesterol, Glycemie, Total protein

Specific Comments/Questions for Consultants: do you agree with my plan? Please give ma a good idea.

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

Examined by: Koy Somontha, RN **Date: 05/04/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: Coblyn, Jonathan Scott,M.D.
Sent: Wednesday, April 05, 2006 6:37 PM
To: dsands@bidmc.harvard.edu; Fiamma, Kathleen M.
Subject: RE: Case #08, Doung Sunly,50M (Taing Treuk)

I agree with the plans outlined by Dr. Sands.
With continued epigastric distress agree with increase of famotidine to 40mg bid.
If need diuretic would taper to as low as possible--or stop it as mentioned depending on clinical response but it sounded like he may need this medication.
Favor decreasing diflunisal to once daily or even stoppping it and observing the effect on his joint pain, as the combination of this drug and aspirin can be upsetting his stomach and causing the chest discomfort.
Omeprazole is better for gi protection, but famotidine at the higher dose of 40mg bid is also excellent protection.
Would also see him in 1 month, but have him titrate the difunisal to his level of joint pain as I am concerned that the pains in his chest are due to gastritis etc fromasa/combination.

From: dsands@bidmc.harvard.edu [mailto:dsands@bidmc.harvard.edu]
Sent: Wed 4/5/2006 2:58 PM
To: Fiamma, Kathleen M.
Cc: Coblyn, Jonathan Scott,M.D.
Subject: RE: Case #08, Doung Sunly,50M (Taing Treuk)

This patient needs several things:

For his cardiac disease:

1. Aspirin 81mg per day (very important)

2. Stress test

3. Propranolol needs to be given twice a day, or he can be changed to atenolol.

If we assume he has gout, we should:

1. Stop HCTZ

2. Can increase beta blocker (propranolol or atenolol) as needed to control his BP better.

See him back in one month.

- Danny

Daniel Z. Sands, MD, MPH, FACP, FACMI

Assistant Clinical Professor of Medicine, Harvard Medical School
Faculty, Harvard-MIT Division of Health Sciences and Technology
Associate in Medicine, Beth Israel Deaconess Medical Center
Director, American Medical Informatics Association
Advisor, Center for Health Information and Decision Systems, Robert H. Smith School of Business, University of Maryland
Phone: 617-667-1510, 214-370-2267
Mobile: 617-256-4775
dsands@bidmc.harvard.edu

From: Lim kruy [mailto:kruylim@yahoo.com]
Sent: Thursday, April 06, 2006 3:30 PM
To: Telemedicine Cambodia; Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Re: Case #08, Doung Sunly,50M (Taing Treuk)

Dear Montha and Rithy,

I am agree with this plan, i had call to montha. you need to devise the propranolole in BID , add aspine if you have sublingle it should give some to him.

if Randome blood sugar >180mg , you should start Glibenclamide 2.5mg QD.

as it new for me, i will help you intermittenly.

Best Regards

Kruy

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:13 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #09, Sim Sophea 29F (Ta Tong)

Dear all,

This is case number 09 with pictures.

Best regards,
Montha

Robib Telemedicine Clinic

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

SOAP Note (Follow-Up)

Patient Name & Village: Sim Sophea, 29F (Ta Tong)

Subjective: 29F, returns for her follow up of Thyroide problem from last visit. She still has headache, upper back pain, (+) some time palpitation. But no SOB, no cough, no tremor, no diarrhea, no GI complain, no peripheral edema, (+) regular periode.

Objective:

Current Medications: none

Allergies: NKA

VS: BP 120/60 P 84 R 20 T 36.5C Wt 54kgs

PE (focused):

- HEENT: unremarkable
- Neck: no JVD, but thyroide gland enlargement with size 4x3 cm, smooth surface and (+) moving
- Lungs: Clear both sides
- Heat: RRR, no murmur
- Abdomen: Unremarkable
- Extremities: no tremor, no peripheral edema

Labs/Studies:

Previously completed: done on 10/03/2006

- T4 < 0.4 pml/L
- TSH 64.91 micro IU/ml

Completed today: none

Assessment:

20. Hypothyroidism

Plan: we would like to re check her thyroide function test again before starting to give L-thyroxine or do you want us to start her in this trip?

1.

Labs or Studies: T4 and TSH

Specific Comments/Questions for Consultants: do you agree with my plan? please give ma a good idea.

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

Examined by: Koy Somontha, RN **Date: 05/04/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: Barbesino, Giuseppe,M.D. [mailto:GBARBESINO@PARTNERS.ORG]
Sent: Thursday, April 06, 2006 1:14 AM
To: Fiamma, Kathleen M.; robibtelemed@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: RE: Case #09, Sim Sophea 29F (Ta Tong)

Interestingly this woman has profound hypothyroidism and goiter typical of Hashimoto's thyroiditis. I would certanly start thyroid hormone treatment with L-thyroxine 50 mcg daily for 2 weeks, then 75 mcg daily, re-test thyroid function tests in 8 weeks and adjust to normal TSH levels as needed.
Thank you.

