

### DISCHARGE SUMMARY

Patient's Name : Mast. Keshav Kumar  
 Age/ Sex : 5 Years/male  
 UHID No. : 071-03-3660  
 IPD No : 723426  
 Date of Admission : 20.04.2024  
 Date of Procedure : 22.04.2024  
 Weight on Admission : 16.3 Kg  
 Weight on Discharge : 16.0 Kg  
 Cardiac Surgeon : DR. K. S. DAGAR  
 Pediatric Cardiologist : DR. MUNESH TOMAR  
 Pediatric Intensivist : DR. PRADIPTA ACHARYA

**Date of Discharge:**

29.04.2024

**DISCHARGE DIAGNOSIS:**

- \* Congenital acyanotic heart disease
- \* Large VSD, with Aortic override, restricted by Aortic valve prolapse (RCC)
- \* Severe AR
- \* Dilated Aortic Annulus
- \* Dilated LA/LV
- \* LVEF 50%
- \* PAH

**PROCEDURE:**

Dacron patch VSD closure + SAM resection + Aortic valve replacement (#21 St Judes) done on 22.04.2024.

SSN : 071-03-3660

**RESUME OF HISTORY**

Mast. Keshav Kumar, 5-year-old male child, out of non-consanguineous marriage is a k/c/o congenital acyanotic heart disease, large VSD with progressively increasing AR. He was diagnosed in the infancy period when he was seen by a local pediatrician and then a cardiologist for inadequate weight gain and frequent cough and cold. He was advised close follow up and early surgical correction. However, it was delayed till date due to various reasons. Repeat echo done about 3 months back revealed severe AR with mild LV dysfunction for which he was advised early surgical correction. No h/o cyanosis, seizures or

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Patient Name : KESHAV, KUMAR

SSN : 071-03-36660

chest pain. He is immunized for age and has no developmental delay.

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

#### INVESTIGATIONS SUMMARY:

##### ECHO (22.04.2024):

" Congenital acyanotic heart disease  
 " Restricted perimembranous VSD  
 " Shunting left to right, PG; 73mmhg  
 " Tricuspid aortic valve, significant RCC prolapse, LCC redundant  
 " Severe AR  
 " Dilated aortic annulus (z score +6.1) and aortic root (Z score +5.7)  
 " Mild TR  
 " Mild MR  
 " Dilated LA/LV  
 " LVEF 50%  
 " Left aortic arch with pan diastolic flow reversal in aorta

##### X RAY CHEST (20.04.2024):

Report Attached.

##### USG WHOLE ABDOMEN (20.04.2024):

Report Attached.

##### PRE DISCHARGE ECHO (29-4-2024.):

VSD patch in situ, no residual shunt, prosthetic valve seen at aortic position, no paravalvular AR. LVOT gradient: 10 mmHg, mild LV dysfunction, LVEF: 40-45%, mild TR, mild MR, dilated LA/LV, left aortic arch, No pericardial or pleural effusion.

##### COURSE IN HOSPITAL:

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

In view of his diagnosis, symptomatic status and Echo findings he underwent Dacron patch VSD closure + SAM resection + Aortic valve replacement (#21 St Judes) surgery on 22.04.2024. The parents were counselled 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.

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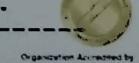
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Postoperatively, he was shifted to CTVS PICU for further management on full ventilation and minimal inotropic supports. He was electively ventilated with adequate sedation and analgesia for about 19 hours and was extubated on 1ST POD to HFNC support electively. He was taken to oxygen by nasal prongs on 2nd POD and then he was weaned off to room air by late 2nd POD.

Associated bilateral basal patchy atelectasis and concurrent bronchorrhea was managed with frequent nebulization, vibration, spirometry and chest physiotherapy. Both mediastinal chest tube inserted perioperatively were removed on 2nd POD once minimal drain was noted. Left pleural drains inserted perioperatively was removed on 3rd POD.

Inotrope was electively given in the form of Adrenaline (0 - 1st POD), Milrinone (0 - 2nd POD) and Dopamine (0-2nd POD) to optimize the cardiac output. Vymada was later started for continued afterload reduction.

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

Anticoagulation was done with Acitrom and its dose was titrated as per the PT/INR. Target Pt/INR 2.0-2.5.

Minimal feed was started on '0' POD. It was gradually built up to normal Acitrom diet by 3rd POD. He was also supplemented with multivitamins & calcium.

He is in a stable condition now and is fit for discharge.

#### CONDITION AT DISCHARGE

Patient is haemodynamically stable, afebrile, accepting well orally, HR 130/min, sinus rhythm, BP 109/71mm Hg, SPO2 98% on room air. Chest - bilateral clear, sternum stable, chest wound healthy.

#### DIET

- \* Fluid Restriction 1000-1100 ml/day x 2 weeks
- \* Normal Acitrom diet

#### FOLLOW UP

- \* Long term pediatric cardiology follow-up in view of Dacron patch VSD closure + SAM resection + Aortic valve replacement (#21 St Judes) surgery.
- \* Regular follow up with treating paediatrician for routine checkups and nutritional rehabilitation.

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## PROPHYLAXIS:

## \* Infective endocarditis prophylaxis

## TREATMENT ADVISED:

- \* Tab. Taxim -0 100 mg twice daily (8am-8pm) - PO x 5 days then stop
- \* Syp. Azithromycin 80 mg once daily (12pm)-PO x 3 days then stop
- \* Syp. Furosemide 8 mg thrice daily (6am - 2pm - 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- \* Tab. Spironolactone 12.5 mg thrice daily (6am - 2pm - 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- \* Syp. Ibugesic Plus 5 ml thrice daily (6am-2pm-10pm) - PO x 2 days and then sos
- \* Syp. Bro Zedex 3 ml thrice daily (6am-2pm-10pm) - PO x 5 days and then stop
- \* Tab. Cidmus 10 mg twice daily (9am - 9pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- \* Syp. A to Z 5 ml twice daily (9am - 9pm) - PO x 2 weeks then stop
- \* Syp. Shelcal 5 ml twice daily (9am - 9pm) - PO x 2 weeks then stop
- \* Tab. Lanzol Junior 15 mg twice daily (8am - 8pm) - 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.

Review after 3 days with serum Na<sup>+</sup> and K<sup>+</sup> level and PT/INR at 2nd floor procedure room in between 2-4:00Pm. 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.

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Principal Director

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Dr. Munesh Tomar  
Director,  
Pediatric Cardiology

Dr P K Acharya  
Asso. Director  
Pediatric cardiac intensive care

Patient Name : KESSHAW, KUMAR

SSN : 071-03-3660

/es/ Pradipta Kumar ACHARYA  
Associate Director  
Signed: 29/04/2024 12:30

/es/ Pradipta Kumar ACHARYA  
Associate Director  
Cosigned: 29/04/2024 12:31  
for KULBHUSHAN SINGH DAGAR  
Principal Director - Pediatrics Cardiac Surgery

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