

When can my baby be discharged home from hospital?

Your baby can be discharged home from hospital when they are taking all their feeds orally and gaining weight. Discharge could be as early as seven to ten days after surgery if there have been no problems. If there have been other complications following surgery or if your baby has other problems this may delay your baby's discharge.

What sort of problems may occur once the oesophageal atresia has been repaired?

Most babies with TOF/OA grow up to live perfectly healthy, normal lives. Whilst some children are fortunate to have no further complications, others may have some problems. You will find more information about this in the brochure Repaired Oesophageal Atresia and TOF – A guide for parents

TOF without oesophageal atresia (H-TOF):

H-TOF involves an abnormal connection (fistula) between the oesophagus (gullet) and trachea (windpipe). Babies with this condition may not be diagnosed immediately after delivery because there is no obstruction to the oesophagus and it could be a number of days or weeks before the condition is diagnosed. The signs that a baby may have an H-TOF include coughing and spluttering with feeds, going blue around the lips with feeds and sometimes these babies may develop pneumonia from milk or saliva entering the lungs through the fistula. The condition is usually confirmed by a contrast study which outlines the TOF between the oesophagus and trachea. Surgery to repair this type of TOF is performed soon after diagnosis. The incision is usually through the baby's neck and involves dividing and closing the TOF at both ends, i.e. the oesophageal and tracheal ends of the TOF. Feeding usually resumes a few days after surgery and your baby can be discharged home when feeding well and gaining weight.

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Oesophageal Atresia & Tracheo-Oesophageal Fistula

A guide for parents

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



Larni (3 Months old)

What is oesophageal atresia?

Oesophageal atresia (OA) is a congenital obstruction in the oesophagus in newborn babies. In this condition the oesophagus ends in a blind upper pouch. In babies born with oesophageal atresia the oesophagus, also known as the gullet (or foodpipe), is not connected to the stomach.

As a result of this obstruction, food and saliva can't pass into the stomach. In most cases, the baby with oesophageal atresia also has a tracheo-oesophageal fistula (TOF).

What is a tracheo-oesophageal fistula?

Tracheo-oesophageal fistula is where a section of the baby's trachea (windpipe) is abnormally connected by a small tube (fistula) to the baby's oesophagus.

How does TOF/OA occur?

The oesophagus and trachea actually form from the one tube. OA and TOF are believed to happen when the oesophagus and trachea fail to differentiate and separate properly. Research is continuing into the cause of TOF/OA; at this stage the cause is not known.

Are there other abnormalities associated with TOF/OA?

Approximately half the babies born with TOF/OA have other abnormalities. This is why a number of investigations are undertaken to see if your baby has any additional problems. Some babies are born with abnormalities of the spine, heart, kidneys, anus and/or radial bone (a bone in the lower arm). If a baby has three or more of these anomalies, it has what is known as "VACTERL association". VACTERL is an acronym where the letters stand for vertebral, anal, cardiac, tracheal (TOF), esophagus (oesophageal atresia), renal and limb.

How common is TOF/OA?

TOF/OA occurs once in every 3,500 live births.

Are there different types of TOF/OA?

There are five main types of TOF/OA including the following:

