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Reversed Gastric Tube Esophagoplasty Using the Gavriliu Technique for Long-Gap Type I Esophageal Atresia in a 4-Year-Old Child: A Case Report and Literature Review

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Abstract | **Case Report**

Background: Type I esophageal atresia (EA) according to the Gross classification corresponds to pure esophageal atresia without tracheoesophageal fistula (TEF), accounting for approximately 8–10% of all EA cases. This variant is invariably associated with a long esophageal gap that precludes primary anastomosis, thereby necessitating a staged approach culminating in delayed esophageal replacement. Among the available reconstructive options, the reversed gastric tube (RGT) technique, first described by Gavriliu, has gained recognition as a dependable method owing to its robust vascular supply, adequate luminal diameter, and adaptable conduit length. ***Case presentation:*** We report the case of a 4-year-old male child with long-gap type I EA who underwent cervical esophagostomy and feeding gastrostomy during the neonatal period. Following rigorous nutritional optimization and comprehensive preoperative assessment including gastrografin opacification studies demonstrating a well-calibrated stomach with a greater curvature measuring 217 mm and a proximal esophageal remnant of 147 mm the child underwent definitive esophageal replacement using the Gavriliu reversed gastric tube technique. The postoperative course was uneventful, with a contrast swallow study on postoperative day 8 confirming anastomotic integrity without leak or stenosis. Oral feeding was progressively resumed and the patient was discharged on postoperative day 14 in good general condition. ***Discussion:*** The Gavriliu reversed gastric tube remains a relevant and reliable alternative to other esophageal substitution techniques in children. Recent literature, including the 2021 ERNICA Consensus Conference recommendations, the 2023 Bambino Gesù case-control study, the 2024 Lausanne 33-year comparative review, the 2025 JIAPS decade-long series, and a 2026 Syrian case report, consistently demonstrates the safety and efficacy of this approach with satisfactory medium- and long-term functional outcomes. ***Conclusion:*** The Gavriliu reversed gastric tube represents a reliable and reproducible technique for esophageal replacement in long-gap type I EA. Staged management incorporating neonatal diversion, sustained nutritional optimization, and delayed reconstruction remains the reference strategy. Prolonged multidisciplinary follow-up monitoring swallowing function, nutritional status, gastroesophageal reflux, respiratory complications, and growth is essential for these patients.

Keywords: Esophageal atresia; Type I; Long gap; Reversed gastric tube; Gavriliu; Esophageal replacement; Pediatric surgery.

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INTRODUCTION

Esophageal atresia (EA) is one of the most common congenital malformations of the upper digestive tract, with an estimated incidence ranging from 1 in 2,500 to 1 in 4,500 live births [1,2]. The Gross classification, universally adopted, distinguishes five anatomical types (A through E). Type A, or pure EA without tracheoesophageal fistula, accounts for approximately 8–10% of all cases and represents the most surgically challenging variant due to the substantial distance separating the two esophageal pouches, thereby defining a "long gap" [1–3]. The upper pouch is typically blind-ending and dilated, while the distal esophageal remnant is rudimentary, leading to a hypoplastic stomach that has not received amniotic fluid transit in utero [3,6].

Long-gap esophageal atresia (LGEA) has been defined by the ERNICA Consensus Conference and the

International Network of Esophageal Atresia (INoEA) as an esophageal gap of three or more vertebral bodies, rendering primary anastomosis either impossible or associated with unacceptable tension [4,5]. In these circumstances, the initial management classically relies on a staged approach: a cervical esophagostomy for salivary diversion and a feeding gastrostomy are performed during the neonatal period, allowing the child to grow until an appropriate age and weight are reached for definitive esophageal replacement [3,6].

Over the past seven decades, several esophageal substitution techniques have been developed and refined, including gastric transposition, colonic interposition, jejunal interposition, and gastric tube fashioning [3,7,8]. Among these options, the reversed gastric tube (RGT), initially described by Gavriliu and Georgescu in Bucharest in 1951 and subsequently popularized by Heimlich and Winfield in the United States in 1955, holds a distinctive position [9–11]. The technique involves the construction of a pedicled tubular conduit from the greater curvature of the stomach, oriented in an antiperistaltic direction ("reversed"), with its blood supply derived from the left gastroepiploic artery, and positioned in a retrosternal or posterior mediastinal route to restore digestive continuity [9–11]. Its advantages include a robust vascular supply, customizable luminal diameter, preservation of a functional gastric remnant, and rapid alimentary transit [3,12]. Potential drawbacks encompass a long suture line with risk of anastomotic leak, stricture formation, gastroesophageal reflux disease (GERD), and the theoretical long-term concern for Barrett esophagus [3,7].

