DISCHARGE SUMMARY

PATIENT NAME: KABYA	AGE: 8 YEARS, 3 MONTHS & 12 DAYS, SEX: F
REGN: NO: 12422778	IPD NO: 137451/23/1201
DATE OF ADMISSION: 07/08/2023	DATE OF DISCHARGE: 25/08/2023
CONSULTANT: DR. K. S. IYER / DR. NEERAJ AWASTHY	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- **Single ventricle physiology**
- **Tricuspid atresia, Normally related great vessels**
- **Severe Pulmonary stenosis**
- **Restrictive ventricular septal defect (Edwards type- IB)**
- **Ostium secundum ASD (Right to left)**
- **Severe pulmonary stenosis**
- **Hypoplastic right ventricle**
- Normal PA pressures (Mean 14mm Hg), Borderline size branch PA (McGoon ratio-1.84, Nakata index-291mm/m^2)
- **Polycythemia. (Hb 21.6gm/dl)**

OPERATIVE PROCEDURE

Primary Fontan /Extra-cardiac Fontan (20mm Intergard graft chosen and anastomosis of Right pulmonary artery to graft done with sucker in Right pulmonary artery keeping the heart beating empty + Cephalic end of the Superior vena cava was anastomosed with Right pulmonary artery in end to side fashion + Another end of the graft was interposed to Inferior vena cava) Anterograde flow- Interrupted + Azygous venous drainage - patent done on 08/08/2023

RESUME OF HISTORY

Kabya is a 8 years old female child (date of birth: 26/04/2015) from Rampur who is a case of congenital heart disease. She is 1st in birth order and is a product of full term normal vaginal delivery. Her birth weight was 2.5 kg. Maternal age is currently 28 years. Other sibling (4 years old boy) is apparently well.

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At ~ 5 months of age, she had history of fever for which she was shown to pediatrician. During evaluation, cardiac murmur was detected. Echo was done which revealed Congenital heart disease

After echocardiography parents were advised for surgery but did not get operated due to some personal issue.

She had history of early fatigability one moths back child developed fever with vomiting, for that she was admitted at Safdarjung hospital Delhi for 17 days and treated with intravenous antibiotics and oxygen support. After discharge she again got fever after 5 days with vomiting and readmitted at Safdarjung hospital on 16/04/2023.

She was brought LAMA to here at Fortis Escort heart Institute, New Delhi, for evaluation management on 19/04/2023

Child was shifted to CCU. Baseline investigations (CBC, CRP, ESR. RFT, LFT, urine culture, Blood group, Cross match) were sent, She underwent CT head and CT pulmonary angio. She was hemodynamically stable throughout her stay. child was continued on intravenous antibiotic (Monocef and vancomycin and tab Folic acid) and ENT opinion was done diagnosed CSOM advised ear drop. Child has improved with medical management. She was discharged on 22/04/2023in stable condition with advice to regular follow up.

CT PULMONARY ANGIOGRAPHY 20/04/2023 revealed

FINDINGS:

Situs solitus; levocardia.

Atrio-ventricular & Ventriculo-arterial concordance.

Tricuspid atresia with hypoplastic right ventricle.

Sinus venosus ASD is seen (SVC type).

Small muscular VSD is seen, measuring approx 4.1mm in maximum diameter.

MPA measures 14.6mm.

Good sized confluent branch pulmonary arteries are seen.

The right pulmonary artery measurement at mediastinal 7.5mm, at hilum – 9.5mm.

The left pulmonary artery measurement at mediastinum – 9.3mm, at hilum – 10.0mm.

No evidence of PDA noted.

Both coronary arteries arise from separate coronary sinuses and are normal in caliber.

The aortic arch is left sided with aberrant origin of right subclavian artery.

No MAPCAs are seen.

Normal pulmonary venous drainage is seen.

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Dilated visualized IVC and hepatic veins.
Lungs show no consolidation. No pleuro-pericardial effusion is seen.

Impression:
Tricuspid atresia with hypoplastic right ventricle.
Sinus venosus ASD (SVC type) with small muscular VSD.
Aberrant origin of right subclavian artery.

