Background and aims Nasal high frequency oscillation ventilation (nHFOV) is a non-invasive ventilation mode that applies an oscillatory pressure waveform to the airways using a nasal interface. NHFOV has been shown to facilitate carbon dioxide expiration, but there is little data about its use in neonates. Therefore, the aim of this study was to collect data about nHFOV use in neonatal intensive care units (NICUs).

Methods From June 2013 to February 2014, we conducted a prospective survey in Austria, Switzerland, Germany, the Netherlands and Sweden. A 26-item questionnaire was sent to NICUs who provide the highest level of care. We asked for indications to start nHFOV, equipment used, nHFOV settings and observed side effects.

Results Of all contacted NICUs, 172/186 (92%) participated. Among those responding, 30/172 (17%) used nHFOV, most frequently in premature infants. O₂, the maximum pressure 10[7–18] cm H₂O, and pressure before switching to nCPAP 7.5[5–15] cm H₂O. The typical nHFOV frequency was 10[6–13] Hz. Abdominal distension (11/30), highly viscous secretions (7/68) and upper airway obstruction due to such secretions (8/30) were the most common nHFOV side effects.

Conclusion Based on individual experience, a number of European NICUs use nHFOV. There are substantial differences in nHFOV equipment, indications and settings. New clinical studies are needed to further investigate the risks and benefits of nHFOV in neonates.
examination, being replaced by type 3 appearance in 29 patients at 24 h of age. In the case of the 4 patients that were ventilated, the type 1 appearance evaluated at type 2 after 48 h of ventilation and at type 3 by 72 h. They were extubated successfully at a mean age of 75 h.

Conclusions Type 1 pulmonary ultrasound appearance correlated with the presence of the respiratory distress and the need for mechanical ventilation. The pulmonary ultrasound appearance improved with the favourable evolution of the patient and the normal ultrasound anticipated the extubation. Pulmonary ultrasound could be used as an aid in the evaluation of the respiratory distress of the term and near term neonates.

PS-178 EVOLUTION OF PULMONARY FUNCTION IN PRETERM INFANTS: A PROSPECTIVE BIRTH COHORT

QL Liao, 2SH Lai, 2YC Yao, 1MH Tsai, 1MC Hua, 1KW Yeh, 2J Huang. 1Pediatrics, Chang Gung Memorial Hospital, Keelung City, Taiwan; 2Pediatrics, Chang Gung Memorial Hospital, Taoyuan County, Taiwan

Background With advanced pre- and post-natal care, the survival rate of extreme preterm infants has increased significantly. As a result, the incidence of respiratory morbidity and complications has also risen and should require further apprehension during follow up of these premature infants as they grow. Due to the lack of facility and normal reference values for lung function tests in the infant population, data for preterm infants in Taiwan are virtually non-existent. In this study, we investigated respiratory function in preterm and term infants until the age of 18 months. The evolution of longitudinal pulmonary function changes were also investigated.

Materials and methods During the period of October of 2012 to September of 2013, infants with informed consent were enrolled in our birth cohort study. After sedation, respiratory function tests were performed by using JAEGER MasterScreen Paediatric, which obtained measurements for the tidal breathing, passive respiratory mechanism, and forced tidal expiration. Tests were measured in preterm infants at corrected ages of 6, 12, and 18 months and term infants at similar age points.

Results Respiratory function exams were performed in 56 term and 20 preterm infants. Several parameters of the tidal breathing were found to be significantly different between term and preterm infants in the same chorological age. Increased airway resistance and reduced lung compliance were observed in the preterm babies when compared to term infants. Values of maximal expiratory flow at functional residual capacity in preterm infants were also significantly lower than those of term infants.

Discussion Premature babies are known to pose a higher risk for pulmonary developmental anomaly. As shown in our study, most preterm infants demonstrated poor performance in several respiratory function exams despite appearing clinically asymptomatic. With the newly developed technique for measuring forced expiratory flows from raised lung volumes in young infants, it is now possible to better understand the natural history and pathophysiology of young infants who were born prematurely. Additionally, the use of pulmonary function test as a clinical diagnostic tool for diseases such as bronchopulmonary dysplasia will be highly predictive and serves as the primary outcome measures.