MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Mast. Sushant Kumar	
Age: 8 months	**Sex: Male**
UHID No: SKDD.913805	**IPD No : 459074**
Date of Admission: 03.08.2022	**Date of Procedure: 05.08.2022** **Date of Discharge: 11.08 2022**
Weight on Admission: 5.0 Kg	**Weight on Discharge: 4.7 Kg**
Cardiac Surgeon: DR. HIMANSHU PRATAP **Pediatric Cardiologist : DR. NEERAJ AWASTHY**	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- Large DC VSD
- Small PDA
- Moderate COA
- Failure to thrive
- PAH

PROCEDURE:

VSD closure plus PDA ligation and end to end COA repair done on 05.08.2022

RESUME OF HISTORY

Mast. Sushant Kumar, 8 months old male child, 2nd in birth order (2nd of twin), a product of non-consanguineous marriage, born at full term via normal vaginal delivery. The child cried immediately after birth. Patient was apparently alright at birth, but developed fast breathing at 2 months of age. Birth weight was 2.2 kg and parents also noted failure to gain weight as compared to the other twin. Patient was taken to a local doctor who advised echocardiography. It revealed congenital heart disease. Child had been on regular follow [illegible]. Developmental milestones are delayed. Child is on Complimentary feeds. The child is fully immunized till date. Now the patient has admitted to this center for further management.

INVESTIGATIONS SUMMARY:

ECHO (18.07.2022):

Situs solitus, levocardia, AV, VA concordance, D-looped ventricles, NRGA. Normal pulmonary and systemic venous drainage. PFO with left to right shunt, PFO mean PG:3mmHg. Large outlet muscular VSD with bidirectional shunt, Additional apical VSD tracts. TV annulus:13mm, mild TR. MV annulus:16mm, Mild MR. AV annulus:6.9mm, No LVOTO, No AR. PV annulus:13mm No RVOTO, Mild peak gradient of:60mmHg, End diastolic:36mmHg. No RVOTO. LVH. IVSD:0.6 (Z score +2.1), LVIDD:2.3 (Z Score +1.4), LVIDS:1.6, LVPWD:1.6 (Z Score +3.0), LVEF:70%. Adequate LV and RV systolic function. Tiny PDA. Confluent branch PAS, RPA:9.0mm, LPA:9.0mm. Juxta ductal coarctation of aorta with max/mean GDT OF:35 /7 mmHg with diastolic tailing. Left arch. Normal coronaries. No IVC congestion. No collection.

CT PULMONARY ANGIOGRAPHY (03.08.2022): Coarctation of aorta with focal narrowing in proximal descending aorta just distal to the origin of left subclavian artery, subaortic VSD measuring 7.2 mm in size, Left Ventricle measures 2.6 cm in size with diffuse left ventricular hypertrophy, Suspicious tiny PDA is seen between the main pulmonary artery and aorta, Main pulmonary artery appear dilated measuring 1.95 cm, Right and left main pulmonary artery are confluent . RPA 1.08 cm and LPA 1.02 cm.

X RAY CHEST (04.08.2022): Report Attached.
USG WHOLE ABDOMEN & CRANIUM (04.08.2022): Report attached.

PRE DISCHARGE ECHO (10.08.2022): **S/P VSD closure +PDA Ligation + COA Repair done on (5/8/2022):** VSD patch in situ, No residual shunt. Mild TR, Max PG:36mmHg. Mild MR. No LVOTO, No AR. No RVOTO, Mild PR. Adequate LV and RV systolic function. LVEF 55%. No residual PDA. Left arch. Good bolus across arch and descending aorta; Peak gradient of 8 mmHg. No pericardial or pleural collection.

COURSE IN HOSPITAL:

On admission an Echo followed by CT Pulmonary Angiography were done which revealed detailed findings above.

In view of his diagnosis, symptomatic status, Echo & CT Pulmonary Angiography findings he underwent **VSD closure plus PDA ligation and end to end COA repair** on 05.08.2022. 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 1st POD to nasal CPAP support and then gradually weaned to oxygen support by 2ND POD and then to room air till 4th POD. Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy, frequent nebulization and suctioning.

Inotropes were given in the form of Adrenaline (0-1st POD), Dobutamine (0-3rd POD) and Milrinone (1-2nd POD) to optimize cardiac function. Decongestive measures were given in the form of lasix boluses. Right and left mediastinal tubes and left pleural ICD inserted perioperatively were removed on 2nd POD once minimal drainage was noted.

Empirically antibiotics were started with Ceftriaxone and Amikacin. Once patient had stabilized and all cultures were negative, intravenous antibiotics were stopped and converted to oral formulations.

Minimal feeds were started on 1st POD and it was gradually built up to normal 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 120/min, sinus rhythm, BP 92/55 mm Hg, SPO2 95-98% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid 450-500 ml/day
- Semisolid diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **VSD closure plus PDA ligation and end to end COA 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 25 mg twice daily (8am-8pm) - PO x 3 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 twice daily (8am-8pm) – PO x 1 month and then as advised by pediatric cardiologist.
- Syp. A to Z 5 ml once daily (2pm) – PO x 1 month and then stop
- Syp. Calcimax P 2.5 ml twice daily (9am – 9pm) – PO x 1 month and then stop
- Tab. Lanzol Junior 5 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- Syp. Crocin 75 mg 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.**

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.**

Nara Vasudev

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

Dr. Himanshu Pratap
Principal Consultant
Neonatal and Congenital Heart Surgery

Dr. Neeraj Awasthy
Head, Principal Consultant & Incharge
Pediatric Cardiology

Max Super Speciality Hospital, Saket
(East Block) - A Unit of Devki Devi Foundation
(Devki Devi Foundation registered under the Societies Registration Act XXI of 1860)
Regd. Office: 2, Press Enclave Road, Saket, New Delhi-110 017
For medical service queries or appointments, call: +91 11 2651 5050
Fax: +91-11-2651 0050

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