ID 451 - RESPONSE TO INHALED NITRIC OXIDE IN CONGENITAL DIAPHRAGMATIC HERNIA: A PREDICTOR OF SURVIVAL

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Background
Infants with congenital diaphragmatic hernia (CDH) are at risk of developing pulmonary hypertension due to abnormal pulmonary vasculature and pulmonary hypoplasia. A Cochrane review concluded inhaled nitric oxide (iNO) is an effective therapy in near term and term infants with hypoxic respiratory failure, but not in those with CDH. We aimed to review the response of iNO in infants with CDH and whether this predicted outcome.

Methods
A retrospective review of the medical records of infants with CDH over a ten year period (2011-2020) was conducted in a tertiary surgical neonatal unit. Blood gases prior to and 30-60 minutes after initiation of iNO were analysed. The partial pressure of oxygen (PaO₂), fraction of inspired oxygen (FiO₂) and mean airway pressure (MAP) were recorded and PaO₂/FiO₂ ratios and oxygenation indices (OI) were calculated. The percentage change in PaO₂/FiO₂ ratio and OI after initiation of iNO was estimated and whether it predicted survival or the need for extracorporeal membrane oxygenation (ECMO) was determined. We also examined whether antenatal intervention of fetoscopic endotracheal balloon occlusion (FETO) affected the response to iNO.

Results
Over the ten year period, 105 infants with CDH were admitted and 72 (68.6%) infants received iNO. Sixty-four infants were included in the study and eight were excluded as the medical records were unavailable or the infants had associated major cardiac anomalies. Forty-one (64.1%) infants died, four (6.3%) infants required ECMO and twenty-one (43.5%) had FETO antenatally. Overall, the PaO₂/FiO₂ ratio improved after initiation of iNO (58 vs 46.6, p:0.002) mm Hg while the OI remained unchanged (28.7 vs 28.6, p:0.21). Infants who survived had higher percentage increase in PaO₂/FiO₂ ratio after iNO initiation (89% vs 11% p:0.018). A percentage increase in PaO₂/FiO₂ ratio of 25% predicted survival with a sensitivity of 73% and specificity of 61%. FETO did not affect the iNO response.

Conclusion
iNO can improve oxygenation in infants with CDH and response to iNO can predict survival in these infants.

None declared
Background

Palivizumab is a monoclonal antibody that reduces the likelihood of serious respiratory tract infection by Respiratory Syncytial Virus (RSV) in infants with Chronic Lung Disease (CLD) defined as an ongoing oxygen requirement at 36 weeks corrected gestation. In the United Kingdom (UK), Palivizumab is offered to high-risk infants with moderate to severe CLD according to their chronological age at the time of RSV season as per Joint Committee on Vaccination and Immunisation (JCVI) guidelines. The American Academy of Pediatrics, in contrast, recommends Palivizumab prophylaxis for all infants born before 29 weeks’ gestation who are younger than 12 months at the start of the RSV season.

Methods

We hypothesised that the RSV hospitalisation rate and length of hospital stay (LOS) within the 1st year of life between preterm babies with CLD discharged in home oxygen immunised according to the JCVI criteria (CLDJCVI) and the additional babies who are considered eligible by the AAP criteria would be comparable. Our cohort included babies born in Nottingham UK between 2009 and 2019. Data was collected from hospital records and the Nottingham CLD database, and analysed using Fisher’s exact test for proportions and Mann-Whitney test for continuous data.

Results

In total there were 5561 babies born preterm at <36 weeks GA in Nottingham UK from 2009 to 2019. 804 babies were born in Nottingham at <29 weeks GA. 300 babies had CLD at 36 weeks corrected GA and 213 of these babies were eligible for Palivizumab (JCVI). Please see attached table for further results.

Conclusion

The RSV hospitalization rate and LOS were not statistically different in babies under JCVI criteria and additional babies qualifying by AAP criteria. A larger multi-centre prospective study is required to prove health and economic benefits of adopting AAP Palivizumab recommendations.

<table>
<thead>
<tr>
<th>Number of babies</th>
<th>Babies immunised according to JCVI criteria</th>
<th>Additional babies who would be eligible by AAP criteria</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>213</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>Confirmed RSV hospitalisations following discharge from neonatal unit within 1st year of life</td>
<td>20 (9.39%)</td>
<td>19 (7.6%)</td>
<td>0.62</td>
</tr>
<tr>
<td>Average LOS in days (IQR)</td>
<td>12.05 days</td>
<td>6.63 days</td>
<td>0.139</td>
</tr>
</tbody>
</table>

Results table
None declared
BACKGROUND
Oxygenation instability is common among premature infants in the first weeks of life, and is associated with adverse outcomes. Objective assessment of oxygenation instability is challenging in clinical care. This study aims to evaluate a classification tool of oxygen saturation (SpO2) histograms to describe the effect of doxapram, a respiratory stimulant, on oxygenation instability in premature infants with severe apnea of prematurity.

