Robib *Telemedicine* Clinic
Preah Vihear Province
A P R I L 2 0 0 7

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

On Monday, April 02, 2007, SHCH staff, Nurse Peng Sovann traveled to Preah Vihear for the monthly Robib Telemedicine (TM) Clinic.

The following two days, Tuesday and Wednesday (mornings), April 03 & 04, 2007, the Robib TM Clinic opened to receive the patients for evaluations. There were 6 new cases and 8 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 04 & 05, 2007.

On Thursday, replies from SHCH in Phnom Penh and Partners Telemedicine in Boston were downloaded. Per advice from Boston and SHCH, Nurses 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: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Monday, March 26, 2007 8:16 AM
To: Rithy Chau; Paul J. M.D. Heinzelmann; Kathy Fiamma; Joseph Kvedar; Kruy Lim; Cornelia Haener; Gary Jacques
Cc: Bernie Krisher; Thero Noun; Laurie & Ed Bachrach; Peou Ouk; Seda Seng; Mony Mao; Tola Khiev
Subject: Schedule for Robib Telemedicine Clinic April 2007

Dear all,

I would like to inform you that the trip for Robib TM Clinic April 2007 will be starting on April 02, 2007 and coming back on April 06, 2007.

The agenda for the trip are as following:

1. On Monday April 02, 2007, we will be starting the trip from Phnom Penh to Rovieng, Phrea Vihea
2. On Tuesday April 03, 2007, the clinic opens to see patients for the whole morning and type patients' data as cases in afternoon then send to both partners in Boston and Phnom Penh
3. On Wednesday April 04, 2007, we will be doing the same as on Tuesday and also download the answer replied from both partners
4. On Thursday April 05, 2007, we download all the answers replied from both partners then make treatment plan accordingly and prepare medication for the patients in afternoon.
5. On Friday April 06, 2007, I draw blood from the patients for lab test at SHCH then came back to Phnom Penh.

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

Best regards,
Sovann

From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Monday, April 02, 2007 8:12 AM
To: Robib Telemedicine
Cc: Rithy Chau
Subject: Re: Schedule for Robib Telemedicine Clinic April 2007

Dear Sovann,
thanks for the schedule, I am waiting for your cases!

Best,

Miriam

On 30/03/07, **Robib Telemedicine** < robibtelemed@yahoo.com> wrote:
Dear Miriam,

This is the foward message of schedule for Robib Telemedicine April 2007.

Best regards,
Sovann

Robib Telemedicine <robibtelemed@yahoo.com > wrote:
Date: Sun, 25 Mar 2007 18:15:40 -0700 (PDT)
From: Robib Telemedicine < robibtelemed@yahoo.com>
Subject: Schedule for Robib Telemedicine Clinic April 2007
To: Rithy Chau < tmed_rithy@online.com.kh>,
"Paul J. M.D. Heinzelmann" <pheinzelmann@partners.org >,
Kathy Fiamma <kfiamma@partners.org>,
Joseph Kvedar < jkvedar@partners.org>, Kruy Lim <kruylim@yahoo.com>,
Cornelia Haener < cornelia_haener@online.com.kh>,
Gary Jacques <gjacques@online.com.kh>
CC: Bernie Krisher < bernie@media.mit.edu>,
Thero Noun <thero@cambodiadaily.com>,
Laurie & Ed Bachrach < lauriebachrach@yahoo.com>,
Peou Ouk <peou@cambodiadaily.com>, Seda Seng < seda@cambodiadaily.com>,
Mony Mao <shch_assist@online.com.kh>, Tola Khiev < khievtola@yahoo.com>

Dear all,

I would like to inform you that the trip for Robib TM Clinic April 2007 will be starting on April 02, 2007 and coming back on April 06, 2007.

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

Best regards,
Sovann

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 03, 2007 9:26 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Paul J. M.D. Heinzelmann; Cornelia Haener
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#1, Satt binn, 38F (Ta Tong Village)

Dear all,

I am at Rovieng for Robib Telemedicine Clinic Apirl 2007. Today there are 2 new cases and 5 follow up cases. This is case number 1, Satt Binn, 38F and Photos.

Please cc to chaurithy@yahoo.com as well when you reply.

Best regards,
Sovann

Robib Telemedicine Clinic

Sihanouk Hospital Center of HOPE and Partners Telemedicine

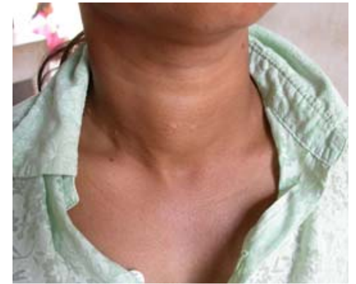
Rovieng Commune, Preah Vihear Province, Cambodia

History and Physical

Name/Age/Sex/Village: **Satt Binn, 38F (Ta Tong Village)**

Chief Complaint (CC): **Neck mass x 17y**

History of Present Illness (HPI): 38M, farmer, came to us complaining of neck mass x 17y. She presented with a small mass about 2x2cm on right anterior neck without any symptoms and the mass progressively developed about 4x6cm. In this year she presented with symptoms of palpitation, insomnia, heat intolerance, tremor on/off, and didn't seek any medical care. She denied of fever, cough, dysphagia, dyspnea, chest pain, nausea, vomiting, constipation, diarrhea, edema.



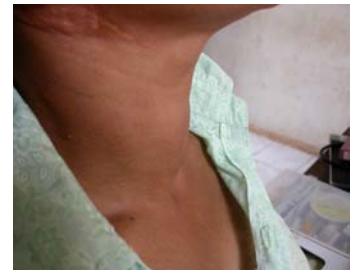
Past Medical History (PMH): Unremarkable

Family History: None

Social History: Drinking alcohol casually, no smoking, 4 children

Current Medications: Oral contraceptive

Allergies: NKDA



Review of Systems (ROS): No cough, no fever, no sore throat, no dyspnea, no dysphagia, no chest pain, no nausea, no vomiting, no stool with blood, regular period, no edema

PE:

Vitals: **BP: 118/70** **P: 76** **R: 20** **T: 36.5^{o}C** **Wt: 48Kg**

General: Look stable

HEENT: No oropharyngeal lesion, pink conjunctiva, Left side thyroid enlargement about, 4 x 6cm, soft, smooth, no tender, no bruit, regular border, no lymph node palpable, no JVD

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

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

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

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

Lab/Study: None

Assessment:

1. Goiter (Thyroid dysfunction)

Plan:

1. Draw blood for TSH and Free T4 at SHCH

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

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

Examined by: Nurse Peng Sovann Date: April 3, 2007

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

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From: Barbesino, Giuseppe,M.D. [mailto:GBARBESINO@PARTNERS.ORG]
Sent: Wednesday, April 04, 2007 4:52 AM
To: Fiamma, Kathleen M.
Cc: tmed_rithy@online.com.kh; robibtelemed@yahoo.com
Subject: RE: Robib TM Clinic April 2007, Case#1, Satt binn, 38F (Ta Tong Village)

This 38 y/o man present with an enlarging goiter and symptoms of hyperthyroidism. Interestingly though, his heart rate is not increased.
I agree with thyroid function tests as suggested. If the test confirms hyperthyroidism, then the differential diagnosis includes Graves' disease and toxic multinodular goiter and other less likely forms of hyperthyroidism. A thyroid scan is usually helpful in these cases and guides management as both Graves' disease and toxic multinodular goiter would respond to treatment with tapazole or PTU.
If hyperthyroidism is not confirmed or if the scan show coexistent "cold" nodules then consideration should be given to fine needle aspiration biopsy of the mass to rule out malignancy.

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

Date: Wed, 4 Apr 2007 10:47:20 +0700
From: "Miriam Haverkamp" <mhaverkamp@post.harvard.edu>
To: "Robib Telemedicine" <robibtelemed@yahoo.com>
Subject: Re: Robib TM Clinic April 2007, Case#1, Satt binn, 38F (Ta Tong Village)
CC: chaurithy@yahoo.com

Dear Sovann,
I agree with your assessment, she definitely needs a TSH and free T4 and will need control of her symptoms. When the TSH and thyroid hormones come back she should be started on medication immediately unless the labs show no hyperthyroidism. I would start her on 20mg of Carbinamzole a day and recheck her TSH and thyroid hormones in 8 weeks, if she is euthyroid reduce to 5mg. If she still has symptoms after a month without any improvement I would tell her to increase her dose on her own to 30mg a day and come for the test a month later as planned. .Carbimazole causes neutropenia, usually within the first three months, if possible can we do a CBC around a month after she starts the medication? Also she needs to be told if she gets a sore throat and fever while on Carbimazole she should seek medical advice immediately and get a CBC to rule out neutropenia. Given the situation she is in I would refer her to our surgeons to evaluate her for a subtotal thyroidectomy as it will be hard for her to continue taking those drugs given her situation and her location. Surgery will be probably the safer option for her. Has the mass recently grown faster than usual? If yes, I would refer her for an ultrasound as soon as possible, if the mass grew over three or four years to more than double its size then it is not as urgent but if the mass grew over six months she would have to be assessed for malignancy. She also needs good education about the dangers of stopping her drugs and that she needs to seek medical attention IMMEDIATELY should she experience increasing symptoms! We have lost several patients in thyroid storm and there is little we can do when they present late! Another thing is to advise her to use iodized salt for cooking with her children once her thyroid is under control, I would not do it before she is taking an anti-thyroid drug as iodine will make her symptoms worse unless the thyroid is controlled.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 03, 2007 9:31 PM
To: Miriam Haverkamp; Miriam Haverkamp; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Paul J. M.D. Heinzelmann; Rithy Chau; Rithy Chau
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#2, Thon Mai, 78M (Boeung Village)

Dear all,

This is case number 2, Thon Mai, 78M and Photo.

Please cc to chaurithy@yahoo.com as well when you reply.

Best regards,
Sovann

History and Physical

Name/Age/Sex/Village: Thon Mai, 78M (Boeung Village)

Chief Complaint (CC): fatigue, polyuria x 1y

History of Present Illness (HPI): 78M, farmer, came to us complaining of fatigue and polyuria x 1y. In last year, he presented with symptoms of polyuria, fatigue, blurred vision, so he went to provincial hospital, diagnosed with DMII and treated with Metformin 500mg 1t po bid. Since then he bought Metformin 500mg taken bid but didn't went for checking up. He said he felt much better but still complained of fatigue, poor appetite, blurred vision, polyuria. He denied of cough, fever, dyspnea, palpitation, oliguria, hematuria, edema, stool with blood.

Past Medical History (PMH): S/P Bladder stone removal in 2005, PTB with complete treatment and DMII

Family History: None

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

Current Medications: Metformin 500mg 1t po bid

Allergies: NKDA

Review of Systems (ROS): Unremarkable

PE:

Vitals: BP: 104/62 P: 76 R: 20 T: 36°C Wt: 41Kg

General: Look sick, cachetic

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

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

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

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

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

Lab/Study: RBS: High, after drinking 1L water BS: 595mg/dl; UA blood 4+, protein trace

Assessment:

1. DMII
2. Cachexia

Plan:

1. Glibenclamide 5mg 1t po bid for one month
2. Metformin 500mg 1t po qhs for one month
3. Captopril 25mg 1/4t po qd for one month
4. MTV 1t po qd for one month
5. Alcohol and smoking cessation
6. Educate on diabetic diet and foot care

Lab/Study Requests: 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 Peng Sovann Date: April 3, 2007

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

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Rithy Chau, MPH, MHS, PA-C
Sihanouk Hospital Center of HOPE
Phnom Penh, Cambodia

-----Original Message-----
From: Kreinsen, Carolyn Hope,M.D. [mailto:CKREINSEN@PARTNERS.ORG]
Sent: Thursday, April 05, 2007 1:51 AM
To: Fiamma, Kathleen M.
Cc: robibtelemed@yahoo.com; tmed_rithy@online.com.kh
Subject: RE: Robib TM Clinic April 2007, Case#2, Thon Mai, 78M (Boeung Village)

This is a 78 year old man, a farmer by profession, presenting with symptoms of fatigue, polyuria, blurred vision and polyuria of one year duration. He had presented for evaluation of the symproms at some time during the past year and was diagnosed with Diabetes Mellitus II. Initial treatment prescribed was metformin 500 mg po BID but he did not follow-up with health providers until now and it's unclear as to whether he continued to take the medication on a regular basis. Initial HGBA1C and other work-up are not available. The patient evidently felt better after starting metformin but has presented with similar symptoms to those he had been experiencinginitially. He has a history of ongoing regular alcohol consumption and long-term tobacco/cigarette smoking. Past medical history includes ureterolithiasis with surgical removal of bladder stone and treated primary tuberculosis in addition to Diabebetes Mellitus II.

