Objective
Presentation of intrauterine diagnosis and clinical course of fetal jejunal atresia.

Methods
Case report.

Results
Fetal small bowel atresias are relatively frequent malformations with the incidence of 1/2500 to 5000 live births; with jejunal atresias accounting for half of the cases, approximately. Those cases are difficult to diagnose before 24 weeks of gestation. They represent with dilated intestinal loops above the level of atresia. Polyhydramnios may complicate these cases according to the level of obstruction. Because of the need for early surgical intervention postnatally, those cases should be delivered in tertiary care centers. Here, we present a case with multiple jejunal atresias (type 4), managed successfully in our institution. 27 year-old patient (gravida 4 para 3) was referred to our department with the diagnosis of fetal bowel dilatation at 25 weeks of gestation. Multiple loops of dilated bowel (17 mm) with hyperechoic walls were detected. Fetal biometry was normal, there was no polyhydramnios. Because of the multiple dilatation of the bowel loops, jejunoileal atresia was diagnosed. Anatomical survey did not reveal any accompanying fetal abnormality, fetal echocardiography was also performed and it was normal. The patient was followed up for fetal biometry and possible polyhydramnios. At 34 weeks of gestation, there were extreme dilatations of fetal bowel measuring up to 35 mm (Figure 1). Amniotic fluid index was 22 cm. patient was admitted to clinic for close follow up. At 35 weeks of gestation, contractions started and cesarean section was performed with the indication of repeat cesarean section. A female fetus of 2320 gr with fifth minutes Apgar score of 10 was delivered. The newborn was operated soon after delivery. During the explorative laparotomy, there were 30 cm dilated jejunai loop following Treitz ligament and multiple sites of jejunal atresia were detected (type 4 jejunal atresia). Resection of those atretic sites and end-to-end intestinal anastomosis were performed. The newborn was accepted to neonatal intensive care unit and went on very well without any prematurity complications or malabsorption.

Conclusion
Jejunal atresia cases represent with dilated bowel loops at second or early third trimester. Detailed sonogram should be performed in these cases to reveal any accompanying fetal anomaly. Because of the risk of polyhydramnios, preterm birth, intestinal perforation and the need for early surgical intervention to the newborn; those cases should be followed up and delivered in tertiary referral centers.