Giuseppe Barbesino, MD
Thyroid Associates
Massachusetts General Hospital-Harvard Medical School
Wang ACC 730S
55 Fruit St
Boston MA, 02114
FAX 617-726-5905
TEL 617-726-7573

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:20 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #10, So Soksan 23F (Thnal Keng)

Dear all,

This is case number 10 with picture.

Best regards,
Montha

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note (Follow-Up)

Patient Name & Village: So Soksan, 23F (Thnal Keng)

Subjective: 23F, returs for her follow up of Nephrotic Syndrome and Dyspepsia. She feel much better with her previous symptoms like no SOB, no headache, no blurred vision, (+) good appetite, no body edema, good urine out put, No GI complain, but she has moon face.

Objective:

Current Medications:

- Prednisolone 5 mg 5 t po q12h
- Furosemide 40 mg 1 t po q12h
- ASA 81 mg 1 t po qd
- Feso4/Folic 200/0.25 mg 1 t po qd
- Lisinopril 5 mg ¼ t po qd
- Omeprazole 20 mg 1 t po qd

Allergies: NKA

VS: BP 120/60 P 80 R 20 T 36.5C Wt

PE (focused):

- HEENT: no orpharyngeal lesion, no pale on conjunctiva, (+) moon face
- Neck: no JVD, no lymphnode palpable
- Lungs: clear both sides
- Heart: RRR, no murmur
- Abdomen: unremarkable
- Extremities: no peripheral edema

Labs/Studies:

Previously completed: UA (Protein +3)

Completed today: UA (Protein +2. PH 8.5)

Assessment:

21. Nephrotic Syndrome
22. Dyspepsia

Plan: I would like to keep the same treatment for two months but suggest to decrease dose of Prednisolon and Furosemide as the following

- Prednisolone 5 mg 5 t po qd for two months
- Furosemide 40 mg 1/2 t po q12h for two months
- ASA 81 mg 1 t po qd for two months
- Feso4/Folic 200/0.25 mg 1 t po qd for two months

- Lisinopril 5 mg ¼ t po qd for two months
- Omeprazole 20 mg 1 t po qd for two months
- Low salt and fatty diet

Labs or Studies: re draw her blood for Lytes, Creat and BUN

Specific Comments/Questions for Consultants: do you agree with my plan? please give ma good idea.

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

Examined by: Koy Somontha, RN **Date: 05/04/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: Fang, Leslie S.,M.D.
Sent: Wednesday, April 05, 2006 2:14 PM
To: Fiamma, Kathleen M.
Subject: RE: Case #10, So Soksan 23F (Thnal Keng)

Although we do not have 24 hour quantitation, the decrease in proteinuria is reassuring
Agree with gradual decrease in steroids and diuretics
Agree that we should stay on low dose ACEI

Make sure that the patient has only morning prednisolone (not BID)
Would actually decrease steroids in one month to minimize toxicity
The hope is that we would be off of steroids altogether in 3 months

Leslie Fang, MD

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:27 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: case #11, Som Sokhom, 25F (Rovieng Tbong)

Dear all,

This is case number 11 with pictures.

Best regards,
Montha

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Patient Name (or identifier) and village: Som Sokhom, 25F (Rovieng Tbong)

Date: 05/04/2006

Chief Complaint (CC): chest tightness on and off for three years

History of Present Illness (HPI): 25F, farmer, comes to us with presentation of SOB on exertion (Claiming stair about nine to 10 step), chest tightness on and off at night without sweating and radiating to upper back, her chest tightness lasts about 5 or 10 minutes then subside on its own. These symptoms happened on and off without searching for medical care, just come to see us today.

Past Medical History (PMH): unremarkable

Social History: no smoking, no alcohol drinking

Review of Systems (ROS): no weigh lose, no fever, no headache, (+) dizziness, (+) SOB, no cough, no IG complain, no peripheral edema.

