Evaluation of Gastroesophageal Reflux in Children Born With Esophageal Atresia Using pH and Impedance Monitoring

**ORIGINAL ARTICLE: GASTROENTEROLOGY**

**ABSTRACT**

**Objectives:** The aim of the study was to evaluate acid and nonacid gastroesophageal reflux in infants and school-aged children with esophageal atresia (EA) using pH-impedance (pH-MII) monitoring. **Methods:** Between 2012 and 2017, all 24-hour pH-MII studies performed in infants (≤18 months) and 8-year olds with EA were included. Antacid therapy was discontinued before study. Exclusion criteria were: isolated tracheoesophageal fistula; esophageal replacement therapy; tube feeding; and monitoring <18 hours. Automatically detected retrograde bolus movements (RBM) were manually reviewed and modified/deleted if necessary. **Results:** We included 57 children (51% boys; 2% isolated EA; 44% thoracoscopic EA repair): 24 infants (median age 0.6 years) and 33 school-aged children (median age 8.2 years). Of the automatically detected 3313 RBM, 1292 were manually deleted from the tracings: 52% of nonacid RBM and 8% of acid RBM (mainly misinterpreted swallows or 1 event recognized as several events). In infants, median reflux index (RI; pH <4) was 2.6% (abnormal in n = 2), median RBM was 61 (62% nonacid, 58% mixed), and median of the mean BCT was 11 seconds. In older children, median RI was 0.3% (abnormal in n = 4), median RBM was 21 (64% nonacid; 75% mixed), and median of the mean BCT was 13 seconds. **Conclusions:** Most children with EA off medication have a normal RI, yet experience a significant number of nonacid RBM. After manual revision of the tracings, a high percentage of RBM was deleted. Our data show that automated impedance analysis software needs refinement for use in infants and children with EA and question the need for standard antacid therapy in these patients. **Key Words:** acid reflux, nonacid reflux, pH-metry, pH-MII study, tracheoesophageal fistula

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**What Is New**

- We present pH-impedance data at the approximate ages at which reflux monitoring in esophageal atresia patients is recommended.
- Most children have a normal reflex index, which questions the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition-North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition recommendation for standard proton pump inhibitor therapy in the first year postsurgery.
- Automated software overdetects reflux events in esophageal atresia patients.

Eosophageal atresia (EA) with or without a tracheoesophageal fistula (TEF) is a relatively common birth defect in which the continuity of the esophagus is interrupted (European prevalence: 2.43 per 10,000 births) (1). As a result of inborn deficient esophageal innervation and surgical nerve injury, EA patients suffer from esophageal dysmotility (2,3). Gastroesophageal reflux (GER; acid and nonacid) is a physiologic phenomenon. When GER causes troublesome symptoms interfering with daily life or complications, it is referred to as GER disease (GERD) (4). GERD is thought to be common after surgical EA repair in both children and adults (5,6). It results in respiratory and gastrointestinal problems in the short-term (eg, aspiration pneumonia, apparent life-threatening events, dysphagia, feeding problems) and long-term (eg, chronic respiratory symptoms, esophagitis, esophageal strictures, Barrett esophagus, esophageal cancer) (6–10). Given the high prevalence of GERD in children with EA (up to 54% in some studies using the definition “fundoplication performed, pH-study positive or endoscopic esophagitis”), it is important to diagnose and manage GERD to reduce associated complications (5,6).

Although many children with EA are exposed to chronic GER, only a few experience troublesome symptoms. Results from pH-impedance (pH-MII) studies as well as endoscopic evaluations in children with EA show that asymptomatic children can have...
or 7 to 9 years with a duration of

cable to the study protocol (protocol ID MEC-2017–185).
Research Involving Human Subjects Act was considered not appli-
jejunal/colonic interposition); and use of tube feeding. The Medical
symptoms, body position, and intake of food and beverages.
asked to fill in a diary during pH-MII monitoring to monitor
All antiacid and prokinetic therapy was discontinued before the start
correct pH channel position (3 vertebrae above the diaphragm) (20).
channels, 1 pH channel). A chest X-ray was performed to ensure
(18,19). A cut-off score (16,17). All 8-year-old children were asked to fill in an online
of anti-reflux medication,
and clinical data at time of pH-MII monitoring (eg, symptoms, use
of care, all children receive PPI for at least 6 months after surgical
EA repair. We retrospectively reviewed all pH-MII studies con-
ducted in children with EA between September 2012 and
October 2017 and included studies performed at ages ≤18 months
or 7 to 9 years with a duration of ≥18 hours. Exclusion criteria were:
isolated TEF; esophageal replacement therapy (eg, gastric pull-up,
jejunal/colonic interposition); and use of tube feeding. The Medical
Research Involving Human Subjects Act was considered not appli-
cable to the study protocol (protocol ID MEC-2017–185).

