

## DISCHARGE SUMMARY

|                                                                       |                               |
|-----------------------------------------------------------------------|-------------------------------|
| PATIENT NAME: PARIDHI MISHRA                                          | AGE: 8 MONTHS, SEX: F         |
| REGN: NO: 16504254                                                    | IPD NO: 234727/26/1201        |
| DATE OF ADMISSION: 05/10/2026                                         | DATE OF DISCHARGE: 13/10/2026 |
| CONSULTANT: DR. K. S. IYER / DR. NEERAJ AWASTHY / DR. HIMANSHU PRATAP |                               |

### DISCHARGE DIAGNOSIS

- Congenital Acyanotic Heart Disease
- Large inlet ventricular septal defect restricted by Septal tricuspid leaflet prolapse
- Tiny nonrestrictive Subaortic membrane
- Dilated right atrium and right ventricle
- Failure to thrive (< 3<sup>rd</sup> Percentile); Z score < -3 SD

### OPERATIVE PROCEDURE

**Trans right atrial Dacron patch closure of ventricular septal defect done on 06/10/2026**

**Tricuspid valve inspected and found satisfactory.**

### RESUME OF HISTORY

Paridhi Mishra is a 8 months old female infant (date of birth: 06/02/2026) from Sant Kabir Nagar, Uttar Pradesh who is a case of congenital heart disease. She is 1<sup>st</sup> in birth order and is a product of full term LSCS (lower segment caesarian section) delivery. Her birth weight was 2.7 kg. Maternal age is currently 30 years.

She had history of fast breathing and feeding difficulty for which she was shown to pediatrician. During evaluation, cardiac murmur was detected. Echo was done which revealed Congenital heart disease. She also had history of failure to thrive. She was referred to Fortis Escorts Heart Institute, New Delhi for further management.

She was seen at FEHI, New Delhi on 05/10/2026. Her saturation at that time was 100% with weight of 4.8 Kg. Echo was done and she was advised surgical management.

Now she is admitted at FEHI, New Delhi for further evaluation and management. On admission, her saturation was 100%, Her Hb 9.9g/dl, TLC was 13,530/cmm, platelets 3.66 lacs/cmm and Hematocrit 33.2% on admission.

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 long term issues.

Weight on admission 4.6 kg, Height on admission 65 cm, Weight on discharge 4.95 kg

Her Weight on admission 4.6 kg. Failure to thrive (< 3<sup>rd</sup> Percentile); Z score < -3 SD

Her blood Group AB positive

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

All blood and urine culture were sterile.

#### INVESTIGATION:

##### ECHO

Done on 05/10/2026 revealed situs solitus, levocardia, D-loop, AV-VA concordance, normal systemic and pulmonary venous drainage, patent foramen ovale (left to right), laminar TV inflow, slight flow acceleration across mitral valve (mean PG 2mmHg), mild tricuspid regurgitation, LV to RA jet, large inlet ventricular septal defect with anterior muscular extension with partial restriction by Septal tricuspid leaflet aneurysm (max PG 35mmHg), no additional ventricular septal defect, laminar outflow, confluent branch Pulmonary arteries, trace pulmonary regurgitation, no aortic regurgitation, ? small non-obstructive subaortic tissue, trileaflet aortic valve, normal coronary origin, left arch, laminar flow in arch, no Coarctation of aorta no Patent ductus arteriosus, no left superior vena cava, dilated left atrium and left ventricle, normal LVEF, no collection, IVSd 0.4cm, LVIDd 3.7cm (Z score +3.9), LVIDs 2.03cm (Z score +3.3), LVFS 33%

## **POST OP ECHO**

**Epicardial Echo** done on 06/10/2026 revealed VSD patch in situ, no residual shunt, mild TR, Laminar inflows and outflows, LVEF 45%

Done on 06/10/2026 (08:00 PM) revealed ventricular septal defect patch in situ, no residual shunt, laminar inflow and outflow, LVEF 40%, no collection

Done on 07/10/2026 revealed ventricular septal defect patch in situ, no residual shunt, laminar inflow and outflow, LVEF 40-45%, no collection

Done on 12/10/2026 revealed ventricular septal defect patch in situ, no residual shunt, laminar inflow, mild tricuspid regurgitation, laminar outflow, LVEF 50%, no collection

## **ABDOMINAL USG**

Done on 06/10/2026 revealed Liver shows homogeneous normal echopattern. Hepatic veins & intrahepatic biliary radicles are not dilated. Portal vein measures 3mm in diameter (normal). • Gall bladder shows normal anechoic pattern. G.B. wall thickness is normal • CBD is normal in caliber. • Pancreas appears normal in size & echogenicity. Rest of the retroperitoneum obscured by bowel gases. • Spleen is normal in size & echogenicity (Span – 3.4cm). • 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 – 5.0cm x 1.3cm. - Left kidney measures – 4.8cm x 2.3cm. • Urinary bladder is empty. • No evidence of free fluid is seen in abdomen.

