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 in utero transfer not planned or possible, 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