



suspected of Downs's syndrome. Later as symptoms persisted, detailed evaluation was done including an ECHO, which revealed large VSD. He was then kept on close medical follow up and was advised early surgical correction. He has history of inadequate weight gain, recurrent episodes of cough and cold, one hospital admission for the same at 8 months of age. No history of cyanosis, loss of consciousness or seizures. He has global developmental delay. He is partially immunized, vaccination at 9 months is pending. 2 elder sisters, 4 and 8 years old; alive and well.

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

Patient Name : VIDHAN, CHAUDHARY

#### INVESTIGATIONS SUMMARY:

##### ECHO (25.12.2023):

- " Congenital heart disease
- " Partial AV canal defect
- " Non-restrictive inlet VSD shunting left to right
- " PFO with left to right shunt
- " Mild MR (central JET)
- " Cleft in mitral valve
- " Dilated LA/LV
- " Normal biventricular function
- " Bilateral SVC, left SVC to coronary sinus
- " Hyperkinetic PAH

##### X RAY CHEST (25.12.2023):

Report Attached.

##### USG WHOLE ABDOMEN & Doppler Cranium (25.12.2023):

Report Attached.

##### PRE DISCHARGE ECHO (03.01.2024):

- VSD patch in situ, no residual shunt
- PFO with left to right shunt
- Moderate TR (two jets seen); PG: 21mmhg
- Mild MR
- Bilateral SVC, left svc to coronary sinus
- Normal biventricular function; LVEF: 55%
- No pericardial or pleural effusion

##### COURSE IN HOSPITAL:

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Max Super Speciality Hospital, Soket

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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 VSD closure plus cleft MV repair plus PDA ligation surgery on 27.12.2023. 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 20 hours and was extubated on 1st POD electively to nasal CPAP support which was gradually weaned off to HFNC support on 2nd POD and then to oxygen by nasal prongs. Oxygen was taken off to room air on 3rd POD.

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

Inotropes were electively given in the form of Milrinone (0-2nd POD), Adrenaline (0-2nd POD) and Dobutamine (0-3rd POD) to optimize the cardiac output.

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

Minimal feed was started on 1st POD and it was gradually built up to full feeds along with weaning diet. He was also supplemented with multivitamins & calcium.

He is in stable condition now and fit for discharge.

#### CONDITION AT DISCHARGE

Patient is haemodynamically stable, afebrile, accepting well orally, HR 100/min, sinus rhythm, BP 98/56 mm Hg, SPO2 98 % on room air. Chest - bilateral clear, sternum stable, chest wound healthy.

#### DIET

- \* Fluid 550 - 600 ml/day x 2 weeks
- \* Weaning diet to be optimized rapidly

#### FOLLOW UP

- \* Long term pediatric cardiology follow-up in view of VSD closure plus cleft MV repair plus PDA ligation surgery.

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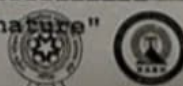
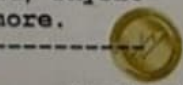
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\* Regular follow up with treating pediatrician for routine check-ups, nutritional rehabilitation, karyotyping, IQ/DQ assessment in due course of time and onward referral for occupational physiotherapy.

PROPHYLAXIS:

- \* Infective endocarditis prophylaxis

TREATMENT ADVISED:

- \* Syp. Cefixime 35 mg twice daily (8am-8pm) - PO x 5 days then stop
- \* Syp. Furosemide 5 mg thrice daily (6am - 2pm - 10pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- \* Tab Aldactone 6.25 mg once daily (2pm) - PO x 2 weeks then as advised by pediatric cardiologist.
- \* Syp. Calcimax P 3.5 ml twice daily (8am-8pm) - PO x 2 weeks then stop
- \* Syp A to Z 3.5 ml once daily (2pm) - PO x 2 weeks then stop
- \* Tab Junior Lanzol 10 mg twice daily (8am-8pm) - PO x 1 week and then stop
- \* Cap. Indomethacin 8 mg thrice daily (6am-2pm-10pm) - PO x 5 days 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 pediatrician after 4 weeks.

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 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. Himanshu Pratap in OPD with prior appointment.  
Dr. Munesh Tomar in OPD with prior appointment.

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

Dr. Himanshu Pratap  
Principal Consultant  
Neonatal and Congenital Heart Surgery

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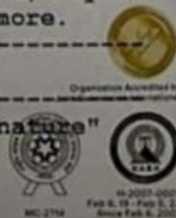
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/es/ Pradipta Kumar ACHARYA  
Associate Director  
Signed: 05/01/2024 12:10

/es/ Pradipta Kumar ACHARYA  
Associate Director  
Cosigned: 05/01/2024 12:10  
for Himanshu PRATAP  
Principal Consultant

Patient Name : VIDHAN, CHAUDHARY

SSN : 071-02-8234

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