MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Mast. Hamdan Ur Rehman	
Age: 3 Years	**Sex: Male**
UHID No: SKDD.963158	**IPD No : 484281**
Date of Admission: 10.04.2023	**Date of Procedure: 11.04.2023** **Date of Discharge: 19.04.2023**
Weight on Admission: 11.8 Kg	**Weight on Discharge: 11.5 Kg**
Cardiac Surgeon: DR. K. S. DAGAR **: DR. HIMANSHU PRATAP** **Pediatric Cardiologist : DR. MUNESH TOMAR** **Pediatric Intensivist: DR. PRADIPTA ACHARYA**	

DISCHARGE DIAGNOSIS

- Congenital Cyanotic Heart Disease
- Tetralogy Of Fallot
- Large Malaligned perimembranous VSD, right to left shunt
- Severe infundibular and valvar PS
- Confluent and adequate sized branch PAs
- PDA
- Dilated RA/RV
- Normal Biventricular function
- MAPCAs
- Progressive cyanosis

PROCEDURE:

Dacron patch VSD closure with rerouting of Aorta to LV + Infundibular resection with Transannular patch + PDA ligation done on 11.04.2023

RESUME OF HISTORY

Mast. Hamdan Ur Rehman, a 3 and 1/2 years old male child, 1st in birth order, born out of non consanguineous marriage at term through LSCS for oligohydramnios and cried immediately after birth. On routine checkup on day 2 of life, a murmur was heard and on detail evaluation was diagnosed to have Tetralogy of Fallot. He has history of bluish discoloration of nails and lips on excessive crying and is progressively increasing. There is history of atopic dermatitis and seasonal URI. There is no history of hospital admission, cyanotic spells or seizure. Mild delayed gross motor developmental milestones noted. Immunization is as per national immunization schedule.

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

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INVESTIGATIONS SUMMARY:

ECHO (03.03.2023): Tetralogy of Fallot. Large Unrestrictive malaligned Perimembranous VSD, R-L shunt. Severe Infundibular and Valvar PS (PG 59 mmHg), anterior deviation of Conal septum seen. Good sized and confluent branch Pas. Pulmonary annulus hypoplastic (9 mm) (EXP – 12 mm), normal coronaries. Dilated RA/RV. Left aortic arch. Normal Biventricular Function.

X RAY CHEST (10.04.2023): Report Attached.

USG WHOLE ABDOMEN (10.04.2023): Report attached.

PRE DISCHARGE ECHO (18.04.2023): VSD patch in situ, no residual shunt, well opened RVOT, PG: 24 mmhg, free PR, good flow in branch PAs; RPA: 9 mm, LPA: 9 mm, mild TR, PFO shunting bidirectionally, dilated RA/RV, RV diastolic dysfunction, normal biventricular systolic function, LVEF: 55%, no collection

COURSE IN HOSPITAL:

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

In view of his diagnosis, symptomatic status & Echo findings he underwent **Dacron patch VSD closure with rerouting of Aorta to LV + Infundibular resection with Transannular patch + PDA ligation surgery on 11.04.2023.** 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 CTVS PICU for further management on full ventilation and moderate inotropic supports. He was electively ventilated with adequate sedation and analgesia for about 18 hours and was then extubated on 1st POD to HFNC support which was then gradually weaned off to oxygen and then to room air by 5th POD.

Associated bilateral basal atelectasis and concurrent bronchorrhoea was managed with frequent nebulization, postural drainage and chest physiotherapy. Mediastinal Chest tubes and left ICD inserted perioperatively were removed on 3rd POD once minimal drainage was noted.

Inotropes were started in the form of Adrenaline (0-5th POD), Nor adrenaline (0-4th POD), Dobutamine (0-6th POD) and Milrinone (0-4th POD) to optimize the cardiac output.

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

Minimal feeds were started on 1st POD and it was gradually built up to normal diet. 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 hemodynamically stable, afebrile, accepting well orally, HR 110/min, sinus rhythm, BP 90/55 mmHg, SPO2 98% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid 900 ml/day x 2 weeks
- Normal diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **Dacron patch VSD closure with rerouting of Aorta to LV + Infundibular resection with Transannular patch + PDA ligation surgery.**
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp. Levofloxacin 120 mg twice daily (8am-8pm) - PO x 3 days then stop
- Syp. Furosemide 10 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Spironolactone 6.25 mg twice daily (8am-8pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Syp. A to Z 5 ml once daily (9pm) – PO x 2 weeks and then stop
- Syp. Calcimax P 5 ml twice daily (9am – 9pm) – PO x 2 weeks and then stop
- Syp. Ibugesic Plus 7.5 ml 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.**

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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. Munesh Tomar in OPD with prior appointment.**

Dr. K. S. Dagar
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Neonatal and Congenital Heart Surgery

Dr. Himanshu Pratap
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