## **USG BRAIN**

Done on 06/10/2026 revealed no obvious focal lesion seen in brain parenchyma. Note is made of septum cavum pellucidum. No ventricular dilatation seen. No midline shift seen

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

Trans right atrial Dacron patch closure of ventricular septal defect done on 06/10/2026

Tricuspid valve inspected and found satisfactory.

**REMARKS:** Diagnosis: - Congenital Acyanotic Heart Disease, large inlet-ventricular septal defect restricted by Septal tricuspid leaflet prolapse, dilated right atrium and right ventricle. Operation:- Trans right atrial closure of ventricular septal defect using a Dacron patch. Operative Findings: - Situs solitus levocardia {S, D, S}, AV- VA concordance, Thymus present, Pericardium normal, Superior vena cava normal, Inferior vena cava normal, Pulmonary Veins normal, right atrium Dilated, Right ventricular outflow tract Normal, Infundibulum wide open, Main pulmonary artery adequate, Branch Pulmonary arteries adequate size, Aorta normal. Tiny nonrestrictive Subaortic membrane, Coronaries normal, interatrial septum intact, ventricular septal defect large inlet ventricular septal defect restricted by Septal tricuspid leaflet prolapse, Tricuspid valve normal, Coronaries normal. Procedure- Routine induction of General Anesthesia and placement of monitoring lines. Median sternotomy. Thymus dissected. Pericardial cradle created. Systemic heparinization (400 U/kg). Aortobicaval cannulation, went on CPB. Cooled to 34°C. Aorta cross-clamped and heart arrested with cold blood cardioplegia delivered antegrade through the aortic root and topical ice-cold saline. Cavae snared. Right atrium opened parallel to the AV groove. LA vented through surgically created patent foramen ovale. Findings confirmed and ventricular septal defect closure done with Dacron patch using pledgeted 5-0 prolene continuous and 5-0 pericardial pledgeted interrupted suture (Subaortic membrane incorporated into the ventricular septal defect sutures). Tricuspid valve inspected and found satisfactory. patent foramen ovale closed directly with 5-0 prolene. Right atrium closed with 5-0 prolene in double layer. Rewarming done. After adequate deairing Aortic cross clamp released. normal sinus rhythm achieved and Weaned off Cardiopulmonary bypass with 5 mcg/kg/min Dobutamine. Hemostasis secured. Protamine given followed by decannulation. Epicardial pacing wires (2 atrial and 1 ventricular) placed. Both pleurae open. Routine sternal closure over drains.

**Her post-operative course was smooth.**

She was ventilated with adequate analgesia and sedation for 20.5 hours and extubated on early 1<sup>st</sup> 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 2<sup>nd</sup> POD. She was weaned from oxygen to air by 2<sup>nd</sup> POD.

She was electively supported with dobutamine (0 - 1<sup>st</sup> POD → 5mic/kg/min @ 1.4 ml/hr which was decreased to 2.5mic/kg/min @ 0.7 ml/hr) in view of large ventricular septal defect closure and metabolic acidosis (BE -4.1mmol/L).

She was also started with milrinone (0 - 6<sup>th</sup> POD → 0.8mic/kg/min @ 1.1 ml/hr) due to impaired mixed venous oxygenation (MVO<sub>2</sub> 67%) and metabolic acidosis (BE -4.1mmol/L)

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

There were no post-operative arrhythmias.

Pacing wire was removed on 6<sup>th</sup> POD.

She had intermittent fever (37.8°C) on 0 - 1<sup>st</sup> POD. She was thoroughly investigated for the same. Her TLC was 13,200/cmm and platelets 1.67 lacs/cmm. This was managed symptomatically with antipyretics. All cultures were negative. She was clinically well all through and afebrile later. Her pre-discharge TLC was 11,760/cmm, platelets were 1.60 lacs/cmm and Hb 10.6 g/dl.