Current Medications: none

Allergies: NKA

Physical Exam (PE):

- V/S BP 100/60 P 90 R 20 T 36.5C WT= 44 kgs O2sat 95% RA
- Look: stable
- HEENT: No oropharyngeal lesion, no pale on conjunctiva
- Neck: No JVD, no lymphnode palpable, no goiter gland enlargement
- Lungs: Clear both sides
- Heart: RRR, (+) systolic murmur at apex
- Abdomen: Soft, flat, no HSM, (+) BS
- Skin: No cyanosis, normal to touch
- Extremities: No peripheral edema, no joint pain

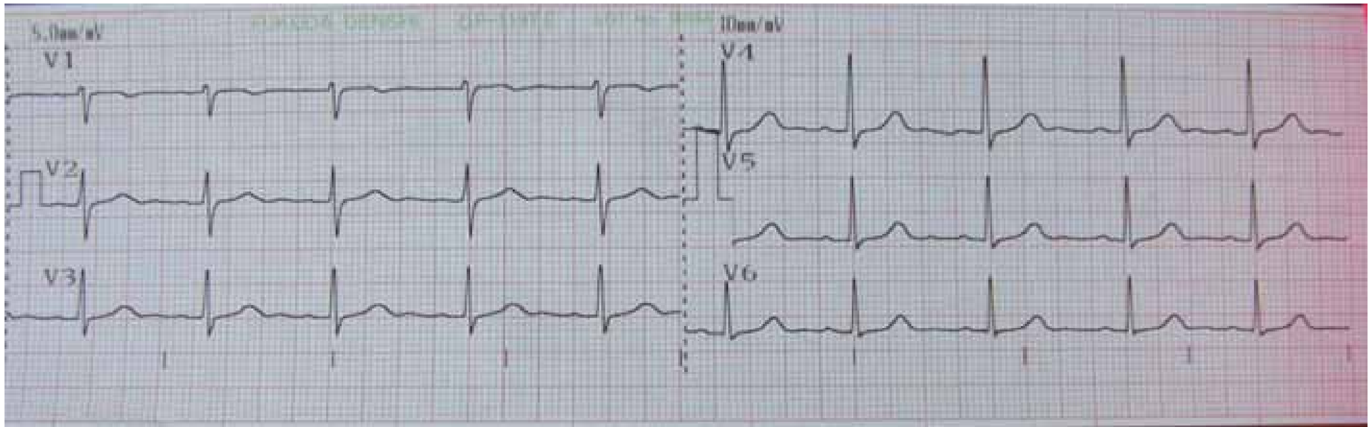
Labs/Studies:

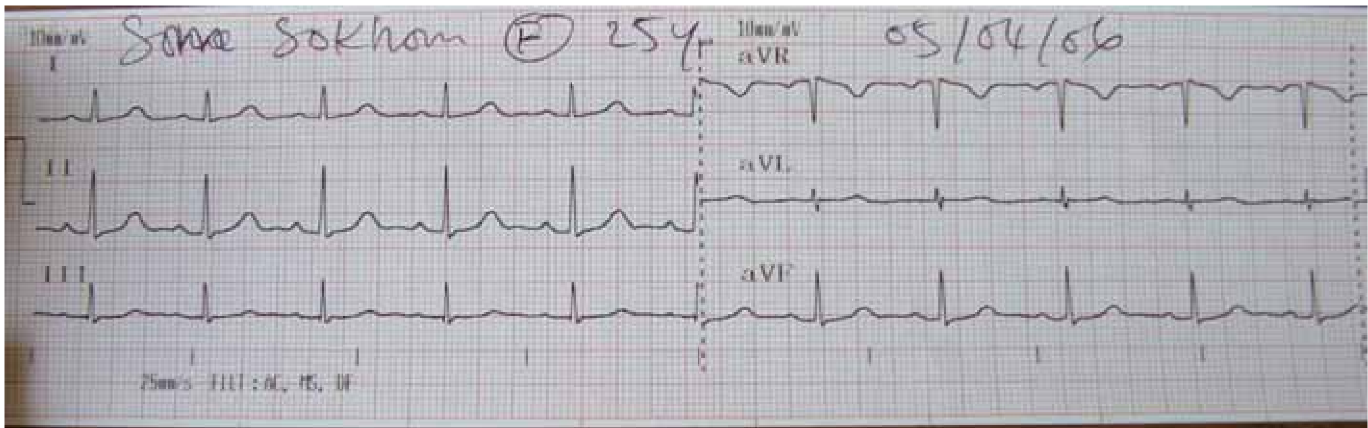
Previously completed: none

Completed today:

- EKG as we attach
- Hgb 11 g /dl

- UA (Normal)





Assessment:

1- Valvulo Heart Disease (MR?/MS?)

Plan: I would like to manage her with plan as the following

1- ASA 81 mg 1 t po qd for one month
2- Lisinopril 5 mg ½ t po qd for one month
3- Low salt diet with less activities
4- Draw blood for some tests like Lytes, BUN, Creat, and Cholestrol
5- Send for CXR at Kg Thom hospital

Specific Comments/Questions from RN to consultants: do you agree with my plan? please give me a good idea.

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

Examined by: Koy Somontha, RN **Date: 05/04/2006**
Please send all replies to robibtelemed@yahoo.com and cc: to tmed_rithy@online.com.kh.

The information transmitted in this e-mail is intended only for the person or entity to which it is addredded and may contain confidential and/or priviledged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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.

