Guest Editorial

It gives me an immense pleasure to announce that this edition of Bombay Hospital Journal is going to be on Advance endoscopic techniques in gastroenterology. Over a period of decades, GI endoscopy has evolved from diagnostic technology to advance therapeutic endoscopic interventions. Now, in GI endoscopy injecting, mucosal excision, mucosal tunneling, muscle cutting, endoscopic suturing, and endoscopic ultrasound for diagnosis and therapeutic procedures have become very common.

Historically, introduction of the fiberoptic gastroscope by Basil Hirschowitz 50 years ago dramatically changed the practice of gastroenterology and that of many other medical disciplines. Although it was previously possible to visualise the inner organs with rigid endoscopes, the flexibility of the fiberoptic endoscope greatly improved manipulation and hence the extent of organ examination. Fiberoptic technology has been replaced by video endoscopy, and today there is a myriad of advanced imaging techniques available. Approximately a decade after the introduction of the fiberoptic gastroscope, endoscopists around the world began to use this instrument to perform therapeutics in the gastrointestinal (GI) tract, such as injecting bleeding ulcers or resecting colon polyps. Thus, GI endoscopy has rapidly progressed from a specialty focused on diagnosis to one dealing with intervention and therapeutics. However, there are three types of endoscopies being performed today. For example, diagnostic endoscopy refers to procedures such as oesophagogastroduodenoscopy for dyspepsia and screening colonoscopy; interventional endoscopy refers to those endoscopies that imply more manipulation or require more technical skills such as endoscopic cholangiography, pancreatography, endosonography-guided fine-needle aspiration or balloon-assisted enteroscopy, and therapeutic GI endoscopy implies the performance of an active treatment through an endoscope such as transmural drainage of pancreatic fluid collections, dilation of oesophageal strictures and polypectomy.

Currently, GI endoscopy department at Bombay Hospital is equipped with all advanced endoscopes and accessories. Recently, we have recruited Endoscopic Ultrasound machine which is very useful technology for various diagnostic and therapeutic indications. Endoscopic Ultrasound facility is not available even in many other big corporate hospitals.

It is impossible to cover all the advanced in GI endoscopy in a single edition. However, we have tried to include as many updates as possible. I would like to thank our DNB students for their contribution. I am really thankful to Dr Suryaprakash Bhandari for his contribution of article on spyglass.

Finally, I would like to thank Dr. O P Kapoor for giving me this opportunity to work as Guest Editor for this issue of Bombay Hospital Journal.

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