Fortis Escorts
HEART INSTITUTE

Escorts Heart Institute and
Research Centre Ltd.
Okhla Road, New Delhi - 110 025 (India)
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DISCHARGE SUMMARY

PATIENT NAME: MUHAMMAD TAHA	AGE: 1 MONTHS & 14 DAYS, SEX: M
REGN: NO: 14270002	IPD NO: 9670/26/1201
DATE OF ADMISSION: 14/01/2026	DATE OF DISCHARGE: 31/01/2026
CONSULTANT: DR. K. S. IYER / DR. NEERAJ AWASTHY	

DISCHARGE DIAGNOSIS

- Complex Cyanotic Congenital Heart Disease
- d-Transposition of great arteries
- Restricted patent foramen ovale
- Good interatrial communication - S/P Balloon dilation (TYSHAK II 10mm x 2cm) and 12mm*3 cm of patent foramen ovale followed by balloon atrial septostomy using Fogarty balloon 5F on 15/01/2026 at Fortis Escorts Heart Institute, New Delhi
- Small perimembranous ventricular septal defect
- Moderate size Patent ductus arteriosus
- Coronaries: 1LCx, 2R
- History of Neonatal Seizure (? Meningitis), Preoperative stabilization with Mechanical ventilation, intravenous antibiotics and Balloon atrial septostomy
- Prematurity (35 weeks)
- Failure to thrive (< 3rd Percentile); Z score < - 3 SD

OPERATIVE PROCEDURE

Arterial Switch Operation + Patent ductus arteriosus ligation and division + Direct closure ventricular septal defect + Direct closure of atrial septal defect done on 23/01/2026

Tricuspid valve tested and found competent

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RESUME OF HISTORY

Muhammad Taha is a 1 month and 14 days old male infant (date of birth: 09/12/2025) from Delhi who is a case of congenital heart disease. He is 3rd (2nd live) in birth order and is a product of pre term (35 weeks) LSCS (lower segment caesarian section) delivery. His birth weight was 2.5 kg, born to a non-consanguineous marriage. Maternal age is currently 38 years. 1st sibling died prior to birth at 9 months of antenatal age. 2nd sibling is apparently well.

Baby had history of poor cry at birth for which the baby was kept in NICU for 6 days. In view of weak suck, baby was put on nasogastric tube feeding. At day 6 of life, echo was done in view of bluish discoloration of skin and was diagnosed as a case of Congenital heart disease – d-Transposition of great arteries, ventricular septal defect with Patent ductus arteriosus. He was on regular follow up. Since last 1 day, there is excessive crying and baby had 2 episodes of increased tone of all 4 limbs as noticed by the mother. Baby was brought to Fortis Escorts Heart Institute, New Delhi emergency for further stabilization on 04/01/2026.

He was admitted in emergency at Fortis Escorts Heart Institute, New Delhi. In view of episodes of abnormal body movement in form of staring looks, refusal to feed with intermittent increased tone of all limbs. Patient had 4 episodes of apnea during 12 hours of admission and relieved by bag and mask ventilation. Baby was started on antimeningitic dose of intravenous antibiotics (cefotaxime and amikacin) along with intravenous Levipil in view of suspected meningitis. CSF (Cerebrospinal fluid) analysis was done which was within normal limits. USG cranium was done which revealed Bilateral periventricular regions show symmetrical increased echogenicity. Cerebellum appears echogenic compared to rest of brain parenchyma. Ventricular system appears normal. No midline shift seen.

Due to personal reason, he was shifted to another hospital on 07/01/2026 for intravenous antibiotics and oxygen therapy and advised to follow up in OPD. Family has been explained in detail regarding the risk associated with transportation.

He was again re-admitted in emergency at Fortis Escorts Heart Institute, New Delhi on 14/01/2025.

Now he is admitted at FEHI, New Delhi for further evaluation and management. On admission, his saturation was 80%, His Hb 10.8g/dl, TLC was 19,770/cmm, platelets 2.46 lacs/cmm and Hematocrit 37.3% on admission.

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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 2.6 kg, Height on admission 46 cm, Weight on discharge 2.6 kg

His Weight on admission 2.6 kg. Failure to thrive (< 3rd Percentile); Z score < - 3 SD

His blood Group A positive

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

He was again admitted on 14/01/2025 in emergency at Fortis Escorts Heart Institute, New Delhi. In view of severe respiratory distress. He was put on non-invasive CPAP ventilation.

