

11/08/2022

TO WHOMSOEVER IT MAY CONCERN

Baby Udhin Jeeyanshi, 22 days old neonate with UHID: ANM1.0000815049 was admitted to Apollo Childrens Hospital, Chennai on 04/07/2022. She was diagnosed to have complex congenital heart disease soon after birth while evaluating for cyanosis. Echocardiogram done showed Transposition of Great arteries, double outlet right ventricle with large subaortic malaligned VSD with 50% aortic override, small ostium secundum ASD and moderate sized PDA. She was initially treated in Apollo Mumbai for sepsis and then shifted here for further management. In view of elevated serum procalcitonin and total counts, she was started on empirical antibiotics as per the Infectious Diseases team advise. Blood and urine cultures sent showed no growth.

She was closely monitored in CT-ICU. Antibiotics were stopped as the cultures were sterile and the repeat total counts showed decreasing trend. She was later shifted to the ward once hemodynamically stable. Echocardiogram and other pre-operative investigations were discussed in the CATH meet and it was decided to go ahead with the high risk Arterial switch operation with VSD closure and PDA ligation. High risk of mortality (20-30%), sepsis, prolonged ventilation, prolonged ICU stay and need for ECMO post-operatively was explained to the parent in detail.

After thorough pre-operative work up, anesthetic clearance and informed consent, she underwent Arterial switch operation + VSD closure+ PDA ligation with subannular patch on 28/07/2022 under cardiopulmonary bypass. Patient did not tolerate weaning of cardiopulmonary bypass and required high inotropic supports. Central V-A ECMO was initiated to support the circulation. Baby was shifted to the CT-ICU with V-A ECMO, chest open and high supports. Patient's critical condition, the need for prolonged ICU stay and prolonged ventilation was explained to the attender. Serial ABG's done on POD 0 showed metabolic acidosis with hyperlactaemia. Elective PD cycling was initiated. There was a drop in hemoglobin levels with continuous high drains and collection in the pericardium. Multiple transfusions (PRC's, platelets and FFP's) was done. Bleeding gradually reduced on POD 1.




No. 15, Shafi Mohammed Road, Thousand Lights, Chennai - 600 006.
Phone : 044 2829 8282 / 2829 6262, Fax : 044 2829 8283
E.mail : drneville_a@apollohospitals.com Website : www.apollohospitals.com
Website : www.apollohospitals.com



The hemodynamics were improving on the POD 2 and flows in the ECMO was reduced to 50%. The inotropic supports were reduced. ECHO done postoperatively on 3/8/22 showed good biventricular function, good flow across the RVOT, good flow in branch PA's and additional tiny residual VSD. She had AKI on POD 3. PD cycling was continued and negative balance was achieved. She developed fever spikes with elevated serum PCT on POD 4. Thrombocytopenia was revealed in complete blood counts, ID opinion was sought. They opined it to be ?surgery related coagulopathy/ ?sepsis. She was started on empirical antibiotics. ECMO flows were reduced to minimal gradually and inotropic supports were weaned off. ECMO was decannulated on POD 8 (5/8/22). Baby was sustaining hemodynamically with moderated supports. She developed seizures on POD 8. Anti-epileptics were started. Chest X-ray showed bilateral consolidation with hypercarbia on ABG's. Inhaled Nitric oxide was started. Serial ABG's showed improving respiratory acidosis. Arterial and central lines were changed in view of suspected sepsis. She was also started on parenteral feeds to supplement nutrition. Chest was eventually closed on POD 11 (8/8/22). Chest drains were removed on POD 11. Proning is being done periodically in view of respiratory acidosis and opacities on chest X-ray. Currently she is on mechanical ventilation requiring minimal inotropic support with spontaneous eye opening and on parenteral nutrition. Hence the expected cost of treatment is revised.



Neville A.G. Solomon, M.S., M.Ch.,
Consultant Paediatric Cardio Thoracic Surgeon
Apollo Children's Hospitals, Chennai.
Reg. No : 48445

 **Dr Neville A G Solomon / Dr Swaminathan**
Consultant Paediatric and Adult Congenital Cardiac Surgeons.
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No. 15, Shafi Mohammed Road, Thousand Lights, Chennai - 600 006.
Phone : 044 2829 8282 / 2829 6262, Fax : 044 2829 8283
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Website : www.apollohospitals.com

