MAX Healthcare

Discharge Summary Pediatric CTVS

Patient Demography Details :

Name	: Mohammad Irshad Ansari	**Patient ID**	: SKDD.1125704	**IP No.**	: 801746
DOB	: 21 SEP, 2020	**Age/Gender**	: 5 Years/MALE	**Primary Consultant**	: Pradipta Kumar Acharya
DOA	: 10 MAR, 2026 12:15	**Ward**	: SKTE-NURSE 2ND FLOOR		
				Secondary Consultant	: Kulbhushan Singh Dagar
Address	: GRAM CHILAHARI, .., BIHAR, 0			**Mobile No.**	: 7503964103

SSN No. : 071125704 Patient Name : Mohammad Irshad Ansari

Date and Time of Discharge : 23 MAR, 2026 12:48

Diagnosis:

* Congenital Cyanotic Heart Disease
* DILV with malposed arteries
* Unrestrictive VSD & ASD
* No AV valve regurgitation
* Good sized branched PAs
* No antegrade flow in PA across pulmonary valve
* Hypoplastic RV
* S/P BD Glenn + Atrial Septectomy+ MPA ligation done on 05/10/2021.
* Patent and well-functioning right Glenn shunt
* Normal left ventricular function
* S/P Cath + MAPCA coiling done on 11/03/2026
* Progressive cyanosis

History of Present Illness:

Mast. Mohammad Irshad Ansari, 5 Years old male child is a known case of congenital cyanotic heart disease. He is second in birth order, born out of non-consanguineous marriage at term by NVD. Birth weight: not known. He Cried immediately at birth. No history of NICU admission. He was apparently alright till about 2 months of age when he was taken to a pediatrician for cough and cold. On evaluation he was detected with a murmur and subsequently echo was done which revealed cyanotic CHD. He was then advised early surgical intervention. Parents were counseled about the need for multiple surgeries. He then revealed progressively increasing cyanosis and he also had h/o multiple cyanotic spells.
He then underwent palliative BD Glenn with atrial septectomy and MPA ligation surgery in October 2021. Post-surgery he improved symptomatically.

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He has no h/o seizures/ recurrent LRTI/ear discharge.
Since last few months he has again started to have progressively increasing cyanosis and easy fatigability for which he was evaluated and was advised Fontan completion surgery.
He is not immunized as per age according to parents. He has achieved all development milestones.

He has now come to this center for further evaluation and management.

On Examination:

**PHYSICAL EXAMINATION ON ADMISSION: **
Body Weight : 13.15 Kg
Heart Rate : 99 /min
Blood Pressure : 129/91 mmHg
Oxygen Saturation (SPO2) : 86% on room air
Respiratory rate (RR) : 24/min
Weight on Discharge : 12.60 Kg

Procedure:

Diagnostic cardiac catheterization and coiling of collaterals done on 11.03.2026.

Surgery:

Non-Fenestrated extracardiac Fontan (#18 PTFE) + Ligation of MPA surgery done on 13.03.2026.

Course in Hospital:

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

In view of his diagnosis, symptomatic status and Echo findings he underwent Diagnostic cardiac cath and coiling of collaterals on 11.03.2026. This was followed by Non Fenestrated extracardiac Fontan(#18 PTFE)+Ligation of MPA surgery on 13.03.2026. The parents were counselled in detail about the risk and benefit and the palliative nature 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 briefly ventilated with adequate sedation and analgesia for about 5 hours and was then extubated on late 0 POD to HFNC. However, by next 12 hours he started to have progressively worsening respiratory distress and impending respiratory failure for which he was electively reintubated on 1st POD and was ventilated for next 20 hours and was extubated on 2nd POD to nasal BIPAP. The BIPAP was alternated with HFNC with progressively increasing duration till 3rd POD and then weaned off to low flow oxygen by nasal prongs which was taken off to room air by late 4th POD.

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Associated bilateral basal atelectasis and concurrent bronchorrhea was managed with frequent nebulization, chest physiotherapy, vibration and spirometry. Mediastinal chest tube inserted perioperatively was removed on 2nd POD once minimal drainage was noted. Left chest tube inserted perioperatively was removed on 4th POD and Right on 5th POD once minimal drainage was noted.

