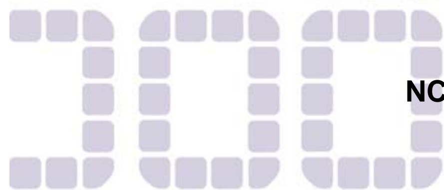

NCCU CLINICAL GUIDELINES
SECTION: 13

SURGICAL CONDITIONS

Section: 13 Surgical Conditions
Guidelines for the transfer of preterm infants with intestinal perforation/NEC;
Consensus opinion of the surgeons and the neonatologists at KEMH and PMH)
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Neonatology Clinical Guidelines
King Edward Memorial/Princess Margaret Hospitals
Perth Western Australia

GUIDELINES FOR THE TRANSFER OF PRETERM INFANTS WITH INTESTINAL PERFORATION/NEC; CONSENSUS OPINION OF THE SURGEONS AND THE NEONATOLOGISTS AT KEMH AND PMH)

The management of premature infants with surgical problems is complicated by the geographic separation of KEMH and PMH. As a general principle it is more appropriate to have surgical infants at PMH where the surgeons are in ready attendance and have access to their support staff.

The following recommendations should apply in most of the scenarios:

1. There should be direct communication between the KEMH Consultant Neonatologist and the duty Consultant Paediatric Surgeon. If for any reason the consultant is extremely busy, the respective senior registrars should take the responsibility while keeping the consultants informed all the time.

   Ideally such discussions should take place at KEMH once the surgeon has physically assessed the infant. It is inappropriate for such decisions to be made at more junior levels or by telephone without actually reviewing the baby. But some times laparotomy is mandated and so transfer needs to be expedited without waiting for a formal visit from the paediatric surgeon. In such situations, the transfer could be organised after telephonic discussions.

2. Once reviewed, the surgeons may decide to do peritoneal drain or laparotomy

   If the baby has peritoneal drainage insertion at KEMH, he/she will be transferred to 6B as soon as the clinical condition stabilises.

   If laparotomy is decided, the baby will be transferred to 6B on the same day.

3. In some cases such as severe NEC without perforation, the surgeons may want to transfer the baby to PMH for close observation. Such transfer will depend on the availability of beds in 6B.

Special scenario: If a baby is extremely critically ill, transport can destabilize and even result in death. If the KEMH neonatologist considers the baby too unstable (eg., HFOV, Nitric Oxide, severe hypotension), more onsite discussions between the surgeons and the neonatologists will need to occur prior to transport. Decompression of the abdomen by means of a peritoneal drain to release the intra-abdominal pressure may improve ventilation and facilitate early transport.

Subsequent to the arrival in 6B:

1. Babies who have peritoneal drainage and do not require any surgery over the next few weeks may be transferred back to KEMH once they are stable.

2. Babies undergoing laparotomy will stay in 6B until discharge. Under exceptional circumstances, they may go back to KEMH after detailed discussions between the neonatologists at KEMH, PMH and the surgeons.

3. Babies with NEC, who come for close observation and do not need laparotomy or peritoneal drainage while in 6B, will be considered for transfer back to KEMH once the acute illness is resolved.