

Overview

PETER B. COTTON

Flexible endoscopy is now a major diagnostic and therapeutic tool in the management of patients with digestive disorders. It was not always so. The discovery of X-rays just over 100 years ago led quickly to the development of the ‘barium meal’. This, and the barium enema, rapidly became the workhorses for the diagnosis of luminal disease. Proctoscopy gave visual access to the anus and rectum, and rigid esophagoscopes were used by a few intrepid surgeons, at some risk. The preoccupation of the Japanese with gastric cancer (and their well-known engineering talents) led to the development of gastro-cameras in the 1950s and 1960s, which were used (along with barium radiology) in massive screening programs. ‘Semi-flexible’ gastroscopes were developed in the mid-part of the century, but did not achieve widespread use, because they were cumbersome and the views were incomplete.

The key modern landmark was the harnessing of fiberoptics in the 1960s. Pioneering work in Britain and USA allowed the development of truly flexible endoscopes, which greatly facilitated esophagoscopy and gastroscopy, and allowed further exploration of the small intestine and the whole colon. Video-endoscopy added an important new dimension, since the images could be widely shared. The ability to take target biopsies added scientific respectability to procedures which were initially ignored, even ridiculed, by the academic establishment. The development and dissemination of a large variety of therapeutic procedures catapulted endoscopy into the mainstream of gastroenterology (and surgery).

The endoscopy success story brought growing pains and increasing responsibilities. What started for many of us 30 or more years ago as an amusing sideline has now become a huge and complex business. We started with one endoscope in a side-room, sometimes with the assistance of a passing nurse, understanding little about the complexities of the tools we were testing, or the diseases we were exploring. We had a naïve belief that only good could come from our activities, with little concept of infection control, the complexities of safe sedation, or how to run an efficient unit.

Now it is universally accepted that high-quality endoscopy demands a sophisticated organization. Patients expect their procedures to be successful and comfortable, and with minimal risk. Fully trained and accredited endoscopists work with expert professional staff, using optimal equipment, in purpose-designed endoscopy units. We need to understand many things outside gastroenterology, such as electrosurgery, lasers, computers, image management, pathology, radiology, and ultrasound, as well as infection control and sedation. Endoscopy unit managers have to be skilled in leadership, business principles, efficiency, and quality improvement.

This book is intended to provide practical guidance for all those attempting to offer (and to teach) quality endoscopy services. This complements and builds on our popular basic book *Practical Gastrointestinal Endoscopy – the fundamentals*, now in its 6th edition. The material in this Advanced Endoscopy series will be updated regularly, and comments are always welcome. I am delighted that so many distinguished colleagues have kindly agreed to share their wisdom on these important topics, to help us in our goal of delivering optimal endoscopic care.