MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Mast. Md Sanaullah	
Age: 7 Years	**Sex: Male**
UHID No: SKDD.899639	**IPD No : 455070**
Date of Admission: 27.06.2022	**Date of Procedure: 28.06.2022** **Date of Discharge: 02.07.2022**
Weight on Admission: 20.1Kg	**Weight on Discharge: 19.6 Kg**
Cardiac Surgeon: DR. K. S. DAGAR **Pediatric Cardiologist : DR. NEERAJ AWASTHY**	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- Large ostium secundum-ASD with absent IVC rims
- Dilated RA/RV
- Failure to thrive

PROCEDURE:

Dacron Patch ASD Closure done on 28.06.2022

RESUME OF HISTORY

Mast. Md Sanaullah, 7 years male child, 2nd in birth order, born out of consanguineous marriage at term through normal vaginal delivery at home and cried immediately after birth. at 4 years of age, parents took child to local doctors with complaints of recurrent cough and cold and on detail evaluation was diagnosed to have congenital heart disease. There is history of failure to thrive, breathlessness on exertion and easy fatigability.
There is no history of prior hospital admission or seizure.
Immunization was done as per parents but records not available
Now the patient has admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (27.06.2022):
Situs solitus, levocardia, AV, VA Concordance. D-looped ventricles, NRGA. Normal pulmonary and systemic venous drainage. Large ostumsecundum ASD measuring 33 mm with left to right shunt, with deficient IVS rim, No PAPVC. Intact IVS. TV Annulus:27mm, MILD TR; PG; 25 mmHg. MV annulus:16mm, No MR. AV annulus:14mm, No LVOTO, No AR. PV annulus:17mm, No RVOTO, Mild PR, peak gradient 14 mmHg. Flat septal motion. Dilated RA/RV. Adequate LV/RV systolic function, LVEF: 65%. Left arch, No COA/PDA/APW/LSVC. Confluent branch PAs. Normal coronaries. No IVC congestion. No collection.

X RAY CHEST (27.06.2022): Report Attached.

USG WHOLE ABDOMEN (27.06.2022): Report attached.

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PRE DISCHARGE ECHO (02.07.2022.): S/P ASD CLOSURE ,,SITUS SOLITUS, LEVOCARDIA, AV, VA CONCORDANCE,D-LOOPED VENTRICLES, NRGA,NORMAL PULMONARY AND SYSTEMIC VENOUS DRAINAGE,ASD PATCH IN SITU, NO RESIDUAL SHUNT ,INTACT IVS,MILD TR; PG; 18 MMHG,NO MR,NO LVOTO, NO AR,NO RVOTO,FLAT SEPTAL MOTION ,ADEQUATE LV/RV SYSTOLIC FUNCTION LVEF: 60%,LEFT ARCH, NO COA/PDA/APW/LSVC,CONFLUENT BRANCH PAS,NORMAL CORONARIES,NO IVC CONGESTION,MINIMAL LEFT PLEURAL EFFUSION ,NO PERICARDIAL EFFUSION.

On admission an Echo was done which revealed detailed findings above.

In view of his diagnosis, symptomatic status and Echo findings he underwent **Dacron Patch ASD Closure** on 28.06.2022. 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 0 POD and then gradually weaned to room air by 1ST 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 (0-1ST POD) and Dobutamine (0- 2ND POD) to optimize cardiac function. Decongestive measures were given in the form of lasix boluses. Mediastinal chest tubes inserted perioperatively were removed on 1ST POD after minimal drains are noted.

Empirically antibiotics were started with Ceftriaxone and Amikacin. Sepsis screen came negative and was converted oral Cefexime .

Minimal feeds were started on 1st POD and it was gradually built up to normal 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 102/min, sinus rhythm, BP-112/70 mm Hg, SPO2 98 % on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid -900ml/day
- Normal diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **Dacron Patch ASD Closure.**
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

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REATMENT ADVISED:

- Tab. Cefixime–O 100 mg twice daily (8am-8pm) - PO x 3 days then stop
- Tab. Furosemide 15 mg twice daily (10am 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Spironolactone 6.25 mg twice daily (9am – 9pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Shelcal 250mg daily (9am – 9pm) – PO x 2 weeks then stop
- Tab. Pantocid 20 mg twice daily (8am-8pm) – PO x 5 days then stop
- Tab. Crocin 250 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 o be decided on follow up. Continued review with the cardiologist for continued care. Periodic review with this center by Fax, email and telephone.

n case of Emergency symptoms like :**Poor feeding, persistent irritability / drowsiness, ncrease in blueness, fast breathing or decreased urine output,** kindly contact mergency: 26515050

or all OPD appointments

- **Dr. K. S. Dagar in OPD with prior appointment.**
- **Dr. NeerajAwasthy in OPD with prior appointment.**

r. K. S. Dagar
rincipal Director
leonatal and Congenital Heart Surgery

Dr. NeerajAwasthy
Head, Principal Consultant &Incharge
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