MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Mast. Hamza	
Age: 1 Year	Sex: male
UHID No: SKDD.885766	IPD No : 431675
Date of Admission: 23.11.2021	Date of Procedure: 24.11.2021 Date of Discharge:01.12.2021
Weight on Admission: 7.0 kg	Weight on Discharge: 6.5 Kg
Cardiac Surgeon: DR. K. S. DAGAR/ Dr HIMANSHU PRATAP Pediatric Cardiologist : DR. NEERAJ AWASTHY	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- Large PM VSD
- Moderate Mitral Regurgitation.
- Failure to Thrive

PROCEDURE:

VSD closure and Mitral valve repair done on 24.11.2021

RESUME OF HISTORY

Mast. Hamza, 1 year male child, 1st in birth order was born to a non consanguineous marriage at term via LSCS (oligohydromnious) with birth weight of 2 kg. The perinatal period was uneventful. Baby was asymptomatic till 9 months of age . He was taken to a local physician for cough and cold when on regular check up he was diagnosed to have cyanotic congenital heart disease .
Now the patient was admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (22.11.2021): situs solitus, levocardia, AV, VA concordance, D-looped ventricles, NRGA,
PFO with left to right shunt, Large perimembranous VSD with inlet extension shunting predominantly left to right, Doming pulmonary valve, valvar PS, PV annulus 15 mm {+2} max PG- 30 mmHg, Dilated MPA, MPA-18 mm, Dilated RPA-10 mm, LPA-11 mm, Mild TR, TV Annulus 15mm (Z score -0.49), AML prolapse, myxomatous MV with mild + Eccentric MR, Posterior 2 jets seen, VC 2.4 mm, Mitral valve annulus 20mm (Z score +1.86), No LVOTO, No AR, Dilated LA/LV, Adequate LV/RV systolic function, LVIDD 41 mm (Z score +5.16), LVEF=60%, Left arch, No COA,
Normal coronaries, No IVC congestion, No collection.

X RAY CHEST (23.11.2021): Report Attached.

USG WHOLE ABDOMEN (23.11.2021): Report attached.

PRE DISCHARGE ECHO (30.11.2021):
S/P VSD closure + MV repair done on 24.11.2021

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Situs solitus, levocardia. AV, VA concordance, D-looped ventricles, NRGA, IAS intact, VSD patch in situ, No residual shunt, No RVOTO, No PR, Dilated MPA and branch PAs, Mild TR, Mild MR, 2 jets seen, No LVOTO, No AR, Dilated LA/LV, Mild LV Systolic Dysfunction, LVEF=42 %, Left arch, no COA, Normal Coronaries, No IVC congestion, 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 VSD closure and Mitral valve repair on 24.11.2021. 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, he was shifted to ICU and ventilated with adequate analgesia and sedation. He
was extubated on 1st POD to nasal CPAP and weaned to room air by 4th POD. Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy,suctioning ,intermittent peep and frequent nebulisations.

Inotropes were given in the form of Adrenaline (0-4th pod), Milrinone (0-3rdPOD)&Dobutamine (0 -5th POD) to optimize cardiac function. Decongestive measures were given in the form of furosemide infusion and boluses. Drains inserted perioperatively were removed on 2nd POD once minimal drainage was noted.

Empirical antibiotics were given in the form of Ceftriaxone and Amikacin . Sepsis screen was negative ,but in view of high tlc and high grade fever antibiotics were upgraded to Tazact . An appropriate course of antibiotics was administered.

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

He is in stable condition now and fit for discharge.

CONDITION AT DISCHARGE
Patient is haemodynamically stable, afebrile, accepting well orally, HR 110/min, sinus rhythm, BP 98/64 mm Hg, SPO2 98% in room air, no respiratory distress. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET
- Fluid 550-600 ml/day
- Normal diet

FOLLOW UP
- Long term pediatric cardiology follow-up in view of VSD closure and Mitral valve repair.
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS
- Infective endocarditis prophylaxis

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TREATMENT ADVISED:

- Syp.Taxim –O 30 mg twice daily (8am-8pm) - PO x 5 days then stop
- Syp. Furosemide 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. Enalapril 0.5 mg once daily (2pm) – PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Lanzol Junior 5 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- 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. Crocin 100 mg 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. 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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