INTRODUCTION

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Patent Ductus Arteriosus is one of the commonest and most benign congenital malformations of the heart being an integral part of the foetal circulation. It tends to close at birth or a few weeks or months thereafter.

Lack of closure or persistent patency of the ductus is usually an indication of either arrested development or a need for patency, in severe malformations with obstruction to pulmonary blood flow and insufficient oxygenation of the blood.

In fact, closure of the ductus in these latter cases may even jeopardise life. It is for this reason that at present manipulation of ductus closure or patency by prostaglandins and indomethacin has become one of the new advances in heart diseases in children.

The ductus arteriosus especially in infancy sometimes does not present with the typical continuous murmur, so often pathognomonic of the lesion. This is due to the infantile pattern of vasospastic pulmonary hypertension which prevents shunting of blood through the patent ductus during diastole.

Hence, it can resemble any cause of pan systolic murmur such as VSD, MI or TI.

There are many lesions which rely on patency of the ductus and hence occur concomitantly with it. It has become the custom to

submit PDA to surgery, once it is clinically diagnosed without invasive investigations.

Yet it is our experience especially in infancy and early childhood, that many of the mimicking and concomitant lesions may be present silently along with ductus arteriosus. As the presence of such lesions may prove detrimental to successful closure of the PDA without complications, it has been our habit to sumbit all patients with ductus arteriosus to cardiac catheterization and angiocardiography prior to surgery. This is specially so in early childhood, and where other murmurs in addition to those of PDA may have been recorded.