No reply received for this patient from Boston.

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:34 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #12, Sath Rim 49F, (Taing Treuk)

Dear all,

This is case number 12 with picture.

Best regards,
Sovann/Montha

Robib Telemedicine Clinic

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

SOAP Note

Patient Name & Village: Sath Rim, 49F (Taing Treuk)

Subjective: 49F, comes for follow up DMII and PNP, DMII, Gastritis. Patient is better than before, denied with previous symptoms of headache, chest pain, palpitation, neck tension, fever, cough, no peripheral edema. Patient still has numbness on the legs, and LUQ like twisting, no radiation, no nausea, no vomiting, good urine output.

Objective:

VS: BP=140/70 P=92 R=20 T=36.7^{0}C Wt=48 kg

PE (focused):

HEENT: no oropharyngeal lesion, no lymph node palpable, no mass
Chest: CTA bilaterally, no rale, no rhonchi; HRRR, no murmur
Abd: soft, no tender, no distension, (+) BS, no HSM
Skin/extremity: pale on concjuntiva, no edema; no foot wounds

Previous Labs/Studies:
Today lab test: Glucose=201mg/dl, U/A= blood trace, protein trace, Hb=10g/dl

Current Medications:
- Meformin 500 mg 1 tab PO qhs
- Glyuride 5 mg 1 tab PO q8h
- Amitriptyline 25 mg 1tab PO qhs
- Lisinopril 25 mg 1tab PO q12h
- Nifedipine 10 mg 1 tab PO q12h
- MgAl(OH)3 250/120mg 2tab PO q8h PRN
- Paracetamol 500mg 1 tab PO q6h PRN

Allergies: NKDA

Assessment:
1. DMII & PNP
2. HTN
3. Anemia?

Plan:
1. Meformin 500 mg 1tab PO qhs
2. Glyburide 5 mg 2tab PO q12h
3. Amitriptyline 25 mg 1/2tab PO qhs
4. Lisinopril 25 mg 1tab PO q12h
5. Nifedipine 10 mg 1 tab PO q12h

6. Paracetamol 500mg PO q6h PRN headache
7. MTV 1tab PO qd
8. FeSO4/Folic Acid 250/0.25mg 1tab PO qd
9. DM & HTN education

Lab/Study Requests:

Specific Comments/Questions for Consultants:

Labs now available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, Pregnancy Test, AFB sputum smears, malaria smear

Examined by: Nurse Peng Sovann/Nurse Koy Somontha **Date: 05/April/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Thursday, April 06, 2006 4:15 AM
To: tmed_rithy@online.com.kh; robibtelemed@yahoo.com; tmed_rithy@bigpond.com.kh
Subject: FW: Case #12, Sath Rim 49F, (Taing Treuk)
Recommendations:

1. Increase metformin to 500mg twice a day

2. Do not start glyburide.

3. Increase lisinopril to 5mg twice a day

4. Send iron, TIBCn folate, and B12 tests

5. Guaiac stool

Follow up in one month.

- Danny

Daniel Z. Sands, MD, MPH
Zix Corporation
BI-Deaconess Medical Center
Harvard Medical School
617-256-4775

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Thursday, April 06, 2006 10:56 AM
To: Fiamma, Kathleen M.
Cc: tmed_rithy@online.com.kh; Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Re: FW: Case #12, Sath Rim 49F, (Taing Treuk)

Dear Dr. Danny,

Thank you for your reply. For this patient,, she has been on glyburide 5mg tid already, do you suggest for us to not increase her dose of glyburide but instead increase metformin 500mg to bid? Guaiac stool neg (Sovann forgot to report this). Too expensive to do the lab tests you suggested, we just treat by clinical suspecion. Again Sovann made a typo mistake with lisonopril, we are already giving Lisinopril 5mg 1 po bid.

Please let us know by tonight if you have any other recommendation for this patient.

Best Regards,
Rithy

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:40 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: case #13, Svay Tevy 41(Thnout Malou)

Dear all,

This is case number 13 with picture.

Best regards,
Sovann/Montha

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note

Patient Name & Village: **Svay Tevy, 41F (Thnout Malou)**

Subjective: 41F, comes for follow up DMII. Patient is much better than before without previous symptoms of chest pain, palpitation, abdominal pain, stool with blood, good urine output. But the patient still complaint of headache, and cough on and off. No ext numbness or edema.

