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DISCHARGE SUMMARY

Patient's Name: Baby Janvi Yadav	
Age: 4 months 16 days	**Sex: Female**
UHID No: 070-066252	**IPD No : 417066**
Date of Admission: 27.07.2021	**Date of Procedure: 29.07.2021**
Weight on Admission: 4.1 Kg	**Date of Discharge: 14.08.2021**
	Weight on Discharge: 3.8 Kg
Cardiac Surgeon: DR. K. S. DAGAR	
Pediatric Cardiologist : DR. NEERAJ AWASTHY	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- Unbalanced AVSD severe PS
- Interrupted IVC with hemiazygous continuation to LSVC
- Bilateral SVC
- Hepatic veins draining to LA with additional channel to RA
- Progressive cyanosis

PROCEDURE:

RMBTS 4mm PTFE + PDA ligation done on 29.07.2021

RESUME OF HISTORY

Baby Janvi Yadav, 4 months 16 days female child, 1st in birth order, born at full term via normal vaginal delivery to a non consanguineous marriage, cried at birth with a birth weight of 2.7 Kg
The patient was apparently alright at birth but at 10-15 days of age, mother noticed bluish discoloration of lips and peripheries and little fever. They went to show a local doctor who referred them to another tertiary care hospital where they were diagnosed with congenital heart disease and was reffered to our institute for further management.
She has admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (27.07.2021): Situs solitus, levocardia, AV concordance, AV discordance, D looped ventricles, , malposed great vessels, interrupted IVC with hemiazygous continuation to LSVC, bilateral SVC, hepatic veins draining into LA , complete unbalanced AV canal mild right AVVR, trivial left AVVR, DORV, severe PS, hypoplastic branch pulmonary arteries RPA- 3.5 mm, LPA - 3.5 mm , left arch (bovine branching pattern).

X RAY CHEST (27.07.2021): Report Attached.

USG WHOLE ABDOMEN & CRANIUM (27.07.2021): Report attached.

CT pulmonary angiography (27.07.2021): DORV, VA discordance, AV canal defect, RVOT atresia with hypoplastic pulmonary branches. PDA, Dual SVC, IVC on left side draining very closely near the opening of left SVC into left atrium, The pulmonary veins draining into the atrium

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seen on left, A venous tributary traversing through the liver parenchyma draining directly into the right atrium.

PRE DISCHARGE ECHO (12.08.2021): S/P RMBTS 4mm PTFE+PDA Ligation on 29.07.2021

Situs Inversus, Levocardia, AV Concordance, VA Discordance, D-looped ventricles, malposed great vessels, Patent BT shunt, Good flow seen in branch PAs, RPA : 4.5 mm, LPA ; 4.5 mm, Interrupted IVC with hemiazygos continuation to LSVC, Bilateral SVC with LSVC draining to coronary sinus, Complete AV canal defect with unbalanced dventricles with hypoplastic LV, Large ostium primum ASD with small secundum ASD shunting left to right, Large muscular VSD amounting to single ventricle, Mild right AVVR, Trivial left AVVR, DORV with aorta anterior to PA, No subaortic obstruction, No AR, Severe infundibular and valvar PS; PG : 70 mmHg, Hypoplastic and confluent branch Pas, Normal septal motion, Adequate ventricular function, Left arch, No COA/PDA/APW, Normal coronaries, No IVC congestion, No pericardial effusion.

COURSE IN HOSPITAL:

On admission an Echo followed by CT Pulmonary Angiography were done which revealed detailed findings above.

In view of her diagnosis, symptomatic status, Echo & CT pulmonary angiography findings she underwent **RMBTS 4mm PTFE + PDA ligation on 29.07.2021**. 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. Soon after that patient developed desaturation and hypotension and ECHO suggestive of blocked BT shunt. Immediately patient was re-explored and patency of shunt established resulting in improvement in saturation and blood pressure. Thereafter patient was stabilized and homeostasis achieved and sternum was kept opened. Patient developed third space loss and swelling over body for which PD catheter was inserted on 1st POD and cycling done. Thereafter patient improved gradually and once hemodynamics stabilized, sternum was closed on 1st POD. Thereafter slow weaning was started and patient was extubated on 5th POD on nasal CPAP support and gradually weaned to room air on 13th POD. Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy and frequent nebulisations.

Inotropes were given in the form of Adrenaline (0-5th POD), Milrinone (0-1st POD), Dopamine (0-9th POD) and Dobutamine (5th - 7th POD) to support cardiac function. Decongestive measures were given in the form of Furosemide boluses and infusion. Mediastinal drain inserted perioperatively was removed on 5th POD once minimal drainage was noted. Left ICD was inserted on 11th POD for left pleural effusion and was removed on 12th POD once minimal drainage was noted.

Empirical antibiotics were given in the form of Tazact, Amikacin and Vancomycin. Due to sick condition of child intravenous antibiotics were upgraded to Meropenem, targocid and fluconazole. Later on patient developed mild discharge from the incision site with intact suture line and stable sternum. Eventually, developed chest signs suggestive of pneumonia and was managed with Azithromycin, Septran, Linezolid and Tazocillin + Clavulanic acid.

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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 128/min, sinus rhythm, BP 96/48 mm Hg, SPO2 88% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid -320-400ml/day
- Ebm/Formula milk diet

FOLLOW UP

- Long term pediatric cardiology follow-up **in view of RMBTS 4mm PTFE + PDA ligation.**
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp. Linezolid 40 mg thrice daily (6am-2pm-10pm) - PO x 7 days then stop
- Syp. Azithral 25 mg twice daily (8am-8pm) – PO x 3 days then stop
- Tab. Bactrim 15 mg twice daily (8am – 8pm) – PO x3 days then stop
- Syp. Furosemide 2.5 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.
- Tab. Ecosprin 20mg once daily (10 am) – PO x 3 months then as advised by pediatric cardiologist in the follow up **(to be titrated as per body weight in doses of 5 mg/kg; not to exceed a maximum of 75 mg/day)**
- Tab. Clopidogrel 6 mg once daily (2pm) –PO x 3 months then as advised by pediatric cardiologist in the follow up
- Syp Visyneral Z 2.5 ml twice daily (9am – 9pm) – PO x 3 weeks then stop
- Syp. Calcimax P 2.5 ml twice daily (9am – 9pm) – PO x 3 weeks then stop
- Syp. Elemental Zinc 2.5 ml once daily (9am)- PO x 10days then stop
- Tab. Lanzol Junior 5 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- Tab. Limcee 100mg once daily (10am) PO x 3 weeks then stop
- Syp. Crocin 60 mg thrice daily (6am – 2pm – 10pm) x 2 days then stop
- Syp. Dexorange 2.5ml once daily (10am) PO x 3 weeks then stop
- **Daily dressing to be done until suture removed.**
- **Stitch removal after one week**

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- **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.**

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