

Case study

Effectual physiotherapy treatment in a 16 year old case of atrial septal defect- A single case study

ABSTRACT:

Background:

Pediatric cardiac surgeries have an immense survival rate and rehabilitation plays a major role in such cases. Many patients are diagnosed with septal defects or valvular defects at birth which come under cardiac surgeries.

Case presentation:

This is a case of 16 year old boy who had atrial septal defect and underwent atrial septal defect closure.

Investigations:

2D echocardiography revealed atrial septal defect.

Management:

Physiotherapy intervention included patient education, breathing retraining, airway clearance techniques, positioning, psychological support and mobility program. Outcome measures have shown enhancement in functional independence and performance of activities of daily living.

Conclusion:

The evidence from this study suggest that pediatric cardiac rehabilitation found to play a pivotal role in managing a patient who had atrial septal defect.

KEYWORDS: Atrial Septal Defect, Congenital Heart Defect, Physical rehabilitation,

INTRODUCTION:

A hole in the septum, the muscular wall that differentiates the heart's two upper chambers, is identified as an atrial septal defect (ASD) (atria). An ASD is a birth defect (congenital defect) that occurs when the septum does not form properly. It is commonly referred to as a "hole in the heart." Atrial septal deformities are common congenital heart defects labelled by inadequate or lacking tissue at the interatrial septum. The average age at diagnosis is more than four years old(1). Indications of ASD closure were all provided to very little faults, somewhat pulmonary hypertensively ASD, older patients and younger kids. The strength of the shunt, right ventricular (RV), volume, pulmonary arterial pressures and the presence of arrhythmias determines the ability for exercise in individuals with unrepaired ASDs(2).

25-30 percent of the new identified congenital heart abnormalities stay undiscovered until adulthood. Septal atrial failure Closure has become a well-established treatment for more and more adult patients(3). Early surgical reparations have great long-term effects, however the results are less favourable when the procedure is postponed until maturity. Even in patients older than 60 years, operating closure was linked with symptoms and potentially survival. In healthy individuals and persons with ischemic heart disease, the benefits of exercise have been established. Children with congenital heart disease are also urged to practise and be completely active following corrective intervention. Kids with congenital cardiac conditions undergoing corrective operations are encouraged to do a graduated rehabilitation programme for exercise(4). The condition was previously analogous to myocardial infarction sufferers. Clinicians considered it more conservative for these patients, for six weeks till thoracotomy

lesions were cured, to avoid strenuous physical exercise. Children were able to resume their previous activities after that period. Clinical investigations have showed that many infants who were operated by congenital cardiac disease have never been completely active. Children with successful cardiac disease repair are often less active than healthy classmates. Some youngsters may complain of tiredness early in a physical exercise, which can in many cases be linked to some decondition(5). Only a minority has a physical activity limitation. This case study focuses on tailor made rehabilitation program on a 16 year old patient diagnosed with atrial septal defect.

PATIENT INFORMATION:

A 16 year old male presented to the hospital with complain of breathlessness, vomiting along with cough after eating food and suffered usually from cough and cold. He also complained about dizziness and suffocation. He stated that he have not done any physical activity in his life. After walking 500 m he used to get breathlessness and fatigue. Consultation with a local doctor revealed a small atrial septal defect. After routine investigations and obtaining fitness from anaesthetist, surgery of ASD closure was carried out. Midline sternotomy approach was used. Patient was intubated during the procedure. The surgery was carried out successfully and patient was shifted to ICU with intubation. The patient was extubated the next day and physiotherapy rehabilitation was started.

Timeline-

Date of admission	10/10/2021
Date of surgery	14/10/2021
Date of physiotherapy referral	15/10/2021
Date of discharge	26/10/2021

Table 1 showing timeline of the patient from the day of admission till the day of discharge

CLINICAL FINDINGS:

Inspection showed that patient was conscious, in supine position, ECG leads present, mediastinal drain present, Foley's catheter was seen. The patient was on 6 litres of O₂ via face mask.

Systemic examination revealed pulse rate- 130 beats/min, blood pressure-130/90 mm Hg, SPO₂-98%, Respiratory Rate: - 36 breaths/min with regular rhythm and abdomino-thoracic type of breathing. Chest excursion was bilaterally decreased, **percussion** revealed bilateral dull note all over the lung fields and auscultation showed bilateral crepitations all over the lung fields.

Diagnostic assessment included 2D echocardiography which revealed small atrial septal defect and chest X-ray.

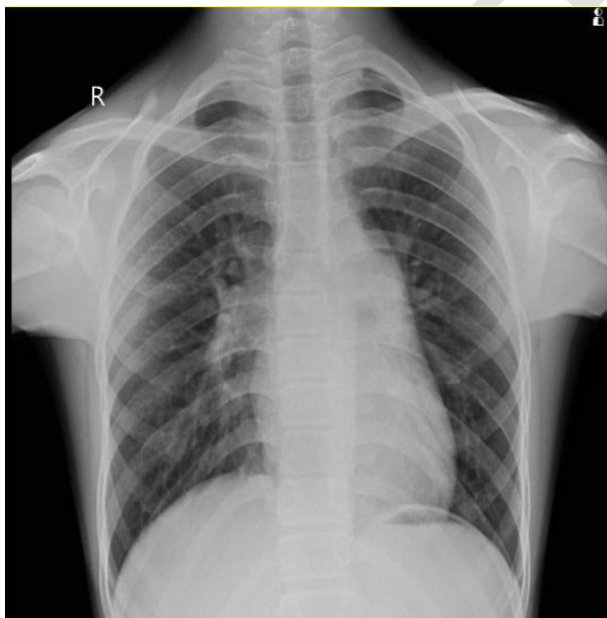


Figure 1- Pre-operative xray showing elongated heart and prominence of vascular zone in right lung

