All the babies found to have ROP were regularly followed up in both our high risk clinic and in Ophthalmology outpatient department for one year.

Results Incidence of ROP was 23% in our study. Incidence was 38% in the 1 st group & 8% in the 2 nd group.

Most common findings were stage III ROP (39%) and zone II ROP (70%). 3 (13%) had APROP (Aggressive posterior ROP) and 2 (8.7%) had retinal detachment.

The incidence of ROP increased as the birth weight and period of gestation decreased- no ROP was found in gestation ≥ 35 weeks and birth weight > 1.828 kg.

In our study, oxygen administration through mechanical ventilator or CPAP, sepsis, therapy with surfactant, apnea, PRBC transfusion, NEC and birth asphyxia were found to be significant risk factors. The risk of ROP is more in RDS, IVH and only head box oxygenation but the risk is not significant. We have not found any ROP in the babies who have undergone exchange transfusion.

13 (57%) babies had spontaneous regression of ROP and rest 10 (43%) required some intervention. To summarize the intervention ($n=10$), 5 (50%) responded to LASER only, 3 (30%) required intravitreal injection with Bevacizumab (anti-VEGF) following LASER, 1 (10%) required TPPV (Trans Pars Plana Vitrectomy) in left eye for ROP stage IVb along with LASER and 1 (10%) baby required all the three- LASER, intravitreal Bevacizumab and left sided TPPV.

Conclusions Thus the need for a routine screening program for the detection of ROP in preterm and sick neonates with risk factors is very essential in our clinical settings. Prevention of blindness from ROP can be very effective through early detection and urgent treatment. This needs awareness among neonatologists and pediatricians for referral to the ophthalmologists at appropriate age of the baby.

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CAN WE REDUCE NEONATAL ADMISSIONS DUE TO JAUNDICE?

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Background Neonatal hyperbilirubinemia is a common cause for neonatal admission in term and preterm infants. These infants are primarily managed on postnatal wards; however, they require admission to neonatal unit due to jaundice above the exchange level, rapidly increasing bilirubin levels, pathological jaundice or sepsis.

Failure to initiate and establish adequate breastfeeding can play an important role in development of severe jaundice. Face-to-face professional support has been shown to increase breastfeeding success.

Objectives The objectives of this project included evaluation of the management of infants admitted to neonatal unit with jaundice including the feeding practices; and identifying the areas of improvement to reduce admissions.

Methods This was a retrospective observational project including infants born at ≥ 35 weeks admitted to neonatal unit at District Hospital with a diagnosis of jaundice from January 1, 2017 to December 2018. Data was collected using proforma, medical records and blood results on computer system.

Results A total of 519 infants ≥ 35 weeks were admitted to the neonatal unit of which 12%(60) infants were admitted

due to jaundice. 42%(25) were preterm and 58%(35) were term infants.

The risk factors for jaundice were identified as male infant (66%), first born (49%), gestation, prematurity, and breast fed babies.

The mean birth weight was 2892.5 grams and 20%(12) were low birth weight. 35%(21) infants were admitted from home (average 3.9 days) and 65%(39) from postnatal wards.

27%(16) infants had jaundice < 24 hours. 6 infants had $> 10\%$ weight loss on admission. DAT was positive in 23%(14) infants of which 8 infants presented < 24 hours.

Sepsis was suspected in 72% (43) infants but was proven in none.

Only 20%(12) received lactation support on the postnatal ward prior to admission whereas 43%(26) did not receive any support. 36 infants were exclusively breastfed, 13 were formula fed and 11 were mixed-fed. After admission, formula feeds were added to 32 infants while 4 infants exclusively breast fed. 10 infants were given intravenous fluids.

The causes of jaundice included prematurity(25), ABO incompatibility(11), Rh incompatibility(3), poor feeding or exaggerated jaundice(25).

33 infants had bilirubin above exchange line, and required a mean of 24 hours (range 6- 144 hours) of phototherapy. None of them required immunoglobulins or exchange transfusion.

The mean length of stay was 3 days (range 1-14 days) and there was a remarkable decrease in breast feeding as only 7 (11.6%) infants were breast fed on discharge.

Conclusions There is a scope to decrease the admissions due to jaundice by optimising the postnatal support on the postnatal wards and community in the presence of risk factors.

Transitional care for late preterm infants is important to reduce admission to the neonatal unit thereby reducing the separation of mother and baby.

The opportunities to support breast feeding on postnatal ward and neonatal unit are often missed.

Effective measures should be taken to promote lactation support at all levels.

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SYRINGE AIR FLUSH TECHNIQUE ELIMINATES SURFACTANT REFLUX AS A LIMITING FACTOR IN USING HIGHER VOLUME SURFACTANT FOR MINIMALLY INVASIVE SURFACTANT THERAPY

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Background Minimally Invasive Surfactant Therapy or Less Invasive Surfactant Administration (LISA) is the preferred way of administration of surfactant in neonates. Surfactant reflux resulting in ineffective surfactant delivery is considered a limiting factor in administering a higher volume surfactant like bovine surfactant by MIST.

Objectives To analyze if syringe air flush technique as incorporated in our MIST procedure protocol eliminates surfactant reflux with higher dose volume bovine surfactant in our cohort of babies that received surfactant by MIST.

Methods Syringe air flush after the surfactant administration is incorporated in our MIST procedure protocol, the default standard of administering surfactant in our neonatal units. Both porcine surfactant (1.5 ml/kg) and bovine surfactant