

GASTROSCHISIS

DEFINITION

- Herniation of intra-abdominal contents (mostly bowel) via a full thickness abdominal wall defect, situated immediately adjacent to the umbilicus

ANTENATAL

- Usually an isolated abnormality
- Fetus is at risk of:
 - in utero growth retardation
 - non-reassuring fetal heart trace
 - other organ anomalies (uncommonly)
- Counsel mothers antenatally and decide place of delivery and preferred surgical unit
- discuss possibility of alternative surgical units

Labour and delivery

- Not a contraindication to vaginal delivery
- If a woman presents in labour and not able/not planned for in utero transfer, inform neonatal consultant on-call
- Contact surgical centre when mother in labour or in unlikely event of planned section
- Introduce yourself to parents
- Prepare for delivery – see below

POSTNATAL

On labour ward

- Resuscitate if necessary
- Examine baby
- Pass large bore NG tube, aspirate gastric contents to decompress the stomach and leave on free drainage
- Examine intestines:
 - note colour of bowel
 - note presence of any narrowing/strictures
 - straighten mesentery to avoid twisting that will limit vascular supply
- Cover and support intestines with cling film from upper chest to lower abdomen, holding intestines in central position
- ensure intestines are visible
- do not wrap cling film tightly as this will reduce perfusion
- alternatively, use gastroschisis bag, if available in your unit
- Place baby in right lateral position (to prevent intestinal ischaemia)
- Transfer to NNU

If you have any concern about the bowel, seek senior advice

On neonatal unit

- Start IV fluids: glucose 10% and sodium chloride 0.18% 90 mL/kg/day
- Replace nasogastric tube losses with sodium chloride 0.9%
- Give sodium chloride 0.9% 20 mL/kg over 30 min. Repeat if bowel remains or becomes dusky/blue
- Start antibiotics:
 - cefuroxime 25 mg/kg IV 12 hrly
 - metronidazole – loading dose 15 mg/kg IV over 10 min, then 7.5 mg/kg IV 12 hrly
- Vitamin K IM – See **Neonatal Formulary** for doses
- Inform surgical team of delivery and status of bowel

COMMUNICATION AND FOLLOW-UP

- Keep parents informed at all times

- When stable, transfer promptly to paediatric surgical unit with transfer letter detailing neonatal consultant name for contact
- send copy of neonatal unit transfer summary to on-call neonatologist and obstetrician