CT HEAD 20/04/2023 revealed
POSTERIOR FOSSA:
4th ventricle is normal in size, shape and position.
Brainstem & cerebellar hemispheres are normal.
SUPRATENTORIAL:
Brain parenchyma shows unremarkable morphology and attenuation values. No obvious focal brain parenchymal lesion seen.
Bilateral ganglio-thalamic nuclear complexes are unremarkable.
3rd & lateral ventricles are unremarkable in size with septum in midline.
Basal cisterns, fissures & cerebral sulci are unremarkable.
No evidence of significant intra / extraaxial collection or hyperdense hemorrhage seen.
No obvious bony injury / lytic or sclerotic bony lesion seen.
Note is made hyperdense intracranial vessels secondary to polycythemia.
Impression: No significant intracranial abnormality detected.

She was diagnosed to have bilateral CSOM and was advised 6 weeks of IV antibiotic. She completed her antibiotic course (ceftriaxone and vancomycin)

She was on regular follow up.

She was seen at FEHI, New Delhi on 02/05/2023. Her saturation at that time was 66% with weight of 19.8 Kg and Height 124 cm. Echo was done which revealed situs solitus, levocardia, normal systemic and pulmonary venous drainage, fossa ovalis atrial septal defect, tricuspid atresia, hypoplastic right ventricle, hypoplastic branch Pulmonary arteries, normal LVEF, no evidence of vegetation, no effusion. She was advised to review after 3 weeks.

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She was again seen at FEHI, New Delhi on 29/05/2023. Her saturation at that time was 61% with weight of 19.7 Kg and Height 127 cm. Echo was done repeated. She was advised close follow up.

She was again admitted at Fortis Escort heart Institute, New Delhi on 28/06/2023 for diagnostic cath to evaluate for BD Glenn/ primary Fontan surgery.

She underwent Diagnostic Cath done on 28/06/2023 (report attached). Cardiac cath revealed Basal Mean PA pressure = 14 mmHg, MacGoon ratio = 1.84. Nakata Index = 291 mm2/M2. She was kept in CCU for monitoring. Case was discussed with Dr. K.S. Iyer, pediatric cardiac surgeon who advised for primary Fontan operation. She was hemodynamically stable throughout her stay. She was discharged on 29/06/2023 in stable condition with advice to regular follow up.

Cath and angiography done on 29/06/2023 revealed

CARDIAC CATHETERIZATION AND ANGIOGRAPHY REPORT
Division of Pediatric Cardiology

Name : Baby kavya
Registration Number : 12422778
DOB : 26/04/2015
Sex : female
IPD No : 113350/23/1201
Height (cms) : 120
Weight (Kg) : 18
Cath Date : 29/06/2023
BSA (M Sq) : 0.78
HB (%) : 21.9
Cath No. : 219769
Sedation : Ketamine and midazolam

Admitting Diagnosis :

- Normal atrial arrangement
- Levocardia
- D Loop (Right Hand Topology)
- Absent right AV valve
- Concordant ventriculo - arterial connection
  Confluent branch PAs

Abnormalities :

- Fossa ovalis atrial septal defect
- Tricuspid Atresia
- Right ventricular hypoplasia
- restrictive VSD
  Severe pulmonary stenosis

Procedure Done :

- Diagnostic Study

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Previous Procedure : Procedure Date
- Nil

Previous Surgery : Surgery Date
- Nil

Vascular Access :

	Size
Right Femoral Artery	6F
Right Femoral Vein	5F

Catheters/Balloons/Stents:	French	Size	Length
Multipurpose A1	5F		
Pigtail catheter	4F,5F		
Right Judkins	5F		
Glide cath	4F		

Guide Wires:	Size	Length	Configuration
Terumo	0.035	260	J

Pressure Data:

Site	Sys	Dia	Mean	Sat	PO_2
DAO	121	74	94	75.8	34.5
LA			9		
PV	20	9	13	95.3	
LV	133		Ed 15	75.4	
PA	19	11	14	74.7	
RA			12	63.7	
SVC				66.6	
IVC				66.1	

Angiogram :

1. LV angiogram (LAO 60, Cranial 30) showed smoothly trabeculated ventricle with normal inflow, outflow and normal contractility with restrictive VSD filling hypoplastic

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right ventricle and branch PA's with good lung arborization and normal levo phase. RPA = 13mm LPA = 11 mm (exp = 10 mm)

