OBJECTIVES
To study the impact of EXIT to AIRWAY on survival of babies with CDH, with LHR of 1.2 to 1.4.

METHODS
5 babies with antenatally diagnosed CDH, without liver herniation and with LHR of 1.2 to 1.4 were offered EXIT to AIRWAY. Mean LHR at primary detection was 1.3 (1.2 – 1.45). Serial LHR monitoring was done every 2 weeks and babies were delivered at 34 weeks by caesarian section with EXIT to AIRWAY. All babies were electively ventilated for a duration of 36 -48 hrs., before surgery. The target saturation was maintained at 97 to 99 percent with low PEEP (3-4) PIP (18‐25). ABG, X‐Ray, 2D ECHO were done in all. For pulmonary vaso‐dilatation, 3 babies required Sildenafil, 2 required both Sildenafil and Milrinone. In case of compromised Cardiac function Milrinone was preferred. All babies were operated between 36-48 hours after stabilization of the pulmonary pressures. 2 babies required mesh, while in 3, the sac cover was used to repair the defect. Postoperative ventilation was continued for another 48 hours and gradually weaned and rest support started.

RESULTS
All babies (5/5) survived. At the surgery bowel was already collapsed and reduced in the abdomen with a relaxed hiatus that facilitated repair without strain on sutures. Collapsed bowel was also well accommodated in the abdominal cavity. Postoperative stay was without any major problems. Average length of stay was ranging from 25 days to 35 days. All the babies were discharged on breast feeding.

CONCLUSIONS
EXIT to AIRWAY in CDH allows a smooth transition from prenatal life to postnatal life, reducing the strain on lungs and pulmonary vascular resistance. Better anesthetic techniques for optimum maternal safety and low‐tidal volume ventilation strategy for the newborn decreases lung injury and inflammation, extra pulmonary organ failure, and mortality, allows gradual lung expansion and improved pulmonary vascular resistance and can offer superior survival results than conventional therapy.