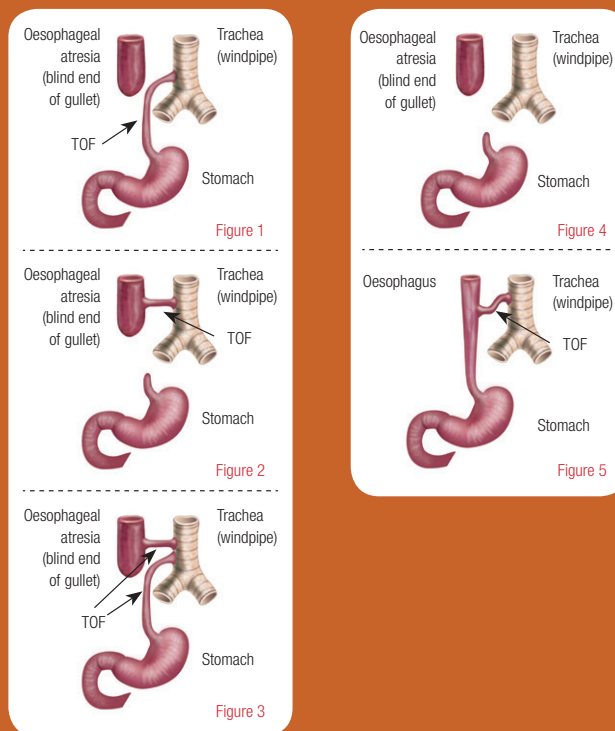
Figure 1. Oesophageal atresia with a distal tracheo-oesophageal fistula. (Abnormal connection between windpipe and lower oesophagus). The most frequently encountered anomaly. i.e. OA with distal TOF.

Figure 2. Oesophageal atresia with a proximal fistula. (Abnormal connection between windpipe and upper oesophagus. No connection from gullet to stomach). i.e. OA with proximal TOF.

Figure 3. Oesophageal atresia combined with fistulae from both oesophageal segments. (Abnormal connections from the upper and lower oesophagus to the windpipe). i.e. OA with double TOF.

Figure 4. Isolated oesophageal atresia without a fistula. (No connection between gullet and stomach). i.e. Pure OA (no TOF).

Figure 5. Tracheo-oesophageal fistula of the "H" type. (Abnormal connection between oesophagus and windpipe). i.e. H-TOF (No atresia of the oesophagus).



How is the TOF/OA repaired?

In most babies with OA and a distal TOF, the surgeons can operate to close the TOF and join the two ends of the oesophagus within the first few days of life. The incision is usually made on the right side of the chest, under baby's arm towards their back. The TOF is divided and the tracheal end of the fistula is repaired with sutures. The two ends of the oesophagus are then brought together, and the upper oesophageal pouch is opened and joined to the lower oesophagus.

In some cases, the gap between the two ends of the oesophagus may be too large to enable an immediate repair of the oesophagus. Occasionally, the baby may be premature or too sick for the surgery to be undertaken. If this is the case the baby will have surgery to close the TOF and the oesophagus will be repaired at a later date. If the oesophagus is not repaired at the same time as the TOF a gastrostomy tube may be inserted through the abdominal wall into the baby's stomach to allow the baby to be fed until further surgery is performed to repair the oesophageal atresia.

What special care will my baby receive following repair of the TOF/OA?

Your baby will not be fed and will instead receive fluid containing water and sugar through an intravenous line. It is not possible to feed your baby orally, as the milk and saliva will pool in the oesophageal pouch and may spill over into your baby's windpipe (trachea) and lungs, resulting in pneumonia.

For this reason your baby's oesophageal pouch will need to be kept clear of saliva and secretions which can spill into their lungs. This is done by suction every 10 – 30 minutes until your baby has their TOF/OA repaired. Alternatively a tube that applies continuous low pressure suction (Replegle tube) may be placed into the oesophageal pouch.

Your baby's heart rate, breathing, oxygen saturation levels and temperature will be monitored as well.

When can my baby start feeding?

Your baby will continue to receive intravenous fluids until milk feeds can begin. The surgeon will decide when this happens. Some surgeons prefer to do a contrast study of your baby's oesophagus to ensure that there are no problems with the join in the oesophagus before they allow your baby to start feeding. This contrast study usually involves your baby drinking some contrast solution to outline the oesophagus in an X-ray to see if the anastomosis has healed properly.

If there have been no complications with the surgery, your baby will usually commence milk feeds on day three or four after surgery. You will then be able to give your baby breast feeds or bottle feeds depending on how you have decided to feed your baby. We strongly encourage breast feeding and there is no reason that your baby should not be able to breast feed. If you are planning on breastfeeding it is important to begin expressing breast milk regularly after birth. A lactation consultant is available for support and advice.