Antibiotics were upgraded due to concerns of sepsis. Blood and ET secretion cultures came out to be sterile.

Inotropes were electively given in the form of Milrinone (0 – 3rd POD) and Dobutamine (0 – 4th POD) to optimize the cardiac output. Enalapril was later added for continued afterload reduction.

He was anticoagulated with Acitrom and its dose titrated as per the PT/INR report.

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

Minimal feed was started on '0' POD which was gradually built up to Acitrom normal diet orally. He was also supplemented with probiotics, prokinetics multivitamins & calcium.

Presently, he is in a stable condition and is fit for discharge.

Condition on Discharge:

Patient is hemodynamically stable, afebrile, accepting well orally, HR 121/min, sinus rhythm, BP 98/62 mm Hg, SPO2 96% on room air. Chest - bilateral clear, sternum stable, chest wound healthy. No signs of venous congestion.

Lab Results:

**ECHO (11.03.2026): **
SEGMENTAL ANALYSIS
CARDIAC POSITION
• Levocardia
• Abdominal Situs solitus
• Atrial situs solitus
• D ventricular Loop
• Antero-posteriorly related great arteries
VEIN
• Patent and well-functioning right Glenn shunt
• Bilateral hepatic veins draining Into IVC into RA
• Normal pulmonary venous drainage
ATRIUM
• Normal right atrial size

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• Normal left atrial size
• Non-restrictive ASD shunting bidirectionally
ATRIOVENTRICULAR VALVES
• Normal tricuspid valve
• Normal mitral valve
VENTRICLES
• Normal left ventricular structure and size
• HYPOPLASTIC RV
• Non-restrictive VSD
SEMILUNAR VALVES
• Normal tricuspid aortic valve
• No antegrade flow across pulmonary valve
GREAT VESSELS
• Normal pulmonary artery branches
• Normal size aorta
FUNCTION
• Normal left ventricular systolic and diastolic function
INFLOW HAEMODYNAMICS
• Normal tricuspid valve velocity.
• No TR
• Normal mitral valve velocity.
• No MR
OUTFLOW HAEMODYNAMICS
• NO ANTEGRADE FLOW ACROSS PULMONARY VALVE
• Normal aortic valve velocity.
• No AR
SHUNTS
• ASD SHUNTING BIDIRECTIONALLY
• VSD SHUNTING left to right.
• No patent ductus arteriosus detected

**X RAY CHEST (10.03.2026): **
Report Attached.

**X RAY CHEST Left Lateral (10.03.2026): **
Report Attached.

USG Whole Abdomen (10.03.2026):

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Report Attached.

** Diagnostic Cardiac CATH and Coiling of Collaterals (11.03.2026) **

1. Glenn Angiogram Done Showed Confluent Branch PAs with no Antegrade Flow Across Pulmonary Valve. RPA Measures 10.6 Mm With Good Peripheral Arborization. LPA Measures 9 Mm With Good Peripheral Arborization. Levophase Shows Pulmonary Venous Drainage into LA.
2. Innominate Venogram Done Shows it Draining Into Right Glenn. No LSVC Seen
3. Ventriculogram Done in Lateral View Shows Well Contractile Smooth Ventricle with Non Restrictive VSD amounting to Single Ventricle giving rise to Aorta.
4. Aortogram Done in AP View Shows Left Sided Aortic Arch With No PDA. No Significant Collaterals From the Arch And Left Subclavian Artery Seen.
5. Selective Right Subclavian Angiogram Showed a Tortuous Significant Collateral Arising Opposite to RIMA Supplying Right (Predominantly) And Left Hilar Lung Fields. This Was Hooked Using 5fr Jr Catheter and After Achieving Stable Catheter Position, This Was Closed Using Cooks 035 3mmx3cm Coil. Post Coil deployment Angiogram Showed No Significant Flow Through The Collateral.
6. IVC Venogram Done Shows Right And Left Sided Hepatic Veins Draining Into IVC Draining Into RA. No Duplication/Interruption Seen. Post Procedure Baby Was Stable And Was Shifted To Peds Ctvs Icu For Observation