Current medication:

- Glibenclamide 5 mg 1tab PO q12

Allergies: NKDA

Objective:

VS: BP=110/70 P=78 R=20 T=36.5^{O}C Wt=60 Kg

PE (focused):

HEENT: **Unremarkable**
Chest: **CTA bilaterally, no rale, no rhonchi; HRRR, no murmur**
Abdomen: **soft, no tender, no distension, (+) BS, no** HSM
Skin/Extremity: **no foot wound, no edema**
Neuro: **unremarkable**

Lab test:

Done Today: BS=266 mg/dl, U/A= protein (+), glucose 2+

Assessment:

1. DMII

Plan:

1. Glybenglamide 5 mg 1tab PO q12 x 1 month
2. Meformin 500 mg 1tab PO qhs
3. Lisinopril 5 mg ¼ tab PO qd
4. Educate patient to eat low fat and sugar diet, and exercise regularly, drink 2L/d water
5. Draw blood for CBC, Glucose, Creatinine, BUN, Chemistry, tot Cholesterol at SHCH

Lab/Study Requests: CBC, Glucose, Creatinine, BUN, Chemistry, tot Cholesterol

Specific Comments/Questions for Consultants:

Labs now available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, Pregnancy Test, AFB sputum smears, malaria smear

Examined by: Nurse Peng Sovann/NurseKoy Somontha **Date: 05/April/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of or takingsss of any action in reliance upon, this information by persons or 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.
Sent: Wednesday, April 05, 2006 9:45 PM
To: Fiamma, Kathleen M.
Subject: RE: case #13, Svay Tevy 41(Thnout Malou)

Kathy, can you please forward this reply to the appropriate emails as I cannot paste them from home.

I agree that the patient needs tighter control of diabetes. Adding metformin is a good start. You will likely need to increase metformin over time. Adding lisinopril as tolerated by blood pressure is an excellent medication for diabetic proteinuria.

Continue glibenaclamide as you are doing.

Good luck

Paul Cusick MD

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:46 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: case#14, Sao Phal, 57F (Thnout Malou)

Dear all,

This is case number 14 wihth picture.

Best regards,
Sovann/Montha

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note

Patient Name & Village: Sao Phal, 57F (Thnout Malou)

Subjective: 57F, come for follow up HTN, DMII, parasititis. Patient is much better than before with the symptom of no headache, no palpitation, no chest pain, no fever, no cough, no peripheral edema. But patient still has the neck tension and epigastric pain, heartburn, good appetite, no nausea, no vomiting, taking medication regularly. She has domestic issue because her husband was drunk every day. She lost her good shoes because her husband took them and threw them away. She went to provincial hospital to get check up for her abdominal problem and was tx for anxiety with amitryptiline. It helped her some for sleep.

Objective:

VS: BP=120/60 P=90 R=20 T=20^{0}C Wt=36 kg

PE (focused):

Gen: slightly anxious, not diaphoretic
HEENT: unremarkable
Chest: CTA bilaterally, no rale, no rhonchi; HRRR, no murmur
Abd: soft, no tender, no distension, no HSM
Skin/extremity: no edema, no numbness, no tremor

Previous Labs/Studies: Na^+=139, K^+=4.9, BUN=2.0, Creatinine=31, Cholesterol=5.3 mmol/L, Triglyceride=1.13, SGOT/AST=31, SGPT/ALT=22, WBC=8, RBC=3.0, Hb=9.3, Ht=27, MCV=90, MCH=31, MCHC=34, Platet count=192, Lym#count=1.9, Microcyte=2+, Reticulocyte count=0.6

Current Medications:

1. HCTZ 50 mg 1/2tab PO qd
2. FeSO4/Folic Acid 250/120 mg 1tab PO qd
3. Paracetamol 500 mg 1tab PO q6 PRN

Allergies: NKDA

Lab/Study Requests:

Done: FBS 168mg/dL

Assessment:

1. DMII?
2. HTN
3. GERD
4. Anxiety?
5. Tension headache

Plan:

1. HCTZ 50 mg 1/2tab PO qd x 1month
2. Lisinopril 5 mg ¼ tab PO qd x 1 month
3. Omeprazole 25 mg 1tab PO qhs x 1month
4. Amitryptiline 25 mg 1tab PO qhs x1 month
5. Metochlopramid 10 mg 1tab POqhs x1 month
6. Paracetamol 500 mg 1tab PO qid PRN headache
7. FeSO4/Folic Acid 250/120 mg 1tab PO qd
8. MTV 1 po qd

Lab/Study Requests: FBS

Specific Comments/Questions for Consultants:

Labs now available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, Pregnancy Test, AFB sputum smears, malaria smear

Examined by: Nurse Peng Sovann/ Nurse Koy Somontha **Date: 05/April/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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.
Sent: Wednesday, April 05, 2006 10:07 PM
To: Fiamma, Kathleen M.
Subject: RE: case#14, Sao Phal, 57F (Thnout Malou)

She has many problems to be addressed.

She has some symptoms of dyspepsia related to excess stomach acid from stress. She will likely benefit from prilosec and a diet that avoids spicy foods. metoclopramide will help with nausea and stomach emptying.

