

AQ3 Table 1: The patient was treated with following medications

Drug name	Dose	ROA	Frequency	Duration (days)
Inj. Piptaz	500 mg	IV	TID	1-17
Inj. Amikacin	40 mg	IV	OD	1-17
Syp. Ambroxol	1 ml	p/o	TID	2-15
Syp. Paracetamol	2.5 ml	p/o	TID	1-3
Neb Budecort	0.3 mcg	Nasal	12 th hrly	1-17
O ₂ Inhalation	5 L/min	Nasal	SOS	1-20
Fuoped drops	0.5 ml	p/o	BD	1-20
Isolyte- P	150 ml	IV	TID	1-14

excessive crying. Medication history of the patient includes, TOF was observed immediate after 10 days of birth. Medication history includes Tab. Propranolol 4 mg TID at the age of 9 months. In addition, patient was prescribed with syrup Digoxin 12.5 µg (0.25 ml) BD since 1 month. Patient was immunized up to the age as per schedule. She was born of a full-term cesarean delivery in the hospital without any peripartum complications but with low-birth weight of 1.77 kg and not cried immediately after birth. Personnel history includes weight - 4.5 kg, abnormal sleep, bowel, and bladder habits that were normal, appetite was normal. There was no history of similar illness in the family.

On examination, the patient was found to be conscious, coherent, and cooperative. She was comfortable at rest. The pulse rate was 118/min, respiratory rate was 62 cpm, temperature was 100°F. The digits of all four limbs and lips are cyanosed and a saturation of 58%. On cardiovascular examination, S1 and S2 were normal. Pan-systolic murmur was heard, loudest. On respiratory examination bilateral coarse crepts also present. Chest X-ray report shows consolidation in both lungs at basal fields and liver was not palpable. 2D Echo reveals double outlet right ventricle, TOF, straddling of tricuspid valve, and mild-to-moderate hypo-plastic left ventricle. During the treatment course, the patient oxygen saturation was reduced day-by-day from 70% to 35%.

Gradually, the patient condition became worsening and dobutamine infusion of 1.35cc was given on days 18 and 19. The patient passed away on day 20 without undergoing surgical intervention.

DISCUSSION

This is a case of an infant with TOF and bronchopneumonia. In general, the diagnosis and clinical management of TOF requires multidisciplinary team that includes a pediatrician, pediatric cardiologist, cardiac surgeon, radiologist, and pharmacist. However, most of the children with TOF need surgery, but timings may vary depending on the condition and severity [13]. This patient undergone symptomatic therapy for TOF and hyper-cyanotic spells since 10 months and patient passed away at the age of 12 months. She does not undergo any intervention. There is 75% mortality rate for child with TOF without any intervention and 70% survival rate for child with TOF who undergone corrective surgery either in childhood or adulthood [13].

In US, infants born with TOF undergoes primary repair within 1st year of life and outcomes were good but after 20 years majority people need pulmonary valve replacement. Nowadays, percutaneous method of implanting pulmonary valve is available, in which child is free from symptoms but the long-term results were unknown. This is important to note that surgery for TOF is palliative but not curative [1]. This case

demonstrates the challenges faced by the child with cyanotic congenital heart disease without any intervention. Hence, this report concludes that there is a need to increase awareness of TOF so as to encourage early diagnosis and therefore promotes better outcomes. However, pharmacist also plays a role in management of TOF by reducing medication errors, drug-drug interaction, improvement of usage of guideline driven therapy, and promotes medication adherence [14].

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COMPETING INTERESTS

We declare that we have no competing interests.

AVAILABILITY OF DATA AND MATERIALS

This is a case report.

ETHICAL APPROVAL

Not required.

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Author Queries???

AQ1: Kindly provide history details

AQ2: Kindly cite figures 1-3 in the text part

AQ3: Kindly cite table 1 in the text part