Her pre-operative renal function showed (S. creatinine 0.22 mg/dl, Blood urea nitrogen 11 mg/dl)

Her post-operative renal function showed (S. creatinine 0.19 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 10 mg/dl)

Her pre-operative liver functions showed (SGOT/SGPT = 40/30 IU/L, S. bilirubin total 0.26 mg/dl, direct 0.08 mg/dl, Total protein 6.3 g/dl, S. Albumin 4.6 g/dl, S. Globulin 1.7 g/dl Alkaline phosphatase 275 U/L, S. Gamma Glutamyl Transferase (GGT) 17 U/L and LDH 156 U/L).

She had mildly deranged liver functions on 1<sup>st</sup> POD (SGOT/SGPT = 137/22 IU/L, S. bilirubin total 0.88 mg/dl & direct 0.31 mg/dl and S. Albumin 4.1 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 = 28/30 IU/L, S. bilirubin total 0.31 mg/dl, direct 0.09 mg/dl, Total protein 6.6 g/dl, S. Albumin 4.5 g/dl, S. Globulin 2.1 g/dl Alkaline phosphatase 175 U/L, S. Gamma Glutamyl Transferase (GGT) 32 U/L and LDH 181 U/L).

Thyroid function test done on 06/10/2026 which revealed T3 4.04 pg/ml (normal range - 2.15 - 5.83 pg/ml), T4 1.24 ng/dl (normal range 0.92 - 1.99 ng/dl), TSH 0.452  $\mu$ IU/ml (normal range - 0.730 - 8.350  $\mu$ IU/ml).

Repeat Thyroid function test done on 12/10/2026 which revealed T3 2.22 pg/ml (normal range - 2.15 - 5.83 pg/ml), T4 1.25 ng/dl (normal range 0.92 - 1.99 ng/dl), TSH 5.110  $\mu$ IU/ml (normal range - 0.730 - 8.350  $\mu$ IU/ml).

Minimal enteral feeds were started on 1<sup>st</sup> POD and cautiously and gradually advanced to full feeds by 2<sup>nd</sup> POD. Oral feeds were started on 3<sup>rd</sup> POD.

#### **CONDITION AT DISCHARGE**

Her general condition at the time of discharge was satisfactory. Incision line healed by primary union. No sternal instability. HR 120-130/min, normal sinus rhythm. Chest x-ray revealed bilateral clear lung fields. Saturation in air is 97-100%. **Her predischARGE x-ray done on 12/10/2026**

**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 has been advised to do chorionic villus sampling or amniocentesis early in any future pregnancy to exclude Trisomy 21 and she has also been advised a detailed congenital anomaly scan in next pregnancy.**

**Other future 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. Large ventricular septal defect closure
2. Possibility of increase in Subaortic membrane

Review on 15/10/2026 in 5<sup>th</sup> floor at 09:30 AM for wound review

Repeat Echo after 9 - 12 months after telephonic appointment

**PROPHYLAXIS :**

Infective endocarditis prophylaxis prior to any invasive procedure

**MEDICATION:**

1. Syp. Paracetamol 75 mg PO 6 hourly x one week
2. Tab. Pantoprazole 5 mg PO twice daily x one week
3. Syp. Lasix 5 mg PO twice daily till next review
4. Tab. Aldactone 3.125 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 4<sup>th</sup> hrly
7. Nebulization with normal saline 4<sup>th</sup> hrly

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

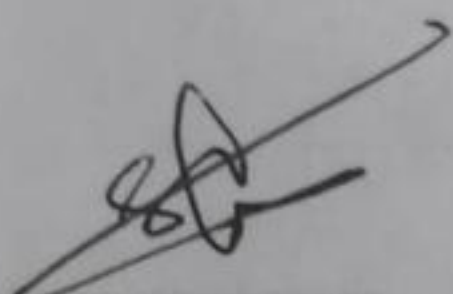
Review at FEHI, New Delhi after 9 – 12 months after telephonic appointment  
In between Ongoing review with Pediatrician

Sutures to be removed on 21/10/2026; Till then wash below waist with free flowing water

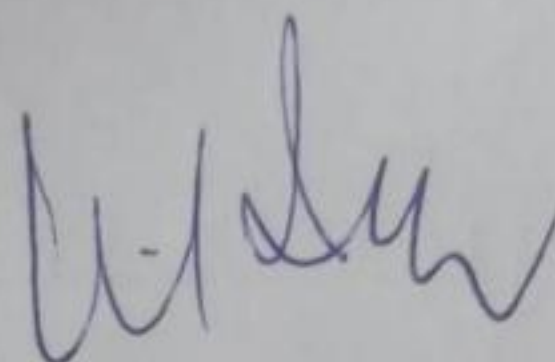
4<sup>th</sup> hrly temperature charting - Bring your own thermometer

➤ Daily bath after suture removal with soap and water from 22/10/2026

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.