METHODS
Sixty-one premature infants [median (IQR) GA 26.1 (24.9–26.7) weeks, birthweight 750 (650–910) gr] who received doxapram therapy during their NICU hospitalization (Erasmus MC–Sophia Children’s Hospital) were included in this observational study. SpO2 histograms were generated over the 24-hour period before and after doxapram initiation. An SpO2 histogram classification system was used to quantify SpO2 instability in each histogram, based on the histogram distribution and time spent in SpO2≤80% (Figure 1). Histogram types of 1-2 were classified as stable, and type 3-5 as unstable. Therapy "response" was defined as a drop by one or more histogram types after therapy initiation, and therapy "success" as no need for intubation within the first 72 hours of therapy.

RESULTS
The median (IQR) histogram type dropped significantly from type 4 (3-4) prior to therapy start to type 3 (2-3) after therapy start (p<0.001), while the median FiO2 remained stable. 35/49 (71%) of infants with an unstable histogram before therapy start responded to doxapram in the first 24 hours, compared to 1/12 (8%) of infants with a stable histogram type (p<0.001). Therapy success was observed among 34/36 (94%) of infants who responded to therapy in the first 24-hours, vs. 15/25 (60%) among non-responders (p=0.002), with an overall intubation rate of 11/36 (31%) among responders and 15/25 (60%) among non-responders (p=0.03). The PPV and NPV of 24-hours response in predicting therapy success was 0.46 and 0.94, respectively.

CONCLUSION
Classification of SpO2 histograms was found to be a useful bedside tool to quantify oxygenation instability in response to doxapram therapy. SpO2 histograms allow for clear, bedside evaluation of the oxygenation status of premature infants, making it possible to track and document the changes in oxygenation instability in response to different interventions.
Figure 1. An example of a change in saturation histogram type 4 to type 3 in the 24 hours before and after therapy initiation.

None declared.
BACKGROUND:
Diaphragm ultrasound (DU), mainly shortening fraction, has been used to predict extubation failure and dia phragm disfunction in adults and children. However it has been poorly studied in preterm infants.

METHODS:
We conducted an observational study including preterm infants born before 32 weeks (PT32w), with DU since birth and weekly until 36 weeks' postmenstrual age (PMA) or discharge, which happened first. We excluded infants with major malformations or chromosomopathies. We measured diaphragm inspiratory and expiratory thickness (DIT and DET) and shortening fraction (DSF) in the apposition zone of the left side of the thorax. Patients were divided in four groups according to birth weight: group 1 (<750g), group 2 (751-1000g), group 3 (1001-1500g), group 4 (>1500g). We compared DIT, DET and SF between groups using ANOVA, and we also calculated a multilevel mixed-effects regression model to predict the three measures' evolution on time, as they were different exams in the same patient. We also analyzed if bronchopulmonary dysplasia (BPD) diagnosis was related with DIT, DET or DSF evolution in these patients.

RESULTS:
One hundred and eighteen patients were included: 26 (22%) in group 1, 27 (23%) in group 2, 54 (46%) in group 3 and 11 (9%) in group 4. We found significant differences between groups in GID at birth(p=0.001), at one(p=0.03), two(p<0.001), three(p=0.02), four(p=0.007), and six weeks(p=0.03). GED were also different at the same time points, except for six weeks (p<0.001, p<0.001, p=0.007, p=0.01, p=0.02). Birth weight was the only variable related to DIT and DET change on time according to multilevel mixed-effects (p<0.001 for both), with a similar linear increase in all groups (see figure 1). BPD diagnosis was not a variable that modified diaphragm growth in this sample. On the other hand, DSF remained equal throughout the duration of the study in all groups.

CONCLUSION:
DIT and DET increase in all PT32w since birth until 36 weeks' PMA or discharge. BPD diagnosis don't affect DIT/DET evolution. DSF did not changed since birth until 36 weeks' PMA or discharge.

