

# Foker technique for long-gap oesophageal atresia

HealthTech guidance  
Published: 25 January 2006

[www.nice.org.uk/guidance/htg98](https://www.nice.org.uk/guidance/htg98)

# Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account, and specifically any special arrangements relating to the introduction of new interventional procedures. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties. Providers should ensure that governance structures are in place to review, authorise and monitor the introduction of new devices and procedures.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations wherever possible](#).

# Contents

1 Recommendations .....	4
2 The procedure .....	5
2.1 Indications .....	5
2.2 Outline of the procedure .....	5
2.3 Efficacy .....	6
2.4 Safety .....	6
2.5 Other comments .....	7
3 Further information .....	8
Sources of evidence .....	8
Information for patients .....	8
4 Update information .....	9

This guidance replaces IPG153.

# 1 Recommendations

- 1.1 Current evidence on the safety and efficacy of the Foker technique for long-gap oesophageal atresia is limited but appears adequate to support the use of the procedure in the context of this rare and serious condition, provided that normal arrangements are in place for consent, audit and clinical governance.
- 1.2 Clinicians wishing to undertake the Foker technique should ensure that parents understand the implications of the condition and know that secondary interventions may be necessary. In addition, use of the information for the public is recommended.
- 1.3 This procedure should be undertaken only in specialist paediatric surgical units by surgeons specifically trained in this technique.
- 1.4 Clinicians should audit and review their results. Publication of further information about the Foker technique and its outcomes may be useful.

## 2 The procedure

### 2.1 Indications

2.1.1 Oesophageal atresia is a congenital condition in which there is a break in the continuity of the oesophagus between the mouth and stomach. In some patients, both the proximal and the distal ends of the oesophagus end in blind pouches; more commonly, one or both ends of the oesophagus are attached to the trachea, forming tracheo-oesophageal fistulae. Saliva and milk enter the lungs after pooling in the upper oesophagus or passing through a tracheo-oesophageal fistula, resulting in episodes of choking, coughing and cyanosis. If untreated, oesophageal atresia leads to death from aspiration pneumonia or malnutrition.

2.1.2 The vast majority of patients are treated by surgical division of the fistula and primary anastomosis of the oesophagus, to allow normal swallowing.

2.1.3 The definition of long-gap atresia varies, but generally it means the gap is greater than 3 cm to 3.5 cm. With long-gap atresia, any direct anastomosis is placed under significant tension. Therefore, any fistula is divided, and a gastrostomy is sited to enable enteral feeding. Repair is delayed for up to 3 months to allow the upper and lower pouches to elongate and hypertrophy, with the intention that anastomosis will then be possible. If it is not possible, alternative surgical approaches include pulling the stomach partially up into the thorax, or using a length of colon to join the oesophageal ends.

### 2.2 Outline of the procedure

2.2.1 Using a transthoracic extrapleural approach, the fistula or fistulae are divided and oversewn. The oesophageal pouches are exposed and traction sutures are placed in the ends, brought out through the skin and fixed with silastic buttons. Traction is applied to the sutures, which stimulates elongation of the oesophagus by 1 mm to 2 mm per day. Once the ends of the oesophagus have come together, or are in close proximity, a primary anastomosis is performed. After the repair, the

patient may be kept sedated and ventilated for a number of days to allow the anastomosis to heal. Oesophageal balloon dilatation may be performed if required.

## 2.3 Efficacy

2.3.1 Reported clinical outcomes varied considerably between studies, and were often qualitative only. One case series reported 70 infants with oesophageal atresia treated by primary repair: 10 of the patients had long-gap atresia and four of these were treated with the Foker technique. All four patients were eating excellently or satisfactorily at a mean follow-up of 8.8 years. After treatment, all 10 of the infants with long-gap atresia had gastro-oesophageal reflux requiring fundoplication. A second case series described 23 cases in which the babies were treated with external traction (atresia length ranged from 3.7 cm to 10 cm). A primary anastomosis was achieved in all cases.

2.3.2 Another case series reported that 67% (2 of 3) of patients achieved full oral feeding at up to 4 months after treatment with the Foker technique. Another found that 50% (1 of 2) of patients were eating solids normally at 1 year, and 50% (1 of 2) still required a gastric tube for feeding. The rate of successful anastomosis varied between studies from 100% (4 of 4 and 2 of 2) to 33% (1 of 3). For more details, see the [overview](#).

## 2.4 Safety

2.4.1 Disruption of sutures during the traction stage of the procedure occurred in 25% of patients (3 of 12) with long-gap atresia across all the studies identified, usually requiring the anastomosis to be performed under greater tension than intended. No deaths were reported that were directly related to repair of the oesophageal atresia.

2.4.2 The specialist advisors noted adverse events including stricture formation and gastro-oesophageal reflux. They also noted other possible adverse events including anastomotic leak, suture disruption during the period of traction,

fistulae, gastric emptying problems and difficulties in swallowing.

## 2.5 Other comments

2.5.1 Long-gap oesophageal atresia is often associated with multiple abnormalities, and mortality after the Foker technique is often related to these conditions rather than to the operation.

## 3 Further information

### Sources of evidence

The evidence considered by the committee is in the [overview](#).

### Information for patients

NICE has produced [information on this procedure for patients and carers](#). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

## 4 Update information

### Minor changes since publication

**January 2026:** Interventional procedures guidance 153 has been migrated to HealthTech guidance 98. The recommendations and accompanying content remain unchanged.

ISBN: 978-1-4731-9108-2

## Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.