IS-021  Esophageal atresia complicated by duodenal atresia and anorectal malformation: A report of two cases

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Introduction: Esophageal atresia (EA) is often complicated by multiple anomalies, such as congenital heart disease, duodenal atresia (DA), and anorectal malformation (ARM). We successfully operated on two EA infants exhibiting DA and ARM with primary esophageal anastomosis. Case 1: A 2,707 g, a 37-week-gestational age girl diagnosed with EA (Gross C), DA and ARM (anocutaneous fistula). She showed severe aspiration pneumonia, and gastrostomy was performed under local anesthesia on Day 1. Following 1-week treatment for pneumonia, division of tracheoesophageal fistula (TEF) and esophagoesophagostomy were done. The length of the gap of the esophagus was 20 mm. Transcervical myotomy of upper esophagus was performed for elongation. Duodenoduodenostomy was also performed. Cut-back anoplasty was performed later on Day 28.

Case 2: A 2,170 g, a 38-week-gestational age boy diagnosed with EA (Gross C), DA and ARM (rectourethral fistula). His respiratory condition was stable, and on Day 1, division of TEF and primary esophagoesophagostomy were performed without myotomy. The length of the gap of the esophagus was 18mm. Duodenoduodenostomy, sigmoid colostomy and resection of Meckel’s diverticulum were also performed on Day 1. Posterior sagittal anorectoplasty was successfully performed at 11 months of age. Postoperative courses of both cases were uneventful.

Conclusion: Primary esophagoesophagostomy for severe esophageal atresias is feasible if respiratory function is stable.