



Discharge Summary Pediatric CTVS

Patient Demography Details :

Name : Hitanshu Jena	Patient ID : SKDD.1060358	IP No. : 750827
DOB : 25 JAN, 2024	Age/Gender: 11 Months/MALE	Primary Consultant : Gaurav Kumar
DOA : 16 DEC, 2024 11:26	Ward : SKTE-2NDFLR-PAEDIATRICS	Secondary Consultant : Kulbhushan Singh Dagar
Address: VILLAGE NADIGAN HIGHER SECONDARY SCHOOL KUDEI NADIGAON BALESHWAR, NADIGAN, ORISSA, 0		Mobile No. : 7982447617

Date and Time of Discharge: 26 DEC, 2024 14:56

Diagnosis:

- Congenital cyanotic heart disease
- Tetralogy Of Fallot
- Doubly committed VSD, bidirectional shunt
- Severe RVOTO
- Confluent and adequate sized branch PAs
- Anomalous coronary artery
- PDA
- Progressive cyanosis
- Recent ARI

History of Present Illness:

Mast. Hitanshu Jena, 11 months old male infant is a known case of congenital cyanotic heart disease, ToF. He is second in birth order, born out of non-consanguineous marriage at term by LSCS (leaking PV with oligohydramnios). Cried immediately at birth. No h/o Antenatal/ Natal/ Postnatal complications. Birth weight: 3.5 Kgs. He was suspected to have a congenital heart disease at birth when he was detected with a murmur on routine evaluation. On further detailed evaluation including an echo he revealed TOF. He was then kept on close medical follow up and was advised early surgical correction. He has no h/o seizures or ear discharge. He has h/o progressive cyanosis and easy fatigability.

Now he has been admitted to this centre for further evaluation and management.

On Examination:

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Weight on Admission : 8.8 Kg
Weight on Discharge : 9.1 Kg

Surgery:

Dacron patch VSD Closure + Infundibular resection + Double barrel RVOT reconstruction + PDA ligation + Decompressive PFO left open surgery done on 17.12.2024.

Course in Hospital:

On admission, he was thoroughly evaluated including an Echo which revealed detailed findings as above.

In view of his diagnosis, symptomatic status and Echo findings he underwent Dacron patch VSD Closure + Infundibular resection + Double barrel RVOT reconstruction + PDA ligation + decompressive PFO left open surgery on 17.12.2024. 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. In view of initial low output state, labile hemodynamics, severe capillary leak syndrome, clinical and radiological evidence of increased lung water he was electively ventilated with adequate sedation and analgesia for next 48 hours and was extubated on 2nd POD electively to nasal CPAP. It was continued for the next 72 hours alternating intermittently with the HFNC till 5th POD. He was then weaned off to Oxygen by nasal prongs on the 5th POD. Oxygen was then gradually weaned off to room air by 7th POD.

Associated bilateral basal atelectasis and concurrent bronchorrhea was managed with frequent nebulization, chest physiotherapy, vibration, suctioning and postural drainage. Both mediastinal chest tubes inserted perioperatively were removed on 4th POD once minimal drainage was noted and left pleural tubes was removed on 5th POD. Post wire cut echo done revealed moderate pleural effusion on the right side which was managed by pleural tapping and optimization of the diuretics.

Inotropes were electively given in the form of Adrenaline (0 to 3rd POD), Milrinone (0 - 2nd POD), Dobutamine (2nd - 5th POD) and Dopamine (0 - 3rd POD), Levosimendan (48 hours) to optimize the cardiac output. Nor-adrenaline (0 - 4th POD) was used to augment the SVR and for low mean systemic pressures.

He revealed Junctional ectopic tachycardia from '0' POD which was further evaluated and was managed by optimizing the electrolytes and amiodarone infusion with due loading and other supportive measures. He responded well to this line of treatment and his rhythm reverted to sinus by the 5th POD.

He had intermittent moderate to high grade fever starting from '0' POD, which was evaluated thoroughly including blood and ET c/s. Pending the culture report he was empirically started on third line broad spectrum IV antibiotics including

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antifungal and staphylococcal cover. He responded well to this and his fever subsided along with normalization of his raised TLC counts. All his cultures were sterile.

