A peculiar complication during trachea-oesophageal fistula repair in a neonate

Sir,

A Day 2, 1.8 kg neonate was posted for trachea-oesophageal fistula repair. After anaesthetic induction and endotracheal intubation, a 12 F sterile, blunt-tipped red rubber catheter was inserted through the oral cavity into the upper blind oesophageal pouch. This is a standard procedure that facilitates identification of the upper blind end of the oesophagus during surgery.[1]

Surgical steps included positioning (left lateral decubitus), right thoracotomy and division of the fistula (Type C). On incising the upper pouch of the oesophagus over the rubber catheter, the surgeons noticed that the blunt tip of the catheter was missing. On digital examination of the oral cavity, the broken tip could be felt but could not be removed. The patient was made supine to enable laryngoscopy and retrieve the foreign body. However, laryngoscopy failed to locate the missing catheter tip. On digital examination, the foreign body could be felt deep down in the left pyriform fossa; it appeared to be firmly lodged. Because repeated attempts to retrieve the broken tip failed, and a trickle of bleeding started, endoscopy was performed, which showed the broken catheter tip lodged high in the nasopharynx. It was retrieved with the help of a Magill’s forceps under endoscopic vision [Figure 1]. A small mucosal tear was seen near the left pyriform fossa, which was managed conservatively. The remainder of the surgery proceeded uneventfully.
To the best of our knowledge, this is the first such reported complication during tracheo-oesophageal fistula surgery. To prevent a similar event from occurring again, it is proposed to:

- Verify the elasticity of the rubber catheter prior to use, or
- Alternatively, use a polyvinyl chloride nasogastric tube.

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**REFERENCE**

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