Predicted diaphragm inspiratory and expiratory thickness (DIT and DET) on time according to birth weight. None declared
ID 459 - COMPARISON OF RSV HOSPITALISATION IN PRETERM INFANTS WITH CHRONIC LUNG DISEASE WHO DO NOT QUALIFY FOR PALIVIZUMAB PROPHYLAXIS WITH THOSE WHO QUALIFY IN NOTTINGHAM, UK.

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1Nottingham University Hospitals, Nottingham, United Kingdom

Background
Palivizumab prophylaxis reduces the likelihood of serious respiratory tract infection by Respiratory Syncytial Virus (RSV) in ex-preterm infants with Chronic Lung Disease (CLD). The Nottingham CLD service follows the Joint Committee on Vaccination and Immunisation (JCVI) guidelines for Palivizumab prophylaxis based on gestation, respiratory status and chronological age at the beginning of RSV season. This retrospective observational study was conducted to compare the RSV hospitalisations in preterm infants with CLD who are offered Palivizumab to those with milder CLD.

Methods
We hypothesised that the RSV hospitalisation rate and length of hospital stay (LOS) within the 1st year of life between preterm babies in home oxygen with CLD immunised according to the JCVI criteria and babies with moderate CLD not discharged in home oxygen would be comparable. Our cohort included babies born in Nottingham UK between 2009 and 2019. Data was collected from hospital records and the Nottingham CLD database, and analysed using Fisher’s exact test for proportions and Mann-Whitney test for continuous data.

Results
In total there were 5561 babies born preterm (<36 weeks GA) in Nottingham UK from 2009 to 2019. 369 babies had CLD at 36 weeks corrected GA. 300 of these babies were discharged in Home Oxygen and 213 of these babies were eligible for Palivizumab (JCVI). Further results are in the attached table.

Conclusion
The RSV hospitalization rate was lower in preterm infants who did not qualify for Palivizumab compared to infants who qualified according to JCVI guideline but this difference was not statistically significant. A large prospective multi-centre study is required to ascertain the clinical and economic benefits of including the wider group for Palivizumab prophylaxis.

<table>
<thead>
<tr>
<th>Number of babies</th>
<th>Babies immunised according to JCVI criteria</th>
<th>Babies with CLD not discharged in Oxygen that would be eligible</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>213</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Confirmed RSV hospitalisations following discharge from neonatal unit within 1st year of life</td>
<td>20 (9.39%)</td>
<td>4 (5.8%)</td>
<td>0.46</td>
</tr>
<tr>
<td>Average LOS in days (IQR)</td>
<td>12.05 days</td>
<td>6.75 days</td>
<td></td>
</tr>
</tbody>
</table>

Results Table
None declared
ID 542 - CERVICAL BIOIMPEDANCE AND CERVICAL AND DIAPHRAGMATIC EMG DURING APNEA AND SPONTANEOUS BREATHING

Marie-Louise Herrmann1, Prof. Ulrich Herbert Thome1, Prof. Andreas W Flemmer2, Doctor Mathias Klemme2, Doctor Tobias Reicherzer2, Cilia Frank2, Dirk Bergholz2, Holger Nahrstaedt4, Wolfgang Braun3, Doctor Benjamin Ackermann1

1University Of Leipzig, Leipzig, Germany, 2Ludwig-Maximilians University Munich, Munich, Germany, 3Fritz Stephan GmbH, Gackenbach, Germany, 4Hasomed, Magdeburg, Germany

Introduction:
The differentiation of central and obstructive apnea in preterm infants is required to apply respiratory support correctly. Cervical bioimpedance, as well as cervical and diaphragmatic EMG, might help to better identify apnea features in preterm infants.

Methods:
A prospective observational study was performed on stable preterm infants with recurrent apnea. Spontaneous breathing was continuously recorded for four hours in each patient; Surface signals of respiration were detected by a Graseby capsule, and respiratory inductance plethysmography (RIP-bands) and verified by reviewing a video recording of the infant. In addition, cervical bioimpedance, as well as cervical and diaphragmatic EMG, were recorded over time. Absolute and relative signal variations of cervical bioimpedance and diaphragmatic and cervical EMG were analyzed during spontaneous breathing and apnea. Values are presented as median and interquartile range or range, as feasible; statistical significance was tested by Mann-Whitney-U-Test.

