We wish to extend to you and your family a warm welcome to the inaugural OARA National Catch-Up Day!

We hope you will enjoy spending the morning with your fellow OARA community members and sharing your stories.

To help you get the discussion started, we have put together some key messages from the recent 3rd International Oesophageal Atresia Conference (held 2-3 October 2014 in Rotterdam, The Netherlands) that you might like to discuss.

We look forward to hearing your feedback from the day and seeing some photos.

https://www.facebook.com/pages/OARA-Ltd/107326759466383?fref=ts

https://twitter.com/OARALtd

Best wishes from the OARA team!

The information presented in this brochure does not constitute medical advice and you should consult your medical professional for such advice.

Oesophageal Atresia (OA) affects 1 in 3500 newborns and is a malformation of the 'food pipe' which is not connected to the stomach and requires life-saving surgery to correct the problem. These patients can then go on to have ongoing issues with narrowing of the oesophagus and reflux, to name a few.
Oesophageal atresia can also be associated with tracheo-oesophageal fistula (TOF), which is an abnormal connection between the oesophagus and the trachea (windpipe). This can cause initial and/or ongoing breathing difficulties.
The Oesophageal Atresia Research Association (OARA) provides support to individuals and families living with this condition Australia wide.

Visit **www.oara.org.au** for information on how you can contribute to OARA so that we may continue this important work long into the future.

Health and wellbeing 'spotlights'

Discussion topics from the 3rd International Oesophageal Atresia Conference – 2-3 October 2014 in Rotterdam, The Netherlands

Prepared in consultation with OA/TOF medical professionals at RCH, Melbourne

Your state representative is

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Tracheomalacia (collapsible lower airway)

- Clear diagnosis is still difficult – fibre-optic bronchoscope is the gold standard in older children
- Cine MRI another option for paediatric chest imaging – main advantage is there is no radiation, but requires expertise and not yet in routine clinical practice
- Drug treatment for tracheomalacia – no evidence that any medication improves the long term prognosis – the anatomy of the tracheomalacia stays the same but the symptoms are usually less severe over time
- Surgical options to treat tracheomalacia are available but need to be patient-specific and still require further understanding
- Physiotherapy techniques are available to assist in mucus expulsion – tracheomalacia can result in mucus being trapped and over time becoming infected: helping kids to learn that they are the boss of the cough. Pursed lip breathing to stabilise the airway and coughing only when mucus is in the upper airway.
- Arguments for and against the use of prophylactic antibiotics to treat symptoms of tracheomalacia
- If you or your child has OA TOF, ask the treating doctor to explain tracheomalacia and the severity for you or your child's trachea, to better understand the suitability of the suggested treatment options.

Long gap oesophageal atresia

- 10 to 15 percent of all OA cases are long gap
- Feeding difficulties – symptoms of breathing and swallowing difficulties are often the same; motility contributes to pulmonary symptoms rather than reflux
- Native oesophagus the best choice - oesophageal replacement reserved only when all other techniques have failed

Dysphagia (swallowing difficulties) and dysmotility (problems with coordinated propulsion down oesophagus)

- Dysmotility is present in patients before repair – drug treatment tried to date has not had great success
- Psychological and emotional considerations - maternal anxiety will rise when there are feeding problems - mothers are biologically wired to feed their babies - relationship with the child is affected and impacts family relations
- Consensus is that feeding and introduction of solids should not be delayed

Barrett's oesophagus

- Condition in which oesophagus changes, so that some of its lining is replaced by tissue similar to that normally found in the intestine.
- Screening with gastroscopy will detect Barrett's at an early age. Some suggest screening to start as young as 5-10 years of age but consensus is to start by adulthood.