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DISCHARGE SUMMARY

Patient's Name: Mast. Prince	
Age: 7 Years	**Sex: Male**
UHID No: SKDD.883718	
Date of Admission: 22.02.2022	**Date of Procedure: 24.02.2022** **Date of Discharge: 07.03.2022**
Weight on Admission: 16.9 Kg	**Weight on Discharge: 16.4 Kg**
Cardiac Surgeon: DR. HIMANSHU PRATAP **Pediatric Cardiologist : DR. NEERAJ AWASTHY**	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- TOF
- Hypoplastic annulus
- Confluent adequate branch PAs
- Old CVA
- Residual right hemiparesis

PROCEDURE:

TOF correction with TAP plus decompressing PFOdone on 24.02.2022

RESUME OF HISTORY

Mast. Prince, 7 years male child, 1st in birth order, born out of a non consanguineous marriage, following full term normal vaginal delivery at home, birth weight not known, cried immediately after birth. He was apparently well until 1 and 1/2 years of age when he developed fever and right side hemiparesis. He was treated by local traditional healers. Around 1 year back parents noticed bluish discoloration of body and shortness of breath on exertion for which ECHO was done and was diagnosed to have cyanotic congenital heart disease.There is no history of cyanotic spell, repeated cough, fever, hospital admission. He has completed all his vaccination according to national schedule. Patient was then admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (21.01.2022): Situs solitus, levocardia. AV, VA concordance. D-looped ventricles. NRGA. Intact IAS. DORV. Large malaligned perimembranous VSD with inet extension shunting bi-directionally with >50% aortic overrride, No additional VSD. PV Annulus :8.0mm, (EXP:14), Severe Infundibular, valvar PS with PG 85mmHg (trickle antegrade flow seen). Confluent and fair sized PAs (EXP- 10mm). RPA- 10 mm, LPA-10mm. Trivial TR. Trivial MR. AV Annulus:22mm, No LVOTO, No AR. Dilated RA, RVH. Adequate LV/RV systolic function. Left arch, No COA/LSVC. Normal coronaries. No IVC congestion. No collection.

X-RAY CHEST (22.02.2022): Report Attached.

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USG WHOLE ABDOMEN (22.02.2022): Report attached.

PRE DISCHARGE ECHO (05.03.2022): S/p TOF repair: Situs solitus, levocardia, AV, VA concordance, D-looped ventricles, NRGA, PFO with bidirectional shunt , VSD patch in situ, no residual shunt, Well opening RVOT, RVOT max pg:14mmhg, free PR , No LVOTO, no AR, Confluent and fair sized PAs (exp- 10mm), RPA- 10 mm, LPA-10mm, Mild TR, Trivial MR, No LVOTO, no AR, Adequate lv/rv systolic function LVEF : 60%, Mild RV diastolic dysfunction , Left arch, no COA/LSVC , Normal coronaries, IVC is normal size with normal respiratory varitaion , 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 with TAP plus decompressing PFO** on 24.02.2022. 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 2nd POD on oxygen support and then gradually weaned to room air by 6th 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 Adrenaline (0-4th POD), Dopamine (0-5th POD), Noradrenaline (0- 3rd POD) and Dobutamine (0-6th POD) to optimize cardiac function. Decongestive measures were given in the form of lasix boluses. Mediastinal chest tubes inserted perioperatively were removed on 4th POD and patient shifted with b/l pleural drain to the ward.

Empirically antibiotics were started with Ceftriaxone and Amikacin. Piperacillin - Tazobactum was added in view of high TLC. Intravenous antibiotics were stopped and converted to oral Cefexime.

Postoperatively patient was found to have keratitis with pain in eyes and photophobia for which ophthalmology review was done and managed accordingly and thereafter patient improved.

Minimal feeds were started on 2nd POD and it was gradually built up to normal oral 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 110/min, sinus rhythm, BP110/60 mm Hg, SPO2 95-97% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid 1000 ml/day
- Normal diet

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FOLLOW UP

- Long term pediatric cardiology follow-up in view of **TOF correction with TAP plus decompressing PFO.**

- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.
- Review in Opthalmology OPD (Dr.Tarun Kapur) after 5 days in view of Keratitis

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp. Taxim –O 75mg twice daily (8am-8pm) - PO x 3 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.
- Syp. A to Z 5 ml once daily (2pm) – PO 3 weeks and then stop
- Syp. Shelcal 5 mll twice daily (9am – 9pm) – PO3 weeks and then stop
- Syp. Vitamin D3 800 IU once daily (2pm) – PO 3 months and then stop
- Tab. Lanzol Junior 15 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- Syp. Crocin 300 mg thrice daily (6am – 2pm – 10pm) – PO x 2 days then as and when required
- Vigamox eye drops 2 hourly B/E
- Tobacin eye drops 2 hourly B/E alternating with above
- Refresh liquigel eye drops 4 times a day B/E
- Ocupol eye ointment once at night B/E
- Eye mist gel eye ointment once at night B/E
- Ocular hygeine to be maintained strictly
- **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**

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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. Himanshu Pratap in OPD with prior appointment.**
- **Dr. Neeraj Awasthy in OPD with prior appointment.**

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