2. Innominate injection given showed RSVC draining to RA and no LSVC

3. Aortogram done showed left arch, normal branching, no PDA, no Coarctation. Small Collaterals at D3 and D4 level supplying Left upper lobe and right middle lobe of Lung respectively without significant lung value. Aorta at diaphragm 13 mm.
4. IVC injection hand injection was done which showed hepatic vein and ivc draining in RA

Comments :

1 Mean PA pressure = 14 mmHg.

3. MacGoon ratio = 1.84

4. Nakata Index = 291 mm2/M2

Final Diagnosis :

Situs solitus, Levocardia

Normal systemic and pulmonary venous drainage

Tricuspid atresia

Ostium secundum ASD (Right to left)

Restrictive VSD (left to right shunting)
Severe pulmonary stenosis
Normal Mean PA pressure

Normal sinus rhythm

Normal ventricular function

S/P Diagnostic cardiac catheterization done on 29/06/2023

Now re-she is admitted at FEHI, New Delhi for further evaluation and management. On admission, her saturation was 72%.

In view of her diagnosis, symptomatic status, CT angio, cath and 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 20.1 kg, Height on admission 122 cm, Weight on discharge 20 kg

Her Weight on admission 20.1 kg. (3rd – 15th Percentile); Z score -1 to – 2 SD

Her blood Group A positive

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

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On admission she had polycythemia. Her Hb was 21.6gm/dl, HCT 72.9%, platelet counts 1.20 lacs/cmm. PTTK control 24.5/ test 30.6 sec, PT control 11.4/, test 14.2 secs INR 1.26. CT head was done which did not show any significant abnormality.

All blood and urine culture were sterile.

INVESTIGATION:

ECHO

Done on 19/04/2023 revealed Situs solitus, levocardia. Normal systemic and pulmonary venous drainage. Fossa ovalis ASD (right to left shunt). tricuspid atresia. hypoplastic RV. NRGA. Restrictive VSD 9right to left shunt). laminar MV inflow. ? broken chordae. Severe pulmonary stenosis 9max PG= 70mmHg). Hypoplastic branch PAs. RPA =8mm, LPA= 8.2mm. Laminar LV outflow. confluent branch PAs. PDA present. Left arch. Laminar flow in arch. No coarctation of aorta. Normal LVEF. Mild pericardial effusion

Done on 02/05/2023 revealed situs solitus, levocardia, normal systemic and pulmonary venous drainage, fossa ovalis atrial septal defect, tricuspid atresia, hypoplastic right ventricle, hypoplastic branch Pulmonary arteries, normal LVEF, no evidence of vegetation, no effusion

Done on 29/05/2023 revealed situs solitus, levocardia, D-loop, hypoplastic right ventricle, tricuspid atresia, Normally related great arteries, fossa ovalis atrial septal defect (right to left shunt), hypoplastic branch Pulmonary arteries, no evidence of vegetation, no effusion

Done on 08/06/2023 revealed situs solitus, levocardia, D-loop, tricuspid atresia, hypoplastic right ventricle, fossa ovalis atrial septal defect, hypoplastic branch Pulmonary arteries, no evidence of vegetation, no collection, normal LVEF

Done on 28/06/2023 revealed situs solitus, levocardia. D-loop ventricle. Normal systemic and pulmonary venous drainage. Fossa ovalis ASD (right to left shunt). tricuspid atresia. hypoplastic RV. NRGA. Restrictive VSD. Laminar MV inflows. ? broken chordae. Severe PS (max PG= 70mmHg). hypoplastic branch PAs. Laminar LV outflow. confluent branch PAs. PDA present. Left arch. Laminar flow in arch. No coarctation of aorta. no LVEF. Mild pericardial effusion. RPA= 8mm. LPA= 8.2mm

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POST OP ECHO

Done on 08/08/2023 revealed patent and well-functioning Bidirectional Glenn Shunt and Fontan circuit, good flow in branch Pulmonary arteries, LVEF 40-45%, mild right pleural collection, no left pleural or pericardial collection

Done on 09/08/2023 revealed patent and well-functioning Bidirectional Glenn Shunt and Fontan circuit, good flow in branch Pulmonary arteries, LVEF 40-45%, trace Atrioventricular valve regurgitation, no collection