Venous blood gas was done which showed pH 7.1, pCO2 45.9mmHg, pAO2 91.6mmHg, metabolic acidosis (BE –11.6mmol/L) and bicarbonate 15.8mmol/L.

Repeat venous blood gas was done after 5 hours showed pH 7.13, pCO2 51.9mmHg, pAO2 21.6mmHg, metabolic acidosis (BE –10.3mmol/L) and bicarbonate 18.4mmol/L.

He was immediately intubated and shifted to CCU and kept on mechanical ventilatory support

His Hb 10.8g/dl, TLC was 19,770/cmm, platelets 2.46 lacs/cmm and Hematocrit 37.3% on admission.

His pre-operative renal function showed (S. creatinine 0.56 mg/dl, Blood urea nitrogen 13 mg/dl)

His pre-operative liver functions showed (SGOT/SGPT = 59/26 IU/L, S. bilirubin total 0.52 mg/dl, direct 0.29 mg/dl, Total protein 5.1 g/dl, S. Albumin 3.6 g/dl, S. Globulin 1.5 g/dl Alkaline phosphatase 228 U/L, S. Gamma Glutamyl Transferase (GGT) 70 U/L and LDH 615 U/L).

He was started on intravenous fluids, inotropic (Dobutamine → 5mic/kg/min @ 1ml/hr till 8th day of admission), empirical antibiotics (Fluconazole, Meropenem and vancomycin) with decongestive therapy.

He underwent Balloon dilation of patent foramen ovale (TYSHAK II 10mm x 2cm and 12mm*3 cm) followed by balloon atrial septostomy using Fogarty balloon 5F done on 15/01/2026 (i.e. 2nd day of admission). Post procedure he was kept in CCU under mechanical ventilatory support.

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He was ventilated with adequate analgesia and sedation for 62.5 hours and extubated on 4th day of admission. Following extubation he was put on non-invasive CPAP ventilation in view of resting tachypnea till surgery.

Minimal enteral feeds were started on 4th POD.

Balloon dilation (TYSHAK II 10mm x 2cm) and 12mm*3 cm of PFO followed by balloon atrial septostomy using Fogarty balloon 5F done on 15/01/2026

Division of Pediatric Cardiology

Name : MUHAMMAD TAHA		**Registration Number :**	14270002
DOB : 9.12.2025	**Sex :** MALE	**IPD No :**	9670/26/1201
Height (cms) : 46	**Weight (Kg) :** 2.4	**Cath Date :**	15/01/2026
	HB (%): 10.8	**Cath No.**	11180

Sedation : General Anesthesia

Admitting Diagnosis :

- Normal atrial arrangement
- Levocardia
- D Loop (Right Hand Topology)
- Concordant atrioventricular connection
- DISCORDANT VA CONNECTION
- Two patent AV valves

Abnormalities :

- Restrictive PFO
- Small anterior muscular VSD
- PDA 5mm (L>R)
- LVH

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Procedure Done :

-Balloon atrial septostomy and ballon dilatation of PFO

Previous Procedure : S/P PDA STENT (27.12.26) AT FEHI

Vascular Access :	Size
Right Femoral Vein	5F

Catheters/Balloons/Stents

Fogarty catheter	5F
Tyshak II	10mmX 2 cm
	12mm*2cm

COMMENT	Balloon dilation of PFO was done using tyshak II ballon (10mm x 2cm) twice followed by tyshak II balloon of size 12mm*3cm twice. This was followed by balloon atrial septostomy using Fogarty catheter (5F) inflated with diluted contrast under fluoroscopic and echocardiographic guidance and pulled across PFO. Procedure was repeated twice. Post BAS procedure, post procedure ECHO showed good interatrial connection with bidirectional shunt across interatrial communication.

DIAGNOSIS

Restricted PFO
DTGA

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	SMALL ANTERIOR MUSCULAR VSD Normal ventricular function
	Normal sinus rhythm S/p Balloon dilation(TYSHAK II 10mm x 2cm) and 12mm*3 cm of PFO followed by balloon atrial septostomy using Fogarty balloon 5F done on15/01/2026.

Once he was stabilized, he was taken up for high risk surgery on 10th day of admission after detailed counseling of family members regarding possibility of prolonged stay as well as uncertain long term issues.

All blood and urine culture were sterile.