Physiacal exam reveals a cachectic appearing man with no concerning findings reported. Vital signs are stable with blood pressure in desired range - 104/62.

Initial lab evaluation at the time of exam showed a (? fingerstick) random blood sugar of 595 mg/dl and a urinalysis with trace protein and 4+ blood.

Discussion:

1.) Diabetes Mellitus: This man has classic symptoms of poorly controlled Diabetes Mellitus II. His blood sugar is very worrisome. It sounds as though he was fairly dehydrated on evaluation, although his heart rate was normal at 76. It would be worth checking orthostatic vital signs and a specific gravity on his urine. Does he have any numbness or tingling in his extremities? If you have the equipment available, it would be helpful to check for vibratory sense in hands and feet and also the presence/absence of sense of touch with a monofilament. It sounds as though his general foot exam showed no edema or wounds. That's encouraging! He should have a dilated eye exam as soon as possible to check for retinopathy. His visual changes may be due to his very high blood sugar, resulting in influx of fluid into the lenses of the eyes and temporary blurring of vision. However, he may have more serious retinopathy, requiring specialized treatment. (At his age, and with years of sun exposure as a farmer, he may have cataracts, as well.) I completely agree with the labs you ordered - HGBA1C (this should be followed every 3 months), electrolytes, fasting blood sugar, and renal functions. He also would benefit from a urine for microalbumin and urine for microalbumin/creatinine ratio to determine if he has nephropathy, involvement of his kidneys. Has he experienced any muscle pain on the metformin? It would be advisable to check a lactic acid level on the metformin to make certain he is tolerating it. LFTs would also be very helpful, given metformin therapy and regular alcohol usage. If he is tolerating metformin, I would not recommend reducing the dosage to once a day from twice a day. It does not cause low blood sugar and helps to sensitize his tissues to insulin. In fact, if he is able to cut down on alcohol, and if his LFTs and lactic acid levels are normal, it would be worth considering gradual increase of the metformin to either 500 mg TID before meals or 1000 mg BID before breakfast and supper. It is most effective when taken at meal time. I would recommend a little slower increase in the glibenclamide, perhaps starting with 2.5 mg twice per day with gradual increase in the dosage. That medication can cause low blood sugars. This man's blood sugars are so high that he may require insulin therapy.He should be watched very closely with follow-up blood sugar in 2 weeks, if possible. It would be beneficial to involve an internal medicine doctor in his care, given the severity of his disease. The very high blood sugar also raise the question of another underlying illness or infection. I think that the addition of the captopril was an excellent idea. This will help to protect the kidneys. If available, lisinopril would perhaps be a better choice since it is sustained release and requires only once a day dosing. I'd recommend a dosage of 2.5 mg of lisinopril every day with repeat BUN/creatinine and potassium levels in 2 weeks to make certain that the kidneys are stable. If so, it would then be helpful to increase the dosage to 5 mg and then to 10 mg every day, as long as his blood pressure remains stable. If captopril is the only ACE inhibitor available to you, and it is not the sustained release form, I'd recommend the 1/4 tablet dosing 3x/dayinitially. That would probably be a difficult schedule for this man to follow. It's great that you have provided education for diet and foot care. These are so necessary! This man will have to control/eliminate his alcohol intake. It's unclear whether he is drinking beer or hard liquor. Regardless, they are both loaded with sugar and will also further dehydrate him. He also will be taking medications processed through the liver and not compatible with the alcohol. This man should be drinking at least 56 to 64 ounces or more of fluid each day to stay hydrated, especially with his high blood sugars, alcohol usage and history of a bladder stone.

2.) Alcohol: This man has a problematic habit. It is especially dangerous in light of his Diabetes. Has he lost weight over the past year? Does he eat regular meals? It might be worth giving him extra folate and oral B12 supplements along with his multivitamin. I would recommend a differential with

the CBC. Again, education and follow-up will be so necessary in helping this man stop drinking.

3.) Microscopic hematuria: This is concerning in an elderly man with a long history of smoking, a history of ureterolithiasis, alcohol usage with possible uric acid elevation and a history of past TB. I would suggest a rectal and prostate exam and a repeat urinalysis/dipstick (to verify the presence of blood), as initial steps. If blood is noted again, he would benefit from a urinalysis with sediment and a urine culture. If hematuria and red blood cells are noted on repeat testing, the patient should have a renal/bladder ultrasound. I'd recommend a uric acid level along with his other labs. Again, I think that his problems are sufficiently complex, that he should see an internal medicine doctor for further evaluation. He is at risk for bladder cancer with his smoking. He is at risk for recurrence of bladder/kidney stones with a history of a past stone and dehydration from Diabetes and ongoing alcohol consumption. He is a farmer, at possible risk for schistosomiasis. The possibilty of recurrent TB would be worth considering if no other source of microscopic hematuria is found.

Hope this is helpful and pleae let me know if you have any questions regarding my response.

Take good care,

Carolyn K

From: Fiamma, Kathleen M.
Sent: Tue 4/3/2007 12:42 PM
To: Kreinsen, Carolyn Hope,M.D.
Subject: FW: Robib TM Clinic April 2007, Case#2, Thon Mai, 78M (Boeung Village)

Hello Dr. Kreinsen:

Here's a new case for you.

Thank you.

Kathy

Date: Wed, 4 Apr 2007 10:47:20 +0700
From: "Miriam Haverkamp" <mhaverkamp@post.harvard.edu>
To: "Robib Telemedicine" <robibtelemed@yahoo.com>
Subject: Re: Robib TM Clinic April 2007, Case#2, Thon Mai, 78M (Boeung Village)
CC: chaurithy@yahoo.com

Dear Sovann,

I agree with your assessment. His blood pressure does not need further control and Captopril might give him renal failure if we cannot follow him up frequently. With that kind of a blood pressure he does not need Captopril from a hypertension point of view. He does have protein in the urine which could indicate that he is already spilling it from the diabetic renal damage, however as he also has a lot of blood that could interfere with the test.. If his creatinine is already >200 it is too risky with such limited follow-up. Considering the age of the patient I think it would be prudent to not start Captopril as he will most likely not live to the point of developing renal failure from diabetes.

I do not think an HbA1c is necessary at this point. I can tell you now it is going to be >10 with that high of a random blood sugar. Once he is controlled we should definitely send one but now I think it would be purely academic.

I think he will need insulin for now and maybe for life as the blood sugar is very much out of control and I doubt Sulfonylureas will do the trick at this point. He is VERY insensitive to the insulin and needs a reset to near normal blood sugar levels. I would probably start him on insulin NPH 10 Units in the morning and 5 right before bed. Do a lot of education on healthy diet (no white rice or only minimal, if he eats white rice to eat it with a fatty meal that slows absorption, Eat brown rice, avoid sweets and as you said he has to stop drinking alcohol! And also on the risks of hypoglycemia and the symptoms)

I am also worried about the four plus blood in the urine he is older and a smoker he is at risk for a urothelial cancer and I think if possible I would refer him for a kidney and bladder ultrasound and if those are normal and he continues to have blood in the urine a cystoscopy.

Once the bleeding issue is resolved he has to start on an aspirin a day to prevent MI and strokes as he is older, a smoker and diabetic.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 03, 2007 9:36 PM
To: Miriam Haverkamp; Miriam Haverkamp; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Paul J. M.D. Heinzelmann; Rithy Chau; Rithy Chau
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#3, So Soksan, 23F (Thnal Keng Village)

Dear all,

This is case number 3, So Soksan, 23F and Photos.

Please cc to chaurithy@yahoo.com as well when you reply.

Best regards,
Sovann

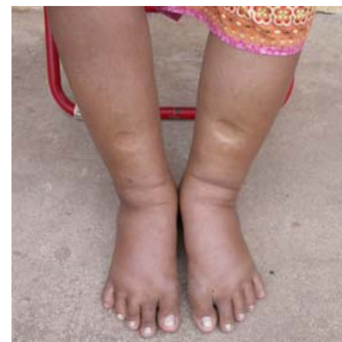
Robib Telemedicine Clinic

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

SOAP Note

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

Subjective: 23F came to follow up of recurrent Nephrotic Syndrome and 4months pregnancy?. In last month follow up, she said she went to have abortion in private clinic but we do the pregnancy test, it is positive so on March 20 2007, she went to private clinic at Preah Vihea province have abortion/recleaning again. She still presented with symptoms of headache, moon face, palpitation, poor appetite, fatigue, oliguria, edema. She denied of fever, cough, dyspnea, chest pain, nausea, vomiting, stool with blood and hematuria, menstrual period.



Objective:

VS: BP: 90/56 P: 120 R: 20 T: 36 Wt: 64kg

PE (focused):

General: Look sick

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

Chest: CTA bilaterally, no rales, no rhonchi; H Tachycardia, RR, no murmur

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

Skin/Extremity: 4+ pitting edema, no rash, no foot wound

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

Labs/Studies: Locally Pregnancy test + ; UA protein 1+

Lab result on March 16, 2007

WBC	=9	[4 - 11x10^9/L]	Na	=139	[135 - 145]
RBC	=3.9	[3.9 - 5.5x10^{12}/L]	K	=4.0	[3.5 - 5.0]
Hb	=12.4	[12.0 - 15.0g/dL]	Cl	=107	[95 - 110]
Ht	=37	[35 - 47%]	BUN	=1.7	[0.8 - 3.9]
MCV	=96	[80 - 100fl]	Creat	=75	[44 - 80]
MCH	=32	[25 - 35pg]	Glu	=3.8	[4.2 - 6.4]
MHCH	=33	[30 - 37%]	Albu	=17	[38 - 54]
Plt	=416	[150 - 450x10^9/L]	Prote	=42	[62 - 80]
Lym	=3.2	[1.0 - 4.0x10^9/L]			
Mxd	=0.5	[0.1 - 1.0x10^9/L]			
Neut	=5.9	[1.8 - 7.5x10^9/L]			

Current Medications:

1. Captopril 25mg 1/2t po qd
2. Furosemide 20mg 1t po bid

Allergies: NKDA

Assessment:

1. Recurrent Nephrotic Syndrome
2. Pregnancy???

Plan:

1. Captopril 25mg 1/2t po qd for one month (# 20)
2. Furosemide 20mg 1t po bid for one month (# 60)
3. Drink 1L/d of water and eat one banana per day

Lab/Study Requests: None

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: April 3, 2007**

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

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From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Wednesday, April 04, 2007 2:38 AM
To: Robib Telemedicine; Rithy Chau
Subject: FW: Robib TM Clinic April 2007, Case#3, So Soksan, 23F (Thnal Keng Village)

From: Fang, Leslie S.,M.D.
Sent: Tuesday, April 03, 2007 2:37 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic April 2007, Case#3, So Soksan, 23F (Thnal Keng Village)

She appears to have recurrent nephrotic syndrome off of steroids.
Creatinine is inching up slightly

The possible etiology of her recurrent nephrotic syndrome includes:

1. Minimal change disease
2. Membranous disease
3. Focal sclerosis

It is interesting that she has repeatedly and persistently positive pregnancy tests despite two supposed therapeutic abortions. Is the pregancy test done through blood HCG screening or is it a urinary screening (the latter may be affected by high grade proteinuria)

I would continue on ACEI but would increase the dose of captopril slightly
I would continue with diuretics

We may have to resume steroids once the issue of pregnancy is definitively settled.

Leslie Fang, MD

Date: Wed, 4 Apr 2007 10:47:20 +0700
From: "Miriam Haverkamp" <mhaverkamp@post.harvard.edu>
To: "Robib Telemedicine" <robibtelemed@yahoo.com>
Subject: Re: Robib TM Clinic April 2007, Case#3, So Soksan, 23F (Thnal Keng Village)
CC: chaurithy@yahoo.com

Dear Sovann,

The pregnancy test will remain positive probably for another six months as the beta HCG will slowly decrease over time. A pregnancy test is not the correct test for her at this point. The beta HCG test will remain positive if the level in the blood is around 1000-2000 and currently if she was around three months pregnant her beta HCG levels will be around 50 000 to 100 000 and thereby will most likely not fall to undetectable for several months. The only way to establish whether the abortion was successful is if you get her a transvaginal ultrasound to rule out retained pregnancy products here at SHCH. I think we need to give her counseling on pregnancy prevention and should most likely recommend for her to have an IUD placed. She is at an increased risk for thrombosis so hormonal methods would not be a good choice for her.

