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Congenital Esophageal Defects in Children

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Abstract
The current state of the problem of providing surgical care to children with developmental defects is presented. Groups of patients were identified according to the urgency of surgical care. An algorithm for the actions of neonatologists at the birth of children with developmental defects is presented.

Keywords: newborns, treatment, congenital malformations, preoperative preparation.

INTRODUCTION

The most important demographic indicators characterizing the effectiveness of the state's social policy and the level of development of society include the infant mortality rate. An analysis of the causes of infant mortality in Uzbekistan showed that in 47% of cases the cause of death is certain conditions that arise in the perinatal period (birth asphyxia, birth of a child with low and extremely low body weight, perinatal damage to the central nervous system, etc.), in 35% of cases are congenital malformations (primarily heart defects) and only 18% are due to other causes of death. The main component of the infant mortality rate is neonatal mortality.

MATERIALS AND METHODS

New procedures for obstetric, gynecological and neonatological medical care are aimed primarily at creating a three-level system of perinatal care, the development of which in economically developed countries has demonstrated high socio-economic efficiency [2-5].

RESULTS AND DISCUSSION

Until now, the treatment of children with congenital surgical pathology included 4 stages: antenatal diagnosis, maternity hospital, transportation from the maternity hospital to a surgical hospital or, in complex cases, to a specialized children's hospital. The negative aspects of the existing system of providing surgical care to children with developmental defects are the following:

1. Until now, the decision on terminating or prolonging pregnancy in case of malformations in the fetus is decided by one specialist - an ultrasound doctor or an obstetrician-gynecologist, who in most cases are unfamiliar with this pathology. This leads to termination of pregnancy in case of

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developmental defects with a favorable prognosis and, conversely, prolongs pregnancy in case of defects that are incompatible with life or lead to profound disability of children.

2. There is no clear coordination between the activities of ultrasound diagnostic units, which are managed by obstetricians, and children's surgical hospitals. This leads to untimely hospitalization in a specialized hospital for children with developmental defects and severe irreversible changes in organs and tissues, which significantly worsens treatment results. According to E.V. Yudina, only 58% of newborns with prenatally diagnosed malformations were transferred to a surgical hospital at the age of the first 3 days of life. The remaining children were admitted to surgical departments after the 4th day of life, of which 8% were admitted on days 16–18 after birth, which led to unfavorable outcomes.
3. Not all doctors in maternity hospitals are sufficiently familiar with the tactics of managing children with developmental defects. The difficulty of diagnosing congenital malformations in children in the first days of life that were not detected prenatally is due to the fact that the initial symptoms of the disease can be mistaken for manifestations of transitional states or maladjustment syndrome. Insufficient quality of prenatal ultrasound diagnostics, lack of surgical vigilance, or incorrect interpretation of the clinical picture of the disease are the main source of diagnostic errors that negatively affect the prognosis of the child's life and health.
4. Great difficulties are associated with the problem of gentle transportation of the newborn. Many children with congenital malformations are in a very serious condition from the first hours of life. They have unstable hemodynamic parameters and severe respiratory disorders, which makes it difficult to timely transport such children to a pediatric surgical hospital.

Depending on the complexity of the fetal malformation, the prognosis of the disease, the expected speed of development of decompensation of the child's condition after birth, the possibility of surgical correction and methods of delivery, in our opinion, it is advisable to distinguish several groups of patients:

1. Pathology requiring immediate surgical intervention immediately after the birth of a child - gastroschisis, embryonic hernias with a narrow base, esophageal atresia, duodenal atresia, atresia of the small and large intestine, anal atresia, diaphragmatic hernias, pulmonary adenomatosis with phenomena of respiratory failure, tumor formations leading to asphyxial syndrome.
2. Pathology requiring delayed surgical intervention - mass formations of the abdominal cavity, multicystic disease, megaureter, hydronephrosis, biliary atresia, common bile duct cysts, teratomas, ovarian cysts.
3. Pathology requiring urgent delivery by cesarean section - large teratomas (larger than the circumference of the child's head), large embryonic hernias (more than 5 cm), large

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lymphangiomas, gastroschisis, ovarian cysts (more than 10 cm) etc.

4. Pathology that gives grounds for discussing the issue of termination of pregnancy is polycystic kidney disease, renal agenesis, urethral atresia, multiple malformations, malignant tumors, chromosomal diseases. The issue of termination of pregnancy is decided in each specific case individually and is determined by the age of the mother, her somatic and gynecological history.

Considering that congenital malformations are primarily dealt with by neonatologists in maternity hospitals, we would like to dwell on the clinical picture, diagnosis and tactics of preoperative management of the most common developmental anomalies.

Esophageal atresia is a developmental defect characterized by a blind ending in the oral end of the esophagus. The esophagus ends blindly at a distance of 10–12 cm from the nasal passages. In 95% of cases, the distal segment of the esophagus communicates with the posterior wall of the trachea (distal tracheoesophageal fistula). Complete obstruction of the esophagus leads to the child's inability to swallow saliva that forms in the oral cavity, resulting in increased salivation and aspiration of contents.

Gastroschisis is intrauterine eventration of internal organs through a defect in the anterior abdominal wall. Unlike an embryonic hernia of the umbilical cord, the defect is almost always localized to the right of the normally formed umbilical cord. The hernial sac is missing.

Omphalocele (hernia of the umbilical cord) is a malformation of the anterior abdominal wall with a defect in the umbilical ring, through which the abdominal organs, covered with peritoneum and umbilical membranes, emerge. Usually, with omphalocele of small and medium size, delivery is carried out through the natural birth canal.

Congenital diaphragmatic hernia is a developmental defect in which the abdominal organs move into the chest cavity through a hole in the diaphragm or by protrusion of its thinned area. The severity of the condition of children is mainly due to three reasons: pulmonary hypoplasia, high pulmonary hypertension and cardiovascular failure.

Volumetric formations. In the abdominal cavity, cysts of various origins are most often found, less often tumors - neuro-, nephroblastomas, teratomas. The risk of damage to the membranes of the formation is low. Delivery usually occurs through the vaginal birth canal. However, if the formations are large (more than 10 cm), delivery by cesarean section is indicated.

CONCLUSION

Thus, the tactics of a neonatologist in a maternity hospital depend on the type and form of the defect. At the same time, delivery of women with prenatally identified malformations in the fetus must be carried out in perinatal centers where there are specialists (resuscitators and pediatric surgeons) who

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can provide qualified assistance immediately after the birth of the child.

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