Recent publications have contributed meaningfully to the evidence base. The case-control study by Zarfati *et al.,*(2023) from the Bambino Gesù Children's Hospital demonstrated comparable outcomes between the isoperistaltic gastric tube and other techniques for LGEA [13]. The 33-year comparative review from the University Hospital of Lausanne (2024) provided long-term data on gastric tube versus colonic transplants [16]. The decade-long retrospective series published in the Journal of Indian Association of Pediatric Surgeons (2025) confirmed the feasibility and safety of staged gastric tube esophageal replacement [14]. Most recently, a 2026 case report from Syria described a complete and complication-free recovery following reversed gastric tube esophagoplasty in a child with long-gap EA associated with anorectal malformation [15].

Herein, we report the case of a 4-year-old child with type I EA who had undergone cervical esophagostomy and gastrostomy during the neonatal period and was scheduled for definitive esophageal replacement using the Gavriliu reversed gastric tube technique. The aim of this report is to describe the diagnostic workup, therapeutic strategy, and technical considerations of this procedure, while providing a comprehensive discussion in the context of current evidence.

Case Presentation

The patient was a male child born at term with a birth weight of 2,353 grams. Esophageal atresia was suspected prenatally based on the presence of polyhydramnios and the absence of a gastric bubble on fetal ultrasound. At birth, the clinical picture was dominated by excessive drooling, inability to pass a nasogastric tube, and mild respiratory distress. A thoracoabdominal radiograph confirmed the diagnosis of type I EA (Gross type A) by demonstrating a blind-ending upper esophageal pouch with no sub-diaphragmatic intestinal gas, indicating the absence of a distal tracheoesophageal fistula. The echocardiographic assessment showed no associated cardiac anomalies. A thorough screening for VACTERL-associated malformations was performed and was unremarkable.

Given the long esophageal gap inherent to type I EA, a staged management strategy was adopted. During the neonatal period, the child underwent a left cervical esophagostomy for salivary diversion, combined with a feeding gastrostomy. Exclusive enteral feeding through the gastrostomy was initiated from the first days of life, with regular nutritional monitoring. Continuous suction of the upper esophageal pouch was maintained during the initial hospitalization to prevent aspiration.

The child was followed closely with respect to growth and nutritional status over the ensuing four years. A multidisciplinary team comprising a pediatric surgeon, pediatric gastroenterologist, nutritionist, and speech-language pathologist ensured satisfactory growth and prepared the child for definitive esophageal reconstruction. An oral stimulation program was instituted to prevent oral aversion, a complication frequently encountered in children with prolonged esophageal discontinuity and exclusive gastrostomy feeding [4,17]. Regular sham feeding sessions were encouraged to maintain the oral feeding reflex.

At 4 years of age, a comprehensive preoperative evaluation was undertaken in anticipation of esophageal replacement. Gastrografin opacification through the gastrostomy revealed a well-calibrated, normally distensible stomach with a greater curvature measuring 217 mm (Figure 1). This measurement was deemed more than adequate for the construction of a reversed gastric tube of sufficient length. Opacification of the upper esophageal pouch through the esophagostomy allowed assessment of the proximal esophageal remnant length at 147 mm (Figure 2). A combined study provided an overview of both segments and confirmed the anatomical configuration prior to surgical planning (Figure 3). Laboratory investigations, chest radiography, echocardiography, and anesthetic evaluation were unremarkable. The child's nutritional status was

satisfactory, with weight-for-height z-scores within normal limits.



Figure 1: Gastrografin opacification through the gastrostomy demonstrating a well-calibrated stomach with a greater curvature measuring 217 mm, confirming adequate gastric tissue for reversed gastric tube construction.