I am worried about this patient as she is tachycardic and hypotensive and is complaining of palpitations and dyspnea. On her labs she looks good no anemia, no white count and her renal function is good. However, a young woman like her should not be so tachycardic without a reason. I am a bit worried about her and think she needs a more extensive assessment at the hospital. Maybe she has a Pulmonary embolism and that is why she is tachycardic. I think I would like her to present to SHCH for a work up (CXR, abdominal/transvaginal ultrasound, LFT, CXR, rule out DVT) . If that is not possible then I am at a loss as to what to do with her. She is not intravascularly fluid overloaded but she is at the same time edematous and SOB. As she was just pregnant she is at a high risk for thrombosis and embolism so I think ultimately she needs to be assessed at a hospital.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 03, 2007 9:41 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Paul J. M.D. Heinzelmann
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#4, Pou Limthang, 42F (Thnout Malou Village)

Dear all,

This is case number 4, Pou Limthang, 42F and Photos.

Please cc to chaurithy@yahoo.com as well when you reply.

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: **Pou Limthang, 42F (Thnout Malou Village)**

Subjective: 42F came to follow up of hyperthyroid and tachycardia. She felt much better than before with good appetite, normal bowel movement, but still complained of palpitation, tremor, heat intolerance, fatigue on/off. She denied of cough, sore throat, fever, dyspnea, dysphagia, stool with blood, oliguria, dysuria, hematuria, edema.

Objective:

VS: **BP: 110/64** **P: 96** **R: 20** **T: 37** **Wt: 58kg**

PE (focused):

General: Look stable

HEENT: No oropharyngeal lesion, pink conjunctiva, thyroid enlargement about 10x12cm, soft, no redness, no tender, regular border, mobile on swallowing, no bruid, no lymph node palpable, no JVD

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

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

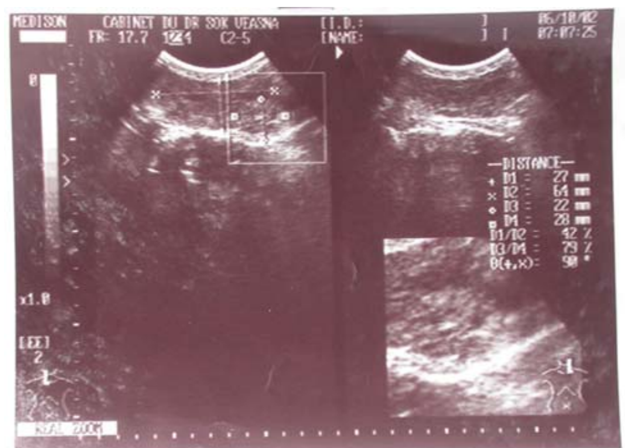
Skin/Extremity: No edema, no rash, no foot wound

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

Lab Result on March 16, 2007

TSH =<0.02 [0.49 - 4.67]
Free T4=69.41 [9.14 - 23.81]

Neck Mass Ultrasound attached
Conclusion: Goiter mixte



Current Medications:

1. Propranolol 40mg 1t po bid
2. Carbimazole 5mg 1t po qd

Allergies: NKDA

Assessment:

1. Hyperthyroidism

Plan:

1. Propranolol 40mg 1t po bid for two months
2. Carbimazole 5mg 1/2t po tid for two months
3. Draw blood for TSH and Free T4 in two months

Lab/Study Requests: None

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: April 3, 2007**

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

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From: Paul Heinzelmann [mailto:pheinzelmann@worldclinic.com]
Sent: Wednesday, April 04, 2007 9:05 AM
To: Fiamma, Kathleen M.; Heinzelmann, Paul J.,M.D.; robibtelemed@yahoo.com
Cc: tmed_rithy@online.com.kh; tmed_rithy@bigpond.com.kh
Subject: RE: Robib TM Clinic April 2007, Case#4, Pou Limthang, 42F (Thnout Malou Village)

Dear Sovann,

Apologies if this comes to you later than expected - seems my email saved them as drafts.

In general, I agree with your plan and I am glad you asked her about sore throat, etc as that can signal a negative effect of carbimazole. (advise her to sekk medical attention if such symptoms develop)

I suspect your doing is not going to be therapeutic. You are recommending 7.5 mg per day. However, a typical dosing regimen is as follws:

Adults: 20-60 mg/day taken as 2-3 divided doses until thyroid activity returns to normal

Maintenance regimen: Gradually decrease dosage to maintain normal thyroid activity. Maintenance dosage can vary from patient to patient in the range 5-15 mg/day. Therapy is usually continued for 12-18 months.

I agree with re-checking her labs.

Best,

Paul Heinzelmann, MD

Date: Wed, 4 Apr 2007 10:47:20 +0700
From: "Miriam Haverkamp" <mhaverkamp@post.harvard.edu>
To: "Robib Telemedicine" <robibtelemed@yahoo.com>
Subject: Re: Robib TM Clinic April 2007, Case#4, Pou Limthang, 42F (Thnout Malou Village)
CC: chaurithy@yahoo.com

Dear Sovann,

I agree that the thyroid is not yet controlled. It is a bit hard for me without knowing her full medication history but I think you need to increase the Carbimazole a bit more aggressively. Increase to 30mg once a day (three times a day usually results in poor compliance as the patients often forgets one dose at least every couple of days and Carbimazole can be given qd) and recheck the thyroid hormones in two months as planned. She also should be referred to the surgeons for subtotal thyroidectomy to take care of her thyroid and the nodules. If she develops hypothyroidism later on Thryroxine is a much safer drug long term than Carbimazole and hypothyroidism is not as dangerous as thyroid storm.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 03, 2007 9:45 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Paul J. M.D. Heinzelmann
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#5, Pheng Roeung, 61F (Thnout Malou Village)

Dear all,

This is case number 5, Pheng Roeung, 61F and Photo.

Please cc to chaurithy@yahoo.com as well when you reply.

Best regards,
Sovann

SOAP Note

Patient Name & Village: Pheng Roeung, 61F (Thnout Malou Village)

Subjective: 61F came to follow up of HTN, and Euthyroid. In this month, she presented with symptoms of epigastric pain, burning sensation, after eating, radiating to left scapular and neck, release in 30minutes. She denied of dyspnea, chest pain, palpitation, vomiting, stool with mucus, blood, oliguria, hematuria, dysuria, edema.

Objective:

VS: BP: 110/64 P: 67 R: 20 T: 36.5 Wt: 62kg

PE (focused):

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

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

MS/Neuro: MS +5/5, sensory intact, DTRs +2/4

Labs/Studies: None

Current Medications:

1. Propranolol 40mg 1t po bid
2. HCTZ 50mg 1/2t po qd

Allergies: NKDA

Assessment:

1. HTN
2. Euthyroid
3. Dyspepsia

Plan:

1. Atenolol 50mg 1t po bid for two months

2. HCTZ 50mg 1/2t po qd for two months
3. Famotidine 10mg 2t po qhs for two months

Lab/Study Requests: None

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: April 3, 2007**

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

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Date: Wed, 4 Apr 2007 10:47:20 +0700
From: "Miriam Haverkamp" <mhaverkamp@post.harvard.edu>
To: "Robib Telemedicine" <robibtelemed@yahoo.com>
Subject: Re: Robib TM Clinic April 2007, Case#5, Pheng Roeung, 61F (Thnout Malou Village)
CC: chaurithy@yahoo.com

Dear Sovann,
I am not entirely clear on her history, has she previously had thyroid problems or why do you point out she is euthyroid? Does she have orthopnea, dyspnea on exertion, does anything else make those symptoms come on? Does she have a color check that is positive? She sounds like she has a duodenal ulcer, gastic cancer or could have angina. For a duodenal ulcer it is a bit unusual of a pain distribution and for angina it is an unusual thing to only occur with eating, for cancer she does not have any of the warning signs aside from age. Eating does divert blood to the intestinal tract away from other organs, but she should have symptoms in other situations, too if it were cardiac angina. She is old enough to have cancer and should get a gastroscopy to rule out a gastric/duodenal malignancy even if she responds to the current treatment. While she is at SHCH I would also get an EKG to rule out ischemia and if she has any of the above symptoms (orthopnea, dyspnea on exertion, other things that make those symptoms come on) she needs to be referred to SHCH IMMEDIATELY for unstable angina.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 03, 2007 9:56 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Paul J. M.D. Heinzelmann; Cornelia Haener
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#6, Chhorn Sophorn, 60M (Taing Treuk Village)

Dear all,

This is case number 6, Chhorn Sophorn, 60M and Photos.

Please cc to chaurithy@yahoo.com as well when you reply.

Best regards,
Sovann

Robib Telemedicine Clinic

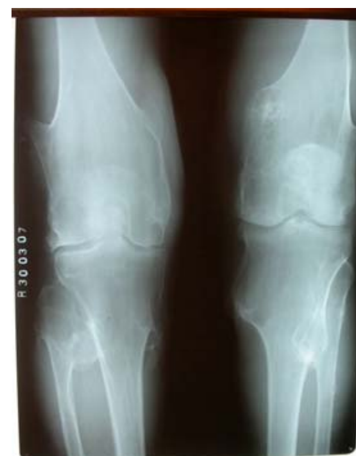
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note

Patient Name & Village: Chhorn Sophorn, 60M (Taing Treuk Village)

Subjective: 60M came to follow up of Arthritis and right knee frozen joint. He is stable with normal appetite, normal bowel movement, denied of pain, swelling, redness, stiffness, but he still complained of unable to flex his right knee.



Objective:

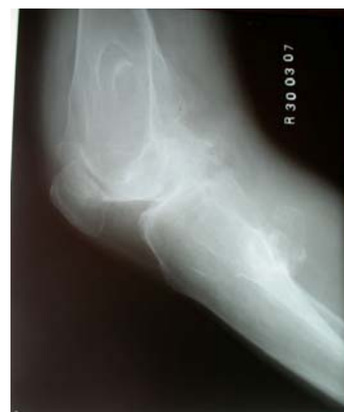
VS: BP: 130/62 P: 80 R: 20 T: 37 Wt: 55kg

PE (focused):

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

Extremity: Deformity on knee joint, no tender, no redness, no swelling,

MS/Neuro: MS +5/5, sensory intact, DTRs +2/4, normal gait, unable to flex right knee

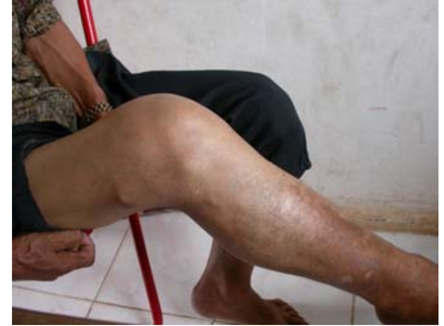
Labs/Studies: Knee x-ray attached

Lab result on March 16, 2007

Test	Result	Normal range	Test	Result	Normal range
WBC	=6	[4 - 11x10^9/L]	Na	=143	[135 - 145]
RBC	=5.5	[3.9 - 5.5x10^{12}/L]	K	=5.1	[3.5 - 5.0]
Hb	=12.2	[12.0 - 15.0g/dL]	Cl	=111	[95 - 110]
Ht	=42	[35 - 47%]	BUN	=3.5	[0.8 - 3.9]
MCV	=75	[80 - 100fl]	Creat	=81	[53 - 97]
MCH	=22	[25 - 35pg]	Glu	=4.7	[4.2 - 6.4]
MHCH	=29	[30 - 37%]			
Plt	=199	[150 - 450x10^9/L]			
Lym	=2.1	[1.0 - 4.0x10^9/L]			
Mxd	=0.5	[0.1 - 1.0x10^9/L]			
Neut	=3.6	[1.8 - 7.5x10^9/L]			

Current Medications:

1. Diflunisal 500mg 1t po bid
2. Paracetamol 500mg 1t po qid prn



Allergies: NKDA

Assessment:

1. Arthritis
2. Right Knee Frozen Joint
3. Both Knee deformity

Plan:

1. Paracetamol 500mg 1t po qid prn pain for one month

Lab/Study Requests: None

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: April 3, 2007**

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

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Date: Wed, 4 Apr 2007 10:47:20 +0700
From: "Miriam Haverkamp" <mhaverkamp@post.harvard.edu>
To: "Robib Telemedicine" <robibtelemed@yahoo.com>
Subject: Re: Robib TM Clinic April 2007, Case#6, Chhorn Sophorn, 60M (Taing Treuk Village)
CC: chaurithy@yahoo.com

Dear Sovann,
How long has he had symptoms for, did they start suddenly or slowly did this get progressively worse or was bad suddenly, did he have trauma to the knee? Is the other knee entirely normal? I am not a bone radiologist so I am not an expert at reading the x-ray that you sent me. It looks to me though that he might never be able to bend that knee. Is that frozen knee due to pain or can he just not bend it? If it is only due to pain I would try a bit stronger pain killers. If he has no history of seizures I would try Tramadol 50mg q6h and increase on his own to a maximum of 100mg q6h if necessary and continue the NSAID. Write him also for Docusate 100mg tid for stool softener as it will most likely constipate him. If that does not control his pain I would probably go for a stronger opioid such as Morphine. If however this is not due to pain but it is just locked or it is due to pain but we cannot control the pain then I would think of a knee replacement. I don't think we replace knees here but that would be another option to pursue to have him evaluated for a knee replacement with one of the visiting orthopedic surgeons.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Tuesday, April 03, 2007 10:18 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Joseph Kvedar; Kathy Fiamma; Kruy Lim; Paul J. M.D. Heinzelmann; Cornelia Haener
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#7, Chan Oeung, 57M (Sangke Roang Village)

Dear all,

This is case number 7, Chan Oeung, 57M and Photos. Please waiting for other cases tomorrow and reply to the cases before Thursday afternoon. Thank you very much for your cooperation and support in this project.