**PRE DISCHARGE ECHO (19.03.2026): **

- ☐ DILV- VA discordance
- ☐ Patent and well functioning right Glenn shunt
- ☐ Patent and well functioning Fontan circuit
- ☐ Normal pulmonary venous drainage
- ☐ Non restrictive ASD shunting bidirectionally
- ☐ Laminar inflows
- ☐ No TR/no MR
- ☐ Non restrictive VSD amounting to single ventricle, shunt left to right
- ☐ Antero posteriorly related great arteries
- ☐ No antegrade flow across pulmonary valve
- ☐ Laminar flow in aorta
- ☐ Confluent and adequate branch pas
- ☐ Left arch. No CoA, no PDA
- ☐ Normal left ventricular function
- ☐ No pericardial collection
- ☐ No pleural collection

Medications During Stay:

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LAST DOSE ADMINISTERED/ GIVEN WARD AFTER BREAKFAST:
Syp. Levofloxacin 130 mg
Tab. Enalapril 1.2 mg
Syp. Furosemide 7.5 mg
Syp. Bro Zedex 2.5 ml
Syp. A to Z 5 ml
Syp. Shelcal 5 ml
Tab. Lanzol Junior 15 mg
Syp. Domperidone 5 ml
Syp. Paracetamol 200 mg
sachet Darolac 2gm

Advice:

DIET
* Fluid restriction 900ml/day x 2 weeks
* Normal Acitrom diet

FOLLOW UP
* Long term paediatric cardiology follow-up in view of Non Fenestrated extracardiac Fontan(#18 PTFE)+ Ligation of MPA surgery.
* Regular follow up with treating paediatrician for routine checkups and nutritional rehabilitation.

**PROPHYLAXIS: **
* Infective endocarditis prophylaxis

** WOUND CARE: **
* Remove surgical dressing from the wound after 1 day
* Daily Scrubbing and bathing if the wound is dry
* Betadine lotion for local application twice daily on the wound x 7 days
* Stitch removal after one week

Discharge Medications Advice:

* Syp. Levofloxacin 125 mg twice daily (8am-8pm) - PO x 5 days
* Tab. Aldactone 6.25 mg twice daily (6am – 6pm) - PO x 2 weeks then as advised by pediatric cardiologist.
* Tab. Enalapril 1.2 mg twice daily (8am- 8pm) - PO x 2 weeks then as advised by pediatric cardiologist.
* Syp. Furosemide 10 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
* Syp. Bro Zedex 2.5 ml thrice daily (6am – 2pm – 10pm) – PO x 5 days
* Syp. A to Z 5 ml once daily (2pm) – PO x 2 weeks then stop

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* 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
* Syp. Paracetamol 200 mg thrice daily (6am – 2pm – 10pm) – PO x 3 days then as and when required
* sachet Darolac 2gm 1 sachet twice daily with feeds x 1 week

* OINTMENT CONTRACTUBEX/HEXILAC ULTRA GEL FOR LOCAL APPLICATION TWICE A DAY ON CHEST WOUND – ONCE THE WOUND IS DRY FOR 2-3 MONTHS
* Intake/Output charting.
* Immunization as per national schedule with local paediatrician after 8 weeks.

Follow Up Advice:

Review after 3 days with serum Na+ and K+ 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. P K ACHARYA in OPD with prior appointment.
Dr. ANKIT GARG in OPD with prior appointment.

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SSN No. : 071125704

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

Dr P K Acharya
Asso. Director
Paediatric cardiac intensive care

Dr. (Maj) Pradipta Kumar Acharya
MBBS, MD (Paediatrics)
Fellowship in Cardiac Critical Care
Observer Fellow in Sick Kids Hospital, Toronto
Associate Director-Paediatric Cardiology &
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Dr. Ankit Garg

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Sr. Consultant
Paediatric Cardiology

/es/ Pradipta Kumar Acharya
Associate Director

Signed: 23 MAR, 2026 12:53

/es/ Pradipta Kumar Acharya
Associate Director

Cosigned: 23 MAR, 2026 12:54

for

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Prepared By: Pradipta Kumar Acharya

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