INVESTIGATION:

ECHO

Done on 04/01/2026 revealed situs solitus, levocardia, d-loop ventricle. Normal systemic and pulmonary venous drainage. AV concordance. 2mm ASD (left to right shunt). TGA with VSD. Laminar inflow. Large anterior muscular VSD (left to right shunt). Laminar outflow. Left arch. No coarctation of aorta. PDA (left to right shunt). No LSVC. Coronaries from facing sinus. Confluent and adequate branch PAs. LVH present. Normal LVEF. RPA= 4.2mm, LPA= 4mm, LVIDd= 1.26cm, LVIDs= 0.6cm, IVSd= 0.4cm, LVFS= 54%.

Done on 14/01/2026 revealed normal segmental analysis, restrictive patent foramen ovale present (left to right shunt). d-Transposition of great arteries, small anterior muscular ventricular septal defect present (left to right shunt), laminar inflow and outflow, left arch, normal branching pattern, no coarctation of aorta, 5mm Patent ductus arteriosus (left to right shunt), no left superior vena cava. coronaries from facing sinus, normal LVEF, LVH present. Confluent and adequate branch Pulmonary arteries

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Done on 22/01/2026 revealed normal segmental analysis, good interatrial communication, d-Transposition of great arteries, moderate size anterior muscular ventricular septal defect (left to right), laminar inflow, laminar RV outflow, mild flow acceleration across Left ventricular outflow tract, max PG 38mmHg, sub valvar level, left arch, laminar flow in arch, confluent and adequate branch Pulmonary arteries, coronaries from facing sinus, 3.5mm Patent ductus arteriosus (left to right), normal LVEF, LVPWd 5.3cm, LV mass index 60 g/m2

POST OP ECHO

Epicardial Echo done on 23/01/206 revealed Laminar inflows, Laminar outflows, small residual VSD shunt, trace neo AR, trace neo-PR, LVEF-45 %

Done on 23/01/2026 revealed small residual ventricular septal defect shunt (left to right) max PG 61mmHg, laminar inflow, mild mitral regurgitation, laminar outflow, mild flow acceleration in Right ventricular outflow tract max PG 16mmHg, trace neo pulmonary regurgitation, trace neo aortic regurgitation, LVEF 45%, trace bilateral pleural collection, no pericardial collection

Done on 24/01/2026 revealed small residual ventricular septal defect shunt (left to right), max PG 70mmHg, laminar inflow, mild mitral regurgitation, laminar outflow, trace neo aortic regurgitation, mild neo pulmonary regurgitation max PG 10mmHg, mild flow acceleration in Right ventricular outflow tract max PG 20mmHg, LVEF 45%, trace right pleural collection, no pericardial collection

Done on 25/01/2026 (11:00 AM) revealed small residual ventricular septal defect shunt (left to right) max PG 42mmHg, laminar inflow, mild mitral regurgitation, trace neo aortic regurgitation, mild neo pulmonary regurgitation, Right ventricular outflow tract flow acceleration max Pg 24mmHg, LVEF 45%, no pleural or pericardial collection

Done on 25/01/2026 (07:00 PM) revealed no collection, LVEF 45%

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Done on 28/01/2026 revealed small residual ventricular septal defect shunt (left to right), max PG 70mmHg, laminar inflow, ? echogenic foci seen in RA, laminar outflow, mild flow acceleration in Right ventricular outflow tract max PG 16mmHg, trace neo pulmonary regurgitation, trace neo aortic regurgitation, LVEF 50%, no collection

Done on 30/01/2026 revealed laminar inflow, echogenic foci seen in right atrium (? Thrombus), small residual ventricular septal defect shunt (left to right) max PG 65mmHg, laminar outflow, mild flow acceleration in Right ventricular outflow tract max PG 20mmHg, trivial neo aortic regurgitation, trace neo pulmonary regurgitation, LVEF 50-55%, no collection, laminar flow in ach, good flow in branch Pulmonary arteries

ABDOMINAL USG

Done on 22/01/2026 revealed Liver is normal in size, measuring 6.5cm & shows homogeneous & normal echopattern. Intrahepatic biliary radicles, hepatic veins & portal vein are normal. Gall bladder is contracted. CBD is normal in course & caliber. Pancreas and retroperitoneum obscured by bowel gases. Spleen is normal in size (3.0cm) & echogenicity. Both kidneys are normal in location, size, shape & echotexture. Cortical thickness & corticomedullary differentiation are well maintained. No dilatation of pelvicalyceal system is seen. Right kidney measures 4.2cm x 2.1cm in size. Left kidney measures 5.0cm x 1.5cm in size. Urinary bladder appears normal in contour & capacity. No calculi / filling defect seen. No evidence of free fluid seen in abdomen.

