MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Baby Mahi Gupta	
Age: 4 years	**Sex: Female**
UHID No: SKDD.771091	
Date of Admission: 11.02.2022	**Date of Operation: 12.03.2022** **Date of Discharge: 19.03.2022**
Weight on Admission: 14 Kg	**Weight on Discharge: 13.6 Kg**
Cardiac Surgeon: Dr. K S DAGAR **Pediatric Cardiologist : DR. NEERAJ AWASTHY**	

DISCHARGE DIAGNOSIS

- Congenital Heart Disease
- Pulmonary atresia
- Ostium secundum ASD, right to left shunt
- Large subaortic VSD with bidirectional aortic override
- DORV
- PDA dependant PA circulation
- Non confluent PAs
- MAPCAs
- Healed vegetation on TV with moderate TR
- Severe desaturation

PROCEDURE:

VSD closure + RV to PA conduit+ PA plasty + PDA division + TV repair done on 12.03.2022

RESUME OF HISTORY

Baby Mahi Gupta, 4 years female child, 1st in birth order was born out of non-consanguineous marriage at term through normal vaginal delivery at hospital and cried immediately after birth. At around 1 year of life, parents noted baby to have bluish discoloration of skin and lips on excessive crying and was taken to local pediatricians. On detailed evaluation patient was diagnosed to have cyanotic congenital heart disease and was then referred for further evaluation and management. There is history of recurrent cyanotic spells. There is no history of feeding diaphoresis or suck rest suck cycle. All developmental milestones are within normal range as per age. Immunization is complete as per the national immunization schedule

INVESTIGATIONS SUMMARY:

ECHO (07.03.2022): Situs solitus, Levocardia. AV concordance. D-looped ventricles. NRGA. Pulmonary atresia. Ostium secundum ASD measuring 10mm with right to left shunt. Large subaortic VSD with bidirectional with >50% aortic override, No additional VSDs, Mobile echogenic mass seen along tricuspid valve leaflet, vertical size 8 mm, Possibly vegetation, Grade II TR TV

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Empirically antibiotics were started with Ceftriaxone and Amikacin. In view of high grade fever and rising TLC, intravenous antibiotics were upgraded to Meropenem and Amikacin. Blood culture from IJV revealed growth of Ralstonia pickettii and as per sensitivity report antibiotics were upgraded to Doxycycline. Patient thereafter becomes stable and afebrile.

She is in stable condition now and fit for discharge.

Condition at Discharge:
Patient is hemodynamically stable, afebrile, HR 110/min, sinus rhythm, BP 95/50 mmHg, SPO2 96% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid restriction 1000 ml/day
- Normal diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **VSD closure + RV to PA conduit+ PA plasty + PDA division + TV repair.**
- Regular follow up with treating pediatrician for routine checkups.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Tab. Doxy 30 mg twice daily (8am-8pm) - PO x 5 days then stop
- Tab. Furosemide 15 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.
- Tab. A to Z 1 tab once daily (2pm) – PO x 1 month and then stop
- Tab. Shelcal 250 mg once daily (2pm) – PO x 1 month and then stop
- Tab. Ecosprin 75 mg once daily (10 pm) – 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. Lanzol Junior 7.5 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- Syp Bromhexine 5ml thrice daily PO x 1 week and then stop
- **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.**

annulus-16mm, (Z Score -1.2). Trivial MR. No LVOTO, No AR. Dilated RA/RVH. Normal LV and RV systolic function. Confluent PA's , RPA smallish, RPA-6.5mm, lpa-9.0mm (EXP-8.5). Small tortuous PDA from arch with LPA insertion, Restricted flow distally, Left coronary system not profiled well, Minimal pericardial collection, IVC mildly distended, collapsible.

X Ray chest (11.03.2022): Report attached.

USG whole abdomen (11.03.2022): Report attached.

CT Pulmonary angiography (08.03.2022-pre admission):
Pulmonary atresia. RPA is relatively smaller and shows upward tubular projection in the AP window without any discernable further continuity into PDA or LPA. PDA is communicating with medial most part of LPA with severe distal narrowing . Multiple small MAPCAS. ASD. Large subaortic VSD . Left sided aortic arch is seen with normal branching and dilated ascending aorta. There is mild ground glassing small confluent nodular opacities in the left lung lower lobe posterobasally. A small 4 mm subpleural nodule is seen in the right lower lobe along the diaphragmatic surface.

PRE DISCHARGE ECHO (19.03.2022): S/P VSD CLOSURE+RV TO PA CONDUIT+ PA PLASTY+PDA DIVISION+TV REPAIR DONE ON 12.3.2022SITUS SOLITUS, LEVOCARDIA, AV CONCORDANCE,,D-LOOPED VENTRICLES,NRGA,,NORMAL PULMONARY AND SYSTEMIC VENOUS DRAINAGE,IAS INTACT,VSD PATCH IN SITU, NO RESIDUAL SHUNT,LAMINAR FLOW ACROSS TRICUSPID VALVE, MEAN PG 3 MMHG, MILD+ TR, TR MAX PG 20 MMHG,TAPSE 12 MM, S' – 7.5CM/S
,TRIVIAL MR,NO LVOTO, NO AR,WELL OPENED RVOT, RVOT MAX PG 10 MMHG, MILD+ PR, PEAK GRADIENT 9 MMHG,DILATED RA/RVH,MILD RV SYSTOLIC AND DIASTOLIC DYSFUNCTION,MILD LV SYSTOLIC DYSFUNCTION, LVEF 50 %,CONFLUENT PA'S, RPA-6.0MM, LPA-8.0MM,NO RESIDUAL PDA,IVC DISTENDED 12 MM IN SIZE WITH MINIMAL RESPIRATORY VARIATION,NO COLLECTION.

COURSE IN HOSPITAL:
On admission, the patient was investigated including echo was done which revealed findings as detailed above.

In view of her diagnosis, symptomatic status, ECHO & CT pulmonary angiography findings she underwent **VSD closure + RV to PA conduit+ PA plasty + PDA division + TV repair** on 12.03.2022.

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

Inotropes were given in the form of Adrenaline (0-4th POD), Dopamine (0-5th POD) and Nor adrenaline (0-3rd POD) to optimize cardiac function. Decongestive measures were given in the form of lasix boluses. Left intercoastal chest tubes inserted perioperatively was removed on 4th POD when minimal drainage was noted.

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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 (Mobile No.: 9811962775 & Email:** n_awasthy@yahoo.com**).**

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