Please cc to chaurithy@yahoo.com as well when you reply.

Best regards,
Sovann

Robib Telemedicine Clinic

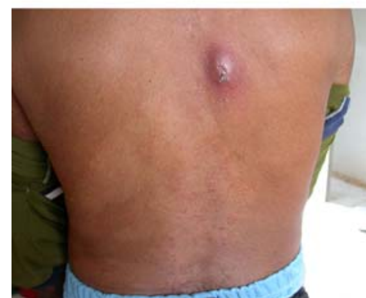
Sihanouk Hospital Center of HOPE and Partners in Telemedicine

Rovieng Commune, Preah Vihear Province, Cambodia

SOAP Note

Patient Name & Village: **Chan Oeung, 57M (Sangke Roang Village)**

Subjective: 57M came to follow up of Arthritis, HTN, Tinea. He has normal appetite, normal bowel movement, but still complained of pain, stiffness on metatasal joints and ankle joints of both feet, worse in early morning and got better in afternoon and evening, he denied of other joints pain, . In these three days, he also developed a small furoncle on the back, with pruritis, pain, redness.



Objective:

VS: **BP: 140/70** **P: 80** **R: 20** **T: 37** **Wt: 62kg**

PE (focused):

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

Back: furoncle about 2x3cm on the back with redness, tender, swelling, hard, no pus

Skin/Extremity: maculo-papula rashes on the back and both arms, some pus, no vesicle, tender, redness, slightly swelling, stiff on Metatasal joints and ankle joints, other joints ok

MS/Neuro: MS +5/5, sensory intact, DTRs +2/4

Labs/Studies:

Lab result on March 16, 2007

WBC	=8	[4 - 11x10^9/L]	Na	=141	[135 - 145]
RBC	=4.6	[4.6 - 6.0x10^{12}/L]	K	=4.4	[3.5 - 5.0]
Hb	=13.9	[14.0 - 16.0g/dL]	Cl	=110	[95 - 110]
Ht	=41	[42 - 52%]	BUN	=1.0	[0.8 - 3.9]
MCV	=90	[80 - 100fl]	Creat	=91	[53 - 97]
MCH	=30	[25 - 35pg]	Gluc	=8.4	[4.2 - 6.4]
MHCH	=34	[30 - 37%]			
Plt	=181	[150 - 450x10^9/L]			
Lym	=1.7	[1.0 - 4.0x10^9/L]			

Current Medications:

1. HCTZ 50mg 1/2t po qd
2. Diflunisal 500mg 1t po bid prn
3. Paracetamol 500mg 1t po qid prn
4. Clotrimazole cream apply bid

Allergies: NKDA

Assessment:

1. HTN
2. Rhumatoid arthritis
3. Tinea Psoriasis
4. Furuncle on the back

Plan:

1. HCTZ 50mg 1/2t po qd for one month
2. Diflunisal 500mg 1t po bid prn severe pain for one month
3. Paracetamol 500mg 1t po qid prn pain for one month
4. Cephalexin 250mg 2t po tid for 10d
5. Fluocinolone cream 0.025% appy bid until rash gone

Lab/Study Requests: None

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: April 3, 2007**

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

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From: Paul Heinzelmann [mailto:paul.heinzelmann@gmail.com]
Sent: Thursday, April 05, 2007 2:03 AM
To: kfiamma@partners.org; robibtelemed@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: Robib TM Clinic April 2007, Case#7, Chan Oeung, 57M (Sangke Roang Village)

Sovann,

1. HTN - its worth verifying that he is actually taking the HCTZ as directed and having him recheck this. This is a wider than normal pulse pressure.

2. Skin rash - tinea AND psoriasis together would be uncommon; I notice that he has an area of hypopigmentation on his back…is this new? Please ask him. If it is, please consider that this is secondary to use of steroid….or uneven use of sunblock….also, make sure he has normal sensation to light tough in this area. (Leprosy can present with hypopigmented areas that have decreased sensation – not sure if this is a problem in the area). If steroid cream has been used and not helped – go with antifungal cream 2 times per

day. If the antifungal cream has been used, try the steroid as you suggest BID.

3. arthralgias – rheumatoid vs psoriatic. Sounds like rheumatoid as it is associated with am stiffness. A trial of diflusinol makes sense.

4. Furuncle – needs Incision and Drainage, if it is not loculated, consider iodiform gauze packing, then cover the area with gauze. If possible, have him return in a day or two to have it either repacked or simply have the packing removed. Cephalexin may or may not be necessary. It appears that the lesion may be close to rupturing ion its own – warm compresses will facilitate that.

Best,

Paul Heinzelmann, MD

Date: Wed, 4 Apr 2007 10:47:20 +0700
From: "Miriam Haverkamp" <mhaverkamp@post.harvard.edu>
To: "Robib Telemedicine" <robibtelemed@yahoo.com>
Subject: Re: Robib TM Clinic April 2007, Case#7, Chan Oeung, 57M (Sangke Roang Village)
CC: chaurithy@yahoo.com

Dear Sovann,
I think the patient does not need antibiotic, yet. He should put warm compresses on it three times a day and if it does not improve or if it gets worse (fever, increasing pain) in the next two weeks he should get Cephalexin and then surgical incision and drainage at SHCH. A furuncle is usually self healing and mostly due to Staphylococcus.

Best Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 04, 2007 10:26 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Paul J. M.D. Heinzelmann; Kathy Fiamma; Joseph Kvedar; Kruy Lim; Cornelia Haener
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#8, Bonn Sophen, 30F (Ta Tong Village)

Dear all,

Today is the second day for Robib TM Clinic April 2006. There are 4 new cases and 3 follow up cases. This is case number 8, continued from yesterday, Bonn Sophen, 30F and photos.

Please cc to chaurithy@yahoo.com and tmed_rithy@online.com.kh as well.

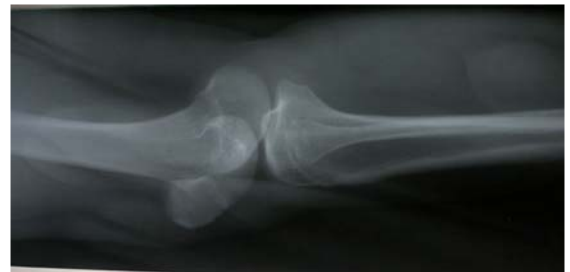
Best regards,
Sovann

History and Physical

Name/Age/Sex/Village: Bonn Sophen, 30F (Ta Tong Village)

Chief Complaint (CC): Knee joint pain x 5 months

History of Present Illness (HPI): 30F, farmer, came to us complaining of knee joints pain for 5 months. In December 2006, she presented with symptoms of pain, warmth, stiffness on right knee, and got treatment from local healer by injecting steroid and pain killer but it didn't get better. One month later the pain start on left knee so she went to Kg Thom hospital and had knee x-ray and got treatment with a few medication (unknown name). Now she still presents with slightly pain on the knee joints, denied of redness, swelling, stiffness, other joint attack.



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): no trauma, no redness, no swelling, no pain on joint, no skin rash, regular period

PE:

Vitals: BP: 100/62 P: 74 R: 20 T: 37°C Wt: 48Kg

General: Look stable

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

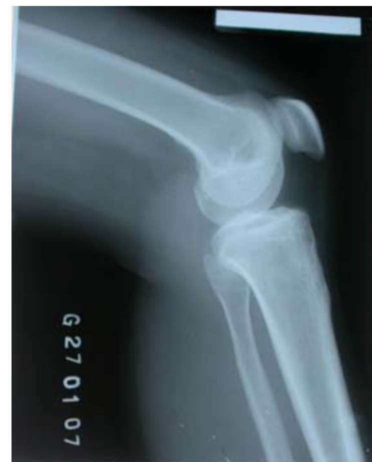
Chest: CTA bilaterally, no rales, no rhonchi; HRRR, no murmur

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

Extremity/Skin: on knee joint, no tender, no redness, no warmth, no swelling, no rash on the skin, no other joint attack

MS/Neuro: MS +5/5, sensory intact, DTRs +2/4, normal gait, full ROM on knee joint, and other joint

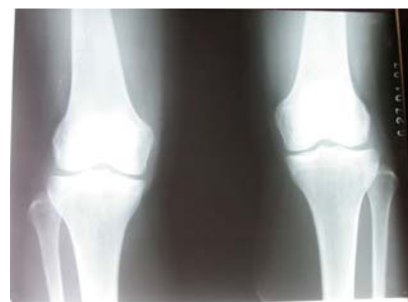
Lab/Study: Knee X-ray on December 27, 2006 attached



Assessment:

1. Arthritis

Plan:



1. Paracetamol 500mg 1t po qid prn pain for two months

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 Peng Sovann **Date: April 4, 2007**

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

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From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Thursday, April 05, 2007 1:56 PM
To: Robib Telemedicine
Cc: chaurithy@yahoo.com; tmed_rithy@online.com.kh
Subject: Re: Robib TM Clinic April 2007, Case#8, Bonn Sophen, 30F (Ta Tong Village)

Dear Sovann,
I agree this is most likely arthritis, or rather now there is not much to be seen. I think I would prefer an NSAID such as Naproxen 500mg bid or Ibuprofen 400-800mg q6h standing until the pain is resolved (for maybe 2 weeks) and then prn. NSAIDs have an inflammatory component and most likely will help a bit better than paracetamol. Also in an chronic pain situation you want to initially treat somebody with around the clock and not prn as the body otherwise continues to feel pain and "learns" to have pain and the pain will get very hard to control.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 04, 2007 10:34 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Paul J. M.D. Heinzelmann; Kathy Fiamma; Joseph Kvedar; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#9, Ros Yearn, 56F (Bakdoang Village)

Dear all,

This is case number 9, Ros Yearn, 56F and photos.

Please cc to chaurithy@yahoo.com and tmed_rithy@online.com.kh as well.

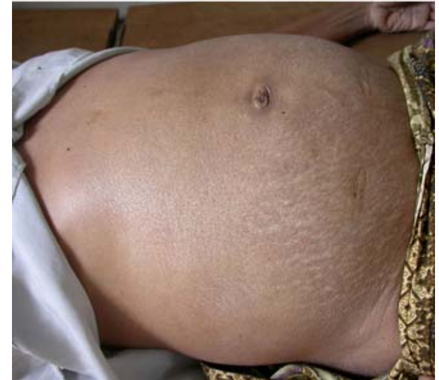
Best regards,
Sovann

History and Physical

Name/Age/Sex/Village: Ros Yearn, 56F (Bakdoang Village)

Chief Complaint (CC): Joint pain x 2y and Abdominal distension x 4 months

History of Present Illness (HPI): 56F, farmer, came to us complaining of joint pain x 2y and abdominal distension x 4 months. In last two years, she presented with symptoms of pain, redness, swelling, stiffness of ankle joint, no other joint attack, so he bought pain killer (NSAIDs) taken prn and traditional medication. The symptoms appeared on/off that why she has to take traditional medication and pain killer since then. In these 4 months, she developed other symptoms as abdominal distension, abdominal discomfort, fatigue, poor appetite, oliguria, edema. She went to local health center and was treated with Furosemide 20mg 2t every other day and asked local healer to give her injection at home. She didn't seek other treatment from other hospital. She denied of nausea, vomiting, cough, fever, chest pain, stool with blood.