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

Minimal feed was started on 1st POD which was gradually built up to full feeds along with weaning feeds by 5th POD. He was also supplemented with Prokinetics, probiotics, human albumin, multivitamins & calcium.

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

Condition on Discharge:

Patient is haemodynamically stable, afebrile, accepting well orally, HR 139/min, sinus rhythm, BP 110/69 mm Hg, SPO2 94% on room air. Chest - bilateral clear, sternum stable, chest wound healthy.

Lab Results:

****ECHO (16.12.2024): ****

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	: PFO R-L shunt	
Ventricular septum	: Large doubly committed VSD shunting bidirectionally	
Tricuspid valve	: Annulus: 16 mm (Z score: +0.29), Mild TR	
Mitral valve	: Annulus: 15 mm (Z score: +0.29), No MR	
Aortic valve	: Annulus: 16 mm (Z score: +3.64), Tricuspid, NO LVOTO,	Trivial
AR, Overriding aorta		
Pulmonary valve	: Bicuspid, Hypoplastic Annulus: 8.4 mm (Z score: - 2.28); Severe Valvar PS; PG	: 78
mmHg		
Branch Pulmonary arteries	: Confluent, RPA: 7.3 mm; LPA: 8.7 mm (Exp 6.5 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	

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****X RAY CHEST & USG WHOLE ABDOMEN (16.12.2024): ****

Report Attached.

****PRE -DISCHARGE ECHO (25.12.2024): ****

- VSD patch in situ, No residual shunt
- Double barrel RVOT
- RV to PA conduit in situ, Conduit gradient: 25 mmHg
- Severe PR
- Flow seen in branch PAs
- PFO shunting bidirectionally
- Mild TR
- Left aortic arch with normal branching
- Normal Biventricular Function; LVEF: 55%
- No pleural and pericardial effusion

Advice:

****DIET****

- Fluid 700 -750 ml/day x 2 weeks
- Feeds as advised and weaning to be optimized rapidly.

****FOLLOW UP****

- Long term paediatric cardiology follow-up in view of Dacron patch VSD Closure + Infundibular resection + Double barrel RVOT reconstruction + PDA ligation + decompressive PFO left open surgery.
- Regular follow up with treating paediatrician for routine checkups and nutritional rehabilitation.

****PROPHYLAXIS: ****

- Infective endocarditis prophylaxis

Discharge Medications Advice:

- Syp. Taxim - O Forte 50 mg twice daily (8am-8pm) - PO x 5 days
- Tab. Fluconazole 80 mg once daily (2pm) - PO x 5 days
- Syp. Furosemide 5 mg thrice daily (6am - 2pm - 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- Resp. Bacillus Clausii 0.5ml resp. twice daily (8am-8pm) - PO x 5 days
- Tab. Spironolactone 3.125 mg thrice daily (8am - 2pm - 6pm) - PO x 2 weeks then as advised by pediatric cardiologist.

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- * Drops A to Z 1 ml once daily (2pm) – PO x 2 weeks then stop
- * Syp. Domperidone 2.5 ml thrice daily (6am – 2pm – 10pm) – PO x 7 days
- * Syp. Crocin 125 mg thrice daily (6am – 2pm – 10pm) – PO x 3 days then as and when required
- * Tab Zytanix 1mg once daily 10 am – PO x 2 days and then stop
- * 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 paediatrician after 4 weeks.

Follow Up Advice:

Review after 3 days with serum Na⁺ and K⁺ level at 2nd floor procedure room in between 2-4:00PM. 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 telephom.

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. Gaurav Kumar in OPD with prior appointment.

Dr. Pradipta Acharya in OPD with prior appointment.

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

Dr. Gaurav Kumar
Sr. Consultant,
Pediatric Cardiology

Dr P K Acharya
Asso. Director
Pediatric cardiac intensive care

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/es/ Pradipta Kumar Acharya
Associate Director

Signed: 26 DEC, 2024 14:59

/es/ Pradipta Kumar Acharya
Associate Director

Cosigned: 26 DEC, 2024 14:59
for Kulbhushan Singh Dagar
Principal Director - Pediatrics Cardiac
Surgery

Entered Date : 26 DEC, 2024 14:56

Prepared By: Pradipta Kumar Acharya

SSN No. : 071060358 Patient Name : Hitanshu Jena

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