Results:
We examined 7 preterm infants (2 female, 5 male) with a gestational age of 26+0 weeks (23+3–27+0), birth weight of 885g (445–1090g), and a median age at examination of 19d (12–40d). Across all infants, we recorded a total of 27.75hrs, 2.25h were excluded before analysis because of handling of the children or misaligned video recording. Of the analyzable time segments, 8.25hrs (29.6%) were excluded due to moving artefacts and 2hrs (6.9%) due to oral movements. Spontaneous breathing was recorded during 12.25hrs (44.5%); and apnea during 3hrs (10.8%; 1952 episodes). During apneic episodes, raw values and relative changes of cervical bioimpedance, as well as cervical and diaphragmatic EMG were analyzed during spontaneous breathing and apnea. Values are presented as median and interquartile range or range, as feasible; statistical significance was tested by Mann-Whitney-U-Test.

Conclusion:
The relative changes of cervical bioimpedance, as well as diaphragmatic and cervical EMG, as a monitor of muscle activity, may be a new approach to detect apnea characteristics in preterm infants with and without non-invasive respiratory support.
<table>
<thead>
<tr>
<th></th>
<th>spontaneous breathing Median (IQR)</th>
<th>apnea Median (IQR)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>episodes [n]</td>
<td>3502</td>
<td>1952</td>
<td></td>
</tr>
<tr>
<td>duration [s]</td>
<td>7.9 (3.9–15.8)</td>
<td>5.0 (3.0–7.2)</td>
<td></td>
</tr>
<tr>
<td>total duration[h/min]</td>
<td>12h 14min</td>
<td>3h 1min</td>
<td></td>
</tr>
<tr>
<td>Bioimpedance raw [Ω]</td>
<td>55.54 (39,38–67.69)</td>
<td>52.1905 (40.31–60.86)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>derivation [Ωs]</td>
<td>0.080 (0.039–0.157)</td>
<td>0.065 (0.028–0.134)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Cervical EMG raw [µV]</td>
<td>2.62 (0.83–8.74)</td>
<td>8.13 (1.39–9.06)</td>
<td></td>
</tr>
<tr>
<td>derivation [µV]</td>
<td>0.485 (0.015–0.159)</td>
<td>0.090 (0.025–0.239)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diaphragmatic EMG raw [µV]</td>
<td>5.99 (4.33–7.65)</td>
<td>5.83 (4.46–7.81)</td>
<td></td>
</tr>
<tr>
<td>derivation [µV]</td>
<td>0.759 (0.032–0.153)</td>
<td>0.051 (0.019–0.143)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Raw and relative changes of cervical bioimpedance, as well as cervical and diaphragmatic EMG, during spontaneous breathing and apnea.

This study was supported by a research grant by the Bundesministerium für Bildung und Forschung (BMBF; German Federal Ministry of Education and Research)
ID 70 - OXYGEN SATURATION INDEX IN NEONATES WITH A CONGENITAL DIAPHRAGMATIC HERNIA: A RETROSPECTIVE COHORT STUDY

Drs. Denise Horn-Oudshoorn¹, Dr. Marijn Vermeulen¹, Dr. Kelly Crossley², Dr. Suzan Cochius-den Otter¹, Dr. Marco Schnater¹, Prof. dr. Irwin Reiss¹, Dr. Philip DeKoninck¹
¹Erasmus MC University Medical Center, Rotterdam, The Netherlands, ²Hudson Institute for Medical Research, Monash University, Melbourne, Australia

BACKGROUND:
The oxygenation index (OI) is a marker for respiratory disease severity and adverse neonatal outcomes. It is calculated based on the mean airway pressure, the fraction of inspired oxygen and the partial arterial pressure of oxygen. The two major disadvantages of the OI are that it requires arterial blood sampling to determine the partial arterial pressure of oxygen and cannot be monitored continuously. The oxygen saturation index (OSI) is an alternative that allows for continuous non-invasive monitoring, but evidence for clinical use in critically ill neonates is scarce. The aim of this study is to evaluate OSI as compared to OI in term neonates with a congenital diaphragmatic hernia (CDH).

METHODS:
A single-center retrospective cohort study including all live-born infants with an isolated CDH between June 2017 and December 2020. Paired values of the OI and the OSI in the first 24 hours after birth were collected. The relation between OI and OSI was assessed, taking into account arterial pH, body temperature, and preductal versus postductal location of oxygen saturation measurement or arterial blood sampling. The predictive value for pulmonary hypertension, need for extracorporeal membrane oxygenation therapy, and survival at discharge were evaluated.

