Fortis Escorts
HEART INSTITUTE

Escorts Heart Institute and
Research Centre Ltd.
Okhla Road, New Delhi-110 025 (India)
Tel. : +91-11-47135000
Emergency Tel. : +91-11-105010
Fax : +91-11-2682-5013
Email : contactus.escorts@fortishealthcare.com
Website : www.fortisescorts.in
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DISCHARGE SUMMARY

PATIENT NAME: ARYA YADAV	**AGE: 1 YEAR, SEX: F**
REGN: NO: 12532215	**IPD NO: 105634/23/1201**
DATE OF ADMISSION: 16/06/2023	**DATE OF DISCHARGE: 21/06/2023**
CONSULTANT: DR. K. S. IYER / DR. NEERAJ AWASTHY	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- **Moderate size Inlet muscular ventricular septal defect (left to right shunt)**
- **Right atrium dilated**

OPERATIVE PROCEDURE

Trans- right atrial Dacron patch closure of ventricular septal defect done on 17/06/2023

Tricuspid valve tested and found to be competent.

Right ventricular outflow tract wide open, Pulmonary valve normal.

RESUME OF HISTORY

Arya Yadav is a 1 year old female infant (date of birth: 18/06/2022) from UP who is a case of congenital heart disease. She is 3rd in birth order and is a product of full term LSCS (lower segment caesarian section) delivery. Her birth weight was 3 kg. Maternal age is currently 33 years. 1st sibling is apparently well. 2nd sibling died at age of 7 years. He had history of seizure disorder.

At 3 months of age, she had history of cough and cold for which she was shown to pediatrician. During evaluation, cardiac murmur was detected. Echo was done by DR. NEERAJ AWASTHY which revealed Congenital heart disease – ventricular septal defect. She was advised surgical management and was referred to FEHI, New Delhi.

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She was seen at FEHI, New Delhi on 15/06/2023. Her saturation at that time was 98% with weight of 7.5 Kg and Height 75 cm. Echo was done which revealed normal segmental analysis, intact interatrial septum, moderate size inlet ventricular septal defect (left to right shunt), posterior muscular, max PG 50mmHg, laminar inflow, myxomatous mitral valve, trace mitral regurgitation, tricuspid aortic valve, laminar outflow, confluent branch Pulmonary arteries, laminar flow in arch, no Coarctation of aorta, no Patent ductus arteriosus, no left superior vena cava, left arch, normal biventricular function, dilated left atrium and left ventricle, LVIDd 3.7 (Z score 3.4), LA 2.1 (Z score +2).

She was advised surgical management.

Now she is admitted at FEHI, New Delhi for further evaluation and management. On admission, her saturation was 98%.

In view of her diagnosis, symptomatic status, echo findings she was advised early high risk surgery after detailed counselling of family members regarding possibility of prolonged stay as well as uncertain long term issues.

Weight on admission 7.4 kg, Height on admission 71cm, Weight on discharge 7.78 kg

Her Weight on admission 7.4 kg. (3^{rd} – 15^{th} Percentile); Z score 0 to – 2 SD

Her blood Group B positive

Baby and her Mother SARS-COV-2 RNA was done which was negative.

On clinical evaluation, she was found to have ? dysmorphic features.

FISH test done for DIGEORGE SYNDROME, 22Q11.2 DELETION, FISH, SPECIMEN WHOLE BLOOD, TOTAL NUMBER OF CELLS – 200, DIGEORGE SYNDROME, 22q11.2 DELETION , FISH 0, NORMAL – 200, INTERPRETATION FISH analysis revealed 200 cells (Interphase and Metaphase) with normal signal pattern

Karyotype was done which revealed 46,XX (ISCN-2020)

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Weaned off Cardiopulmonary bypass with support of 5μg/kg/min dobutamine. Hemostasis secured. Protamine given followed by decannulation. Both pleurae intact. Routine sternal closure over drains.

Her post-operative course was smooth.

She was ventilated with adequate analgesia and sedation for 5 hours and extubated on 0 POD to oxygen by hood. Post extubation chest x-ray revealed bilateral mild patchy atelectasis. This was managed with chest physiotherapy, nebulization and suctioning.

She was shifted to ward on 1st POD. She was weaned from oxygen to air by 2nd POD.

Inotropes were not required.

Decongestive therapy was given in the form of lasix (boluses) and aldactone.

There were no post-operative arrhythmias.

Pacing wire was removed on 3rd POD.

She had intermittent fever (37.3°C) on 0 - 1st POD. She was thoroughly investigated for the same. Her TLC was 11,280/cmm and platelets 2.42 lacs/cmm. This was managed symptomatically with antipyretics. All cultures were negative. She was clinically well all through and apyrexial later. Her predischarge TLC was 9,950/cmm and platelets were 2.43 lacs/cmm.

