measured 2 hours after the initiation of intravenous PGE1 were slightly increased compared to levels before initiation of intravenous PGE1 (p<0.05).

Discussion Although intravenous PGE1 is more effective than oral PGE1 in short term usage, oral PGE1 is also sufficiently effective in keeping the ductus open. For this reason until the intravenous PGE1 is supplied oral PGE1 may be used as an alternative treatment choice. We think that in long term use oral PGE1, which is cheaper and easy to use, could be used instead of intravenous PGE1 without need of admission to hospital and opening intravenous line.

Background and Aim of study Frequently in low-birth-weight infants, ductus arteriosus fails to close spontaneously. This study evaluates the results of surgical ligation of symptomatic PDA in low birth weights preterms.

Methods We reviewed the medical records of all infants undergoing surgical closure of PDA from 2000 to 2010. Demographic data, weight at operation, respiratory assistance pre-operative, surgical technique to close PDA and outcome were analyzed.

Results Thirty infants underwent surgical closure of PDA in which either indomethacin or ibuprofen treatment had failed or was contraindicated. The mean GA was 27 and the mean birth weight was 752 g. The average weight at operation was 790.5 g. PDA was surgically closed by left thoracotomy using hemoclips.

Postoperative complication occurred in 4 patients, which included intraoperative bleeding (1), pneumothorax (1), lymphatic leak (2). No vocal cord paralysis nor diaphragmatic paralysis were observed. We also registered outcomes related to PDA: broncodelia (2). No vocal cord paralysis nor diaphragmatic paralysis were measured 2 hours after the initiation of intravenous PGE1.

Conclusion We conclude that surgical closure of hemodynamically significant PDA is safe and effective in preterm low birth weights infants when pharmacological treatment is ineffective or contraindicated. The associated morbidity is minimal and no surgery-related mortality was observed.

Severe congenital heart defects might be symptom free in first days of life. Therefore only half of the congenital heart defects were diagnosed in neonatal period.

In six years period, 86 neonates with the diagnosis of cyanotic congenital heart defects out of 5672 neonates hospitalized in our unit were evaluated. Neonates with the diagnosis of Down syndrome, trisomies and major congenital defects other than heart were excluded from the evaluation. Mean gestational weeks and birth weights of the neonates were 39, 3 (35–40) week and 3128 g respectively. The most common pathology of the heart defects was transposition of great arteries (TCA) in 31 neonates (%36) and the second common pathology was pulmonary atresia in 17 neonates (%19.8). Four of the 31 neonates with TGA had arterial switch operation and four of them had septostomy procedure, while 23 did not need any invasive procedure. Fourteen of 17 neonates with pulmonary atresia had central or peripheral shunt operations. 51, 2% of the neonates were discharged while 12.8% of them were discharged due to request of the family. Three of the neonates who had arterial switch operation and 11 neonates who had shunt operation were discharged.

Early recognition of infants with congenital heart disease that has high mortality and morbidity in neonatal period and implementation of early intervention in patients with ductus-dependent heart defects was considered to have a positive effect on prognosis.
Results A total of 58 babies were identified with 64 episodes of medical treatment for PDA with Indomethacin or Ibuprofen. Mean gestational age was 25.5 weeks and birth weight of 737.1 grams. Mean age at treatment was 26.7 weeks with pre-treatment PDA size of 1.5–6 mm and platelet count of 34–602 x10^9/L.

Mean age at treatment was 26.7 weeks with pre-treatment PDA gestational age was 25.5 weeks and birth weight of 737.1 grams.

PAR1 and PAR2 have been shown to be involved in regulating vascular tone. Thrombin activates PAR1, whereas trypsin activates PAR1 and PAR2. Our aim was to evaluate the functional presence of PAR1 and PAR2 in the ductus arteriosus (DA).

Background and Aims PARs belong to a family of G protein-coupled receptors, thus mediating the cellular effects of proteinases. PAR1 and PAR2 have been shown to be involved in regulating vascular tone. Thrombin activates PAR1, whereas trypsin activates PAR1 and PAR2. Our aim was to evaluate the functional presence of PAR1 and PAR2 in the ductus arteriosus (DA).

Methods We investigated, using wire myography, the mechanical responses induced by thrombin (0.1 to 3 U/mL), trypsin (0.1 to 30 U/mL), the PAR1-activating peptide TFLLR-NH2 (1 to 100 µmol/L) and the PAR2-activating peptide SLIGRL-NH2 (0.1 to 10 µmol/L) in DA rings from 15-, 19-, and 21-d-old chicken embryos.

Results Thrombin, trypsin, and TFLLR-NH2, all caused concentration-dependent contraction of the pulmonary side of chicken DA. These contractions were not observed in the aortic side of the DA, in the femoral artery or in the pulmonary artery. Thrombin-, trypsin- and TFLLR-NH2-induced contractions were endothelium-independent but markedly impaired by the elimination of calcium from the external medium. The contraction evoked by thrombin and trypsin increased between day 15 and 19 of incubation and was not affected by oxygen tension. SLIGRL-NH2 (≥10 µmol/L), evoked endothelium-dependent relaxation of the DA.

Conclusions PARs are functionally present in the chicken DA but not in other vascular tissues. Recent studies demonstrate that loss of platelet number or function leads to defective DA closure. We speculate that the role of platelets in DA closure might be partially mediated through the PAR-mediated vasoactive effects of thrombin.

### Abstracts

**ANTENATAL VS POSTNATAL DETECTION OF MAJOR CONGENITAL HEART DISEASE IN A LARGE DISTRICT-GENERAL HOSPITAL IN UK: A SIX-YEAR REVIEW**

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**Background and Aims** Major congenital heart disease (CHD) is defined as CHD that needs operative or catheter based intervention in the first year of life. National institute of clinical excellence (NICE) in March 2008 recommended screening of outflow-tracts in addition to four-chamber view as part of the anomaly scan to improve CHD detection rates. We aimed to examine the clinical spectrum of antenatally and postnatally diagnosed major CHD in our institute pre- and post-introduction of NICE guideline.

**Methods** This is a retrospective review over six years from Jan 2006 to Dec 2011. Data was obtained from antenatal records, patient’s clinical and electronic records.

**Results** A total of 74 babies had major CHD diagnosed out of which 37 (50%) were diagnosed antenatally. Antenatal diagnosis pre-and post- NICE guidelines were 12/29 (41%) and 25/45 (55%) respectively as also termination of pregnancies with critical CHD was 5 months.

**Conclusions** Success of PDA closure after medical treatment was not related to the platelet counts in our study group.