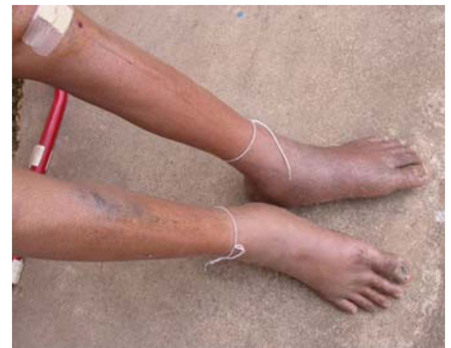
Past Medical History (PMH): Arthritis x 2y treated with traditional medication, and pain killer (NSAIDs)

Family History: Unremarkable

Social History: No alcohol drinking, no smoking

Current Medications: Furosemide 20mg 2t po every other day

Allergies: NKDA



Review of Systems (ROS): abdominal distension, abdominal discomfort, fatigue, poor appetite, oliguria, edema, no stool with mucus/blood, no jaundice, no icturus, no skin rash

PE:

Vitals: BP: 120/70 P: 112 R: 22 T: 37.5°C Wt: 45Kg??

General: Look sick, unable to walk due to ankle joint pain

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

Chest: CTA bilaterally, no rales, no rhonchi; H Tachycardia, RR, no murmur

Abd: Soft, no tender, distended, (+) BS, no HSM, (+) fluid wave, dilated collateral vein, no spider angioma, (+) striae, no CVA tenderness

Extremity/Skin: 2-3+ pitting edema, no rash, redness, tender, swelling on ankle

MS/Neuro: MS +4/5, sensory intact, DTRs +1/4 on ankle, other are normal

Rectal Exam: Lose sphincter tone, no mass palpable, (-) colocheck

Lab/Study: Hb: 11g/dl, BS: 118mg/dl, UA normal

Assessment:

1. Ascitis
2. Liver cirrhosis?
3. Nephrotic Syndrome??
4. Arthritis

Plan:

1. Omeprazole 20mg 2t po bid for two weeks
2. Metronidazole 250mg 2t po bid for two weeks
3. Amoxicillin 500mg 2t po bid for two weeks
4. Spironolactone 25mg 1t po bid for one month
5. Furosemide 20mg 1t po bid for two weeks
6. Diflunisal 500mg 1t po bid prn severe pain for one month
7. Paracetamol 500mg 1t po qid prn pain for one month
8. Draw blood for CBC, Lyte, BUN, Creat, Gluc, LFT, Hep B, Hep C at SHCH
9. Send to Kg Thom for abdominal ultrasound

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

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

Examined by: Nurse Peng Sovann **Date: April 4, 2007**

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

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From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Thursday, April 05, 2007 7:44 PM
To: Robib Telemedicine; Rithy Chau
Subject: FW: Robib TM Clinic April 2007, Case#9, Ros Yearn, 56F (Bakdoang Village)

From: Fang, Leslie S.,M.D.
Sent: Wednesday, April 04, 2007 7:55 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic April 2007, Case#9, Ros Yearn, 56F (Bakdoang Village)

```
If the urinalysis is totally negative, this is not nephrotic syndrome:
    ?cirrhosis (most likely)
    ?portal vein thrombosis
    Biventricular failure is less likely in view of the absence of JVD or HJR

Leslie Fang, MD
```

From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Thursday, April 05, 2007 1:56 PM
To: Robib Telemedicine
Cc: chaurithy@yahoo.com; tmed_rithy@online.com.kh
Subject: Re: FW: Robib TM Clinic April 2007, case#9, Ros Yearn, 56F (Bakdoang Village)

Dear Sovann,
First of all a question does the picture just come out bad or are the feet of a different coloration than the rest of her skin? Are both ankles or only one painful? Does she have good pulses on both feet? What are the two scars on her lower abdomen? Her face is kind of uneven, does she have a history of a stroke or have any facial weakness? How is her speech?
I agree that this woman has ascitis, but I am not clear on the etiology, it could be that she took a traditional drug that gave her severe liver toxicity or that she has had a longstanding liver problem that now has worsened. She is febrile and tachycardic and I am worried she might have spontaneous bacterial peritonitis. I think she needs to be evaluated for that in a faster fashion than we can provide at your sight.
However if that is not possible you should treat her for an assumed spontaneous bacterial peritonitis, with blood cultures drawn, an ascites tap and then you start her on for example Amoxicillin/Clavunic Acid 875mg bid to cover anaerobes, as well as Gram pos and negatives and the outcomes at least iv have been the same as for a third generation Cephalosporin.
Ascites/edema: I think we need a potassium back before we start her on Sprionolactone, you are telling me that she has be oliguric I am worried that her kidney is also failing from chronic NSAID abuse or other toxicity. I think there is no urgency for Spironolactone for now and we should maybe stick with the lasix for now and wait for the results of the lab tests.
Pain killer: I would be very careful in a woman like her with NSAIDS, they all stop your platelets from working and so if she has varices in the esophagus and they open up she will very likely bleed to death. So stick with the Paracetamol at the low dose as her liver can most likely not tolerate more and if you have to give her Tramadol 25mg g6h for pain as that will not influence your liver and not your platelets.
I agree with the omeprazole as you want as little irritation to the possible varicose veins as possible. You might want to add a non selective beta blocker such as Propranolol 20mg tid after we have a confirmed diagnosis of liver failure in order to decrease the portal hypertension.

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 04, 2007 10:40 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Paul J. M.D. Heinzelmann; Kathy Fiamma; Joseph Kvedar; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, Case#10, Heng Pheary, 30F (Thkeng Village)

Dear all,

This is case number 10, Heng Pheary, 30F and photo.

Please cc to chaurithy@yahoo.com and tmed_rithy@online.com.kh as well.

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: **Heng Pheary, 30F (Thkeng Village)**

Chief Complaint (CC): **Dyspnea x 10y**

History of Present Illness (HPI): 30F, farmer, came to us complaining of dyspnea x 10y. She presented with symptoms of dyspnea, fever, cough, sneezing. The symptoms happened during cold temperature and got into with smoking, she bought medication and taken prn. In last two months, she went to us and treated with Albuterol Inhaler and made appointment in this month. Now she got better with less SOB, no fever, no cough, normal appetite, normal bowel movement.

Past Medical History (PMH): Asthma 10y

Family History: Unremarkable

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

Current Medications: Albuterol Inhaler 2puffs bid prn

Allergies: NKDA

Review of Systems (ROS):

PE:

Vitals: BP: 110/72 P: 90 R: 22 T: 37°C Wt: 51Kg O2sat: 99%

General: Look stable

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

Chest: Fine crackle on lower lobes, no whezzing; HRRR, no murmur

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

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

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

Lab/Study: None

Assessment:

1. Asthma

Plan:

1. Albuterol Inhaler 2puffs po bid prn severe SOB for two months

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 Peng Sovann **Date: April 4, 2007**

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

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From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Thursday, April 05, 2007 1:56 PM
To: Robib Telemedicine
Cc: chaurithy@yahoo.com; tmed_rithy@online.com.kh
Subject: Re: Robib TM Clinic April 2007, Case#10, Heng Pheary, 30F (Thkeng Village)

Dear Sovann,
I agree with your assessment, I would treat her with a steroid inhaler unless she only needs the Albuterol inhaler for less than 1-2 times per week. I know we have inhalers and that would be the best choice for her. As the Albuterol inhaler is not long acting she should take it q4h prn in addition to the Steroid inhaler. Long acting Albuterol inhalers have been associated with increased mortality and should never be used unless steroid inhalers have been tried previously. She needs to understand they are to be taken bid whether she has symptoms or not and that if she notices that she is needing a lot of Albuterol she needs to come to see a doctor immediately to get treated for asthma excacerbation. How you take the steroid inhaler depends on the formulation so whatever you have dose it as per insert. If we ran out of steroid inhalers she will have to make neds meet with Albuterol q4h prn and maybe she can buy the steroid inhaler for around $10 a month? Ultimately the goal should be she takes the Albuterol inhaler once or twice a week and just uses the steroid inhaler every day.

Best,

Miriam

From: Fiamma, Kathleen M. [mailto:KFIAMMA@PARTNERS.ORG]
Sent: Thursday, April 05, 2007 7:46 PM
To: Rithy Chau; Robib Telemedicine
Subject: FW: Robib TM Clinic April 2007, Case#10, Heng Pheary, 30F (Thkeng Village)

From: Healey, Michael J.,M.D.

Sent: Wednesday, April 04, 2007 7:08 PM
To: Fiamma, Kathleen M.
Subject: RE: Robib TM Clinic April 2007, Case#10, Heng Pheary, 30F (Thkeng Village)

If her symptoms persist, I would recommend adding an inhaled steroid on a standing basis. Given the crackles, but no wheezes, a chest x-ray may also be of use. Has she had a PPD or other evaluation for tuberculosis?
Michael J. Healey, MD

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 04, 2007 11:07 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Paul J. M.D. Heinzelmann; Joseph Kvedar; Kathy Fiamma; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, case#11, Prum Ra, 48F (Koh Pon Village)

Dear all,

This is case number 11, Prum Ra, 48F and photo.

Please cc to chaurithy@yahoo.com and tmed_rithy@online.com.kh as well.

Best regards,
Sovann

History and Physical

Name/Age/Sex/Village: Prum Ra, 48F (Koh Pon Village)

Chief Complaint (CC): Epigastric pain x 2y

History of Present Illness (HPI): 48F, farmer, came to us complaining of epigastric pain for 2y. First she presented with symptoms of epigastric pain, burning sensation, burping with sour taste, the pain start after eating, no radiation, she went to kg Thom hospital and diagnosed with gastritis and treated with antacid for two months. She got better for a few months later, then the symptoms developed again and she didn't go for checking up, just went to get treatment from local health center. She denied of vomiting, dysphagia, stool with blood, edema.

Past Medical History (PMH): S/P Thyroidectomy in 1988

Family History: Unremarkable

Social History: No alcohol drinking, no smoking, 11 children

Current Medications: unknown name antacid for epigastric pain prn

Allergies: NKDA

Review of Systems (ROS): no nausea, no vomiting, no fever, no cough, no palpitation, no stool with mucus/blood, 1y post menopause

PE:

Vitals: BP: 120/66 P: 82 R: 20 T: 37°C Wt: 52Kg

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; HRRR, no murmur

Abd: Soft, slightly tender on epigastric area, no distension, (+) BS, no HSM

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

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

Lab/Study: None

Assessment:

1. GERD
2. Parasititis

Plan:

1. Famotidine 10mg 2t po qhs for two months
2. Mebendazole 100mg 1t po bid for 3d
3. GERD prevention education

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

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

Examined by: Nurse Peng Sovann Date: April 4, 2007

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

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From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Thursday, April 05, 2007 1:56 PM
To: Robib Telemedicine
Cc: chaurithy@yahoo.com; tmed_rithy@online.com.kh
Subject: Re: Robib TM Clinic April 2007, case#11, Prum Ra, 48F (Koh Pon Village)

Dear Sovann,
Does she have a positive occult blood in her stool? I agree with your assessment. She should be referred to SHCH for gastroscopy as she is close in age to 50 and looks remarkably older and her symptoms are recurring.

Best,

Miriam

From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]
Sent: Thursday, April 05, 2007 7:50 PM
To: Fiamma, Kathleen M.; robibtelemed@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: RE: FW: Robib TM Clinic April 2007, case#11, Prum Ra, 48F (Koh Pon Village)

The patients symptoms sound like gastritis with possibly reflux.
It is not clear how the diagnosis of gastritis was made at the Thom hospital.

Treating with famotadine and diet are appropriate approaches for acid induced problems.
Are you treating her with mebendazole because her water supply is likely contaminated? You did not present too many symptoms of diarrhea or abdominal cramping/pain to suggest infection

Best of luck,

Paul

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 04, 2007 11:09 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Paul J. M.D. Heinzelmann; Joseph Kvedar; Kathy Fiamma; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, case#12, Tum Lam, 57M (Reusey Srok Village)

Dear all,

This is case number 12, Tum Lam, 57M and photos.

Please cc to chaurithy@yahoo.com and tmed_rithy@online.com.kh as well.