USG BRAIN

Done on 22/01/2026 revealed Bilateral periventricular regions show symmetrical increased echogenicity. Cerebellum appears echogenic compared to rest of brain parenchyma. Ventricular system appears normal. No midline shift seen.

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

Arterial Switch Operation + Patent ductus arteriosus ligation and division + Direct closure ventricular septal defect + Direct closure of atrial septal defect done on 23/01/2026

Tricuspid valve tested and found competent

REMARKS: Diagnosis: - Complex Cyanotic Congenital Heart Disease, D-Transposition of great arteries, Small perimembranous ventricular septal defect, Moderate size Patent ductus arteriosus , Good interatrial communication (S/P Balloon atrial septostomy @ 15.01.2026, Fortis Escorts Heart Institute, New Delhi,), History of Neonatal Seizure (? Meningitis), Preoperative stabilization with Mechanical ventilation, intravenous antibiotics and Balloon atrial septostomy. Operation:- Arterial Switch Operation + Patent ductus arteriosus Double ligation and division + Direct closure ventricular septal defect + Direct closure of atrial septal defect. Operative Findings: - Situs solitus, levocardia, AV concordance and VA discordance, Thymus present, Innominate vein normal, Pericardium normal, Superior vena cava normal, Inferior vena cava normal, Pulmonary Veins normal, Pulmonary artery annulus adequate, Main pulmonary artery Left and Posterior to Aorta, Branch Pulmonary arteries Confluent and Adequate, left ventricle Normal, No Left ventricular outflow tract obstruction, right ventricle adequate size, Aorta Right and Anterior to Main pulmonary artery, adequate size, Patent ductus arteriosus small size, patent, interatrial septum fossa ovalis atrial septal defect, (S/P Balloon atrial septostomy), interventricular septum Small perimembranous ventricular septal defect, Pulmonary valve Tricuspid, Infundibulum wide open, Aortic Valve Tricuspid, Coronaries: 1LCx, 2R. Procedure- Routine induction of General Anaesthesia and placement of monitoring lines. Median sternotomy. Subtotal thymectomy done, rectangular pericardial patch harvested and Pericardial cradle created. Aorta, Main pulmonary artery, branch Pulmonary arteries and Patent ductus arteriosus dissected. Systemic heparinization (300 U/kg), aorto-bicaval cannulation & Cardiopulmonary bypass established. Patent ductus arteriosus doubly ligated, transfixed at both ends and divided in between. Cooled to 29°C. Aorta cross-clamped and heart arrested with cold blood cardioplegia delivered antegrade through the aortic root and topical ice-cold saline. Caval snaring done and right atrium opened parallel to AV groove. Left atrium vented through atrial septal defect. interventricular septum examined. Tiny perimembranous ventricular septal defect closed directly with plegetted 6-0 suture. Tricuspid valve tested and found competent. Aorta transected, coronary anatomy examined thoroughly. Two Coronary buttons harvested. The defect in the native aorta reconstructed with untreated autologous pericardium with prolene 7-0 suture in continuous manner. Main pulmonary artery transected just below the bifurcation. Pulmonary valve, Left ventricular outflow

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tract and branch Pulmonary arteries ostia inspected and found adequate. LeCompte's maneuver was performed. The buttons were transferred to the corresponding sinus of the Pulmonary artery using 8-0 prolene continuous sutures. Neo-aorta was anastomosed with distal native ascending aorta with 7-0 prolene in running continuous manner. Atrial septal defect closed directly with 6/0 prolene suture. Rewarming, deairing and cross-clamp removal done. normal sinus rhythm achieved. End to end anastomosis of the neo-Main pulmonary artery with the pulmonary bifurcation done using 7-0 prolene. Right atrium closed with 6-0 prolene in double layers. LA line placed. Patient was gradually weaned off Cardiopulmonary bypass on Dobutamine at 5 mcg/kg/min and Milrinone 0.5 mcg/kg/min. Venous decannulation done. Protamine administered and aortic decannulation done. PD catheter placed. Epicardial pacing wires (2 atrial and 1 ventricular) placed. Right pleura opened and left pleura intact. Haemostasis achieved and sternum approximated with Ethibond suture. Skin closed in layers

His post-operative course was associated with complex surrey (arterial switch operation with ventricular septal defect closure) and need for prolonged ventilation.