Done on 12/08/2023 revealed patent and well-functioning Bidirectional Glenn Shunt and Fontan circuit, mild flow acceleration at Superior vena cava to Right pulmonary artery junction (mean PG 1mmHg), good flow in branch Pulmonary arteries, LVEF 40-45%, trace right pleural collection, no left pleural or pericardial collection

Done on 17/08/2023 (08:00 AM) revealed moderate to severe pericardial collection, mild left pleural collection, no right pleural collection, LVEF 30%

Done on 17/08/2023 revealed mild pericardial collection, no pleural collection, LVEF 40-45%

Done on 18/08/2023 revealed mild + pericardial collection, no pleural collection, LVEF 40%

Done on 19/08/2023 revealed mild pericardial collection, trace left pleural collection, right pleural collection, LVEF 40%

Done on 20/08/2023 revealed trace to mild pericardial collection, no pleural collection, LVEF 40%

Done on 21/08/2023 revealed mild pericardial collection, no pleural collection, LVEF 40-45%

Done on 21/08/2023 (01:20 PM) revealed mild pericardial collection, no pleural collection, LVEF 40-45%

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Done on 22/08/2023 (07:30 AM) revealed patent and well-functioning Bidirectional Glenn Shunt and Fontan circuit, good flow in branch Pulmonary arteries, LVEF 40%, mild left pleural collection, mild pericardial collection

Done on 22/08/2023 (09:00 AM) revealed mild pericardial collection, trace left pleural collection, LVEF 40-45%

Done on 23/08/2023 revealed mild pericardial collection, no pleural collection, LVEF 40-45%

Done on 24/08/2023 revealed mild pericardial collection, no pleural collection, LVEF 45-50%

Done on 24/08/2023 revealed patent and well-functioning Bidirectional Glenn Shunt and Fontan circuit, trace Atrioventricular valve regurgitation, good flow in branch Pulmonary arteries, LVEF 53%, mild pericardial collection, no pleural collection

ABDOMINAL USG

Done on 07/08/2023 revealed Liver shows homogeneous normal echopattern. Hepatic veins are prominent. Intrahepatic biliary radicles are not dilated. Portal vein measures 8mm in diameter (normal). • Gall bladder is partially distended (Post prandial). No calculus seen. • CBD is normal in caliber. • Pancreas appears normal in size & echogenicity. • Spleen measures 9.2cm in span and shows homogeneous echopattern. • Both kidneys are normal in location, size, shape & echotexture. Cortical thickness & corticomedullary differentiation are well maintained. No dilatation of pelvicalyceal system seen. - Right kidney measures – 7.7cm x 3.1cm. - Left kidney measures – 8.4cm x 3.8cm. • Urinary bladder is partially filled. No calculi / filling defect seen. • Minimal free fluid noted in abdomen.

HEAD CT (PLAIN)

Done on 07/08/2023 revealed POSTERIOR FOSSA: 4 th ventricle is normal in size, shape and position. Brainstem & cerebellar hemispheres are normal. SUPRATENTORIAL: Brain parenchyma shows unremarkable morphology and attenuation values. No obvious focal brain parenchymal lesion seen. Bilateral ganglio-thalamic nuclear complexes are unremarkable. 3 rd & lateral ventricles are unremarkable in size with septum in midline. Basal cisterns, fissures & cerebral sulci are unremarkable. No evidence of significant intra / extraaxial collection or hyperdense hemorrhage seen. No obvious bony injury / lytic or

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sclerotic bony lesion seen. Note is made hyperdense intracranial vessels secondary to polycythemia. Note is made of soft tissue mucosal thickening left maxillary sinus and sphenoid sinus.
IMPRESSION: No significant intracranial abnormality detected.