METHODS

Patients
All children with EA born in our hospital are offered a 24-
hour pH-MII study at the age of 0.5 and 8 years as part of a
longitudinal multidisciplinary follow-up program (15). As standard
of care, all children receive PPI for at least 6 months after surgical
EA repair. We retrospectively reviewed all pH-MII studies con-
ducted in children with EA between September 2012 and
October 2017 and included studies performed at ages ≤18 months
or 7 to 9 years with a duration of ≥18 hours. Exclusion criteria were:
isolated TEF; esophageal replacement therapy (eg, gastric pull-up,
jejunal/colonic interposition); and use of tube feeding. The Medical
Research Involving Human Subjects Act was considered not appli-
cable to the study protocol (protocol ID MEC-2017–185).

Data Collection
Data retrieved from patient records included baseline char-
acteristics (eg, sex, gestational age, type of EA, type of EA repair)
and clinical data at time of pH-MII monitoring (eg, symptoms, use
of anti-reflux medication, z-scores height, and weight-for-height)
(16,17). All 8-year-old children were asked to fill in an online
validated questionnaire for detecting GERD by Manterola et al
(18,19). A cut-off score >3 was used.

Small for gestational age was defined as a birth weight 2
standard deviations (SD) below normal. Prematurity was defined as
gestational age <37 weeks. Pulmonary infections were defined as
lower respiratory tract infections requiring antibiotic therapy and/or
hospital admission.

pH-MII Monitoring Protocol
Children were intubated with an age-appropriate pH-MII
catheter. We used 2 available types of pH-MII catheters to perform
24-hour pH-MII studies: Greenfield (Dover, USA) single use
antimony pH-MII catheters (6.4 French, 6 impedance channels,
1–2 pH channels) and Laborie ion-sensitive field-effect transistor
(ISFET) disposable pH-MII catheters (6 French, 6 impedance
channels, 1 pH channel). A chest X-ray was performed to ensure
correct pH channel position (3 vertebrae above the diaphragm) (20).
All antacid and prokinetic therapy was discontinued before the start
of the pH-MII assessment (5 and 2 days, respectively). Parents were
asked to fill in a diary during pH-MII monitoring to monitor
symptoms, body position, and intake of food and beverages.
Patients were instructed not to eat acid foods or drink carbonated
beverages.

Manual Correction of Reflux Events
Initial manual review was performed to ensure correct diary
records and to delete artefacts. Then MMS database software 9.5
(Medical Measurement Systems B.V., Enschede, The Netherlands)
was used for automated analysis (acid/alkaline limits; pH 4.0 and
7.0; minimum reflux duration pH- and MII-results: 5 seconds; air
threshold: 5000Ω). All reflux events—identified as such by the
software—were manually reviewed and modified (duration; number
of impedance channels involved; liquid/mixed reflux content)
by 1 researcher unaware of the clinical symptoms (F.V.). A second
reviewer (M.v.W.) examined inconclusive events. RBM were
deleted in case both reviewers agreed the RBM was misinterpreted
by the software.

Data Analysis
Parameters analyzed in this study included number of pH
changes to <4; reflux index (RI; acid exposure index [%]); number
of long (>5 minutes) acid exposures; longest acid exposure (min-
utes); number of retrograde bolus movements (RBM); number of
acid/nonacid (pH ≥4) RBM; number of liquid/mixed RBM; mean
bolus clearance time (BCT; seconds); number of proximal bolus
exposures (reaching proximal impedance channel); symptom index
for reflux (SI); and symptom association probability (SAP; window
of 120 seconds before and after a reflux event). An RI >7% was
considered to be abnormal, <3% to be normal, and 3% to 7% to be
indeterminate (21). SI ≥50% and SAP ≥95% were considered
positive (22).

