A CASE STUDY OF LONG GAP OESOPHAGEAL ATRESIA FOLLOWED TO ADULTHOOD

M Steven¹, P McGrogan², R Carachi¹

¹Department of Surgical Paediatrics, University of Glasgow, Scotland, United Kingdom
²Department of Gastroenterology, Royal Hospital for Sick Children, Glasgow, Scotland, United Kingdom

Case Study

We report a single interesting case study involving the fifteen year follow-up of a child with long gap oesophageal atresia (LGOA).

A 30 week gestation baby was transferred in utero from a peripheral hospital due to concerns over prolonged rupture of membranes. The baby was born in good condition by normal delivery and was noted to have increased secretions and a diagnosis of pure oesophageal atresia was made. A Stamm gastrostomy was made on day 2 of life and a Replage tube was left in situ. After 6 weeks of aggressive feeding to induce reflux the child proceeded to thoracotomy and a tight anastomosis was performed. He was paralysed for 10 days postoperatively and was ventilated for three weeks. Subsequent contrast showed an anastomotic stricture and gastro-oesophageal reflux (GOR). He underwent serial balloon dilatations and at 7 months of age had an open fundoplication. He made an excellent recovery and was followed up routinely. At the age of four he complained of some dysphagia, but there was evidence of further stricture and was treated medically for GOR. Further contrast studies (fig 1) over the next decade demonstrated a patent anastomosis and at the age of fourteen he underwent oesophageal manometry and impedance studies. These have interestingly shown no obstruction, but no demonstrable peristaltic waves in the oesophagus (fig 2).

Discussion

There remains much debate in the literature with regards to how best to treat LGOA and practice continues to vary across the United Kingdom¹. Some centres advocate oesophageal replacement whilst others have tried novel techniques to preserve the native oesophagus at all costs²,³. There are an increasing number of centres that have followed patients into early adulthood and performed motility studies that have shown longer transit time and slower propagation⁴. Complete lack of peristalsis as seen in this case is also increasingly recognised.

Conclusion

In conclusion, preserving the native oesophagus is possible when the surgeon is committed to this goal and this is still our preferred option. This patient demonstrates that the native oesophagus may only function as tube with no motility but that patients can be largely asymptomatic from this and continue to grow and thrive.

References

²Foket, Krosch, Caron et al “Long-gap oesophageal atresia treated by primary insertion and early follow-up results” Seminars in Pediatric Surgery (2009) Vol 16, Issue 1, 23-29