COURSE DURING STAY IN HOSPITAL (INCLUDING OPERATIVE PROCEDURE AND DATES)

Primary Fontan /Extra-cardiac Fontan (20mm Intergard graft chosen and anastomosis of Right pulmonary artery to graft done with sucker in Right pulmonary artery keeping the heart beating empty + Cephalic end of the Superior vena cava was anastomosed with Right pulmonary artery in end to side fashion + Another end of the graft was interposed to Inferior vena cava) Anterograde flow- Interrupted + Azygous venous drainage - patent done on 08/08/2023

REMARKS: Diagnosis: - Cyanotic congenital heart disease, Decreased pulmonary blood flow, Tricuspid atresia, Normally related great vessels, Severe Pulmonary stenosis, Restrictive ventricular septal defect (Edwards type- IB), Hypoplastic right ventricle, Single ventricle physiology, Normal Pulmonary artery pressures (Mean 14mm Hg), Borderline size branch Pulmonary artery (McGoon ratio-1.84, Nakata index-291mm/m^2), Normal LV function, Normal Sinus Rhythm. Operation: Primary Fontan /Extra-cardiac Fontan with 20mm Intergard interposition graft, Anterograde flow- Interrupted, Azygous venous drainage- patent. Operative Findings: Situs solitus, levocardia, AV-VA concordance (S, D, S), Innominate vein – present, pericardium – normal, no effusion, systemic and pulmonary venous drainage – normal, Patent ductus arteriosus – absent, Main pulmonary artery – normal, soft, coronaries – normal, aorta – normal, side by side with Pulmonary artery, branch Pulmonary artery - Borderline in size, with good flow. Procedure:- Routine induction of general anaesthesia and placement of invasive pressure monitoring lines. Supine position placed. WHO surgical safety checklist confirmed. Median sternotomy. Pericardial cradle created with silk 3-0 suture. Aortic purse string taken with Ethibond 4-0, Systemic heparinization (400 U/kg). Bicaval purse string (High Superior vena cava and Low Inferior vena cava) Prolene 5-0 suture. On aortobicaval cannulation, ACT>480s, went on Cardiopulmonary bypass, whole body perfusion established & systemic hypothermia to 35°C. Both cavae looped. Both cavae snared. Azygous vein looped and snugged. Internal mammary vein was dissected, ligated and divided. Right pulmonary artery stay suture taken, Superior vena cava – right atrium junction divided. Right atrium stump closed with Prolene 5-0. SVC stay suture taken with Prolene 5-0. RPA opened on the superior aspect. Cephalic end of the SVC was anastomosed with RPA in end to side fashion with Prolene 5-0 double arm. MPA was dissected circumferentially, divided at bifurcation site and RVOT stump end sutured (Anterograde flow interrupted). Bifurcation site wide opened for anastomosis, Hegar no.11 administered freely. 20mm Intergard graft chosen and anastomosis of RPA to graft done with sucker in RPA keeping the heart beating empty. IVC-RA junction divided without injuring the RCA, IVC stay sutures with silk no. 3-0 and RA stump closed with Prolene 4-0 in

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two layers. Another end of the graft was interposed to IVC. Rewarming started, haemostasis achieved and stable hemodynamics. Caval and azygous desnaring. Epicardial pacing wires (2 atrial and 1 ventricular) placed. Weaned off CPB with Dobutamine 5mcg/Kg/Min. Serial venous decannulation. Meticulous hemostasis secured. Protamine given followed by decannulation. 24F straight chest drains placed in pericardium, mediastinum and in both pleurae. Counts tallied. Pericardium closed over RA and RV. Both pleurae left open. Hemostasis ensured. Routine sternal closure with Steel no.5.

Her post-operative course was prolonged due to significant pericardial collection needing pericardial tapping.

She was ventilated with adequate analgesia and sedation for 16 hours and extubated on early 1st POD to oxygen by mask. She had initial chest drainage (775ml) on 0 POD.

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 8th POD. She was weaned from oxygen to air by 11th POD.

She was electively supported with dobutamine (0 – 4th → 5mic/kg/min @ 3ml/hr) in view of univentricular repair and lactic acidosis (Lactate 2.02mmol/L).

Tab. Enalapril was commenced on 6th POD for continued after load reduction the doses of which were gradually increased.

Fontan associated pleural effusion was managed with diuretics, fluid restriction and electively delayed chest drain removal (11th POD). upto 1080 on 3rd POD ml pleural fluid was obtained per day

On 17/08/2023 (i..e. 9th POD) Echo was done revealed moderate to severe pericardial collection, mild left pleural collection.

This was managed with pericardial tapping and 380 ml serosanguinous pericardial fluid was aspirated. A pigtail catheter was kept in situ.

Pericardial aspiration done on 10th POD. 140ml fluid aspiration done.

