# Winter Meeting 2021

**Thursday November 18th**

*Friend's House, 173-177 Euston Road, London, NW1 2BJ*

## Agenda

**13.30** Welcome / Registration

**13.35** Research / Audit / Case presentations - *Chair Miss Dhanya Mullassery*

4 x 10 min presentation with 5 min for questions and discussion

1335-1350
Laparoscopic cholecystectomy is feasible and safe for paediatric surgeons after trans gastric pancreatic necrosectomy.
Green PA, Wilkinson DJ, Peters R, Puleston J, Geraghty J, Lansdale N
Royal Manchester Children's Hospital

1350-1405
'Cut and push' as an alternative to endoscopic retrieval for PEG tube removal
Claxton H, Dick K, Taylor R, Allam M, Stedman F, Keys C, Hall N
Department of Paediatric Surgery and Urology Southampton Children's Hospital
University of Southampton

1405-1420
Woodfall K, Mitchell T & The Toast Study Team
Acceptability of the Treating Oesophageal Atresia to Present Stricture (TOAST) trial
Institute of Population Health, University of Liverpool

1420-1435
Congenital Oesophageal stenosis: Resection and primary anastomosis is safe and effective after oesophageal atresia repair.
O'Shea K, Lansdale N, Wilkinson D, Peters R.
Royal Manchester Children's Hospital

**14.30** Key note speaker *Mr Nick Maynard*
Consultant Adult UGI Surgeon, Oxford
President AUGIS

***The Adult oesophagus following neonatal TOF repair***

**15.30** Coffee

**15.45** Complex Case discussions - *Chair Mr Nick Lansdale*

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| Shabnam Parker | St Georges Hospital |
| Roland Partridge | Alderhey Children's Hospital |
| Nigel Hall | Southampton Children's Hospital |
| Ed Hannon | Leeds Children's Hospital |
| Michael Aworanti | Leeds Children's Hospital |
| Nick Lansdale | Royal Manchester Children's Hospital |

**17.00** Research Update *Mr Iain Yardley*

**18.30** Presidential Drinks and Dinner (19.30)

*Monatgue on the Gardens*
15 Monatague Street, London, WC1B 5BJ

# Abstracts:

**Laparoscopic cholecystectomy is feasible and safe for paediatric surgeons after trans gastric pancreatic necrosectomy.**

**Green PA, Wilkinson DJ, Peters R, Puleston J, Geraghty J, Lansdale N**

**Background:** Transgastric pancreatic necrosectomy is a useful therapeutic option in the treatment of walled off necrosis in acute pancreatitis. In our centre we use an AXIOS™ Stent as this allows several courses of necrosectomy without stent exchange. This series describes our experience of laparoscopic cholecystectomy following AXIOS necrosectomy.

**Methods**: A retrospective review was performed of all patients in our institution having cholecystectomy following AXIOS necrosectomy. Data collected included age, comorbidities, cause of pancreatitis, operative interventions and sequelae. All data presented as Median (range).

**Results**: Three children underwent transgastric pancreatic necrosectomy followed by cholecystectomy. Age at presentation was 15 (9-15) years. Pancreatitis was secondary to gallstones, sludge and idiopathic (n=1 each). Median number of endoscopic interventions was 4 (2-6) and all children had stents removed prior to laparoscopic cholecystectomy. Time from last endoscopic intervention to cholecystectomy was 133 (14-437) days and the median post-operative length of stay was 1 (0-4) day. Median operative time was 105 mins (83-129) and two were performed by trainees. 2/3 children had intraoperative cholangiograms as part of their procedure. No significant complications were reported.

**Conclusions**: Laparoscopic cholecystectomy is feasible and safe for paediatric surgeons in patients who have undergone previous transgastric pancreatic necrosectomy. Whilst interval between cholecystectomy and last endoscopic intervention was fairly long in these patients, this correlated with a surgical environment that permitted training, reasonable operative times and good patient outcomes

**'Cut and push' as an alternative to endoscopic retrieval for PEG tube removal.**

**Harry Claxton1, Karen Dick1, Rhoda Taylor1, Maddie Allam1, Francesca Stedman1, Charlie Keys1, Nigel J Hall1,2**

**1. Department of Paediatric Surgery and Urology, Southampton Children's Hospital**

**2. University Surgery Unit, University of Southampton**

**Background**: Percutaneous Endoscopically placed Gastrostomy (PEG) tubes are frequently used in children. The traditional endoscopic method to remove/change the PEG device requires general anaesthesia in children. A minimally invasive alternative is the 'Cut and Push' method (C&P). Data regarding safety and effectiveness of C&P in children are lacking with concerns raised about the possibility of gastrointestinal obstruction. A further advantage of C&P which became more relevant during the COVID pandemic was avoidance of wait time for general anaesthesia.

**Method**: We retrospectively reviewed all cases of PEG removal/change to button in children (<18yrs) between December 2020 and November 2021. Decision for C&P versus endoscopic retrieval was made by the responsible consultant. Cases were identified from a prospectively maintained database. Parents/carers were asked if the child had suffered any complications following C&P, if they had seen the flange pass in the stools and if so at what time. The average waiting time was compared for C&P versus endoscopic retrieval.The project was approved as a service evaluation.

