Neonatal stomas – piecing it together

12th Annual Midlands and East Perinatal Conference

Claire Jackson, Consultant Paediatric Surgeon
Karen King, Advanced Neonatal Dietitian

- Antenatal polyhydramnios & bowel dilatation noted
- Due for further imaging but not performed as born prematurely

- 34+6; 2.76kg (75th centile); HC 32.5cm (50th – 75th centile)
- Born in good condition

Initial examination findings

- Abdomen distended, obvious loopy bowel seen and palpable; not tense
- Anus present and appeared patent
- NGT on free drainage NGT size 8, dark green aspirates

- Operative findings: multiple atresia
- Operative procedure:
  - Defunctioning proximal stoma
  - Resection of ischaemic segment
  - Anastomosis over feeding tube of multiple atresias

Post operative instructions

- Standard post op care
  - NBM until ileus resolves/stoma active
  - Parenteral nutrition
- Stent in distal bowel left in situ

Feeding in stoma patients

- Use of the East of England standardised feeding protocol – often fed as per high risk
- Start with EBM as first line
  - Non short gut if no EBM then consider suitable whole protein
  - Short gut if no EBM then consider extensively hydrolysed formula

Feeding in stoma patients

- Advance feeds to maximum tolerated limit
- Agreed threshold – e.g. 20mls/kg
- Once at threshold to consider optimising feed regimen
- Consider use of stoma loss recycling where appropriate

Feeding in stoma patients

- Skin excoriation
- High losses
- Leaking stoma bags
- Lactose intolerance

Repeat laparotomy

- Criteria for stoma closure:
- size & weight
- Fitness
- feed limitations
- adhesions
- Contrast distal bowel clear

Feeding with short bowel

- Same principles as feeding with a stoma
  - BO frequency/consistency/skin integrity
  - Continue to monitor Ur Na
  - May still require a proportion of nutrition as PN
  - May require change in feed regimen

Conclusion

- Importance of joint thinking
- Good communication within and between teams and families