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Case Report

A rare association of esophageal atresia and tracheoesophageal fistula with microgastria: A case report

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ABSTRACT

We present a case of esophageal atresia with tracheoesophageal fistula which was associated with microgastria. Following primary esophageal anastamosis developed leak and went into severe sepsis and died.

Keywords: Esophageal atresia, Tracheoesophageal fistula, Microgastria

INTRODUCTION

Congenital microgastria is a rare anomaly of the stomach resulting from abnormal development of the foregut. This results in tubular stomach with reduced capacity. It is almost always associated with other congenital anomalies.[1] Association of tracheoesophageal fistula (TEF) with microgastria is a very rare entity.

CASE REPORT

A 1.5 kg preterm was born by LSCS to a primigravida mother of 26 years. Baby was born with drooling of saliva and was kept in NICU. On radiological evaluation was found to have [Figure 1] coiling of tube with absent gastric shadow. However, minimal bowel shadows noted distally. Baby was taken for emergency surgery on day 1 of life. Intraoperatively was found to have esophageal atresia with TEF (Type C) with long gap. Anastomosis is done under tension [Figure 2]. Trans-anastomotic tube was going with difficulty; hence, laparotomy was done and found to have microgastria [Figure 3]. The stomach was so small, tubular could not be delivered outside for gastrostomy; hence, feeding jejunostomy was done. Postoperatively baby was under ventilator support. Later developed anastomotic leak and sepsis following which baby died.

DISCUSSION

Esophageal atresia with tracheoesophageal fistula in association with microgastria is very rare. Several other anomalies are reported in association with microgastria. Microgastria is characterized by megaesophagus with incompetence of gastroesophageal sphincter.[2] Isolated microgastria is very rare and very few are reported in literature.[3] The diagnosis of microgastria is usually made by upper gastrointestinal dye study which shows small tubular stomach in midline.

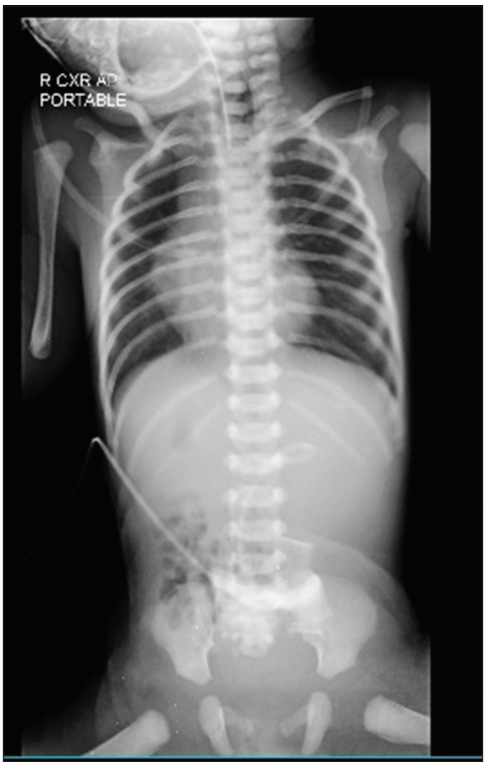

Figure 1: Baby gram showing coiling of tube I upper pouch with absent stomach shadow and minimal distal bowel shadow.

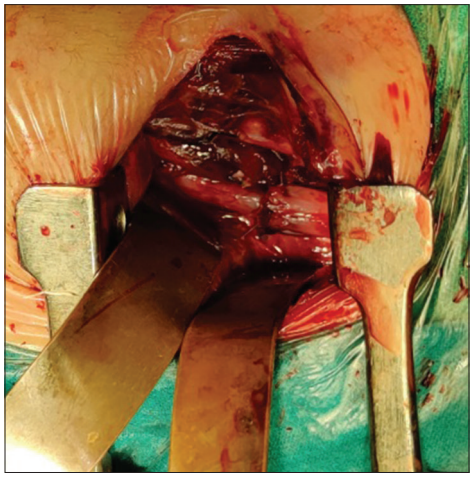

Figure 2: Showing esophageal anastomosis under tension.

In our case, pre-operative baby gram showing absent stomach shadow was a highlighting finding in the presence of minimal distal bowel shadow. Treatment of microgastria can be conservative (or) surgical, depending on severity of microgastria. Conservative treatment includes continuous small frequent feeds (nasogastric/naso-jejunal feeds).[4] Surgical intervention includes gastric augmentation by creation of Hunt-Lawrence pouch have been described.[5,6]

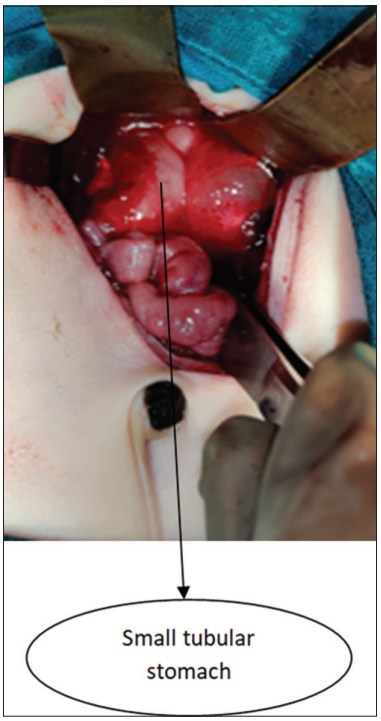

Figure 3: Intraoperatively showing small stomach.

CONCLUSION

A high view of suspicion must be considered in TEF babies if baby gram shows coiling with absence of stomach shadows in presence of minimal bowel shadows.

Cervical esophagostomy could probably save baby instead of primary anastomosis.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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