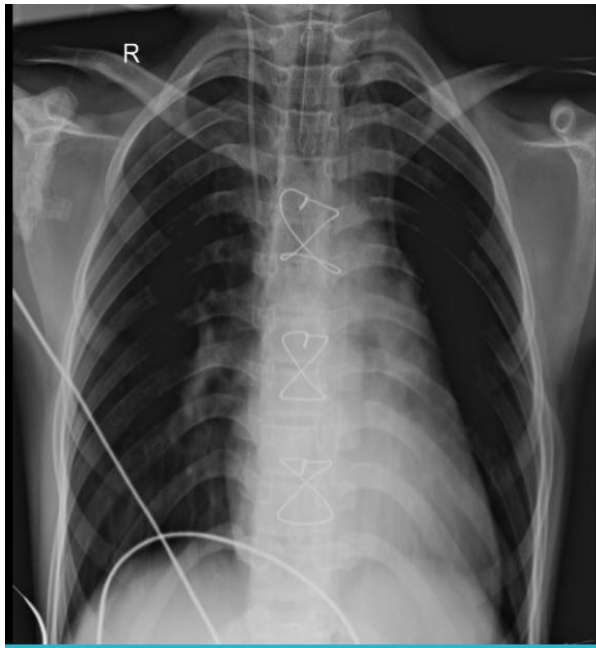


Figure 2-Post-operative xray showing presence of ET tube and mid sternal sutures

THERAPEUTIC INTERVENTION:

On reference to physiotherapy, patient and relative education was done first. Awareness about the need and benefits of rehabilitation after cardiac surgery was explained. Written consent was taken from the patient's relative. The patient's goal was to resume his daily life activities as soon as possible without assistance. Therapist's goal was to maintain the bronchial hygiene of the patient, targeted towards early mobilisation and improving the functional capacity.

In a paediatric cardiac operation, the risk of pulmonary complications (retention of the secretions, atelectasis, pneumonia) is reduced and those complications are treated in the pre- and postoperative period, as well to ensure that the appropriate ventilation and extorsion are carried out successfully.

Physiotherapy involves clearing and expansion method, abdominal support and instruction for parents or escorts, and patients capable of understanding such information, on the

significance and aims of intervention for physiotherapy. Vibration in the chest wall, percussion, compression, manual hyperinflation, manoeuvre of extension, placement, position drainage and cough stimulation], aspiration, respiratory exercising, mobility and incentive spirometer are the procedures utilised in post-operative physiotherapy. Few recent studies on the role of physiotherapy in the post-operative post-cardiac operation, especially those that deal with the efficacy of pre-operative physiotherapy to avoid pulmonary problems following cardiac operation.

OUTCOME MEASURES

Outcome measures used included ICU Mobility Scale, WHOQOL-BREF and spirometer which showed patient's improvement in the course of hospitalization.

SCALES	Day 1	Day 7
ICU mobility scale	0(lying on bed)	10(walking independently)
WHOQOL-BREF	66	80

Incentive Spirometer(lung capacity)	<600cc	900cc
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Table 2 showing scoring on ICU Mobility Scale, WHOQOL-BREF and Spirometer indicative of patient's improvement in the condition.

DISCUSSION

Cardiac rehabilitation is a tried-and-true treatment for people who have had heart surgery. The current single case study adds to the existing evidence on the efficacy of cardiac rehabilitation in improving the patient's overall condition. Outcome measures revealed an improvement in the patient's overall quality of life as well as lung capacity. Thus, tailored phase I cardiac rehabilitation can be used effectively in patients who have had valve replacement surgeries.

Children with cardiac problems are taught about proper physical exercise through heart rehabilitation programmes(6). The US Heart Association and the European Guidelines for Children with CHDs advocate physical exercise.(7). In particular, guidelines for physical exercise in children with CHDs underline the significance of a developmentally appropriate and pleasurable minimum of 60 minutes of daily activities. Chevrous activity is advised for a minimum of three days a week, and training is required three days a week to improve bone and muscle (e.g. high-impact and anaerobic bursting activities such as leaping)(8). Your involvement in high-intensity activities, particularly competition, may nonetheless be restricted by children with specific heart problems (e.g, transposition of major arteries or single ventricle disorders). The screening time for children under the age of 5 should be limited to 2 hours per day, and no display time for children under the age of 3 must be permitted(9).

CONCLUSION:

Findings of this study indicates that pediatric cardiac rehabilitation found to play a pivotal role in managing a patient who is diagnosed with atrial septal defect and undergone atrial septal defect closure ,which included breathing retraining and airway clearing techniques, mobility training. The pediatric cardiac rehabilitation program was extremely beneficial in terms of enhancing overall functional efficiency and improving quality of life.

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