MAX Healthcare

DISCHARGE SUMMARY

Patient's Name	: Mr. Mohd Soyeb
Age/ Sex	: 16 Years/Male
SSN. No.	: 071-08-6413
IPD No	: 772177
Date of Admission	: 20.06.2025
Weight on Admission	: 42.2 Kg
Weight on Discharge	: 41.8 Kg
Cardiac Surgeon	: DR. K. S. DAGAR
Pediatric Cardiologist	: DR. GAURAV KUMAR
Pediatric Intensivist	: DR. PRADIPTA ACHARYA

**Date of Discharge: **
30.06.2025

**DISCHARGE DIAGNOSIS: **
- Congenital cyanotic heart disease
- Tetralogy of Fallot
- Large unrestrictive VSD, right to left shunt
- Severe infundibular and valvar PS
- Confluent and adequate sized branch PAs
- PDA
- Progressive Cyanosis
- Multiple MAPCAs, One coiled
- Late Presentation

**PROCEDURE (1): **
Diagnostic Cath + coiling of MAPCA done on 21.06.2025.

**PROCEDURE (2): **
Dacron patch VSD closure + Infundibular resection + Pulmonary valvotomy + PDA ligation surgery done on 23.06.2025

RESUME OF HISTORY
Mr. Mohd Shoeb, 16 years old young male, is a known case of Congenital Cyanotic Heart Disease. He is first in birth order, born out of consanguineous marriage at term by normal vaginal delivery. Cried immediately after birth. He was apparently alright till 2 months of age when he was noticed to have difficulty in breathing along with bluish discoloration of skin and mucus membrane for which he was taken to a local pediatrician. On examination he was detected with a murmur and further detailed evaluation including an echo revealed congenital cyanotic heart disease. (Tetralogy of Fallot). He was then kept on close medical follow up and was advised early surgical correction, however it was delayed till date due to various reasons. He has h/o progressively increasing cyanosis and easy fatigability. He has no history of frequent admissions, syncope, chest pain, seizures or ear discharge.
He is unimmunized for age and has no h/o any developmental delay.
He is not on any medication.
He has now come to this center for further evaluation and management.

**PHYSICAL EXAMINATION ON ADMISSION: **

Body Weight	: 42.2 Kg
Heart Rate	: 71/min
Blood Pressure	: 104/75 mmHg
Oxygen Saturation (SPO2)	: 82% on room air
Respiratory rate (RR)	: 21/min
Discharge wt	: 41.8Kg

**INVESTIGATIONS SUMMARY: **

**ECHO (20.06.2025): **

Situs	: Solitus
Cardiac Position	: Levocardia
Atrioventricular connection	: concordant
Ventriculoarterial connection	: concordant
Ventricles Loop	: D loop
Great vessels relation	: Normally related

Pulmonary veins	: Normal connection
Systemic Veins	: Normal connection
Atrial septum	: Intact
Ventricular septum	: Large Unrestrictive Subaortic VSD shunting R-L
Tricuspid valve	: Annulus: 24.5 mm (Z score: + 0.12), Mild TR
Mitral valve	: Annulus: 18.4 mm (Z score: -1.42), Mild MR
Aortic valve	: Tricuspid, NO LVOTO, And NO AR. Overriding aorta
Pulmonary valve	: Annulus: 10 mm, Hypoplastic, Anterior deviation of
Conal septum seen; Severe Infundibular and Valvar PS; PG: 63 mmHg,	
Branch Pulmonary arteries	: Confluent. RPA: 10 mm, LPA: 9 mm, (exp: 14 mm)
LV/RV systolic function	: Normal. EF: 60%
Diastolic dysfunction	: No IVC congestion
Aortic arch	: LEFT ARCH, normal arch branches, NO COA
Ductus arteriosus	: No ductal shunt

M MODE ANALYSIS:

IVSd : 7 mm	IVSs	: 9 mm	
LVIDd: 28 mm	LVIDs	: 20 mm	
LVPWd: 6 mm	LVPWs	: 8 mm	
EF : 60%			

Doppler cm/s:

Mitral : E/A= 61/35 cm/sec
Tricuspid: E/A = 62/53 cm/sec
Aortic velocity: 124 cm/s
Pulmonary gradient PG: 63 mmHg

****X RAY CHEST (20.06.2025): ****
Report Attached.

****USG WHOLE ABDOMEN (20.06.2025): ****
Report Attached.

****DIAGNOSTIC CATH + COILING OF MAPCA (21.06.2025): ****
Angiograms:
1. Innominate Venogram done using 5F MPA II catheter (FV-IVC-RA-SVC) in AP view showed innominate vein draining into right SVC draining to RA.

2 RV angiogram done in RAO 30 And LAO 15 Cranial 40 views using 5F Pigtail Catheter (RFV - IVC - RA - RV) showed well contractile RV with severe infundibular and Valvar PS with presence of large unrestrictive Perimembranous VSD with simultaneous filling of both great arteries. Confluent branch Pas, RPA=12mm LPA=13mm, with good peripheral arborisation with normal pulmonary venous return in levophase.

