Objective
The presence of dilated bowel loops antenatally suggests fetal bowel obstruction and depending on the level and extent of obstruction have different variations in presentation. Antenatal detection of surgically correctable anomalies would ideally reduce perinatal morbidity and mortality by allowing a planned delivery with early prompt surgical intervention and resuscitation. Duodenal atresia is the most common intestinal atresia diagnosed in a fetus. Presently there are no significant abnormalities of the fetal gastrointestinal tract that benefit from fetal intervention. However a thorough understanding of the disease processes is necessary for diagnosis and treatment of intestinal obstruction.

Methods
A G3P2 referred from primary care at 33 weeks gestation. The previous two babies were delivered spontaneously and was found to have some fetal anomaly post natally. However both are alive and well had some an anomaly which was not known. The patient had no medical or surgical history. On examination she was well. Abdominal examination suggested 32 weeks size uterus. USS performed suggested fetal weight of 2.1 kg. Placenta and liquor volume was normal. Fetal movements were normal. Abdomen was distended with whirl appearance of bowel and distended loops. Small intestinal obstruction was suspected. CTG showed poor variability with baseline tachycardia of 170 /mt. CS was carried out after steroid administration and discussion with a paediatric surgeon. Baby was flat at delivery with Apgar of 6 and 8 at 1 and 5 minutes respectively. Baby was given surfactant and intubated. Abdomen was distended with pale skin. The diagnosis of intestinal obstruction with volvulus was made. Further investigation suggested no malrotation and volvulus as suspected. Resection of gangrenous bowel was carried out with ileo-ascending colon anastomosis Baby at follow up at 6 months was doing well and gaining weight.

Results
Fetal bowel dilatation is characterized by fluid-filled intestinal loops which measure at least 15 mm in length or 7 mm in diameter. Ultrasonographic image of dilated fetal bowel is a sign of intestinal mechanical or functional obstruction and its prevalence depends on the underlying condition such as bowel atresia or stenosis, malrotation with volvulus, meconium ileus, total colonic aganglionosis, and meconium plug syndrome. The diagnosis of an intestinal dilatation cause is difficult as some obstructions may not be seen until the late second or third trimester. The difference between dilated small bowel loops and colon by ultrasound imaging is challenging as is the accurate identification of the number and location of obstructions.

Conclusion
Fetal bowel dilatation is an indirect sonographic sign of mechanical or functional bowel obstruction. The etiology of fetal bowel dilatation is a difficult prenatal diagnosis since ultrasound has limited accuracy for bowel evaluation. With advances in neonatal intensive care and management there has been a significant decrease in mortality rates of neonates with intestinal obstruction. As such, fetal bowel dilatation might be associated with different postnatal outcomes which makes the prenatal management and parental counseling problematic.