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DISCHARGE SUMMARY

Patient's Name: Baby Hayat Khan	
Age: 2 years	**Sex: Female**
UHID No: SKDD.949116	**IPD No :**
Date of Admission: 09.01.2023	**Date of Procedure:11.01.2023** **Date of Discharge: 21.01.2023**
Weight on Admission: 9.9 Kg	**Weight on Discharge: 9.6 Kg**
Cardiac Surgeon: DR. HIMANSHU PRATAP **: DR. K. S. DAGAR** **Pediatric Cardiologist : DR. GAURAV KUMAR**	

DISCHARGE DIAGNOSIS

- Congenital heart disease
- Situs solitus
- TOF
- Adequate confluent Branch PAs
- Large malaligned subaortic VSD shunting bidirectionally
- S/P MAPCA coiling

PROCEDURE:

TOF correction (RA-PA) without TAP done on 11.01.2023

RESUME OF HISTORY

Baby Hayat Khan, 2 years female child, 2nd in birth order was born out of non-consanguineous marriage at term through LSCS (for non-progress of labour). She cried immediately at birth. At 2 months of age parents took baby to doctors for cough and cold where on evaluation a murmur was detected . She was evaluated in detail and diagnosed to have cyanotic congenital heart disease. There is history of bluish discoloration of skin and lips on excessive crying with breathlessness while playing. There is history of feeding difficulties and suck rest suck cycle. There is no history of seizure or cyanotic spell. Immunisation is incomplete and developmental milestones are normal for age. Patient was admitted to this centre for further management.

INVESTIGATIONS SUMMARY:

ECHO (Pre-op: 9.1.2023): Situs solitus, levocardia, AV, VA concordance, D-looped ventricles, NRGA, Normal pulmonary and systemic venous drainage, Tetralogy of fallot, IAS, Large malaligned subaortic VSD shunting bidirectionally with >50% aortic override, TV annulus: 15mm, trivial TR, MV annulus: 12mm, trivial MR, AV annulus: 13mm, no LVOTO,no AR, PV annulus: 6mm(expected: 11mm), severe infundibular, valvar with PG 70mmhg, Confluent and fair sized branch PAs (expected: 7.5 mm), Proximal RPA:5.5mm, hilum :7mm, Prominal LPA: 4.5mm, hilum : not well visualized, Dilated RA, RVH, Adequate LV/RV systolic function, Left arch, no COA/PDA/APW/LSVC, No IVC congestion, No collection, ?MAPCAS

X RAY CHEST (09.01.2023): Report Attached.

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USG WHOLE ABDOMEN (09.01.2023): Report attached.

CARDIAC CATHETERIZATION (10.01.2023):
RV ANGIOGRAM done using 5F pigtail catheter (FV-IVC-RA-RV) in LAO 15 cranial 40 view and RAO30 view showed severe infundibular and valvar PS with hypoplastic annulus PV annulus:7mm (expected:11mm),with confluent fair sized branch PAs. LPA:6mm RPA:6mm (Exp : 7.5) and presence of large subaortic VSD and simultaneous filling of both great arteries with normal pulmonary venous return in levophase.
LV ANGIOGRAM done using 5F catheter (FA-DA-AA-LV) in LAO cranial-50/20 showed normall LV size. normal contractility with large subaortic VSD , no additional VSD with normal coronaries , No coronaries crossing RVOT, no PDA/APW. Aortic root angiogram done in LAO 30 showed normal origin of both coronaries with no coronary crossing RVOT.
DESCENDING AORTOGRAM done in AP view using 5F catheter(FA-DA) showed large collateral at t5 level arising from right border of descending aorta and supplying right middle and lower lobe was coiled with 5x 4 mm cook's coil. No other MAPACAs seen.
SVC VENOGRAM done using 5F RCA catheter (FV-IVC-RA-SVC*LIV) in AP view showed innominate vein draining to SVC to RA, No LSVC

PRE DISCHARGE ECHO (20.01.2023): **TOF CORRECTION (RA-PA) WITHOUT TAP(11.01.2023)**: PFO shunting left to right, VSD patch in situ no residual shunt, Mild TR, TAPSE :8mm, Trivial MR, no LVOTO, no AR, Well opened RVOT, RVOT gradient 20mmhg, moderate PR, Good flow seen in branch PAs, RPA:7 mm, LPA:6mm, Dilated RA, RVH, Grade 2 RV diastolic dysfunction present , Adequate LV/RV systolic function; LVEF:55%, Left arch, no COA/PDA/APW/LSVC, No IVC congestion, Mild right pleural collection

COURSE IN HOSPITAL:
On admission an Echo followed by cardiac cath were done which revealed detailed findings above.

In view of her diagnosis, symptomatic status, Echo & B cardiac cath findings she underwent **TOF correction (RA-PA) without TAP** on 11.01.2023. 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. There was si8gnificant right ventricular dysfunction with unstable hemodynamics requiring escalation of inotropes in early post operative period. Patient also developed pulmonary hemorrhage requiring increase in PEEP and ventilator support. Thereafter patient gradually improved with clearing of ET secretions and improvement in hemodynamics and right ventricular dysfunction. She was extubated on 3rd POD and electively kept on nasal CPAP support and then gradually weaned to oxygen support and room air by 6th POD. Associated lung atelectasis and bronchorrhoea was managed with frequent nebulization, suctioning and chest physiotherapy.

Inotropes were given in the form of Adrenaline (0-5th POD), Noradrenaline (0-4th POD), Dopamine (1st - 8th POD) and Dobutamine (0-7th POD) to support cardiac function. Decongestive measures were given in the form of lasix infusion and boluses. Mediastinal Chest tubes and left pleural ICD inserted perioperatively were removed on 4th POD once minimal drainage was noted.

Antibiotics were given in the form of Ceftriaxone and Amikacin. Antibiotics were upgraded in view of high TLC and progressive thrombocytopenia to Inj. Meropenem, Minocycline and Fluconazole were added. Sepsis screen was negative and after an appropriate duration, intravenous antibiotics were stopped and converted to oral formulations. Minimal feeds were

started on 1st POD and it was gradually built up to normal oral feeds. She is in stable condition now and fit for discharge.

CONDITION AT DISCHARGE

Patient is haemodynamically stable, afebrile, accepting well orally, HR 100/min, sinus rhythm, BP 88/55 mmHg, SPO2 98% on room air, no distress. Chest – bilateral clear, sternum stable, chest wound healthy.

DIET

- Fluid 900 ml/day
- Normal diet

FOLLOW UP

- Long term pediatric cardiology follow-up in view of **TOF correction (RA-PA) without TAP.**
- Regular follow up with treating pediatrician for routine checkups and nutritional rehabilitation.

PROPHYLAXIS

- Infective endocarditis prophylaxis

TREATMENT ADVISED:

- Syp. Taxim –O 50 mg twice daily (8am-8pm) - PO x 3 days then stop
- Syp. Furosemide 5mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Tab. Spironolactone 3.125 mg thrice daily (6am – 2pm – 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Syp. A to Z 5 ml twice daily (9am – 9pm) – PO x 7 days and then stop
- Syp. Shelcal 5 ml twice daily (9am – 9pm) – PO x 7 days and then stop
- Tab. Lanzol Junior 10 mg twice daily (8am – 8pm) – PO x 1 week and then stop
- Syp. Paracetamol 150 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.**

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Review after 3 days with serum Na+ and K+ level. 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. Gaurav Kumar in OPD with prior appointment.**

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