Data are presented as frequencies, mean (SD) or median
(minimum; maximum; interquartile range [IQR]). Data were ana-
yzed with SPSS 21.0 (SPSS Inc., Chicago, IL) using descriptive
statistics. Nonparametric Mann-Whitney U test was used to com-
pare continuous variables and Pearson chi-square test or Fisher
exact test for categorical variables. The 2-tailed level of significance
was set at P = 0.05.

RESULTS

Demographics
Of the 69 children born between 2011 and 2017 (ages ≤18
months in study period), 3 children had died. Sixteen children
fulfilled exclusion criteria, mainly because of tube feeding (Fig. 1).
We included 24/50 (48.0%) eligible infants (median age 0.6 [range
0.2–1.5] years). Reasons for not being included are listed in
Figure 1.
Of the 74 children born between 2004 and 2009 (ages ≥8 years
in study period), 6 children had died. Nine children fulfilled
exclusion criteria. We included 33/59 (55.9%) children (median
age 8.2 [range 8.0–9.0] years; Fig. 1).

Demographics of the 57 included children (Table 1) and the
52 nonincluded children did not significantly differ (Supplementary
Table 1, Supplemental Digital Content, http://links.lww.com/MPG/
B702). In 43.9% of included children, thoracoscopic EA repair
was performed. Twenty-four children were using antireflux medi-
cation (91.7% of infants and 6.1% of older children), which was
discontinued before pH-MII monitoring. Nissen fundoplication
was previously performed in 8 (24.2%) 8-year-old children (median
age 0.5 years) (Table 1).
pH-MII Studies

Greenfield catheters were used in 30 (52.6%) and ISFET catheters in 27 (47.4%) of the 57 pH-MII studies. Of the 57 included pH-MII studies, we evaluated 52 complete pH-MII studies, 3 studies showed no reliable pH results because of pH-sensor malfunctioning and in 2 studies, impedance results were not analyzed (after deleting artefacts, duration of the impedance tracing was <18 hours).

Manual Correction of Reflux Events

In total, 3313 RBM were detected by MMS software of which 1287 (39%) RBM were manually deleted from the tracings: 52% of all nonacid RBM (mainly swallows misinterpreted as being a RBM) and 8% of all acid RBM (mainly swallowing or a single event being recognized as several events by the software; Supplementary Figure 1, Supplemental Digital Content, http://links.lww.com/MPG/B702). Median RI was 2.6% in infants and 0.6% in older children. Table 2 shows all other pH-MII parameters.

In infants, pH results were abnormal in 2/22 (10%) evaluated pH studies; one of these had apparent life-threatening events based on intracerebral bleeding and ischemia (n = 1), sudden death with unknown cause (n = 1). Clinical reasons for absence of pH-MII studies: absence of symptoms after a recent Nissen fundoplication (n = 1); normal esophagus observed at endoscopy in an asymptomatic child treated with antireflux medical therapy (n = 1); and expectative management in a child with a short esophagus, intrathoracic stomach, and proven gastroesophageal reflex (n = 1).

PH results had undergone fundoplication surgery before the pH-MII study. Indeterminate pH results were found in 2 (6%) children, both asymptomatic, and pH results were normal in 26 (81%) children, 5 (19%) reported symptoms (regurgitation, nausea, abdominal pain, foetor ex ore/abdominal pain, and night cough). A median of 21 (range 0–54) RBM were observed and none of the older children had >70 RBM/24 hours (22).

Symptoms

Before pH-MII monitoring, 12 children/parents spontaneously reported symptoms (16.7% of the infants and 24.2% of the older children; Table 1). Diaries recorded during the measurement were missing in 2 children. Twenty-seven children did experience symptoms during pH-MII monitoring, of whom 21 reported non-specific and unlikely to be GER related (eg, sneezing, hiccup) or very few (<3 times per 24 hours) symptoms. As a result, symptom analysis was performed in only 4 infants (coughing, belching, and twice crying) and 2 older children (coughing and nausea/burping/regurgitation/vomiting). SI and SAP were positive in 1/6 (16.7%) and 3/6 (50.0%), respectively. If only acidic episodes were considered, SI and SAP were positive in 0/6 and 4/6 (66.7%), respectively. Without manual correction, only 3 of these latter 4 children had a positive SAP.

