MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Mast. Dhruv Kumar	
Age: 4 Years	**Sex: Male**
UHID No: SKDD. 892565	**IPD No : 449144**
Date of Admission: 04.05.2022	**Date of Procedure: 06.05.2022** **Date of Discharge: 14.05.2022**
Weight on Admission: 11 Kg	**Weight on Discharge: 10.6 Kg**
Cardiac Surgeon: DR. HIMANSHU PRATAP **Pediatric Cardiologist : DR. NEERAJ AWASTHY**	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- TOF
- VSD restricted by RCC prolapse
- Mild AR
- Severe subvalvar PS
- S/P MAPCA coiling

PROCEDURE:

TOF Correction done on 09.05.2022

RESUME OF HISTORY

Mast.Dhruv Kumar, 4 years male child, 2nd in birth order, born out of non-consanguineous marriage at preterm through normal vaginal delivery and cried immediately after birth with birth weight 1.6 kg. Patient stayed in hospital NICU for 1 month and got treated for neonatal sepsis. During stay on detail evaluation patient was also diagnosed to have congenital heart disease. There is history of breathlessness and easy fatigue on playing and doing some activities. There is no history of feeding diaphoresis, seizure, suck rest suck cycle. Developmental history is delayed. Immunization done as per age and national immunization schedule.
Now the patient has admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (03.05.2022):

Situs solitus, levocardia, AV, VA Concordance. D-looped ventricles, NRGA. Normal pulmonary and systemic venous drainage, Bilateral SVC, LSVC to dilated coronary sinus. Tetralogy of Fallot. PFO shunting bidirectionally. TV annulus:17mm, Mild TR. MV annulus:15mm, Trivial MR.
Large perimembranous VSD partially restricted by RCC prolapse and septal Leaflet of tricuspid valve shunting right to left. PV annulus:10mm, (EXP:12), Muscle bundle seen in RVOT,Flow turbulence in RVOT; RVOT Max PG:80mmHg. AV annulus:17mm, Subaortic membrane seen, LVOT gradient of:10mmhg, Mild AR. Dilated RA/RVH. Normal LV and RV systolic function. Confluent branch PAs (EXP:8.5). RPA:8.0mm,LPA: 7.2mm. left arch, No COA/APW/LSVC. Normal coronaries. No IVC congestion. No collection.

X RAY CHEST (04.05.2022): Report Attached.

USG WHOLE ABDOMEN (04.05.2022): Report attached.

PRE DISCHARGE ECHO (12.05.2022):
VSD patch in situ, no residual shunt, well open rvot, mild pr
Normal LV and RV systolic function , LVEF:60 %, TAPSE:15 mm
No collection

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** on 06.05.2022. 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, he was shifted to PICU and ventilated with adequate analgesia and sedation. He was extubated on 1st POD and then gradually weaned to room air by 2ND POD. Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy, frequent nebulizations and incentive spirometery.
Inotropes were given in the form of Dopamine (1-5TH POD), Adrenaline (0-3rd POD) and Dobutamine (0- 5TH POD) to optimize cardiac function. Decongestive measures were given in form of lasix boluses. Mediastinal chest tubes inserted perioperatively were removed on 3rd POD after minimal drains were noted.
Empirically antibiotics were started with Ceftriaxone and Amikacin. Sepsis screen came negative and was converted oral cefexime.
Minimal feeds were started on 1st POD and it was gradually built up to normal feeds. He was also given supplements in the form of multivitamins & calcium.
He is in stable condition now and fit for discharge.

CONDITION AT DISCHARGE

Patient is haemodynamically stable, afebrile, accepting well orally, HR 117/min, sinus rhythm, BP-112/74mm Hg, SPO298% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid 700 ml/day
- Normal diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **TOF Correction.**
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp.Taxim –O 50 mg twice daily (8am-8pm) - 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.
- Tab. Spironolactone 6.25 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Syp. Calcimax P 5 ml twice daily (9am – 9pm) – PO x 3 weeks then stop
- Syp.Visyneral 2.5 ml twice daily (9am – 9pm) – PO x 3 weeks then stop

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- Tab. Lanzol Junior 10 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- Syp. Crocin 165 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. Himanshu Pratap in OPD with prior appointment.**
- **Dr. Neeraj Awasthy in OPD with prior appointment.**

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