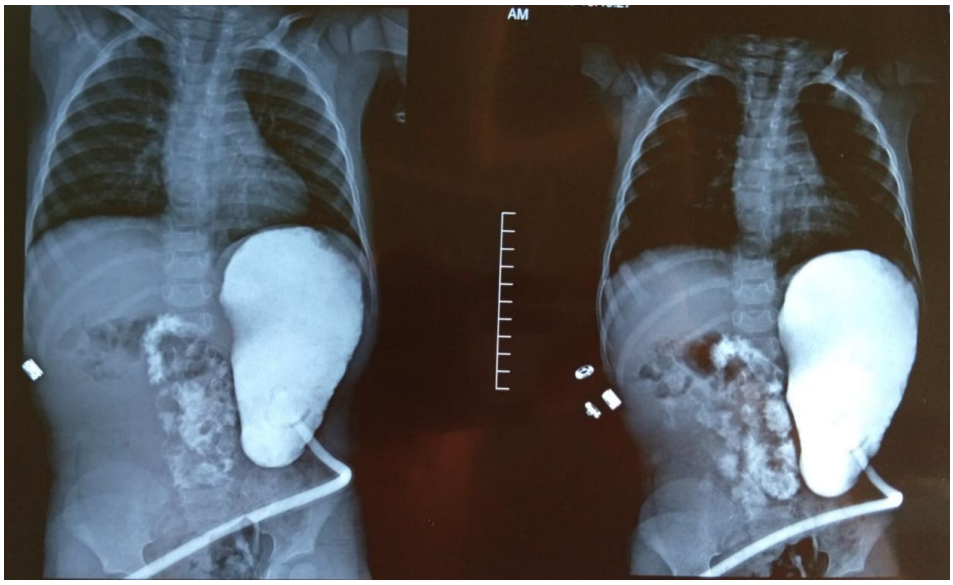


Figure 2: Gastrografin opacification of the upper esophageal pouch through the cervical esophagostomy, showing the blind-ending proximal esophageal segment with a measured remnant length of 147 mm

