of CKD stages, there was a statistically significant increase in the thickness of the heart walls and the size of the heart cavities.

We compared echocardiographic parameters of the heart in patients with different stages of CKD and the control group using the Scheffe's test. The patients with stage I CKD differed from the control group by slightly increased EchoCG indices, but the differences were not statistically significant ($p > 0.05$ for all parameters).

Of particular interest were the EchoCG parameters determined among patients with CKD stage III. They showed a significant increase in the thickness of left ventricular posterior wall ($p = 0.001$) and the left ventricle end-diastolic diameter ($p = 0.037$). Changes in the interventricular septum thickness, the size of the left atrium and the left ventricular systolic dimension were not statistically significant ($p > 0.05$).

Patients with CKD stage V differed in a statistically significant increase in the size of the left atrium, the thickness of left ventricular posterior wall and interventricular septum ($p < 0.001$) and a statistically significant increase left ventricular systolic and diastolic dimensions ($p < 0.05$).

The analysis showed that the left ventricular mass, left ventricular mass index significantly increased with the progression of CKD stages ($p < 0.001$). The left ventricular mass in patients with CKD stage V was significantly increased in 2,3 times in comparison with the control group.

Conclusions Structural-functional changes of the heart in children with CKD manifest left ventricular myocardial hypertrophy in the early stages and the addition of an increase in the left ventricular cavity in patients with CKD stage V.

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A CASE OF A STRANGE DYSPNEA

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10.1136/archdischild-2019-epa.404

Infantile hemangioma is the most common benign tumor of infancy, affecting 1–2% of infants. Hemangiomas of the airway constitute an even smaller percentage, but their management can be challenging due to the potential for life threatening airway compromise. A Subglottic hemangioma (SGH) makes up 1.5% of all congenital laryngeal anomalies, it is twice more common in females than males and have been linked to low birth weight and prematurity. It is during the early proliferative phase (1–3 months of life) that patients became symptomatic, developing characteristic stridor which may progress to respiratory distress. In this early stage, a SGH is often mistaken for a more common condition such as croup. The aim of this case is to underline what a recurrent dyspnea or laryngeal stridor in the first 6 months might hide.

Case report A 4 months-old-girl who was born at term of natural childbirth (birth weight 2.500 kg-SGA), presented with several weeks of unremitting stridor, substernal retractions. She was diagnosed to have bronchiolitis and she had been hospitalized twice in an another hospital and treated with oral steroids and nebulized racemic epinephrine without significant

improvement in her symptoms; Than she had been sent to our hospital. She had intercostal and subcostal retractions. Both lungs had equal contribution to respiration, respiratory sounds were coarse and she had both inspiratory and expiratory stridors which were more obvious on bilateral sibilant rales, and inspiratory phase. She also had wheezing. Laboratory tests, echocardiogram and electrocardiogram were normal. Her follow-up showed that she was not responding to treatment and her respiratory distress was increasing, thus she had a laryngofibroscopy that did not reveal any clear structural abnormalities, and performed a CT scan of the neck, that revealed a laryngeal mass, confirmed by an MRI of the neck, which showed a solid tissues of low intensity on T1-weighted spin-echo images and of hyperintensity on T2-weighted spin-echo images (6x8 mm), compatible with SGH. After her workup was complete, she received an initial dose of propranolol at 0.5 mg/kg, which was increased to 2 mg/kg, and no adverse effects were noted. SGH is a rare but potentially life-threatening disease. A high index of suspicion is vital for the early, accurate diagnosis of this disease. Propranolol treatment has many advantages, it is non-invasive and it has a low complication rate; thus, the use of propranolol as a first-line treatment for SGH is proposed.

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OUTCOMES OF ATRIOVENTRICULAR VALVE REGURGITATION IN PATIENTS WHO HAD ATRIOVENTRICULAR SEPTAL DEFECT REPAIR SURGERY

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10.1136/archdischild-2019-epa.405

Aim Left atrioventricular (AV) valve regurgitation is the most serious residual lesion after surgical correction of atrioventricular septal defect (AVSD). Despite improvements in surgical techniques, left AV valve regurgitation continues to be the most serious problem after surgery. In this study, it was aimed to investigate the risk factors of the left AV valve regurgitation by evaluating clinical and echocardiographic findings of patients with AVSD, retrospectively.

Material and methods In this study, 78 patients were enrolled. Preoperative echocardiographic findings, operation data, postoperative echocardiography findings were recorded.

Results Fifteen patients (19%) were partial, 26 patients (33%) were intermediate and 37 patients (47%) were complete type. Forty-seven patients (60.3%) were female and 25 patients (32%) had Down's syndrome. The median age at diagnosis was 6 months ranged from one day to 12 years. The median age at operation was 10 months (3–180 months) and the median weight at operation was 6.8 kg (4–49 kg). The total follow-up was a median of 103 months (28 days–268 months). In patients with partial AVSD, there was no significant difference in left AV valve regurgitation in the first, postoperative and last echocardiography ($p > 0.05$). In patients with intermediate and complete AVSD, left AV valve regurgitation was higher in the final echocardiography than in the first echocardiography ($p = 0.007$ and $p = 0.01$, respectively). According to the univariate analysis; age, gender, the presence of Down syndrome, operation type, annuloplasty, and pulmonary hypertension were not associated with moderate or severe left AV regurgitation after surgical repair ($p > 0.05$). Left AV valve

regurgitation in the first echocardiographic examination was found to be the only predictor of left AV valve regurgitation in the last echocardiographic examination ($p=0.001$). There was only one patient who was reoperated for severe left AV valve regurgitation.