Pericardial aspiration done on 11th POD. 50ml fluid aspiration done.

Subsequent echoes were better and further drainage was not required. Pigtail was removed on 13th POD. The predischarge echo on 16 POD showed mild pericardial collection but there was no increased in pericardial collection over 48 hours.

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Pericardial fluid analysis done on 17/08/2023 showed
PERICARDIAL FLUID ANALYSIS VOLUME 10 mL
APPEARANCE HAZY
COLOUR REDDISH
CLOT FORMATION ABSENT
PROTEINS 4.4 (TRANSUDATE : < 3 EXUDATE : > 3 gms/dL)
TOTAL COUNT 2,250 cells / cumm
NEUTROPHILS 70 High %
LYMPHOCYTES 25 < 50 % METHOD

TRIGLYCERIDES, SERUM - Triglycerides - 68.2 mg/dl (Pericardial Fluid) (< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High mg/dL)

Pericardial fluid culture was negative.

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

She had low magnesium level (1.7mg/dl) on 0 POD which was corrected. There were no post-operative arrhythmias.

Pacing wire was removed on 13th POD.

She had no fever but had persistent thrombocytopenia. Her TLC was 6,760/cmm and platelets 0.70 lacs/cmm and repeat TLC was 8,540/cmm and platelets 0.69 lacs/cmm on 0 POD.

Her TLC was 5,250/cmm and platelets 0.60 lacs/cmm and repeat TLC was 7,880/cmm and platelets 0.65 lacs/cmm on 1st POD.

Her TLC was 7,900/cmm and platelets 0.64 lacs/cmm and repeat TLC was 10,600/cmm and platelets 0.86 lacs/cmm on 2nd POD. This was managed with blood products and platelet transfusion.

All cultures till date are negative. Antibiotics were not required. She was clinically well and apyrexial all through. Her predischarge TLC was 7,120/cmm and platelets were 1.93 lacs/cmm.

Her pre-operative renal function showed (S. creatinine 0.53 mg/dl, Blood urea nitrogen 12 mg/dl)

She also had mild renal dysfunction (S. creatinine 1 mg/dl, Blood urea nitrogen 43 mg/dl) on 3rd POD. This was managed with fluid restriction, diuretic therapy and avoidance of nephrotoxic drugs. Her pre-discharge renal function showed blood urea nitrogen 0.50 mg/dl and creatinine 27 mg/dl.

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Her pre-operative liver functions showed (SGOT/SGPT = 41/22 IU/L, S. bilirubin total 0.48 mg/dl, direct 0.07 mg/dl, Total protein 7 g/dl, S. Albumin 4.5 g/dl, S. Globulin 2.5 g/dl Alkaline phosphatase 265 U/L, S. Gamma Glutamyl Transferase (GGT) 30 U/L and LDH 450 U/L).

She had mildly deranged liver functions on 1st POD (SGOT/SGPT = 46/53 IU/L, S. bilirubin total 4.60 mg/dl & direct 2.75 mg/dl and S. Albumin 4.4 g/dl).

On 2nd POD (SGOT/SGPT = 40/43 IU/L, S. bilirubin total 1.90 mg/dl & direct 0.87 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.

Her predischarge liver function test are SGOT/SGPT = 21/13 IU/L, S. bilirubin total 0.32 mg/dl, direct 0.12 mg/dl, Total protein 6.7 g/dl, S. Albumin 3.7 g/dl, S. Globulin 3 g/dl Alkaline phosphatase 158 U/L, S. Gamma Glutamyl Transferase (GGT) 87 U/L and LDH 249 U/L)

Intravenous heparin was given in the immediate post-operative period for anticoagulation. Tab. Colsprin was started on 2nd POD for continued oral anticoagulation.

Thyroid function test done on 08/08/2023 which was normal - revealed T3 5.11 pg/ml (normal range – 2.53 – 5.22 pg/ml), T4 1.67 ng/dl (normal range 0.97 - 1.67 ng/dl), TSH 4.490 µIU/ml (normal range – 0.600 – 4.840 µIU/ml).

Repeat Thyroid function test done on 09/08/2023 which was normal - revealed T3 2.35 pg/ml (normal range – 2.53 – 5.22 pg/ml), T4 1.38 ng/dl (normal range 0.97 - 1.67 ng/dl), TSH 0.942 µIU/ml (normal range – 0.600 – 4.840 µIU/ml).