Her blood pressure is well controlled on the HCTZ and I would not add lisinopril at this time.

She has an elevated glucose. It would be worth checking a fasting glucose (if possible) and to start on a low dose of metformin if it is still elevated.

She has a very difficult home situation with much stress. It is understandable that she has neck tension and upset stomach. Amitryptiline may help with her sleep and anxiety. She should try to use any local resources (family or friends) to help her reason with her husband and try to help him address his behavior and alcohol abuse.

Good luck
Paul Cusick MD

From: Telemedicine Cambodia [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 05, 2006 9:57 PM
To: Rithy Chau; Rithy Chau; Joseph Kvedar; Paul J. M.D. Heinzelmann; Kathy Fiamma; Kruy
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach
Subject: Case #15, Prom Sourn, 64M (Taing Treuk)

Dear all,

This is the last case with pictures. Thank you very much for your support in Robib TM project.

Best regards,
Sovann/Montha

SOAP Note

Patient Name & Village: Prom Sourn 64M (Taing Treuk)

Subjective: 64M, comes for follow up CHF, and Dyspepsia. Patient is much better than before with previous symptom of no abdominal pain, no headache, no chest pain, no palpitation, no SOB, no fever, no peripheral edema, good appetite, good urine output but he still complaint of blurred vision.

Objective:

VS: BP= 120/68 P= 66 R20 T=36 Wt=44 kg

PE (focused):
HEENT: PEERLA and EOMI, pink conjunctiva, handheld card visual acuity test 20/70 bilaterally
Chest: CTA bilaterally, no rale, no rhonchi, HRRR, no murmur
Abd: soft, no tender, no distension, (+) BS, no HSM
Skin/extremity: no edema

Previous Labs/Studies:

Current Medications:

- Lisinopril 25 mg 1/4tab PO q6h
- Mg Al(OH)3 250/120 mg 2tab PO q8h
- HCTZ 50 mg 1/2tab PO qd

Allergies: NKDA

Assessment:

2. CHF
3. Myopia

Plan:

1. Lisinopril 25 mg 1tab PO qd
2. HCTZ 50 mg 1/2tab PO qd
3. Tell patient to see eye Dr. in Phnom Penh for eyeglasses

Lab/Study Requests:

Specific Comments/Questions for Consultants:

Labs now available locally: Hemoglobin, UA, Glucose, Stool Occult Blood, Pregnancy Test, AFB sputum smears, malaria smear

Examined by: Nurse Peng Sovann/Nurse Koy Montha **Date: 05/April/2006**

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

The information transmitted in this e-mail is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of or taking of any action in reliance upon, this information by persons or 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.

No reply received from Boston for this patient.

Thursday, April 6, 2006

Follow-up Report for Robib TM Clinic

There were 6 new and 9 follow-up patients seen during this month Robib TM Clinic (and other patients came for medication refills only). The data of all 15 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.]

Robib TM Treatment Plan for April 2006

I- Rin Ren, 9F (Ta Tong)

a- Diagnosis

1- Right Neck Abscess
2- Malnutrition?

b- Treatment

1- Incision abscess with pus drainage
2- Cephalexin 250 mg 1 t po q8h for two weeks
3- Cotrimoxazole 480 mg 1 t po q12h for two weeks
4- Diflunisal 500 mg 1/2 t po q12h for 10 days
5- MTV 1 t po qd for one month
6- FeSO4/Folate 200/0.25 mg 1t po qd for one month
7- Similac cereal 350g 3 scoops dilute with 190cc of water po q12h for one month.
8- Clean wound every day at local health center

II- Srey Thouk, 56F (Taing Treuk)

a- Diagnosis

1- HTN
2- Renal insufficiency?

b- Treatment

1- Propranolol 40 mg ½ t po q12h for one month
2- ASA 81 chew 1 t po qd for one month
3- Draw blood for Creat, BUN, Lytes, tot Cholesterol, CBC
4- Send for CXR at Kg Thom
5- Low salt, fat diet with regularly exercise

III- Prum Pri, 52M (Rovieng Chheung)

a- Diagnosis

1- CHF (with VHD??)
2- Pneumonia, PTB?
3- Anemia due to Vit/Iron deficiency?
4- Parasititis?
5- Left Elbow Ulcer
6- DMII?

b- Treatment

1- Lisinopril 5 mg 1 t po q12h for month
2- Furosemide 40 mg 1/2 t po q12h for one month
3- MTV 1 t po qd for one month
4- FeSO4/Folic 200/0.25 mg 1 t po q12h for one month
5- Augmentin 250 mg 2 t po q8h for ten days
6- Mebendazole 100 mg 1 t po q12h for three days
7- Similac Cereal 350 g 3 scoops dilute with 190cc of water po q12h for one month.
8- Draw blood for Lytes, BUN, Creat, CBC, Cholesterol, Liver function, Glucose, HBsAg, Anti-HCV, Peripheral blood smear, and Reticulocyte.
9- Check AFB at local Health Center and also will repeat EKG next visit.
10- Send for CXR and abd US at Kg Thom Hospital
11- Low salt, fat and sugar diet