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: Tum Lam, 57M (Reusey Srok Village)

Subjective: 57M came to follow up of Gouty arthritis, Cushing's syndrome, anemia, and hyperlipidemia. He felt much better than before with symptoms of less pain, stiffness, but still unable to walk. He stop taking FeSO4/Vit and Cephalexin because he got severe stomach upset, and now still presented with epigastric pain, burping with sour taste for sometime. He denied of nausea, vomiting, stool with mucus, blood, oiguria, hematuria, edema.

Objective:

VS: BP: 200/110 (both arms) P: 86 R: 20 T: 37
Wt: kg (Unable to stand for weight)

PE (focused):

General: Look sick

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

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

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

Skin/Extremity: Rash on the left elbow still presented; rash on armpit has gone; tender, stiffness on all joints of extremity but can move better than last month

MS/Neuro: MS +2/5 due to joint stiffness, sensory intact

Lab result on March 16, 2007

Test	Result	Normal	Test	Result	Normal
WBC	=8	[4 - 11x10^9/L]	Na	=142	[135 - 145]
RBC	=3.9	[4.6 - 6.0x10^{12}/L]	K	=3.4	[3.5 - 5.0]
Hb	=11	[14.0 - 16.0g/dL]	Cl	=113	[95 - 110]
Ht	=36	[42 - 52%]	BUN	=5.2	[0.8 - 3.9]
MCV	=91	[80 - 100fl]	Creat	=191	[53 - 97]
MCH	=28	[25 - 35pg]	Gluc	=5.9	[4.2 - 6.4]
MHCH	=31	[30 - 37%]	Uric Aci	=604	[200 - 420]
Plt	=472	[150 - 450x10^9/L]	SGOT	=62	[<33]
Lym	=1.6	[1.0 - 4.0x10^9/L]	SGPT	=51	[<40]
Mxd	=0.4	[0.1 - 1.0x10^9/L]			
Neut	=5.9	[1.8 - 7.5x10^9/L]			

Current Medications:

1. Paracetmaol 500mg 1t po qid prn

Allergies: NKDA

Assessment:

1. Gouty Arthritis
2. HTN
3. Cushing Syndrome
4. Hyperlipidemia
5. Dyspepsia

Plan:

1. Atenolol 50mg 1t po bid for one month
2. Omeprazole 20mg 1t po qhs for one month
3. Paracetamol 500mg 1t po qid prn for one month
4. Warmth compression prn joint pain

Lab/Study Requests: None

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: April 4, 2007**

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

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From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Thursday, April 05, 2007 1:56 PM
To: Robib Telemedicine
Cc: chaurithy@yahoo.com; tmed_rithy@online.com.kh
Subject: Re: Robib TM Clinic April 2007, case#11, Prum Ra, 48F (Koh Pon Village)

Dear Sovann,
Why does he have cushing syndrome and are we treating that in any way? I agree with your assessment but am a bit worried why this 57 year old male is anemic. We should send off a Ferritin or rather do we have on even before we started him on iron? Does he have hemoccult positive stool? If he does he needs a gastroscopy as he is anemic, over 50 and has symptoms that could just be GERD or he could have H pylori or even worse a cancer.
I am not sure on the symptoms that he has? Gouty arthritis is usually in one joint only. His feet though look a bit deformed and how are his pulses? He might have sever arterial insufficiency that could cause his symptoms. But then he would not elevate his legs so much. A man who cannot walk due to so severe pain needs a stronger medication give him at least Tramadol 50-100mg q6h and if that does not do it start him on Morphine 30mg extended release.

For the hypertension I agree to give him Atenolol.

Can you send a picture of the rash maybe he has psoriasis?

Best,

Miriam

From: Cusick, Paul S.,M.D. [mailto:PCUSICK@PARTNERS.ORG]
Sent: Thursday, April 05, 2007 8:16 PM
To: Fiamma, Kathleen M.; robibtelemed@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: RE: Robib TM Clinic April 2007, case#12, Tum Lam, 57M (Reusey Srok Village)

This is a difficult case. I have consulted with a rheumatologist and a dermatologist regarding this case.

It is not clear how the patient was diagnosed with Cushing's sydrome.

The cause of the lower limb pain and deformity and inabilty to walk may be from an arthritis such as gout. However, we are not entirely certain of this. Treating with acetominophen and heat is a good approach.

His high blood pressure needs to be treated and I agree with atenolol.

I agree treating the sour stomach w/ omeprazole.

further instructions depend on further information from the specialists.

Paul

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 04, 2007 11:12 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Paul J. M.D. Heinzelmann; Joseph Kvedar; Kathy Fiamma; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, case#13, Chea Bunseang, 60M (Phnom Dek Village)

Dear all,

This is case number 13, Chea Bunseang, 60M and photo.

Please cc to chaurithy@yahoo.com and tmed_rithy@online.com.kh as well.

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: Chea Bunseang, 60M (Phnom Dek Village)

Subjective: 60M came to follow up of DMII, anemia. In March, his FBS was 216mg/dl so we increase Glibenclamide 5mg 1t bid to 11/2t bid and follow up in one month. He is stable with normal appetite, normal bowel movement, denied of fever, cough, chest pain, palpitation, polyuria, oliguria, hematuria, edema, but complained of numbness and tingling on the sole.

Objective:

VS: BP: 110/60 P: 80 R: 20 T: 36.5 Wt: 51kg

PE (focused):

General: Look stable

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

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

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

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

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

Lab/Study: FBS: 201mg/dl on April 3, 2007
FBS: 212mg/dl on April 4, 2007

Lab Result on February 16, 2007

Test	Result	Normal	Test	Result	Normal
WBC	=7	[4 - 11x10^9/L]	Na	=140	[135 - 145]
RBC	=4.8	[4.6 - 6.0x10^{12}/L]	K	=4.7	[3.5 - 5.0]
Hb	=11.2	[14.0 - 16.0g/dL]	Cl	=106	[95 - 110]
Ht	=36	[42 - 52%]	BUN	=2.7	[0.8 - 3.9]
MCV	=73	[80 - 100fl]	Creat	=127	[53 - 97]
MCH	=23	[25 - 35pg]	Glu	=10.4	[4.2 - 6.4]
MHCH	=32	[30 - 37%]	T. Chol	=2.6	[<5.7]
Plt	=100	[150 - 450x10^9/L]			
Lym	=2.0	[1.0 - 4.0x10^9/L]			
Mxd	=1.6	[0.1 - 1.0x10^9/L]			
Neut	=3.0	[1.8 - 7.5x10^9/L]			
Retic Count	= 1.7	[0.5 - 1.5]			
HbA1C	=14.7	[4 - 6]			

Current Medications:

1. Glibenclamide 5mg 11/2t po bid
2. Captopril 25mg 1/4t po qd
3. ASA 300mg 1/4t po qd
4. FeSO4/Folic Acid 200/0.25mg 1t po qd

Allergies: NKDA

Assessment:

1. DMII with PNP
2. Anemia

Plan:

1. Glibenclamide 5mg 2t po bid for two months
2. Captopril 25mg 1/4t po qd for two months
3. ASA 300mg 1/4t po qd for two months
4. FeSO4/Folic acid 200/0.25mg 1t po qd for two months
5. Amitriptylin 25mg 1/2t po qhs for two months

Lab/Study Requests: None

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: April 4, 2007**

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

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From: Paul Heinzelmann [mailto:paul.heinzelmann@gmail.com]
Sent: Thursday, April 05, 2007 2:07 AM
To: kfiamma@partners.org; robibtelemed@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: FW: Robib TM Clinic April 2007, case#13, Chea Bunseang, 60M (Phnom Dek Village)

Dear Sovann,

How long was the tingling? Does he have normal sensation to touch on his feet. If the tingling has been present n the past and has decreased sensation, then yes consider peripheral neuropathy and start the amitriptyline.

Best,

Paul Heinzelmann, MD

From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Thursday, April 05, 2007 1:56 PM
To: Robib Telemedicine
Cc: chaurithy@yahoo.com; tmed_rithy@online.com.kh
Subject: Re: Robib TM Clinic April 2007, case#13, Chea Bunseang, 60M (Phnom Dek Village)

Dear Sovann,
Anemia:
I don't think this is iron deficiency anemia as his MCV is disproportionately low for this HCT. You do not need to give him Iron that is not going to do anything. Most likely he has a hemoglobinopathy. Otherwise I am a bit surprised that his platelets are so low. You should observe that and resend a platelet count to see how it develops.

Diabetes:
His diabetes is not controlled and increasing the Glibenclamide by a half pill will do nothing. As a rule of thumb oral antiglycemics decrease the Hba1c by a maximum of 1g/dl. You need to start him on Insulin NPH 10 units in the morming and 5 units in the evening and re assess him after a month. He needs better control as he is already having problems with this nerves. How long has he had the Captopril and what is the creatinine development on it? If this is newly elevated or >10% but not more than 30% he needs a repeat if it is >30% higher than before you have to stop the Captopril

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Wednesday, April 04, 2007 11:17 PM
To: Rithy Chau; Rithy Chau; Miriam Haverkamp; Miriam Haverkamp; Paul J. M.D. Heinzelmann; Joseph Kvedar; Kathy Fiamma; Kruy Lim
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach
Subject: Robib TM Clinic April 2007, case#14, Prum Norn, 56F (Thnout Malou Village)

Dear all,

This is the last case for Robib TM clinic April 2007, case number 14, Prum Norn, 56F and photos. Please reply to the cases before tomorrow afternoon. Thank you very much for your cooperation and support in this project.

Please cc to chaurithy@yahoo.com and tmed_rithy@online.com.kh as well.

Best regards,
Sovann

Robib Telemedicine Clinic

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

SOAP Note

Prum Norn, 56F (Face)
Prum Norn, 56F (EKG)

Patient Name & Village: Prum Norn, 56F (Thnout Malou Village)

Subjective: 56F came to follow up of Liver cirrhosis with PHTN, anemia. She is better than last month, but still complained fo fainting, fatigue, dizziness, dyspnea, and chest pain two time in this month while she carried the water and have to wait about 10minutes then she can do her normal work. She denied cough, fever, palpitation, stool with blood, oliguria, dysuria, hematuria, edema.

Objective:

VS: BP: 100/58 P: 48 R: 22 T: 36.5 Wt: 41kg

PE (focused):

General: Look stable

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

Chest: CTA bilaterally, no rales, no rhonchi; H bradycardia, skip beat after two beats, no murmur, (+) pulse on radius and dorsalis pedis but weak

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

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

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

Lab result on March 16, 2007

Test	Result	Normal	Test	Result	Normal
WBC	=3	[4 - 11x10^9/L]	Na	=146	[135 - 145]
RBC	=3.1	[3.9 - 5.5x10^{12}/L]	K	=4.5	[3.5 - 5.0]
Hb	=6.5	[12.0 - 15.0g/dL]	Cl	=120	[95 - 110]
Ht	=23	[35 - 47%]	BUN	=1.9	[0.8 - 3.9]
MCV	=72	[80 - 100fl]	Creat	=158	[44 - 80]
MCH	=20	[25 - 35pg]	Glu	=4.5	[4.2 - 6.4]
MHCH	=29	[30 - 37%]	SGOT	=33	[<30]
Plt	=171	[150 - 450x10^9/L]	SGPT	=21	[<30]
Lym	=0.7	[1.0 - 4.0x10^9/L]			
Mxd	=0.5	[0.1 - 1.0x10^9/L]			
Neut	=1.7	[1.8 - 7.5x10^9/L]			
Retic count	= 0.2	[0.5 - 1.5]			
Hypocromic 2+					
Microcytic 2+					

Schistocyte 1+
Elliptocyte 2+

2D echo result on April 4, 2003
EF 55%, normal systolic function, valve normal, interventricular septum dilated, difficulty with relaxation; Conclusion: Hypertensive cardiomyopathy

Current Medications:
1. Propranolol 40mg 1t po bid
2. Spironolactone 25mg 1t po bid
3. HCTZ 50mg 1/2t po qd
4. FeSO4/Folic Acid 200/0.25mg 1t po tid

Allergies: NKDA

Assessment:

1. Liver cirrhosis with PHTN
2. HTN
3. Hypocromic Microcytic Anemia
4. Hyertensive cardiomyopathy
5. Bradycardia

Plan:

1. Stop Propranolol
2. Spironolactone 25mg 1t po bid for one month
3. HCTZ 50mg 1/2t po qd for one month
4. FeSO4/Folic Acid 200/0.25mg 1t po tid for one month

Lab/Study Requests: None

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: April 4, 2007**

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

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From: Paul Heinzelmann [mailto:paul.heinzelmann@gmail.com]
Sent: Thursday, April 05, 2007 7:24 AM
To: Fiamma, Kathleen M.; robibtelemed@yahoo.com
Cc: tmed_rithy@online.com.kh
Subject: Re: FW: Robib TM Clinic April 2007, case#14, Prum Norn, 56F (Thnout Malou Village)

This patient has a difficult situation...recent studies suggest that propanolol is beneficial for patients with cardiomyopathy - on the other hand if it slows the heart too much and lowers the BP its risk outweighs its

benefit. ACE inhibitors (i.e. captopril, enalapril) might be a better option if available.

