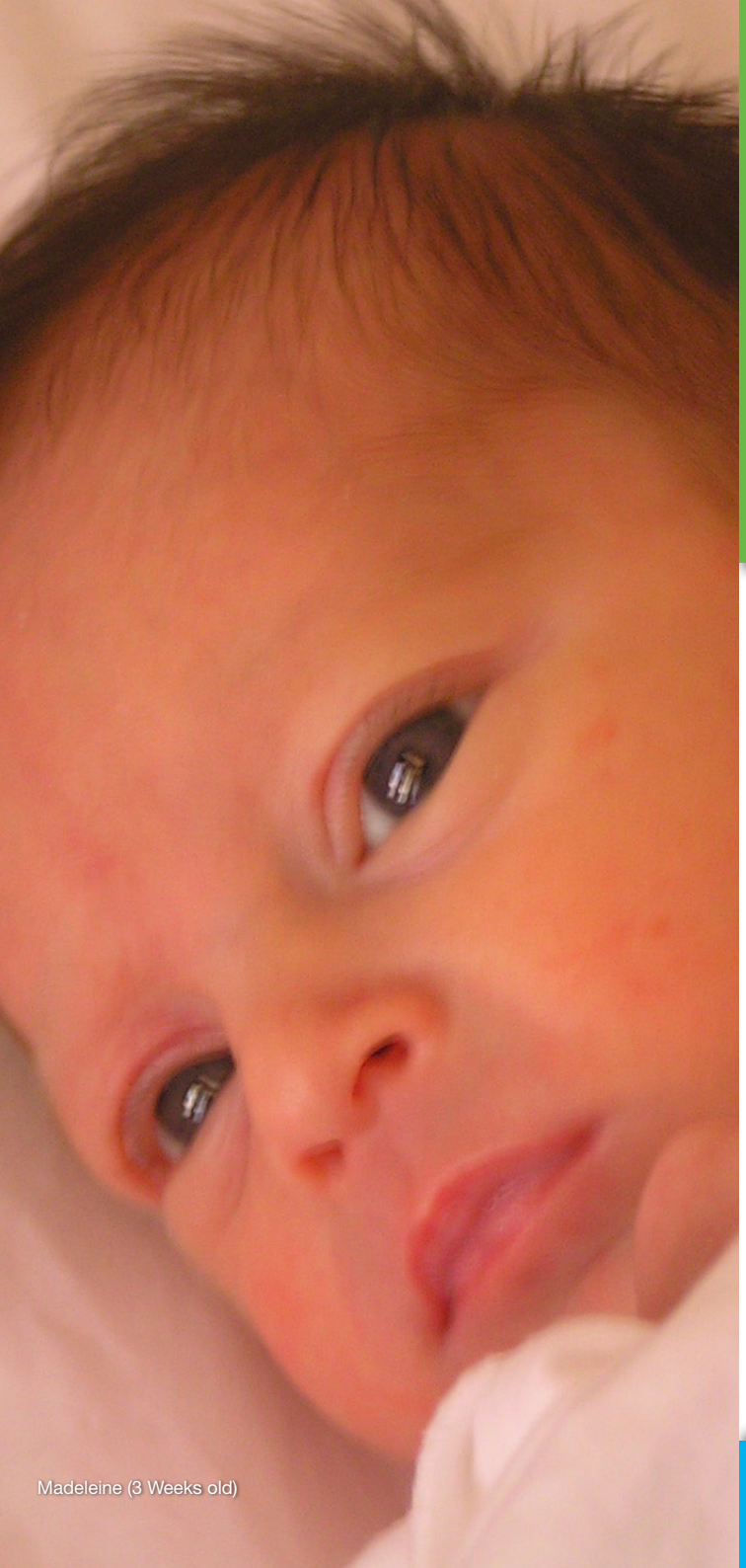

Madeleine (3 Weeks old)

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

Repaired Long-gap Oesophageal Atresia

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

Nate (18 Months old)

oara AUSTRALIA Oesophageal Atresia Research Association

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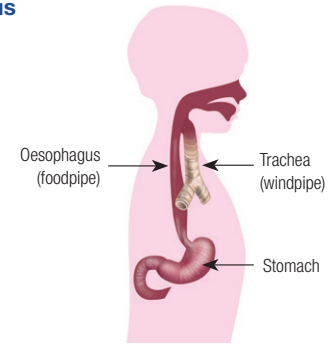
Your baby has oesophageal atresia (OA)

The upper end of the oesophagus ends in a blind upper pouch (atresia). There is no connection between the mouth and the stomach.

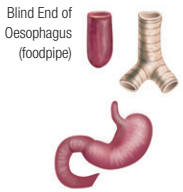
The gap between the two ends of your baby's oesophagus is usually too large for the ends to be joined immediately.
Your baby will require suctioning of the oesophageal pouch to remove saliva and prevent this from spilling over into their lungs.

An operation will usually be performed in the first few days of life so your baby can be fed. A tube known as a gastrostomy will be inserted into your baby's stomach through the abdomen, so milk feeds can be given through the tube.

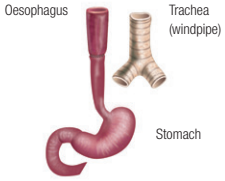
Normal oesophagus & trachea



Oesophageal atresia



Repaired oesophageal atresia:



What follows surgery?

Following your baby's surgery for repair of the oesophageal atresia their oesophagus should serve them well for the rest of their life. However, there are some complications that 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 and he/she will be available for such discussions.

The most common problems that you may encounter are:

Gastro-oesophageal reflux (also know as reflux)

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

Symptoms include:

- vomiting (can range from small amounts 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: stridor (noisy breathing), episodes of recurrent pneumonia (lung infections) and possibly episodes of apnoea (where the baby stops breathing for longer than 20 seconds at a time).

If a 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. Call an ambulance if you are concerned about your baby's breathing on 000.

Reflux is thought to be a major cause of oesophagitis (inflammation of the foodpipe), frequent lung infections and oesophageal strictures (narrowing of the foodpipe); 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 suctioning.

In an older child, the first sign of a stricture may be that food becomes stuck in their 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. This will require a general anaesthetic.

These symptoms need to be reviewed by your child's surgeon. If symptoms are severe they should be taken to the emergency department, preferably at your local children's hospital.

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 an anti-reflux operation. This procedure is called a fundoplication. Strictures are uncommon after the age of five and this is thought to be due to growth of the child's oesophagus.

Feeding and swallowing difficulties

When feeds are started after repair of the oesophageal atresia, it may take some time for your baby to learn to feed orally. Most babies are discharged home still requiring some feeds via their gastrostomy tube in addition to breast or bottle feeds.

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. As your child gets older, you will need to encourage them to chew their food well before swallowing. It is also helpful for your child to drink fluids with a meal.

Respiratory (chest) infections

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

Author: Alisa Hawley