ABSTRACT

The tracheosophagial fistula with esophageal atresia is the most common congenital anomaly of the esophagus. Congenital TEF has incidence of 1:2500-3000 live births. It has been seen that neonates with congenital esophageal atresia / Tracheosophagial fistula often present with minimal lung pathology and excellent lung compliance. The surgical management is right lateral thoracotomy or thorascoscopic primary repair occasionally staged repair is indicated for long –gap atresia. Neonates with TEF and EA frequently have associated anamolies described by acronym VACTERAL. These anamolies and their associated incidences include VERTEBRAL 17%, ANAL 12%, CARDIAC 20%, TRACHEOSOPHAGIAL FISTULA and ESOPHAGEAL ATRESIA, RENAL 16%, LIMBS 10% and other midline defects (cleft lip and palate 2%), urogenital abnormalities 5%.

Keywords: Tracheosophagial Fistula, Esophageal Atresia, Urogenital Abnormalities

A CASE REPORT

The patient was delivered at 37wks of gestation by LSCS. He was the second child born to a non-consanguineous marriage from a healthy 38 years old mother and 42 years old father. His brother was normal and family history was un remarkable. The birth weight of the newborn was 2.5kg (3rd to 5th percentile), length 49 cm (10th-25th percentile). Apgar score 4/10 at 5min .The neonatal examination revealed excessive secretion of saliva, coughing, gagging, choking and inability of nasogastric tube to pass into the stomach . There was obstruction at 11cm. The child then turned cyanosed. Confirmation of the diagnosis was made at birth by chest X-ray which showed NG tube curled in the upper chest or neck (Fig 1.1).

The patient was then shifted to NICU. Now, other type of VACTERAL anamolies was evaluated. Echocardiography revealed TOF. USG REPORT was normal .Then the child was then intubated for mechanical ventilation at 5hrs of life.(fig 1.2). The patient was then sent to dept. of pediatric surgery for right thoracotomy. After surgery the post-operative management was done with minimal handling, no neck extension, suctioning till 5cm and I.V fluids.
DISCUSSION

In this case, TEF with EA was associated with TOF. Prenatal ultrasound suspicion of EA is usually based on the presence of polyhydramnios and fetal stomach that is absent or shows reduced filling. Surgical repair is the definitive treatment for EA with TEF with TOF. SURGERY is performed within 24 to 72 hrs of life. Delay in surgical correction increases the risk of aspiration of saliva as a result of accumulation in the upper esophageal pouch. Reflux of gastric acid through lower pouch and a TEF can cause pneumonitis. Prophylactic antibiotic should be given to prevent RTI. Prognosis regarding the patient should be done prior to surgery.

REFERENCES