

DISCHARGE SUMMARY

PATIENT NAME: HESHAAM KHAN	AGE: 8 MONTHS, SEX: M
REGN: NO: 14436376	IPD NO: 72095/26/1201
DATE OF ADMISSION: 04/04/2026	DATE OF DISCHARGE: 11/04/2026
CONSULTANT: DR. K. S. IYER / DR. NEERAJ AWASTHY	

DISCHARGE DIAGNOSIS

- Cyanotic Congenital Heart Disease
- Tetralogy of Fallot
- Large Peri-membranous ventricular septal defect (right to left shunt)
- Severe Infundibular, valvar, supra-valvar Pulmonary stenosis
- Right atrium mild dilatation
- Right ventricle hypertrophy +

OPERATIVE PROCEDURE

Dacron patch closure of ventricular septal defect + Infundibular resection done on 06/04/2026

Infundibulum and Main pulmonary artery admitted Hegar 9 freely.

RESUME OF HISTORY

Heshaam Khan is a 7 months old male infant (date of birth: 04/08/2025) from Uttar Pradesh who is a case of congenital heart disease. He is 2nd in birth order and is a product of full term normal vaginal delivery. His birth weight was 2.78 kg, born to a non-consanguineous marriage. Maternal age is currently 21 years. 1st sibling is apparently well (2½ years old girl).

He had history of bluish discoloration for which he was shown to pediatrician. During evaluation, cardiac murmur was detected. Echo was done which revealed Congenital heart disease = Tetralogy of Fallot. He was referred to Dr. K. S. Iyer at Fortis Escorts Heart Institute, New Delhi for further management by their relative.

He was seen at FEHI, New Delhi on 02/04/2026. His saturation at that time was 78% with weight of 7.7 Kg. Echo was done which revealed normal segmental analysis, AV-VA concordance, intact interatrial septum, laminar inflow, trace tricuspid regurgitation, non-restrictive perimembranous ventricular septal defect with outlet extension (right to left shunt) with aortic override, laminar LV outflow, severe Pulmonary stenosis (infundibular, valvular and supra-valvar) mainly infundibular, max PG 80mmHg, confluent branch Pulmonary arteries, left arch, laminar flow in arch, no Coarctation of aorta, no Patent ductus arteriosus, no left superior vena cava, normal LVEF, no collection, RVH present, PA annulus 8.5mm (Exp 9.5mm), Main pulmonary artery 6mm, Right pulmonary artery 6.4mm, Left pulmonary artery 6.5mm (Exp 6.25), LVIDd 1.8cm, LVIDs 1.2cm.

He was advised early surgical management.

Now he is admitted at FEHI, New Delhi for further evaluation and management. On admission, his saturation was 80%, His Hb 13.6g/dl, TLC was 14,110/cmm, platelets 3.90 lacs/cmm and Hematocrit 43.7% on admission.

In view of his diagnosis, symptomatic status, echo findings he 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 7.8 kg, Height on admission 72 cm, Weight on discharge 7.8 kg

His Weight on admission 7.8 kg. (15th – 50th Percentile); Z score 0 to – 2 SD

His blood Group B positive

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

CONDITION AT DISCHARGE

His general condition at the time of discharge was satisfactory. Incision line healed by primary union. No sternal instability. HR 120-130/min, normal sinus rhythm. Chest x-ray revealed bilateral clear lung fields. Saturation in air is 100%. His predischarge x-ray done on 10/04/2026

In view of congenital heart disease in this patient his 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 : 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. Possibility of recurrence of Right ventricular outflow tract obstruction**
- 2. Mild pulmonary regurgitation**

Review on 13/04/2026 in 5th floor at 09:30 AM for wound review

Repeat Echo after 6 - 9 months after telephonic appointment

PROPHYLAXIS :

Infective endocarditis prophylaxis prior to any invasive procedure

MEDICATION:

1. Syp. Paracetamol 125mg PO 6 hourly x one week
2. Tab. Pantoprazole 10 mg PO twice daily x one week
3. Syp. Lasix 10 mg PO twice daily till next review
4. Tab. Aldactone 6.25 mg PO twice daily till next review
5. Syp. Shelcal 2.5 ml PO twice daily x 3 months

6. Nasoclear nasal drop 2 drop both nostril 4th hrly
7. Nebulization with normal saline 4th hrly

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

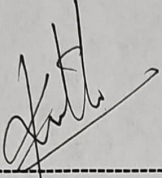
Review at FEHI, New Delhi after 6 – 9 months after telephonic appointment
In between Ongoing review with Pediatrician

Sutures to be removed on 20/04/2026; Till then wash below waist with free flowing water

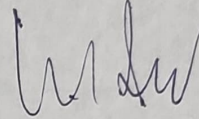
4th hrly temperature charting - Bring your own thermometer

- Daily bath after suture removal with soap and water from 21/04/2026

Telephonic review with Dr. Parvathi Iyer (Mob. No. 9810640050) / Dr. K. S. IYER (Mob No. 9810025815)



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



(DR. K.S. IYER)
**(CHAIRMAN
PEDIATRIC & CONGENITAL HEART 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, poor feeding, fast breathing, breathing difficulty, chest pain, wound discharge, 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.