IV- Chhin Chheut, 12M 9Trepang Reusey)

a- Diagnosis

1- NS
2- Hypochromic Microcytic Anemia
3- Renal Insufficiency
4- UTI?
5- Malnutrition

b- Treatment

1- MTV 1 t po qd for one month
2- Feso4/Folic 200/0.25 mg 1 t po qd for one month
3- ASA 300 mg ¼ t po qd for one month
4- Prednisolone 5 mg 4 t po qd for one month
5- Cipro 500mg 1 tab po bid x 10d
6- Draw blood for Lytes, Creat, BUN, Albumin, tot Protein, tot Cholesterol, Liver function, and Glucose.
7- Low salt diet

V- Pou Limthang, 42F (Thnout Malou)

a- Diagnosis

1- Euthyroid

b- Treatment

1- Methimazole 10 mg ½ t po q12h for four months
2- Paracetamol 500 mg 1 t po q6h for prn
3- Draw blood for T4 and TSH which will be sent to SHCH

VI- Dourng Sunly, 50M (Taing Treuk)

a- Diagnosis

1- Gout?

2- HTN
3- Lateral IHD??
4- Dyspepsia
5- DMII??

b- Treatment
1- HCTZ 50 mg ½ t po qd for one month
2- Propranolol 40 mg ½ t po q12h for one month
3- ASA 81 mg 1 t po qd for one month
4- Diflunisal 500 mg 1 t po q12h for one month
5- Famotidine 40 mg 1 t po q12h for one month
6- Draw blood for tot Cholesterol, BUN, Creat, lytes, Glucose
7- Low salt, fat and sugar diet.

VII- Sim Sophea, 29F (Ta Tong)

a- Diagnosis
1- Hypothyroidism
2- Tension Headache

b- Treatment
1- L-Thyroxine 50 mcg ½ t po qd for two months
2- Paracetamol 500 mg 1 t po q6h for prn of headache
3- Check thyroid panel in two months

VIII- So Soksan, 23F (Thnal Keng)

a- Diagnosis
1- Nephrotic Syndrome
2- Dyspepsia (Improving)
3- Anemia due to Iron deficiency?
4- Hypokalemia

b- Treatment
1- Predisolone 5 mg 5 t po qd for one month
2- Furosemide 40 mg 1 t po qd for one month
3- Feso4/Folic 200/0.25 mg 1 t po qhs for one month
4- ASA 81 mg 1 t po qd for one month
5- Lisinopril 5 mg 1/4 t po qd for one month
6- Omeprazole 20 mg 1 t po qhs for one month
7- Low salt and fat diet, eat 2 ripe banana qd
8- Draw blood for re check Lytes, Creat, BUN which will be sent to SHCH.

IX- Som Sokhom, 25F (Rovieng Tbong)

a- Diagnosis
1- t/c VHD (MR?)??
2- Thyroid Dysfunction?

b- Treatment
1- ASA 81 t po qd for one month
2- Send CXR at Kg Thom
3- Draw blood for Lytes, BUN, Creat, Cholesterol, CBC, THS and T4 which will be sent to SHCH

X- Svay Tevy, 41F (Thnout Malou)

a- Diagnosis
1- DMII

b- Treatment
1- Glybenclamide 5 mg 1 t po q12h for one month
2- Meformin 500 mg 1 t po qhs for one month
3- Draw blood for CBC, Glucose, BUN, Creat, Lytes, and Cholesterol which will be sent to SHCH.

XI- Sath Rim, 48F (Taing Treuk)
a- Diagnosis
1- DMII with PNP
2- HTN
3- Dyspepsia
b- Treatment
1- Meformin 500 mg 1 t po q12h for three months
2- Glibenclamide 5 mg 1 t po q8h for three months
3- Amitriptyline 25 mg 1 t po qd for three moths
4- Lisinopril 5 mg 1 t po q12h for three months
5- Nifedipine 10 mg 1 t po q12h for three months
6- Paracetamol 500 gm 1 t po q6h for prn
7- DM and HTN education

XII- Prum Sourn, 64M (Taing Teuk)
a- Diagnosis
1- CHF
2- HTN
b- Treatment
1- Lisinopril 5 mg 1 t po qd for three months
2- HCTZ 50 mg ½ t po qd for three months
3- Low salt and fat diet

XIII Sao phal, 57F (Thnout Malou)
a- Diagnosis
1- HTN
2- DMII
3- GERD
4- Hypochromic Microcytic Anemia
b- Treatment
1- HCTZ 50 mg 1/2 t po qd for one month
2- MTV 1 t po qd for one month
3- Feso4/Folic 200/0.25 mg 1 t po qd for one month
4- Omeprazole 20 mg 1 t po qhs for one month
5- Metochlopramide 10 mg 1 t po qhs for two weeks
6- Amitriptyline 25 mg 1 t po qhs for one month
7- Draw blood for Glycemia which will be sent to SHCH
8- HTN, DM and GERD education

XIV- Ros Yoeu, 29M (Taing Treuk)
a- Diagnosis
1- Gastritis
2- Parasititis
3- Tinea versicolor
4- Nummular eczema??

