

Upper respiratory tract complications are a threat to life in both the preoperative and the postoperative periods. In addition to pneumonia, there is a constant danger of respiratory distress resulting from atelectasis, pneumothorax, and laryngeal edema. Any persistent respiratory difficulty after removal of secretions is reported to the surgeon immediately. The infant is monitored for anastomotic leaks, such as purulent chest tube drainage, an increased WBC count, and temperature instability.

For the infant who requires esophageal replacement, nonnutritive sucking is provided by a pacifier. Sometimes small amounts of water or formula are given orally, and although the liquid drains from the esophagostomy, this process allows the infant to develop mature sucking patterns. Other appropriate oral stimulation prevents feeding aversion. Infants who take nothing by mouth (NPO) for an extended period or who have not received oral stimulation have difficulty eating by mouth after corrective surgery and may develop oral hypersensitivity and feeding aversion. They require patient, firm guidance to learn the techniques of taking food into the mouth and swallow after repair. A referral to a multidisciplinary feeding behavior team may be necessary.

Some infants with EA/TEF may require periodic esophageal dilations on an outpatient basis. Discharge education should include instructions about feeding techniques in the child with a repaired esophagus, including a semi-upright feeding position, small feedings, and observation for adequacy of swallowing (regurgitation, cyanosis, choking). Tracheomalacia is often a complication, and parents are educated regarding the signs and symptoms of this condition, which include a barking cough, stridor, wheezing, recurrent respiratory tract infections, cyanosis, and sometimes apnea. GER may also occur when feedings resume and may contribute to reactive airway disease with wheezing and labored respirations as the prominent clinical manifestations. Problems with thriving and gaining weight may occur in the first 5 years of life in the child with EA/TEF, especially if the infant is born preterm, and the nurse should be alert to the achievement of developmental milestones that indicate a need for early intervention and multidisciplinary referral.

Preparing parents for discharge of their infant involves teaching the techniques that will continue at home. Parents learn signs of