RESULTS:
Of 33 subjects included, 398 paired values of OI (median 5.8 [3.3-17.2]) and OSI (median 7.3 [3.6-14.4]) were collected. OI and OSI correlated strongly (r=0.77, p<0.001). OSI values corresponding to relevant OI values (10, 15, 20, 40) were 8.9, 10.9, 12.9, and 20.9, respectively. The predictive values of OI and OSI were comparable for all adverse neonatal outcomes. No difference was found in the area under the receiver operating characteristic curves for the first and highest OI and corresponding OSI for adverse neonatal outcomes (Figure 1).

CONCLUSION:
OSI measurements could be used instead of OI measurements in infants with a CDH. The continuously measured OSI has the potential to offer a real-time guidance on therapy in clinical practice.
Receiver Operating Characteristic Curves of Oxygen Index and Oxygenation Saturation Index
None declared
ID 37 - THERAPEUTIC POTENTIAL OF TRICETIN ON RESPIRATORY ORGAN INFECTION: BIOLOGICAL ROLE IN THE MEDICINE THROUGH SCIENTIFIC DATA ANALYSIS

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¹Department of Pharmaceutical Sciences, SHUATS, Prayagraj, India

Background:
Herbal medicine and other natural products from various natural sources such as plants, animals and minerals have important biological function in the medicine and they can treat different form of human diseases in the modern medicine. Plants based preparation in the medicine and health sectors have been increased in the modern medicine due to their world wide acceptance and fewer side effects.

Methods:
Natural medicine has various important pharmacological activities in the medicine and other allied health sectors. In the present work, in order to know the biological importance of tricetin in the medicine, numerous scientific data has been searched and analyzed in the present work. Therapeutic potential of tricetin on respiratory organ infection has been also investigated through literature data analysis of different research work of the scientific field.

Results:
Literature data analysis of different scientific research work revealed the biological importance of tricetin in the medicine. Literature data analysis revealed the therapeutic potential of tricetin on respiratory organ infection in the system pharmacology based study. Other pharmacological activities were also correlated with their medicinal uses in the present investigation through literature data analysis.

Conclusion:
Literature data analysis revealed the biological importance of tricetin in the medicine.
None declared
The State of Health of Children Aged Three Years Who Were Born Very Premature with Congenital Pneumonia.

Mrs Natalia Shilova, Mrs Anastasia Budalova, Mrs Natalia Kharlamova

Objective:
To establish the features of the health status of deeply premature children with congenital pneumonia.

In Russia, there is a system of medical dispensary monitoring of children. Assessment of children's health status includes: analysis of infectious morbidity, physical and neuropsychiatric development, functional state of the main body systems, degree of resistance to adverse external influences, disability. Based on the results of a comprehensive assessment, a health group is set up: I group of health - healthy children who have normal physical and neuropsychiatric development, do not have anatomical defects, functional and morphofunctional disorders. II group of health - children do not have chronic diseases, but there are some functional and morphofunctional disorders, physical development delay in the absence of diseases of the endocrine system, frequent and/or long-term infections. III group of health - children with chronic diseases in clinical remission, with rare exacerbations with preserved or compensated functions of organs and systems of the body. IV group of health - children with chronic diseases in the active stage and the stage of unstable remission with frequent exacerbations. V group of health - children with severe chronic diseases, with rare clinical remissions, with a continuously recurring course, pronounced decompensation of the functions of organs and body systems.

Methods:
We examined 115 children with a birth weight of less than 1500 g and a gestational age of less than 32 weeks. All patients in the neonatal period had respiratory disorders. Newborns divided into 2 groups: group 1 – 62 children with congenital pneumonia, group 2 – 53 children with respiratory distress syndrome.

Results:
We have installed, it was revealed that more than 75% of them have normal physical development by the age of three, more than 55% - normal neuropsychiatric development and more than 55% - II group of health. However, children with pneumonia by the age of three are significantly more likely to have group III health, a low degree of resistance to external influences and higher rates of disability.

Conclusion:
It is necessary to conduct catamnestic monitoring of the health status of children up to at least three years of age.

not declared
ID 548 - FROM FETUS TO POSTNATAL SURGERY: A COMPREHENSIVE PATHWAY FOR CONGENITAL DIAPHRAGMATIC HERNIAS (CDH)

Doctor Sadaf Bhayat¹, Dr Anna McCorquodale², Dr Andreea Taune¹, Ms Emma Bredaki¹, Mr George Attilakos¹, Dr Simon Hannam², Dr Christina Kortsalioudaki¹

¹University College Hospital London, London, United Kingdom, ²Great Ormond Street Hospital, London, United Kingdom

BACKGROUND
CDH occurs in approximately 1/4000 live-births. Following diagnosis, patients are seen in Fetal Medicine Units (FMU) for specific multidisciplinary counselling.