Questionnaire

Twenty-four (72.7%) 8-year old children completed the Manterola questionnaire (Supplementary Table 2, Supplemental Digital Content, http://links.lww.com/MPG/B702). Demographics, RI, and number of RBM of these children did not significantly differ...
from the 9 children who did not complete the questionnaire (Supplementary Table 3, Supplemental Digital Content, http://links.lww.com/MPG/B702). The score was suggestive for GERD in 7 (29.2%) children. Nocturnal cough (n = 7), regurgitation (n = 6, weekly in 4), dysphagia (n = 5) and heartburn (n = 5, weekly in 1 and daily in 1) were the most frequently reported symptoms. In only 2/7 children abnormal pH results were found: an RI of 13% in a child with complaints of heartburn at least once a month and an index of 14% in a child with occasional chest pain. pH-MII parameters (automated or manual), SI and SAP did not differ significantly between children with a high (>3) or low (≤3) score.

### Change of Antireflux Treatment

The majority (22/24; 91.7%) of infants were using anti-reflux medication before the pH-MII study. In infants, medication was continued in 3 (1 abnormal and 2 indeterminate pH results), discontinued in 18 (4 indeterminate, 12 normal, and 2 unreliable pH results), and discontinued in 1 infant with abnormal pH results who underwent Nissen fundoplication (Supplementary Table 4, Supplemental Digital Content, http://links.lww.com/MPG/B702). Of the older children, only 2/33 (6%) were using anti-reflux medication before the pH-MII study. Medication was discontinued in both (normal pH results). Upper endoscopy was performed in 3 children with abnormal pH results, in 2/3 PPI was started for mild esophagitis (Supplementary Table 4, Supplemental Digital Content, http://links.lww.com/MPG/B702). In 2 children (1 with abnormal pH results and 1 with night cough), medication was started without endoscopy.

### DISCUSSION

In this study, we evaluated acid and nonacid GER using pH-MII monitoring in 57 children with EA in infancy and at school-age. Observed RBM were mainly nonacid boluses (infants: 62% of RBM, older children: 64% of RBM) and mixed boluses (infants: 58% of RBM, older children: 75% of RBM).
Compared with available reference values in children without EA (asymptomatic neonates or children with symptoms), we found similar results for RI, number of RBM (Fig. 2A) and BCT (22–25).

Although several groups have published their pH-MII monitoring results in children with EA, reference values are lacking (2,11,12,26–30). Differences in patient selection and study protocols make comparing results difficult. For instance, 1 study in 35 children with EA continued PPI therapy, whereas medication was discontinued in other studies (26). Moreover, they included children of all ages (0.3–17.2 years) whereas 2 other studies focused on infants/toddlers (29) and school-aged children (11). In the latter study, children with nonacid reflux were excluded (11). Compared with studies in children with EA, number of RBM in infants in our study was high compared with a small group of Dutch children, but similar to other cohorts (2,11,30). Results in 8-year old children (2,11,30) were comparable. We found a lower RI in both infants (2.6% vs 2.5–8.3%) and older children (0.3% vs 2.5–8.3%) (Fig. 2C). RI was similar to other cohorts (2,11,30). Results in 8-year old children, but in only 2/7, an RI >7% was found. Compared with 130 symptomatic children without EA (ages 5–10 years), they had similar number of RBM (21 vs 24), but a lower mean BCT (11 vs 17 seconds) (22). We found similar pH-MII parameters in children with low and high Manterola scores, possibly because of a larger day-to-day variability of pH-MII studies in EA patients, or perhaps disturbed impedance patterns make pH-MII studies unsuitable for GER detection in EA patients (32). Dysphagia was scored positive by 5/7 children with a positive Manterola questionnaire, which may be the result of dysmotility, eosinophilic esophagitis, or strictures rather than GER. Furthermore, regurgitation was also scored often (6/7) which—in children with EA—can also be regurgitation from the esophagus rather than the stomach. It may, therefore, be that the Manterola questionnaire is not suitable for EA patients.

After visual validation of RBM identified as such by the software, 39% was deleted from the tracings. These were mainly nonacid swallows, which the software incorrectly identified as RBM (Supplementary Figure 1, Supplemental Digital Content, http://links.lww.com/MPG/B702). Abnormal esophageal motility, stasis of fluids, and gas caused disturbed patterns, which were misinterpreted by the software. Stasis of fluids was mostly present in Z3–Z4, at the level of the esophageal anastomosis. The software did not recognize this stasis and measured a shorter BCT. This is in accordance with previous literature (33). In automated analysis, swallowing patterns were classified as proximal GER events. A pattern was recognized as GER by the software.