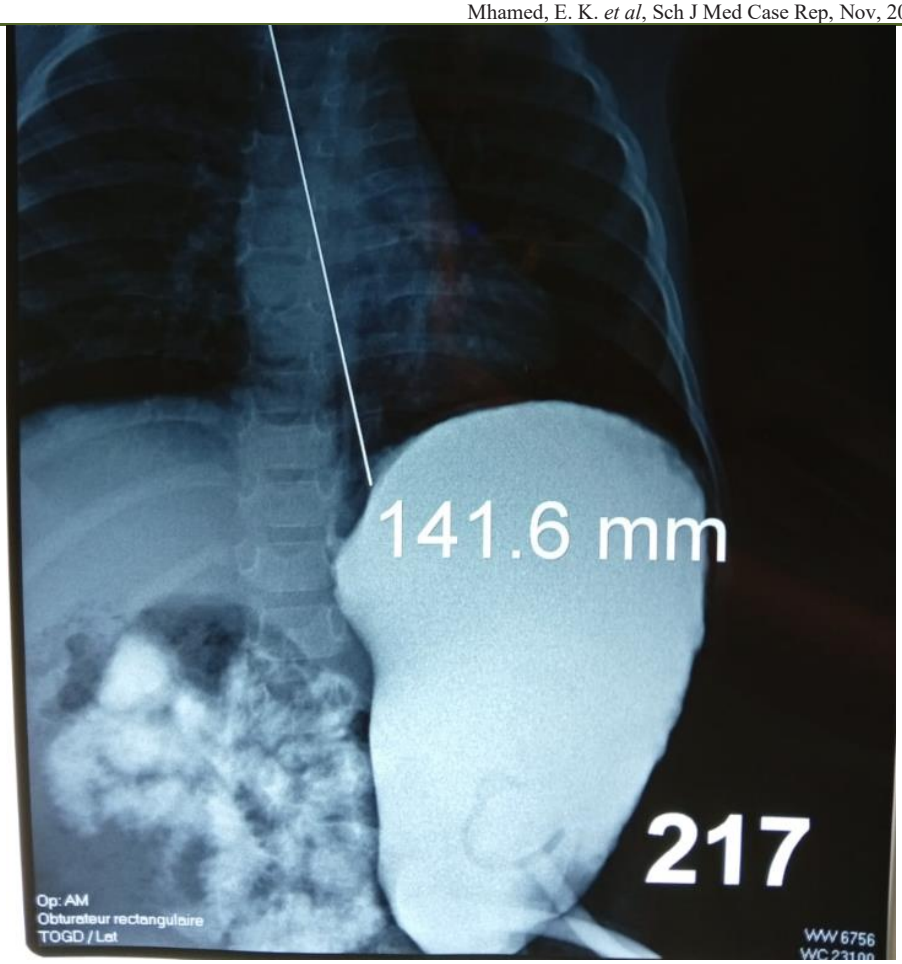


Figure 3: Combined gastrografin study providing an overview of the upper esophageal pouch and gastric anatomy, illustrating the spatial relationship between the two segments and guiding surgical planning for the reversed gastric tube reconstruction

The procedure was planned according to the Gavriliu reversed gastric tube technique. The patient was positioned supine under general anesthesia with orotracheal intubation. The abdominal approach was performed through an upper midline laparotomy. Following exploration of the abdominal cavity and confirmation of adequate gastric caliber, the construction of the gastric tube was undertaken in the following sequential steps.

First, complete mobilization of the stomach was performed with division of the short gastric vessels and the right gastroepiploic artery, while meticulously preserving the left gastroepiploic pedicle and the left gastric artery to ensure the vascular supply of the future conduit. The gastrocolic and gastrosplenic ligaments were divided to achieve full gastric mobilization.

Second, the gastric tube was fashioned using a series of linear stapler applications along the greater curvature, parallel to it, proceeding from the pylorus toward the fundus (Figure 4). The resulting conduit was an antiperistaltic tubular graft, nourished by the left gastroepiploic arcade, of uniform caliber and sufficient length to reach the cervical region. The staple lines were reinforced with a running seroserosal suture using absorbable suture material. The gastric remnant was closed, and the gastrostomy was repositioned.

Third, a retrosternal tunnel was created by careful blunt digital dissection from the abdomen to the cervical region, passing behind the sternum and anterior to the pericardium. The reversed gastric tube was drawn upward through this retrosternal route to the cervical region without tension or torsion, with meticulous verification of the absence of compression or twisting of the vascular pedicle (Figures 5, 6, 7).

Fourth, the cervical anastomosis between the proximal end of the gastric tube and the upper esophageal stump (at the level of the previous esophagostomy) was performed in an end-to-end fashion using interrupted absorbable sutures in a single layer. The gastrostomy was maintained postoperatively for enteral feeding and decompression. The abdominal cavity was closed over a suction drain, and a cervical drain was left in contact with the anastomotic site.

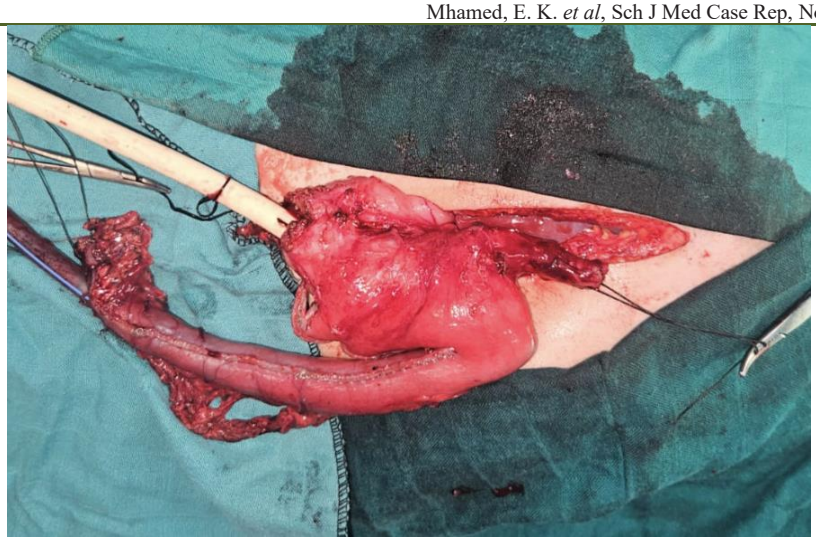


Figure 4 – Step 1: Fashioning of the reversed gastric tube. Intraoperative view showing the tubular conduit constructed from the greater curvature of the stomach using a linear stapler. The staple line is clearly visible along the length of the tube. The gastric remnant and the gastrostomy tube are identified.