Her pre-operative renal function showed (S. creatinine 0.22 mg/dl, Blood urea nitrogen 10 mg/dl)

Her post-operative renal function showed (S. creatinine 0.18 mg/dl, Blood urea nitrogen 9 mg/dl) on 0 POD

Her pre-discharge renal function showed (S. creatinine 0.21 mg/dl, Blood urea nitrogen 8 mg/dl)

Her pre-operative liver functions showed (SGOT/SGPT = 35/15 IU/L, S. bilirubin total 0.15 mg/dl, direct 0.08 mg/dl, Total protein 7.1 g/dl, S. Albumin 4.9 g/dl, S. Globulin 2.2 g/dl Alkaline phosphatase 315 U/L, S. Gamma Glutamyl Transferase (GGT) 10 U/L and LDH 289 U/L).

She had mildly deranged liver functions on 1st POD (SGOT/SGPT = 59/17 IU/L, S. bilirubin total 0.37 mg/dl & direct 0.13 mg/dl and S. Albumin 4 g/dl). This was managed with avoidance of hepatotoxic drug and continued preload optimization, inotropy and after load reduction. Her liver function test gradually improved. Her other organ parameters were normal all through.

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All blood and urine culture were sterile.

INVESTIGATION:

ECHO

Done on 15/06/2023 revealed normal segmental analysis, intact interatrial septum, moderate size inlet ventricular septal defect (left to right shunt), posterior muscular, max PG 50mmHg, laminar inflow, myxomatous mitral valve, trace mitral regurgitation, tricuspid aortic valve, laminar outflow, confluent branch Pulmonary arteries, laminar flow in arch, no Coarctation of aorta, no Patent ductus arteriosus, no left superior vena cava, left arch, normal biventricular function, dilated left atrium and left ventricle, LVIDd 3.7 (Z score 3.4), LA 2.1 (Z score +2)

POST OP ECHO

Epicardial Echo done on 17/06/2023 revealed VSD patch in situ. No residual shunt. Laminar inflows, trace MR, LVEF: 40-45%

Done on 17/06/2023 (06:20 PM) revealed ventricular septal defect patch in situ, no residual shunt, laminar inflow, mild tricuspid regurgitation, mild mitral regurgitation, laminar outflow, trace pulmonary regurgitation, LVEF 40-45%, no pericardial collection, trac right pleural collection

Done on 18/06/2023 (06:30 AM) revealed ventricular septal defect patch in situ, no residual shunt, laminar inflow, mild tricuspid regurgitation max PG 16mmHg, mild mitral regurgitation, laminar outflow, trace pulmonary regurgitation max PG 11mmHg, trace aortic regurgitation, LVEF 40-45%, trace right pleural collection, no left pleural or pericardial collection

Done on 20/06/2023 revealed ventricular septal defect patch in situ, no residual shunt, laminar inflow, mild tricuspid regurgitation, mild mitral regurgitation, laminar outflow, trace aortic regurgitation, laminar flow in arch, no Coarctation of aorta, LVEF 45%, mild bilateral pleural collection, no pericardial collection

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Thyroid function test done on 17/06/2023 which revealed was normal→ Thyroid function test showed T3 4.35 pg/ml (normal range – 2.15 – 5.83 pg/ml), T4 1.05 ng/dl (normal range 0.92 - 1.99 ng/dl), TSH 2.42 µIU/ml (normal range – 0.730 – 8.350 µIU/ml).

Gavage feeds were started on 0 POD. Oral feeds were commenced on 1st POD.

CONDITION AT DISCHARGE

Her general condition at the time of discharge was satisfactory. Incision line healed by primary union. No sternal instability. HR 120/min, normal sinus rhythm. Chest x-ray revealed bilateral clear lung fields. Saturation in air is 100%. **Her predischarge x-ray done on 20/06/2023**

In view of congenital heart disease in this patient her mother is advised to undergo fetal echo at 18 weeks of gestation in future planned pregnancies.

In view of advanced maternal age, the mother had been advised to do chorionic villus sampling or amniocentesis early in any future pregnancy to exclude Down's syndrome and she has also been advised a detailed congenital anomaly scan in next pregnancy.

Other siblings are advised detailed cardiology review.

PLAN FOR CONTINUED CARE:

DIET : Semisolids diet as advised

Normal vaccination (After 6 weeks from date of surgery)

ACTIVITY: Symptoms limited.

FOLLOW UP:

Long term cardiology follow- up in view of:-

1. Mild tricuspid regurgitation
2. Mild mitral regurgitation

Review on 23/07/2023 in 5th floor at 09:30 AM for wound review

Repeat Echo after 9 – 12 months after telephonic appointment

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(DR. KEERTHI AKKALA)
(CTVS RESIDENT)

(DR. K.S. IYER)
(EXECUTIVE DIRECTOR
PEDIATRIC CARDIAC SURGERY)

Please confirm your appointment from (Direct 011-47134540, 47134541, 47134500/47134536)

- **Poonam Chawla Mob. No. 9891188872**
- **Treesa Abraham Mob. No. 9818158272**
- **Gulshan Sharma Mob. No. 9910844814**
- **To take appointment between 09:30 AM - 01:30 PM in the afternoon on working days**

OPD DAYS: MONDAY – FRIDAY 09:00 A.M

In case of fever, wound discharge, breathing difficulty, chest pain, bleeding from any site call 47134500/47134536/47134534/47134533

Patient is advised to come for review with the discharge summary. Patient is also advised to visit the referring doctor with the discharge summary.