PP-097 ASSESSMENT OF THE CRITICAL CONDITION OF NEWBORNS WITH CONGENITAL ANOMALIES

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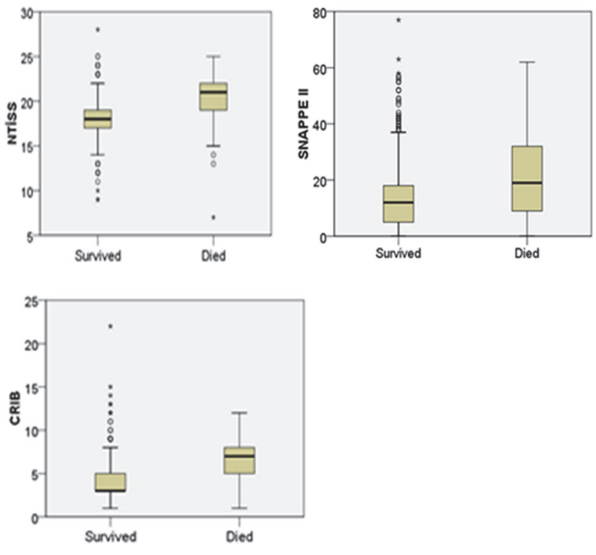
Aim Babies diagnosed with congenital anomalies occupy a special place and make up approximately 15% among the patients admitted to the neonatal intensive care unit in critical condition. Scoring systems are designed and used to assess the severity of the critical condition of the disease and to predict the morbidity, mortality and progress of newborns in neonatal intensive care unit. The purpose of this study is a comparative analysis of various scales to assess the effectiveness of determining the severity of the critical condition of infant diagnosed with congenital anomalies in the intensive care unit.

Material and Method 1256 children (15.2%) under 1 year of age hospitalized between 2019–2022 patients in the intensive care unit with a diagnosis of congenital anomaly were included in the study. These neonates were initially stabilized in the intensive care unit and evaluated according to the SNAPPE II, CRIB, NTISS scales within the first 24 hours. The final score was calculated as the arithmetic sum of the points given for each item.

Results Out of 1256 patients, 1084 patients (86.3%) survived (297 premature, 787 term) and 172 patients died (13.7%) (78 premature, 94 term) babies. NTISS average scale was 18.1 ±0.1 points in survived group and NTISS mean score 20.6 ±0.2 (pU< 0.001) in died group (figure 1). In survived group SNAPPE II mean score was 12.5 ± 0.3 points and in died group SNAPPE II average score is 21.9±1.2 (pU< 0.001) (figure 2). CRIB mean score was 4.0 ±0.1 points in survived group and CRIB average score was 6.7±0.2 (pU< 0.001) in died group (figure 3).

Conclusions Statistical analysis of the clinical material of our study showed that the SNAPPE II, CRIB and NTISS scale was significantly higher results were obtained in the congenital anomalies diagnosed mortal group compared to the survived group.



Abstract PP-097 Figure 1,2,3 1) Comparative analysis according NTISS scale in survived and died group; 2) Comparative analysis according SNAPPE II scale in survived and died group; 3) Comparative analysis according CRİB scale in survived and died group

PP-098 LUNG ULTRASOUND COMPARED TO CHEST X RAY IN DIAGNOSING RDS: A PROSPECTIVE COHORT STUDY

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Aim Chest X ray has been used in diagnosing RDS since long. Lung Ultrasound is an upcoming bedside, point of care modality with no radiation exposure to diagnose RDS. This study aims to compare lung ultrasound and traditional chest X ray for diagnosing respiratory distress syndrome.

Material and Method This study was conducted in level III Neonatal Intensive Care Unit of a tertiary care Hospital. Preterm newborns (GA <34 weeks) with respiratory distress (Downe s greater than 4) within 2 hours of birth, and FiO2 >0.3% were included in this study. Chest X ray and Lung ultrasound were done within 2 hours of birth. Preterm Neonates with FiO2 requirement of >0.4% with RDS were given surfactant. Also neonates with septic shock, Chorioamnionitis, Meconium Aspiration Syndrome and antenatally diagnosed congenital lung disease were excluded from the study. Data was analysed using SPSS software. P Value of <0.5 was significant.

Results Out of total 180 preterm newborns, We enrolled 70 cases. Mean gestational age was 30.17 + 2.90 weeks. Median Birth weight was 1387 grams (IQR 865 - 1850 grams). As per chest X Ray 72% cases were suggestive of Hyaline Membrane Disease. As per criteria (FiO2 > 40% and RDS) 45.7% (31 cases) were given surfactant. Lung Ultrasound done within 2 hours of birth was suggestive of RDS in 53.7% cases. Area under Curve for Lung ultrasound was 0.89 and score of 8 was kept cut off.

Conclusions Lung ultrasound along with FiO2 requirement has a predictive value to administer surfactant in preterm neonates.

PP-099 FEBRILE SEIZURES IN YOUNG CHILDREN

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Aim Febrile seizures(FS) represent the most common cause of seizure among children between 6 months to 5 years of age. FS occurs in 4% of all children in presence of fever >38 *c and no other identifiable causes. Simple FS last <15 min and occur only once in 24h period. Complex FS last >15 min and recurs within 24h associated with focal features. The risk of subsequent epilepsy is ~2% greater than that of the general population. Recurrence rate is about 35%(1–5 years of age) and about 50%(6 months -1 year of age). Monozygotic twins have a much higher concordance rate. FS occur during bacterial or viral infections and sometimes after certain vaccinations.

Material and Method Diagnosis and cases: tipically seizures are clonic but some manifest as atonic or tonic posturing periods. Laboratory tests are important when FS are associated with vomiting or diarrhea(glc, Na, Ca, Mg, P, kidney and liver function tests are needed. Cranial CT, MRI and EEG are important only in Complex FS to identify the risk of recurrence FS after records of high electrical activity in brain. EEG is first done during the first week of complex FS