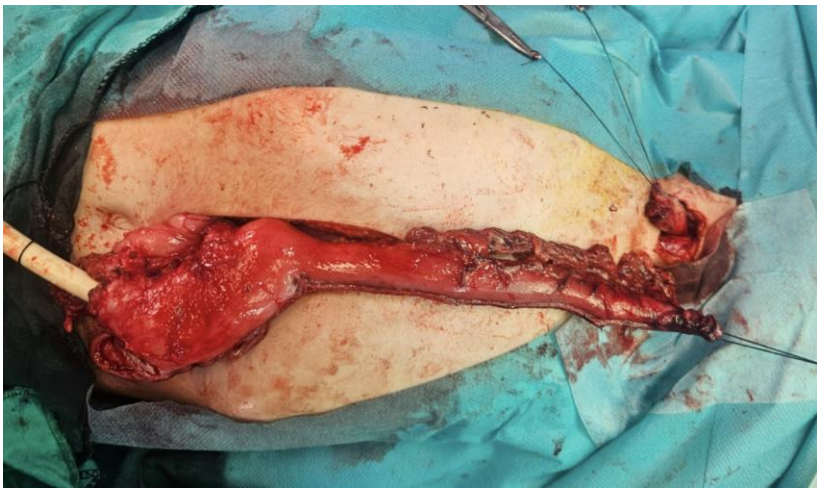


Figure 5 – Step 2: Assessment of conduit length. The completed reversed gastric tube is displayed along the patient's torso, demonstrating adequate length to reach from the gastric remnant (abdomen) to the cervical region for retrosternal esophageal replacement

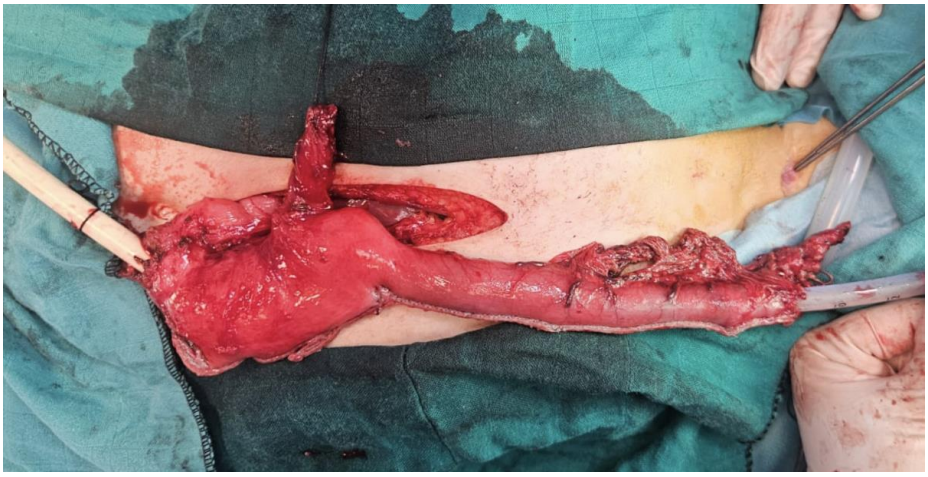


Figure 6 – Step 3: Complete surgical construct. Overview showing the reversed gastric tube with its vascular pedicle based on the left gastroepiploic arcade. The gastric remnant, the fashioned tubular conduit with reinforced staple line, and the preserved vascular supply are visible prior to retrosternal tunneling



Figure 7 – Step 4: Retrosternal ascension of the reversed gastric tube. The conduit has been passed through the retrosternal tunnel, with the proximal end emerging at the cervical incision (top) and the abdominal entry point visible at the lower incision (bottom), confirming a tension-free route anterior to the pericardium

The postoperative course was uneventful. The patient was admitted to the pediatric intensive care unit for the first 48 hours for hemodynamic and respiratory monitoring. Enteral nutrition was administered exclusively through the gastrostomy, and a nasogastric tube was maintained for decompression during the initial postoperative days. The cervical wound remained clean, with no signs of infection or salivary leak. The cervical drain was removed on postoperative day (POD) 5 after output had ceased. The abdominal drain was removed on POD 6.