3. LV angiogram done using 5F Pigtail Catheter (FA-DA-AA-LV) in LAO cranial-50/20 showed normal LV size. Normal contractility with large subaortic VSD, No additional VSDs and normal origin of coronaries with no coronary crossing RVOT.

4. Aortic root angiogram done in LAO15 view showed normal origin of Right Coronary artery and left coronary artery from respective sinuses with no coronary crossing RVOT.

5. Descending Aortogram done in AP view using 5F Pigtail Catheter showed no coarctation/ PDA. One significant collateral seen supplying to right lung. This was hooked using 5F Judkins Right catheter and successful coil occlusion done using cooks 0.035x 3mmx4cm and 0.035x4mmx4cm coil.

6. Right subclavian artery injection done using 5F right judkins catheter showed no MAPCAS

7. Left subclavian artery injection showed no MAPCAS

****PRE- DISCHARGE ECHO (30.06.2025): ****
- IVS patch intact, NO residual shunt
- Well open RVOT, PG= 10mmhg
- Grade 2/4 PR
- Mild MR
- Mild TR, PG= 15MMHG
- Normal biventricular function
- No pericardial and pleural collection

****COURSE IN HOSPITAL: ****
On admission, he was thoroughly evaluated including an Echo followed by Diagnostic Cardiac Cath which revealed detailed findings as above.

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In view of his diagnosis, symptomatic status, Echo & Diagnostic Cardiac Cath findings he underwent Dacron patch VSD closure + Infundibular resection + Pulmonary valvotomy + PDA ligation surgery on 23.06.2025. The parents were counselled 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, He was shifted to CTVS PICU for further management on full ventilation and moderate inotropic supports. He was electively ventilated with adequate sedation and analgesia for about 15 hours and was then extubated on 1st POD to HFNC and nasal prongs which was used alternatively till 3rd POD, and was later weaned off to room air by 4th POD.

Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with frequent nebulization, chest physiotherapy and spirometry. Both mediastinal chest tubes inserted perioperatively were removed on 2nd POD once minimal drainage was noted.

Inotropes were electively given in the form of Adrenaline (0 to 3rd POD), Nor-adrenaline (1st - 2nd POD) and Dobutamine (0-3rd POD) to optimize the cardiac output. Digoxin was added for rate control.

Decongestive measures were given in the form of Furosemide boluses, infusion and spironolactone was added for its potassium sparing action.

Minimal feed was started on '0' POD which was gradually built up to normal diet. He was also supplemented with multivitamins & calcium.

Presently, he is in a stable condition and is fit for discharge.

CONDITION AT DISCHARGE
He is haemodynamically stable, afebrile, accepting well orally, HR 82/min, sinus rhythm, BP 110/62 mm Hg, SPO2 100% on room air. Chest - bilateral clear, sternum stable, chest wound healthy.

DIET
* Fluid restriction 1800 ml/day x 2 weeks
* High protein Normal diet

FOLLOW UP
* Long term paediatric cardiology follow-up in view of Dacron patch VSD closure + Infundibular resection + Pulmonary valvotomy + PDA ligation surgery.
* Regular follow up with treating paediatrician/physician for routine check-ups.

**PROPHYLAXIS: **
* Infective endocarditis prophylaxis

** WOUND CARE: **
* Remove surgical dressing from the wound after 1 day
* Daily Scrubbing and bathing if the wound is dry
* Betadine lotion for local application twice daily on the wound x 7 days
* Stitch removal after one week
* Ointment Hexilac ultra gel for local application on chest wound 2-3 times daily - once the wound is dry for 2-3 months

**TREATMENT ADVISED: **
* Tab. Levoflox 250 mg twice daily (8am-8pm) - PO x 5 days
* Tab. Spironolactone 25 mg twice daily (8am - 8pm) - PO x 2 weeks then as advised by paediatric cardiologist.
* Tab. Lasix 10 mg twice daily (6am - 2pm - 10pm) - PO x 2 weeks then as advised by paediatric cardiologist.
* Tab. Digoxin 0.25 mg once daily (9am)- PO - 5 days in a week x 2 weeks then as advised by paediatric cardiologist.
* Tab. Paracetamol 650 mg thrice daily (6am - 2pm - 10pm) - PO x 3 days then as and when required
* Cap. Pan-D 40 mg 1-cap once daily (6am) - PO x 1 week
* Tab. Shelcal 250 mg twice daily (9am - 9pm) - PO x 2 weeks
* Tab. Neurobion Forte 1-tab once daily(2pm) - PO x 2 weeks
* **Intake/Output charting.**

Review after 3 days with serum Na+ and K+ level at 2nd floor procedure room in between 1-3:00Pm. Dose of diuretics to be decided on follow up. Continued review with the cardiologist for continued care.

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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. K. S. DAGAR in OPD with prior appointment.
Dr. P K ACHARYA in OPD with prior appointment.
Dr. Gaurav Kumar in OPD with prior appointment.

Dr. K. S. Dagar
Principal Director
Neonatal and Congenital Heart Surgery

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