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FACE THE EXAMINER

ESOPHAGEAL ATRESIA WITH/WITHOUT TRACHEOESOPHAGEAL FISTULA

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QUESTIONS

1. What clinical and sonographic features should make one suspect esophageal atresia in a pregnancy?
2. What is the quickest method of diagnosing esophageal atresia, with or without tracheo-esophageal fistula (TEF)?
3. What management principles should be followed in a newborn with esophageal atresia ± TEF till surgery is carried out?
4. What difficulties are encountered in a newborn with esophageal atresia ± TEF and right aortic arch?
5. What are advantages and disadvantages of trans-anastomotic tubes in esophageal atresia ± TEF?
6. What are the management options in anastomotic leak in esophageal atresia ± TEF repair?
7. What immediate postoperative care is recommended in a neonate operated for esophageal atresia ± TEF?
8. What long term follow-up is recommended in a survival of esophageal atresia?
9. What management options are available in a child who develops stricture at anastomotic site following esophageal atresia ± TEF repair?
10. What are different investigations in a child suspected to have H type TEF?

Note: This section is meant for residents to check their understanding regarding a particular topic

ANSWERS

1. Polyhydromnios, small gastric bubble, dilated upper esophageal pouch [1].

2. Pass a soft blunt tipped rubber catheter through mouth. If it arrests at 10 cm from gum margin, baby has esophageal atresia. Observe the stomach; if it is scaphoid, baby may have isolated esophageal atresia, if it is distended, baby is likely to have TEF [1].

3. Frequent upper pouch suction, semi-erect position, hydration, antibiotics, stop feeds, vitamin K, and warmth [1].

4. Lower esophageal segment concealed under the descending aorta, difficult to locate, anastomosis touched by pulsating aorta, iatrogenic injury to vital structures due to unfamiliarity with anatomy [1].

5. Transanastomotic tubes allow early feeding, prevent catabolism, and prevents double bites of esophageal wall; but can obstruct esophageal lumen and prevent salivary drainage leading to secretions in throat, compromised anastomosis [2].

6. These are; TPN; Gastrostomy/jejunostomy feeds/Transanastomotic tube feeds; Oral feeds if leak is small; Drainage of leak; Esophagostomy and gastrostomy [1,2].

7. These are; Upper pouch suction; Chest physiotherapy; Humidified oxygen; Analgesics; Care of chest tube/NG tube [2].

8. Monthly weight record for first few months; Esophageal calibration for first year; Growth monitoring every year; Investigate for dysphagia; Evaluate for GER if suspicion [2].

9. Anti-reflux measures such as position, Thick formula feeds; H2 blockers; Dilatation; Dilatation and local bleomycin/steroid; Balloon dilatation; Stricturoplasty; Replacement [1,2].

10. Barium swallow; Esophagoscopy/bronchoscopy; CT/MRI [1,2].

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