A water-soluble contrast swallow study was performed on POD 8, which demonstrated satisfactory passage of contrast through the cervical anastomosis without evidence of leak or stenosis. The gastric tube conduit showed adequate caliber and smooth transit into the gastric remnant. Progressive oral feeding was initiated on POD 9, beginning with clear liquids and advancing to a semi-solid diet over the following days. The child tolerated oral intake well, with no evidence of dysphagia, regurgitation, or respiratory symptoms.

The patient was discharged on POD 14 in good general condition, with oral feeding well established and the gastrostomy maintained as a supplementary route. A structured outpatient follow-up plan was organized, including regular consultations with the pediatric surgeon, nutritionist, and speech-language pathologist for swallowing rehabilitation. Gradual gastrostomy weaning was planned in conjunction with the progressive increase in oral caloric intake.

DISCUSSION

Type I esophageal atresia (Gross type A) remains one of the most formidable challenges in pediatric surgery owing to the invariable absence of a tracheoesophageal fistula and the resulting long gap between the two esophageal segments, which renders any attempt at primary anastomosis hazardous or impossible [1–3]. Unlike type C EA, which accounts for approximately 85% of cases and generally permits primary repair, type I EA mandates a staged strategy with delayed esophageal replacement [4,5]. The complexity of this condition is compounded by the associated gastric hypoplasia resulting from the absence of amniotic fluid transit through the gastrointestinal tract during fetal life [3,6].

The 2021 ERNICA Consensus Conference established that delayed primary esophageal anastomosis remains the ideal goal when feasible, even under tension [4]. However, when the residual gap is too extensive even after techniques such as the Foker procedure, Kimura technique, internal bougienage, or magnetic compression anastomosis esophageal replacement becomes the necessary course of action [4,5,18]. The consensus also highlighted gastric tubulization techniques as a priority for future research [4].

Among the available substitution methods, three principal techniques are employed: gastric transposition (gastric pull-up) as described by Spitz, colonic interposition, and gastric tube fashioning [3,7,8]. Gastric transposition, while technically simpler and requiring only a single anastomosis, places a large gastric volume within the thorax, potentially compromising respiratory function [14]. Colonic interposition provides excellent graft length but is associated with graft necrosis, leakage at three required anastomoses, and conduit dysmotility over time [3,16]. The gastric tube offers a customizable caliber and length tailored to the individual gap, while preserving a functional gastric remnant [9–12].

The reversed gastric tube, originally described by Gavriliu and Georgescu in 1951 and disseminated by Heimlich from 1955, relies on a pedicled tube from the greater curvature, oriented in an antiperistaltic direction and vascularized by the left gastroepiploic arcade [9–11]. As Zarfati *et al.,*noted in their 2023 study, the distinction between iso- and antiperistaltic orientation has limited functional significance because the peristaltic activity of the gastric graft is inherently altered regardless of orientation [13].

In the present case, several factors guided the choice of the Gavriliu technique. First, the stomach exhibited excellent caliber with a greater curvature measuring 217 mm, providing ample tissue for conduit construction a critical determinant of feasibility [12,14]. Second, the patient's age of 4 years, although later than in many contemporary European series where replacement is often undertaken between 6 and 12 months [13,14], conferred the advantage of a fully developed stomach with more favorable anatomical dimensions. Third, the child's satisfactory nutritional status, maintained through prolonged gastrostomy feeding, constituted an indispensable prerequisite for an operation of this magnitude [4,15].

Contemporary evidence supports the safety and efficacy of this approach. The landmark case-control study by Zarfati *et al.,*(2023) compared five patients treated with isoperistaltic gastric tube to ten matched controls at the Bambino Gesù Children's Hospital [13]. Despite a significantly longer esophageal gap in the gastric tube group (4.5 versus 3.6 vertebral bodies, $p = 0.019$), no statistically significant differences were observed in perioperative outcomes, including anastomotic leak rate (20%), stricture formation (20%), GERD, dysphagia, vocal cord paralysis, or mortality at 24 months [13]. Auxological outcomes were comparable, and no patient developed metaplasia, dysplasia, or Barrett esophagus [13].

