	Gastroschisis	Omphalocoele (Exomphalos)
Incidence	1:4000 to 1:10 000. Increase with maternal age<20, smoking, drug use, low weight, genitourinary infection and low SES	1:5000
M:F	1:1	2:1
Etiology	2-5cm defect, usually right sided, intact umbilical cord. Due to omphalomesenteric artery occlusion. Bowel evisceration with fibrin thickening. Intestinal atresia in 10-15% of cases	Due to failure of abdo wall infolding in 3rd week of development. Midgut does not return post rotation allowing other organs to herniate. Herniation is through base of umbilical cord. Defect 2-10cm.
Associated with	Small baby, other non GI anomalies rare	50-70% associated other issues. Beckwith Weidemann 15%. Chromosome trisomy 13,18,21. Cardiac, pulmonary hypoplasia Other midline: Pent of Cantrell, imperf anus, ileal atresia, meningocoele Renal, limb, facial
Diagnosis	Antenatal ultrasound with increased alpha feto protein	Antenatal ultrasound
Management	Fluid rests, gastroschisis far more (up to double expected) Broad spectrum Abx NGT with decompression At delivery protect viscera, cove with cling film, not wet swabs	Same
Surgical	Urgent repair, if closure not possible, silo insertion	<8cm – Small – Try primary closure or silo >8 or with liver – Giant – will need later closure. Sac covered with escharotic agents and ventral hernia closed later.
Anaesthesia	GA with caudal ideal. CVP, intragastric and CVP pressures useful for monitoring tightness of closure. Insp pressures suddenly raised or 20-30cmH2O OR gastric pressures > 20, silo recommended SpO2 monitoring pre and post ductal May indicate arterial insufficiency in Abdo Compartment Syndrome.	Same
Post-Op	Monitor urine output and sepsis Ventilatory management IAP monitoring TPN May be required Survival 90%	Ventilatory management Treat associated conditions Survival 70-90% depend on conditions
Complications	Unrecognized atresia Abdo wall cellulitis and breakdown NEC Sepsis Cholestasis	Pulmonary and cardiac Gastro-oesophageal reflux Abdo wall breakdown Sepsis