As low baseline impedances are observed in esophagitis and motility disorders (27) it is not surprising that children with EA have baseline impedances that are approximately 75% lower than in symptomatic patients without EA (12). Even in EA patients without esophagitis baseline impedances are 44% lower than in control patients with esophagitis (28). Low baseline impedances impair bolus detection, resulting in an underestimation of the reflux burden in EA patients. This is a major limitation of pH-MII in EA patients. Previous studies show high inter- and intra-observer variability in pH-MII analysis (34,35). The percentage of deleted RBM raises the question how accurate pH-MII analysis in EA patients is. We believe this number is too high to ignore and to make comparisons with other studies.
perform automated analyses without manual revision. Manual revision, however, carries the risk of greater inter-observer variability. Refinement of automated software is needed to identify impedance reflux patterns in patients with complex motility disorders, such as EA.

The recent ESPGHAN-NASPGHAN Guideline recommends to treat all EA patients with antacid treatment in the first year of life and to monitor GER with pH-MII monitoring and/or endoscopy at time of discontinuation (regardless of symptoms) and during long-term follow-up in symptomatic children (6). However, no studies have been performed to show benefit of routine pH-MII monitoring in EA patients and a recent SR showed evidence—albeit of low quality—that prophylactic antireflux medication does not prevent stricture formation after EA repair (36). As discussed above, reflux in our patients was mainly nonacid. These nonacid reflux events would be missed on pH monitoring without impedance tracing.

FIGURE 2. pH-MII parameters (number of retrograde bolus movements and reflux index) of study cohort compared with available reference values in (A) children without esophageal atresia (asymptomatic neonates or children with gastrointestinal, pulmonary or neurological symptoms) and (B and C) children with esophageal atresia.
Impedance tracing has additional benefits to correlate extra-esophageal symptoms with reflux events (6). In infants, symptoms were mainly associated with nonacid RBM, whereas symptoms in older children were mainly associated with acid RBM (29). Treatment options of nonacid GER are limited. A small, double-blinded placebo-controlled RCT in children showed that Baclofen inhibits transient lower esophageal sphincter relaxation and accelerates gastric emptying, but is dissuaded in guidelines as a first-choice therapy in children because of known side effects in adults (4,37). Surgical antireflux procedures are available, but have side effects and it is unclear, which patients would benefit. Further research is needed to determine the optimal duration of antacid therapy after EA repair.

The strengths of our study are the manual evaluation of RBM, the inclusion of both symptomatic as well as asymptomatic children with EA, and both infants and older children. International guidelines recommend to monitor GER at time of discontinuation of antacid treatment (around 1 year) and during long-term follow-up in symptomatic children with EA (6). Our study is the first to show pH-MII results in these 2 age-groups. Still, some limitations need to be mentioned. First, 2 different pH electrodes were used. Although significant differences have been found in acid exposure times between ISFET, glass, and antimony electrodes, our results from both catheters were similar (38). Second, only 52% of eligible children of our follow-up program were included. As demographics did not differ and the majority (79%) was asymptomatic, selection bias does not seem to be a major factor influencing our results. Third, only RBM recognized by the software were manually reviewed and modified. This method might have resulted in under-reporting of reflux events. Although the software is designed to over-detect reflux events, we cannot exclude the option that episodes were missed. This is important to realize, and manual revision of pH-MII tracings should be considered in all EA patients, especially in case of unexplained symptoms or persistent growth impairment. Last, because of the lack of longitudinal data, we did not compare results between infants and older children. Infants seem to have worse pH-MII parameters compared with older children; however, differences in type of feeding (liquid vs solid food), body position during feeding, and other demographics (ie, thoracoscopic surgery, use of anti-reflux medication, and history of fundoplication surgery) would have made the comparison unreliable.

In conclusion, most infants and school-aged children with EA off medication have a normal RI, yet experience a significant number of nonacid RBM. After manual revision of the tracings, a high percentage of RBM was deleted. These were mainly nonacid swallows, which the software incorrectly identified as RBM. Our data show that automated impedance analysis software needs refinement for use in infants and children with EA and question the need for standard antacid therapy in these patients.