The decade-long retrospective series from India (JIAPS, 2025) corroborated these findings by reporting favorable outcomes with staged isoperistaltic gastric tube esophageal replacement, reinforcing the technique's feasibility across different clinical settings [14]. A 2026 case report from Syria described complete recovery without complications following reversed gastric tube esophagoplasty in a child with EA and associated anorectal malformation, underscoring that optimal outcomes are attainable through meticulous conduit construction and careful vascular preservation [15].

The comparative review from the University Hospital of Lausanne (2024), spanning 33 years with 124 children who underwent esophageal replacement for caustic burns, compared colonic (n = 101) and gastric tube transplants (n = 23) [16]. The results revealed a significantly higher intraoperative complication rate with colonic transplants (34%, $p < 0.001$), with no significant difference in short- and mid-term postoperative complications [16]. While the etiological context differs from congenital atresia, these data reinforce the gastric tube as a viable and potentially safer alternative to colonic interposition.

A single-center study from Shanxi Provincial Children's Hospital (2025), covering 7 LGEA patients (6 with type I EA), reported staged surgery with a 14.3% mortality rate, highlighting the importance of individualized treatment strategies [22]. The long-term follow-up studies by Gupta *et al.,*(2011) and the 30-year experience by Cohen *et al.,*in 34 pediatric patients confirmed that the reversed gastric tube provides satisfactory neo-esophageal function and adequate growth with manageable complications [21,23].

The choice of conduit route warrants consideration. The retrosternal route, selected in our case, avoids mediastinal dissection and provides more direct cervical access, which is particularly beneficial in the setting of a previously fashioned cervical esophagostomy [3,10]. The posterior mediastinal route follows the anatomical course of the native esophagus and provides a shorter path but requires more extensive dissection [3]. The choice depends on surgical experience and individual patient anatomy.

Postoperative gastrostomy maintenance is of paramount importance, serving the dual purpose of providing enteral nutrition during anastomotic healing and enabling gastric tube decompression, thereby reducing the risk of distension and anastomotic disruption [4,15]. Progressive gastrostomy weaning, concurrent with oral feeding resumption, is guided by a multidisciplinary team in which the speech-language pathologist plays a pivotal role in swallowing rehabilitation and oral aversion prevention [4,17].

The question of optimal timing for esophageal replacement in type I EA remains debated. Some centers advocate early intervention before 12 months of age to mitigate the consequences of prolonged oral feeding deprivation [13,14], while others favor a longer delay to allow adequate gastric growth [6]. In our patient,

replacement was performed at 4 years of age, which afforded the benefit of operating on a stomach with optimal dimensions (greater curvature of 217 mm). Penikis *et al.,*(2024) emphasized that gastric conduits are the preferred approach when native esophageal preservation is not possible, based on operative simplicity, low morbidity, and long-term durability [6].

Regarding long-term outcomes, the principal complications reported following gastric tube esophagoplasty include anastomotic stricture requiring iterative endoscopic dilatations, GERD potentially necessitating fundoplication, dysphagia, oral aversion, and growth disturbances [4,13,17]. Prolonged multidisciplinary follow-up is unanimously recommended [4,5,13,14].

This report has limitations inherent to single-case studies, including the inability to draw generalizable conclusions. Nonetheless, it adds to the growing body of evidence supporting the Gavriliu technique in the specific context of type I EA with long gap and illustrates the importance of meticulous preoperative planning, nutritional optimization, and multidisciplinary collaboration.

Conclusion

The Gavriliu reversed gastric tube constitutes a reliable and reproducible technique for esophageal replacement in long-gap type I esophageal atresia. This approach, validated by over seven decades of international experience and corroborated by recent publications from referral centers worldwide, yields favorable perioperative and functional outcomes. The staged management strategy comprising neonatal esophagostomy and gastrostomy, sustained nutritional optimization, and delayed esophageal reconstruction remains the reference approach. The uneventful postoperative course in our patient, with early confirmation of anastomotic integrity and successful resumption of oral feeding, underscores the importance of meticulous surgical technique and multidisciplinary collaboration. Prolonged follow-up monitoring swallowing function, nutritional status, gastroesophageal reflux, respiratory complications, and somatic growth is indispensable. Future well-designed multicenter studies are warranted to better define optimal timing, compare substitution techniques, and evaluate long-term quality of life.

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