**Prenatal Diagnosis—VISIT #1**
1. Level II ultrasound  
2. Cardiac screening ultrasound  
3. Growth documentation  
4. Placental size and appearance

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**Isolated Gastroschisis**  
- No

**Multiple Anomalies**
- Yes
  - Karyotype NOT recommended
  - Karyotype IS recommended

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**Subsequent Perinatal Visits**
1. Monitor growth at least Q monthly  
2. Monitor amniotic fluid levels  
3. Bowel appearance documented  
   a. Thickening (mm)  
   b. Dilated bowel (mm)  
   c. Dilated bowel in or out of abdomen?  
   d. Liver or other organs out of abdomen

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**Normal Intrauterine Growth (weight at > 10th percentile)**
1. Monthly OB visits until 28 weeks  
2. Every other week OB visits until 32 weeks  
3. Weekly OB visits after 32 weeks  
4. Weekly Biophysical profiles at 32 weeks  
5. Vaginal delivery  
6. Deliver at 37 weeks or for  
   a. Labor  
   b. Fetal distress  
   c. Maternal indications

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**Decreased Intrauterine Growth (weight < 10th)**
1. Begin weekly OB visits earlier if infant < 10th percentile  
2. Begin the following fetal surveillance at 30 weeks  
   a. Twice weekly evaluations  
   b. Non-Stress Test each week  
   c. Biophysical profile each week  
   d. Doppler each week  
3. Deliver by 37 weeks or for  
   a. Labor  
   b. Fetal distress  
   c. Maternal indications  
   d. Worsening Biophysical profile  
   e. Doppler indicating reversed flow

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**Key Contact Information**

**Minneapolis**
- Perinatal Clinic: 612-863-4502  
- Fetal Therapy Coordinators: 612-654-1602  
- Schedule Neonatal Consult: 612-813-6288  
- Schedule Pediatric Surgery Consult: 612-813-8000

**St Paul**
- Perinatal Clinic: 651-241-6270  
- Perinatal Navigators: 651-241-6332  
- Schedule Neonatal Consult: 651-220-6260  
- Schedule Pediatric Surgery Consult: 612-813-8000

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**Fax updated info to NICU and NICU office**  
2. Parents offered repeat consultation (same neonatologist), if questions
**Resuscitation**
1. Dry the infant
2. Assess respiratory status
3. Provide respiratory support
4. Attach monitors
5. Protect exposed viscera
   a. Saran wrap followed by Kerlix creating gauze silo
   b. Lateral position to protect silo of wrapped bowel
6. Place peripheral IV
7. Begin IV glucose infusion – 120/kg
8. Fluid bolus-normal saline – 10 ml/kg
9. Nasogastric tube, aspirate stomach and low intermittent suction
10. Blood cx
11. Temperature stabilization

**NICU**
1. Infant is weighed
2. Infants length is measured
3. Attach monitors
4. Respiratory support
5. Call pediatric surgeons
   a. Notify surgeon in advance (day/evening only)
   b. During Night only call when he/she should come to the NICU
6. Blood work
   a. CBC with differential
   b. Glucose
   c. Type and screen
7. Intubated and paralyzed, if clinically indicated
8. OG Tube to LIS, #8-#10 Fr. Replogle
9. Urinary catheter (Foley)
10. Spring loaded silo placed if abd. Closure not possible
11. Amp. and Gentamicin until 24 hrs after abd. closure
12. PICC line for all infants
   a. If PICC line not central Broviac may be placed at closure

**Primary Surgical Closure**
1) PIP <25 cm H2O (Vt 4-6 ml/kg)
2) Measure intra-abdominal pressure (IAP)
3) Hourly X 2 days or until consistently ≤ 12 mm Hg (16 cm H2O) (12 mm Hg is the 90th percentile for neonates)
4) If IAP > 12 mm Hg. (16 cm H2O), notify doctor & consider:
   a) Elevate HOB to 30 degrees (maximum)
   b) Remove constricting dressings
   c) Neuromuscular blockade
   d) Vasoactive meds to increase perfusion
5) For IAP > 20 mm Hg (27 cm H2O), which is the official definition of intra-abdominal compartment syndrome &/or urine output < 1 ml/kg/hr, consider surgical intervention

**Silo followed by Surgical Closure**
1) Measure intra-abdominal pressure (IAP)
   a) Hourly X 1 days or until consistently ≤ 12 mm Hg (16 cm H2O)
   b) Hourly X 1 day after each silo reduction until consistently ≤ 12 mm Hg (16 cm H2O)
2) For IAP > 20 mm Hg (27 cm H2O) consider undoing silo reduction
3) Monitor SpO2 on silo every hour (not continuously—can damage the bowel)
   a) Apply probe to the TOP of the silo outside the topmost part of bowel.
   b) Do NOT remove plastic liner from the probe—in other words do not expose and do not apply sticky part of probe to silo (can damage silo). Use tape to keep probe in place and move as silo is reduced.
   c) Notify neonatologist if SpO2 on silo and hand is more than 10% different
Post-Discharge Follow-Up
1. Recommend close monitoring of growth (at least 6, 12, 18 months) (2 X risk of poor growth in first 3 years)
2. ≥ 50% chance of re-hospitalization (especially in complicated cases- atresias and bowel resections)
3. Slightly higher risk of delayed development (mostly in atresia/resection patients)
4. Follow up with primary surgeon 1-2 months.

1. Morphine or Fentanyl drip (NICU Sedation PowerPlan)
2. Ativan 0.1 mg/kg IV agitation q4H PRN
3. OG to LIS
4. Monitor IAP hourly. (Should be < 12 mm Hg (16 cm H2O))
5. Notify MD if IAP ≥ 12 mm Hg (20 cm H2O) & consider medical treatment
   a. N/G suction
   b. Remove any constrictive dressings
   c. Elevate head of bed to 30 degrees
   d. Neuromuscular blockade
   e. Vasoactive meds to keep perfusion pressure adequate
6. Notify MD if IAP > 20 mm H2O (27 cm H2O) &/or urine output < 1 ml/kg/hr AND consider surgical decompression

Attempt Feeding
1. Assess stooling, OG drainage and OG color
2. 2 weeks post operative suppository
3. Begin with bolus 20 mL/Kg/day offered by mouth divided Q3H
4. Begin with breast milk, standard formula or Elecare

Failure to Progress
1. Reassess by 2 months post surgery
2. Consider GI patency studies
3. Consider exploratory surgery
   a. Possible obstruction

Successful Feeding