

Letter to the Editor

Reply to: Comment on “Acquired Tracheoesophageal Fistula after Esophageal Atresia Repair”

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To the Editor;

We have read the comment on our report entitled “Acquired Tracheoesophageal Fistula after Esophageal Atresia Repair” by the author Vedat Akçaer (*Akçaer V. Comment on “Acquired Tracheoesophageal Fistula after Esophageal Atresia Repair”. *Balkan Med J. doi: 10.4274/balkanmedj.galenos.2020.2020.6.85**). However, we found some comments valuable; we would like to share our responses and comments for this letter.

Akçaer V suggests defining these complex samples of TEF as esophagotracheal or esophagopulmonic fistulas instead of standard TEF (1). Although, these two definitions outline the anatomical relationship between two foregut structures, the term ‘acquired fistula’ is commonly used for fistulas between native or replaced esophagus and airway (2, 3). Smithers et al (3) classified TEFs as congenital, recurrent and acquired according to the etiology and anatomy. In that classification, acquired TEFs include esophagobronchial (n=6), esophagopulmonary (n=2) and gastric conduit to trachea (n=2). It is not clear which one of these classifications has been mentioned by Akçaer V (1) with the term ‘standard TEF’. If TEF persists after operation, then it is called congenital TEF which are either missed during initial operation or incomplete repaired ones. Recurrent TEFs are fistulas occurred after first successful repair in the same location of index fistula. Acquired TEF’s (Acq-TEF) are new pathways between airway and esophagus and occurs different from the original fistula sites (3). Acq-TEFs can also locate between esophageal anastomosis and pulmonary parenchyma, bronchus or the trachea. Rarely, they can be seen between colon and gastric conduit along with the entire respiratory system. Therefore, true nomenclature for such fistulas is Acq-TEF.

In our previous manuscript, we suggested that there is no consensus on timing and type of surgical treatment in recurrent TEF. As a comment, Akçaer V stated that end-to-end anastomosis has better results regarding the frequencies of recurrent TEFs. End-to-end anastomosis can be a preventive method, but not a surgical management option of recurrent TEFs. Therefore, still there is no consensus on surgical management of recurrent TEFs.

Finally, author comments on the endoscopic treatment of TEF, complications of muscle flaps and the use of fibrin glue in the treatment of recurrent TEFs. The fistula tract in Acq-TEFs has mostly irregular pathway and hardly to localize. It is usually impossible to localize or catheterize the fistula orifice through endoscope. Although minimally invasive techniques are preferable, it is mostly impossible in such cases. In addition, the surgical treatment of recurrent and acq-TEFs are more difficult and hazardous than congenital ones because of dense adhesions and mediastinal fibrosis. Failure rates are common and several fistula repairs may be needed. Therefore, minimal invasive techniques should be kept in mind as alternative management method (4, 5).

However, there is limited information and no randomized controlled trial about the use of endoscopic treatment and fibrin glue in the treatment of recurrent TEFs. Also, use of muscle flaps is well known and widely accepted maneuver to prevent TEF recurrence. Thus, it is difficult to suggest these treatment modalities, as standards for treatment of recurrent TEFs.

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