Conclusion The most important postoperative problem in patients with AVSD is left AV valve regurgitation. Left AV valve regurgitation in the first echocardiographic examination was found as a potential risk factor on left AV valve regurgitation.

P51 UNUSUAL EARLY CLINICAL MANIFESTATION OF BLAND – WHITE – GARLAND SYNDROME IN A NEONATE

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10.1136/archdischild-2019-epa.406

This case report describes a 24-day-old neonate who was admitted at our hospital because of tachypnoea, tachycardia, failure to thrive, and breastfeeding fatigue.

He was a late preterm newborn; born at 36th week of gestation with normal Apgar score. He manifested increased effort of breathing few hours after birth, while initially being treated for respiratory distress syndrome via High-Flow-Nasal-Cannula (HFNC) with 40% of inspired oxygen supplementation for 10 days. Because of persistent tachydisпноea and feeding difficulties in maternity, hospital antimicrobial treatment was initiated unsuccessfully. Afterwards, he has been misdiagnosed with a coronary fistula and sent to our hospital. Systolic murmur was noticed. ECG showed typical changes for the left heart ischemia – antero-septal ischemia with negative T-wave V1-V2, aVL and DII-DIII. There were no signs of cardiogenic shock. Our ECHO revealed moderately dilated left ventricle with slightly depressed systolic function, increased echogenicity of the papillary muscles, and mild mitral regurgitation. The dilatation of right coronary artery was also shown, but the left coronary artery was not visible. The diagnosis of Bland-White-Garland syndrome was set.

The day after, he underwent cardiac catheterization when the diagnosis of anomalous origin of the left coronary artery from the pulmonary artery (ALCAPA syndrome) was confirmed. Few days later, Takeuchi procedure was performed as the method of repair. There were no major complications postoperatively. In the follow-up period he progressed favorably and now he is asymptomatic, but still has abnormal ECG. ECHO has shown significant supravulvar pulmonary stenosis.

Discussion ALCAPA is usually presented with signs of myocardial ischemia and dilated cardiomyopathy between the ages of two months throughout the adult period. The management of respiratory distress in the preterm newborn infant with oxygen supplementation had detrimental effect on myocardial perfusion and caused decrease in PVR with early presentation of DCM. This case emphasizes the importance of identifying the coronary origins as a routine part of a complete pediatric echocardiogram.

P52 EVALUATION OF COMPLEMENTARY CARDIOLOGICAL TESTS IN PEDIATRIC PATIENTS WITH SYNCOPE

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10.1136/archdischild-2019-epa.407

Syncope most frequent etiopathogenic mechanism in children is Vasovagal, which is produced by decreased cerebral blood flow, and stimulation of the mechanoreceptors of the left ventricle in the context of relative central hypovolemia that causes vigorous ventricular contraction and exaggerated reflex vagal response with hypotension, bradycardia and syncope.

Objective Analyze cardiac structure and function in pediatric patients with clinical syncope.

408 cases of patients who have consulted the Pediatric Cardiology service of the Hospital de Nens de Barcelona, from March 2013 to March 2018, with syncope, between 5 to 18 years old. To establish the discard of cardiopathy or associated vascular pathology, studies were carried out such as: electrocardiography, transthoracic echocardiography, Rhythm Holter and Ergometry with moving tape (stress test). 203 masculine, 205 female patients; single test average age: 11.2 years, 95% Confidence Index (CI): 10.8 - 11.2. Heart rates (HR) showed progressive decrease, with greater fall between 0 - 7 years, both average and minimum; mean HR: 85.34 (95% CI: 84.2 - 86.494); and mean minimum HR: 49.1 (95% CI: 48.2 - 49.9). In the Pearson Correlation Analysis, negative results were evidenced for mean and minimum HR, for age: maximum HR: -0.291'; average HR: -0.586' and minimum HR: -0.452'; and sex: maximum HR: 0.022; average HR: 0.129' and minimum: 0.0184'. In Rhythm Holter: 79.7% of patients (n=325) had normal results; 6.1% (n=25): second-degree atrioventricular block type 1; 5.4% (n=22) supraventricular extrasystoles; 4.4% (n=18) ventricular extrasystoles; 2.5% (n=10) first degree atrioventricular block; 0.5% (n=2) sinus bradycardia; 0.5% (n=2) second degree atrioventricular block type 2; 0.4% (n=2) Wolf Parkinson's White syndrome. All patients had normal anatomical and functional cardiac evaluations, except 1 patient (0.2%): severe systolic and diastolic dysfunction FE: 49%, second-degree auto-ventricular block type 2 II grade 2, and highly impaired ergometry: HR under maximum: 50%, syncope with any movement. Ergometry: 406 patients obtained normal results, maximum heart rates - 87.7% average of 100% calculated per patient (95% CI 87.2 - 88.3). Mets obtained - single test average: 13.7 IC (13.4 - 14.0). 2 patients with less than 80% maximum heart rate, due to dyspnea due to physical exertion, presented normal echocardiography and altered rhythm Holter with diagnoses of second degree atrioventricular block type II.

Conclusions Most of the patients analyzed with rhythm Holter, echocardiography and ergometry, did not present diagnoses related to syncopal symptoms. Only 1 patient with syncope (0.2%): severe diastolic and systolic dysfunction, second-degree atrioventricular block type 2 II grade 2, and highly altered ergometry.