She likely has HYPERTROPHIC (not hypertensive) cardiomyopathy. RESTRICTIVE cardiomyopathy refers to a global inability to relax - few medicines can help. Her ECHO seems to support hypertrophic cardiomyopathy.....
[See: http://www.nlm.nih.gov/medlineplus/ency/article/000192.htm for more info].

Her anemia is also quite severe. Are we certain that this is diet-related? Can we do a Colocheck to rule out GI bleed? (Though this is less likely with a normal BUN). I agree with diet and Fe supplement, but would consider hospitalization if that's an option.

Paul Heinzelmann

From: miriamhaverkamp@gmail.com [mailto:miriamhaverkamp@gmail.com] **On Behalf Of** Miriam Haverkamp
Sent: Thursday, April 05, 2007 1:56 PM
To: Robib Telemedicine
Cc: chaurithy@yahoo.com; tmed_rithy@online.com.kh
Subject: Re: Robib TM Clinic April 2007, case#14, Prum Norn, 56F (Thnout Malou Village)

Dear Sovann,
This case is a bit of a mystery to me. She needs an IMMEDIATE blood transfusion as she is symptomatic with her anemia and her hemoglobin was 6 three weeks ago! (at least two it not three units) You are correct to stop the propranolol. She is in sinus rhythm and has a poor R wave progression but otherwise it is all fine. Furthermore we need to find out why is she anemic. She needs a stool guaiac and needs to be worked up with a ferritin and possibly a bone marrow if the ferritin is >150. She needs a gastroscopy and colonoscopy is she is truly iron deficient as a woman her age should not be that severely anemic. The iron should not be started until she gets the colonoscopy as Dr Pouv will otherwise not see anthing. The other thing is she should have her stool examined for O and P and maybe take some Albendazole 400mg qd for three days just in case it is worms that make her so anemic.
I am not clear on what you base the liver cirrhosis with the portal hypertension. She has no ascites in your assessment and her LFTs are entirely normal. If her LFTs are normal I would expect her to be in severe liver failure which Sprironolactone should not work for that well to not have any ascites.

Best,

Miriam

From: Robib Telemedicine [mailto:robibtelemed@yahoo.com]
Sent: Thursday, April 05, 2007 8:24 PM
To: Kathy Fiamma
Cc: Bernie Krisher; Thero Noun; Laurie &, Ed Bachrach; Rithy Chau
Subject: Robib TM Clinic April 2007 cases received

Dear Kathy,

I have already received 9 cases from you. Below are the cases received:

Case#1, Satt Binn, 38F
Case#2, Thon Mai, 78M
Case#3, So Soksan, 23F
Case#4, Pou Limthang, 42F
Case#7, Chan Oeung, 57M

Case#9, Ros Yearn, 56F
Case#10, Heng Pheary, 30F
Case#13, Chea Bunseang, 60M
Case#14, Prum Norn, 56F

Thank you very much for your replies.

Best regards,
Sovann

Thursday, April 5, 2007

Follow-up Report for Robib TM Clinic

There were 6 new and 8 follow-up patients seen during this month Robib TM Clinic and the other 32 patients came for medication refills only, and one patient missed appointment. The data of all 14 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 April 2007

1. Satt Binn, 38F (Ta Tong Village)
Diagnosis:

1. Goiter

Treatment:

1. Draw blood for TSH and Free T4 at SHCH

Lab result on April 6, 2007

TSH	=0.81	[0.49 - 4.67]
Free T4	=13.61	[9.14 - 23.81]

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

1. DMII
2. Cachexia

Treatment:

1. Glibenclamide 5mg 1/2t po bid for one month (# 35)
2. ASA 300mg 1/4t po qd for one month (# 10)
3. MTV 1t po qd for one month (#30)
4. FeSO4/Folic Acid 200/0.25mg 1t po qd for one month (# 30)
5. Alcohol and smoking cessation
6. Educate on diabetic diet and foot care

Lab/Study Requests: Draw blood for CBC, Lyte, BUN, Creat, Gluc at SHCH
Lab result on April 6, 2007

WBC	=7	[4 - 11x10^9/L]	Na	=129	[135 - 145]
RBC	=5.1	[4.6 - 6.0x10^{12}/L]	K	=3.8	[3.5 - 5.0]
Hb	=14.1	[14.0 - 16.0g/dL]	Cl	=105	[95 - 110]
Ht	=42	[42 - 52%]	BUN	=1.7	[0.8 - 3.9]
MCV	=82	[80 - 100fl]	Creat	=98	[53 - 97]
MCH	=28	[25 - 35pg]	Gluc	=18.8	[4.2 - 6.4]
MHCH	=34	[30 - 37%]			
Plt	=180	[150 - 450x10^9/L]			
Lym	=1.9	[1.0 - 4.0x10^9/L]			
Mxd	=0.7	[0.1 - 1.0x10^9/L]			
Neut	=3.9	[1.8 - 7.5x10^9/L]			

3. So SokSan, 23F (Thnal Keng Village)
Diagnosis:

1. Recurrent Nephrotic Syndrome

Treatment:

1. Captopril 25mg 1/2t po bid for one month (# 30)
2. Furosemide 20mg 1t po bid for one month (# 60)
3. Drink 1L/d of water and eat one banana per day

Lab/Study Requests: None

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

1. Hyperthyroidism

Treatment:

1. Propranolol 40mg 1t po bid for one month (#60)
2. Carbimazole 5mg 6t po qd for one month (#180)
3. Draw blood for TSH and Free T4 in two months

Lab/Study Requests: None

5. Pheng Roeung, 61F (Thnout Malou Village)
Diagnosis:

1. HTN
2. Euthyroid
3. Dyspepsia

Treatment:

1. Atenolol 50mg 1t po bid for three months (# 180)
2. HCTZ 50mg 1/2t po qd for three months (# 60)
3. Famotidine 10mg 1t po qhs for one months (# 30)

Lab/Study Requests: None

6. Chhorn Sophorn, 60M (Taing Treuk Village)
Diagnosis:

1. Arthritis
2. Right Knee Frozen Joint
3. Both Knee deformity

Treatment:

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

7. Chan Oeung, 57M (Sangke Roang Village)
Diagnosis:
1. HTN
2. Rhumatoid arthritis
3. Tinea Psoriasis
4. Furuncle on the back

Treatment:
1. HCTZ 50mg 1/2t po qd for one month (# 15)
2. Diflunisal 500mg 1t po bid prn severe pain for one month (# 20)
3. Paracetamol 500mg 1t po qid prn pain for one month (# 30)
4. Fluocinolone cream 0.025% 15mg apply bid until rash gone (# 1)
5. Warmth compression on the joint and furuncle

Lab/Study Requests: None

8. Bonn Sophen, 30F (Ta Tong Village)
Diagnosis:
1. Arthritis

Treatment:
1. Paracetamol 500mg 1t po qid prn pain for one month (# 30)

9. Ros Yearn, 56F (Bakdoang Village)
Diagnosis:
1. Ascitis
2. Liver cirrhosis?
3. Arthritis

Treatment:
1. Furosemide 20mg 2t po bid for two weeks (# 60)
2. Diflunisal 500mg 1t po bid prn severe pain for one month (# 20)

Lab/Study Requests: Draw blood for CBC, Lyte, BUN, Creat, Gluc, LFT, Hep B, Hep C at SHCH, and Send to Kg Thom for abdominal ultrasound

Lab result on April 6, 2007

WBC	=7	[4 - 11x10^9/L]	Na	=121	[135 - 145]
RBC	=4.1	[3.9 - 5.5x10^{12}/L]	K	=2.0	[3.5 - 5.0]
Hb	=9.9	[12.0 - 15.0g/dL]	Cl	=89	[95 - 110]
Ht	=31	[35 - 47%]	BUN	=1.3	[0.8 - 3.9]
MCV	=75	[80 - 100fl]	Creat	=57	[44 - 80]
MCH	=24	[25 - 35pg]	Gluc	=5.4	[4.2 - 6.4]
MHCH	=32	[30 - 37%]	SGOT	=55	[<30]
Plt	=54	[150 - 450x10^9/L]	SGPT	=12	[<30]
Lym	=0.9	[1.0 - 4.0x10^9/L]	HBs-Ag	None reactive	
Mxd	=0.5	[0.1 - 1.0x10^9/L]	HCV	Reactive	
Neut	=5.1	[1.8 - 7.5x10^9/L]			

10. Heng Pheary, 30F (Thkeng Village)
Diagnosis:
1. Asthma

Treatment:

1. Albuterol Inhaler 2puffs po bid prn severe SOB for two months (# 2)

11. Prum Ra, 48F (Koh Pon Village)
Diagnosis:

1. GERD
2. Parasititis

Treatment:

1. Famotidine 10mg 2t po qhs for two months (# 90)
2. Mebendazole 100mg 1t po bid for 3d (# 6)
3. GERD prevention education

12. Tum Lam, 57M (Reusey Srok Village)
Diagnosis:

1. Gouty Arthritis
2. HTN
3. Hyperlipidemia
4. Dyspepsia

Treatment:

1. Atenolol 50mg 1/2t po bid for one month (# 30)
2. Mg/Al(OH)3 250/125mg chew 2t po bid prn for one month (# 50)
3. Paracetamol 500mg 1t po qid prn for one month (# 30)
4. Warmth compression prn joint pain

Lab/Study Requests: None

13. Chea Bunseang, 60M (Phnom Dek Village)
Diagnosis:

1. DMII with PNP
2. Anemia

Treatment:

1. Glibenclamide 5mg 11/2t po bid for two months (# 180)
2. Metformin 500mg 1t po qhs for two months (# 60)
3. Captopril 25mg 1/4t po qd for two months (# 15)
4. ASA 300mg 1/4t po qd for two months (# 15)
5. FeSO4/Folic acid 200/0.25mg 1t po qd for two months (# 60)
6. Amitriptylin 25mg 1/2t po qhs for two months (# 60)

Lab/Study Requests: Draw blood for Lyte, BUN, Creat, Gluc at SHCH

Lab result on April 6, 2007

Na	=136	[135 - 145]
K	=3.7	[3.5 - 5.0]
Cl	=109	[95 - 110]
BUN	=4.5	[0.8 - 3.9]
Creat	=155	[53 - 97]
Gluc	=8.9	[4.2 - 6.4]

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

1. Liver cirrhosis with PHTN
2. HTN
3. Hypocromic Microcytic Anemia

4. Cardiomyopathy
5. Bradycardia

Treatment:

1. Propranolol 40mg 1/2t po bid for one month (# 30)
2. Spironolactone 25mg 1t po bid for one month (# 60)
3. HCTZ 50mg 1/2t po qd for one month (# 15)
4. FeSO4/Folic Acid 200/0.25mg 1t po tid for one month (# 90)

Lab/Study Requests: None

Patients who came to refill medication

1. Yin Tann, 61F (Thkeng Village)
Diagnosis:

1. GERD
2. Subclinical Hyperthyroidism

Treatment:

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

Lab/Study: None

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

1. Arthritis
2. Anemia
3. Elevated BP

Treatment:

1. Paracetamol 500mg 1t po qid prn pain for one month (# 30)
2. FeSO4 200mg 1t po qd (# 30)
3. Do regular exercise, and eat low Na diet
4. Recheck BP in next follow up

Lab/Study Requests: None

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

1. GOUT
2. Dyspepsia
3. HTN

Treatment:

1. Paracetamol 500mg 1t po qid prn pain for two months (# 50)
2. HCTZ 50mg 1/2t po qd for one month (# 20)

Lab/Study Requests: None

4. Srey Hom, 62F (Taing Treuk Village)
Diagnosis:

1. HTN
2. DMII with PNP
3. Renal Insufficiency

4. UTI

Treatment:

1. Glibenclamide 5mg 1t po bid for one month (# 60)
2. Nifedipine 10mg 1/2t po bid for one month (# 30)
3. ASA 300mg 1/4t po qd for one month (# 8)
4. Amitriptylin 25mg 1/2t po qhs for one month (# 15)
5. Review him on diabetic diet, hypoglycemia sign and foot care