**Results**: During the time period, 19 PEG's were removed or changed to button via C&P. The average waiting time for C&P was 15.4 days, significantly shorter than the 6 month predicted local waiting time for an elective endoscopic PEG removal. There were no complications of C&P recorded in casenotes or reported retrospectively by carers at median 70 days (range 25-301). In two cases the flange was visualised in the stool, at 3 and 5 weeks following C&P respectively.

**Conclusions**: Although limited numbers, these data suggest C&P is an effective and safe means to facilitate minimally invasive and prompt PEG removal/change to button in children. We recommend further evaluation of the safety of this technique alongside estimates of reduced resource utilisation and cost savings.

**Kerry Woolfall (presenter) [a],Tracy Mitchell [a] and the TOAST study team**

**[a] Institute of Population Health, University of Liverpool, UK**

**Acceptability of the Treating Oesophageal Atresia to Prevent Stricture (TOAST) trial**

**Background and aims:** TOAST is a multicentre randomised controlled trial of proton pump inhibitors (PPI) for treating oesophageal atresia to prevent stricture. We conducted a mixed methods feasibility study to explore parent and practitioner views on the acceptability of the trial, as well as inform approaches to recruitment, consent and treatment pathways.

**Methods and sample:** Interviews with parents of infants born with oesophageal atresia (OA) and an online survey and interviews with practitioners involved in the care of infants with OA.

**Results:** 18 parents (13 mothers/5 fathers) took part in semi-structured telephone or online interviews. 51 practitioners (49 surgeons/2 neonatologists) representing 20 out of 25 UK surgical centres (80%) completed the survey. Interviews were conducted with 2/4 (50%) surgeons who indicated in the survey that they did not find the trial acceptable. Parents found the trial acceptable and would have provided consent for their child in the hope that participation would help other children and families in the future. A few stated they would provide consent so long as: 1) the trial broached by a clinician with knowledge of OA, 2) explanation is given that differences in treatment are already happening, and 3) children can access PPI if clinically necessary. Parents preferred informed consent over an 'opt-out' approach for TOAST, and suggested that parents should be given a copy of the Alternative Treatment Pathway. The majority of practitioners (47/51, 92%) found the trial acceptable. Interviews with the few who did not find the trial acceptable provided insight into factors and resources that may help facilitate 'buy in'. These included: 1) demonstrating parental support for the trial, 2) providing papers for the two cohort studies that indicated increased stricture rates in babies treated prophylactically with PPI following OA repair, and 3) reducing timeframes in the alternative treatment pathway for managing reflux.

**Discussion and conclusion:** Our findings suggest the TOAST trial is feasible. The majority of parents and practitioners supported the trial and highlighted aspects of the research materials (Parent Information Leaflet; Alternative Treatment Pathway; Medication Guidance Sheet; study App) and protocol that could be refined to help improve acceptability, assist practitioner 'buy in' and inform site training.

**Congenital Oesophageal stenosis: Resection and primary anastamsis is safe and effective after oesophageal atresia repair.**

**Kathryn O'Shea, Nick Lansdale, David Wilkinson, Robert Peters.**

**Royal Manchester Children's Hospital**

Congenital oesophageal stenosis (COS) is a rare clinical entity, with up to 50% associated with oesophageal atresia with distal tracheoesophageal fistula (OA/TOF). Whilst membranous and fibromuscular hypertrophy subtypes may be managed successfully by dilatation, tracheobronchial remnants (TBR) usually require surgical intervention.

When COS co-exists with repaired OA/TOF, concerns have been raised about residual vascular supply of the intervening oesophagus leading some to advocate upfront oesophageal replacement rather than resection and anastomosis or oesophagoplasty.

We describe two cases successfully managed with resection and primary anastomosis.

Patient 1, a 39 week gestation boy, birth weight 2.50kg, with phenylketonuria had primary repair of OA/TOF on day 3 of life. At 10 months the parents reported difficulty in swallowing. Six attempts at dilatation were carried out including one injection of triadcortyl without symptomatic relief. At 19 months resection was performed via a right posterolateral thoracotomy. Two subsequent repeat endoscopies did not detect residual stricture.

Patient 2, a 34 week gestation boy, birth weight 2.52kg underwent primary repair of OA/TOF on day 1 of life. On the 11$^{th}$ postoperative day, a contrast confirmed no leak and 10mm length stricture in the lower oesophagus consistent with COS. One attempt was made to dilate this without success. At 9 months of age, he underwent resection and end to end anastomosis via left thoracoscopy. Two subsequent repeat endoscopies did not detect residual stricture.

Both children have continued to feed orally and manage a variety of age-appropriate textures.

Due to the association of OA and COS, routine post-operative water-soluble contrast is recommended to allow early identification and differentiation from a later occurring reflux stricture.

Resection and primary anastomosis are safe and effective in congenital oesophageal stenosis with repaired oesophageal atresia, with good medium-term outcomes.