MAX Healthcare

DISCHARGE SUMMARY

Patient's Name: Baby Trisha	
Age: 1 Years	**Sex: female**
UHID No: SKDD.911471	**IPD No : 459680**
Date of Admission: 09.08.2022	**Date of Procedure: 11.08.2022** **Date of Discharge: 19.08.2022**
Weight on Admission: 6.9 Kg	**Weight on Discharge: 6.6 Kg**
Cardiac Surgeon: DR. HIMANSHU PRATAP **Pediatric Cardiologist : DR. NEERAJ AWASTHY**	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- Tetralogy of fallot
- Trickle antegrade flow

PROCEDURE:

TOF correction with TAP plus decompressing PFO done on 11.08.2022

RESUME OF HISTORY

Baby Trisha, 1-year-old female child, 1st in birth order to a non-consanguineous marriage, born at term via normal vaginal delivery in hospital, the child cried immediately at birth with birth weight around 3kg. Baby started having weakness and episodes of fall for which she was shown to local practitioner at 7 months of age and was evaluated. On detail evaluation patient was diagnosed to have Cyanotic Congenital Heart Disease and was on follow up there. There is history of cyanosis, weakness, fallure to thrive and delayed developmental mllestones. There is no history of seizure or recurrent LRTI or feeding diaphoresis. Patient was then referred here for further evaluation and management.

History of delayed developmental milestones present and regression present since last 3 months duc to weakness.

Immunization is incomplete.

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

INVESTIGATIONS SUMMARY:

ECHO (10.08.2022): Situs solitus, levocardia. AV, VA concordance. D-looped ventricles, Normally related great arteries. Normalsystemic and pulmonary venous drainage. PFO with right to left shunt. Tetralogy of fallot. Large malaligned perimembranous VSD shunting bidirectinally with >50% aortic override. PV annulus:9.7mm, (EXP-9.5)Muscle bundle seen in lower infundibulam, severe infundibular, valvar PS (Trickle antegrade flow), with PG 55 mmHg. Confluent and fair sized PAs. (EXP- 6.5 MM). RPA- 5.5 mm, LPA-7.0mm. Mild TR. No MR. No AR. Dilated RA, RVH. Adequate LV/RV systolic function. Left arch, No COA. Anterior origin of RCA with prominent conal branch. No IVC congestion. No pericardial effusion.

X RAY CHEST (10.08.2022): Report Attached.

USG WHOLE ABDOMEN (10.08.2022): Report attached.

CT PULMONARY ANGIOGRAPHY (10.08.2022): TOF morphology, with overriding of aorta and subaortic perimembranous VSD. There is valvular and infravalvular infundibular stenosis of

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RVOT with confluent pulmonary arteries. Thin MAPCAs noted fromdescending aorta. Hypodense the patient defects noted in liver and small infarcts noted in spleen and right kidney.

PRE DISCHARGE ECHO (19.08.2022.):

Vsd patch in situ, no residual shunt,pfo with bidirectional shunt ,mild tr ,no mr,well opened rvot, rvot max pg:20mmhg, moderate pr ,no lvoto, no ar ,normal lv and rv systolic function lvef:60% mild rv diastolic dysfunction ,good flow seen in branch pas ,left arch, no coa ,ivc is normal size with normal respiratory varitaion ,mild left pleural effusion,no pericardial effusion

COURSE IN HOSPITAL:

On admission an Echofollowed by CT pulmonary angiography was done which revealed detailed findings above.

In view of her diagnosis, symptomatic status, Echo &CT pulmonary angiography findings she underwent **TOF correction with TAP plus decompressing PFO** on 11.08.2022. 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, she was shifted to PICU and ventilated with adequate analgesia and sedation. She was extubated on 1st POD onto nasal cpap support and weaned to room air by 6th POD. Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy, intermittent peep and frequent nebulizations.

Inotropes were given in the form of Adrenaline (0-5th POD), Dopamine (0-6th POD) and Milrinone (0 -3rd POD) to optimize cardiac function. Decongestive measures were given in the form of lasix boluses. Mediastinal /intercostal chest tubes inserted perioperatively were removed on 5th POD when minimal drainage was noted. Patient had arrhthmyia (atrial flutter) on 5th POD and was loaded with Amiodarone and infusion given and once sinus rhythm achieved , then converted to oral formulation.

Initial antibiotics were given in form of Ceftriaxone and Amikacin. Intravenous antibiotics were upgraded to Linezolid in view of MRSA positive. Once patient was stabilized and afebrile, repeat cultures were negative, intravenous antibiotics were stopped and converted to oral Linezolid.

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.

She is in stable condition now and fit for discharge.

CONDITION AT DISCHARGE

Patient is haemodynamically stable, afebrile, accepting well orally, HR -108/min, sinus rhythm, BP98/56 mm Hg, SPO2 94% on room air. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid 800 ml/day
- Normal diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **TOF correction with TAP plus decompressing PFO.**
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp. Linezolid 70 mg twice daily (8am-8pm) - PO x 7 days then stop

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- Syp. Furosemide 7 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Metinix 1mg once daily (2pm) x 7 days then stop
- Tab. Spironolactone 6.25 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Amlodarone 25 mg twice daily (9am-9pm) –PO x 2 weeks then as advised by pediatric cardiologist.
- Syp. A to Z 5 ml once daily (2pm) – PO x 2 weeks then stop
- Syp. Calcimax P 2.5 ml twice daily (9am – 9pm) – PO x 2 weeks then stop
- Tab. Lanzol Junior 7.5 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- Syp. Domperidone 1.5 ml thrice daily (6am – 2pm – 10pm) – PO x 2 weeks then stop
- Syp. Crocin 100 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.**

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