5- t/c Psoriasis???

b- Treatment

1- Famotidine 40 mg 1 t po qhs for one month
2- Mebendazole 100 mg 1 t chew q12h for three days
3- Griseofulvin 500 mg 1 t po q12h for one month
4- Use herbal solution for external application
5- Draw blood for CBC, LFT which will be sent to SHCH

XV- Tem Sophea, 18M (Trapang Reusey)

a- Diagnosis

1- Dysenteria
2- Parasititis
3- Malaria
4- Anemia due to 1, 2 and 3
5- Dyspepsia

b- Treatment

1- Metronidazole 250 mg 2 t po q8h for two weeks
2- Mebendazole 100 mg 1 t chew q12h for three days
3- Metoclopramide 10 mg 1 t po q8h for 15 days
4- Chloroquine 250 mg 2 t po qd foe two days and 1 t po qd for one day
5- Paracetamol 500 mg 1 t po q6h for prn of fever and headache
6- MTV 1 t po q12h for one month
7- Feso4/Folic 200/0.25 mg 1 t po q12h for one month
8- Mg Al (OH)3 250/20 mg 2 t chew q8h prn for upset stomach
9- GERD education

For patient who comes to refill medications

I- Eam Neut, 54F (Taing Treuk)

a- Diagnosis

1- HTN
2- Tension Headache

b- Treatment

1- Propranolol 40 mg ½ t po q12h for 4 months
2- Paracetamol 500 mg 1 t po q6h prn for headache

II- Pang Sidoeun, 31F (Rovieng Tbong)

a- Diagnosis

1- HTN
2- Anxiety
3- Dyspepsia

b- Treatment

1- Lisinopril 5 mg ½ t po q8h for four months
2- HTCZ 50 mg ¼ t po qd for four months
3- Amitriptyline 25 mg ¼ t po qhs for four months

III- Kul Chheung, 78F (Taing Treuk)

a- Diagnosis

1- HTN
2- COPD

b- Treatment

1- MTV 1t po qd for three months
2- HCTZ 50 mg 1/2 t po qd for three months
3- Albuterol inhalation 2 puff q12h for two months
4- Similac cereal 350g 3 scoops mix with 190cc water q12h

IV- Kourch Be. 76M (Thnout Malou)

a- Diagnosis

1- HTN
2- COPD

b- Treatment

1- Nifedipine 10 mg 1 t po qd for two0 months
2- Albuterol inhalation 2 puffs q12h for two months

V- Srey Bin, 64F (Bos)

a- Diagnosis

1- Hypochromic Microcytic Anemia
2- Malnutrition
3- Dyspepsia

b- Treatment

1- Feso4/Folic 200/0.25 mg 1 t po q12h for three months
2- MgAl/(OH)3 250/120 mg 2 t chew q12h prn for upset stomach
3- MTV 1 t po qd for three months
4- Similax 350 mg 3 scope mix with 190cc water q12h
5- Encourage her to eat more fruit and vegetable

VI- Srey Hom, 60F (Taing Treuk)

a- Diagnosis

1- HTN
2- DMII
3- Renal Insufficiency

b- Treatment

1- Glibenclamide 5 mg 1 t po qd for three months
2- Lisinopril 5 mg po qd for three months
3- ASA 300 mg 1/4 t po qd for three months
4- DM and HTN education

VII- Leng Hak, 70M (Thnout Malou)

a- Diagnosis

1- HTN
2- Stroke

b- Treatment

1- Nifedipine 10 mg 1 t po q8h for three months
2- Propranolol 40 mg 1 t po q12h three months
3- MTV 1 t po qd for three months
4- ASA 300 mg 1/4 t po qd for three months
5- HTN edecation
6- Similax Cereal 350g 3 scoops mix with 190cc water q12h

VIII- Chhim Paov, 50M 9Beung)

a- Diagnosis

1- GOUT

b- Treatment

1- Diflunisal 500 mg 1 t po q12h prn for join pain for two months

2- Paracetamol 500 mg 1 t po q6h prn for fever

The next Robib TM Clinic will be held on
May 03 – 05, 2006