Repeat Thyroid function test done on 10/08/2023 which revealed T3 1.85 pg/ml (normal range – 2.53 – 5.22 pg/ml), T4 1.15 ng/dl (normal range 0.97 - 1.67 ng/dl), TSH 2.710 µIU/ml (normal range – 0.600 – 4.840 µIU/ml) for which Tab. Thyroxine was started.

Repeat Thyroid function test done on 13/08/2023 which revealed T3 3.30 pg/ml (normal range – 2.53 – 5.22 pg/ml), T4 1.45 ng/dl (normal range 0.97 - 1.67 ng/dl), TSH 8.250 µIU/ml (normal range – 0.600 – 4.840 µIU/ml) for which Tab. Thyroxine was increased to 25 mcg.

Repeat Thyroid function test done on 21/08/2023 which revealed T3 3.71 pg/ml (normal range – 2.53 – 5.22 pg/ml), T4 1.54 ng/dl (normal range 0.97 - 1.67 ng/dl), TSH 7.810 µIU/ml (normal range – 0.600 – 4.840 µIU/ml) for which Tab. Thyroxine was increased to 37.5 mcg.

Escorts Heart Institute and Research Centre Ltd.
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Repeat Thyroid function test done on 25/08/2023 which revealed T3 4.87 pg/ml (normal range – 2.53 – 5.22 pg/ml), T4 1.52 ng/dl (normal range 0.97 - 1.67 ng/dl), TSH 9.380 µIU/ml (normal range – 0.600 – 4.840 µIU/ml) for which Tab. Thyroxine was increased to 37.5 mcg.

Gavage feeds were started on 1st POD. Oral feeds were commenced on 2nd POD.
Folic acid was commenced in view of pre-existing Polycythemia (Hb 21.6gm/dl).

CONDITION AT DISCHARGE

Her general condition at the time of discharge was satisfactory. Incision line healed by primary union. No sternal instability. HR 98/min, normal sinus rhythm. Chest x-ray revealed bilateral clear lung fields. Saturation in air is 100%. **Her predischarge x-ray done on 24/08/2023**

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.

Other siblings are advised detailed cardiology review.

PLAN FOR CONTINUED CARE:

DIET : High protein, fluid restricted 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. Univentricular repair
2. Aspirin therapy
3. Enalapril therapy

Review on 26/08/2023 in 5th floor at 09:30 AM for wound review

Repeat Echo after 6 - 9 months after telephonic appointment

Repeat Thyroid function test after 3 – 4 months

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PROPHYLAXIS :

Infective endocarditis prophylaxis prior to any invasive procedure

MEDICATION:

- Tab. Paracetamol 300 mg PO 6 hourly x one week
- Tab. Pantoprazole 20 mg PO twice daily x one week
- Tab. Lasix 20 mg PO thrice daily till next review
- Tab. Aldactone 6.25 mg PO once daily till next review
- **Tab. Colsprin 75 mg PO once with feed till next review - not to be stopped**
- **(Dose of Colsprin to be increased (5mg/kg/day) according to weight gain upto maximum of 100mg once daily)**
- Tab. Shelcal 250 mg PO twice daily x 3 months
- **Tab. Folic Acid 5 mg PO once daily x one year**
- **Tab. Thyroxine 37.5mcg PO once daily x 3 months and then repeat Thyroid function test (Empty Stomach)**
- **Tab. Enalapril 2.5 mg PO twice daily till next review**

- **All medications will be continued till next review except the medicines against which particular advice has been given.**

Review at FEHI, New Delhi after 6 – 9 months after telephonic appointment
In between Ongoing review with Pediatrician

4th hrly temperature charting - Bring own your thermometer

- **Frequent hand washing every 2 hours**
- **Daily bath after suture removal with soap and water from 26/08/2023**

Telephonic review with Dr. Parvathi Iyer (Mob. No. 9810640050) / Dr. K. S. IYER (Mob No. 9810025815) if any problems like fever, poor feeding, fast breathing

Fortis Escorts
HEART INSTITUTE

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(DR. KEERTHI AKKALA)
(ASSOCIATE CONSULTANT
PEDIATRIC CARDIAC SURGERY)

For (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.