MAX Healthcare

DISCHARGE SUMMARY

Patient's Name	: Mast. Sekh Yousuf Ali
Age/ Sex	: 3 Years/Male
SSN. No.	: 071-04-2097
IPD No	: 719823
Date of Admission	: 18.03.2024
Date of Procedure	: 19.03.2024
Date of Discharge	: 28.03.2024
Weight on Admission	: 13.9 Kg
Weight on Discharge	: 13.5 Kg
Cardiac Surgeon	: DR. K. S. DAGAR
Pediatric Cardiologist	: DR. MUNESH TOMAR
Pediatric Intensivist	: DR. PRADIPTA ACHARYA

Patient Name : SEKH YOUSUF ,ALI

SSN : 071-04-2097

DISCHARGE DIAGNOSIS:

* Congenital heart disease
* Large unrestrictive perimembranous VSD, shunting bidirectionally
* Severe Infundibular stenosis
* PDA
* Confluent branch PAs
* Small size LPA
* Mild TR
* Right arch with mirror image branching with atresia of the innominate artery
* Dilated RA/RV

PROCEDURE:

Dacron patch VSD closure + Infundibular resection + PDA ligation + Interposition graft between the left sided innominate artery and aorta surgery done on 19.03.2024.

RESUME OF HISTORY

Mast. Sekh Yousuf Ali, 3 years old male child, first in birth order, born out of non-consanguineous marriage at term by LSCS and cried immediately at birth. He was diagnosed to have CHD at 3 months of age when during a routine checkup, he was detected with a murmur and on detailed evaluation including echo was found to have a large VSD with infundibular stenosis. He was then advised early surgical correction and was kept on close medical follow up. He has history of feeding diaphoresis and easy fatigability. There is no history of bluish discoloration of skin, seizures or recurrent LRTI.
Child has attained developmental milestones as per age and has been immunised as

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per national immunisation schedule.

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

INVESTIGATIONS SUMMARY:

ECHO (14.03.2023):

Congenital Heart Disease
Large unrestricted Perimembranous VSD shunting Bidirectionally
Severe RVOTO; PG: 68 mmHg
Prominent muscle band in upper infundibulum forming Double chambered RV
Confluent Branch PAs, RPA: 10 mm, LPA: 6 mm (Exp : 9 mm)
Flow turbulence in LPA, LPA gradient: 30 mmHg
Mild TR
Normal coronaries
Dilated RA/RV
Right aortic arch, First arch branch not well profiled
Normal Biventricular Function

X RAY CHEST (18.03.2024):

Report Attached.

USG WHOLE ABDOMEN (18.03.2024):

Report attached.

PRE DISCHARGE ECHO (26.03.2024):

VSD patch in situ, no residual VSD
PFO shunting bi-directionally
Moderate TR (Eccentric jet); PG: 43 mmHg
Flow turbulence in RVOT; Peak gradient: 40 mmHg, Mild PR
Flow seen in branch PAs
Normal biventricular function
Mild pericardial effusion M-Mode 8/5mm behind LV
No pleural effusion

COURSE IN HOSPITAL:

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

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In view of his diagnosis, symptomatic status and Echo findings he underwent Dacron patch VSD closure + Infundibular resection + PDA ligation + Interposition graft between the left sided innominate artery and Aorta surgery on 19.03.2024. 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.

Postoperatively, he was shifted to CTVS PICU for further management on full ventilation and moderate inotropic supports. He was electively ventilated with adequate sedation and analgesia for next 18 hours and was then extubated on 1st POD to oxygen by nasal prongs and was later weaned off to room air by 2nd POD.

Associated bilateral basal atelectasis and concurrent bronchorrhoea was managed with frequent nebulization, chest physiotherapy and vibration. Both mediastinal chest tubes and left pleural drain inserted perioperatively were removed on 3rd POD, once minimal drainage was noted.

Inotropes were electively given in the form of Dobutamine (0 - 3rd POD), Levosimendan (0 - 2nd POD) to optimize the cardiac output.

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

Acitrom was added for its anti-coagulant action and dose is being titrated as per INR levels.

Feed was started on 1st POD which was gradually built up to normal diet by 3rd POD. He was also supplemented with multivitamins & calcium.

He is in stable condition now and fit for discharge.

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CONDITION AT DISCHARGE

Patient is haemodynamically stable, afebrile, accepting well orally, HR 124/min, sinus rhythm,
BP 96/52 mm Hg, SPO2 97 % on room air. Chest - bilateral clear, sternum stable, chest wound healthy.

DIET

* Fluid 900-950 ml/day x 2 weeks
* High protein Acitrom diet

FOLLOW UP

* Long term paediatric cardiology follow-up in view of Dacron patch VSD closure + Infundibular resection + PDA ligation + Interposition graft between the left sided innominate artery and Aorta surgery.

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* Regular follow up with treating paediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS:

* Infective endocarditis prophylaxis

TREATMENT ADVISED:

* Syp. Taxim -O 70 mg twice daily (8am-8pm) - PO x 5 days then stop
* Syp. Furosemide 10 mg (= 1 ml of 1ml/10 mg solution) thrice daily (6am - 2pm - 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
* Tab. Spironolactone 6.25 mg once daily (6am) - PO x 2 weeks then as advised by pediatric cardiologist.
* Syp. Digoxin Paed 1 ml once daily (2 pm) - PO 5/7 days x 1 week and then as advised by pediatric cardiologist.
* Syp. A to Z 5 ml once daily (2pm) - PO x 2 weeks and then stop.
* Syp. Shelcal 5 ml twice daily (9am - 9pm) - PO x 2 weeks and then stop
* Cap. Indomethacin 10 mg thrice daily (6am - 2pm - 10pm) - PO X 1 week and then stop
* Tab. Acitrom 1 mg once daily (6pm) -PO x 3 months, target PT/INR - 2.0
* Syp. Paracetamol 200 mg thrice daily (6am - 2pm - 10pm) - PO x 3 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 PT/INR 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 centre 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
(Cardiac & Congenital Heart Surgery
Neonatal & Cardiac Transplant)
Max Super Speciality Hospital (East Wing)
(A unit of Devki Devi Foundation)
2, Press Enclave Road, Saket, New Delhi-110 017
DMC Regd. No. 4478

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

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MAX Healthcare

Principal Director
Neonatal and Congenital Heart Surgery

Dr. Munesh Tomar
Director
Pediatric Cardiology

Dr P K Acharya
Asso. Director
Pediatric cardiac intensive care

/es/ Pradipta Kumar ACHARYA
Associate Director
Signed: 28/03/2024 12:47

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