to the ruptured SOVA. Because of the presence of important residual leak on the edge of the implant the procedure had to be supplemented by closing of the distal RV orifice of SOVA with 10 mm Amplatzer Muscular VSD Occuder .Trivial aortic regurgi-tation occurred in 1 pt without progression in follow-up. In one pt 3 y after the procedure new shunt close to occluded RSOVA was found. The patient is scheduled for another attempt of TCC of RSOVA.
Conclusion: In appropriately selected pts with RSOVA, trans-catheter closure is a feasible and effective method of treatment.

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Short- and Mid-term Results of Balloon Angioplasty for Coarctation of the Aorta in Neonates
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Background: To review our clinical experience with short- and mid-term results of balloon angioplasty for coarctation of aorta in neonates.
Methods: The data of 51 neonates who underwent balloon angioplasty for aortic coarctation between December 2004 and March 2010 were retrospectively studied.
Results: Balloon angioplasty was performed in 51 neonates (mean age 13 ± 9 days). Of these 41 (80.4%) were male and 10 (19.6%) female. Isolated coarctation was found in 13 patients (25%) and complex coarctation, in 38 (75%). The mean systolic pressure gradient across the coarctation site fell from 36 ± 20 mm Hg before dilatation to 8.6 ± 7.0 mm Hg following the intervention. The mean follow up period was 8.7 ± 9.6 months (range 1-46, median 6 months). Recoarctation developed in 20 (39.2%) patients after an average 3.2 ± 3.1 months. Of these, 9 (45%) underwent redilatation and 11 (55%) surgical repair. On follow up, seven (13.7%) patients died with a follow-up of 1-7 months.
Conclusion: According to our short- and mid-term results, balloon angioplasty has a higher recoarctation rate than surgery. For this reason, balloon angioplasty should be done to ensure survival until full corrective surgery can be performed in patients with complex cardiac disease and poor general condition
Key words: aortic coarctation, balloon angioplasty, neonates.

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Transcatheter Closure of Atrial Septal Defect by Amplatzer Occluder Devices [ASO] In Benghazi Cardiac Center
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Objective: Our study reports the clinical experience and outcome of transcatheter closure of atrial septal defect done in Benghazi Cardiac Center. Significant atrial septal defects are closed surgically or through a transcatheter device, in order to avoid pulmonary hypertension in late life.
Methods: During a 5 years period between December 2004 and December 2009, 68 ASD patients were referred to Benghazi cardiac center for possible transcatheter closure with ASO .17 patient were excluded for TCC, 10/17 patients after TOE evaluation [in which 4 with small defect, 4 with large ASD, 2 with deficient inferior rim], 7/17 after angiographic, balloon sizing and TOE. TCC with ASO done in 51 patients [35 female and 16 male] All procedure carried out under general anesthesia & fluoroscopy guide and TOE control .The selected device was 1 to 2 mm larger than the maximum defect size .The physical examination and TTE were performed prior to procedure and follow up [0,1,3,6,12 months and yearly after].
Result: Patients age between 3.5–61 years, and weight between 15–108 kg, diameter of ASD 6 – 3.2 mm.42 patients with single defect, 4 with 2 ASD [, 5 with fenestrated ASD. The size of device range 8–34 mm [ASO, PFO and cribriform device].
Conclusion: The Amplatzer septal occluder is an effective ASD transcatheter treatment device Careful and detailed patient evaluation and selection of an ASO of appropriate size are important factors for success and avoidance of complication .The atrial septal aneurysm which is frequently associated with multiple fenestrated defects is not problem for transcatheter closure.

P-273
Percutaneous dilation of inferior caval vein and closure of left superior caval vein in the patient after Fontan operation
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Introduction: The purpose of this abstract is presentation of percutaneous treatment of patient after Fontan operation with sudden development of cyanosis.
Material: The 3-year-old girl was born with double inlet right ventricle. The banding of pulmonary artery was performed at 3 month of life, and later a hemi-Fontan operation was performed at 8 month of life. A Fontan completion was done at 10 month of life. She had a catheterization study prior to the Fontan operation which revealed good haemodynamic and morphology. The left superior caval vein was not present. She was doing well with saturation = 90%. When she was 2,5 year-old the saturation decreased to 72-74%. The angiographies revealed stenosis of inferior caval vein and the main flow from lower parts of body was through the hemiazygos and hemiazygos accesoria veins to patent left superior caval vein and to pulmonary veins atrium. The left superior caval vein was connected to right superior caval vein.
Results: After balloon occlusion test of left superior caval vein the increase of arterial saturation from 75 to 94%, without negative consequences, was observed. In these circumstances the successful balloon angioplasty of inferior caval vein was performed. A 8/6 Amplatzer Duct Occluder was deployed in left superior caval vein below the entrance of hemiazygos accessory vein. Control angiographies revealed right flow from lower parts of body with total occlusion of left superior caval vein without restriction of flow. There was no increase of pulmonary artery pressure.
On FU the girl is doing well. The saturation is about 94- 95%.
Conclusion: The active investigation of causes of desaturation in the Fontan patients is necessary in all cases. The best method is diagnostic catheterization with angiographies. The most complications can be treated during the same procedures.

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Cerebral Microemboli Detection during Transcatheter ASD Closure
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