MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Mast. Md Osman	
Age: 1 Years	**Sex: Male**
UHID No: SKDD. 905094	**IPD No : 469762**
Date of Admission: 14.11.2022	**Date of Procedure: 17.11.2022** **Date of Discharge: 30.11.2022**
Weight on Admission: 5 Kg	**Weight on Discharge: 4.8 Kg**
Cardiac Surgeon: DR. HIMANSHU PRATAP **DR. K. S. DAGAR** **Pediatric Cardiologist : DR. NEERAJ AWASTHY**	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- Supracardiac TAPVC with dual SVC
- Restrictive ostium secundum ASD
- Intact IVC
- Failure to thrive

PROCEDURE:

Supracardiac TAPVC repair done on 17.11.2022

RESUME OF HISTORY

Mast. Md. Osman, 1 year male child, 3rd in birth order, born out of non consanguineous marriage at term through LSCS for previous C-Section and cried immediately after birth. At 4 months of age parents noticed baby to have tachypnea with chest retractions and fever. Parents took baby to local doctors and on detailed evaluation was diagnosed to have complex congenital heart disease.

There is history of feeding diaphoresis.

There is no history of seizure, cyanotic spell.

Baby is vaccinated till 9 months of age as per their national immunization schedule.

Now the patient has admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (14.11.2022):

Situs solitus, levocardia, D looped ventricles. AV, VA concordance. NRGA. Normal systemic venous drainage. Supracardiac TAPVC, all four PVS forming a confluence and draining into vertical vein, flow turbulence at the junction of opening of confluence to vertical vein with mean PG:3mmHg. Restrictive ostium secundum ASD measuring 4.0mm with right to left shunt. Intact IVS. TV annulus 20mmm(+1.6Z) : Mild TR, Max PG:70mmHg. MV annulus :13mm (-0.3Z) No MR. AV annulus : 10mm (+2.2Z) No LVOTO, No AR. PV annulus : 15mm(+3.2Z) ; Mild flow turbulence in RVOT, RVOT Max PG:15mmHg, MILD PR, Peak gradient of:51mmHg. good sized and confluent branch PAs. Dilated RA/RV/PA. adequate LV/RV systolic function LVEF:60%. left arch, no COA/PDA/APW/LSVC. normal coronaries, no collection, severe PAH.

Max Super Specialty 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
www.maxhealthcare.in

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X RAY CHEST (15.11.2022): Report Attached.

USG WHOLE ABDOMEN & CRANIUM (15.11.2022): Report attached.

CP PULMONARY ANGIOGRAPHY (15.11.2022): Supracardiac TAPVC, with dual SVC with H type configuration supracardiac TAPVC noted. Right superior and inferior pulmonary veins draining a
horizontal venous channel joined by left inferior pulmonary vein and courses superiorly along the left lateral mediastinal margin with multiple tributaries of left superior pulmonary veins draining into it. The venous channel joins the brachiocephalic vein and drains into SVC on right side - Congestive changes in lungs with mosaic attenuation and prominent vascular markings with few patchy opacities and air trapping in lower lobes.

PRE DISCHARGE ECHO (30.11.2022.):
Laminar flow seen across pulmonary venous confluence draining to la; ,mean gradient of 2 mmhg,pfo shunting lfet to right ,intact ivs,mild tr, max pg:18mmhg,no mr,no lvoto, no ar no rvoto,good flow seen in branch pas,normal lv and rv systolic function; lvef : 55%
left arch, no coa,no ivc congestion,no pleural collection

COURSE IN HOSPITAL:
On admission an Echo & CT pulmonary angiography were done which revealed detailed findings above.

In view of his diagnosis, symptomatic status, Echo & CT Pulmonary angiography findings he underwent **Supracardiac TAPVC repair** on 17.11.2022. 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 ICU ventilated with adequate analgesia and sedation. He was extubated on 2nd POD and electively kept on nasal cpap and later weaned to room air by 5th POD.
Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy and frequent nebulizations.
Inotropes were given in the form of Dobutamine (0- 5th POD) and Adrenaline (0- 4th POD) to support cardiac function. Decongestive measures were given in the form of lasix boluses. Chest tubes inserted peroperatively were removed on 4th POD when minimal drainage was noted.Antibiotics were given in the form of Tazact and Amikacin. Sepsis screen was negative and an appropriate course of antibiotics had been administered and later changed to oral formulation.
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 & calcium.
He is in stable condition now and fit for discharge.

CONDITION AT DISCHARGE
Patient is haemodynamically stable, afebrile, accepting well orally, HR 114/min, sinus rhythm, BP 98/60 mm Hg, SPO2 98% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

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DIET

- Fluid 450 ml/day
- Milk/weaning diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **Supracardiac TAPVC repair.**
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp.Taxim –O 30mg twice daily (8am-8pm) - PO x 5 days then stop
- Syp. Furosemide 5 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Spironolactone 3.125mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Folic Acid 5 mg once daily (2pm) – PO x 2 weeks then stop
- Syp. Calcimax P 2.5 ml twice daily (8am-8pm) –PO x 2 weeks then stop
- Syp. A to Z 2.5 ml twice daily (8am-8pm) – PO x 2 weeks then stop
- Syp. Cholecalciferol 800 IU once daily (2pm) – PO x 2 weeks then stop
- Tab. Lanzol Junior 5 mg twice daily (8am – 8pm) – PO x 5days 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

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For all OPD appointments

- **Dr. Dr. Himanshu Pratap in OPD with prior appointment.**
- **Dr. Neeraj Awasthy in OPD with prior appointment.**

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

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