The principal aim was to identify factors associated with outcomes, to provide an individualised approach and to enable counselling and informed decision-making. The secondary aim was to recognise postnatal-factors associated with poor outcomes to guide family discussions.

METHOD
We conducted a single-centre cohort study of all CDH cases over 5 years (2014-2018) at one of the largest FMU centres in the UK. During this period FETO (Fetoscopic Endoluminal Tracheal Occlusion) was not offered in our centre. Data were collated from maternal and baby records. Descriptive statistics were used for data analysis while Mann-Whitney-U and chi-2-square tests were used to compare continuous and categorical variables respectively.

RESULTS
There were 59 confirmed fetal cases of CDH, 92% of which were referred from other centres for specialised FMU input.

Following counselling, 37%(n=22) opted for termination (TOP). 54%(n=32) underwent an amniocentesis, of which 22%(n=7/32) had abnormal genetics (6/7 had TOP). Women who had TOP were older (mean-age:31 vs 28, p=0.026). The hernia side did not influence the TOP decision TOP [right-sided CDH was 13.6% in TOP-group versus 21.6% in non-TOP group, p=0.44], nor did the O/E LHR (for TOP-group 39% vs 43% for non-TOP group, p=0.27).

Out of 36 livebirths, 30 were in-born (Table 1). Overall mortality of all babies born alive was 31%(n=11) but dropped significantly to 23%(n=7) (p=0.03) if they followed the single-centre care-pathway. 24/30(80%) underwent corrective surgery. Of them, 9(30%) had thoracoscopy versus laparotomy. Median time-to-surgery was 6-days (IQR:4-12.5). 91% required inhaled nitric-oxide, and 74% inotropic-support prior to surgery. Amongst the survivors, median duration-of-ventilation post-operatively was 5-days (IQR:2-8). 9(39%) babies developed surgical complications.

CONCLUSION
Antenatal cases of CDH should be referred and counselled at a specialised tertiary regional-centre where a holistic but individualised approach can be offered. Delivery in the regional centre is advised as is associated with better overall survival(77%). Low O/E LHR ratios, associated anomalies, need for ECMO, are correlated with higher risk of mortality. In our series, presence of right-sided CDH was not associated with worse outcome. Survival to surgery is associated with a favourable outcome.
<table>
<thead>
<tr>
<th></th>
<th>SURVIVORS (N=23)</th>
<th>NON-SURVIVORS (N=7)</th>
<th>p VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA at birth (median [IQR])</td>
<td>38.2 [36.3–38.6]</td>
<td>38.1 [37.9–38.9]</td>
<td>0.58</td>
</tr>
<tr>
<td>GA at birth &lt; 37 weeks n (%)</td>
<td>7 (27)</td>
<td>1 (14)</td>
<td>0.48</td>
</tr>
<tr>
<td>Birth weight in grams (median [IQR])</td>
<td>2751 [2201-3230]</td>
<td>3250 [3064-3604]</td>
<td>0.06</td>
</tr>
<tr>
<td>Gender: proportion of male infants n (%)</td>
<td>14 (58)</td>
<td>3 (42)</td>
<td>0.47</td>
</tr>
<tr>
<td>Mode of delivery (vaginal delivery) n (%)</td>
<td>10 (43)</td>
<td>3 (43)</td>
<td>0.98</td>
</tr>
<tr>
<td>O/E LHR (median [IQR])</td>
<td>49.1 [41.5-56.0]</td>
<td>26.2 [20.9-26.9]</td>
<td>0.01</td>
</tr>
<tr>
<td>Right-sided CDH n (%)</td>
<td>5 (20.5)</td>
<td>1 (14.3)</td>
<td>0.71</td>
</tr>
<tr>
<td>Liver herniation n (%)</td>
<td>6 (25)</td>
<td>4 (57.1)</td>
<td>0.12</td>
</tr>
<tr>
<td>Normal genetic testing (Karyotype and CGH array) n (%)</td>
<td>13 (100)</td>
<td>7 (100)</td>
<td>N/A</td>
</tr>
<tr>
<td>Associated anomalies n (%)</td>
<td>2 (8.7)</td>
<td>4 (57)</td>
<td>0.04</td>
</tr>
<tr>
<td>ECMO prior to surgery n (%)</td>
<td>0 (0)</td>
<td>2 (28.6)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 1. Demographics and clinical characteristics for postnatal survivors and non-survivors. None declared.