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**REFERENCES**

1. Pedersen RN, Calzolari E, Husby S, et al. Oesophageal atresia: prevalence, prenatal diagnosis and associated anomalies in 23 European regions. *Arch Dis Child* 2012;97:227–32.
2. van Wijk M, Knuppe F, Osmari T, et al. Evaluation of gastroesophageal function and mechanisms underlying gastroesophageal reflux in infants and adults born with esophageal atresia. *J Pediatr Surg* 2013; 48:2496–505.
3. Tovar JA, Fragoso AC. Gastroesophageal reflux after repair of esophageal atresia. *Eur J Pediatr Surg* 2013;23:175–81.
4. Rosen R, Vandendip Y, Singendonk M, et al. Pediatric gastroesophageal reflux clinical practice guidelines: joint recommendations of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition. *J Pediatr Gastroenterol Nutr* 2018;66:516–54.
5. Vergouwe FW, Isselsteijn H, Wijnjen RM, et al. Screening and surveillance in esophageal atresia patients: current knowledge and future perspectives. *Eur J Pediatr Surg* 2015;25:345–52.
6. Krishnan U, Mouha H, Dall’Oglio L, et al. ESPGHAN-NASPGHAN Guidelines for the Evaluation and Treatment of Gastrointestinal and Nutritional Complications in Children With Esophageal Atresia-Tracheoesophageal Fistula. *J Pediatr Gastroenterol Nutr* 2016;63:550–70.
7. Vergouwe FTW, Isselsteijn H, Biermann K, et al. High prevalence of Barrett’s esophagus and esophageal squamous cell carcinoma after repair of esophageal atresia. *Clin Gastroenterol Hepatol* 2018;16:513.e6–21.e6.
8. Vergouwe FW, Gottrand M, Wijnhooven BP, et al. Four cancer cases after esophageal atresia repair: time to start screening the upper gastrointestinal tract. *World J Gastrointest Endosc* 2018;24:1056–62.
9. de Benedictis FM, Bush A. Respiratory manifestations of gastro-oesophageal reflux in children. *Arch Dis Child* 2017;103:292–6.
10. Vergouwe FTW, Vlot J, Isselsteijn H, et al., DCEA Study Group. Risk factors for refractory anastomotic strictures after oesophageal atresia repair: a multicentre study. *Arch Dis Child* 2019;104:152–7.
11. Di Pace MR, Caruso AM, Catalano P, et al. Evaluation of esophageal motility and reflux in children treated for esophageal atresia with the use of combined multichannel intraluminal impedance and pH monitoring. *J Pediatr Surg* 2011;46:443–51.
12. Frohlich T, Otto S, Weber P, et al. Combined esophageal multichannel intraluminal impedance and pH monitoring after repair of esophageal atresia. *J Pediatr Gastroenterol Nutr* 2008;47:443–9.
13. Castilloux J, Bouron-Dal Soglio D, Faure C. Endoscopic assessment of children with esophageal atresia: lack of relationship of esophagitis and esophageal metaplasia to symptomatology. *Can J Gastroenterol* 2010;24:312–6.
14. Sistonen SJ, Pakarinen MP, Rintala RJ. Long-term results of esophageal atresia: Helsinki experience and review of literature. *Pediatr Surg Int* 2011;27:1141–9.
15. Gischler SJ, Maier P, Duijvensvoorden HJ, et al. Interdisciplinary structural follow-up of surgical newborns: a prospective evaluation. *J Pediatr Surg* 2009;44:1382–9.
16. Gross RE. The surgery of infancy and childhood. Philadelphia: W. B. Saunders Company; 1953:441–444.
17. Talma H, Schönbeck Y, Bakker B, et al. Groeiagrammen 2010: Handleiding bij het meten en wagen van kinderen en het invullen van groeiagrammen Leiden: TNO innovation for life; 2010.
18. Manterola C, Munoz S, Grande L, et al. Initial validation of a questionnaire for detecting gastroesophageal reflux disease in epidemiological settings. *J Clin Epidemiol* 2002;55:1041–5.
19. Peetsold MG, Heij HA, Deurloo JA, et al. Health-related quality of life and its determinants in children and adolescents born with oesophageal atresia. *Acta Paediatr* 2010;99:411–7.
20. A standardized protocol for the methodology of esophageal pH monitoring and interpretation of the data for the diagnosis of gastroesophageal reflux. Working Group of the European Society of Pediatric Gastroenterology and Nutrition. *J Pediatr Gastroenterol Nutr* 1992; 14:467–71.
21. Vandendip Y, Rudolph CD, Di Lorenzo C, et al., North American Society for Pediatric Gastroenterology Hepatology and Nutrition, European Society for Pediatric Gastroenterology Hepatology and Nutrition, Pediatric gastroesophageal reflux clinical practice guidelines: joint recommendations of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN). *J Pediatr Gastroenterol Nutr* 2009;49:498–547.
22. Pilic D, Frohlich T, Noh P, et al. Detection of gastroesophageal reflux in children using combined multichannel intraluminal impedance and pH measurement: data from the German Pediatric Impedance Group. *J Pediatr* 2011;158:650.e1–4.e1.
23. Lopez-Alonso M, Moya MJ, Cabo JA, et al. Twenty-four-hour esophageal impedance-pH monitoring in healthy preterm neonates: rate and characteristics of acid, weakly acidic, and weakly alkaline gastroesophageal reflux. *Pediatrics* 2006;118:e299–308.

