

Discharge Summary Pediatric CTVS

Patient Demography Details :

Name : Anurag Verma	Patient ID : SKDD.1048280	IP No. : 733470
DOB : 19 FEB, 2021	Age/Gender: 3 Years/MALE	Primary Consultant 1 : Munesh Tomar
DOA : 17 JUL, 2024 15:19	Ward : SKTE-2NDFLR-PAEDIATRICS	Primary Consultant 2 : Gaurav Kumar
		Secondary Consultant : Kulbhushan Singh Dagar
Address: KHAPURWA BAHRAICH, FAKHARPUR, UTTAR PRADESH, 0		Mobile No. : 9648165285

Date and Time of Discharge: 22 JUL, 2024 13:50

Diagnosis:

- * Congenital heart disease
- * Perimembranous VSD with partial restriction, left to right shunt
- * Bicuspid Aortic valve
- * Tiny Subaortic membrane
- * No LVOT obstruction
- * Dilated LA/LV
- * Recent ARI

Presenting Complaints:

Mast. Anurag Verma, 3 years old male child 1st in birth order born out of a non-consanguineous marriage at term by LSCS. He was apparently alright till about 6 months of age when he was taken to a local pediatrician for cough and cold and on evaluation was detected with a murmur. Subsequently a 2D echo done revealed a large VSD with left to right shunt. He was then kept on close medical follow up and was advised early VSD closure surgery. He has history of suck rest suck while feeding during infancy and now he gets easily fatigued while playing. He has no h/o cyanosis, seizures or ear discharge. Developmental history was normal according to the father. Immunized as per schedule.

Now he has been admitted to this centre for further evaluation and management.

Course in Hospital:

For post-hospital care at home, call Max@Home at 8744 888 888 (24x7 helpline). Services include Critical Care@home, Nursing Healthcare Attendant, Physio-therapy, X-Ray, Sample Collection, Medicine Delivery, Medical Equipment and more.

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****PROCEDURE: ****

VSD closure with DACRON patch + PDA ligation surgery done on 18.07.2024.

****INVESTIGATIONS SUMMARY: ********ECHO (PRE-OP): ****

Situs solitus, levocardia, AV VA concordance, d loop ventricles, normally related great arteries, normal pulmonary and systemic veins, intact inter atrial septum, restrictive perimembranous VSD shunting left to right gradient of 90 mm of hg, restricted by large septal aneurysm, mild TR, mild MR, bicuspid aortic valve, tiny subaortic membrane, no LVOTO, mild AR, confluent and dilated branch pulmonary arteries, normal biventricular function, normal coronaries, left arch, normal arch branches, no COA, no ductal shunt.

****X RAY CHEST (17.07.2024): ****

Report Attached.

****PRE-DISCHARGE ECHO (22.07.2024): ****

- VSD patch in situ, no residual shunt
- Mild TR, PG: 22 mmHg
- Bicuspid aortic valve (fused RCC & LCC)
- Mild AR
- Normal chamber dimension
- Normal PA pressure
- Normal Biventricular function
- Thin Pericardial effusion around LV free wall
- Small left pleural collection

****COURSE IN HOSPITAL: ****

On admission, he was thoroughly evaluated including an Echo which revealed detailed findings as above.

In view of his diagnosis, symptomatic status and Echo findings he underwent VSD closure with DACRON patch + PDA ligation surgery on 18.07.2024. The parents were counselled in detail about the risk and benefit of the surgery and also the possibility of prolonged ventilation and ICU stay was explained adequately to them.

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Postoperatively, he was shifted to CTVS PICU for further management on full ventilation and minimal inotropic supports. He was electively ventilated with adequate sedation and analgesia for about 16 hours and was then extubated on 1st POD to HFNC support. HFNC was taken off to oxygen by nasal prongs by late 1st POD which was then gradually weaned off to room air by 2nd POD.

Associated bilateral basal atelectasis and concurrent bronchorrhea was managed with frequent nebulization, vibration, incentive spirometry and chest physiotherapy. Mediastinal chest tubes inserted perioperatively were removed on 2ND POD once minimal drain was noted.

Inotropes was electively given in the form of Adrenaline (0-1st POD) and Milrinone (1st-2nd POD) to optimize the cardiac output.

Decongestive measures were given in the form of Furosemide infusion and boluses and spironolactone was added for its potassium sparing action.

Minimal feed was started on 0 POD and was gradually built up to normal diet. He was also supplemented with multivitamins & calcium.

He is in a stable condition now and fit for discharge.

****CONDITION AT DISCHARGE****

Patient is haemodynamically stable, afebrile, accepting well orally, HR 78/min, sinus rhythm, BP 89/62mm Hg, SPO2 96-98% on room air. Chest - bilateral clear, sternum stable, chest wound healthy.

****DIET****

- * Fluid 1000 ml/day x 2 weeks
- * Normal diet

****FOLLOW UP****

- * Long term paediatric cardiology follow-up in view of VSD closure with DACRON patch + PDA ligation surgery.
- * Regular follow up with treating paediatrician for routine checkups and nutritional rehabilitation.

****PROPHYLAXIS****

- * Infective endocarditis prophylaxis

****TREATMENT ADVISED****

- * Syp Taxim -O 100 mg twice daily (10am-10pm) - PO x 5 days then stop
- * Syp. Furosemide 7.5 mg thrice daily (6am - 2pm - 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.

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Patient Name : Anurag Verma
SSN No. : 071048280

- * Tab. Spironolactone 6.25 mg twice daily (6am – 6pm) – PO x 2 weeks then as advised by pediatric cardiologist.
- * Syp. Paracetamol 175mg thrice daily (6am-2pm-10pm) – PO x 3 days and then as and when required
- * Syp. A to Z 5 ml once daily (9am) – PO x 2 weeks
- * Syp. Shelcal 5 ml twice daily (10am – 10pm) – PO x 2 weeks

- * Betadine lotion for local application twice daily on the wound x 7 days
- * Stitch removal after one week
- * Intake/Output charting.
- * Immunization as per national schedule with local pediatrician after 4 weeks.

Review after 3 days with serum Na⁺ and K⁺ level at 2nd floor procedure room in between 2-4:00Pm. Dose of diuretics to be decided on follow up. Continued review with the cardiologist for continued care.

Periodic review with this center by Fax, email and telephone.

In case of Emergency symptoms like: Poor feeding, persistent irritability / drowsiness, increase in blueness, fast breathing or decreased urine output, kindly contact Emergency: 26515050

****For all OPD appointments ****

Dr. K. S. DAGAR in OPD with prior appointment.
Dr. Munesh Tomar in OPD with prior appointment.

Dr. KULBHUSHAN S. DAGAR

M.S. M.Ch.

Principal Director

Neonatal & Congenital Heart Surgery

Dr. K. S. DAGAR
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Dr. Munesh Tomar
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Max Super Speciality Hospital, Saket

(East Block) - A Unit of Devki Devi Foundation

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