



DISCHARGE SUMMARY

Patient's Name: Baby Ishanvi Sharma	
Age: 1 Year	Sex: female
UHID No: SKDD.919533	IPD No : 464602
Date of Admission: 25.09.2022	Date of Procedure: 26.09.2022 Date of Discharge: 04.10.2022
Weight on Admission: 8.6 Kg	Weight on Discharge: 8.3 Kg
Cardiac Surgeon : DR. HIMANSHU PRATAP Cardiac Surgeon: DR. K. S. DAGAR Pediatric Cardiologist : DR. NEERAJ AWASTHY	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- TOF
- Adequate branch PAs

PROCEDURE:

TOF correction (RA/PA approach) done on 26.09.2022

RESUME OF HISTORY

Baby Ishanvi Sharma, 1 year old female child, 2nd in birth order, a product of non consanguineous marriage, born full term via normal vaginal delivery. The child cried immediately after birth. Child was asymptomatic at birth, but later was noted to have systolic murmur & was advised echocardiography and diagnosed to have Tetralogy of Fallot (TOF). Child was advised for surgery at a later date. Thereafter parents noted child to have mild cyanosis.
No history suggestive of cyanotic spells.

Now the patient has admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (23.09.2022):

Situs solitus, Levocardia, AV, VA Concordance. D-looped ventricles, NRGA. Normal systemic and pulmonary venous drainage. Tetralogy of Fallot. PFO flap seen. TV annulus:13.4mm, Mild TR. MV annulus:12.7mm, No MR. Large malaligned perimembranous VSD shunting bidirectionally with >50% aortic override, No additional VSDs. PV annulus: 8.5 mm, (Exp:9.5), Severe infundibular + valvar PS, PS Max PG:82 mmHg. AV annulus:11mm, No LVOTO, No AR. Dilated RA, RVH. Adequate LV/RV. Systolic function, LVEF=60%. Small PDA seen. Confluent and fair sized PAs (EXP- 6.5mm). RPA-7.0 mm, LPA-7.0 mm. Left arch, No COA. Normal coronaries. No IVC congestion. No collection.

X RAY CHEST (25.09.2022): Report Attached.

Max Super Speciality Hospital, Saket

(East Block) A Unit of Devki Devi Foundation

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PRE DISCHARGE ECHO (03.10.2022.):

PFO SHUNTING BIDIRECTIONALLY
VSD PATCH IN SITU, NO RESIDUAL SHUNT
NO LVOTO/NO AR
WIDE OPEN RVOT, MILD FLOW TURBULENCE SEEN ; PG ; 22MMHG
FLOW SEEN IN BRANCH PAS
ADEQUATE BIVENTRICULAR SYSTOLIC FUNCTION ; LVEF : 55%
RV DIASTOLIC DYSFUNCTION
TRACE PERICARDIAL EFFUSION
NO PLEURAL EFFUSION

COURSE IN HOSPITAL:

On admission an Echo was done which revealed detailed findings above.

In view of his diagnosis, symptomatic status and Echo findings he underwent **TOF correction (RA/PA approach)** on 26.09.2022. The parents were counseled 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.

Postoperatively, she was shifted to PICU and ventilated with adequate analgesia and sedation. She was extubated on 1st POD on nasal cpap support and weaned to oxygen support gradually at 1 lit/min and weaned to room air by 4th POD. Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy, intermittent peep and frequent nebulizations.

Inotropes were given in the form of Adrenaline (0-3rd POD),Dopamine (0-2nd POD) and Milrinone (0 -2nd POD) to optimize cardiac function. Decongestive measures were given in the form of lasix boluses. Mediastinal /intercostal chest tubes inserted perioperatively were removed on 3rd POD when minimal drainage was noted.

Initial antibiotics were given in form of Ceftriaxone and Amikacin. Once patient was stabilized and afebrile, repeat cultures were negative, intravenous antibiotics were stopped and converted to oral Cefexime.

Minimal feeds were started on 1st POD and it was gradually built up to normal oral feeds. She was also given supplements in the form of multivitamins, vitamin C & calcium.

She is in stable condition now and fit for discharge.

CONDITION AT DISCHARGE

Patient is haemodynamically stable, afebrile, accepting well orally, HR 102/min, sinus rhythm, BP 100/60 mm Hg, SPO2 98% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid -750 ml/day
- Normal diet

Max Super Speciality Hospital, Saket

(East Block) **FOLLOW UP** Devi Foundation

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For & To: P. 2, 22

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MC-37H

- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp. Taxim -O 45 mg twice daily (8am-8pm) - PO x 5 days then stop
- Syp. Furosemide 10 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Spironolactone 3.125 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Syp. Shelcal 5 ml twice daily (9am – 9pm) – PO x 2 weeks then stop
- Syp. A to Z 5 ml once daily (2pm) x 2 weeks then stop
- Tab. Lanzol Junior 7.5 mg twice daily (6am – 6pm) – PO x 1 week and then stop
- Syp. Crocin 135 mg thrice daily (6am – 2pm – 10pm) – PO x 2 days then as and when required
- **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 and Chest X-Ray. 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. Neeraj Awasthy in OPD with prior appointment.

Dr. K. S. Dagar Awasthy
 M.S., DNB (Pediatric Cardiology)
 Neonatal and Congenital Heart Surgery
 Department of Pediatric Cardiology
 Max Super Speciality Hospital (East Block)
 (A unit of Devki Devi Foundation)

2, Press Enclave Road, Saket, New Delhi-110 017
 (East Block) **Head, Department of Pediatric Cardiology & In-charge**
 (Devki Devi Foundation) Regd. Office: 2, Press Enclave Road, Saket, New Delhi-110 017
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Dr. Himanshu Pratap
 Principal Consultant
 Neonatal and Congenital Heart Surgery