24. Mousa H, Machado R, Orsi M, et al. Combined multichannel intraluminal impedance-pH (MII-pH): multicenter report of normal values from 117 children. *Curr Gastroenterol Rep* 2014;16:400.

25. Francavilla R, Magista AM, Bacci N, et al. Comparison of esophageal pH and multichannel intraluminal impedance testing in pediatric patients with suspected gastroesophageal reflux. *J Pediatr Gastroenterol Nutr* 2010;50:154–60.

26. Tong S, Mallitt KA, Krishnan U. Evaluation of gastroesophageal reflux by combined multichannel intraluminal impedance and pH monitoring and esophageal motility patterns in children with esophageal atresia. *Eur J Pediatr Surg* 2016;26:322–31.

27. Tambucci R, Thapar N, Salakellis E, et al. Clinical relevance of esophageal baseline impedance measurement: just an innocent bystander. *J Pediatr Gastroenterol Nutr* 2015;60:776–82.

28. Pedersen RN, Markow S, Kruse-Andersen S, et al. Esophageal atresia: gastroesophageal functional follow-up in 3-15 year old children. *J Pediatr Surg* 2013;48:2487–95.

29. Catalano P, Di Pace MR, Caruso AM, et al. Gastroesophageal reflux in young children treated for esophageal atresia: evaluation with pH-multichannel intraluminal impedance. *J Pediatr Gastroenterol Nutr* 2011;52:686–90.

30. Iwanczak BM, Kosmowska-Miskow A, Kofla-Dlubacz A, et al. Assessment of clinical symptoms and multichannel intraluminal impedance and pH monitoring in children after thoracoscopic repair of esophageal atresia and distal tracheoesophageal fistula. *Adv Clin Exp Med* 2016;25:917–22.

31. Rosen R, Amirault J, Giligan E, et al. Intragastric pressure recording improves the detection of cough during multichannel intraluminal impedance testing in children. *J Pediatr Gastroenterol Nutr* 2014;58:22–6.

32. Dalby K, Nielsen RG, Markow S, et al. Reproducibility of 24-hour combined multiple intraluminal impedance (MII) and pH measurements in infants and children. Evaluation of a diagnostic procedure for gastroesophageal reflux disease. *Dig Dis Sci* 2007;52:2159–65.

33. de Bortoli N, Martinucci I, Savarino EV, et al. Manually calculated esophageal bolus clearance time increases in parallel with reflux severity at impedance-pH monitoring. *Dig Liver Dis* 2015;47:1027–32.

34. Loots CM, van Wijk MP, Blondeau K, et al. Interobserver and intraobserver variability in pH-impedance analysis between 10 experts and automated analysis. *J Pediatr* 2012;160:441.e1–6.e1.

35. Plici D, Hof's C, Weitmann S, et al. Inter- and intraobserver agreement in 24-hour combined multiple intraluminal impedance and pH measurement in children. *J Pediatr Gastroenterol Nutr* 2011;53:255–9.

36. Miyake H, Chen Y, Hock A, et al. Are prophylactic anti-reflux medications effective after esophageal atresia repair? Systematic review and meta-analysis. *Pediatr Surg Int* 2018;34:491–7.

37. Omari TI, Bennina MA, Sansom L, et al. Effect of baclofen on esophageogastric motility and gastroesophageal reflux in children with gastroesophageal reflux disease: a randomized controlled trial. *J Pediatr* 2006;149:466–74.

38. Hemmink GJ, Weusten BL, Oors J, et al. Ambulatory oesophageal pH monitoring: a comparison between antimony, ISFET, and glass pH electrodes. *Eur J Gastroenterol Hepatol* 2010;22:572–7.