Lab/Study Requests: None

5. Deng Thin, 53M (Chhnoun Village)
Diagnosis:

1. HTN

Treatment:

1. HCTZ 50mg 1/2t po qd for one month (# 15)
2. Do regular exercise and eat low Na diet

Lab/Study Requests: None

6. Vong Yan, 72F (Boeung Village)
Diagnosis:

1. HTN
2. Anemia

Treatment:

1. HCTZ 50mg 1t po qd for two months (# 60)
2. FeSO4/Folic Acid 200/0.25mg 1t po qd for two months (# 60)
3. Do regular exercise and eat low Na diet

Lab/Study Requests: None

7. Same Kun, 28F (Boeung Village)
Diagnosis:

1. Hyperthyroidism
2. Tachycardia

Treatment:

1. Carbimazole 5mg 2t po tid for one month (#180)
2. Propranolol 40mg 1½t po bid for one month (# 90)

Lab/Study Requests: Draw blood for TSH and Free T4 at SHCH in two months

8. Tann KIn Horn, 51F (Thnout Malou Village)
Diagnosis

1. DMII

Treatment

1. Glibenclamide 5mg 1t po bid for two months (# 120)
2. Metformin 500mg 1t po qhs for two months (# 60)
3. Captopril 25mg 1/4t po qd for two months (# 15)
4. Review patient about DMII diet and regular exercise

Lab/Study requested: None

9. Tann Sopha Nary, 22F (Thnout Malou Village)
Diagnosis

1. Hyperthyroidism

Treatment

1. Propranolol 40mg 1t po bid for two months (120tab)
2. Carbimazole 5mg 1/2t po tid for two months (# 90)

Lab/Study Requests: Draw blood for Free T4 at SHCH in two months

10. Ros Lai, 65F (Taing Treuk Village)
Diagnosis:

1. Subclinical Hyperthyroidism
2. Nodular Goiter
3. Anemia
4. Tachycardia

Treatment:

1. Propranolol 40mg 1/4t po bid for one month (# 10)
2. FeSO4 200mg 1t po qd for one month (30tab)
3. MTV 1t po qd for one month (30tab)

Lab/Study Requests: Draw blood for Free T4, and TSH at SHCH

Lab Result on April 6, 2007

TSH =0.58 [0.49 - 4.67]
Free T4=10.50 [9.14 - 23.81]

11. Ros Oeun, 50F (Thnout Malou Village)
Diagnosis:

1. HTN
2. DMII

Treatment:

1. Glibenclamide 5mg 2t po bid for two month(# 240)
2. Metformin 500mg 2t po bid for two month (# 240)
3. Lisinopril 20mg 1/2t po qd for two month (# 30)
4. ASA 300mg 1/4t po qd for two month (# 15)

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

1. HTN
2. Anemia

Treatment:

1. HCTZ 50mg 1/2t po qd for three months (# 45)
2. MTV 1t po qd for three months (# 90)
3. FeSO4/Folic Acid 200/0.25mg 1t po qd for three months (# 90)

13. Chorn Samoeun, 15M (Sangke Roang Village)
Diagnosis:

1. Epilepsy

2. Cachexia

Treatment:

1. MTV 1t po qd for two months (# 90)
2. Follow up prn

Lab/Study Requests: None

14. Say Soeun, 67F (Rovieng Cheung Village)
Diagnosis:

1. HTN
2. DMII
3. Anemia

Treatment:

1. Glibenclamide 5mg 1t po bid for two months (# 120)
2. Metformin 500mg 1t po bid for two months (# 120)
3. Lisinopril 20mg 1t po qd for two months (# 60)
4. HCTZ 50mg ½t po qd for two months (# 30)
5. ASA 300mg ¼t po qd for two months (# 15)
6. FeSO4/Folic Acid 200/0.25mg 1t po qd for two months (# 60)
7. MTV 1t po qd for two months (# 60)
8. Review patient on hypoglycemia sign and regular exercise

Lab/Study Requests: None

15. Nung Chhun, 70F (Ta Tong Village)
Diagnosis:

1. HTN
2. DMII
3. Anemia

Treatment:

1. Glibenclamide 5mg 1t po bid for two months (# 120)
2. Metformin 500mg 1t po bid for two months (#120)
3. Lisinopril 20mg 1/4t po dd for two months (# 15)
4. ASA 300mg 1/4t po qd for two months (# 15)
5. FeSO4/Folic Acid 200/0.25mg 1t po qd for two months (# 60)
6. Review patient hypoglycemia sign, regular exercise

Lab/Study Requests: None

16. Lim Samnang, 26M (Bos Pey Village)
Diagnosis:

1. Anemia secondary to PUD

Treatment:

1. FeSO4/Folic Acid 200/0.25mg 1t po tid for two months (# 180)
2. MTV 1t po bid for two months (# 120)

Lab/Study Requests: Draw blood for CBC, Reticulocyte, peripheral smear at SHCH
Lab result on April 6, 2007

WBC	=5	[4 - 11x10^9/L]
RBC	=5.8	[4.6 - 6.0x10^{12}/L]
Hb	=13.3	[14.0 - 16.0g/dL]

Ht =45 [42 - 52%]
MCV =78 [80 - 100fl]
MCH =23 [25 - 35pg]
MHCH =29 [30 - 37%]
Plt =217 [150 - 450x10^9/L]
Lym =2.9 [1.0 - 4.0x10^9/L]
Mxd =0.7 [0.1 - 1.0x10^9/L]
Neut =1.4 [1.8 - 7.5x10^9/L]
Hypocromic 2+
Elliptocyte 2+
Poikilocytosis 2+
Dacryotcytes 2+
Reticulocyte Count=0.5 [0.5 - 1.5]

17. Som Thol, 57M (Taing Treuk Village) (Check BS)
Diagnosis:

1. DMII
2. PNP

Treatment:

1. Glibenclamide 5mg 2t po bid for three months (# 360)
2. Metformin 500mg 1t po qAM and 2t po qPM for three months (# 270)
3. ASA 300mg ¼t po qd for three months (# 25)
4. Amitriptyline 25mg 1t po qhs for three months (90tab)
5. Review him on diabetic diet and hypoglycemia sign

Lab/Study Requests: None

18. Kong Nareun, 31F (Taing Treuk Village)
Diagnosis:

1. VHD (Mitral Stenosis/Regurgitation)
2. PVC

Treatment:

1. Atenolol 50mg 1/2t po bid for two months (# 60)
2. Furosemide 20mg 1t po bid for two months (# 120)
3. ASA 300mg 1/4t po qd for two months (# 15)

Lab/Study Requests: None

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

1. Post partum cardiomegaly?

Treatment:

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

Lab/Study Requests: None

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

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

Treatment:

1. Spironolactone 25mg 1t po bid for two months (# 120)
2. FeSO4/Vit C 500/105mg 1t po qd for two months (# 60)
3. MTV 1t po bid for two months (# 60)
4. Folic Acid 5mg 1t po qd for two months (# 60)

Lab/Study Requests: None

21. Sath Rim, 50F (Taing Treuk Village)
Diagnosis:

1. HTN
2. DMII
3. Anemia

Treatment:

1. Metformin 500mg 1t po bid for two months (# 180)
2. Glibenclamide 5mg 11/2t po bid for three months (# 270)
3. Lisinopril 20mg 1t po qd for three months (# 90)
4. Atenolol 50mg 1t po bid for three months (# 180)
5. HCTZ 50mg ½ t po qd for three months (# 45)
6. Amitriptylin 25mg 1t po qhs for three months (# 90)
7. FeSO4/Folic Acid 200/0.25mg 1t po qd for three months (# 90)
8. Do regular exercise, educate on hypoglycemia sign

Lab/Study Requests: None

22. Tith Hun, 54F (Ta Tong Village)
Diagnosis:

1. HTN
2. Hypocromic Microcytic Anemia

Treatment:

1. Atenolol 50mg ½t po bid for three months (# 90)
2. Lisinopril 20mg ¼t po qd for three months (# 25)
3. HCTZ 50mg 1t po qd for three months (# 90)
4. FeSO4/Folic Acid 200/0.25mg 1t po qd for three months (# 90)

Lab/Study Requests: Draw blood for CBC, Lyte, BUN, Creat, Gluco at SHCH
Lab Result on April 6, 2007

WBC	=4	[4 - 11x10^9/L]	Na	=141	[135 - 145]
RBC	=3.6	[3.9 - 5.5x10^{12}/L]	K	=3.8	[3.5 - 5.0]
Hb	=9.6	[12.0 - 15.0g/dL]	Cl	=114	[95 - 110]
Ht	=29	[35 - 47%]	BUN	=4.1	[0.8 - 3.9]
MCV	=83	[80 - 100fl]	Creat	=197	[44 - 80]
MCH	=27	[25 - 35pg]	Gluc	=6.2	[4.2 - 6.4]
MHCH	=33	[30 - 37%]			
Plt	=168	[150 - 450x10^9/L]			
Lym	=1.7	[1.0 - 4.0x10^9/L]			
Mxd	=0.5	[0.1 - 1.0x10^9/L]			
Neut	=1.8	[1.8 - 7.5x10^9/L]			

23. Sim Sophea, 29F (Ta Tong Village)
Diagnosis:

1. Hypothyroidism
2. Pregnancy

Treatment:

1. L-thyroxin 50cmg ½ t po qd for one month (# 20)

Lab/Study Requests: Draw blood for TSH at SHCH

Lab Result on April 6, 2007

TSH = 25.41 [0.49 - 4.67]

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

1. Euthyroid Goiter
2. Hypocromic Microcytic Anemia

Treatment:

1. FeSO4 200mg 1t po qd for three months (#90)
2. MTV 1t po qd for three months (#90)

Lab/Study: Draw blood for TSH, Free T4 at SHCH
Lab Result on April 6, 2007

TSH =0.47 [0.49 - 4.67]
Free T4=11.54 [9.14 - 23.81]

25. Uy Noang, 55M (Thnout Malou)
Diagnosis:

1. DMII

Treatment:

1. Glibenglamide 5mg 1t po qd for three months (90tab)
2. Captopril 25mg ¼ tab po qd for three months (25tab)
3. ASA 300mg ¼ tab po qd for three months (25tab)

Lab/Study: None

26. Prum Sok, 77M (Taing Treuk Village)
Diagnosis:

1. COPD
2. Anemia

Treatment:

1. Salbutamol inhaler 2puffs bid prn SOB for four months (4vial)
2. FeSO4 200mg 1t po qd for four months (120tab)
3. MTV 1t po qd for four months (120tab)

Lab/Study Requests: None

27. Chheak Leangkry, 65F (Rovieng Cheung)
Diagnosis

1. DMII, PNP
2. HTN

Treatment

1. Meformine500mg 2t po qhs for four months (240tab)
2. lisinopril 20mg 1/2t po qd for four months (60tab)
3. Amitriptyline 25mg 1t po qhs for four months (120tab)

4. ASA 300mg 1/4t po qd for four months (30tab)

28. Eam Neut, 54F (Taing Treuk)
Diagnosis

1. HTN
2. Tension Headache

Treatment

1. Atenolol 50 mg ½ t po q12h for 4 months (120tab)
2. Paracetamol 500 mg 1 t po q6h prn for headache (50tab)

29. Srey Thouk, 56F (Taing Treuk Village)
Diagnosis:

1. HTN

Treatment:

1. Atenolol 50mg ½ t po qd for four months (60tab)
2. ASA 300mg 1/4t po qd for four months (30tab)

Lab/Study Requests: None

30. Pang Sidoeun, 31F (Rovieng Tbong Village)
Diagnosis:

1. HTN
2. Anxiety

Treatment:

1. Captopril 25mg ½ t po q8h for four months (180tab)
2. HCTZ 50mg ¼ t po qd for four months (30tab)
3. Amitriptyline 25mg ¼ t po qhs for four months (30tab)

Lab/Study Requests: None

31. Dy Niem, 37F (Sangke Roang Village)
Diagnosis:

1. GERD

Treatment:

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

32. Thorng Sam Oeun, 46F (Taing Treuk Village)
Diagnosis:

1. Tinea Corporis
2. Tinea vesiculor
3. Psoriasis?

Treatment:

1. Clothrimazole 1% apply on rash bid until completely healed(1tube)

Patient who missed appointment

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

1. HTN

The next Robib TM Clinic will be held on
April 30- May 04, 2007