He was ventilated with adequate analgesia and sedation for 90.25 hours in view of complex surgery – Arterial switch operation with ventricular septal defect closure and puffiness.

His highest LA pressure (LAP 11mm) on 0 POD. His LA line removed on 2nd POD.

He was extubated on 4th POD to oxygen by hood. Post extubation chest x-ray revealed bilateral mild patchy atelectasis. This was managed with chest physiotherapy, nebulization and suctioning.

He was shifted to ward on 6th POD. He was weaned from oxygen to air by 7th POD.

He was electively supported with dobutamine (0 – 5th POD → 5mic/kg/min @ 0.7 ml/hr) in view of complex surgery – Arterial switch operation with ventricular septal defect closure and lactic acidosis (Lactate 3.6mmol/L).

He was also started with milrinone (0 – 6th POD → 0.8mic/kg/min @ 1.2ml/hr) due to impaired mixed venous oxygenation (MVO2 35%) and lactic acidosis (Lactate 3.6mmol/L).

His impaired mixed venous oxygenation improved to (MVO2 76%) on 5th POD.

Decongestive therapy was given in the form of lasix (boluses & infusion), aldactone and drainage by intraoperatively sited peritoneal dialysis catheter till 5th POD. Dialysis was also commenced for significantly increased body water with diuretics resistance (1st 3rd POD). 365 ml fluid was obtained per day.

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His CPK (39 – 308) / CPKMB (0.30-6.22) were 1250/173.1 IU/L respectively and predischarge CPK/CPKMB were 28/2.5 IU/L

TROPONIN T was high 4007 pg/mL (0-14pg/mL) and and predischarge TROPONIN T was better 614.2 pg/mL pg/mL (0-14pg/mL).

He was continued on Levetiracetam post operatively in view of pre-operative history of Neonatal Seizure (? Meningitis). He had no seizure or seizure equivalents post operatively. He was fully conscious all through.

There were no post-operative arrhythmias.

Pacing wire was removed on 7th POD.

He was continued on empiric broad spectrum antibiotics (Meropenem and Fluconazole) including anti staphyloccal cover post operatively in view of pre-operative sick state.

He had no fever but had mild thrombocytopenia. His TLC was 9,800/cmm and platelets 1.08 lacs/cmm on 0 POD. He was thoroughly investigated for the same.

Colistin was added on 3rd POD in view of low albumin. Antibiotics were continued in view of this. The antibiotics were stopped once all cultures were sterile. He was clinically well later and apyrexial all through. His predischarge TLC was 6,820/cmm, platelets were 2.19 lacs/cmm and Hb 16.9 g/dl.

His pre-operative renal function showed (S. creatinine 0.56 mg/dl, Blood urea nitrogen 13 mg/dl)

His post-operative renal function showed (S. creatinine 0.40 mg/dl, Blood urea nitrogen 10 mg/dl) on 3rd POD

His pre-discharge renal function showed (S. creatinine 0.45 mg/dl, Blood urea nitrogen 15 mg/dl)

His pre-operative liver functions showed (SGOT/SGPT = 59/26 IU/L, S. bilirubin total 0.52 mg/dl, direct 0.29 mg/dl, Total protein 5.1 g/dl, S. Albumin 3.6 g/dl, S. Globulin 1.5 g/dl Alkaline phosphatase 228 U/L, S. Gamma Glutamyl Transferase (GGT) 70 U/L and LDH 615 U/L).

He had mildly deranged liver functions on 1st POD (SGOT/SGPT = 95/16 IU/L, S. bilirubin total 1.06 mg/dl & direct 0.40 mg/dl and S. Albumin 3.5 g/dl).

On 2nd POD (SGOT/SGPT = 34/13 IU/L, S. bilirubin total 0.39 mg/dl & direct 0.15 mg/dl and S. Albumin 2.4 g/dl). Albumin improved to (3.1 g/dl) over 24 hours after starting Colistin.

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This was managed with avoidance of hepatotoxic drug and continued preload optimization, inotropy and after load reduction. His liver function test gradually improved. His other organ parameters were normal all through.

