Feeding and swallowing difficulties

When solids are introduced, problems with swallowing may develop as the movement of food down the oesophagus is not normal. Problems with obstruction of the oesophagus with food become less common after the age of two years. As your child gets older, you will also need to encourage them to chew their food well before swallowing. It is also helpful for your child to drink fluids with their meals.

Respiratory (chest) infections

These are more common in the first few years of life and become less common after the age of six.

Recurrence of a tracheo-oesophageal fistula

This is a rare complication following repair of oesophageal atresia and tracheo-oesophageal fistula. Recurrence of a TOF causes food/ milk to travel from the oesophagus to the lungs resulting in recurrent pneumonia.

Symptoms include:

Coughing and spluttering episodes with feeding, usually associated with cyanosis (a blue colour around the mouth and face).

Sophia (6 Days old)

Contact OARA:

Website: **www.oara.org.au**

Email: **mail@oara.org.au**

Facebook.com/oara

Postal address:

OARA, P.O. Box 502, Pakenham, VIC 3810

Further information:

If you have any further questions, please speak to the nurse caring for your baby.

Your baby's surgeon will also be happy to answer any questions you may have. You should contact him/her if your child develops any symptoms such as those described.

Further information can also be obtained from OARA. (Oesophageal Atresia Research Association) which is a group founded by parents of babies and children with this condition. They offer support and also help to fund further research into this condition.

oara AUSTRALIA Oesophageal Atresia Research Association

Repaired Oesophageal Atresia & Tracheo-Oesophageal Fistula

A guide for parents

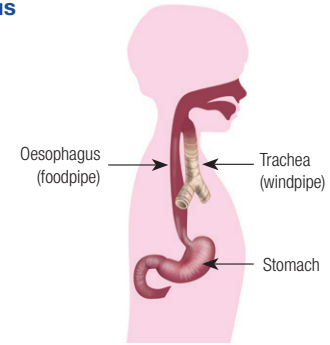
Nate (6 Weeks old)

oara AUSTRALIA Oesophageal Atresia Research Association

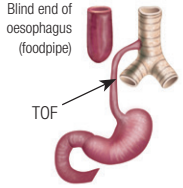
What is oesophageal atresia and tracheo-oesophageal fistula?

- The trachea (windpipe) is the tube that connects the throat with the lungs and allows the movement of air into and out of the lungs.
- The oesophagus (gullet/foodpipe) transports food from the mouth to the stomach.
- Your baby has an oesophageal atresia (OA) with a tracheo-oesophageal fistula (TOF).
- The upper end of the oesophagus ends in a blind upper pouch (atresia). Therefore, there is no connection between the mouth and the stomach.
- There is a connection (fistula) between the trachea (windpipe) and the lower part of the oesophagus (foodpipe).
- Surgery has been performed to close the TOF and join the two ends of the oesophagus together.

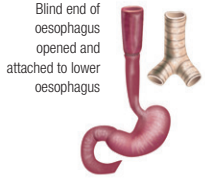
Normal oesophagus & trachea



Oesophageal atresia



Repaired oesophageal atresia:



What follows surgery?

Following your baby's surgery for repair of the oesophageal atresia and tracheo-oesophageal fistula, their oesophagus should serve them well for the rest of their life. However, some complications may occur in the future and you need to be aware of these. Your child's surgeon is the best person to discuss any problems or potential complications with. He/she will be available for such discussions.

The most common problems that you may encounter are:

'TOF' cough

This is a loud barking, brassy cough. It is normal, occurring in most infants and children who have undergone repair of OA and TOF, and may continue into adulthood.

Gastro-oesophageal reflux (also know as reflux)

Reflux involves movement of stomach contents back into the oesophagus and occurs in about half of infants following repair of oesophageal atresia and TOF. The reflux may range from mild to severe.

Symptoms include:

- *vomiting (can range from small to large amounts)*
- *respiratory obstruction (choking episodes)*
- *failure to gain weight.*

In severe cases, the stomach contents may reflux back into the oesophagus and spill over into your child's airway (trachea), which can result in respiratory symptoms such as: noisy breathing (stridor), episodes of recurrent lung infections (pneumonia) and possibly episodes of apnoea (where the baby stops breathing for longer than 20 seconds at a time).

If your baby's colour changes to blue, this is a severe symptom and it will be necessary for baby to be seen by a doctor immediately. If you are concerned about your baby's breathing please call an ambulance on 000.

Reflux is thought to be a major cause of inflammation of the foodpipe (oesophagitis), frequent lung infections and narrowing of the foodpipe (oesophageal strictures); therefore, if your baby has any of these symptoms, especially any respiratory symptoms, he/she should be seen by your child's surgeon.

Treatment of reflux may include:

- *thickening your baby's feeds*
- *feeding baby smaller feeds more often*
- *nursing baby upright*
- *medications prescribed by your baby's doctor.*

In some babies it may be necessary to perform an anti-reflux operation.

Oesophageal stricture

Oesophageal stricture is a narrowing of the oesophagus at the site where the two ends of the oesophagus were joined together (anastomosis). Babies with gastro-oesophageal reflux are more likely to have strictures.

Symptoms:

Often the first sign of an oesophageal stricture is that your baby may not be interested in feeding or becomes slow to feed. They may also appear to have more frequent episodes of reflux. If the oesophageal stricture has caused a lot of narrowing, your baby may be unable to swallow their own saliva and this may need to be removed by suction.

In an older child, the first sign of a stricture may be that food becomes stuck in the oesophagus. If this happens and the food is not vomited, it will need to be removed by a procedure known as an oesophagoscopy. This involves an instrument like a telescope being passed through the mouth into the oesophagus and will require a general anaesthetic.

These symptoms need to be reviewed by your child's surgeon. If symptoms are severe your child should be taken to the emergency department, preferably to your local children's hospital. Oesophageal atresia is not a common condition, so we recommend your child is reviewed by medical staff with knowledge of the problem.

Treatment for an oesophageal stricture is to have the area of narrowing stretched. This procedure is known as an oesophageal dilatation and is usually performed under a general anaesthetic. The number of dilatations necessary depends on the individual child.

In some cases, if the stricture is associated with gastro-oesophageal reflux, your child's surgeon may suggest that he/she has an anti-reflux operation performed. This procedure is called a fundoplication. Strictures are uncommon after the age of five years and this is thought to be due to growth of the child's oesophagus.

Author: Alisa Hawley