His predischarge liver function test are SGOT/SGPT = 21/24 IU/L, S. bilirubin total 0.51 mg/dl, direct 0.24 mg/dl, Total protein 5.4 g/dl, S. Albumin 3.5 g/dl, S. Globulin 1.9 g/dl Alkaline phosphatase 160 U/L, S. Gamma Glutamyl Transferase (GGT) 60 U/L and LDH 365 U/L).

Intravenous heparin was given in the immediate post-operative period for anticoagulation. Tab. Colsprin was started on 5th POD for continued oral anticoagulation.

Thyroid function test done on 23/01/2026 which revealed normal→ Thyroid function test showed T3 3.37 pg/ml (normal range – 1.95 – 6.04 pg/ml), T4 1.50 ng/dl (normal range 0.89 – 2.20 ng/dl), TSH 2.460 µIU/ml (normal range – 0.720 – 11.000 µIU/ml).

Repeat Thyroid function test done on 26/01/2026 which revealed T3 2.18 pg/ml (normal range – 1.95 – 6.04 pg/ml), T4 0.96 ng/dl (normal range 0.89 – 2.20 ng/dl), TSH 3.670 µIU/ml (normal range – 0.720 – 11.000 µIU/ml) for which Tab. Thyroxine was started.

Repeat Thyroid function test done on 27/01/2026 which revealed normal→ Thyroid function test showed T3 2.70 pg/ml (normal range – 1.95 – 6.04 pg/ml), T4 1.81 ng/dl (normal range 0.89 – 2.20 ng/dl), TSH 4.150 µIU/ml (normal range – 0.720 – 11.000 µIU/ml).

Repeat Thyroid function test done on 29/01/2026 which revealed normal→ Thyroid function test showed T3 3.63 pg/ml (normal range – 1.95 – 6.04 pg/ml), T4 1.75 ng/dl (normal range 0.89 – 2.20 ng/dl), TSH 9.690 µIU/ml (normal range – 0.720 – 11.000 µIU/ml).

Minimal enteral feeds were started on 3rd POD and cautiously and gradually advanced to full feeds by 6th POD. Oral feeds were started on 7th POD.

On 7th POD, he had one episode of vomiting. This was managed symptomatically. There after there was no vomiting.

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CONDITION AT DISCHARGE

His general condition at the time of discharge was satisfactory. Incision line healed by primary union. No sternal instability. HR 130-150/min, normal sinus rhythm. Chest x-ray revealed bilateral clear lung fields. Saturation in air is 100%. **His predischarge x-ray done on 30/01/2026**

In view of advanced maternal age, preferably she is advised not to have any more pregnancies

He was fully conscious with no new abnormal behavior or focal deficit.

Other siblings are advised detailed cardiology review.

PLAN FOR CONTINUED CARE:

DIET : Breast feeds / Spoon feeds 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. **Arterial Switch operation with ventricular septal defect closure**
2. **Aspirin therapy**

Review on 01/02/2026 in 5th floor at 09:30 AM for review and then again on 02/02/2026

Repeat Echo after 6 - 9 months after telephonic appointment

Repeat Thyroid function test after 3 – 4 months

EEG to be done after 3 – 4 months

PROPHYLAXIS :

Infective endocarditis prophylaxis prior to any invasive procedure

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MEDICATION:

1. Syp. Paracetamol 40 mg PO 6 hourly x one week
2. Tab. Pantoprazole 3 mg PO twice daily x one week
3. Tab. Fluconazole 15 mg PO once daily x one week
4. Syp. Lasix 5 mg PO twice daily till next review
5. Tab. Aldactone 3.125 mg PO twice daily till next review
6. **Tab. Colsprin 15 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)**
7. Syp. Shelcal 2.5 ml PO twice daily x 3 months
8. **Tab. Thyroxine 12.5mcg PO once daily x 3 months and then repeat Thyroid function test (Empty Stomach)**
9. **Tab. Levetiracetam 50 mg PO twice daily till next review**
10. **Syp. Emeset 1 mg oral as required**
11. **Nasoclear nasal drop 2 drop both nostril 4th hrly**
12. **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 3 – 4 months after telephonic appointment
In between Ongoing review with Pediatrician

Sutures to be removed on 06/02/2026; 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 07/02/2026**

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

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A NABH Accredited Institute

(DR. SNEH LALWANI)
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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, 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.